Keeping one step ahead: tandem, an assessment and intervention programme for parents of adolescents at risk of problem behaviour.

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KEEPING ONE STEP AHEAD: TANDEM, AN ASSESSMENT AND
INTERVENTION
PROGRAMME FOR PARENTS OF ADOLESCENTS AT RISK OF PROBLEM
BEHAVIOUR.

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CERTIFICATION

I, Gerard John Stoyles, declare that this thesis, submitted in fulfilment of the requirements for the award of Doctor of Philosophy, in the Department of Psychology, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

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April 1st, 2002
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Abstract

This research emerged from a recognised need arising from other research literature as well as clinical practice to identify and intervene with adolescent problem behaviour at its earliest stages. Working with parents as co-facilitators with the clinician was acknowledged as being the primary means of motivating and supporting adolescents to alter behavioural patterns that if left unattended would most likely lead to complications of a legal and self-harming nature. The importance of looking to parents as the main focus of intervention recognised both the major influence of parents in the life of the adolescent and the underlying prerequisite of a warm, supportive, and hence protective family environment to promote adaptive adolescent development. These essential aspects gave rise to the TANDEM programme, with “The Family Check-Up” (Dishion, Kavanagh & Kiesner, 1999) providing the developmental model. As the focus of this research, this programme aimed to ameliorate dysfunctional adolescent behaviour through clear identification of harmful risk-behaviour, the involvement of the parent in this assessment process, and the supportive development of appropriate skills and self-attributes within the parent as a means of reducing problem adolescent behaviour and an improved parent-adolescent relationship.

The principal theoretical orientation of this research was cognitive-behavioural. At the outset, an assessment instrument was developed to identify harmful adolescent risk-behaviour. This development also served to identify domains that reflected normal adolescent risk-behaviour. The development of the assessment instrument commenced with a preliminary investigation of adolescent behavioural patterns. Data for the preliminary investigation was obtained from a metropolitan sample of male and female adolescent high school students (n = 187) ranging in age from 12 to 17 years (M = 14.53 years, SD = 0.50 years). A factor analysis of this data suggested the ongoing
development of this assessment instrument. Findings from the preliminary investigation led to the initial instrument being restructured prior to its further administration. A parent version was also developed for this second research phase. The final shape of the assessment instrument included a revised format of the original questionnaire used in the preliminary investigation, together with the inclusion of additional questionnaires. These additional questionnaires investigated the adolescent’s use of alcohol, tobacco, and marijuana, and the adolescent’s self-perception of future harmful risk. A questionnaire investigating parental resilience was included in the parent version only. The final format of both versions of the instrument was entitled the *Adolescent Problem Behaviour Assessment (APBA)*.

The APBA was administered to a metropolitan high school sample of adolescents (n = 410), ranging in age from 12 years to 16 years 9 months (M = 14.32 years, SD = 1.31 years). Two hundred and one students were male and 209 students were female. Apart from 14 males, the APBA was also administered to the parents of these students. Four hundred and eighty five parents responded (60.9% of the total parent sample), including 282 mothers and 203 fathers. Apart from responses to alcohol, tobacco, and marijuana use, factor analyses were conducted in order to identify principal factors within each questionnaire of the APBA. Of particular note was the emergence of three factors that identified proneness towards problem behaviour in adolescence. These factors were entitled *Peer Modelling*, *Parent/Family Relationships*, and *Parental Monitoring/Limit Setting*, and resembled the three factors describing adolescent behaviour resulting from the factor analysis of data from the preliminary investigation. A discriminant function analysis (DFA) was also conducted with adolescent data to determine the capacity of the APBA to classify adolescents’
behaviour along a continuum of risk. Due to inconsistencies in parent data, the final parent version of the *APBA* was configured from the adolescent version.

The implementation of the TANDEM programme for this research followed the development of the *APBA*. The running of this programme followed a linear process of adolescent risk assessment, feedback and discussion of assessment results, and the offer of a place in the six-week parenting course as a means of intervention. Parents were centrally involved at every point of this process. The *APBA* provided the principal means of risk assessment. Three further questionnaires were included with the parent version of the *APBA* as measures of parenting skill, perceived self-efficacy, and aspects of the family environments of participating parents. Parents and willing adolescents completed the *APBA* during the intake phase of the TANDEM programme. Sixteen mothers (*M* = 42.20 years of age, *SD* = 5.74 years) and 6 fathers (*M* = 43.29 years of age, *SD* = 10.40 years), together with 19 adolescents, completed the *APBA* and the commencement of the programme. Adolescent age and gender was not taken into account due to the small sample size. Measures of parents’ depression, anxiety, and stress were also taken during the intake phase.

During the intake phase, parents were also invited to describe the current quality of the home environment and parent adolescent relationship, as well as their chosen strategies for dealing with adolescent problems. Statistically significant differences were found for all assessment domains between the normative and TANDEM adolescent and parent samples, resulting in the total sample of 22 parents being offered a place in the TANDEM-parenting course. All parents accepted this offer and completed the parenting course. The researcher, drawing upon relevant research literature, qualitative data from a small normative parent sample, and prior clinical experience, also developed a 147-page parent manual for use by parents throughout the course. Due to the researcher’s
familiarity with the manual contents, a presenter’s manual was not developed, with the manual itself being used by the researcher as a guide to presentation.

Measures of depression, anxiety, and stress, as well as measures of parent resilience, parenting skill, and self-perceived efficacy were taken once more at the conclusion of the parenting course, thus providing pre and post measures of intervention effectiveness. Apart from the latter three questionnaires contained in the APBA, the complete APBA was not administered again since notable positive shifts in adolescent problem behaviour were not anticipated over the relatively short six-week duration of the parenting course. Following the removal of one outlier, statistical analyses of remaining data indicated marginal improvements in resilience, and notable improvements in skill competency and self-efficacy. Parents’ comments at the conclusion of the course supported these findings. In particular, parents reported noteworthy progress in relationships with their adolescents and partners, and a personally enhanced sense of well-being. Two booster sessions were provided, scheduled at four-weekly intervals. However, due to parents’ requests, data was not obtained at these sessions. Alternative arrangements for gaining this data from future booster sessions have been considered. Strengths and weaknesses evident from this research in the TANDEM programme, together with directions for future research, have been discussed in the concluding chapter.

The TANDEM programme was found to be a simple, affordable, readily adaptable, and effective means of identifying and ameliorating adolescent problem behaviour. Placing an essentially central focus on the parent in this process enabled the parent to become a successful role model and beneficially therapeutic source for the troubled adolescent. Parents who have participated in this and other TANDEM programmes have described the experience as providing them with a valuable means of
supporting the difficulties of their adolescents. As a result, parents have been able to re-establish fundamentally protective family environments and more robust relationships with their adolescent son or daughter.
INTRODUCTION

This thesis has arisen out of my work as a clinical psychologist and researcher. During the past four years, a major portion of my clinical work has been involved with parents of adolescents who have been adversely affected by the gradual deterioration of the relationship between themselves and their son or daughter. In many instances, this relationship breakdown produced a debilitating effect on the parents concerned. Parents both related incidents describing the worsening situation between themselves and their adolescent child, and also expressed a personal sense of bereavement for what they believed could have been possible in this relationship.

Perhaps the most alarming part of speaking with these parents was the fact that by and large they had waited too long before seeking help. During the intervening time, parents had either hoped that relationship difficulties would repair themselves, or that their sons or daughters would simply “grow out of” the difficult phase they seemed to be going through. Often it was not until legal or professional community intervention occurred that parents realised their need for outside assistance. In these latter instances, the influence of a dysfunctional peer group had become so firmly entrenched with the troubled adolescent that the possibility of rebuilding the by-now fractured relationship was extremely difficult. This phenomenon, referred to as ‘flight to peer’ (Dishion & McMahon, 1998), was an alarmingly common factor entwined with parent-adolescent relationship problems. Hence a principal part of interaction with these particular parents was one of continually encouraging them not to give up hope in their desire to rebuild the relationship with their son or daughter.

From a clinical perspective, my work mainly occurred on a one-to-one basis with parents. The intervention aim was to ameliorate relationship difficulties between
parents and adolescents by primarily working with the parent rather than the adolescent. Within our clinical environment, two colleagues in psychology engaged the adolescents of my parent-clients. Combined meetings between parents and their adolescents would be planned if team meetings considered this to be beneficial to both parties. However, in the majority of cases clinical intervention took place with the parents alone because it was rare for the adolescent to choose to become involved in the intervention process.

Parents welcomed the opportunity to speak openly about their feelings towards their son or daughter, as well as the various individual situations that underpinned ill feeling between both parties. This was certainly a most important aspect of counselling in the beginning stages. However, during these times of discussion it became clear that parents felt unable to clearly define the nature of what they perceived as being a problem in the adolescents’ behaviour. The task of obtaining a clear picture of the adolescent’s behavioural patterns was mostly cumbersome and at best incomplete, since the parent had not previously been given the opportunity to consider the adolescent’s behaviour according to any organised method. Eventually, with the help of my psychology colleagues, I developed a series of questions to investigate with parents various domains of the adolescent’s behaviour. However, while it was possible to gain a more or less adequate behavioural profile of a referred adolescent through this semi-structured style of questioning, at the same time there was a lack of a normative profile against which to refer the adolescent’s behaviour. Thus there existed a clear need to develop a more robust and normative form of assessment of adolescent behaviour, and this need emerged as one of the principal aims of this research.

Two related benefits emerged from the eventual development of this instrument, entitled the Adolescent Problem Behaviour Assessment (APBA). Firstly, the normative data obtained during the development phase provided a comparative baseline of normal
adolescent behaviour. Secondly, by comparing the findings from the clinical administration of the APBA with normative data, it was possible to determine how far the referred adolescent’s behaviour had drifted from the normative baseline. The development of the APBA moved the semi-structured approach of generally interviewing parents about their adolescent’s behaviour to the more accurate point of clearly identifying those behavioural domains where problem behaviour appeared evident. The increased accuracy offered by the APBA also indicated the urgency and intensity required in intervention.

In telling their stories, parents would invariably describe adopted and practised strategies of parenting that were inappropriate for adolescence, even though these strategies might have achieved compliance when the adolescent was a child. Furthermore, parents often appeared to feel overwhelmed and cornered by their adolescent, which would then result in parents feeling the need to ‘fight and win’ with the adolescent. Where the parent won the battle, resentment from the adolescent’s perspective would occur, together with a ‘flight to peer’ response. Where the parent lost the battle, the parent appeared to either retaliate against the adolescent through alternative opportunities (such as withholding or refusing responses to the adolescent’s fair requests), withdrawing emotionally or even physically from the adolescent, or continuing to maintain pressure upon the adolescent until eventually the parent did win the battle. In these latter circumstances, these battles invariably became wars in their own right. Hence, it was apparent that the parents who came for help lacked fundamental skills that would both enhance the relationship with the adolescent son or daughter, as well as enhance their own feelings of efficacy in being the parent of the adolescent.
Initial intervention strategies with parents occurred on a one-to-one basis. However, over time certain common trends emerged in the content of these interventions. Most evident was the need to develop honest and clear strategies of communication with the adolescent. The majority of disagreements between adolescents and parents were handled more appropriately where the parent took time to listen to and speak openly with the adolescent. The ability to reach mutually acceptable solutions when problems and conflicts occurred was strongly linked to the skills of effective communication.

The skill of monitoring the adolescent’s activities, as well as placing age and developmentally appropriate limits on these activities, was a recurring weakness with parents, and was also linked to the need for effective communication. All too often parents were ignorant of the details of their adolescent’s movements and peer relationships, and were unclear as to how to obtain this information in a manner that would not erode parent-adolescent trust. Against this background, parents expressed fears about the type of peer-related company their adolescent was keeping, yet felt incapable of either monitoring or limiting the activities related to this company as well as learning about the personalities of their adolescent child’s friends. In many circumstances, particularly in cases where the referred adolescent was the parent’s first experience of adolescent development, parents were unclear as to whether a certain form of behaviour was reflective of normal adolescent development or not. Finally, there was an unmistakable need for parents to develop self-care strategies, as well as adopt more constructive patterns of thinking and private speech in relation to the way they handled adolescent difficulties, and in relation to the opinions they had built up about their skills as parents.
Because assessment and intervention was conducted on a one-to-one basis in these early phases of working with parents, discussion about the most appropriate form of intervention always took place between the parent and myself prior to implementing an intervention plan. This discussion was based on the outcomes of the formal behavioural assessment, which in turn helped to motivate the parent to act where a fragmenting relationship was identified between the son or daughter and the parent. It was also evident that parents appreciated being involved in the process in this manner. It was as if they were seeking a second chance, and through this opportunity actually be the people who brought the benefits of this second chance into reality. At the same time, the parents I worked with were nervous about taking a new path with their adolescent, and yet were willing and eager to do so with professional support. Yet the combination of both desire to be the parent-therapist and feeling nervous in doing so showed a courage and insight that appeared to emerge from the very nature of being a parent.

What could be described as a simple mark of respect for the parent’s right to exercise the parental role with his or her children became a poignant factor in maintaining the motivation and interest of the parent during the course of intervention. Against the background of this respect, parents’ successes with their adolescents adopted a special meaning. Parents appeared to enjoy the fact that they had achieved these indications of success rather than feel as if they were simply an extension of my professional intervention in their family lives. Research has also strongly emphasised the need for this respect when working with parents in situations such as these (Dishion, Kavanagh & Kiesner, 1999; Smith & Stern, 1997; Stern & Smith, 1999). Stern and Smith (1999) have noted the gradual shift among professionals who work with parents of bringing the parent more into the helping role, and away from the more peripheral role of ‘treatment compliancy’. This observation could be translated into seeing the
parent as becoming his or her therapist in the process of helping the troubled adolescent. Therefore my experience with parents supported the need to follow the approach of Stern and Smith (1999).

From the standpoint of placing primary focus of assessment and intervention upon the parent, a number of aims converged as focal research objectives. Firstly, identifying the behavioural characteristics of a normal sample of adolescents and parents, as well as obtaining the perspectives of parents in regard to this behaviour, underpinned the development of the APBA. This assessment instrument ultimately comprised a number of questionnaires, with each questionnaire designed to unveil various domains of adolescent behaviour and attitudes to that behaviour. Secondly, the various content areas of skill formation that had been used with individual parents over time needed to be compiled in a structured fashion. This eventually led to the development of a parenting manual that presented in an ordered and simple manner the primary skills required for the appropriate parenting of an adolescent. The content of this manual arose from both my own clinical experience and the findings of related research. Both the APBA and the parenting manual therefore became the pivotal point of a programmed approach to helping parents of troubled adolescents.

The programme commenced with the assessment of adolescent behaviour, continued with a feedback and discussion of assessment results with the parent, and concluded with motivating the parent to consider the benefits of participating in a six-week parenting course component. The complete programme was entitled TANDEM. The title TANDEM was an acronym that emphasised the need to seize the opportunity of describing and effectively addressing adolescent problem behaviour through the help and support of another qualified person, namely:
- Take the opportunity; take time to sort things out
- Assess the situation – how are things really going?
- Network with people who can help
- Discuss possibilities
- Ease yourself into new ways of thinking and acting
- Make a difference!

The developmental model for the TANDEM programme was that of “The Family Check-Up” (Dishion, Kavanagh & Kiesner, 1999). This model outlined the process of working with parents through the TANDEM programme.

This thesis will therefore describe the evolution of the TANDEM programme, beginning with the development of the APBA and progressing to the use of this instrument during the initial implementation of the TANDEM programme in a group setting. The results of this research were pleasing, and fulfilled the needs and aims that prompted its development. Further to this was the granting on November 6th, 2001 of a Commonwealth Government of Australia funding grant of $A78,892.00. This was made available for the development of the TANDEM programme for regional areas that lacked access to this type of parenting assistance. The grant also supported the development of a video format of the programme for use by other co-ordinators. This development has already commenced as part of the ongoing development and research for the TANDEM programme. Further research linked to, but also beyond the parameters of this funding will also be undertaken as time progresses, such as developing the TANDEM programme for situations of high-risk adolescent behaviour. Furthermore, the TANDEM programme has recently been adopted by other professional helping agencies. These agencies have found the programme to be of valuable benefit in their work with parents.
In this thesis, the reader will note the use of the word “parent” to describe the parenting role, rather than a more generalised term to describe the breadth of portrayal that the title “parent” can subsume these days. The alternative of “caregiver” was considered, yet this term was ultimately rejected as being unsuitable. The title of “parent” suggests a warmth and bond of relationship with one’s son or daughter that a title such as “care-giver” cannot signify. A parent can care for a child, yet a caregiver does not need to be the child’s parent, nor possess the same level of warmth and bond that the child’s actual parent might possess. In the TANDEM parent manual, the use of the title “parent” is explained in the introduction pages as being an umbrella term for the variety of ways in which this role might be exercised.

A brief summary of the chapters of this thesis will now follow. These summaries will include the principal areas of research described in each chapter.

**Chapter one** investigates the various markers of adolescent development, with attention paid to issues related to the emergence of these markers, such as age-appropriateness, gender differences, cognitive development, the increasing influence of the peer group, and the process of individuation. Reference is made to the investigations of Piaget and Elkind into the impact of these issues on adolescent development, particularly in relation to cognitive development and adolescent individuation. Chapter one also considers the importance and contribution of the parental role during adolescence. Aspects discussed in this first chapter are repeatedly viewed against the background of adolescent risk-taking behaviour.

**Chapter two** focuses on the notion of adolescent risk-taking. The meaning and influence of risk and protective factors, together with the protective influence of resilience, is discussed in the context of adolescent risk behaviour. Domains of adolescent risk-taking that are specific to this research are concisely treated. The place
of the parent’s role as a protective factor in adolescent risk-taking is treated according to the type of parenting style appropriate for adaptive adolescent development. Finally, as a concluding comment for the initial two chapters, the issue of cultural sensitivity is addressed as an essential requirement of respect towards both the parent and the adolescent. While time limitations prevented a detailed treatment of cultural sensitivity within this research, it was nonetheless possible to ensure that this aspect was sensitively addressed during the assessment and intervention phases.

**Chapter three** presents the theoretical underpinnings of this research. The principal theoretical application was provided by problem behaviour theory (Jessor R. & Jessor, S.L., 1977). The description of the conceptual framework of problem behaviour theory takes into account the concepts of proneness in adolescent problem behaviour that in turn is applied to the notion of psychosocial proneness, together with a description of the impact of proximal and distal variables in problem behaviour proneness. Research methodologies that have adopted problem behaviour theory as their point of departure are considered under the designation of the biopsychosocial approach to adolescent development. The parent-adolescent relationship and the concept of protectiveness are also viewed against the background of the biopsychosocial approach. Finally, the clinical application of problem behaviour theory is discussed.

**Chapter four** is a brief chapter that introduces the research and clinical purpose of the TANDEM programme. Chapter four begins with an outline of the place and role of the parent in adolescent development, insofar as this relates to the assessment and intervention domains of the TANDEM programme. This segment describes the primacy of the parental role in both the adolescent’s and the siblings’ lives, the personal needs of the parent, and the unique feature of enabling the parent to become the principal therapeutic source throughout the TANDEM programme. Chapter four then moves into
the actual development of the TANDEM programme, describing its basis in relevant research findings, and its goals of simplicity, adaptability, and affordability. The foundation of “The Family Check-Up” (Dishion et. al., 1999) is also presented as the developmental model of the TANDEM programme.

Chapter five traces the development of the Adolescent Problem Behaviour Assessment (APBA), beginning with a preliminary investigation that led to the formulation of the APBA. The eventual structure of the APBA comprised a number of questionnaires, with each questionnaire investigating a particular domain of adolescent behaviour. These domains included peer relations, family relationships, parent monitoring and limit setting, as well as the consumption of alcohol, tobacco, and marijuana use and the adolescent’s self-perception of future risk base on current behaviour. A parent version was structured from adolescent data, which further included an investigation into parent resilience. The parent and adolescent versions of the APBA were administered to a normative sample of high school adolescents and their parents. Of important note is the rationale that lay beneath the structuring of the parent version, since it was not possible to achieve this version on the basis of parent data alone. Discriminant function analyses and analyses of correlation conducted with adolescent data are also outlined and discussed.

Chapter six presents the normative data obtained from the administration of the Adolescent Problem Behaviour Assessment (APBA). This chapter commences with a description of the usefulness of this data as an assessment baseline in the clinical setting. The frequencies and amounts of alcohol, tobacco, and marijuana consumption by the normative adolescent sample are outlined in the first part of the chapter. Comparisons are drawn between adolescent and parent perceptions of the consumption of these substances, and comment is made on the level of concordance between parent
and adolescent responses. The second part of the chapter is given over to a presentation of normative data for the remaining domains of adolescent risk-taking, as well as the usefulness of this data for the assessment of self-harming risk behaviour. Once again, this presentation includes both adolescent and parent perceptions. Multivariate and univariate analyses of the response differences between adolescents and parents about adolescent risk-behaviour are presented and discussed at the end of this chapter.

Chapter seven illustrates the implementation of the TANDEM programme for this research, incorporating the Adolescent Problem Behaviour Assessment (APBA) as the principal means of risk assessment in adolescent behaviour. This chapter is divided into two segments. The first segment describes the intake procedure for parents who sought help through the TANDEM programme, using both a formal assessment structure through the APBA and personal one-to-one interviews. Two further questionnaires investigating parenting skills and parental self-efficacy were included in the APBA for its use in the TANDEM programme. In the second segment of the chapter, the progression of the TANDEM programme commencing with assessment and discussion of assessment results is presented in detail, including the development of the parent manual. As part of this segment, pre and post measures of the effectiveness of the parenting course component, and the benefit of this course for the parent-adolescent relationship are also presented.

Chapter eight draws the thesis to a conclusion, discussing the usefulness and limitations of both the Adolescent Problem Behaviour Assessment (APBA), and the overall value of the TANDEM programme as a linear progression of assessment, discussion, intervention, and follow-up booster sessions. The central role of the parent in this progression is addressed in particular. The directions of future research are presented as concluding accounts within this chapter. Further development of the APBA
and the TANDEM-parenting course, current applications of the TANDEM programme by other professional helping agencies, and the influence of the Australian Government funding grant on the specific direction of the ongoing development of the TANDEM programme are the principal aspects covered in this outline of future research.

The TANDEM intervention package. A separate document called the TANDEM intervention package has been included with this thesis. This package includes all the information relating to the implementation of the TANDEM programme for this research. This information comprises the assessment instruments administered to parents and their adolescents who were associated with the programme, as well as the normative data for the scoring of these instruments. All advertising material that was used for the TANDEM programme, and the TANDEM parent manual, has also been included in this package. In other words, a clinician who wished to conduct the TANDEM programme in his or her own work setting would find all the necessary information and data to implement the programme.
CHAPTER ONE

THE DYNAMIC OF RISK-TAKING IN ADOLESCENT DEVELOPMENT

As a general experience of human behaviour, risk can be understood according to three perspectives - as action, as a potentiality that is unclear in its outcome, and as a pathway towards achieving some desired goal, even if this pathway entails possible harm. As part of adolescent development, risk adopts a special significance. In one sense, adolescent risk does not differ characteristically from general human behaviour. However, at the same time the adolescent is most likely to lack experience and a subsequent ability to either identify that an activity does in fact contain risk, or to remain in control of the identified risk. The markers of adolescent development underlie the extent of this capacity (Coleman & Hendry, 1990). While these markers identify that the child is moving into adolescence, at the same time they indicate the need to learn new strategies for coping effectively with life’s encounters. The potential to become involved in risk behaviour that has the propensity of escalating into self-harming behaviour becomes a reality for the adolescent. This chapter will therefore investigate the dynamics of adolescent risk-taking against the background of the timing of adolescence, as well as the age appropriateness of adolescent behaviour, the influence of gender, cognitive development, and individuation, and the importance of the peer group as a means of establishing self-identity.

1.1 The timing of adolescence

Adolescence spans an approximate ten-year period, marked by the onset of pubertal maturation. Pubertal maturation can occur as young as 8 years in girls and 9.5 years in boys, and as late as 13 years in girls and 13.5 years in boys. In terms of years, adolescent development is not made up of one homogenous transition, but rather
comprises a number of phases bracketed by ranges of age. For boys and girls generally, early adolescence extends from approximately 11 years of age to 14 years of age. Middle adolescence begins at around 15 years of age and continues until 18 years of age, after which late adolescence leads into early adulthood, at approximately 21 to 23 years of age (Steinberg, 1996).

The timing of pubertal maturation is an important consideration in risk-taking behaviour and has been found to represent an important variable in understanding the role of individual differences in the adolescent’s social behaviours. An adolescent’s outward physical appearance might not denote a corresponding level of psychological and emotional maturity. This form of asynchronous development can lead to the adolescent either looking older or younger than his or her years. In particular, where the adolescent appears physically older than he or she actually is, the potential for involvement in self-harming risk activity heightens as a result, since older adolescents or adults treat these adolescents as if they were the age they appear to be physically (Silbereisen & Kracke, 1993).

This disparity between chronological and developmental age can lead to social incompetence in adolescence simply because the adolescent is not sufficiently emotionally and mentally mature to act in a manner suggested by a more mature outward physical appearance. Where adolescents experience social incompetence and lack of confidence because of this disparity, they are more likely to find interactions with parents, peers, teachers, and other significant individuals frustrating and unrewarding. In particular, finding a satisfactory place within an age-appropriate peer group will become difficult for the adolescent. Furthermore, topics of conversation, social relationships, personal confidence and the like will leave this type of adolescent floundering socially. Consequently, where the adolescent becomes involved in risk-
related activities or situations that are beyond his or her level of competence or confidence, such as under age drinking, then the possibility of self-harm increases (Oyserman & Saltz, 1993).

Girls who reach puberty early and so begin to develop physically at an earlier age have been found to experience a low level of self-image, because for girls puberty equals a perception of increased fatness. They also appear to experience higher levels of emotional and psychosomatic problems, and exhibit higher levels of non-normative behaviour since early maturation encourages females to mix more freely with older peers, and so readily engage in behaviour that is more age-appropriate for an older female group (such as dating behaviour). When early maturing females associate with older working males, they have been found to be more sexually active, use greater amounts of alcohol, and adapt more easily to anti-social behavioural patterns. On the other hand, late maturing girls appear to experience greater satisfaction with weight, height, and self-esteem, as well as perform more confidently and successfully in the academic arena (Silbereisen & Kracke, 1993). Early maturing boys experience an increase in muscularity with a consequent increase in overall positive self-image, particularly in respect to body image. They also appear to be more self-confident and to experience greater popularity with males of their own age. Yet again, boys who mature later than their peers experience a reduction in self-image since a lag in maturation also means a lag in the development of physical stature. They also experience greater academic difficulties (Silbereisen & Kracke, 1993; Simone, Lenssen, Doreleijers, van Dijk & Hartman, 2000).

Individual ages for the onset of puberty and the consequent rate of development will therefore affect how the adolescent ‘fits in’ with adult and peer-related social groups and activities, as well as the robustness of the adolescent’s self-perception while
mixing in these contexts. The adolescent who finds this to be a relatively comfortable and satisfying experience will also find it to be an adaptively formative experience. Alternatively, if this experience is continually jarring, then the adolescent will be left socially on the outer rim, with an equal sense of personal inadequacy and sadness. Such an adolescent is then at risk of engaging in problem behaviour (Lerner, 1985; Oyserman & Saltz, 1993).

1.2 Age-appropriateness and adolescent risk-behaviour

The social arena is the principal context of adolescent development. It is the natural laboratory wherein the adolescent challenges, experiments with, and learns from interactions with both familiar and unfamiliar people and events (Lerner, 1985). By influencing these contexts, the adolescent is able to influence his or her development. Where adolescent activity reflects the expectations of each progressive age-frame, then it might be described as age-appropriate and therefore protective. However, where the opposite occurs, then the adolescent will be likely to find him or herself in situations of risk due to a lack of maturity and experience to adequately and safely cope. Age and risk management are therefore intricately interwoven variables, and as such are an essential consideration in determining whether adolescent behaviour is normative or problematic. For example, intimate sexual activity or drinking behaviour by an 18 year-old adolescent would be considered normative. Such behaviour by a 12 year-old would be considered problematic.

Autonomy, self-mastery and increasing intimacy are adolescent attributes developed in concordance with the increasing willingness to personally expose oneself before another person, or confront new and challenging situations, and so forth. However, these opportunities are beneficial only when they occur within the protective context of experience gained over a number of years. Hence risk behaviour can express
a positive role in adaptive adolescent development only insofar as it is age appropriate and is endorsed by the presence of beneficial experience and a protective environment, thus indicating that adolescent is capable of handling new challenges in a generally competent manner (Baumrind, 1991; Igra & Irwin, 1996; Silbereisen, 1998; Swaim, 1991). The failure to take time-appropriate healthy risks has also been seen as a risk factor in itself (Baumrind, 1991).

1.3 Gender differences and adolescent risk-behaviour

Gender differences play a significant role in adolescent risk and problem behaviour, although in defining the importance of these differences, Bell-Dolan, Foster & Christopher (1995) have observed the criticism levelled at the tendency of psychological research to predominantly use male participants and to generalise findings based solely on male participants to individuals in general. The role of gender differences has been noted in the arenas of self-esteem (Chubb, Fertman & Ross, 1997), depression and other negative affect conditions such as stress and anxiety (Compas, Connor & Hinden, 1998; Pike, McGuire, Hetherington, Reiss & Plomin, 1996), economic stresses (Conger, R.D., Conger, K.J., Elder, Lorenz, Simons & Whitbeck, 1992, 1993; Lempers & Clark-Lempers, 1997), urban poverty and family disintegration (Sampson & Laub, 1994), loneliness (Mijuskovic, 1986), and adjustment following divorce (Slater & Haber, 1984).

The above negative experiences disrupt and fragment the stability of an adolescent’s personal and family life by promoting behaviour that has the potential of becoming and obstacle to healthy adolescent development. The manner of coping with these experiences will vary between males and females according to the type of response made by each gender and the amount of harm involved in the adolescent’s response. In situations where adolescents engage in domains of harmful risk-taking
behaviour such as those described in the previous paragraph, females more than males, females more than males are prone to negative affect conditions such as depression, body image problems and eating disorders (Khoury, 1998). Alternatively, males tend to exhibit more externalising criminal behaviour and drug misuse, although drug misuse is not reserved for males alone. Suicide is a response to negative life events made by both males and females, with males being more successful in their attempts, due possibly to an inclination to use more lethal means (Khoury, 1998). Moffitt, Caspi, Rutter and Silva (2001) have noted that anti-social behaviour is more consistently prevalent in males than in females. They have also noted that within the first two decades of life, males who engage in extreme problem behaviour exhibit a higher frequency and broader range of criminally offensive behaviour than females, with a greater level of seriousness and violence displayed within this criminal behaviour. This observation does not suggest that females do not engage in anti-social or criminal behaviour. Rather, Moffitt et al. (2001) point out that even the most actively offending females offend at a much lower rate than the majority of active males, although at around 15 years of age, females are most likely to resemble males in their anti-social behaviour.

Depression is also a problem for both male and female adolescents, and is of itself a serious element of adolescent risk (Leas & Mellor, 2000; Petersen, Sarigiani & Kennedy, 1991). After 11 years of age, the occurrence of depressive syndromes is higher for females than males, and remains high following this age although during pre-adolescence no gender differences have been found for depressive symptoms (Khoury, 1998; Zahn-Waxler, 1993). A literature review conducted by Moffitt et al. (2001) found that anti-social behaviour was linked with depression among females, with conduct disorder among females being channelled into internalising problems such as depression. Moffitt et al. (2001) further found that depressive disorders in anti-social
females increased in severity as they entered adulthood. Males and females also display differing patterns of depressive behaviour. The tendency for males to display more characteristically external and aggressive behaviour rather than the more internal and affective characteristics of female depressive behaviour greatly accounts for these differing patterns. (Flannery, Vazsonyi, Torquati & Fridrich, 1994; Khoury, 1998; Loeber & Hay, 1997; Simone et al., 2000). Furthermore, Leas and Mellor (2000) have noted both a positive relationship between delinquency and depression, and the possible tendency of adolescents to mask their depressed mood state by negative acting-out behaviour, thus avoiding the debilitating feelings associated with depression.

Gender differences have also been noted in adolescent involvement in alcohol and drugs. The issue of gender and adolescent substance use will be discussed in section 2.6.1.3 of chapter two.

1.4 Cognitive development in adolescence

For both males and females, the onset of adolescence heralds a significant change in cognitive flexibility. This step in cognitive development is linked with age, and because the onset of adolescence differs for males and females, indications that this cognitive change has begun will become evident at a later age for males than for females (Steinberg, 1996). The most remarkable change for both genders is seen in the movement from a concrete to a more abstract expression of thought. As time passes, adolescent thinking becomes increasingly fluid and hypothetical in the capacity to reason logically. This transition in thinking facilitates a further transition in the adolescent’s self-perception within his or her social world. Adolescents now see themselves more clearly as one person among many people. As such, the adolescent’s world-view widens. The adolescent is motivated to enter new experiences of relationship, to become more flexible in these relationships, and to respect another’s
right to form opinions about the world and those within it (Heaven, 1990; 1994; Steinberg, 1996).

The opinions and comments of others take on new meaning and importance. The adolescent becomes conscious of the need to be accepted by others, especially by peers, and to feel recognised, respected, wanted and needed, understood, and treated as an independent and responsible person. In return, the adolescent is challenged to respect the rights of the other person to have the same needs fulfilled. This challenge might mean that previously stable relationships become strained, particularly with those who care for the adolescent’s welfare, such as teachers, authority figures, and in particular, parents. As a consequence, reasonable expectations can be perceived as unfair demands, constraints can become interferences with yearnings for autonomy, and caution about the future can be blurred with the appealing possibilities of the present (Heaven, 1994).

1.4.1 **Piaget and cognitive development**

Piaget (1955, 1972) saw the emergence of formal thought as the principal transitional marker of adolescent development. Piaget understood the ability to think in abstract and hypothetical terms about people and situations as taking the child beyond the strictures of the immediate moment onto the pathway towards adulthood. By comparison, the concrete operational thinking patterns of middle childhood did not fully allow the child to realize his or her self-definition over and against societal relationships. Furthermore, the pre-adolescent child’s thinking and reasoning was understood as being fundamentally contained by the concrete and immediate ‘here and now’ nature of what the child saw and heard (Inhelder & Piaget, 1958). The pre-adolescent child could be described as socially and personally a child of the moment (Piaget, 1955).
Inhelder and Piaget (1958) emphasised that the onset of formal thought often left the adolescent in an arena of contextual imbalance. That is, in breaking away from the confines of a concrete interpretation of the world, the young adolescent emerged upon a trail of cognitive maturity, yet the immaturity of this capacity at its onset threatened to leave the adolescent in a state of vulnerability. As a result, there was a potential for the adolescent to over-value his or her competence to act safely in an adult world, thus running the risk of attributing inflated optimism to one’s reasoning ability and the subsequent actions arising from that ability. The gradual maturation of cognitive processes was also understood to converge with the role of the peer group in adolescent development. The peer group was viewed as providing the means whereby one could test personal ideologies against those of others. Yet the peer group was also seen as bringing about a consciousness of self that caused the adolescent to hesitate from acting or speaking from one’s own belief structures for fear of failure or ridicule (Inhelder & Piaget, 1958).

Piaget’s theories have implications in understanding risk behaviour in adolescence. The adolescent’s perception of potentially risky behaviour, together with the desired outcomes of that behaviour, involves abstract thinking since the behaviour has not yet occurred, and the outcome has not yet been experienced (Igra & Irwin, 1996). Therefore this embryonic behaviour resides initially in the adolescent’s mind, together with the adolescent’s belief about the possible presence of harmful risk and the adolescent’s self-perceived ability to cope with that risk. The adolescent’s previous experience of similar situations, and the support that he or she has had in successfully dealing with these situations, will determine the size of the gap between what the adolescent thinks (or hopes) will happen in terms of risk, and what actually will happen (Lightfoot, 1997). The predicted payoff also envisaged by the adolescent such as
acceptance by the peer group, enhancement of one’s reputation, declaration of one’s autonomy, and so on, will also affect the adolescent’s cognitive justification for taking a particular risk (Fischhoff, 1992). Remaining safe in potentially risky situations is therefore a combination of experience and cognitive maturity that can be gained only through the passing of the years and the presence and direction of a protective environment (Irwin, 1993).

The relationship between experience and cognitive ability is linked with the adolescent’s capacity to think abstractly. Linked with the adolescent’s ability to think abstractly is the adolescent’s desire to gain personal autonomy. The adolescent’s mental self-concept is underpinned by the need to cast off any bonds that tie the adolescent to childhood dependency. If the adolescent is to form a mental image of self as being someone who is independent, resourceful, acceptable, ‘adult’, capable, and so forth, then the parallel image of the child who is dependent, halting, or insecure becomes an obstruction. In conceptualising how this autonomous lifestyle might be achieved, the adolescent can fall into the trap of over-evaluating his or her actual ability to do so (Igra & Irwin, 1996). This over-evaluation of ability is potentially a risk factor for self-harming behaviour.

1.4.2 Elkind and youthful egocentrism

David Elkind (1967, Elkind & Bowen, 1979) developed a theoretical basis for understanding the concept of ‘adolescent egocentrism’ (or what is now referred to as ‘adolescent invulnerability’), whereby the adolescent expresses an optimistic bias in certain behaviours that place him or her at personal risk (see also Igra & Irwin, 1996; Quadrel, Fischhoff & Davis, 1993). According to Elkind’s understanding, the adolescent not only develops a self-concept formulated from the various postulations and conclusions of one’s own thinking, but also believes that he or she can accurately
conclude that the same self-concept is also present in another person’s thinking. For example, the adolescent develops the self-image of being a fearless and competent football star, and also concludes that his or her friend has formed the same image. The problem with this tendency of thought is that the adolescent believes in the personal ability to accurately interpret what is in the other person’s thinking, and act as if that information were factual. The adolescent’s own patterns of thought have thus become the conceptual baseline for accurately identifying the thoughts of another person. This can lead the adolescent into potentially harmful risk, as when the adolescent feels the need to live up to a potentially dangerous self-image (such as being tough enough to experiment with any drug available) in order to maintain that image in another person’s thinking.

Within the context of youthful egocentrism, Elkind (1967) proposed two phenomena relevant to adolescent risk behaviour, namely the imaginary audience and the personal fable. Elkind based each phenomenon on the adolescent’s presumption that his or her self-image provided the template for the other person’s perception of that adolescent.

1.4.2.1 The imaginary audience. Elkind’s (1967) concept of the imaginary audience underpinned the adolescent’s belief that others are as preoccupied with the adolescent’s appearance and behaviour as is the adolescent. The imaginary audience is therefore a fabrication of the adolescent’s thinking that places the adolescent at the central focus of its attention. In actual or impending social situations, the adolescent anticipates other peoples’ interpretations of his or her actions, and will react according to that interpretation. Elkind (1967) believed that the adolescent’s unique need for privacy, as well as reluctance to come under the public gaze, emanated from the feeling of being under the constant scrutiny of this imaginary audience.
1.4.2.2 The personal fable. Corresponding to this notion of the imaginary audience was Elkind’s (1967) concept of the personal fable. Elkind described this concept as representing the adolescent’s rendition of the sort of person he or she dreamed of being, or believed to exist. The central hub of this representation lay in the adolescent’s readiness to over-evaluate one’s ability to cope well with potentially harmful and even life-threatening situations. According to the personal fable, the adolescent will adopt the attitude that he or she is fundamentally bullet proof – ‘bad things will happen to the other person and never to me, and even if they do I can handle it’.

1.4.2.3 The significance of Elkind’s theories. Elkind’s (1967) theories still have strong appeal in the attempt to understand why adolescents readily place themselves and others at risk with little or no concern for the possibility of harmful outcome. It must also be pointed out that they are theories lacking in a firm foundation of systematic evidence (Dolcini et al., 1989 – quoted in Quadrel at al., 1993; Lapsley, Harwell, Olson, Flannery & Quintana, 1984; Quadrel et al., 1993), although at the same time Elkind’s theories appear to align neatly alongside the wider concept of adolescent risk-taking. One might suggest that Elkind’s theory of adolescent egocentrism, and in particular his related theories of the imaginary audience and the personal fable, highlight the general human tendency of risk-taking as characterising the progression of adolescent development. If risk-taking is indeed a normal part of adolescent maturation, then concern for the adolescent resides not so much in the fact that risks are taken but in the possibility that risks are taken without the wisdom and support of maturity and experience (Quadrel at al., 1993).
1.5 The meaning and significance of individuation during adolescence

Elkind’s (1967) theoretical concepts reflect a further marker of adolescent development, namely the gradual process of disengagement from the protective parental environment. In a psychoanalytic framework, this process of disengagement was originally labelled *individuation* (Blos, 1962; 1979), but is a term now used in a more general sense. As separation from parents becomes increasingly established in the life of the adolescent, the importance and social involvement of the peer group and the need to be actively accepted by one’s peer group takes a stronger hold. The adolescent will invest much energy in protecting the self-perceived extent of his or her acceptance, identity, and respect within the milieu of the peer group (Lightfoot, 1997; Vuchinich, Bank & Patterson, 1992).

Individuation is a necessary part of healthy adolescent development. Individuation both enables and challenges the adolescent to participate in a social world that exists apart from the family, and to discover and refine one’s genuine niche within that world. Furthermore, individuation does not need to occur in the midst of family turmoil and conflict. Rather, successful individuation results from the opposite experience. Where parents are willing and able to offer their adolescent son or daughter positive support, the individuation process will not only emerge as an adaptive facet of adolescent development, but will also sustain a strong parent-adolescent relationship. In this way, parent and adolescent co-operate in a gradual loosening of ties between both parties.

If individuation is the process of adolescent separation from the protective context and influence of parents and family, then responsible autonomy is the desired outcome of that process (Youniss, 1980). The word *autonomy* is derived from two ancient Greek words namely, AUTOS meaning “of one’s self”, and NOMOS meaning a
law, rule, or standard (Green, undated – original published in 1794). Autonomy is therefore a definitive word that describes a gradual movement towards self-regulation within the process of individuation. Where autonomy is the outcome of disjointed and inconsistent parental influence, then the adolescent is likely to engage with the world according to self-derived standards that are at odds with personal safety, respect for others, and accepted social mores. On the other hand, where autonomy has been founded on a formative parental influence that has wisely drawn the balance between holding the adolescent back and trusting the adolescent’s readiness for personal responsibility, then beneficial autonomy is more likely to result. In the latter situation, the adolescent will be inclined to develop a standard for life that resembles the formative and adaptive influence expressed by his or her parents, as well as that of others in authority.

The beginnings of individuation take hold before the adolescent has fully developed the necessary skills and awareness to be autonomous in a responsible and safe manner. Indications of responsible autonomy do not become apparent until later adolescence (15 years of age onwards) when a coherent sense of self-identity is established. Prior to this time the movement towards autonomy will be coloured by the adolescent’s presumption that he or she can readily and safely interact with the world at large without the need for further help or support (Noack & Puschner, 1999; Silverberg & Steinberg, 1987). Hence healthy adolescent individuation relies heavily on the protective and positive influence of parents and trusted authority figures. Where an adolescent separates from this influence under a continual cloud of conflict and resentment, the potential for that person to fall victim to harmful risk behaviour increases (Noack & Puschner, 1999; Paikoff & Brooks-Gunn, 1991). Elkind’s (1967) theories of the imaginary audience and the personal fable indicate the potential for
adolescent vulnerability as individuation unfolds. While individuation is a necessary pathway towards responsible and autonomous adulthood, individuation is, by its very nature, also a process that entails the possibility of serious at-risk behaviour.

Robin and Foster (1984) indicated five critical developmental tasks that the adolescent needs to master in order to gain healthy entry into adulthood. These include development of independence from parents; coping with the physical and psychosexual changes of puberty (see also Buchannan, Eccles & Becker, 1992); the development of a value system and sense of identity; establishment of adaptive peer relationships; and preparation for a career. Of these tasks, Robin and Foster (1984) described the ability of the adolescent to function independently from his or her parents as being pivotal, and as necessarily disrupting the previously homeostatic parent-child relationship that resulted in the child’s compliance with the outcomes of parental decision making.

Individuation therefore is not a simple trajectory of development. Rather individuation is a multidimensional arena of learning and experience. Hopefully the adolescent will first learn the skills of self-reliance within the protective confines of childhood and the family home. In later years, this protective vantage point will sustain the adolescent’s testing of self-reliance in the company of one’s peers and in the province of a world that can be unsure and even hostile. Thus the social world of the family paves a way into the confines of another social world that resides outside the protective realms of home and family (Klein, Forehand, Armistead & Long, 1997; Openshaw, Mills, Adams & Durso, 1992; Paulson & Sputa, 1996).

Age-appropriate responses by parents, as well as their readiness to step into the world-view of the adolescent in an open and communicative manner, will be the primary determinants of the direction determined by individuation. Effective parenting skills will be particularly valuable when the adolescent erroneously believes that a
parent’s decisions are being made for no other purpose than to hinder the goals of freedom. Motivating the adolescent to abide by parents’ limitations, decisions, suggestions, and so forth can be a difficult task requiring the parent to develop a careful and wise balance between knowing when to stand firm on an issue and when to take a backward step and trust in the adolescent’s responsibility and maturity. At all times this balance will be determined by the amount of risk entailed in the adolescent’s desired activities, and the confidence the parent possesses in the adolescent’s ability to handle a particular risk (Bosma, Jackson, Zijssing, Zani, Cicognani, Xerri, Honess & Charman, 1996).

1.6 The place of the peer group in adolescent individuation

Gaining a comprehensible notion of the peer group is a somewhat slippery task. The peer group has been described as the carrier of collective culture (Lightfoot & Gariepy, 1997), a description that encapsulates the general day to day ‘hanging around’ with fellow members of similar age and interests, and from there leading to friendships that reflect increasing degrees of intimacy. In younger adolescence, the peer group dictates the parameters within which one must remain in order to belong. Therefore, continued membership within a peer group results from adherence to matters such as acceptable activities, codes of conduct, manner of dress, hairstyle, and so on. As external identifiers of peer group cohesion, these matters provide the formal rituals of initiation and acceptance. In the movement away from parents and family, the peer group therefore provides the maturing adolescent with a milieu of social contact and identification. As individuals grow older, the peer group takes on a different meaning, and provides a safe and comfortable environment within which to expose one’s feelings and beliefs, and feel accepted and validated for no other reason than one is a member of
that group (Heaven, 1994). From this perspective, the intimacy of friendship resides in embryonic form within the general context of the peer group.

1.6.1 The peer group as clique or crowd.

Dunphy (1990) has categorised the peer group into cliques and crowds. A clique is a small number of same-gender adolescents who share closeness in friendship and activity. Shared school attendance, similarity in age, and close proximity in the location of the home are important elements in the formation and maintenance of the clique. A cohesive and small sized clique encourages a level of trust and intimacy wherein information is shared and entrusted, with outsiders finding it difficult to enter its midst. Leaders and followers characterise cliques, and continued membership is guaranteed only by adhering to the often unspoken directives struck and upheld by the leader.

Crowds on the other hand lack the intimacy of the clique, mostly comprise a number of different cliques, and are heterosexual in character. Whereas cliques are the preferred avenue of social contact and security for the young adolescent, crowds are characteristic of middle adolescence because they fulfil the need for heterosexual contact during this stage of development. The clique therefore is the initial form of single-gender adolescent social contact that enhances the confidence to move into the less clearly defined context of the heterosexual crowd. Intimate relationships that lead to dating, sexual contact, and ultimately one-to-one partnerships develop from within the crowd (Dunphy, 1990; Graber, Brooks-Gunn & Galen, 1998). Nor are intimate relationships confined to opposite gender relationships. Friendships at the childhood level generally revolve around one’s playmates, whereas adolescent friendships are marked by an increase in intimacy that provides opportunities for more frequent expressions of companionship, personal disclosure, and personal support (Mitchell, 1990). This is particularly so when the adolescent feels unsure about discussing
personal problems with parents or family members. Where intimacy of friendship is lacking, there is heightened stress and loneliness, a loss of security and sense of personal worth, and a loss of social support. The provision of healthy social support by one’s peer group, particularly when the adolescent needs to cope with difficult life-style situations, is therefore an important protective factor against involvement in harmful risk behaviour.

1.6.2 The strengthening of self through the peer group.

The self-validation that arises from healthy intimate friendship protects against poor adolescent adjustment and related social problems (Burhmester, 1990). Hence while younger adolescents are more concerned about being part of the most popular and influential group of friends, older adolescents tend to think more abstractly about the attitudes and values upheld by the group, and the extent to which they are willing to adhere to them. Younger adolescents see the group as a means of gaining friends, whereas older adolescents describe membership within the group in terms of their own self-worth and self-validation (Heaven, 1994). A low sense of self-esteem and subsequent reticence to be open and trusting towards one’s peers is a risk factor for developing unpolished and possibly detrimental social peer relationships. As a result, the potential for mixing with peers of like ilk and engaging in dysfunctional ways to gain social acceptance is heightened (Dekovic & Meeus, 1997; Dishion, Eddy, Haas, Li & Spracklen, 1997; Dishion, McCord & Poulin, 1999; Snyder, Dishion & Patterson, 1986).

The adolescent who has difficulty in forming fulfilling and long-lasting peer friendships will nonetheless continue to experience the need for satisfying peer relationships. Being neglected or rejected by one’s peers has the propensity of leading the adolescent into antisocial and deviant behaviour. The tendency of antisocial
adolescents to either seek out other antisocial and/or rejected adolescents, or to be motivated towards these types of people through personality or family characteristics, has its beginnings in middle childhood and escalates into adolescence because it has not been adequately addressed during this earlier age (Coie & Kupersmidt, 1983; Dishion, Andrews & Crosby, 1995; Dodge, Coie & Brakke, 1982; Parker & Asher, 1993).

Furthermore, the failure to achieve satisfying social friendships is often entwined with other forms of failure (such as academic failure) that again progress into adolescence and adulthood. In adulthood this progressive experience of failure is translated into a further loss of social skills and acceptance, academic underachievement, and problems with marriage and family relationships (Dishion, 1990; O’Donnell, Hawkins & Abbott, 1995).

1.6.3 The mutual influence of peers and parents.

When the peer group becomes an extension of parental management that is inherently protective, the peer group promotes the protective influence of the home environment (Lackovic-Grgn & Dekovic, 1990). During the later adolescent years, a peer group that reflects a protective home environment has been found to provide a buffering effect against the deleterious consequences of peer-related dysfunctional behaviour (Greenberger, Chen, Tally, & Dong, 2000; Petersen et al., 1991). On the other hand, where the relationship between parent and adolescent is fragmenting or fractured, resulting in little or no protective influence over the adolescent’s activities, then the peer group has the capacity to become an extension of the harmful risk engendered by the dysfunctional family environment.

When the foundation of the family environment does not promote connectedness, warmth, and acceptance for the adolescent, there is a resulting likelihood, though not a necessary one (Rutter, 1987), that the peer group will take over
as the primary behavioural influence in the adolescent’s life (Dishion & McMahon, 1998; Klein et al., 1997). Where this influence involves the expansion and maintenance of antisocial and harmful behaviour, then the protective influence of the home environment can be threatened. If the impact of a negative peer group on the parent’s management of the adolescent heightens, then the adolescent is also likely to view any attempt of the parents to protect and curtail the adolescent’s behaviour as being an unwanted interference in what has eventuated as a dysfunctional style of life for the adolescent (Dishion et al., 1997; Dishion & McMahon, 1998).

1.7 Are adolescents naturally ‘risk takers’?

Jessor (1991) argued that the tendency to dismissively categorise adolescents as ‘risk takers’ is an unfortunate tautology that ignores the fact that risk-taking in adolescence is not automatically indicative of problem behaviour. Adolescent risk behaviour does not necessarily indicate the presence of problematic or anti-social attitudes (Moore & Gullone, 1996). Risk-taking becomes problematic when it has reached the stage of being personally harmful behaviour carried out in a social context of harmful risk (such as drug use, modelling anti-social peers, school disengagement), with this level of risk implicating contempt for societal norms and values, delinquent behaviour, and resulting social harm. In these circumstances, a precarious cycle is set up whereby continued participation in harmful risk behaviour is reinforced by negative social conditions in which this risk behaviour takes place (Lightfoot, 1997). One might therefore hypothesise that where risk behaviour is unacceptable according to social sanctions and disapproval then the adolescent who takes this risk is also open to becoming unacceptable as a person within that society. This in turn can adversely affect the adolescent’s motivation to become a functional part of society since continued practice of that behaviour strengthens the adolescent’s label of being socially
acceptable. As a result, feeling and even being socially unacceptable has small significance for the adolescent, since the adolescent has probably reached the point of having little to personally lose.

A paradox exists here. The unacceptable behaviour might place the adolescent on the outer fringe of society, yet at the same time this behaviour identifies the adolescent’s place within that social fringe. The behaviour is therefore purposeful, even though it might also be dysfunctional and isolating. As a result, the adolescent continues to participate in a purposeful though dysfunctional form of behaviour. Even though this behaviour consequently defines the adolescent as a social fringe dweller, the adolescent maintains the behaviour in order to retain some form of social (albeit anti-social) identity. The cyclic and disintegrative nature of this type of behaviour would represent a level of risk that had escalated into serious problem behaviour.

Outside the realm of adolescent problem behaviour, and in a non-dismissive manner, research has indicated that adolescents per se are risk takers at heart (Donovan & Jessor, 1985; Irwin, 1993; Lightfoot, 1997; Maggs, Frome, Eccles & Barber, 1997), with adolescents being over-represented in many categories of risk behaviour (Greene, Krcmar, Walters, Rubin and Hale, 2000). Risk-taking has been identified as necessary for adaptive adolescent development (Fischhoff, 1992; Jessor R. and Jessor, S.L., 1977; Moore & Gullone, 1996). Risk behaviour has been further described as representing the human tendency to seek physical and mental stimulation by engaging in risk, even potentially self-harming risk (Arnett, 1992; 1994), with some individuals having a stronger sociobiological need for stimulation than others (Greene et. al, 2000; Lopes, 1993). Lightfoot (1997) considered risk taking activity as being part of the changing relationship between the adolescent and the world, stating “that within the historical evolution of cultural conceptions of self…this relationship has constituted persons as
individuals, worlds as dynamic contexts of action, and risks as transformative experience” (p. 55).

The choices made by an adolescent about any form of risk taking behaviour become statements that declare who the adolescent is. The adolescent’s risk taking choices define who the adolescent wants to be, to whom the adolescent wishes to relate, in whom the adolescent wishes to confide, and what values the adolescent wishes to promote (Levitt & Selman, 1996). The concept of meaning, when applied to adolescent risk taking behaviour, might be considered as the shaping element that personalises the particular form of risk experienced by the adolescent. The adolescent more or less knows what is entailed in the chosen risk. At the same time, the adolescent understands the chosen risk within the context of interpersonal relationships, particularly relationships characterised by shared experiences. The adolescent’s knowledge and understanding about risk is then integrated into ‘choice as action’ by the process of personal meaning (Levitt & Selman, 1996). “Personal meaning is the lens through which knowledge of risks and risk management skills are integrated and focused to effect outcome behaviour” (Levitt & Selman, 1996, p.204).

Lightfoot (1997) takes up the concept of risk personalisation through the medium of meaning when she wrote that “risks are a fount of memories and secrets, of shared knowledge and experience, and invested with the meanings of group identity” (p.129). Lightfoot’s words (1997) closely reflect those of Levitt and Selman (1996) in relation to the style of meaning placed by the individual on any form of risk taking behaviour. For Lightfoot (1997) as for Levitt and Selman (1996), shared risks are symbolically instrumental in the development of interpersonal relationships and group cohesion. Furthermore, the meaning attached to risk taking will vary according to the social history and psychological development of those involved. Where interpersonal
identity is in the process of being created, the sharing of risk by group members will be understood as providing an experiential medium for establishing the group. Where the group is already forged, the sharing of risks will be seen as endowing group members with representations of identity. Either way, the maturity of one’s interpersonal history will go hand in hand with what it means to take a risk. In turn, the particular meaning applied to risk taking will describe who the person is, and who that person would like to become. In the sense of meaning and risk, risk taking becomes a goal-oriented activity, imbued with hopefulness (Lightfoot, 1997).

The concept of meaning as it is pertains to risk can be applied to the notion of adolescent development as signified by participation in adult-type behaviour. Adolescent risk taking behaviour has been described as an exploratory and experimental response to the critical changes that occur at this time in the life cycle - a feeling of belonging to the world of adulthood signified by the adolescent’s participation in activities commonly reserved to the adult domain (Fischhoff, 1992; Igra & Irwin, 1996; Jessor R. & Jessor S.L., 1977; Moore & Gullone, 1996). Furthermore, there is support for the notion that adolescent risk behaviour is a rationally thought out process whereby adolescents are acutely aware that a certain behaviour is in fact risky (Gardner, 1993; Lightfoot, 1997). At the same time, immature cognitive development and a lack of experience can at best lead to poor judgments about taking risks, and at worst constitute a syndrome of problem behaviour where a socially deviant living environment is also present.

While adolescents might be competent in correctly identifying the presence of risk, they do not always possess the equal and necessary ability to adequately weigh up the consequences of risk before becoming involved in it (Greene et al., 2000; Irwin, 1993; Tonkin, Cox, Blackman & Sheps, 1990). However, there is no reason to suggest
that adolescents lack a *fundamental competence* in their choice to engage in or avoid certain risk behaviours. A purposeful clinical approach to adolescent risk behaviour would not so much seek to eliminate risk, but rather help the adolescent to develop this competence, and so distinguish between developmentally enhancing risk behaviour and risk behaviour that reflected pathological expressions with little or no positive secondary gain (Irwin, 1993). Therefore the problem with adolescent risk behaviour does not so much lie in the adolescent’s ability to identify the element of risk contained in a particular activity, but rather to correctly weigh up the extent and consequences of risk.

Leas and Mellor (2000) have cautioned against adopting too narrow a focus when attempting to understand and describe the foundations of adolescent risk behaviour. In particular, Leas and Mellor (2000) commented on research by Arnett (1994) that investigated non-compliant and antisocial behaviour amongst a high school adolescent sample. Arnett (1994), using the sensation-seeking model of Zuckerman (1979; 1990 – cited in Leas & Mellor, 2000), related norm breaking behaviour to the physical and cognitive predisposition of adolescents to breach stimulation thresholds, thus achieving intense levels of physiological and psychological stimulation. In response to the research of Arnett (1994) and the foci of other similar research findings, Leas and Mellor (2000) have encouraged the adoption of a multifaceted view of adolescent risk behaviour, as opposed to a physiological, solely personality-related focus. According to this notion, problem risk behaviour can be understood as a compounded phenomenon, so that more serious risk behaviours such as misuse of drugs and alcohol can also involve and be maintained by other less threatening (though still serious) behaviours including non-compliance with parents’ limits, avoidance of school commitments, petty theft, vandalism, and so on (Greene et al., 2000; Igra & Irwin,
1996; Jessor R. & Jessor S.L., 1977). This is not to deny the influence of physiological influences and personality characteristics. Rather, where adolescent risk behaviour has become problematic, the influence of individual differences such as these would be viewed over and against the influences of a much wider environmental milieu.

1.8 The interactional nature of adolescent risk-behaviour

Research literature has indicated that factors that either exacerbate or attenuate risk in adolescence pervade the entire fabric of adolescent behaviour (Baer, MacLean & Marlatt, 1998; Hagan, 1998). No single domain of risk or protective factors alone has been found to be responsible for the positive or negative outcome of an adolescent’s behaviour (Lavery, Siegel, Cousins & Rubovits, 1993; Lee, Su & Hazard, 1998). The interactive matrix of different areas of influence in an adolescent’s life such as modelling peer behaviour, family and societal influences, individual differences, and biological and temperamental characteristics, predispose the adolescent towards harmful or developmentally adaptive risk. The task is therefore one of identifying the broader picture of risk or protection sketched by the interactive effect across a matrix of behaviours (Capuzzi & Lecoq, 1983; Hawkins, Catalano & Miller, 1992; Loeber, Farrington, Stouthamer-Loeber & Van Kammen, 1998; Quadrel et al., 1993; Smith & Stern, 1997). This issue will provide the principal focus of discussion in chapter two.

1.9 Chapter summary

This chapter has presented adolescent risk behaviour as an experience interwoven within the fabric of adolescent development. The need to depart from the environment of childhood leads the adolescent into the various domains of the adult world, although the adolescent initially lacks the necessary experience that assures fruitful participation and at times survival within this world. This experience comes about as the by-product of adaptive adolescent development that neither denies the
importance of being exposed to risky situations nor guarantees that the adolescent will not at times be adversely affected by risk. Particular characteristics of adolescent development such as the adolescent’s self-image, the vulnerability of that image within society, the adolescent’s need to establish self-identity and acceptance within his or her social milieu, the supportive nature of the peer group, and the adolescent’s general yearning for autonomy, were presented in this chapter.

These characteristics will affect the manner in which the adolescent passes through this phase of development. Where the adolescent lacks support in attempting to cope effectively with these developmental characteristics, then the likelihood of moving from adaptive levels of risk behaviour into the arena of problem behaviour will heighten accordingly. In these circumstances, problem behaviour will be the outcome of an influential matrix of various risk factors rather than of one discrete domain of risk. Chapter two will review the notion of adolescent risk behaviour against the background of risk and protective factors in adolescent development.
CHAPTER TWO

RISK AND PROTECTIVE FACTORS IN ADOLESCENT BEHAVIOUR

Of its nature, adolescent behaviour entails risk. Risk is purposeful for the adolescent in that it enables the adolescent to establish autonomy from parents and authority figures, demonstrate a departure from childhood to adulthood, and develop significant relationships with peers. Protective factors such as strong parent management skills and a functional peer group do not block the influence of risk, but rather act as a buffer against adolescent risk escalating into problem behaviour. Protection from harmful risk for the adolescent therefore equates to the predominant influence of protective factors in an adolescent’s life at any one time. The most important of protective factors is that provided by a nurturing parent and family environment. Domains of risk specific to this thesis, and the effect of positive parenting skills as a protective factor will now be discussed.

2.1 The notion of risk and protective factors in adolescent behaviour

Jessor R. and Jessor S.L., (1977) and Jessor (1998) noted that adolescent involvement in harmful risk-related activity results from the direct and indirect interaction of certain antecedent factors, and the extent to which the adolescent has been exposed to these factors. Furthermore, Jessor (1998) claimed that these antecedents (or risk factors) extend far beyond global areas such as a general propensity towards risk-taking to incorporate a variety of specific risk domains that compromise health, emotional and psychological well-being and social performance. While exposure to risk factors increases the adolescent’s vulnerability to being harmed by the outcome of risk behaviour, the presence of protective factors lessens the possibility of engaging in harmful behaviour, or reduces the impact of its harmful outcome. The role of protective factors is therefore to act as a cushion between the adolescent’s exposure to and
involvement in risk behaviour, rather than blanketing the adolescent from any involvement in risk behaviour.

Research has examined the interplay between risk and protective factors in the quest to explain the potential for adolescents to engage in behaviour that can place them in a state of personal harm (Hawkins, et al., 1992; Jessor, Van Den Bos, Vanderryn, Costa & Turbin, 1995; Loeber et al., 1998; McDermott, 1984; Pandina, 1996a, 1996b; Swaim, 1991; Wills, Pierce & Evans, 1996; Wills, Vaccaro & McNamara, 1992). This behaviour may be interpreted as “problem behaviour”, and takes place within the personal, biological, psychological, social and environmental contexts of the adolescent’s life experiences. Problem behaviour, as an expression of how an adolescent conducts his or her life, demonstrates either an adaptive or a maladaptive influence in adolescent development. These contexts, along with their associated behaviours, are not isolated from each other. Rather they tend to covary in a complex and influential matrix of interrelationship. For example, an adolescent who has grown up in the midst of an unstable and unhappy family environment and impoverished socio-economic context, and whose early school drop-out has resulted from years of trouble and failure, is likely to model peers who engage in deviant, illegal and anti-social behaviour. Each aspect of this maladaptive scenario has its own part to play, while at the same time interacting within a constellation of mutual influence (Millstein, Irwin, Adler, Cohn, Keegles & Dolcini, 1992).

Protective factors are found in the governing roles of parents and similar figures of authority, as well as other authoritative aspects of control such as community sanctions. Protective factors also result from involvement in activity that is incompatible with or opposed to problem behaviour (such as involvement with family activities and celebrations, and sports associations), as well as commitment to conventional
institutions such as school and church organisations (Jessor, R. & Jessor, S.L., 1977). For adolescents who are exposed to situations of problem behaviour, the meaning of being ‘at risk’ is that they have entered a trajectory away from these protective influences towards behaviours that are potentially deviant, and that therefore compromise the adolescent’s quality of life and health. While risk-related exploration is a normal part of adaptive adolescent risk behaviour, problems begin when the exploratory nature of this behaviour leads into commitment to the behaviour.

Being ‘at risk of problem behaviour’ describes the progression of the adolescent as being at an earlier stage of this continuum. If left unchecked, there is every possibility that this progression will ultimately lead into a state of high-risk problem behaviour. Clearly, the optimum environment to strive after is one where protective factors predominantly outweigh risk factors. Resilience is one quality that identifies and maintains a protective environment.

2.2 The protective influence of resilience

Resilience explains why some individuals (child, adolescent, and adult) are able to maintain high self-image and self-efficacy in the face of risk situations that would lead other people down a pathway of self-harming attitudes and behaviour. Pandina (1996a) refers to the notion of resilience as exercising a positive effect on some individuals who, even though they might be exposed to risk factors of a self-harming nature, do not experience negative outcomes associated with the risk factors in question. In similar fashion, Rutter (1987, 1990) noted that the primary function of protection is one of providing a buffer against harmful risk. Rutter (1987) linked the concept of protective factors with the notion of resilience, suggesting it would be more helpful to define risk and protection as mutually interactive mechanisms as well as discretely defined individual factors. As such they would exercise a catalytic and synergistic effect
on situations of vulnerability towards risk, thus ameliorating the negative impact of risk. These mechanisms are linked to resilience in the sense that the effect of a protective mechanism is activated when an individual is challenged by a situation of risk. Therefore protection is found not in the avoidance of the situation but rather in the ability to successfully engage in it. Hence exposure to risk can, of itself, become a protective influence. Like immunisation, exposure to risk in the presence of protective mechanisms strengthens the individual’s ability to effectively cope both in the present situation and in any future similar situations.

The importance of Rutter’s (1987) understanding of risk and protection relates to the life situations of some adolescents and their families who unavoidably find themselves involved in high-risk environments. The optimum answer for these people is not one of taking away the risk or removing them physically or psychologically from it. Nor would it always be possible to do this because of issues such as economic limitations, the need to retain children in a stable school environment, the presence of a supportive extended family, and so on. Instead of a policy of dislocation, it would seem more appropriate to educate and support parents and children in developing the type of protective lifestyles that keep the damaging influences of risk at bay.

Rutter (1987) emphasised the importance for people to structure their protective environments (for instance, by developing and achieving strong parenting skills, academic success, and positive social skills) in order to develop protective mechanisms that immunise them against risk rather than remove the risk. Rutter’s (1987) understanding of risk and protection also means that the relationship between risk and protective factors does not need to be negative, so that high risk necessarily approximates to low protectiveness. The presence of strong mechanisms of resilience would reasonably lead to high protectiveness in settings where the number of risk
factors was also high. Therefore protection is not simply defined as the absence of risk or the residual point of ‘least risk’, but rather as the protective outcome of interactive mechanisms of risk and protection (Jessor et al., 1995; Rutter, 1987).

It is important to point out that Rutter (1987) is not advocating a departure from viewing risk and protective factors as separate notions. Risk and protective influences still represent opposite ends of a risk continuum, as well as comprising interactive mechanisms of influence. This is necessarily so for three reasons. Firstly, separate notions of risk and protection indicate whether the focus of risk lies towards the vulnerability end or the protective end of this continuum. Secondly, the positive notion of protection as opposed to the negative undertone of risk emphasises the benefit of developing protective mechanisms in the face of potentially harmful risk. Thirdly, to speak of a ‘protective mechanism’ necessarily implies that the main effect of the mechanism derives from the positive end of the variable.

2.3 Domains of risk implicated in adolescent problem behaviour

2.3.1 Drug and alcohol use

Hawkins et al. (1992) presented a systematic review of the principal adolescent risk factors that lead towards problem drug and alcohol use. These risk factors cluster around four specific domains, namely culture and society, interpersonal issues, psychobehavioural issues, and biogenetic issues (see also Oetting & Beauvais, 1991; Segal, 1991). Adolescent substance misuse has also been found to be an outcome of early childhood histories of problem behaviour, as well as being characteristic of families where frequent unresolved conflict is a common occurrence, or where parental bonding with the adolescent and the effectiveness of parental discipline style is poor (Jenson, Howard & Yaffe, 1995; Masse & Tremblay, 1997). It has been suggested that 13 to 14 years of age is a critical period during adolescent development when
adolescents are especially vulnerable to experimentation with drugs and alcohol (Cady, Winters, Jordan, Solberg & Stinchfield, 1996; Hansen & O’Malley, 1996). At this age adolescents commonly find themselves having to adjust from leaving the relatively protective environment of junior school to coping with the less contained and regulated environment of the senior school years. The onset of puberty has generally become established at this age, particularly for boys. Puberty impacts upon adolescent adjustment, leading the adolescent towards a trajectory of drug and alcohol misuse in particular (Segal, 1991). This impact occurs because puberty brings to light the adolescent’s heightened awareness of self, especially in relation to the need for peer acceptance and group participation (see Chapter 1, Section 1.5 for a more comprehensive discussion of this point).

Drug and alcohol misuse is symptomatic of a cluster of risk behaviours that describe a lifestyle of problem behaviour (Newcomb, 1995). Jessor R. and Jessor S.L. (1977) originally addressed the issue of adolescent problem behaviour in terms of problem-behaviour theory (this theory will be elaborated upon more fully in chapter three). By means of this theory they described adolescent substance use as one facet of a syndrome of attitudes and behaviour that were problematic and unconventional for a given developmental stage.

Newcomb and Bentler (1988, as cited in Newcomb, 1995) found that adolescent polydrug use was highly correlated with negative outcomes of risk-related adolescent problem behaviour, such as low conformity to social norms, criminal behaviour, deviant friendship networks, and precocious sexual activity. Psychosocial risk factors likely to lead to the negative outcome of problem drinking would include low expectations for school success, continual academic failure, early school drop-out, fragmented quality of family life, low self-image, a sense of hopelessness, deviant peer modelling,
disassociation from parents and other supportive authority figures, and association with deviant peers (Beck, Scaffa, Swift & Ko, 1997; Botvin, 1996a; Botvin, 1996b; Costa, Jessor & Turbin, 1997; Jones & Heaven, 1998). The pattern of problem behaviour resulting from adolescent substance misuse forms a network of attitudes and behaviour “that must not be addressed by focusing on single strands without including the total fabric” (Newcomb, 1995, p. 23). Alternative attitudes and behaviour that reflect higher conventionality of beliefs and attitudes, and indicate a stronger bond to conventional society, institutional groups, and family values, act as a protective buffer against initiation into problem drinking (Costa et al., 1997; Jessor R. and Jessor, S.L., 1977).

It is common for risk factors for adolescent drug and alcohol use to initially find expression in consumption of the more commonly used drugs of alcohol, tobacco, and marijuana. Kandel and Faust (1975) described a stage theory approach for understanding the progressive use of alcohol, tobacco, and marijuana. Experimentation with alcohol and tobacco was seen to lead towards heavier use of these substances by a smaller number of users, followed by experimentation with and continual use of marijuana, and eventual continuation into the ‘harder’ illicit drugs. Analyses of longitudinal data that tracked adolescent drug use throughout the 1970’s and into the mid to late 1980’s by Ellickson, Hays and Bell (1992) similarly confirmed a general ordering of legal and illegal substances.

Vega, Gil and Kolody (1998), however, suggested caution in interpreting a stage theory of substance use as a deterministic model. They mirrored the suggestion of Newcomb (1995), as cited by Vega et al., (1998) who pointed out that arrival at a particular point of substance use does not necessarily lead to a following and more serious stage of use. Adolescent development generally, along with related aspects of this development such as cultural and personal differences, and socio-economic
background needs also to be taken into account. Therefore it would appear that early use of alcohol, tobacco, and marijuana does not necessarily predict or explain future progression into harder drug use such as heroin or cocaine, although increased involvement in alcohol, tobacco, and marijuana, particularly in the more readily available substances of alcohol and tobacco, is still an apparent risk factor for further involvement in harder substances (Ellickson, Hays & Bell, 1992). Furthermore, for adolescents of all cultural backgrounds, the use of these more common drugs does not necessarily cease with initiation into harder drugs. Rather involvement in alcohol, tobacco, or marijuana is likely to be deepened, with the harder drug being added to the adolescent’s repertoire (Gil, Vega & Biafora, 1998).

2.3.1.1 Substance use among Australian adolescents. Two principal sources of research into Australian substance consumption have been the Statistics on Drug Use in Australia (National Drug Strategy Household Survey, 1998) and the Household Survey (CEIDA, 1999). Alcohol has been rated as being among the most widely used drugs in Australia, with 80.7% of the population aged 14 years and older having consumed alcohol in the previous 12 months, and 48.6% of this population drinking weekly (CEIDA, 1999). A recent Australian study found that the proportion of adolescents who reported drinking alcohol increased for each age level from 11 to 12 years of age up to 17 to 18 years of age, with the highest proportion of adolescents who reported drinking alcohol occurring at 15 to 16 years of age (Oei, Ross & Loveday, 1997). In relation to tobacco consumption, one fifth of Australians aged 14 years and older reported being regular consumers of tobacco, indicating consumption on a daily basis or on most days. Marijuana has been found to be the next most commonly used drug after alcohol and tobacco. Of persons aged 14 years of age and older, 39.3% of persons reported trying marijuana, and 17.9% were found to have recently used
marijuana on a regular basis. This percentage of use (whether on a trial or regular basis) approximated to two fifths of Australians who were 14 years and older in 1998 (National Drug Strategy Household Survey, 1998).

These percentages are alarming, and strongly suggest that the consumption of alcohol, tobacco, and marijuana among Australian adolescents would be an important domain of investigation when determining the presence and extent of problem-prone adolescent behaviour. In particular, evidence highlighting substance use among adolescents as young as 14 years raises the likelihood of a predisposition for problem substance use in later years. It has been established that delaying the onset of drug use can act as a major influence in harm minimisation. Where onset has been delayed, drug use has been found to be of shorter duration and less severe (Ellickson et al., 1992; Kandel & Faust, 1975; Labouvie, Bates & Pandina, 1997; Swadi, 1998). Hence, assessment of adolescent substance use would appear to be a predetermining factor in establishing an effective course of intervention for harmful risk-behaviour (Catalano, Kosterman, Haggerty, Hawkins & Spoth, 1999).

2.3.1.2 Substance use among Aboriginal and Torres Strait Islander adolescents. Research conducted within the Australian context has highlighted the seriousness of substance misuse for the Aboriginal and Torres Strait Islander population of Australia (Dunne, Yeo, Keane & Elkins, 2000). In support of this finding, the most recent survey conducted by the National Aboriginal and Torres Strait Islander Survey (Australian Bureau of Statistics, 1994), recorded that indigenous youth comprised approximately 21% of Australia’s indigenous population (a total of 303,300 persons) while non-indigenous youth comprised 15% of the total Australian population (17.8 million persons). Alcohol repeatedly emerged as being the overriding issue of concern for indigenous youth (affecting almost 60% of these youth), with males (47%) being
more seriously affected than females (29%). It was noted that alcohol was seen as being even more of a concern for the health of Aboriginal and Torres Strait Islander adolescents than the use of illicit drugs, particularly marijuana. Finally, tobacco use was very much under-rated by this population as being a health risk. Nearly 33% believed that one pack per day (approximately 20 cigarettes) could be smoked before their health was damaged. Only three percent of Aboriginal and Torres Strait Islander adolescents (in comparison to 33% of the general community) believed that tobacco was responsible for most drug-related deaths.

Clearly, if one were to speak of adolescents being found in situations of high risk for problem behaviour, then Aboriginal and Torres Strait Islander youths would be extremely vulnerable members of this category, although this investigation would extend beyond the practical parameters of this research. Comment focusing on the link between this research and ethnic sensitivity has been presented in section 2.8 of this chapter.

2.3.1.3 Gender differences and adolescent substance use. While gender differences have also been noted in adolescent drug use (Wickrama, Conger, Wallace & Elder, 1999), the role of gender specific factors in adolescent problem substance use is still not totally clear (Burt, Dinh, Peterson & Sarason, 2000; Flannery et al., 1994; Kandel, 1998; Simone et al., 2000; Windle, Shope & Buckstein, 1996). In terms of offensive and anti-social behaviour, Moffitt et al. (2001) note that males and females demonstrated their highest similarity in drug and alcohol related offences. Kandel (1998) found that males and females aged as young as 12 years of age onwards were prone to dependency on tobacco, marijuana, alcohol, and cocaine once they had initially become used to these drugs. With respect to the timing of substance use initiation, males tend to initiate drug use before females. Females however, have been found to exhibit
less post-treatment alcohol use than males, although no other gender effect was found for other substances (Latimer, Newcomb, Winters & Stinchfield, 2000). Females are more inclined to refer to their incidental use of hard and soft drugs than males, and tend to talk more often about addiction problems (Simone et al., 2000).

Except for tobacco use, older adolescent males tend to use drugs in slightly higher quantities and across a wider range of types than females, a tendency that is maintained throughout the high school years (Hansen & O’Malley, 1996; Jensen et al., 1995; Newcomb, 1995). However, in younger adolescence females have been found to be closer to males in rate of substance use, possibly due to females maturing at a slightly younger age than males, as well as their tendency to associate with older males (Hansen & O’Malley, 1996).

Cross-cultural research conducted in America by Khoury (1998) found that the rate of substance use was lower for females than for males at around 13 years of age. By around 15 years of age consumption rate for females approximated and even exceeded that for males, especially in relation to alcohol and tobacco use. Khoury (1998) found further that initiation into alcohol use occurred at approximately 12 years of age for males of all cultural groups in her sample, and approximately twelve months later for all females. Initiation into tobacco use followed a similar pattern, while initiation into marijuana use occurred for males at approximately 13 or 14 years of age and again at approximately 12 months later for females. These findings appeared to be consistent with the approach of stage theory for progressive substance use (Kandel & Faust, 1975; Kandel, Kessler & Margulies, 1978). Again, these findings are alarming. At 12 years of age for males, and twelve months later for females, results such as those stated above indicate that already adolescents are potentially prone to self-harm in relation to substances that are either illegal (such as marijuana or heroin), or substances such as
tobacco and alcohol that belong to the domain of adulthood. Furthermore, these ages of initiation generally align with the beginning years of adolescence, and not at the later stages of development.

Finally, Khoury (1998) has noted that the substantial body of research on gender differences during pubertal maturation has not been reflected in research on gender differences for substance use, which for the most part has been “sparse and inconclusive” (p.100). Khoury (1998) has called for much needed research into gender differences for male and female substance use. A greater understanding of areas such as similarities in gender-specific risk factors between males and females, the implication of these differences in substance use, and the implication of emotional distress in female substance use, have been flagged as important steps in paving the way for effective prevention programmes, particularly in relation to females.

2.3.1.4 **Peer modelling and adolescent substance use.** Research undertaken by Jenkins (1996) with male and female adolescents at their early to middle stage of development found that peer influence remained the clearest prevalent variable in drug involvement. By comparison, the contribution made by the protective variables of academic achievement and enjoyable extracurricular activities was small, although establishing these factors as arenas of protectiveness was still warranted. Other research has documented a strong association between adolescent drug involvement and affiliation with drug using friends and a general youth culture of drug use (Dawkins, 1997; Dishion, Capaldi, Spracklen & Li, 1995; Hansen, Graham, Sobel, Shelton, Flay & Johnson, 1987).

The adolescent’s seeking for this affiliation has been further linked to stressful life events, as well as to parents and families who both demonstrate a favourable attitude towards drug use and who use drugs themselves (Costa et al., 1997; Hawkins et

Dishion et al. (1997) found that ongoing social interactions between peer group members, especially discussions among best friends that endorsed substance misuse and antisocial behaviour, predicted adolescent violence. Adolescents who were older and more involved in substance use and other problem behaviour have also been found to be more susceptible to an iatrogenic effect via their peers. Additionally, adolescents who were involved in moderate levels of deviancy and those who had deviant friends were more likely to escalate to more serious forms of deviant behaviour, including substance misuse (Dishion et al., 1999; Poulin, Dishion & Haas, 1999).

Once adolescents have been initiated into and consequently committed to substance use, it is unlikely that they will readily cease this involvement particularly if it is fulfilling the need state of increased self-confidence and the sense of being an acceptable member of one’s peer group (Ellenbogen & Chamberlain, 1997; Mainous III, Martin, Oler, Richardson & Haney, 1996). Not even the knowledge that physical harm (let alone social and psychological harm) can result from substance use will have the effect of deterring adolescents from this type of behaviour. Friedman, Lichtenstein and Briglan (1985, as cited by Dishion et al., 1995) found that 89% of first experiences of smoking by adolescents resulted from experiences of shared initiation. That is, adolescents who shared a common group affiliation smoked their first cigarette as an
expression of their commonality rather than in response to peer pressure (see also Sheppard, Wright & Goodstadt, 1985). This is an important consideration for developing intervention objectives that target potentially problematic adolescent behaviour. It is essential that intervention objectives take into account a clear and precise understanding of the motivation that lies behind adolescent behaviour, particularly in relation to peer group experiences.

2.3.1.5 Parental modelling of substance use. The adolescent’s modelling of parental substance use has been linked to potentially harmful adolescent risk, especially where the substance use of parents has reached problematic proportions (Coombs & Paulson, 1988; Hussong & Chassin, 1997; Hawkins et al., 1992; Igra & Irwin, 1996; Jenkins & Zunguze, 1998). Etz, Robertson and Ashery (1999) have referred to a number of research findings showing that substance abuse disorders among parents and other members of the family pose serious genetic and social risk factors for children. Parental smoking has been noted as a significant risk factor for cigarette use among females in particular. Research has indicated that females whose parents smoke were twice as likely to use tobacco than females whose parents have never smoked (Khoury, 1998). Hawkins et al. (1992) have cited evidence for transmission of alcohol problems in adopted males of whom 18% to 27% have had a biological alcohol dependent parent compared to 5% to 6% of adopted males where there was no alcohol dependent parent.

More recent research with biological parents has demonstrated that alcohol, tobacco, and other drug dependency, together with anti-social personality disorder, have constituted significant risk factors for similar problems in both male and female children, even when adopted at birth (Ge, Conger, Cadoret, Neiderhiser, Yates, Troughton & Stewart, 1996; Kandel, 1998). Other research has also shown that adolescents who have problems with drug use apart from tobacco and alcohol are also
more likely to have at least one parent who uses drugs, and will also tend to disengage early from the family sphere of influence towards deviant peer affiliations (Blackson, Tarter, Loeber, Ammerman & Windle, 1996; Jenkins & Zunguze, 1998; Kandel, 1998; McDermott, 1984; Wills et al., 1996). Finally, Moffit et al. (2001) have noted a lack of evidence to suggest that males are more vulnerable than females, or the opposite, to being negatively affected by parental substance misuse. Parents’ insight into the need to model healthy and adaptive attitudes towards drug-use provides a protective control against the potentially damaging influence of adolescent substance use.

2.3.2  The social environment

The social context is a broad area of concern for harmful adolescent risk. A disadvantaged neighbourhood has been found to diminish the ability of parents to monitor and manage adolescent behaviour (Conger, Ge, Elder, Lorenz & Simons, 1994; Hawkins et al., 1992; Sampson & Laub, 1994; Smith & Stern, 1997). Socio-economic deprivation reflected by poverty, poor levels of housing, overcrowding, and subsequent child adjustment problems mediated primarily by coercive and pathogenic parenting practices are some issues that lie at the basis of adolescent problem behaviour (Diaz, Dusenbury, Botvin & Farmer-Huselid, 1997; Dishion, 1990; Farrington, Loeber, Elliott, Hawkins, Kandel, Klein, McCord, Rowe & Tremblay, 1990). Research has indicated that financial pressures and economic hardship evident in disadvantaged neighbourhoods tend to demoralise and distress parents, adversely affect the skill of parenting practices, and ultimately impose a negative influence upon the adaptive nature of adolescent development. This negative impact has been found amongst both male and female youth (Conger et al., 1992; 1993).
2.3.3 **Economic hardship**

Continual and increasing economic hardship creates an undue level of preoccupation with budgetary management and financial issues, resulting in frustration and anger, depression, escalating and unresolved conflict, inconsistent discipline practices, marital/partnership conflict, and gradual fragmentation among close family members (Conger et al., 1993; Lempers & Clark-Lempers, 1997; Lempers, Clark-Lempers, & Simons, 1990). Furthermore, adolescents from families that have experienced job loss have been shown to report higher levels of conflict with their parents (Flanagan, 1990). A negative inverse association between impoverished socio-economic status and adolescent drug and alcohol misuse has also been noted (Robins & Ratcliff, 1979, as cited by Hawkins et al., 1992).

2.3.3.1 **Poverty and adolescent problem behaviour.** While Jessor et al. (1977; 1998) have acknowledged that one must not ignore efforts to understand social and personal deficits brought about by poverty and social disadvantage, at the same time they emphasise that many youth are not defeated by poverty. That is, poverty does not automatically mean that youth fail to stay at school and graduate, or mean that they will necessarily fall foul of the law, or engage in health and life-compromising activities (Jessor et al., 1998). The challenge therefore is one of both understanding the social and personal processes that underpin poverty and disadvantage, as well as accounting for reasons why a significant number of adolescents do well in spite of limited opportunities and personal dangers inherent in their life settings (Jessor et al., 1998). This challenge once more calls to mind the notion of resilience presented earlier (Rutter, 1987).

In short, it is a challenge of understanding the mutual relationship of risk and protection, with one being found in the presence of the other. If an awareness of the
importance of developing a protective environment can be strengthened in the parents of adolescents who are potentially vulnerable to problem-related risk, then the likelihood of adolescents being defeated by social, peer-related, and economic pressures will be lessened. In other words, where parents succeed in developing a protective environment, the reward will be increased adolescent resilience against such negative influences.

2.3.4 Physiological and psychological factors

Physiological factors have been implicated in the predisposition of an adolescent towards harmful risk behaviour (Hawkins et al., 1992; Igra & Irwin, 1996; Udry, 1990). For example, asynchronous development is a further contributing factor in harmful adolescent risk behaviour. That is, where physical development precedes cognitive or emotional development, the adolescent will appear to others to be more mature than he or she actually is, and will therefore be more readily acceptable to older people. In turn, such an adolescent will be prompted to engage in more adult behaviours (drinking, smoking, sexual intercourse), as well as tend to associate with an older peer group where these behaviours would be considered normative (Igra & Irwin, 1996). Sensation seeking, prevalent in some adolescent behaviour, provides a further example of a predisposition to the excessive pursuit of potentially harmful risk (Arnett, 1994; Greene et al., 2000; Zuckerman, 1990). Intelligence is yet a further aspect that has been implicated in the adolescent’s transition from the family towards a deviant peer group. Research has shown that juvenile delinquents generally record lower IQ’s, particularly in the arena of verbal IQ, than non-delinquent adolescents (Moffitt et al., 2001; White, Moffitt & Silva, 1989). The relationship between IQ plus individual differences in neuropsychological functioning and anti-social activity holds true when IQ has been measured before the first appearance of illegal behaviour, with this relationship also
holding after controlling for socio-economic status, race, academic achievement, and motivation during testing (Moffitt et al., 2001).

Personal adolescent stressful experiences such as school experience (including high levels of stress and frustration, fear of failure, continued academic failure) and alienation from the protective values and mores of society have been flagged as risk factors for future adolescent behavioural difficulties (Seiffge-Krenke & Shulman, 1993; Stephenson, Henry & Robinson, 1996). In a comparison between Asian-Australian youth and Anglo-Australian youth, Heaven and Goldstein (2001) found that parenting factors inculcating a warm and supportive family atmosphere were important in shaping the mental health outcomes of these adolescents, and in fact were more important in the case of Anglo-Australian youth. Conversely, general family stress levels that are severe and ongoing, and the approach adopted by the adolescent in attempting to make sense of stressful situations, have been noted as a more powerful predictor of adolescent well-being than individual negative life events, as well as being a formative and negative influence on the adolescent’s chosen style of coping with stress (Seiffge-Krenke & Shulman, 1993).

Kilpatrick, Acierno, Saunders, Best & Schnurr (2000) found from their research that physical and sexual assault, the delinquent acts of peers, and other forms of witnessed violence were among the most powerful risk factors for disorders related to substance use. Psychopathological disorders associated with childhood and adolescent development, as well as ongoing domestic violence within households where the adolescent is prevented from escaping this experience, have been allied with later development of problem behaviours, including drug and alcohol misuse (Hawkins et. al., 1992; Kilpatrick et al., 2000). Oppositional defiant disorder, mood disorders, learning and reading disorders, neurobiological factors, executive cognitive function
deficits, and abnormal responses to anger that arise from an inability to measure, modify and inhibit emotional responses, rate highly amongst these disorders (Hawkins et al., 1992; Jesser, R. & Jesser, S.L., 1977; Jesser, 1998; Levy, 1997; Moffitt et al., 2001; Swaim, 1991; Vik, Brown & Myers, 1997).

The use of stimulant medications in childhood as a pharmacological intervention regimen for attention-deficit hyperactivity disorder (ADHD) has also been implicated as a risk factor for future adolescent and adult problem behaviours (Frederick & Olmi, 1994; Loebe et al., 1998; Weinberg & Glantz, 1997). Where the adolescent has relied on the support of medication without the parallel backing of a behavioural modification programme, then the adolescent will have little to draw upon in terms of personal coping resources. If this situation is further complicated with childhood memories of an attributional link between medication and improvement in behaviour and school related tasks, then it is possible for the adolescent to descend into a helpless and hopeless response style in those cases where medication ceases to be effective or is withdrawn. This scenario is especially evident where failure has been followed by successive experiences of failure (Allen & Drabman, 1991; Barkley, 1997; Dishion, Spracklen, Andrews & Patterson, 1996; Pelham, Murphy, Vannatta, Milich, Licht, Gnagy, Greenslade, Greiner, Vodde-Hamilton, 1992; Reid & Borkowski, 1987). This helpless and hopeless response style can potentially lead to socially unacceptable conduct problems, crime related behaviour, suicide attempts, substance misuse, and a general pattern of risk behaviour (Barkley, 1997).

It is not so much the use of stimulant medications to help control ADHD symptoms (which in fact might be necessary) that leads to behavioural problems, but rather the potential for negative attributional thinking that might lead from this use. It is the attributional thinking of an individual, particularly in the arenas of success and
failure, personal coping strategies, the capacity for behavioural inhibition and self-
regulation, and the ability to set goals and work towards achieving these goals that
requires careful investigation, rather than simply whether or not the individual has been
prescribed stimulant medication for attentional difficulties (Barkely, 1997).

Issues of attributional thinking and developmental differences in manifestations
of ADHD symptoms are important considerations for understanding the impact of this
disorder during adolescence. The mainly hyperactive diagnostic items of ADHD, as
noted by criteria of the Diagnostic and Statistical Manual of Mental Disorders (1994),
tend to lose their sensitivity with increasing age from childhood through to adolescence
while items related to executive functioning, particularly inattention, become more
prevalent across middle childhood and particularly into adolescence (Hart, Lahy,
Loeber, Applegate & Frick, 1995). Furthermore, items related to executive functioning
have been found to persist into adulthood (Murphy & Barkley, 1996). Assessment of
adolescent problem behaviour would therefore consider the influence of ADHD-related
items more commonly found in adolescence. The aim of this component of assessment
would not be to diagnose ADHD in adolescence. Rather, once the clinician has
determined that ADHD has been properly diagnosed prior to or during adolescence, the
aim would be one of exploring avenues of behaviour that reflected problems in
executive functioning, particularly problems linked to behavioural self-regulation and
inattention.

2.3.5 Negative parental affect

Associations have been found between parental stress and depression, negative
family interactions, and adolescent problem behaviour. This is particularly notable for
parents in single-parent situations since they lack the support of another significant
person (Heinicke & Vollmer, 1995). Furthermore, stress and depression have been
described as umbrella terms subsuming negative life events, discord among partners, poor socio-economic status, problems with alcohol and drug use, and daily hassles. Consequently, parenting effectiveness suffers (Heinicke & Vollmer, 1995; Henry, Caspi, Moffitt & Silva, 1996). In these situations, coercive styles of discipline emerge, fracturing the bond between parent and adolescent. In turn, these coercive styles describe a violent cycle of the stressed parent reacting irritably to the provocative and aggressive adolescent (Smetana, 1995).

Emotional fragmentation is often characterised by a serious lack of outside social contact and support from friends and extended family, particularly for the single parent. This social isolation becomes intensified when the greatest majority of interaction experienced by the parent is represented by unpleasant hostile contact with resentful and aggressive sons and daughters (Ge, Conger, Lorenz & Simons, 1994; Smith & Stern, 1997; Webster-Stratton, 1990). A subsequent fractured relationship between parent and adolescent will undermine the adaptive nature of adolescent autonomy (Hawkins et al., 1992; Smetana, 1995; Smith & Stern, 1997). This fracturing will exacerbate an already established risk factor for negative adolescent behaviour, particularly in relation to the adolescent’s choice of peer associations (Clark & Shields, 1997; Pastore & Ainley, 2000; Pinderhughes, Dodge, Bates, Pettit & Zelli, 2000).

2.3.6 Modelling of peer behaviour

The peer group is a crucial factor when considering the level of harm in adolescent behaviour. Adolescents’ actions have their clearest and strongest meaning when they serve the purpose of achieving a stronger sense of self and a firmer sense of belonging within the realm of one’s friendship group. When this comes about as a result of harmful risk behaviour, personal goals have still been achieved and behaviour has
still been rewarded, with future repetition of that behaviour being dysfunctionally reinforced as desirable and purposeful (Greene et al., 2000; Lightfoot, 1997).

Negative and unhelpful friendship patterns have been found to set the scene for deviancy training. Poulin and Dishion (1999) found that boys who engaged in delinquent activities also reported poor quality friendships from 13 to 14 years of age. They also experienced the highest rate of escalation in delinquent behaviour. Poulin and Dishion (1999) suggested that the reciprocal models of selection and negative influence explained this phenomenon. Similar to functional friendships, dysfunctional adolescent friendships provide relational networks that are autonomous from the protective environment of the family, with the troubled or marginal character of these friendships influencing the establishment of further unhealthy friendships. A combination of poor quality friendships with a history of deviancy would lead to an escalation in patterns of problem behaviour, thus amplifying the notion of deviancy training.

The synergistic effect of rituals of acceptance and rejection, peer interactions, and status of relationships can influence the escalation of deviant behaviour by attracting and “training” adolescents who are already engaged in delinquency, and who in the past have experienced poor quality friendships. Adolescents who are influenced by these friendships further escalate in problem behaviour in a feedback process and consequently influence and train other adolescents who follow in their footsteps (Dishion, McCord & Poulin, 1999). Furthermore, while boys appear to engage in more aggressive and crime-related behaviour than do girls (Moffitt et al., 2001; Poulin & Dishion, 1999; Simone et al., 2000), it would seem reasonable to assume that girls would still seek out close friendships among female adolescents who shared similar needs, and who in turn would influence others who became part of that peer group.
2.3.7 *Disengagement from school.*

Disengagement from school has been found to be a risk factor for adolescent deviant behaviour and family fragmentation (Steinberg, Brown & Dornbusch (1996), since engagement within the school environment will be less likely to leave spare time for deviant behaviour due to a school-focused attention on curricular and extracurricular activities. Furthermore, the presence and influence of a peer group that strives after academic achievement has been noted as a strong protective factor against adolescent problem behaviour (Steinberg & Avenevoli, 1998). A positive association between authoritative parenting and successful school performance, and an alternative negative association between authoritarian and permissive parenting, has also been indicated in research literature (Steinberg, Elmen & Mounts, 1989).

Steinberg and Avenevoli (1998) found interesting links between school disengagement and two indicators of contextual risk, namely parental permissiveness and the adolescent’s intensive part-time employment. They found that school disengagement was more likely to predict parental permissiveness and part-time employment, rather than the reverse. Although other research has noted that students who have left school prematurely, or who are loosely committed to school achievement, are more likely to become involved in seeking part-time jobs and working long hours at these jobs (Steinberg & Cauffman, 1995), Steinberg and Avenevoli (1998) found that parental permissiveness is likely to be a reaction to school disengagement rather than a causative factor.

Steinberg and Avenevoli (1998) have suggested parental frustration at not being able to control both the adolescent’s involvement in part-time work, and the presence of other dysfunctional adolescent behaviours or attitudes that have become enmeshed in the adolescent’s school disengagement and job-involvement, as being likely factors
leading to this reaction. As a result, the matrix of adolescent problem attitudes and
behaviour would be likely to push the parent away from using protective strategies such
as monitoring and limiting the adolescent’s activities, opting instead for an attitude born
of frustration whereby the parent would eventually give up on the adolescent.
Furthermore, where adolescents have already engaged in delinquent behaviour, parents
would be apt to becoming lax and apathetic about the need to monitor their adolescents’
whereabouts and activities, especially in cases where other agencies or individuals have
already taken over control of the adolescent’s aberrant behaviour (Dishion, Patterson,
Stoolmiller & Skinner, 1991). In like manner, problem behavioural characteristics in the
adolescent’s behaviour, especially those of rebelliousness and oppositional behaviour,
would be likely to urge the adolescent into school disengagement. The intersection of
these various parent and adolescent factors would conceivably emerge as a general
parental and family environment of risk for the adolescent. This in turn would be likely
to lead into a pattern of problematic adolescent behaviour, and the subsequent potential
for a dysfunctional peer group becoming the primary influential presence in the
adolescent’s life.

2.4 The protective influence of functional parenting skills

The parent management skills described in this section have been found to
provide an environment of protective influence over the adolescent when located within
the family context. Research has clearly acknowledged that intervention will have a
positive outcome for the troubled adolescent only if the parent is committed to forming
management skills that are more appropriate for healthy adolescent development
et al. (1997) supported the conclusion that poor parental supervision, parental rejection,
and low levels of parent involvement will ultimately lead to a fragmented parent-
adolescent relationship, and strongly predict conduct problems and delinquent behaviour among adolescents. Andrews, Foster, Capaldi & Hops (2000) have stressed the link between the presence of conflict within the family during adolescence and the conflictual nature of a dyadic relationship in young adulthood. Dysfunctional behaviour patterns modelled by parents and learned by their children or adolescents will most likely be practised during future courtship and marriage (Andrews et al., 2000).

The strength and quality of the relationship between parent and adolescent is a central issue when attempting to describe, understand, and improve an adolescent’s manner of interacting with people and events (Kumpfer at al., 1999). The research findings of Andrews et al. (2000) supported other research that has noted a relationship between parent-adolescent conflict (especially in the domain of dysfunctional parent-adolescent communication patterns) and the child or adolescent’s inability to function well in future dyadic relationships. The findings of Andrews et al. (2000) further emphasised the importance of developing a family environment during adolescence that enhanced positive communication patterns, and prepared the way for future social relationships, thus providing a nurturing environment while the adolescent moved towards adulthood.

2.4.1 The reappraisal of parenting skills for adolescence

The physical, emotional, cognitive, and relational changes embedded in adolescent development challenge the parent to reappraise not only the physical and verbal style of relationship with the adolescent, but also the parent’s perception of the adolescent’s changing role in both family and society (Bosma et al., 1996; Grolnick, Weiss, McKenzie & Wrightman, 1996; Noller & Callan, 1991; Noller & Patton, 1990; Riesch, Tosi, Thurston, Forsyth, Kuenning & Kestly, 1993). The parent is further challenged to readjust patterns of communication, problem solving and parenting style,
as well as develop the readiness to allow the adolescent to become more personally responsible for his or her actions and decisions. During adolescence in particular, a parent needs to become more flexible in his or her discipline style, matching this style to the adolescent’s perceptions of and reactions to conflict situations (Hastings & Grusec, 1997). The content of ‘old’ parenting skills (such as the need for parents at times to have the final say, or to be responsible for the adolescent’s safety) might still be valid in adolescence. However, the manner in which this content is portrayed must be re-defined by the parent – ‘old’ strategies need to be honed so that they fit more comfortably and appropriately with the different stages of adolescent development (Biggam & Power, 1998; Bosma et al., 1996; Cay Kelly & Goodwin, 1983; Clark & Shields, 1997).

The use of developmentally appropriate parenting skills during adolescence leads to a transformation, not a weakening or abandonment, of the role of the adolescent within the family. Appropriate skills lead also to a strengthening of the relationship between the adolescent and each family member (Robin & Foster, 1984; Foster & Robin, 1998). Adopting this approach reinforces in the adolescent the sense of being closer to the privileges and responsibilities of adulthood rather than to the dependency of childhood. This in turn will enable the adolescent to develop a sense of autonomous self that orients him or her towards mature adulthood, with the added benefit of encouraging the adolescent to model a healthy parent-adolescent relationship for younger siblings (Hanson, Henggeler, Haefele & Rodick, 1984; Smetana, 1995). Thus adolescent behaviour may be viewed as belonging to a comprehensive family-ecological approach within a relationship-context that is reciprocal and bi-directional in nature (Henggeler, Cunningham, Pickrel, Schoenwald & Brondino, 1996; Henggeler, Rodick, Borduin, Hanson, Watson & Urey, 1986; Schoenwald, Brown & Henggeler, 2000; Stern, 1999).
A family environment that advances positive and effective communication, warmth and acceptance, strong parental support, and a readiness for discussion and negotiation with the adolescent is therefore ideal for healthy adolescent development (Pastore & Ainley, 2000; Robin & Foster, 1984; Foster & Robin, 1997). On the other hand, an atmosphere dominated by criticism, rejection, and lack of readiness to communicate and negotiate will foster poor self-image and encourage risk-prone problem behaviour within the adolescent (Baumrind, 1991; Foster & Robin, 1997; Jenkins & Zunguze, 1998; Juang & Silbereisen, 1999; Klein et al., 1997; Mak & Kinsella, 1996; Noller & Patton, 1990).

2.4.2 Communication skills and the parent-adolescent bond

Effective communication patterns between parents and adolescents have consistently remained the essential factor for ensuring that the parent and adolescent maintain trust, support, and warmth in their relationship (Andrews et al., 2000; Foster & Robin, 1997; Grolnick et al., 1996; Pastore & Ainley, 2000; Robin & Foster, 1984). Pastore & Ainley (2000) strongly suggested that the manner in which a parent or adolescent appraised levels of conflict and hostility in situations of verbal interchange is an important factor in determining the quality of the outcome of this interchange. Being able to avoid initial aggravation, antagonism, and even rage in parent-adolescent communication relies on both parties adopting the correct interpretation of what has been spoken between them. At the same time, correct interpretation of what is spoken between parent and adolescent does not necessarily insist on mutual agreement between both people about the content of the communication.

In family environments where adolescent problem behaviour was absent, Youniss and Smollar (1985) found that adolescents perceived their communication with each parent differently. Adolescents (and in particular daughters) viewed mothers as
being more understanding and responsive, as showing greater interest in the daily events and problems of their sons or daughters, and more ready to enter negotiation. On the other hand, adolescents appeared less willing to engage in conversation with their fathers over issues of personal adjustment or feelings. Furthermore, adolescents perceived their father to be more evident as the figure of authority than their mother. Research by Noller and Callan (1990) showed little difference between younger and older adolescents in how they viewed communication with their parents. When levels of dominance were rated, adolescents indicated their belief that parents dominated the conversation and offered little opportunity for them to express their opinions. Increases in age did not appear to effect any change in this finding.

Noller and Callan (1990) also found that under normal circumstances adolescents did not ‘tell all’ to their parents. Furthermore, with regard to sexual attitudes, information and problems, relationships, future plans, and general problems, they found that the highest level of disclosure for these topics was between females and mothers. Males tended to disclose more to their fathers than did females about sexual information, sexual problems, and general problems. The adolescent’s plans for the future provided the most discussed topic by males and females with both parents. Noller and Callan (1990) saw the reason for this focus as founded in the adolescent’s need for parental support in helping to bring these plans to reality. Finally, females appeared to feel more satisfaction when speaking with their mothers than with their fathers, whereas males were equally content to speak with both parents.

Research findings by Marta (1997) also revealed differences between mothers’ and fathers’ communication with their adolescents. Although traditionally less involved with child rearing, fathers emerged as important figures in discussing situations of risk with the adolescent. Fathers also appeared to be more reliable sources of information about
significant issues involving their sons and daughters, especially in relation to matters of self-adjustment. On the other hand, Marta (1997) found that mothers were not as reliable, even if the adolescent perceived him or herself as having a better relationship with the mother than with the father. These findings would have important implications for the clinical reliability of assessment findings for adolescent behavioural risk using information provided by the parent only.

Where adolescent problem behaviour is evident, family members have been found to interact with each other in ways that neither resolve conflict nor invite productive communication, with a clear failure to respect and involve all parties concerned. High levels of conflict and poor communication are likely to result in the automatic perception that any response from any family member is necessarily and intentionally aggressive. The failure to address problem issues with the adolescent through effective communication patterns further leads to situations of stress and conflict within the family environment, and this in turn results in inappropriate and poorly executed attempts by parents to find a solution. Usually a coercive response cycle emanates, with parents desperately attempting to suppress aggressive reactions, enforce compliance, and quell the escalation of antagonistic behaviour by constraint, mostly with little success (Clark & Shields, 1997; Kumpfer et al., 1996; Smith & Stern, 1997). Parent management styles, and particularly coercive parent-adolescent interactions, have also been found to produce unskilled and coercive adolescent response patterns towards peers and later partners in adulthood (Andrews et al., 2000).

2.4.3 Parental monitoring and limiting of adolescent behaviour

The interrelated strategies of parental monitoring and limit setting are closely linked to an open and conciliatory style of communication (Dishion et al., 1999; Dishion & McMahon, 1998; Reisch et al., 1993). Parental monitoring is an
interconnected set of apt behaviours that enable the parent to keep track of the adolescent’s whereabouts, activities, and intentions (Dishion & McMahon, 1998), and in turn leads to the setting of limits upon the adolescent’s behaviour. In general, monitoring has been described as a “common denominator” across a variety of intervention and developmental theories concerning parenting practices (Dishion & McMahon, 1998, p.63). A lack of parental monitoring and related limit setting has been linked with a wide range of adolescent problem behaviours, particularly a general level of association with deviant peers and early onset of substance misuse that is modelled and approved of by the deviant peer group (Dishion et al., 1999). Monitoring of adolescent behaviour has been further highlighted as a prerequisite for effective family management practices (Patterson & Stouthamer-Loeber, 1984).

The adolescent’s peer group provides age-related mates with whom the adolescent participates in youthful activities and experiments with adult-oriented behaviour. It is essential therefore for the parent to be aware of what comprises this peer-related behaviour, when and where it is taking place (and how safe that environment is), with whom it is taking place, and for how long it will occur. This information also provides the context for knowing how far the parent needs to limit the adolescent’s activities. A parental approach such as this greatly enhances the role of providing a safe and protective setting for the son or daughter (Dekovic & Meeus, 1997; Dishion & McMahon, 1998; Kirchler, Palmonari & Pombeni, 1993). When engaged in both tasks of monitoring and limit setting, parents walk a fine line between tracking their children’s activities while also respecting the need for adolescent privacy. Respectful and honest communication between adolescent and parent, with the parent being the primary person responsible for this style, becomes the founding principle for
maintaining this balance (Foster & Robin, 1997; Grolnick et al., 1996; Robin & Foster, 1984).

Effective parental monitoring and limit setting underpins a number of facets of parental management. Firstly, age-appropriate and developmentally appropriate strategies of monitoring and limit setting presumes that the parent understands the implications of the various stages of adolescent development, especially with regard to the adolescent need for autonomy. Secondly, an open interchange of communication between parent and adolescent is required so that when broaching sensitive issues with the adolescent such as peer related activity and relationships, the parent will be able to trust in receiving an honest response from the adolescent. This is of particular importance in the early adolescent years when the child is most vulnerable to risk behaviour, due mainly to a lack of experience and an associated sense of newfound freedom (Stoolmiller, 1994). Finally, the readiness of the parent to monitor and limit adolescent activity within an atmosphere of respect and genuine concern can become a further means of strengthening the bond of warmth and trust between the adolescent and the parent.

Mutual trust between adolescent and parent is the fundamental element that enables the monitoring and limiting of adolescent behaviour to function as a protective factor embedded in a nurturing relationship, rather than as a reactive quest for information founded on the type of suspicion that undermines this relationship (Grolnick et al., 1996; Peterson, 1990).

2.4.4 Parenting style

The manner of parenting style adopted by a parent will be a strong determinant in the outcome quality of any parent-adolescent interchange, whether in connection to monitoring and limiting adolescent activity, resolving problems or conflicts, or merely
dealing with everyday issues. Parenting styles appropriate for adolescent development vary along two orthogonal dimensions. One dimension refers to the necessary demands a parent places upon the adolescent. The other dimension refers to the manner in which the parent responds to the adolescent when these demands are expressed by the parent or acknowledged by the adolescent. When crossed, these dimensions produce distinct styles of parenting. They have been described as authoritative, authoritarian, permissive, and neglecting/rejecting styles of parenting (Baumrind, 1991; Smetana, 1995). The principal difference between the authoritative and authoritarian styles of parenting, and the permissive and neglecting/rejecting styles, is that the former styles adopt the standpoint of having the right to regulate the adolescent’s behaviour, with the authoritative style being superior to the authoritarian style. Permissive and rejecting/neglecting styles express no control, and attribute the right of self-regulation to the adolescent, regardless of the adolescent’s readiness to responsibly undertake this task (Baumrind, 1991).

The use of an authoritative parenting style with an adolescent is appropriately linked with indicators of adolescent development, such as hypothetical reasoning, the need for autonomy, the increasing importance of the peer group’s influence, and so forth. The readiness of the authoritative style to enter discussion with the adolescent about responsibilities, conflicts, and problems, reasons for decisions, flexibility in considering possible alternatives, and conclusions that as far as possible are mutually acceptable, fits well with adaptive adolescent development (Baumrind, 1978; Shaw & Scott, 1991; Smetana, 1995). An authoritative style of parenting with an adolescent is closely underpinned by effective skills of communication, monitoring, and limit setting. An authoritative style reflects a parent who is sensitive to the feelings, needs, and wishes of the adolescent, and yet at the same time is prepared to ask difficult questions
about the adolescent’s social engagements away from home. The authoritative parent will not back away from making firm decisions even in the face of a negative reaction from the adolescent. After all has been discussed and heard, there are occasions when the parent will need to close further discussion and adhere to an unpalatable decision.

The authoritative style is the preferred style for achieving adaptive adolescent development. According to the orthogonal dimension of responsiveness and demand, the authoritative style results with a balance that will most likely lead to the adolescent’s compliance with the parent’s expectations, as well as the reassurance that this compliance is genuine and therefore able to be trusted. When set, resulting expectations should be clear, as also should the consequences for non-compliance. The parent’s level of monitoring should provide sufficient knowledge about the son or daughter’s activities without being intrusive or inappropriately restrictive. Furthermore, the authoritative style enables the parent to model qualities of assertiveness and self-regulation for the adolescent’s use when he or she needs to make decisions in the absence of parental support.

Where problem-solving discussions are fraught with conflict, as would be the case when the parent adopts a purely authoritarian style, the ‘flight to peer’ phenomenon can occur (Dishion & McMahon, 1998). In this response, the adolescent deals with family conflict by escaping home and parent and spending more and more time with peers. In these situations the peer group that is sought out in preference to home and family is more likely to be a troubled group, since ‘like attracts like’. Where this peer group is deviant, the adolescent will ensure that any attempts by the parent to keep track of his or her activities are avoided by seeking out community and other settings where protective adults are absent. The parent will increasingly lose contact with the adolescent, as well as the ability to control the various facets of the adolescent’s activities, and the deviant
peer group will increasingly become the formative point of influence for the adolescent. If this becomes the commonly accepted basis for the parent-adolescent relationship, then it is conceivable that the parent will tend to give up on the son or daughter by adopting a permissive or neglecting style of parenting. Blissful ignorance about the son or daughter’s activities will eventually justify the outcome of accepting no obligation to act upon the adolescent’s behaviour (Dishion & McMahon, 1998).

Vuchinich, Bank and Patterson (1992) have espoused the link between parenting style and quality of parent-child interactions, and the probability of negative behavioural outcome as the child moves into adolescence due to inappropriate and therefore unhelpful parenting style. The research findings of Vuchinich et al. (1992) have shown evidence for a reciprocal effect between ineffective parent discipline and childhood antisocial behaviour that has the effect of maintaining both aspects in a cyclic fashion. Vuchinich et al. (1992) have also cited longitudinal studies of childhood temperament linking ongoing inept parenting practices, particularly erratic expressions of anger towards the child, with the maintenance of childhood antisocial behaviour. As the child grows into the adolescent years, this antisocial behaviour becomes generalised into and supported by a delinquent peer group. The emerging interplay between antisocial behaviour and a delinquent peer group further leads to and solidifies the “flight to peer” phenomenon described by Dishion & McMahon (1998).

Deviant peer involvement and risk behaviour can also be placed in the historical context of family relationships as well as inept parenting practices. Different forms of parental authority coexist during the adolescent years, with both adolescents and parents being found to hold differing views about what domains of behaviour would constitute legitimate parental authority (Smetana, 2000). Smetana and Daddis (2002) have examined parental authority within the context of parent-adolescent conflict over
personal freedoms versus social-conventional issues. Matters such as choice of friends, decisions to engage in preferred activities, and issues pertaining to the personal aspects of one’s life, would be considered by adolescents to lie outside the arena of their parents’ control and authority. On the other hand, parents and adolescents would agree that issues concerning societal norms, moral matters, and family regulation would rightly belong to the domain of parental authority (Smetana, 2000). This separation of opinion concerning what does and does not lie within the realm of parental authority derives from the adolescent's psychological need for autonomy. The desire and expectation to regulate one’s personal life, as opposed to having authority over social, moral, and family matters, enables the adolescent to increasingly perceive him or herself as being an effective, competent, and uniquely identifiable individual within the social realm (Barber, 1996). This psychological need for autonomy and personal competency is eventually satisfied when the adolescent defines a clear arena of control over his or her personal issues (Nucci & Smetana, 1996).

Disagreement between adolescents and parents over where to draw the boundaries of legitimate parental authority has been found to play a major role in parent-adolescent conflict (Smetana, 2000; Smetana & Daddis, 2002). When adolescents believe that their parents are involving themselves in personal arenas such as friendships, self-care, organising one’s time, and so forth, it is likely that adolescents will interpret this involvement as psychologically intrusive and controlling (Pettit, Laird, Dodge, Bates, & Criss, 2001). Parent-adolescent conflict is then likely to result, with this conflict extending into the adolescent’s rejection of the parent’s attempts to monitor his or her activities and associations, even if the parent’s attempts at monitoring the adolescent’s behaviour are both appropriate and justified (Pettit et al., 2001). This combination of parent-adolescent conflict and an eventual lack of behavioural control by the parent is
likely to lead to morally and socially offensive behaviour by the adolescent (Smetana & Daddis, 2002), with the further likelihood that this type of behaviour will draw the adolescent away from the milieu of parent and family into the influential circle of a dysfunctional peer group (Dishion & McMahon, 1998).

Appropriate parenting style that respects the different developmental needs ranging from childhood to adolescence provides the strongest buffer against this damaging progress of events between parent and adolescent. A longitudinal study conducted by Pettit et al. (2001) found that proactive parenting extending from early childhood into adolescence predicted healthy and effective levels of parental monitoring of behaviour during adolescence, together with the adolescent’s readiness to accept parental monitoring as legitimate. The adolescent’s readiness to accept legitimate parental monitoring was strengthened by the parent’s willingness to allow the adolescent to exercise increasing levels of control over personal issues, as the adolescent grew older (Smetana, 2000; Smetana & Daddis, 2002).

Hirschi (1969), according to control theory, hypothesised a connection between the tendency of adolescents towards socially aberrant behaviour and the level of adolescent attachment to and respect for parents. Other research has furthered the concept of attachment to teachers and school (LaGrange & White, 1985). The research findings of Hirschi (1969), that described the depth of attachment and consequent affection between the parent and adolescent as being the strongest predictor of adolescent ant-social behaviour, provide firm support for encouraging a parenting style that engenders a robust and genuine parent-adolescent bond, and that in turn also retains the adolescent within the protective sphere of positive parental influence.

Unlike the research findings of Hirschi (1969) and other later related research, the findings of Leas and Mellor (2000) indicated only a low predictive power for the
variable of parental attachment in relation to adolescent delinquency. However, a subsequent analysis of subscales of parent attachment showed that trust and communication made small though significant contributions to the predictive power of parent attachment for delinquency. In response to this finding, Leas and Mellor (2000) highlighted the importance of the relationship between parental understanding, respect, and mutual parent-adolescent trust, and the wellbeing of the adolescent. The findings of Leas and Mellor (2000) further emphasise the importance of developing an appropriate style of parenting with an adolescent, since these characteristics describe the essential elements of an authoritative style of parenting.

It would stand to reason that where the quality of the parent-adolescent relationship has seriously deteriorated because of a breakdown in these characteristics, the respect of the adolescent for his or her parents, as well as the adolescent’s wish to maintain a bond with one’s parents, would most likely diminish. As a result, the adolescent’s drift towards attachment to a deviant though accepting peer group would very likely become a desirable alternative to the unhappy outcomes of a coercive or dismissive parenting style. In circumstances where the adolescent saw the bond with one’s parents as having little or no value, then the cost entailed in placing this bond at risk by engaging in a problem behaviour lifestyle would be considered as inconsequential by the adolescent. Alternatively, where the parent encouraged a relationship of genuine openness, interest, and trust towards the adolescent, it would be reasonable to assume that the adolescent would not only appreciate such an approach but would also value it and avoid jeopardising his or her parent’s approval or affection by engaging in socially aberrant behaviour (Leas & Mellor, 2000).

Conrade and Ho (2001) cited research conducted by Baumrind and Black (1967) in which were found gender differences in parenting styles and gender-related differential
treatment towards the child. At the same time, Conrade and Ho (2001) pointed out that these findings have been largely overlooked until recently, even though they would appear to have much importance in research on parenting styles. Studies on gender differences in parenting styles have shown that mothers may be more authoritative than fathers in their parenting styles (Conrade & Ho, 2001; Smetana, 1995).

2.5 Cultural sensitivity – a comment

Foster and Martinez (1995) suggested that while ethnicity and culture are words often used interchangeably, culture is the more inclusive term that denotes the unique identity of individual social groups, and hence the rightful membership of people within a particular social group. As such, Foster and Martinez (1995, p.215) have defined the word culture as inclusive of a “shared set of learning experiences, situations, beliefs and behavioural norms…as well as physical objects unique to that group (e.g., tools, art, and buildings)”. It would therefore be evident that when attempting to help parents who belong to various cultural backgrounds, it would be both respectful and essential to take into account their formative experiences via exposure to the elements referred to by Foster and Martinez (1995), especially those formative experiences related to their parenting practices, and linked to family of origin experiences. These issues are by no means insignificant, particularly in relation to adolescent development, behaviour, and the parent-adolescent relationship, especially when this relationship begins to break down and intervention is required. Scheier, Botvin, Diaz and Ifill-Williams (1997) have reported a number of studies demonstrating the specific role of cultural identity in the aetiology of mental health problems, self-esteem, personal and social development and well-being, academic achievement, and both a positive and negative relationship between cultural identity and drug use.
Scheier et al. (1997) have also linked cultural issues with the developmental task of identity formation in adolescence. They have noted that minority youth face the added challenge of coming to terms with issues of cultural self-identification and validation, stating that the failure “to create a balance between ethnic and personal identity may result in feelings of cultural and personal inadequacy, marginality, and role confusion…” (pp.23-24). There is an added issue linked to this sense of personal and cultural identity, namely the possible differentiation between adolescents who have been born in Australia and their parents who have been born in their native country and emigrated to Australia. The presence of cultural confusion would most likely be evident in conflict between these parents and their adolescents with respect to role-expectations expressed by both parties.

Within Australia, the research for this thesis was principally conducted within the Illawarra and Shoalhaven Regions, and the Campbelltown-Macarthur Region of New South Wales. The challenges arising from different cultural backgrounds such as those outlined above by Scheier et al. (1997), and related to the cultural elements described by Foster and Martinez (1995), would also apply to so-called minority groups within these community regions. A nation-wide census is currently being taken within Australia; hence the following percentages were necessarily gleaned from the previous 1996 census (Australian Bureau of Statistics, Census of Population and Housing, 1996). According to these earlier figures, within the Illawarra Region, 2.3% of the total population of persons were of Aboriginal or Torres Strait Islander origin, and 19.6% came from cultural backgrounds other than Australian-born. For the Shoalhaven Region (the southern geographic neighbour of the Illawarra Region), 3.2% of the population were of Aboriginal or Torres Strait Islander origin, and 11.1% came from cultural backgrounds other than Australian-born. In the Campbelltown-Macarthur Region (the
north-western neighbour of the Illawarra Region) these percentages were 2.3% and 18.7% respectively.

These percentages clearly indicate the need to be aware of and sensitive towards the variety of cultural needs among people. The need for such awareness and sensitivity was not ignored at the outset of this research. Yet as time progressed, it became evident that a detailed investigation into the implications of cultural issues for adolescent parenting practices extended far beyond the parameters of this research. As a dichotomous situation, the crossover between the need for awareness and sensitivity, and the practical limitations of time and resources, nonetheless needed to be satisfactorily resolved. Speight, Myers, Cox and Highlen (1991) addressed a similar issue of multicultural differences among people who sought counselling. Within the wider context of counselling, they cast doubt over the tendency to equip counsellors with mastery over all possible characteristics of cultural groups before being permitted to work with these people.

Speight et al. (1991) have described this tendency as a multicultural ‘cookbook’ approach, with every cultural group receiving a ‘recipe’ of counselling checklists and instructions (see also Myers, Speight, Highlen, Cox, Reynolds, Adams & Hanley, 1991). In response, Speight et al. (1991) queried how many pages would be required in this cookbook in order to address every issue of every group. Alternatively, they suggested that the ‘best’ counselling scenario was one that minimised the cultural differences among clients, leaving counsellor and client on mutually comfortable ground regarding important racial or cultural dimensions. Furthermore, Speight et al. (1991) refer to Sue (1988) who questioned the value offered by such distal variables as race and ethnicity in clarifying the influence of cultural issues such as attitudes, emotions and values of individuals who seek help. That is, placing the focus on the
cultural characteristics of the client might result in compromising the personal characteristics of the individual (Speight et al., 1991). The further risk of oversimplifying the reality of peoples’ difficulties (regardless of cultural background) might also result from a complex portrayal of cultural characteristics (Myers et al., 1991).

These comments appeared to offer a path towards resolving how the issue of cultural differences might be addressed in this research. The concern was that in attempting to account for all cultural issues that might surface among parents, one would lose touch with the very human and immediate situations confronting these people as individual parents in their individual family situations. It was envisaged that when parents arrived seeking help for relationship problems with their adolescent, they would do so as distinct and unique persons. Though cultural backgrounds might be different, a parent’s need to improve relationship difficulties with the adolescent son or daughter would be the common factor binding this particular parent with other parents in similar circumstances. This need to improve the parent-adolescent bond was seen to exist regardless of any one cultural background. It was not that cultural backgrounds would therefore cease to matter. Rather, cultural backgrounds would be entwined with the rich fabric of experience that each parent brought to the eventual intervention group experience. A further related issue was also considered. It could become possible that any obvious delineation of cultural and other related issues might be perceived by parent participants as a form of judgment on their parenting and family situations. That is, parents of differing cultural backgrounds might hear the message that their family management difficulties have resulted in some way from their awkward cross-cultural handling of situations and events with their child.
When the intervention programme was developed, cultural differences were therefore respected by adopting a flexible approach to actually conducting the programme week by week. Sensitivity towards cultural considerations was accounted for in a twofold manner. Firstly, it would always remain the responsibility of the one who implemented the programme to exercise sensitivity for the requirements of his or her audience without alienating any individual group member (this would also apply in the one-to-one setting). Secondly, parents within any one group would be encouraged to support each other regardless of their background (cultural or otherwise). That is, the bond that drew them together was based first and foremost on the experience of being a parent. This would also mean that parents would have the opportunity of sharing the experiences of people who came from cultural backgrounds that differed from their own. Therefore group leadership would demand a ready and watchful openness towards cultural sensitivity throughout the progression of the programme, rather than a ‘how to do it’ list of directions applicable to each individual consideration (Foster, Martinez & Kulberg, 1996).

2.6 Chapter summary

This chapter has reviewed the notion of adolescent risk against the background of risk and protective factors in adolescent development. In particular, domains of adolescent risk possessing the potential to escalate into problem behaviour were considered, including drug and alcohol use, the social environment, economic hardship, psychological and physiological factors, negative parental affect, and the modelling of peer behaviour. The protective nature of effective parenting approaches during adolescent development was treated in detail, including the skills of communication, monitoring and limit setting of adolescent behaviour, and the benefit of utilising an authoritative style of parenting. Finally, the manner in which cultural sensitivity was
treated in this research was described as a concluding comment in this chapter. Chapter three will describe the theoretical underpinnings that led to the development of the TANDEM programme.
CHAPTER THREE
THEORETICAL UNDERPINNINGS OF THE RESEARCH

Research literature presented so far has noted adolescence as being a developmental phase that is highly sensitive to psychological, physical, and emotional vulnerability. The necessary support of protective factors for adaptive entry into adulthood is not always available for the adolescent. Nor do those who are in the position to offer this support always possess the skills or readiness to be a means of support. Hence adolescent vulnerability can readily turn into adolescent deviancy, whereby the adolescent deviates from an adaptive pathway of development. The dictionary meaning of the verb to deviate is the act of turning away from an accepted norm of behaviour. Thus when the adolescent deviates from developmental pathways that have been proven to result in functional and reasonably contented adulthood, the end point of this deviance is a life marked out by problems of many different though intricately linked kinds. The problem behaviours characterising this deviancy will arise from an interactive matrix of risk factors belonging to a range of biological, psychological, and social domains.

3.1 The biopsychosocial model of adolescent problem behaviour

The model describing this interaction of domains has been termed the biopsychosocial model of adolescent problem behaviour (Igra & Irwin, 1996; Newcomb, 1995). The biopsychosocial model encompasses both normative and non-normative adolescent behaviour. The model views the timing of adolescent maturation as being the prime influential component surrounding the adolescent’s physical development (biological domain), cognitive range and self-perception (psychological domain), and perceptions of the social environment together with the adolescent’s
personal values (social domain). In turn, how the adolescent experiences these domains during the course of adolescent development is a primary predictor of present and future harmful adolescent risk behaviour (Igra & Irwin, 1996).

### 3.2 Problem-behaviour theory

The biopsychosocial model of adolescent problem behaviour has its roots in the seminal work of Jessor R. and Jessor, S.L. (1977), who developed an interactive psychosocial model of adolescent risk behaviour entitled problem-behaviour theory. This theory in turn emerged from the concepts of social learning theory (Merton, 1957; Rotter, 1954). As with the biopsychosocial model, problem-behaviour theory described adolescent risk behaviour as resulting from an interaction of various risk factors arising from the biological, psychological, environmental, family, economic and behavioural domains of personal interaction. In particular, Jessor R. and Jessor S.L. (1977) addressed the adolescent behavioural problem areas of alcohol and drug misuse according to a longitudinal research design. The research that gave birth to problem-behaviour theory concerned a five-year longitudinal study involving 400 high school and 200 college male and female youth, ranging in ages from 12 to 22 years. Problem-behaviour theory was found to account for approximately 50% of the variance in the composite measure of adolescent problem behaviour, and in some cases more than 60% of this variance. From this point, problem-behaviour theory has continued to develop within a social-psychological framework.

Problem behaviour theory was further developed by approaching adolescent behaviour according to a multidisciplinary behavioural perspective, particularly within the contexts of family, school, and neighbourhood (Donovan & Jessor, 1985; Jessor, 1987, 1991; 1993). This theory was applied to post 1977 research into adolescent problem drinking as a means of successfully replicating the original findings (Donovan,
Jessor & Costa, 1997) and as a means of determining the role of psychosocial risk and protective factors at work in adolescent initiation into problem drinking (Costa et al., 1997; Jessor et al., 1995) and marijuana use (Jessor, Donovan & Costa, 1986). A link has also been drawn between adolescent conventional-unconventional behaviours and adolescent health-related behaviour (Donovan, Jessor & Costa, 1991) and the rejection of societal norms and early initiation into sexual intercourse (Costa, Jessor, Donovan & Fortenberry, 1995).

3.2.1 The appeal of problem behaviour theory for this research

The attractive nature of problem-behaviour theory as a theoretical basis for this research arose from its portrayal of the complex and varied nature of adolescent behaviour. According to problem-behaviour theory, no single component or domain of adolescent behaviour (for instance, substance misuse, rejection of societal norms, flight to a deviant peer group) can of itself explain or account for the situational or behavioural influences that surround adolescent activity (Jessor, 1991). Problem behaviour is conceived as an underlying syndrome or constellation of interrelated unconventional behaviours, with the adolescent taking central position within this constellation. The adolescent is the actor of these behaviours, and the recipient of the consequences resulting from the problematic covariation of the impact of these behaviours. The focus of problem-behaviour theory is therefore primarily upon the adolescent who acts, with the adolescent’s behaviour manifesting the motivation underlying that behaviour. In terms of behaviour, the focus of problem-behaviour theory is placed on the purposeful nature of the adolescent’s behaviour without making any moral or ethical judgment about the personal attributes of the adolescent.

This two-fold focus is an important consideration where the effectiveness of intervention primarily resides with a third party, as with the present research where
intervention principally engaged the parent rather than the adolescent. In the present research, the parent was encouraged to understand the problematic nature of the adolescent’s behaviour from the perspective of purpose rather than as an indication of the “goodness” or “badness” of the adolescent personally. Hopefully, this approach would further encourage the parent to strengthen the parent-adolescent bond while at the same time attempting to ameliorate unwanted adolescent behaviour through improved parenting strategies. When considered in this manner, intervention effectiveness would rely on a parent’s understanding of the impact and outcome of a covariance of adolescent behaviours, as well as a parent’s respect for the adolescent’s personality, life experience, and perception of his or her environment (Jessor R. & Jessor S.L., 1977, Jessor, 1987; 1991).

3.2.2 The conceptual framework of problem-behaviour theory

The conceptual framework of problem-behaviour theory is essentially formed around the basic tenet that all learned behaviour is functional, purposeful, and instrumental towards achieving some desired goal. The norms and expectations of the wider social culture and the day-to-day experiences of the individual adolescent shape the meanings, goals, and expressions of this behaviour (Jessor R. & Jessor S.L., 1977; Jessor, 1987; Jessor, 1998). The research focus of Jessor R. and Jessor S.L. (1977) was centred on the notion of problem behaviour in youth, and included drug use, sexual behaviour, use of alcohol, and the type of behaviour associated with excessive drinking, protest behaviour (common for the 1970’s era), and general deviance such as aggression, stealing, and lying. From a psychosocial perspective, dysfunctional behaviour linked to these domains was seen to extend beyond the genetic and biological aspects of the adolescent as well as beyond the nature of the behaviour itself. Rather, problem behaviour was viewed as relating to the personality, behavioural, and perceived environmental
characteristics of the adolescent who engages in the behaviour, including the wider social context of the adolescent’s lifestyle, and the adolescent’s attributional beliefs about the situation in which the behaviour takes place. Of its very nature, the biopsychosocial model is behaviourally inclusive, and so by definition would apply to a full range of behaviours indicative of an adolescent’s lifestyle, as indeed it does.

The definition of problem behaviour presented by Jessor R. and Jessor S.L. (1977) described the type of behaviour that incurs the control or sanction of the society in which it occurs, ranging from reproof to incarceration. The purposeful nature of adolescent behaviour and the developmentally related needs of the adolescent can lead to this behaviour becoming problematic. Adolescents who engage in potentially harmful behaviour are not necessarily pathological, irrational or perverse. Rather, engaging in behaviours such as sexual activity and drinking are an indication of the adolescent’s desire to affirm his or her maturity and entry into adulthood. When this behaviour occurs at an age-appropriate time and within the ordered context of a protective environment, it may be considered as normal and developmentally adaptive. It becomes a problem when this type of behaviour is neither age-appropriate nor buffered by a protective environment, and consequently leads the adolescent into arenas of self-harm and maladaptive development (for example, alcohol misuse and unwanted pregnancy). Age-inappropriate behaviour also becomes a problem when it represents the adolescent’s desire to satisfy unattainable goals in a roundabout way. For instance, a girl who feels controlled by parents and so unable to gain autonomy from them might engage in precocious sexual activity and even become pregnant to compensate for this unfulfilled desire for autonomy. In this situation, there would be a high likelihood that the problem was initiated by inappropriate parental management, although at the same
time acted out by the adolescent who purposefully chose pregnancy as a means of coping (albeit in an unhelpful way) with her perception of over-controlling parents.

3.2.3 The concept of proneness in problem-behaviour theory

One might imagine adolescent behaviour as a fluid continuum, with unconventional problem behaviour lying at one end, and socially acceptable behaviour lying at the other (Donovan et al., 1991). The fluidity between both points of the continuum is translated into a behavioural tension between conventionality and unconventionality. This tension may then be conceptualised as the underlying orientation towards a behavioural profile reflecting both an involvement and eventual commitment to socially acceptable values or behaviour that is opposed to these values (Donovan et al., 1991). According to problem-behaviour theory, the adolescent’s trajectory towards engaging in problem behaviour (or unconventional behaviour) is described as proneness. An adolescent’s proneness towards problem behaviour occurs within the framework of risk behaviour.

Proneness is fundamental to problem-behaviour theory, and can be contextually defined according to three systemic psychosocial domains, namely the domains of the Personality System, the Perceived Environment System, and the Behaviour System. The variables within each system comprise proneness towards problem behaviour, and they exercise a mutual, rather than a discrete, influence upon behaviour. As a result, proneness is the dynamic state generated by this mutually interconnected influence of factors. The dynamic nature of this state means that the variables belonging to each systemic domain will either instigate or set the necessary scene for an individual’s behaviour to become problematic, or control against the individual’s involvement in problem behaviour. When all systems are taken as an influential unity, then one may
speak of the adolescent as being in a state of *psychosocial proneness* either towards or away from behavioural transgression.

In the everyday reality of life, psychosocial proneness is described by the presence or absence of *psychosocial risk* factors such as poor parenting, poor socio-economic status, involvement with a dysfunctional peer group, academic failure, and so on. Furthermore, psychosocial proneness is reflected by a *covariance* of risk factors rather than representing a series of discrete risk factors, with the type of risk factors described in the previous sentence having an interactional impact upon each other. Psychosocial proneness is therefore a more complex notion than the more conventional understanding of viewing psychosocial risk as pertaining to discrete instances in an adolescent’s life. The essential notion of problem-behaviour theory is that psychosocial proneness emerges from the interaction of the person and the environment, within which one systemic domain influences the other in either a positive or a negative direction.

### 3.2.4 *Psychosocial proneness plus proximal and distal variables*

Problem-behaviour theory identifies a large number of variables in its consideration of psychosocial proneness towards deviant behaviour. These variables include antecedent demographic factors (such as education, occupation, and religious group of the parents), and socialisation factors (such as maternal and paternal religiosity, traditional beliefs, and tolerance of deviance, home climate, and peer and media influences). They also include social-psychological variables (for example the value placed on academic achievement, variables that comprise one’s personal beliefs and personal control, and variables that comprise one’s perceived environment system). Finally, they include social-behaviour variables that reflect the tension between the adolescent’s problem-behaviour structure (such as marijuana use, problem drinking,
general deviancy) and the adolescent’s conventional-behaviour structure (such as academic performance and church attendance).

All variables exercise either a *proximal* (direct) or *distal* (indirect) influence on the adolescent’s behavioural pattern. Proximal variables by virtue of the directness of their impact would yield the stronger influence, with distal variables being less evident though still influential in their impact. Jess R. and Jess S.L. (1977) described distal variables as often being of greater theoretical influence because their sway was not so obvious, always managing to stay just out of sight and yet still able to exercise influence over the adolescent’s behaviour. That is, while proximal variables might be readily noticeable, the influence of distal variables is present though not immediately evident.

### 3.2.5 The Personality System, The Perceived Environment System, and the Behaviour System

In problem-behaviour theory, variables that constitute the Personality System lie at the sociocognitive level and reflect social meanings and developmental experiences of the adolescent, such as expectations, attitudes, beliefs, and values orientated towards self and others. Therefore, an adolescent who overvalues independence and unconventionality, who experiences low expectation for achieving goals, who experiences low self-esteem, high external control and high social criticism would most likely experience a personality proneness towards problem behaviour.

The milieu underlying the Perceived Environment System comprises significant persons, institutions, and events that exercise social support and control, and social expectations. This system is referred to as the *Perceived* Environment System since the adolescent needs to actually *perceive* the variables that belong to this system if they are to have any positive influence. That is, the meaning they have for the adolescent would arise out of the way the adolescent perceives their presence and effect in his or her life.
or social environment. Thus, where the social context of an adolescent’s experience is located more towards peers, and away from parents and family, the adolescent would perceive the notion of control and expectations as belonging more to the predominance of peers and friends and less to that of parents and family. Furthermore, the adolescent might also perceive parental attitudes and beliefs about drug and alcohol use as expressing approval rather than disapproval. Such perceptions that diminish or deny societal behavioural norms point towards perceived environment proneness towards problem behaviour.

Finally, variables within the Behaviour System reveal the extent to which the adolescent’s behaviour either depicts the adolescent as either a contributive or detrimental presence within society. In this latter situation, the adolescent’s behavioural pattern indicates that proneness towards problem behaviour has now reached the point of being problem behaviour.

Given that the intervention component of this thesis engaged parents, it would be reasonable to accept that the Personality System, Perceived Environment System, and Behaviour System of the parents would also enter the matrix of adolescent behaviour. Relating these notions to parents would not necessarily indicate problem behaviour on the part of the parent. It would however suggest that the parent’s own expectations, attitudes, beliefs, and values orientated towards self and others, as well as the manner in which the parent perceived the meaning and importance of his or her social environment would contribute to the parent’s manner of relating to the adolescent, as well as the parent’s sense of self-efficacy in the parental role.

### 3.2.6 Summary of problem-behaviour theory

Jessor R. and Jessor S.L. (1977) included drug use, sexual intercourse, problem drinking, general deviant behaviour, and activist protest in their list of problem
behaviours. At the same time it has been acknowledged that this was by no means an exhaustive list (Donovan et al., 1991), so that any behaviour that functions to serve a negative purpose such as repudiating parental authority, seeking harmful levels of autonomy, and participating in a deviant peer group would be worthy of inclusion.

The attractiveness of problem-behaviour theory for this research was twofold. Firstly, as indicated earlier, problem-behaviour theory placed the primary focus upon the adolescent as the one who acts out the behaviour rather than upon the behaviour itself. Secondly, the emphasis of problem-behaviour theory on measuring the level of problem-proneness of an adolescent’s behaviour by viewing it in terms of a covariance of behavioural variables rather than as individual discrete behaviours suggested the need for intervention to take into account the overall underlying pattern of the adolescent’s life-style. For this research, intervention was seen to move away from an approach whereby unacceptable behaviours would be considered one by one after each preceding behaviour, and address behaviour according to the relative amount of underlying risk across a broad span of precursors and correlates. Thus within the sphere of assessment and intervention, the multiple facets of an adolescent’s psychosocial functioning would become a measure of risk describing a cumulative index of functioning (Scheier et al., 1997).

3.3 Other research approaches that reflect problem-behaviour theory

Several other sources of research support the usefulness of viewing an individual’s behaviour as similarly portraying a matrix of interrelated behaviours (Igra & Irwin, 1996; Loeber, Farrington, Stouthamer-Loeber & Van Kammen 1998; Maggs, Frome, Eccles & Barber 1997). Igra and Irwin (1996) described adolescent risk behaviours as demonstrating a developmental trajectory, as well as covarying as a unitary construct around the antecedent pole of environmental, biological, and
psychological elements of daily experience. Maggs et al. (1997) on the other hand cautioned against viewing problem behaviour only as a syndrome of behaviours. While they agreed that significant covariation occurs among domains of risk behaviour, with certain elements of risk behaviour sharing similar antecedents and serving mutual psychosocial functions, Maggs et al. (1997) also saw value in distinguishing between multiple domains. Some hazardous risk behaviour can have useful developmental outcomes while other behaviours do not. Maggs et al. (1997) offered as an example a comparison between alcohol, tobacco, and illicit drugs. Presuming that the use of alcohol is appropriate according to age and level of development, moderate forms of drinking can have positive effects on social relations without necessarily having deleterious effects on one’s health. By comparison, the use of tobacco and illicit drugs would be expected to have likely harmful effects on health, even if used in so-called moderation. Converging both these facets of drug use under the one unitary construct of ‘substance use’ would be likely to eclipse any positive or negative outcomes for the use of each drug (Maggs et al., 1997).

Loeber et al. (1998) along with others (for example, White, 1991) suggested that the joint approaches of viewing problem behaviour as a unitary construct as well as separate entities of behaviour could be useful in describing the antecedent and consequent aspects of adolescent problem behaviour. Before one chooses to adopt a unitary construct approach to problem behaviour, or alternatively a theoretical approach that considers problem behaviour as a unitary construct with different presentations at various ages, Loeber et al. (1998) suggested an evaluation of at least two criteria. Firstly, can interrelations be identified among problem behaviours? Secondly, are levels of risk for different problem behaviours more prevalent at some ages than at others?
This latter criterion would also respect the increase in intensity, frequency and variety of problem behaviours that occur in the adolescent’s life as the years pass by.

With these two criteria in mind, Loeber et al. (1998) did not reject the value of accounting for a large portion of the variance within a wide range of problem behaviours by means of a unitary construct of behaviour. They suggested that when attempting to explain adolescent problem behaviour, inter-related proximal behaviours showed stronger internal associations than those that were more distal. According to their suggestion, physical aggression and dysfunctional peer modelling would be more proximally related to delinquency than the further distal variable of substance use which of itself may or may not lead to deviant behaviour, depending on the age-appropriateness of its use. As such, these proximal variables could be combined as a single construct to explain a greater proportion of variance in determining the level of delinquency operative in an adolescent’s life style. Nonetheless, Loeber et al. (1998) also stressed that at an outcome level, certain risk factors were more strongly related than others to specific outcomes, so that factors such as a broken family, negative mood state, poor socio-economic status, and a problem prone neighbourhood were more strongly related to externalising than internalising problems. This emphasis reflected that of Leas and Mellor (2000) who stressed the need to consider personal difficulties when attempting to understand the wider scope of adolescent behavioural problems. It has also been suggested elsewhere that a matrix of general risk factors might function in such a way as to bring an individual’s level of proneness for problem behaviour to a general risk-taking threshold. Having reached this threshold, specific risk factors would determine the nature of the harmful risk behaviour that would follow from this point on (Crowe, 1999).
3.4 Problem-behaviour theory and the parent-adolescent relationship

The biopsychosocial approach underscored by problem-behaviour theory and other theoretical approaches provides a valuable means of assessing, describing, and intervening with the fragmenting parent-adolescent relationship. The intervention structured for this research did not focus on directly addressing problem-prone behaviour with the adolescent, but rather focused on the parent’s perception of that behaviour and its resulting effect on the parent-adolescent relationship, and then on ameliorating any negative consequences by working clinically with the parent rather than the adolescent.

Problem-behaviour theory and related theories of the biopsychosocial approach reflected a broadly cognitive-behavioural orientation for the present research. That is, in the theoretical approaches described thus far there appeared to be a relationship between the individual’s perception and cognitive interpretation of a particular situation or situations, and the behaviour that would be most likely to follow this perception and interpretation. A positive and supportive element in this cognitive-behavioural pattern would presumably lead to constructive outcomes in behaviour and relationships, while a negative element would most likely lead to poor outcomes.

In a similar, though more evident vein, the research of Beck (1976) as well as related research (e.g. Beck, 1978) into the relationship between cognitive interpretation of events and the behavioural outcome linked to those events in human behaviour, also influenced the theoretical underpinning of the present research. At the same time, it must be noted that while the present research was carefully constructed on cognitive-behavioural principles, this focus was purposefully broad. A broad theoretical focus enabled research outcomes to be readily adaptable to clinical perspectives apart from the cognitive-behavioural perspective, such as that provided by psychoanalytic theory or
personal construct theory. It was important to acknowledge the variety of theoretical perspectives that might underscore the theoretical orientations of a clinician who sought to utilise the outcomes of the present research.

When considering an adolescent’s fragmented relationship with his or her parent, viewing the underlying behaviour within that relationship has comparative value from the perspective of an inter-related composite approach as well as from the perspective of discrete actions, attitudes, and so forth. Thus it is important to emphasise that Jessor R. and Jessor S.L. (1977), along with research following this seminal work, did not deny the importance of acknowledging the influence of individual behaviours in problem-behaviour theory. Rather, individual behaviours (or variables) were viewed as covarying with either distal or proximal impact to describe problem-behaviour proneness in terms of a general underlying dimension of unconventionality.

At the same time, research that favours viewing behaviour primarily as a multifaceted phenomenon rather than as a global construct only (e.g., Maggs et al., 1997; Leas & Mellor, 2000) suggests that individual domains underpinning adolescent behaviour can contribute to an overall matrix of relationship. Hence, with respect to this present research, it was considered necessary to avoid an “either-or” approach when seeking the contribution of each general perspective. The intervention component of the research sought to draw upon the benefits of both approaches, enabling intervention to address issues surrounding adolescent behaviour not only in terms of an overall interactive matrix, but also in terms of individual actions and attitudes characteristic of certain points within that matrix.

3.4.1 Problem-behaviour theory within a clinical context

Within the context of problem-behaviour theory (Jessor R. and Jessor S.L., 1977), a global image of the adolescent’s behaviour would be discussed with the parent
against the background of the three systemic psychosocial domains. These domains would provide a neat and useful starting point for describing the adolescent’s behaviour as such. For example, both clinician and parent would question whether or not the referred adolescent was modelling deviant peer behaviour, (the Personality System), or over-valuing the beliefs of deviant peers at the expense of values espoused by parents or protective social institutions (the Perceived Environment System). The clinician would also question whether or not the referred adolescent had reached a point where proneness towards problems in behaviour reflected a commitment to the various facets of that behaviour (the Behaviour System). Furthermore, the proximal and distal effects of risk and protective factors would also be investigated.

It would be insufficient to stop at a point of investigation that simply acknowledged the adolescent as exhibiting a general pattern of problem behaviour. Rather it would be necessary for clinician and parent to investigate the specifics of the adolescent’s activities, attitudes, and responses against the broad background of an interactive covariation of the proximal and distal effects of these specific activities. This subtle combination of unitary and discrete risk factors operative in an adolescent’s life has been reflected in the approach of Loeber et al (1998). For example, therefore, both clinician and parent would query what the adolescent was actually doing that indicated a modelling of dysfunctional behaviour (such as under-age drinking, or getting drunk, using illegal substances, engaging in vandalism, and so forth). The parent might also describe how the adolescent responded to his or her request for information about where and with whom the adolescent is going, or how he or she responds to limits placed on behaviour (what the adolescent says or does; how the adolescent leaves the house; the time the adolescent returns home). Furthermore, the extent to which certain behaviours such as drinking, physical fights, substance use, rebuff of monitoring and limiting by
the parents had become entrenched might also be investigated, particularly in relation to how these behaviours currently defined the adolescent’s overall behavioural profile.

Decisions surrounding intervention would follow on as a natural outcome of this progression. That is, having decided that there is cause for concern about the adolescent’s behaviour, and having been able to identify behaviours that underpin that concern, what decision will be made about taking action in favour of helping the adolescent as quickly and effectively as possible? This progression very briefly summarises the clinical thrust of this research, and will be presented in detailed format in later chapters that describe the specifically designed assessment and intervention components of this research.

3.4.2 Problem behaviour theory and psychosocial protective proneness

Finally, against the background of problem-behaviour theory, it is also possible to conceive the notion of psychosocial protective proneness as operative in the adolescent’s life in the same way as one might consider various levels of psychosocial risk. This proneness either towards or away from psychosocial protectiveness might be further conceived as also reflecting a matrix of inter-related protective behaviours. Appropriate parenting practices such as open communication and good monitoring and limit setting strategies, offering encouragement for academic success, modelling socially acceptable behaviour, and prompting the adolescent to seek the company of a protective peer group would be included among an inter-related list of protective variables.

3.5 Chapter summary

This chapter presented the biopsychosocial model as the principal theoretical model underpinning this research. Problem-behaviour theory (Jessor R. & Jessor S.L., 1977) provided a firm footing for the approach of clinical assessment, assessment
feedback, and intervention adopted for the present research. The notion of problem behaviour proneness, with the related concepts of proximal and distal psychosocial risk and protective factors, further echoed the clinical character of the present research. Furthermore, viewing an adolescent’s behaviour against the background of the three principal systems of problem-behaviour theory, namely the Personality System, The Perceived Environment System, and the Behaviour System, was seen as providing a valuable foundation for discussion between clinician and parent about the nature and seriousness of an adolescent’s behavioural pattern. Other research findings reflecting the empirical tenets of problem-behaviour theory were also presented. These findings suggested that while value was to be found in viewing behaviour as a unitary construct, at the same time the value of also viewing behaviour and its consequences as discrete expressions was not to be dismissed.

When discussing an adolescent’s behaviour with a parent, both approaches were envisaged as beneficial in arriving at a clear definition of the adolescent’s behaviour as well as suggesting the most effective intervention process for ameliorating that behaviour. The TANDEM programme was consequently developed according to the theoretical foundation described in this chapter. This programme provided a means of assessing adolescent behaviour, discussing the assessment outcomes with the parent, and finally moving in the direction of acting to positively turn the unwanted behaviour around. Chapter four will describe the TANDEM programme in detail.
CHAPTER FOUR

THE TANDEM PROGRAMME

The complete title developed for the intervention programme of this research was “TANDEM – Making Things Different: Making Things Work! A Programme for Parents of Adolescents”. The inclusive assessment and intervention approach developed for the TANDEM programme was described by an acronym arising out of the word TANDEM, namely:

- **Take** the opportunity; take time to sort things out
- **Assess** the situation – how are things really going?
- **Network** with people who can help
- **Discuss** possibilities
- **Ease** yourself into new ways of thinking and acting
- **Make** a difference!

A structured linear process comprised the TANDEM programme. Following the parent’s initial approach in seeking help, a formal assessment of the adolescent’s behaviour was undertaken, with the results of this assessment subsequently being explained to the parent by the clinician who directed the assessment procedure. This feedback of results was accompanied by a discussion between parent and clinician about the severity and future implications of the adolescent’s behaviour, thus enabling both parent and clinician to more clearly understand the nature and purpose of the identified behaviour. Where assessment results indicated that concern both for the adolescent’s welfare and the strength of the parent-adolescent relationship was warranted, the clinician’s role was then one of supporting and motivating the parent to positively address this concern by means of a structured intervention. The intervention phase was
specifically designed for the TANDEM programme, and consisted of a six-week parenting course directed at reinforcing the self-efficacy and management skills of the parent. The process of moving from discussion between the parent and the therapist to the point of reaching a greater understanding of what might be underscoring the adolescent’s behaviour is discussed more fully in Section 4.2.1 of this chapter.

The TANDEM programme required the development of two key instruments, namely a suitable measure of the seriousness of risk in an adolescent’s behaviour, and the subject areas of the six-week parenting course. Following extensive research and data collection, the *Adolescent Problem Behaviour Assessment (APBA)* was developed in both adolescent and parent versions as the principal measure of harm entailed in an adolescent’s behaviour. The decision to inaugurate a completely new measure rather than implement current measures of harmful adolescent risk behaviour made it possible to identify principal domains of risk-related behaviour among an Australian population of adolescents, and so utilise the findings of this research in the development of suitable subject areas for the subsequent parenting manual. Thus a link was established between the assessment of adolescent risk behaviour, namely the *APBA*, and the content of the intervention instrument, namely the TANDEM-parenting manual.

Following this chapter describing the foundation of the TANDEM programme, the presentation of this thesis will consist of three stages. Chapters five and six will present the first stage. Chapter five will track the investigation into risk behaviour among an Australian population of adolescents together with the eventual development of the *APBA*. Normative data arising from this research will be presented in chapter six. These data were necessary for the clinical interpretation of the evidence of harm expressed in an identified adolescent’s behaviour. The second and third stages of the research will be presented in chapter seven. The second stage will track the
development of the six-week TANDEM-parenting course, with a specific focus on the formulation of the manual that was used with this course. The third stage will focus on the method and results of the initial implementation of the TANDEM programme.

4.1 The primacy of the parent-role

A portrayal of the fundamental reasons underlying the primacy of the parent-role in the assessment and intervention of adolescent problem behaviour will now be presented prior to outlining the structure of the TANDEM programme. Research has shown that working with parents is effective in positively modifying unhelpful adolescent behaviour (Dishion et al., 1999; Heller & Fantuzzo, 1993; Sanders & Lawton, 1993). This approach does not diminish the need for programmes that are targeted directly at adolescent involvement, such as those conducted within the school or community setting. Nor does it ignore the need to address the personal needs of the adolescent or the parent, particularly those that affect the quality of either person’s life and his or her consequent capacity to cope effectively with difficult family situations (Robin & Foster, 1984).

The priority given to stressing personal individual difficulties together with and even prior to addressing the systemic complications of the family has been noted in research (Leas & Mellor, 2000). Rather, the approach adopted for the TANDEM programme reflected a current trend in research of seeking out intervention strategies that address the presence of risk factors by focusing on the ameliorating benefits offered by developing protective factors within the context of person-environment settings (Tolan, Guerra & Kendall, 1995). It was anticipated that in working with parents towards improving the skill-based infrastructure of parent-adolescent relationships in families where this relationship was fractured, then personal issues linked to affect and self-efficacy for both the parent and the adolescent would also be ameliorated. In other
words, improving the “tools” of effective relationships between parents and adolescents would provide the foundation for also improving the way parents and adolescents felt about family situations and about each other.

In the TANDEM programme, the family environment and the role of the parent within this setting has been adopted to represent the hub of a supportive person-environment setting. There is also a fundamental logic in focusing intervention upon the role of parents, thus respecting the central importance of the parent in the life of the adolescent son or daughter (Smith & Stern, 1997). While professional health-care workers and community agencies are available to provide support and direction for parents, the responsibility entailed in nurturing and caring for the adolescent belongs initially and ultimately to the parent (Robin & Foster, 1998). This has been so from the moment of birth, and will continue to be so until the adolescent is able to personally adopt this responsibility. Even though continual and immediate contact between parent and adolescent widens as age progresses and autonomy takes hold, the sense of responsibility and concern for one’s son or daughter continues, and in fact is intensified by the situations and outcomes attached to the adolescent’s increasingly autonomous life-style (Foster & Robin, 1998; Robin & Foster, 1984). The parent’s feelings of responsibility and concern will be likely to weaken in those cases where the parent-adolescent relationship is fragmenting, even to the point of complete rupture (Robin & Foster, 1998), although one might wonder whether these feelings and concerns are ever entirely extinguished by this relationship breakdown.

This unique bond between parent and child rightfully presumes the parent’s involvement in any discussion or planned intervention designed to increase the adolescent son or daughter’s quality of life and personal safety (Smith & Stern, 1997; Stern & Smith, 1999). As a point of departure for intervention, this parent-centred
approach may be considered as a given, as a necessary point of entry, that opens the way to further investigation and possible treatment. If this entry point is lacking then one may understandably question the extent to which the parent’s role has been respected in the decision to proceed further. There are at least four reasons why the primacy of the parent role in the assessment and intervention of adolescent problem behaviour needs to be respected. These reasons will be presented in the following four sections.

4.1.1 The prominence of the parent in the adolescent’s life

In family situations where the parent-adolescent bond is still intact, the parent is the person who spends the greatest amount of time with the adolescent, even though this time naturally diminishes in the face of adolescent autonomy. The parent certainly has greater amounts of contact with the son or daughter than does the helping professional. Furthermore, the parent’s contact with the son or daughter potentially occurs against the background of a wide variety of contexts that absorb an adolescent’s use of time. Experiences at school, at sport, or with friends, as well as problems and conflicts arising from these situations, have the potential for creating extremely valuable links of communication between parent and adolescent. These links in turn have the capacity to strengthen the bonds of friendship, interest, and trust between parent and adolescent. Furthermore, where links of communication and trust are strong, then difficulties, personal risks, and everyday adolescent fears and tensions will be productively discussed between parent and adolescent, resulting in a higher possibility of a beneficial outcome for the adolescent. In this way, the parent becomes the point of contact between the adolescent and his or her social world (Dishion, 1996; Riesch et al., 1993).

At the same time it also needs to be acknowledged that the role of the parent as being the most essential positive influence on the adolescent is not universally embraced. Harris (2000) adopted a position that seeks rigorous testing of the extent to
which the parent has the power to influence a child’s behaviour both inside and outside the family home before it is accepted as a “given”. Harris (1998) described the evidence that promotes the parent as the prime source of influence as being ambiguous at best, based on the all-too readily accepted assumption of what Harris (1998; 2000) called the “nurture assumption” – the “assumption that the most important aspect of the child’s environment is the child’s parents” (Harris, 2000; page 626). Harris (2000) continued by offering three further correlates implicated in parenting problems and childhood difficulties that extend into adolescence. The influence of the neighbourhood is the first correlate presented by Harris (2000), followed by the influence of multiple residential moves and finally the impact of genetic influences. Harris (2000) would appear to place substantial emphasis on the influence of the neighbourhood in relation to parenting difficulties, stating that the small community, rather than the parents, provides the socializing factor for the child. According to Harris (2000), the subculture of the neighbourhood will differ from one environment to the other, with the child adapting his or her behaviour to that of the social group. The positive or negative expressions of the child’s behaviour will then reflect the social norms of that particular group (Harris, 2000). Nonetheless, while this viewpoint of Harris (1998; 2000) is acknowledged, there is sufficient research evidence available to support the primacy of the parent’s place in the healthy development from childhood to adolescence, to adulthood. At the same time, this primacy of parenting does not necessarily discount the impact of further influences such as those put forward by Harris (1998; 2000).

When the adolescent is away from the protective environment of home, parental support is still very much needed although out of respect for the adolescent this support must occur without the parent being physically present. That is, it would be inappropriate for the parent to continually and physically intrude in the adolescent’s
social life away from home. When the parent takes time to engage in open, respectful, and genuinely interested discussion with the adolescent about what is happening in his or her social environment, then the adolescent will be more likely to take the content and advice arising from these discussions into the concrete reality of this environment. Where the influence of one’s peers is more immediate and prominent than the influence of one’s parents, an adolescent’s esteem for a parent’s advice and encouragement might very well be all that stands between the possibility of self-harming and even potentially fatal risk-taking, and the adolescent’s decision to step aside and reconsider consequences. In short, genuine, honest, and open communication between parent and adolescent is the fundamental ingredient of a reliable and supportive relationship between both parties. No outside professional or concerned adult can replace the parent in this essential task (Dishion, 1996).

4.1.2 The effect of the parent-adolescent relationship on siblings

It is often the case that in situations where a trajectory towards problem behaviour already exists, there are brothers and sisters involved in some way. Even if siblings are present as mere observers of what is going on in their older brother or sister’s lifestyle, they are still at risk of adopting similar patterns of behaviour (Hanson et al., 1987; Robin & Foster, 1984). Where parental control over the problem-prone adolescent is either weakened or lost, the result is usually seen in an adolescent family member who behaves and responds according to the whims or demands of the moment, with no concern about the consequences of this behaviour, regardless of whether these consequences are risk-laden or benign. There is the likelihood that younger family members will model the dysfunctional behaviour of older brothers or sisters, especially when they observe older brothers or sisters getting what they want from this behaviour, such as relaxation of restrictions, demands about how they use leisure time, refusal to
respect responsibilities, and so forth. This risk would be further exacerbated in situations where the parent is still able to exercise some measure of control over the younger children. That is, the younger children would see themselves as being restrained while the older sibling appeared to run free.

Parent-focused interventions offer the opportunity for a ‘ripple effect’ upon younger children (Robin & Foster, 1984), even in those circumstances where hope for success with the older adolescent is severely limited. Parents may find that the relationship between the troubled adolescent and themselves has fragmented to a point where reversal is either extremely improbable or sadly impossible. However, if the same parents have discovered new and richer ways of relating to their younger children, and feel confident in using these new approaches, then not only can the potential for problem behaviour proneness in the younger children be avoided, but a “ripple effect” might also occur with the older, troubled adolescent. That is, the older adolescent may envy the more secure and contented level of parent-child relationship that will hopefully enter the younger children’s lives, and so be more open to adopting a lifestyle that will result in achieving a similar end. Once again, it is the parent, not the helping professional, who is central to this family oriented scenario, and who therefore possesses the highest probability of effecting change across the entire child-parent spectrum of the family relationship.

4.1.3 The personal needs of the parent

In those homes where adolescent problem behaviour has caused distressing and seemingly irreversible rifts amongst family members, the needs of the parent must not be overlooked. First and foremost is the need for parental self-efficacy. In order to feel positive about undertaking a process of change in their approach to parenting, parents
need first to believe that they are worthwhile as both person and parent (Smith & Stern, 1997; Stern & Smith, 1999).

It is important that parents first and foremost genuinely value the self-efficacy inherent in their role as a parent, as well as observe their role as something to be valued by their children, friends, and even the broader society within which they live. Placing emphasis on developing a sense of value in being a parent is not merely a shallow exterior of hopeful performance. Rather, this emphasis expresses the right of parents to respect themselves and to sense the respect of other family and social members as they carry out their parenting role, simply because they have been prepared to invest time, self-giving, and ongoing effort in the task and responsibility of providing a safe and adaptive environment for their children. Even within the confines of a fragmenting parent-adolescent relationship, this respect is still an essential requirement. A fragmenting relationship does not necessarily imply a lack of caring on the parent’s part. Therefore, according to the general principle of good leadership, if the leader feels confident and resilient in his or her task, then those whom they lead will more likely follow with confidence.

Herein lies a further reason for bringing the focus to bear on the parent in this type of intervention. Parents will model a certain form of behaviour for their children, and either a positive or a negative effect will flow on from this modelling. Negative modelling is likely to flow from a parent’s self-awareness that is self-defeating and continually tinged by the experience of failure, so that eventually the parent is prompted to simply give in and allow the relationship with their adolescent to find its own (usually risk-laden) course. Positive modelling will most likely flow from the opposite self-image. The task therefore would seem to be one of strengthening parents by offering them new parenting approaches to changing situations with their children, and
so help them to reform old ways of relating to the child who is now on the way to becoming an adult (Dishion et al., 1999). In this manner, parents will hopefully feel increasingly confident, take a more self-supportive view of those times when the outcome with their adolescent was not as they would have wished, and perhaps most importantly, come to enjoy their children rather than tolerate them and even resent their presence.

4.1.4 *The parent as therapist*

The parent’s involvement as the central focus in an intervention programme for unwanted adolescent behaviour results in improved use of time, personnel, and material resources (Kumpfer, 1996). Thus the role of the helping professional primarily becomes one of providing parents with opportunities that encourage new approaches to parenting, that help the parent refine old skills, and that encourage an increasing sense of parental self-efficacy. Where these opportunities have been presented in a formal intervention format, which realistically would take place anywhere from daily to weekly periods over a prescribed number of weeks, the contact of the professional with the parent, adolescent, and other family members becomes extremely limited. Once the parent leaves the physical space where the programme has been conducted, he or she must then practise the skills that have previously been learned, monitor strengths and weaknesses in parenting as time progresses, and continually work towards effecting positive change in the adolescent son or daughter’s behaviour. For this to happen effectively, the parent needs to believe that he or she is *capable* of undertaking this task, as well as feel a sense of achievement when successful outcomes occur.

4.1.5 *Intervention approaches for parents in difficulty*

Kumpfer (1996), in referring to the escalating rates of juvenile crime, child abuse and drug use, emphasised the increasing need for programmes that provided
professional support for families where parents were struggling to raise well-adjusted children. Kumpfer makes this very clear when she states that “improved parenting practices is the most effective strategy for reducing adolescent substance abuse and associated problem behaviours” (1996, p.2). While Kumpfer’s (1996) emphasis referred to research into the prevention of adolescent drug misuse, the significance of issues stressed as essential for reducing family and child related problems would equally refer to any programme of intervention, such as TANDEM, designed to support parents, children and adolescents who lived in disturbed family environments. In particular, Kumpfer (1996) reinforced the elementary place of the parental role in reducing problem substance use among youth, and in positively mediating the influence of peer relationships and behaviour (see also Dishion, 1996; Dishion et al., 1995; Hansen et al., 1987; Sanders & Lawton, 1993).

The involvement of family members with each other, the teaching and strengthening of skills that reduced family conflict and enhanced open communication, and the readiness of parents to be aware of their son or daughter’s activities away from home, have been cited in research elsewhere as being priorities for reducing problem behaviours (Clark & Shields, 1997; Dishion & Andrews, 1995; Dishion & McMahon, 1998; Kumpfer, Molgaard, & Spoth, 1996; Kumpfer et al., 1999).

Kumpfer (1996) proposed a number of research questions for determining the effectiveness of family support projects. These included establishing the most effective programme components, the parallel effectiveness of family and child-only programmes, and the maintenance of positive programme outcomes for participants over the long term. Following on from these issues, Kumpfer (1996) also indicated the need to seek out the best recruitment and retention methods, as well as the need to consider the cost-benefits of implementing programmes. Kumpfer (1996) indicated that
some agencies expressed a greater readiness than others to become involved in programmes such as TANDEM. Examining the reason why this appeared to be so would reasonably lead to a wider dissemination of the benefits of successful programmes beyond the location of their original development. This was an important consideration for further development of the TANDEM programme beyond the current scope of this research, so that it would be more readily adaptable within the professional setting of a variety of helping agencies.

Where communities or agencies lack the enthusiasm, the time, the energy, or the resources to seek out and to implement parenting programmes that have exhibited positive results in limited settings, parents and families will indirectly suffer as a result. It would appear essential therefore to uncover as many reasons as possible as to why barriers such as these exist. In the case of the TANDEM programme, the issue of cost was weighed up against the anticipated personal and socio-economic difficulties of parents who would conceivably benefit from participation (McMahon & Slough, 1996). No matter how potentially effective a programme might be, if those who might benefit from it do not have the necessary financial means to participate, then the effectiveness of the programme will be diminished from the outset.

Dishion (1996) highlighted other important practical considerations that would most likely promote the success of parent/family interventions. Dishion (1996) noted that programmes need to be flexible with respect to both the days and times at which they are scheduled and the location of their delivery. Furthermore, the duration of the programme and the background skills of the person who leads the programme have been raised by Dishion (1996) as issues that affect the level of successful progress and outcome of parenting programmes. Dishion (1996) described long duration programmes such as 16 weeks with 2 hours per night as a huge commitment that challenges people to
even consider the prospect of participation. Consequently, the duration of the parenting course was set at six weeks, with a two-hour meeting time allocated for each week.

Dishion, Ackerland, and Duran (1996) addressed a number of barriers arising from issues such as accessibility, content suitability, suitability of approach, and ultimately outcome measures that indicated success. Dishion et al. (1996) appeared to attribute a large portion of successful intervention outcome to the insight and individual learning style of the parent, which in turn would be likely to affect the point at which beneficial change occurred for the parent within the programme’s session-by-session progress. They also strongly encouraged organisers of group programmes to structure these programmes around the salient issues happening for the parents at that time. The research findings of Prinz and Miller (1994) have suggested that programme approaches that focus on parenting issues to the exclusion of other related family and adult concerns could lead to early parent dropout from treatment. This suggestion would support the need to incorporate into any chosen parent intervention programme those salient lifestyle issues relevant to parents who have elected to enter treatment.

Dishion et al. (1996) presented the example of programmes that directly related to the current concerns of parents for their children, such as academic issues, or concerns about their children’s after school activities. Dishion (1996) also suggested that directing the focus of a programme to encompass the immediate worries and cares of parents would be more likely to encourage the participation of parents rather than a programmed approach of ‘one size fits all’ (Dishion et al., 1996). Hence each separate implementation of the TANDEM programme was viewed as being tailored to the general needs of the participant group. These needs would become evident during the assessment and feedback phase when parents discussed the assessment findings and their home situation with the clinician responsible for conducting the programme.
Dishion et al. (1996) outlined the value of offering parents a menu of options when considering the form of intervention that was most appropriate for themselves and their family situation. The rationale behind offering a menu of options was that parents would be more likely to commit to a course of positive action where that course represented a choice from a number of possible options, rather than being funnelled into a choice because there was one option only being offered (Patterson & Forgtach, 1985). Within the context of this present research, a menu of options was not adopted for TANDEM. Issues such as cost, simplicity, accessibility, and reproducibility influenced the present development of TANDEM, and so introducing a menu of options was not considered at this present stage. This decision did not deny the value of having a menu of options as part of any parent-adolescent programme, including TANDEM. In future development of TANDEM, separate options for intervention choices would become available according to the approach suggested by Dishion et al. (1996). For this research, a six-week parenting course was the only form of intervention offered to parents.

4.1.6 “The Family Check-Up”

“The Family Check-Up”, developed by Dishion et al. (1999), provided the structural basis for the development of the TANDEM programme. “The Family Check-Up” was created to assist parents in accurately appraising the level of risk entailed in their son or daughter’s behaviour. The notion of a check-up was akin to visiting one’s medical practitioner for a physical check-up to determine the possible presence of physical problems. Hence “The Family Check-Up” simply invited parents to begin answering their concerns about the son or daughter’s behaviour by identifying whether or not problems were actually evident, as well as considering the appropriateness of their own style of family management practices. Following the assessment procedure of
“The Family Check-Up”, the parent was offered a menu of parenting resources aimed at reducing risk and promoting an adjusted parent-adolescent relationship. This initial stage of approaching a therapist for a “check-up” of adolescent behaviour and parenting practices was considered by Dishion et al. (1999) to be the key component of a selective intervention strategy that targeted maladaptive parenting practices.

Results arising from assessment sessions during “The Family Check-Up” provided parents with information about what the adolescent was actually doing to create concern for the parent. Assessment results also described the strength of the bond between adolescent and parent in terms of communication and other interactions with the adolescent, such as problem solving, conflict resolution, monitoring, the adolescent’s peer network, and so forth. The pencil and paper segment of the assessment covered three principal areas, namely child adjustment problems, peer influences, and family influences. Child adjustment problems included both internalising and externalising expressions of behaviour, and were observed from the teacher’s perspective as well as the mother and father’s perspective. Peer and family influences were individually assessed according to the balance between risk and protective factors present within the adolescent’s peer group and family. The feedback session that followed included an identification of strengths and weaknesses evident in the child’s adjustment, peer relationships, and family relationships. The assessment outcomes of adolescent risk status and parenting practices were then discussed with the parents. Possible courses of action were then offered for the parents’ consideration, aimed at improving their quality of family life, the manner of the adolescent’s behaviour, and the protective characteristics of the home environment.

Throughout the entire check-up of adolescent behaviour and parenting practices, the therapist who worked with a particular parent during “The Family Check-Up”
undertook a strongly motivational approach. This approach was particularly important when the parent was asked to decide on an appropriate course of action. The motivational model of FRAMES, developed by Miller and Rollnick (1991), provided the underlying model for prompting rather than manipulating the parent to consider undertaking an appropriate course of action to positively address problem areas identified by the assessment. The acronym of the word “FRAMES” (Miller and Rollnick, 1991) represented issues of feedback (F), responsibility for change by the parent (R), advice offered by the therapist (A), a menu of options (M), accurate empathy (E), and resulting self-efficacy (S). Discussing the assessment outcome and potential pathways of intervention with parents in this manner enabled parents to focus their attention on positively addressing their family situation rather than attempting to adequately cope with it. During “The Family Check-Up”, parents were continually encouraged to reassure themselves of the importance of the role they assumed in any course of effective intervention. The willing readiness of the parent to act on behalf of assisting their son or daughter by taking into account the appropriateness of their family management practices was constantly emphasised as being an important measure of a gratifying intervention outcome (Dishion et al., 1999).

A skills-based parent-training programme was offered through “The Family Check-Up” as one possible option for parents when they were invited to consider pathways of appropriate intervention. This programme contained three essential steps. The first step was to aid parents in clarifying whatever concerns they had for their son or daughter and to enable them to state these concerns clearly and objectively. The second step was parent-focused. Parents were motivated to reduce their harsh reactions to unwanted behaviours, and be consistent in setting limits with their son or daughter. Finally, parents were encouraged to improve communication patterns with their
adolescent, as well as develop strategies of monitoring and limit setting in order to closely supervise their son or daughter’s behaviour. Dishion et al. (1999) understood positive communication as a primary foundation for strong parent-adolescent relationships, and for beneficial outcomes in conflict negotiation and problem solving.

4.2 The development of the TANDEM programme

Central focus was attributed to the role of the parent in each stage of the programme. The TANDEM programme (also referred to as TANDEM) was viewed as offering the parent an effective and authoritative means of addressing the realisation that the relationship with one’s son or daughter was now in the process of fragmentation. The intervention process that followed assessment and discussion of assessment results involved the parent rather than the adolescent. This pathway did not diminish the role of the parent’s son or daughter during the intervention phase. Rather, it emphasised the right of the parent to be the one principally responsible for the adolescent’s current welfare and development into adulthood. Caution was exercised at all times to avoid giving parents the notion that anyone participating in the programme was a ‘bad parent’. Rather, the parent’s readiness to acknowledge difficulties in the adolescent’s behaviour, and seek a means of positively addressing them, was lauded and encouraged. Furthermore, through the support of the clinician-researcher who directed the intervention, the parent was encouraged to become his or her own therapist in the task of strengthening the fracturing parent-adolescent relationship.

The TANDEM programme was developed on the foundation of a psychoeducational model, couched in cognitive-behavioural techniques for understanding and addressing maladaptive parenting practices linked to potentially harmful adolescent behaviour. The TANDEM programme comprised a number of
sequential steps in addressing adolescent problem behaviour via the parent’s involvement.

4.2.1 “The Family Check-Up” as the model for the TANDEM programme

The basic structure underlying “The Family Check-Up” of assessment and feedback of results, open and honest discussion between parent and therapist, and provision of a practical and effective means of suitable intervention, was chosen as a model for the development of the TANDEM programme. Similar to the structure of “The Family Check-Up”, TANDEM presented parents with an opportunity to objectively articulate their concerns through a formal assessment process, discuss the results with the clinician, and choose a means of positive action in order to ameliorate the adolescent’s problematic behaviour. This process always occurred in an atmosphere of motivation and confidentiality.

A particular emphasis was placed on thorough assessment of the level of risk in the referred adolescent’s behaviour in the TANDEM programme. Thorough assessment was seen to be the result of combining pencil and paper assessment with discussion of assessment findings between the parent and the clinician. The Adolescent Problem Behaviour Assessment (APBA) was viewed as making an important though partial contribution to the overall assessment process. In describing a specific therapeutic intervention using a family systemic approach, Mellor, Manias, Schjeflo and Storer (1994) cautioned against the contaminating influence of confirmation bias. In so doing, they emphasised the importance of ensuring that the assessment and assessment outcomes of the causal features underlying peoples’ problems are not structured to fit the initial hypotheses of those responsible for the assessment. Thus the discussion between the clinician and parent following the completion of pencil and paper assessments addressed a number of domains related to this caution. Firstly, discussion
about written assessment results attempted as much as possible to “fill in” the gaps created by the parent’s lack of knowledge about the adolescent’s behaviour. Secondly, the opportunity for discussion individualised the adolescent’s behaviour by placing it within the context of a specific family and social environment setting. Thirdly, the ensuing discussion guarded against either parent or clinician forming unsubstantiated predisposed conclusions about the adolescent’s level of harmful risk based only on the completion of the APBA and other written assessments used during this phase. Finally, the ensuing discussion emphasised the importance of the parent’s input into the overall assessment process.

The very nature of the clinician-client relationship implies a power differential in favour of the clinician, since the very nature of the clinician’s role is most likely to be seen by the client in terms of expertise (Ivey, Ivey, Simek-Morgan, 1993). That is, the clinician is in a position to help because he or she is the expert who has been approached for this help. A healthy clinician-client relationship is structured around a sense of mutual and genuine respect that acknowledges the potential for this power differential to place the client in a position of powerlessness (Ivey et al., 1993; Mellor et al., 1994). To guard against any inappropriate intrusion of the power differential between parent and clinician during the assessment of a referred adolescent’s behaviour, and to avoid an attitude indicating that the input of the parent was either unnecessary or of no value, special care was therefore given to ensuring that the parent was placed squarely within the focus of the assessment process. The parent’s knowledge and insight was viewed as a primary source of information not only about the home environment, but also about the adolescent’s behaviour both within and outside the confines of that environment (Mellor, Storer & Firth, 2000). The need for this emphasis has been emphasised in other related research (Smith & Stern, 1997; Stern & Smith, 1999).
The strong emphasis on parental involvement in the assessment and intervention phases, and the motivational approach used to encourage a positive response to intervention, represented essential aspects of “The Family Check-Up”. Consequently these aspects formed the hub of the overall TANDEM programme. The right of parents to be presently and ultimately in control of what followed on from the assessment and feedback sessions of any parent-based intervention was not only stressed by Dishion et al. (1999), but in research elsewhere has also been presented as affording parents the respect due to them in their exercise of this role (Smith & Stern, 1997; Stern & Smith, 1999). The role of the clinician within “The Family Check-Up” was also applied to the TANDEM programme. Parents who sought help via TANDEM were encouraged to view the role of the clinician as being that of a consultant who guided and supported parents through a deepening of their insight into concerns about the son or daughter’s behaviour.

As with “The Family Check-Up”, the clinician was seen to have a three-point role in this progression. Firstly, the clinician discussed with parents their understanding of how the assessment results mirrored their own perception of both their son or daughter’s behaviour and the manner in which they responded to this behaviour. Secondly, and in the light of the parents’ responses to the assessment, the clinician discussed with parents the benefits of participating in the six-week TANDEM-parenting course, or alternatively stopping at this point and using these results to improve matters between themselves and their child. Whether the parent chose to participate in the course or stop at the assessment point, the clinician’s motivation for the parent to decide to act was seen as an essential feature at this step of the process. This motivation was also based on the direction taken by Miller and Rollnick (1991). Thirdly, if parents wished to proceed beyond the point of assessment, the clinician provided further
information about the six-week TANDEM-parenting course. At this point, the clinician’s role was one of ensuring that parents were clear about the contents of this course, how the different facets of the course would help them, and what their commitment would entail if they still wished to participate. The span of time between assessment and the parent’s decision to participate in the parenting course, and the commencement of the course, was deliberately kept short with a view to maintaining the parent’s enthusiasm to engage in intervention.

### 4.2.2 Outline of the TANDEM programme

Engaging the parent through the TANDEM programme was seen to begin at the point of referral, and then continue with an assessment of the adolescent’s behaviour, using the Adolescent Problem Behaviour Assessment (APBA) as the primary means of assessment. The clinician (who was also the researcher) gave feedback of assessment results, and then followed this feedback by discussing with the parent the seriousness of risk described by these results. In situations where adolescent risk was found to be potentially harmful, the parent was encouraged to positively act upon this risk. Finally, where the parent indicated a wish to act upon adolescent risk behaviour, the parent was offered a place in the six-week TANDEM-parenting course.

At all times throughout the programme, the essential importance of the role of the parent in achieving a successful intervention outcome was emphasised. Therefore the clinician’s role in the TANDEM programme was seen to consistently be that of providing reliable information about the seriousness of adolescent risk, together with encouragement for the parent to effectively act on that risk. In the TANDEM programme, the parent rather than the adolescent was viewed as the person primarily involved in the assessment and intervention phases, although the adolescent’s contribution was welcomed if this contribution was freely forthcoming.
Where the adolescent was willing to contribute to the assessment phase of the programme, the parent invited the adolescent to confidentially complete the adolescent version of the APBA at home. The parent explained that the adolescent’s responses would be seen by the clinician only, and not by the parent or any other authority figure. The parent also explained that the adolescent’s contribution was part of an overall attempt to improve what the parent saw as problems in the parent-adolescent relationship, problems in the adolescent’s behaviour, and consequently disruption within the family home. The nature of confidentiality, however, prevented the clinician from sharing the adolescent’s responses with the parent. The adolescent’s responses therefore benefited the clinician only, and were used by the clinician to tailor the emphasis of the intervention to the particular needs of participating parents. Following the assessment and feedback phase of the programme, the parent could stop at this point and use the information gained from the assessment to address any areas of adolescent behaviour that were assessed and confirmed as being dysfunctional. It has been suggested that simply discovering through assessment results that adolescent risk is a reality can in itself have a positive effect on reversing the harmful outcome of risk behaviour (Dishion et al., 1999).

The benefit of the APBA as a measure of risk entailed in adolescent behaviour was also acknowledged in its capacity to identify the principal domains of behaviour where problems were most likely to be situated. Foster and Robin (1998) gave weight to this benefit when they indicated the need to accurately identify the behavioural domain that underpinned problems in the parent-adolescent relationship. Foster and Robin (1998) suggested that the choice of one treatment approach over another for situations of poor family communication and related adolescent difficulties relied on the more fundamental issue of whether one treats the conflictual patterns that underlie the poor
communication, or the individual issues that led to poor communication and subsequent conflict in the first place. Foster and Robin (1998) have suggested that one would address this dichotomy by examining the role of parent-adolescent conflict in maintaining the adolescent’s problems. Whether the conflict itself emerged as being the primary cause of parent-adolescent problems, or whether the consequential problems arising from conflict constituted the primary cause, would require both careful assessment and treatment planning based on the assessment outcomes.

Foster and Robin (1998) have further proposed that problem behaviour in an adolescent, and the corresponding unhelpful manner in which this is addressed by the parent, is functional. They strongly advocated the need to analyse the function of maladaptive adolescent and parent behaviour, and then structure treatment around the outcome of this analysis. Foster and Robin (1998) also pointed out that both the function and the consequences of the parent’s role in the adolescent’s maladaptive behaviour would need to be considered in any comprehensive intervention that addressed unwanted family interactions resulting from negative and non-compliant adolescent behaviour.

In response to the recommendation of Foster and Robin (1998), the patterns of maladjusted parenting responses to unwanted adolescent behaviour, and the function that these responses provided for the parent, were addressed in the ensuing discussion following the assessment of the adolescent’s behaviour. The APBA was used to identify particular domains of adolescent behaviour that appeared to both place the adolescent in situations of harmful risk and undermine the parent-adolescent relationship. During the discussion following the assessment phase, these domains were identified for the parent within the context of the parenting manual contents. Thus a link was drawn between assessment domains of adolescent behaviour and the contents of the parenting course.
Establishing this link further assisted the clinician to draw out the relationship between what the parent actually observed as being unacceptable in the son or daughter’s behaviour, and helping the parent seize the opportunity of developing effective parenting strategies in order to improve both the adolescent’s behaviour and the state of the parent-adolescent relationship. The parent was able to achieve this twofold link through the TANDEM programme. As a result, the parent was offered practical means to effectively deal with already identified problem adolescent behaviour. This ‘package approach’ of TANDEM was therefore seen as an important method of guiding the parent through the process of referral, assessment, intervention, and follow-up. The follow-up phase was provided through two post-programme booster sessions.

4.2.3 The goals of simplicity, adaptability, and affordability

The TANDEM programme was designed around the fundamental tenets of simplicity, affordability, and adaptability. TANDEM was developed to be implemented either in its unchanged format, or in a format adapted to any setting that sought to help parents improve a fractured relationship with their son or daughter. Ideally, TANDEM could also be adapted for other domains of adolescent problem behaviour apart from delinquency-related activity, such as eating disorders, obsessive-compulsive disorder, and depressive or anxiety disorders. In fact, because the skills of the parenting-course component converged around basic interactional skills such as communication and problem solving, any disorder that was exacerbated because of a deficiency in these skills would benefit from the approach of TANDEM. However, in those circumstances the means of assessment would need to be adapted to reflect the particular disorder under investigation. Finally, any person suitably qualified and skilled would be able to undertake the implementation of the TANDEM programme.
TANDEM was developed so that only very few material and personal resources were required to implement it. A clinician who had access to limited material and personal resources would therefore be in the position to implement TANDEM in his or her professional setting. The basic requirement of resources would include assessment instruments appropriate for the clinical setting within which the programme was implemented, particularly the Adolescent problem Behaviour Assessment (APBA), access to a suitable space, a television, a video playback machine, an overhead projector, and the TANDEM manual. At this stage of research, the TANDEM manual was used by the researcher-clinician as the guide to presenting each session, although the development of a presenter’s manual was earmarked for future research. If the clinician did not feel competent to direct the programme, then another suitably qualified person who felt at ease in this role could be trained to do so.

In short, TANDEM was designed to be relatively inexpensive to implement, requiring a minimum of physical space and the professional skills necessary to implement a psychoeducational programme based on a cognitive-behavioural model of understanding behaviour. Furthermore, the content areas of the TANDEM parenting-manual were formulated with an emphasis on simplicity and directness. As a result of this emphasis, a professional clinician would be able to train other less qualified though still competent people to undertake the pivotal role of consultant in both areas of assessment and intervention. The clinician in this case would also undertake the role of supervisor, supporting those who worked directly with the parents.

4.4 Chapter summary

This chapter has described the rationale underpinning the development of the TANDEM programme. This programme was designed to provide parents with a multi-layered means of identifying and positively addressing concerns about the behaviour of
their adolescent son or daughter. Two principal arenas comprised the development of TANDEM. Firstly, the *Adolescent Problem Behaviour Assessment (APBA)* was developed to measure the level of risk entailed in an adolescent’s behaviour. Secondly, a parent manual was especially devised for use in the six-week parenting course. This course provided the intervention component of the TANDEM programme. Rather than include already developed measures of risk in the TANDEM programme, the decision to develop a new measure of risk in adolescent behaviour made it possible to identify domains of risk currently evident among a normative sample of Australian adolescents. These identified domains were then used to shape the contents of the parent manual. Hence a link was established between research-identified domains of risk and the means of intervening in harmful trajectories of adolescent risk. Issues of simplicity, adaptability, and affordability were considered to be of paramount importance in developing TANDEM. “The Family Check-Up” (Dishion et al., 1999) provided the key model for structuring the TANDEM programme. Chapter five will describe the development of the *Adolescent Problem Behaviour Assessment (APBA).*
CHAPTER FIVE
THE DEVELOPMENT OF THE ADOLESCENT PROBLEM BEHAVIOUR ASSESSMENT

The Adolescent Problem Behaviour Assessment (APBA) was developed in both adolescent and parent format as an assessment instrument to identify proneness towards problem behaviour in an adolescent’s chosen lifestyle. The title Adolescent Problem Behaviour Assessment was chosen to describe the extent to which an adolescent might already be established on a trajectory that if left unchecked would most likely demonstrate a problem behaviour outcome. It is important to emphasise from the outset that the APBA was not developed as a ‘stand-alone’ diagnostic instrument of adolescent problem behaviour. Rather, the APBA was developed as the risk assessment component of the TANDEM programme. Hence the APBA became the primary means of identifying proneness towards problem behaviour in the adolescent’s life-style.

The title Adolescent Problem Behaviour Assessment (APBA) was used as an umbrella title for a number of separate though linked questionnaires that investigated proneness towards problem behaviour in a referred adolescent’s life-style. Four questionnaires comprised the APBA. The first questionnaire was entitled the Interpersonal Support Questionnaire, and investigated levels of harm in adolescent risk across three factors of behaviour. The second questionnaire, entitled the Adolescent Drug Use Questionnaire determined the frequency and amount of an adolescent’s consumption of alcohol, tobacco, and marijuana over the previous four-week period. The third questionnaire of the APBA, entitled the Self-Perception of Risk Questionnaire, investigated the level of insight displayed by the adolescent into the amount of harm entailed in his or her behaviour. The fourth questionnaire was included in the parent version only, and investigated the amount of resilience experienced by the adolescent’s
parents during times of difficult interaction with the adolescent. Descriptive data were also derived from the statistical analyses of each questionnaire of the *APBA*. These descriptive data were ultimately intended for clinical use as normative data for the assessment of harm in adolescent risk behaviour. These descriptive data will be presented separately in chapter six.

A preliminary investigation involving a small sample of adolescents was conducted with a colleague in psychology as the initial step towards the development of the *APBA*. The aim of this preliminary investigation was to identify the principal domains of adolescent risk behaviour. A questionnaire was especially developed by the researcher and his colleague for the preliminary investigation, and was entitled the *Risk Behaviour Questionnaire*. This chapter will therefore commence with the process and outcome findings of this preliminary investigation. The chapter will then move into describing the developmental phases for the different questionnaires of the *APBA*, commencing with analyses, findings, and discussion of findings for the *Interpersonal Support Questionnaire*, and then proceeding sequentially and in like fashion with every other questionnaire according to the structure of the *APBA* booklet.

### 5.1 The preliminary investigation

Categories that described proneness towards adolescent problem behaviour were specifically developed for the *Risk Behaviour Questionnaire (RBQ)*, and founded on the biopsychosocial model described in chapter three. These categories were derived from identified risk factors provided by literature related to developmental issues, family issues, and adolescent risk-taking, as well as drug use literature and relevant current questionnaires. Current questionnaires included *The Family Check-Up*, (Dishion et. al., 1996), *The Adolescent Drug Abuse Diagnosis [ADAD]*, (Friedman & Utada, 1989; Leceese & Waldron, 1994), and the *Health Behaviour Questionnaire*, (Jessor, 1987).
Seven category domains of adolescent behaviour and related environmental experiences were structured from this material.

5.1.1 Objectives of the preliminary investigation

Three objectives were set for the preliminary investigation. The first objective was to identify the principal factors of the RBQ. A second objective was to determine the capability of these resulting factors to discriminate between those adolescents who were and were not at risk of problem behaviour. A third objective was to identify research issues that would suggest further development.

5.1.2 Participants

One hundred and eighty seven high school students from schools in the Illawarra and Campbelltown-Macarthur regions of New South Wales (Australia) completed the Risk Behaviour Questionnaire (RBQ). The age of participants ranged from 12 to17 years, with a mean age of 14.53 years, and a standard deviation of 0.50 years. For the benefit of non-Australian readers, students aged 12 to13 years, 14 to 15 years, 15 to 16 years, and 16 to 17 years within the Australian high school setting would be allocated to educational years entitled Years 7, 8, 9 and 10 accordingly. While students were asked to nominate gender, 53 omitted to do so. Of the remaining sample, 88 students were male and 46 students were female. Because of the size of this omission, a decision was made not to divide the sample according to gender.

Teachers referred to administratively as Year Coordinators were people who had substantial contact with students. From their knowledge of students’ general behaviour in the school setting, Year Coordinators were asked to classify participating students into three categories of problem risk behaviour, namely low, moderate, and high problem risk. Year Coordinators allocated 108 participants to the low risk group, 46 participants to the moderate risk group, and 33 participants to the high-risk group.
Twenty-seven participants within the high-risk group attended a special school for adolescents who exhibited extreme levels of problem behaviour. These students ranged across all school year levels.

5.1.3 Instrument – Risk Behaviour Questionnaire

The Risk Behaviour Questionnaire (RBQ) was used in the preliminary study. Seven category domains describing adolescent behaviour comprised this 63-item questionnaire. These domains have been identified by research to be potentially implicated in the trajectory towards adolescent problem behaviour. Categories have been presented in Table 5.1, together with representative literary sources, questionnaire item numbers, and reliability values (Cronbach’s alpha) obtained for each category. The RBQ has been reproduced in Appendix 1.

Table 5.1
Categories of the Risk Behaviour Questionnaire.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Literary Source</th>
<th>Item Numbers</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family relations and home behaviour</td>
<td>McCrady, 1986; Coombs &amp; Paulson, 1988</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 15, 27, 29.</td>
<td>0.89</td>
</tr>
<tr>
<td>General Behaviour</td>
<td>Loeber et al., 1988</td>
<td>12, 14, 16, 18, 20, 22, 24, 25, 26.</td>
<td>0.75</td>
</tr>
<tr>
<td>Attitude to school</td>
<td>Jessor, 1987; Steinberg &amp; Avenevoli, 1998.</td>
<td>17, 19, 21, 23, 28, 30, 31, 33.</td>
<td>0.71</td>
</tr>
<tr>
<td>Impact of peer modelling</td>
<td>Jessor, 1998; Newcomb; 1995.</td>
<td>32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 46.</td>
<td>0.88</td>
</tr>
<tr>
<td>Peer modelling of drug and alcohol use</td>
<td>Colder et al., 1998; Hawkins et al., 1992; Jenkins, 1996.</td>
<td>56a, 56b, 56c, 57a, 57b, 57c, 57d.</td>
<td>0.81</td>
</tr>
<tr>
<td>Family bonding</td>
<td>Marta, 1997; Stephenson et al., 1996.</td>
<td>43, 45, 47, 48, 49, 50, 51.</td>
<td>0.80</td>
</tr>
<tr>
<td>Parental management</td>
<td>Baumrind, 1991; McMahon &amp; Metzler, 1999.</td>
<td>52, 53, 54, 55.</td>
<td>0.69</td>
</tr>
</tbody>
</table>

Reliability values for all category domains were considered acceptable.
5.1.4 Procedure

The principals of participating schools distributed a letter containing information concerning the purpose of the research, as well as reassurance of confidentiality and anonymity of responses (see Appendix 2). Together with this letter was a consent form seeking permission of parents and adolescents to use their responses in this research (see Appendix 3). The final student sample was brought together into an allocated school classroom space that was deemed suitable in terms of lighting, comfort, and ventilation for administering the questionnaire. One desk was provided for each student, and was positioned to preserve the student’s confidentiality. The procedure for completing the questionnaire was explained to students prior to commencement, along with reassurances regarding the confidentiality and anonymity of their responses. The different points of this presentation have been presented in Appendix 4. To further ensure anonymity and confidentiality, students were asked to place their own questionnaires in a container as they left the room. Finally in order to reduce undue disturbance, students were asked not to leave the room until at least 25 minutes had elapsed from the time of commencement. If any student had a query, he or she raised a hand and was attended to by the researcher and a research assistant who were present in the room throughout the process.

5.1.5 Results of the preliminary investigation

5.1.5.1 Internal consistency of the Risk Behaviour Questionnaire.

Reliability values (Cronbach’s alpha) for each category of the Risk Behaviour Questionnaire (RBQ) ranged from 0.69 to 0.89 (see Table 5.1). Internal consistency for the total pool of 63 items was 0.94. These values were considered acceptable.

5.1.5.2 Factor analysis of the Risk Behaviour Questionnaire. A factor analysis was conducted on the total pool of responses to all category domains of the
RBQ using a principal component analysis extraction with promax rotation and Kaiser normalisation. The resulting pattern matrix of the factor analysis, with item numbers and factor loadings, have been presented in Appendix 5. Only those items with a loading greater than or equal to 0.40 were retained.

Thirteen of the 19 items comprising factor one described the manner in which the adolescent modelled the behaviour of his or her peers. Ten items of factor one belonged to the domain of “Impact of Peer Modelling”, while three items belonged to the domain of “Peer Modelling of Drug and Alcohol Use”. Therefore the label of Peer Modelling was applied to this factor. The six items excluded from this factor due to a lack of conceptual coherency were items 12, 14, 16, 20, 24 and 25. All 12 items that clustered within factor two described the adolescent’s relationship with his or her family in terms of acceptance and bonding. Six items belonged to the category domain of “Family Relations and Home Behaviour” and six items belonged to the domain of “Family Bonding”. The title of Family Relationships was given to factor two in order to portray the concept of the adolescent’s relationship patterns within his or her family.

Seven of the 13 items that clustered within factor three indicated the extent to which the adolescent’s activities were being monitored and limited by parents. Three items belonged to the category domain of “Parental Management”, and four items belonged to the category domain of “Family Relations and Home Behaviour”. Hence factor three was labelled Parental Monitoring/Limit Setting. This label reflected the parent’s role in the practices of monitoring and limiting the adolescent’s behaviour within the context of the family environment (as reflected by items comprising the domain of “Family Relations and Home Behaviour”). Items 9, 17, 19, 21, 31 and 57d were excluded due to a lack of conceptual coherence. The factor analysis resulted in five of the seven category domains being represented within one of the three emergent factors. The item
numbers and wording of each factor, together with excluded items, have been presented in Appendix 6.

In summary, therefore, three factors emerged from the total pool of 63 items comprising the RBQ, namely Peer Modelling (13 items), Family Relationships (12 items), and Parental Monitoring/Limit Setting (7 items).

The reliability value (Cronbach’s alpha) for the total item pool comprising the three factors was 0.91. With each factor considered separately, the reliability value for Peer Modelling was 0.89, for Family Relationships 0.90, and for Parental Monitoring/Limit Setting 0.76. These values were considered acceptable.

5.1.5.3 Discriminant function analysis of the Risk Behaviour Questionnaire. The research question of whether the three factors of the Risk Behaviour Questionnaire (RBQ) were able to discriminate between adolescents according to the low, medium, or high-risk ratings allocated by Year Coordinators was then investigated.

Multivariate analyses were initially conducted with the three factors of Peer Modelling, Family Relationships, and Parental Monitoring/Limit Setting. At the multivariate level, significant differences were found across all factors (Pillai’s $T = .942, F(3.00,182.00) = 982.82, p<.001, \eta^2 = .942$). At the univariate level, significant differences were found for the two factors of Peer Modelling \[F(2,184) = 21.94, p<.001, \eta^2 = .193\] and Family Relationships \[F(2,184) = 4.51, p<.05, \eta^2 = .047\] only. While significant differences were found between risk groups for Peer Modelling and Family Relationships, it was also noted that at the univariate level the effect size (\(\eta^2\)) of both factors was extremely small, although when the effect of these factors was combined at the multivariate level the effect size was extremely strong since the variables of both factors were combined at this level. The low finding for effect size at the univariate level indicated that as independent variables these factors were
accounting for no more than approximately 20% of the variance. It was noted that these low values reflected the fact that each factor was individually only accounting for 13 variables in *Peer Modelling* and 12 variables in *Family Relationships*. Furthermore, the small size of the adolescent sample included in the analysis would also have contributed to the low effect size. Multiple post hoc tests were then conducted on these two factors. For *Peer Modelling*, mean score differences (abbreviated as MD) were significant between group one (low risk) and group three [high risk] (MD=0.92, SE=0.14, p<.001), and group two (medium risk) and group three (MD=0.66, SE=0.16, p<.001), and non-significant between group one and group two. For *Family Relationships*, mean score differences were significant between group one and group three only (MD=0.35, SE=0.15, p<.05).

A discriminant function analysis (DFA) using a saturated model was conducted on the three factors. The loadings for this analysis were 0.97 (*Peer Modelling*), 0.35 (*Family Relationships*), and 0.09 (*Parental Monitoring/Limit Setting*). When all factors were considered, this analysis resulted in only 50.8% of participants being correctly classified to either group one (low risk), two (medium risk), or three (high risk), with statistical significance being found between groups one and two only [χ²(6, n=187) = 45.24, p<.001, Wilks Λ = .781]. A DFA using a stepwise model was then conducted. This analysis indicated that *Peer Modelling* was the only factor that resulted in statistical significance [χ²(2, n=187) = 39.36, p<.001, Wilks Λ = .807]. The factor loading for this variable was 1.00. However, this factor was able to correctly classify only 48.7% of participants into each group. Both at the saturated level and stepwise level of the discriminant function analysis, the capability of the three factors to correctly classify participants into one of the three risk groups was poor.
The significant mean score differences for the two factors of Peer Modelling and Family Relationships between groups one and three suggested that the RBQ might more successfully discriminate between participants who were categorised into either group one or group three (that is, the low risk group and the high risk group). To this end, a discriminate function analysis was conducted between group one and group three only. Since the mean score differences were statistically significant for Peer Modelling and Family Relationships only, a stepwise model was used for this analysis. This analysis indicated that Peer Modelling was the only factor that resulted in statistical significance $[\chi^2 (1, n=187) = 39.54, p<.001, \text{ Wilks } \Lambda = .752]$, with the factor loading for this variable being 1.00. The factor of Peer Modelling correctly classified 75.9% of participants into either group one (low risk) or group three (high risk).

5.1.6 Discussion concerning the preliminary investigation

Factor analyses of the total pool of items for the seven category domains of the Risk Behaviour Questionnaire (RBQ) resulted in three factors. The majority of items of factor one were conceptually coherent with the notion of peer modelling, while all items of factor two were coherent with the notion of relationships with one’s family and parents. Approximately half the items of factor three were conceptually coherent with the notion of monitoring and limiting the activities of the adolescent. Reliability coefficients for the total pool of factor items, and for items belonging to each factor individually, were acceptable. Finally, the items comprising each of the three factors reflected five of the seven original category domains used in the questionnaire, and the items of these five domains were congruent with the meaning of their relevant factors.

Results of discriminant function analyses using a saturated model indicated that the three factors lacked the sensitivity necessary to correctly classify participants into any of the three categories of adolescent risk behaviour. Although a stepwise
discriminant function analysis found that the factors of Peer Modelling and Family Relationships were statistically significant, the percentage of participants who were correctly classified into any of the three categories by these factors was particularly poor. Multiple post hoc analyses of mean score differences indicated that the factors of Peer Modelling and Family Relationships were significantly different between the first (or low) and third (or high) risk groups. On the basis of this finding, a discriminant function analysis was conducted with group one and group three using the three emergent factors in a stepwise model. This analysis indicated that only the factor Peer Modelling was statistically significant in discriminating between these two extremes of risk, correctly classifying 75.9% of participants into either the low-risk or high-risk category. While this percentage was not particularly high, at the same time it represented a notable improvement over the results of the previous saturated model of the discriminant function analyses conducted across all three categories of risk behaviour.

A decision was made to proceed with a further phase of development for the following reasons. Firstly, factor analyses resulted in three factors that contained items relevant to arenas emphasised in findings of research literature, namely the importance of peer behaviour for the developing adolescent (e.g., Loeber et al., 1998; Moffitt et. al, 2001; Poulin & Dishion, 1999), the need for a cohesive and therefore protective bond between the adolescent and the parents and family (e.g., Kumpfer et al., 1996; Moffitt et al., 2001; Smith & Stern, 1997), and the protectiveness that results from effective strategies of parental monitoring and limiting of an adolescent’s behaviour (e.g., Dishion & McMahon, 1998). In addition, the finding that Peer Modelling was the only factor to successfully discriminate between adolescents who were categorised as belonging either to the low-risk or high-risk group was also linked to research literature.
This literature emphasised the importance of modelling the behaviour of peers when considering issues implied by adolescent problem behaviour (Dishion & Andrews, 1995; Dunphy, 1990; Heaven, 1994; Moffitt et al., 2001; Poulin & Dishion, 1999). Furthermore, the internal consistency for these factors was acceptable. Finally, the items comprising the factors of Peer Modelling and Family Relationships were logically relevant to the tension between the influence of parents and peers in adolescent behaviour (Dishion & McMahon, 1998).

A number of research issues arose from the preliminary investigation. These included the need for a larger participant pool; the need to take into account male and female gender (Vega et al., 1998); the wording of some items that appeared to create confusion for participants; finally, the need for Year Coordinators to be given specific directions for classifying students according to levels of risk, which did not happen sufficiently well during the preliminary study. Year Coordinators were only briefly instructed on areas of behaviour to observe when classifying students into risk level. It is possible therefore that some students were incorrectly classified, and this possibility might have contributed to the poor findings for the discriminant function analyses. Finally, to reflect the importance of parents’ perceptions in identifying harmful adolescent risk behaviour, as well as respecting the role of parents in intervention for adolescent problem behaviour (Barnes, 1990; Shucksmith, Glendenning & Hendry, 1997; Smith & Stern, 1997), there was the need to develop a parent version for the assessment of harmful risk in adolescent behaviour. The further research into the behavioural patterns of a different Australian adolescent sample that led to the development of the Adolescent Problem Behaviour Assessment (APBA) will now be presented, beginning with the first questionnaire of the APBA, namely the Interpersonal Support Questionnaire.
5.2 The development of the Interpersonal Support Questionnaire

The research issues that arose from the administration of the Risk Behaviour Questionnaire (RBQ) led to an extensive revision of this questionnaire. A much-revised questionnaire emerged from this revision, and was given the new name of the Interpersonal Support Questionnaire (ISQ). The title Interpersonal Support Questionnaire (ISQ) was purposefully chosen to describe the breadth of protective support offered by people and social situations that were currently active in the adolescent’s life. That is, where the support of this protective environment was diminished, the adolescent was placed at higher risk of engaging in activities of harm towards self and others. On the other hand, strengthening this support was seen as being a logical step in reducing this harmful risk. Items of the ISQ described the interpersonal character of this support through the adolescent’s family, parental and peer relationships, significant authority figures, and school and neighbourhood environment.

The revision of the RBQ towards developing the new ISQ also brought to light the need to investigate other arenas related to adolescent behaviour, and so further questionnaires were added. These further questionnaires investigated drug and alcohol use, self-perception of risk, and parents’ sense of resilience in the parental role, which was included in the parent version of the APBA only. The end result was an assessment instrument comprising these questionnaires, entitled the Adolescent Problem Behaviour Assessment (APBA). During this latter section of chapter five, each questionnaire will be treated separately, including a brief description of its purpose as well as results of analyses and discussion of these results relevant to each questionnaire. Issues arising from the preliminary investigation will first be addressed. The treatment of these issues directed the development of the ISQ, since the ISQ was the direct descendant of the
The ISQ will therefore be the first questionnaire outlined in terms of analyses, results and discussion, followed by other questionnaires comprising the APBA.

5.2.1 Research issues following the preliminary investigation

Research issues evident from the preliminary investigation were addressed prior to this second phase of research. Firstly, the need to consider gender differences was apparent. Gender differences have been noted as important considerations in this type of research (Khoury, 1998; Vega et al., 1998; Vega et al., 1998). The majority of participants omitted recording their gender during the administration of the Risk Behaviour Questionnaire (RBQ). To guard against a repetition of this omission, the two questions for gender and age were presented in bold font on the title page, and students were specifically asked to complete these questions before continuing further.

Secondly, the wording of items in the RBQ was revised for the Interpersonal Support Questionnaire (ISQ) with a view to obtaining clear and specific item meanings. This revision addressed potential confusion about the purpose of an item because of vague wording (e.g., RBQ item 16: “I get into fights sometimes”), complex grammatical structure (e.g., RBQ item five: “I almost always tell my parents who I am going out with at night”), and confusion arising from items that appeared to ask two separate questions (e.g. RBQ item 44: “A fair few of my friends skip classes or wag school”). For the modelling of peer behaviour (“How many of your friends…”), the words “regularly” (ISQ item 21: “How many of your friends would regularly smoke cigarettes?”), “more than once or twice” (ISQ item 33: “How many of your friends have been in trouble with the police more than once or twice?”), or “repeatedly” (ISQ item 5: “How many of your friends would repeatedly get into trouble at school?”) were added to relevant items. These additions clarified the frequency of behaviour since frequency was not made clear in the meaning of the response format. Furthermore, whenever grammatical sense
allowed, the wording of items for the ISQ was altered from a question format to a statement format in order to encourage self-reflection rather than suggest the idea that some ‘absent person’ was questioning the participant. This grammatical revision was carried out in consultation with three fellow researchers and clinicians, namely a clinical psychologist with a background in secondary school education, a research-psychologist with a background in secondary school education, and a psychologist who practised in the field of drug and alcohol rehabilitation for adolescents and adults.

Thirdly, the response format for the ISQ was changed from a five-point Likert scale to a four-point Likert scale in order to identify each participant’s response as a movement from not at risk to highly at risk. Thus the option of “Not Sure” used in the original version was discarded. It was considered that the appearance of “Not Sure” in the middle of an evidently logical movement from ‘little’ to ‘much’ would jolt the flow of the response format. Therefore the response format of the ISQ offered the four choices of “Never”, “Sometimes”, “Often”, “Always”, indicating the movement from low risk (“Never”) to high risk (“Always”). In addition, a response format indicating frequency was included in the ISQ, namely “None”, “A Few”, “A Lot”, and “All”, also indicating a movement from low risk to high risk. Research has shown that no significant loss in reliability would result from using a four-point scale (Chang, 1994). Chang (1994) found that the 4-point scale resulted in higher reliability than the six-point scale. Furthermore, Grichting (1994) has advised against the inclusion of a “Don’t Know” (or in the case of this research, “Not Sure”) option for continuous scales that measure opinions, attitudes, or beliefs. Grichting (1994) also noted that the inclusion of this option has been found to have an undesirable impact on correlation values.

Fourthly, the number of category domains was increased in the ISQ. The category domain of “Family Relations and Behaviour at Home” was expanded into the
two domains of “Behaviour at Home” and “Relationships within the Family Environment”. To indicate a separation between peer modelling in general and school-related experiences, the category of “Impact of Peer Modelling” was expanded into two new categories, namely “Peer Modelling of Attitudes to School” and “Peer Modelling of General Behaviour”. The category of “Family Bonding” was changed to “Parent and Adolescent Bonding” since the retained and reformulated items from the category “Family Bonding” referred more to the bond between the adolescent and the parent rather than the bond between the adolescent and his or her family. The original category of “Parental Management” was also restructured into two separate categories, namely “Parental Limit Setting” and “Parental Monitoring”, thus reflecting the emphasis on both parental monitoring and limit setting. Hence the content of the ISQ was increased from 7 to 10 category domains.

Fifthly, new items were developed for the ISQ. Replicated items such as “My parents are cold and distant towards me” (RBQ item 50) and “My parents are not abusive towards me” (RBQ item 51) were replaced in the ISQ with the single item of “My parents are affectionate towards me” (ISQ item 34), using reverse scoring to denote the level of risk. Furthermore, the evidently negative tone of items such as “I don’t like school – school sucks!” (RBQ item 30) was softened. There were also instances in the RBQ where items relevant to peer modelling also had a counterpart in items reflecting personal actions, as with “Some of my friends destroy property or vandalise places” (RBQ item 36) and “I have vandalised property” (RBQ item 20). This did not happen consistently in the RBQ, and so each item related to personal actions in the ISQ was allocated an item relevant to peer modelling. Additional items also referred to running away from home (ISQ items 66 and 68) and feeling stressed and depressed more than other adolescents (ISQ items 67 and 69). In households where conflict is
commonplace, or where harsh discipline practices, stressful life events, and the parents' own feelings of depression characterise families, adolescents can respond to these experiences through their own negative mood state (Ge et al., 1996). Finally, items were further randomised in the *ISQ*, and the adolescent sample size was also increased.

Finally, in order to assist Year Coordinators in classifying participants into a particular level of harmful risk behaviour, a list of primary research-identified risk domains was compiled. This list has been presented in Table 5.3, in section 5.2.3.

### 5.2.2 Method

All questionnaires comprising the one questionnaire booklet of the *Adolescent Problem Behaviour Assessment (APBA)* were administered together to the adolescent sample (n = 410) and parent sample (n = 485) who consented to complete the *APBA*. Fourteen males attended a high school specifically structured for adolescents who have displayed significant delinquency problems. Hence the method will be identical for each questionnaire of the *APBA*, although the results for each questionnaire and the discussion of these results will be presented separately in this chapter.

#### 5.2.2.1 Participants

**Adolescent participants.** Male and female adolescents who were 12 years to 16 years 9 months in age, and who attended metropolitan secondary schools within the Sydney, Illawarra and Shoalhaven regions of the Australian state of New South Wales were invited to complete all questionnaires comprising the *Adolescent Problem Behaviour Assessment (APBA)*. The mean adolescent age was 14.32 years, with a standard deviation of 1.31 years. Four hundred and ten adolescents participated with the consent of their parents or guardians. The total male sample size was 201, and the total female sample size was 209.
**Parent or guardian participants.** Seven hundred and ninety two parents or guardians also consented to complete the *APBA*. The parents of the 14 males who attended the school for students displaying delinquent behaviour did not consent to complete the *APBA*. Three hundred and seventy one families had two people in the role of parent (n = 742), while 50 families were single parent families. However, not every parent of guardian who subsequently received the *APBA* booklet completed and returned it. Of the 792 booklets taken home to parents by adolescents (that is, two questionnaires per family), 282 mothers and 203 fathers returned a completed booklet. Mean parent age was not determined since there was no intention to consider age in the analyses of parent data. Of the 485 returns, 402 booklets were returned by both people in the parent role and 83 booklets were returned by one parent only. The lack of response by remaining parents was possibly due to a single parent family, to a loss of interest by the parent, or to the neglect of the adolescent to give the *APBA* booklet to his or her parents. In percentage, 60.85% of parents returned a validly completed *APBA* booklet. The distribution of the adolescent sample across age and gender as well as the distribution of the parent sample has been presented in Table 5.2. Adolescent and parent sample sizes for both genders were considered adequate for statistical purposes. Where adolescent age has been taken to one decimal place, the value represents years plus months, so that 13.9 years would represent “13 years 11 months”.
Table 5.2
Distribution of adolescent and parent participants according to age and gender.

<table>
<thead>
<tr>
<th>Adolescent age in years and months</th>
<th>Male</th>
<th>Mother</th>
<th>Father</th>
<th>Female</th>
<th>Mother</th>
<th>Father</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 to 13.9 years</td>
<td>41</td>
<td>22</td>
<td>21</td>
<td>32</td>
<td>23</td>
<td>14</td>
</tr>
<tr>
<td>13 to 13.9 years</td>
<td>51</td>
<td>40</td>
<td>28</td>
<td>52</td>
<td>42</td>
<td>29</td>
</tr>
<tr>
<td>14 to 14.9 years</td>
<td>41</td>
<td>28</td>
<td>21</td>
<td>42</td>
<td>30</td>
<td>21</td>
</tr>
<tr>
<td>15 to 15.9 years</td>
<td>40</td>
<td>27</td>
<td>17</td>
<td>56</td>
<td>39</td>
<td>30</td>
</tr>
<tr>
<td>16 to 16.9 years</td>
<td>28</td>
<td>11</td>
<td>6</td>
<td>27</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td>Total participants</td>
<td>201</td>
<td>128</td>
<td>93</td>
<td>209</td>
<td>154</td>
<td>110</td>
</tr>
</tbody>
</table>

5.2.2.2 Instrument. The Adolescent Problem Behaviour Assessment (APBA) was administered in a booklet format to parents and adolescents, and comprised the various questionnaires investigating adolescent risk. Following the description of the administration procedure, each questionnaire of the APBA will be treated in separate sections beginning with the Interpersonal Support Questionnaire.

5.2.3 Procedure

Explanations to students. The researcher addressed all students in two separate groups (Year 7 students with Year 8 students, and Year 9 students with Year 10 and 11 students) in each nominated high school. This division enabled information to be presented in a simpler format to younger students in comparison to older students. Students gathered in adequately lit and ventilated spaces, thus enabling students to clearly see and hear the researcher. The researcher explained the purpose of the project, the value of the students’ contribution, and the requirements for students who eventually decided to participate. The reason for inviting their parents to participate was also explained to students. The confidential and anonymous nature of students’ and parents’
responses was carefully detailed to allay potential concerns that parents or any other authority figure would have access to students’ responses. The use of numeric identifiers was also outlined to students in relation to confidentiality and anonymity, with the emphasis that the number identifying students and parents could not be personally matched to parent or student. The use of the same number for parents and students was presented as a practical means of matching questionnaire booklets following the administration process. Finally, students were told that if they chose to participate they would complete the Adolescent Problem Behaviour Assessment (APBA) during school hours while their parents would complete the APBA at home. Following this explanatory presentation, students were invited to take home a research information form (see Appendix 7) and consent form (see Appendix 8). Students understood that participation in the research required prior completion of the consent form by both the student and at least one parent or guardian.

Although this information was delivered in a consistent and ordered format, a standardised format was not used. The different ranges of age and maturation required a variety of presentation styles and adjustments in language complexity in order to best suit each level of adolescent development.

The role of teachers. A number of teachers were approached to act as supervisors during the administration of the APBA, with the supervisor-student ratio during administration being approximately 1 supervisor to 10 students. One of these teachers who held the position of Year Coordinator, and therefore who had the most familiar knowledge of participating students’ behaviour, was asked to assess participating students’ current level of behaviour. The mean years of high school teaching experience for Year Coordinators who assessed behaviour was 17.75 years, with a standard deviation of 4.04 years.
Meeting with teachers. One week prior to the administration of the APBA, the researcher individually met with Year Coordinators of participating schools who were to assess students’ levels of behaviour, as well as with teachers who accepted the role of supervisor. This meeting had two purposes. The first was to explain the rationale and content of all questionnaires comprising the APBA (in both adolescent and parent version) thus equipping teachers to adequately answer students’ enquiries during the administration as well as understand the sensitivity of some areas of enquiry that required privacy from the interference of fellow students. The second purpose of the meeting was to explain to Year Coordinators the rationale and method of assessing each participating student’s current level of behaviour. The requirements of confidentiality during this task were stressed. This was particularly important since the person in this role had access to the names of students who were participating in order to allow time prior to the day of administration to reflect upon the behaviour of each student.

The Year Coordinator was instructed to complete this task in a private space, away from the notice of other teachers and students. The Year Coordinator was also instructed not to copy the sheet of names in any way, nor make any notes on any other sheet of paper. As an aid to memory on the day of administration, the teacher was instructed to simply place either ‘L’, ‘M’, or ‘H’ (that is, low, medium, or high risk) beside each student’s name. These letters would be meaningless should any other person accidentally gain access to the names, since no other information apart from participants’ names would be recorded on the sheet. When not in use, the teacher was instructed to lock the sheet away in a personal storage area (such as a filing cabinet). Following the administration process, this sheet of names was given to the researcher who shredded all name sheets as soon as practical after the day of administration. The various risk factors to be considered when assessing students’ level of harm in risk were
also discussed with the Year Coordinator. Risk factors were compiled by the researcher against the background of research described in chapters one to three of this thesis. These factors have been presented in Table 5.3.

**Table 5.3**
**Risk factors representing each participant’s behavioural assessment.**

- Regular and higher than normal absenteeism from school; student skips class regularly
- Failure to complete assigned homework tasks
- Tendency towards a deviant peer group
- Aggressive and abusive behaviour towards peers and teachers
- Unstable and/or unhappy family environment (to the best of the teacher’s knowledge)
- Common experience of academic failure or under-achievement
- Known or suspected participation in anti-social and/or illegal activity
- Known or suspected problem use of drugs and/or alcohol

*The visual analogue scale.* On the day allocated for administration, the Year Coordinator who was assessing harmful risk behaviour received a booklet of slips with a visual analogue scale (VAS) on each slip. The VAS was a 10-centimetre line that moved between the two points of *Low Problem Behaviour* to *High Problem Behaviour*. The Year Coordinator placed a cross somewhere on this line representing the student’s previously considered level of current behaviour. The number on each VAS slip was matched with the student’s identification number. VAS slips were correctly matched with their corresponding identification number by the ordered sequence in which copies of the *APBA* were placed on each desk. That is, the number of the *APBA* placed on the first desk was written on the first VAS slip by the researcher, and the Year Coordinator then continued on with this numbering sequence.

*The day of administration.* The spaces chosen for administration were adequately ventilated and lit, with one desk and chair allocated for each participant. Desks were situated so that verbal and visual contact between students was controlled.
Students had been asked to take a pen or pencil with them before leaving their classroom. However, spare pens and pencils were available in the administration room if needed. Before students entered the administration room the researcher placed a ‘kit’ containing one copy of the adolescent version and two copies of the parent version of the APBA on each desk. Two envelopes marked “Confidential” and two copies of instructions for completing the parent version were attached to the parent copies of the APBA. Students did not commence answering their questionnaires until the researcher explained certain requirements. The different points of this explanation were the same as for the administration of the Risk Behaviour Questionnaire, and have been presented in Appendix 4.

All students’ queries were answered in an atmosphere of quiet and confidentiality. When answering a query, the supervisor or researcher was to physically position him or herself in such a way as to respect the confidentiality of the student’s responses. The Year Coordinator who had previously considered students’ current level of behaviour unobtrusively transferred assessments to the visual analogue scale (VAS), and only after students had begun completing the APBA. Students did not leave the administration room until everyone had finished completing the APBA. As students departed, they personally placed their copies of the APBA in a container at the front of each row of desks, thus ensuring anonymity. When the last student had departed, the researcher collected all VAS slips, including the slips that had not been used.

5.2.4 Results of the Interpersonal Support Questionnaire

The 10 category domains and their relevant item numbers comprising the Interpersonal Support Questionnaire (ISQ) have been presented in Table 5.4, together with reliability values for each domain (Cronbach’s alpha).
Table 5.4
Structure of the Interpersonal Support Questionnaire.

<table>
<thead>
<tr>
<th>Category</th>
<th>Item numbers</th>
<th>Alpha adolescent</th>
<th>Alpha mother</th>
<th>Alpha father</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Behaviour at home</td>
<td>7, 13, 62, 65.</td>
<td>0.50</td>
<td>0.44</td>
<td>0.44</td>
</tr>
<tr>
<td>2. Relationships within the family environment</td>
<td>2, 17, 19, 24, 30, 61, 66, 67, 68, 69.</td>
<td>0.80</td>
<td>0.60</td>
<td>0.69</td>
</tr>
<tr>
<td>3. General Behaviour</td>
<td>4, 9, 18, 29, 35, 42, 46, 58, 64.</td>
<td>0.68</td>
<td>0.27</td>
<td>0.23</td>
</tr>
<tr>
<td>4. Attitudes to school</td>
<td>3, 12, 27, 37, 43, 47, 53.</td>
<td>0.77</td>
<td>0.66</td>
<td>0.68</td>
</tr>
<tr>
<td>5. Peer modelling of attitudes to school</td>
<td>5, 14, 22, 32, 38, 57.</td>
<td>0.73</td>
<td>0.66</td>
<td>0.71</td>
</tr>
<tr>
<td>6. Peer modelling of general behaviour</td>
<td>1, 10, 16, 20, 28, 33, 40, 45, 48, 51, 54.</td>
<td>0.84</td>
<td>0.58</td>
<td>0.62</td>
</tr>
<tr>
<td>7. Peer modelling of drug and alcohol use</td>
<td>8, 21, 25, 31, 39, 41, 52.</td>
<td>0.90</td>
<td>0.74</td>
<td>0.23</td>
</tr>
<tr>
<td>8. Parent and adolescent bonding</td>
<td>6, 23, 26, 34.</td>
<td>0.79</td>
<td>0.67</td>
<td>0.73</td>
</tr>
<tr>
<td>9. Parental limit setting</td>
<td>11, 44, 55, 60.</td>
<td>0.74</td>
<td>0.48</td>
<td>0.48</td>
</tr>
<tr>
<td>10. Parental monitoring</td>
<td>15, 36, 49, 50, 56, 59, 63.</td>
<td>0.82</td>
<td>0.20</td>
<td>0.71</td>
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Apart from the category domain of “Behaviour at Home”, reliability values for each of the 10 categories for the adolescent version of the ISQ were judged to be adequate, and reflected the reliability values of comparative categories used in the preliminary investigation. The decision was made to retain the domain of “Behaviour at Home” in spite of the low value for reliability, since to remove it would have disturbed the psychological construct of the questionnaire. The value of 0.50 for this domain was
not considered so low as to argue against retaining this category domain. However, values of internal consistency for the parent version were generally not as strong as the adolescent version. In some cases these values were unacceptably low, as with “General Behaviour” and “Parental Monitoring”. This issue will be further addressed in section 5.2.4.2.

5.2.4.1 Factor analysis of adolescent responses. Internal consistency (Cronbach’s alpha) was measured for the total pool of 69 items, resulting in an alpha coefficient of 0.95. This value was considered acceptable. A factor analysis was then conducted on the total pool of items using a principal component analysis extraction with promax rotation and Kaiser normalisation. At this point, risk classification was not taken into account for the factor analysis, since it was necessary to make use of the total sample size of adolescents (n = 410) in order to ensure variability in scores as well as obtain true correlations between items and factors. However, risk classification was eventually considered. The purpose of classifying adolescents according to risk behaviour was to examine the capacity of the resulting questionnaires of the Adolescent Problem Behaviour Assessment (APBA) to discriminate between four designated quartiles of risk behaviour, ranging from nil or low risk through to extremely harmful risk. This analysis will be presented in Section 5.4.3. For the factor analysis, only those items with a loading greater than or equal to 0.40 were retained from the resulting pattern matrix. Items were also deleted if the meaning was not aligned with the overall conceptual coherence of the factor content. Factor analysis resulted in three factors. Final item numbers and factor loadings are recorded in Table 5.5.
Table 5.5
Factors and factor loadings for the *Interpersonal Support Questionnaire* (adolescent).

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<th>Item</th>
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| Eigenvalue | 18.09 | 4.59 | 4.04 |
| % of variance | 26.22 | 6.65 | 5.85 |
| Cumulative variance | 26.22 | 32.87 | 38.72 |
The factor analysis of the total pool of items that comprised the adolescent version of the *Interpersonal Support Questionnaire (ISQ)* resulted in three factors, resembling the results of the factor analysis of the *Risk Behaviour Questionnaire (RBQ)*. This was particularly so for factor one of each study. Thirteen of the 19 items in factor one of the *RBQ* and 17 of the 27 items of factor one of the *ISQ* each reflected the notion of peer modelling. In the *RBQ*, this factor accounted for 22.65% of the variance, while the same factor for the present study accounted for 26.22% of the variance. Hence the concept of modelling the behaviour of one’s peers appeared to exercise a strong influence within adolescent behaviour. Consequently, the label of *Peer Modelling* given to factor one in the *RBQ* was also adopted for factor one in the *ISQ*.

For the remaining two factors, comparisons between the *RBQ* and the *ISQ* revealed a difference in the ordering of these two factors for each study. Firstly, 12 out of the 15 items comprising factor two of the *ISQ* reflected the notion of monitoring and limiting the adolescent’s activities, and accounted for 6.65% of the variance. These items resembled the conceptual meaning of items in factor three of the *RBQ*. Therefore factor two of the *ISQ* was also labelled *Parental Monitoring/Limit Setting*. Secondly, 12 of the 13 items comprising factor three of the *ISQ* reflected the influence of the parent as well as the family in an adolescent’s life, and accounted for 5.85% of the total variance. This factor differed from the conceptual meaning of factor two of the *RBQ* by including the influence of the parent in the adolescent’s life. Hence factor three of the *ISQ* was labelled *Parent/Family Relationships* to embrace this parental influence.

In summary, emergent factors for the *ISQ* were *Peer Modelling* (17 items), *Parental Monitoring/Limit Setting* (12 items), and *Parent/Family Relationships* (12 items). These factors included 41 of the total pool of 69 items. The wording of each factor item for the *ISQ* has been presented immediately after the factor items of the *RBQ*.
on p.2 of Appendix 6. Presenting the wording of factor items in this manner will enable a comparison to be drawn more easily between the items of each questionnaire.

Analyses of reliability (Cronbach’s alpha) were conducted for the three combined factors of the ISQ. This value was found to be adequate ($\alpha = 0.96$). Reliability analyses were then conducted for the three factors separately. Internal consistency for Peer Modelling was 0.93, ($\alpha = 0.89$ for the RBQ). For Parental Monitoring/Limit-Setting internal consistency was 0.82 ($\alpha = 0.76$ for the RBQ), and 0.88 for Parent/Family Relationships ($\alpha = 0.90$ for the RBQ). These values were particularly satisfactory, and compared well with the internal consistency of comparable factors in the RBQ.

**The three factors replaced the 10 category domains.** On the basis of the factor analysis for the adolescent version of the questionnaire, a decision was made to replace the 10 category domains developed from the Risk Behaviour Questionnaire (RBQ) with the three factors of the Interpersonal Support Questionnaire (ISQ). The three factors of Peer Modelling, Parental Monitoring/Limit Setting, and Parent/Family Relationships contained items that condensed 7 of the 10 category domains comprising the ISQ. The factor of Peer Modelling comprised the category domains of “Peer Modelling of Drug Abuse”, “Peer Modelling of General Behaviour”, and “Peer Modelling of Attitudes to School”. The factor of Parental Monitoring/Limit Setting comprised the category domains of “Parental Limit Setting” and “Parental Monitoring”. Finally, the factor of Parent/Family Relationships comprised the category domains of “Relationships within the Family Environment” and “Parent and Adolescent Bonding”.

**5.2.4.2 Factor analysis of parent responses.** Even though values of internal consistency for the parent version were particularly low (and in some cases unacceptably low) for each category domain, factor analyses were nonetheless
conducted for responses of mothers and fathers separately, using a principal component analysis extraction, with promax rotation and Kaiser normalisation. The sufficiently high parent sample size (282 mothers and 203 fathers) justified conducting the factor analysis of parent responses. A statistical analysis of combined responses of mothers and fathers could not be carried out due to at least one variable having zero variance. Similar to the adolescent data, only those items with a loading greater than 0.40 were retained. The pattern matrices for these factor analyses have been presented in Appendix 9 rather than in the body of the thesis since the parent version of the Interpersonal Support Questionnaire (ISQ) was eventually structured from the factor analysis for adolescent responses.

The results of the factor analyses for mothers and fathers were interesting. Across all factors, 24 items out of a total pool of 35 items for mothers were also found in any one factor within the factor analysis for adolescents. Again across all factors, 28 items out of a total pool of 39 items for fathers were also found in the adolescents. The main differences between the results for parents and adolescents were found in the percentages of variance indicated by each factor. The factor analysis for adolescents resulted in factor one (Peer Modelling), accounting for the highest percentage of variance (26.22%). For mothers, items with the same conceptual meaning as Peer Modelling (7 out of 11 items) clustered around factor three, with this factor accounting for 5.21% of the variance. For fathers, items with the same conceptual meaning as Peer Modelling (9 out of 14 items) clustered around factor two, with this factor accounting for 5.62% of the variance. The factor analysis for adolescents resulted in factor two (Parental Monitoring/Limit Setting) accounting for the second highest percentage of variance (6.65%). For mothers, only item 49 in factor one reflected the same conceptual meaning as Parental Monitoring/Limit Setting. For fathers, only 8 of the total pool of 20
items in factor one reflected the same conceptual meaning as *Parental Monitoring/Limit Setting*. Finally, the factor analysis for adolescents resulted in factor three (*Parent/Family Relationships*) accounting for the third highest percentage of variance (5.85%). For mothers, 10 items out of a total pool of 14 items with the same conceptual meaning as *Parent/Family Relationships* clustered around factor two, with this factor accounting for 6.10% of the variance. For fathers, only 7 out of a total pool of 20 items in factor one reflected the same conceptual meaning as *Parent/Family Relationships*.

Not only were substantial differences found between the factor structures of adolescents and both parents, but differences were also found between the factor structures of mothers and fathers. For mothers, factor one accounted for the highest percentage of variance, and reflected the same conceptual meaning of the same factor in the adolescent results (*Peer Modelling*). For fathers, however, 16 of the total pool of items that clustered together in factor one could be found in all three factors resulting from the analysis of adolescent responses, with only item 52 reflecting the meaning of *Peer Modelling*. Therefore, for the factor of *Peer Modelling*, communality was found between adolescents and mothers but not between adolescents and fathers.

Analyses of reliability (Cronbach’s alpha) for parent responses were also conducted, and were found to be marginally lower than values for adolescent responses. An analysis of reliability was conducted for the combined three factors for mothers, and resulted in a value of 0.83. Analyses of reliability were then conducted for the three factors separately. Reliability for factor one was 0.81. For factor two, reliability was 0.79, and 0.73 for factor three. An analysis of reliability was also conducted for the combined three factors for fathers, and resulted in a value of 0.87. Analyses of reliability were then conducted for the three factors separately. Reliability for factor one was 0.82. For factor two, reliability was 0.82, and 0.69 for factor three.
The differences in both factor structure and item reliability between adolescents and parents, as well as between mothers and fathers, raised the issue of concordance of risk perception between adolescents and their parents, and between mothers and fathers. This issue was a necessary consideration since a principal purpose of developing an assessment instrument for adolescent risk behaviour was to enable a clinician to compare the perceptions of adolescents and parents about levels of harmful risk. Analyses of parent responses did not sufficiently allow for the adolescent and parent versions of the ISQ to measure the same factor items of adolescent behaviour. While the reliability of responses by mothers and fathers was acceptable, even though slightly lower than those of adolescents, this result did not sufficiently address the disparity between factor structure among adolescent and parent responses.

Two further issues were considered in the context of this problem. Firstly, *a priori* logic suggested that adolescents, rather than parents or authority figures, would possess clearer knowledge about their daily life experiences. The natural process of autonomy would tend to exclude adults from much of what occurs in adolescent experiences, particularly as the adolescent grew older. Secondly, the factor analysis of adolescent responses resulted in clearer conceptual coherence of items within each factor, with very few items needing to be rejected because of a lack of conceptual coherence. Furthermore, the adolescent factor that accounted for the largest percentage of variance was that which reflected the concept of peer modelling in factor one. There was disparity between mothers and fathers over the meaning of factor one, although factor one for mothers resembled factor one for adolescents. However, factor one for adolescents reflected a higher number of items focusing on the concept of peer modelling than did factor one for mothers. This indicated that factor one for adolescents was more robust than factor one for mothers.
The eventual decision was to formulate the parent version of the ISQ on the factor structure of the adolescent version. Items of the parent version of the ISQ were therefore retained or rejected to resemble the three factors of the adolescent version. Following this process, analyses of reliability (Cronbach’s alpha) were conducted for the combined factors of the parent version of the ISQ. Reliability values were found to be adequate for mothers ($\alpha = 0.87$) and for fathers ($\alpha = 0.84$), although these values were again still marginally lower than the value for adolescents ($\alpha = 0.96$). Analyses of reliability were also conducted for mothers and fathers on the three factors separately. For Peer Modelling, reliability for mothers was 0.84, and 0.59 for fathers. For Parental Monitoring/Limit-Setting, reliability for mothers was 0.75 and 0.73 for fathers. Finally, reliability for Parent/Family Relationships was 0.76 for mothers and 0.81 for fathers. These reliability values were acceptable for each factor of the parent version. While the reliability value for fathers for Peer Modelling was comparably smaller, it was not so small as to create a problem in retaining this factor. This low reliability value suggested that fathers appeared to be less consistent in their perceptions of adolescent modelling of peer behaviour.

The ISQ can be found on pages two to five of Appendix 10 (the adolescent version of the APBA) and pages three to six of Appendix 11 (the parent version of the APBA). Items of the ISQ with reversed scoring have been noted on the cover pages of Appendices 9 and 10.

5.2.5 Discussion concerning the Interpersonal Support Questionnaire

The resulting factor analysis of adolescent responses to the 10-categories of the Interpersonal Support Questionnaire (ISQ) identified three factors that reflected the meaning of 7 of the original 10 category domains. The conceptual meaning of the items comprising each factor of the ISQ gave rise to three factor labels, namely Peer
**Modelling** for factor one, **Parental Monitoring/Limit Setting** for factor two, and **Parent/Family Relationships** for factor three. Due to difficulties with concordance between the factor structure of the parent and adolescent versions of the questionnaire, a decision was made to structure the parent version of the ISQ according to each factor of the adolescent version. Ensuring that both versions of the ISQ complemented each other was an important consideration for the clinical use of the final assessment instrument.

The importance of these factor meanings in the clinical setting cannot be emphasised too strongly, especially the factor of **Peer Modelling**. Each of the 17 items of the factor **Peer Modelling** signified the various aspects of initiation into peer group membership and ongoing participation in its midst. Items referring to age appropriateness of membership, use or misuse of drugs and alcohol, problems at school or home, trouble with legal authorities, and anti-social behaviour described these aspects. Taken as a whole, the items of **Peer Modelling** mirrored the type of adolescent activity that might lead to a trajectory of problem behaviour (eg., Hawkins et al., 1992; Igra & Irwin, 1996; Jessor, 1991; Jessor et al., 1995). As part of a clinical assessment, the factor of **Peer Modelling** would therefore represent a primary indicator of the level of risk associated with the type of peer behaviour modelled by an adolescent.

The twelve items belonging to the factor entitled **Parent/Family Relationships** indicated the strength of the bond between the parent and the adolescent. The warmth and closeness of this relationship, the parent’s readiness to use effective communication, the parent’s response to stressful situations with the adolescent, and the nature of the home environment, would provide indicators of how much support and bonding currently existed within the home. In addition, enquiry by the clinician into whether or not the adolescent was attempting to cope with a poor home environment either by running away or by becoming sad and depressed would provide further insight.
into what might be an unpleasant and potentially destructive home environment. Giving attention to these details would vitally underpin the success of any attempt to ameliorate a fractured relationship between adolescent and parent. A strong parent-adolescent relationship would provide the necessary pre-requisite for repairing the fractured nature of this bond.

The twelve items of the factor *Parental Monitoring/Limit Setting* generally reflected the essential elements of the many intervention and developmental theories that circumscribe parenting practices (Dishion & McMahon, 1998). Clear knowledge about the adolescent’s activities would reassure the parent about the adolescent’s personal safety, as well as helping the parent set realistic and age appropriate limits on these activities (Patterson & Stouthamer-Loeber, 1984). Each item of this factor clearly elucidated the various aspects that would comprise the task of parental monitoring and limit setting. Setting boundaries of time and space, insisting upon the parental right to permit or deny particular adolescent activities, making the effort to know the adolescent’s friends and their parents, and generally monitoring the adolescent’s movements, indicated an approach that would place the parent one step ahead of the adolescent. These issues were reflected by this factor, and would enable the clinician to gain a clear insight into the parent’s emphasis on ensuring, as far as practically possible, the safety of the son or daughter while away from home. The type of monitoring and limit setting exercised by the parent would also enable the clinician to grasp some understanding into whether an authoritative or permissive parenting style was being used towards the adolescent.

The inability to structure a parent version of the *ISQ* from parent data was disappointing, and consequently the development of a parent questionnaire that adequately assessed adolescent risk behaviour from the mother or father’s point of view
was seen as a necessary task of future research. The drawback of structuring the parent version according to adolescent data resided in the parent being asked to comment on risk behaviour primarily through the adolescent’s eyes, since the three factors of the adolescent version emerged from adolescent responses. Future research would therefore focus on developing a parent-based means of assessing adolescent problem behaviour that allowed for a clinical concordance to be drawn between the parent’s perception of the adolescent’s behaviour and that of the adolescent. This research would require a further parent sample that was larger in size, without the necessary participation of the adolescent son or daughter.

Nonetheless, it must also be emphasised that using the adolescent-based version as the basis for the parent version of the questionnaire did not therefore diminish the credibility of the parent’s perception of his or her adolescent child’s behaviour. Firstly, previously cited research has indicated that the items comprising the three factors of adolescent behaviour reflected behavioural aspects that are essentially important in considering potential risk behaviour, regardless of whether the perception of this behaviour belonged to either the adolescent or the parent. Secondly, the fact that a parent did not know the answers to items describing adolescent behaviour, particularly behaviour that occurred away from home, would itself be important information for both parent and clinician to consider. The parent might not be legitimately expected to know about certain aspects of adolescent behaviour, as in the case of an older adolescent. However, age-inappropriate adolescent behaviour and poor parental knowledge about that behaviour would become the focus of discussion between the clinician and the parent where parents were concerned about their lack of knowledge in these arenas.
It was only possible to speculate on what led to the lack of communality between the factor analysis of parent and adolescent data, and between mothers and fathers for parent data. The psychometric purpose of a factor analysis is to test those variables correlated to one another while also being independent of other subsets of variables that might be combined into factors as well (Tabachnick & Fidell, 1996). Each resulting factor of a factor analysis is therefore the measurement outcome of the original psychological construct. Therefore, discrepancies between the results of the factor analyses of adolescent and parent data indicated that adolescents and parents, and mothers and fathers, did not generally share the same views about what aspects of adolescent behaviour were important when considering the nature of that behaviour.

Overall, the factors of the ISQ provided a neatly structured foundation for describing a particular adolescent’s potential for becoming involved in harmful risk. In identifying the tendency of the adolescent to model the behaviour of peers, the factor Peer Modelling would indicate whether this peer influence is either protective or harmful. The factor Parent/Family Relationships would describe the interaction dynamic occurring between the adolescent and his or her family members, as well as parents. Finally, in describing how parents exercised control over the adolescent’s activities, the factor Parental Monitoring/Limit-Setting would indicate the extent and impact of parental authority in the adolescent’s life, particularly when he or she was away from home. It would stand to reason that where peer relationships were healthy and adaptive, and where the parent imposed sufficient and appropriate authority to monitor and limit the son or daughter’s activities, then relations between the adolescent and his or her parents and family would be relaxed and supportive (Kirchler et al., 1993).
5.3 The Adolescent Drug Use Questionnaire

Inferential statistics were not conducted with adolescent and parent responses to the Adolescent Drug Use Questionnaire (ADUQ). Rather, the adolescent’s frequency and amount of consumption of alcohol, tobacco, and marijuana according to the ADUQ was measured in percentage values. These percentages of consumption provided part of the clinical baseline used by a clinician to determine a referred adolescent’s proneness towards problem behaviour. The analyses that gave rise to these data will be presented separately in chapter six, together with descriptive data derived from the remaining questionnaires of the Adolescent Problem Behaviour Assessment (APBA). However, to maintain the sequential flow of the APBA, the foundation for the composition of the ADUQ will be outlined at this point in the thesis.

The Adolescent Drug Use Questionnaire (ADUQ) has been situated immediately after the Interpersonal Support Questionnaire (ISQ) and investigated an adolescent’s consumption of alcohol, tobacco, and marijuana from an adolescent and parent’s viewpoint. These drugs were specifically chosen for investigation since they represented a possible pathway into harder drug use commitment by the adolescent (Ellickson et al., 1992; Kandel & Faust, 1975). The questionnaire developed by Wragg (1986; 1992a; 1992b) to assess the consumption of alcohol, tobacco, and marijuana, together with other substances, underpinned the development of the ADUQ. Wragg’s questionnaire (1992a; 1992b) focused on drug education for substance misuse and relevant adolescent activities that either buffered or exacerbated problems arising from adolescent substance use. Questions for the prevalence of drug use developed for Wragg’s (1992a; 1992b) research were administered by Wragg to a normative adolescent male and female sample (n = 239) of an age range equivalent to this present research. These questions were of a self-report nature, and were structured in conformity to the recommended
methodology for surveys of student drug use suggested by the World Health
Organisation (1980) surveys, as well as standards set by the Commonwealth
Department of Health [Australia] (1981). While Wragg’s total pool of items
investigated six categories of drug use, namely, alcohol, tobacco, marijuana, analgesics,
inhalants, illegal drugs, and illegal use of prescription drugs, only questions referring to
the gateway use of alcohol, tobacco and marijuana were adapted for this research.
Reliability coefficients for these questions ranged from 0.80 to 0.85, and were
considered acceptable. The development of questions for the investigation of the ADUQ
into adolescent use of alcohol, tobacco, and marijuana was subsequently undertaken
with Wragg’s permission.

Adolescents and parents were asked to consider both amount and frequency of
consumption over the previous four-week period. A period of four weeks was
considered by the researcher to provide a reasonable estimate of adolescent behaviour in
this arena, since the investigation of adolescent substance use in the ADUQ was part of
an overall measure of various forms of current adolescent behaviour. Furthermore, a
four-week period was the maximum period nominated in the research of adolescent
substance use in Australia (Commonwealth Department of Human Services and Health,
& Australian Institute of Health and Welfare, 1998), as well as one of three periods of
time nominated by Wragg (1992a; 1992b) for his research.

Questions developed for the ADUQ included three stages for each drug. Firstly,
adolescents and parents were asked to respond with a ‘yes’ or ‘no’ answer to whether a
substance had ever been used. This question enabled the parent or adolescent to pass
over to the next section if the particular substance was never used. If a particular
substance had been used at some time, then enquiry continued by investigating the
number of days over the previous four-week period during which the adolescent might
have used alcohol or tobacco. The question concerning marijuana use was presented differently. Frequency was calculated according to the number of times when marijuana might have been used over the four-week period, rather than the number of days. Amounts of marijuana consumption were not investigated. Establishing accurate amounts of marijuana was seen as being more difficult due to the occasional practice of mixing marijuana with other substances such as tobacco (Campbell, 2001). As a result, a lengthy and complicated investigation would have been needed to gain accurate information about the specific amount of marijuana consumed, rather than whether or not a particular adolescent was using marijuana, regardless of its purity.

Values of internal consistency for the total item pool of the ADUQ can be presented at this point in the thesis. Reliability values (Cronbach’s alpha) for adolescent and parent responses to the total item pool of the ADUQ were found to be adequate. Reliability for adolescent responses was 0.95. For mothers, this value was 0.86, and 0.83 for fathers. The ADUQ, together with relevant questions for alcohol, tobacco, and marijuana consumption, can be found both in the adolescent version of the APBA (Appendix 10, pp. 6-7), as well as the parent version (Appendix 11, pp 7-8).

5.4 The Self-Perception of Risk Questionnaire

A seven-item construct entitled the Self-Perception of Risk Questionnaire (SPRQ) was also developed for inclusion in the Adolescent Problem Behaviour Assessment (APBA) and was answered during the administration of the APBA. Adolescents and parents responded to the seven questions comprising the SPRQ. These questions were derived from literature investigating the nature of adolescent behaviour, as well as findings resulting from research into the outcomes of adolescent behaviour. Once again, the findings of literature and research relevant to the development of this questionnaire have been presented in the first three chapters of this thesis. Questions
comprising the SPRQ represented problems with the police, problems at home and at school, and peer-related problems in relation to both the police and drug and alcohol use. The SPRQ was designed to assess the insight of the adolescent and parent into the possibility of future problem behaviour in relation to these behavioural domains if the adolescent’s current behavioural pattern continued unabated. While the title of the SPRQ for the parent version remained unchanged, the purpose of asking the parent to complete the SPRQ was one of gaining the parent’s understanding of the adolescent’s insight into the possibility of future problem behaviour. Subsequent statistical analysis of this construct resulted in a single four-item factor. The adolescent version of the SPRQ can be found in Appendix 10, pages seven to eight, while the parent version can be found in Appendix 11, pages eight to nine.

The rationale for developing the SPRQ emerged from a model of behaviour that investigated why people failed to engage in programmes of either health-risk prevention or detection (Glanz, Lewis, & Rimer, 1990; Janz & Becker, 1984). Glanz et al. (1990) concluded that if a person is to achieve a successful change in behaviour, then there is a preceding need for that person to first feel threatened by his or her current pattern of behaviour. Furthermore, a health promoting change in behaviour relies upon the person placing significant value on this outcome, even though personal cost in terms of effort and persistence will be required to gain this outcome. Finally, successful changes in behaviour require the type of environment and action plan that will support and motivate the person to achieve the change that he or she seeks. This model has been termed the health belief model of behaviour.

Critics of the health belief model of behaviour claim that environmental, economic, social, and peer-related factors are not taken into account in its application (Dennison, 1996; Rosenstock, 1990; Stowe & Ross, 1992). However, the principles of
the health belief model described in the paragraph above were considered relevant to issues addressed in the *SPRQ*. That is, if adolescents are to modify their behaviour into a style that is less prone to problem outcomes, then they need to perceive their current behaviour as being a threat to their overall well-being. They also need to see the value of change as leading them towards beneficial outcomes in the future, as well as increasing their quality of life in the present, and believe that with help they will be able to successfully tackle the demands of that change. Finally adolescents who are at risk of harmful behaviour need to acknowledge that these benefits come at the cost of personal involvement and effort.

Assessment results of the *SPRQ* would provide the parent or adolescent with a balance (or lack thereof) between insight into the possibility of future behavioural problems and identified levels of current behaviour. Where the perception of future harmful risk was low, yet current reports of behaviour indicated high levels of harmful risk, then one could presume that the adolescent concerned was already on a trajectory of future problems in behavioural outcome without being aware of it.

5.4.1 **Results of the Self-Perception of Risk Questionnaire**

5.4.1.1 **Factor analysis of the Self-Perception of Risk Questionnaire.** Similar to the factor analysis of parent data for the *Interpersonal Support Questionnaire (ISQ)*, a lack of communality also emerged between the results of the factor analyses for mothers and fathers for the *Self-Perception of Risk Questionnaire (SPRQ)*. As with the *ISQ*, this finding led to a decision to structure the parent version of the *SPRQ* on the findings of the factor analysis of adolescent responses. For this reason, only the factors and factor loadings for adolescents will be presented in the body of this thesis. Factors and factor loadings for mothers and fathers have been presented in Appendix 12, although the results of analyses for mothers and fathers will be discussed in the next paragraph.
Following this discussion, the factor analysis of adolescent responses will be presented. Factor analyses of data for adolescents, mothers and fathers for the *SPRQ* were conducted using a principal component analysis extraction with promax rotation and Kaiser normalisation. Only those items with a factor loading greater than 0.40 were retained.

**Factor analyses of parent responses.** The number of items that comprised factor one was equivalent for mothers and fathers. However, only items 3b, 4a, and 4b were common for the data of mothers and fathers in factor one. Two items comprised factor two for mothers and three items comprised factor two for fathers, although item 2 was the only common item for the data of mothers and fathers in factor two. Hence, while the percentages of variance for factors one and two were closely similar for mothers and fathers, there was a notable lack of communality between the items of these factors for mothers and fathers. This was especially so for factor two. Analyses of reliability (Cronbach’s alpha) were also conducted for these factors. Reliability for mothers was 0.62, and 0.61 for fathers. While these findings were adequate, the lack of communality in items between mothers and fathers remained a problem.

**Factor analysis of adolescent responses.** The factors and factor loadings of adolescent data for the *Self-Perception of Risk Questionnaire* have been presented in Table 5.6.
Table 5.6
Factors and factor loadings for the *Self-Perception of Risk Questionnaire* (adolescent).

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1b</td>
<td>.85</td>
<td></td>
</tr>
<tr>
<td>4a</td>
<td>.84</td>
<td></td>
</tr>
<tr>
<td>4b</td>
<td>.75</td>
<td></td>
</tr>
<tr>
<td>1a</td>
<td>.67</td>
<td></td>
</tr>
<tr>
<td>3a</td>
<td>.64</td>
<td></td>
</tr>
<tr>
<td>3b</td>
<td></td>
<td>.93</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>.46</td>
</tr>
</tbody>
</table>

| Eigenvalue | 3.10 | 1.05 |
| % of variance | 44.25 | 14.93 |
| Cumulative Variance | 44.25 | 59.18 |

Factor two was removed from the final structure of the *SPRQ* for two reasons. Firstly, the internal consistency for the two items in factor two was extremely low ($\alpha = 0.18$). Secondly, item 3a (*How likely is it that you will leave school because you just don’t want to be there?*) was deleted because it lacked conceptual coherence. That is, the item begs the question as to why the adolescent does not wish to be at school. The vague nature of the phrase ‘*just don’t want to be there*’ does not clarify the situation. *Any* adolescent who might find school unpalatable might also look to leaving for a number of reasons without this necessarily implying proneness towards problem behaviour. In addition, this item was not conceptually coherent with items 1a, 1b, 4a, and 4b. The items finally included in the *SPRQ* emerged as one factor only. The wording of items of the final formulation of the *SPRQ* has been presented in Appendix 13.

Structuring the *SPRQ* as a single factor provided a coherent interpretation of self-perception of risk across two clear clinical domains. Items 1a and 1b described the adolescent’s self-perception of risk for future problems in the legal domain. Items 4a
and 4b described the adolescent’s self-perception of risk for problems in the area of problem drug use. When the parent version of SPRQ was formulated from the adolescent version, reliability values were moderate for fathers ($\alpha = 0.69$) and low for mothers ($\alpha = 0.43$). Following an analysis of reliability for mothers and fathers together, this value was found to be 0.61. This value was notably lower than the reliability value for adolescents ($\alpha = 0.78$), though still statistically acceptable.

5.4.2 Discussion concerning the Self-Perception of Risk Questionnaire

The clinical value of the Self-Perception of Risk Questionnaire (SPRQ) resided in its capacity to offer the clinician an understanding of the adolescent’s readiness to change negative behaviour, according to either the adolescent or the parent’s perspective. To this end, a poor level of insight into the present and future seriousness of adolescent behaviour would be indicated where responses to the Interpersonal Support Questionnaire (ISQ), as well as reported levels of drug and alcohol use (yet to be presented in chapter six), indicated escalated levels of harmful risk behaviour, while responses to the SPRQ indicated that future potential for harmful risk behaviour was not of concern in the adolescent’s thinking. On the other hand, a reasonably high level of insight into current and future behaviour would be indicated by the adolescent (or by the parent’s perception of the adolescent’s behaviour) who was aware of being currently involved in problem behaviour and yet was also aware that this would lead to future problems. A readiness to engage in intervention and an effective outcome for this intervention would be more likely in the latter rather than the former situation.

While limits of confidentiality would prevent the clinician from discussing the adolescent’s responses with the parent, at the same time having access to both adolescent and parent responses for the SPRQ would enable the clinician to identify a level of concordance between the perceptions of both parent and adolescent. Thus the
clinician would more easily determine the amount of motivation necessary to encourage the parent and possibly also the adolescent to consider the benefits of changing the direction of current behaviour. Knowing where the point of balance lay between the outcome measures of present risk and insight into future harmful risk would also suggest the amount of expected co-operation between the parent and the adolescent during the course of the chosen intervention.

Concern was raised about the fact that similar to the Interpersonal Support Questionnaire, the parent version of the SPRQ was formulated from adolescent data rather than from parent data. Therefore future research would revisit the SPRQ with a view to revising the items that comprised it with a larger sample size of parents. Developing the parent version of the SPRQ from actual parent data would enable the content of this questionnaire to reflect the uniqueness of the parent’s discernment about the adolescent’s behaviour and beliefs. Nonetheless, the SPRQ was adequate for the purpose of this research, since post-assessment discussion between the researcher and parent was able to bring to light any gaps in the parent’s perceptions about the adolescent’s proneness towards future harmful risk behaviour.

5.4.3 Discriminant function analysis of the Interpersonal Support Questionnaire and the Self-Perception of Risk Questionnaire

The capacity of the Self-Perception of Risk Questionnaire (SPRQ) and the Interpersonal Support Questionnaire (ISQ) to correctly classify adolescent participants along a spectrum from low to high risk was determined by means of a discriminant function analysis. Year Coordinators assessed the level of harmful risk entailed in the current behaviour of adolescent participants along a 10-centimetre visual analogue scale (VAS), extending from nil or low risk through to high risk. Each student’s rating was measured at a point between 0.00 and 10.00, and the entire range was divided into four
quartiles. The first quartile was measured from 0.00 to 2.49, the second quartile from 2.50 to 4.49, the third quartile from 5.00 to 7.49, and the fourth quartile was measured from 7.50 to 10.00. Teachers classified 111 males and 169 females into the first quartile, 49 males and 31 females into the second quartile, 14 males and 8 females into the third quartile, and 27 males and 1 female into the fourth quartile. The smaller sample sizes of the second, third, and fourth quartiles were expected, given the generally low risk character of the overall adolescent sample. The dominance of males over females in quartiles beyond the first quartile, and particularly in the fourth quartile, was also noted. This was not surprising, since research has noted the high representation of males in harmful risk taking behaviour (Khoury, 1998; Moffitt et al., 2001). Because of the imbalance between males and females in the second, the third, and especially the fourth quartiles, the discriminant function analysis was conducted with adolescents as a combined male and female sample.

The research question of interest was whether the ISQ and the SPRQ was able to discriminate between adolescents for current proneness to problem behaviour according to each quartile of harmful risk. In terms of clinical assessment of adolescent risk behaviour, this was an important question. Indicating where an adolescent’s behaviour lies on a spectrum of risk would offer the clinical advantage of knowing whether an adolescent’s risk assessment is distant from or close to the threshold of nil or low risk, and if so, how far from this threshold. The need to combine males and females into the one sample for the discriminant function analysis was not seen to adversely affect the outcome of this analysis since the research question concerned the capacity of these questionnaires to correctly classify any adolescent regardless of gender into one of the four quartiles of risk behaviour.
According to a spectrum of risk behaviour, indications that an adolescent is already established on a trajectory of problem behaviour could conceivably be identified at any point within the first three quartiles before reaching the fourth quartile, which was nominated by the researcher as the threshold of high-risk behaviour (7.50 to 10.00). The initial research question focused on the capability of the three factors of the ISQ and the one factor of the SPRQ to correctly classify an adolescent within any of these first three quartiles of risk, thus enabling a person to decide whether an adolescent was distant from or close to the threshold of high-risk behaviour (i.e., a rating of 7.50 or greater). For the purpose of succinctness, the three factors of the ISQ together with the one factor of the SPRQ used in this and further analyses will be described as “the four factors”.

To answer the initial research question, a discriminant function analysis (DFA) using a saturated model containing the four factors was then conducted to investigate their sensitivity in correctly classifying adolescents into either the first through to the third quartile, the second through to the third quartile, or the third quartile of risk behaviour. Only 57.5% of adolescents were correctly classified into either the first through to the third quartile \( \chi^2 (12, n=409) = 212.21, p<.001, \text{Wilks } \Lambda = .588 \) or from the second through to the third quartile \( \chi^2 (6, n=409) = 18.58, p<.01, \text{Wilks } \Lambda = .955 \). Results for the third quartile were not statistically significant \( \chi^2 (2, n=409) = 2.72, p<.05, \text{Wilks } \Lambda = .993 \). The loadings for this analysis have been presented in Table 5.7.
Table 5.7
Loadings for the DFA (saturated model) between quartiles one to three for the four factors.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Quartile 1 through to quartile 3</th>
<th>Quartile 2 through to quartile 3</th>
<th>Quartile 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer modelling</td>
<td>.304</td>
<td>-1.270</td>
<td>-.198</td>
</tr>
<tr>
<td>Parent/family relationships</td>
<td>-.023</td>
<td>.027</td>
<td>1.154</td>
</tr>
<tr>
<td>Parental monitoring/limit setting</td>
<td>.445</td>
<td>.384</td>
<td>-.152</td>
</tr>
<tr>
<td>Self-Perception of Risk Questionnaire</td>
<td>.593</td>
<td>.911</td>
<td>-.376</td>
</tr>
</tbody>
</table>

Therefore, even though statistical significance was evident for two out of three quartile ranges, a classification percentage of 57.5% indicated that the four factors lacked the necessary clinical sensitivity to identify any level of risk that occurred within these three quartiles.

Adolescents who were classified somewhere between quartiles one and three were then considered as one group. A DFA was then conducted on adolescent groups from the first through to the third quartile and in the fourth quartile. The first to third quartiles represented all adolescents who had not reached the point of high risk (i.e., less than a rating of 7.50) and the fourth quartile represented adolescents who were already rated as being at or beyond this high-risk point (a rating greater than 7.49). Statistically significant differences were found between both groups of adolescents for Peer Modelling \(F(1,402) = 117.27, p<.001, \eta^2 = .226\), Parental Monitoring/Limit-Setting \(F(1,402) = 89.10, p<.001, \eta^2 = .181\), Parent/Family Relationships \(F(1,402) = 50.11, p<.001, \eta^2 = .111\), and the one factor of the SPRQ \(F(1,402) = 158.28, p<.001, \eta^2 = .282\). It was noted that the effect size (\(\eta^2\)) of all factors was extremely small. This
indicated that as independent variables, these factors were accounting for approximately 10% to 30% of the variance, although it was also noted that at the univariate level each factor was accounting for a small number of variables, which in turn were attempting to describe many facets of adolescent behaviour. Under these circumstances, the low values of effect size were tolerable. A DFA using a saturated model was then conducted with data for these two groupings of adolescents. The loadings for this DFA have been presented in Table 5.8.

**Table 5.8**

Loadings for the DFA (saturated model) between the first to third quartiles and the fourth quartile for the four factors.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer modelling</td>
<td>.166</td>
</tr>
<tr>
<td>Parent/family relationships</td>
<td>-.047</td>
</tr>
<tr>
<td>Parental monitoring/limit setting</td>
<td>.482</td>
</tr>
<tr>
<td>Self-Perception of Risk Questionnaire</td>
<td>.694</td>
</tr>
</tbody>
</table>

This analysis resulted in 93.3% of adolescents being correctly classified either into a level of risk somewhere between the first and third quartiles (a rating of 0.00 to 7.49) or to the fourth quartile (a rating of 7.50 to 10.00) \[\chi^2 (4, n=409) = 173.51, p<.001, \text{Wilks } \Lambda = .649\]. A DFA using a stepwise model was then conducted to identify the factors most effective in classifying group membership. This analysis indicated that the factor of *Parental Monitoring/Limit-Setting* and the one factor of the *SPRQ* were the two factors most effective in correctly classifying adolescents into either group \[\chi^2 (2, n=409) = 171.73, p < .001, \text{Wilks } \Lambda = .652\]. The factor loadings for these variables were .518 and .775 respectively. These factors correctly classified 93.6% of adolescents as displaying harmful risk either somewhere between the first and third quartiles or within the fourth quartile.
While these results were more satisfying than those for the initial DFA, at the same time the problem of correctly classifying adolescents somewhere within the first three quartiles of risk remained. That is, one could only indicate whether an adolescent was still yet to reach the point of high-risk, or had actually crossed the threshold into high-risk behaviour. Thus, the problem of the four factors lacking sufficient sensitivity to classify adolescents into a quartile of risk behaviour was still not resolved. A decision was made to investigate the capability of the four factors to classify adolescents into either the first quartile of risk (nil to very low risk) or the fourth quartile of risk (very high risk). The rationale for adopting this approach arose from the pilot study. In the preliminary investigation, a discriminant function analysis (DFA) using a saturated model indicated that the three factors of the Risk Behaviour Questionnaire (RBQ) also lacked the sensitivity necessary to correctly classify adolescents into either the predetermined low, moderate, or high categories of risk. However, the results of a DFA using a stepwise model indicated that it was possible to correctly classify students into either the low or high-risk category, although in that analysis of the RBQ only the factor of Peer Modelling was capable of doing this. In the RBQ, Peer Modelling correctly classified 75.9% of adolescents into either the low or high-risk category, although this percentage was only moderately high. These results suggested a similar statistical analysis for the present study.

A DFA was therefore conducted between adolescents who were either classified somewhere within the first quartile of nil or low risk (i.e., a rating of 0.00 to 2.49) and adolescents who were classified into the fourth quartile of high risk (i.e., a rating of 7.50 to 10.00). The loadings for this DFA have been presented in Table 5.9.
Table 5.9
Loadings for the DFA (saturated model) between the first quartile and the fourth quartile for the four factors.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer modelling</td>
<td>.350</td>
</tr>
<tr>
<td>Parent/family relationships</td>
<td>-.127</td>
</tr>
<tr>
<td>Parental monitoring/limit setting</td>
<td>.467</td>
</tr>
<tr>
<td>Self-Perception of Risk Questionnaire</td>
<td>.603</td>
</tr>
</tbody>
</table>

When all factors were considered in a saturated model, this analysis resulted in 94.8% of adolescents being correctly classified into either the first or the fourth quartile of harmful risk behaviour \( \chi^2 (4, n=409) = 181.25, p < .001, \text{Wilks } \Lambda = .549\). In order to determine which factors were most effective in classifying risk group membership, a DFA using a stepwise model was then conducted. This analysis indicated that the factors of Peer Modelling, Parental Monitoring/Limit-Setting, and the one factor of the SPRQ were the three factors that were most effective in correctly classifying adolescents into either group \( \chi^2 (3, n=409) = 180.03, p < .001, \text{Wilks } \Lambda = .551\). The factor loadings for these variables were .320, .435, and .587 respectively. These factors correctly classified 95.1% of adolescents into either the first quartile of risk behaviour or the fourth quartile of risk behaviour.

This analysis involving the first and fourth quartiles of risk behaviour was then taken one step further. A DFA was conducted between data of adolescents who were classified as not being at risk of harmful behaviour at all (i.e., a rating of 0.00) and adolescents who were classified in fourth quartile only. Due to the small number of adolescents in each group (13 adolescents with a rating of 0.00 and 28 adolescents with a rating >7.50), a stepwise model only was used, being the preferred function for small sample sizes (Tabachnick & Fidell, 1996). This analysis indicated that Peer Modelling and Parental Monitoring/Limit-Setting were most effective in correctly classifying 95%
of adolescents into either group [$\chi^2$ of 38.62 (2, n=40), $p<.001$, Wilks $\Lambda = .352$]. The loadings for these variables were .774 and .669 respectively.

A final analysis was conducted across the four quartiles of risk by comparing the mean score differences for the four factors between each quartile in order to confirm the sensitivity (or lack thereof) of the four factors to correctly identify adolescents as belonging to any one quartile along the spectrum from low to high risk. Firstly, at the multivariate level, significant differences were found between adolescents across the four quartiles of risk [Pillai’s $T = .931$, $F (4.00, 397.00) = 1344.17$, $p<.001$, $\eta^2 = .931$]. At the univariate level, significant differences were found for Peer Modelling [$F(3,400) = 54.36$, $p<.001$, $\eta^2 = .290$], Parental Monitoring/Limit Setting [$F(3,400) = 32.76$, $p<.001$, $\eta^2 = .197$], Parent/Family Relationships [$F(3,400) = 20.56$, $p<.001$, $\eta^2 = .134$], and the one factor of the SPRQ [$F(3,400) = 57.24$, $p<.001$, $\eta^2 = .300$]. Secondly, post hoc multiple comparisons of mean score differences were conducted in order to identify the quartile within which these differences were situated. The results of this analysis have been presented in Table 5.10.
Table 5.10
Multiple *post hoc* comparisons of mean scores differences between quartiles for the four factors.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Quartile 1 Mean (SD)</th>
<th>Quartile 2 Mean (SD)</th>
<th>Quartile 3 Mean (SD)</th>
<th>Quartile 4 Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Modelling</td>
<td>1.35 bc (.34)</td>
<td>1.57 ad (.39)</td>
<td>1.72 ad (.53)</td>
<td>2.27 abc (.55)</td>
</tr>
<tr>
<td>Parental Monitoring/ Limit Setting</td>
<td>1.66 cd (.48)</td>
<td>1.76 d (.47)</td>
<td>1.93 ad (.52)</td>
<td>2.62 abc (.59)</td>
</tr>
<tr>
<td>Behaviour/ Relationships At Home</td>
<td>1.66 d (.47)</td>
<td>1.72 d (.36)</td>
<td>1.10 d (.67)</td>
<td>2.36 abc (.58)</td>
</tr>
<tr>
<td>Self-Perception of Risk Questionnaire</td>
<td>1.08 cd (.27)</td>
<td>1.16 d (.29)</td>
<td>1.30 ad (.49)</td>
<td>2.00 abc (.80)</td>
</tr>
</tbody>
</table>

a = quartile 1: 0.00-2.49  
b = quartile 2: 2.50-4.49  
c = quartile 3: 5.00-7.49  
d = quartile 4: 7.50-10.00

a,b,c,d indicate those quartiles that resulted in a significant difference for the factor mean of each particular quartile. Statistical significance is at the .05 level.

Multiple *post hoc* comparisons of mean score differences between quartiles confirmed that the four factors of Peer Modelling, Parental Monitoring/Limit Setting, Parent/Family Relationships and the one factor of the SPRQ did not effectively classify adolescents anywhere along the quartile spectrum from nil to high risk for problem behaviour proneness. Rather, these comparisons indicated that the four factors were only best able to classify adolescents into either the very low or very high categories of risks. These findings confirmed the results of the prior discriminant function analyses.

**Brief discussion concerning the findings of the discriminant function analysis.**

It would be most useful to have the capacity to indicate with reasonable accuracy where an adolescent’s behaviour lay on the quartile spectrum from low to high risk, and therefore whether or not the adolescent was distant from or close to the low-risk
threshold. While not having this capacity was noted as a limitation, the results of the discriminant function analyses indicated that two factors of Parental Monitoring/Limit Setting and Peer Modelling, as well as the one factor of the SPRQ were most effective in correctly classifying adolescent behaviour into either the first or low risk quartile (0.00 to 2.49) or the fourth or extreme risk quartile (7.50 to 10.00). Furthermore, the factor of Parental Monitoring/Limit Setting and the one factor of the SPRQ were found to be most effective in classifying an adolescent’s behaviour as being situated somewhere along the first three quartiles of risk. In other words, only the factor of Parent/Family Relationships was consistently excluded from the stepwise analyses of the DFA. In a clinical sense, therefore, it would seem appropriate to pay particular attention to both the adolescent’s peer relationships and the extent of the parent’s monitoring and limiting of adolescent activity, as well as the adolescent’s insight into future harm, when attempting to assess a referred adolescent’s behaviour.

Being able to classify risk behaviour into either the first or fourth quartiles only would provide valuable knowledge in assessing adolescent risk. Furthermore, knowing that an adolescent’s behaviour lay somewhere beyond nil level of risk without having reached the point of high risk would also be of value. Both avenues of possible risk behaviour would open the way for further discussion between parent and the clinician. Therefore, the results of the discriminant function analyses indicated that the two factors of the Interpersonal Support Questionnaire and the SPRQ would provide a beneficial starting point for discussion about an adolescent’s behaviour by specifying whether this behaviour placed the adolescent at some point before the threshold of extreme risk behaviour, or beyond this threshold.

The reason for the breakdown of the capacity of the ISQ and the SPRQ to correctly classify adolescent behaviour into the second and third quartiles of risk was
not immediately evident. It was likely that the small adolescent sample size beyond the low (or first) quartile of risk was a strongly contributing factor to this breakdown. The discriminant function analyses that included only those adolescents who were given a rating of 0.00 appeared to support the fact that the majority of adolescents rated within the first quartile were either classified as not being at risk or very marginally at risk. Therefore further research into improving the sensitivity of the ISQ and the SPRQ in classifying adolescent behaviour along the spectrum from low to high risk would begin by increasing the male and female adolescent sample size within each of the three quartiles of risk located at and beyond the low-risk level. This would also require a review of the procedure in which participants’ behavioural patterns were allocated to various levels of risk.

The system undertaken for the present research implicated a distinct level of subjectivity in the Year Coordinator’s rating of a student’s risk level. From external demonstrations of behaviour, a Year Coordinator would presumably have little difficulty in classifying a student either to a very low risk rating (the first quartile) or to a very high risk rating (the fourth quartile). That is, a student who appeared to remain out of trouble within the school setting would logically be classified into the nil to low risk domain, whereas a student who obviously and continuously attracted trouble would logically be classified into the highest quartile of risk. Problems of accuracy would logically be found with the middle quartiles of risk level. That is, how accurately could a teacher define an adolescent’s risk level once it moved beyond the level of low risk without having reached the point of obvious high risk? Therefore, future research would principally be aimed at achieving a more accurate classification of behaviour within the two middle quartiles. One possible approach would be to use the visual analogue scale once more, yet divide the 10-centimetre line into four quartiles rather than leave it as
one continuous line. If those responsible for assessing behaviour were able to place a cross within a particular quartile rather than somewhere along a continuous line, they might be prompted to consider more closely the behavioural risk level of a particular participant.

5.5 The Parent Resilience Questionnaire

The Parent Resilience Questionnaire (PRQ) was structured for the parent version of the Adolescent Problem Behaviour Assessment (APBA) only as an 11-item construct that focused on the parent’s ability to positively reframe their responses to escalated situations of conflict with their adolescent son or daughter, and so regain any lost stability in the parent-adolescent relationship. A five-point Likert rating scale, ranging from 1 (‘I strongly disagree with the statement’), to 5 (‘I strongly agree with the statement’), with 3 indicating ‘I am not sure either way’, was adopted to measure a parent’s sense of resilience and support of a significant other. Unlike the use of a four-point Likert scale that measured adolescent risk in terms of a continuum from low to high risk-level, the five-point scale was adopted to permit the choice of “not sure” in the response options. Hence discrete points of measure indicated that parents experienced either a weak or strong sense of resilience and another’s support, or they were unsure either way. The PRQ was eventually developed for use with both parents, regardless of mother or father role.

The total pool of items was divided into two domains. Items 1, 2, 3, 5, 6, 7, 8, 9, and 10 formed the first domain. The items for this domain were developed from research literature indicating those areas where parent-adolescent relationships were most likely to break down, thus placing the parent’s feeling of resilience at risk of becoming diminished. Among these items, items 1, 2, and 8 reflected parents’ negative feelings resulting from distress and disillusionment (Barnes & Olson, 1985;
Pinderhughes et al., 2000; Silverberg & Steinberg, 1987). Items 5, 9, and 11 reflected a parent’s response to parent-adolescent conflict (Grolnick et al., 1996). Items 3, 6 and 7 reflected the determination exhibited by the parent who is confronted with situations that are potentially damaging for the parent-adolescent relationship. These items represented the more common areas such as parent-adolescent communication where parent-adolescent relationships would most likely suffer fragmentation (Clark & Shields, 1997; Noller & Bagi, 1985; Noller & Callan, 1990). The manner in which parents and adolescents interpreted each other’s rights and responsibilities within the family structure was also considered in the development of all the above items of the PRQ (Bosma et al., 1996; Pastore & Ainley, 2000). Where parents and adolescents have reached the point of being out of step with each other over issues such as personal freedom, rights and responsibilities, who has the final say in decision making, and so on, then the relationship between parent and adolescent is at risk of deteriorating. Furthermore, where parents perceive unacceptable adolescent behaviour as both a personal attack and a weakening of their self-efficacy in the role of parent, then they will be likely to find themselves struggling with a resulting sense of shame and failure (Stern & Smith, 1997). A parent with the ability to adopt a positive outlook in spite of these feelings would be described as possessing a strong level of resilience.

Items 4 and 10 of the PRQ formed the second domain that measured the amount of support a parent felt from another significant person. Normally this person would be in close relationship with the parent, such as a partner, extended family member, or close friend. Items 4 and 10 were derived from the theoretical underpinning of research that investigated the supportive role offered by loved ones of a person who suffered from an alcohol misuse problem, particularly in those cases where people had become resistant to treatment (Meyers, Miller, Hill & Tonigan, 1999; Meyers & Smith, 1997;
Meyers, Smith & Miller, 1998; Wolfe & Meyers, 1999). These latter research findings directed the understanding of the significant other’s supportive role for the parent. The support of a concerned significant other would offer a vital means of increasing a positive self-perception in the parent. Consequently, this support would help the parent reframe the belief that their son or daughter’s behaviour was personally damaging into a belief that this behaviour need not reflect negatively on the skills of the parent. In practice, the significant other would offer evident encouragement at times when the parent focused on maintaining a positive outlook yet would personally withdraw at times when the parent reacted irrationally and unhelpfully, thus indicating that this type of irrational response would not be sustained. The support of the significant other would therefore take the shape of reinforcing the parent’s constructive responses to the adolescent, while also remaining neutral to destructive responses (Stern & Smith, 1999).

5.5.1 Results of the Parent Resilience Questionnaire

5.5.1.1 Factor analysis of the Parent Resilience Questionnaire. Separate factor analyses using a principal component analysis extraction with promax rotation and Kaiser normalisation were conducted for responses of mothers (n = 282) and fathers (n = 203). Only those items with a loading greater than 0.40 were retained. Resulting factors and factor loadings from these analyses have been presented in Table 5.11 for mothers and Table 5.12 for fathers.
### Table 5.11
Factors and factor loadings for the *Parent Resilience Questionnaire* (mothers).

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>.79</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>.79</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>.72</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>.67</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>.65</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>.63</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>.60</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>.44</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>.33</td>
<td>.90</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>.88</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>1.42</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Eigenvalue</th>
<th>% of variance</th>
<th>Cumulative variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4.03</td>
<td>36.63</td>
<td>36.63</td>
</tr>
</tbody>
</table>

### Table 5.12
Factors and factor loadings for the *Parent Resilience Questionnaire* (fathers)

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.82</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>.82</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>.76</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>.76</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>.73</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>.70</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>.68</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>.63</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>.48</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>.97</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Eigenvalue</th>
<th>% of variance</th>
<th>Cumulative variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5.32</td>
<td>48.40</td>
<td>48.46</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>11.11</th>
<th>59.57</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.22</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
From Tables 5.11 and 5.12, it can be seen that factor one for mothers contained eight items, while factor one for fathers contained nine items. Item two was excluded from the factor analysis for mothers since it resulted in a factor loading of 0.33. This item was retained in the factor analysis for fathers, with a comparatively higher factor loading of 0.82. However, since a loading of 0.33 was approaching the selected baseline loading of 0.40, and as such was still acceptably robust, the decision was made to include this item and so bring both analyses into line with each other. All items in factor one for mothers and fathers were now conceptually coherent with the first domain of the PRQ, namely the general level of resilience experienced by the parent.

Factor two for both mothers and fathers contained only items 4 and 10. However, both items measured an important aspect of parental resilience, namely the extent to which a parent feels the support of another significant person in times of escalated difficulty with the adolescent, and so conceptually reflected the second domain in the initial structuring of the PRQ. A lack of this type of support (particularly for a single parent) would correspond to a weakening of the protective parental influence over the adolescent, and so represent a risk factor for adolescent problem behaviour. Furthermore, the factor loadings for these items for mothers and fathers were strong. Therefore the decision was made to retain these two items as a factor. At the same time, however, a two-item factor is prone to being problematic, especially in the area of internal consistency and construct validity. Therefore a task of future research with this questionnaire would be one of developing additional items for this factor.

Factor one for both parents was labelled General Resilience. This factor reflected the parent’s ability to positively reframe a situation of escalated conflict with the adolescent, and so “bounce back” after experiencing this conflict. A sense of hopefulness, a strong element of perceived self-efficacy, and knowing that one has
access to workable solutions, underpinned the meaningfulness of this factor. Factor two for both parents was labelled *Support of a Significant Other* because it reflected the extent to which either parent was able to rely on the support of a significant person during difficult times with one’s son or daughter. Analyses of reliability (Cronbach’s alpha) were then conducted on each factor for parents individually and together. To facilitate ease of reference, reliability values have been presented in Table 5.13.

Table 5.13
**Internal consistency (Cronbach’s alpha) for General Resilience and Support of a Significant Other**

<table>
<thead>
<tr>
<th>Individually Factor</th>
<th>Mother</th>
<th>Father</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Resilience</td>
<td>.80</td>
<td>.88</td>
</tr>
<tr>
<td>Support of a Significant Other</td>
<td>.77</td>
<td>.78</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Combined Factor</th>
<th>Mother and Father combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Resilience</td>
<td>.88</td>
</tr>
<tr>
<td>Support of a Significant Other</td>
<td>.70</td>
</tr>
</tbody>
</table>

Reliability values for *General Resilience* were similar when calculated for parents both individually and combined. However, there was a noticeable drop in the reliability value for *Support of a Significant Other* when the internal consistency for this factor was measured for mothers and fathers as a combined group. While this drop in value was not extreme, it indicated the need to further develop this factor, especially in relation to the number of items comprising it.

The final format of the *PRQ* can be found on page two of the parent version of the *Adolescent Problem Behaviour Assessment (APBA)* in Appendix 11. Items of the *PRQ* with reversed scoring have been noted on the cover page of Appendix 11. The wordings of items comprising each factor have been presented in Appendix 14.
5.5.2 Discussion concerning the Parent Resilience Questionnaire

The clinical usefulness of the Parent Resilience Questionnaire (PRQ) resides in providing the clinician with an understanding of the parent’s capacity to reframe negative attitudes and beliefs in situations of conflict that otherwise might substantially lower the parent’s sense of self-efficacy and self-worth. The ability to reframe such situations would encourage parents to feel a sense of resilience when confronted by the son or daughter’s negative or aggressive behaviour (Stern & Smith, 1999). The support of another concerned and significant person would act as an aid to bolstering this resilience, especially where the parent was a single parent, or where the parent was attempting to cope in the midst of serious external stressors (Stern & Smith, 1999). Where the factor of Support of a Significant Other indicated the absence of another significant person in the parent’s life, this would identify parents who required stronger therapeutic support because they would need to assume the greater burden of parental responsibilities. Included in this group would be single parents, or families where one parent was either non-supportive in adopting new strategies or physically or psychologically absent from the family for much of the time. The PRQ would also indicate the parent’s ability to persist with the intervention plan. A parent who experienced low resilience and who lacked the support of another significant person would reasonably be more vulnerable to early dropout from the planned intervention.

The need to further develop items comprising the factor of Support of a Significant Other was evident from the results of factor analyses. Increasing the number of items for this factor would be likely to increase the reliability value of this factor as well as extend the scope of clinical enquiry into the level of another’s support for the parent, especially a single parent.
5.6 Overall focus on the Adolescent Problem Behaviour Assessment

Each questionnaire comprising the Adolescent Problem Behaviour Assessment (APBA) was designed to act as an interrelated measure of harmful risk entailed in adolescent behaviour. This was an essential focus of research since the purpose of developing the APBA was to provide both parent and clinician with a clear perspective of the most prominent behavioural factors implicated in the adolescent’s harmful risk, and the amount of insight demonstrated by the adolescent in relation to possible future harm because of his or her current behaviour. This information was seen to provide a solid foundation for discussion between clinician and parent before deciding upon the most appropriate course of action. In order to demonstrate the interrelatedness of the questionnaires comprising the APBA as they have been described in this chapter, analyses of correlation were conducted between the factors of each of these questionnaires. The results of these analyses have been described below.

5.6.1 Analyses of correlation

Using the adolescent version of the Interpersonal Support Questionnaire (ISQ), correlations (Pearson Correlation, 2-tailed) were conducted between the three factors of the ISQ. Correlations were also conducted between the three factors of the ISQ and all items of the ISQ computed as one variable. Finally, correlations were conducted between the three factors of the ISQ and the Self-Perception of Risk Questionnaire (SPRQ). Findings for these analyses have been presented in Table 5.14.
Table 5.14
Analyses of correlation within the three factors (ISQ), and between these factors (ISQ) and the one variable (ISQ), and the SPRQ.

<table>
<thead>
<tr>
<th>Adolescent Version</th>
<th>Peer Modelling</th>
<th>Parental/Monitoring Limit Setting</th>
<th>Parent/Family Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Modelling</td>
<td>1.000</td>
<td>.402**</td>
<td>.418**</td>
</tr>
<tr>
<td>Parental Monitoring/Limit Setting</td>
<td>.402**</td>
<td>1.000</td>
<td>.369**</td>
</tr>
<tr>
<td>Parent/Family Relationships</td>
<td>.418**</td>
<td>.369**</td>
<td>1.000</td>
</tr>
<tr>
<td>One Variable (ISQ)</td>
<td>.805**</td>
<td>.757**</td>
<td>.756**</td>
</tr>
<tr>
<td>Self-Perception of Risk Questionnaire</td>
<td>.615**</td>
<td>.302**</td>
<td>.426**</td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed)

The findings in Table 5.14 suggested that when correlated with each other, the three factors of the ISQ were measuring related aspects of adolescent behaviour, although the relatively low significant positive values of correlation indicated that redundancy was not evident among these three factors. When correlated with the ISQ as one variable, the resulting high significant positive values of correlation suggested that each factor of the ISQ was strongly measuring aspects of adolescent behaviour in relation to the total item pool of the ISQ. These anticipated results were satisfying.

The findings in Table 5.14 for the analyses of correlation between the three factors of the ISQ and the SPQR indicated a significant positive relationship between reported risk level via the ISQ and insight into the possibility of future harmful risk via the SPRQ. This finding further meant that a clinician could draw a dependable comparison between the adolescent’s reported current risk level and his or her insight.
into future harmful risk, and so note the presence or absence of dissonance between both reports.

For the parent version of the ISQ and the SPRQ, analyses of correlation (Pearson Correlation, 2-tailed) were also conducted between the SPRQ and the factors of Peer Modelling, Parental Monitoring/Limit Setting, and Parent/Family Relationships.

Findings for these analyses have been presented in Table 5.15.

Table 5.15
Analyses of correlation between the ISQ (parents) and the SPRQ (parents).

<table>
<thead>
<tr>
<th>Parent Version</th>
<th>SPRQ (mothers)</th>
<th>SPRQ (fathers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Modelling (mothers)</td>
<td>.221**</td>
<td></td>
</tr>
<tr>
<td>Parental Monitoring/Limit Setting (mothers)</td>
<td>.316**</td>
<td></td>
</tr>
<tr>
<td>Parent/Family Relationships (mothers)</td>
<td>.162**</td>
<td></td>
</tr>
<tr>
<td>Peer Modelling (fathers)</td>
<td></td>
<td>.424**</td>
</tr>
<tr>
<td>Parental Monitoring/Limit Setting (fathers)</td>
<td></td>
<td>.342**</td>
</tr>
<tr>
<td>Parent/Family Relationships (fathers)</td>
<td></td>
<td>.266**</td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed)

The significant positive correlations in Table 5.15 suggested that mothers and fathers did not perceive their sons or daughters as being vulnerable for engaging in high-risk activity in the future because they believed that their current activity did not reflect harmful risk. These findings also indicated a clinical benefit similar to that described for the adolescent version of the ISQ and SPRQ. That is, a clinician could draw a dependable comparison between the parent’s perception of the adolescent’s
current risk level and the parent’s insight into the adolescent’s potential for future harmful risk, and again note the presence or absence of dissonance between both reports.

The significant positive correlations between the SPRQ and the factors of Peer Modelling, Parental Monitoring/Limit Setting, and Parent/Family Relationships in both the adolescent and parent versions were encouraging. These findings indicated acceptable levels of consistency between the perceptions of adolescents and parents about current levels of harmful risk behaviour and insight into the potential for future problem behaviour. The behaviour of the normative adolescent sample was generally classified as being at low-risk, and so these correlations were further interpreted as meaning that adolescents saw themselves as not being vulnerable to future harmful risk because they viewed their current behaviour as reflecting low risk. Results of internal consistency for parents’ responses were also interpreted as meaning that parents reflected the same consistency of perception as their sons or daughters. The findings for all correlations also considered suggested an appropriate degree of construct validity (Drew & Hardman, 1988). Consequently, the items comprising the three factors of Peer Modelling, Parental Monitoring/Limit Setting, and Parent/Family Relationships, and the one factor of the SPRQ appeared to be measuring what they were intended to measure in terms of adolescent behaviour. However, with regard to the parent version of the ISQ and the SPRQ, the conclusion about construct validity would require caution, since the analyses of parent data resulted in the parent version of these questionnaires being formulated on the basis of adolescent data.

Finally, analyses of correlation (Pearson Correlation, 2-tailed) were conducted between the three factors of the adolescent and parent versions of the ISQ. These analyses were conducted in order to gain some indication of how the adolescent,
mother’s, and father’s scores on the ISQ factors correlated with each other, given that the parent version of the ISQ was necessarily formulated from items that comprised the adolescent version of the ISQ. Findings for these analyses have been presented in Table 5.16.

Table 5.16
Analyses of correlation between the three factors of the parent and adolescent versions of the ISQ.

<table>
<thead>
<tr>
<th>Adolescent Version and Mothers (Parent Version)</th>
<th>Peer Modelling (Mothers)</th>
<th>Parental/Monitoring Limit Setting (Mothers)</th>
<th>Parent/Family Relationships (Mothers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Modelling (Adolescents)</td>
<td>.434**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental Monitoring/Limit Setting (Adolescents)</td>
<td>.241**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent/Family Relationships (Adolescents)</td>
<td>.461**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adolescent Version and Fathers (Parent Version)</th>
<th>Peer Modelling (Fathers)</th>
<th>Parental/Monitoring Limit Setting (Fathers)</th>
<th>Parent/Family Relationships (Fathers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Modelling (Adolescents)</td>
<td>.396**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental Monitoring/Limit Setting (Adolescents)</td>
<td>.321**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent/Family Relationships (Adolescents)</td>
<td>.438**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed)

The findings in Table 5.16 suggested that when correlated with each other, the three factors comprising the adolescent and parent version (with mother and father
responses considered separately) of the ISQ were measuring related aspects of adolescent behaviour. As with the findings in Table 5.14, the relatively low significant positive values of correlation indicated that redundancy was not evident among these three factors. These results indicated that although the parent version of the ISQ was necessarily constructed as a mirror format of the adolescent version, parents and adolescents were reflecting similar perceptions about adolescent behaviour described by the three factors of the ISQ. This information was considered informative when the ISQ came to be used within a clinical population of parents and adolescents.

**The Interpersonal Support Questionnaire and the Parent Resilience Questionnaire.** A research question yet to be investigated was whether a relationship existed between adolescents’ reports of risk-related behaviour and parents’ feelings of general resilience and their sense of being supported by another significant person. To answer this question, analyses of correlation (Pearson Correlation, 2-tailed) were conducted between the factors of General Resilience and Support of a Significant Other (for mothers and fathers separately) comprising the Parent Resilience Questionnaire (PRQ), and the three factors of the adolescent version of the ISQ, namely Peer Modelling, Parental Monitoring/Limit Setting, and Parent/Family Relationships. The findings for these analyses have been presented in Table 5.17.
Table 5.17
Analyses of correlation between the *Interpersonal Support Questionnaire* and the *Parent Resilience Questionnaire*.

<table>
<thead>
<tr>
<th></th>
<th>General Resilience (mothers)</th>
<th>General Resilience (fathers)</th>
<th>Support of a Significant Other (mothers)</th>
<th>Support of a Significant Other (fathers)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peer Modelling</strong></td>
<td>.013&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.031&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.032&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-.087&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Parental Monitoring/Limit Setting</strong></td>
<td>-.090&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-.083&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-.067&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-.056&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Parent/Family Relationships</strong></td>
<td>-.199**</td>
<td>-.177&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-.167**</td>
<td>-.122&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup> Correlation is significant at the 0.01 level (2-tailed)
<sup>**</sup> Correlation is significant at the 0.01 level (2-tailed)

The findings described in Table 5.17 indicate that significant negative correlations were found for mothers only between the factor of *General Resilience* and the factor of *Parent/Family Relationships* ($r = -.199$, $p < .01$), and the factor of *Support of a Significant Other* and the factor of *Parent Family Relationships* ($r = -.167$, $p < .01$).

The negative value of these results logically suggested that as the adolescent perceived the relationship fragmenting with his or her mother and/or family, the mother in turn felt a decrease in general resilience and another significant person’s support. Correlations for the data of fathers were non-significant for both factors of the *PRQ* and the three factors of the *ISQ*. This indicated that there was no relationship between the father’s sense of resilience and another’s support, and the level of the adolescent’s behaviour identified by the three factors of the *ISQ*.

### 5.7 Chapter Summary

This chapter has tracked the development of the *Adolescent Problem Behaviour Assessment (APBA)*, beginning with a preliminary investigation into adolescent risk behaviour that suggested the benefit of further developing an assessment measure of this
behaviour. The APBA represented the outcome of this further research and development, with the aim of identifying any escalation towards harm within an adolescent’s behaviour. An adolescent and a parent version of this assessment instrument was developed, thus enabling a perspective of behaviour to be drawn from reports of either the adolescent or the parent. However, due to inconsistencies in the factor analyses of parent data, it became necessary to structure the parent version of the APBA from the adolescent version.

The APBA comprised a number of questionnaires that were designed to investigate the characteristics of adolescent behaviour from a variety of angles. The Interpersonal Support Questionnaire (ISQ) described behaviour according to three factors of peer modelling of behaviour, parental monitoring and limiting skills, and parent/family relationships. Adolescent drug use (to be described in the next chapter) outlined risk according to the use of alcohol, tobacco, and marijuana. Finally, having responded to each of these domains of behaviour, the adolescent’s insight into future harm from risk behaviour was described on the basis of current patterns of behaviour. For the parent version only, a measure of general resilience and the support of another significant person was developed to identify the extent of these influences in the parent’s exercise of the parental role. Finally, analyses of correlation were conducted for all questionnaires of the APBA with varying results.

As a clinical means of identifying and clarifying characteristics of adolescent behaviour, the APBA provided a firm foundation for clearly describing the effect of risk or protective factors in the adolescent’s life style, and the need for positive and immediate intervention where risk overshadowed protection. This foundation was seen as further enabling the clinician to motivate the parent towards adopting a positive course of intervention, as well as maintaining this course of action. Hence the APBA
provided the essential link between a parent’s suspicions that a problem existed in an adolescent’s behaviour, and the parent’s decision to seek help in relation to these suspicions.

The next chapter will describe the normative data that emerged from the development of the *APBA*, including in particular the normative profile of adolescent consumption of alcohol, tobacco, and marijuana. This data was necessary for the clinical application of the *APBA*, in that it provided the clinician with a means of comparing the results of a referred adolescent’s behavioural profile with data provided by the normative adolescent and parent sample.
CHAPTER SIX

NORMATIVE DATA OF THE PARTICIPANT SAMPLE FOR THE

ADOLESCENT PROBLEM BEHAVIOUR ASSESSMENT

The Adolescent Problem Behaviour Assessment (APBA) was developed as the principal assessment module of the TANDEM programme. The APBA provided the therapist with an overview of an adolescent’s behavioural pattern from either an adolescent or parent’s viewpoint. Therefore, availability of baseline data gleaned from the normative parent and adolescent sample who participated in the development of the APBA was essential for this clinical level of use. Normative data enabled the therapist to compare the assessment results of a referred adolescent with the age and gender-related data of the normative sample.

The following normative data were derived from an analysis of the raw data that emerged from the administration of the APBA to the original sample of adolescents (n = 410) and their parents (n = 485). However, only data for adolescents classified within the first to third quartiles of risk behaviour were included in these analyses, together with relevant parent data (see section 6.1.1.1). While the sample size of parents who returned a completed questionnaire was smaller than the adolescent sample size, it was still sufficiently large enough to enable comparisons to be drawn between adolescent and parent responses. Furthermore, there was an initial independent measure of risk level conducted by teachers that also enabled these data to be classified across a continuum of risk behaviour. The analyses presented in this chapter resulted in descriptive statistics (mean scores and standard deviations) measured across adolescent age and gender for each factor of the APBA.

The benefit of these statistical findings was twofold. Firstly they addressed essential research questions regarding risk behaviour across age and gender, the
interaction of age and gender in relation to risk behaviour, the relationship between levels of risk and increases in adolescent age, and the level of concordance between adolescent and parent perceptions concerning behavioural risk. Secondly, these normative data provided a necessary clinical baseline for the identification of harmful risk evident in the behaviour of a referred adolescent. A clinician would require this data both to score the APBA (in both adolescent and parent versions) and to identify levels of behavioural risk, in order to clearly discuss assessment measures and the clinical conclusions surrounding these measures with the adolescent’s parent.

This chapter will firstly present and discuss the percentage values of adolescent use of alcohol, tobacco, and marijuana. The responses of adolescents and parents to the Adolescent Drug Use Questionnaire (ADUQ) will be used to determine these percentage values. Following this presentation, mean scores and standard deviations across age and gender will be analysed and discussed for remaining questionnaires of the APBA, including the Interpersonal Support Questionnaire (ISQ), the Self-Perception of Risk Questionnaire (SPRQ), and for the parent version only, the Parent Resilience Questionnaire (PRQ). Following the presentation of these descriptive data, the statistical significance of resulting mean score differences for all questionnaires (except the ADUQ) will be determined using multivariate and univariate analyses. Because the percentage values of substance use derived from the ADUQ and the mean scores and standard deviations derived from the ISQ, the SPRQ, and the PRQ were also used in the clinical setting, the data tables relevant to these questionnaires have been reproduced in the TANDEM intervention package, included with this thesis. This fact will be indicated for each relevant table of data. This chapter will therefore commence with the presentation of percentage values for adolescent substance use derived from the ADUQ.
6.1 Normative data for adolescent drug and alcohol consumption

Because the consumption of alcohol, tobacco, and marijuana has been found to represent the potential onset of adolescent problem behavioural patterns (Elickson et al., 1992; Kandel, 1982; Kandel & Faust, 1975; Welte & Barnes, 1987), adolescent consumption of these drugs only was investigated in this research. The Adolescent Drug Use Questionnaire (ADUQ) investigated the frequency and amount of adolescent consumption of alcohol, tobacco, and marijuana over the previous four-week period. The reason for choosing this particular span of time was discussed in section 5.3 of chapter five. Inferential statistics were not conducted for this data. Rather, the task was to provide a profile of alcohol, tobacco, and marijuana consumption by this low-risk normative adolescent sample. Reporting findings in percentage form was considered sufficient to provide an adequate clinical baseline against which to compare the reported consumption of a referred adolescent.

6.1.1 Method

Similar to all questionnaires comprising the Adolescent Problem Behaviour Assessment (APBA), the Adolescent Drug Use Questionnaire (ADUQ) was administered to the original samples of adolescents (n = 410) and parents (n = 485) at the one time as part of the APBA booklet of questionnaires. The method has been described in section 5.2.2 of chapter five.

6.1.1.1 Participants. Since the purpose of this data analysis was to obtain a normative profile of alcohol, tobacco, and marijuana use by adolescents who were not currently exhibiting extreme levels of problem behaviour, only the responses of adolescents whom Year Coordinators rated as falling into the first to third quartiles (that is, 0.00 to 7.49) were selected for analysis (see section 5.2.3 of chapter five for a complete description of how and why data were divided into quartiles).
This was a necessary decision since the findings of these analyses were intended for use as normative data by a clinician who was attempting to determine the risk level of a referred adolescent in terms of his or her consumption of alcohol, tobacco, and marijuana. Frequencies and amounts of substance use by the normative sample were recorded as percentage values, which represented actual frequency (in terms of days over a four week period) and amounts of use, rather than representing substance use according to mean scores and standard deviations. Hence if a clinician was to effectively use these normative data as a baseline for determining the presence or absence of escalating harmful risk, then it was necessary to ensure that these normative data were not contaminated by the inclusion of adolescents’ responses, as well as responses of their parents, who were rated by Year Coordinators as exhibiting high-risk behaviour. The data of adolescents who were classified with a rating equal to or greater than 7.50 were therefore excluded since 7.50 represented the researcher-nominated threshold for high-risk harmful behaviour. For ease of perusal, the breakdown of the total adolescent sample (n = 410) into each quartile reported in 5.4.3 has been reproduced in tabular format in Table 6.1.

Table 6.1
Adolescent sample sizes according to quartiles of risk behaviour.

<table>
<thead>
<tr>
<th></th>
<th>1st Quartile</th>
<th>2nd Quartile</th>
<th>3rd Quartile</th>
<th>4th Quartile</th>
<th>Total Male/Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>111</td>
<td>49</td>
<td>14</td>
<td>27</td>
<td>201</td>
</tr>
<tr>
<td>Females</td>
<td>169</td>
<td>31</td>
<td>8</td>
<td>1</td>
<td>209</td>
</tr>
<tr>
<td>Total Adolescent Sample</td>
<td><strong>280</strong></td>
<td><strong>80</strong></td>
<td><strong>22</strong></td>
<td><strong>28</strong></td>
<td><strong>410</strong></td>
</tr>
</tbody>
</table>
From Table 6.1, it can be seen that Year Coordinators rated the majority of males and females as belonging to the lowest category of risk (the first quartile). It can also be noted that teachers rated more males than females as moving beyond the very low risk threshold (the first quartile) into higher thresholds of risk (the second and third quartiles). This reflected the tendency of males more than females to be inclined to engage in harmful at-risk behaviour (Moffit et. al, 2001). Excluding the data of those adolescents and their parents who fell into the fourth quartile (n = 28) meant marginally reducing the total number of participants for the data analysis, although the final sample size was still adequate for the purpose of analysis. The adolescent and parent samples for quartiles one to three whose data were analysed for the ADUQ have been presented across age and gender in Table 6.2. Where age has been taken to one decimal place, the value represents years plus months, so that 12.9 years would represent “12 years 11 months”.

Table 6.2
Adolescent and parent sample sizes for descriptive analyses of the ADUQ.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Mother</th>
<th>Father</th>
<th>Female</th>
<th>Mother</th>
<th>Father</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-12.9</td>
<td>39</td>
<td>21</td>
<td>21</td>
<td>32</td>
<td>23</td>
<td>14</td>
</tr>
<tr>
<td>13-13.9</td>
<td>46</td>
<td>38</td>
<td>28</td>
<td>52</td>
<td>42</td>
<td>29</td>
</tr>
<tr>
<td>14-14.9</td>
<td>30</td>
<td>27</td>
<td>19</td>
<td>42</td>
<td>30</td>
<td>21</td>
</tr>
<tr>
<td>15-15.9</td>
<td>36</td>
<td>26</td>
<td>16</td>
<td>55</td>
<td>39</td>
<td>29</td>
</tr>
<tr>
<td>16-16.9</td>
<td>23</td>
<td>7</td>
<td>5</td>
<td>27</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>174</td>
<td>119</td>
<td>89</td>
<td>208</td>
<td>154</td>
<td>109</td>
</tr>
</tbody>
</table>

6.1.1.2 Instrument. The Adolescent Drug Use Questionnaire (ADUQ), developed from Wragg’s (1992a, 1992b) research, was the instrument by which
adolescent alcohol, tobacco, and marijuana consumption was investigated from both an adolescent and a parent perspective. The ADUQ, described in section 5.3 of chapter five, can be found both in the adolescent version of the Adolescent Problem Behaviour Assessment (APBA) [Appendix 10, pp. 6-7] and the parent version of the APBA (Appendix 11, pp. 7-8). For Tables 6.3, 6.4, 6.5, 6.6, and 6.7, decimal values for frequencies and amounts of consumption represent the median values of ranges for days (e.g. “1-3 days” is represented by 1.5 days) and amounts (e.g. “3-4 drinks” is represented by 3.5 drinks).

6.1.2 Procedure.

Similar to the method, the procedure for administering the Adolescent Drug Use Questionnaire (ADUQ) was identical to the procedure for administering all questionnaires comprising the Adolescent Problem Behaviour Assessment (APBA). The administration procedure has been fully described in section 5.2.3 of chapter five.

6.1.3 Results

6.1.3.1 Percentages for frequency of alcohol consumption. Adolescents and parents were asked to report the number of days over the previous four-weeks when alcohol might have been consumed. Question two in the Adolescent Drug Use Questionnaire (ADUQ) referred to frequency of alcohol consumption. Percentage sizes of the adolescent and parent samples for frequencies of alcohol consumption during the previous four weeks have been presented in Table 6.3. Percentages of parents and adolescents did not agree in their reports of alcohol use. Where this phenomenon occurred, percentage differences have been recorded in brackets.
Table 6.3
Percentage sizes of the adolescent and parent samples describing frequencies of alcohol consumption during the previous four weeks*.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Mother</th>
<th>Father</th>
<th>Female</th>
<th>Mother</th>
<th>Father</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-12.9 years</td>
<td>n = 39</td>
<td>n = 21</td>
<td>n = 21</td>
<td>n = 32</td>
<td>n = 23</td>
<td>n = 14</td>
</tr>
<tr>
<td>Nil days</td>
<td>74.4</td>
<td>90.9 (-16.5)</td>
<td>90.5 (-16.1)</td>
<td>81.3</td>
<td>95.8 (-14.5)</td>
<td>93.3 (-12.0)</td>
</tr>
<tr>
<td>1.5 days</td>
<td>20.5</td>
<td>9.1 (11.4)</td>
<td>9.5 (11.0)</td>
<td>18.8</td>
<td>4.2 (14.6)</td>
<td>6.7 (12.1)</td>
</tr>
<tr>
<td>4.0 days</td>
<td>2.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;20 days</td>
<td>2.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-13.9 years</td>
<td>n = 46</td>
<td>n = 38</td>
<td>n = 28</td>
<td>n = 52</td>
<td>n = 42</td>
<td>n = 29</td>
</tr>
<tr>
<td>Nil days</td>
<td>73.9</td>
<td>87.8 (-13.9)</td>
<td>90.3 (-16.4)</td>
<td>82.7</td>
<td>86.4 (-3.7)</td>
<td>74.2 (8.5)</td>
</tr>
<tr>
<td>1.5 days</td>
<td>21.7</td>
<td>12.2 (9.5)</td>
<td>9.7 (12.0)</td>
<td>15.4</td>
<td>13.6 (1.8)</td>
<td>22.6 (-7.2)</td>
</tr>
<tr>
<td>4.0 days</td>
<td>2.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;20 days</td>
<td>2.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.9</td>
</tr>
<tr>
<td>14-14.9 years</td>
<td>n = 30</td>
<td>n = 27</td>
<td>n = 19</td>
<td>n = 42</td>
<td>n = 30</td>
<td>n = 21</td>
</tr>
<tr>
<td>Nil days</td>
<td>36.7</td>
<td>66.7 (-30.0)</td>
<td>80.0 (-43.3)</td>
<td>57.1</td>
<td>90.3 (-33.2)</td>
<td>90.5 (-33.4)</td>
</tr>
<tr>
<td>1.5 days</td>
<td>43.3</td>
<td>29.6 (13.7)</td>
<td>15.0 (28.3)</td>
<td>35.7</td>
<td>9.7 (26.0)</td>
<td>9.5 (26.2)</td>
</tr>
<tr>
<td>4.0 days</td>
<td>13.3</td>
<td>3.7 (9.6)</td>
<td>5.0 (8.7)</td>
<td>4.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.5 days</td>
<td>6.7</td>
<td></td>
<td></td>
<td>2.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-15.9 years</td>
<td>n = 36</td>
<td>n = 26</td>
<td>n = 16</td>
<td>n = 55</td>
<td>n = 39</td>
<td>n = 29</td>
</tr>
<tr>
<td>Nil days</td>
<td>44.4</td>
<td>82.1 (-37.7)</td>
<td>85.0 (-40.6)</td>
<td>51.9</td>
<td>84.2 (-32.3)</td>
<td>86.2 (-34.3)</td>
</tr>
<tr>
<td>1.5 days</td>
<td>33.3</td>
<td>14.3 (19.0)</td>
<td>15.0 (18.3)</td>
<td>26.9</td>
<td>10.5 (16.4)</td>
<td>10.3 (16.6)</td>
</tr>
<tr>
<td>4.0 days</td>
<td>16.7</td>
<td>3.6 (13.1)</td>
<td>9.6</td>
<td>5.3 (4.3)</td>
<td>3.4 (6.2)</td>
<td></td>
</tr>
<tr>
<td>7.5 days</td>
<td>5.6</td>
<td></td>
<td>9.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.5 days</td>
<td></td>
<td></td>
<td>1.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-16.9 years</td>
<td>n = 23</td>
<td>n = 7</td>
<td>n = 5</td>
<td>n = 27</td>
<td>n = 20</td>
<td>n =16</td>
</tr>
<tr>
<td>Nil days</td>
<td>26.1</td>
<td>63.6 (-37.5)</td>
<td>83.3 (-57.2)</td>
<td>48.1</td>
<td>77.3 (-29.2)</td>
<td>73.3 (-25.2)</td>
</tr>
<tr>
<td>1.5 days</td>
<td>39.1</td>
<td>36.4 (2.7)</td>
<td>16.7 (22.4)</td>
<td>33.3</td>
<td>22.7 (10.6)</td>
<td>6.7 (26.6)</td>
</tr>
<tr>
<td>4.0 days</td>
<td>30.4</td>
<td></td>
<td>18.5</td>
<td></td>
<td></td>
<td>20.0 (-1.5)</td>
</tr>
<tr>
<td>7.5 days</td>
<td>4.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Bracketed values indicate percentages of adolescents and parents who did not agree in their reports.

From Table 6.3 it can be seen that as age increased so too did percentages of consumption frequency. While percentages for the majority of adolescents of all ages indicated low numbers of days over four weeks during which alcohol was consumed, there was a notable tendency for males and females to report a movement from ‘nil’
days to any number of days on which alcohol was consumed. At 12 years of age, 74.4% of males and 81.3% of females reported not drinking on any day in the previous four-week period. At 16 years of age, only 26.1% of males and 48.1% of females reported not using alcohol on any day in four weeks. For both males and females, a sharp increase in percentage was found among 14 year-old adolescents who reported an increase from 1.5 to 14.5 days, with increases in percentage occurring incrementally from 14 to 16 years of age. At 12 and 13 years of age, a comparatively small percentage of males reported using alcohol in excess of 1.5 days over four weeks. Only 1.9% of 13 year-old females reported using alcohol in excess of 20 days. The remaining percentages of 12 and 13 year-old females did not report using alcohol in excess of 1.5 days over four weeks. At 14 years of age for males and females, the most notable increase was a movement from 1.5 days to 4.0 days over four weeks, with the percentage of adolescents who reported using alcohol in excess of 7.5 days also being very small. With one exception, a comparison of percentages between males and females indicated that a higher percentage of males than females across all ages reported a greater number of days when alcohol was consumed. The one exception occurred at 15 years of age, when the majority of males tended to report no higher than 4.0 days, while approximately 20% of females reported a range of 4.0 to 14.5 days.

A comparison was drawn between the percentages found for 14 to 16 year-old adolescents in the present research and percentages describing alcohol consumption among an Australian adolescent sample in 1998 (Commonwealth Department of Human Services and Health, & Australian Institute of Health and Welfare, 1998). While noting the need for caution in making this comparison, since data for the consumption of alcohol for the Australian adolescent population in 1998 was compiled over 12 months, 10% of males and 13% of females among the 1998 Australian adolescent sample
reported using alcohol on one day in four weeks, while in the present research 14% of males and 20% of females reported using alcohol over three to four days in four weeks. Two differences were noted within this comparison. Firstly, in the present research, higher percentages of males than females reported days when alcohol was used, whereas the opposite was found for the 1998 Australian adolescent data. Secondly, the numbers of days for alcohol consumption reported by adolescents in the present research was higher than the number of days for alcohol consumption reported by Australian adolescents in 1998 (Commonwealth Department of Human Services and Health, & Australian Institute of Health and Welfare, 1998).

Table 6.3 has been reproduced in the TANDEM intervention package for use in the clinical setting.

6.1.3.2 Percentages for frequency of tobacco consumption. Adolescents and parents were asked to report the number of days over the previous four-weeks when tobacco might have been consumed. Question five in the Adolescent Drug Use Questionnaire (ADUQ) referred to frequency of tobacco consumption. Percentage sizes of the adolescent and parent samples describing frequencies of tobacco consumption during the previous four weeks have been presented in Table 6.4. Once again, the percentage differences for adolescents and parents who did not agree in their reports have been recorded in brackets.
Table 6.4
Percentage sizes of the adolescent and parent samples describing frequencies of tobacco consumption during the previous four weeks*.

<table>
<thead>
<tr>
<th></th>
<th>Male n = 39</th>
<th>Mother n = 21</th>
<th>Father n = 21</th>
<th>Female n = 32</th>
<th>Mother n = 23</th>
<th>Father n = 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-12.9 years Nil days</td>
<td>92.3</td>
<td>100 (-7.7)</td>
<td>100 (-7.7)</td>
<td>93.8</td>
<td>6.3</td>
<td>100 (-6.2)</td>
</tr>
<tr>
<td>1.5 days</td>
<td>2.6</td>
<td>5.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.0 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.5 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 13-13.9 years Nil days | n = 46 | 93.5         | 97.6 (-4.1)    | 100 (-11.5)   | 100 (-11.5)   |
| 1.5 days | n = 38 | 4.3          | 96.8 (-3.3)    | 3.2 (1.1)     | 7.7           |
| 4.0 days | n = 28 | 2.2          | 2.4 (2.4)      |               |               |
| 7.5 days |         |              |               |               |               |
| 14.5 days | >20 days |             |               |               |               |
| Daily    |             | 1.9          |               |               |               |

| 14-14.9 years Nil days | n = 30 | 66.7         | 92.6 (-25.9)   | 100 (-33.3)   | 100 (-11.9)   |
| 1.5 days | n = 27 | 6.7          | 3.7 (3.0)      | 7.1           | 3.2 (3.9)     |
| 4.0 days | n = 19 | 13.3         | 2.4            |               |               |
| 7.5 days |         | 6.7          |               |               |               |
| 14.5 days | >20 days |             |               |               |               |
| Daily    |         | 3.3          | 3.7 (3.7)      | 2.4           | 3.2 (3.2)     |

| 15-15.9 years Nil days | n = 36 | 77.8         | 100 (-22.2)    | 80.8          | 94.7 (-13.9)  | 100 (-19.2)   |
| 1.5 days | n = 26 | 13.9         | 9.6            | 2.6 (7.0)     |               |               |
| 4.0 days | n = 16 | 5.6          | 1.9            | 2.6 (-0.7)    |               |               |
| 7.5 days |         | 2.8          |               |               |               |               |
| 14.5 days | Daily |             |               |               | 3.8           | 3.8           |

| 16-16.9 years Nil days | n = 23 | 73.9         | 100 (-26.1)    | 70.4          | 100 (-29.6)   | 100 (-29.6)   |
| 1.5 days | n = 7  | 17.4         | 11.1           |               |               |               |
| 4.0 days | n = 5  | 4.3          | 3.7            |               |               |               |
| 7.5 days |         | 4.3          | 7.4            |               |               |               |
| 14.5 days |         |             | 7.4            |               |               |               |

* Bracketed values indicate percentages of adolescents and parents who did not agree in their reports.
Adolescent reports of tobacco consumption recorded in Table 6.4 indicated a movement similar to alcohol from days of abstinence to days of consumption. However, it appeared that a lower percentage of males than females at 13, 15, and 16 years of age used tobacco in excess of 1.5 days over four weeks. At 12 and 14 years of age the opposite appeared to be the case. However, compared to the sample size of males and females, these percentages were small. The movement beyond nil number of days did not indicate large differences in percentage. At 12 years of age, 92.3% of males and 93.8% of females reported not using tobacco on any day over four weeks. At 16 years of age this figure had not decreased by any great extent. That is, 73.9% of 16 year-old males and 70.4% of 16 year-old females reported not using tobacco on any day over four weeks. However, 14 year-old males reported a sharp decrease in this figure. For 14 year-old males, the percentage for nil days in four weeks dropped from 73.9% at 13 years to 66.7% at 14 years of age, indicating that higher percentages of males at this age were reporting days when tobacco was used. At 15 years of age, the percentage of males who reported nil days for tobacco use then rose to 77.8%, an increase of approximately 10%. A notably large number of 14 year-old males who reported a frequency in excess of 4.0 days accounted for the decrease in percentage of nil days for this age group.

For females, there were no sharp increases or decreases in the percentage of those who reported excesses of 1.5 days during which tobacco was used. However, there was a notable though small increase in the percentage of 15 and 16 year-old females who reported days of tobacco use of 4.0 days and higher. Generally, at 12 and 13 years of age, 92.3% of 12 and 13 year-old males and 98.1% did not report any more than 1.5 days per four weeks when tobacco was consumed. For the majority of 14 to 16 year-old males and females, this frequency did not increase beyond 4.0 days in four weeks. Noteworthy variations in reports of days occurred for 14 year-old males. For
males, 14 years of age reflected the highest number of reported days beyond 1.5 days for tobacco consumption. A possible reason for this finding was that Year Coordinators rated these adolescents as being at a lower level of risk than was in fact the case.

Once again, a comparison was drawn between the percentages found for 14 to 16 year-old adolescents in the present research and percentages emerging from data compiled for the 14 to 19 year-old Australian adolescent sample in 1998 (Commonwealth Department of Human Services and Health, & Australian Institute of Health and Welfare, 1998). Due to limitations of concordance in the methods of data collection for both research studies previously described in section 6.1.3.1, only the percentages of adolescents who reported being regular or daily smokers were compared. In the 1998 data, 16% of males and females reported being regular smokers, meaning daily or most days throughout the previous 12 months. This percentage was considerably higher than findings for the present research. In the present research, only 3.3% of 14 year-old males and 3.8% of 15 year-old females reported using tobacco on a daily basis.

Table 6.4 has been reproduced in the TANDEM intervention package for use in the clinical setting.

6.1.3.3 Percentages for frequency of marijuana consumption. Adolescents and parents reported the number of days over the previous four-weeks when marijuana might have been consumed. Question eight in the Adolescent Drug Use Questionnaire (ADUQ) referred to frequency of marijuana consumption. Percentage sizes of the adolescent and parent samples describing frequencies of marijuana consumption during the previous four weeks have been presented in Table 6.5. As with alcohol and tobacco, the percentage differences for adolescents and parents who did not agree in their reports have been recorded in brackets.
Table 6.5
Percentage sizes of the adolescent and parent samples describing frequencies of
marijuana consumption during the previous four weeks*.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Mother</th>
<th>Father</th>
<th>Female</th>
<th>Mother</th>
<th>Father</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-12.9 years</td>
<td>n = 39</td>
<td>n = 21</td>
<td>n = 21</td>
<td>n = 32</td>
<td>n = 23</td>
<td>n = 14</td>
</tr>
<tr>
<td>Nil days</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>95.8 (4.2)</td>
<td>100</td>
</tr>
<tr>
<td>1.5 days</td>
<td>4.2</td>
<td>4.2</td>
<td>4.2</td>
<td>4.2</td>
<td>4.2</td>
<td>4.2</td>
</tr>
<tr>
<td>13-13.9 years</td>
<td>n = 46</td>
<td>n = 38</td>
<td>n = 28</td>
<td>n = 52</td>
<td>n = 42</td>
<td>n = 29</td>
</tr>
<tr>
<td>Nil days</td>
<td>97.8</td>
<td>97.6 (0.2)</td>
<td>96.8 (1.0)</td>
<td>96.2</td>
<td>100 (-3.8)</td>
<td>100 (-3.8)</td>
</tr>
<tr>
<td>1.5 days</td>
<td>2.2</td>
<td>2.4 (-0.2)</td>
<td>3.2 (-1.0)</td>
<td>1.9</td>
<td>1.9</td>
<td>1.9</td>
</tr>
<tr>
<td>4.0 days</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>14-14.9 years</td>
<td>n = 30</td>
<td>n = 27</td>
<td>n = 19</td>
<td>n = 42</td>
<td>n = 30</td>
<td>n = 21</td>
</tr>
<tr>
<td>Nil days</td>
<td>80.0</td>
<td>92.6 (-12.6)</td>
<td>100 (-20.0)</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>1.5 days</td>
<td>6.7</td>
<td>7.4 (-0.7)</td>
<td>6.7</td>
<td>6.7</td>
<td>6.7</td>
<td>6.7</td>
</tr>
<tr>
<td>4.0 days</td>
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<td>3.3</td>
<td>3.3</td>
<td>3.3</td>
<td>3.3</td>
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<tr>
<td>&gt;40 days</td>
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<td>15-15.9 years</td>
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<td>n = 26</td>
<td>n = 16</td>
<td>n = 55</td>
<td>n = 39</td>
<td>n = 29</td>
</tr>
<tr>
<td>Nil days</td>
<td>88.9</td>
<td>96.4 (-7.5)</td>
<td>100 (-11.1)</td>
<td>92.3</td>
<td>97.4 (-5.1)</td>
<td>100 (-7.7)</td>
</tr>
<tr>
<td>1.5 days</td>
<td>8.3</td>
<td>3.8</td>
<td>1.9</td>
<td>2.6 (1.2)</td>
<td>2.6 (1.2)</td>
<td>2.6 (1.2)</td>
</tr>
<tr>
<td>4.0 days</td>
<td>8.3</td>
<td>3.8</td>
<td>1.9</td>
<td>2.6 (1.2)</td>
<td>2.6 (1.2)</td>
<td>2.6 (1.2)</td>
</tr>
<tr>
<td>29.5 days</td>
<td>2.8</td>
<td>3.6 (-0.8)</td>
<td>1.9</td>
<td>1.9</td>
<td>1.9</td>
<td>1.9</td>
</tr>
<tr>
<td>16-16.9 years</td>
<td>n = 23</td>
<td>n = 7</td>
<td>n = 5</td>
<td>n = 27</td>
<td>n = 20</td>
<td>n = 16</td>
</tr>
<tr>
<td>Nil days</td>
<td>91.3</td>
<td>100 (-8.7)</td>
<td>100 (-8.7)</td>
<td>81.5</td>
<td>100 (-18.5)</td>
<td>93.3 (-11.8)</td>
</tr>
<tr>
<td>1.5 days</td>
<td>8.6</td>
<td>18.5</td>
<td>18.5</td>
<td>18.5</td>
<td>18.5</td>
<td>18.5</td>
</tr>
</tbody>
</table>

* Bracketed values indicate percentages of adolescents and parents who did not agree in their reports.

In contrast to alcohol and tobacco, percentages for frequency of marijuana use reported by males and females for all ages was small. This was not surprising, possibly given the fact that possession and use of marijuana is illegal in Australia with consequential punitive repercussions, presumably impacting on its availability and consumption. Furthermore, adolescent participants represented a “normal” sample, and so one would not expect high levels of consumption for marijuana, or indeed for alcohol
or tobacco. On the other hand, the fact that some adolescents who were less than 18 years of age (the legally and socially accepted age in Australia for drinking and smoking) reported even low levels of marijuana consumption, as well as alcohol and tobacco consumption, needs to be emphasised as being a serious community concern. 

Apart from 14 year-old males, the majority of adolescents reported not using marijuana at all. Adolescents who did report using marijuana generally reported a consumption of no more than 1.5 times in four weeks. Fourteen year-old males stood apart for reported numbers of days related to marijuana consumption, and appeared to reflect a pattern of marijuana use similar to that for tobacco use. That is, 10% of 14 year-old males reported use of marijuana between 1.5 and 14.5 times in four weeks, while 3.3% of 14 year-old males reported using marijuana in excess of 40 times in four weeks. At the same time, the percentages of 14 year-old males who reported in excess of 1.5 days were small in comparison to the overall sample size of males for this age group. It was not possible to draw a comparison between data for the present research and 1998 data for the Australian adolescent sample. For the 1998 data, marijuana consumption was measured for a combined adult and adolescent sample, rather than in age groups as with data for alcohol and tobacco consumption (Commonwealth Department of Human Services and Health, & Australian Institute of Health and Welfare, 1998).

Table 6.5 has been reproduced in the TANDEM intervention package for use in the clinical setting.

### 6.1.3.4 Concordance between adolescent and parent data for consumption frequencies.

Apart from 12 year-old males and their parents who each reported 100% nil marijuana use, a percentage of adolescents and parents within each age group disagreed with each other about the number of days relating to substance use over the
previous four-week period. Negative percentage differences indicated that parents reported a higher number of days than did adolescents, and positive differences indicated the opposite trend. The highest percentages of parents who disagreed with their sons or daughters occurred for ‘Nil’ days. In addition, the majority of negative percentage differences also occurred for ‘Nil’ days. This finding indicated that in situations where a lack of concordance was found, parents were more inclined to describe their adolescent as not using a substance on any day in four weeks, and were less inclined to say that he or she was using a substance on 1.5 days or more. Percentage differences were smaller for younger adolescents and larger for older adolescents.

The percentage of adolescents and parents who were not in accord with each other’s thinking was generally higher for males than females. Between both genders this discordance was most evident for alcohol, less evident for tobacco, and least evident for marijuana. Mothers generally exhibited lower percentages of discordance with their sons or daughters than did fathers. In many cases mothers and fathers were in common agreement with each other about the number of days they thought their sons or daughters were using tobacco or marijuana, even though their beliefs did not reflect those of the adolescent. This observation was not reflected in the reported perceptions of mothers and fathers for the number of days over which they believed their sons or daughters used alcohol.

6.1.3.5 Percentages for amount of alcohol consumption. Adolescents and parents were asked to indicate the amount of alcohol consumed during a previous four week-period. No actual size or type of an alcoholic drink was specified, since to do so would have increased the complexity of the question that focused on the amount alcohol consumption as well as exceeding the research and clinical purpose of this particular domain of enquiry. In New South Wales (Australia), the State wherein this research was
conducted, amounts of alcohol are measured according to standard drinks. A standard drink is equivalent to 285ml of full strength beer, or 425ml of low-alcohol beer, 30ml of spirit, 100ml of table wine, or 60 ml of fortified wine (Roads and Traffic Authority of New South Wales, 1997). To gain data of adolescent alcohol consumption according to these standards would have represented a task exceeding the final clinical purpose of the Adolescent Problem Behaviour Assessment (APBA). The research aim for the APBA was only to acquire general measures of adolescent alcohol consumption over a four-week period. Furthermore, the clinical purpose of the Adolescent Drug Use Questionnaire (ADUQ) within the context of the Adolescent Problem Behaviour Assessment (APBA) was to contribute to an overall impression of current risk levels of adolescent behaviour. With reference to alcohol consumption, the type of alcohol and the amount of each drink would be ascertained within the interview setting if this information was seen as being necessary for assessment or intervention purposes.

Jessor R. and Jessor S.L. (1977) defined the act of drinking as actually being a drink of alcohol rather than a sip or a taste. Since participants could report having only a sip of alcohol, the same criterion was applied in the present research. In the present research, therefore, only amounts of 1.5 drinks or more were noted following analyses of consumption on any day over the previous four-week period, although amounts defined by “sips’ have been included in the tabulated presentation of data for the sake of completeness. Question three in the Adolescent Problem Behaviour Assessment (APBA) referred to amount of alcohol consumption. Percentage sizes of the adolescent and parent samples describing amounts of alcohol consumption during the previous four weeks have been presented in Tables 6.6. Percentages of parents and adolescents did not mutually agree in their reports of alcohol use. Where this phenomenon occurred, the percentage differences have been recorded in brackets.
Table 6.6
Percentage sizes of the adolescent and parent samples describing amounts of alcohol consumption during the previous four weeks*.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Mother</th>
<th>Father</th>
<th>Female</th>
<th>Mother</th>
<th>Father</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-12.9 years</td>
<td>n = 39</td>
<td>n = 21</td>
<td>n = 21</td>
<td>n = 32</td>
<td>n = 23</td>
<td>n = 14</td>
</tr>
<tr>
<td>Nil drinks</td>
<td>46.2</td>
<td>63.6 (17.4)</td>
<td>61.9 (15.7)</td>
<td>53.1</td>
<td>66.7 (13.6)</td>
<td>66.7 (13.6)</td>
</tr>
<tr>
<td>Sips</td>
<td>38.5</td>
<td>36.4 (2.1)</td>
<td>38.1 (0.4)</td>
<td>40.6</td>
<td>33.3 (7.3)</td>
<td>33.3 (7.3)</td>
</tr>
<tr>
<td>1.5 drinks</td>
<td>12.8</td>
<td>6.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5 drinks</td>
<td>2.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 13-13.9 years | n = 46 | n = 38 | n = 28 | n = 52 | n = 42 | n = 29 |
| Nil drinks | 32.6 | 61.0 (28.4) | 67.7 (35.1) | 50.0 | 63.6 (13.6) | 58.1 (8.1) |
| Sips | 47.8 | 36.6 (11.2) | 29.0 (18.8) | 36.5 | 36.4 (0.1) | 41.9 (5.4) |
| 1.5 drinks | 13.0 | 2.4 (10.6) | 3.2 (9.8) | 11.5 |
| 3.5 drinks | 4.3 |
| 6.5 drinks | 2.2 |

| 14-14.9 years | n = 30 | n = 27 | n = 19 | n = 42 | n = 30 | n = 21 |
| Nil drinks | 13.3 | 37.0 (23.7) | 55.0 (41.7) | 35.7 | 51.6 (15.9) | 47.6 (11.9) |
| Sips | 33.3 | 48.1 (14.8) | 30.0 (3.3) | 33.3 | 48.4 (15.1) | 47.6 (14.3) |
| 1.5 drinks | 36.7 | 11.1 (25.6) | 15.0 (21.7) | 16.7 |
| 3.5 drinks | 13.3 | 3.7 (9.6) | 7.1 |
| 6.5 drinks | 3.3 |
| >12 drinks | 1.9 |

| 15-15.9 years | n = 36 | n = 26 | n = 16 | n = 55 | n = 39 | n = 29 |
| Nil drinks | 8.3 | 53.6 (45.3) | 45.0 (36.7) | 13.5 | 47.4 (33.9) | 55.2 (41.7) |
| Sips | 22.2 | 42.9 (20.7) | 45.0 (22.8) | 40.4 | 39.5 (0.9) | 41.4 (1.0) |
| 1.5 drinks | 38.9 | 3.6 (35.3) | 5.0 (33.9) | 21.2 |
| 3.5 drinks | 11.1 | 5.0 (6.1) | 17.3 |
| 6.5 drinks | 11.1 |
| 10.5 drinks | 5.6 |
| >12 drinks | 2.8 |

| 16-16.9 years | n = 23 | n = 7 | n = 5 | n = 27 | n = 20 | n = 16 |
| Nil drinks | 17.4 | 18.2 (-0.8) | 16.7 (0.7) | 11.1 | 40.9 (-29.8) | 26.7 (15.6) |
| Sips | 4.3 | 45.5 (12.2) | 33.3 (-29.0) | 29.6 | 50.0 (-20.4) | 46.7 (-17.1) |
| 1.5 drinks | 43.5 | 18.2 (25.3) | 50.0 (-6.5) | 18.5 | 9.1 (9.4) | 20.0 (-1.5) |
| 3.5 drinks | 4.3 | 18.2 (-13.9) | 29.6 |
| 6.5 drinks | 26.1 |
| >12 drinks | 4.3 |

* Bracketed values indicate percentages of adolescents and parents who did not agree in their reports.
Data for males and females recorded in Table 6.6 will be considered separately. Generally, higher percentages of males than females across all ages consumed alcohol, and as age increased so too did amounts of alcohol consumption over a four-week period. With respect to males, the greater percentage of 12 year-old males reported drinking 1.5 drinks in four weeks. This amount remained at 1.5 drinks for the majority percentage of 13 year-old males. There was a noticeable increase in the percentage of 14 year-old males who were consuming amounts greater than 1.5 drinks over four weeks. However, unlike the reports of 14 year-old males for the number of *days* when alcohol was consumed, reports of percentages for the *amounts* of alcohol consumption did not stand apart from other age groups. At 15 years of age, the percentage of males who reported consuming 6.5 drinks in four weeks increased, together with the introduction of a small percentage of males who reported drinking more than 10.5 drinks. By 16 years of age, 26.1% of males reported a consumption of 6.5 drinks over four weeks, and 4.3% of males reported consuming in excess of 12 drinks over four weeks.

At 12 years of age, 6.5% of females reported consumption in excess of a few sips. This result approximated to half the amount of male consumption at the same age. At 13 years of age, 11.5% of females moved to 1.5 drinks with 1.9% consuming 6.5 drinks. At 14 years of age, there was a pattern of increase similar to that for 14 year-old males. Higher percentages of 14 year-old females who reported larger amounts of alcohol consumption increased incrementally to 16 years of age, although percentages for consumption of 6.5 drinks or more were lower for females than for males at 15 and 16 years of age. Similar to males, as females increased in age so too did percentages for reported amounts of alcohol consumption.
In Jessor R. and Jessor S.L.’s (1977) study, half the high school participants were non-drinkers yet over the four years of their data collection there was a significant and substantial increase in drinking rates amongst the same group. Although the data for the present study were not obtained longitudinally as were Jessor R. and Jessor S.L.’s (1977) data, there was nonetheless a similarly observable pattern of behaviour. That is, for 12 year-old participants, 46.2% of males and 53.1% of females reported not having drunk alcohol for the previous four-week period. By 16 years of age, these percentages had decreased to 17.4% for males, and 11.1% for females.

Table 6.6 has been reproduced in the TANDEM intervention package for use in the clinical setting.

6.1.3.6 Percentages for amounts of tobacco consumption. Adolescents and parents also reported the amount of tobacco that might have been consumed on any day over the previous four-week period. Only an amount of three cigarettes or more was considered in the following analysis, since a puff of a cigarette was not considered as actually smoking a cigarette. This decision again followed the logic of Jessor R. and Jessor S.L.’s (1977) research (see section 6.1.3.5). Once again, amounts defined by “puffs” have been included in the tabular presentation of data for the sake of completeness. Percentage sizes for the adolescent and parent samples for amounts of tobacco consumption during the previous four weeks have been presented in Table 6.7. Percentages of parents and adolescents did not mutually agree in their reports of tobacco use. Where this phenomenon occurred, percentage differences have been recorded in brackets.
Table 6.7
Percentage sizes of the adolescent and parent samples describing amounts of tobacco consumption during the previous four weeks*.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Mother</th>
<th>Father</th>
<th>Female</th>
<th>Mother</th>
<th>Father</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-12.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil cig'ettes</td>
<td>79.5</td>
<td>95.5 (-16.0)</td>
<td>90.5 (-11.0)</td>
<td>93.8</td>
<td>100 (-6.2)</td>
<td>100 (-6.2)</td>
</tr>
<tr>
<td>Puffs</td>
<td>12.8</td>
<td>4.5 (8.3)</td>
<td>9.5 (3.3)</td>
<td>6.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 cigarettes</td>
<td>7.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-13.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil cig'ettes</td>
<td>78.3</td>
<td>92.7 (-14.4)</td>
<td>93.5 (-15.2)</td>
<td>80.8</td>
<td>95.5 (-14.7)</td>
<td>96.8 (-16.0)</td>
</tr>
<tr>
<td>Puffs</td>
<td>17.4</td>
<td>7.3 (10.1)</td>
<td>6.5 (10.9)</td>
<td>15.4</td>
<td>4.5 (10.9)</td>
<td>3.2 (12.2)</td>
</tr>
<tr>
<td>3 cigarettes</td>
<td>4.3</td>
<td></td>
<td></td>
<td>1.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 cig'ettes</td>
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<td>1.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Nil cig'ettes</td>
<td>46.7</td>
<td>85.2 (-38.5)</td>
<td>90.0 (-43.3)</td>
<td>66.7</td>
<td>93.5 (-26.8)</td>
<td>100 (-33.3)</td>
</tr>
<tr>
<td>Puffs</td>
<td>30.0</td>
<td>11.1 (18.9)</td>
<td>10.0 (20.0)</td>
<td>23.8</td>
<td>3.2 (20.6)</td>
<td></td>
</tr>
<tr>
<td>3 cigarettes</td>
<td>16.7</td>
<td>3.7 (13.0)</td>
<td>7.1</td>
<td>3.2 (3.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 cig'ettes</td>
<td>6.7</td>
<td></td>
<td>2.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-15.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil cig'ettes</td>
<td>52.8</td>
<td>92.9 (-40.1)</td>
<td>90.0 (-37.2)</td>
<td>67.3</td>
<td>94.7 (-27.4)</td>
<td>96.6 (-29.3)</td>
</tr>
<tr>
<td>Puffs</td>
<td>25.0</td>
<td>7.1 (17.9)</td>
<td>10.0 (15.0)</td>
<td>17.3</td>
<td>2.6 (14.7)</td>
<td>3.4 (13.9)</td>
</tr>
<tr>
<td>3 cigarettes</td>
<td>22.2</td>
<td></td>
<td>13.5</td>
<td>2.6 (10.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 cig'ettes</td>
<td></td>
<td>1.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-16.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil cig'ettes</td>
<td>47.8</td>
<td>100 (-52.2)</td>
<td>100 (-52.2)</td>
<td>48.1</td>
<td>90.9 (-42.8)</td>
<td>73.3 (-25.2)</td>
</tr>
<tr>
<td>Puffs</td>
<td>17.4</td>
<td></td>
<td>25.9</td>
<td>9.1 (16.8)</td>
<td>26.7 (-0.8)</td>
<td></td>
</tr>
<tr>
<td>3 cigarettes</td>
<td>30.4</td>
<td></td>
<td>25.9</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>30 cig'ettes</td>
<td>4.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Bracketed values indicate percentages of adolescents and parents who did not agree in their reports.

From Table 6.7, it can be seen that across all age groups male consumption of tobacco exceeded female consumption. Again, male and female data will be considered separately. At 12 years of age only 7.7% of males reported smoking three cigarettes in the previous four-week period. This percentage of males decreased to 4.3% at 13 years of age. At 14 years of age, the percentage of males who reported smoking three
cigarettes increased by four times the percentage at 13 years of age, and a small percentage of males appeared at this age who reported smoking 20 cigarettes over four weeks. At 15 years of age, the percentage of males who reported smoking three cigarettes increased again, though none reported consumption beyond this amount. At 16 years of age there was a slight increase in the percentage of males who reported smoking three cigarettes, with 4.3% of males reporting a consumption of 30 cigarettes over four weeks. Therefore, while a gradual increase occurred for percentages of males who reported smoking three cigarettes or more, the majority percentage of males from 12 to 16 years of age did not report exceeding this amount.

No percentage of females at 12 years of age reported tobacco consumption any higher than a few puffs. At 13 years of age, only 1.9% of females reported using three cigarettes in four weeks, with an increase of 1.9% of females reporting a consumption of 20 cigarettes. At 14 years of age, the percentage increase of females who reported consuming three cigarettes increased to 7.1%. This increase was almost four times the percentage of 13 year-old females who reported smoking three cigarettes, and reflected an increase similar to that of 14 year-old males. Furthermore, 2.4% of 14 year-old females reported smoking 20 cigarettes in four weeks. At 15 years of age, 17.3% of females reported smoking three cigarettes over four weeks, and 1.9% of females reported using 20 cigarettes. At 16 years of age, female consumption reached a ceiling at three cigarettes, though the number of females who reported using this amount increased to 25.9%.

It was not possible to draw comparisons between amounts of alcohol and tobacco consumption between this research and the data for amounts of alcohol and tobacco consumption according to the 1998 Australian adolescent data. This was due to the fact that percentages for the latter research were calculated for the overall adolescent

Table 6.7 has been reproduced in the TANDEM intervention package for use in the clinical setting.

6.1.3.7 Concordance between adolescent and parent data for consumption amounts. On no occasion did parents and adolescents agree about the amount of alcohol and tobacco consumption over the previous four-week period. Furthermore, parents and adolescents disagreed with each other in a pattern similar to that for frequency of substance use. That is, higher negative percentages were apparent for ‘nil’ amounts of alcohol and tobacco. This finding indicated that parents were more inclined than adolescents to say that their sons or daughters were not using any alcohol or tobacco over four weeks. This tendency also increased as age increased.

Where parents did describe their adolescents as using alcohol or tobacco, percentages of amount were more conservative when compared to amounts reported by adolescents. In addition, while parents of older adolescents appeared to be more willing to acknowledge that their sons or daughters were using alcohol or tobacco, this did not generally extend beyond 1.5 drinks or three cigarettes. Thus, as more adolescents reported using alcohol or tobacco, the gap in agreement between parents and adolescents widened. Finally, percentages for parents who disagreed with sons were higher than for parents who disagreed with daughters.

Mothers and fathers were most closely in agreement with each about their adolescents’ use of alcohol and tobacco at 12 and 13 years of age, even though they were still in disagreement with the adolescent. However, beyond these ages there was no discernible pattern of agreement between mothers and fathers. In some cases mothers and fathers were close in agreement (as with 15 year-old males) while in others there
was a wide gap of disagreement (as with 16 year-old females). For amounts of 1.5 drinks or greater, and three cigarettes or greater, parents were less in agreement with their adolescents about reported amounts of alcohol consumption than for amounts of tobacco consumption. However, the gaps in disagreement for tobacco consumption might have been lessened by the fact that adolescents reported using less tobacco than alcohol.

6.1.3.8 The findings for adolescent use of alcohol, tobacco, and marijuana consumption as clinical baseline data. For any adolescent, the ideal baseline data for substance consumption would be nil, both in frequency and amount. However, the normative data of this research suggested that this figure would exist in an ideal world only. The trends evident in this comparative data suggested that, as they grew older, less than 10% of male and female adolescents were moving beyond the nil point for frequency and amount of consumption towards consuming more alcohol and tobacco over a higher number of days. The ceiling indicated by this level of frequency and amount of consumption would provide a useful clinical baseline for determining a cut-off point as part of the assessment of harmful risk behaviour. The limitation present in the normative sample of adolescents was that resulting data was not longitudinal so that each age group represented a separate group of adolescents, with equally separate behavioural patterns, different family and socio-economic backgrounds, and so forth. Future research into adolescent consumption of alcohol and tobacco, as well as marijuana, would benefit from a longitudinal investigation, enabling trends in frequencies and amounts of consumption to be studied among the same participant sample across age and gender.

Using normative adolescent data for alcohol, tobacco, and marijuana consumption as baseline data would mean comparing the outcome findings for a
referred adolescent with the findings for the majority as well as the minority percentages of the normative sample of adolescents. Such comparisons would indicate trends in harmful risk rather than determine specific levels of risk. Nonetheless, determining trends beyond nil to low levels of risk behaviour would be sufficient clinically, given that the aim of the Adolescent Problem Behaviour Assessment (APBA) was one of providing a general and structured foundation for discussion between parent and clinician concerning harmful adolescent risk behaviour. The intention in developing the APBA was one of formulating a profile of adolescent behaviour across a number of behavioural domains, including substance use, rather than providing a ‘stand alone’ diagnostic instrument for adolescent risk behaviour. How a clinician might actually use these data will be specifically addressed in section 6.2.4.

6.1.3.9 Analyses of correlation. In order to demonstrate the relationship between the Adolescent Drug Use Questionnaire (ADUQ) and other questionnaires comprising the Adolescent Problem Behaviour Assessment (APBA), namely the three factors of the Interpersonal Support Questionnaire (ISQ), and the one factor of the Self-Perception of Risk Questionnaire (SPRQ), analyses of correlation (Pearson Correlation 2-tailed) were conducted. The results of these analyses have been recorded in Table 6.8. Abbreviations have been used within questions relating to substance use. That is, “Ever” refers to whether or not the substance has ever been used, and “Freqy” refers to the days over a four-week period when the adolescent reported using a particular substance. The abbreviation “Amt” refers to how much of the substance was used during this time, and “Times” refers to the number of times the adolescent reported using marijuana over the previous four-week period.
Table 6.8
Analyses of correlation between the ADUQ, the ISQ, and the SPRQ.

<table>
<thead>
<tr>
<th>Factor</th>
<th>ALCOHOL (ADUQ)</th>
<th>TOBACCO (ADUQ)</th>
<th>MARIJUANA (ADUQ)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Modelling (ISQ)</td>
<td>.415** .544**</td>
<td>.438** .495**</td>
<td>.510** .517** .055a</td>
</tr>
<tr>
<td>Parental Monitoring/Limit Setting (ISQ)</td>
<td>.340** .278**</td>
<td>.326** .269**</td>
<td>.290** .282** .043a</td>
</tr>
<tr>
<td>Parent/Family Relationships (ISQ)</td>
<td>.254** .211**</td>
<td>.198** .281**</td>
<td>.252** .239** .157**</td>
</tr>
<tr>
<td>Self-Perception of Risk Questionnaire (SPRQ)</td>
<td>.219** .443**</td>
<td>.396** .282**</td>
<td>.499** .472** .493** .172**</td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed)
a. Value is non-significant.

Statistically significant positive correlations were found between adolescent reports of initiation, frequency, and amount of alcohol and tobacco consumption, and all three factors of the ISQ (Peer Modelling, Parental Monitoring/Limit Setting, and Parent/Family Relationships) and the SPRQ. For consumption initiation and consumption frequency of marijuana, a significant positive correlation was found for the factor of Parent/Family Relationships and the SPRQ. Therefore, a clinician would be able to investigate the seriousness of adolescent risk-behaviour by comparing reports of adolescent alcohol and tobacco consumption and the adolescent’s modelling of peer behaviour (Peer Modelling), the extent of parents’ monitoring and limiting practices (Parental Monitoring/Limit Setting), and the adolescent’s relationships with parents and family (Parent/Family Relationships). In relation to marijuana, this comparison would be possible between reported marijuana consumption and the adolescent’s relationship.
with parents and family (*Parent/Family Relationships*), as well as the adolescent’s insight into the potential for future behavioural problems (the *SPRQ*).

### 6.1.4 Discussion concerning adolescent alcohol, tobacco, and marijuana consumption

The majority of male and female adolescents who participated in the present research did not appear to have excessively consumed alcohol, tobacco, or marijuana, with regard either to frequency or amount. This finding was so even for the older age group of adolescents (15 years to 16 years 11 months). These findings were not surprising, given that Year Coordinators rated the selected adolescent sample (*n* = 382) as being at low risk for problem behaviour. The small percentages of adolescents who did report using larger amounts of alcohol, tobacco, and marijuana over a higher frequencies of days than their peers might conceivably have represented those who were rated as exhibiting low levels of at-risk behaviour, and yet were in fact behaving at a level of risk somewhere beyond the rated low level of risk. Although remaining low, the increase in frequencies and amounts of substance use for males and females as age increased reflected other research findings, and as such was not an unexpected finding (e.g., Oetting & Beauvais, 1991; Segal, 1991). Additionally, the results of the present research reflected the temporal lag of females behind males for initiation into and continuing consumption of alcohol and tobacco, as has been identified by research literature (e.g., Khoury, 1998). This lag was at least twelve months in duration and sometimes longer (as with alcohol consumption). This lag was not as evident for marijuana consumption. There was minimal difference between male and female marijuana use at 12 and 13 years of age. At 14 years of age marijuana use by males exceeded that of females, and at 15 years of age male and female use of marijuana generally converged. At 16 years of age female use of marijuana notably exceeded that
of males, reflecting Khoury’s (1998) finding that female substance use approximated and even exceeded male use from 15 years of age onward.

This normative data provided beneficial clinical application, particularly for a comparison between frequency and amount of consumption (see section 6.1.3.8). For example, it would be conceivable that a frequency of 1.5 days would be more indicative of proneness to problem behaviour than a frequency of 14.5 days if the adolescent were drinking a considerable amount (for example, ‘binge’ drinking) during the 1.5 days, in comparison to the adolescent who is having a few sips at dinner with the family over 14.5 days. The clinical usefulness of this data for assessing risk level of a referred adolescent would be twofold. Firstly, this data would provide a baseline of frequency and amount of substance use against which to measure reports of the referred adolescent, or his or her parents. Hence, reports that escalated notably beyond baseline data for frequency and amount of consumption for alcohol and tobacco, and frequency for marijuana, would indicate the need to investigate potential problems in this arena. Secondly, a similar need would exist in situations of escalated substance use where consumption amount exceeded indicated levels of consumption frequency, since this would indicate excessive use over small periods of time.

Two avenues of further research emerged from this data. Firstly, unlike Jessor R. and Jessor S.L. (1977), the collection of data was not carried out in longitudinal fashion. Hence each age group represented distinct groups of individuals whose responses reflected both their independent life-styles and the various socio-economic conditions in which they lived. Therefore future research would implement a longitudinal design. At the same time, the resulting data of this research did describe tendencies of adolescent substance use for individual age groups, as well as indicate patterns of variation across age and gender, thus enabling these data to be a clinically useful baseline measurement.
A measurement outcome that indicated concern would provide the opportunity to motivate the parent (or the adolescent) to consider effective intervention before behaviour escalated to further levels of risk. Like the jigsaw puzzle, the final interpretation of adolescent behaviour would be gained only when all the pieces provided by the findings of each questionnaire comprising the *Adolescent Problem Behaviour Assessment (ABPA)* had been assembled into one coherent image. Secondly, the need to develop a parent version of the *APBA* emerged once more.

It was notable that a lack of concordance existed between this low risk normative sample of parents and adolescents. When considering the issue of concordance between adolescent and parent responses, the smaller parent sample sizes in comparison to the adolescent sample sizes was noted. This was particularly so for males who were 16 years to 16.9 years of age. The parent sample sizes for this age group were particularly small by comparison. While a lack of concordance between adolescent and parent perceptions of substance use was generally found, at the same time this finding was to be treated with caution. The parent sample size compared to the adolescent sample size determined findings of concordance. Had the same number of parents as adolescents completed the *ADUQ*, concordance between adolescent and parent perceptions might have been stronger, although this conclusion could not be verified without the missing parent data being at hand. A larger sample size of adolescents and parents might also have led to stronger levels of concordance between the perceptions of both groups.

While full concordance between the perceptions of adolescents and parents about substance use would certainly be unrealistic, at the same time the issue of concordance concerning alcohol tobacco, and marijuana consumption must be considered when attempting to determine the harmful risk-level of a referred adolescent.
This would be especially so where the adolescent’s home environment and parental relationships was fragmented and therefore compromised. It would also be feasible that, for sound reasons, parents might not have this information at their fingertips, particularly where the adolescent was in the beginning phase of substance use. In this latter state of affairs, proneness towards problem use might be difficult to identify, even for the professional. In situations such as these, a notable lack of concordance would alert both clinician and parent to the possible occurrence of harmful substance use by the adolescent. Perhaps the primary task of the clinician in relation to the issue of concordance would be to help the parent decide how much of a lack in knowledge about the adolescent’s behaviour is acceptable.

The evident gap between the perceptions of parents and adolescents about substance use, and the manner in which this gap appeared to widen as age increased, also suggested an expected relaxation of parental sanctions and controls as the adolescent grew older. Increases in adolescent age will necessarily and naturally result in the parent knowing less and less about the adolescent’s lifestyle. Furthermore, as the adolescent grows older, it will be the adolescent, and not the parent, who decides what parents need to know about activities away from home. Jessor R. and Jessor S.L. (1977) noted a similar divergence between the perceptions of adolescents and parents as time and age increased. Consequentially, with a gradual loosening of parental control, the parent would become less informed about the son or daughter’s behaviour. However, this emerging pattern would still create concern where adolescent use of alcohol, tobacco, and especially marijuana implied illegal activity.

For alcohol use, this would suggest a grey area since in many families parents supervise alcohol use at what they consider to be a suitable age, and at occasions such as family meals. Adolescents who reported having a ‘few sips’ of alcohol might have
been referring to this type of experience. With tobacco consumption, and especially with marijuana consumption, a different story would most likely emerge. Acknowledging that 18 years of age represents the legal age for purchasing and consuming alcohol, and purchasing tobacco in Australia, and acknowledging the fact that tobacco is commonly documented as being inherently damaging to physical health, as well as the fact that the possession and use of marijuana in Australia is illegal, it would be difficult to sanction the use of these substances under the banner of parental supervision (Commonwealth Department of Human Services and Health, & Australian Institute of Health and Welfare, 1998).

Furthermore, it has long been established that delaying the onset of drug use leads to a less severe and shorter duration of later drug use (Elickson et al., 1992; Khoury, 1998; Swadi, 1988). Khoury (1998) mirrored this caution by voicing the general concern that professionals must be continually alert towards “the need to renew prevention efforts for both male and female adolescents” (p.122). Parental supervision of adolescent substance use does not provide an automatic protective buffer for the adolescent. There is the further issue to be considered as to whether the adolescent should be using any particular substance at all. Parental monitoring strategies, supervision of behaviour, and decision making practices therefore need to happen as an interrelated whole.

Correlations between the adolescent data for the Self-Perception of Risk Questionnaire (SPRQ) and the factors of Peer Modelling, Parental Monitoring/Limit Setting, and Parent/Family Relationships, and adolescent data for consumption initiation, consumption frequencies and amounts of alcohol and tobacco consumption indicated a statistically significant positive relationship between both domains. That is, the extent to which adolescents perceived their modelling of peer behaviour, their
parents’ monitoring and limiting of activities, and the quality of their relationships with parents and family mirrored their reported levels of risk in relation to frequencies and amounts of alcohol and tobacco consumption. For initiation into and frequency of marijuana consumption, significant positive correlations were found only with Parent/Family Relationships and the SPRQ. The clinical benefit of these findings would exist in being able to compare adolescent reports of substance use with domains of peer and family related behaviour in order to determine relationships between both arenas in terms of risk behaviour.

6.2 Normative data for assessment of harmful risk behaviour (apart from substance use)

Normative adolescent and parent data were analysed for the remaining questionnaires of the Adolescent Problem Behaviour Assessment (APBA), including the three factors of the Interpersonal Support Questionnaire (ISQ), the Self Perception of Risk Questionnaire (SPRQ), and the Parent Resilience Questionnaire (PRQ). These normative data were included with data that emerged from adolescent and parent reports of adolescent substance use described in the initial sections of this chapter.

As with the Adolescent Drug Use Questionnaire (ADUQ), the purpose of these analyses was to provide a useful clinical method of assessing levels of adolescent risk behaviour against the background of a baseline description of normative adolescent behaviour. The manner in which each questionnaire of the APBA was answered facilitated the analyses of normative data. Mean scores and standard deviations were measured for each factor of the ISQ and the SPRQ. Adolescents and parents responded to questionnaire items according to a continuum of risk, so that a value of one (or “never”, “none”) indicated low risk, while a value of four (or “always”, “all”) indicated high risk. Therefore, it was expected that low risk levels for the normative adolescent sample (according to either the adolescent or the parent) would be indicated by
correspondingly low mean scores for their responses. The response method for the *Parent Resilience Questionnaire* was according to a five-point Likert scale. While this scale did not resemble the same continuum of movement as that used for the *ISQ* and the *SPRQ*, at the same time a score within the parameters of this scale made it possible to identify the amount of resilience felt by a parent.

Descriptive data were analysed across age and gender since a clinician would need to consider age and developmental appropriateness of behaviour in the assessment of harmful risk. Therefore the resulting profile of the normative sample will be described according to mean scores and standard deviations of adolescent and parent responses, although not according to inferential statistics at this point of the investigation. Following the presentation of these descriptive data, the statistical significance of mean score differences between the adolescents themselves, and between adolescents and their parents will be presented. Difference measures across age and gender for the parent and adolescent versions of the three factors of the *ISQ* and the one factor of the *SPRQ*, as well as the *PRQ*, were undertaken using multivariate and univariate analyses of variance.

6.2.1 Method

Questionnaires comprising the *Adolescent Problem Behaviour Assessment* (*APBA*) from which normative data were derived, were administered to the original adolescent sample (*n* = 410) and parent sample (*n* = 485) as part of the *APBA* booklet of questionnaires. This method has been described in section 5.2.2 of chapter five.

6.2.1.1 Participants. As with data analyses for the *Adolescent Drug Use Questionnaire (ADUQ)*, data used to derive descriptive statistics were drawn from adolescent and parent samples who belonged to the first, second, and third quartiles of risk only. Excluding data for adolescents (and their parents) who were classified into the
fourth quartile of risk behaviour ensured that the resulting descriptive statistics would provide a clinically useful normative adolescent and parent sample for the assessment of a referred adolescent’s level of harmful risk. The rationale for this decision has been outlined in Section 6.1.1.1. The adolescent sample (n = 382) and parent sample (n = 471) for quartiles one to three whose data were used in the following descriptive analyses have been reproduced across age and gender in Table 6.2 since it was not possible to insert sample sizes for each age and gender in the following data tables due to a lack of space. Where age has been taken to one decimal place, the value represents years plus months, so that 12.9 years would represent “12 years 11 months”.

Table 6.9
Adolescent and parent sample sizes for descriptive analyses apart from the *ADUQ*.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Mother</th>
<th>Father</th>
<th>Female</th>
<th>Mother</th>
<th>Father</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-12.9 Years</td>
<td>39</td>
<td>21</td>
<td>21</td>
<td>32</td>
<td>23</td>
<td>14</td>
</tr>
<tr>
<td>13-13.9 years</td>
<td>46</td>
<td>38</td>
<td>28</td>
<td>52</td>
<td>42</td>
<td>29</td>
</tr>
<tr>
<td>14-14.9 years</td>
<td>30</td>
<td>27</td>
<td>19</td>
<td>42</td>
<td>30</td>
<td>21</td>
</tr>
<tr>
<td>15-15.9 years</td>
<td>36</td>
<td>26</td>
<td>16</td>
<td>55</td>
<td>39</td>
<td>29</td>
</tr>
<tr>
<td>16-16.9 years</td>
<td>23</td>
<td>7</td>
<td>5</td>
<td>27</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>174</td>
<td>119</td>
<td>89</td>
<td>208</td>
<td>154</td>
<td>109</td>
</tr>
</tbody>
</table>

6.2.1.2 *Instruments.* The *Interpersonal Support Questionnaire (ISQ)*, the *Self-Perception of Risk Questionnaire (SPRQ)*, and the *Parent Resilient Questionnaire (PRQ)* were the three questionnaires included in the analyses of normative data.
6.2.2 Procedure.

The procedure was that undertaken for the administration of the Adolescent Problem Behaviour Assessment (APBA) to the original sample of adolescents (n = 410) and parents (n = 485), and underpinned the following analyses of normative data. This procedure was described in section 5.2.3 of chapter five.

6.2.3 Results

6.2.3.1 The Interpersonal Support Questionnaire. Normative data was obtained from the three factors of the Interpersonal Support Questionnaire (ISQ), namely Peer Modelling, Parental Monitoring/Limit Setting, and Parent/Family Relationships. Mean scores and standard deviations for Peer Modelling have been presented in Table 6.10. Where age has been taken to one decimal place, the value represents represent years plus months, so that 12.9 years would represent “12 years 11 months”.
Table 6.10
Mean scores and standard deviations for *Peer Modelling*.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male n = 174</th>
<th>Female n = 208</th>
<th>Mother n = 273</th>
<th>Father n = 198</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>12.0-12.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.25 (.18)</td>
<td>1.16 (.15)</td>
<td>1.16 (.16)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.11 (.15)</td>
<td>1.06 (.15)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.0-13.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.37 (.36)</td>
<td>1.20 (.26)</td>
<td>1.16 (.16)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.16 (.13)</td>
<td>1.12 (.24)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.0-14.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.60 (.50)</td>
<td>1.38 (.35)</td>
<td>1.20 (.32)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.19 (.17)</td>
<td>1.15 (.17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.0-15.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.71 (.38)</td>
<td>1.60 (.48)</td>
<td>1.20 (.17)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.21 (.19)</td>
<td>1.20 (.17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.0-16.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.85 (.55)</td>
<td>1.50 (.33)</td>
<td>1.20 (.19)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.19 (.18)</td>
<td>1.24 (.16)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From Table 6.10 it can be seen that both male and female adolescents recorded a steady increase in their mean scores as age increased from 12 years of age onwards, although the mean scores of 12 and 13 year-old adolescents were extremely small. The mean scores of mothers and fathers on the other hand were equally small across all ages, with only very marginal increases in mean score as age increased. Furthermore, a pattern emerged whereby the mean scores of mothers and fathers were higher in relation to males than to females. This suggested that parents of males more than parents of females perceived risk level as being escalated due to the modelling of peer behaviour. Similarly, when compared to younger adolescents, older adolescents rather than younger adolescents appeared to believe that the level of risk resulting from modelling peer behaviour was more highly escalated. However the extent of this belief did not seem to be reflected by parents. Furthermore, mothers and fathers appeared to agree
with each other that their son or daughter’s modelling of peer behaviour was not leading
them into problematic at-risk situations. Again it needs to be stressed that mean scores
indicated a generally low level of risk, even for older adolescents. Table 6.10 has been
reproduced in the TANDEM intervention package for use in the clinical setting.

Mean scores and standard deviations for the factor of *Parental Monitoring/Limit
Setting* have been presented in Table 6.11.

### Table 6.11
Mean scores and standard deviations for *Parental Monitoring/Limit Setting*.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Adolescent</th>
<th>Mother</th>
<th>Father</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male n = 174</td>
<td>Female n = 208</td>
<td>Male n = 273</td>
</tr>
<tr>
<td>12.0-12.9 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.70 (.51)</td>
<td>1.18 (.14)</td>
<td>1.41 (.31)</td>
</tr>
<tr>
<td>Female</td>
<td>1.38 (.43)</td>
<td>1.18 (.16)</td>
<td>1.13 (.10)</td>
</tr>
<tr>
<td>13.0-13.9 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.67 (.42)</td>
<td>1.18 (.16)</td>
<td>1.28 (.23)</td>
</tr>
<tr>
<td>Female</td>
<td>1.52 (.53)</td>
<td>1.22 (.38)</td>
<td>1.32 (.36)</td>
</tr>
<tr>
<td>14.0-14.9 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.84 (.50)</td>
<td>1.18 (.20)</td>
<td>1.27 (.20)</td>
</tr>
<tr>
<td>Female</td>
<td>1.67 (.49)</td>
<td>1.22 (.18)</td>
<td>1.35 (.17)</td>
</tr>
<tr>
<td>15.0-15.9 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.94 (.54)</td>
<td>1.28 (.18)</td>
<td>1.35 (.23)</td>
</tr>
<tr>
<td>Female</td>
<td>1.68 (.39)</td>
<td>1.26 (.27)</td>
<td>1.37 (.31)</td>
</tr>
<tr>
<td>16.0-16.9 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2.07 (.51)</td>
<td>1.63 (1.12)</td>
<td>1.38 (.18)</td>
</tr>
<tr>
<td>Female</td>
<td>1.93 (.44)</td>
<td>1.40 (.34)</td>
<td>1.49 (.43)</td>
</tr>
</tbody>
</table>

From Table 6.11, and in comparison to *Peer Modelling*, it can be seen that the
factor of *Parental Monitoring/Limit Setting* indicated higher mean scores for male and
female adolescents from 12 years of age onwards when compared to older adolescents,
with marginal increases being evident as age increased. Increases in mean score,
together with increases in age, were again apparent for this factor, with increases also
occurring for parents. For both mothers and fathers, mean scores were generally low,
ranging between a score of 1.0 and 1.5. This value was situated at the low end of the risk continuum, and suggested that parents of these adolescents did not believe that their sons or daughters were exposed to harmful risk because of poor monitoring and limit setting strategies. In comparison, the mean scores of adolescents were higher than those of their parents, even at a younger age. This suggested that adolescents saw themselves as engaging in more harmful levels of risk behaviour than did their parents. However, having stated this, it is also necessary to note that mean score sizes suggested that the level of risk exhibited by the behaviour of the adolescent normative sample due to laxity in monitoring and limit setting habits was generally perceived as being low by both adolescents and parents. Table 6.11 has been reproduced in the TANDEM intervention package for use in the clinical setting.

Mean scores and standard deviations for the factor of Parent/Family Relationships have been presented in Table 6.12.
Table 6.12
Mean scores and standard deviations for *Parent/Family Relationships*.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Adolescent Male n = 174</th>
<th>Adolescent Female n = 208</th>
<th>Mother n = 273</th>
<th>Father n = 198</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>12.0-12.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.61 (.37)</td>
<td>1.54 (.25)</td>
<td>1.60 (.26)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.51 (.33)</td>
<td>1.40 (.26)</td>
<td>1.35 (.15)</td>
<td></td>
</tr>
<tr>
<td>13.0-13.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.66 (.43)</td>
<td>1.48 (.22)</td>
<td>1.59 (.33)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.55 (.47)</td>
<td>1.47 (.23)</td>
<td>1.43 (.24)</td>
<td></td>
</tr>
<tr>
<td>14.0-14.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.65 (.42)</td>
<td>1.47 (.24)</td>
<td>1.46 (.23)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.70 (.50)</td>
<td>1.49 (.27)</td>
<td>1.50 (.24)</td>
<td></td>
</tr>
<tr>
<td>15.0-15.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.83 (.43)</td>
<td>1.49 (.25)</td>
<td>1.63 (.31)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.91 (.64)</td>
<td>1.50 (.38)</td>
<td>1.57 (.38)</td>
<td></td>
</tr>
<tr>
<td>16.0-16.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.99 (.56)</td>
<td>1.49 (.27)</td>
<td>1.42 (.21)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.84 (.45)</td>
<td>1.60 (.41)</td>
<td>1.65 (.49)</td>
<td></td>
</tr>
</tbody>
</table>

From Table 6.12, it can be seen that the most noticeable difference between the previous two factors and the factor of *Parent/Family Relationships* was the comparatively higher mean scores for mothers and fathers of males and females who were 12 years of age and older. Furthermore, the mean scores of both parents more closely approximated the mean scores of adolescents for this factor. The range of mean scores approximated from 1.5 to 1.9 for males and females, and from 1.4 to 1.6 for mothers and fathers. Mean scores for adolescents and parents remained relatively constant across age groups. As with the factor of *Parental Monitoring/Limit Setting*, the mean scores for males and females were higher from 12 years of age onwards when compared to the factor of *Peer Modelling*, with marginal increases occurring as age increased. Increases in adolescent mean scores were again evident in relation to
increases in age, though these increases were marginal and did not extend beyond a mean score of 2.0 (or a belief that they “sometimes” reflected the behaviour indicated by the question). These higher mean scores indicated that both parents and adolescents were not entirely comfortable with the quality of parent-adolescent or family-adolescent relationships, although once again mean score sizes were not sufficiently high to be a risk-related concern. Table 6.12 has been reproduced in the TANDEM intervention package for use in the clinical setting.

**Summary.** Mean scores and standard deviations of adolescent and parent responses for the three factors of the ISQ were generally very small. The smallness of adolescent and parent mean scores indicated that adolescents were depicting a pattern of very low risk behaviour, and that their parents also viewed their adolescents’ behaviour as exhibiting low risk. The standard deviations were extremely small. As a measure of variability, these values indicated that the scores of this adolescent and parent sample were generally located no more than a distance of approximately 0.50 from the mean. The smallness of standard deviations generally indicated that the level of risk suggested by responses of the entire adolescent and parent normative sample closely reflected the sample mean score. For both genders and all age groups, mean scores did not exceed a score of 2.0, once again indicating that this participant sample described a profile of low risk, and in some instances appeared to depict a level of nil risk. This outcome was especially evident in the responses of 12 and 13 year old males and females for the factor of Peer Modelling.

Mean score differences were apparent between males and females across all age groups. Males recorded the higher mean score, and differences in mean scores for both males and females gradually increased with age. There were more noticeable mean score differences between adolescents and parents, with parents recording the lower
mean score. According to the risk continuum from low risk to high risk, adolescents generally viewed their behaviour and beliefs as indicating a higher level of risk than did their parents, even at the lower age groups. Adolescent males considered their behaviour and beliefs to be at a higher level of risk than females, although not greatly so. Mean scores and standard deviations of mothers and fathers were similar, generally indicating a congruency of perception regarding their son or daughter’s level of risk. However, for both parents and adolescents, the low values in mean scores and standard deviations across all age groups indicated a participant group that belonged to a very low category of at-risk behaviour. Multivariate and univariate analyses of variance for all factor mean scores will be discussed in a later section of this chapter.

6.2.3.2 The Self-Perception of Risk Questionnaire. The mean scores and standard deviations for adolescent and parent responses to the one factor of the Self-Perception of Risk Questionnaire were also examined to obtain a profile of the normative adolescent and parent sample in relation to the meaning of this factor. These mean scores and standard deviations have been presented in Table 6.13.
Table 6.13
Mean scores and standard deviations for the Self-Perception of Risk Questionnaire.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Adolescent Male n = 174</th>
<th>Adolescent Female n = 208</th>
<th>Mother n = 273</th>
<th>Father n = 198</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>12.0-12.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.08 (.18)</td>
<td>1.01 (.05)</td>
<td>1.04 (.12)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.01 (.04)</td>
<td>1.01 (.05)</td>
<td>1.00 (.00)</td>
<td></td>
</tr>
<tr>
<td>13.0-13.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.09 (.20)</td>
<td>1.06 (.18)</td>
<td>1.03 (.14)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.08 (.26)</td>
<td>1.00 (.00)</td>
<td>1.00 (.00)</td>
<td></td>
</tr>
<tr>
<td>14.0-14.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.27 (.47)</td>
<td>1.03 (.11)</td>
<td>1.00 (.00)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.07 (.14)</td>
<td>1.02 (.09)</td>
<td>1.02 (.09)</td>
<td></td>
</tr>
<tr>
<td>15.0-15.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.22 (.42)</td>
<td>1.00 (.00)</td>
<td>1.01 (.06)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.20 (.53)</td>
<td>1.01 (.09)</td>
<td>1.01 (.05)</td>
<td></td>
</tr>
<tr>
<td>16.0-16.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.14 (.23)</td>
<td>1.05 (.15)</td>
<td>1.00 (.00)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.08 (.22)</td>
<td>1.01 (.06)</td>
<td>1.09 (.38)</td>
<td></td>
</tr>
</tbody>
</table>

From Table 6.13 it can be seen that, with the exception of 14 and 15 year-old males, and 15 year-old females, there was a close approximation between the mean scores of parents and adolescents, and between the mean scores of mothers and fathers. Males between 14 years of age and 16 years of age indicated mean scores that were slightly higher than mean scores for males between 12 years of age and 13 years of age. This was not surprising since increases in age also mirror increases in the amount of perceived or actual risk in adolescent activity (Loeber et al., 1998). Hence a priori logic would suggest that if the adolescent was aware of the presence of risk in a certain domain of activity (particularly peer-related behaviour that might occur away from the protective environment of the home) then it would stand to reason that he or she would also be conscious of the potential for personal risk. By comparison, the mean scores for females were remarkable. Although differences in mean scores between males and females appeared to be very marginal across all age groups, mean scores for females
remained constantly low across age groups. This outcome possibly indicated the
propensity for males more so than females to become involved in problem behaviour
(Moffitt et al., 2001; Moon, Hecht, Jackson & Spellers, 1999). Lower mean scores for
females also suggested the need for further research into differences between the nature
of male and female related behaviour (Khoury, 1998). In spite of these differences and
increases, however, the mean scores for males and females did not indicate a high self-
perceived risk for future problems in behaviour based on current behavioural patterns.

In comparison to the mean scores for males and females, the mean scores for
mothers and fathers were notably low from 12 years of age onwards, remaining at this
low level across all ages and for both genders. Parental mean scores indicated that
mothers and fathers did not perceive their son or daughter as being at risk for future
problem behaviour, regardless of age or gender. Standard deviations were also
extremely small for adolescents and parents, and across age and gender, generally
indicating that individual responses of the adolescent and parent normative sample
closely reflected the sample mean score. The low values of mean scores and standard
deviations for both parents and adolescents were not surprising, given the low level of
risk indicated by the three factors of the Interpersonal Support Questionnaire (ISQ).
Table 6.13 has been reproduced in the TANDEM intervention package for use in the
clinical setting.

6.2.3.3 The Parent Resilience Questionnaire. The mean scores and standard
deviations for the responses of mothers and fathers to the two factors of General
Resilience and Support of a Significant Other comprising the Parent Resilience
Questionnaire (PRQ) were also examined. These values have been presented in
Table 6.14.
Table 6.14
Mean scores and standard deviations for *General Resilience* and *Support of a Significant Other (SSO)* across age and gender.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male n = 174</th>
<th>Female n = 208</th>
<th>General Resilience</th>
<th>Support of a Significant Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mother n = 273</td>
<td>Father n = 198</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>12.0-12.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4.12 (.34)</td>
<td>4.02 (.69)</td>
<td>4.00 (.89)</td>
<td>3.86 (.76)</td>
</tr>
<tr>
<td>Female</td>
<td>4.09 (.58)</td>
<td>4.00 (.76)</td>
<td>3.98 (1.01)</td>
<td>3.68 (1.37)</td>
</tr>
<tr>
<td>13.0-13.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4.00 (.48)</td>
<td>3.90 (.91)</td>
<td>3.95 (.94)</td>
<td>3.52 (1.2)</td>
</tr>
<tr>
<td>Female</td>
<td>4.09 (.54)</td>
<td>3.98 (.72)</td>
<td>3.98 (.97)</td>
<td>3.80 (1.07)</td>
</tr>
<tr>
<td>14.0-14.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4.30 (.46)</td>
<td>4.20 (.50)</td>
<td>4.56 (.54)</td>
<td>4.23 (.72)</td>
</tr>
<tr>
<td>Female</td>
<td>4.10 (.57)</td>
<td>3.92 (1.18)</td>
<td>3.97 (1.09)</td>
<td>4.07 (1.11)</td>
</tr>
<tr>
<td>15.0-15.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4.31 (.42)</td>
<td>4.16 (.38)</td>
<td>4.06 (.96)</td>
<td>3.85 (1.06)</td>
</tr>
<tr>
<td>Female</td>
<td>4.11 (.45)</td>
<td>3.87 (.74)</td>
<td>3.91 (1.10)</td>
<td>3.86 (1.06)</td>
</tr>
<tr>
<td>16.0-16.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4.31 (.45)</td>
<td>3.93 (.61)</td>
<td>4.05 (.93)</td>
<td>4.00 (1.05)</td>
</tr>
<tr>
<td>Female</td>
<td>3.76 (.69)</td>
<td>3.98 (.38)</td>
<td>3.76 (.84)</td>
<td>3.50 (1.20)</td>
</tr>
</tbody>
</table>

The findings recorded in Table 6.14 indicate that, according to the five-point Likert scale used for this questionnaire, the mean scores for mothers and fathers were generally high for each factor, irrespective of the age or gender of the adolescent, with the mean scores for mothers being marginally higher than the mean scores for fathers. Therefore mothers and fathers appeared to enjoy generally high levels of resilience as well as feeling the supportive presence of another significant person. The close similarities between the mean scores for mothers and fathers in relation to the two factors indicated a positive mutuality in the way they felt about issues involving their sons or daughters. Standard deviations for the factor of *Support of a Significant Other* were marginally higher for mothers and slightly higher again for fathers in comparison...
to the factor of General Resilience. These scores suggested that responses of mothers and, in particular of fathers, to the factor of Support of a Significant Other were slightly more varied in relation to the mean score. The small number of items would most likely have acted as a contributing factor in this circumstance. However, while standard deviations for the factor of Support of a Significant Other were evidently higher, the overall variance was small. Table 6.14 has been reproduced in the TANDEM intervention package for use in the clinical setting.

6.2.3.4 Multivariate and univariate analyses of normative sample data. While mean score differences were generally found between adolescent males and females, between adolescents and parents, and between mothers and fathers for the three factors of the Interpersonal Support Questionnaire (ISQ), the one factor of the Self-Perception of Risk Questionnaire (SPRQ), and the two factors of the Parent Resilience Questionnaire (PRQ), it remained to ascertain whether these differences were statistically significant or not. In order to examine the effects of gender, age, and relationship between adolescents, mothers, and fathers, two separate analyses were conducted. The term “relationship” was used as an umbrella term for the relationship between adolescents and their parents, and between mothers and fathers.

The first analysis measured the interaction effects of the independent variables of relationship and age group, with the dependent variables for this analysis being the three factors of the ISQ, the one factor of the SPRQ, and the two factors of the PRQ. The second analysis measured the interaction effects of the independent variables of relationship and gender. The dependent variables for this second analysis were the same as for the first analysis. The independent variable of age group was organised differently for statistical purposes, for the following reason. The majority ages of adolescents who were 12 years to 12 years 11 months clustered closely around the top end of this age-
range, meaning that the majority of these adolescents were close to 13 years of age. Therefore this group was combined with adolescents who were 13 years to 13 years 11 months to ensure adequate statistical power. The variable of age group was therefore arranged into four partitions, namely 12 years to 13 years 11 months, 14 years to 14 years 11 months, 15 years to 15 years 11 months, and 16 years to 16 years 11 months.

**Relationship and age.** At the first instance, a multivariate analysis of relationship by age was undertaken for the three factors of the ISQ. At the multivariate level, statistically significant differences were separately found for relationship (Pillai’s T = .501, F(6.00, 180) = 30.08, p<.001, η² = .501) as well as for age (Pillai’s T = .187, F(9.00, 555) = 4.10, p<.001, η² = .062). A significant multivariate interaction was also found between age and relationship (Pillai’s T = .188, F(18.00, 546) = 2.03, p<.01, η² = .063). When the interaction effects were examined for each factor of the Interpersonal Support Questionnaire, the interaction between relationship and age was found to be significant only for Peer Modelling (Greenhouse-Geiser F(5.34, 329.00) = 5.91, p<.001, η² = .09) and Parent/Family Relationships (Greenhouse-Geiser F(5.15, 317.55) = 2.73, p<.05, η² = .04).

Interactions between relationship and age were further analysed by examining simple main effects. Firstly, no statistically significant differences were found between mothers and fathers for any age group among any of the three factors of the ISQ. In order to examine simple main effects, multiple pairwise comparisons were conducted between relationship status and each adolescent age group. Results of these comparisons indicated significant differences at various ages between adolescents and parents for each of the three factors of the ISQ. In the following presentation of mean score differences, “mean difference” has been abbreviated to “MD”, and “standard error” has been abbreviated to “SE”.
For Peer Modelling, mean score differences were statistically significant at across all ages between adolescents and both parents. Fathers’ results for this factor have been placed in round brackets. Significant mean score differences were found between adolescents and each parent at 12 to 13 years 11 months
\[\text{MD}=0.117 \ (0.092), \ SE=0.030 \ (0.032), \ p=0.000 \ (0.014)\], at 14 to 14 years 11 months
\[\text{MD}=0.279 \ (0.262), \ SE=0.044 \ (0.047), \ p=0.000 \ (0.000)\], at 15 to 15 years 11 months
\[\text{MD}=0.346 \ (0.345), \ SE=0.044 \ (0.047), \ p=0.000 \ (0.000)\], and finally at 16 to 16 years 11 months \[\text{MD}=0.260 \ (0.262), \ SE=0.063 \ (0.067), \ p=0.000 \ (0.000)\].

For Parent/Family Relationships, significant mean score differences were first found between adolescents and mothers only occurred at 12 to 13 years 11 months \(\text{MD}=0.121, \ SE=0.045, \ p=0.024\). Significant mean score differences for Parent/Family Relationships were not evident again until 15 years of age. At this juncture, mean score differences were found between adolescents and each parent at 15 to 15 years 11 months \[\text{MD}=0.361 \ (0.324), \ SE=0.066 \ (0.069), \ p=0.000 \ (0.000)\], and at 16 to 16 years 11 months \[\text{MD}=0.296 \ (0.316), \ SE=0.094 \ (0.099), \ p=0.006 \ (0.005)\].

Finally, the overall univariate interaction between relationship and age for Parental Monitoring/Limit Setting was statistically non-significant. However, when the simple main effects were analysed for this factor, multiple pairwise comparisons indicated significant mean score differences between adolescents and both parents across all ages. In recording these mean score differences, the findings for fathers have been placed in round brackets. For the factor of Parental Monitoring/Limit Setting, significant mean score differences were found between adolescents and each parent at 12 to 13 years 11 months \[\text{MD}=0.380 \ (0.279), \ SE=0.055 \ (0.047), \ p=0.000 \ (0.000)\], at 14 to 14 years 11 months \[\text{MD}=0.500 \ (0.405), \ SE=0.080 \ (0.068), \ p=0.000 \ (0.000)\], at 15 to 15 years 11
months [$\text{MD}=.451 (.347), \text{SE}=.080 (.068), p=.000 (.000)]$, and at 16 to 16 years 11 months [$\text{MD}=.326 (.408), \text{SE}=.114 (.097), p=.014 (.000)]$.

The findings for each of the three factors indicated that mothers and fathers were consistently in agreement with each other about their son or daughter’s behaviour, even though differences in perception between their adolescent children and themselves were evident. For the two factors of Peer Modelling and Parental Monitoring/Limit Setting divergent perceptions about the risk-level of adolescent behaviour were evident between adolescents and parents from 12 years of age onwards. The mean scores for these two factors indicated that adolescents believed their behaviour reflected a higher level of risk than did their parents. For the factor of Parent/Family Relationships, 15 and 16 years of age appeared to indicate the point of divergence between adolescent and parent’s perceptions about risk level in relation to the quality of the parent-adolescent and family-adolescent relationship, although one isolated significant mean score difference occurred between adolescents and mothers at 12 to 13 years 11 months.

**Relationship and gender.** Secondly, the effects of relationship and gender for the three factors of the ISQ were examined. At the multivariate level, statistically significant differences were again found for relationship (Pillai’s $T = .485$, $F(6.00, 182) = 32.25, p<.001, \eta^2 = .515$). While an overall non-significant difference was found for gender at the multivariate level, at the univariate level a significant gender difference was found for the factor of Peer Modelling (Greenhouse-Geiser $F(1.72, 320.73) = 3.73, p<.05, \eta^2 = .020$). Furthermore, at the level of simple main effects, multiple pairwise comparisons indicated significant mean score differences between males and their parents, and females and their parents, for each factor of the ISQ. In presenting these values, mean score differences between males and females and their fathers have been recorded in round brackets for each factor.
For the factor *Peer Modelling*, mean score differences were found between males and parents [MD = .277 (.237), SE = .031 (.034), p = .000 (.000)] and between females and parents [MD = .166 (.172), SE = .029 (.031), p = .000 (.000)]. For the factor *Parent/Family Relationships*, mean score differences were found between males and parents [MD = .207 (.158), SE = .046 (.048), p = .000 (.004)], and females and parents [MD = .190 (.194), SE = .043 (.045), p = .000 (.000)].

Finally, for the factor *Parental Monitoring/Limit Setting*, mean score differences were found between males and parents [MD = .462 (.379), SE = .055 (.046), p = .000 (.000)], and females and parents [MD = .376 (.297), SE = .050 (.043), p = .000 (.000)]. These significant mean score differences suggested that when comparisons were drawn between the perceptions of males and their parents, and the perceptions of females and their parents, males rather than females saw themselves as being at higher risk than did their parents in relation to the meaning of each factor of the *ISQ*.

The interaction between gender and age was also considered for adolescents only. At the multivariate level, and across all factors of the *ISQ*, statistically significant differences were found between adolescents for age (Pillai’s T = .221, F(9.00, 1110) = 9.82, p < .001, $\eta^2 = .074$) and for gender (Pillai’s T = .047, F(3.00, 368) = 6.10, p < .001, $\eta^2 = .047$). However, the interaction between age and gender was non-significant for the factors of *Peer Modelling*, *Parent/Family Relationships*, and *Parental Monitoring/Limit Setting*. That is, differences in risk perception between males and females in relation to these three factors remained constant across all age groups.

In summary, it appeared that mothers and fathers were constantly in agreement about their perceptions of the risk entailed in their sons’ or daughters’ behaviour in relation to the three factors of the *Interpersonal Support Questionnaire*. This occurred
for every age. However, for the factors of Peer Modelling and Parental Monitoring/Limit Setting, the risk perception of adolescents diverged from that of their parents from 12 years of age onwards. For the factor Parent/Family Relationships, this divergence occurred from 15 to 16 years of age onwards. Furthermore, when differences in risk perception were examined between males and females and their parents, males reported higher levels of risk perception than females when compared to the risk perceptions of their parents. This was so for each factor of the ISQ. Finally, the differences between males and females in relation to risk perception remained constant across all age groups.

6.2.3.5 Univariate analysis for the Self-Perception of Risk Questionnaire. At the univariate level, statistically non-significant interactions were found for the one factor of the Self-Perception of Risk Questionnaire between relationship and gender, and relationship and age. It appeared therefore that parents and adolescents were in agreement over the level of risk exhibited by adolescents’ behaviour, with this agreement remaining constant across age and gender.

6.2.3.6 Multivariate analyses of the Parent Resilience Questionnaire. With regard to the Parent Resilience Questionnaire (PRQ), multivariate analyses were conducted for the factors of General Resilience and Support of a Significant Other to examine the interaction effects of adolescents and mothers and fathers in terms of age and gender. For this analysis, gender referred to the parent-son or parent-daughter relationship. A statistically significant difference was found between mothers and fathers (Pillai’s $T = .074$, $F(2.00,184) = 7.32$, $p<.001$, $\eta^2 = .074$). At the univariate level this difference was significant for the factor of General Resilience (Greenhouse-Geiser $F(1.00, 185.00) = 6.11$, $p<.014$, $\eta^2 = .032$) and the factor of Support of a Significant Other (Greenhouse-Geiser $F(1.00, 185.00) = 12.63$, $p<.000$, $\eta^2 = .064$). However, a
statistically non-significant interaction was found between parents and gender, and parents and age group. Therefore sentiments surrounding personal resilience and the support of another significant person differed between mothers and fathers, and these differences remained constant across adolescent gender and age.

6.2.4 Discussion concerning normative data other than substance use

As indicated by the Interpersonal Support Questionnaire (ISQ) and the Self-Perception of Risk Questionnaire (SPRQ), the descriptive statistics of the normative sample depicted a behavioural profile of extremely low levels of harmful risk. Mean scores of these adolescents and parents generally clustered around a mean score value that was no higher than 2.0 on a Likert scale of one to four, where a score of two represented a response of either “sometimes” or “a few”. While increases in adolescent mean scores were found as age increased, the size of these increases was not of clinical concern. Research has indicated that adolescent risk behaviour will become more prominent as age increases, although this would not necessarily suggest the presence of problem behaviour. Research has also noted that the tendency to be drawn towards elements of risk in behaviour, and to under-rate the level of risk involved, is coincidental with progressive adolescent development (Lightfoot, 1997; Steinberg, 1996).

Therefore, comparable increases between mean scores and age for the normative adolescent sample was not unexpected. At the same time, the tendency of adolescents to under-rate the level of risk exhibited in their behaviour would indicate a potential for harm, with the adolescent also possibly under-reporting his or her realized levels of behavioural risk. Therefore, responses of the normative adolescent and parent sample suggested adaptive, beneficial, and safe peer-related activities, close monitoring and limiting of the adolescents’ behaviour by parents, and healthy relationships in the home.
environment with parents and family. Finally, as would be anticipated with a low-risk profile, adolescents and parents did not anticipate future behavioural problems on the basis of current behaviour.

The clinical usefulness of normative data emerged from the primary reason for developing the *Adolescent Problem Behaviour Assessment (APBA)*, namely to *describe* adolescent behaviour within the context of a clinical interview, rather than confidently *diagnose* the level of risk present in an adolescent’s behaviour. Furthermore, other assessment instruments might also be administered to either support the findings of the *APBA*, to clarify isolated concerns that might underlie an adolescent’s behaviour, or to dispel any presenting concerns. The *APBA* was not designed as a ‘stand-alone’ instrument for identifying the presence of problem-prone adolescent behaviour. With such a low-risk normative profile, any divergence away from this profile of a referred adolescent’s behavioural pattern would be relatively easy to identify.

At the same time one would need to be cautious in determining the actual level of harm entailed in the adolescent’s behavioural pattern since the possibility would exist of falsely identifying behaviour as problem-prone. Therefore, assessment evidence indicating that a referred adolescent’s behaviour diverged from a low-risk baseline would not automatically indicate the presence of problematic at-risk behaviour. Furthermore, the *APBA* displayed insufficient sensitivity to reliably classify an adolescent’s behavioural profile along a continuum from low risk to the threshold of high risk (see section 5.3.3 of chapter five).

In situations where a referred adolescent’s behaviour notably diverged from the normative baseline of the *APBA*, a cautious and prudent conclusion would be that the particular adolescent might be demonstrating proneness towards problem behaviour. Such a conclusion would also become the focus of discussion between the clinician and
adolescent or parent, or both. This conclusion would vary in accordance with the amount of divergence evident in the assessment of the referred adolescent’s behaviour.

Given that the above need for caution would exist, the assessment questionnaires comprising the Adolescent Problem Behaviour Assessment (APBA) would still exercise a valuable role in the identification of adolescent at-risk behaviour. Slade, Thornicroft & Glover (1999) defined the feasibility of an assessment instrument as being a psychometric property in itself. They described the feasibility of an assessment instrument as indicating “the extent to which it is suitable for use on a routine, sustainable and meaningful basis in typical clinical settings, when used in a specified manner and for a specified purpose” (p.6). Slade et al. (1999) further defined a meaningful assessment as one where psychometric properties developed in a research setting have been preserved in a routine clinical setting. They understood a clinical setting as one where staff members are not routinely involved in research. Slade et al. (1999) further understood a specified manner as indicating what is being assessed, the place where assessment occurs, and the one qualified to undertake the assessment. Finally, they defined a specific purpose as identifying the use to which the information derived from the assessment would be put.

The APBA fulfils these requirements. While the APBA is yet to be psychometrically validated, the various factors of this assessment instrument were determined from sound psychometric processes. These factors demonstrated the ability to clinically describe the profile of an adolescent’s behaviour, and so interpret this behaviour in accordance with the results derived from these factors. Furthermore, the APBA has been designed for use by a clinician within a clinical setting, for the purpose of describing the potential for adolescent at-risk behaviour, and for discussing the assessment outcome with the parent and, where possible, the adolescent. The clinician
would be one suitably qualified to identify the type of adolescent behaviour that would eventuate in conflict with legal authorities, or compromise the health and safety of the adolescent and those who moved within his or her sphere of relationship, were this behaviour left unattended. Finally, the notion of a clinical setting described the specific purpose of conducting a clinical interview and intervention, although research may also occur as an outcome of that clinical work. Therefore, within the definitive boundaries imposed by Slade et al. (1999), the APBA would offer a useful and appropriate means of assessing proneness towards adolescent problem behaviour, either in its own right or as a supplement to other routes of clinical assessment.

The relevance of normative data for each questionnaire comprising the APBA apart from the Adolescent Drug Use Questionnaire (ADUQ), which was discussed in section 6.1.4, will now be discussed separately.

**The Interpersonal Support Questionnaire.** When each factor of the Interpersonal Support Questionnaire (ISQ) was examined at the univariate level, there were indications that at various ages the mean scores for adolescents differed significantly from the mean scores for parents. For the factor of Peer Modelling and Parental Monitoring/Limit Setting, these differences were significant from 12 years of age onwards, while for the factor of Parent/Family Relationships differences were statistically significant from 15 to 16 years of age onwards.

Divergences in risk perception between parents and adolescents for each of these factors reflected the influence of adolescent autonomy (Noack & Puschner, 1999). The adolescent mean scores for the factor of Peer Modelling increased as age increased, suggesting those adolescents’ perceptions of risk level increased as age increased. That is, as adolescents grew older, they appeared to believe that mingling with their friends was leading them further into situations of risk, even though the level of this risk may
not have been high. It is possible that older adolescents would be more aware of potential risk entailed in peer-related activities. Furthermore, the mean scores for parents in relation to this factor were small from 12 years of age, and continued to be noticeably smaller than adolescent mean scores across the age span. This result indicated that, unlike adolescents, parents did not at any time see their son or daughter as being exposed to any level of risk because of the type of behaviour they shared with their peers.

These findings pointed to the increasing influence of adolescent autonomy. As the individual progresses through the stages of adolescent development, it is likely that parents will not be privy to what happens with their son or daughter when he or she is away from home and mixing with the peer group. Consequently the adolescent and not the parent would directly experience situations of harmful risk simply because the adolescent was actually involved in those situations. From the mean score findings, this gradual separation of awareness between parents and adolescents appeared to be most evident from 14 years of age onwards, though it initially became evident at the relatively young age of 12 years.

The unavoidable reality of the adolescent’s ongoing need for personal autonomy from the control of parents reinforces the importance of establishing a bond of trust and openness between parent and adolescent not only during adolescence but also prior to this stage of development. Findings indicating the age-related divergence between the perceptions of adolescents and parents about risk once more called for the development of a specially structured parent version of the APBA. A specific parent version would take into account the parent’s perception of the amount of risk entailed in the son or daughter’s activities without having to rely on questionnaire items that reflected risk behaviour from a specifically adolescent viewpoint.
The pattern of parent mean scores for Parental Monitoring/Limit Setting was similar to that of Peer Modelling in that the mean scores of parents increased in size along with adolescent age, although at 15 and 16 years of age, parents’ mean scores were higher than for Peer Modelling. Following pairwise comparisons, significant mean score differences were also found between adolescents and parents across all ages. The comparison between adolescent and parent mean scores for this factor appeared to indicate that adolescents saw themselves as having their activities more strictly monitored and limited by parental authority than did their parents. This finding for Parental Monitoring/Limit Setting was an interesting finding in relation to the low level of risk indicated by the normative sample of parents and adolescents. Competent monitoring and limit setting by parents in relation to adolescent activities has been highlighted as a prerequisite for effective family management practices and healthy adolescent development (Dishion et al., 1999; Dishion & McMahon, 1998). Careful monitoring has been described as a common denominator by a variety of intervention and developmental theories concerning parenting practices (see especially Dishion & McMahon, 1998, p.63). The higher mean scores of adolescents in comparison to parents for this factor, and the statistically significant differences between these mean scores across all ages, appeared to support the link between avoidance of adolescent problem behaviour through effective parental monitoring and limiting practices. That is, these adolescents were a low risk sample, and yet they viewed themselves as being more closely monitored and limited in their activity than did their parents.

The mean scores of both parents and adolescents at 12 years of age reflected mean scores for adolescents at 16 years to 16 years 11 months, with the mean scores of parents closely resembling the mean scores of adolescents. However, a statistically significant interaction between age and relationship for Parent/Family Relationships
was evident from 15 years of age onwards. From this age on, the differences between adolescents and parents concerning beliefs about the quality of relationship within the family environment were statistically significant. Similar to the factors of Peer Modelling and Parental Monitoring/Limit Setting, the divergence between mean scores of adolescents and parents for the factor of Parent/Family Relationships quite possibly mirrored the influence of adolescent autonomy. For the older adolescent, becoming one’s own person would very likely involve the need to also see oneself as separated from the seemingly restrictive bonds of parents and family. Increases in cognitive flexibility for the adolescent would also indicate a readiness to interpret family interactions over and against his or her own outlook on life, and at times even misinterpret these interactions. As they grew older, the adolescent sample appeared to experience increasing difficulties in parent and family relationships. On the other hand, their parents seemed to maintain a constant outlook with regard to their adolescent’s relationship to them and their family, even though mean scores of parents for Parent/Family Relationships, when compared to mean scores of parents for Peer Modelling and Parental Monitoring/Limit Setting were higher from the outset. However, parents did not appear to view levels of risk described by the meaning of Parent/Family Relationships as being overly serious, although the meanings of items for this factor, and parents’ mean scores for this factor, suggested that they believed that antagonism did exist to some extent between themselves and their son or daughter.

The findings of the two factors of Peer Modelling and Parent/Family Relationships suggested important implications for adolescent risk. Supportive and positive parent and family relationships would suggest a decrease in the likelihood of the adolescent’s involvement with deviant peer groups. In situations of dysfunctional parent-adolescent relationships and fractured home environments, the adolescent would
be more likely to seek out peer groups from a similar background. This has been identified as the ‘flight to peer’ concept (Dishion & McMahon, 1998). Furthermore, where the adolescent’s respect for his or her parents has diminished, or in particular has been lost altogether, then the dysfunctional peer group would be more likely to represent the primary formative influence upon the developing attitudes and beliefs of the adolescent.

Fifteen and 16 years of age appearing to be the critical point of divergence between the perceptions of adolescents and parents concerning the level of risk entailed in the adolescent’s behaviour. That is, as adolescents grew older, parents seemed to become less cognizant about their son or daughter’s peers or peer-related activities, and less aware of how he or she saw parent/family relationships. This not only emphasised the need for parents to continually aim at maintaining a healthy and communicative relationship with their adolescent son or daughter, but also indicated that this relationship needed to be struck at an age prior to adolescence. It also pointed to the somewhat disturbing possibility that if a dysfunctional peer group has replaced the influence of parents and family as the adolescent’s primary point of reference, then turning this about would arguably be a difficult task.

Therefore, while a clinician might need to guard against falsely assessing an adolescent’s behaviour as being problem-prone, any remarkable movement away from the profile of behaviour and parental involvement as described by the normative adolescent sample would need to be closely investigated. The importance of identifying proneness towards adolescent problem behaviour as early as possible cannot be overstressed. Finally, although mean scores appeared to notably differ between males and females, there were no statistically significant gender differences either between the adolescents themselves or between sons and daughters and their parents. This was an
interesting finding, since males have been shown to exhibit more aggressive externalising behaviour than females (Khoury, 1998; Moffitt et al., 2001; Vega et al., 1998).

**The Self-Perception of Risk Questionnaire.** A univariate analysis of the *Self-Perception of Risk Questionnaire* (SPRQ) indicated no statistically significant differences between the adolescents themselves, or between adolescents and parents, regardless of gender. These findings suggested that adolescent participants did not see themselves as being at risk of future problem behaviour, nor did their parents perceive them as being so. The ratings of teachers generally corroborated these findings. This outcome would appear to be a logical one given that the responses of adolescents and parents to the *Interpersonal Support Questionnaire* (ISQ) in particular did not indicate proneness towards problem behaviour. One would not expect either adolescents or parents to fear future occurrences of problem behaviour if present behaviour appeared to be adaptive and free of any harmful at-risk characteristics.

**The Parental Resilience Questionnaire.** Multivariate analyses were conducted for the two factors of the *Parent Resilience Questionnaire* (PRQ), namely *General Resilience* and *Support of a Significant Other*, to examine the effects of the parent-adolescent relationship and adolescent gender. At the multivariate level, no statistically significant interaction occurred between male and female adolescents and parents at any age. At the univariate level, a significant difference was found between mothers and fathers for the factors of *General Resilience* and *Support of a Significant Other*. According to these findings, mothers appeared to differ from fathers in the way each group perceived their own overall level of resilience, as well as the support they received from another significant person. Mean scores for each factor further indicated that mothers experienced slightly higher levels of resilience and support than did
fathers, although the mean scores of fathers and mothers suggested that the sense of resilience and support was generally high.

Given that the behaviour of adolescent participants indicated a low level of risk, it would reasonably be expected that a parent’s resilience would not be vulnerable to erosion. It was therefore conceivable that low risk behaviour by an adolescent son or daughter would lead to stronger feelings of resilience, simply because there appeared to be little or nothing in terms of aberrant behaviour from which to “bounce back”. Secondly, it would also seem logical that where the behaviour of a son or daughter did not subject a parent’s level of resilience to fragmentation, this in turn would assist the parent in retaining sufficient reserves of energy to maintain a healthy lifestyle for the son or daughter. Additionally, strong resilience would be likely to maintain or even increase the sense of parental self-efficacy enjoyed by the mother or father. If, in everyday situations, the adolescent’s behaviour was not constantly chipping away at the parent’s authority or undermining the well-being and happiness of the home environment, then the parent would most likely feel good about being a parent.

A similar conclusion might also be drawn about having the support of another significant person. If a parent were to feel that he or she was able to rely on the support of someone else while carrying out the parental role, then feeling efficacious about oneself as a parent would very likely be strengthened as a result. This would be particularly so when hard decisions that opposed the adolescent’s wishes were required. Hence, there appeared to be a link between the apparently effective monitoring and limit setting strategies of parents and parents’ sense of resilience and another’s support.

*Clinical implications.* How a clinician would use these normative data would be linked to the overall assessment process including questionnaire responses by the parent and discussion between clinician and parent about the referred adolescent’s behaviour.
The small sizes of standard deviations for the Interpersonal Support Questionnaire and the Self-Perception of Risk Questionnaire posed issues for the clinical use of normative data for these questionnaires. The sensitivity of these questionnaires to classify risk level was insufficient to determine a referred adolescent’s risk level according to the number of standard deviations from the normative mean score. Furthermore, this approach would place the APBA within the category of a stand-alone diagnostic measure of behavioural risk, which was not the purpose envisaged for the APBA. Rather, the APBA was designed to facilitate discussion between parent and clinician about a referred adolescent’s possible at-risk lifestyle.

Nonetheless, the issue of effectively using the APBA within the clinical arena for the assessment of adolescent risk across all behavioural domains still required resolution. The researcher resolved this issue by using the concept of a confidence interval. Therefore for the Interpersonal Support Questionnaire and the Self-Perception of Risk Questionnaire, a drift greater than 0.10 (or beyond the 90% confidence interval) away from the normative mean score was considered sufficient to warrant further investigation with the parent into the adolescent’s behaviour. This decision addressed the issue of sensitivity in relation to the APBA. That is, identifying a drift away from normative data in a referred adolescent’s mean score rather than attempting to locate the adolescent’s mean score according to standard deviations away from any normative mean score indicated either the beginnings or the extent of problem behaviour rather than classifying the adolescent’s behaviour into a particular quartile of risk. For example, when considering the mean score of a referred 13 year-old male adolescent for the factor of Peer Modelling ($M = 1.37$), a clinician would note a score either equal to or greater than $M = 1.47$ as possibly indicating either the beginnings or established presence of harmful risk in relation to modelling peer behaviour. This finding would
also be considered in relation to other findings for the APBA. As a further example, a mean score that approximated a level of 2.0 would indicate that the adolescent was engaging in at-risk behaviour sometimes or more, or was involved in at-risk situations a few times or more, whereas the normative group would have reported either never or none in relation to at-risk behaviour (an approximate level of 1.0).

A lack of age-related concordance was found between normative adolescent and parent descriptive data. This would need to be taken into account in the clinical use of the APBA where only the parent of a referred adolescent was available to complete the APBA. In this case, the mean score findings recorded for the parent’s responses would be compared with both parent and adolescent data. If the parent’s mean scores for the adolescent’s behaviour compared favourably with normative parent data, and yet were lower than the mean scores for related normative adolescent data, then it might be concluded that while the parent’s knowledge of the referred adolescent’s behaviour was comparable to that of the relevant normative parent sample, at the same time there might be problems present in the adolescent’s behaviour. The absence of adolescent data would not automatically indicate that adolescent problem behaviour was present.

A parallel approach of using a 90% confidence interval was taken in assessing the parent’s level of resilience and support of a significant other according to the Parent Resilience Questionnaire, except that in the case of this questionnaire a drift less than 0.10 in comparison to normative data indicated the possibility of reduced levels of resilience or support of a significant other. Concordance was not an issue for consideration with the Parent Resilience Questionnaire.

A similar situation existed for the clinical use of the Adolescent Drug Use Questionnaire. In the case of this questionnaire, normative data was recorded in percentage values. A confidence interval of 95% was chosen for this questionnaire,
since this value represented the responses of approximately 95% of the normative sample of adolescents and parents. Hence, a substance frequency or amount reported by a referred adolescent or the parent that reflected the lower 5% (or beyond the 95% confidence interval) of the normative adolescent or parent sample would represent a possible cause for concern. For example, if the amount of alcohol use was reported as being equal to or greater than 3.5 drinks over the previous four weeks (the amount reported by 4.3% of the adolescent sample) for the above 13 year-old male adolescent, then this amount might indicate the beginnings or established presence of problem behaviour. Once again, this finding would need to be considered in relation to the percentage values for the remaining reports of amounts and frequencies of substance use, as well as other domains of adolescent behaviour.

The issue of concordance between parent and adolescent responses for alcohol, tobacco, and marijuana use was also considered. While a lack of concordance was understandable and generally minimal, it was nonetheless apparent. As with the Interpersonal Support Questionnaire and the Self-Perception of Risk Questionnaire, the issue of concordance would need to be considered in the clinical use of the Adolescent Drug Use Questionnaire. Where only the parent of a referred adolescent was available to complete the Adolescent Drug Use Questionnaire, then percentage values reported by the parent for frequencies and amounts of substance use would be compared to percentage values recorded for both parent and adolescent normative samples. As described above, a parent’s knowledge of the referred adolescent’s substance use might resemble the knowledge of the normative parent sample, yet if it was lower than findings for related adolescent data then the possibility of problem behaviour being evident in the adolescent’s lifestyle would need to be discussed with the parent.
concerned. However, again there would be no implication that problem behaviour was present simply because the adolescent did not complete the *APBA*.

### 6.3 Chapter Summary

This chapter firstly presented the normative data describing adolescent alcohol, tobacco, and marijuana consumption according to the *Adolescent Drug Use Questionnaire (ADUQ)*. Adolescent frequency and amounts of consumption of these three substances increased as age increased, although percentages of frequency and amount were generally small at all ages. Concordance between parents and adolescent perceptions of frequency and amounts of consumption for all three substances was inconsistent and in some cases absent, particularly from 15 years of age onwards. Positive directions in correlation were also found between the *ADUQ*, and the *Interpersonal Support Questionnaire (ISQ)* and the *Self-Perception of Risk Questionnaire (SPRQ)*.

This chapter then presented normative data in relation to the adolescent’s participation in harmful at-risk behaviour according to the *ISQ* and the *SPRQ*, as well as for the parent’s level of resilience in relation to adolescent behaviour according to the *Parent Resilience Questionnaire (PRQ)*. Concordance between parent and adolescent perceptions of harmful risk in relation to the *ISQ* and *SPRQ* was not always consistent, and tended to diverge at approximately 15 and 16 years of age for both males and females. The statistical significance of mean score differences was also analysed across age and gender for each questionnaire. Findings from these analyses generally indicated statistically significant differences between the perceptions of adolescents and parents, although mothers and fathers consistently expressed agreement about their adolescent’s behaviour. For the factors of *Peer Modelling* and *Parental Monitoring/Limit Setting* comprising the *ISQ*, mean score differences were significant from 12 years of age
onwards. For *Parent/Family Relationships*, also incorporated in the *ISQ*, mean score differences between adolescents and parents were significant from 15 years of age onwards. Differences in risk perception between males and females were statistically non-significant across all ages. No statistically significant differences were found between parents and adolescents, or between males and females, for the *SPRQ* indicating that adolescents and parents agreed that future risk identified against the background of current behaviour was not likely. Finally, with the *PRQ*, sentiments surrounding personal resilience and the support of another significant person differed between mothers and fathers, and these differences remained constant across adolescent gender and age. The clinical usefulness of this normative data, together with its intended manner of use in the clinical setting, was also outlined.

The next chapter will describe the first implementation of the TANDEM programme, including the development of the six-week parenting course, using both the *APBA* as a primary assessment instrument of adolescent behaviour and the parenting course as the principal means of intervention.
CHAPTER SEVEN
IMPLEMENTATION OF THE TANDEM PROGRAMME

This chapter will be presented in two distinct though inter-connected parts. The first part will outline the intake assessment process and the results of this assessment for each parent who requested help through the TANDEM programme (also referred to simply as TANDEM). The second part will describe the six-week parenting course that provided the intervention, together with the results of post measures of intervention effectiveness. Discussions will be presented at the conclusion of each part.

Three research questions were developed for this part of the research. Firstly, were improvements evident in levels of resilience, skill, self-efficacy, and emotional well-being for the parent as a result of participating in the TANDEM programme? Secondly, according to the perception of the parent, to what extent was the otherwise fragmenting parent-adolescent relationship strengthened as a result of benefits gained by the parent? From the perspective of a priori logic, improvements in parenting style, parental self-efficacy, and resilience that led to increases in trust, openness, and warmth of relationship between a parent and adolescent would also lead to a strengthening of protective factors within the adolescent’s lifestyle (Baumrind, 1991; Conger et al., 1994; Dishion, 1996; Dishion & Andrews, 1995; Juang & Silbereisen, 1999; Smith & Stern, 1997; Webster-Stratton, 1990). As a result, the adolescent would be less inclined to seek out the company of a dysfunctional peer group in preference to an unhappy home situation (Dishion & McMahon, 1998). Thirdly, did previously identified levels of depression, anxiety, and stress among the TANDEM sample of parents decrease by the conclusion of the programme?
7.1 Intake assessments

7.1.1 Method

7.1.1.1 Participants. A total of 22 parents sought help through the TANDEM programme. Sixteen parents were mothers, and six were fathers. Of the 22 participants, there were six partner couples. Four parents attended without their partners (with one of the four parents being a father), and six participants were single mothers. The mean age of mothers was 42.20 years, with a standard deviation of 5.74 years. The mean age for fathers was 43.29 years, with a standard deviation of 10.40 years. While the mean ages of mothers and fathers resembled each other, standard deviations indicated that mothers’ ages were closer to the mean than fathers’ ages. The range for mothers was 35 to 50 years of age, while for fathers the range was 28 to 59 years of age. Two independent programmes were conducted on a morning and evening basis. Nine mothers and one father participated in the morning programme and six mothers and six fathers participated in the evening programme. Adolescents who were the focus of parents’ concerns number 13 males and 6 females. Adolescent’s ages ranged from 11 years to 15 years 11 months (or 15.9 years). The mean age for all adolescents was 14.5 years, with a standard deviation of 1.6 years. In three cases parents were concerned for two adolescent children in their families. Following assessment and feedback of results, all parents opted to participate in the six-week TANDEM-parenting course. Two mothers were unavoidably absent for 2 sessions each, and one father was absent for one session. The remaining parents attended all sessions.

7.1.1.2 Instruments

The Adolescent Problem Behaviour Assessment (APBA). Parent and adolescent versions of the Adolescent Problem Behaviour Assessment (APBA) were used to ascertain the presence and intensity of adolescent at-risk behaviour. The parenting
course was considered suitable for parents where assessment outcomes of the APBA indicated that an adolescent’s behaviour was at least exhibiting the beginnings of harmful risk. The development of the APBA has been detailed in chapter five. As part of the assessment procedure of the TANDEM programme, three scales were added to the parent version of the APBA. These were The Parental Knowledge Scale, The Parental Feeling Scale, and the Stressors Scale. The Depression Anxiety Stress Scales – 21-item version (DASS 21) was also included with the APBA as a measure of depression, anxiety, and stress (see the TANDEM intervention package for the format of the APBA as it was administered within the TANDEM programme). Each additional scale, as well as the DASS 21, will now be described.

The Parental Knowledge Scale and The Parental Feeling Scale.

Rationale for developing both scales. The concepts of self-efficacy and skill competency are both cognitive and affective. This notion would therefore emphasise the importance of the way people both think about their personal abilities and feel about the way they deal with and control the challenges of life (Rutter, 1987). Self-efficacy implies a person’s belief that he or she possesses the attributes necessary to bring about some desired end. For parents, this end would focus on effective family management and a strong parent-adolescent bond. Skill competency refers to knowledge of parenting skills that would lead to this sense of self-efficacy. As such, both concepts are interrelated. Strong self-efficacy encourages the confidence to learn to be competent and so be (or feel) competent. In turn, the possession of appropriate and adequate parenting skills encourages helpful self-efficacy. This link can also be described through the analogy of playing a game. One cannot feel confident in playing any game if one has not been taught how to play the game. Hence while the Parental Knowledge Scale and the Parental Feeling Scale were designed to measure different aspects of parents’
family management, the resulting information described both sides of the same coin. Finally, there would appear to be further a link between these two scales and the notion of hardy resilience reflected in the *Parent Resilience Questionnaire*. If resilience is to be understood as the ability to ‘bounce back’ after confrontation or hurt through the behaviour of the adolescent, then feeling secure in one’s parenting competency and self-efficacy would provide a reinforcing mainstay for resilience, as opposed to retreating into a mindset of helplessness and hopelessness.

At the opposite end of a strong sense of self-efficacy would lie a sense of learned helplessness and associated feelings of hopelessness. The concept of learned helplessness and hopelessness would refer to a parent who has become overwhelmed with seemingly untenable situations, feeling that he or she no longer possesses the skill, confidence, or even the energy necessary to successfully cope with the challenge of these situations. In terms of risk and protective factors, self-efficacy would represent a reliable protective factor in adolescent and family management, whereas learned helplessness and hopelessness would represent a risk factor. As a risk factor, learned helplessness and hopelessness would threaten to erode the relationship between parent and adolescent and place the adolescent at risk of harmful behaviour.

*Description of the Parental Knowledge Scale and the Parental Feeling Scale.*

The *Parental Knowledge Scale* and the *Parental Feeling Scale* each contained three items, and were developed to measure separate aspects of parental management. All scale items were developed with a colleague in psychology who conducted intervention programmes with parents of behaviourally difficult children and adolescents. Both scales were presented in a single six-item questionnaire format to parents, with items presented in random order. This questionnaire format was inserted into page three of the *Adolescent Problem Behaviour Assessment (APBA)*, following the *Parent Resilience*
Questionnaire (see the TANDEM intervention manual for this format as it appeared in the APBA). Both scales can also be found as a separate questionnaire in Appendix 15.

Items 1, 3, and 5 comprised the Parental Knowledge Scale, and measured the parent’s knowledge of those skills necessary to achieve a comfortable relationship with an adolescent. Items 2, 4, and 6 comprised the Parental Feeling Scale, and measured the parent’s sense of self-efficacy and satisfaction in exercising the parental role. For ease of reference, these items have been presented in Table 7.1.

Table 7.1
Items of the Parental Knowledge Scale and the Parental Feeling Scale.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Wording</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Knowledge Scale</td>
<td>1. I do not know what I need to do to change the problems I have with my son or daughter.</td>
</tr>
<tr>
<td></td>
<td>3. I am clear about what skills I need to relate comfortably with my son or daughter.</td>
</tr>
<tr>
<td></td>
<td>5. I do not have much knowledge about the basic communication and problem solving skills necessary for a good relationship with my son or daughter.</td>
</tr>
<tr>
<td>Parental Feeling Scale</td>
<td>2. I feel confident about setting limits on my son or daughter’s activities and behaviour.</td>
</tr>
<tr>
<td></td>
<td>4. I feel unhappy about the way things are working out between me and my son or daughter.</td>
</tr>
<tr>
<td></td>
<td>6. As the parent of an adolescent, I feel confident about successfully getting through the difficult times with my son or daughter.</td>
</tr>
</tbody>
</table>

As with the Parent Resilience Questionnaire (see section 5.5, chapter five), a five-point Likert rating scale, ranging from 1 (‘I strongly disagree with the statement’), to 5 (‘I strongly agree with the statement’), with 3 indicating ‘I am not sure either way’, was adopted to measure a parent’s skill knowledge and feeling. Unlike the use of a four-point Likert scale that measured adolescent risk in terms of a continuum from low to
high risk-level, the five-point scale was adopted to permit the choice of “not sure” in the response options. Hence discrete points of measure indicated that parents experienced either a weak or strong sense of skill or efficacy, or they were unsure either way. Analyses of reliability (Cronbach’s alpha) were conducted on each scale. Reliability of the *Parental Knowledge Scale* was 0.59, and 0.57 for the *Parental Feeling Scale*. The small number of items would have contributed to these low alpha values, although the values were not so low as to preclude the use of these scales in this research.

The skills chosen for items two and five as a general measure of self-efficacy and skill will be clarified since the reason for choosing these skills as item examples is not immediately apparent. Item two referred to the parent’s sense of confidence in setting limits on the adolescent’s activities and behaviour. A competent parent management style would reflect the appropriate imposition of limits on an adolescent’s activities, which in turn would rely on the parent’s knowledge of the adolescent’s activities and whereabouts (Dishion & McMahon, 1998). This type of management style would lead to a sense of confidence in the parent who aims to approach issues of limit setting and monitoring in a way that maintains and even strengthens the parent-adolescent bond, rather than fragmenting it. This example was therefore considered appropriate for item two. For item five, the basic skills of communication and problem solving were chosen as item examples since open communication between parent and adolescent has been found to lead to more effective problem solving and conflict resolution practices, and so provide a protective factor against adolescent problem behaviour (Clark & Shields, 1997; Rueter & Conger, 1998).

*The Stressors Scale.*

**Rationale for development of the Stressors Scale.** Demographic items were developed after consultation with fellow psychologists who also investigated and
intervened with parent-adolescent relationship problems. Items were also formulated from various research findings. Thus parental death or parental divorce has been linked to mental health outcomes, depression, acting-out behaviour, and low self-esteem of the child (Reese & Roosa, 1991). Adolescent substance misuse, attention-deficit hyperactivity disorder, and depression have been linked with multiple characteristics of adolescents and their family relations, peer relations, school experiences, and quality of the neighbourhood setting (Barkley, 1997; Cantwell, 1996; Hart et al., 1995; Henggeler, Rowland, Randall, Ward, et al., 1999; Lerner, Hertzog, Hooker, Hassibi & Thomas, 1988; Moffitt et al., 2001; Weinberg, Rahdert, Colliver & Glantz, 1998). Research has identified serious outcomes resulting from economic deprivation within families. These have included increased punitive and arbitrary parenting behaviours, less involved parenting, negative parent-child interactions, and a decrease in the quality of marital relationships, all of which have been found to adversely affect the development of adolescent males and females (Conger et al., 1992, 1993; Lempers & Clark-Lempers, 1997; Lempers et al., 1990; Sampson & Laub, 1994). A link has also been found between economic deprivation within the family and high patterns of stress and associated dysphoria, leading to hostile behaviours between family members (Conger et al., 1994). Generally, the pervasive impact of stressors upon both the physical and psychological well being of the individual has been especially indicated by research literature (Kidman, 2000; Little, Jordans, Paul, Montgomery & Philipson, 1998; Sali, 1997).

**Description of the Stressors Scale.** This 16-item construct was entitled the *Stressors Scale*, and parents were requested to respond to each item with a *Yes* or *No* answer rather than a range of responses, since the aim was to simply know whether or not these item-related issues were present. The *Stressors Scale* indicated the presence or
absence of broadly focused stressors within school, family, economic, health-related, and neighbourhood-related environments. These stressors investigated the adolescent’s school environment, including one item concerning the diagnosis of attention-deficit hyperactivity disorder (4 items), parental status (1 item about single parent structure), economic stability (2 items), substance use by the referred adolescent, parents, and other family members (2 items), mental health of the referred adolescent, parents, and other family members (2 items), and family illness and death (3 items). In addition, there was one item asking whether the children ever needed to be cared by friends or a welfare agency, and one item that inquired whether the family lived in a neighbourhood where adolescent crime and substance misuse was a problem. Item numbers, item domains, and the format in which the questionnaire was presented, can be found in Appendix 16.

The Stressors Scale was inserted into the parent version of the APBA as it was used with the TANDEM sample of parents (pp. 8-9), following the Self-Perception of Risk Questionnaire (see the TANDEM intervention package).

The knowledge emerging from the Stressors Scale provided an individual information benchmark for personal and family issues, and complemented the discussion of assessment results with the parent during the intake stage of the TANDEM programme.

The Parent Resilience Questionnaire. The Parent Resilience Questionnaire was developed as part of the APBA, and provided a measure of parents’ resilience (see Appendix 11, p.2). The development of this questionnaire has been described in section 5.4 of chapter five.

Depression Anxiety Stress Scales (21 item version) – DASS-21

Rationale for measuring depression, anxiety, and stress. Problems with adolescent behaviour not only lead to poor parent management practices. They also
place the parents at risk of increased levels of personal and emotional suffering,
specifically focused on the three negative affect states of depression, anxiety, and stress
(McMahon & Slough, 1996). Parents affected in this way have also been found to be
more vulnerable to social and economic pressures, particularly social isolation. In cases
where these parents undertake training programmes to help them in their parenting
practices, it has been found that they are more highly vulnerable to premature
termination, less improvement in treatment, and/or failure to maintain treatment gains
(Dadds, Schwartz & Sanders, 1987; Kazdin, 1990). Research has also indicated that
hostile interchanges among family members and coercive family practices are often the
outcome of high levels of upset. These hostile behaviours have the potential to be
reinforced into a cycle of manipulative control between members, with the behaviour of
one person acting as an aversive stimulus for the behaviour of another (Conger et al.,
1994). Escalated levels of anxiety, depression, and stress have been further related to
issues such as negative life events, partner discord, drug and alcohol misuse, economic
strain, and pressures of single parenthood. Research has indicated the importance of
interpersonal factors that might mediate the effects of stress between parents and
children. The impact of stressful life events on parents has been found to amplify
dysfunctional family interactions, resulting in maladaptive adolescent outcomes,
particularly adolescent depression (Ge et al., 1996; Leas & Mellor, 2000; Moffitt at al.,

**Description of the Depression Anxiety Stress Scales (21 item version)** –

**DASS 21.** The 21-item version of the *Depression Anxiety Stress Scales* emerged from
original research linked to the 42-item version of this scale. Original research on the
*Depression Anxiety Stress Scales (DASS)* was conducted in a variety of clinical settings
(Brown, Chorpita, Korotitsch & Barlow, 1997; Brown, Korotitsch, Chorpita & Barlow,
Brown et al. (1997) suggested that the DASS might be a more accurate index of severity of negative affect than the two-factor models of anxiety and depression, such as that found in the Beck Depression Inventory (Beck, 1978; Beck & Steer, 1993) and the Beck Anxiety Index (Beck, 1990). Generally, the DASS has been found to exhibit sound psychometric properties and robust convergent and discriminant validity. Antony, Bieling, Cox, Enns & Swinson (1998) found that the internal consistency and concurrent validity of the DASS and DASS-21 “were in the acceptable to excellent ranges” (p. 176). Their findings also suggested that the 21-item version appeared to have advantages over the original 42-item version, since it included fewer items, a cleaner factor structure, and smaller inter-factor correlations. For this reason, and in order to reduce the burden of completing assessment questionnaires, the 21-item version was chosen to measure the three emotional states of depression, anxiety, and stress in parents who participated in the TANDEM programme. Furthermore, in keeping with the aim of maintaining the TANDEM programme at a minimum cost, the fact that the DASS was available as a public access document without cost was a serious consideration in favour of its use.

Reliability values for each scale of the 21-item version were found to be adequate. With a normal, non-clinical sample size of 717, reliability values were 0.81 for depression, 0.73 for anxiety, and 0.81 for stress (Lovibond, S.H. & Lovibond, P.F., 1995b). The DASS-21 also comprised part of pre and post measures of intervention effectiveness of the TANDEM programme by investigating the extent to which depression, anxiety, and stress was reduced as a result of participating in the programme (see Appendix 17 for item numbers for each scale of the DASS-21, together with the questionnaire format).
The TANDEM parent manual. The researcher developed the TANDEM parent manual specifically for parents who participated in the TANDEM programme, and was as necessary component used in the week-by-week sessions of the parenting course. The manual was developed according to three main avenues of enquiry, namely, research literature, the clinical experience of the researcher, and qualitative data provided by parents.

Research Literature. Effective communication has been noted as the fundamental skill linked to the strengthening or weakening of the parent-adolescent bond. Effective communication patterns have been found to reinforce further interrelated skills such as apt negotiation techniques and effective monitoring of the adolescent’s activities and whereabouts. Effective communication has also been described as the key factor in nurturing family attachment, bonding, and affective relationships (see Barnes & Olson, 1985; Clark & Shields, 1997; Foster & Robin, 1997, 1998; Noller & Bagi, 1985; Noller & Callan, 1991). It would therefore seem logical that in order for a parent and adolescent to fruitfully resolve conflicts and problems, and develop a bond of trust and honesty, there would be the prior requirement for both parties to be proficient in interacting with each other at the most basic level of communication. Negotiation of problems and conflicts would necessitate a readiness and ability to speak openly about the issues that underlie the problem or conflict. Effective monitoring would rely on the honesty of the adolescent, and this honesty in turn would be encouraged by the parent’s ability to speak comfortably with the adolescent about issues that may of themselves engender uneasiness or embarrassment, such as peer-related activities.

Moffitt et al. (2001), when discussing the place of parental monitoring in the context of healthy parent-adolescent relationships, pointed out that monitoring strategies
could backfire on the parents where the adolescent felt controlled. Moffitt et al. (2001) continued by describing adolescents, rather than parents, as becoming the agents of control over how much the parent is allowed to know about the adolescent’s activities. This would be likely even where the adolescent is not engaged in problem behaviour, and would be even more likely where adolescent problem behaviour is already an issue. Furthermore, in those circumstances where the adolescent is already delinquent, parents would be apt to becoming lax and apathetic about the need to monitor their adolescents’ whereabouts and activities, especially in cases where other agencies or individuals have already taken over control of the adolescent’s aberrant behaviour (Kerr & Stattin, 2000; Moffitt et al., 2001). Moffitt et al. (2001) did not deny the importance of monitoring and limit setting, but rather seemed to suggest that this strategy needs to be exercised with sensitivity. Consequently, communication would emerge as the essential skill for ensuring that a parent’s attempts to track the adolescent’s behaviour resulted in honest and reliable information, and not a mere cover-up designed by the adolescent to maintain his or her personal agenda.

Specific research literature has supported the importance of effective communication in developing positive family management skills. Dishion et al. (1999) considered effective communication skills as being the foundation for strengthening parent-child relationships and effectively negotiating conflict. Effective communication subsequently reduced tendencies towards irritable and coercive parenting styles, and increased the consistency and effectiveness required in setting limits on the adolescent’s activities, as well as monitoring these activities. As a protective factor, this approach would act as a determinant of harm minimisation for the adolescent, especially in relation to avoiding unsupervised time with deviant peers. Kumpfer et al. (1999) supported the need for strong patterns of communication when they suggested that poor
parent-child relationships, together with family conflict, have been associated with a variety of problems for the adolescent. These have included the risk factors of school attachment, low self-esteem and self-efficacy, association with dysfunctional peers, chronic substance misuse, and delinquency (see also Mak, 1993). Mak and Kinsella (1996) noted that adolescents, who perceived their parents as demonstrating high levels of hostility and low levels of affection in their communication styles, were more inclined towards high levels of drug and alcohol use. Clark & Shields (1997) held that the breakdown in family functioning and cohesiveness, parent-adolescent bond, and increases in harsh and coercive parenting styles can be traced to poor levels of open and expressive communication patterns between parents and children (see also Masselam, Marcus & Stunkard, 1990). Clark & Shields (1997) emphasised that communication among family members was both a crucial facet of interpersonal family relationships and a key factor in understanding the dynamics of family relationships.

It was for reasons such as these that skill of effective communication was a continually reinforced foundation throughout the TANDEM parent manual. In effect, the art of communicating with an adolescent was viewed as the hub of each and every skill presented in the TANDEM-parenting course. Flexible and consistent communication patterns were presented as being fundamental to the development of skills such as negotiation of conflict, problem solving with the adolescent, and monitoring the adolescent’s activities. Honest communication between a parent and an adolescent was therefore consistently presented both during the parenting course as well as in the manual contents as a key consideration for achieving a fruitful relationship with one’s adolescent son or daughter.

The cognitive model. The cognitive model was chosen to underpin the strategies and techniques contained in the TANDEM parent manual. According to the cognitive
model, the attitudes, assumptions, and beliefs that a person brings to a situation will
determine the varying levels of response to an interpretation of the situation,
consequently influencing the verbal, psychological, and physiological response to that
approach based on the cognitive model was adopted for the TANDEM-parenting
course. The psychoeducational approach was viewed as providing the most adaptive
vehicle for teaching parents new skills that led to practical and effective management
strategies with their adolescent, as well as refining or reformulating previously learned
skills. This would further help parents realise that the manner in which they perceived
their adolescent child subsequently affected the relationship between them both.

**Clinical experience.** Prior to, and during the progression of this research project,
the researcher was professionally involved with parents of adolescents who were
identified as being at a serious level of risk for self-harm, harm to others, anti-social
attitudes, and conflict with legal authorities. The problem behaviour proneness
demonstrated by these adolescents was by and large the result of the ‘flight to peer’
syndrome described by Dishion and McMahon (1998) whereby the adolescent tended to
seek escape to his or her peer group from what was perceived as being an unpalatable
home environment. Parents who approached the researcher in the clinical setting apart
from the TANDEM programme generally exhibited poor patterns of communication,
inappropriate approaches to problem solving and negotiation of conflicts, temper
outbursts as a response to escalated stress with ensuing violent reactions by the
adolescent, and generally a sense of parental helplessness and hopelessness. This in turn
couraged the ‘flight to peer’ response by the adolescent.

Subsequent intervention programmes generally focused on identifying areas of
family management where parents were least likely to effect positive change in both the
adolescent’s behaviour and the resulting hostile atmosphere of the family home. These interventions stressed the need to positively address deficits in both parental style and parent-adolescent relationships. Therefore the primary intervention aim was one of strengthening areas of identified weakness by enabling and encouraging parents to feel confident as well as competent in implementing new family management skills and redefined approaches to parenting within their family environments.

Prior to the development of the TANDEM programme, all clinical intervention work carried out with parents was on a one-to-one basis, and the content of this work was tailored for individual family circumstances following discussion with parents, although overlap between individual intervention approaches was common. Refining and redefining skills of communication, which in turn were directed towards new approaches for problem solving, conflict negotiation, and monitoring practices, were common denominators for intervention approaches undertaken with each parent. The negotiated span of time undertaken for each intervention plan ranged from three to five weeks, with one to two weekly sessions scheduled during this time, depending on the clinical severity of each situation. A manual had not been developed for parents’ use in each of these one-to-one intervention programmes. Rather, parents worked from handouts written specifically for the skill or issue under discussion.

Due to the commonality between many parents’ situations with their adolescent son or daughter, and the subsequent overlap of handout material, it was considered beneficial to develop a manual-type format. Formulating the psychoeducational information into a manual was seen as providing a means of generalising and sculpturing the teaching and refining of skills from one session to the next, thus optimising preparation time spent by the clinical practitioner as well as collating material resources into an organised entity. A manual also helped the parent to organise
information in a meaningful manner, as well as review newly learned skills and techniques at a later date. Consequently the handout materials used during individual sessions with parents, particularly the flowcharts and the week-by-week activities, were incorporated into the TANDEM parent manual for use in this research.

Preliminary investigation with a consultative parent sample. A group of approximately 50 parents who resided in the mainly working class suburb of Berkeley, N.S.W., Australia (situated near the location chosen for the TANDEM programme) was requested to complete a questionnaire describing the manner in which they related to their adolescent son or daughter during day-by-day interactions. Twenty-eight questionnaires were distributed, although only seven mothers and two fathers returned completed questionnaires one week later. The purpose of this preliminary investigation was to provide a partial guide in developing the TANDEM parent manual. The preliminary investigation sought to gain the perspective of this consultative parent sample in relation to the positive and negative outcomes entailed in interactions with their adolescents, as well as their insights into reasons underlying interactional outcomes. Items comprising the questionnaire included the domains of communication, problem solving, and conflict resolution, as well as the parents’ approaches to issues of self-care. The aim, method, results, and discussion of the preliminary investigation have been presented as a separate study in Appendix 18.

To assist the reader, a brief abstract of the type of responses made by the consultative parent sample will be presented at this point of the thesis. The majority of parents (71.3%) appeared to realise with some surprise that their adolescent was now drawn more to the influence of peers than parents. As a result, this parent sample indicated feeling sidelined when attempting to speak with their adolescents, as well as feeling more exposed to confrontation and attack by their sons or daughters. Comments
relating to how parents handled these challenges to communication were almost evenly split between helpful and unhelpful strategies. Approximately half the parent sample (42.8%) adopted a self-defensive, somewhat aggressive stand with their son or daughter when communication became difficult. The remainder of the sample advocated removing oneself from the heated situation and waiting until one felt calmer before attempting to speak with the adolescent. Comments by the majority of parents (88.2%) indicated a readiness to adopt a steady approach when addressing problems or conflicts with their adolescents. The need to select the most appropriate time to do this, as well as the need to model an attitude of mutual respect between the adolescent and parent was also emphasised by this parent majority. However, a lesser percentage of parents appeared to advocate power and control as the primary means of solving problems with an adolescent (11.8%). Finally, with regard to issues of self-care, the total parent sample advocated the importance of dedicating time to one’s personal needs without feeling guilty for doing so. Nurturing supportive adult relationships was a suggested approach for developing positive strategies of self-care.

The comments made by the consultative parent sample further reinforced the need to stress effective communication strategies in the contents of the parent manual, especially in relation to problem solving and conflict resolution with the adolescent. In turn, this emphasis was seen to flow over into encouraging a sense of openness and trust between the adolescent and parent that would also prove beneficial when the parent sought to monitor and place appropriate limits on the adolescent’s activities and relationships. However, it appeared from the consultative sample that a sense of powerlessness and anger, as well as anxiety for the adolescent’s safety, was sometimes associated with communication experiences between parent and adolescent. Hence, this negative feeling also required attention in the parent manual, and this was addressed
within the context of self-care issues. The need to adopt constructive patterns of thoughts and beliefs in relation to oneself as well as one’s adolescent was given special consideration through encouraging disputational thinking strategies to counteract distorted thinking (Beck, 1995). A healthy belief system and pattern of thinking by the parent was presented as a necessary baseline for making time for oneself as a parent, as well as being realistic about the level of success that was possible with one’s son or daughter.

The content of the TANDEM parent manual. Table 7.2 summarises the content of the 147-page, 7-chapter TANDEM manual, together with chapter and page numbers, and the session in which chapter material was presented. The manual has also been presented in full in the TANDEM intervention package. A 14-point font was used throughout the manual to facilitate ease of reading, and the language style was colloquial to reflect a less than formal approach to presenting the various subject areas. Clip-art was inserted where appropriate to direct the reader and appropriately lighten the seriousness of subject areas. Wherever possible, flowcharts were used to clarify what was discussed in written form. Finally, activities such as written work and suggested video material were presented at the conclusion of each chapter. These were designed as homework tasks in between each session.
Table 7.2
Summary of the content of the TANDEM manual.

<table>
<thead>
<tr>
<th>Chapter &amp; Page</th>
<th>Chapter Content</th>
<th>Course Content</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. An Introduction</strong> (p.4)</td>
<td>Introduction to the programme, stressing the importance of the family and the strength of relationship between adolescent and parent. The umbrella term ‘parent’ is also defined as meaning any person who functions in that role. The image of the seesaw was used to describe this relationship at the first session. The reason for and importance of homework, and the need for group confidentiality, was also emphasised at this session.</td>
<td>At-home reading (with selected points explained at Session One)</td>
</tr>
<tr>
<td><strong>2. Adolescent Development</strong> (p.8)</td>
<td>An investigation of the psychological, physical, emotional, and cognitive indicators that signify the onset and progression of adolescence. The importance of this developmental period is addressed in terms of the parent-adolescent relationship, and being able to recognize when this relationship has begun to fracture.</td>
<td>Session for Week One</td>
</tr>
<tr>
<td><strong>3. Styles of Parenting</strong> (p.21)</td>
<td>An investigation of the autocratic, permissive, and democratic style of parenting, and the impact of each style on the satisfaction of parent and adolescent and the cohesiveness of the bond between both parties. Democracy is interpreted as a ‘fluid line’ that represents healthy compromise between parent and adolescent.</td>
<td>Session for Week Two</td>
</tr>
<tr>
<td><strong>4. The Art of Communication</strong> (p.34)</td>
<td>Parents investigate communication as an ‘art form’ in itself. The precipitating elements of effective and non-effective communication are discussed, using the concrete application of a TV remote control unit. ‘You’ and ‘I’ messages are specifically discussed, as well as various ways of ‘killing’ the conversation from the outset. A flowchart summarises helpful speaking and listening strategies</td>
<td>Session for Week Three</td>
</tr>
</tbody>
</table>
| 5. Problem Solving  
(p.58) | A description of a ‘problem’ pre-empts a step-by-step approach to problem solving with an adolescent. The concept of alliance is applied to problem solving as parent and adolescent together finding a solution to something out there. The image of planning and undertaking a sea journey underpins the approach to problem solving. Effective communication skills are consistently presented as a necessary constituent of effective problem solving strategies. The chapter opens with a discussion of the difference between conflicts and problems. The role of effective communication and open parenting style, the role of the parent as an adult, the parent’s insight into the part he or she plays in the conflict, act as a preamble to the outline of conflict resolution as a process of awareness, accepting responsibility, and candid negotiation. The chapter concludes with a summary of what does and does not work in the process of conflict resolution. | Session for Week Four: Presented in the one session since strategies required for both skills were similar. |
| 6. Conflict Resolution  
(p.76) | These areas are treated as three schemas of the one operation. Stages of adolescent development define the appropriateness of limit setting and consequences for broken limits. A healthy understanding of control is also linked to adolescent development. Monitoring is then discussed as a skill that relies on and aids apt limit setting. Networking is the parent’s means of keeping in touch with the child’s activities away from home and with peers especially by maintaining contact with the parents of the child's friendship group. Parents are encouraged to view networking as being their mainstay of mutually supportive teamwork. | |
| 7. Monitoring, Limit Setting, Networking  
(p.92) | | Session for Week Five. |
8. Thinking Your way to Change: Look After Others by Looking After Yourself (p.117)

The focus of this chapter is the parent’s need for healthy self-care and sound thinking practices. The typical thinking cycle is presented according to the cognitive model, with each aspect of the cycle being explained in detail. A distorted thinking checklist is outlined, containing examples of both distorted and more adaptive thinking. Various ‘encouragers’ are described for parents, to be used especially when parents feel they have made mistakes with their son or daughter. ‘Making time for yourself’ is part of this section and discusses the importance of setting time aside for one’s personal life as a parent.

7.1.1.3 Procedure.

Advertising TANDEM. Two months prior to the scheduled commencement of the TANDEM programme, a formal letter advertising the TANDEM programme and explaining its purpose was sent to organisations that acted as referral centres for adolescents whose level of risk behaviour was sufficiently high to threaten rupturing the parent-adolescent bond. These organisations included state government juvenile departments, church-related adolescent remediation centres, community and government area health centres, and private psychology practices. Letters were also sent to high schools. Only high schools and organisations that fell within a radius of 10 kilometres were contacted. This radius was chosen because of the practical limitation of parents eventually having to travel to and from the location where the programme was to be conducted.

Because the researcher was using a professional space that was not his own, this letter was sent under the signature of the location’s director. The letter outlined details of the programme, including entry qualifiers, dates, times, cost, contact person and telephone number, and programme contents (see TANDEM intervention pack).
Included in the letter were a telephone contact number and contact person (apart from the researcher) for further information. Brochures directly advertising the programme to parents were also sent with the letter, with the request for them to be prominently placed in the waiting rooms of contacted organisations (see the TANDEM intervention package). These brochures repeated the information contained in the letter in a more colloquial manner. Each high school was asked to either send home a brochure to the family of each adolescent or alternatively advertise the programme in the weekly school news bulletin using an enclosed abbreviated version of the brochure (see the TANDEM intervention package). Information letters and brochures were eventually sent to 20 professional agencies and 22 high schools.

**Initial contact by parents.** The Northfields Clinic linked to the Department of Psychology, University of Wollongong, Australia, was chosen as the physical location for the programme. This location is a clinical psychology training centre, and a point of referral for helping agencies outside the university confines. The receptionist at the Northfields Clinic passed on to the researcher details of parents who were interested in participating in the TANDEM programme. The researcher then telephoned these parents in order to ensure that they had been clearly informed about the programme, and to ensure, at least at this preliminary stage, that the programme would be suitable for their situation. During the telephone call the researcher also explained the purpose and process of the pre-programme intake procedure, as well as the fact that parents who participated in these particular programmes would be linked to this research. Parents were consequently told that in order to participate in these initial programmes they would be asked to sign consent forms outlining their rights and the requirements of participation. If parents were content with the participation requirements, then a two-
hour interview time was set for a meeting between the researcher and each parent or parent couple.

**The first interview.** Upon arrival for their interview, the researcher explained to parents the purpose of the preliminary interview, and the purpose and content of the assessment instruments. The concept of pre-testing and post-testing was also explained to parents, pointing out that they would be asked to complete certain assessment measures at the conclusion of the parenting course. Once it was clear that parents understood this information, they then completed all assessment instruments with the researcher present so that he could answer any questions from parents.

When all intake assessment measures were scored, the researcher explained the results to parents, highlighting areas that he considered to be of concern. Parents were invited to respond to the researcher’s explanations and interpretations from the background of their personal experience with the son or daughter’s behaviour, and of the atmosphere within the home environment. The researcher linked parents’ concerns about their adolescents’ behaviour with assessment findings. This link provided evidence that the concerns of parents were in fact warranted. Measures of parental resilience, self-efficacy, and levels of parenting skill were also discussed with the parents, and linked back to the assessment of adolescent behaviour.

Where assessment outcomes indicated problems in a particular adolescent’s behaviour, and a breakdown of the parent’s ability to cope, the researcher strongly encouraged the parent to positively address the overall fragmenting situation by undertaking the six-week TANDEM-parenting course. A copy of the manual was used to describe the course content, especially content that was relevant to individual parents’ concerns. Parents were given a flowchart that summarised the parenting course, and
were invited to take this home for later reference (see the TANDEM intervention package).

Parents were given the opportunity of taking home the adolescent version of the *Adolescent Problem Behaviour Assessment (APBA)* for their son or daughter to complete, along with the necessary consent forms for the adolescent’s perusal and signature. The researcher discussed with parents the adolescent’s possible reaction to this opportunity, and the feasibility of making the offer in the first place. The researcher also explained to parents that the adolescent’s responses could not be discussed with them because of confidentiality issues. In reality, however, this was not an issue since parents had already made a decision about participating in the six-week TANDEM-parenting course by the time adolescents returned their completed questionnaires by mail. Thus adolescent’s responses to the *APBA* were beneficial for the researcher’s knowledge alone, enabling him to determine the amount of concordance between the parent and adolescent’s perception of risk in the adolescent’s behaviour. Consequently, the researcher tailored the presentation of the course content so that it specifically targeted those areas where agreement between parents and adolescents seemed weakest.

In accord with research that emphasised the necessary role of parents in any intervention programme similar to TANDEM (Dishion et al., 1999; Smith & Stern, 1997; Stern & Smith, 1999), parents were told that successful outcome was most likely to occur where there was a readiness to value their present efforts over possible past failures, and where there was openness to learning and practising new skills. In this way the parental role was respected and parents were allowed the dignity of taking control of their situation through their efforts to improve it. At all times during the intake interviews, rapport was maintained with parents through the skills of motivational interviewing (Miller and Rollnick, 1991). This technique has been described in section
4.3 of chapter four. All parents who came for this initial interview ultimately indicated their wish to take part in the TANDEM-parenting programme. Therefore the interview concluded with parents being given all necessary information to attend the first programme session. The space of time between the intake interview and the first session was deliberately small, extending to no further than one week for parents who had the first interview appointments. The purpose of maintaining this brief time span was to ensure that parents did not wane in their enthusiasm to participate in the parenting course.

7.1.2 Intake results

After completing the consent form (see Appendix 19), parents who responded to the TANDEM programme were asked to complete the intake assessments comprising the parent version of the Adolescent Problem Behaviour Assessment (APBA) as it was used in the TANDEM programme and the Depression Anxiety Stress Scales – 21-item version (DASS-21). The DASS-21 was attached to the end of the APBA. Assessment measures, together with the discussion of these measures, indicated the parent’s suitability for participating in the TANDEM-parenting course. A parent was deemed suitable for participation in the parenting course if the adolescent’s behaviour was elevated, or beginning to escalate, beyond levels indicated by the normative sample, and if the discussion between the clinician and parent supported this evidence. See section 6.2.4 in chapter six under the sub-heading of “Clinical Implications” for a description of the scoring procedure of the APBA.

Adolescents who completed the APBA were also required to complete a consent form, as were their parents who gave permission for their adolescents to participate (see Appendix 19). The consent form was structured to facilitate combined parent and adolescent consent. Combining both consents was not viewed as a problem since
parents were first invited to discuss with the adolescent the purpose behind both completing the consent and the APBA. The adolescent returned the completed questionnaire to the researcher in a separate postage paid sealed envelope. The request for age and gender in the TANDEM adolescent version of the APBA was repositioned as the first item in the body of the questionnaire. This was to guard against the adolescent omitting to complete this information by not reading the title page closely, especially given that the researcher would not be present to direct the adolescent to these questions. Intake assessment results have been presented separately in the following sections, and so are different from the results of pre and post measures conducted to determine the effectiveness of the six-week TANDEM-parenting course. Results of pre and post measures have been presented separately in the second half of this chapter.

**The Adolescent Problem Behaviour Assessment.** The parent version of the Adolescent Problem Behaviour Assessment (APBA) was used as a measure of intake suitability only, and not as a pre and post measure of intervention effectiveness. It was unlikely that the APBA would indicate any notable change in adolescent behaviour over the relatively brief six-week duration of the programme. By completing the APBA, parents provided information about their adolescent’s behaviour in relation to the three factors of the Interpersonal Support Questionnaire, their understanding of the adolescent’s self perception of risk, and the extent of their adolescent’s use of alcohol, tobacco, and marijuana. Parent’s also indicated perceptions about their current skill levels and feelings of efficacy, and the amount of resilience they experienced in relation to their son or daughter’s behaviour. Finally, by completing the Stressors Scale, parents provided a description of issues operating in a positive or negative manner within their social and family environment. These data, apart from data obtained from the Parental
Knowledge Scale and Parental Feeling Scale, were compared with the normative data obtained during the development of the APBA. Data for the Parental Knowledge Scale and the Parental Feeling Scale have been presented in section 7.2.2 of this chapter.

In relation to the adolescent version of the APBA, a total sample of 13 male and 6 female adolescents agreed to complete the APBA. Because the family management skills and self-efficacy of parents was the primary focus of attention during the intervention phase of TANDEM, there appeared little value in dividing the adolescent TANDEM sample into age and gender. The value of adolescent data was one of providing levels of concordance between parent and adolescent perceptions of risk, as well as indicating levels of adolescent risk per se irrespective of age or gender. Hence the decision was made to compare the responses of the normative and TANDEM adolescent samples without taking age or gender into account.

Statistically significant differences between the normative sample of parents and adolescents (referred to as the normative sample) and the data of the parents and adolescents who were connected with the TANDEM programme (referred to as the TANDEM sample) would indicate some level of problem behaviour among adolescents from the TANDEM sample. Multivariate and univariate analyses of questionnaires comprising the parent and adolescent versions of the APBA were conducted to determine the statistical significance of differences between the mothers, fathers and adolescents of both samples. The results of each questionnaire of the APBA will now be considered separately.

The Interpersonal Support Questionnaire. At the multivariate level, significant differences were found between mothers from the normative and TANDEM samples for the Interpersonal Support Questionnaire [ISQ] (Pillai’s T = .280, F(4.00,292) = 28.37, p<.001, n² = .280). Significant differences were also found between the fathers from
both samples for the ISQ (Pillai’s $T = .122$, $F(4.00,205) = 7.108$, $p<.001$, $\eta^2 = .122$). For the adolescents from both samples, significant differences were found for the ISQ (Pillai’s $T = .087$, $F(4.00,393) = 9.31$, $p<.001$, $\eta^2 = .087$). The small sample sizes of the TANDEM parent and adolescent samples were noted as the principal contributing factor for the low values of effect size ($\eta^2$). At the univariate level, significant differences were found for each factor of the ISQ between mothers and adolescents from the normative sample and mothers and adolescents from the TANDEM sample. With regard to the data of fathers for the ISQ, a significant difference was found between the normative and TANDEM samples only for the factor of Parent/Family Relationships. For ease of perusal, these findings have been presented in Table 7.3. Mean scores for the normative sample of parents and adolescents have been defined as ‘Normative’, while mean scores for the TANDEM sample of parents and adolescents have been defined as ‘TANDEM’. All data analyses were conducted with both samples collectively, rather than according to age and gender. The aim of these analyses was to determine only whether or not statistically significant mean score differences existed between the normative and TANDEM samples, rather than establish where these differences were situated in relation to age and gender.
Table 7.3

Differences between the TANDEM and normative groups for the *Interpersonal Support Questionnaire*.

<table>
<thead>
<tr>
<th>Sample and factor</th>
<th>Mean (SD) Normative</th>
<th>Mean (SD) TANDEM</th>
<th>F (df, error) values</th>
<th>(η²)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mothers:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normative: n=273</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TANDEM: n=16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Modelling</td>
<td>1.15 (.17)</td>
<td>1.38 (.32)</td>
<td>21.78 (1,295)***</td>
<td>.069</td>
</tr>
<tr>
<td>Parental Monitoring/Limit Setting</td>
<td>1.24 (.34)</td>
<td>1.48 (.32)</td>
<td>7.58 (1,295)**</td>
<td>.025</td>
</tr>
<tr>
<td>Parent/Family Relationships</td>
<td>1.49 (.28)</td>
<td>2.03 (.46)</td>
<td>51.51 (1,295)***</td>
<td>.149</td>
</tr>
<tr>
<td><strong>Fathers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normative: n=198</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TANDEM: n = 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Modelling</td>
<td>1.17 (.19)</td>
<td>1.10 (.52)</td>
<td>.684 (1,202) a</td>
<td>.003</td>
</tr>
<tr>
<td>Parental Monitoring/Limit Setting</td>
<td>1.34 (.29)</td>
<td>1.43 (.33)</td>
<td>.613 (1,202) a</td>
<td>.003</td>
</tr>
<tr>
<td>Parent/Family Relationships</td>
<td>1.52 (.30)</td>
<td>2.08 (.39)</td>
<td>19.10 (1,202)***</td>
<td>.086</td>
</tr>
<tr>
<td><strong>Adolescents</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normative: n=382</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TANDEM: n = 19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Modelling</td>
<td>1.42 (.38)</td>
<td>1.68 (.40)</td>
<td>7.17 (1,396)**</td>
<td>.018</td>
</tr>
<tr>
<td>Parental Monitoring/Limit Setting</td>
<td>1.70 (.48)</td>
<td>2.42 (.80)</td>
<td>32.20 (1,396)***</td>
<td>.075</td>
</tr>
<tr>
<td>Parent/Family Relationships</td>
<td>1.70 (.48)</td>
<td>2.22 (.79)</td>
<td>16.68 (1,396)***</td>
<td>.040</td>
</tr>
</tbody>
</table>

a. non-significant

**p<.01

***p<.001

From Table 7.3 it can again be noted that the effect size (η²) of all factors was extremely small. This indicated that as independent variables, these factors were accounting for no more than 10% of the variance. Two issues contributed towards this finding. Firstly, each factor was accounting for a small number of variables. Secondly,
the size of the TANDEM sample was very small in relation to the normative sample. Under these circumstances, the low values of effect size were acceptable. Table 7.3 also indicates that while mean score differences for both groups were not large, they were significantly different in all but two factors for fathers. Mean scores for adolescents from the TANDEM sample were higher than mean scores for adolescents from the normative sample, with mean score differences also being statistically significant. These findings indicated that the TANDEM sample of adolescents believed that their behaviour tended more towards problem behaviour than did adolescents from the normative sample. The TANDEM sample of adolescents appeared to believe that problems existed as a result of modelling of peers’ behaviour and relationships with parents and family, as well as a result of the way their behaviour was monitored and limited by their parents. Mean scores of mothers from the TANDEM sample were also higher across all factors than mean scores for mothers of the normative sample. Furthermore, mean score differences for mothers of both samples were statistically significant. These findings indicated that mothers from the TANDEM sample believed that their adolescents’ behaviour was at higher risk than did mothers of the normative sample, hence reflecting the perceptions of the TANDEM sample of adolescents.

With regard to fathers, no significant mean score differences were found between the fathers of the normative sample and fathers of the TANDEM sample for the factors of Peer Modelling and Parental Monitoring/Limit Setting. For the factor of Parent/Family Relationships, mean scores for fathers from the TANDEM sample were higher than mean scores for fathers from the normative sample, with the mean score difference being statistically significant. This finding indicated that fathers from the TANDEM sample perceived their adolescents as being at risk through problems with parent or family relationships. However, the non-significant mean score differences
found for the factors of Peer Modelling and Parental Monitoring/Limit Setting indicated comparative perceptions of risk between the TANDEM and normative samples of fathers in relation to the modelling of dysfunctional peer behaviour and to parents’ practices of monitoring and limit setting.

A statistically significant difference was found only between the mean scores of mothers and adolescents from the TANDEM sample for the factor Parental Monitoring/Limit Setting (Greenhouse-Geisser $F(1.00,9.00) = 12.160$, $p<.05$, $\eta^2 = .575$), with mean scores being higher for adolescents ($M=2.04$, $SD=0.66$) than for mothers ($M=1.49$, $SD=0.30$). In terms of risk level, this finding indicated that mothers perceived themselves as monitoring and limiting their adolescents more strictly than did the adolescents themselves. Consequently, mothers perceived their adolescents’ risk level as being low for this factor. Apart from this finding, non-significant differences for the remaining factors of the ISQ indicated that mothers, fathers, and adolescents from the TANDEM sample were in agreement about the level of risk entailed in adolescent behaviour. This finding seemed to indicate that the parents and adolescents of the TANDEM sample were judging the amount of potentially harmful risk in behaviour as extending beyond levels found to be normal by the researcher.

The Adolescent Drug Use Questionnaire. Parents from the TANDEM sample, together with adolescents of the TANDEM sample who agreed to complete the APBA, responded to the Adolescent Drug Use Questionnaire (ADUQ). The responses of parents and adolescents from the TANDEM sample were compared to those of parents and adolescents from the normative sample. Comparative responses have been presented in Table 7.4. For these analyses, data from the normative sample of parents have been presented collectively, rather than according to age group and gender. Furthermore, data relating to frequency and amount of consumption have been
presented as mean scores rather than percentages. The reason for these decisions was to present data as simply as possible, since the aim was to indicate only whether or not statistically significant differences existed between the responses of parents and adolescents from the normative sample and from the TANDEM sample.
Table 7.4  
Comparison of the normative and TANDEM samples for substance use.

<table>
<thead>
<tr>
<th>Sample and substance</th>
<th>Mean (SD) Normative</th>
<th>Mean (SD) TANDEM</th>
<th>F(df, error) values</th>
<th>Effect size (η²)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mothers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normative: n=273</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TANDEM: n=16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol: Days</td>
<td>0.42 (0.91)</td>
<td>0.24 (0.97)</td>
<td>0.51 (1,70) a</td>
<td></td>
</tr>
<tr>
<td>Alcohol: Drinks</td>
<td>0.75 (0.94)</td>
<td>0.74 (0.85)</td>
<td>0.01 (1,70) a</td>
<td></td>
</tr>
<tr>
<td>Tobacco: Days</td>
<td>0.56 (2.88)</td>
<td>2.09 (7.26)</td>
<td>1.64 (1,70) a</td>
<td></td>
</tr>
<tr>
<td>Tobacco: Cigarettes</td>
<td>0.24 (0.72)</td>
<td>0.47 (0.80)</td>
<td>1.31 (1,70) a</td>
<td></td>
</tr>
<tr>
<td>Marijuana: Times</td>
<td>0.44 (2.64)</td>
<td>0.00 (0.00)</td>
<td>0.46 (1,70) a</td>
<td></td>
</tr>
<tr>
<td><strong>Fathers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normative: n=198</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TANDEM: n=6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol: Days</td>
<td>0.19 (0.50)</td>
<td>0.92 (1.63)</td>
<td>5.30 (1,46)*</td>
<td>.107</td>
</tr>
<tr>
<td>Alcohol: Drinks</td>
<td>0.54 (0.59)</td>
<td>1.00 (1.38)</td>
<td>2.12 (1,46) a</td>
<td></td>
</tr>
<tr>
<td>Tobacco: Days</td>
<td>0.00 (0.00)</td>
<td>7.42 (12.49)</td>
<td>16.19 (1,46)**</td>
<td>.269</td>
</tr>
<tr>
<td>Tobacco: Cigarettes</td>
<td>0.05 (0.22)</td>
<td>1.17 (1.47)</td>
<td>22.48(1,46)**</td>
<td>.338</td>
</tr>
<tr>
<td>Marijuana: Times</td>
<td>0.00 (0.00)</td>
<td>0.00 (0.00)</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td><strong>Adolescents</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normative: n=382</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TANDEM: n=19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol: Days</td>
<td>1.20 (2.63)</td>
<td>2.06 (3.96)</td>
<td>1.58 (1,399) a</td>
<td></td>
</tr>
<tr>
<td>Alcohol: Drinks</td>
<td>1.51 (2.07)</td>
<td>1.41 (1.44)</td>
<td>0.04 (1,399) a</td>
<td></td>
</tr>
<tr>
<td>Tobacco: Days</td>
<td>1.00 (3.76)</td>
<td>5.91 (10.70)</td>
<td>20.63 (1,399)**</td>
<td>.049</td>
</tr>
<tr>
<td>Tobacco: Cigarettes</td>
<td>0.80 (2.41)</td>
<td>1.69 (1.40)</td>
<td>2.15 (1,399) a</td>
<td></td>
</tr>
<tr>
<td>Marijuana: Times</td>
<td>0.35 (2.47)</td>
<td>1.49 (4.02)</td>
<td>3.09 (1,399) a</td>
<td></td>
</tr>
</tbody>
</table>

a. non-significant  
*p<.05  
**p<.01

Mean score differences between mothers from the normative and TANDEM samples were statistically non-significant. This finding indicated that similar to mothers from the normative sample, mothers from the TANDEM sample did not believe that
their adolescent was at risk due to his or her use of alcohol, tobacco, or marijuana. This finding was in relation to both amount and frequency of use over the previous four-week period. The mean scores for fathers from the TANDEM sample in relation to frequency of alcohol consumption, frequency of tobacco consumption, and amount of tobacco consumed, were higher than mean scores of the normative sample of fathers for these substances. Mean score differences were also statistically significant. These findings indicated that fathers from the TANDEM programme saw their sons or daughters as drinking on a slightly higher number of days than did fathers from the normative sample. However, fathers from the TANDEM sample also saw the amount of consumption as creating a similar low level of concern compared to fathers from the normative sample. That is, fathers from the TANDEM sample saw their adolescents as drinking the same amount as adolescents from the normative sample over a slightly higher number of days. With regard to tobacco, fathers from the TANDEM sample perceived their sons or daughters as smoking more cigarettes over more days than did fathers from the normative sample. With regard to marijuana, fathers from the TANDEM sample believed that their sons or daughters were not using this substance at all, as did fathers from the normative sample.

Apart from tobacco, the mean score differences between adolescents from the TANDEM sample and adolescents from the normative sample were statistically non-significant, and also reflected findings for mothers from both samples. With regard to tobacco, adolescents from the TANDEM sample saw themselves as smoking over a higher number of days than did adolescents from the normative sample, though the mean score for the number of cigarettes smoked did not differ significantly from adolescents belonging to the normative sample. This finding was somewhat different to that for fathers from the TANDEM sample, who apparently saw their sons or daughters
as smoking more over a higher number of days than did fathers of the normative sample.

In relation to the TANDEM sample of parents and adolescents, the mean scores of mothers and adolescents for the number of cigarettes smoked over the previous four-week period were significantly different (Greenhouse-Geisser $F(1.00, 4.00) = 11.25$, $p<.05$, $\eta^2 = .556$). Furthermore, the mean score for adolescents was higher ($M=1.70$, $SD=1.42$) than the mean score for mothers ($M=0.70$, $SD=0.95$). This finding indicated that adolescents reported smoking more cigarettes over the previous four-week period than did their mothers. Apart from this finding, the remaining mean score differences between mothers and adolescents and fathers and adolescents from the TANDEM sample were statistically non-significant, thus indicating a comparable perception between parents and adolescents from this sample for the consumption of alcohol, tobacco, and marijuana.

The findings for substance use by adolescents from the TANDEM sample need to be interpreted with caution, for two reasons. Firstly, the sample size of fathers was small when compared to that of mothers and the sample size of adolescents was not much greater. The effect of small sample sizes was also reflected in the generally low values for strength of association ($\eta^2$). Secondly, and more importantly, during the intake interviews, comments made by a some parents of these adolescents left the impression that at times they were attempting to make an educated guess about the substance use of their sons or daughters.

*The Self-Perception of Risk Questionnaire*. At the univariate level, statistically significant differences were found between the mean scores of mothers, fathers, and adolescents of the normative sample and the TANDEM sample for the *Self-Perception of Risk Questionnaire (SPRQ)*. These findings have been presented in Table 7.5.
Table 7.5
Differences between the normative and TANDEM samples for the *Self-Perception of Risk Questionnaire*.

<table>
<thead>
<tr>
<th>Sample</th>
<th>Mean (SD) Normative</th>
<th>Mean (SD) TANDEM</th>
<th>F (df, error) values</th>
<th>(η²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothers</td>
<td>1.02 (.09)</td>
<td>1.48 (.76)</td>
<td>87.11 (1,295)*****</td>
<td>.228</td>
</tr>
<tr>
<td>Fathers</td>
<td>1.02 (.13)</td>
<td>1.25 (.42)</td>
<td>14.90 (1,202)*****</td>
<td>.069</td>
</tr>
<tr>
<td>Adolescents</td>
<td>1.11 (.30)</td>
<td>1.31 (.47)</td>
<td>6.54 (1,396)*</td>
<td>.016</td>
</tr>
</tbody>
</table>

* p<.05
*** p<.001

Once again, the smallness of the TANDEM parent and adolescent sample sizes constituted the principal reason for low values of effect size. Mean score differences between mothers and adolescents, fathers and adolescents, and between the adolescents themselves from the normative sample and the TANDEM sample were statistically significant, with mean scores being higher for adolescents and parents from the TANDEM sample than mean scores for adolescents and parents from the normative sample. These findings indicated that adolescents from the TANDEM sample perceived themselves as being at higher risk for future problem behaviour than did adolescents from the normative sample. Furthermore, statistically significant mean score differences between both parent samples indicated that the parents of the TANDEM sample also perceived their adolescent children as being at higher risk for future problem behaviour when compared to parents from the normative sample. There were no statistically significant differences between adolescents, mothers, and fathers from the TANDEM sample for the *SPRQ*. This finding suggested that adolescents and parents shared similar perceptions in relation to the level of future adolescent risk behaviour based on current behaviour patterns.
The Parent Resilience Questionnaire. Multivariate and univariate analyses of variance were conducted between the mothers and fathers from the normative and TANDEM samples for the two factors of the Parent Resilience Questionnaire (PRQ), namely, General Resilience and Support of a Significant Other. At the multivariate level, statistically significant differences were found across both factors (Pillai’s $T = .122$, $F(4.00,205) = 7.11$, $p<.001$, $\eta^2 = .122$). Once again, the small size of the TANDEM sample, as well as the small number of variables for this factor, would have resulted in the low value for effect size ($\eta^2$). At the univariate level, significant differences were found between mothers and fathers from both samples for the factor of General Resilience. Significant differences were found only between the fathers from both samples for the factor of Support of a Significant Other. These values have been presented in Table 7.6. Mean scores for all parents from the normative sample have been defined as ‘Normative’, while those for parents from the TANDEM sample have been defined as ‘TANDEM’.
Table 7.6
Differences between the normative and TANDEM samples for the *Parent Resilience Questionnaire*

<table>
<thead>
<tr>
<th>Sample and factor</th>
<th>Mean (SD) Normative</th>
<th>Mean (SD) TANDEM</th>
<th>F (df, error) values</th>
<th>((\eta^2))</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Resilience</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mothers</td>
<td>n=273</td>
<td>n=16</td>
<td>16.49 (1,208)***</td>
<td>.073</td>
</tr>
<tr>
<td></td>
<td>4.11 (.54)</td>
<td>3.58 (.74)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fathers</td>
<td>n=198</td>
<td>n=6</td>
<td>18.02 (1,208)***</td>
<td>.080</td>
</tr>
<tr>
<td></td>
<td>3.98 (.76)</td>
<td>3.24 (.61)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Support of a Significant Other</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mothers</td>
<td>n=273</td>
<td>n=16</td>
<td>0.35 (1,208) a</td>
<td>.002</td>
</tr>
<tr>
<td></td>
<td>4.11 (.93)</td>
<td>3.98 (1.09)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fathers</td>
<td>n=198</td>
<td>n=6</td>
<td>11.16 (1,208)***</td>
<td>.051</td>
</tr>
<tr>
<td></td>
<td>3.81 (1.07)</td>
<td>2.98 (.94)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. non-significant ** p<.01 *** p<.001

Mean score differences between the normative sample and the TANDEM sample for the factor of *General Resilience* were statistically significant for both mothers and fathers, with mean scores being lower for mothers and fathers from the TANDEM sample. This finding indicated that mothers and fathers from the TANDEM sample appeared to experience a lower sense of resilience in coping with situations involving their son or daughter than did parents from the normative sample. For the factor of *Support of a Significant Other*, a statistically significant difference was found between the mean scores of fathers from the normative sample and fathers from the TANDEM sample. Once again, the mean scores were lower for fathers from the TANDEM sample. This finding indicated that fathers from the TANDEM sample appeared to experience less support than did fathers from the normative sample. Mean score differences of mothers from the normative and TANDEM samples for the factor of *Support of a Significant Other* were statistically non-significant, indicating that
mothers from the TANDEM sample felt a similar sense of support to that felt by mothers from the normative sample.

The mean scores for parents from the TANDEM sample were lower for fathers than for mothers for the factors of General Resilience and Support of a Significant Other. These mean score differences were statistically significant for both General Resilience (Greenhouse-Geisser $F(1.00, 4.06) = 5.413, p<.05, \eta^2 = .222$) and Support of a Significant Other (Greenhouse-Geisser $F(1.00, 14.00) = 13.57, p<.05, \eta^2 = .417$). These findings indicated that fathers from the TANDEM sample experienced a lower sense of general resilience and support of another significant person than did mothers from the TANDEM sample. Finally, low values of effect size ($\eta^2$) resulted from the small sample size of TANDEM parents, as well as the fact that both factors of the Parent Resilience Questionnaire accounted for a small number of variables.

The Stressors Scale. The majority TANDEM sample of 16 mothers and 6 fathers did not appear to experience any stressors indicated by the various categories. Where parents noted stressors, mothers rather than fathers appeared to indicate the presence of stressors in their lives. One single mother stood apart from the group in that she had experienced an array of stressors, including a mental health problem (clinically diagnosed depression), substance use problems with both herself and her adolescent, difficulties in finding work, school related problems with her adolescent, and the need for welfare care. Among the remaining mothers, three mothers indicated that their adolescents had been diagnosed with attention-deficit hyperactivity disorder (ADHD), while six mothers reported that their adolescents had been suspended from school. The six mothers reported school-related behaviour that reflected low levels of behavioural inhibition and self-regulation in their adolescents, together with resentful and aggressive acting-out behaviour. It was likely that these deficits were linked to undiagnosed
ADHD, although obtaining a diagnosis to ascertain this likelihood was not possible. Five mothers were single parents, and two of these mothers reported being out of work for long periods of time, although no parents lacked sufficient funds for basic everyday needs. No fathers reported any problems in these areas.

With regard to substance use, two mothers reported that they personally had experienced having a drug and alcohol problem, and three mothers stated that the adolescent they were concerned about had experienced similar problems at some stage in his or her life. According to interview material, one father only reported having problems with the consumption of marijuana. Eight mothers said that their children had at least once had a mental health problem. Again from interview material, these children were older siblings, and their problems related to drug misuse. Two mothers reported having a close family member die over the previous 12 months and two mothers also reported having a family member in hospital with a serious illness or accident during the previous 12 months. Eight mothers and three fathers stated that the adolescent they were concerned about had spent time in hospital due to illness or accident over the previous twelve months. According to interview information, the adolescent had been hospitalised because of accidents such as skateboarding or illnesses such as appendicitis, and hospital stays in these instances were not long term. Finally, the mother who was suffering from clinically diagnosed depression reported that she occasionally needed foster care for her family. This need arose when the mother’s levels of depression prevented her from adequately coping with her sons. Five mothers and two fathers believed that they lived in a neighbourhood where crime and substance use created problems.

*Depression Anxiety Stress Scales – 21-item version (DASS-21).* The DASS-21 was administered both as an intake measure of depression, anxiety, and stress and as a
pre and post measure of intervention effectiveness. Because the *DASS-21* was administered to the TANDEM sample only, outcome measures were not compared to the normative sample [as with other questionnaires of the *Adolescent Problem Behaviour Assessment (APBA)*]. Pre and post measures for the *DASS-21* will be presented later in this chapter when all pre and post measures for the TANDEM-parenting course will be reported and discussed. In this way, unnecessary repetition will be avoided.

*The Parental Knowledge Scale and The Parental Feeling Scale.* As with the *DASS-21*, the *Parental Knowledge Scale* and the *Parental Feeling Scale* were administered both at the intake interview, and as a pre and post measure of intervention effectiveness for the TANDEM sample of parents only. For the same reasons as with the *DASS-21*, results of these measures will be presented later in this chapter.

*Use of the assessment feedback form.* Assessment results were discussed with parents by means of a structured feedback form, although this form was not passed onto parents. Instead, the feedback form and the completed *APBA* questionnaires were retained in a file drawn up for each parent. A similar feedback form was also completed for adolescents’ responses to the *APBA*. However, due to confidentiality limitations, this information was used for the researcher’s benefit only, and was not passed onto parents. The feedback forms for adolescents and parents can be found in the TANDEM intervention package. Copies of completed parent and adolescent versions (a mother and her 12 years 11 month old son) of the feedback form have also been included in the TANDEM intervention package to indicate how these forms were used in practice.

*Summary of parent interviews.* The comments of parents to be presented in this section arose from the discussion with the researcher following the intake assessment process. These comments described the parent’s perceptions of his or her resilience,
affective state, and sense of knowledge-based competency and self-efficacy in the parenting role. These perceptions were couched in the information that emerged from the parent version of the APBA. In general, the discussions based on feedback of results of the APBA indicated that the adolescents of these parents were demonstrating levels of at-risk behaviour that were comparatively higher than levels of the normative adolescent sample. As will shortly be seen, these results appeared to be linked to parents’ comments concerning their feelings of resilience, competency and self-efficacy, and affect states. For the purpose of intelligibility, the researcher has occasionally supplemented parents’ comments with his words. These words have been enclosed in square brackets.

In general, parents illustrated a shared sense of feeling lost as they discussed the demands of parenting. This sense of feeling lost reflected various areas of parenting skill. The most prevalent area involved experiences of communication between parent and adolescent. Parents seemed to find themselves locked into a one-way dead end street when they attempted to speak about important matters with their son or daughter. One mother described this as a simple wish of not wanting “the channels of communication to close with [my daughter]”. Another parent was more explicit when she described her attempts at communication with her daughter. She reflected on this by saying: “What I don’t want is for me to say ‘no’ and for her to run yelling and screaming into her room, slamming doors, and threatening to leave home”. This same mother also said: “We never discuss problems. Afterwards I just let things go and carry on as if nothing happened”. Yet another parent reflected this sense of feeling lost in speaking with her child when she said: “I have some basic ideas, but how I put these into place is not the best delivery sometimes. There is something in my delivery that she is not buying, and then she walks off and slams the door”.
In a further instance there was evidence of a dismissive attitude by a father when speaking with his son. In discussing how he approached communication with his son, he simply believed the best solution was found by offering what he saw as good advice. When his son spoke about a desire to join the A-grade soccer team, he described his response as: “Aw mate – there are kids out there who have been doing this for a long time. I don’t know…” He said that he regretted replying in this way and understood why his son would feel deflated by this, though he could think of no other way of approaching the situation. His wife on the other hand wanted to “learn how to listen” to her son so that she “didn’t cut him off”. This situation in particular indicated a potentially serious discrepancy in parenting styles as well as communication approaches of each parent. Both parents acknowledged that their son was excessively “quiet” and that he “stood back” and lacked confidence, yet they were unsure as to how to ameliorate the difficulties that resulted for their son because of these traits. “I don’t know where to look” was the mother’s response.

Outcomes of poor communication patterns varied in seriousness and intensity, from the child walking out of the parent’s presence to more serious consequences. One mother reported her distress at the way her husband handled a potentially dangerous situation with their daughter. A disagreement between the father and daughter escalated to the point where the daughter took to her father with a kitchen knife. When she threatened, “to kill” her father, he replied by saying “Well, do it – go on, do it!” The mother stated that “after last night [this incident] I just want to be rid of her”, and further commented that “she has no respect”. While this child was also under police and legal care, this type of response indicated the possible point of exit that could result from unattended escalating problems of communication between adolescents and their parents. This worrying sense of a parent not being sure about how much he or she
actually liked one’s child was reflected by another parent who was struggling to communicate more effectively with his daughter in “the mundane things of life”. His desire was to reach a point where he could “like his daughter more”.

In terms of a parent’s knowledge about the son or daughter’s use of drugs and alcohol, there appeared to be a link between poor communication and the normal process of adolescent autonomy. Some parents expressed concern about not knowing what was happening in this arena. One parent couple, upon completion of the \textit{APBA}, apologised for their responses to the drug and alcohol items, saying: “We really didn’t have much idea about these questions”. Another mother stated: “I guess if he’s a normal sort of kid he’d be into this stuff in some way”. Yet another parent admitted to making an educated guess about her responses. On the other hand, a single mother described how she and her son openly discussed his use of alcohol, stating that while the son knew his mother used marijuana, he wouldn’t use it himself. She couched this in her wider comment of: “There isn’t much we don’t talk about [with each other]”. While this situation might have appeared somewhat dysfunctional, it nonetheless emphasised the importance of being able to speak openly with one’s son or daughter, even concerning sensitive issues such as drug and alcohol use. The fact that some parents expressed embarrassment or concern about \textit{not} being aware of their child’s habits in the area of drug and alcohol consumption provided an opportunity to review the way communication practices took place in their wider family environments. With regard to the appropriateness of the parent version of the \textit{APBA}, this evident lack of knowledge about the adolescent’s substance use further indicated the need to conduct ongoing research with this version of the questionnaire.

Difficulties with monitoring the adolescent’s activities and feeling secure enough to place limits on these activities was also evident in the parents’ comments.
Problems in monitoring and limit setting were reflected by the comment of a parent who said: “I know I have let out too much rope at times – I did once and she…got herself pregnant”. The same mother acknowledged that she felt unsure about dealing with her daughter’s demands for excessive freedom when she said: “I know I’m being manipulated and I know I give in but I want her to be safe”. After discussion, this mother was able to understand the possible at-risk outcomes that were likely to result from the dissonance contained in this statement. That is, keeping her daughter safe did not result from giving in, although this was the mother’s way of justifying her knowledge of being manipulated by the daughter. Another parent stated that she felt a tug between being responsible as a parent while not losing her daughter’s affection. She stated that she had difficulty in trying “to get [her daughter] to be my friend, while not backing down on the important things like setting boundaries and so on”.

A parent couple agreed that they used opposing parenting styles, with the mother displaying a more democratic approach and the father agreeing that his approach was autocratic. This difference resulted in their daughter playing one parent off against the other to gain her freedom. The response of both parents was to project this ‘push-pull’ situation onto the daughter’s responsibility by stating that they hoped that she “will be trustworthy so we can give her more freedom”. Ultimately these parents were able to see that the daughter’s trustworthiness would result more easily from a shared democratic parenting style. This in turn would increase the level of honesty between the daughter and both parents, and therefore establish the daughter’s security of knowing that what had been decided was the consequence of discussion between her parents. By placing one parent in opposition against the other, and so gaining her own way, meant that ultimately the daughter needed to take responsibility for her own actions without the combined support of her parents.
A father who came for interview believed that his own battle with drug and alcohol misuse exacerbated problems with monitoring and limiting his daughter’s activities. He had previously coped with his problems through substance misuse. His motivation to cease this came from his daughter’s adolescent development. He stated: “I am paranoid about what she’s doing – I know her friends drink and smoke and I know she joins in but I don’t know how much. Our friends say she does”. In the past he would have solved this issue through his own substance misuse. However, without the support of his chosen substance, he was at a loss as to how he might cope otherwise. This parent also believed he suffered from depression, and believed that his daughter copied his depressed moods. In relation to this belief he said: “[Daughter] and I bounce off each other in our depression. I know she gets depressed also. I am sometimes afraid she will end up like I am”. His final comment resembled a plea for help that also involved his daughter when he said: “I am looking for a way to cope with her that is going to do something for both of us”.

A basic lack of knowledge about issues such as adolescent development and the purpose of adolescent thinking or behaviour were evident in parents’ discussions. In speaking about their lack of knowledge in these matters, parents made comments such as “I want to know more about what’s going on in their heads” and “All I want are some answers”. A mother believed that her own late development as an adolescent meant that she herself missed out on the experience of what she understood as normal adolescent development. This in turn led her to feel that she lacked confidence in coping with her adolescent sons’ development. She was unsure as to how to handle her younger and older sons’ budding need for autonomy when she said: “I want to foster a sense of independence in both my children – for themselves, in a positive way – to have good esteem”. In trying to come to terms with her sons’ needs, this mother “wanted more
patience” as well as wanting to “value his feelings”. The same parent was concerned about how she would discuss the onset of puberty with her younger son since she lacked a male partner.

Parents’ comments about their children’s own difficulties revealed a number of problem areas. These included behaviour indicative of attention-deficit hyperactivity disorder (evident from ages as early as 6 years), aggressive and violent behaviour, general non-compliance and defiance, depression and substance misuse, and problems with the police and other legal authorities (such as legal court proceedings). One parent stood apart in her comments about her two sons. She was a single mother who believed that she had something to fear about her sons’ development into adolescence, though found it difficult to clearly describe this fear. When she read some of the items in the APBA, she was horrified that her sons, particularly her older son, might be involved in this type of behaviour (such as carrying weapons, misusing drugs and alcohol). She stated: “Some of these questions – this is awful! I hope my child doesn’t get into this stuff. Do you think he might do this?” Ultimately this mother was accepted into the programme simply because she was unsure about whether her adolescent sons were in fact engaging in problem behaviour, and if so was unsure as to how to handle what they were doing. This mother believed that she would benefit from having the skill to ask the right questions in order to gain honest responses from her children. According to APBA findings, her sons were not at risk of problem behaviour, although this mother was allocated a place in the TANDEM programme as a preventative measure against the possible occurrence of future adolescent risk.

7.1.3 Discussion concerning intake assessments

A broader discussion of the overall TANDEM programme will be presented in section 7.2.3. At this point, a brief discussion concerning the intake assessments will be
outlined. The issues that arose in post-assessment discussions between parents and the researcher enhanced the assessment findings of the parent version of the *Adolescent Problem Behaviour Assessment (APBA)* as it was used in the TANDEM programme. The differences in mean scores between the responses of the normative parent sample and the TANDEM parent sample, though statistically significant on the whole, were not large. This indicated that parents who requested a place in the TANDEM programme were experiencing some management difficulties with their sons and daughters, yet these adolescents were not at particularly high risk for problem outcomes in their behaviour. Nonetheless, from the perspective of *proneness* towards becoming engaged in problem behaviour (Jessor R. & Jessor S.L., 1977), results of both the adolescent and parent versions of the *Adolescent Assessment of Problem Behaviour (APBA)* for the TANDEM adolescent and parent sample did suggest that the beginnings of adolescent problem behaviour were evident, and this indicated the need for intervention.

Some comments by parents during assessment feedback and discussions, such as those indicating legal processes or use of a weapon, were disparate with the smallness of mean score differences between the normative and TANDEM samples. This disparity might have arisen from a parent’s need to downplay the seriousness of the adolescent’s behaviour, either because of embarrassment over the dysfunctional nature of the adolescent’s behaviour, or because of difficulty in facing up to the seriousness of dysfunctional behaviour. This evident disparity further emphasised the need to not only administer the *APBA* but also to personally discuss the results of the *APBA* with the parent concerned.

The added information supplied by interviews with parents in conjunction with the scoring and feedback of assessment results also emphasised the importance of enabling parents the opportunity to discuss assessment results against the background of
parents’ perception of their son or daughter’s behaviour. Parents’ comments during these interviews pointed to the fact that they were variously concerned about their adolescent children’s behaviour, as they perceived it happening in everyday reality. According to parents’ comments, their adolescents appeared to be exhibiting higher levels of harmful risk than the normative sample. Parents also seemed lost in handling this type of behaviour. They described poor or confused patterns of communication with their adolescents, as well as poor monitoring and limit setting skills, and conflicting styles of parenting that in the main were ineffectual with their sons or daughters. Parents also expressed concern and some ignorance about their adolescents’ use of alcohol, tobacco, and marijuana. Finally, difficulties in parenting were compounded by some parents’ own personal problems, such as depressed mood and evident feelings of hopelessness. The assessment results of the parent version of the APBA (adolescent results could not be used due to limits of confidentiality) provided a quantitative measure of adolescent behaviour that supported these concerns.

The interplay between the outcome findings of the APBA and the ensuing discussion with parents about these findings was evident during the intake interviews. Information gained from the APBA about adolescent behaviour provided a solid knowledge base for discussion with the parents about concerns for their adolescent and their capacity to effectively cope with what they saw as harmful behaviour. The contribution of both the formal pencil and paper assessment questionnaires and the following discussion between parent and researcher on the basis of assessment results appeared to reinforce in parents’ thinking the need for speedy intervention. These combined levels of feedback also appeared to clarify the focal points of concern for parents about their adolescents. The intake assessment as a complete process of written format and discussion therefore proved to be an effective means of clarifying areas of
adolescent behaviour that warranted concern, as well as encouraging parents to seriously consider the need to positively address these concerns about their son or daughter’s current quality of lifestyle.

7.2 The TANDEM-parenting course

7.2.1 Method

Measurements were taken at two points in time in order to assess the effectiveness of the six-week TANDEM-parenting course. At the intake interview, the questionnaires described in section 7.2.1.2 below were administered to parents as part of pre-test measures of suitability for the TANDEM-parenting course. All parents who completed intake assessments were considered suitable for the six-week TANDEM-parenting course. At the conclusion of the parenting course parents again completed the intake assessments described in 7.2.1.2 as post-test measures of intervention effectiveness.

7.2.1.1 Participants. Twenty-two parents completed one of two parenting courses (16 mothers and six fathers). Ten parents self-nominated for the morning course, and 12 parents self-nominated for the evening course. This was the same participant sample that initially sought help through the TANDEM programme. A complete description of the participant sample can be found in section 7.1.1.1.

7.2.1.2 Instruments.

Pre and post measures. The Depression Anxiety Stress Scales - 21-item version (DASS-21), (Lovibond, P.F. & Lovibond, S.H., 1995b), the Parental Knowledge Scale, the Parental Feeling Scale, and the Parent Resilience Questionnaire were used as pre and post test measures.

The TANDEM parent manual. The TANDEM parent manual was issued to each parent participant for use during the course, and was retained by parents after they
completed the course. The manual was to be an integral component of the week-to-week sessions of the parenting course. This manual has been described in section 7.1.1.2 and has been reproduced in its entirety in the TANDEM intervention package.

7.2.1.3 Procedure.

The progression of the six-week parenting course. The first session of the parenting course began with an opportunity for members to identify and introduce themselves, as well as describe their individual goals for participating in the course. The researcher stressed the fact that each week’s session was the parents’ own time. It was a time to be enjoyed and looked forward to, as well as an opportunity to learn new skills and increase one’s confidence as a parent. The basic requirement of confidentiality was also stressed. This was emphasised in a clear statement that whatever was discussed within the group was not to be taken outside that setting. In this way, trust among group members would develop. Mutual respect among members was emphasised, particularly in relation to speaking and listening during sessions. It was pointed out that if the expectation of mutual respect was to be expected of one’s adolescents then this expectation should commence within the parent setting of each TANDEM session. Members were also asked to arrive at sessions on time, and perhaps even aim at arriving ten minutes prior to the scheduled starting time. This was also presented in the context of mutual respect among members, although unexpected problems preventing one’s arrival on time were acknowledged.

The skills-based rather than therapeutic nature of the course was described, and within this context parents were asked to consider the appropriate use of examples from one’s home experiences that did not resemble specifically personal information. If parents required special assistance, they were invited to approach the researcher for a confidential one-to-one meeting. The manner in which the manual was to be utilised
was also addressed. The researcher made clear to the parents that it would not be possible to cover every aspect of manual chapters in each session. Rather, principal aspects of each chapter would be chosen in order to adequately direct parents reading during the following week. Along with activities at the end of each chapter, this reading material comprised homework on a weekly basis. Finally, housekeeping issues were addressed. Each parent was given a handout sheet outlining this introductory information. This sheet can be found in the TANDEM intervention package.

Apart from the initial session, all sessions resembled each other in their format. That is, following a brief review of the previous week’s presentation, parents were invited to highlight any problems they had experienced in implementing the skills covered during the past week. No more than ten minutes was allocated for this feedback. Specific difficulties requiring closer examination could be addressed in a one-to-one interview time. If this was necessary, an interview time was arranged with the researcher after the session. Thus the bulk of allocated time was used for presenting the parenting skills for that particular session. During this time the principal areas of each chapter were outlined and explained, and if appropriate were modelled through role-play by the researcher and volunteer parents. Parents were referred to sections of the chapter not covered during the session for later reading at home. Principal areas were chosen for each session by the researcher according to the concordance between the responses of parents and adolescents to the APBA, as well as areas of specific difficulty indicated by parents during post-assessment discussions.

Parenting skills and related issues that were covered during the session were presented in a detailed manner. The topic for each week related to the chapter topics of the parenting manual. However, time constraints placed upon each session meant that not every aspect of each chapter was given equal emphasis. Hence the choice of chapter
content emphasised in each week’s session was directed by information arising from the feedback interviews with parents during the assessment phase of the TANDEM programme. In general terms, the topics of the psychology of adolescent development, communication skills, problem solving and negotiation skills, monitoring and limit setting of adolescent activity, and self-care issues for the parent were covered during the parenting course. The principles comprising these topics were also applied to specific content areas addressed each week. For example, communication skill was a principal domain that permeated each session, since communication skills also underpinned effective problem solving, conflict negotiation, and monitoring and limit setting of behaviour. As a result, it became evident to parents that these further areas of parent management would be difficult to achieve effectively without the support of strong communication skills. Modelling of appropriate behaviour by the parent for the adolescent was yet another domain that buttressed the content areas taught and discussed each week.

The discrepancies between the perceptions of harmful risk behaviour indicated by the adolescent and the parent in relation to the APBA assessment of the three factors of the Interpersonal Support Questionnaire provided further direction in choosing input and discussion areas for weekly sessions. From Table 7.3 of this chapter it can be seen that parents and adolescents differed in their perceptions of the amount of harmful risk entailed in the manner in which the adolescent modelled the behaviour of peers. Similar discrepancies were found between parents and adolescents about the level of harmful risk arising from issues related to monitoring and limiting of adolescent behaviour by the parent. On the other hand, perceptions about issues related to relationships with parents and within the family environment, were similar between parents and adolescents, although these were escalated in risk level for each group when compared
to the factors of Peer Modelling and Parental Monitoring/Limit Setting. Hence special attention was paid to these areas by the researcher when selecting content areas for special emphasis within each session, thus meeting the needs of this particular parent sample.

With regard to how data arising from the assessment of substance use was used for establishing the content areas of the parenting course (see Table 7.4 within this chapter), the issue of substance use was not addressed directly. Apart from tobacco consumption, mean score differences between the TANDEM and normative samples of parents and adolescents were all virtually statistically non-significant. Secondly, during the assessment feedback interviews with parents, comments made by some parents suggested that they were making educated guesses about the substance use of their sons and daughters. Hence, there was the concern that if the issue of substance use was directly discussed with parents during the course, then parents would possibly over-concentrate on this issue out of a concern for not having a clear awareness of their adolescents’ substance use habits to the detriment of addressing other parenting skills. Issues surrounding substance use did arise, however, when topics such as communication, problem solving, and in particular the psychology of adolescent development were discussed. Dealing with the issues of adolescent substance use within the context of these content areas was considered a more beneficial approach. Discussing substance use in the context of communication skill, for example, meant that the importance of using good communication approaches to monitor possible substance use by the adolescent was more important than attempting to work out the “if” and the “what” of specific arenas of substance use.

The flowcharts were of particular help in the task of preparing and presenting weekly sessions. Appropriate examples from parents’ experiences with their adolescent
also provided a means of grounding the presentation in order to make it relevant to parents’ home situations. A ten-minute refreshment break was always allocated after the first hour. This time also allowed for informal discussion among parents. The session was finally rounded off with a summary of the content, a final period for questions, and a very brief preview of the next week’s work. Parents were also directed towards activities for the week during this final time.

**The booster sessions.** At the conclusion of the programme, two booster sessions were offered to parents. These were scheduled at four-weekly intervals. The purpose of these sessions was to ensure that parents continued to feel supported by the TANDEM programme. During booster sessions, parents were invited to discuss the weaknesses and strengths they had found in their families and their management styles since the conclusion of the programme or the previous booster session. This discussion enabled the researcher to focus revision topics on specific areas of need. Booster sessions also provided parents with an opportunity to reinforce a sense of competency in their parenting role.

Because parents expressed a keenness to see these one-off sessions as being used for their own needs rather than for research purposes, ongoing data was not collected during booster sessions out of respect for this general request. One parent commented that she “usually [reached a stage] of [becoming tired] of wasting all your time filling out forms”. Another parent stated that filling out questionnaires led her to doubt her abilities as a parent – “I see all those things I should be doing staring back at me from the page, and I go away feeling lousy”. This comment would be understandable where a parent felt personally fragile about his or her competency as a parent. For future TANDEM programmes, the decision was made to conduct data collection for booster sessions by post one week prior to each session. Parents would be asked to complete a
set of questionnaires at home and bring these with them to the session. Data from booster sessions would also provide a means of tracking parents’ capacity to maintain previously learned skills.

7.2.2 Results of pre and post measures of intervention effectiveness

Results of pre and post measures have been presented for mothers and fathers as a combined sample, since the aim of these analyses was to consider the general role of parent rather than the discrete roles of mother and father when measuring the effectiveness of the six-week course. The results of each assessment measure will be presented separately, with pre-test measures described as ‘Time 1’ and post-test measures described as ‘Time 2’.

The Depression Anxiety Stress Scales - 21-item version (DASS-21). The Depression Anxiety Stress Scales, 21-item version (DASS-21) (Lovibond, P.F. & Lovibond, S.H., 1995b) was used as a pre and post measure of parents’ levels of depression, anxiety, and stress. Descriptive ranges provided by the Manual for the Depression Anxiety Stress Scales [Second Edition] (Lovibond, S.H. & Lovibond, P.F., 1995b) were used to clinically describe the mean scores of the TANDEM parent sample for Time 1 and Time 2. From the lower to the higher end of the range, mean scores were described as either normal, mild, moderate, severe or extremely severe.

During the clinical interview, one participant described herself as being “extremely depressed”, as well as reporting that she had been “very depressed” throughout the parenting course. The findings of the DASS-21 for this person indicated a moderate level of depression at Time 1 (M=16.00) and a moderate level of depression at Time 2 (M=18.00). Her levels of anxiety were recorded as extremely severe both at Time 1 (M=20.00) and at Time 2 (M=22.00), and her levels of stress were recorded as severe at Time 1 (M=30.00) and moderate at Time 2 (M=22.00). In fact, this
participant’s mean score for depression increased from Time 1 to Time 2. For the *DASS-21*, this participant’s mean scores ranged from 1.5 to 4.5 standard deviations higher than the group mean score. Hence, each outcome measure of the *DASS-21* for this participant was considered an outlier, and so her mean scores were excluded from the group analysis of the *DASS-21*. On the other hand, for the *Parental Knowledge Scale*, the *Parental Feeling Scale*, and for the *Parent Resilience Questionnaire*, the mean scores of this participant were less than 1.0 standard deviation higher than the group mean score. Hence her mean scores were included in the group analyses of each of these latter assessments measures.

The mean scores for severity of parents’ depression, anxiety, and stress at Time 1 and again at Time 2 have been presented in Table 7.7. The mean age of parents who participated in TANDEM was 42.2 years. Measurement findings were compared with the normative mean scores for the age group of 40 to 49 years for each affect condition (Manual for the Depression Anxiety Stress Scales [Second Edition], Lovibond, S.H. & Lovibond, P.F., 1995b). Normative mean scores have been recorded in square brackets following each mean score for the Time 1 condition of the TANDEM parent sample.

**Table 7.7**

<table>
<thead>
<tr>
<th>Condition (n=22)</th>
<th>Time 1: Mean (SD)</th>
<th>Time 2: mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>9.70 (10.22) [4.43 (6.40)]</td>
<td>7.20 (6.27)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>4.40 (5.36) [3.37 (4.92)]</td>
<td>2.90 (4.33)</td>
</tr>
<tr>
<td>Stress</td>
<td>15.30 (8.10) [8.13 (8.75)]</td>
<td>10.80 (7.35)</td>
</tr>
</tbody>
</table>

Mean scores for depression suggested that parents were experiencing mild levels of depression at Time 1, returning to the borderline between the normal and mild ranges at Time 2. For anxiety, mean scores of parents were situated within the normal range for
both Time 1 and Time 2. Finally, mean scores for stress suggested that parents were experiencing mild levels of stress at Time 1, returning to the borderline between the normal and mild ranges at Time 2. At Time 1, mean scores of the TANDEM parent sample for depression and stress indicated a standard deviation of approximately 1.0 higher than the normative mean score for these affect conditions. At Time 2, mean scores for depression and stress had reduced from a standard deviation of approximately 1.0 to a standard deviation of approximately 0.5 higher than the normative mean score for these conditions.

To determine the statistical significance of the mean score differences between Time 1 and Time 2 for depression and stress, univariate analyses were conducted for each of these negative affect conditions. The mean score difference for depression between Time 1 and Time 2 was statistically non-significant. For stress, a significant mean score difference was found between Time 1 and Time 2 (Greenhouse-Geisser $F(1.00,823.50) = 4.67, p<.05, \eta^2=.197$). However, at a clinical level it was important to ask if this statistically significant finding truly represented a level of stress that was of clinical concern. While this result was statistically significant ($p=.04$), the low value of effect size ($\eta^2=.197$) indicated a lack of practical significance. That is, the variables comprising the factor for stress were accounting for no more than 20% of the variance, which was insufficient to reliably conclude that change experienced by parents (as indicated by the statistically significant finding) occurred because of a reduction in stress levels. Furthermore, the difference in mean score between Time 1 and Time 2 for stress did not indicate a remarkable shift in the level of stress between these occasions. On the other hand, it is also important to note that significant mean score differences were all in the desired direction.
The findings of the DASS-21 for anxiety, depression, and stress were not surprising. At the commencement of the TANDEM-parenting course (Time 1), parents’ reports for anxiety were situated within the normal range, while their reports for depression differed only very slightly from the normative sample. Of the three negative affect conditions, parents appeared to be most affected by stress, though again the mean score of the TANDEM parent sample for stress only differed from the normal sample by approximately 1.0 standard deviation from the mean. Furthermore, while the mean scores of the TANDEM parent sample for depression and stress were still slightly elevated beyond normative mean scores at Time 2, the levels of depression and stress experienced by the TANDEM parents were situated on the borderline between normal and mild. Therefore, while levels of depression and stress did not markedly reduce for the TANDEM parents following the conclusion of the six-week parenting course, these levels were only very marginally elevated beyond the normal level at the commencement of the programme. These affect conditions also appeared to remain stable over the duration of the parenting course.

The Parental Knowledge Scale and the Parental Feeling Scale. When re-administered at Time 2, these scales were restructured as a single questionnaire apart from the Adolescent Problem Behaviour Assessment (APBA). A comparison of mean scores for each scale at Time 1 and Time 2 has been presented in Table 7.8.

Table 7.8
Pre and post measures for the Parental Knowledge Scale and the Parental Feeling Scale

<table>
<thead>
<tr>
<th>Scale</th>
<th>Time 1: Mean (SD)</th>
<th>Time 2: Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Parental Knowledge Scale</td>
<td>2.98 (0.83)</td>
<td>3.98 (0.49)</td>
</tr>
<tr>
<td>The Parental Feeling Scale</td>
<td>3.10 (0.66)</td>
<td>3.89 (0.53)</td>
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</tbody>
</table>
A 5-point Likert rating scale, ranging from 1 (“I strongly disagree with the statement”) to 5 (“I strongly agree with the statement”), with a mid-way point of 3 (“I am not sure either way”) was adopted to assess the extent to which parents perceived their beliefs about the domains of each scale. The mean scores for each scale at Time 1 suggested that parents generally appeared to be unsure about the extent of their skill level or their sense of self-efficacy as a parent. Mean scores at Time 2 for both scales had increased, indicating that parents believed their levels of parenting skill and self-efficacy had improved by the time the TANDEM-parenting course had concluded.

Univariate analyses were conducted to determine the statistical significance of mean score differences from Time 1 to Time 2 for both scales. A significant difference was found between Time 1 and Time 2 for the Parental Knowledge Scale (Greenhouse-Geisser $F(1.00, 20.00) = 37.80$, $p<.001$, $\eta^2 = .654$), indicating that parents believed their knowledge of basic family management skills had increased by the conclusion of the TANDEM-parenting course. A significant difference was also found for the Parental Feeling Scale (Greenhouse-Geisser $F(1.00, 20.00) = 22.69$, $p<.001$, $\eta^2 = .531$). This finding indicated that parents felt a stronger sense of self-efficacy in the parenting role by the time they had finished the course. What was not known from these findings was the contributing factor for increases in mean scores for each construct. Furthermore, these findings did not indicate the areas of specific change in either parenting skills (such as communication, problem solving) or parental self-efficacy (such as feeling confident about coping with difficult times with the adolescent). However, these findings indicated that parents experienced a general improvement in both their parenting skills and their sense of self-efficacy. The sufficiently strong values for treatment effect ($\eta^2 = .654$ for the Parental Knowledge Scale and $\eta^2 = .531$ for the Parental Feeling Scale) were also noted.
The Parent Resilience Questionnaire. The Parent Resilience Questionnaire (PRQ) was re-administered to parents at Time 2 as a separate questionnaire from the Adolescent Problem Behaviour Assessment (APBA). The Parent Resilience Questionnaire was measured across its two factors, namely General Resilience and Support of a Significant Other. Improvements in parents’ resilience from Time 1 to Time 2 suggested that over the six-week period of the TANDEM-parenting course parents had developed the ability to adaptively reframe potentially damaging situations for the parent-adolescent relationship. A comparison of mean scores at Time 1 and Time 2 for each factor of General Resilience and Support of a Significant Other has been presented in Table 7.9.

**Table 7.9**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Time 1: Mean (SD)</th>
<th>Time 2: Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Resilience</td>
<td>3.74 (0.61)</td>
<td>3.94 (0.50)</td>
</tr>
<tr>
<td>Support of a Significant Other</td>
<td>4.12 (0.89)</td>
<td>4.07 (1.06)</td>
</tr>
</tbody>
</table>

A 5-point Likert rating scale, ranging from 1 (“I strongly disagree with the statement”) to 5 (“I strongly agree with the statement”), with a mid-way point of 3 (“I am not sure either way”) was also adopted for the Parent Resilience Questionnaire (PRQ) to assess the extent of parents’ resilience and support of another significant person. At Time 1, the mean score for General Resilience appeared to situate the responses of parents around an adequate sense of resilience. The mean score for Support of a Significant Other at Time 1 indicated that parents enjoyed an acceptable level of support from another significant person. At Time 2, the mean score for General Resilience increased marginally, indicating a general shift by parents towards increased
feelings of resilience. The mean score for *Support of a Significant Other* decreased marginally at Time 2, though parents still appeared to feel another’s support in this area.

Univariate analyses were conducted to determine the statistical significance of mean score differences from Time 1 to Time 2 for both factors. A statistically significant difference was found between Time 1 and Time 2 for the factor of *General Resilience* (Greenhouse-Geisser $F(1.00,20.00) = 6.16, p<.05, \eta^2 = .235$). Improvements in parents’ resilience from Time 1 to Time 2 suggested that over the six-week period of the TANDEM-parenting course parents had developed the ability to adaptively reframe potentially damaging situations for the parent-adolescent relationship. A statistically non-significant difference was found between Time 1 and Time 2 for the factor of *Support of a Significant Other*. This indicated those parents’ beliefs about having the support of another significant person during interactions with their son or daughter did not alter during the course of the programme.

**Summary of all assessment findings.** Prior to the commencement of the six-week TANDEM-parenting course, assessment results described a group of participants who did not appear to be unduly affected by depression, anxiety, and stress, who appeared to enjoy a sense of resilience and the support of another person when exercising their role as a parent, yet also felt unsure about their competency in parenting skills and parental self-efficacy. Measures taken at the conclusion of the programme indicated that parents had experienced increases in their parenting skill level and sense of self-efficacy in their role as a parent, as well as an increase in general resilience. Parents’ levels of depression, anxiety, and stress, as well as their feelings of support of another significant person, appeared to remain stable from Time 1 to Time 2. The most remarkable change reported by parents upon completion of the programme was found in parents’ levels of parenting skill and their feelings of self-efficacy in exercising the role
of parent. This in turn would have led to the marginal increase in the parents’ sense of general resilience. It appeared that as parents felt more in control of the parenting role, both in terms of skill level and self-efficacy, then their sense of resilience improved as well.

**Comments of parents at the conclusion of the TANDEM programme.** Because the participant sample for the TANDEM programme was not considered sufficiently large for quantitative assessment to be adopted as the sole pathway of measuring intervention effectiveness, qualitative data was also sought from parents at the conclusion of the sixth week of the parenting course. Furthermore, as Foster and Mash (1999) point out, demonstrating the statistical significance of positive change as a function of treatment effect does not guarantee that change has been meaningful for the client or the client’s significant others – in the case of this research, meaningful for parents as well as adolescents and partners. Foster and Mash (1999) stress that meaningfulness is the important aspect when attempting to determine how much the person has benefited from the chosen intervention. In the case of this research, meaningfulness would equate to determining to what extent the outcomes of the parenting course component had meaning for parents in the context of their management skills, feelings of self-efficacy, resilience and affect, the quality of their parent-adolescent relationship, and hopefully a reduction of their adolescent’s behavioural difficulties.

At the conclusion of the course, parents were therefore asked to briefly describe how they had experienced change in four areas during the TANDEM-parenting course. These areas comprised personal change in themselves, personal change in their son or daughter, personal change in their partner, and change in the parent-adolescent relationship. The only instruction to parents was to answer each question with “a few
brief words or statements” (see TANDEM intervention pack for this questionnaire). Twenty-one parents responded to these questions. One parent omitted to do so for unknown reasons. Parents’ responses to these questions have been fully collated under summary headings in Appendix 20. To facilitate reading, a summary of comments collated in Appendix 20 has been presented below, grouped together under the four headings of the questionnaire.

**Parents’ comments concerning personal change.** With regard to personal change, 33.3% of parents expressed an increased readiness to “step back”, to “start to think about what to say”, and so take a “broader view” of situations surrounding their adolescent’s behaviour. Flowing through many comments was a sense of personal renewal. Parents appeared to be questioning preconceived ideas about their adolescent and the unhelpful manner in which they saw themselves previously responding to him or her. Parents also seemed to recognize the importance of assessing situations that focused on their adolescent in order to discover the optimal way of responding to both the situation and the circumstances that surrounded it. As one parent stated: “I am more aware of what [my daughter] is saying to me…I am stopping, assessing the situation, and then reacting – most of the time”. Another parent was more succinct about this necessity when she wrote: “Time to think before opening my mouth”.

A smaller percentage of parents (19%) seemed to feel more confident in the direction their parenting skills now appeared to be taking, as well as feeling increased confidence in confronting disagreements with their son or daughter. One parent described this increased confidence by referring to the adage much used throughout the course namely, “…give a bit to get a bit”. In a similar vein, parents reported feeling more positive about coping with their adolescent, particularly in difficult situations, and feeling “more flexible [and] less autocratic”. One parent summarised his feelings of
personal change in terms of a process. Change for this father was couched in a clarification of relationships with all his family members, and a “renewed questioning of [his] behaviour and [that] of other family members…” He further wrote that this direction of change led to a “more positive and open interaction” with his children. Finally, one mother gave the impression of being overwhelmed with her feelings of depression when she stated that she had been “very depressed whilst doing this course”.

Generally, the majority percentage of parents did not report extensive personal change. However the majority percentage of parents did report a heightened sense of awareness towards their adolescents and towards their responsibility as a parent, and increased feelings of confidence in achieving positive outcomes when addressing any situation with the adolescent.

*Parents’ comments concerning change they noticed in their adolescent.* A comparatively large percentage of parents (28.6%) recognised little or no change in their son or daughter, for different reasons. Parents who perceived minor change appeared to view this as being a shift from what was previously a negative standpoint. For example, one parent who reported “minor” change said that her adolescent was “more willing to talk on confrontational issues”. One parent understood a lack of change in his son as resulting from the son’s poor choices in life, while another parent believed that lack of change was due to the “horrifying” experiences her child had just been through. Yet another parent saw change as occurring in the other children apart from the identified adolescent.

Parents who did perceive change in their son or daughter described this in terms of the course goals. For instance, a majority of parents saw their son or daughter as now being more open and communicative. One parent described her daughter’s change of attitude by writing: “Where she would become frustrated and have a tantrum, now she
attempts to talk about her situation, feelings and needs”. Where change was indicated, this appeared to generate outcomes of increased happiness, increased readiness to be honest and open, and decreased tension for the adolescent son or daughter. One parent described her adolescent as being “easier to live with…more settled”. Other parents described adolescent change in terms of reductions in arguments and hostility, and increases in self-responsibility. A mother referred to her adolescent as now “moving away from me more, becoming more independent, more self responsible”. Finally, the parent who was experiencing depression viewed her son as “taking advantages of my down moods to get what he wants”. This parent appeared to be finding it equally difficult to cope with her own affective state as with her son’s demands.

Parents’ comments concerning change they noticed in their partner. The comments of parents who had partners were varied. The majority percentage of parents (56.2%) recorded positive comments. However one of three parents whose partners did not attend the programme found that tensions and disagreements over parenting issues had increased, while another could not see the positive changes the male partner believed he was making. The third parent could not see many changes, and felt she “should have insisted he come to the course”.

Positive comments circulated around a heightened willingness in partners to increase their efforts, as well as around improved communication and listening styles, improved parenting style, and increased levels of being at ease and patient with one’s adolescent. Improvements noticed in relationships were often two-way, that is between partner and partner, and partner and adolescent. With regard to communication, for example, one parent stated that her partner had been “thinking more about how he communicates with our son”, whereas another parent described improved communication “about situations between us [my partner and I]”. Reports of better
mutual support in parenting styles were encouraging. Comments related to this issue came from parents who described their partners as giving “more support by voicing his support for me”, as well as: “there is a more common view on how to parent better”. Another parent stated that her partner was “willing to talk more and listen to my point as well. He is willing to change his views”. Finally, two parents expressed views that referred to their personal situations though these were unrelated to the question. One of these statements reflected a strong bond of support between both partners who participated together in the programme. This parent commented: “[My wife] will never change, she is a great lady – she does practise a lot of what’s in the booklet for sure”.

Parents’ reports about perceiving positive changes in their partners were of interest for two reasons. Firstly, approximately half the parent sample did not have their partners with them at the programme. Reported changes in relationships with partners therefore indicated a ripple effect in improved parenting. That is, as the parent who participated in the programme began to adaptively change then his or her partner who did not participate apparently exhibited positive change also. Secondly, there seemed to be an interactional effect in relationship between both partners, and between parents and the adolescent. That is, improved relationships with the partner seemed to flow over to improved relationships with the son and daughter, and vice versa.

Parents’ comments concerning changes in the parent-adolescent relationship.

An area of intervention effect that was not quantitatively assessed related to possible improvements in relationships between parents and their adolescent children. The positive nature of parents’ comments about this domain was greatly encouraging. At the same time, parents did not appear to report major signs of change, using words such as “some”, “a few”, “at times”, “moderate”, and “slightly less” to preface their comments.
One parent did not look for change, since she believed the parent-adolescent relationship was healthy to begin with.

Forty-two per cent of parents reported that the relationship with sons or daughters had become “more harmonious”, “less stressed”, and “not quite as volatile in certain circumstances…” during the parenting course. One parent described the parent-adolescent relationship as being characterised by “much less wailing and gnashing of teeth, slightly calmer”. These comments did not clarify the factors that led to this direction of change, although 28.6% of parents also reported that avenues of communication between themselves and their adolescents were now clearer and more positive. These reports of change in communication patterns, though again not large, nonetheless indicated a useful foundation for related parenting skills, such as problem solving and setting limits on the adolescent’s activities. Parents reported now being able to have “a pleasant conversation”, to “talk more…just the two of us”, and have “a better relationship, more communication”. One parent stressed that improvements in the relationship with her daughter were linked to her ability to “put into place some strategies taught in this course – if I can keep positive WE will both have succeeded”.

**Relationship between post intervention measures and research aims.** Findings for the initial implementation of the TANDEM programme supported two out of the three research aims. Firstly, parents’ feelings of resilience and self-efficacy, as well as their skill levels, increased over the duration of the six-week programme. Parents’ comments at the conclusion of the programme also indicated notable improvements in their feelings of well-being, and these feelings appeared to be related to better levels of resilience, efficacy, and parenting skill. Secondly, parents’ comments indicated marginal though notable improvements in the parent-adolescent relationship. Patterns of communication, mutual awareness of need, a general sense of comfort between parent
and adolescent, and a reduction in adolescent aggression were indicated in parents’
comments at the conclusion of the programme. Thirdly, levels of affect did not alter
over the duration of the course. Values for parents’ levels of depression, anxiety, and
stress were not remarkably elevated at the commencement of the programme. Hence it
was not unexpected that these values did not alter markedly.

7.3  Discussion concerning the TANDEM-parenting course

Parents who participated in the course component of the TANDEM programme
reported difficulties in the basic areas of parenting, including communication skills and
the related area of problem solving, appropriate parenting style, monitoring and limit
setting, and knowledge about the progression of adolescent development. Parents
described personal experiences of depression, anxiety, a sense of helplessness and
hopelessness, and substance misuse. These arenas of difficulty were evident in varied
form among the parents who requested the initial interview. One interesting revelation
from these discussions was the level of insight generally displayed by parents regarding
the manner in which they recognized problems in their children’s behaviour. Parents
generally tended to focus on the need to find solutions from within themselves rather
than focus blame on their children. The frequent use of ‘I-statements’ rather than ‘You-
statements’ by parents seemed to emphasise this self-focused insight. Parents’ use of ‘I-
statements’ gave the impression that they felt a personal responsibility to improve
channels of communication with their adolescents, together with the desire to develop
better management skills with their adolescents and understand the process of
adolescent development more fully.

Parents indicated that they sought improvement in their son or daughter’s
behaviour, and that this improvement would occur because they had made the time and
effort to further develop their parenting skills. No single aspect of the overall process of
assessment and discussion would have led to this outcome. Rather, parents appeared to require the full extent of the overall process of assessment, feedback of results, and subsequent discussion around these assessment results, in order to arrive at this point of decision-making.

Mean scores of depression, anxiety, or stress for parents who participated in the parenting programme did not indicate clinically serious levels, with results for these conditions closely aligning with normative scores. Given the sometimes intense feeling expressed in parents’ comments, it was surprising that levels of negative affect were not higher than those indicated by the Depression Anxiety Stress Scales – 21-item version (DASS-21). In a speculative sense, these findings might have been due to the self-attributions of parents at the time they completed the DASS-21. That is, it could have been possible that if parents reported their true sense of negative affect, then their responses might be interpreted as complaint. If this was true, then parents might have underrated their levels of negative affect. Low findings for negative affect might also have reflected parents reaching a stage of resignation to tolerating unpleasant situations with their son or daughter. That is, if one tolerates a poor living environment for long enough, then there is a heightened likelihood that the situation will come to be seen as normal (Moffitt et al., 2001).

A combination of assessment results and discussion indicated that parents also appeared to experience reasonable levels of resilience and support from other significant people. It was possible that adequate levels of resilience and support enabled parents to exercise their parenting role in sometimes difficult circumstances without becoming seriously depressed, anxious or stressed. It was also possible that where parents had experienced personal distress due to their adolescents’ behaviour over a long period of
time, the resulting unpleasant situation eventually adopted a sense of normality about it (Dishion et al., 1991).

The decision to involve the person whose assessment results for depression, anxiety, and stress were remarkably elevated beyond those of other participants required further consideration. Furthermore, her comment about “being very depressed” during the six-week course placed doubt over how much benefit this person actually received from her eventual participation. The circumstances and emotional feeling described by this participant pointed to the possibility that the issues surrounding her adolescent sons and her family environment might have required a different or more intensive implementation of the TANDEM-parenting course than that offered for this research.

Two conclusions therefore emerged from this situation. Firstly, the importance of assessing and discussing the level of adolescent risk behaviour through the Adolescent Problem Behaviour Assessment, and the impact of this behaviour on parents and family cannot be over-emphasised. This would evidently need to occur prior to any decision regarding intervention, so that the chosen intervention approach could be adequately tailored to meet the specific needs of the parent and adolescent. It is possible that this outcome did not occur for the participant in question. Secondly, and in relation to the first conclusion, it is apparent that a “one size fits all” approach cannot be taken in connection to adolescent parenting programmes. Various intensities of adolescent risk and the impact of this risk on parents and family, the parent’s experiences of success or failure in dealing with risk-related issues, and the duration over which adolescent problem behaviour has been occurring need to be considered when constructing the most effective intervention approach and necessary follow-up support.

This second point in particular had implications for future applications of the TANDEM programme. The notion of “one size fits all” was not seen as denying the
usefulness of the TANDEM programme as being a portable, compact, and economical means of intervention with parents of problem adolescents. Rather, this notion reflected the manner in which the programme was implemented, and not the programme itself. Indeed, the flexibility of the TANDEM programme would enable various modules of the course to be especially adapted to suit the various levels of intensity experienced by parents with their adolescents. Parents who might be experiencing particularly poor levels of personal coping within their families, and who might also be trying to manage situations of extreme risk in their adolescent’s behaviour, would need more intensely focused strategies of effective parenting methods, as well as higher levels of support from the programme co-ordinator. For example, where an adolescent reacted to a parent’s reasonable requests or limits with physical violence, then the response of the parent would necessarily move into the arena of self-protection and protection of other family members.

Therefore, while basic skills of parenting would still apply, their effectiveness would be dependent on first containing the violence exhibited by the adolescent. Hence while the skills advocated by TANDEM are valuable in themselves for effective family management and self-care issues, the appropriateness of their application to various levels of adolescent risk and parental coping would need to be carefully considered in order to realistically answer the needs of the parent who has sought help. If the results of risk assessment indicated extreme adolescent risk behaviour and ineffective parental management and coping strategies, then the course content would need to be tailored to meet these levels of assessment. Where the parenting course component occurred for these parents in a group setting, then parents would work with and support each other as people involved in similar situations of difficulty. Alternatively, parents might find it more beneficial to first engage with a therapist in the one-to-one setting prior to entering
the TANDEM-parenting course. This and other supports for parents either before the programme commenced, or during the programme, would be valuable in those communities where implementing the programme for a heterogenous group of parents in low and high-risk situations would be unavoidable (such as in smaller and isolated community settings).

At the completion of the programme, post-test measures indicated that the parents’ levels of skill competency and self-efficacy were significantly different to indicated levels prior to starting the parenting course. Qualitative data provided by parents’ comments at the end of the six-week course supported the statistical significance of the mean score differences between pre and post conditions. Improvements in skill competency and self-efficacy were seen as being important outcomes of the overall TANDEM programme both in terms of research findings and clinical intervention. They specified that parents felt more able to cope in their family management responsibilities because of the skills they had learned and because they had personally developed during the programme. Parents’ comments also showed a readiness to continue developing these beneficial outcomes in the future. Although comments did not suggest large shifts in improvement, parents reported that positive changes within themselves and their family environments were beginning to occur, and as such were making a favourable contribution to the contentment of their family lives.

During the six-week course, parents increasingly became the primary catalyst for establishing noticeable patterns of change within the milieu of their family environment. They believed that change was possible, and made the effort to act on this belief and bring change about. As a result, parents expressed heightened feelings of confidence in themselves, and an increased sense of capably dealing with situations involving their son or daughter. It was exemplary that parents saw themselves as
establishing this new direction for change in the relatively brief period of six weeks, with only two hours available each week for face-to-face interaction with the researcher. This achievement represented an important turning point for parents in moving further forward and strengthening the bond that linked their family members together.

The values for treatment effect denoted by the two scales of Parental Knowledge ($\eta^2 = 0.65$) and Parental Feeling ($\eta^2 = 0.53$) indicated that the course component of the TANDEM programme achieved a positive outcome for parents in relation to parenting skill and self-efficacy. This particular result was pleasing since the course component of TANDEM was characteristically psychoeducational, with the principal aim of helping parents to increase their store of more appropriate and functional family management strategies, and encouraging them to feel more confident and competent as a parent. In addition to the findings for Parental Knowledge and Parental Feeling, the comments made by parents concerning their perception of the effectiveness of the programme gave clear indication that parents found the course component of TANDEM practically useful in their personal lives, and in relationships with their sons or daughters. It was therefore anticipated that increased sample sizes resulting from future programmes would indicate a statistically stronger treatment effect as a result of participating in the TANDEM programme.

The Adolescent Problem Behaviour Assessment (APBA) was used only to assess levels of harm in adolescent risk at the intake period of the TANDEM programme, and so further assess the suitability of the programme and in particular the course component for parents who sought help. Because of the relatively short period of time over which the parenting course was conducted, it was not anticipated that remarkable changes in adolescent behaviour would occur, and in fact the comments by parents at the conclusion of the course indicated this. However, it would be interesting to
administer the *APBA* to parents who participated in the course component as a follow-up assessment of adolescent risk behaviour. If this were to happen after the second booster session, then the period of time between the first administration of the *APBA* at the point of intake (Time 1) and the second administration of the *APBA* at the second booster session (Time 2) would be approximately 14 weeks. This duration would be more likely to indicate any notable improvements in adolescent behaviour according to quantitatively measured assessment outcomes. This quantitative level of pre and post measurement through the *APBA* would complement qualitative comments made by parents both at the completion of the course component and at booster session times.

Finally, the issue of financial expense was considered in the overall development of the TANDEM programme. This expense was successfully kept to a minimum. The manual was the most costly item, and was printed at a non-profit cost of $Aus12.00 (approximately $U.S.6.00). The researcher was a clinical psychologist, who conducted the programme as part of his day-to-day responsibilities. While the chosen site was an established clinic, equipped with the human and material resources necessary for a clinic environment, this need not necessarily have been so. That is, any area suitable in size for 10 to 12 participants, with basic media requirements (overhead projector, white board, television/video unit) would have sufficed. The need for basic requirements only in order to implement the TANDEM programme was considered a beneficial feature of the programme. In situations where access to funds (for both clinicians and parents) was limited, the need for basic requirements such as the above would provide an appealing feature. If necessary, the only expense need be the TANDEM parent manual itself. Future research will continue in this area by enabling the TANDEM programme to become more accessible to other helping agencies that work with parents of adolescents.
who exhibit harmful levels of risk behaviour. This issue will be addressed more fully in chapter eight.

### 7.4 Chapter summary

This chapter has described the implementation of the TANDEM programme for the purpose of this research. Intake assessments indicated that concerns of the TANDEM sample of parents about their adolescents’ risk behaviour were generally warranted, although comparison of these assessment results with the normative sample did not indicate highly elevated levels of harmful risk. All parents who presented themselves for the TANDEM programme commenced and completed the six-week parenting course. Levels of emotional affect, resilience, and support of a significant other were adequate at the point of intake, and so did not alter markedly over the time of the course component. However, parents reported notable improvements in relation to self-efficacy and skill acquisition. Parents’ comments in these arenas were supported by pre and post measures for the *Parental Knowledge Scale* and the *Parental Feeling Scale*. Mean score differences for these pre and post conditions were statistically significant, with effect sizes for both scales also strong. This was a pleasing result, given the psychoeducational emphasis on the desired outcomes of increased skill acquisition and increased parental self-efficacy. Parents’ comments at the conclusion of the parenting course also supported these findings, with a consequent positive effect of strengthening the bond between parent and adolescent. As such, the TANDEM programme achieved its purpose. Future research will continue with the TANDEM programme, with the aim of increasing the number of community settings for its implementation. The deliberately reduced need for high expenditure in implementing the TANDEM programme will facilitate this aim, particularly for helping agencies
where funding sources are limited. This latter aspect will be considered more fully in
the next concluding chapter, as will directions for future research.
CHAPTER EIGHT

CONCLUSION

The purpose of this research was firstly to develop a means of identifying and effectively addressing adolescent problem behaviour as early as possible before reaching the stage of becoming an established influence in a particular adolescent’s life. Findings of this initial stage of research resulted in the development of the Adolescent Problem Behaviour Assessment (APBA), an adolescent-related assessment instrument comprising a number of interrelated questionnaires. In the first place, three factors entitled Peer Modelling (the modelling of peer behaviour), Parent/Family Relationships (the quality of adolescent-parent and adolescent-family relationships), and Parental Monitoring/Limit Setting (the extent of parental monitoring and limiting of the adolescent’s behavioural patterns) measured the balance of risk and protection operative in an adolescent’s life. These factors formed the Interpersonal Support Questionnaire.

The description of behaviour emerging from these factors was linked to the adolescent’s use of alcohol, tobacco, and marijuana as measured by the Adolescent Drug Use Questionnaire, thus providing a further contribution to the adolescent’s risk profile. It was then possible to establish the adolescent’s awareness of the seriousness of current risk behaviour through his or her insight into where this trajectory of risk would most probably lead. This was achieved by means of the Self-Perception of Risk Questionnaire.

Finally, a parent version of this assessment measure was structured from the adolescent version, and included a measure of parental resilience, the amount of parenting skill possessed by the parent, the parent’s sense of self-efficacy in the parenting role, and a description of demographic issues related to the parent’s family.
The second stage of research entailed the development of an intervention to ameliorate adolescent problem behaviour by improving the parent’s family management skills, the parent’s resilience in difficult parent-adolescent situations, and the parent’s self-efficacy in the parenting role. Within the clinical setting, an adolescent’s behaviour was initially measured by using the parent version of the APBA as the primary means of assessment, while the parent’s sense of parenting skill and self-efficacy was measured using specially structured instruments included in the parent version of the APBA. The parent’s affective state was also measured through the administration of the Depression Anxiety Stress Scales – 21-item version. The assessment of adolescent behaviour was conducted in a sequential manner.

Having ascertained that an adolescent’s behaviour was problematic, and following discussion between clinician and parent about this outcome, the parent was invited to consider developing aspects of the parent role through a six-week parenting course. The central aim of this course was to strengthen the parent-adolescent bond and thereby gradually reverse the course of problem behaviour by improving the parent’s skill, resilience, and self-efficacy. This sequential process of assessment, discussion, and intervention was entitled the TANDEM programme.

8.1 Research conclusions

8.1.1 The effectiveness of the Adolescent Problem Behaviour Assessment.

The questionnaire structure of the Adolescent Problem Behaviour Assessment (APBA) provided a convenient platform for both assessment and discussion of an adolescent’s behaviour between a parent and clinician. The APBA assessed adolescent risk in an ordered, sequential fashion, and therefore helped the parent to consider a son or daughter’s risk-related harm as an interconnected picture rather than in piecemeal fashion. Clinically, the composition of the APBA provided the conventional step-by-step
process of undertaking any assessment of behaviour. However, a parent who was not a professional in this field, and who would have experienced an adolescent’s dysfunctional behaviour in many different forms and various levels of intensity, could not be presumed to naturally consider the adolescent’s behaviour in this ordered clinical way. Therefore, a principal benefit of the assessment process was to offer a parent this opportunity. Furthermore, a well thought out conclusion about the meaning and direction of the adolescent’s behaviour also enabled the parent to weigh up the influence of his or her responses to this behaviour. Through the parent version of the APBA this occurred through the assessment of resilience, parenting skill, and self-efficacy, all viewed against the background of the adolescent’s behavioural profile. Furthermore, the parent was offered the opportunity of reviewing his or her levels of negative affect by completing the Depression Anxiety Stress Scales – 21-item version (DASS-21).

The APBA and DASS-21 were therefore effective means of assessment for the parent’s benefit first and foremost, since an effective outcome for intervention relied heavily on the parent’s understanding of the problem nature of the adolescent’s behaviour as well as the effect this behaviour might be having on the parent personally. In addition, the parent’s motivation to adhere to the intervention plan of the parenting course was most likely be strengthened by the parent’s appreciation of the seriousness of the adolescent’s behaviour, particularly the likelihood of harm escalation if this behaviour was not addressed. Therefore, while the APBA was undoubtedly a useful clinical assessment tool of adolescent behaviour, it was also a valuable tool for the parent’s understanding of his or her adolescent’s behaviour and the level of negative affect related to that behaviour. Perhaps in some cases the APBA signified the parent’s first opportunity to fully grasp the magnitude and importance of the son or daughter’s manner of acting. From the clinician’s perspective, who was also the researcher,
ensuring the parent’s central place in the assessment process helped to establish a clear atmosphere of empathy and alliance with the parent. Placing the process of assessment within this atmosphere served to bring the worlds of the parent and clinician-researcher into a single focus, enabling the clinician-researcher to enter the reality of the parent’s world, as he or she perceived it. In this way, considerable understanding was gained of what it was like for the parent to cope with the son or daughter’s dysfunctional behaviour. The atmosphere of the clinical setting can tend to diminish the starkness of the struggle that for many parents of troubled adolescents can become a way of life in their attempt to hold onto their sons or daughters as well as maintain a bonded relationship with them (Moffitt et al., 2001).

The insistence on retaining the primacy of the parent-role in both assessment and intervention was therefore emphasised in this research. Stern and Smith (1999) have noted the gradual and positive movement over the last decade from viewing a parent’s participation in assessment and intervention of adolescent behaviour as belonging more to the helping system rather than the peripheral client system. By inviting the parent to share his or her insight with the clinician into the adolescent’s behavioural profile, the clinician is thereby inviting the parent to make a valuable contribution to whatever course of action is eventually undertaken to help the adolescent. The parent thus becomes an indispensable part of the helping system, rather than merely an outsider who looks on while the professional takes over a role that should properly be assigned to the parent.

There is also a logical necessity in emphasising the primacy of the parent’s participation, and this necessity arises from the uniqueness of relationship between the parent and adolescent. Because the parent is the one who has most contact with the adolescent, a priori logic would suggest that the parent would be the first person to at
least suspect that problems were present in the son or daughter’s behaviour. Ensuring
the priority of the parent’s participation in the TANDEM programme served to establish
from the very outset that the primary role of the clinician was not one of ‘fixing the
adolescent up’, but rather of helping the parent to strengthen the limitations of skill and confidence that were woven into the fabric of disintegration that most likely accompanied the adolescent’s behavioural decline. The TANDEM programme aimed to offer professional and sound advice within the context of encouragement and support, thus handing over to the parent the primary responsibility of restructuring and strengthening the bond between parent and adolescent. For the TANDEM programme to be successful as a means of assessment and intervention, the parent was always to be seen as the one properly endowed with the irreplaceable position of developing a protective relationship with the son or daughter, thereby becoming the crucial adaptive influence in the adolescent’s life. If adolescent behaviour were to reach extreme levels of harmful risk that eventually led to the total disintegration of this relationship, then the parent as well as the adolescent would be first among a list of people to suffer the tragic consequences of this trajectory.

8.1.2 The extent of adolescent risk evident among the TANDEM sample.

Parents who sought help through the TANDEM programme described their adolescents as engaging in a level of risk behaviour that appeared to depart marginally from normative levels, although mean score differences between the assessment results of the TANDEM sample and the data of the normative parent and adolescent samples were on the whole statistically significant. The adolescent behaviour described by the TANDEM parent sample, together with the difficulties they experienced in coping with this behaviour, validated their involvement in the TANDEM-parenting course.
Pre and post measures of intervention effectiveness indicated that parents benefited from this course particularly in the areas of increased parenting skill and self-efficacy. The pre and post measures for the scales of Parental Knowledge and Parental Feeling indicated a moderately strong treatment effect size (η = 0.65 and η = 0.53 respectively). The effect size for Parent Resilience was not as strong, though still moderate in strength (η = 0.24). This was a satisfactory result, given the small size of the TANDEM parent sample (n=22). These findings indicated that this intervention component was practically effective in helping parents adjust their parenting approaches and so enjoy improved relationships with their son or daughter, as well as feel more personally adequate in their parenting roles. These findings also justified further implementation and development of the TANDEM programme.

The fact that parents responded to advertisements for the TANDEM programme indicated that they were concerned about the type of behaviour exhibited by their sons or daughters. The intake assessment interviews further revealed that these parents hoped for a better relationship with their adolescents generally, as well as improving specific strategies in relating to their sons or daughters. Furthermore, the initial response of parents to the advertised TANDEM programme, and their comments during intake interviews, demonstrated that parents saw their role as being the fundamental channel of intervention for problem adolescent behaviour. The TANDEM parent sample not only acknowledged that problems were evident in their adolescents’ behaviour, but also acknowledged that these problems could be positively addressed through reflecting on and working with their own relationship with the son or daughter in question. Increased levels of parenting skill and self-efficacy at the conclusion of the parenting course suggested that parents possessed the necessary motivation and insight to achieve the improvements they initially sought.
8.1.3 Limitations evident in the TANDEM programme.

Apparent limitations in the development of the Adolescent Problem Behaviour Assessment (APBA), as well as the implementation of the APBA in both the assessment and intervention phases of the TANDEM programme, have been addressed throughout this thesis whenever they became evident. Hence the following sections will provide an overview of research limitations, concentrating on the development of the APBA and the TANDEM-parenting course since these two aspects of the present research provided the dual pivotal points of assessment and intervention within the TANDEM programme.

8.1.3.1 The Adolescent Problem Behaviour Assessment. While the adolescent sample was of a sufficiently large size (n = 410), at the same time this sample reported a predominantly low-risk level of behaviour. This predominance was not unexpected among a sample of adolescents whose descriptions of behaviour appeared to be normative (n = 280). However, there emerged smaller sub-samples of adolescents (n = 102) who, when compared to the total sample size, were classified beyond the first low-level quartile of risk behaviour into higher levels of risk behaviour (the second and third quartiles). The small sizes of these higher risk sub-samples most likely explained why the Interpersonal Support Questionnaire (ISQ) and the Self-Perception of Risk Questionnaire (SPRQ), both of which partially comprised the Adolescent Problem Behaviour Assessment (APBA), lacked the capacity to correctly classify adolescents as being situated somewhere within these middle quartiles of risk behaviour.

Having the capacity to describe an adolescent’s behaviour to the parent as a location within a specific quartile of low or high risk was seen as a highly desirable aspect of further research with the APBA. The benefit of this capacity would be evident in the discussion of assessment results with the parent. Accurate identification of risk
level, particularly where risk behaviour was serious, would help to gauge the amount of emphasis necessary to encourage intervention on the parent’s behalf. Nonetheless, this research indicated that the APBA in its present form was a valuable platform for discussion between therapist and parent about issues of adolescent behaviour and the parent’s response to this behaviour.

Given the nature of autonomy as being a necessary part of adolescent development, it would have been unrealistic to expect perfect levels of concordance between adolescents and their parents in relation to behaviour. However, the lack of concordance between the perceptions of mothers and fathers about their adolescents’ behavioural risk level, and the unacceptable findings for reliability and factor analyses of parent data, led to the necessary development of the parent version of the APBA from adolescent data. While this version was adequate as a measure of adolescent risk for this research, a requirement for a specific parent-related measure of adolescent risk behaviour was marked for future research. The emergence of adolescent autonomy was the most likely reason for this lack of concordance between parent and adolescent data. Adolescent autonomy would suggest that as the adolescent grew older, so the parent’s knowledge of the adolescent’s behaviour would diminish, particularly in areas where the adolescent would be less inclined to discuss behaviour with parents, such as substance use or intimate relationships. Future research would therefore focus on identifying those arenas that would best enable a parent to describe adolescent behaviour according to the parent’s perception. This would be particularly useful in those situations where the adolescent’s collaboration in the assessment process was absent.

8.1.3.2 The TANDEM-parenting course. The content of the parenting course was structured in such a way as to be adaptable to different situations involving parents
and adolescents across a variety of problem behaviour domains. The course content was compiled to include the basic skills of parenting with adolescents so that a clinician could adapt either the entire course or aspects of it to particular circumstances. However, the experience of one participant for this research who reported highly escalated levels of depression, anxiety, and stress during the intake assessment interview emphasised the importance of tailoring the parenting course to fit more evenly with the specific situations of parents who sought help. Clearly, there was an explicit need for this particular participant to address her negative emotional state, perhaps even before attempting to deal with the difficulties she described with parenting her two adolescent sons. This experience raised further questions concerning the suitability of basic parenting skills for parents of adolescents, whose behaviour had reached the point of extreme risk for harm and even included the involvement of legal services. If behaviour has been assessed as residing at the extreme negative point of the risk continuum, then the TANDEM programme would need to closely fit the specific manner in which both the adolescent was acting and the parent was responding.

The suitability of six weeks for the duration of the TANDEM-parenting course also required review. While parents reported notable improvements both personally and in the relationship with their adolescent over this duration, it was also noted that there was little time to spare in weekly sessions for parents to discuss particular content areas more fully or to explore specific issues related to their own family situations. It was reasonable to expect that aspects of the course would raise definite questions in parents’ minds in relation to their individual family circumstances. As such, these questions would be personally important to parents and so would deserve an appropriate level of response if only to further clarify the meaning of the particular aspect of content under discussion.
The lack of a control group for inclusion in the assessment of the effectiveness of the TANDEM-parenting course was acknowledged. The inclusion of a control group would have made a useful contribution to assessing treatment effectiveness of the parenting course. However, difficulties in obtaining a suitably sized treatment group of parents precluded the possibility of also obtaining sufficient parents to form a control group. At the same time, pre and post statistical data, together with the qualitative comments of parents who completed the course, indicated that the TANDEM programme and the parenting course in particular was effective in addressing aspects of adolescent risk behaviour by working directly with the parent. Provisions will be made for the inclusion of a control group in future applications of the TANDEM programme through the presence of a parent waiting list.

Finally, while the booster sessions offered parents the opportunity of discussing areas of parenting difficulty that had become apparent during time away from the TANDEM programme, these booster sessions did not provide ongoing data indicating the level at which parents were able to maintain newly acquired strategies.

### 8.2 Future research

#### 8.2.1 The Adolescent Problem Behaviour Assessment

Future research for the Adolescent Problem Behaviour Assessment (APBA) would focus principally on three areas. Firstly, the male and female adolescent sample sizes for the second and third quartiles of risk, and even for the fourth quartile of risk which was small (n = 28) and which contained only one female, would be increased. This direction would be an appropriate starting point for improving the capacity of the APBA to correctly classify adolescent behaviour along the continuum from low to high risk. Having this capacity would make it possible to compare a referred adolescent’s mean score with a normative sample for each of the four risk quartiles. This would
allow for a further clarification of risk level in addition to the present procedure of defining risk in terms of the distance of the referred adolescent’s mean score from the normative mean score.

Secondly, together with increases in sample size would be the re-administration of the APBA according to a longitudinal design. A longitudinal design would enable research to both track the development of behaviour (whether indicative of serious risk or not) over a time and age spectrum with the same adolescent and parent sample, as well as study behavioural presentations that were characteristic for the adolescents’ transition across each age frame. Furthermore, a longitudinal design would more clearly enable research to identify plateau points and variations in behaviour, particularly those ages where some behavioural domains might be more influential than others, such as substance use, sexual intimacy, peer influences, and so on.

Thirdly, a parent version of the APBA would be developed to obtain a parent’s specific perspective of adolescent risk. The parent version would therefore incorporate behavioural domains that would more easily facilitate a parent’s identification of harmful risk in an adolescent’s behaviour, rather than a reiteration of the adolescent’s perspective of harmful risk-taking. The aim of developing a parent version would be focused primarily on the parent’s relationship with the adolescent, and then on the adolescent’s behaviour within this relationship context. The findings of the present research revealed parents’ confusion about certain aspects of their son or daughter’s behaviour, especially concerning substance use, and so it would be unlikely that the parent would be fully aware of specific details about an adolescent’s behavioural patterns. On the other hand, a parent would more likely be aware that the relationship with the adolescent was in a state of decline, and be more able to describe those areas underpinning this decline.
This approach to investigating adolescent behaviour from a parent’s perspective might be quite different to the approach taken with the adolescent’s perspective, in that the parent version would consider the parent-adolescent relationship while the adolescent version would focus on actual behaviour. The hub linking both perspectives would be the balance of risk and protective factors in the adolescent’s life, with this balance being viewed from two different though related viewpoints. The important point to consider would be that specifically dedicated parent and adolescent versions of the APBA would ensure that both parties were describing the same behaviour from their own experiential perspective.

Fourthly, issues of validity were not specifically addressed in this research, and so future research would seek to establish acceptable levels of validity through further administrations of the APBA, with the specific aim of showing a relationship between the APBA and other well-validated measures related to adolescent risk behaviour. This would be established in connection with increasing the adolescent and parent sample sizes within a longitudinal design. Gullone, Moore, Moss and Boyd (2000) have raised concerns over the development of a number of current questionnaires designed to assess various aspects of adolescent risk behaviour, claiming “the assessment of adolescent risk remains largely idiosyncratic across individual studies” (p. 234). In particular, Gullone et al. (2000) noted sample selection, item length, and researcher-nominated items as limitations. The concerns of Gullone et al. (2000) were not seen to be a major problem for the development of the APBA. Ultimately, the usefulness of any questionnaire, including the APBA, resides in its capacity to measure with reasonable levels of accuracy what it claims to measure. This is construct-related validity. Construct-related validation is an ongoing process, so that over time many observations gradually clarify what an assessment measure means. In terms of construct-related
validity, the value of the APBA will be demonstrated through ongoing research indicating a relationship between the APBA and other relevant well-validated measures (Howell, 1992). Thus the usefulness of the APBA as a measure of adolescent risk behaviour will be increasingly clarified each time meaning is attached to it.

The APBA will also be administered across a more demographically varied sample pool in order to discern the capacity of the APBA to identify the presence and absence of harmful adolescent risk against the background of differing demographic characteristics. Cultural differences would also be taken into account alongside an expansion of the demographic background. While it was not possible to take into account cultural differences during the development of the TANDEM programme, at the same time the need to do so was acknowledged. It would be appropriate and respectful to various cultural backgrounds to consider these differences in future research efforts. Furthermore, while the adolescent version of the APBA indicated adequate measures of reliability, time-related sources of error were not taken into account. This issue would be addressed by establishing test-retest levels of reliability during further administrations of the APBA across these wider sample pools.

8.2.2 The TANDEM-parenting course

Reference has already been made to the need for reviewing the development of the TANDEM-parenting course for specific applications to various levels of escalated adolescent risk behaviour, as well as the need to review the length of time allocated to the parenting course component of TANDEM (see section 8.1.2.3). Both reviews have already commenced in current applications of the TANDEM programme.

8.2.2.1 Current professional applications of the TANDEM programme

Professional helping agencies. At the time of writing, the TANDEM programme has been adopted by various professional helping agencies. One particular
agency has implemented the TANDEM programme with a focus on a psychoanalytic perspective. The researcher has been involved in this approach by offering suggestions as to how this focus might be successfully put into action. The purpose of this psychoanalytic application was to offer participating parents the opportunity of exploring the meaning of personal experiences from their past lives over and against relationship and parenting difficulties with their adolescent sons and daughters. This agency has recently commenced a second TANDEM programme after the successful completion of the first programme (see Appendix 21).

Another similar professional helping agency has implemented the TANDEM programme for parents of adolescents whose risk behaviour had escalated into high-risk proportions. The researcher of this thesis acted in a supervisory role for the clinician who conducted the programme. From this experience, it was noted that while the TANDEM programme in its current format was found to be generally helpful for the parents who participated in this particular programme, at the same time certain participants who were experiencing severe home-related and personally-related problems with their adolescents appeared to seek more specific avenues of support. There appeared to be a need for more intense one-to-one intervention with these parents, thus enabling them to more successfully implement skills that were newly acquired through the parenting course component (see Appendix 21).

This outcome reflected the research findings of this thesis, indicating that further development of the programme would benefit from structuring its application to more closely reflect the individual needs of parents whose adolescents were exhibiting severe levels of risk. Such an approach would fit well with the aims of adaptability for various implementations of TANDEM. The implementation of the TANDEM programme in this latter helping agency reinforced the notion that while parents of high-risk
adolescents were ready to learn new skills of interaction with their sons and daughters, at the same time opportunities to exercise these skills at home were being sabotaged by firmly entrenched dysfunctional adolescent behaviour. Finally, the researcher has continued to conduct the TANDEM programme at the Northfields Clinic, University of Wollongong, New South Wales (Australia). This venue was chosen for the research-focused implementation of the TANDEM programme. The time span for these further programmes at Northfields Clinic has recently been increased to eight rather than six weeks. Research related to the benefits of increasing the time span is ongoing.

The above agencies, along with other agencies possibly interested in using the TANDEM programme within the confines of their own professional work, would generate a separate level of research for the ongoing development of the TANDEM programme. Varying the approach for each implementation of TANDEM would enable the programme to become practically useful within a wide variety of situations involving parents and their troubled adolescents. The contribution made by other professional helping agencies has also proven valuable with respect to further research. Originally, the parenting course component of the TANDEM programme was structured upon a psychoeducational framework only. However, the application of a therapeutic framework from a psychoanalytic perspective by the first agency mentioned in this chapter (see Appendix 21) has suggested that the TANDEM programme has the capacity to provide a balance between a psychoeducational and therapeutic orientation. On the one hand TANDEM can provide a learning foundation for parents through the step-by-step structure of the parenting course, while on the other hand parents are offered the opportunity to address their adolescent-related personal needs and difficulties. Both orientations are balanced by the emphasis placed on one or other approach according to the magnitude of parents’ needs. Therefore the emphasis of one
approach over another would be determined by the needs of the parent, the ability of the parent to exercise new or refined strategies, and the extent to which the adolescent’s behaviour had escalated into problematic proportions.

In cases where intense intervention was not required, or where the focus was preventative rather than treatment-oriented, the balance would move more towards a psychoeducational orientation since in these situations the adolescent’s behaviour would presumably not present the parent with any serious obstacles to putting new strategies into practice. However, where the parent-adolescent relationship had fractured, or the adolescent’s behaviour was at the point of extreme risk, the balance would shift to a therapeutic orientation aimed at helping the parent to personally cope with likely distressing experiences with the adolescent and the family environment.

This concept of determining a balance between orientations would also emphasise the importance of conducting a thorough intake assessment of adolescent behaviour and parental coping abilities when considering the suitability of the parent’s situation for one or other orientation. Once again, there is a strong requirement of a suitable parent version of the Adolescent Problem Behaviour Assessment (APBA), a requirement that will be given a high priority in future research.

**Acquisition of a funding grant.** On November 6th 2001, the Commonwealth Government of Australia approved a grant of money totalling $A78,892.00 for the further development of the TANDEM programme. This grant was made possible through the National Illicit Drug Strategy – Community Partnerships Initiative (see Appendix 22). The Government parameters for this further development were twofold. Firstly, the TANDEM programme was to be developed for implementation in outlying regions of New South Wales (Australia), where access by parents of problem-prone adolescents to professional psychological help was limited. The second parameter of
development would facilitate the first by constructing a videotape format of the TANDEM programme. This format would enable helping professionals and other suitably qualified persons to effectively conduct the TANDEM programme. Future research and development of the TANDEM programme by the researcher and his colleagues at Kedesh Rehabilitation Services, Berkeley, New South Wales (Australia), will be largely directed by the parameters of this Commonwealth Government funding grant.

The task of making TANDEM available to helping professionals in outlying regions would involve a number of steps. Firstly, helping professionals would need to be familiar with the domains of risk behaviour covered by the Adolescent Problem Behaviour Assessment (APBA) as well as the administration, scoring, and interpretation of the APBA, since the assessment of adolescent risk and the discussion of assessment results with the parent involved is a necessary first step in the TANDEM process. Time and personnel limitations have been considered in this aspect of further developing the TANDEM programme. During the research phase, the researcher was able to allocate two-hour interviews for each potential programme participant. However, it would be unrealistic to presume that this length of time availability would always be possible within the work demands of every helping agency. Even for the second implementation of the TANDEM programme by the researcher, the amount of time taken for completing and scoring the APBA was reviewed. Therefore, during the second implementation of the TANDEM programme, the APBA was sent out to parents for their completion prior to the initial interview. Parents returned the completed APBA to the researcher in a self-addressed envelope. Hence the APBA was already be scored and interpreted by the time the parents came for their interview, so that the interview commenced with the feedback and discussion.
It might be necessary for the TANDEM programme to be conducted by suitable people other than psychologists, who would do so under supervision of a psychologist from the particular agency or by the researcher and his colleagues from Kedesh Rehabilitation Services. Non-psychologists may not be familiar with the skills required in scoring and interpreting psychological assessment measures. Hence a computerised format of the APBA is being developed to address these issues by facilitating and streamlining the process of risk assessment. A computerised format would reduce the amount of time and skill level required in both scoring and interpreting the APBA.

Secondly, helping professionals would need to be committed to the primary role of the parent in the process of the TANDEM programme. This aspect has been emphasised throughout this thesis, and supported by current research findings. Thirdly, helping professionals would need to be familiar with the content areas of the parenting course, as well as understand why these areas have been chosen for inclusion. As well as understanding content areas of the course, presenters would also need to be skilled in the actual method of presenting the course. Issues such as presenting material in a clear and non-jargon like manner, enabling parents to assimilate course content without feeling overwhelmed or threatened, dealing with stress or conflict among group members, feeling comfortable with presenting the course in a group setting, appropriate use of video scenarios and role-play, and using an inductive style of presentation would comprise the more essential aspects of formation for presenters. Putting these aspects into practice would be facilitated through use of the video format. The video format would indicate the most effective strategies for course delivery, address potential problems that might arise within the group setting, and provide scenarios illustrative of skills that would be taught in the course component.
Fourthly, ongoing support for the parent would be achieved through strategies such as the booster sessions and opportunities for one-to-one counselling during the duration of the course. The ability of professionals to provide these services within the confines of finance and time limitations would need to be explored with them. The fundamental aim of this grant-related development would be to integrate the TANDEM programme into the overall parameters of support services made available to parents and adolescents by each particular agency. Resources of time, personnel, and finances might be severely restricted for various helping agencies, and so part of the process would be to help professionals who work in agencies where resources are particularly limited to tailor the programme around limitations without diminishing the effectiveness of the programme.

With specific reference to booster sessions, two reasons underpinned the evident need to fine-tune the process of determining skill maintenance following the conclusion of the parenting course implemented for this research. Firstly, the gathering of data identifying the capacity of parents to maintain previously acquired skill levels was seen as an important aspect to be addressed in ongoing research. In terms of continuing care for parents, this data would indicate the amount of follow-up necessary for different parent groups at the conclusion of the parenting course. Some groups might only require the basic number of two booster sessions, whereas other groups might require assistance other than this basic level of follow-up care. This level of care would also apply to parents as individuals. However, the limitation of resources would again need to be taken into account here, and so the provision of follow-up care would be linked to developing a means of maintaining continual contact with parents apart from physically meeting with them, namely through Internet and electronic mail services, and even through telephone support. While one would need to avoid any development of
unhealthy dependency of the parent on the clinician, and while a lack of resources would practically limit the amount of follow-up care available to parents, at the same time it was seen as essential that parents were not left to possibly flounder when the parenting course concluded. This duty of care would especially apply in situations where parents became aware of otherwise hidden personal issues through their involvement in the parenting course.

Secondly, data emerging from booster sessions would support the ongoing development of the TANDEM programme by highlighting its weaknesses and so direct the path of further research. The two-fold aim of helping parents to increase their levels of parenting skill, self-efficacy, and resilience, as well as ensuring that they were given every opportunity to maintain these newly found competencies, would be continually pursued with the support of this data.

Finally, the helping professionals themselves would need personal as well as professional support from the researcher and his colleagues prior to the commencement of the TANDEM programme, during the implementation of the programme, and finally during the follow-up phase at the conclusion of the programme. Professionals would also require access to a presenter's manual as part of this ongoing support. While the video format of the course component of TANDEM would visually describe the presentation of course material, at the same time having access to a presenter’s manual that was clearly structured in a step-by-step arrangement would be necessary and beneficial. A presenter’s manual would also complement both the parent manual and the video format of the course. Initial discussions for the ongoing development of the TANDEM programme have also investigated the availability of Internet and CD-Rom technology. By means of an Internet service, parents as well as professionals would have the capacity to network with each other through a central web site, as well as
remain in contact with the professionals responsible for the TANDEM programme. This point of contact would support parents through interaction with each other, as well as offer parents the opportunity to make contact with a professional person, particularly when extra help was needed. With regard to the parent and presenter’s manuals, having these documents available through both Internet and CD-Rom technology would reduce the cost of production and distribution. Having access to these manuals through the Internet would also enable the inclusion of new material without the imposition of ongoing reprinting costs.

It is envisaged that the TANDEM programme will experience ongoing development once it has been established in accordance with the requirements of the funding grant. During this present time of further development, the researcher and his colleagues through Kedesh Rehabilitation Services will be responsible for the provision of ongoing contact and support to those agencies who have agreed to participate in this development. However, beyond this present developmental phase, the participant agencies themselves would be in the position to undertake the role of support and ongoing development currently adopted by Kedesh Rehabilitation Services. Kedesh Rehabilitation Services would then become a focal point for support and ongoing development, yet at the same time also be one agency among a number of agencies who by then will also have adopted this role.

8.3 Concluding statement

Through the TANDEM programme, parents were offered the opportunity to acknowledge, assess, reflect upon, and then act upon the type of behaviour displayed by their adolescent son or daughter that showed itself as a source of discord between both parties. The directive, motivational, and educative role of the clinician throughout the TANDEM procedure positioned the parent in principal focus. From this focal point, the
parent first and foremost made the decision to improve his or her relationship with the adolescent by critically evaluating relationship aspects that were either supportive or corrosive. Through the parenting course component, the parent then strengthened strategies and attitudes that were positive and restructured strategies that were negative. The statistical findings and qualitative comments of parents both prior to and after the initial implementation of the TANDEM programme indicated not only improvements in the relationship between parent and adolescent, with parallel indications of improvement in the adolescent’s behaviour, but also clear signs that parents were starting to feel better about themselves as a parent. These findings encouraged the ongoing development of the TANDEM programme, which is currently taking place with the aid of a Commonwealth Government funding grant.
References


Kedesh Rehabilitation Services, 568 Northcliffe Drive, Berkeley, New South Wales, Australia. On-line - homepage: [http://www.kedesh.web.com](http://www.kedesh.web.com)


APPENDICES
APPENDIX 1

The Risk Behaviour Questionnaire administered for the preliminary investigation.
THE RISK BEHAVIOUR QUESTIONNAIRE

PLEASE CIRCLE ONE OF THE FOLLOWING:

MALE

FEMALE

THERE ARE NO RIGHT OR WRONG ANSWERS. YOUR ANSWERS ARE WHAT YOU THINK.

DO NOT WRITE YOUR NAME ON THE QUESTION PAGES.

NO ONE WILL SEE YOUR ANSWERS.
THEY WILL NOT BE SHOWN TO YOUR PARENTS OR TEACHERS.

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Research Title: An evaluation of an adolescent risk-status assessment questionnaire.
Researcher: Trevor Crowe & Gerard Stoyles
This research is being conducted as part of the degree Doctor of Philosophy (Clinical Psychology). This degree is being supervised by Dr Jessica Grainger, Department of Psychology, University of Wollongong, NSW, Australia.

ALL QUESTIONS START ON THE BACK OF THIS PAGE
What is your age? ________ Years

This questionnaire will ask you to think about issues concerning your family, friends, and school experiences, as well as the way you and your friends might use drugs and/or alcohol.

When answering these questions, remember that there are no right or wrong answers – rather each question is asking you to give your opinion on how things are happening for you personally.

Please answer the following questions without spending a lot of time thinking about your answer.

It is important to remember that there are no right or wrong answers.

When a question asks you to circle a number, please use the following scale for your answers:

| 1 = I strongly disagree with the statement |
| 2 = I disagree with the statement          |
| 3 = I am not sure either way              |
| 4 = I agree with the statement            |
| 5 = I strongly agree with the statement   |

1. I follow family rules 1 2 3 4 5
2. I often get into trouble at home. 1 2 3 4 5
3. When I go out I usually tell my parents where I’ll be. 1 2 3 4 5
4. I don’t like taking my friends home. 1 2 3 4 5
5. I almost always tell my parents who I’m going
   out with at night 1 2 3 4 5
6. There are often arguments at home. 1 2 3 4 5
7. I think my family really cares about me. 1 2 3 4 5
8. My parents disapprove of my friends. 1 2 3 4 5
9. I do my jobs around the house 1 2 3 4 5
10. If I go out at night I come home when I feel like it. 1 2 3 4 5
11. My parents would agree with my friends about
    the important things in life. 1 2 3 4 5
12. I’ve got into trouble with teachers at school. 1 2 3 4 5

PLEASE CONTINUE ON THE NEXT PAGE
13. On most nights, our family eats together at the table.  
14. I’ve been in trouble with the police.  
15. I believe I am a valued family member.  
16. I get into fights sometimes.  
17. It is important to get good marks at school.  
18. I sometimes carry a weapon.  
19. Staying at school is important for my future.  
20. I have vandalized property.  
21. I like school.  
22. I miss classes at school.  
23. I always do my homework and completing assignments.  
24. I have wagged/skipped school sometimes.  
25. I have been on dates.  
26. I have had sex.  
27. I feel close to my family.  
28. In my school-work I find that I fail at more things than I succeed.  
29. My parents set clear limits for what I do.  
30. I don’t like school – school sucks.  
31. Putting in my best effort at school makes me feel good about myself.  
32. Quite a lot of my friends get into trouble at home.  
33. Giving time to my school-work is just as important as giving time to enjoyable things out of school.  
34. My friends misbehave and get into trouble at school.  
35. The kids I hang around with don’t skip/wag school.

**PLEASE CONTINUE ON BACK OF THIS PAGE**
1 = I strongly disagree with the statement
2 = I disagree with the statement
3 = I am not sure either way
4 = I agree with the statement
5 = I strongly agree with the statement

36. Some of my friends sometimes destroy property or vandalize places. 1 2 3 4 5
37. My friends think school is really important. 1 2 3 4 5
38. My friends don’t really care about their marks at school. 1 2 3 4 5
39. My friends like school. 1 2 3 4 5
40. Most of my friends are older than I am. 1 2 3 4 5
41. My friends usually do their homework and assignments. 1 2 3 4 5
42. My friends pressure me not to do well at school. 1 2 3 4 5
43. My parents are warm towards me. 1 2 3 4 5
44. A fair few of my friends skip classes or wag school. 1 2 3 4 5
45. My parents always listen to me. 1 2 3 4 5
46. A lot of my friends get into trouble at school. 1 2 3 4 5
47. My parents enjoy talking to me. 1 2 3 4 5
48. My parents often yell at me. 1 2 3 4 5
49. My parents are strict with me. 1 2 3 4 5
50. My parents are cold and distant towards me. 1 2 3 4 5
51. My parents are not abusive towards me. 1 2 3 4 5
52. My parents always expect me to ask before I can go out. 1 2 3 4 5
53. My parents expect me to come home at a set time. 1 2 3 4 5
54. My parents always want to know where I am going. 1 2 3 4 5
55. My parents always want to be told whom I am with. 1 2 3 4 5

56. How many of your friends would use:
   a. Alcohol: None 25% 50% 75% 100%
   b. Tobacco: None 25% 50% 75% 100%
   c. Marijuana: None 25% 50% 75% 100%
   on a regular basis?

PLEASE CONTINUE ON THE NEXT PAGE
57. When I am with my friends, I tend to:
   a. Drink alcohol       Yes  No
   b. Smoke Tobacco       Yes  No
   c. Use alcohol regularly Yes  No
   d. Get drunk often     Yes  No
   e. Use other drugs     Yes  No

END OF QUESTIONNAIRE

THANK YOU!
APPENDIX 2

Information form for parents and adolescents who wished to participate in the preliminary investigation by completing the *Risk Behaviour Questionnaire*. 
UNIVERSITY OF WOLLONGONG

RESEARCH PARTICIPANT’S INFORMATION FORM

Research Title: An evaluation of an adolescent risk-status assessment questionnaire.

Researchers: Trevor Crowe and Gerard Stoyles

This research is being conducted as part of the degree of Bachelor of Science (Hons) for Trevor, and the degree of Doctor of Philosophy for Gerard, supervised by Dr Jessica Grainger, in the Department of Psychology, at the University of Wollongong.

Research Aims: This research examines the nature of risk and protective factors in relation to harmful adolescent risk taking behaviour. Subsequently, the aim is to trial and evaluate questionnaires aimed at both measuring the levels and presence of risk and protective factors in the adolescent’s life, and being able to assess the adolescent’s risk-status. This is measured from both the perspectives of the parent/caregiver and the adolescent. Risk-status is a measure of how much someone is vulnerable to the development of, and/or continuance of, harmful risk taking behaviour (e.g. harmful drug/alcohol abuse). Someone’s risk-status is based on the nature and mixture of the risk and protective factors currently impacting on the person’s life. It is hoped that if these questionnaires are useful for measuring risk and protective factors, the confidential information received may be helpful in the development of programmes such as parenting training and early intervention programmes that have as their aims to prevent or intercept the development of harmful risk taking behaviours in adolescence.

Procedure: After receiving written consent from both the parent/guardian and the adolescent, the procedure is a simply matter of filling out the questionnaires and returning them as outlined on the instruction sheet. No names or other identifiers are required, and the data collected will only be used as group data. That is, individual data will be used to form a larger database purely for the purpose of testing the questionnaire. If as a result of participating in this research, anyone would like to assess their risk status personally, they are more than welcome to contact Trevor Crowe or Gerard Stoyles at Frameworks For Families on (02) 4227 4624 for another assessment and a discussion of intervention options if required.

Benefits: As mentioned above, if the questionnaire is found to be a good way of exploring risk and protective factors, then the community as a whole could benefit by having prevention/intervention programmes guided by the questionnaires use.

Freedom to participate: Participation in this research is completely voluntary. Participants are free to refuse to participate, or having consented, to withdraw their consent at any time without that withdrawal in any way affecting their normal education or service provision. The research seeks to include participant’s data in a database that will ensure both confidentiality and anonymity. Further, because the completion of the questionnaire requires no personal identifying details, it is not possible to link any questionnaire results to any individual.

Further Inquiries: I am happy to answer any further inquiries regarding this research, Trevor Crowe (02) 4227 4624. Also, if you any concerns about the way the research is, or has been, conducted, you are welcome to contact the secretary of the University of Wollongong, Human Research Ethics Committee, on (02) 4221 4457. You may also discuss your concerns with my Supervisor for this research, Dr Jessica Grainger on (02) 4221 3652

Trevor Crowe   Gerard Stoyles
APPENDIX 3

Consent form for parents and adolescents who wished to participate in the preliminary investigation by completing the Risk Behaviour Questionnaire.
UNIVERSITY OF WOLLONGONG

CONSENT FORM
Parent/Care-Giver and Participant

Research Title: An evaluation of an adolescent risk-status assessment questionnaire.

Researchers: Trevor Crowe and Gerard Stoyles

This research is being conducted as part of the degree Bachelor of Science (Hons) for Trevor, and the degree of Doctor of Philosophy for Gerard, supervised by Dr Jessica Grainger, in the Department of Psychology, at the University of Wollongong.

Brief Account of Research: This research examines the nature of risk and protective factors in relation to harmful adolescent risk taking behaviour. Subsequently, the aim is to trial and evaluate questionnaires aimed at both measuring the levels and presence of risk and protective factors in the adolescent’s life, and being able to assess the adolescent’s risk-status. This is measured from both the perspectives of the parent/care-giver and the adolescent. Risk-status is a measure of how much someone is vulnerable to the development of, and/or continuance of, harmful risk taking behaviour. Someone’s risk-status is based on the nature and mixture of the risk and protective factors currently impacting on the person’s life. It is hoped that if these questionnaires are useful for measuring risk and protective factors, the confidential information received may be helpful in the development of programmes such as parenting training and early intervention programmes that have as their aims to prevent or intercept the development of harmful risk taking behaviours in adolescence.

Freedom to participate: Participation in this research is completely voluntary. Participants are free to refuse to participate, or having consented, to withdraw their consent at any time without that withdrawal in any way affecting their normal education or service provision. The research seeks to include participant’s data in a database that will ensure both confidentiality and anonymity. Further, because the completion of the questionnaire requires no personal identifying details (no names required), it is not possible to link any questionnaire results to any individual.

Further Inquiries: We are happy to answer any further inquiries regarding this research, Trevor Crowe or Gerard Stoyles (02) 4227 4624. Also, if you any concerns about the way the research is, or has been, conducted, you are welcome to contact the secretary of the University of Wollongong, Human Research Ethics Committee, on (02) 4221 4457. You may also discuss your concerns with my Supervisor for this research, Dr Jessica Grainger on (02) 4221 3652.

Parent’s/Care-Giver’s permission to have your son/daughter fill out the adolescent questionnaire

“I, ____________________________________________, give permission for my son/daughter ____________________________________________, to participate in the research of Trevor Crowe and Gerard Stoyles”.

Signed ____________________________________________
Date ____________________________________________

Participants consent: (i.e. son or daughter’s signature) “I __________________________, consent to participate in the research of Trevor Crowe and Gerard Stoyles.” Date __________________________
APPENDIX 4

Instruction format addressed to participating students prior to completion of the *Risk Behaviour Questionnaire* and the *Adolescent Problem Behaviour Questionnaire*.
The researcher addressed the following points to the first adolescent sample (n = 187) prior to commencing the Risk Behaviour Questionnaire and to the second (n = 410) adolescent sample prior to commencing the Adolescent Problem Behaviour Assessment. These instructions were not presented in a standardised format since ages of participating adolescents were varied. Because variations in age occurred, the researcher wished to make sure that all adolescents understood the instructions according to their levels of cognitive development.

1. Students were to take the parent versions of the questionnaire with them and give them to their parents when they arrived home.

2. The researcher briefly explained the layout of the questionnaire material and how the material was to be answered.

3. The researcher emphasized the requirement for each person to respect the privacy of fellow students.

4. Students were also told that their answers were not going to be judged as right or wrong. Rather they reflected each person’s personal beliefs about his or her behaviour.

5. Students were again reminded of the rights and requirements of confidentiality and anonymity.

6. If any student had a query he or she was to raise a hand and a supervisor would assist the student.

7. All students were asked not to leave the room until 25 minutes had elapsed. For the Adolescent Problem Behaviour Assessment, students were asked to wait until everyone had finished before leaving the room. This alteration was made to ensure that students were not disturbed towards the end of the administration process by the movement of furniture and people. It also guarded against students prematurely finishing their questionnaire simply because others were leaving.

8. Students were also asked to check their questionnaires for accidental omissions prior to submitting it. In order to ensure that only students handled their completed questionnaires, they personally placed them in a container as they left the room.
APPENDIX 5

Factors and factor loadings for the *Risk Behaviour Questionnaire*. 
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APPENDIX 6

Item numbers and wording of items of the *Risk Behaviour Questionnaire* and the *Interpersonal Support Questionnaire* following the factor analyses of responses to each questionnaire.
The Risk Behaviour Questionnaire

Factor One
Peer Modelling – 13 items

46. A lot of my friends get into trouble at school.
44. A fair few of my friends skip classes or wag school.
34. My friends misbehave and get into trouble at school.
56b. How many of your friends would use tobacco?
36. Some of my friends sometimes destroy property or vandalise places.
35. The kids I hang around with don’t skip/wag school.
41. My friends usually do their homework or assignments.
57a. When I am with my friends I tend to drink alcohol.
32. Quite a lot of my friends get into trouble at home.
37. My friends think school is really important.
38. My friends don’t really care about their marks at school.
56c. How many of your friends would use marijuana?

Rejected items due to lack of conceptual coherence.
24. I have wagged/skipped school sometimes.
12. I’ve got into trouble with teachers at school.
16. I get into fights sometimes.
14. I’ve been in trouble with the police.
20. I have vandalised property.
25. I have been on dates.

Factor Two
Family Relationships – 12 items

27. I feel close to my family.
45. My parents always listen to me.
47. My parents enjoy talking to me.
50. My parents are cold and distant towards me.
7. I think my family really cares about me.
15. I believe I am a valued member of my family.
6. There are often arguments at home.
43. My parents are warm towards me.
8. My parents disapprove of my friends.
2. I often get into trouble at home.
48. My parents often yell at me.
51. My parents are not abusive towards me.
Factor Three
Parent Monitoring/Limit Setting – 7 items

52. My parents always expect me to ask before I can go out.
53. My parents expect me to come home at a set time.
29. My parents set clear limits for what I do.
54. My parents always want to know where I am going.
10. If I go out at night I come home when I feel like it.
3. When I go out I usually tell my parents where I’ll be.
5. I almost always tell my parents who I am going out with at night.

Rejected items due to lack of conceptual coherence.

19. Staying at school is important for my future.
57d. When I am out with my friends I tend to get drunk often.
31. Putting in my best effort at school makes me feel good about myself.
21. I like school.
17. It is important to get good marks at school.
9. I do my jobs around the house.

The Interpersonal Support Questionnaire

The category domains (not items) developed for the Risk Behaviour Questionnaire have been numbered in brackets after each of the following items in order to show the relationship between both.

Factor One
Peer Modelling (17 items)

25. How many of your friends would regularly smoke pot (marijuana)? (7)
41. When I am out with my friends I get drunk. (7)
52. When I am out with my friends I do drugs. (7)
16. How many of your friends would have sex regularly? (6)
39. When I am out with my friends I drink alcohol. (7)
21. How many of your friends would regularly smoke cigarettes? (7)
57. How many of your friends would regularly skip/jig class? (5)
8. How many of your friends would regularly use alcohol? (7)
20. How many of your friends would bust up property or places just for the fun of it? (6)
48. How many of your friends would carry a weapon with them, such as a knife? (6)
33. How many of your friends have been in trouble with the police more than once or twice? (6)
40. How many of your friends would regularly go out looking for trouble? (6)
14. How many of your friends would repeatedly skip/jig school? (5)
31. When I am out with my friends I smoke cigarettes. (7)
5. How many of your friends would repeatedly get into trouble at school? (5)
10. How many of your friends would repeatedly get into trouble at home? (6)
28. How many of your friends would be more than one year older than you are? (6)
Rejected items due to lack of conceptual coherence.

*54. How many of your friends would have sex once or on a couple of occasions only?  
27. I skip/jig classes at school.  
46. I have had sex.  
18. I have been in trouble with the police.  
58. I have gone on dates.  
43. I skip/jig school.  
**45. How many of your friends would regularly go on dates?  
35. I carry a weapon, like a knife.  
3. I get into trouble at school.  
42. I have busted up property just for the fun of it.  

*Item 54 is reflected in Item 45, and so was rejected.  
**Item 45 is overly vague in meaning. For example, how does one define ‘going on a date’ in terms of at-risk behaviour?

Factor Two  
Parental Monitoring/Limit Setting (12 items)

60. My parents insist I come home by a certain time. (9)  
55. My parents say I have to get their permission before I can go out. (9)  
15. When I go out my parents want to know where I am going. (10)  
59. My parents check out if somewhere is safe before they let me go there. (10)  
49. My parents want to know whom I am going out with. (10)  
56. My parents care about the sort of people I make friends with. (10)  
44. When my parents set limits for me they make sure I keep them. (9)  
36. My parents are interested in knowing about my friends. (10)  
11. My parents put limits on how much I am allowed to do. (9)  
63. When I go out I tell my parents where I am going. (10)  
50. My parents make an effort to get to know the parents of my friends. (10)  
4. I tell my parents who I go out with at night. (3)  

Rejected items due to lack of conceptual coherence

37. I do my homework and finish my projects.  
53. Trying hard at school makes me feel good about myself.  
12. It is important for me to put in my best effort at school.

Factor Three  
Parent/Family Relationships – 12 items

69. I seem to get sad and depressed about things more than others. (2)  
67. I seem to get stressed out more than others. (2)  
6. My parents listen to me. (8)  
23. My parents enjoy talking to me. (8)  
34. My parents are affectionate to me. (8)  
68. I have thought about running away from home. (2)  
61. I feel close to my family. (2)  
26. My parents yell at me. (8)
19. I can tell my family cares about me by the way they act towards me. (2)
13. I get into trouble at home. (1)
2. I feel uncomfortable about taking friends home. (2)
17. There are arguments at home. (2)

*Rejected items due to lack of conceptual coherence.*

24. My parents show they think my friends are OK by the way they treat them. (2)
*This factor could be confused with the concept of peer modelling.***
APPENDIX 7

Information form for adolescents and parents who consented to complete the Adolescent Problem Behaviour Assessment (adolescent and parent versions).
UNIVERSITY OF WOLLONGONG

RESEARCH PARTICIPANT’S INFORMATION FORM

Research Title: An evaluation of an adolescent risk-status assessment questionnaire and the consequent intervention with parents aimed at preventing the escalation of ‘at risk’ behaviour.

Researcher: Gerard Stoyles

This research is being conducted for the degree of Doctor of Philosophy in psychology supervised by Dr Beth Marlow in the Department of Psychology, University of Wollongong.

Research Aims: This research examines the nature of risk and protective factors in relation to harmful adolescent risk taking behaviour. Subsequently, the aim is to trial and evaluate questionnaires directed towards both measuring the levels and presence of risk and protective factors in the adolescent’s life, and therefore assessing the adolescent’s ‘at-risk’ status. This is measured from the perspective of both the parent/care-giver and the adolescent.

Risk-status is a measure of how much someone is vulnerable to the development of, and/or continuance of harmful risk taking behaviour (e.g. harmful drug/alcohol abuse). Someone’s risk-status is based on the nature and mixture of the risk and protective factors currently impacting on the person’s life. Once these questionnaires are considered ready for general use, parents whose children are believed to be ‘at risk’ in one or other aspect of their behaviour will be confidentially offered a number of options for intervening in the progress of this behaviour. The ultimate aim of this assessment ‘feed-back’ and offer of options to parents is to prevent risk from escalating to a point where it becomes seriously hurtful to the adolescent.

Procedure: After receiving written consent from both the parent/guardian and the adolescent, the procedure is simply a matter of filling out the questionnaires and returning them as outlined on the instruction sheet. No names or other personal identifiers are required, and the data collected will only be used as group data. That is, individual data will be used to form a larger database purely for the purpose of testing the questionnaire. If as a result of participating in this research, anyone would like to assess their risk status personally, they are more than welcome to contact Gerard Stoyles at Frameworks For Families on (02) 4227 4624 for another assessment and a discussion of intervention options if required.

Benefits: As mentioned above, the hope is that this questionnaire will effectively explore risk and protective factors. As a result, the wider social community (particularly the school community) will then benefit through the availability of parent programmes designed to help parents/care-givers guide and support their teenage children throughout adolescent development.

Freedom to participate: Participation in this research is completely voluntary. Participants are free to refuse to participate, or having consented, to withdraw their consent at any time without that withdrawal in any way affecting their normal education or service provision. The research seeks to include participant’s data in a database that will ensure both confidentiality and anonymity. Further, because the completion of the questionnaire requires no personal identifying details, it is not possible to link any questionnaire results to any individual.

Further Inquiries: I am happy to answer any further inquiries regarding this research telephone (0242.274624). Also, if you have any concerns about the way the research is, or has been conducted, you are welcome to contact the secretary of the University of Wollongong, Human Research Ethics Committee, on (02) 4221 4457. You may also discuss your concerns with my Supervisor for this research, Dr Beth Marlow on (02) 42214073.

(Gerard Stoyles)
APPENDIX 8

Consent form for adolescents and parents who consented to complete the Adolescent Problem Behaviour Assessment (adolescent and parent versions).
UNIVERSITY OF WOLLONGONG

CONSENT FORM
For Adolescent and Parent/Care-Giver

**Research Title:** An evaluation of an adolescent risk-status assessment questionnaire and the consequent intervention with parents aimed at preventing the escalation of ‘at risk’ behaviour.

**Researcher:** Gerard Stoyles

This research is being conducted as part of the degree of Doctor of Philosophy in psychology, supervised by Dr Beth Marlow, in the Department of Psychology, at the University of Wollongong.

**Brief Account of Research:** This research examines the nature of risk and protective factors in relation to harmful adolescent risk taking behaviour. Subsequently, the aim is to trial and evaluate questionnaires designed to both measure the levels and presence of risk and protective factors in the adolescent’s life, as well as assess the adolescent’s risk-status. This is measured from the perspectives of both the parent/care-giver and the adolescent. Risk-status is a measure of how much someone is vulnerable to the development of, and/or continuance of, harmful risk taking behaviour. Someone’s risk-status is based on the nature and mixture of the risk and protective factors currently impacting on the person’s life. If these questionnaires are useful for measuring risk and protective factors, it is hoped that the confidential information received will lead to the development of programmes of parent training and early intervention. The aim of these programmes will be to prevent or intercept in the development of harmful risk taking behaviours in adolescence. **This request for consent to participate is for completing the questionnaire only.**

**Freedom to participate:** Participation in this research is completely voluntary. Participants are free to refuse to participate, or having consented, to withdraw their consent at any time without that withdrawal in any way affecting their normal education or service provision. The research seeks to include participant’s data in a database that will ensure both confidentiality and anonymity. Further, because the completion of the questionnaire requires no personal identifying details (no names required), it is not possible to link any questionnaire results to any individual.

**Further Inquiries:** If you have any enquiries about this research please ring Gerard Stoyles on (02) 4227 4624. Also, if you any concerns about the way the research is, or has been, conducted, you are welcome to contact the secretary of the University of Wollongong Human Research Ethics Committee, on (02) 4221 4457. You may also discuss your concerns with my Supervisor for this research, Dr Beth Marlow on (02) 4221 4073.

**Parent’s/Care-Giver’s permission to have your son/daughter fill out the adolescent questionnaire**

“I ____________________________, give permission for my son/daughter ____________________________, to participate in the research of Gerard Stoyles”.

Signed: ___________________________ Date: ___________________________

**Participants consent:** (i.e. son or daughter’s signature) “I ____________________________, consent to participate in the research of Gerard Stoyles.” Date ___________________________

**Parent’s Consent:** “I ____________________________ consent to participate in the research of Gerard Stoyles”.

Signed: ___________________________ Date: ___________________________
APPENDIX 9

Factors and factor loadings for the *Interpersonal Support Questionnaire* (parent version).
Factors and factor loadings for the *Interpersonal Support Questionnaire* (mothers)

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Eigenvalue | 10.22 | 4.82 | 3.60 |
% of variance | 14.81 | 6.10 | 5.21 |
Cumulative Variance | 14.81 | 21.80 | 27.02 |
Factors and factor loadings for the *Interpersonal Support Questionnaire* (fathers)

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Eigenvalue | 11.94 | 3.88 | 3.00 |
% of Variance | 17.31 | 5.62 | 4.35 |
Cumulative Variance | 17.31 | 22.93 | 27.27 |
APPENDIX 10

The Adolescent Problem Behaviour Assessment (APBA) – Adolescent Version.

REVERSE SCORED ITEMS

The Interpersonal Support Questionnaire (ISQ) – pages two to five.

Item numbers: 1, 4, 6, 7, 11, 12, 15, 19, 22, 23, 24, 30, 32, 34, 36, 37, 44, 49, 50, 53, 55, 56, 59, 60, 61, 62, 63.
THE ADOLESCENT PROBLEM BEHAVIOUR ASSESSMENT (Adolescent Version)

PLEASE CIRCLE: MALE FEMALE

YOUR AGE: ________ (Years) ________ (Months)

PLEASE NOTE!
THE QUESTIONS BEGIN ON THE BACK OF THIS PAGE, AND THEN ON THE FRONT AND BACK OF EVERY OTHER PAGE.

STRICTLY CONFIDENTIAL

THERE ARE NO RIGHT OR WRONG ANSWERS. YOUR ANSWERS ARE WHAT YOU THINK.

DO NOT WRITE YOUR NAME ON THE QUESTION PAGES.

NO-ONE WILL SEE YOUR ANSWERS. THEY WILL NOT BE SHOWN TO YOUR PARENTS OR TEACHERS.

---

Research Title: An evaluation of an adolescent risk-status assessment questionnaire.
Researcher: Gerard Stoyles.
This research is being conducted as part of the degree Doctor of Philosophy. This degree is being supervised by Dr Beth Marlow, Department of Psychology, University of Wollongong, NSW, Australia.
THE QUESTIONS START HERE:

Please answer the following questions as best you can. In the next section, think about each question and then circle the word beside it that answers the question best for you. There are no right or wrong answers. If there are any you do not know the answer to, please leave them blank.

1. How many of your friends would be expected to check if its OK with their parents before they go out?

   None  A few  A lot  All

2. I feel uncomfortable about taking friends home…

   Never  Sometimes  Often  Always

3. I get into trouble at school…

   Never  Sometimes  Often  Always

4. I tell my parents who I go out with at night…

   Never  Sometimes  Often  Always

5. How many of your friends would repeatedly get into trouble at school?

   None  A few  A lot  All

6. My parents listen to me…

   Never  Sometimes  Often  Always

7. I keep family rules…

   Never  Sometimes  Often  Always

8. How many of your friends would regularly use alcohol (like beer, wine, and so on)?

   None  A few  A lot  All

9. I come home when I feel like it, not when I’m told to come home…

   Never  Sometimes  Often  Always

10. How many of your friends would repeatedly get into trouble at home?

    None  A few  A lot  All

11. My parents put limits on how much I am allowed to do…

    Never  Sometimes  Often  Always

12. It is important for me to put in my best effort at school…

    Never  Sometimes  Often  Always

13. I get into trouble at home…

    Never  Sometimes  Often  Always

14. How many of your friends would repeatedly skip/jig school?

    None  A few  A lot  All

15. When I go out, my parents want to know where I am going…

    Never  Sometimes  Often  Always
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
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</thead>
<tbody>
<tr>
<td>16. How many of your friends have sex regularly?</td>
<td>None A few A lot All</td>
</tr>
<tr>
<td>17. There are arguments at home…</td>
<td>Never Sometimes Often Always</td>
</tr>
<tr>
<td>18. I have been in trouble with the police…</td>
<td>Never Sometimes Often Always</td>
</tr>
<tr>
<td>19. I can tell my family cares about me by the way they act towards me…</td>
<td>Never Sometimes Often Always</td>
</tr>
<tr>
<td>20. How many of your friends bust up property or places just for the fun of it?</td>
<td>None A few A lot All</td>
</tr>
<tr>
<td>21. How many of your friends would regularly smoke cigarettes?</td>
<td>None A few A lot All</td>
</tr>
<tr>
<td>22. How many of your friends would believe that it is important to put in one’s best effort at school?</td>
<td>None A few A lot All</td>
</tr>
<tr>
<td>23. My parents enjoy talking to me…</td>
<td>Never Sometimes Often Always</td>
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<tr>
<td>24. My parents show they think my friends are OK by the way they treat them…</td>
<td>Never Sometimes Often Always</td>
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<tr>
<td>25. How many of your friends would regularly smoke pot (marijuana)?</td>
<td>None A few A lot All</td>
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<tr>
<td>26. My parents yell at me…</td>
<td>Never Sometimes Often Always</td>
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<td>27. I skip/jig classes at school…</td>
<td>Never Sometimes Often Always</td>
</tr>
<tr>
<td>28. How many of your friends would be more than one year older than you are?</td>
<td>None A few A lot All</td>
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<tr>
<td>29. I get into fights (like punch-ups)…</td>
<td>Never Sometimes Often Always</td>
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<td>30. My family eats together around the table on most nights…</td>
<td>Never Sometimes Often Always</td>
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<tr>
<td>31. When I am out with my friends, I smoke cigarettes…</td>
<td>Never Sometimes Often Always</td>
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<tr>
<td>32. How many of your friends would regularly finish their homework and school projects?</td>
<td>None A few A lot All</td>
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<tr>
<td>33. How many of your friends would have been in trouble with the police more than once or twice?</td>
<td>None A few A lot All</td>
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<td>34</td>
<td>My parents are affectionate towards me…</td>
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<td>35</td>
<td>I carry a weapon (like a knife)…</td>
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<tr>
<td>36</td>
<td>My parents are interested in knowing about my friends…</td>
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<tr>
<td>37</td>
<td>I do my homework and finish my projects…</td>
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<td>38</td>
<td>How many of your friends would hassle you if you do well at school?</td>
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<td>39</td>
<td>When I am out with my friends, I drink alcohol (beer, wine, and so on)…</td>
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<td>40</td>
<td>How many of your friends would regularly go out looking for trouble?</td>
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<td>41</td>
<td>When I am out with my friends, I get drunk…</td>
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<td>42</td>
<td>I have busted up property just for the fun of it…</td>
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<td>43</td>
<td>I skip/jig school…</td>
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<td>44</td>
<td>When my parents set limits for me, they make sure that I keep them…</td>
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<td>45</td>
<td>How many of your friends would regularly go on dates?</td>
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<td>46</td>
<td>I have had sex…</td>
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<td>I stuff up my schoolwork more than I get it right…</td>
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<td>48</td>
<td>How many of your friends would carry a weapon with them, such as a knife?</td>
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<td>49</td>
<td>My parents want to know whom I am going out with…</td>
</tr>
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<td>50</td>
<td>My parents make an effort to get to know the parents of my friends…</td>
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<td>51</td>
<td>How many of your friends would go home when they feel like it, and not when they are told to?</td>
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<tr>
<td>Question</td>
<td>Options</td>
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<tr>
<td>52. When I am out with my friends, I do drugs….</td>
<td>Never  Sometimes  Often  Always</td>
</tr>
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<td>53. Trying hard at school makes me feel good about myself…</td>
<td>Never  Sometimes  Often  Always</td>
</tr>
<tr>
<td>54. How many of your friends have had sex once or on a couple of occasions only?</td>
<td>None  A few  A lot  All</td>
</tr>
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<td>55. My parents say that I have to get their permission before I can go out…</td>
<td>Never  Sometimes  Often  Always</td>
</tr>
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<td>56. My parents care about the sort of people I make friends with…</td>
<td>Never  Sometimes  Often  Always</td>
</tr>
<tr>
<td>57. How many of your friends would regularly skip/jig class?</td>
<td>None  A few  A lot  All</td>
</tr>
<tr>
<td>58. I have gone on dates…</td>
<td>Never  Sometimes  Often  A lot</td>
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<td>59. My parents check out if somewhere is safe before they let me go there…</td>
<td>Never  Sometimes  Often  Always</td>
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<td>60. My parents insist that I come home by a certain time…</td>
<td>Never  Sometimes  Often  Always</td>
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<td>61. I feel close to my family…</td>
<td>Never  Sometimes  Often  Always</td>
</tr>
<tr>
<td>62. I do my jobs around the house…</td>
<td>Never  Sometimes  Often  Always</td>
</tr>
<tr>
<td>63. When I go out, I tell my parents where I am going…</td>
<td>Never  Sometimes  Often  Always</td>
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<td>64. I have been bullied or threatened by other kids…</td>
<td>Never  Sometimes  Often  Always</td>
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<td>65. My parents say they will kick me out of home unless I behave…</td>
<td>Never  Sometimes  Often  Always</td>
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<tr>
<td>66. I have run away from home…</td>
<td>Never  Sometimes  Often  Always</td>
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<tr>
<td>67. I seem to get stressed out more than others…</td>
<td>Never  Sometimes  Often  Always</td>
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<tr>
<td>68. I have thought about running away from home…</td>
<td>Never  Sometimes  Often  Always</td>
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<tr>
<td>69. I seem to get sad and depressed about things more than others…</td>
<td>Never  Sometimes  Often  Always</td>
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</table>
The next lot of questions ask you about whether you use alcohol and/or drugs, and if so, how much and how often. They are not saying that this is right or wrong.

Put a cross beside the answer that is best for you.

The questions look something like this:

**During the last four weeks, how often did you go to the beach?**
- None
- On 1-2 days
- On 3-5 days
- On 6-9 days
- On 10-19 days
- On 20 or more days
- Every day

Because I am a real beach fan, I went on 20 or more days to the beach, and so I would put a cross (‘x’) next to ‘On 20 or more days’.

**THE QUESTIONS START HERE:**

1. Have you ever had a drink of alcohol (like beer, wine, spirits, and so on)?
   - Yes
   - No

   If you answered NO to this question, go to Question 4.

2. On how many days did you have an alcoholic drink in the last four weeks?
   - None
   - On 1-2 days
   - On 3-5 days
   - On 6-9 days
   - On 10-19 days
   - On 20 or more days
   - Every day?

3. On a day when you have an alcoholic drink, how many drinks would you usually have?
   - A few sips
   - 1-2 drinks
   - 3-4 drinks
   - 5-8 drinks
   - 9-12 drinks
   - Over 12 drinks?

The next few questions are about smoking tobacco in cigarettes, rollies or pre-packed:

4. Have you smoked tobacco ever?
   - Yes
   - No

   If you answered NO to this question, go to Question 7.
5. On how many days have you smoked tobacco in the last four weeks?
- None
- On 1-2 days
- On 3-5 days
- On 6-9 days
- On 10-19 days
- On 20 or more days
- Every day?

6. On a day when you smoke cigarettes how many would you usually smoke?
- A few puffs
- 1-5 a day
- Approximately half a packet a day
- Approximately three quarters a packet a day
- Approximately one packet a day
- More than one packet a day

The next few questions are about marijuana (grass, pot, joint, cannabis or hashish – hash, hydro, hash oil):

7. Have you ever used marijuana in your life?
- Yes
- No
If you answered NO, skip the next question.

8. How many times have you used marijuana or hash in the last four weeks?
- None
- 1-2 times
- 3-5 times
- 6-9 times
- 10-19 times
- 20-39 times
- 40 times or more

Think about the answers you have given to all the questions so far. These next four questions ask how you see yourself in the future if you keep on doing things the same as you do now.

1a. How likely is it that you will have problems with the police because of the people you hang around with?
- Not likely
- Somewhat likely
- Likely
- Very likely

1b. How likely is it that you will have problems with the police because of the things you do?
- Not likely
- Somewhat likely
- Likely
- Very likely
2. How likely is it that you will leave home because of the problems you experience there?

<table>
<thead>
<tr>
<th>Not likely</th>
<th>Somewhat likely</th>
<th>Likely</th>
<th>Very likely</th>
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</thead>
</table>

3a. How likely is it that you will leave school because you just don’t want to be there?

<table>
<thead>
<tr>
<th>Not likely</th>
<th>Somewhat likely</th>
<th>Likely</th>
<th>Very likely</th>
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</table>

3b. How likely is it that you will leave school because of the kids you hang around with?

<table>
<thead>
<tr>
<th>Not likely</th>
<th>Somewhat likely</th>
<th>Likely</th>
<th>Very likely</th>
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4a. How likely is it that you will have problems with drug abuse because of the things you do?

<table>
<thead>
<tr>
<th>Not likely</th>
<th>Somewhat likely</th>
<th>Likely</th>
<th>Very likely</th>
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</table>

4b. How likely is it that you will have problems with drug abuse because of the people you hang around with?

<table>
<thead>
<tr>
<th>Not likely</th>
<th>Somewhat likely</th>
<th>Likely</th>
<th>Very likely</th>
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</table>

THERE ARE NO FURTHER QUESTIONS

THANK YOU!
APPENDIX 11

The Adolescent Problem Behaviour Assessment (APBA) – Parent Version.

**REVERSE SCORED ITEMS**

1. **The Interpersonal Support Questionnaire** (pages three to six)
   
   Item numbers: 1, 4, 6, 7, 11, 12, 15, 19, 22, 23, 24, 30, 32, 34, 36, 37, 44, 49, 50, 53, 55, 56, 59, 60, 61, 62, 63.

2. **The Parent Resilience Questionnaire**
   
   Item numbers: 2, 8, 11 (page two).
1. PLEASE CIRCLE either  

   Mother (or role of mother)  
   Or  
   Father (or role of father)  

2. PLEASE CIRCLE GENDER OF SON/DAUGHTER:  MALE  
   FEMALE  

3. YOUR SON/DAUGHTER’S AGE IS:_______(YRS)_____(MTHS)  

PLEASE NOTE!  
THE QUESTIONS BEGIN ON THE BACK OF THIS PAGE,  
AND THEN ON THE FRONT AND BACK OF EVERY OTHER PAGE.  

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YOUR ANSWERS ARE NOT SHOWN TO ANYONE.  
DO NOT WRITE YOUR NAME OR ANYTHING THAT MIGHT IDENTIFY YOU ON THE QUESTION PAGES.  

Research Title: An evaluation of an adolescent risk-status assessment questionnaire.  
Researcher: Gerard Stoyles.  
This research is being conducted as part of the degree Doctor of Philosophy. This degree is being supervised by Dr Beth Marlow, Department of Psychology, University of Wollongong, NSW, Australia.
The following questions look at your ability to cope as a parent, and ‘bounce back’ when events do not turn out as well as you might have wished. When answering each question, think about the way things are going for you at the present time. Don’t spend too much time thinking about each question, and remember that there are no right or wrong answers – your answer to each question is the one that is best for you.

Use this scale for each answer:

1 = I **strongly disagree with the statement**
2 = I **disagree with the statement**
3 = I **am not sure either way**
4 = I **agree with the statement**
5 = I **strongly agree with the statement**

When my son or daughter is doing the wrong thing…

1. I know I can still keep going in spite of feeling upset. 1 2 3 4 5
2. I just don’t know how I’ll ever cope. 1 2 3 4 5
3. I think things will work out. 1 2 3 4 5
4. I have someone who helps me get through difficult times. 1 2 3 4 5
5. I know that I can handle the problem. 1 2 3 4 5
6. I can work on some strategies that will help. 1 2 3 4 5
7. Even though I feel angry with my son or daughter, I still think things will turn out OK. 1 2 3 4 5
8. I get so stressed out I just want to give up on my son or daughter. 1 2 3 4 5
9. No matter how hard it gets, I will make it. 1 2 3 4 5
10. There is someone with whom I can share my feelings, and I feel I can depend on that person. 1 2 3 4 5
11. Sometimes when I’m angry with my son or daughter, I believe I have run out of solutions. 1 2 3 4 5

(THERE ARE MORE QUESTIONS OVER THE PAGE)
In the next section, think about each question and then circle the word beside it that best fits your answer. To make wording easier, the word ‘child’ has been used to refer to your adolescent son or daughter.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How many of your child’s friends would be expected to check if it’s OK with their parents before they go out?</td>
<td>None A few A lot All</td>
</tr>
<tr>
<td>2. My child feels uncomfortable about taking friends home…</td>
<td>Never Sometimes Often Always</td>
</tr>
<tr>
<td>3. My child gets into trouble at school…</td>
<td>Never Sometimes Often Always</td>
</tr>
<tr>
<td>4. My child tells me who he/she goes out with at night…</td>
<td>Never Sometimes Often Always</td>
</tr>
<tr>
<td>5. How many of your child’s friends would repeatedly get into trouble at school?</td>
<td>None A few A lot All</td>
</tr>
<tr>
<td>6. I listen to my child…</td>
<td>Never Sometimes Often Always</td>
</tr>
<tr>
<td>7. My child keeps family rules…</td>
<td>Never Sometimes Often Always</td>
</tr>
<tr>
<td>8. How many of your child’s friends would regularly use alcohol (like beer, wine, and so on)?</td>
<td>None A few A lot All</td>
</tr>
<tr>
<td>9. My child comes home when he/she feels like it, not when he/she is told to come home…</td>
<td>Never Sometimes Often Always</td>
</tr>
<tr>
<td>10. How many of your child’s friends would repeatedly get into trouble at home?</td>
<td>None A few A lot All</td>
</tr>
<tr>
<td>11. I put limits on how much my child is allowed to do…</td>
<td>Never Sometimes Often Always</td>
</tr>
<tr>
<td>12. My child believes it is important to put in his/her best effort at school…</td>
<td>Never Sometimes Often Always</td>
</tr>
<tr>
<td>13. My child gets into trouble at home…</td>
<td>Never Sometimes Often Always</td>
</tr>
<tr>
<td>14. How many of your child’s friends would repeatedly skip/jig school?</td>
<td>None A few A lot All</td>
</tr>
<tr>
<td>15. When my child goes out, I want to know where he/she is going…</td>
<td>Never Sometimes Often Always</td>
</tr>
<tr>
<td>16. How many of your child’s friends would have sex regularly?</td>
<td>None A few A lot All</td>
</tr>
<tr>
<td></td>
<td>Question</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>17.</td>
<td>There are arguments at home…</td>
</tr>
<tr>
<td>18.</td>
<td>My child has been in trouble with the police…</td>
</tr>
<tr>
<td>19.</td>
<td>My child can tell the family cares about him/her by the way they act towards him/her…</td>
</tr>
<tr>
<td>20.</td>
<td>How many of your child’s friends bust up property or places just for the fun of it?</td>
</tr>
<tr>
<td>21.</td>
<td>How many of your child’s friends would regularly smoke cigarettes?</td>
</tr>
<tr>
<td>22.</td>
<td>How many of your child’s friends would believe that it is important to put in one’s best effort at school?</td>
</tr>
<tr>
<td>23.</td>
<td>I enjoy talking to my child…</td>
</tr>
<tr>
<td>24.</td>
<td>I show that I think my child’s friends are OK by the way I treat them…</td>
</tr>
<tr>
<td>25.</td>
<td>How many of your child’s friends would regularly smoke pot (marijuana)?</td>
</tr>
<tr>
<td>26.</td>
<td>I yell at my child…</td>
</tr>
<tr>
<td>27.</td>
<td>My child skips/jigs classes at school…</td>
</tr>
<tr>
<td>28.</td>
<td>How many of your child’s friends would be more than one year older than he/she is?</td>
</tr>
<tr>
<td>29.</td>
<td>My child gets into fights (like punch-ups)</td>
</tr>
<tr>
<td>30.</td>
<td>Our family eats together around the table on most nights…</td>
</tr>
<tr>
<td>31.</td>
<td>When my child is out with his/her friends, he/she smokes cigarettes…</td>
</tr>
<tr>
<td>32.</td>
<td>How many of your child’s friends would regularly finish their homework and school projects?</td>
</tr>
<tr>
<td>33.</td>
<td>How many of your child’s friends would have been in trouble with the police more than once or twice?</td>
</tr>
<tr>
<td>34.</td>
<td>I am affectionate towards my child…</td>
</tr>
<tr>
<td>Question</td>
<td>Options</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>35. My child carries a weapon (like a knife)…</td>
<td>Never</td>
</tr>
<tr>
<td>36. I am interested in knowing about my child’s friends…</td>
<td>Never</td>
</tr>
<tr>
<td>37. My child finishes homework and projects…</td>
<td>Never</td>
</tr>
<tr>
<td>38. How many of your child’s friends would hassle him/her for doing well at school?</td>
<td>None</td>
</tr>
<tr>
<td>39. When my child is out with his/her friends, he/she drinks alcohol (beer, wine, and so on)…</td>
<td>Never</td>
</tr>
<tr>
<td>40. How many of your child’s friends would regularly go out looking for trouble?</td>
<td>None</td>
</tr>
<tr>
<td>41. When my child is out with his/her friends, he/she gets drunk…</td>
<td>Never</td>
</tr>
<tr>
<td>42. My child has busted up property just for the fun of it…</td>
<td>Never</td>
</tr>
<tr>
<td>43. My child skips/jigs school…</td>
<td>Never</td>
</tr>
<tr>
<td>44. When I set limits for my child, I make sure that he/she keeps them…</td>
<td>Never</td>
</tr>
<tr>
<td>45. How many of your child’s friends would regularly go on dates?</td>
<td>None</td>
</tr>
<tr>
<td>46. My child has had sex…</td>
<td>Never</td>
</tr>
<tr>
<td>47. My child gets school work wrong more than he/she gets it right…</td>
<td>Never</td>
</tr>
<tr>
<td>48. How many of your child’s friends would carry a weapon with them, such as a knife?</td>
<td>None</td>
</tr>
<tr>
<td>49. I want to know whom my child is going out with…</td>
<td>Never</td>
</tr>
<tr>
<td>50. I make an effort to get to know the parents of my child’s friends…</td>
<td>Never</td>
</tr>
<tr>
<td>51. How many of your child’s friends would go home when they feel like it, and not when they are told to?</td>
<td>None</td>
</tr>
<tr>
<td>Question</td>
<td>Never</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>52. When my child is out with his/her friends, my child uses drugs….</td>
<td></td>
</tr>
<tr>
<td>53. Trying hard at school makes my child feel good about himself/herself…</td>
<td></td>
</tr>
<tr>
<td>54. How many of your child’s friends have had sex once or on a couple of occasions only?</td>
<td>None</td>
</tr>
<tr>
<td>55. I say that my child has to get my permission before he/she can go out…</td>
<td></td>
</tr>
<tr>
<td>56. I care about the sort of people my child makes friends with…</td>
<td></td>
</tr>
<tr>
<td>57. How many of your child’s friends would regularly skip/jig class?</td>
<td>None</td>
</tr>
<tr>
<td>58. My child has gone on dates…</td>
<td></td>
</tr>
<tr>
<td>59. I check if somewhere is safe before I let my child go there…</td>
<td></td>
</tr>
<tr>
<td>60. I insist that my child come home by a certain time…</td>
<td></td>
</tr>
<tr>
<td>61. My child feels close to his/her family…</td>
<td></td>
</tr>
<tr>
<td>62. My child does his/her jobs around the house…</td>
<td></td>
</tr>
<tr>
<td>63. When going out, my child tells me where he/she is going…</td>
<td></td>
</tr>
<tr>
<td>64. My child has been bullied or threatened by other kids…</td>
<td></td>
</tr>
<tr>
<td>65. I say they I will kick my child out of home unless he/she behaves…</td>
<td></td>
</tr>
<tr>
<td>66. My child has run away from home…</td>
<td></td>
</tr>
<tr>
<td>67. My child seems to feel stressed out more than others…</td>
<td></td>
</tr>
<tr>
<td>68. My child has thought about running away from home…</td>
<td></td>
</tr>
<tr>
<td>69. My child seems to get sad and depressed about things more than others…</td>
<td></td>
</tr>
</tbody>
</table>
Please answer the following questions according to your knowledge about possible drug and/or alcohol use by your son or daughter by placing a cross in a box. When answering these questions, remember that there are no right or wrong answers – rather each question is asking for your opinion on how things might be happening for your son or daughter regarding possible drug and/or alcohol use.

Answer each question by circling the response that best fits your answer.

1. Has your child ever had an alcoholic drink?
   - Yes
   - No
   If you answered NO, go to question 4.

2. On how many days did your child have an alcoholic drink in the last four weeks?
   - None
   - On 1-2 days
   - On 3-5 days
   - On 6-9 days
   - On 10-19 days
   - On 20 or more days
   - Every day?

3. On a day when your child has an alcoholic drink, how many drinks would he or she usually have?
   - A few sips
   - 1-2 drinks
   - 3-4 drinks
   - 5-8 drinks
   - 9-12 drinks
   - Over 12 drinks?

The next few questions are about smoking tobacco in cigarettes, rollies or pre-packed:

4. Has your child ever smoked tobacco?
   - Yes
   - No
   If you answered NO to this question, please go to Question 7.

5. On how many days has your child smoked tobacco in the last four weeks?
   - None
   - On 1-2 days
   - On 3-5 days
   - On 6-9 days
   - On 10-19 days
   - On 20 or more days
   - Every day?
6. On a day when your child smokes cigarettes how many would he or she usually smoke?
- A few puffs
- 1-5 a day
- Approximately half a packet a day
- Approximately three quarters a packet a day
- Approximately one packet a day
- More than one packet a day

The next few questions are about marijuana (grass, pot, joint, cannabis or hashish – hash, hydro, hash oil):

7. Has your child ever used marijuana?
- Yes
- No
If you answered NO, skip the next question.

8. How many times has your child used marijuana or hash in the last four weeks?
- None
- 1-2 times
- 3-5 times
- 6-9 times
- 10-19 times
- 20-39 times
- 40 times or more

Now that you have finished answering these questions, how do you see your child in the future if he or she continues to do things the same as now?

1a. How likely is it that your child will have problems with the police because of the people he or she hangs around with?
- Not likely
- Somewhat likely
- Likely
- Very likely

1b. How likely is it that your child will have problems with the police because of the things he/she does?
- Not likely
- Somewhat likely
- Likely
- Very likely

2. How likely is it that your child will leave home because of the problems he/she experiences there?
- Not likely
- Somewhat likely
- Likely
- Very likely

3a. How likely is it that your child will leave school because he/she just doesn’t want to be there?
- Not likely
- Somewhat likely
- Likely
- Very likely
3b. How likely is it that your child will leave school because of the kids he/she hangs around with?

<table>
<thead>
<tr>
<th>Not likely</th>
<th>Somewhat likely</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
</table>

4a. How likely is it that your child will have problems with drug abuse because of the things he/she does?

<table>
<thead>
<tr>
<th>Not likely</th>
<th>Somewhat likely</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
</table>

4b. How likely is it that your child will have problems with drug abuse because of the people he/she hangs around with?

<table>
<thead>
<tr>
<th>Not likely</th>
<th>Somewhat likely</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
</table>

THERE ARE NO FURTHER QUESTIONS.
THANK YOU!
APPENDIX 12

Factors and factor loadings for the *Self-Perception of Risk Questionnaire* (parent version).
Factors and factor loadings for the *Self-Perception of Risk Questionnaire* (mothers)

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>4b</td>
<td>.75</td>
<td></td>
</tr>
<tr>
<td>3a</td>
<td>.74</td>
<td></td>
</tr>
<tr>
<td>3b</td>
<td>.74</td>
<td></td>
</tr>
<tr>
<td>4a</td>
<td>.56</td>
<td></td>
</tr>
<tr>
<td>1b</td>
<td>.45</td>
<td></td>
</tr>
<tr>
<td>1a</td>
<td></td>
<td>.92</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>.70</td>
</tr>
</tbody>
</table>

Eigenvalue | 2.44 | 1.32 |
% of variance | 34.85 | 18.81 |
Cumulative Variance | 34.85 | 53.66 |

Factors and factor loadings for the *Self-Perception of Risk Questionnaire* (fathers)

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>.92</td>
<td></td>
</tr>
<tr>
<td>4b</td>
<td>.86</td>
<td></td>
</tr>
<tr>
<td>3b</td>
<td>.71</td>
<td></td>
</tr>
<tr>
<td>4a</td>
<td>.53</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>.79</td>
</tr>
<tr>
<td>1b</td>
<td></td>
<td>.58</td>
</tr>
<tr>
<td>4a</td>
<td></td>
<td>.41</td>
</tr>
</tbody>
</table>

Eigenvalue | 2.57 | 1.33 |
% of variance | 36.79 | 19.01 |
Cumulative Variance | 36.79 | 55.79 |
APPENDIX 13

Item numbers and wording of items of the *Self-Perception of Risk Questionnaire*. 
**Item numbers and wording of items of the Self-Perception of Risk Questionnaire.**

1a. How likely is it that you will have problems with the police because of the people you hang around with?

1b. How likely is it that you will have problems with the police because of the things you do?

4b. How likely is it that you will have problems with drug abuse because of the people you hang around with?

4a. How likely is it that you will have problems with drug abuse because of the things you do?

**Note:** These items were numbered 1, 2, 3, and 4 respectively when the *Self-perception of Risk Questionnaire* was formulated for use by the TANDEM sample of parents and adolescents.
APPENDIX 14

Item numbers and wording of items of the two factors of General Resilience and Support of a Significant Other belonging to the Parent Resilience Questionnaire.
Item numbers and wording of items of the two factors of General Resilience and Support of a Significant Other belonging to the Parent Resilience Questionnaire.

General Resilience

1. I know I can still keep going in spite of feeling upset.

2. I just don’t know how I’ll ever cope.

3. I think things will work out.

5. I know that I can handle the problem.

6. I can work on some strategies that will help.

7. Even though I feel angry with my son or daughter, I still think things will turn out OK.

8. I get so stressed out I just want to give up on my son or daughter.

9. No matter how hard it gets, I will make it.

11. Sometimes when I’m angry with my son or daughter, I believe I have run out of solutions.

Support of a Significant Other

4. I have someone who helps me get through difficult times.

10. There is someone with whom I can share my feelings, and I feel I can depend on that person.

Note: Items 2, 8, and 11 are reverse scored.
APPENDIX 15

The Parental Knowledge Scale (items 1, 3, 5) and the Parental Feeling Scale (items 2, 4, 6)

These scales were presented as the one questionnaire for the TANDEM sample of parents only. The following format was inserted into p.3 of the parent version of the Adolescent Problem Behaviour Assessment (APBA), following the Parent Resilience Questionnaire (see TANDEM intervention package for this version of the APBA).

Reverse scored items:

The Parental Knowledge Scale: items 1, 5.
The Parental Feeling Scale: item 4.
The following questions are about the amount of skill you believe you have at this time for dealing with situations involving your son or daughter, as well as your feelings about being the parent of an adolescent.

Once again, don’t spend too much time thinking about each question, and remember that there are no right or wrong answers – your answer to each question is the one that is best for you.

As before, there are five responses going from ‘Strongly Disagree’ to ‘Strongly Agree’. Place a circle around the response that is most suitable for you.

1. I do not know what I need to do to change the problems I have with my son or daughter.
   
   Strongly Disagree    Disagree    Undecided    Agree    Strongly Agree

2. I feel confident about setting limits on my son or daughter’s activities and behaviour.
   
   Strongly Disagree    Disagree    Undecided    Agree    Strongly Agree

3. I am clear about what skills I need to relate comfortably with my son or daughter.
   
   Strongly Disagree    Disagree    Undecided    Agree    Strongly Agree

4. I feel unhappy about the way things are working out between me and my son or daughter.
   
   Strongly Disagree    Disagree    Undecided    Agree    Strongly Agree

5. I do not have much knowledge about the basic communication and problem solving skills necessary for a good relationship with my son or daughter.
   
   Strongly Disagree    Disagree    Undecided    Agree    Strongly Agree

6. As the parent of an adolescent, I feel confident about successfully getting through the difficult times with my son or daughter.
   
   Strongly Disagree    Disagree    Undecided    Agree    Strongly Agree
APPENDIX 16

Item domains (in **bold** font) and item numbers for the *Stressors Scale*.

This scale was inserted into the parent version of the *Adolescent Problem Behaviour Assessment (APBA)* as it was used for the TANDEM sample of parents (see the TANDEM intervention package), and followed the *Self-Perception of Risk Questionnaire*. 
School Environment

1. Has your child been diagnosed with attention-deficit hyperactivity disorder (ADHD)?

2. Has your child changed schools more than twice in the last year (this does not include going from primary to high school)?

3. Has your child ever had to repeat a year at school?

4. Has your child ever been suspended from school?

Parental Status

5. Is your family a single parent family?

Economic Stability

6. Have you been out of work for long periods of time in the last 12 months?

7. Would you say that your family does not have enough money for the basic things of life, like food & clothes?

Substance Use (referred adolescent, parent or family members)

8. Have you ever had a drug or alcohol problem?

9. Have any of your children ever had a drug or alcohol problem?

Mental Health Problem (referred adolescent, parent or family members)

10. Have you ever had a mental health problem?

11. Have any of your children ever had a mental health problem?

Family Illness or Death

12. Has a close member of your family died in the last 12 months?

13. Has someone in your family had to spend time in hospital during the last 12 months because of a serious illness or accident?

14. Has the child you are concerned about ever had to spend time in hospital during the last 12 months because of a serious illness or accident?

Foster Parent Support

15. Has it ever been necessary for your family to be looked after by people like relations, foster parents, or welfare agencies because you could not cope?
Neighbourhood Quality

16. Do you live in an area where it is common for adolescents to regularly get involved in crime, alcohol or drugs?

The following questionnaire format shows the Stressors Scale as it appeared in the Adolescent Problem Behaviour Assessment when used with the TANDEM sample of parents (see the TANDEM intervention package)

For these next questions, put a circle around either YES or NO:

1. Has your child been diagnosed with attention-deficit hyperactivity disorder (ADHD)?
   Yes   No

2. Has your child changed schools more than twice in the last year (this does not include going from primary to high school)?
   Yes   No

3. Has your child ever had to repeat a year at school?
   Yes   No

4. Has your child ever been suspended from school?
   Yes   No

5. Is your family a single parent family?
   Yes   No

6. Have you been out of work for long periods of time in the last 12 months?
   Yes   No

7. Would you say that your family does not have enough money for the basic things of life, like food and clothes?
   Yes   No.

8. Have you ever had a drug or alcohol problem?
   Yes   No

9. Have any of your children ever had a drug or alcohol problem?
   Yes   No

10. Have you ever had a mental health problem?
    Yes   No

11. Have any of your children ever had a mental health problem?
    Yes   No

12. Has a close member of your family died in the last 12 months?
    Yes   No
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Has someone in your family had to spend time in hospital during the last 12 months because of a serious illness or accident?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Has the child you are concerned about ever had to spend time in hospital during the last 12 months because of a serious illness or accident?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Has it ever been necessary for your family to be looked after by people like relations or foster parents, or by welfare agencies because you could not cope?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Do you live in an area where it is common for adolescents to regularly get involved in crime, alcohol or drugs?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 17

The Depression Anxiety Stress Scales (DASS) – 21 item version (Lovibond, P.F. & Lovibond, S.H., 1995b), with item numbers for each scale.
The Depression Anxiety Stress Scales – 21 item version
(Lovibond, S.H. & Lovibond, P.F., 1995b)

Item numbers for depression, anxiety, stress scales

<table>
<thead>
<tr>
<th>Depression</th>
<th>Anxiety</th>
<th>Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>10</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>13</td>
<td>9</td>
<td>11</td>
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<tr>
<td>16</td>
<td>15</td>
<td>12</td>
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<td>17</td>
<td>19</td>
<td>14</td>
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<tr>
<td>21</td>
<td>20</td>
<td>18</td>
</tr>
</tbody>
</table>
APPENDIX 18

The following appendix describes the preliminary investigation with the consultative parent sample conducted to provide a partial guide the development of the TANDEM parent manual. The consent form completed by parents who participated in this investigation has been reproduced on page 14 of this appendix. The questionnaire that was used has been reproduced on pages 15 to 17 of this appendix.
PRELIMINARY INVESTIGATION FOR THE DEVELOPMENT OF THE TANDEM PARENTING COURSE MANUAL

As a precursor to the development of the parent manual used in the course component of the TANDEM programme, a group of parents from a primarily working class suburb were invited to complete a questionnaire. This questionnaire was specially constructed for the preliminary investigation. Research literature reviewed for the development of the TANDEM parent manual (see section 7.1.1.2 of chapter seven) was the principal source of information for the development of this questionnaire. Colleagues in psychology who worked with parents of adolescents and adolescents exhibiting problem behaviour also contributed to the development of the questionnaire by reviewing each field of enquiry for conceptual meaning. The resulting qualitative data was intended for use as a partial guide in structuring both the content and outline of the manual. The questionnaire was not given a title, and so will simply be referred to in this appendix as “the questionnaire”.

The questionnaire addressed a limited though essential range of issues related to being the parent of an adolescent. The aim of this preliminary investigation was to gain the perspective of these parents in relation to the positive and negative outcomes entailed in interactions with their adolescents, as well as their insights into reasons underlying interactional outcomes. Parents were asked to describe the challenges they felt when communicating with their son or daughter, as well as the traps they might possibly have encountered during these times. Parents were then invited to describe how they handled any negative outcomes of communication, and to offer tips for achieving effective communication results. In relation to problem solving and conflict negotiation, parents were requested to explore the various approaches they used when attempting to solve problems or resolve conflicts with their son or daughter. They were also asked to
describe the signs that helped them know when their approaches in these areas were either effective or ineffective. As with experiences of parent-adolescent communication, parents were then invited to offer their tips for achieving a mutually satisfying outcome between themselves and their child. Finally, parents were asked to describe their chosen way of looking after themselves in what at times was a demanding responsibility.

18.1 Method

The questionnaire was administered by the researcher as a take-home self-report questionnaire to a parent sample whose adolescents were situated within the age-range adopted for this research. Participating parents were part of a regular weekly community group meeting comprising approximately 50 parents. The researcher returned to the meeting one week later to collect completed questionnaires.

18.1.1 Participants

Twenty-eight parents who resided in the mainly working class suburb of Berkeley, N.S.W., Australia (situated near the location chosen for the TANDEM programme) consented to complete a questionnaire. Ages of parents and adolescents were not requested, since it was sufficient only to ensure that all adolescents of the parent sample were situated within the age range of the adolescent sample for this research, as was the case.

18.1.2 Procedure

The researcher addressed all parents at the commencement of their meeting, outlining the reason for requesting parents’ participation of the questionnaire and presenting a brief outline of the background and purpose of the overall research. Because of a limited time frame, it was not possible to ascertain the quality of relationship between these parents and their adolescent children. However, the co-ordinator of the gathering who knew the parents well believed that by and large all
parents present experienced a reasonable relationship with their children. Parents were ensured that their responses would be treated with confidentiality, and that all parents who agreed to participate would remain anonymous. The use of numeric identifiers for each questionnaire was explained in the context of maintaining confidentiality and anonymity. The need for participating parents to complete a consent form was also explained. Twenty-eight questionnaires together with consent forms were distributed to participating parents at the conclusion of the meeting. This provided parents with the opportunity to personally discuss any unresolved issues with the researcher. The researcher returned one week later to collect completed questionnaires. Both the consent form and the questionnaire have been reproduced in the format in which they were administered on pages 13 and 14 of this appendix.

18.2 Results.

Seven mothers and two fathers returned completed questionnaires one week later. The collective wording of parents’ responses has been presented in percentage values in Table 18.1 according to the content of each question. Words in square brackets indicate expressions chosen by the researcher to facilitate clarity in the parents’ comments.

Table 18.1
Collective wording of parents’ responses to questionnaire items.

<table>
<thead>
<tr>
<th>1. What are the greatest challenges you experience in communicating with your adolescent, compared to when he or she was a younger child?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collective response</td>
</tr>
<tr>
<td>They don’t want to listen. They already seem to know everything, and are not interested in knowing what you think or say, especially when they're angry. They turn off: “I’m okay, mum!”</td>
</tr>
</tbody>
</table>


The adolescent lives in [his or her] own world – no one has ever experienced what [he or she] is experiencing; no one is allowed to tell them what is the proper way to behave.

Friends know much more than parents know. Kids are less open and sharing with their parents and family now. Adolescents follow ideas that are opposed to what being a part of a family means.

It is difficult and unsettling to work out the balance between allowing them freedom and giving them guidance. The hard part is teaching them to accept responsibility for their actions.

It is difficult to stand back and watch them make their own decisions. I worry.

They now have the ability to formulate vicious attacks that really hurt.

2. If you have ever felt trapped in a corner when communicating with your adolescent, what sort of things led to this happening?

<table>
<thead>
<tr>
<th>Collective response</th>
<th>Percentage with this response</th>
</tr>
</thead>
<tbody>
<tr>
<td>[You can feel trapped] when you find yourself controlling your child’s behaviour simply because you just don’t believe you can trust your child.</td>
<td>23.1%</td>
</tr>
<tr>
<td>[You can feel trapped] by the criticism or attack of your child. They use words like “You don’t understand like other parents do!” or “Make me!”</td>
<td>23.1%</td>
</tr>
<tr>
<td>I have never felt trapped.</td>
<td>15.4%</td>
</tr>
<tr>
<td>[You can feel trapped] when you try too hard to get across the idea that you are genuinely concerned for your child because you realize your child is not interested in what you are saying or doing.</td>
<td>15.4%</td>
</tr>
<tr>
<td>[You can feel trapped] when you react to their message to you that they can’t see past their own point of view; that they will nag until they get what they want.</td>
<td>15.4%</td>
</tr>
<tr>
<td>[You can feel trapped] when you are not up front with your child in the first place.</td>
<td>7.7%</td>
</tr>
</tbody>
</table>
3. When you have felt trapped, how have you handled this?

<table>
<thead>
<tr>
<th>Collective response</th>
<th>Percentage with this response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demand they respect you – if they don’t want to shape up, then they can leave home.</td>
<td>28.6%</td>
</tr>
<tr>
<td>Go away, calm down, and return with a more open attitude.</td>
<td>21.4%</td>
</tr>
<tr>
<td>By listening and being completely honest.</td>
<td>14.3%</td>
</tr>
<tr>
<td>State your position. Set the ground rules.</td>
<td>14.3%</td>
</tr>
<tr>
<td>Yell and scream. That gets their attention</td>
<td>14.2%</td>
</tr>
<tr>
<td>By realising you don’t give ultimatums you can’t follow through with.</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

4. What helpful tips would you offer to parents when communicating with their adolescents?

<table>
<thead>
<tr>
<th>Collective response</th>
<th>Percentage with this response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treat your child with respect by speaking with your child, and not at your child. This will avoid the controller/dictator approach.</td>
<td>23.8%</td>
</tr>
<tr>
<td>Take genuine interest in your child. Take every opportunity to speak with your child about what is important to [him or her].</td>
<td>23.8%</td>
</tr>
<tr>
<td>Try to understand any difficult situation from your child’s point of view as well as your own.</td>
<td>19.1%</td>
</tr>
<tr>
<td>Whenever possible, be available to them. Offer them any help they need to sort things out.</td>
<td>14.3%</td>
</tr>
<tr>
<td>Show patience and trust towards your child.</td>
<td>14.3%</td>
</tr>
<tr>
<td>Remember what it was like for you as an adolescent.</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

5. When does problem solving or conflict resolution work best with your adolescent?

<table>
<thead>
<tr>
<th>Collective response</th>
<th>Percentage with this response</th>
</tr>
</thead>
<tbody>
<tr>
<td>[A positive outcome is likely to occur] when you make the effort to approach your child and the situation calmly.</td>
<td>29.4%</td>
</tr>
</tbody>
</table>
[A positive outcome is likely to occur] when each person understands the other’s point of view – when the conversation is two-sided. 17.6%

[A positive outcome is likely to occur] when the adolescent feels that [he or she] has worked through the situation with your help. 17.6%

[A positive outcome is likely to occur] when the adolescent knows that you have freely made time to listen. 11.8%

[A positive outcome is likely to occur] when the stakes are so high for your kid that [he or she] has no choice but to do what you want. 11.8%

[A positive outcome is likely to occur] when your expectations as a parent are clear and reasonable. 5.9%

[A positive outcome is likely to occur] when both of you are feeling at your best – like after breakfast or first thing in the morning. 5.9%

6. When you are solving a problem or resolving a conflict with your adolescent, what signs do you get (from the way you feel, as well as from your adolescent) that all seems to be going well?

<table>
<thead>
<tr>
<th>Collective response</th>
<th>Percentage with this response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good body language [smile, eye contact, warmth] tells you that you have got through to him or her.</td>
<td>50.0%</td>
</tr>
<tr>
<td>The adolescent let’s you know that [he or she] is OK about it all and is willing to give your way a go.</td>
<td>35.7%</td>
</tr>
<tr>
<td>When the adolescent and the parent are both able to admit their own part in the problem or conflict.</td>
<td>14.3%</td>
</tr>
</tbody>
</table>

7. When you are trying to solve problems or resolve conflicts with your adolescent, what signs do you get that things look like turning out badly?

<table>
<thead>
<tr>
<th>Collective response</th>
<th>Percentage with this response</th>
</tr>
</thead>
<tbody>
<tr>
<td>[A poor outcome is likely] when the adolescent makes it obvious that [he or she] is refusing to listen and not ready to negotiate.</td>
<td>38.9%</td>
</tr>
<tr>
<td>[A poor outcome is likely] when the adolescent [resorts to] controlling you with emotions – like tears, voice, loudness, talks over you.</td>
<td>33.3%</td>
</tr>
</tbody>
</table>
A poor outcome is likely when the adolescent shows negative body language – a stubborn face, turns the back on you. 22.2%

A poor outcome is likely when you [the parent] get so angry that you walk away. 5.6%

8. What helpful tips would you offer to parents when dealing with problems or conflicts with their adolescent?

<table>
<thead>
<tr>
<th>Collective response</th>
<th>Percentage with this response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continually try to listen calmly, even if you don’t agree with what’s being said.</td>
<td>42.9%</td>
</tr>
<tr>
<td>Try to deal with the facts, and work at keeping emotion out of it as much as possible.</td>
<td>14.3%</td>
</tr>
<tr>
<td>Don’t belittle or run your child down.</td>
<td>7.1%</td>
</tr>
<tr>
<td>Deal with problems when you and [your child] are in a good mood.</td>
<td>7.1%</td>
</tr>
<tr>
<td>Be ready to compromise.</td>
<td>14.2%</td>
</tr>
<tr>
<td>Don’t give up just because things have failed the first time round.</td>
<td>7.1%</td>
</tr>
<tr>
<td>Just because he doesn’t agree with you doesn’t mean he gets his own way.</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

9. If you had a ‘wish list’ of self-care opportunities, what would these be?

<table>
<thead>
<tr>
<th>Collective response</th>
<th>Percentage with this response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take time to clear your head and recharge the batteries without feeling guilty – even if this is only an hour each day.</td>
<td>45.5%</td>
</tr>
<tr>
<td>Go out and DO something – go to the movies, play sport, go dancing, just take a walk.</td>
<td>27.2%</td>
</tr>
<tr>
<td>Nurture good friends with whom you can share your [concerns].</td>
<td>18.1%</td>
</tr>
<tr>
<td>Talk to other parents and see how they handle things.</td>
<td>9.1%</td>
</tr>
</tbody>
</table>

From Table 18.1 it can be seen that parents felt free to interpret what communication with their son or daughter meant, whether this was verbal or non-verbal communication, or communication of ideas, values, emotions, and so forth. Parents
illustrated the challenges they saw in communicating with their adolescent child. For the majority of parents, challenges in communication reflected the parents’ realisation that their son or daughter was now advancing in autonomy, thus relying more on the influence of peers than of parents. As a result, parents appeared to see themselves as becoming increasingly sidelined in their child’s personal life and feeling more exposed to personal attack and confrontation, with one parent describing this confrontation as the adolescent’s ability to “formulate vicious attacks that really hurt”. For some parents, the need to let go of their children in an atmosphere of trust embodied both a challenge when it happened and a trap when they believed that the amount of trust they had attributed to their child was weak. One mother’s words clearly described this two-way pull between protecting one’s child and letting one’s child move into the world when she wrote: “It is difficult to stand back and watch them make their own decisions: I worry”.

The almost even split in the positive and negative ways parents used to handle these challenges was interesting. Slightly more than half the parents encouraged an attitude of removing oneself from a potentially disastrous outcome and returning when one’s control and coping ability had improved. However, 42.8% of parents preferred to adopt a more aggressive response to their feelings of being trapped in a corner when communicating with their son or daughter. One mother stated that her choice was to “yell and scream” since that approach “gets their attention”. A father believed that if one’s child did not want to “shape up” then he or she could “leave home”. An anomaly appeared to exist between these negative responses and the tip offered by all parents who encouraged an attitude of genuineness and understanding, with some parents also clearly indicating an attitude that favoured yelling and screaming, and eviction of the adolescent!
Responses focusing on parent-adolescent communication suggested that the information content in the TANDEM parent manual concerning effective communication and the undesirability of poor communication patterns would need to encompass two broad areas. The first would be the teaching of basic skills of how a parent was able to achieve a positive and satisfying outcome through all avenues of communication with an adolescent. The second area would need to address the associated feelings of disturbance, anger, or powerlessness that were associated with the communication experiences of a number of the parents of the consultative sample. Overall, an important question was posed that required a clear resolution. That is, as well as being able to communicate effectively, how does a parent cope when he or she feels verbally (or even physically) threatened when attempting to speak with one’s son or daughter or express decisions, feelings, or attitudes to him or her? How does a parent communicate trust and openness to one’s child, thus allowing that child the necessary freedom of autonomy, even though the parent might also feel anxiety in allowing this freedom?

Responses recorded in Table 18.1 in relation to the resolution of problems and conflicts with one’s son or daughter indicated that the majority of the consultative sample of parents suggested a calmness in approach, selection of the optimum time to address the issue at hand, and the recognition of the primary role of the parent in setting the baseline for necessary mutual respect. Generally, parents believed that a positive outcome was more likely to occur when each party sought to “understand the other’s point of view”, and “when the conversation [was] two-sided”. A minority (11.8%) advocated the use of power and control. For this parent minority, a positive outcome would most likely occur “when the stakes are so high for your kid that [he or she] has no choice but to do what you want”. The majority of parents also appeared to rely on the
adolescent’s non-verbal body language to ascertain whether the solution or resolution process was working effectively or not. Taking the responsibility of owning one’s part in a problem or conflict was suggested, with 14.3% of parents indicating that being able to “admit [one’s] own part in the problem or conflict” led to the expectation that problems and conflicts would eventually be solved or resolved. Tips offered by parents appeared to revolve around an attitude of mutual respect and calm listening. A majority of parents proposed that one should “continually try to listen calmly, even if you don’t agree with what is being said”. A smaller percentage advocated that parents should “be ready to compromise”, while fewer again warned against the temptation to “belittle or run your child down”.

For the development of the TANDEM parent manual, an important message arising from parents’ responses that focused on conflict resolution and problem solving was that effective skills with one’s son or daughter in these arenas begins with and relies on the parent’s *positive attitude*. This attitude needs to consolidate a readiness to be open to a variety of issues beneath the umbrella of positive attitude. These issues appeared to include being open to alternatives, being honest with the adolescent (especially regarding one’s role as a parent in the problem and conflict), taking primary responsibility as a parent in the overall process, and being perceptive to signs that progress is or is not being made with one’s adolescent.

Finally, Table 18.1 recorded parents’ reflections on approaches to self-care issues. In general, parents advocated an approach of putting aside time for one’s own needs without entertaining any associated feelings of guilt. Alongside this attitude was the suggestion of nurturing adult companionship. The majority of parents described these opportunities as taking “time to clear your head and recharge the batteries without feeling guilty – even if this is only for an hour each day”. The suggested activities were
not complicated, and included activities such as playing sport, going to the movies, or simply taking a walk. The need for having adults that one might share concerns with, or from whom one might receive advice, was also emphasised by parents. Responses generally indicated that parents were personally important in the task and responsibility of ensuring that one’s adolescent son or daughter experiences this phase of development in an adaptive way. Thus parents expressed the need to protect their mental and physical resources in order to enhance this opportunity for adaptive adolescent development as strongly as possible.

An emphasis on parental self-care was therefore warranted for the development of the TANDEM parent manual. This emphasis would need to focus primarily on the reasons why a parent’s self-care was important, the manner in which this might be achieved, and the probable outcomes that would occur where this was either maintained or neglected. It was decided to present the need for parental self-care in the context of rational versus distorted thinking patterns according to the cognitive model. The rationale for this decision was contained in the logical conclusion that an emphasis placed by parents on making time for one’s self-care relied upon the parent’s ability to provide relevant and sensible arguments as to why this needed to be the case. Furthermore, self-care was seen to move beyond simple though important aspects such as making time for activities. The state of mental health that accompanies non-distorted cognition was seen as a fundamental requirement for any direction towards care of self.

18.3 Discussion

The value of this preliminary investigation was largely situated in the fact that parents who were considered to have a fundamentally fruitful relationship with their adolescent son or daughter expressed the insight that this relationship had both moments of stress and difficulty as well as the reassurance of possessing a bond of openness and
trust with their adolescents. Furthermore, not every parent within this participant sample indicated using approaches that could be characteristically considered to facilitate a productive parent-adolescent relationship.

This important aspect needed to be considered in the development of a parent manual that was to be used both as the primary means of information and sustenance for parents who were to seek help through the TANDEM programme, as well as the means of describing and modelling parenting skills in a manner that helped such parents to feel encouraged in their efforts towards this end. The reflections of the consultative parent sample showed that the unrealistic ‘perfect’ parent and the equally unrealistic ‘perfect’ parent-adolescent relationship did not in fact exist. It seemed that for the consultative parent sample, generally achieving and maintaining a solid and fruitful parent-adolescent relationship was an art that required skill knowledge, perceptiveness, patience, shrewdness, and a readiness to express empathetic understanding to oneself as a parent as well as one’s adolescent.

Therefore, while emphasising the importance of developing an open and trusting relationship with one’s adolescent was an important starting point in the TANDEM manual, it seemed appropriate to emphasise that accomplishing this end could be a personally taxing, albeit rewarding, task to be measured in terms of realistic and observable achievement, and not perfection. Such an approach, presented in the opening pages of the parent manual, was seen as communicating a sense of respect for parents who participated in the TANDEM-parenting course regardless of the level of difficulty they might be experiencing with their son or daughter.

A further benefit gleaned from the reflections of the parent consultative sample was that the majority of approaches undertaken by these parents with their adolescents revolved around the need to develop and maintain a skilful and age-appropriate use of
communication patterns. Communication appeared to represent the hub of what these parents were attempting to achieve when interacting with their son or daughter. Positive outcomes seemed to rely on positive communication patterns, while negative outcomes seemed to result from poorly expressed feelings or wishes on the part of the parent, and consequently on the part of the adolescent. This finding confirmed the decision to see effective communication between parent and adolescent, as well as the responsibility of the parent for modelling a fitting style of communication, as being an essential and continuous thread linking all the parenting skills that comprised the TANDEM manual.

At the same time, the consultative parent sample appeared to feel a sense of powerlessness, anger, and anxiety in some situations involving their son or daughter. An emphasis was therefore placed in the TANDEM manual on explaining the impact of one’s self-attributorial thinking and actions, the influence of one’s core-beliefs and predispositions towards negative automatic thoughts and unhelpful thinking, and the need to develop practical strategies in addressing issues of self-care and self-encouragement. Parents would need to understand that it would be virtually impossible to effectively rebuild a fractured parent-adolescent relationship if their own fractured sense of esteem and efficacy was not also addressed in a nurturing manner.
CONSENT FORM

This consent relates to the research of Gerard Stoyles that is being carried out in relation to the TANDEM-parenting parenting programme. Please complete sections A or B for this consent.

If you have any questions or difficulties, you can contact Gerard Stoyles (0419 012 690) or Dr Beth Marlow (42 214073) who will do their best to answer your questions.

A. Care-Giver in Role of Mother “I ____________________ give my consent to participate in the research of Gerard Stoyles for the “TANDEM” programme.

Signed: ___________________________ Date: __________________

B. Care-Giver in Role of Father “I ____________________ give my consent to participate in the research of Gerard Stoyles for the “TANDEM” programme.

Signed: ___________________________ Date: __________________

Note: This consent form is stored and locked away separately to the questionnaires.

All information supplied by you is private and confidential, and no one sees it except the researcher, Gerard Stoyles.
Please circle:  

Mother Role  

Father Role

Thank you for taking the time to reply to these questions!

I am preparing a programme for parents of adolescents. This programme will hopefully help the skills of parents in at least three areas: communication, problem solving/conflict resolution, and self-care/nurturing.

A number of parents who will use this programme experience some difficulties in relating to their adolescent son or daughter. I therefore wish to offer them information that just doesn’t come out of textbooks, but that also comes from the everyday experience of parents.

This is where your help will be most valuable!

If you have any further questions or issues you might wish to discuss, please ring me (Gerard Stoyles) on 0419.012.690. If I am unavailable, leave a message and your number and I will return your call.

Thank you.
With the following questions, please jot down any thoughts or feelings that come from your own personal experience – no matter how simple or ordinary they might seem! Your experiences in these areas have probably been both good and not so good – things don’t always work out the way we wished they did! However, your comments on the not-so-good experiences will be just as helpful (and maybe even more helpful) as your comments on the good experiences.

What are the greatest challenges you experience in communicating with your adolescent, compared to when he or she was a younger child?

(Space inserted for parent’s response)

If you have ever felt trapped in a corner when communicating with your adolescent, what sort of things led to this happening?

(Space inserted for parent’s response)

When you have felt trapped, how have you handled this?

(Space inserted for parent’s response)

What helpful tips would you offer to parents when communicating with their adolescents?

(Space inserted for parent’s response)

When does problem solving or conflict resolution work best with your adolescent?

(Space inserted for parent’s response)

When you are solving a problem or resolving a conflict with your adolescent, what signs do you get (from the way you feel, as well as from your adolescent) that all seems to be going well?

(Space inserted for parent’s response)

When you are trying to solve problems or resolve conflicts with your adolescent, what signs do you get that things look like turning out badly?

(Space inserted for parent’s response)

What helpful tips would you offer to parents when dealing with problems or conflicts with their adolescent?

(Space inserted for parent’s response)

If you had a ‘wish list’ of self-care opportunities, what would these be?
Thank you – that is all! To keep your questionnaire confidential, please fold it over and put a staple through it so that it can’t be opened.
APPENDIX 19

Consent form for parents and adolescents who participated in the TANDEM programme, and who completed the intake assessments used to assess suitability for entry into the programme.
CONSENT FORM

This consent relates to the research of Gerard Stoyles that is being carried out in relation to the TANDEM-parenting programme, as was personally discussed with you prior to joining the programme. Please complete sections A and/or B for this consent.

Please note that if your son or daughter participates by completing a questionnaire, he or she also needs to give consent. You also give your permission for this to happen. Sections C & D cover this consent.

If you have any questions or difficulties, you can contact Gerard Stoyles (0419 012 690) or Dr Beth Marlow (42 214073) who will do their best to answer your questions.

A. Care-Giver in Role of Mother “I_________________________ give my consent to participate in the research of Gerard Stoyles for the TANDEM programme.

Signed:_________________________ Date:____________________

B. Care-Giver in Role of Father “I_________________________ give my consent to participate in the research of Gerard Stoyles for the TANDEM programme.

Signed:_________________________ Date:____________________

C. Care-Giver(s) permission for son or daughter fill out the adolescent questionnaire

“I,_________________________ give permission for my son/daughter ______________ to participate in the research of Gerard Stoyles for the TANDEM programme.

Signed_________________________ Date____________________

D. Son or Daughter’s Consent: “I_________________________ give my consent to participate in the research of Gerard Stoyles for the TANDEM programme.

Signed_________________________ Date____________________

Note: This consent form is stored and locked away separately to the questionnaires.

All information supplied by you is private and confidential, and no one sees it except the researcher, Gerard Stoyles.
APPENDIX 20

Reflections of parents on the benefits they gained from participating in the six-week TANDEM parent course.
Each parent was requested to answer each of the following four questions. One parent omitted this question sheet for unknown reasons. Percentages of parents who responded in each particular manner have been recorded after sub-headings. Words in square brackets represent the researcher’s clarifications of parents’ responses.

Over the last six weeks, since starting **TANDEM**, think about how things might have changed for you personally. Think also about how things might have changed at home between you and your adolescent (or adolescents) and your partner.

Now please answer the following **with a few words or brief statements**.

*What personal changes have you noticed in yourself? (n=21)*

**[Step back – think before [I speak]/take a broader view/be more aware/respond, not react – 57.1%]**

- Time to think before opening my mouth. Take more time to listen.
- Thinking more about what I ‘do’ and say – but not necessarily bringing this to action!
- I’m more conscious of my actions and reactions. I keep thinking of scenarios we have discussed in class.
- I have tried to stop, slow down and think before acting.
- Not to jump straight in. Take a step back & think 1st.
- Have started to think about what to say to him instead of just getting upset with him.
- I have started to take a broader view of any problems with my child.
- More aware of other peoples’ feelings.
- The ability to step back and respond not react. Realised that I’m not wholly and solely responsible for sons actions
- I have become more aware of possible situations & am better equipped to confront now, thanks to Tandem.
- I am more aware of what [my daughter] is saying to me  (verbal and non-verbal). I am stopping, assessing the situation, and then reacting – most of the time. Since starting this course I am giving [my daughter] more time to herself. She enjoys staying home while I do chores, etc. It is giving her freedom and personal responsibility.

**[Feeling more positive/better able to cope/more flexible – 19.0%]**

- I feel a bit more positive about my ability to cope with my son.
- I’ve become more positive about being able to handle difficult situations.
- I’m more positive and have broadened my ideas – i.e. I’m more flexible, less autocratic.
- I have noticed a variety of changes including more clarity in my relationships with family members, renewed questioning of my behaviour and those of other family members, more open and positive interaction with children.
[Improved self confidence/confidence in my parenting – 14.3%]

- Improved confidence that I am heading in the right direction and confirmation of reasoning parenting skills I already have.
- More confidence when disagreeing with son – being able to give a bit to get a bit.
- The course has reinforced some of the ways I parent and basically given me confidence in my parenting ways. In other areas, I have gained better skills to use in my relationship with my partner and children.

[Depression/a rocky time – 9.5%]

- I have been very depressed whilst doing this course.
- Lots – A very rocky time including sons’ expulsion from school and fathers’ death.

What changes have you noticed in your son or daughter? (n=21)

[None/minor/some/not [for] my son, but [for] others– 28.6%]

- None – he is involved in a number of activities that have generated his (?) own problems
- Minor, slightly more willing to talk on confrontational issues.
- Not [my son], but others are saying their true feelings.
- Not many, however this last 6 weeks, by coincidence, have been rather horrifying as far as my child is concerned
- Thinks [sic] have changed a little but am unsure whether it is due to my new approach.
- Some. Seems more mature and has a realisation that he has burnt a major bridge.

[Telling me more/more open and communicative – 28.6%]

- Seems to be telling me more about what is going on at school.
- The children respond much better to ‘better’ parenting. They are happier and communicate more easily and honestly.
- Less tension between her and myself, a willingness to discuss things, trying out boundaries + expectations etc. with an understanding that things are changing.
- A little more open and communicative.
- [My daughter] is communicating more verbally. Where she would become frustrated and have a tantrum now she attempts to talk about her situation, feelings and needs.
- I think she is trying because I’m trying – we have discussed this and she’s pleased I’m doing TANDEM. She seems happier.

[Less hostile/less argumentative/increased self-responsibility– 23.8%]

- He is aware of ‘changes’ and hasn’t worked them out to his advantage.
- Has at times not reacted as hostile to my answer to his requests to go places and do things.
• He is moving away from me more, becoming more independent, more self-responsible.
• Less argumentative, more at ease with himself.
• Less arguments.

[More settled/not as tense – 14.3%]
• He is not as tense.
• Seems generally more settled but ‘worried/anxious’ about stuff???
• Easier to live with. More settled.

[Uses advantage for self – 4.8%]
• Taking advantages of my down moods to get what he wants

What changes have you noticed in your partner (leave out if you are a single parent)? (n=16)

[Not many/more tension – 18.8%]
• He seems to think he has changed and has stopped yelling, but I haven’t seen them (changes).
• Not many – I should have insisted he come to the course!
• More tension and disagreements over parenting.

[More ready to communicate and listen – 18.8%]
• He has been thinking more about how he communicates with our son
• More communication about situations between us. More at ease.
• Is learning to listen.

[Mutual parenting style/increased support and openness – 18.8%]
• Has given me more support by voicing his support for me.
• There is a more common view on ‘how’ to parent better. He has a much healthier way of looking at the children (in my view).
• He is willing to talk more and listen to my point as well. He is willing to change his views.
[More patient/relaxed/at ease – 18.8%]

- Is a little more patient with our son.
- More relaxed.
- Much more at ease.

[More willing to express self/positive– 12.5%]

- A little more willing to talk about his feelings. Parenting style has changed slightly.
- Generally positive but heavy workload at work/home sometimes gets her down.

[Comments unrelated to question – 12.5%]

- [My wife] will never change, she is a great lady – she does practise a lot of what’s in the booklet for sure!
- Hard time expressing grief as she was not present when my father died – through no fault of her own.

What changes have you noticed in your relationship with your son or daughter? (n=21)

[Less wailing/less volatile – 42.9%]

- The children are obviously happier with common parenting views from both parents.
- Much less wailing and gnashing of teeth, slightly calmer. More affectionate.
- Much easier to live with. Getting on.
- We are living together more harmoniously, less arguments.
- More democratic.
- We have a better relationship now.
- It has been slightly less stressed.
- Not quite as volatile in certain circumstances, more thoughtful in some situations (these are not regular difficult situations, just occasional, that were still difficult.
- We have been happy to be in each other’s company. Life has been quieter, happier and more stable.
- See above = He is not as tense.

[We communicate better – 28.6%]

- We have discussed a few issues lately and achieved some revision on remediation that has made us both consider each other’s viewpoint.
- Understanding what is a teenager has enabled me to have some communication.
- Can at times have a pleasant conversation.
- We talk more when we are at home, just the two of us (more of an adult in my child at13 yrs).
- A better relationship, more communication. We have a more open relationship now because I have put into place some strategies taught at this course – if I can keep positive WE will both have succeeded.
- Communication a little better.
[Little change – with good reason… - 9.5%]

- There isn’t any with [my daughter] as there is not much contact as yet.
- No great change. We get on pretty well

[Not a great deal/slight improvement – 9.5%]

- Again, not a great deal due to the circumstances at present. However, I am most grateful for the insights I have received – the past 6 weeks would have been unbearable without the support of the group and particularly [researcher]. He has put me in touch with the [clinic] for further assistance.
- Slight/moderate improvement – better ability to talk, joke, etc.

[More mature – 9.5%]

- More mature in some ways. Has been told of the ‘big bad world’ and now has to face it.
APPENDIX 21

Letters written by two professional persons who have implemented the TANDEM programme as a means of helping parents who have been referred to their agencies because of problems experienced with their adolescent’s behaviour.
Appendix 21 not supplied. Please see print copy.
APPENDIX 22

Letter confirming the grant of Australian Commonwealth Government funding for the future development of the TANDEM programme.
Appendix 22 not supplied. Please see print copy.
TANDEM

INTERVENTION

PACKAGE
CONTENTS

Part 1  Flowchart describing the procedure for the TANDEM programme

Part 2  Advertising the TANDEM programme

Part 3  The Adolescent Problem Behaviour Assessment (parent version)

Part 4  The Adolescent Problem Behaviour Assessment (adolescent version)

Part 5  Normative data tables

Part 6  The Depression Anxiety Stress Scales – 21-item version (DASS-21)

Part 7  Feedback forms for the Adolescent Problem Behaviour Assessment (parent and adolescent versions)

Part 8  Examples of completed feedback forms

Part 9  Flowchart used to describe the TANDEM-parenting course, to motivate parents to engage in intervention, and to maintain motivation to commence the course

Part 10  The TANDEM-parenting course manual

Part 11  Group directions for the TANDEM-parenting course

Part 12  Measures of intervention effectiveness
The following flowchart describes the overall procedure of the TANDEM programme, commencing with programme advertising and the initial interview of potential participants, and continuing through to the end of the parenting course and the booster sessions that followed the course.

Note that the parent version of the Adolescent Problem Behaviour Assessment has been noted in the flowchart as being posted out for completion prior to the first interview with the parent. While this approach was not adopted for the current research, it has become the preferred and workable option for ongoing implementations of the TANDEM programme. Two further suggestions appear in this flowchart that were not adopted for the current research. Firstly, the duration of the programme has been set in the flowchart at eight weeks, rather than the six-week duration set aside for the current research. Secondly, pre-booster assessment materials have been noted in the flowchart as being posted out prior to the booster session, although no assessment was carried out for booster sessions conducted during the research-related programme. To date, assessment materials for booster sessions have been the same as those used in the pre and post measures, with copies of the Adolescent Problem Behaviour Assessment (parent and adolescent versions) also being sent out prior to the second booster session.
Publication of programme
- Letters to agencies with rationale/details
- Include brochures

Referrals
Initial phone contact with interested parents – gain overview of home situation
Give overview of TANDEM programme
Explain questionnaire process
Arrange interview
Address immediate issues
Post out APBA (parent) + consent for TANDEM participants with addressed return envelope

Prior to Interview
Score returned APBA – note items of special concern
Complete feedback form

Interview with Parent
Explain results of APBA via feedback form
Note areas of special concern with parent
Use feedback to gain parent’s perception of situation with adolescent / home situation / parent’s capacity to cope
How has parent previously attempted to cope?
What does parent seek most to improve situation (hopes for self and adolescent)

Parent not deemed suitable…
Discuss why this decision
Discuss alternatives
Offer support for alternatives (referral; individual counselling)
Suitable for later programme?

Parent deemed suitable…
Discuss possibility of parenting course
Explain course content with parent using manual – indicate areas that will be most helpful for this parent
Does parent want this option? Does it address hopes of parent? Can parent commit to course?

Preparation
Set up files for participants
Prepare necessary materials/equipment especially print off manuals (if planned hard copy)
Ensure space available and suitable
Contact participants with details one week prior to starting course

TANDEM parenting course
Parenting course conducted over 8 weeks (with mid course interview)
At end of course:
Parents complete post-course assessments
Participants decide date of first booster session
Set up contact arrangements in between course end and booster

Booster Session One
Post out assessments to return one week prior to booster
Structure booster around these assessment results – what do parents still find difficult?
Conduct booster
Set date for second booster
PART 2

ADVERTISING THE TANDEM PROGRAMME

The TANDEM programme commenced with a letter and advertising material being sent out to all high school principals and directors of helping agencies that either worked with adolescents who were exhibiting problem behaviour, or their parents, or both. Schools and agencies were located within a 10-kilometre radius of the location where the TANDEM programme was conducted. Each school and agency received a letter explaining the TANDEM programme, as well as a brochure for any client or school family interested in participating in the programme. School bulletin inserts were given to principals as an alternative to the brochure. Brochures repeated information in the letter in a more colloquial form.

For helping agencies, the brochure was sent in a format ready for display, as well as in a format suitable for photocopying should the agency require more copies. For schools, only the photocopying format was sent because of the large numbers of students’ families involved. Hence the reason for also sending the bulletin insert should the school be hesitant about the cost of copying large numbers of the brochure.
Dear Sir/Madam,

Northfields Clinic will be running two groups for the parents of adolescents, to be led by Gerard Stoyles, a clinical psychologist. They are based on a new program, called TANDEM, which he has put together after conducting research looking at the main factors associated with the development of troubled adolescent behaviour. Each group is for six two-hour sessions held weekly, which will be followed by two booster sessions two months apart. Group sizes will be limited to 12-15 members.

Both groups will be run on Wednesdays, starting on November 1st. The day group will be from 9.30 to 11.30 and the evening group from 7 to 9.

The program is aimed at parents of adolescents aged 12 to 16, who are experiencing serious relationship problems with their son or daughter and who are having trouble coping with the situation. There may be significant behaviour problems, drug use may be a concern, the children may be missing school and getting into trouble, they may experience their child as out of their control. Whatever the possible causes and associated problems the program is aimed at parents who find that their relationship with their adolescent child or children is fracturing and they want to rebuild a good relationship with them. This is not a group for reluctant parents but one for parents who are genuinely concerned about what is happening and are keen to learn better ways of dealing with their children.

The program will introduce parents to an understanding of basic parenting skills useful for raising adolescents. It will seek to teach a practical approach of applying skills in a fruitful manner and to find ways of providing ongoing support for the parents. A goal will be to keep or restore a solid parent-child relationship. Positive parenting, effective communication skills, problem-solving, limit setting and monitoring and the need for the parents to make sure they care for themselves and use supports effectively are the main areas to be covered. If you have any parents who you think might be suitable for either of these groups please feel free to refer them. You can make referrals by phone or in writing. Gerard will have a personal talk to all parents referred and tell them about the program, find out their special concerns and get them to complete questionnaires as part of the assessment and evaluation of the program.

The cost of the group has been deliberately set low at only $30.00 and will include a booklet and notes. This cost covers the booster sessions as well.

Would it be possible to include a half page insert in your school bulletin/magazine? A copy is enclosed. Also enclosed is a flyer and fold over brochure, both for your information and perhaps for sending out to parents. This brochure is suitable for public display. You are free to make as many copies of this brochure for your information/display stand.

If you have any questions at all about the program please give Northfields Clinic a call on 4221-3747. You are also free to ring Gerard on 4229 2801, this is also a fax number.

Regards,
John Freestone
Director, Northfields Clinic per

Helen Kouksenko (Administration Assistant) – Enclosed.
PART 3

THE ADOLESCENT PROBLEM BEHAVIOUR ASSESSMENT (PARENT VERSION)

When parents who wished to participate in the TANDEM programme first arrived at the Northfields Clinic, they were requested to complete the Adolescent Problem Behaviour Assessment (parent version). Extra questionnaires were included in this assessment instrument for use with the TANDEM parent sample. Extra questionnaires comprised the two scales of Parental Knowledge and Parental Feeling, the Stressors Scale, and the Depression Anxiety Stress Scales – 21-item version (DASS-21). Parents completed this instrument with the researcher present so that he could answer any queries. The researcher scored all questionnaires as soon as they were completed, so that immediate feedback could be given to parents for discussion with the researcher.

The Parent Resilience Questionnaire, the two scales of Parental Knowledge and Parental Feeling, and the DASS-21 were administered again at the conclusion of the parenting course as a measure of treatment effect.

The names of each questionnaire comprising the Adolescent Problem Behaviour Questionnaire have been inserted to aid the reader. However, when administered to the TANDEM parent sample, the questionnaire titles were omitted.
1. PLEASE CIRCLE either Mother (or role of mother)
   Or Father (or role of father)

2. PLEASE CIRCLE GENDER OF SON/DAUGHTER: MALE FEMALE

3. YOUR SON/DAUGHTER’S AGE IS: (YRS) (MTHS)

PLEASE NOTE!
THE QUESTIONS BEGIN ON THE BACK OF THIS PAGE,
AND THEN ON THE FRONT AND BACK OF EVERY OTHER PAGE.

STRICTLY CONFIDENTIAL

THERE ARE NO RIGHT OR WRONG ANSWERS. YOUR ANSWERS ARE WHAT YOU THINK.
YOUR ANSWERS ARE NOT SHOWN TO ANYONE.
DO NOT WRITE YOUR NAME OR ANYTHING THAT MIGHT IDENTIFY YOU ON THE QUESTION PAGES.

Research Title: An evaluation of an adolescent risk-status assessment questionnaire.
Researcher: Gerard Stoyles.
This research is being conducted as part of the degree Doctor of Philosophy. This degree is being supervised by Dr Beth Marlow, Department of Psychology, University of Wollongong, NSW, Australia.
Please write your age: ___________ years

**Parent Resilience Questionnaire**

The following questions look at your ability to cope as a parent, and ‘bounce back’ when events do not turn out as well as you might have wished. When answering each question, think about the way things are going for you at the present time. Don’t spend too much time thinking about each question, and remember that there are no right or wrong answers – your answer to each question is the one that is best for you.

There are five responses going from ‘Strongly Disagree’ to ‘Strongly Agree’. Place a circle around the response that is most suitable for you.

When my son or daughter is doing the wrong thing…

1. I know I can still keep going in spite of feeling upset.
   Strongly Disagree  Disagree  Undecided  Agree  Strongly Agree

2. I just don’t know how I’ll ever cope.
   Strongly Disagree  Disagree  Undecided  Agree  Strongly Agree

3. I think things will work out.
   Strongly Disagree  Disagree  Undecided  Agree  Strongly Agree

4. I have someone who helps me get through difficult times.
   Strongly Disagree  Disagree  Undecided  Agree  Strongly Agree

5. I know that I can handle the problem.
   Strongly Disagree  Disagree  Undecided  Agree  Strongly Agree

6. I can work on some strategies that will help.
   Strongly Disagree  Disagree  Undecided  Agree  Strongly Agree

7. Even though I feel angry with my son or daughter, I still think things will turn out OK.
   Strongly Disagree  Disagree  Undecided  Agree  Strongly Agree

8. I get so stressed out I just want to give up on my son or daughter.
   Strongly Disagree  Disagree  Undecided  Agree  Strongly Agree

9. No matter how hard it gets, I will make it.
   Strongly Disagree  Disagree  Undecided  Agree  Strongly Agree

10. There is someone with whom I can share my feelings, and I feel I can depend on that person.
    Strongly Disagree  Disagree  Undecided  Agree  Strongly Agree

11. Sometimes when I’m angry with my son or daughter, I believe I have run out of solutions.
    Strongly Disagree  Disagree  Undecided  Agree  Strongly Agree
Parental Knowledge Scale and the Parental Feeling Scale

The following questions are about the amount of skill you believe you have at this time for dealing with situations involving your son or daughter, as well as your feelings about being the parent of an adolescent.

Once again, don’t spend too much time thinking about each question, and remember that there are no right or wrong answers – your answer to each question is the one that is best for you.

There are five responses going from ‘Strongly Disagree’ to ‘Strongly Agree’. Place a circle around the response that is most suitable for you.

1. I do not know what I need to do to change the problems I have with my son or daughter.
   Strongly Disagree    Disagree     Undecided     Agree    Strongly Agree

2. I feel confident about setting limits on my son or daughter’s activities and behaviour.
   Strongly Disagree    Disagree     Undecided     Agree    Strongly Agree

3. I am clear about what skills I need to relate comfortably with my son or daughter.
   Strongly Disagree    Disagree     Undecided     Agree    Strongly Agree

4. I feel unhappy about the way things are working out between me and my son or daughter.
   Strongly Disagree    Disagree     Undecided     Agree    Strongly Agree

5. I do not have much knowledge about the basic communication and problem solving skills necessary for a good relationship with my son or daughter.
   Strongly Disagree    Disagree     Undecided     Agree    Strongly Agree

6. As the parent of an adolescent, I feel confident about successfully getting through the difficult times with my son or daughter.
   Strongly Disagree    Disagree     Undecided     Agree    Strongly Agree

Interpersonal Support Questionnaire

In the next section, think about each question and then circle the word beside it that best fits your answer. To make wording easier, the word ‘child’ has been used to refer to your adolescent son or daughter.

<table>
<thead>
<tr>
<th>R 1. My child feels uncomfortable about taking friends home…</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>M 2. My child tells me who he/she goes out with at night…</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>P 3. How many of your child’s friends would repeatedly get into trouble at school?</td>
<td>None</td>
<td>A few</td>
<td>A lot</td>
<td>All</td>
</tr>
<tr>
<td>R 4. I listen to my child…</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>P 5. How many of your child’s friends would regularly use alcohol (like beer, wine, and so on)?</td>
<td>None</td>
<td>A few</td>
<td>A lot</td>
<td>All</td>
</tr>
<tr>
<td>Question</td>
<td>Options</td>
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<td>------------------------------------------------------------------------</td>
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<tr>
<td>P 6. How many of your child’s friends would repeatedly get into trouble</td>
<td>None  A few  A lot  All</td>
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<tr>
<td>at home?</td>
<td></td>
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<td></td>
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<tr>
<td>M 7. I put limits on how much my child is allowed to do…</td>
<td>Never  Sometimes  Often</td>
<td>Always</td>
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<tr>
<td>R 8. My child gets into trouble at home…</td>
<td>Never  Sometimes  Often</td>
<td>Always</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P 9. How many of your child’s friends would repeatedly skip/jig school?</td>
<td>None  A few  A lot  All</td>
<td></td>
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<tr>
<td>R 10. When my child goes out, I want to know where he/she is going…</td>
<td>Never  Sometimes  Often</td>
<td>Always</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P 11. How many of your child’s friends would have sex regularly?</td>
<td>None  A few  A lot  All</td>
<td></td>
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<tr>
<td>R 12. There are arguments at home…</td>
<td>Never  Sometimes  Often</td>
<td>Always</td>
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<tr>
<td>R 13. My child can tell the family cares about him/her by the way they</td>
<td>Never  Sometimes  Often</td>
<td>Always</td>
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<tr>
<td>act towards him/her…</td>
<td></td>
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<tr>
<td>P 14. How many of your child’s friends bust up property or places just</td>
<td>None  A few  A lot  All</td>
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<td>for the fun of it?</td>
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<tr>
<td>P 15. How many of your child’s friends would regularly smoke cigarettes?</td>
<td>None  A few  A lot  All</td>
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<td></td>
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<tr>
<td>R 16. I enjoy talking to my child…</td>
<td>Never  Sometimes  Often</td>
<td>Always</td>
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<td>P 17. How many of your child’s friends would regularly smoke pot</td>
<td>None  A few  A lot  All</td>
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<tr>
<td>(marijuana)?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>R 18. I yell at my child…</td>
<td>Never  Sometimes  Often</td>
<td>Always</td>
<td></td>
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<tr>
<td>P 19. How many of your child’s friends would be more than one year</td>
<td>None  A few  A lot  All</td>
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<tr>
<td>older than he/she is?</td>
<td></td>
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<tr>
<td>P 20. When my child is out with his/her friends, he/she smokes</td>
<td>Never  Sometimes  Often</td>
<td>Always</td>
<td></td>
<td></td>
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<tr>
<td>cigarettes…</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P 21. How many of your child’s friends would have been in trouble with</td>
<td>None  A few  A lot  All</td>
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<tr>
<td>the police more than once or twice?</td>
<td></td>
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</tr>
<tr>
<td>R 22. I am affectionate towards my child…</td>
<td>Never  Sometimes  Often</td>
<td>Always</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M 23. I am interested in knowing about my child’s friends…</td>
<td>Never  Sometimes  Often</td>
<td>Always</td>
<td></td>
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</tr>
<tr>
<td>Question</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>P 24. When my child is out with his/her friends, he/she drinks alcohol (beer, wine, and so on)…</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P 25. How many of your child’s friends would regularly go out looking for trouble?</td>
<td>None</td>
<td>A few</td>
<td>A lot</td>
<td>All</td>
</tr>
<tr>
<td>P 26. When my child is out with his/her friends, he/she gets drunk…</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M 27. When I set limits for my child, I make sure that he/she keeps them…</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>P 28. How many of your child’s friends would carry a weapon with them, such as a knife?</td>
<td>None</td>
<td>A few</td>
<td>A lot</td>
<td>All</td>
</tr>
<tr>
<td>M 29. I want to know whom my child is going out with…</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>M 30. I make an effort to get to know the parents of my child’s friends…</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>A lot</td>
</tr>
<tr>
<td>P 31. When my child is out with his/her friends, my child uses drugs….</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>M 32. I say that my child has to get my permission before he/she can go out…</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>M 33. I care about the sort of people my child makes friends with…</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>P 34. How many of your child’s friends would regularly skip/jig class?</td>
<td>None</td>
<td>A few</td>
<td>A lot</td>
<td>All</td>
</tr>
<tr>
<td>M 35. I check if somewhere is safe before I let my child go there…</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>M 36. I insist that my child comes home by a certain time…</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>R 37. My child feels close to his/her family…</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>M 38. When going out, my child tells me where he/she is going…</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>R 39. My child seems to feel stressed out more than others…</td>
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<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td>R 40. My child has thought about running away from home…</td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
</tbody>
</table>
R 41. My child seems to get sad and depressed about things more than others…  Never  Sometimes  Often  Always

Adolescent Drug Use Questionnaire

Please answer the following questions according to your knowledge about possible drug and/or alcohol use by your son or daughter by placing a cross in a box. When answering these questions, remember that there are no right or wrong answers – rather each question is asking for your opinion on how things might be happening for your son or daughter regarding possible drug and/or alcohol use.

Answer each question by circling the response that best fits your answer.

1. Has your child ever had an alcoholic drink?
   - Yes
   - No
   If you answered NO, go to question 4.

2. On how many days did your child have an alcoholic drink in the last four weeks?
   - None
   - On 1-2 days
   - On 3-5 days
   - On 6-9 days
   - On 10-19 days
   - On 20 or more days
   - Every day?

3. On a day when your child has an alcoholic drink, how many drinks would he or she usually have?
   - A few sips
   - 1-2 drinks
   - 3-4 drinks
   - 5-8 drinks
   - 9-12 drinks
   - Over 12 drinks?

The next few questions are about smoking tobacco in cigarettes, rollies or pre-packed:

4. Has you child ever smoked tobacco?
   - Yes
   - No
   If you answered NO to this question, please go to Question 7.
5. On how many days has your child smoked tobacco in the last four weeks?
- None
- On 1-2 days
- On 3-5 days
- On 6-9 days
- On 10-19 days
- On 20 or more days
- Every day?

6. On a day when your child smokes cigarettes how many would he or she usually smoke?
- A few puffs
- 1-5 a day
- Approximately half a packet a day
- Approximately three quarters a packet a day
- Approximately one packet a day
- More than one packet a day

The next few questions are about marijuana (grass, pot, joint, cannabis or hashish – hash, hydro, hash oil):

7. Has your child ever used marijuana?
- Yes
- No
If you answered NO, skip the next question.

8. How many times has your child used marijuana or hash in the last four weeks?
- None
- 1-2 times
- 3-5 times
- 6-9 times
- 10-19 times
- 20-39 times
- 40 times or more

**Self-Perception of Risk Questionnaire**

Now that you have finished answering these questions, how do you see your child in the future if he or she continues to do things the same as now?

1. How likely is it that your child will have problems with the police because of the people he or she hangs around with?
- Not likely
- Somewhat likely
- Likely
- Very likely

2. How likely is it that your child will have problems with the police because of the things he/she does?
- Not likely
- Somewhat likely
- Likely
- Very likely
3. How likely is it that your child will have problems with drug abuse because of the people he/she hangs around with?

<table>
<thead>
<tr>
<th>Not likely</th>
<th>Somewhat likely</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
</table>

4. How likely is it that your child will have problems with drug abuse because of the things he/she does?

<table>
<thead>
<tr>
<th>Not likely</th>
<th>Somewhat likely</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
</table>

**Stressors Scale**

For these next questions, put a circle around either YES or NO:

1. Has your child been diagnosed with attention-deficit hyperactivity disorder (ADHD)?
   - Yes    No

2. Has your child changed schools more than twice in the last year (this does not include going from primary to high school)?
   - Yes    No

3. Has your child ever had to repeat a year at school?
   - Yes    No

4. Has your child ever been suspended from school?
   - Yes    No

5. Is your family a single parent family?
   - Yes    No

6. Have you been out of work for long periods of time in the last 12 months?
   - Yes    No

7. Would you say that your family does not have enough money for the basic things of life, like food & clothes?
   - Yes    No

8. Have you ever had a drug or alcohol problem?
   - Yes    No

9. Have any of your children ever had a drug or alcohol problem?
   - Yes    No

10. Have you ever had a mental health problem?
    - Yes    No

11. Have any of your children ever had a mental health problem?
    - Yes    No
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Has a close member of your family died in the last 12 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Has someone in your family had to spend time in hospital during the last 12 months because of a serious illness or accident?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Has the child you are concerned about ever had to spend time in hospital during the last 12 months because of a serious illness or accident?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Has it ever been necessary for your family to be looked after by people like relations, foster parents, or welfare agencies because you could not cope?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Do you live in an area where it is common for adolescents to regularly get involved in crime, alcohol or drugs?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**THERE ARE NO FURTHER QUESTIONS**

**THANK YOU**
Part 3: DASS 21 Survey not supplied. Please see print copy.
PART 4

THE ADOLESCENT PROBLEM BEHAVIOUR ASSESSMENT (ADOLESCENT VERSION)

The parents who participated in the TANDEM programme were invited to approach their adolescent son or daughter with the suggestion of completing the adolescent version of the Adolescent Problem Behaviour Assessment (APBA). The researcher and parent discussed how this would be most beneficially approached. The parent was asked by the researcher to emphasise the anonymous and confidential nature of the adolescent’s responses. An envelope addressed to the researcher was also given to the adolescent, enabling the adolescent to be in complete control of completing and passing on the APBA.

As with the parent version, the names of each questionnaire comprising the APBA have been inserted to aid the reader. However, when administered to adolescents, the questionnaire titles were omitted.
THE ADOLESCENT PROBLEM BEHAVIOUR ASSESSMENT (ADOLESCENT VERSION)

STRICTLY CONFIDENTIAL

PLEASE NOTE!
The questions begin on the back of this page, and then on the front and back of every other page.

DO NOT WRITE YOUR NAME ON THE QUESTION PAGES

YOUR ANSWER IS WHAT IS RIGHT FOR YOU, NOT FOR SOMEONE ELSE

YOUR ANSWERS WILL NOT BE SHOWN TO ANYONE

Research Title: An evaluation of an adolescent risk-status assessment questionnaire.
Researcher: Gerard Stoyles.
This research is being conducted as part of the degree Doctor of Philosophy. This degree is being supervised by Dr Beth Marlow, Department of Psychology, University of Wollongong, NSW, Australia.
### INTERPERSONAL SUPPORT QUESTIONNAIRE

**THE QUESTIONS START HERE:**

Please answer the following questions as best you can. In the next section, think about each question and then circle the word beside it that answers the question best for you. There are no right or wrong answers. If there are any you do not know the answer to, please leave them blank.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>R 1. I feel uncomfortable about taking friends home…</td>
<td>Never  Sometimes  Often  Always</td>
</tr>
<tr>
<td>M 2. I tell my parents who I go out with at night…</td>
<td>Never  Sometimes  Often  Always</td>
</tr>
<tr>
<td>P 3. How many of your friends would repeatedly get into trouble at school?</td>
<td>None  A few  A lot  All</td>
</tr>
<tr>
<td>R 4. My parents listen to me…</td>
<td>Never  Sometimes  Often  Always</td>
</tr>
<tr>
<td>P 5. How many of your friends would regularly use alcohol (like beer, wine, and so on)?</td>
<td>None  A few  A lot  All</td>
</tr>
<tr>
<td>P 6. How many of your friends would repeatedly get into trouble at home?</td>
<td>None  A few  A lot  All</td>
</tr>
<tr>
<td>M 7. My parents put limits on how much I am allowed to do…</td>
<td>Never  Sometimes  Often  Always</td>
</tr>
<tr>
<td>R 8. I get into trouble at home…</td>
<td>Never  Sometimes  Often  Always</td>
</tr>
<tr>
<td>P 9. How many of your friends would repeatedly skip/jig school?</td>
<td>None  A few  A lot  All</td>
</tr>
<tr>
<td>M 10. When I go out, my parents want to know where I am going…</td>
<td>Never  Sometimes  Often  Always</td>
</tr>
<tr>
<td>P 11. How many of your friends have sex regularly?</td>
<td>None  A few  A lot  All</td>
</tr>
<tr>
<td>R 12. There are arguments at home…</td>
<td>Never  Sometimes  Often  Always</td>
</tr>
<tr>
<td>Question</td>
<td>Options</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>R 13. I can tell my family cares about me by the way they act towards me...</td>
<td>Never</td>
</tr>
<tr>
<td>P 14. How many of your friends bust up property or places just for the fun of it?</td>
<td>None</td>
</tr>
<tr>
<td>P 15. How many of your friends would regularly smoke cigarettes?</td>
<td>None</td>
</tr>
<tr>
<td>R 16. My parents enjoy talking to me...</td>
<td>Never</td>
</tr>
<tr>
<td>P 17. How many of your friends would regularly smoke pot (marijuana)?</td>
<td>None</td>
</tr>
<tr>
<td>R 18. My parents yell at me...</td>
<td>Never</td>
</tr>
<tr>
<td>P 19. How many of your friends would be more than one year older than you are?</td>
<td>None</td>
</tr>
<tr>
<td>P 20. When I am out with my friends, I smoke cigarettes...</td>
<td>Never</td>
</tr>
<tr>
<td>P 21. How many of your friends would have been in trouble with the police more than once or twice?</td>
<td>None</td>
</tr>
<tr>
<td>R 22. My parents are affectionate towards me...</td>
<td>Never</td>
</tr>
<tr>
<td>M 23. My parents are interested in knowing about my friends...</td>
<td>Never</td>
</tr>
<tr>
<td>P 24. When I am out with my friends, I drink alcohol (beer, wine, and so on)...</td>
<td>Never</td>
</tr>
<tr>
<td>P 25. How many of your friends would regularly go out looking for trouble?</td>
<td>None</td>
</tr>
<tr>
<td>P 26. When I am out with my friends, I get drunk...</td>
<td>Never</td>
</tr>
<tr>
<td>M 27. When my parents set limits for me, they make sure that I keep them...</td>
<td>Never</td>
</tr>
<tr>
<td>P 28. How many of your friends would carry a weapon with them, such as a knife?</td>
<td>None</td>
</tr>
<tr>
<td>M 29. My parents want to know whom I am going out with...</td>
<td>Never</td>
</tr>
</tbody>
</table>
M 30. My parents make an effort to get to know the parents of my friends…

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>A lot</th>
</tr>
</thead>
</table>

P 31. When I am out with my friends, I do drugs….

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
</table>

M 32. My parents say that I have to get their permission before I can go out…

<table>
<thead>
<tr>
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M 33. My parents care about the sort of people I make friends with…

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P 34. How many of your friends would regularly skip/jig class?

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<th></th>
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</table>

M 35. My parents check out if somewhere is safe before they let me go there…

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<th>Often</th>
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</table>

M 36. My parents insist that I come home by a certain time…

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
</table>

R 37. I feel close to my family…

<table>
<thead>
<tr>
<th></th>
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<th>Always</th>
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M 38. When I go out, I tell my parents where I am going…

<table>
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<th>Often</th>
<th>Always</th>
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</table>

R 39. I seem to get stressed out more than others…

<table>
<thead>
<tr>
<th></th>
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</table>

R 40. I have thought about running away from home…

<table>
<thead>
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<th></th>
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<th>Sometimes</th>
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<th>Always</th>
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</table>

R 41. I seem to get sad and depressed about things more than others…

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Sometimes</th>
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<th>Always</th>
</tr>
</thead>
</table>

**ADOLESCENT DRUG USE QUESTIONNAIRE**

The next lot of questions ask you about whether you use alcohol and/or drugs, and if so, how much and how often. They are not saying that this is right or wrong.

Put a cross beside the answer that is best for you.
The questions look something like this:

**During the last four weeks, how often did you go to the beach?**
- None
- On 1-2 days
- On 3-5 days
- On 6-9 days
- On 10-19 days
- On 20 or more days
- Every day

Because I am a real beach fan, I went on 20 or more days to the beach, and so I would put a cross (‘x’) next to ‘On 20 or more days’.

**THE QUESTIONS START HERE:**

1. Have you ever had a drink of alcohol (like beer, wine, spirits, and so on)?
   - Yes
   - No
   If you answered NO to this question, go to Question 4.

2. On how many days did you have an alcoholic drink in the last four weeks?
   - None
   - On 1-2 days
   - On 3-5 days
   - On 6-9 days
   - On 10-19 days
   - On 20 or more days
   - Every day?

3. On a day when you have an alcoholic drink, how many drinks would you usually have?
   - A few sips
   - 1-2 drinks
   - 3-4 drinks
   - 5-8 drinks
   - 9-12 drinks
   - Over 12 drinks?

The next few questions are about smoking tobacco in cigarettes, rollies or pre-packed:

4. Have you smoked tobacco ever?
   - Yes
   - No
   If you answered NO to this question, go to Question 7.
5. On how many days have you smoked tobacco in the last four weeks?
- None
- On 1-2 days
- On 3-5 days
- On 6-9 days
- On 10-19 days
- On 20 or more days
- Every day?

6. On a day when you smoke cigarettes how many would you usually smoke?
- A few puffs
- 1-5 a day
- Approximately half a packet a day
- Approximately three quarters a packet a day
- Approximately one packet a day
- More than one packet a day

The next few questions are about marijuana (grass, pot, joint, cannabis or hashish – hash, hydro, hash oil):

7. Have you ever used marijuana in your life?
- Yes
- No
If you answered NO, skip the next question.

8. How many times have you used marijuana or hash in the last four weeks?
- None
- 1-2 times
- 3-5 times
- 6-9 times
- 10-19 times
- 20-39 times
- 40 times or more

**Self-Perception of Risk Questionnaire**

Think about the answers you have given to all the questions so far. These next four questions ask how you see yourself in the future if you keep on doing things the same as you do now.

1. How likely is it that you will have problems with the police because of the people you hang around with?

<table>
<thead>
<tr>
<th>Not likely</th>
<th>Somewhat likely</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
</table>

2. How likely is it that you will have problems with the police because of the things you do?

<table>
<thead>
<tr>
<th>Not likely</th>
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<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
</table>
3. How likely is it that you will have problems with drug abuse because of the people you hang around with?

<table>
<thead>
<tr>
<th>Not likely</th>
<th>Somewhat likely</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
</table>

4. How likely is it that you will have problems with drug abuse because of the things you do?

<table>
<thead>
<tr>
<th>Not likely</th>
<th>Somewhat likely</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
</table>

THERE ARE NO MORE QUESTIONS
THANK YOU.
PART 5

NORMATIVE DATA TABLES

The following tables contain normative data that were used for scoring the various questionnaires of the Adolescent Problem Behaviour Assessment (parent and adolescent versions).

Note that normative data were not available for the Parental Knowledge Scale and the Parental Feeling Scale. The procedure for scoring these scales has been described separately.

The Adolescent Problem Behaviour Assessment in both parent and adolescent versions has been included in this intervention package.
The Parent Resilience Questionnaire – comprising:

The factor of General Resilience and the factor of Support of a Significant Other (SSO)

Mean scores and standard deviations*

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Father</th>
<th>Female</th>
<th>Father</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.0-12.9 years</td>
<td>4.12 (.34)</td>
<td>4.09 (.58)</td>
<td>4.02 (.69)</td>
<td>4.00 (.76)</td>
<td>4.00 (.89)</td>
</tr>
<tr>
<td>13.0-13.9 years</td>
<td>4.00 (.48)</td>
<td>4.09 (.54)</td>
<td>3.90 (.91)</td>
<td>3.98 (.72)</td>
<td>3.95 (.94)</td>
</tr>
<tr>
<td>14.0-14.9 years</td>
<td>4.30 (.46)</td>
<td>4.10 (.57)</td>
<td>4.20 (.50)</td>
<td>3.92 (1.18)</td>
<td>4.56 (.54)</td>
</tr>
<tr>
<td>15.0-15.9 years</td>
<td>4.31 (.42)</td>
<td>4.11 (.45)</td>
<td>4.16 (.38)</td>
<td>3.87 (.74)</td>
<td>4.06 (.96)</td>
</tr>
<tr>
<td>16.0-16.9 years</td>
<td>4.31 (.45)</td>
<td>3.76 (.69)</td>
<td>3.93 (.61)</td>
<td>3.98 (.38)</td>
<td>4.05 (.93)</td>
</tr>
</tbody>
</table>

* A mean score is derived for the total sum of scores for each factor, giving a mean score for the parent’s overall general resilience and the parent’s belief about being supported by another significant person. Mean scores for each factor are then compared to normative data for adolescent age and gender to determine whether or not there is need for concern. Given the smallness of standard deviations, a drift equal to or less than 0.10 (using a 90% confidence interval) away from the normative mean score would be considered sufficient to warrant further investigation into either the parent’s sense of resilience or beliefs about another’s support.
**The Parental Knowledge Scale** (a measure of parenting skill)

**Items:**
1, 3, 5

**Reverse scored items:**
1, 5

**Scoring:**
A five-point Likert scale was used for scoring purposes, so that:

- Strongly Disagree – a score of 1
- Disagree – a score of 2
- Undecided – a score of 3
- Agree – a score of 4
- Strongly Agree – a score of 5

The sample size of the TANDEM parent sample was insufficiently large to derive normative data for the *Parental Knowledge Scale*. Therefore, the current knowledge of parenting skills possessed by an individual parent would be assessed according to where the parent’s score might approximate along the five-point Likert scale, so that a score approximating 1 would indicate low knowledge, and a score approximating 5 would indicate high knowledge. A score approximating 3 would indicate that the parent was unsure about his or her level of current skill knowledge.

---

**The Parental Feeling Scale** (a measure of parental self-efficacy)

**Items:**
2, 4, 6.

**Reversed scored item:**
4

**Scoring:**
A five-point Likert scale was used for scoring purposes, so that:

- Strongly Disagree – a score of 1
- Disagree – a score of 2
- Undecided – a score of 3
- Agree – a score of 4
- Strongly Agree – a score of 5

The sample size of the TANDEM parent sample was insufficiently large to derive normative data for the *Parental Feeling Scale*. Therefore, the current sense of self-efficacy possessed by an individual parent would be assessed according to where the parent’s score might approximate along the five-point Likert scale, so that a score approximating 1 would indicate low self-efficacy, and a score approximating 5 would indicate high self-efficacy. A score approximating 3 would indicate that the parent was unsure about feelings of self-efficacy.
### The Interpersonal Support Questionnaire – Peer Modelling

*All item numbers for this factor are prefixed with the letter “P”

*There are no reverse scored items*

---

#### Mean scores and standard deviations*

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Mean (SD)</th>
<th>Male</th>
<th>Female</th>
<th>Mean (SD)</th>
<th>Male</th>
<th>Female</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.0-12.9 years</td>
<td>1.25 (.18)</td>
<td>1.16 (.15)</td>
<td>1.11 (.09)</td>
<td>1.09 (.08)</td>
<td>1.16 (.16)</td>
<td>1.11 (.09)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.0-13.9 years</td>
<td>1.37 (.36)</td>
<td>1.20 (.26)</td>
<td>1.11 (.13)</td>
<td>1.13 (.24)</td>
<td>1.16 (.16)</td>
<td>1.15 (.15)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.0-14.9 years</td>
<td>1.60 (.50)</td>
<td>1.38 (.35)</td>
<td>1.19 (.17)</td>
<td>1.15 (.19)</td>
<td>1.20 (.32)</td>
<td>1.16 (.17)</td>
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<tr>
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<td>1.60 (.48)</td>
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<td>1.20 (.17)</td>
<td>1.17 (.16)</td>
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</tr>
<tr>
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<td>1.20 (.19)</td>
<td>1.25 (.31)</td>
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</tr>
</tbody>
</table>

*The derived adolescent and/or parent mean scores for this factor are compared to mean scores in the above table according to age and gender. Given the smallness of standard deviations, a drift equal to or greater than 0.10 (using a 90% confidence interval) away from the normative mean score would be considered sufficient to warrant further investigation with the parent into the adolescent’s behaviour. Concordance between the mean score findings for both adolescent and parent would be noted according to age and gender. Lack of concordance might indicate possible adolescent problem behaviour. Note that confidentiality would prevent the clinician from revealing adolescent findings for this questionnaire to the parent.*

Where only the parent is available to answer this questionnaire, then the parent’s mean score for adolescent risk behaviour would be compared to both parent and adolescent normative data. This would be done in order to determine the normality of the parent’s level of concordance in relation to normative parent data, as well as compare the parent’s mean score (i.e. perception) for the son or daughter’s level of risk behaviour with relevant adolescent data. Where the parent’s mean score indicated elevated levels of risk behaviour according to this factor, then this finding would need to be discussed with the parent, even if concordance were comparable to normative parent data. Note that this finding would not automatically indicate the presence of problem behaviour.
The Interpersonal Support Questionnaire - Parental Monitoring/Limit Setting

All item numbers for this factor are prefixed with the letter “M”

Reverse scored items: 2, 7, 10, 23, 27, 29, 30, 32, 33, 35, 36, 38

<table>
<thead>
<tr>
<th>Age Group</th>
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<th>Male</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.0-12.9 years</td>
<td>1.70 (.51)</td>
<td>1.38 (.43)</td>
<td>1.18 (.14)</td>
<td>1.18 (.16)</td>
<td>1.41 (.31)</td>
<td>1.13 (.10)</td>
</tr>
<tr>
<td>13.0-13.9 years</td>
<td>1.67 (.42)</td>
<td>1.52 (.53)</td>
<td>1.18 (.16)</td>
<td>1.22 (.38)</td>
<td>1.28 (.23)</td>
<td>1.32 (.36)</td>
</tr>
<tr>
<td>14.0-14.9 years</td>
<td>1.84 (.50)</td>
<td>1.67 (.49)</td>
<td>1.18 (.20)</td>
<td>1.22 (.18)</td>
<td>1.27 (.20)</td>
<td>1.35 (.17)</td>
</tr>
<tr>
<td>15.0-15.9 years</td>
<td>1.94 (.54)</td>
<td>1.68 (.39)</td>
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<td>1.35 (.23)</td>
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</tr>
<tr>
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<td>1.93 (.44)</td>
<td>1.63 (1.12)</td>
<td>1.40 (.34)</td>
<td>1.38 (.18)</td>
<td>1.49 (.43)</td>
</tr>
</tbody>
</table>

* The derived adolescent and/or parent mean scores for this factor are compared to mean scores in the above table according to age and gender. Given the smallness of standard deviations, a drift equal to or greater than 0.10 (using a 90% confidence interval) away from the normative mean score would be considered sufficient to warrant further investigation with the parent into the adolescent’s behaviour. Concordance between the mean score findings for both adolescent and parent would be noted according to age and gender. Lack of concordance might indicate possible adolescent problem behaviour. Note that confidentiality would prevent the clinician from revealing adolescent findings for this questionnaire to the parent.

Where only the parent is available to answer this questionnaire, then the parent’s mean score for adolescent risk behaviour would be compared to both parent and adolescent normative data. This would be done in order to determine the normality of the parent’s level of concordance in relation to normative parent data, as well as compare the parent’s mean score (i.e. perception) for the son or daughter’s level of risk behaviour with relevant adolescent data. Where the parent’s mean score indicated elevated levels of risk behaviour according to this factor, then this finding would need to be discussed with the parent, even if concordance were comparable to normative parent data. Note that this finding would not automatically indicate the presence of problem behaviour.
The Interpersonal Support Questionnaire - Parent/Family Relationships
All item numbers for this factor are prefixed with the letter “R”
Reverse scored items: 4, 13, 16, 22, 37

Mean scores and standard deviations*

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<thead>
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<td>Male n = 273</td>
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<tr>
<td>Male</td>
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<td>1.60 (.26)</td>
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</tr>
<tr>
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<td>1.51 (.28)</td>
<td></td>
<td>1.35 (.15)</td>
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</tr>
<tr>
<td>13.0-13.9 years</td>
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<td></td>
<td></td>
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</tr>
<tr>
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<td></td>
<td>1.59 (.33)</td>
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<td>1.47 (.23)</td>
<td></td>
<td>1.43 (.24)</td>
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</tr>
<tr>
<td>14.0-14.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.65 (.42)</td>
<td>1.70 (.50)</td>
<td></td>
<td>1.46 (.23)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.70 (.50)</td>
<td>1.49 (.27)</td>
<td></td>
<td>1.50 (.24)</td>
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</tr>
<tr>
<td>15.0-15.9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
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<td>1.91 (.64)</td>
<td></td>
<td>1.63 (.31)</td>
<td></td>
</tr>
<tr>
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<td>1.50 (.38)</td>
<td></td>
<td>1.57 (.38)</td>
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</tr>
<tr>
<td>16.0-16.9 years</td>
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<td></td>
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</tr>
<tr>
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<td>1.49 (.27)</td>
<td></td>
<td>1.42 (.21)</td>
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<tr>
<td>Female</td>
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<td>1.60 (.41)</td>
<td></td>
<td>1.65 (.49)</td>
<td></td>
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</tbody>
</table>

* The derived adolescent and/or parent mean scores for this factor are compared to mean scores in the above table according to age and gender. Given the smallness of standard deviations, a drift equal to or greater than 0.10 (using a 90% confidence interval) away from the normative mean score would be considered sufficient to warrant further investigation with the parent into the adolescent’s behaviour. Concordance between the mean score findings for both adolescent and parent would be noted according to age and gender. Lack of concordance might indicate possible adolescent problem behaviour. Note that confidentiality would prevent the clinician from revealing adolescent findings for this questionnaire to the parent.

Where only the parent is available to answer this questionnaire, then the parent’s mean score for adolescent risk behaviour would be compared to both parent and adolescent normative data. This would be done in order to determine the normality of the parent’s level of concordance in relation to normative parent data, as well as compare the parent’s mean score (i.e. perception) for the son or daughter’s level of risk behaviour with relevant adolescent data. Where the parent’s mean score indicated elevated levels of risk behaviour according to this factor, then this finding would need to be discussed with the parent, even if concordance were comparable to normative parent data. Note that this finding would not automatically indicate the presence of problem behaviour.
For alcohol, tobacco, and marijuana consumption, percentage values for consumption frequency and amount by the referred adolescent are compared to normative adolescent and parent percentage values according to age and gender. Comparing percentage values reported by the referred adolescent and the parent would indicate levels of concordance. Percentage values for the referred adolescent that indicated frequencies and amounts greater than percentages for approximately 95% of the normative adolescent and parent samples (a 95% confidence interval) would warrant further investigation into the adolescent’s use of the above substances with the parent.

Where only the parent is available to answer this questionnaire, then the parent’s percentage value in relation to either amount or frequency for adolescent substance use would be compared to percentage values for both normative parent and adolescent samples. This would be done in order to determine the normality of the parent’s level of concordance in relation to normative parent data, as well as compare the parent’s percentage value for the son or daughter’s substance consumption (i.e. the parent’s perception) with relevant adolescent data. Where the parent’s percentage value indicated elevated levels of consumption in terms of either frequency or amount, then this finding would need to be discussed with the parent, even if concordance were comparable to normative parent data. Note that this finding would not automatically indicate the presence of problem behaviour.

In all circumstances, issues of confidentiality would prevent the clinician from revealing the adolescent’s findings to the parent.

Tables showing normative adolescent and parent percentage values in relation to frequencies and amounts of alcohol, tobacco, and marijuana consumption during the previous four-week period are presented from the next page on.
## FREQUENCY of ALCOHOL consumption during the previous four weeks*

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Mother</th>
<th>Father</th>
<th>Female</th>
<th>Mother</th>
<th>Father</th>
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<td>n = 14</td>
</tr>
<tr>
<td>1.5 days</td>
<td>74.4</td>
<td>90.9 (-16.5)</td>
<td>90.5 (-16.1)</td>
<td>81.3</td>
<td>95.8 (-14.5)</td>
<td>93.3 (-12.0)</td>
</tr>
<tr>
<td>4.0 days</td>
<td>20.5</td>
<td>9.1 (11.4)</td>
<td>9.5 (11.0)</td>
<td>18.8</td>
<td>4.2 (14.6)</td>
<td>6.7 (12.1)</td>
</tr>
<tr>
<td>&gt;20 days</td>
<td>2.6</td>
<td>2.6</td>
<td>2.6</td>
<td>2.6</td>
<td>2.6</td>
<td>2.6</td>
</tr>
<tr>
<td>13-13.9 years</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Nil days</td>
<td>n = 46</td>
<td>n = 38</td>
<td>n = 28</td>
<td>n = 52</td>
<td>n = 42</td>
<td>n = 29</td>
</tr>
<tr>
<td>1.5 days</td>
<td>73.9</td>
<td>87.8 (-13.9)</td>
<td>90.3 (-16.4)</td>
<td>82.7</td>
<td>86.4 (-3.7)</td>
<td>74.2 (8.5)</td>
</tr>
<tr>
<td>4.0 days</td>
<td>21.7</td>
<td>12.2 (9.5)</td>
<td>9.7 (12.0)</td>
<td>15.4</td>
<td>13.6 (1.8)</td>
<td>22.6 (-7.2)</td>
</tr>
<tr>
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<td>2.2</td>
<td>2.2</td>
<td>1.9</td>
<td>1.9</td>
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<td></td>
<td></td>
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</tr>
<tr>
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<td>n = 27</td>
<td>n = 19</td>
<td>n = 42</td>
<td>n = 30</td>
<td>n = 21</td>
</tr>
<tr>
<td>1.5 days</td>
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<td>66.7 (-30.0)</td>
<td>80.0 (-43.3)</td>
<td>57.1</td>
<td>90.3 (-33.2)</td>
<td>90.5 (-33.4)</td>
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<td>4.0 days</td>
<td>43.3</td>
<td>29.6 (13.7)</td>
<td>15.0 (28.3)</td>
<td>35.7</td>
<td>9.7 (26.0)</td>
<td>9.5 (26.2)</td>
</tr>
<tr>
<td>14.5 days</td>
<td>13.3</td>
<td>3.7 (9.6)</td>
<td>5.0 (8.7)</td>
<td>4.8</td>
<td>4.8</td>
<td>4.8</td>
</tr>
<tr>
<td>15-15.9 years</td>
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</tr>
<tr>
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<td>n = 16</td>
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<td>n = 29</td>
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<td>51.9</td>
<td>84.2 (-32.3)</td>
<td>86.2 (-34.3)</td>
</tr>
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<td>14.3 (19.0)</td>
<td>15.0 (18.3)</td>
<td>26.9</td>
<td>10.5 (16.4)</td>
<td>10.3 (16.6)</td>
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<td>16.7</td>
<td>3.6 (13.1)</td>
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<td>9.6</td>
<td>5.3 (4.3)</td>
<td>3.4 (6.2)</td>
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<td>1.9</td>
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</tr>
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<td>83.3 (-57.2)</td>
<td>48.1</td>
<td>77.3 (-29.2)</td>
<td>73.3 (-25.2)</td>
</tr>
<tr>
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<td>22.7 (10.6)</td>
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<td>18.5</td>
<td>18.5</td>
<td>18.5</td>
<td>20.0 (-1.5)</td>
<td>20.0 (-1.5)</td>
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</table>

* Bracketed values indicate percentages of adolescents and parents who did not agree in their reports.
## FREQUENCY of TOBACCO consumption during the previous four weeks*

<table>
<thead>
<tr>
<th>Age Group</th>
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<th>Male</th>
<th>Father</th>
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</thead>
<tbody>
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<td>12-12.9 years</td>
<td></td>
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<tr>
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<td>100 (-7.7)</td>
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<td>100 (-7.7)</td>
</tr>
<tr>
<td>1.5 days</td>
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<td>93.8</td>
<td>6.3</td>
<td>2.6</td>
<td>93.8</td>
</tr>
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<td>4.0 days</td>
<td>5.1</td>
<td>14.5 days</td>
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</tr>
<tr>
<td>13-13.9 years</td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Nil days</td>
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<td>100 (-6.2)</td>
<td>n = 38</td>
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<td>96.8 (-3.3)</td>
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<td>2.4 (2.4)</td>
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</tr>
<tr>
<td>4.0 days</td>
<td>2.2</td>
<td>88.5</td>
<td>7.7</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
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<td>2.4 (2.4)</td>
<td>1.9</td>
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<td></td>
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<td>n = 27</td>
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<td>3.7 (3.7)</td>
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<tr>
<td>4.0 days</td>
<td>13.3</td>
<td>88.1</td>
<td>7.1</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
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<td>3.2 (3.2)</td>
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</tr>
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<td>3.2 (3.2)</td>
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<td>3.2 (3.2)</td>
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<tr>
<td>15-15.9 years</td>
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<td></td>
<td></td>
</tr>
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<td>n = 26</td>
<td>100 (-22.2)</td>
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<td>90.8</td>
<td>9.6</td>
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<td>5.6</td>
<td>9.6</td>
<td>1.9</td>
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<td>3.8</td>
<td>3.8</td>
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<tr>
<td>14.5 days</td>
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</tr>
<tr>
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<td>3.8 (3.8)</td>
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<td>16-16.9 years</td>
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* Bracketed values indicate percentages of adolescents and parents who did not agree in their reports.
**FREQUENCY of MARIJUANA consumption during the previous four weeks*.**

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* Bracketed values indicate percentages of adolescents and parents who did not agree in their reports.
## AMOUNT of ALCOHOL consumption during the previous four weeks*

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* Bracketed values indicate percentages of adolescents and parents who did not agree in their reports.
## AMOUNT of TOBACCO consumption during the previous four weeks*

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<td>20 cig’ettes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14-14.9 years</td>
<td>n = 30</td>
<td>n = 27</td>
<td>n = 19</td>
<td>n = 42</td>
<td>n = 30</td>
<td>n = 21</td>
</tr>
<tr>
<td>Nil cig’ettes</td>
<td>46.7</td>
<td>85.2 (-38.5)</td>
<td>90.0 (-43.3)</td>
<td>66.7</td>
<td>93.5 (-26.8)</td>
<td>100 (-33.3)</td>
</tr>
<tr>
<td>Puffs</td>
<td>30.0</td>
<td>11.1 (18.9)</td>
<td>10.0 (20.0)</td>
<td>23.8</td>
<td>3.2 (20.6)</td>
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</tr>
<tr>
<td>3 cigarettes</td>
<td>16.7</td>
<td>3.7 (13.0)</td>
<td></td>
<td>7.1</td>
<td>3.2 (3.9)</td>
<td></td>
</tr>
<tr>
<td>20 cig’ettes</td>
<td>6.7</td>
<td></td>
<td></td>
<td>2.4</td>
<td></td>
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</tr>
<tr>
<td>15-15.9 years</td>
<td>n = 36</td>
<td>n = 26</td>
<td>n = 16</td>
<td>n = 55</td>
<td>n = 39</td>
<td>n = 29</td>
</tr>
<tr>
<td>Nil cig’ettes</td>
<td>52.8</td>
<td>92.9 (-40.1)</td>
<td>90.0 (-37.2)</td>
<td>67.3</td>
<td>94.7 (-27.4)</td>
<td>96.6 (-29.3)</td>
</tr>
<tr>
<td>Puffs</td>
<td>25.0</td>
<td>7.1 (17.9)</td>
<td>10.0 (15.0)</td>
<td>17.3</td>
<td>2.6 (14.7)</td>
<td>3.4 (13.9)</td>
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<tr>
<td>3 cigarettes</td>
<td>22.2</td>
<td></td>
<td></td>
<td>13.5</td>
<td>2.6 (10.9)</td>
<td></td>
</tr>
<tr>
<td>20 cig’ettes</td>
<td></td>
<td></td>
<td></td>
<td>1.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-16.9 years</td>
<td>n = 23</td>
<td>n = 7</td>
<td>n = 5</td>
<td>n = 27</td>
<td>n = 20</td>
<td>n = 16</td>
</tr>
<tr>
<td>Nil cig’ettes</td>
<td>47.8</td>
<td>100 (-52.2)</td>
<td>100 (-52.2)</td>
<td>48.1</td>
<td>90.9 (-42.8)</td>
<td>73.3 (-25.2)</td>
</tr>
<tr>
<td>Puffs</td>
<td>17.4</td>
<td>25.9</td>
<td></td>
<td>25.9</td>
<td>9.1 (16.8)</td>
<td></td>
</tr>
<tr>
<td>3 cigarettes</td>
<td>30.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>30 cig’ettes</td>
<td>4.3</td>
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</tbody>
</table>

* Bracketed values indicate percentages of adolescents and parents who did not agree in their reports.*
## The Self-Perception of Risk Questionnaire

This is a single-factor questionnaire. There are no reverse scored items.

Mean scores and standard deviations*

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Adolescent Males n = 174</th>
<th>Mother n = 273</th>
<th>Father n = 198</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td><strong>12.0-12.9 years</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.08 (.18)</td>
<td>1.01 (.05)</td>
<td>1.04 (.12)</td>
</tr>
<tr>
<td>Female</td>
<td>1.01 (.04)</td>
<td>1.01 (.05)</td>
<td>1.00 (.00)</td>
</tr>
<tr>
<td><strong>13.0-13.9 years</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.09 (.20)</td>
<td>1.06 (.18)</td>
<td>1.03 (.14)</td>
</tr>
<tr>
<td>Female</td>
<td>1.08 (.26)</td>
<td>1.00 (.00)</td>
<td>1.00 (.00)</td>
</tr>
<tr>
<td><strong>14.0-14.9 years</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.27 (.47)</td>
<td>1.03 (.11)</td>
<td>1.00 (.00)</td>
</tr>
<tr>
<td>Female</td>
<td>1.07 (.14)</td>
<td>1.02 (.09)</td>
<td>1.02 (.09)</td>
</tr>
<tr>
<td><strong>15.0-15.9 years</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.22 (.42)</td>
<td>1.00 (.00)</td>
<td>1.01 (.06)</td>
</tr>
<tr>
<td>Female</td>
<td>1.20 (.53)</td>
<td>1.01 (.09)</td>
<td>1.01 (.05)</td>
</tr>
<tr>
<td><strong>16.0-16.9 years</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1.14 (.23)</td>
<td>1.05 (.15)</td>
<td>1.00 (.00)</td>
</tr>
<tr>
<td>Female</td>
<td>1.08 (.22)</td>
<td>1.01 (.06)</td>
<td>1.09 (.38)</td>
</tr>
</tbody>
</table>

* The derived adolescent and/or parent mean scores for this factor are compared to mean scores in the above table according to age and gender. Given the smallness of standard deviations, a drift equal to or greater than 0.10 (using a 90% confidence interval) away from the normative mean score would indicate that the adolescent and/or parent believed that the possibility for future harmful risk was to some extent high. This finding would be considered sufficient to warrant further investigation with the parent into the adolescent’s perception of future harmful risk. Concordance between the mean score findings for both adolescent and parent would be noted according to age and gender. Lack of concordance might, but not necessarily, indicate adolescent problem behaviour.

The adolescent’s mean score for the Self-Perception of Risk Questionnaire needs to be considered against all mean scores describing the adolescent’s behavioural profile (i.e., according to the Interpersonal Support Questionnaire and the Adolescent Drug Use Questionnaire). Where the mean score for the Self-Perception of Risk questionnaire has been found to be smaller than mean scores indicating problems with the adolescent’s behavioural profile, then this finding would describe a possible lack of insight by the adolescent into the potentially harmful nature of his or her behaviour. As such, this finding would necessitate further investigation in terms of possible adolescent problem behaviour.

Where only the parent is available to answer this questionnaire, then the parent’s mean score for the adolescent’s perception of future harmful risk would be compared to both
parent and adolescent normative data. This would be done in order to determine the normality of the parent’s level of concordance in relation to normative parent data, as well as compare the parent’s mean score (i.e. perception) for the son or daughter’s belief that future harmful risk will occur if current behaviour does not positively change. Where the parent’s mean score indicated possible problems with the adolescent’s insight into future harmful risk, then this finding would need to be discussed with the parent, even if concordance was comparable to normative parent data. Note that this finding would not automatically indicate the presence of problem behaviour.

Note that confidentiality would prevent the clinician from revealing adolescent findings for this questionnaire to the parent.
PART 6

THE DEPRESSION ANXIETY STRESS SCALES – 21-ITEM VERSION (DASS-21)

The Depression Anxiety Stress Scales – 21-item version (DASS-21) was included with the parent version of the Adolescent Problem Behaviour Assessment as measures of depression, anxiety, and stress.

Items for the DASS-21 are as follows:

Depression:
3, 5, 10, 13, 16, 17, 21

Anxiety:
2, 4, 7, 9, 15, 19, 20

Stress:
1, 6, 8, 11, 12, 14, 18

Scoring procedure for the DASS-21 can be found in the manual for this questionnaire.

Access to the manual can be gained by obtaining the following reference -


A copy of the DASS-21 has been included on the next page. The DASS-21 is a public domain questionnaire.
Part 6: DASS 21 Survey and DASS Profile Sheet not supplied. Please see print copy.
PART 7

FEEDBACK FORMS FOR THE ADOLESCENT PROBLEM BEHAVIOUR ASSESSMENT (PARENT AND ADOLESCENT VERSIONS)

Assessment results for the parent and adolescent versions of the Adolescent Problem Behaviour Assessment and the Depression Anxiety Stress Scales (Dass-21) were recorded on feedback forms. These forms were developed to enable a clear summary of assessment measures for each questionnaire, which in turn facilitated discussion between the researcher and the parent about the level of risk exhibited by the referred adolescent’s behaviour. Two separate feedback forms were available for adolescent and parent results. Due to confidentiality, outcome measures for the adolescent’s responses were not discussed with the parent, and were therefore used only by the researcher to determine concordance between parent and adolescent responses, as well as topics requiring special emphasis during the parenting course.
PRIVATE AND CONFIDENTIAL

ASSESSMENT SUMMARY AND FEEDBACK SHEET

Adolescent Problem Behaviour Assessment (Parent Version)

FOR CLINICIAN’S USE ONLY

Directions for use

Mark the parent’s mean score for each questionnaire on the continuum provided. Using a different colour, mark the normative mean score on the same continuum. For the Adolescent Drug Use Questionnaire, note the amount and frequency of consumption beside the three indicated substances, also noting the normative amount and frequency of consumption in a different colour. For normative scores, take gender and age into consideration. Using different colours enables comparisons to be drawn between the scores of the identified adolescent and normative scores. Finally, note any relevant comments in the spaces provided for each questionnaire.

Name: ________________________________

1. Parent Resilience Questionnaire: What is the parent’s general level of resilience (the ability to “bounce back”) after serious/aggressive interactions with the identified adolescent (IA) in the areas of –

General Resilience (the parent’s overall level of resilience)

<table>
<thead>
<tr>
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<th>2.0</th>
<th>3.0</th>
<th>4.0</th>
<th>5.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Weak</td>
<td>Unsure</td>
<td>Very Strong</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Support of a Significant Other (the level of support from another significant person [partner/spouse, extended family, close friend, etc.] available to the parent)

<table>
<thead>
<tr>
<th>1.0</th>
<th>2.0</th>
<th>3.0</th>
<th>4.0</th>
<th>5.0</th>
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<tr>
<td>Very Weak</td>
<td>Unsure</td>
<td>Very Strong</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: _______________________________________________________________________
______________________________________________________________________________
2. Parental Knowledge Scale: What is the parent’s level of parenting skill in relation to the IA?

<table>
<thead>
<tr>
<th>1.0</th>
<th>2.0</th>
<th>3.0</th>
<th>4.0</th>
<th>5.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Weak</td>
<td>Unsure</td>
<td>Very Strong</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: __________________________________________

3. Parental Feeling Scale: What is the parent’s sense of self-efficacy in the parenting role with the IA?

<table>
<thead>
<tr>
<th>1.0</th>
<th>2.0</th>
<th>3.0</th>
<th>4.0</th>
<th>5.0</th>
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<tbody>
<tr>
<td>Very Weak</td>
<td>Unsure</td>
<td>Very Strong</td>
<td></td>
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</tr>
</tbody>
</table>

Comments: __________________________________________

4. Interpersonal Support Questionnaire

Peer Modelling: To what extent does the parent see problem behaviour (PB) as being a result of the identified adolescent’s modelling of peers’ behaviour?

<table>
<thead>
<tr>
<th>1.0</th>
<th>1.5</th>
<th>2.0</th>
<th>2.5</th>
<th>3.0</th>
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<th>4.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nil Risk</td>
<td>Mid Point</td>
<td>High Risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: __________________________________________

Parental Monitoring/Limit Setting: To what extent does the parent see PB as being a result of the parent’s monitoring and placing limits on the IA’s activities/behaviour?

<table>
<thead>
<tr>
<th>1.0</th>
<th>1.5</th>
<th>2.0</th>
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<th>3.0</th>
<th>3.5</th>
<th>4.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nil Risk</td>
<td>Mid Point</td>
<td>High Risk</td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

Comments: __________________________________________
**Parent/Family Relationships:** To what extent does the parent see PB as being a result of the quality of relationship between the IA and parent, and between the IA and other family members?

<table>
<thead>
<tr>
<th></th>
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<td>4.0</td>
<td></td>
</tr>
<tr>
<td>Nil Risk</td>
<td>Mid Point</td>
<td>High Risk</td>
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<td></td>
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</tbody>
</table>

Comments: ____________________________________________

____________________________________________________

**5. Adolescent Drug Use Questionnaire**

Note the IA’s **frequency** of consumption reported by the parent over four weeks (number of days) for each of the following substances:

**Alcohol:** __________ (IA) __________ (normative score)

**Tobacco:** __________ (IA) __________ (normative score)

**Marijuana:** __________ (IA) __________ (normative score)

Comments: ____________________________________________

____________________________________________________

Note the IA’s **amount** of consumption reported by the parent over four weeks for each of the following substances:

**Alcohol:** __________ (IA) __________ (normative score)

**Tobacco:** __________ (IA) __________ (normative score)

**Marijuana:** __________ (IA) __________ (normative score)

Comments: ____________________________________________

____________________________________________________

**6. Self-Perception of Risk Questionnaire:** Following a consideration of present levels of harmful risk, to what extent does the parent see the adolescent as being at risk of future PB in terms of:

**Legally-related problems**

**Due to dysfunctional peer modelling (Q 1):**

<table>
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<tr>
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<td>Not likely</td>
<td>Mid Point</td>
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Adolescent Problem Behaviour Assessment – Parent Version
Due to behaviour (Q 2):

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<table>
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<td>2.5</td>
<td>3.0</td>
<td>3.5</td>
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<td>Not likely</td>
<td>Mid Point</td>
<td>Very likely</td>
<td></td>
<td></td>
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</tbody>
</table>

*Drug-related problems*

Due to dysfunctional peer modelling (Q 3):

<p>| | | | | | | |</p>
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<td>3.0</td>
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<tr>
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Due to behaviour (Q 4):

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<tr>
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<td>Mid Point</td>
<td>Very likely</td>
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Comments:__________________________________________________________

__________________________________________________________

7. **DASS 21 results**: What are the levels of depression, anxiety, and stress reported by the parent (note both score and description [e.g., normal, moderate, etc.] of level)?

D = Score_________Description_______________

A = Score_________Description_______________

S = Score_________Description_______________

8. **Demographic Information**: Describe any significant information in relation to

Schooling of IA_____________________________________________________

Socio-economic_____________________________________________________________________

Neighbourhood______________________________________________________________________

Family relationships______________________________________________________________

Mental health of parent__________________________________________________________

Drug use by the parent___________________________________________________________

Mental health of siblings__________________________________________________________

Drug use of siblings______________________________________________________________

Mental health of the IA___________________________________________________________

Drug use of the IA_______________________________________________________________

Physical illness/accident_________________________________________________________________

Death_____________________________________________________________________________
9. General level of knowledge by parent(s) in relation to the IA: How would you describe the parent’s general level of knowledge/insight in relation to the IA?

________________________________________________________

________________________________________________________

Overall Summary Comments

________________________________________________________

________________________________________________________

________________________________________________________

Decision of parent in relation to intervention

________________________________________________________

________________________________________________________

Clinician __________________ Date ____________ Signature ________________
Directions for use

Mark the identified adolescent’s mean score for each questionnaire on the continuum provided. Using a different colour, mark the normative mean score on the same continuum. For the Adolescent Drug Use Questionnaire, note the amount and frequency of consumption beside the three indicated substances, also noting the normative amount and frequency of consumption in a different colour. For normative scores, take gender and age into consideration. Using different colours enables comparisons to be drawn between the scores of the identified adolescent and normative scores. Finally, note any relevant comments in the spaces provided for each questionnaire.

Name: __________________________

1. Interpersonal Support Questionnaire

Peer Modelling: To what extent is problem behaviour (PB) a result of the identified adolescent’s (IA) modelling of peers’ behaviour?

<p>| | | | | | | |</p>
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<td>3.0</td>
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<td>4.0</td>
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<tr>
<td>Nil Risk</td>
<td>Mid Point</td>
<td>High Risk</td>
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</tbody>
</table>

Comments: ____________________________________________

Parental Monitoring/Limit Setting: To what extent is PB a result of the parent’s monitoring and placing limits on the IA’s activities/behaviour?

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<tbody>
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<td>3.0</td>
<td>3.5</td>
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<td>Nil Risk</td>
<td>Mid Point</td>
<td>High Risk</td>
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</tbody>
</table>

Comments: ____________________________________________

Adolescent Problem Behaviour Assessment – Adolescent Version
**Parent/Family Relationships:** To what extent is PB a result of the quality of relationship between the IA and parent, and between the IA and other family members?

<table>
<thead>
<tr>
<th>1.0</th>
<th>1.5</th>
<th>2.0</th>
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<th>3.0</th>
<th>3.5</th>
<th>4.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nil Risk</td>
<td>Mid Point</td>
<td>High Risk</td>
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</tr>
</tbody>
</table>

Comments: ___________________________________________________________

____________________________________________________________________

**2. Adolescent Drug Use Questionnaire**

Note the **frequency** of consumption over four weeks for each of the following substances:

- **Alcohol:** ___________(IA) ___________(normative score)
- **Tobacco:** ___________(IA) ___________(normative score)
- **Marijuana:** ___________(IA) ___________(normative score)

Comments: __________________________________________________________

____________________________________________________________________

Note the **amount** of consumption over four weeks (number of days) for each of the following substances:

- **Alcohol:** ___________(IA) ___________(normative score)
- **Tobacco:** ___________(IA) ___________(normative score)
- **Marijuana:** ___________(IA) ___________(normative score)

Comments: __________________________________________________________

____________________________________________________________________
3. **Self-Perception of Risk Questionnaire:** Following a consideration of present levels of harmful risk, to what extent does the adolescent see him or herself as being at risk of future PB in terms of -

**Legally-related problems**

**Due to dysfunctional peer modelling (Q 1):**

<table>
<thead>
<tr>
<th></th>
<th>1.0</th>
<th>1.5</th>
<th>2.0</th>
<th>2.5</th>
<th>3.0</th>
<th>3.5</th>
<th>4.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not likely</td>
<td></td>
<td></td>
<td></td>
<td>Mid Point</td>
<td></td>
<td></td>
<td>Very likely</td>
</tr>
</tbody>
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**Due to behaviour (Q 2):**

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**Drug-related problems**

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Comments: 

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**Overall Summary Comments**

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Clinician_________________________ Date_________________ Signature_________________
PART 8

EXAMPLES OF COMPLETED FEEDBACK FORMS

Examples of completed feedback forms for a mother and her 12 years 11 month old son have been included in this part of the TANDEM intervention package to demonstrate how the researcher used these forms in practice.
Part 8: Assessment Summary and Feedback Sheet for
Adolescent Problem Behaviour Assessment (Parent Version) &
Adolescent Problem Behaviour Assessment (Adolescent Version)
were not supplied. Please see print copy.
This flowchart was presented to parents once adolescent problem behaviour had been identified. By means of this flowchart, parents were encouraged to participate in the parenting course in order to intervene with identified adolescent problem behaviour. Together with the parenting course manual, the flowchart was also used to summarise the basic construct of the parenting course by outlining its principal intervention aims. Finally, parents took the flowchart home with them as a summary of the course, as well as a means of maintaining motivation until the commencement of the parenting course.
ADOLESCENT DEVELOPMENT

CHANGES
- Physical
- Emotional
- Mental

Lead to changes in parent/family and adolescent relationships

Movement along the line of adolescent development means that *inter-personal skills* need to shift in the way they are applied: 
*Flexibility* is required

Changes in relationship mean new/different demands on:
- Parents
- Adolescent
- Siblings

Contact with each other can be *enjoyable* and *not enjoyable*:

Conflict can be expected in these relationships

Good resolution of conflict is helped by:
- Refining old skills
- Gaining new skills

Skills of:
- Communication
- Problem Solving/Conflict Resolution
- Monitoring/Limit Setting
- Understanding why things go wrong & go right: *insight*

Issues of *Self-Care*:
- Feeling *confident* in the role of parent, including: Authority Responsibility Flexibility
- Feeling *comfortable* about exercising this role
- Staying with a decision when it is clear that this is the direction to take.
Parents used the TANDEM-parenting course manual throughout the six-week course. The manual was an essential component for the course, and guided the researcher’s presentation of contents each week. The manual was also designed to be an ongoing support for parents as a reference book, particularly when they felt the need to revise learned parenting skills and strategies for coping with their son or daughter.
For Part 10: The *TANDEM*-Parenting Course Manual, please see the ‘TANDEMManual’ file attached to this thesis.
PART 11

GROUP DIRECTIONS FOR THE TANDEM-PARENTING COURSE

At the first session of the parenting course, a discussion was conducted with parents concerning basic and essential requirements to be maintained for the duration of the course. These included both housekeeping arrangements as well as issues related to the sessions for each week and the manner of expected interaction among group members during these sessions.
As we begin…

Welcome to the TANDEM-parenting course! There are some important issues to present to you as we begin our time together.

Confidentiality. Simply, this means that what is said or what happens in the group room stays in the group room. Confidentiality is absolutely essential for peoples’ dignity and for an increase in trust between us as the weeks pass by.

Mutual respect. Mutual respect refers to the way members listen to each other without cutting others off, waiting till someone else has finished speaking before starting to speak, not ‘holding the floor’ when speaking, not ‘putting down’ someone else’s ideas or comments, and so on. Staying on track with what the group is talking about, rather than having sideline conversations, is yet another way to keep mutual respect in focus.

Being on time each week. This is also part of mutual respect. While it isn’t possible to plan for those last minute disasters, members are asked to be on time each week, and even try to be present 10 minutes before the starting time (this will also give you time for a caffeine kick-start!). At night someone has to go to the door to manually open it, so being on time, especially at night, is important.

Sharing experiences. It is important to avoid speaking about very personal issues that might have happened at home, and that should stay at home. While group members are invited to offer examples from their own experiences during sessions, at the same time members are asked to make sure that what is shared within the group is not going to cause any embarrassment.

If you can’t make it? If you can’t get in for a particular session, please do your best to ring beforehand – this will help with organising special needs for each meeting.

Each week, please bring…your parent manual, a pen or pencil, a notebook if you wish (though you might find it easier to jot things down in the manual – you don’t lose your jottings that way), and a mug. The idea of the mug is to avoid buying styrene cups. Also, smoking is not permitted inside the clinic building.

It’s your time!
These sessions are YOUR time! They are your opportunity to do something just for yourself! First and foremost therefore we hope that you enjoy our time together. This time is not meant to be a burden. We don’t want people getting out of bed and thinking “Oh no, not TANDEM
again!” All the points above are aimed at making sure that you not only enjoy the TANDEM experience but also gain rich benefits that will help yourself, your son or daughter, and other members of your family.

**Stick with it!** Do your best to reach the end of the six weeks! Sticking to your commitment will be a strong support for you and your fellow group members. When someone drops out of a group like this, there is usually a sense of loss and sadness among the other group members. Also, dropping out means being left with unfinished business. There won’t be the opportunity to know what things would have been like if the person who dropped out had stayed to the end!! So please remember - not only is this group experience important for you – you are also an important and essential part of this group experience!

**And if you need help along the way?** During the course there will be opportunities for all group members to have a one-to-one meeting with the psychologist who is presenting the sessions. However, if at any time things at home or for you personally become too difficult to manage, or if there is something in the course that you need extra help with or don’t fully understand, then don’t hesitate to ask for help. Don’t suffer in silence!

**Using the manual.** Because we only have two hours each week, we won’t have time to go through each chapter of the manual point by point. However, parts of each chapter will be used as the main focus of our discussions. You will be asked to read the chapter during the week after our meeting, as well as complete the tasks at the end of the chapter. Because each session is meant to help you better understand each chapter, only read the chapter of the previous week. Avoid the temptation to read on ahead of the group meetings! When the TANDEM course is over, the TANDEM manual will also be a useful way of going back over the different areas of parenting we have discussed together. Therefore, the manual is also meant to be a ‘refresher’ in future times.

**Finally, the role of the parent...** No one can replace you as the parent – no one person, and certainly no institution. Whether you are mother or father, grandmother or grandfather, uncle or aunt, parent by adoption, or whatever title you can think of, you are the parent of your son or daughter *because* he or she *is* your son or daughter. This is so regardless of the description you might give to your role as “parent”. That is why the most important aim of TANDEM is one of helping the relationship between parent and child become as strong as it possibly can. While we can help you discover ways of achieving this, the hard work must be put in by you. We hope that you will come to enjoy the rewards of that effort!
PART 12

MEASURES OF INTERVENTION EFFECTIVENESS

A. Parents were invited to briefly comment on the effectiveness of the parenting course for them individually. Parents were given a sheet with four questions for this purpose.

B. Four measures were also used as a pre and post measure of intervention effectiveness for the TANDEM-parenting course. These measures were –

- The *Parent Resilience Questionnaire*
- The *Parental Knowledge Scale*
- The *Parental Feeling Scale*
- The *Depression Anxiety Stress Scales – 21-item version (DASS 21)*

All measures were administered on the final day of the parenting course. Results of the *Parent Resilience Questionnaire, the Parental Knowledge Scale, the Parental Feeling Scale* and the *DASS 21* were compared with the findings of these questionnaires when they were administered at the intake interviews.
Over the last six weeks, since starting **TANDEM**, think about how things might have changed for you personally. Think also about how things might have changed at home between you and your adolescent (or adolescents) and your partner.

Now please answer the following **with a few words or brief statements**.

1. What personal changes have you noticed in yourself?

2. What changes have you noticed in your son or daughter?

3. What changes have you noticed in your partner (leave out if you are a single parent)?

4. What changes have you noticed in your relationship with your son or daughter?

Thank you.
**Parent Resilience Questionnaire**

The following questions look at your ability to cope as a parent, and ‘bounce back’ when events do not turn out as well as you might have wished. When answering each question, think about the way things are going for you at the present time. Don’t spend too much time thinking about each question, and remember that there are no right or wrong answers – your answer to each question is the one that is best for you.

There are five responses going from ‘Strongly Disagree’ to ‘Strongly Agree’. Place a circle around the response that is most suitable for you.

When my son or daughter is doing the wrong thing…

1. I know I can still keep going in spite of feeling upset.
   - Strongly Disagree
   - Disagree
   - Undecided
   - Agree
   - Strongly Agree

2. I just don’t know how I’ll ever cope.
   - Strongly Disagree
   - Disagree
   - Undecided
   - Agree
   - Strongly Agree

3. I think things will work out.
   - Strongly Disagree
   - Disagree
   - Undecided
   - Agree
   - Strongly Agree

4. I have someone who helps me get through difficult times.
   - Strongly Disagree
   - Disagree
   - Undecided
   - Agree
   - Strongly Agree

5. I know that I can handle the problem.
   - Strongly Disagree
   - Disagree
   - Undecided
   - Agree
   - Strongly Agree

6. I can work on some strategies that will help.
   - Strongly Disagree
   - Disagree
   - Undecided
   - Agree
   - Strongly Agree

7. Even though I feel angry with my son or daughter, I still think things will turn out OK.
   - Strongly Disagree
   - Disagree
   - Undecided
   - Agree
   - Strongly Agree

8. I get so stressed out I just want to give up on my son or daughter.
   - Strongly Disagree
   - Disagree
   - Undecided
   - Agree
   - Strongly Agree

9. No matter how hard it gets, I will make it.
   - Strongly Disagree
   - Disagree
   - Undecided
   - Agree
   - Strongly Agree

10. There is someone with whom I can share my feelings, and I feel I can depend on that person.
    - Strongly Disagree
    - Disagree
    - Undecided
    - Agree
    - Strongly Agree

11. Sometimes when I’m angry with my son or daughter, I believe I have run out of solutions.
    - Strongly Disagree
    - Disagree
    - Undecided
    - Agree
    - Strongly Agree
Parental Knowledge Scale and the Parental Feeling Scale

The following questions are about the amount of skill you believe you have at this time for dealing with situations involving your son or daughter, as well as your feelings about being the parent of an adolescent.

Once again, don’t spend too much time thinking about each question, and remember that there are no right or wrong answers – your answer to each question is the one that is best for you.

There are five responses going from ‘Strongly Disagree’ to ‘Strongly Agree’. Place a circle around the response that is most suitable for you.

1. I do not know what I need to do to change the problems I have with my son or daughter.
   Strongly Disagree    Disagree     Undecided     Agree    Strongly Agree

2. I feel confident about setting limits on my son or daughter’s activities and behaviour.
   Strongly Disagree    Disagree     Undecided     Agree    Strongly Agree

3. I am clear about what skills I need to relate comfortably with my son or daughter.
   Strongly Disagree    Disagree     Undecided     Agree    Strongly Agree

4. I feel unhappy about the way things are working out between me and my son or daughter
   Strongly Disagree    Disagree     Undecided     Agree    Strongly Agree

5. I do not have much knowledge about the basic communication and problem solving skills necessary for a good relationship with my son or daughter.
   Strongly Disagree    Disagree     Undecided     Agree    Strongly Agree

6. As the parent of an adolescent, I feel confident about successfully getting through the difficult times with my son or daughter.
   Strongly Disagree    Disagree     Undecided     Agree    Strongly Agree
Part 12: DASS 21 Survey not supplied. Please see print copy.
TANDEM
MAKING THINGS DIFFERENT
MAKING THINGS WORK!

A PROGRAMME FOR PARENTS OF ADOLESCENTS

GERARD STOYLES

(COPYRIGHT 2000)
TANDEM
MAKING THINGS DIFFERENT
MAKING THINGS WORK!
A PROGRAMME FOR PARENTS OF ADOLESCENTS

T  Take the opportunity; take time to talk things out
A  Assess the situation – how are things really going?
N  Network with people who can help
D  Discuss possibilities
E  Ease yourself into new ways of thinking and acting
M  Make a difference!

A TANDEM BIKE has two wheels and TWO seats! This means that the job of pushing the bike along is halved. In the same way, the job of being a parent to an adolescent is made easier when someone else is sitting in that second seat with you!
CONTENTS

Page 4: Introduction
Page 8: Adolescent Development
Page 21: Styles of Parenting
Page 34: The Art of Communication
Page 58: Problem Solving
Page 76: Conflict Resolution
Page 92: Monitoring, Limit Setting, Networking
Introduction

The aim of this manual is both to build on parenting skills you already have, and offer other basic skills, as you work at building up a strong relationship with your adolescent son or daughter.

The teenage years are the link between childhood and adulthood. They are also complicated years when the adolescent is challenged with new situations that are not solved by old (childhood) ways of thinking. Answers no longer seem as easy as they once did. Relationships with adults and friends (especially parents) can be both reassuring and confusing, and the fear of being left alone and out of the ‘group’ will at times be a strong influence in determining the pattern of the adolescent’s behaviour and attitudes.

For those in the role of parent there is the tension between holding back their child and letting their child go; between the need to come and rescue, and the need to stand back and wait; between pride and disillusionment; between affection and hurt; between the past child and the developing adult. Adolescence is a time that calls for support, encouragement, wisdom, and new approaches to old skills, or new skills for old approaches – for parent and adolescent alike.

The TANDEM Programme

This programme is not designed to offer parents the magic formula for coping with the adolescent years. Its approach lies at the basic ‘bread and butter’ end of the line. The aim is to offer parents support by…

- Building on present skills, and where necessary helping parents develop new skills;
- Leading parents towards developing stronger relationships with their teenage son or daughter;
- Encourage parents to be realistic about expectations for their own coping ability so that they can be just as realistic about their son or daughter;
- Encourage parents to look after themselves as well as their son or daughter;
Encourage parents to develop support networks instead of expecting that they should be the faultless parent of an adolescent without any other help. This is especially important for the parent who must cope alone in this role.

**The Importance of the Family**

The family is the most desirable support structure for adolescent development. No one person or institution can take the place of the family in that all-important task of helping the adolescent reach a healthy adult maturity. Nor can any person or institution become a worthy substitute for the bond of love and respect of parents for their children (regardless of who steps into the role of ‘parent’) no matter how committed or efficient the person or institution might be. Therefore, the role of the parent and the essential importance of the family will always provide the foundation for whatever is presented in this manual.

**The Relationship between Parent and Adolescent**

The importance of developing a strong relationship between parent and adolescent is the essential ingredient for every part of the TANDEM programme. The over-riding aim is always to work at building up this relationship. A strong relationship rewards parent and adolescent with a greater quality of life, the satisfaction of enjoying each other instead of putting up with each other, and the ability to rebuild the relationship when it fractures.

The parent-adolescent relationship is like looking at a carton of milk. Turn it one way and you will see the carton from a certain direction. Turn the carton and the view now changes. By shifting the carton around you continually change your viewing angle. Yet it always remains the same carton! A similar idea applies to the quality of the parent-adolescent relationship. You can build it up from various angles (by means of new communication skills, or different ways of resolving conflict, or changes in your parenting style, and so on) yet it is always fundamentally the same relationship. What you have done is viewed the relationship from a number of different angles.
The ‘See-Saw’ Image

Take a pencil and balance it on your finger. Notice how much energy it takes not only to balance the pencil in the first place but also to keep it in balance! Now think about the amount of energy it takes to keep the relationship between yourself and your adolescent in balance when you are continually waiting for things to blow up around you. What happens is that you, as the parent, become predictable, so that your son or daughter gets to know exactly how you will react so as to ‘keep the peace’. So you will say ‘yes’ to going out at night when you would rather say ‘no’, because if you don’t agree, you know from past experience that there will be a screaming match and your adolescent will get his or her own way in the end! The purpose of undertaking the TANDEM programme is to tip the balance; to encourage you to become unpredictable; to have your adolescent wondering why you are not acting or speaking as you should! This will feel uncomfortable at first, and the TANDEM programme is designed to help you through this discomfort. Eventually you will reach a stage of knowing that you are doing and saying what you believe should be said and done with your son or daughter. The bottom line is that if things are to get any better with your adolescent then the old dysfunctional balance must be upset. You can no longer remain the predictable parent!

Homework

Before leaving this introductory chapter, it is important to speak about the use of homework tasks. Homework is an important part of the TANDEM approach to refining old skills and learning new parenting skills with adolescents. Homework exercises appear at the end of each chapter, and are linked to the contents of that chapter. Homework is the hinge between what is presented and discussed in each session, giving the parent an opportunity to think about and review the contents of each chapter in the week after the group session. It is also an opportunity to reflect on how details of a particular chapter personally apply in an individual parent’s life. Homework is not intended to drag you back into school, or make you feel like a school pupil again!

The strong suggestion is to dedicate at least an hour or two each week for these homework exercises and to do this on the same day and at the same time, if this is possible. Like the weekly TANDEM group sessions,
homework is *your* personal time, spent by you on *you* alone. The alternative to not undertaking the homework tasks is to enter each week’s group work as a separate experience, without any connection to the previous week. This will eventually feel unsatisfying and could easily be an influential factor in dropping out of the course.

**The Use of the Word ‘Parent’**

Finally, the word ‘parent’ is used in this manual to describe the person who holds the *role* of mother or father with the adolescent. This person can be the mother or father, or the grandmother or uncle, or any person who has taken the adolescent into his or her care. Furthermore, it is possible that there is only one person in this care-giving role. The word ‘parent’ is therefore a convenient ‘umbrella’ term that takes in all these possibilities.
ADOLESCENT DEVELOPMENT
Adolescent Development: a child no more...

We begin by looking at signs that point to the adolescent years.

**New Ways of Thinking**

From 12 years onwards, the child relies less and less on the physical world for thinking. Thinking starts to become *abstract*. There is an attempt to work things out with the mind. The child begins to mentally work out the various meanings of his or her experiences, what other people are saying and doing, and so on. A good use of this skill takes time and practice!

**Physical and Emotional Change**

There are changes in body shape and emotions. Emotions in particular can take wild swings during adolescence as hormones click in and go through a settling down process. These changes can be embarrassing and confusing. They can create havoc for parent and adolescent!

**Feeling Exposed to the World**

With these changes comes a new awareness of people. Adolescents can feel very much ‘exposed’ to the world. They can feel as if everyone is watching their every move. This can make them feel ten feet tall, as well as two feet short! The more self-conscious adolescents feel about themselves, the more wary adolescents become about what they believe others are thinking about them or what they are doing. Furthermore, when they do feel confused or embarrassed, they won’t want people to know this or see their feelings in action. Therefore, they hide these feelings with shows of bravado.
**Becoming and Individual**

Individuation is a very important part of adolescent development. This is the movement away from home and family to outside group membership – usually the peer group. Adolescents need to feel autonomous in their individuality. What results is the strange combination of wanting to be an individual, yet avoiding anything that makes them appear or feel different to their peers. Going away on holidays in the family wagon will normally become a thing of the past unless it suits the adolescent’s purpose in some way!

**The Importance of the Peer Group**

The peer group is an esteemed part of the adolescent’s life. Being noticed and valued by the peer group is important to the adolescent. Therefore an adolescent tends to take on the values of the peer group and join in with anything it does. Being left out or rejected is a disaster! Furthermore, being accepted by ‘the group’ can also involve the adolescent in any number of risky situations, with the risk of getting hurt taking a poor second place to being accepted as part of the group. Therefore the adolescent will often do crazy and even life-threatening things so as not to be left out, or seen to be different. The idea is not to wrap the adolescent in cotton wool, but teach the adolescent how to deal with risky situations with the least possibility of self-harm.

**Adolescents are Risk-Takers: ‘I can handle it!’**

Because they are adolescents, adolescents are risk-takers. One aspect of risk-taking relates to the adolescent’s belief that he or she is ‘bulletproof’. Nothing will happen to me, only the other person, and anyway if it does I can handle it! The challenging and often hard part for the parent is to help pick up the pieces when risk goes wrong, and encourage and support the adolescent in getting back onto his or her feet.
Adolescents are Risk Takers: Experimentation.

Experimentation is part of adolescent development, and is part of adolescent risk-taking. ‘The world is my oyster, so I’ll try what I can if I can!’ Drugs, alcohol, sex, dares – these are among the most common ways of experimenting. Adolescents will also do things with friends they wouldn’t dream of doing by themselves. This is part of the need to ‘be like my friends’, and is one of the strongest factors of risk. It can be extremely difficult to prevent an adolescent from experimenting. The best approach is to reduce the possibility of harm as much as possible by knowing what your child is up to, with whom and where, and keeping the channels of communication and trust open at all times. Not an easy call!

Adolescents still need Love!

Adolescents need you as a parent. They might believe that they are totally confident and capable, but they also do need to know that you are around, especially when things go wrong. They may give the impression that affection and closeness is out, but knowing that they are loved and respected by parents is still essential for an adolescent’s security and happiness. Take every opportunity to show your son or daughter that your love is very much alive. Say that you love and respect him or her as often as possible, and take every opportunity to show this when it is appropriate to do so. Remember that it will be harder for the adolescent than you as an adult to show love and affection, but this doesn’t mean that your son or daughter has stopped loving you or doesn’t need you – in fact, quite the opposite!

Love and affection also comes from being able to step into the adolescent’s world. Love and affection becomes more natural when you can see things through the adolescent’s eyes, even when the relationship is stretched to its limits. Remember that the adolescent also feels doubt, fear, anger, the need to love and feel loved, and has hopes and dreams for the future. An adolescent will most likely find it difficult to express these feelings, or else will express them badly because of the inexperience and cockiness that comes with the adolescent years. Showing understanding, love, and respect can be a strong support at these times.
The Need for Parents to Keep One Step Ahead!

The best way to stay in touch during the years of adolescent development is to keep one step ahead of what your son or daughter is planning or doing. This doesn’t mean becoming a spy-school graduate. Rather it means feeling the assurance that a major surprise probably won’t pop up out of the woodwork one day. If a major surprise does happen, then it also means feeling that you will be able to cope.

Keep one step ahead in areas such as:

- Contacts and activities with friends; ages of friends; what the friends are getting up to
- Use of money; use of free time (particularly excessive time spent alone)
- Any sudden change in mood, attitudes, manner of doing things
- Excessive desire for secrecy (phone calls, mixing with and meeting people, and so on)
- Knowing what your adolescent child is doing, when he or she is doing it, with whom, where, and for how long
- Keeping links of communication and trust free of obstacles as much as possible
- Not being afraid to ask for information that is important for keeping you on top of things – from your adolescent, from outside people, and from anyone else who has links with your child (such as parents of his or her friends)
- Networking with the parents of your child’s friends – getting to know them and discretely getting to know your child’s friends.

Respect for the Adolescent’s Privacy

In all this you will be walking a fine line between keeping one step ahead and respecting your son or daughter’s privacy. Their privacy is both a right and a need. However, there is a point at which respect for privacy must give way to laying your cards on the table about matters that could end up with your child being placed at serious risk.
Look at the flowcharts on this and the next page. They describe how both parents and adolescents can be affected by the experiences and feelings described in the boxes. Go through them, and ask yourself if they apply to your son or daughter or to you, and if so, in what way and how much.
…and at times parents feel ‘I…

- respect my child
- love my child
- have regrets
- see the new adult in my child
- find it hard to love my child
- wish my child was like other kids
- think I’ve got it, then know I’ve lost it!
- enjoy a new closeness to my child
- feel distant from my child
- look forward to growing older with my child around
- mis the little kid in my child
- find it hard to like my child
- have great hopes for my child
- feel out of control
- wonder how much I really understand about my child
- stick my foot in it
- am disappointed by my child
- look forward to growing older with my child around
- find it hard to like my child

Notice the wide variety of feelings here, meaning that adolescence can be an enjoyable and an unsettling time for both the parent and adolescent. Confusing or negative feelings do not mean that things are therefore falling apart for both of you. We will now look at what makes up the movement from a stable to a fractured or broken relationship between a parent and an adolescent.

A healthy relationship between parent and adolescent has certain necessary ingredients…
What do you believe about yourself?
What do you believe about your child?
BELIEFS LEAD TO BEHAVIOUR!

The right style of parenting
Open to change.
Acknowledges the parent as well as the adolescent.
Reflects how you see your child.

Genuine caring:
A soft heart
A hard head!

Communication:
Speaks with listening.
Avoids blaming & labelling.
Respects age & place in family

Problem Solving:
With negotiation.
Give some and get some.
What is the problem?
Who has the problem?
How can we solve it together?

Monitoring & Limit Setting:
With respect;
With responsibility;
With flexibility

Without these a relationship starts to fracture
It’s possible to recognize the signs of a relationship that is FRACTURING...

**A Fracturing Relationship Means...**

- ongoing conflict - feels like you're continually dodging land mines

such as

- Arguing nagging
- No trust
- Feeling hopeless & helpless
- Lost respect
- Physical violence
- Eventually the adolescent rejects parent and all authority figures

**BREAK DOWN IN RELATIONSHIP HAPPENS**
adolescent shifts more towards friends with similar problems - these friends have more influence than parents
Stable does not mean perfect…

It is important to realize that a stable relationship between adolescent and parent does not mean the absence of problems, even serious problems. The goal is to aim for a relationship with your son or daughter that is basically stable. After all, the most difficult part of living with other people is learning to live with other people!

Action starts with recognition…

It is also important to recognize the difference between a stable relationship and a relationship that is on the way to breaking down, or fracturing. Relationships with adolescents don’t break down overnight. They break down because the foundation has been so badly chipped away by bad experiences that it is no longer strong enough to support the happiness and peace of all involved.

Don’t wait to act…

The idea is to recognize when a relationship is heading in this direction and so do something about it straight away before the whole thing does crumble and fall over. It’s better to lock the gate before the horse escapes and gallops all over the paddock!

Those niggling feelings…

It is possible to know deep down inside that things are starting to fall apart. Questions like the following can throw some light on this feeling…

- Can I put my finger on exactly how I feel?

- If I feel uneasy about my child, what is it exactly that I feel uneasy about?
• If I am feeling down and out, negative, angry, resentful, hurt, whatever, is it more because of me than my child?

• How well do we talk together?

• Are things solved between us, or won and lost on the battlefield of control and power?

• How much do I know about my adolescent’s activities? How much do I know about my adolescent’s friends?

• Is my son or daughter really safe?

• Do I want to be different as a parent, or am I happy with the way I am?

• Do I need to be different as a parent?

Adolescence is like discovering a new room in the same house. Both you and your child open a door into this room, but from different ends. The trick is to understand what it’s like to open the door from the other person’s side!

While adolescence means things are changing for your son or daughter, don’t forget that things are changing for you too during this time. Don’t play down the difficulty and challenge of that experience for you too!
ACTIVITIES

1. Watch a video!

There are a number of videos around at the present time that deal with adolescence. Here are a few you might be interested in watching:

‘Stand By Me’
This is the story of a group of kids who set off on a quest together. The movie gives an inside look into the things they find important as they move from childhood to adolescence – what they talk about, what they think about, the need for close friendships, their dreams and hopes for the future, and so on. The story is supported by a competent group of young actors. It is a movie well worth watching, and is suitable for watching with your younger adolescent.

‘The War’
This movie traces the relationship between a father and his family, and in particular describes the relationship between him and his eldest son. The father is a returned soldier who has suffered Post Traumatic Stress Disorder, and this disorder affects his ability to work and relate to his son and family as he would like to. Yet he struggles to provide the best for his family. How the son deals with all this, and the feelings he has for his father, would give parents a helpful insight. This video is also suitable for younger adolescents.

‘Parenthood’
An amusing, clever, and broad look at a number of related families who are faced with their own difficulties of child rearing and self-survival! However, watch this one by yourself because of adult themes.

These movies are not heavy going, and are well worth watching.
2. Take note of your own teenagers and those you come across elsewhere.

✓ Observe your own adolescent son or daughter. Note what he or she says or does, and the way in which this is done.
✓ When you go out, watch the way adolescents relate to each other. By doing this, put some ‘flesh and bones’ on what we have been speaking about in this chapter.
✓ Think back to your own adolescent years. What was your own experience of moving through adolescence? How is this similar or dissimilar to the experience of your own son or daughter? How would you survive as an adolescent today? Jot down some of your treasured memories of adolescence in the box below…
STYLES OF PARENTING
Developing a style of parenting that keeps the relationship between you and your son or daughter strong is a bit like juggling raw eggs:

- You need someone to show you how to do it without making a mess everywhere.
- Learning how to do it means picking up the eggs and doing it!
- Yes – you are going to break a few (probably a lot in the beginning!) and end up in a sticky mess: how else will you learn?
- But it’s a great feeling when you can put the eggs back in the carton in the same condition as they came out!

SO…

WE WILL LOOK AT THREE BASIC AND DIFFERENT STYLES OF PARENTING:

- AUTOCRATIC
- PERMISSIVE
- DEMOCRATIC

THE AUTOCRATIC STYLE

This style is for the Great High Commander In Chief. The GHCIC lays down the law:

- What I say goes
- Don’t even think about questioning my decision!
- I’m in charge around here – who or what do you think you are?

And so on…

They might sound pretty harsh, but that is how the person on the receiving-end feels treated by the GHCIC. This person will probably hear…
‘I don’t care what you think!’ ‘I couldn’t care less about what you have to say!’
‘I don’t even know why you bothered asking!’
‘While you live under my roof, you’ll…!’

This style usually shows itself with…

✓ A loud and powerful voice
✓ A ‘put down’ tone
✓ Resistance is often met by physical force – only the GHCIC can win

Therefore…

✓ Discussion is out
✓ Give and take is out
✓ Changing your mind and trying the other person’s way is out
✓ And certainly – listening is out.

The autocratic style has a sad effect…

✓ Warmth and affection go out the window
✓ Continual conflict, resentment, hostility & aggression come in the window
✓ Low self-esteem and low self-confidence develops in the adolescent
✓ The adolescent withdraws mentally, emotionally, and even physically
✓ There is a lot of walking away, and eventually total rejection of authority by an angry and resentful adolescent

As a result there is no opportunity for the parent and adolescent to learn how to discuss, how to listen, and how to make decisions. Usually the adolescent ends up repeating the same cycle as an adult.

THE PERMISSIVE STYLE

This style is at the opposite end of the autocratic style…

✓ Parenting becomes a ‘puppet government’
✓ Parental authority is handed over to the adolescent
✓ What’s the use? No one takes any notice.
✓ And so on.
You will probably hear words like…

‘I might as well save my breath – he’s going to do it anyway!’
‘I guess she knows what she’s doing – she’s almost an adult anyway’
‘You do whatever you think is the right thing’
‘I don’t care what you do – anything for peace and quiet!’

Often the parent who uses this style…

✓ Does care, but doesn’t know how to care with authority,
✓ Or acts as if the adolescent is already a seasoned adult,
✓ Or lacks confidence – afraid of what the adolescent might say, think, or do,
✓ and therefore retreats, hides, and hopes for the best,
✓ or truly believes that the adolescent has every right to run freely at any time.

What usually happens is that the adolescent takes control and calls the shots – and can often end up in serious trouble because he or she doesn’t get the opportunity to learn before doing. Asking and discussing give way to the adolescent telling the parent how things are going to be. Too much rope is let out too soon, and when some drama happens it becomes impossible to pull it in.

THE DEMOCRATIC STYLE

This style is based on clear and firm guidelines for the adolescent son or daughter to follow.

✓ There is a willingness to listen, to discuss, to give a bit, and in the end, to exercise parental authority and decide
✓ There is a basic principal of: ‘My rights, your responsibility; your rights, my responsibility’
✓ People know where they stand and are generally comfortable with this even though clashes happen from time to time
✓ There is a feeling of warmth and openness
With the democratic style it is common to hear…

‘I think we need to talk about this’
‘What you want is…but I think…’
‘What do you reckon?’
‘I can’t let you…but I suggest…’
‘I wasn’t totally happy about it at the start, but I’m willing to give it a go’.

People are more likely to feel satisfied with an outcome when they feel that they have been heard. This doesn’t mean you end up with the ‘Brady Bunch’ as a family. There will still be times of heated stand off, arguments and clashes, and refusal to see the other person’s point of view. However, when there is a basic democratic style of parenting at work, there is also a readiness to re-look at things during heated times because past experience says that trying again is worth it. This is the key reason for using a democratic style of parenting.

THE FLUID LINE OF DEMOCRACY

A democratic style of parenting does not automatically mean that decisions go all the way of the person with the most convincing argument.

Rather, a democratic style moves between two points…

![We do things your way](image)

Sometimes, when all the negotiation and discussion is over, and both sides have had their say, you as parent will need to make a decision that is fundamentally unacceptable to what the adolescent wants. That is, your decision will fall closer to your end of the line than your son or daughter’s
end. However, a democratic style says that there are well thought out reasons for this conclusion. They might include safety reasons, feeling unsure about trusting your adolescent either because of age, experience, or past betrayals of trust, unfair inconvenience to you or other family members, and so on. A democratic style also says that you are prepared to discuss these reasons with your son or daughter, and will stand by your decision no matter what the reaction might be. Similarly, your decision might also end up being closer to your son or daughter’s end of the line because you think it is time to let out more rope, or you feel comfortable about trusting your adolescent, or you know that your fears are not well-founded. Therefore, words like the following will be heard…

‘We’ve talked about how important this is to you. However, I don’t believe that this is safe for you, and so I’ve decided that you cannot go’.

Or…

‘OK – you can go to the dance, but I am not happy about you coming home after midnight in your friend’s car. I will pick you up from the dance at 11.30’.

‘When it comes down to it, it’s your responsibility to get this assignment finished. You can go out with your friends today and work tomorrow. I’m trusting you though to stick by your word’.

‘Give a bit to get a bit’…

‘Give a bit to get a bit’ is an important part of the democratic style, although this does not mean giving up you’re authority or responsibility as a parent. As parent, you have the final say, because you have the final responsibility!

The democratic style happens more easily when the parent is able to develop understandings such as…

✓ The adolescent is a capable and responsible person because the adolescent has shown in the past that he or she can be capable and responsible
The adolescent needs to be given appropriate opportunities to learn to be capable and responsible.
The adolescent needs to be given opportunities to learn how to communicate feelings, suggestions, responses to unpleasant outcomes, and requests to be trusted.

At the same time, the democratic style means that the adolescent will learn how to…

- Cope with making decisions, discussing pros and cons about these decisions, and at times cope with failure.
- Accept consequences for personal decisions and actions.
- Build positive relationships within family and society.
- Think things through to a logical and sensible end.

It is essential to develop CONSISTENCY in one’s parenting style (that is, become the consistently democratic parent), rather than bounce backwards and forwards between all three styles. Bouncing around styles results not only in the adolescent not knowing where he or she stands with you as the parent, but also a loss of the adolescent’s confidence in your ability to be a dependable and genuinely open person.

Personality differences and the democratic style…

Personality differences can affect the ease with which a democratic style is put in place with individual children in a family. For example, what worked for one child at 14 years of age might not work for another child at the same age. Hence, the democratic style does not mean that ‘one size fits all’. Rather, this parenting style needs to be exercised over and against the unique personality characteristics of each child in the family. This emphasises the uniqueness of relationship between the child and the parent when the parent makes decisions. Adolescents often end up at risk when the individuality of the adolescent is ignored, or simply absorbed into a ‘one size fits all’ approach. The ‘it can’t be us because the other two are OK’ syndrome usually says more about parenting style than about the adolescent son or daughter.
Two parent family or a single parent family?

Families of today can have a variety of appearances. Parents can either be the biological parents or relatives or other people who have taken on the role of parent.

Families can also be either ‘two parent’ families or ‘single parent’ families.

Obviously being a parent is that much harder in families where there is only one parent. Issues such as support, companionship, discipline, opportunities to ‘get away’ for a while, juggling work, meals, cleaning and other household chores, kids’ sport, and so on, are reduced considerably for the single parent. Developing a democratic style of parenting can become so much harder when these issues become a burden for the single parent. The following suggestions might help parents who are in this situation…

- Single parents need the support of a friend or community member outside the family. This support will either be for everyday demands (like driving kids around) as well as for more serious issues (such as discipline problems).

- Single parents need adult companionship. Single parents might love their children, but love for themselves demands that they mix with other adults from time to time. This can range from something as simple as meeting for coffee to a day out together.

- This leads to another need, namely ‘baby-sitting’. Even where it is possible to leave the children with an older brother or sister it is still necessary to have a contact person should something go wrong.

- Telephone support is also valuable for the single parent. Just to be able to ring someone up for a chat, or for advice, or to unload, can make the difference between coping and losing the plot altogether.

- If single parents can network with other parents (forming group friendships) then there are opportunities to feel supported and even share the load. Sharing the load might only mean that a parent feels that
There is someone around for support if necessary. This can be most valuable.

When one parent has recently ‘moved into’ the family…

This situation can be difficult. When a person moves into a family and takes on the role of parent, he or she picks up with that family from then on. The person has not been there from the beginning. At times when hard discipline is needed it is not uncommon for adolescents to throw this back at the ‘new’ father or mother. Comments like ‘You’re not my father/mother’, ‘We were better off before you came along’ can be common.

Gentleness (with firmness) and patience (with genuine caring) is needed to develop a relationship between the new parent and adolescent. It is also important to remember that this relationship might not ever become a completely solid relationship because there has been too much hurtful and unresolved past history for one or both people.

The ‘newly arrived’ parent therefore needs to enter the world of the adolescent and hope that the adolescent can do the same in reverse. The skill of knowing when to move ahead and when to back off and allow some distance is tricky to achieve. However, the answer is not found in complete withdrawal. The new parent has still taken on the role of the parent and the role of support for the other parent, and these roles needs to be exercised with responsibility, sensitivity, and respect for oneself as the new parent.

Finally…

- A consistent and democratic parenting style is essential for strengthening the relationship with the adolescent son or daughter. The wrong style will eventually pull the relationship apart.

- Where there are two people in the role of parent, a democratic style of parenting must involve both parents. It’s useless when one parent is working towards a democratic style and the other parent is happy to use power and control, or be permissive.
✓ Developing the right style of parenting starts with honesty about your present style of parenting. **If your style is not working then it has to change!**

### SOME ACTIVITIES TO TRY

1. **HOW WOULD YOU DESCRIBE YOUR PARENTING STYLE?**

How you react at times like the following will tell you something about your own style of parenting:

As a parent, how do you expect your son or daughter to treat you?

__________________________________________________________________________

__________________________________________________________________________

If something goes wrong between you and your son or daughter, how do you react? What do you say?

__________________________________________________________________________

__________________________________________________________________________

If your son or daughter challenges your decision about something, how do you react? What do you say?

__________________________________________________________________________

__________________________________________________________________________
When your son or daughter gets angry with you or chats you back, how do you react? What do you say?

How and why do you believe your son or daughter should treat you as a parent?

In the relationship between your and your adolescent, what rights do you think your son or daughter should have?

2. THINK ABOUT YOUR OWN PARENTS –

How did your parents expect you to treat them?

If something went wrong between you and your parents, how did they react? What did they say?

If you challenged your parents’ decision about something, how did they react? What did they say?
When you got angry with your parents or chatted them back, how did they react? What did they say?

________________________________________________________________________________________

________________________________________________________________________________________

How did your parents believe you should treat them when you were an adolescent? Why?

________________________________________________________________________________________

________________________________________________________________________________________

In the relationship between your and your parents, what rights did your parents think you should have?

________________________________________________________________________________________

________________________________________________________________________________________

3. WHAT THINGS ARE SIMILAR BETWEEN YOU AND YOUR PARENTS (IN PARENTING STYLE)?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

4. WHAT THINGS ARE NOT SIMILAR?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

5. WHAT WOULD YOU SAY ARE THE STRONG POINTS (THE ONES YOU WOULD LIKE TO KEEP) ABOUT YOUR PARENTING STYLE?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
6. WHAT WOULD YOU SAY ARE THE WEAK POINTS (THE ONES YOU WOULD LIKE TO CHANGE) ABOUT YOUR PARENTING STYLE?


A PLAN FOR ACTION!

What style are you using?

How do you feel when you operate from this style?

Do you want your parenting style to change?

If so, what do you intend to do TODAY AND ONWARDS to bring these changes about?

1. 

2. 

3. 

4. 

5. 

THE ART OF COMMUNICATION
Remember the story of the Sorcerer’s Apprentice? If you aren’t aware of this story it goes something like this:

The sorcerer’s first job for Franz, his teenage apprentice, was to wash the dishes each day. That was bad enough. What was worse was going down a long, steep flight of steps to the river for his washing up water. The only way to carry the water was in two buckets, and because the cauldron was deep this meant having to make a lot more than just one trip. After the first couple of trips his legs were turning to jelly, and he decided that there had to be a better way of getting this water! When he first arrived he watched his master mix a potion that turned a broom into a dancing helper, so he decided to have a go at mixing the same potion. After some attempts he finally succeeded. He sprinkled the potion onto the broom and the broom sprang into life. It marched down the stairs carrying two buckets and in no time was back throwing the water into the cauldron. When the cauldron was full, Franz started to give the command to stop but found that he had forgotten the words. The broom kept going after water and in his panic to make it stop Franz chopped the broom into little bits. But the bits came to life as an army of mops with buckets. Soon there was a raging torrent of water rushing through the castle. By now everything was out of control. Franz couldn’t stop the mops from working, and the water level was rising. There was nothing he could do to stop what he started. In no time the castle was flooded. As if from nowhere the sorcerer arrived on the scene. He commanded the brooms to stop and the water to depart. With a simple command everything returned to normal.

What on earth has this got to do with communication, I hear you saying? In fact, quite a lot! Imagine a scenario like the following:

Your adolescent wants something from you. However, the way he or she asks pushes your negative buttons and you react angrily, feeling as if you are being nudged into a corner. In return you say things that push your adolescent’s buttons, and this triggers off an equally fired-up response back to you. Can you see how easily things
A conversation goes badly from the start

start to spiral downwards, getting worse as they go, until eventually there is a lot of screaming, slamming and stamping away?

It is like the mops and buckets of water. First there is one mop (the request) but it quickly gets out of control. Then the ‘mops’ start to multiply and before you know it there are so many mops and buckets that the place gets flooded. That is, the words and reactions multiply until they get away from your control and the control of your son or daughter. Unless there is a way of putting a quick stop to it all, you both run the risk of drowning.

The hard part is that both adolescent and parent often speak in words and tones that don’t reflect how they really feel about each other. If you have experienced something like this, have you ever found yourself wondering afterwards where it all went wrong? Or wishing that you could go back and change everything from the start (as Franz probably wished)? Or beating yourself up, blaming yourself and wishing you weren’t ‘such an idiot’? I wonder how much the adolescent thinks the same things when the heat of the moment cools down? Yet sadly both parties don’t seem to give themselves the opportunity to say these things, or to decide to speak about difficult things in a way that leads to a peaceful outcome.

Instead of conversations like this ending up in peace, they are often repeated negatively, like a game that is played over and over. Let’s call this game the ‘HURT AND UPROAR GAME’…
Son arrives home early after being suspended from school. He comes into the house looking glum and passes his father who is sitting near the door reading the paper. The father puts his paper down and looks up at his son –

Father: ‘Hello – you’re home early! What’s up?’
Son: (Angry and hurt; throws bag onto chair) ‘It’s those teachers – they’re always onto me. Everyone else was talking but he picked on me. Then the principal suspended me. Why always me? What about the others?’
Father: (slaps down paper) – ‘Great! It’s always the teachers, isn’t it? Always the teachers – never you! You’re always stirring things up and causing trouble!’
Son: Whaddya mean ‘me’!! That’s right – take the teachers’ side. You never take mine! You’re just as bad as they are!’ (storms off to his room, slams the door)
Father: ‘Come back here – I haven’t finished with you yet…’
Both sides end up defending their own territory. Father and son feel threatened. Their anger leads into fury, and as the heat rises both people go on the attack. Eventually the clash will reach a point of no return, with each person saying or even doing something they most likely will regret later. The possibility of physical violence is strong in situations like these.

Another approach that cuts across this destructive spiral downwards might be something like:

Son arrives home early after being suspended. He comes into the house looking glum and passes his father who is sitting near the door reading the paper. The father puts his paper down and looks up at his son –

Father: ‘Hello – you’re home early! What’s up?’
Son: (Angry and hurt; throws bag onto chair) ‘It’s those teachers – they’re always onto me. Everyone else was talking but he picked on me. Then the principal suspended me. Why always me? What about the others?’

The father might feel a sudden surge of anger at this, and hear himself thinking things like ‘here we go again – he’s always into trouble and this is just more of the same!’ However, if he stops himself from actually saying this then the downhill spiral can be prevented. He therefore might respond with:

Father: ‘You sound in a bad way. Come on, slow it down! Here, sit down and let’s talk. We can work this out’.

The key is ‘WE CAN WORK THIS OUT’
Follow this more positive approach in the next flowchart…

Son home early – is suspended – ‘it’s those teachers – they’re always picking on me!’

Father FEELS surge of anger: thinks – ‘here we go again – more of the same old trouble!’

NEXT TIME a similar situation happens both feel more able to deal with it: trust increases, respect increases, and the relationship remains together.

Son feels heard – father and son aim at finding a solution by seeing the situation as THAT PROBLEM, and not YOUR PROBLEM

Father THINKS: ‘Back off – think twice. Talk to him – find out what’s wrong: WE CAN WORK THIS OUT!’

Father SAYS: ‘Settle down – let’s talk about this: WE CAN WORK THIS OUT!’

Situation has good chance of being resolved without screaming and violence.

After playing the ‘hurt and uproar game’, people feel a lot of regret. Yet both parties get sucked into it because words and attitudes fly between them without any control (like the mops and water). Finally both people let go of control as their temper increases and the need to defend oneself becomes stronger.
If you asked the parent and adolescent if this is really what both people wanted, they would probably say ‘no’. Yet it happens, and with sad consequences.

In the last chapter we will speak more about this idea of self-talk and how it can be both friend and enemy. In this present chapter we will speak about the one skill that can cut this game off right at the very start – the skill of healthy communication.

Communication is a partnership that aims to build up a good relationship…

In the ideal world somewhere west of the planet Pluto this means that nothing will go wrong in the conversations you have with your son or daughter. But reality on planet Earth says that things will go wrong occasionally. Therefore…

- Aim to reduce the breakdown factor in communication, and have good damage control tactics on hand
- Understand yourself well enough to know that you’ve lost it, and when you are losing it
- Know your trigger points
- Realize that communication doesn’t happen in empty space. It happens along with feelings, and past experiences (good and bad), at right and wrong times of the day, and so on.

Did you get the message?

A message is made up of VERBAL (words) and NON-VERBAL (everything else) units…

Words = 7%
Body language (face, hands, movements, etc.) = 55%
Sound of voice, tone, stress on words, etc. = 38%

So…
WHAT is said = 7%
HOW it is said = 93%

A message is like building blocks:

If we take time to think about the conversations we have with our son or daughter, we know the ones that worked and the ones that didn’t, and we know how we felt about them.

The image of the remote control…

Think about the remote control for your video cassette recorder. It has a number of buttons, and each button serves a different purpose…

The REMOTE CONTROL works something like this…
On the next page is how the REMOTE CONTROL might work in practice…

As conversation goes along, you might need **REWIND** (‘go back a bit, I missed something’) or **PAUSE** (‘stop a minute – I need to think for a while’). These buttons let you keep ‘on track’ and not miss or misunderstand any vital information.

### Positive (with pause?) means respect:
‘I understand what you’re saying – let’s move on’

### Positive:
‘I want to stop at this time and think about this – we’ll come back to it later’

### Positive now:
‘I want to remember this good experience’

### Positive before:
‘I remember good past experiences’

### Negative means disrespect:
‘I’ve heard all this before – it was no then, and it’s still no now!’

### Negative:
‘I’ve had enough - the answer is NO, now go away!’

### Positive:
‘I want to stop at this time and think about this – we’ll come back to it later’

### Negative:
‘It’s always been this way, it always will be this way!’

### BAGGAGE!

### Rumination…
Going over and over things from the past; feeling anger increase – always playing the **REWIND** button negatively
A productive and enjoyable conversation (one worth remembering or recording!) happens when both the speaker and the listener in a conversation not only have a remote control, but also use it respectfully with the other person. Fighting over one remote control means a poor outcome in a conversation. All that happens is that someone ends up having all the power. This is just like watching a video. If one person controls the buttons, then the other person has no say in what is being watched.

‘White Ants’ to Communication

On the next page you will see some negative ways in which the remote control is used. You will notice statements aren’t helpful for good communication. We will call them ‘WHITE ANTS’ because they eat away at a good relationship. If these ‘white ant’ statements aren’t recognized and dealt with, they will eventually work their way through the whole relationship between you and your son or daughter, leaving only the dead wood of the outside shell. Therefore whenever we hear or use them it is important to recognize white ant statements for what they are.
White ant statements...

✓ ‘You listen to me!’
✓ ‘Shut up! I was speaking!’
✓ ‘Here we go again!’
✓ ‘You’re not going out with *those* losers!’
✓ ‘She treats me like an idiot!’
✓ ‘How many times do I…have I…?’
✓ ‘Nobody gives a damn about me!’
✓ ‘There’s one rule for me and another rule for everyone else!’
✓ ‘Try and make me!’
✓ ‘I’m sick and tired of…’

AND

✓ ‘**You** are always on my case – **you** make me sick!’
✓ ‘**You** don’t care, do **you**?’
✓ ‘**You** never listen to me!’
✓ ‘**You** always want things **your** way!’

**This last lot are called YOU messages (more about these in the next section).** They usually end up with abuse, swearing, yelling, name-calling, hitting, slamming, walking away, threatening, and so on. They attack the person instead of saying **how I feel** about something. The other person ends up feeling the need to defend his or her own territory.

**And you don’t always need words to end up with WHITE ANTS…**

✓ eyes raised, head tilted – *the angelic wonder*
✓ clenched fists, raised hand – *the thug*
✓ leaning over – *bad breath syndrome*
✓ put down, aggressive tone – *the shrinker*
✓ slumped shoulders, hanging arms, limp body, ‘sigh, why me? – *beat me!* beat me!*
✓ curled lip, sneer – *the good, the bad, and the UGLY!*
✓ back turned around; end of story – *the terminator*

The question to be answered is where do these white ants come from in the first place?
Further Ways of Killing Communication from the Beginning!

‘You’ and ‘I’ messages…

‘You’ messages are among the strongest white-anting communication killers around. Examples of ‘you’ messages are statements like…

‘You never care about anyone’
‘You never lift a finger around this place to do anything’
‘You always expect others to be around when you want something, but when it comes to you helping out, then you couldn’t care less – you selfish sod!’

The mere sound of these messages gives the idea of someone being on the attack! And if someone is on the attack against you, then you go on the defensive! And when you hear poor communication loaded with ‘you’ messages a counter attack is usually what happens…

‘Who are you to tell me who I care about?’
‘Go to hell! I never see you with your hands in work!’

As you can imagine, the counter attack will be followed by a further counter-attack, until in the end there will be a lot of abuse, swearing, and even physical attack, with a final stamping away. Nothing gets worked out!

‘I messages’ keep away from attack. They speak about the way things are viewed by the speaker. They are not aimed at judgment, abuse, or humiliation.

‘I’ messages keep the focus on the speaker. They make it easier to keep control over what is said, even if the listener does counter attack with an abusive ‘you’ message. At the end of the line, the listener can either agree or disagree. The speaker might feel the emotional temperature rising. That’s only human and normal. However, because the speaker is saying how he or she feels about something, that person can also honestly say: ‘That’s how I feel – take it or leave it’. These words can put a quick stop to any ugliness in a conversation…
Adolescent: ‘I don’t care what you think – you and this place suck!’
Parent: ‘Well, that’s how I feel – take it or leave it!’

Tyranny of the ‘Shoulds’…

Around the 1950’s a psychoanalyst named Karen Horney called the way we use words like ‘should’, ‘must’, ‘have to…’, and so on, the TYRANNY OF THE SHOULDS.

This is an excellent way of describing what these words can do to the health of a communication bond between two people. Words like ‘should’, ‘must’, and so forth need to be used with great care. They can cause some fairly strong feelings to spring up in the listener because…

✓ When I speak these words I can sound like I am telling you what you can and can’t do, say, or think.
✓ These words can leave little or no room for discussion and sharing of feelings. They shut the door to further suggestions and responses.
✓ When I speak these words I can seem like I am setting myself up as the final authority on the matter under discussion. Only what I think counts.
✓ When they are used over and over again they can drain the other person’s confidence in his or her ability to offer opinions, think for oneself, make decisions, and so on. They can end up creating a lot of anger and resentment.

While there are valid ‘shoulds’ in life such as self-care issues, respect issues, and so forth, they need to be offered for the other person’s consideration, not dumped onto the other person. When they are dumped without respect, ‘shoulds’ become TYRANNY. Tyranny always needs a TYRANT, and a tyrant is an AUTOCRAT. To keep communication open and healthy, avoid the TYRANNY OF THE SHOULDS at all costs.
Mind reading…

When I MIND READ someone else, I am deciding what is going on inside the other person without making any effort to find out if what I think is going on is actually going on!

A damaging way to use mind reading in communication and problem solving is to finish sentences for the adolescent (or anyone else for that matter!). Usually sentences are finished with what we have put together from our past experiences with the other person. That is, because we think we have heard it all before we feel safe enough to leap in and finish what the other person is trying to say. Therefore, it might go something like…

Adolescent: ‘I didn’t say I was going to do that because I...’  
Parent: ‘That’s right, you’re not, because you don’t care about anyone else but yourself – you never have!’

All anyone can say after this is ‘What’s the use of going on?’ because the other person has everything tied up in a tight, neat, disrespectful package!

Baggage and communication…

‘Baggage’ is the sack of past experiences we choose to carry through life. The word ‘baggage’ doesn’t mean that what we carry around is all garbage. There are some things in our sack that we would not want to get rid of – enjoyable memories from our past. However, there are also items in our sack that are there because at some time in the past we were hurt, or used for someone else’s advantage, or were intimidated by another person, and so on. We continually remember these occasions, and when we remember them they hurt all over again. And so we carry them through life, and the more negative experiences we add to our sack, the heavier the sack becomes. This baggage can become a real burden.

In communication, it is possible to speak through our baggage. That is, if the other person (your son or daughter, for example) has said or done something that painfully reminds you of an item of hurt in your sack, then it is very likely that you will react as if your son or daughter was actually the person who created that hurt in your past. This communication will be confusing,
because the other party will have no idea where the content of what you are saying is coming from, or why your reaction is one of anger, or rejection, or distress. The reason for this is that our baggage is mostly made up of very personal items of memory that are not shared with many people, if shared with anyone at all!

It is also important to remember that your son or daughter probably also has baggage, and similar to your sack, your adolescent’s sack is also made up of hurtful items out of his or her past. Communication can therefore become disastrous when both people are communicating from their baggage, with that baggage being a mystery to each person!

It is healthy to take time out every now and then to open our sack and look at what is inside. If we choose to carry this sack around we can also choose to toss out certain hurtful items in it. The question is, why carry around a load of aching memories that we don’t have to? If a damaging experience has happened in the past, and we are no longer able to change this experience for the better in the present, then why continue to drag it around with us? It will only continue to hurt us, and others we love as well. When we throw out unwanted and personally damaging items, then there is more space available to put pleasant memories. Carrying pleasant memories around is not a burden.

Throwing out some items of hurt can take a while. Letting go of these items can be upsetting because hand in hand with this experience of letting go is the realisation that we cannot go back into our past and ‘fix things up’ as we now think they should (that word again!) have been. Furthermore, how we throw these items out is important. We may not be able to change history, but there are ways in which we can act now that will help us look at our past personal wounds in a different and more positive manner. There isn’t space enough in this manual to describe this process. However, a professional such as a psychologist or counsellor can show you some extremely useful skills to help you look again at past experiences that are still hurting you in the present. In the same way, if this experience of emptying the sack becomes too distressing, then it is essential that you go to a professional for help. A professional can walk through this experience with you and support you in what very easily could be a difficult task.
Finally, try using Empathy with your Remote Control.

Empathy is an interesting word. It is different from the word ‘sympathy’ which means feeling with the other person. We usually feel sympathy with another person from a distance, even though the sympathy is genuine. Empathy however means entering the skin of the other person. It means being able to see the world through the other person’s eyes. Empathy is a valuable addition to your remote control. Empathy let’s you view yourself and what you are saying as the other person is viewing it. Getting inside the other person’s skin with empathy might change the button you originally wanted to press, or stop you pressing any buttons at all!

It’s Not Personal!

There is a small yet necessary point that needs to be discussed before we leave this chapter. It involves a readiness to use empathy during adolescent development – to enter the adolescent’s skin and see the world through the adolescent’s eyes as well as the parent’s.

The process of individuation in adolescent development results in the adolescent wanting to spend less and less time in the parent’s company (as with holidays or one-day outings), or preferring not to have the parent involved in activities that once easily included the parent (such as shopping for clothing). It is not unusual for adolescents to feel extremely uncomfortable or even run for cover if their friends come by while they are in public with their parents. In addition, this need to have parents publicly separated from them at a distance greater than arm’s length doesn’t happen as a result of explanation and discussion on the adolescent’s part! It mostly happens with the adolescent making very clear in an abrupt and even abrasive manner that the parent is simply not welcome in what the adolescent wants to do! If you sit down and think about this for a while, to what extent would you also want to be involved in some of the adolescent-type activities – rock concerts, ‘hanging out’ with friends, listening to heavy metal music? In reverse, to what extent would an adolescent want to be involved in parent-type activities – a quiet day in the country, a candle-light dinner with friends, going to the opera, listening to 70’s or classical music? It might happen sometimes, but it is more likely that it would happen very rarely!
This message to the parent of being an unwanted or even an embarrassing appendage to the adolescent can be a very hurtful experience for the parent, especially the first time the parent encounters this change in attitude, as with the first child into adolescence. The parent can be left with self-thinking such as “What did I do?” or “What’s wrong with me?” There can be a sense of anger within the parent, who feels cast off by the adolescent for no apparent reason, with an accompanying thought like “After all I’ve done, and that’s how I get treated!” After the second or fourth child into adolescence, this attitude is usually expected as a matter of course, although even then there will be times of considerable pain! Adolescents are not always the most thoughtful or sensitive of people! However, in the first round it can be an experience for the parent that unsettles and stings!

It’s not personal! It is the adolescent attempting to establish his or her sense of autonomy away from parents. There is no intention to hurt, humiliate, or be ashamed of the parent. Rather it is a further result of feeling ‘exposed to the world’; of believing that the entire universe is observing the adolescent’s every action. Rather than aiming to embarrass you, it is more likely that the adolescent fears ending up in some awkward situation (such as coming across friends while in the parent’s company in public) and not knowing what to say or do! Some adolescents at a younger age would feel comfortable with “Hello, these are my parents – this is my friend!” However, in general this is a level of maturity and self-confidence that needs to be entered after time and experience. Rather than taking a defensive and hurt approach, it is more self-caring for the parent, as well as empathetic towards the adolescent, to give the adolescent the space he or she is looking for, as well as the time to get used to being an individual in a world of adults. This can be simply achieved by inviting the adolescent to join your company, while respecting and accepting the possibility of refusal – as long as this refusal is not a means of getting caught up in something unsafe.

Don’t be afraid to positively upset the balance by changing the way you communicate with your son or daughter!
We can summarize helpful speaking and listening with the following:

- **Message spoken**
- **Message heard**

- **Loaded?** (old hurts, anger, frustration, bias, etc)
- **Yes**
  - Press **PAUSE** or **STOP**: Deal with it!
- **Press PLAY**
  - I care about you.
  - I respect you.
  - I want to listen to you.
  - What you say is important to me.
  - I understand you.
  - I want to help.
  - We can work this out.

- **Press PAUSE** or **REWIND** or **STOP** before things go past the point of no return.

- **NO**
  - Press **PAUSE** or **STOP**
  - Deal with it!
  - And **PLAY** keeps going because…

- Feeling confused?
- Losing the plot?
- Getting angry?
- Starting to lose respect?
- Starting not to care?
- Starting to use ‘YOU’ messages?
- Bad ‘body language’?
- Need a deep breath?
- And so on – then…

Back to **PLAY** when things settle down: maybe even another time or place.
**SOME ACTIVITIES**

Think about the last time that you had a relaxed and enjoyable conversation with your son or daughter, and jot down some thoughts about this time in the following box…

<table>
<thead>
<tr>
<th>While we were speaking…</th>
<th>Because…</th>
<th>And we used our remote control by pressing…</th>
</tr>
</thead>
<tbody>
<tr>
<td>I knew I was listening …</td>
<td></td>
<td></td>
</tr>
<tr>
<td>( ) knew he/she was being heard because</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I didn’t feel tense…</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I enjoyed our conversation……</td>
<td></td>
<td></td>
</tr>
<tr>
<td>( ) enjoyed our conversation….</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Now think about a conversation when you DID NOT FEEL relaxed, and you DID NOT ENJOY it. Jot down some thoughts in the following box about this conversation…

<table>
<thead>
<tr>
<th>While we were speaking…</th>
<th>Because…</th>
<th>And we used our remote control by pressing…</th>
</tr>
</thead>
<tbody>
<tr>
<td>I knew I was not listening …</td>
<td></td>
<td></td>
</tr>
<tr>
<td>( ) knew he/she was not being heard …</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt tense…</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I did not enjoy our conversation…</td>
<td></td>
<td></td>
</tr>
<tr>
<td>( ) did not enjoy our conversation,…</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Over the years, we also develop favourite ways of responding when people trigger off negative feelings in us. These old favourites can also press buttons on our remote control that switch off the conversation.

Because these are personal ways of coping, think about your own ‘favourites’ and jot them down in the boxes below:

<table>
<thead>
<tr>
<th>FAVOURITE WORDS AND PHRASES WHEN I AM NOT COPING WITH A CONVERSATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FAVOURITE WAYS OF USING BODY AND VOICE WHEN I AM NOT COPING IN A CONVERSATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
How many of your statements or body movements are ‘white ants’? Think about them, and in the boxes below write down statements or physical appearances that you think could replace the ‘white ants’. At first it will be hard to use these instead of the favourite old ‘white ants’. However with practice they will eventually become your automatic ways of speaking and acting with your son or daughter.

**NEW WORDS OR PHRASES**

**NEW WAYS OF ACTING IN CONVERSATIONS WITH MY SON OR DAUGHTER**
AND TRY THESE NEXT TIME YOU GET THE CHANCE!

WATCH TV!

Next time you watch TV, think about what you see and hear going on between the characters. How much can you pick up from the way they speak to each other and treat each other (words and non-words)? Who do the characters remind you of?

One excellent way of checking out how you feel when someone is speaking to (or at!) you is to pay attention to the ads on TV. As you watch them, ask yourself...

- Do you feel hammered?
- Do you feel pressured?
- What ads do you enjoy?
- What ads do you press the mute button for?
- What ads make you angry?
- What ads make you really notice how you feel?

Then ask HOW they made you feel that way!

WHEN YOU TRAVEL ON A BUS OR TRAIN

Next time you are on a bus or train, do some eaves dropping! Without getting yourself thrown off, pick up on the way people are speaking with each other (both the words and the non-words).

NEXT TIME YOU DRIVE SOMEWHERE

Have you ever been tailgated? Has another driver ever abused you? Have you ever done something silly and then felt silly because of the way another driver reacted to you?

Have you ever done or felt something like this?

How has the other driver put the message across?

How did you get your message across?
Interestingly, most communication on the road is without words (non-verbal) - for obvious reasons! Yet in cases like those above this sort of communication can be very powerful in getting a message across. There is nothing like having a driver sitting two inches off your tail and mouth obscenities at you! Or how would you feel if someone looked directly at you and shook their head when you indicated right and then turned left?

We can get very clear messages across to people without ever opening our mouths!!! Therefore…

NEXT TIME YOU ARE SERVED BY SOMEONE WHEN YOU GO SHOPPING

✓ How did you feel treated by that person?
✓ How did the person who served you manage to do this?
✓ What feelings did this person work up inside you?
✓ Did you feel like you wanted to have a conversation as well as pay for something, or not? How did the person serving you manage to do this?
✓ Did you feel so angry that you just wanted to get out of there?
✓ Would you go back (if you had the choice)? Why? Why not?
✓ Did the person serving you make you feel that you were a customer or someone who was using up precious time and energy? How did he or she manage to do this?

If the experience you had with someone who served you (someone you probably did not know) worked up good or bad feelings in you, how much more meaning would these feelings have with someone you did know and care about?
PROBLEM SOLVING
SOLVING PROBLEMS

Good problem and conflict resolution starts with using a style that encourages you and the other person to look for a solution together. It is the sort of style that…

<table>
<thead>
<tr>
<th>Style</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negotiates, give a little to get a little, as with…</td>
<td>‘You want it this way…I want it that way…let’s work this out’</td>
</tr>
<tr>
<td>Doesn’t corner, as with…</td>
<td>‘OK, have it your way, but if it doesn’t work out then don’t come whining to me!’</td>
</tr>
<tr>
<td>Doesn’t manipulate, as with…</td>
<td>‘If you’re going out with this bunch of kids then don’t come asking me for any money’.</td>
</tr>
<tr>
<td>Doesn’t cut down, as with…</td>
<td>‘I know what you’re thinking, and it’s not on – don’t try coming at that one with me!’</td>
</tr>
<tr>
<td>Is not prepared to run away from parental responsibility, as with…</td>
<td>‘I have to be sure you’re safe. I’m not happy about what happened last night, so you and I need to sit down and talk about this’.</td>
</tr>
<tr>
<td>Deals with a problem as a problem, not as an emotional dumping ground, as with…</td>
<td>Not: ‘And after everything I have done for you, THIS is how you thank me!…’, but: ‘Seeing you brought home drunk really hurt me, but I’m worried that you didn’t know how to handle things last night. Perhaps the problem was not knowing what to do?’</td>
</tr>
<tr>
<td>Defines the problem</td>
<td>‘Things didn’t go too well by the look of this. Let’s try and work out how all this happened’.</td>
</tr>
<tr>
<td>Rejects the situation, not the person, as with…</td>
<td>‘You know how much I hate that sort of thing, but I want you to know that I still love you and care about you.’</td>
</tr>
<tr>
<td>Encourages discussion by using a gentle tone, ‘I’ messages, words that don’t humiliate, avoiding physical aggression, respecting the privacy of the son or daughter, listening, as with…</td>
<td>‘Let’s go somewhere quiet to talk about this’&lt;br&gt;‘I’m feeling pretty angry, and you look like you’ve had better days too!’&lt;br&gt;‘I trust you – I believe that you will do things differently next time’&lt;br&gt;‘Okay, we won’t talk about this now, but since we do need to talk, when are we going to get together?’&lt;br&gt;‘I’m picking up that you’re feeling embarrassed as well as angry about what happened’.</td>
</tr>
</tbody>
</table>
A simple formula for problem solving is...

Respectful Communication + Democratic Parenting Style = Effective Problem Solving

‘THE PROBLEM’!

A Definition

A problem is something that threatens or undermines the safety, security, harmony, trust or energy of one or more persons.

Grades of a Problem and the Difference between them

There are different ‘grades’ of problems. The problem of leaving it too late to get fuel for tomorrow’s early morning trip is different to taking the family car out with your mates and driving home over the alcohol limit.

The urgency to solve ‘low grade’ problems is different to the urgency for ‘high grade’ problems. The second example is a ‘high grade’ problem. In this example, peoples’ lives are being threatened, from the son or daughter, to the mates in the car, to innocent road users. Therefore, ‘high grade’ problems need to be solved as immediately as possible.

Action

Urgency links with action. Ideally, problem solving involves everyone concerned, especially the person at the centre who is causing the problem (not necessarily the adolescent, by the way!). If the problem is serious, such as putting peoples’ lives in danger, and the person at the centre doesn’t believe a problem exists or refuses to deal with it, then action must be taken even though that person won’t participate in the solution.
The Adolescent can ask for Help

Don’t expect the adolescent to make a clear statement in asking for help. An adolescent is more likely to give out signs to the parent that things are not right, that he or she is not coping well, and therefore that he or she needs help. Some of these signs can be having unusually large amounts of money, unusual use of free time, a desperate need to spend time alone, an excessive desire for secrecy (hiding things, phone calls, meeting friends, and so on), sudden changes in mood, attitudes, and manner of acting, loss of appetite, age-inappropriate behaviour, and so forth. As a parent, it is important to know your adolescent well enough so that you will pick up the difference between ‘normal’ and ‘abnormal’ behaviour. At times like these it may very well be necessary to make the first move towards taking the lid off what is happening. Using positive communication skills is essential here – the right words, the right attitude, and choosing the right time to speak with your son or daughter.

Problem Solving: A Step-By-Step Process

Problem solving begins with accepting the fact that a problem does exist. A solution comes about because all the facts surrounding the problem are looked at by all concerned. This is done without blame, or guilt, or loss of temper, within an atmosphere of openness and respect, and with the help of those with the greatest amount of experience to guide the process – namely, the parents. Of course, all this presumes that the adolescent is willing to find a solution. If not, then using force won’t work. In situations where the adolescent won’t participate, the solution is still not complete until the adolescent comes around to seeing the wisdom of defining and solving the problem.

The pathway towards a solution depends on the seriousness of the problem and the level of disharmony or inconvenience it is causing. Sometimes this pathway will take the solution away from the adolescent into the hands of authorities – even legal authorities. The safety of the adolescent and of other people cannot be sacrificed simply to keep the problem within the perimeter of family privacy.
This flow chart describes a problem solving process…

ADOLESCENT
‘I have a problem’

OR

PARENT
‘There seems to be a problem

FACT
A problem exists

DO WE ALL AGREE
THAT A PROBLEM
EXISTS?

NO
Then how urgent is it?
How long can you wait before taking action?
Who is at risk, and how seriously?

YES

DESCRIBE
THE PROBLEM
What are the facts?

WHAT IS THE
PAYOFF VIA
THIS PROBLEM
(see next page)?

WHO IS AT THE
CENTRE OF
THE PROBLEM?

WHO ELSE IS
INVOLVED

HOW
IMPORTANT
IS IT TO FIND A
SOLUTION?
WHY?
DOES EVERYONE
AGREE?

HOW QUICKLY
DOES A SOLUTION
HAVE TO BE
FOUND? WHY?

WHO ARE THE BEST
PEOPLE TO BE INVOLVED
IN FINDING A SOLUTION?
WHY?

PLOT THE COURSE FOR A
SOLUTION!
Getting to this point sounds like a walk in the park – don’t be fooled too easily!

**The Payoff Factor**

REMEMBER: All behaviour has a purpose, whether the behaviour is acceptable or not. The payoff factor means that someone (the adolescent) is getting something out of the problem, such as finding acceptance in the peer group, money, fame and fortune, escape from responsibility, and so on. Therefore, a solution will mean giving something up that has brought a number of opportunities and benefits. And here you are, actually suggesting that this should be changed (gasp!)?

**Getting past the Payoff Factor**

Getting past the payoff factor will most likely take encouragement, suggestion, logic, and patience – within reason, of course. Getting to the point of saying that there is a problem about which something has to be done could very well be the first problem looking for a solution! There is a *burning question* that can (and should!) be asked at this point –

<table>
<thead>
<tr>
<th>THE BURNING QUESTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. If nothing changes and everything keeps going as it is now, then (this) is where things are going to end up for you.</td>
</tr>
<tr>
<td>B. For you that is going to mean:</td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>Etc.</td>
</tr>
<tr>
<td>C. Is this where you want to end up in your life?</td>
</tr>
<tr>
<td>D. If not, do you want to do something about changing what is happening? I am willing to help you find a way to change things.</td>
</tr>
</tbody>
</table>
When outlining the argument used in ‘the burning question’, there are some necessities for the parent to take account of, such as those in the following box…

- Be clear in your own mind as to what is going on with your son or daughter and why it should change
- Make sure that what you think is a problem, is a problem – have the facts clear: if you think you’re biased, ask someone you trust for advice
- Be clear on how serious the situation is
- Pick the right time and place
- Involve only the immediate stakeholders in the issue (unnecessary people will be a threat and not a help)
- Don’t beat around the bush – come to the point (this shows respect)
- Use ‘I’ statements – ‘Why do I see things this way? How do they make me feel? I would like things to change because…’
- Invite the adolescent to reply and offer an opinion – problem solving is a sharing of opinions first and foremost
- Don’t get caught up in game playing – be up front with the facts
- Don’t corner or manipulate the adolescent; be honest and sincere
- Seek agreement on the facts of the situation, rather than set out to prove that you are right and the adolescent is wrong
- If needed, give (reasonable) space and time to consider options or requests – this is also negotiated: ‘we will leave things go for some thought, but I want to discuss this again with you (at) or (by)’. Don’t let this become an excuse for escape, especially if there is urgency involved!

…and if you keep hitting a brick wall?

- How serious is the problem? How urgently is a solution needed?
- How long can you reasonably allow your adolescent to ‘come around’ to seeing the problem?
- What action do you need to take in the meantime?
Where a solution is urgently needed…

- ACT – you as a parent have the responsibility to take action over something that might threaten the safety of your son or daughter, or other people involved.

- You can only do your best to involve your son or daughter in the solution – you can’t force co-operation.

- One way of approaching this is suggested by the following…

‘Here are the facts of the situation – A, B, C. Understand that I can’t let things keep on going the way they are, because you or someone else is sure to get hurt. I was hoping that you would see that there is a real problem here and work with me to find a solution. However, that doesn’t seem likely to happen. Therefore understand that I am going to have to act by (doing this or that), and in the meantime (this will happen)’.

Decide on the action you need to take, and then take it. Where resistance is ongoing, keep the door open for a change of heart in your son or daughter.

Hitting a brick wall in finding a solution to a problem describes the ‘worst case scenario’. However, let’s not immediately go for the jugular vein. Let’s presume that a solution with your son or daughter is possible. On the following pages are some important ‘ingredients’ for effective problem solving.
ALLIANCE

Alliance in problem solving can be outlined like this…

Approaching a problem in this way means that you have developed *alliance* with your son or daughter. ‘Alliance’ means that neither the adolescent nor the parent is the problem. The problem that is having a bad effect on you and your adolescent, and probably others in the house as well is ‘the problem out there’, and *together* you are setting out to solve it. Using alliance means that guilt, aggression, or blame does not become the focus of problem solving. Where parent and adolescent are aggressive towards each other, or where both people make each other the target of guilt and blame for what is happening, the adolescent or the parent becomes *enmeshed* in the problem, and finally becomes the problem itself. Approaching the problem on the basis of guilt, aggression, or blame would look like this…
Alliance in problem solving therefore means…

✓ Taking a *team approach* to finding a solution. Teamwork also means helping each other make the solution work.

✓ Keeping the problem apart from the people who are caught up with it. Alliance means that you are separating the DEED from the DOER.

✓ Not using guilt, aggression, and blame simply because the solution is difficult, or because things aren’t working out as you thought they would.

Guilt, aggression, and blame (GAB) create a situation where the other person is pulled back into the centre of the problem. Statements like the following make this clear…

‘It’s only because of *you* that all this is happening!’
‘I’m sick of your carrying on – you’re a damned nuisance around here!’
‘I am the way I am because of you!’

**Finding a Solution is like Mapping a Course**

Imagine you’re heading off across an ocean. The idea is start out from somewhere to get to somewhere. To do this you need a map that is going to get you there safely and with little complication.

The map begins with the question (the ‘burning question’)…

‘Do you want to keep ripping the bottom out of your boat and trying to drown yourself in order to get to where *you* think is the right place to go, or do you want to find a workable solution?’

So the idea of mapping a solution is to get to where you want to go *without* ripping the bottom out of your boat and trying to drown yourself. Therefore finding the solution that will *most likely work* is like mapping the course that will *most likely get you* to where *you* (either the adolescent, you, or someone else) want to go.
Where are the obstacles along the way?

What is most likely to get in the way of achieving your goal?
Who are the people who will most likely steer you away from achieving your goal?
What are the big temptations that will blind you to a solution? How can these be chained up?
What parts of you are likely to become obstacles?
Part of plotting the safest course is to identify possible obstacles before they appear. More often than not, these are the factors that helped create the problem in the first place, and still keep it going as a problem.

What about storms along the way?

You can’t guarantee smooth sailing!

What plan of action do you have for that unexpected ‘storm’?
Where are ‘storms’ most likely to happen?
When are ‘storms’ most likely to happen?

Dry dock!

Storms can knock you around a bit – even damage your boat.

It might be necessary to go into dry dock and do some running repairs. If this is necessary, then see it as a sensible decision rather than failure. It’s stupid to keep pushing along with trying to solve things while water continues to pour into the boat (baling is hard work, too!) Time out is needed at these points to reflect on how things have gone so far, and what needs to be attended to in order to keep moving in a positive direction. When things get back up to scratch, then you will feel confident about sailing again. A ‘positive’ view about being in dry dock is that dry dock is an opportunity to increase one’s knowledge base through experience (even bad experience).

Plan out some harbours along the way…

This is plain common sense. When plotting a course, leave yourself a way out if the going gets rough or difficult. A harbour is away
from the open sea (which can be unpredictably dangerous). It gives time to go over things, get advice, perhaps re-plan, and then head off again.

What offers the most welcome and safest harbours? A trusted friend? Home? Relatives? A quiet, favourite spot? Doing something different? Who can offer you the best help in these harbours? How rough will things have to get before you choose to head for a harbour (an important personal question for each adolescent).

In the doldrums…

The going can also get difficult when all you’re doing is sitting around bored – no wind, no action, nowhere to go. This is usually the time when stupid things are done.

What are you going to do when it makes more sense to go back to old ways than to keep trying for change? Who are you going to talk to? What will you say or ask for? Where will you go? Going back to friends who belong to the old way of life is not sensible.

Sometimes it is necessary to sit the doldrums out. However, how long are you prepared to do this before looking elsewhere for some ‘motivation’ to get going again?

When you get there…

Getting ‘there’ means that you have overcome many obstacles and so have made a valuable achievement! When difficulties swamped you, you headed for harbours or even for dry dock and worked them out. You avoided storms and rode out the ones you couldn’t avoid.

The first journey is always the hardest!

Remind yourself that when you have made this trip once, each trip after that gets easier: you know more about what to expect. Other trips to different places – solving other and different problems - also become easier to plot.
As the parent of a sea-faring adolescent…

When working through a problem situation with your son or daughter, look at the situation from as many different angles as possible. Help your adolescent to think about the harbours that might be needed, the storms that might come along, when he or she might end up in the doldrums, and so on. Then encourage your child to put the plan into action, and offer help when asked without giving into the temptation to take over.

✔️ When things work out, congratulate your son or daughter and celebrate the achievement.

✔️ When things don’t work out, then together with your son or daughter go back over what happened and find the weak spots. Offer help to find the most constructive way to strengthen these weak spots.

✔️ Always support and encourage the problem-solving journey. Keep in mind that your place as a parent is on the shore (as well as possibly in the harbours and dry-docks along the way). What you can’t do is take over the helm, even in the roughest storms, unless the adolescent asks you to step in. Even then, develop the wisdom to know when to hand control back to the adolescent.

✔️ Your time will come when the boat limps into dry dock. Here you might be called on to help with repairs. Encourage your son or daughter not to give up but to keep going.

A big part of this encouragement is to remind your son or daughter why this journey started in the first place.

More as a parent…

Once you’ve planned out the solution together, and worked out the possible pitfalls and what to do to avoid them or handle them well, it is necessary to hand control over to your son or daughter. It can be difficult for the parent to move into the background and let the adolescent
work through the process for him or herself. However, it is important for this to happen. The older the adolescent, the more important this becomes.

The extent of the parent’s involvement depends on a few things…

Age

Younger adolescents will most likely need outside help more than older adolescents. The amount of help you give will depend on the wisdom of knowing how much rope to let out before too much is let out!

Respect

Respect means allowing the adolescent to take control of his or her life, as long as taking that control does not mean risking the adolescent’s personal safety or dignity, or the safety or dignity of others. If as a parent you can foresee that more input from you is necessary to head off embarrassment, repeated failure, or further problems caused by inexperience, then bring that input into action in a way that doesn’t look as if you are taking over.

Offering assistance without looking as if you are taking over can perhaps be achieved by offering your suggestions in such a way that the adolescent thinks he or she came up with the solution.

‘I wonder what would happen if…?’
‘I remember a similar time when I…’

Again, use ‘I’ statements rather than ‘you’ statements.

Trust

Here is an opportunity to trust your son or daughter. If everything up to now has told you that this trust is possible, then do take that step and trust your son or daughter.

Trust and being around when things go wrong

A strong level of trust is evident when the adolescent comes to you for support after things go wrong. This trust is strengthened even more when you greet your son or daughter with genuine understanding and support, and a readiness to help him or her to find a way around present
difficulties. This is a clear message that you love and respect your son or daughter, even if things have reached their lowest point.

The ‘power differential’…

We will finish this chapter by looking at the concept of the ‘power differential’ in problem solving. The power differential refers to the amount of influential ‘push’ that one or other party might exercise in the problem solving process. In the case of a parent and adolescent, the parent would most likely have the greater power differential through increased experience, confidence, and maturity, a higher amount of information, more influence among outside people or authorities, and so forth. The adolescent might also exercise a greater (negative) power differential by refusing to cooperate in accepting that a problem exists or in finding a solution. The adolescent might also undermine efforts towards making a solution work. Similar to the differential gearing of a car, the power differential directs the flow of influential power through issues such experience, knowledge, cooperation, and so on.

A parent can use the power differential in a positive or negative manner. Positive use would be shown by the parent who observes potential problems in the solution process, yet keeps quiet about them because this knowledge would only mean further unnecessary problems for the adolescent. However, in this case the parent would also possess the wisdom of knowing when to expose this knowledge for the adolescent’s benefit. A parent who kept back vital information from the adolescent simply out of revenge or anger would show a negative display of the power differential. In fact, this action would amount to ‘power mongering’, with a necessarily damaging outcome.

Having the power differential is a responsibility for the parent. This balance of influential power towards the parent’s favour will occur by necessity in most cases because of factors such as age and experience. Therefore, the parent needs to not only be aware of having this balance of power, but also needs to know how it will be put to best use. That is, the parent needs to choose whether all the facts and options are brought to light at the start of the solution process, or only partial facts and options. This decision will be based on the parent’s awareness of the age, personality, experience, and creativity of the adolescent, as well as on the strength of the relationship between the parent and adolescent. The parent-adolescent relationship can be
seriously damaged where the adolescent believes the parent is simply playing ‘mind games’ in the problem solving process.

As a final word, preventing problems from arising, or finding early solutions, is far preferable to crisis management!

SOMETHING TO DO

1. How do you solve your own problems? The style we use with our own problems will mostly be the same style we will use when we are involved with other peoples’ problems. Describe your problem solving style…

2. ABOUT YOURSELF

What parts of your personality are helpful for solving problems?

What parts of your personality get in the way when you set out to solve problems?

How do you cope with ‘brick walls’ when you try to solve problems?
3. ABOUT YOUR SON OR DAUGHTER

What parts of your son or daughter’s personality are helpful for solving problems?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

What parts of your son or daughter’s personality get in the way in solving problems?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

How does your son or daughter cope with ‘brick walls’ when trying to solve problems?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

4. On the next page there is a flowchart. Think about situations that you have been involved in with your son or daughter. These situations can be problem free or centred around a problem. When the flowchart uses the word ‘bag’ (such as ‘holding the bag’), this refers to all the unwanted consequences that have arisen from the solution. For example, a solution may involve you having to pick your son or daughter up from a friend’s party at an earlier time than previously planned. Even though this was agreed upon for the sake of the adolescent’s safety, you are the one who is left with the majority of hassles needed to make this work. That is, you have to go out late at night, in the middle of winter, park around the corner, walk to the house, knock on the door then hide in case a friend sees you there, drop off one or two other friends, and so on. A parent can end up feeling used and resentful at times like these. Yet occasions like these happen, and when they do, these outcomes need to be recognised and dealt with. We will look at these occasions at the start of next week’s work. Until then, think about possible situations like this, and jot down their details in the boxes of the flowchart.
What is life like when it is ‘problem free’?

What is life like during a problem situation?

Who ends up ‘holding the bag’?

What is usually ‘in the bag’?

How is the stuff in the bag usually sorted out?
CONFLICT RESOLUTION
CONFLICTS AND PROBLEMS

You might be wondering what the difference is between a conflict and a problem. Aren’t they the same?

A conflict might be described as a CLASH of ideas, beliefs, wants, needs, feelings, activities, and so on, between two (or more) people – and it can be very personal!

Conflict need not be damaging. Often conflict, if properly handled, can lead to positive and constructive conclusions that might not come to light if the conflict had not occurred. A well-learned lesson of life is that we aren’t all going to think the same way about things! However, the approach to understanding conflict in this chapter is the clash between two people who want their own way at the other person’s expense, or who think that the only way of doing something is MY way. Resolving this potentially harmful conflict so that something positive surfaces will only happen if both people listen to each other, see the situation from the other person’s point of view as well as their own, and are prepared to give a bit in order to get a bit (if this is appropriate). All this can be very personal to anyone involved in the conflict, because resolution means that not everything will go ‘my way’.

Perhaps the difference between problems and conflicts lies in the effect conflicts have on us. Conflicts are more personal – closer to home. A problem can also have personal meaning to us (especially when it makes our own life difficult), and very often the presence of negative conflict is itself a problem. However, a problem can often be solved as something ‘out there’ more easily than conflict because conflicts with other people mostly touch something personal in me, and so are more liable to create a defensive attitude as a response. Conflicts can bring us face-to-face with our feelings of inadequacy, so that we feel as if the imperfections of our person are being exposed to the world for all to see. Therefore, it can be difficult to separate ‘me’ from the actual ‘conflict situation’.
Furthermore, we are not machines programmed to work efficiently regardless of what goes on around us. Our feelings, defense systems, past experiences, needs and wants, ambitions and so on mean that at times we will clash with people, especially with people we know well and care a lot about. It can even take a while to realize that a conflict is actually happening with someone. Therefore conflict is to be expected in normal everyday life. The amount of distress caused by conflicts will depend on how well we handle them. Have a look at the picture above the heading for this chapter. Poorly handled conflict can be like the person locked into the middle of a spiral. The more caught up we become in defending our own territory in a conflict situation, the more we become locked into the middle of a harmful spiral. Furthermore, the longer the conflict continues unresolved, the more deeply we end up in the spiral. Finding a resolution that is comfortable for both sides is like finding the key that gets us out of the spiral.

**CONFLICT RESOLUTION**

Generally, conflicts between parents and adolescents will occur as a result of ongoing nagging and aggravation, or as a result of some decision that is unacceptable to the adolescent or the parent.

Conflict resolution with your adolescent son or daughter goes hand in hand with respectful and effective communication skills and a democratic style of parenting. This attitude will mean that conflicts will not be ignored or go unnoticed, because they will be dealt with honestly and openly by all people concerned. The two-way path to conflict resolution is opened when your adolescent clearly picks up the idea that you are willing to listen and discuss the conflict situation, and if possible, shift your point of view. The message from this is that you respect your son or daughter, with the result that he or she will be encouraged to model your behaviour in return. The equation we used with problem solving can also be used with conflict resolution…

| Respectful Communication + Democratic Parenting Style = Effective Conflict Resolution |
Some suggestions for resolving conflict with your adolescent

**Pick the right time and climate...**

Conflicts are best resolved at times when interruptions can be avoided or kept to a minimum. If you are feeling worked up or unwell, or if your adolescent is feeling likewise, then the time is not right to resolve a conflict. It would be absurd to attempt any resolution during a blow-up with your child. Furthermore, it would certainly be unacceptable to deal with conflicts in front of your adolescent’s friends! Privacy is essential for conflict resolution.

**Being aware of the adolescent’s individuality...**

Conflict resolution requires a willingness to speak openly and honestly with each child as an individual. No two children in a family will be the same. The way you relate as a parent to one child in the family might be entirely different to how you relate to another. This will also have an impact on how reasonable your expectations of the adolescent might be. Treating a 16 year-old like a 12 year-old is very likely to cause conflict. If conflict is occurring because the adolescent is being treated beneath his or her age or maturity, then perhaps the resulting conflict is saying that the adolescent is seeking a more adult level of relationship with the parent.

Being conscious of the adolescent’s increasing age, maturity, and readiness towards greater responsibility will help you to show the type of trustworthiness that prompts the adolescent to adopt an age-appropriate and mature approach to life. This in turn will make the task of resolving conflicts between you and your adolescent more straightforward.

**The role of the parent in conflict resolution...**

It is rare that two people who are involved in a conflict situation come to the realization at the same time that something needs to be done to settle the conflict. The person who is more aware of the distress created by the conflict will be in the best position to make the first move. In conflict situations with an adolescent son or daughter, this person could equally be the parent or the adolescent. The following features define this role for the parent...
1. Awareness

- Make every effort to know your son or daughter well so that when you recognize the presence of conflict, you will feel more comfortable in seeking to resolve the cause of the conflict with your son or daughter.
- Develop the ability to balance out the demands and responsibilities of your parent role with the needs and wishes of your adolescent. This balance will be similar to the idea of ‘give a bit to get a bit’. That is, you may be able to slacken off somewhat, even though you may not be able to go the adolescent’s way completely in meeting his or her wishes. This will particularly apply in situations where the conflict has come about because the adolescent has wanted something you don’t approve of.

- Understand what is going on inside you when you feel conflict between you and your adolescent. What is the conflict triggering in you? How is it making you resistant to change, or defensive, or angry?

- Keep a hard head with a soft heart at all times.

2. Changing the Dynamic

The ‘dynamic’ is what takes place between you and your son or daughter. It is the flow of words, ideas, thoughts, feelings and so on, between each of you. In this way you ‘bounce off’ each other, either for good or not so good.

Remember the activity in the Introduction of balancing the pencil on your finger? When you change one side of the dynamic (that is, when you put more weight on one side of the pencil), then the whole movement of words, feelings, and so forth between you and your adolescent change accordingly. Your responses and attitudes will no longer be predictable. The adolescent is brought to a halt with the thought: ‘hang on, that’s not the way you are supposed to answer! You always do this, or say that’.

Changing the dynamic is useful at those times when abrasive or damaging responses are automatically triggered off in you by something the adolescent says or does. If these responses happen often enough, then not only will the adolescent expect them as your normal reaction, but the conflict that arises
as a result will also be expected. If you change the dynamic by responding differently and more positively, or even by not responding at all, then the adolescent will be left hanging in mid-air. Changing the dynamic in this way will be more likely to set up the right atmosphere for resolving present conflict, and so avoid further conflict that didn’t happen because you didn’t respond (or react!) in the usual way. Changing the dynamic probably won’t have an immediate effect. However, over time the pattern of responses between you and your child will change because the expectations of what will be said or done are no longer the same. Hence, conflict is more likely to be resolved.

3. Are You Responding or Reacting?

Ask yourself some basic questions when you find yourself in conflict situations with your son or daughter…

1. In day-to-day conflicts, am I reacting to something that is really normal behaviour for the particular age and time of development of my son or daughter, or am I responding to something that is unacceptable and therefore cannot happen or needs to change?

2. When my son or daughter and I are in conflict over decisions or limits, am I being completely reasonable, or am I being over-protective or even just difficult to get along with? Your son or daughter’s behaviour might just be normal adolescent behaviour for anyone at his or her age. It might still get at you, but it might also be asking you to become more tolerant.

SIMPLY...

- How much am I getting up tight over something that is really nothing at all? Am I getting TOO up tight, and so need to pull back a bit and look at things more objectively?

- Is this a reality check that is telling me to relax, and cut more slack for my son or daughter?
4. Take the Opportunity to Speak when there is no Conflict

It would soon become a pretty miserable relationship if the only time you spoke with your son or daughter was during times of conflict. In fact, the home would start to resemble the Peace-Keeping Corps, with each person avoiding the presence of the other. Therefore, look for opportunities to talk about everyday things with your adolescent: school, sport, bathing the dog, teaching the bird to sing, anything! These opportunities don’t have to be complicated, formal, or time-consuming. Passing ordinary time together will be of great help when it becomes necessary to work out difficulties between you and your adolescent.

THE ROLE OF PERSONAL SOUL SEARCHING IN CONFLICT RESOLUTION – THE ACHILLES HEEL

The story of Achilles comes out of ancient Greek literature. It describes how Achilles’ mother took him as a baby to the river Styx. She held him by the heel under the water, believing that the river Styx would give Achilles divine protection from physical harm. Because Achilles’ heel did not touch the water, this became the only vulnerable point on his body. Eventually Achilles was killed with an arrow through his heel.

From this story comes the idea of a person’s Achilles heel. It is our personal weak point. No matter how strong our personality might be, we all have an Achilles heel. It is the part of us that is most likely to fail under pressure. Our Achilles heel can develop from our unrealistic thoughts or expectations of people, or from past bad experiences with people, or from our ‘funny little ways’ of doing things with the expectation that others must (there’s that word again!) fall into line with these ways. Some examples of a person’s Achilles heel might be…

- Being short tempered
- Having little tolerance with people who are slow to pick up on what you are saying or demonstrating
- Wanting things done a certain way (parking the car out of gear with the handbrake on)
- Wanting things left in a certain place
✓ Wanting everything organized to the last detail
✓ Being over protective

And very importantly –

Making the other person the target of our own unresolved conflicts (for example, problems at work with our boss).

The first task of soul-searching is to be able to recognize and name our Achilles heel. Our Achilles heel will most likely be the first area to snap in any conflict, and if it gets the better of us it can cause an unreasonable reaction to the adolescent (or any other person) instead of a calmer and more rational response.

THEREFORE:

Develop the ability to describe the Achilles heel of your personality, and don’t be surprised if your Achilles heel is the first part of you that starts to come undone in a conflict situation. In fact, be on guard for this to happen! In particular, where someone else knows the location of your Achilles heel, while you don’t, can increase your vulnerability with that person.
Think of conflict resolution as a process (much like problem solving)…
What is the conflict all about?

**Aggravating Behaviour**
- Continual annoying behaviour
- Selfishness
- Fighting/breaking rules/aggression
- Ignoring others rights

**A Decision**
You have made a decision as the parent and your son or daughter doesn’t like it:
- ‘be home by this time’
- ‘don’t go there’
- ‘you can’t sleep over’

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CONFLICT

Time to talk honestly and openly about why the conflict has resulted, with give & take on both sides. Both sides speak their mind. Both sides are heard with respect. Where conflict results from a decision, this is far preferable to one or both people walking off in anger and resentment, fuming over what is seen as unfair (and typical!) treatment and unfair (and typical!) reaction.

Nipping this conflict in the bud may even lead to a revision of the original discussion and outcome.

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**Aim to...**
Reach agreement on both sides as to how things are going to be
(not 100% agreement, but mutual satisfaction)
BE AWARE of the presence of your Achilles heel and the impact this is having on the conflict process.
The Screaming Walkout Reaction.

It could be possible that your request to discuss an issue that is either a problem, or causing serious conflict, or both, will be met with an aggressive reaction from your adolescent with an accompanying walkout. What do you do and say?

Firstly, yelling out after the adolescent to return and discuss the issue, or worse still running after the adolescent and doing the chase and yell routine down the street, would be futile and embarrassing at this point. It would achieve nothing productive. In the end, you would feel distressed and anxious, your adolescent would probably feel likewise, and now further serious issues have been added onto the original issue that only complicate the entire scenario. Secondly, since your son or daughter’s safety is now the primary issue, do your best to find out where he or she has gone. If you are in serious doubt about your adolescent’s safety then call in help, even the police if safety is seriously compromised for your adolescent. Deal with the backlash of this decision when you have the adolescent back safe and sound.

When the adolescent returns, what happens then? First and foremost, remember the basic skills of relationship building, especially communication. You may be at ignition point emotionally, but aim to put this last on the list of your concerns. First on the list is insight into what you need to model for your adolescent – respectful speaking and listening, ‘I’ and not ‘You’ messages, and dealing with the issue at hand without the extra load of past baggage. It is also possible that the adolescent will return in a hangdog state, wondering what your reaction is going to be. Responding in a quiet, measured manner will upset the balance of negative predictability. If you take the opportunity of his or her return to yell and scream also, then this predictability has been confirmed for the adolescent.

Together with your personal response will need to be a resolution of the original purpose for wanting to speak with your son or daughter. This still has not been resolved, and now must be resolved – or as soon as possible after the return. Negotiate this! Treat the walkout as a hiccup in the proceedings – a freezing of time, if you like. If you now abandon this original issue for the sake of the walkout and other related aspects, then you have given a clear message to the adolescent that screaming and walking out can jettison uncomfortable discussions. Naturally, you do have to deal with
the adolescent’s aggressive reaction. However, this happens after the original issue has been addressed – all in good time.

Remain quiet, reserved, soft toned, use ‘I’ messages, and give the message that the walkout was unacceptable, and will also need to be discussed, but after the issue that sparked the walkout. And don’t forget the consequences. Modelling acceptable behaviour requires the adolescent to personally learn what is and is not acceptable response to peoples’ justified requests and needs. Remember that you had a reason (and a right) to make the original request to discuss your concern with the adolescent. As long as there was a justified reason for this, then it must happen. You, as parent, are the one who possesses the first and responsible authority in the household.

While this may sound somewhat overwhelming and even fairytale-ish, what is the alternative? Instead of resolution will come an escalation in aggressive behaviour from the adolescent and possibly (or in time, probably) from you also. Problems and conflicts will not be resolved, and the parent-adolescent relationship will undoubtedly fracture.

What DOES work in conflict resolution is…

- Agreement that conflict is happening, ability to identify it, and a willingness to deal with it so that the needs of everyone are respected
- An understanding that whatever is agreed upon is to be taken seriously – this agreement is not a means of setting up a short circuit for getting one’s own way
- A readiness by both parent and adolescent to genuinely work towards avoiding whatever has fired up the conflict in the past
- Waiting until the time is right! Trying to solve a conflict while one or both parties are hot under the collar can only throw fuel onto the smouldering fire.

It is better to walk away during ‘hot’ times and return to the conflict when temperatures have settled down. Pushing and pulling an angry adolescent to reach a solution with you during these ‘hot’ times will usually result in a bigger blow up, more angry words, slamming and banging, and most likely a stronger determination on the adolescent’s part to hang in there and not budge an inch! Nothing is worked through – everything just gets worse!
What DOES NOT work in conflict resolution is…

- People complaining behind each other’s back
- Ranting, raving, and yelling to bully the other person into submission
- Taking the easy way out and return to old habits when the ‘old’ conflict is likely to occur again simply because either of you can’t be bothered trying
- A refusal to accept that failure will still occur from time to time – on both the parent and adolescent’s side.

In summary, therefore, the process of conflict resolution includes the following…

**P robe** – Is there conflict between us?

**R eflect** – How are we going to find a way around this conflict? Is now the right time to do it? How long can resolution wait if the present time is not right? How far can things be let go as they are? How much slack am I, as the parent, willing to give?

**A gree** – If we talk, we need to agree on a course of action that is basically acceptable to all concerned (that respects everybody’s point of view and personal needs)

**I dentify** – What identifies success? What identifies a ‘couldn’t care less’ attitude about making the conflict situation more harmonious to all concerned?

**S et in motion** - Do what we have all agreed to do!

**E xamine** – If our efforts fall apart, then what is to happen? Was it unworkable in the first place and if so, why? Was it workable, although people just weren’t doing their best to make it work? Do we need to look at a new approach, or do we need to look at different attitudes to the agreed approach?
The word PRAISE is an important response to your son or daughter’s efforts to stick to what has been agreed upon with words like:

‘I appreciated you being home by 11.30 last night. Thank you!’
‘I have noticed that you don’t leave your sports gear lying all around the lounge-room. I appreciate you thinking of us in this way!’
‘I was proud of you for organizing your party at home instead of the beach’

And praise yourself too – it might have been hard for you to give out some slack and so believe that your son or daughter has shown that he or she can be trusted.

The task that lies ahead for any parent of an adolescent is to model the skills of conflict resolution, as well as problem solving, by putting the theory into action. This task can be infuriatingly frustrating, especially when old and unhelpful approaches have been used for a long time. The risk of giving up on practising new approaches is highest at times of frustration and charged emotion, and especially at times of failure. Yet once again, what is the alternative if not the gradual and eventual breakdown of the parent-adolescent relationship? When confronted by an angry adolescent who has not got his or her way, or who continually sets you off with a style of body language and vocabulary that would try the patience of a saint, it helps to realize the following…

**Firstly**, how the parent responds to this behaviour is a matter of choice. Hard though this might be to accept, it is the bottom line. As individuals, we make the choice to respond to people in a certain manner. No other person is responsible either for that choice, or for any negative outcomes that occur because of it.

**Secondly**, there is a huge difference between an action in itself, and one’s interpretation of the action. If an adolescent’s aggressive and confronting attitude is interpreted by the parent as a personal assault, then the parent will react accordingly. If on the other hand, the parent interprets the adolescent’s manner as something that can be placed at a distance outside one’s personal space, then the parent will find greater resources of energy and skill to handle the adolescent’s aggression in a competent manner. Once again, this choice is a matter of individual responsibility.
1. In the box below, jot down as many features as possible that describe your Achilles heel…

Your Achilles heel is made up of…

Now do the same for your son or daughter…

Your adolescent’s Achilles heel is made up of…)
Now describe how the ‘clash of the heels’ can lead to conflict…

2. At times of conflict, it can be easy to forget your own or the other person’s good qualities, and instead focus on all the negatives that are caught up in the conflict at that time. Here is an opportunity to describe your own strong and likeable qualities as well as those of your son or daughter. These are the links that will forge a bond between you and your adolescent.

Your likeable qualities…
Your son or daughter’s likeable qualities…
MONITORING

LIMIT SETTING

NETWORKING
Monitoring has been described by professional research as the **basic ingredient** of a parenting approach that is most capable of keeping an adolescent safe. Monitoring simply means that you know **as far as possible** what your adolescent is doing, who he or she is doing it with, where it is taking place, and how long it is going to happen for – whatever activity ‘it’ might be. Your ability to know these facts will depend on the age and responsibility of the adolescent, your familiarity with his or her friendship group, and the strength of the relationship between the adolescent and yourself. The older the adolescent is, the less you are going to know about his or her ‘away from home’ activities. This is acceptable, since with increasing adolescent age comes the increasing adolescent need for self-responsibility along with the expectation of greater privacy in what they do either alone or with friends.

Keeping track of your adolescent’s activities needs to be part of the everyday relationship between you and your son or daughter. Hopefully, the adolescent sees your need for information about ‘away from home’ activities as well as social contacts as being a normal part of your responsibility as a parent. If this has happened from a young age, then withdrawing from the arena of full knowledge about your adolescent’s activities will not only leave you feeling reasonably comfortable about safety issues, but will also be a natural outcome of handing over increasing levels of responsibility to the adolescent.

Monitoring is not spying. You don’t monitor your adolescent’s activities by hiding around doors and under beds, or by bugging rooms and telephone lines. Try this sort of thing and it will only be a matter of time before the relationship between you and your adolescent breaks down – and with good reason. No one likes being spied on.

**The Image of the Computer Monitor**

Seeing the invisible…

Think about the monitor (TV) that is used with a computer. The monitor is not the place where all the computing wizardry takes place. Rather the monitor *shows* you what is going on inside the computer.
You can’t actually see what goes on inside the computer casing. However the words and images of all those computer operations come together in familiar form on the monitor screen. Then they make sense! For example, I am able to see the letters I am presently typing on this keyboard because they come onto my screen from the computer. I have no idea how they get scrambled up inside all those wires and chips (that I cannot see) but I am able to say that they are being scrambled up properly because I can read and understand what is coming onto the screen. The monitor reassures me that the computer is doing its job properly! At the same time, if I type something sensible onto the keyboard and it appears as gobblygook on the screen, then I know that something is going haywire inside the computing system.

The ‘adolescent monitor’ lets you track your adolescent’s activities…

While it is helpful to know something about what rattles and hums inside the computer casing, this understanding does not have to be exceptional unless you are someone who works with computers. In the same way, you don’t have to understand all the ins and outs of your son or daughter’s mind to monitor his or her activities. You can leave that up to people like psychologists. What is necessary is the knowledge that lets you understand what you are picking up on your ‘adolescent monitor’ – the various signals that come from your adolescent’s general behaviour. Once again, it is essential to know what is ‘normal’ behaviour for your adolescent so that you notice ‘abnormal’ behaviour when it happens.

**MONITORING WITH YOUR ADOLESCENT MONITOR**

The computer monitor doesn’t do the ‘thinking’. The bits and pieces inside the computer casing do this. Commands (or typed messages) are given to the chips, wires, and all the other magical bits via the keyboard (notice that this is a *really* simple computer we are using!). The magical bits then assemble these commands into some order and display it onto the monitor screen. So that your adolescent monitor gives you the best possible and most sensible information, it is first necessary to type in certain commands. We will now look at some of the more important commands that need to be typed in.
Feeling comfortable with your son or daughter…

Work towards having a generally comfortable relationship with your son or daughter. A comfortable relationship means that you will find it easier to speak with your adolescent about what is going on in his or her life. Your adolescent is the expert about what he or she does when away from home. Your adolescent is therefore the main source of your information, and so it makes sense to go to the source in order to build up the best form of monitoring! In this way, you will both know what is on each other’s mind, and this in turn will encourage a level of trust and honesty between you and your adolescent.

When building up the store of information for your adolescent monitor, carefully pick the time and place to do this, and steer clear of heavy ‘one-on-one’ conversations as much as possible. This type of monitoring can come from opening statements such as:

‘How are things going between you and your friends lately?’
‘You seem to be really looking forward to next Saturday night’
‘I’ve noticed that Brett isn’t coming around as much as he used to’.
‘Karen’s mother and I have spoken about some ideas for the party next weekend’

The idea is not to set out looking for problems that don’t exist or to read warning signs that are not there. Monitoring is not spying! It is simply keeping your finger on the pulse of your son or daughter’s activities so that you know what is happening.

**Where will your Information come from?**

The keyboard can’t think either! Therefore you need to first go looking for information to type into the computer. The following suggestions show some areas where you can obtain this information. You could add to these suggestions from your personal experience.
FRIENDS

✓ Who are your child’s friends? Do you know their names? What do you know about them? Are they around the same age as your son or daughter (friends who are older than the adolescent are labelled as a risk factor for problem behaviour)?
✓ Do you know what type of behaviour the friends would approve of?
✓ Have these friends ever been in trouble with legal authorities?
✓ Do they have a relatively trouble-free time at school? Do they skip school, or skip classes?
✓ Has your adolescent’s behaviour changed through becoming involved with an old or new group of friends?
✓ How do your adolescent’s friends use their spare time? How do they involve your adolescent in what they do? What aspect of their behaviour does your adolescent model?
✓ How many of your adolescent’s friends drive or have access to a car?
✓ What are the drug and/or alcohol habits of your adolescent’s friends?
✓ Is your child wary or uncomfortable about bringing friends home?
✓ Who are your adolescent’s closest friends?
✓ Generally, are your adolescent’s friends the sort of people you would want your son or daughter mixing with?

PARENTS OF FRIENDS

✓ How well do you know the parents of your adolescent’s friends? How often have you spoken to them?
✓ Have you ever mixed socially with the parents of your adolescent’s closest friends?
✓ What are the values of these parents? What values do they instill in their own children?
✓ What limits do they set for their own children? Do you think these limits are appropriate? How well are their limits respected by their adolescent children?
✓ What are the alcohol and/or drug habits of these parents?
✓ Have they ever been in trouble with legal authorities?
✓ Generally, do you feel comfortable with these parents?
ACTIVITIES

✓ Where does your adolescent go when he or she goes out? Does your adolescent actually go where you think he or she is going?
✓ What goes on there? Is it safe? Is your adolescent capable of handling anything that is potentially unsafe there?
✓ If it is a public place, how good is the security there?
✓ How long will he or she be away from home?
✓ Can your adolescent contact you easily if anything goes wrong?
✓ Are your adolescent’s activities age-appropriate?
✓ If your adolescent has gone to a friend’s place, are the friends’ parents at home?

YOUR CHILD

✓ What type of activities does your adolescent enjoy doing? How often do you talk about your adolescent’s likes and dislikes?
✓ How clear is your message that you are interested in what your adolescent does?
✓ How often do you make time to discuss your values with your adolescent? How well do you know the values of your adolescent?
✓ Can you pick up sudden changes in habits, mood, or attitude in your adolescent? Would you know if your child was worried by something (just by using your observation)?
✓ Is there a sudden and excessive desire for privacy (phone calls, retreat to the bedroom, leaving home secretly, and so on)?
✓ Is there a sudden surge of spending, or a new availability of money that hasn’t come from you or from a known and trusted source?
✓ Is your adolescent appearing and disappearing at odd times, although you don’t know where to, let alone what is happening ‘there’?

YOURSELF

✓ Is anything troubling you about your son or daughter at the present time?
✓ Are you getting mixed messages from your adolescent (‘everything’s fine’, but evidence points in the opposite direction)?
✓ Are you more inclined than usual to hold the rope tight with your adolescent? Can you say why?
✓ Are you getting negative feelings about your adolescent’s friends?
✓ Are people passing comments to you about your son or daughter or about his or her activities that you find disturbing?
✓ Putting the hard evidence aside, what is your gut feeling saying to you?

YOUR PARTNER (WHERE A PARTNER IS PRESENT)

✓ What are the points of agreement or disagreement between you and your partner about your adolescent, or about your adolescent’s activities?
✓ If you are clashing over something to do with your adolescent, is it possible that one of you may have a good reason to clash?
✓ How well do you communicate together – is it good enough to support each other in monitoring your adolescent?
✓ Do you hold the same basic values in living?
✓ If there is disagreement between each of you about what you should know regarding your adolescent’s activities, how do you handle this? Is this type of disagreement an invitation for your adolescent to play one of you off against the other?

Gut Feeling

You gut feeling is a worthwhile source of information for your adolescent monitor. Develop the ability to understand what your gut is saying to you. It is probably the most basic indicator of whether things are going well, or need checking out.

Finally, if you are coming up with matters of concern about your adolescent, then DON’T IGNORE THEM. They won’t just disappear!

If matters of concern are ignored, or if essential action is put off, then the behaviour surrounding the issues you are presently concerned about will become expected adolescent behaviour as time passes, even though you are convinced that this behaviour is most certainly not normal and acceptable. You will possibly reach a stage where it will be easier and more convenient to ignore possible problems rather than confront them, especially if nothing
harmful has happened up to this point. Finally, it is insufficient to simply say that obtaining this information is too difficult, and therefore belongs to the ‘too hard basket’. In order to provide the best possible environment for your adolescent to grow up in, this and other similar information is absolutely essential. You must have it – and this is a valid use of the word ‘must’!

**Monitor your own Monitoring as well.**

Make sure that you are not overreacting about something that is normal behaviour, or that you are not trying to wrap your son or daughter up in cotton wool. Move gently and weigh up all the evidence before acting on something.

**LIMIT SETTING**

Monitoring and limit setting go hand in hand. Limit setting simply means that as a parent you have decided that your son or daughter can go THIS FAR and NO FURTHER.

Limit setting can apply across a number of situations. As a parent, you set limits around issues such as the way family members treat each other and the fair distribution of household jobs. However, the type of limit setting we will be discussing in this chapter will deal with more specific situations related to adolescent activity, such as social outings by your son or daughter (parties, stop-overs, trips), where and when he or she is allowed to go out, time to be home, travelling in friends’ cars, use of alcohol, drugs, and so on.

Limit setting also goes hand in hand with conflict resolution because there will be times when the outer edges of your limits will create conflict between you and your son or daughter. Communication style is the essential foundation of limit setting and quelling any conflicts that might arise from your limits. The manner in which you listen to and speak with your son or daughter will affect your point of view, and might possibly lead to shifting the borders of your limits.

**‘EVERYDAY’ LIMIT SETTING**

Although in this chapter we will be focusing on limit setting
for adolescent activity, everyday limit setting has an important influence on this activity-related limit setting. Regardless of the ‘appearance’ of a family (whether it be materially rich or poor, with one or two parents, large or small, etc.), the family is the one place on earth where those who live in its midst have a right to feel ‘at home’, contented, and safe. This does not mean developing a Brady Bunch set-up, because there will be times when people do not feel ‘at home’ in a family. However, if we are to speak of protective influences for the adolescent (as well as for others) then these influences need to find their birth in a generally harmonious and welcoming family environment.

Limit setting in the family environment is your decision as a parent to expect that environment to have a base-line quality about it. Limit setting in this fashion is focused on maintaining a healthy interpersonal system. Therefore limits are placed around…

✓ The way people speak and deal with each other
✓ The way people share household responsibilities
✓ The way children relate to their parents (as well as the flip-side of this coin)
✓ Requests and expectations
✓ ‘My rights, your responsibilities; your rights, my responsibilities’

**LIMIT SETTING AND ADOLESCENT ACTIVITY**

As a parent, you will assume the right and responsibility to set limits around your son or daughter’s activities.

Setting limits *does not* mean making a good time miserable.

**Setting** limits *does* mean that as a parent you are willing to carry out the rights and responsibilities of being a parent.

**Limit setting means** that you let out the rope gradually. You let out more rope as the years go by, as long as past experience with your adolescent supports the wisdom of letting out more rope. You don’t let out rope unless you trust your adolescent not to get tangled up in it and end up in trouble. The more rope you let out, the harder it is to pull it in!
Setting Limits, Adolescent Activity, and Responsible Parenting.

Limit setting belongs to the responsibility of being the parent of an adolescent:

- It is your right to have the first say in what your son or daughter does, because you are there to guide your adolescent towards being a responsible adult.

- You have been around planet Earth longer, and so it is reasonable to assume that you will also have a better knowledge of the pitfalls that are part of living on this planet!

- Linked to this is the responsibility of making sure (as far as possible) that your son or daughter is safe. This does not mean wrapping your adolescent up in cotton wool!

- You want your son or daughter to get the clear message that you intend to be a responsible parent, and that you will be carrying out this responsibility by setting limits.

Setting Limits needs Serious Thought

Limit setting is not just a haphazard affair that comes out of the whim of the moment. It needs careful thought, wisdom, and understanding about issues such as the following.

Limits will change as the adolescent grows older. An aim of limit setting is to gradually let out the rope as the adolescent shows that he or she is able to handle limits responsibly. More responsibility = more rope. You wouldn’t expect a 17 year-old to be in bed by 7.30pm, or allow a 13 year-old to roam the streets at 11pm.

Past experience of how your son or daughter has coped with limits will guide you in setting them. If limits have been continually broken in the past, then extending them instead of working out why they have been broken is only inviting disaster.
Making it clear that limits are widened when they are kept gives your son or daughter good reason to keep them!

When it comes to setting limits on adolescent activity, age and past performance go hand in hand with the type of activity the adolescent wants to do. The following guidelines direct the extent to which an adolescent’s activity is to be limited. Notice also how these guidelines link strongly with the skill of monitoring the adolescent.

- How much can you guarantee the safety of your adolescent?
- If the activity is risky, does your son or daughter have the maturity and skills to handle risk safely?
- If your son or daughter needs to get out of trouble, can this be done easily?
- How easy will it be to contact you?
- What general reputation does this activity have?
- Is it during the night or day? If at night, how late does it go?
- Who is the activity with? Do you know these people? Is it appropriate for your son or daughter to be mixing with these people?
- If you are not providing transport, then what transport is available and when? If a friend is driving, then how safe is this friend? If another parent is providing transport, then who is this parent?
- Are drugs and/or alcohol going to be present? If so, will they provide an unfair risk to your son or daughter?
- If the activity is a gathering of adolescents, what type of supervision is going to be provided? By whom? Do you know the people who will be acting as supervisors? What sort of reputation do they have?

All this means that you will need to go looking for necessary information before you consider what limits you will set. Contact people who can give you correct answers to any questions you might have. If it is a party at a friend’s home, ring up the parents of the friend and ask whatever you need to know. If it is in a public place, then get your information from the municipal council or from trusted friends who might know. Using “I guess it’s OK” as a way out of this investigation is not good enough.
Seeking information like this is not prying into your son or daughter’s private affairs! Rather, this is the basis for reaching good limit-setting decisions. The bottom line is that if your son or daughter wants to go somewhere then this process must first happen.

If past experience and older adolescent age makes you feel comfortable about trusting your son or daughter, then it will normally be enough to ask him or her for this information. If your adolescent becomes cagey about giving out this information, then it is time for you to ask elsewhere! Believing your son or daughter’s information, even though deep down you know this is not a good idea, can have bad consequences.

**Two Points Worthy of Note.**

Consider the following points…

Limit setting is shaped by how well you know your son or daughter…

Limit setting is greatly helped by an open and honest relationship with your son or daughter. The possibility of game playing and sneaking around behind a parent’s back is greatly reduced, if not ruled out altogether, when adolescents and parents know they can speak freely with each other. On the other hand, suspicion about the real motive behind a parent’s decision, dishonesty on the part of the adolescent, and inconsistency in limit setting, pushes parents and adolescents alike to make sure that their own territory is fully protected. Strengthening the relationship with your son or daughter is the basis for good limit setting practices.

Comments such as…

‘But last time I went there you said I could come home with the others, and nothing happened then! You can’t make up your mind!’

‘You don’t really expect me to believe you, do you?’
‘You never trust me with anything! You always treat me like some little kid!’

and…

‘I know what your friends are like – those dropkicks! You’ll stay right here and keep away from them!’

and…

‘You did not tell me to be home by 10pm – get real! You just make things up to suit yourself!’

…reveal a serious gap in the relationship between the two people who matter most in decisions about limit setting: the adolescent and the parent.

When monitoring and setting limits, always keep in mind…

‘SUSPICION IS FED BY IGNORANCE’

CONSEQUENCES

All is not fair in love and war! It would be unrealistic to expect an adolescent to keep within limits that are vague and unfair. Set limits need to be clear and evenhanded. Furthermore, when a parent makes a decision about consequences for broken limits, it is essential for the adolescent to understand exactly what will happen. Consequences are part of limit setting. That is, if the limits surrounding the final agreement are broken then something will happen as a consequence. Fairness demands that any consequence is especially clear to your son or daughter beforehand.

A consequence is not a punishment…

Life’s reality suggests that adolescents will often feel guilt if and when they are found out! When dealing with consequences, never separate the adolescent from responsibility for behaviour. Whether a consequence is seen as an outcome or as a punishment depends on the person at the receiving end. A consequence is something that occurs because something has happened. The consequence only occurs because someone has set things
going in a certain direction. Consequence and personal responsibility must go together.

The goal of being personally responsible for one’s own consequences…

Behaviour only changes when *I choose to change* that behaviour, and *I* choose to change behaviour when there is a good enough reason for *me* to do so. When *I* understand and accept responsibility for my behaviour, *I* also understand and accept responsibility for consequences arising from that behaviour. If *I* get fat because *I* am over-eating, but *I* don’t like being fat, then change will only happen when controlling my eating habits becomes something I want to do. If *I* want to hire a video, but arrive at the store after closing time because *I* was slack in getting there, then the consequence is not watching a video.

Consequence and moral development are part of adolescent learning. This essential link in adolescent development becomes increasingly difficult the longer its importance is ignored. If this development doesn’t happen then it is possible to reach a stage where the only consequence to be avoided is punishment. In these situations, fear is the motivating factor, with the result that changes in behaviour occur only while the threat of punishment continues. Behaviour is then not directed by personal responsibility.

How do you deal with an adolescent son or daughter who has learned that nothing will happen if he comes home drunk, throwing his weight around and terrifying all in the household? Do you stand up one night and make the bold announcement that you will not allow him to go out with his mates if this happens again? The reality of being told by the adolescent where to go and even ending up with a fat lip is high. As the years pass, you are no longer dealing with a child – you are dealing with someone who is bigger and stronger than you, and who thinks on a mental level similar to yours.

At the less serious end of the scale, how do you cope with an adolescent who continually wants money even though she has a fair and regular allowance? Or an adolescent who treats the house like a pigsty and expects everyone else to clean it up? How does one deal with an adolescent who uses abuse and physical threat to get his own way?
In these cases you might set limits on adolescent behaviour, and make consequences clear for broken limits, but the chance of success will depend on how much the adolescent has personally taken the importance of those consequences on board. For example, if the adolescent understands that treating the place like a pigsty while expecting everyone else to clean it up is disrespectful, then he or she will see that consequences for this behaviour will have a firm basis in fair play and personal rights. He or she will be more likely to accept them as being fair. In justice to the adolescent, this doesn’t begin half way through adolescence – it starts at childhood.

Do you therefore give up and leave home yourself?

By no means!

The aim of setting consequences is to help your son or daughter understand that behaviour will always have some outcome, both for self and others, and either for good or bad. The hope is that the adolescent will eventually learn to use consequence as a personal measure of his or her behaviour. That is, the adolescent chooses either to do or not to do something because of the consequences the behaviour will have on others as well as oneself. By imposing consequences on behaviour, you are helping that learning process to develop. The alternative is giving up your rights as a person and your responsibility as a parent.

Obviously, *how* consequences are set and enforced becomes an important issue. We will look at this issue now.

**1. How Consequences are Set is Important.**

Setting consequences is not the same as giving orders. A consequence is the outcome attached to the limits you impose on your adolescent’s activities or attitudes. A consequence is something you state as a condition of not maintaining those limits. They have no guilt or blame attached to them. They do not put either you or your adolescent down. The limits may be open to discussion, but once limits are set, the consequences too are set. Consequences are not open for discussion since loose consequences imply loose limits.

When consequences are treated in this way, the adolescent understands the outcome of the choice to either respect limits or defy them. If limits are
broken, then it needs to be made clear that the adolescent has chosen the consequences. You as the parent simply set the consequences in motion as a matter of course, and the adolescent agrees to them also as a matter of course, since limits can’t be accepted without the consequences attached to them. At all times, the adolescent is (and must always be) in charge of his or her personal behaviour. That cannot be anyone else’s responsibility. However, this sense of personal responsibility for limits and consequences presumes that the limits were fair in the first place.

2. How Consequences are Enforced is Important.

Consequences applied to limits must be enforceable. Consequences that cannot be enforced are useless. The following example will attempt to explain this.

This story focuses on a single mother with an adolescent 15 year-old son and two younger children. Being a working mother, her time was valuable. Home chores needed to be shared around, with little room for tolerating selfishness. For some time the mother had attempted to place limits on the adolescent’s activities, which he chose to ignore. He would come home when he felt like it, go where he wanted and with whom he wanted, without any reference to his mother. The situation went from bad to worse, and soon the younger children were starting to copy his behaviour. The mother attempted to discuss the conflict with her son who basically told her to mind her own business – he would run his own life, thanks, and don’t try to stop me! The size and age of the adolescent made it clear that ‘grounding’ him was out of the question, so another way had to be found around this increasingly difficult situation. Eventually the boy’s mother negotiated the son’s limits with a new deal. In short she stated: ‘I expect you to discuss with me where you are going and whom you are going out with. I also want you home by a certain time when you do go out. So far you haven’t done this, and now the others are starting to copy you. I still expect you to respect me in this. If you ignore me any further I will see this as your way of showing no respect for me or for your sisters. Therefore until your ways change, I will not be cooking you any further meals or washing any more of your clothes. Do you understand what I am saying?’
The 15 year-old did understand, but didn’t really care. The same behaviour continued, and his mother carried out what she stated would happen as a consequence. No further meals were cooked for him, and his clothes piled up in his room. He could handle the ‘meals’ side of things – toast, baked beans, McDonalds – it all provided a solution. The clothes however became a different story. A 15 year-old can only wear the same clothes for so long before either shame or disgust drives him to find a clean set – until that is, the clean clothes run out. The boy’s clothes had reached the stage where they were starting to walk around the house at night! Nonetheless, the mother sweated it out even though she felt as if she was rejecting her son.

Eventually he found himself in an extremely difficult situation. It was now a case of either squeeze into his younger sisters’ clothes or wear his mother’s clothes. Both options were out of the question. Nor was he going to spend his own money on a Laundromat or on new clothes! One Saturday morning he tried to wash his own clothes but had no idea how to work the washing machine and managed only to flood the laundry with soap until it looked like a ski resort. Not only did he have filthy clothes, he was now the not-so-proud owner of soggy filthy clothes!

At this point his mother offered to discuss the situation again with her son. Reluctantly he agreed, and after much effort they worked out a solution. He would not go out until he discussed this with his mother first, and he accepted that there would be times when his mother would put limits on what he did, and where he did it, although they would speak about this first. In return, his meals would be cooked again, and (since there was a wardrobe full of washing) the boy’s mother offered to help him wash his own clothes this time round, after which she would once more do his washing.

This story describes some basic points for enforcing consequences.

- It is not possible to physically force consequences on an adolescent. Physically enforcing consequences is not only an exercise in futility, it also places you and other family members in potential physical danger.

- However, it is just as destructive to ignore a continual breaking of limits by your adolescent.
Therefore choose a consequence that is going to have a personal effect on your son or daughter.

This consequence is one that you need to have personal control over. It is something that your son or daughter cannot force you to pull back from, in the same way as you could not force your original consequence on your son or daughter.

Note that when putting consequences into play (as with the story), a personal context is always used. There is no attempt to order your adolescent around, or threaten or force the issue. The parent simply states what he or she has chosen to do in response to clear and fair limits not being respected.

Furthermore, as a parent you cannot give in – you have to sweat things out, even if it means that you become personally inconvenienced in the process!

**Consequences include the Notion of Control.**

Consider the following flowchart…

It is important that you or members of your family are not controlled by the unpleasant consequences of your son or daughter’s behaviour. Keeping your own form of control over any unwanted consequences is like visiting the lion’s cage at the zoo. If you are outside the lion’s cage looking in, then you have the personal control to stay and look, leave and come back, or leave for good. You can even come and go through the turnstile as often as you like. That is, you are in control of your movements. But if you are with the lions on the inside looking out, then you too are caged in. You are caught up in
the growling and snarling, unable to escape being eaten. You cannot come and go as you like. You are at the mercy of the lions caged up with you.

This is similar to your power of choice when your adolescent defies your fair expectations. Even though you might not be able to enforce any consequences you have set, such as grounding your son or daughter for not respecting coming-home times, you can still stay in control. You don’t have to get into the cage and do battle with your son or daughter. Like the mother in the story, you stay in control by setting your own further consequences for the adolescent’s betrayal of limits and snubbing of consequences. This is like standing outside the lion’s cage looking in. You have the control and the right to make sure that your life is not being dominated and manipulated by an abusive or self-focused adolescent. By deciding to set and follow your own consequences in these situations, you are not deserting your son or daughter but rather you are respecting and protecting yourself and other members of your family. It can be intimidating for a parent when an adolescent is older, or stronger and bigger than the parent, especially when he or she challenges the parent to try and do something about it! Often the parent physically and emotionally cannot do something about it. These are the times when the parent does not step into the cage, but stays on the outside looking in. That is, it may not be possible to control the adolescent directly, but it is possible for the parent to control his or her response to the adolescent. The parent does not continue providing the adolescent with ‘services’ while the adolescent rejects the parent’s authority or rights, or the rights of other family members.

Limits and consequences demand fair play from both sides. Fair play by the parent means fairness in discussion and listening with the adolescent before making any final decisions. Fair play for the parent also means setting limits that are reasonable in their expectations. On the other hand, fair play for the adolescent means respecting not only the responsibility and therefore the right of the parent to set limits and expectations, but also the necessity that this responsibility must be exercised because the parent is responsible and accountable for the adolescent’s welfare.

What do you do if Things Spiral Down into Physical Violence?
In extreme cases you may be confronted with a situation where your son or daughter puts you and/or your family members, or
your property, under physical threat. Negotiating consequences or setting limits in these situations is out of the question. Personal safety is the main concern. Furthermore, your son or daughter may not be in personal control (he or she may be drunk or under the influence of drugs) and so rational discussion would be useless.

There is little choice here apart from either calling in the police or perhaps other people in authority who can take over the situation.

**HOWEVER**, you are taking this action not in order to remove your son or daughter, but to handle a problem that you cannot handle. This may sound like hair-splitting (especially if the police do remove your son or daughter). Yet it is essential to see the relationship with your son or daughter as being separate from the problem happening at that moment. That is, you love your son or daughter, but you are not prepared to let the violence he or she is creating continue unchecked. There is too much else at risk – yourself, other children, your property, your reputation, and so on.

Separating the individual from the problem (and therefore seeing your actions as dealing with a ‘problem’) means that the way is not blocked for future discussion with your adolescent to find a workable solution. This course of action might be all that is left open to you because you are not physically able to deal with it yourself, and your son or daughter is either not able, or unwilling, to allow a more peaceful way to happen.

An example would be something like the following…

“Parents have informed their adolescent son that they cannot give him a lift to his mate’s place to watch videos. He loses his temper. The father tries to calm him down, but this makes things worse. The son quickly loses control, and the swearing and yelling leads to him kicking holes in the wall”.

No one would expect these parents to stand by while their son kicks the house in. The only decision would be to get outside help, as in calling the police, even though this action may be repulsive to any parent. The first priority here is personal safety and protection of others and property – the reason why the police are being called.
NETWORKING

Monitoring and networking also go together. Imagine owning a large paddock, surrounded by a fence. In order to keep your livestock inside the paddock, as well as make sure the livestock is safely under your watchful attention, you need to know how solid the fence is. It’s too late to fix the fence after the livestock has escaped.

To check on the fence, you can do one of two things…

**EITHER** you can run around the paddock checking the fence yourself. This can be tiring and not very efficient. As time goes by you will probably just give a quick glance to see that everything is more or less OK and so miss the gaps.

**OR** you can look for people you trust to help you check on the fence.

This is **NETWORKING**. When you network you involve people you trust in your efforts to keep harm at a minimum for your adolescent. A network approach to monitoring an adolescent’s activities usually focuses on the parents of the adolescent’s friends. This is one way of learning about the parents of your child’s friends. A network can begin with a one-off monitoring experience like the following…

(Parent on phone to parent of a friend): “Hello, I’m Craig’s mum. Craig tells me there is a party at your place next Saturday night, and I was wondering if I could ask you a few questions about it...”

The network can then continue with parents arranging to keep in touch with each other over the various activities that include all their adolescent children. That is, over time parents get to know more about each other’s expectations and values, as well as having more frequent contact with each other.
A more structured form of networking might include…

✓ If a group of adolescent friends are getting together for a nighttime party, then the parents of those adolescents contact each other and work out the limits. They will ask questions such as what time will it start and finish, what they can or can’t bring, who is going to be there and be responsible for their safety, transport home, and so on.

✓ If you do not have information about something that relates to your son or daughter, then you can contact one of your ‘network group’ who might know.

Positive results arise from network groups…

✓ Parents of friendship groups work with each other to provide safe opportunities for their adolescents to get together.

✓ Parents arrange with each other to pick up each other’s sons or daughters after an activity.

✓ Parents trust each other with their contact information – home and work numbers, mobile phone numbers, and so on.

✓ Parents know and respect each other’s expectations for their own children.

For networking to work, very simple things only are needed…

1. Parents need to be willing to make the time to set up a network coalition with others. People in the network coalition can be other parents, organizations, groups, whatever. They are people or organizations that are connected with your adolescent in some way, and who care about the safety of your child in the same way as you care.

2. Those who are part of the network need to be committed to the welfare and safety of both their own children and the
children of others. This is a shared level of responsibility, not a dumping of responsibility onto someone else.

3. **In order to work, a network must be put to work.** It is no good having a parent network if a party happens and the majority of parents in the network have no idea about what is going on.

4. **Particularly for parents in a network situation, there must be trust amongst those involved.** One parent needs to know that his or her son or daughter will be safe in the care of another parent. If a parent says that a party is going to be drug and alcohol free, then parents need to feel sure that there will be ways of making sure that drugs or alcohol will not be present.

5. **There is also a need for a good level of trust between parent and adolescent.** Parent networks need to be seen as a normal part of deciding what an adolescent can and cannot do. That is, the adolescent accepts that the parent’s ringing around is a normal part of going somewhere or doing something.

**IN CONCLUSION**

All in all, monitoring, limit setting, and networking are all part of the overall approach to making sure that wherever your adolescent goes, and whatever activity he or she takes part in, you as the parent have made every effort to keep your child as safe as realistically possible.
1. Think about and respond to this flowchart (write your answers down on paper)...

1. CONSIDER THREE GROUPS: 12-13.9 yrs  14-15.9 yrs  16 yrs to adulthood

2. WHAT INFORMATION WOULD YOU WANT BEFORE MAKING A DECISION? [MONITORING AND NETWORKING]

3. WHAT LIMITS WOULD YOU SET?

4. WHAT CONSEQUENCES WOULD BE IN PLACE FOR BROKEN LIMITS?

5. DO THE THREE INDIVIDUAL AGE GROUPS REQUIRE SPECIAL CONSIDERATION, AND IF SO, WHAT?
2. How much do you know about your adolescent’s closest friends and their parents? Jot down what you know in the spaces below…

The names of your adolescent’s closest friends are:________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

The parents of your adolescent’s closest friends are:________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Pick out your adolescent’s closest friend – write down what you know about this person (likes, dislikes; what this person does, thinks, believes, the type of people this person mixes with, and so on):________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Now do the same with the parents of this closest friend:______________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

You might have had trouble answering these questions. However, they are important questions, because these friends (especially the closest friends) will be the people your son or daughter will probably spend a lot of free time away from home with. As has been stressed earlier in this and other chapters, there is no alternative to obtaining this type of information.
THINKING YOUR WAY TO CHANGE: LOOK AFTER OTHERS BY LOOKING AFTER YOURSELF!
THINKING YOUR WAY TO CHANGE

Epicletus, an early Greek philosopher, proclaimed that we are affected by events in life because of the way we think about them, not because of the events themselves. The majority of this chapter will therefore be devoted to the way we think, and how helpful thinking can lead to better feeling and better decision making (and therefore a happier life).

Can you Remember when you Signed on the Dotted Line to be a Parent?

Being a parent is a most difficult job – if not the most difficult job! Most parents normally find themselves employed for this role before they have had time to think about what the role is going to mean – both in the short and the long term!

Nor do your children come along with a warranty attached to them – for example, ‘if this product is found to be faulty, return it to the manufacturer within the first five years for repair or replacement’.

This does not mean that you do not love your children! It does mean that you can be taken by surprise by your adolescent when you least expect it, or that the wheels suddenly fall off when you think you have everything down to a fine art. Nor is it a case of ‘what you see is what you get’. That small infant has grown into a young child, and that young child has grown into something as tall as you are! Therefore coping with change is a very large part of being a parent – not just change in your child, but change in yourself, particularly in the way you think.
SUCCESS STARTS WITH BELIEVING YOU ARE WORTHWHILE, AND BELIEVING THAT YOU ARE WORTHWHILE STARTS WITH THINKING THAT YOU ARE WORTHWHILE!

Self-care is a wide area of discussion. Whole books are devoted to the subject! All we can do in this chapter is look at a few main issues that are essential for self-care.

The beginning of self-care is always found in THINKING. The way we think about people, events, and ourselves can have an amazing effect on how we feel about people, events, and ourselves. If someone thinks hard and long enough that he or she is hopeless at doing something, then eventually that person will believe that this is totally true, even if all the evidence points in the opposite direction.

I went right through school to Year 11 believing that I was hopeless at maths. As a desperate effort my parents found me a tutor in Year 11 to get me through HSC maths. That tutor was the first person to ever tell me that I had a natural ability for maths! By that time of course, the belief that I was a hopeless mathematician was so deeply buried that it was impossible to completely turn it around. However, the belief of just one person that things could be different was enough to get me through HSC maths relatively unscathed (though I’ll never be a rocket scientist!)

We are thinkers…

Our thinking lies at the bottom of everything we say and do. Our thinking steers the way we think about ourselves. Our thinking steers the way we think about others. Our thinking can support and encourage us, or create problems for us.

If we are going to talk about caring about ourselves, then we must start with our thinking!

The typical thinking cycle…

As well as thinking about ordinary, mundane situations and objects, thinking can also happen in a cyclic pattern. The ordinary level of thinking (‘will I have tea or coffee for breakfast?’) is mostly very quick and
‘one-off’. Cyclic thinking, on the other hand, occurs in stages, with each stage being linked to the previous and the next stage. These stages can also happen quickly. We will call this particular process of thought the ‘thinking cycle’, and in this case it will be a negative thinking cycle.

- The typical thinking cycle always starts with a stimulus that works like a TRIGGER. That is, something SETS THE THINKING OFF – a word, a request, an action or reaction, whatever.

- The trigger then sets off a series of FEELINGS inside us. These feelings can happen automatically, and are like Franz’ multiplying mops. Even though there was a ‘first time’ for a particular feeling, continual repetition of triggers leads to continually intensifying ‘feeling’ reactions.

- In the negative cycle, the person REACTS rather than responds to these feelings. This reaction will have very little reason behind it. It is usually a white flash of flame that devours everything in its path. The reaction happens because the feelings say that what you THINK is happening is FACT. Even though this belief might be faulty, it is a fact to the person who is thinking about the event.

- Because the cycle so far has been a negative experience, then a negative outcome is expected. That is, the person ends up EXPECTING a negative outcome because that is how the cycle of thinking has been viewed so far. In addition, that is how it has always been in the past! It’s almost as if the person is just waiting for the inevitable to happen!

- The expectation is fulfilled. It’s as if there is an underlying little voice that says over and over ‘See, I told you that it was going to happen this way!’

  If you expect something to happen, and it does happen, then this strengthens the belief that you were right all along to expect the outcome that occurred.

In relation to our thinking cycle, this means that when a similar trigger occurs next time, the entire cycle also repeats itself. The only difference will be that on this occasion, and on any following occasion, it becomes more intense in its negativity. The repeated negative thinking cycle has become
the fuel that drives the whole machinery towards the expected negative outcome.

It is called a **CYCLE** because this type of thinking goes round and round in circles. It ends up getting a life of its own, and the longer it repeats itself the harder it is to change.

On the next page is a diagram that describes this cycle in a ‘round and round’ fashion. Compare this diagram with what has been written above. Ask yourself a simple question…

| If you were going to change this way of thinking, where would you break the cycle? |

[Diagram of a perplexed person with exclamation marks]
If you said you would break the cycle at the THINKING STAGE, you would be 100% correct. The way we THINK about things has an extremely powerful effect on where we go from there.
How the Trigger Relates to our Thinking.

The word TRIGGER is a good analogy for describing what goes on here! When you press the trigger of a gun, the hammer drops onto the primer of the cartridge case, the gunpowder is ignited, the pressure builds up in the case, and the bullet is punched down and out the barrel. It all happens in a split second, but once the trigger is pressed everything is set in motion and there is no way of getting the bullet back. It is also a poor analogy, since it can become possible to reverse the potentially damaging reaction due to our thinking. More about that later!

As we said earlier, when someone ‘triggers off’ a negative response in us it is our thinking about that trigger that begins a downward spiral in our words and actions that follow. Our thinking drops the hammer onto the primer and sets the whole operation into action. What is needed is something that slows the process down, and has the power to stop the hammer falling and firing off words and actions we most likely will regret later.

Let’s look at examples of some negative thinking reactions to triggers (notice the ‘YOU’ messages in the triggers!)…

<table>
<thead>
<tr>
<th>TRIGGER</th>
<th>THINKING REACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yeah, whatever...</td>
<td>That’s right – he won’t do it: he has no intention of helping me!</td>
</tr>
<tr>
<td>You always...</td>
<td>She never listens – I don’t know why I bother asking!</td>
</tr>
<tr>
<td>Wait a sec – I’m busy!</td>
<td>If this isn’t important enough to come now then you can go take a running jump!</td>
</tr>
<tr>
<td>You will do exactly as I...</td>
<td>I’m being treated like a little kid! If you think I’m going to put up with this, think again…who do you think you are anyway? So cop this!</td>
</tr>
<tr>
<td>If only you were...</td>
<td>Here we go again – he doesn’t trust me – he never has: so why bother?</td>
</tr>
<tr>
<td>NOW what do you want!</td>
<td>I’m just a nuisance round this place – no-one cares about me!</td>
</tr>
</tbody>
</table>
Let’s take one example from this box…

TRIGGER: ‘Wait a sec – I’m busy!’
THINKING REACTION: ‘If this isn’t important enough to come now then you can take a running jump!’

Whether the trigger is negative or simply one way of answering (even though it might have been said better!) is beside the point. The thinking about this trigger is the important part. This thinking reaction is saying things like…

‘You have no respect for me!’
‘What I want is important, not what you want’
‘I’m just the lackey around here, waiting on your convenience!’

Now lets put a pause between the thoughts and the words…

Thinks: ‘He’s never organised!’ (Pause)
Says: ‘I’ll wait, but not for long’

Thinks: ‘Here we go again – what’s he lost now?’ (Pause)
Says: ‘I’d better give you a hand otherwise we’ll never get there’

The feelings of frustration or anger might still be there, and the automatic reaction to these feelings might still rise up. However, by taking a few moments to think about our response means that a better response happens.

Favourite words and phrases…

The sort of thinking that leads to ‘lash-out’ type reactions is usually built on certain words or phrases, and these words or phrases are like strong glue that makes unhelpful thinking difficult to shift and change. The list below describes some of the old favourites in unhelpful thinking. Put a circle around any that you think reflect your favourites!
Old favourites for unhelpful thinking…

<table>
<thead>
<tr>
<th>He must…</th>
<th>I’ll bet she…</th>
<th>That makes me…</th>
</tr>
</thead>
<tbody>
<tr>
<td>I should…</td>
<td>I guess…</td>
<td>It’s my entire fault…</td>
</tr>
<tr>
<td>Nothing helps…</td>
<td>I’ll never…</td>
<td>If only… (a ‘biggie’!)</td>
</tr>
</tbody>
</table>

**Automatic Thinking.**

Unhelpful phrases like those in the box above can become so much a part of our everyday language and experience that we stop being aware of them. These phrases represent our thinking and become automatic. That is, words (and ideas) pop into our heads without any invitation or effort on our part, and bring with them feelings of unhappiness, anger, frustration, helplessness, and so forth. Automatic thoughts are like gatecrashers at a party – the thoughts aren’t wanted there, they create havoc, and the feelings they bring with them are hard to get rid of! Notice the link between the automatic phrases and the automatic thinking in the following…

‘He must think I’m an idiot – I’m not going to hang around here all day!’

‘Now he’s missed out on going to the movies with his friends – it’s all my fault as usual’.

‘The way she carries on – she makes me react like that: it’s all her fault!’

Over time it is possible to learn to instantly put automatic thoughts together with the unpleasant or negative feelings we have about people or situations. They become instant summaries of our beliefs, opinions, guilt, self-blame, and so on. They represent a response that has already been unconsciously made even before we open our mouths to speak.

Obviously, as our thinking and speaking becomes more automatic, so too does it become more difficult to break out of it. The words are out in the open before we know about it. Nonetheless, if reactions are going to become responses, then new thinking needs to help this happen. One place to start is by realizing that we mentally, and even unconsciously at times, filter out
information that comes to us from people or events. In so doing we look for possible pit-falls in what is being said and done.

**The Mental Filter.**

We all have a mental filter that carefully checks out the information we receive from people or situations. This filter is an important accessory to our thinking and feeling. It allows us to feel confident that what we are being told, or shown, or asked to do, is not going to be unpleasant or harm us in some way. The more we trust people or situations, the less work this filter has.

At times the mental filter will be hard at work. This will happen when we do not trust people or situations, or feel uneasy about them in some way. It will also happen when we feel confronted, or put at risk. At times like these the filter will tell us to put up our defence shields.

Our mental filter can also filter out too much information, and find problems that do not exist or insert information that is not there. At these times it is operating far above the normal range.

**Core Beliefs and the Mental Filter**

Is thinking and believing the same thing? Possibly and possibly not! When I think about something, I weigh up the evidence so that the conclusion becomes the resulting belief about the thought-out situation. Therefore, we will refer to thinking and beliefs as being separate yet linked entities. From this perspective, our thoughts and beliefs adjust the working level of the mental filter. When the sensitivity of the filter is turned way past normal it is most likely that our thinking and belief system is out of tune. This means that we are too much on our guard – we are expecting hurtful responses where probably no hurt was intended. We can end up reading incorrect information into what we see, hear, and feel, yet we act on the information as if it was true.

When we speak of a ‘belief system’ we mean the intermingling of beliefs that have been put together over time, and have been born of past positive and negative thinking. A **core belief** is the most basic belief that lies
underneath what we think we believe and believe we think about people and life’s situations. The core belief is the main fuelling point for the entire daily thinking and believing that comes from it. It might look something like this flowchart…

All the thinking and resultant believing in the boxes above the core belief is basically negative. Furthermore, while this thinking and believing has been adapted for every situation, there is a common theme running through each response, namely: “I have been born on this planet only to serve other peoples’ convenience”. This entire system is represented by the one basic negative core belief: “I’m a loser!”

It is possible that this negative core belief lies so far at the bottom of the pile that the person is not even aware of it. Yet the core belief will colour any
thinking about people or situations that is seen as a threat. This thinking can also be upsetting and confusing: ‘Why do I think like that? Why am I angry all the time? Why am I depressed all the time? Why can’t I cope?’ In order to change this thinking and its conclusive beliefs, as well as the associated distressing feeling, it is essential to dig down and find the core belief. We get to our core belief by considering some serious reality checks about what our thinking is really saying. For example…

**THINKS:** If I wasn’t so weak I could stand up for myself – but what’s the use? They’d only laugh and tell me to get on with it!

**ARGUES:**
Who says I’m weak? Weak about what? If I were all that weak I wouldn’t have lasted so long! OK – I haven’t stood up for myself as much as I’ve wanted. But this lot would make Attila the Hun cringe! I can understand why I feel afraid about defending myself! They would laugh at me – ‘what’s the old hag think she’s up to? Who does she think she is? Come on! Get those hands into the sink! There’s work to be done here!’ But I’m worthy of respect and love, and I’m not getting it! I think it’s time to make a stand – and I’ll make it a good one!

**BUT BEWARE:** There is no magic formula here. A person isn’t going to leap up and suddenly discover his or her core belief from just one or two soul-searchers like the one above. On the other hand, if a person takes every opportunity to seriously consider the stark truth about his or her thinking, then eventually the core belief will come to light. Over time the person will think: ‘I’ve been treated as if I’m worth nothing around here. And I let them get away with it because I thought I wasn’t worth very much anyway. But now I want that to change’.

**Name What’s Going on in Your Thinking.**

For some people, unhelpful personal thinking and believing can have their beginnings from childhood. If a person believes that she is useless and can’t get anything right in life, it is possible that as a child she was told over and over that she was a hopeless kid. Any failure meant being hopeless, and this conclusive belief grew along with the person into adulthood.
Negative personal thinking and believing can also come about from being continually abused to a point where the person has lost any ability to cope, and yet must still deal with the abusive situation. A parent who is treated shabbily by his or her family and yet is always expected to be there can be in this situation. Eventually the person will come to believe that the only value he or she has is being useful for the wants of others, and so hold little personal value.

In one sense it is not essential to go back and find the roots of these beliefs. It is also unwise to do so without professional help because once you dig something up that has been buried in the past it is essential to know how to deal with it. However, it is possible to work with what is happening now in one’s thinking by checking out how much this thinking might be distorted. We will therefore look at common ways of distorting our thinking. Distorted thinking means that what we think is going on is not really what is going on.

Distorted Thinking Checklist.

1. Catastrophizing:

   This name says it all – everything is a complete catastrophe! Nothing will help to make the situation better. The wheels have completely fallen off!

   For example…
   Imagine you are the mother of a teenage daughter. You have just checked your phone messages. One of them is asking you to come to the school tomorrow and meet with the principal. You go cold and automatically presume that your daughter is in trouble again. Last week she was caught up in fights on the school bus, and now you are sure that this meeting tomorrow is about more of the same. You think to yourself:

   ‘That kid! I can’t cope anymore! She is always in trouble at that school! She is going to get kicked out of that school – I just know it! The principal will give her a bad report – she’s going to end up being banned from every school in the State! I’m going
to have her home here for the rest of my life! We’re just going to have to pack up and move house – go to another state – Jim will have to quit his job and try and get another one! All because of that damned kid!!’

Can you see how the whole situation has reached catastrophic proportions? It’s all over and done with, and the meeting hasn’t happened yet! This meeting might have nothing to do with the daughter. It might be something as simple as a canteen roster! But already this mother has blamed the daughter, moved house, made her husband quit his job, and who knows what else, all on the basis of what she thinks is undoubtedly the reason for the meeting!

A healthier approach might be…

‘I wonder what this is all about! I hope Karen isn’t in trouble again. That’s the last thing I want! Well, I guess I’ll just have to wait and see what the principal wants!’

This approach is called De-catastrophising. It simply means defusing the bomb before it goes off. Catastrophic thinking usually leads to feeling panicky and out of control. De-catastrophising leads to bringing the whole situation back into reality. That is, there are many reasons why the principal might want a meeting. At the moment, you just don’t know why! So all you can do is wait and find out, even if you still feel anxious about it. Of course, things can reach catastrophic proportions at times! Some events in life do end up being a catastrophe. However, the idea is not to make catastrophes out of situations before the facts about what is happening are known.

2. Over-Generalising:

Over-generalising means that thinking is made up of wide, sweeping statements that are based only on very little evidence, or even on no evidence at all. Everything becomes black and white, and other possibilities are written off.

Father: ‘I look at all his friends and all I can think is “what a pack of dropkicks”! Bill told me they were hanging around his workshop the other day. I’ll bet they were waiting to knock the
place off! There’s nothing good about them – they’re nothing but trouble. I know everything they do spells trouble!’

Words like ‘everything’, ‘nothing’, ‘nothing but’, ‘I’ll bet’, are usually linked to sweeping statements that cry out for evidence. A person listening could make comments such as: ‘Surely there is something good about them!’ ‘Are these kids really so bad that everything they do spells trouble? Calling them “dropkicks” is pretty strong stuff!’

A healthier approach might be…

Father: ‘I look at his friends and worry! Bill saw them hanging around his workshop the other day. I can’t help thinking that they were waiting to knock the place off. There is something about them I don’t like! I’m worried he’s going to end up in trouble if he hangs around with them! We’re going to have to talk about this!

Again this response deals with the evidence. The father is worried, and he knows what he’s worried about. He has one piece of knowledge from Bill, namely that they were hanging around the workshop. However, this is not hard evidence that they were planning to steal from the workshop. Therefore the answer lies in getting the facts, and he will do this by first speaking with his son.

Over-generalized thinking can also lead to catastrophic thinking.

We will call the father’s second response a **Single Event Challenge**. He is not allowing his thinking to run over the hill on the basis of one piece of knowledge.

3. **Permanently set in concrete:**

   With this type of thinking, nothing changes! It’s always been that way, it is now, and so therefore it is always going to be that way!

   ‘All we ever do is fight! It’s always been that way. I say something and all he does is tell me where to go! There’s no use in trying. Things will never change!’
Words like ‘always’, ‘never’, ‘no use’, ‘why bother?’ point to thinking that is permanently set in concrete. People who think this way have already written off any possibility of change taking place because they are controlled by the past. The past has set the mould for the future, and the future will never be different. The mould can never be broken.

A healthier approach might be…

‘It seems like all we ever do is fight! Yet there have been times when he’s been a real support around the place! Things turned out differently then! I know we can work on this!’

It seems like the only way of life is fighting but the evidence also points in another direction. The answer lies in believing that the relationship can be different because at least some past evidence has said so. On the basis of these shreds of evidence, the parent can start working at making these better occasions the basis for a usual way of relating to each other.

The argument against permanently set thinking comes from asking the question: “Where is the evidence?” Where is the evidence that it has always been like this? Where is the evidence that things can never change?

4. SHOULD and MUST thinking:

We have already spoken about this type of thinking. When people condemn themselves to the harmful expectations of ‘you should’ or ‘you must’ they place others’ unfair burdens on themselves. Harmful statements containing SHOULD and MUST demand that you must match up to the global expectations of some person or ideal regardless of whether these are right or possible for you. Should and must can be words that take away your right to make your own decisions about your life and your responsibilities.

‘Everyone says I should do more to keep that kid in line! I guess they’re right. After all, it’s my responsibility as her mother – I must realize that!’

The opposite might be: ‘I’ll try it this way, and see if it works! I can only do my best!’
5 ‘You made me’:

This type of thinking shifts responsibility for an unwanted outcome away from you onto someone or something else.

Mother thinks: ‘I’m not to blame me for the way things have turned out! After all, she’s the one who made me lose my temper!’

Another response might be…

‘Things haven’t turned out too well. I guess we both had something to do with that!’

The simple use of the words ‘I choose’ can level out the playing field of responsibility. Accepting responsibility for the way something turns out does not mean laying total blame at someone’s feet. Rather, using ‘I choose’ means that the people who are involved in the poor outcome are willing to accept this outcome without resorting to blame or guilt as the solution (remember the skill of conflict resolution here!). A willingness to share responsibility for poor outcome places all people concerned in the position to work out a solution together.

6. Mind Reading:

Mind reading means what it says. Mind reading presumes that someone knows what another person is thinking or planning without first checking out the facts with that person.

‘I know that look! I’ll bet he thinks I’m a real dragon! Well, he’s going to learn who’s boss around here – the hard way!’

Words like I’ll bet’, ‘I reckon’, or self-talk that interprets another person’s look or tone of voice without checking this out with that person, lead to mind reading. Any decisions that follow on the heels of mind reading usually end up in disaster because they presume that their interpretation of what is seen or felt equals fact when this might not necessarily be so.
Another approach might be...

Thinks: ‘There’s that look again!’
Says: ‘You look as if you think I’m being unfair. Is that true?’

7. **All or nothing thinking:**

This is a type of perfectionist approach to thinking. **If something is not 100% right, then it is 100% wrong.** Because one particular aspect of an entire situation has gone wrong, therefore *everything* is wrong. Something is either a total success or an absolute failure. No flexibility is allowed with this thinking. There is no room for weakness or improvement.

‘He didn’t post that letter like I asked him. He knew how important that was! He is totally irresponsible – he can’t be trusted with anything!’

There is no attempt to wonder why the letter wasn’t posted, or to think that this was simple forgetfulness even if the job was important. All or nothing thinking leads from this one forgetful act right across to total irresponsibility – in one swift movement! It is rare that a 100% hit rate is ever possible. Mostly we need to be satisfied with less than perfect, and enjoy that much!

8. **Selective attending:**

With this thinking, a person focuses on the negative only and ignores any positive parts that might have been there as well. A person who is ‘selectively attending’ in his or her thinking will generally come up with all the horrible things that happened and will totally ignore the encouraging things. For example…

‘All I wanted was to make his birthday party a success. But the icing on his cake went soft! The whole thing was a complete failure!’

You could ask how a *complete failure* could arise out of a simple and relatively small thing like the icing going soft on the birthday cake! Selective attending is similar to all or nothing thinking (and even similar to catastrophising). That is, the parent has ignored all the successes that
happened during the party and has only focused on one event that was really something very minor. A serious problem with selective attending is rumination. Rumination would happen here if the parent went away and continually turned the melted icing over in his or her head until it did reach catastrophic proportions. Rumination needs a response like: “Stop! I’m being ridiculous! Forget the icing”.

Therefore, a healthier approach might be…

‘Great party! Shame about the icing!’

9. ‘Beat me! Beat me!’:

With this type of thinking, people beat themselves up whenever anything goes wrong. The fault is totally theirs; they are a complete write-off. This thinking usually contains words such as:

‘It’s always my fault!’
‘I’m a complete fool!’
‘No-one will ever come near me again after that – and can you blame them?’

At it’s very worst, the idea behind this thinking is: ‘Beat me, beat me, I am but scum!’

A fairer way of thinking is to accept responsibility as far as it was one’s own responsibility, and to let others take their fair share of responsibility. If a mistake is happening over and over again, and making life miserable for people, then the answer lies in doing something constructive to change it. There is no future in beating yourself up!

**Why work on Distorted Thinking?**

It is most likely that if your thinking is distorted then your view of the world and people will also be distorted in some way. When your thinking about a person or situation is bent out of shape and doesn’t give you the true picture, it is possible to end up feeling depressed, resentful, hopeless, helpless, and so on.
There are two necessary steps to changing distorted thinking…

**CATCH YOURSELF OUT:**
Be on the look out for distorted thinking. Be able to recognize it as being distorted and be able to identify how it is distorted. The nine examples of distorted thinking you have just read about are the most basic ways in which thinking can be bent out of shape.

**DON’T JUST SIT BACK AND PUT UP WITH IT:**
Changing your distorted thinking can be extremely difficult especially when it has become the usual way of thinking. But it will only change with practice. The alternative is putting up with the distorted thinking and the misery it causes.

**NAME IT  CHANGE IT  PRACTISE IT**

One simple way of teaching yourself to change unwanted thinking is to talk to yourself whenever the unwanted thinking starts to happen, perhaps with a statement like this…

**Keep it or ditch it?**

The self-talk statement you end up using can be anything at all. It only needs to make sense to you, not to anyone else. Using your statement is a message to you that your thinking is about to cause you or someone else problems if it goes from thought to word.

At the start of the change process, self-talk might happen when the thinking is over and the words have already been spoken! This can be disappointing. However, with practice your thinking will gradually turn around the other way! It is important not to give up trying to change it.

The way we think can also be affected by the way we treat ourselves. Our thinking can also be weakened by the personal demands we put on ourselves. In the following section we will look at some areas of self-care that are related to the usefulness of our thinking.
LIFE IS NOT A DRESS REHEARSAL

Sadly many people live life as if it was a rehearsal for the real thing. They pay little or no attention to the fact that the years are passing by and they can’t be brought back again. The present moment is there to be enjoyed and not tossed aside as if it doesn’t matter. Therefore, consider the following points…

The offer of your best is all you can offer…

All you can do at any one time is the best you have to offer at that time. Sometimes this will be marvellous, and at other times it will be pretty terrible. The idea is to aim for a ‘general best’ – not perfection at all times.

This fits in with healthy thinking. At times you will try and miss, yet all you can do is learn from the result and move onto the next step in life. Unhealthy thinking means that you are moving your feet but getting nowhere in life. Unhealthy thinking pins you down to the one spot and doesn’t let you move on.

Being responsible has its limits…

What is your responsibility as someone who has the role of being a parent to an adolescent? Each person needs to work out the finer points of this responsibility for him or herself. While these finer points will rely on each individual situation, there are some basic standards that need to be considered…

Firstly, people CHOOSE to be responsible, either directly (I will take responsibility for…) or indirectly (I choose to have children, therefore I accept the responsibility of caring for my children). For responsibility to be respected, it needs to be the result of one’s choice. Responsibility can’t be forced on anyone.

Secondly, however, people have the right to know what they are getting themselves into. For some people, this freedom of choice can be fuzzy around the edges because of the circumstances in which the choice was made. Inexperience, outside pressures, unrealistic hopes and dreams, sheer bad luck, being dumped by another person who shared the choice (and so
shared the responsibility), are just some of the circumstances that affect how free the choice really was. Therefore responsibility is not a black and white issue, and needs to take into account points such as the following…

✓ Carrying out one’s responsibility is going to be harder for some people than for others.

✓ This doesn’t mean that it’s OK to toss the responsibility aside. It does mean that people who are faced with obstacles such as being a single parent, having little money, having little outside help, are going to find responsibility a tougher job than someone faced with fewer obstacles.

✓ When the responsibility that comes with being a parent is tougher than it should be, then understanding and support is needed. Guilt, blame, and rejection is certainly not needed.

✓ If some people find it harder than others to carry out their responsibility (regardless of why this might be so) then there will be a higher possibility of things going haywire. This is especially so for people in the role of parent. If being a parent is an ongoing uphill battle then there is a greater chance that things will go wrong for both the parent and the adolescent.

✓ Sadly, parents who have difficulty in the parent role, and whose children go off the rails from time to time, do experience a response from others of guilt, blame, and rejection (which they don’t need) instead of help and support (which they do need!).

✓ What is even more alarming is that parents who feel that parenting is tougher than wading through treacle, and who find that their children do go off the rails on a regular basis, often give up on themselves because others have given up on them.

The right kind of thinking is necessary for any person in the parent role. You can only give of your best at any one time, and you can only work with the resources you have, not the resources you wished you had.
There is a flip side to tough responsibilities…

The words above do not give permission to find a lonely corner somewhere and drift off into the oblivion of self-pity. Tough going in parenting can be made easier by…

✓ Taking opportunities to use available resources in more helpful ways
✓ Using support offered by people or agencies
✓ Developing new skills and building on old skills
✓ Being realistic about what responsibility means in practice. You might want a family like the Brady Bunch [though who would?!] but this is your family, and here is where your responsibility is carried out.
✓ Doing your best at any one time with what you have, and being content with your best. If you want it to be better, then find a way to make this happen. Let it become a personal goal for you.
✓ You’re doing the TANDEM-parenting course, aren’t you???

Self-Care

Now, before everyone rushes off for the tissues to dab the tears, let’s remain hardheaded about this! Parental responsibility is one of the most demanding responsibilities on planet Earth. It also ranks among the most highly accountable of responsibilities because it involves children who in their younger years especially are very dependent upon those who care for them. Children have a right to support, and the best approach is to help their parents and family provide this support. No agency or other individual can replace parents or family, no matter how kind hearted other people or agencies might be.

Therefore the person who has the role of parent also has the equal responsibility of finding and taking every opportunity to carry out this role as well as possible. Among the most important of these responsibilities is that of self-care. If you as a parent go under because you have not been taking care of yourself, then who will care for those you love? The following
suggestions are some pointers towards self-care, but they do not represent an exhaustive list. Think about them, but if at all possible, add to them! Keep in mind that it is difficult to shape self-care suggestions so that ‘one size fits all’. Certain suggestions will work in some families, while others will not. Therefore weigh each suggestion against the characteristics of your own family.

**MAKE TIME FOR YOURSELF**

When was the last time you…

- Spent some money on something just for you?
- Went out somewhere and did what you wanted to do?
- Bought something new to wear?
- Told everyone to disappear and took some time out?
- Watched your own TV show?
- Listened to your own music?
- Have someone else cook a meal for you?
- Were taken out to dinner (no matter how humble)?

The list could go way past this. The fundamental question asks how much time, energy, and resource you put into looking after yourself.

It is not unusual for parents to continually put themselves in second place for the sake of other people in their family, as if their own needs didn’t really matter. You can only do this for so long before you start to feel phased out, start to get that glazed look about you, and begin to feel slightly crazed about people and things around you. Let’s call it the

**PHASED GLAZED CRAZED SYNDROME.**

This doesn’t mean rushing out and filling the wardrobe with designer clothes, eating at exotic restaurants, and buying anything you set your eyes on while the rest of the household goes down to gurgler. It does mean taking a balanced view to meeting your own needs. That is, if you are prepared to dedicate 100% effort to your family, then be prepared to dedicate 100% to yourself as well. What form this 100% takes will be different for every situation.
EXPECT PROBLEMS TO HAPPEN

The wheels will fall off from time to time, and it’s a wise person who not only expects this but also has a ‘Plan B’ that he or she can call on when it does happen. When this happens, follow the process of finding a solution that keeps you in control. Work with (not against) those who are involved, and see ‘the problem’ as something ‘out there’ to be solved. This is a simple and effective ‘Plan B’.

Do not forget that there will be days when you want the world to take a running jump; when people can do what they like; when you will want nothing to do with the traumas and dramas of peoples’ lives. On days like these your energy levels will be low and you simply won’t be able to get up enough oomph to take the world on. Balance means that if you have great days then you will also have lousy days! On lousy days like these, consider retreat from hassles and dramas a real possibility!

BEATING YOURSELF UP HURTS

When the wheels fall off, avoid the temptation to beat yourself up with thinking that puts you in the spotlight of blame and incompetence. Any person who has been around long enough has known times when all the lines of life intersect at the worst possible point.

Deal with this as well as you can with what you’ve got at that moment. If you need help, then find whatever support you can, and aim for the best solution not the perfect solution.

Beating yourself up by telling yourself what a dreadful, useless, uncaring person you are does little else but waste time and energy.

IT’S HARD ENOUGH LIVING YOUR OWN LIFE!

Being responsible for your son or daughter does not mean having to live their lives for them. In fact, this would be most unacceptable. You can offer what you have in terms of personal formation, and genuinely help them live lives that are fruitful and not harmful. In their younger years you will naturally be on the lookout for your children so that they won’t get themselves into a sticky mess that will bring the sort of harm or distress they
can’t handle alone. There will come a time when they must head off and be responsible for the choices they make in life. Until then, your job is only to prepare your child to move through childhood and adolescence to a point where he or she can live responsibly as an adult, not to live life for your child.

AVOID THE TRAP OF COMPARISONS

The people who make up your family are the people you have thrown your lot in with, regardless of how good or bad things might get. First and foremost, they are ‘your family’. The value of your family is not worked out according to how well it shapes up against some other family. No one has the right to put a value judgment on your family. No one has the right to place a value judgment on you or your efforts as a parent, on your life-style, or on any member of your family. The ‘Brady Bunch’ starts and ends with the TV set!

We might end with a statement that you can use for encouragement when you feel as if you’re at the bottom of the pile -

DEMAND WHAT YOU’RE WORTH!

Some Activities

Watch another VIDEO!

There is a movie called “The Never Ending Story”. At first appearance it looks like a kid’s movie. However, while it appeals to younger people it also has a very powerful message for adults. It is the story of a small boy who does not mix in with his peers, and who has lost the ability to believe in
himself. It is also the story of the world of fantasy that is crumbling away because people have forgotten to dream and imagine. Don’t miss it!

What is your SCRIPT FOR LIFE?

It is very healthy to be able to write down our personal script. This script is the story we act out on a regular basis. It describes how we usually respond to people, to ourselves, and to situations that happen around us. It can be positive, negative, or a mixture of both (and never perfect!).

This is not an invitation to put yourself down (hopefully by now this is not an issue!). Rather, it is an opportunity to view in a concrete writing format your style of mixing in the world, and then to decide what you like and don’t like about it; what you want to keep, and what you want to change.

It usually begins with:

‘I am the sort of person who…’

On a separate sheet of paper that you can keep in a confidential place, start with these words and then keep writing. Don’t think about what you write down. This will only stop your flow of thinking. You will be surprised how easily words come to you after a while! When you have finished, either put your script away safely or destroy it.

Think about the last week…

✓ Write down how many times you did something just for yourself.
✓ Work out how much time you spent on yourself during these occasions.
✓ Write down how much money you spent just on yourself.
✓ Write down all the places you went to just because you wanted to go there.
✓ Write down the number of phone calls you made for yourself.
✓ Write down how many times you enjoyed a meal uninterrupted.
✓ How many times did someone else clear the table? Wash up? Make their bed? Wash their clothes?
✓ How many TV shows did you watch that were just for you?
✓ How much time did you have to just sit and do nothing?
✓ How many times did you have the car just to do what you wanted?

Plus any more you can think of!
Take a few moments to answer the following questions. It is important that you spend only a few moments thinking about each one…

1. Is there someone else to share the ‘parent-load’ with you? Yes=4 No=2
2. Do you make sure that you have some time just for yourself each day (even if only 15-30 minutes)? Yes=2 No=1
3. Do you make sure that you do some form of exercise each day (long and hard enough to make you ‘sweat it out’, and not just housework)? Yes=2 No=1
4. Do you have something you can enjoy for relaxation (for example, music, reading, gardening)? Yes=2 No=1
5. Do you find that the only people you mix with during the day are your children? Yes=1 No=2
6. Do you make time to have three regular meals a day? Yes=2 No=1
7. When you eat, do you ‘eat on the run’, or grab whatever others haven’t eaten? Yes=1 No=2
8. Do you smoke? Yes=1 No=2
9. Do you drink more than three mugs of coffee per day? Yes=1 No=2
10. Do you drink more than two standard drinks of alcohol per day? Yes=1 No=1
11. Do you wake up feeling tired or always feeling you need more sleep? Yes=1 No=2
12. Did you have something to look forward to either yesterday or today, no matter how small or unimportant it might have seemed? Yes=2 No=1
13. When you got dressed this morning, did you put on something that made you feel good rather than just grab the first thing you could find? Yes=2 No=1

The Maximum Score is 28. If you have scored close to 14 or less, perhaps you are not giving as much time and energy to yourself as you could be. You might be getting close to scraping the bottom of the barrel. If so, then go back to the previous activity and look at your responses to those questions. It is very possible that you are not spending enough time, energy, or resource on yourself!
| NOTES | IDEAS | THINGS TO DO |
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