Open access • Journal Article • DOI:10.1037//0022-006X.55.3.396

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Published on: 01 Jun 1987 - Journal of Consulting and Clinical Psychology (American Psychological Association)

Topics: Parent training, Adjunctive treatment and Conduct disorder

Journal of Consulting and Clinical Psychology (1987) 55 (3):. 396-403 doi: 10.1037/0022-006X.55.3.396

Marital Discord and Treatment Outcome in Behavioral Treatment of Child Conduct Disorders

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This article was supported by a grant from the Department of Psychology Research Fund at the University of Queensland. Thanks are extended to John Bain for advice on data analysis and to Alan Gardiner and Brett Behrens for serving as observers.

Abstract

Research assessing the role of marital variables in the treatment of childhood conduct disorders is scarce. The aim of this study was (a) to assess the role of marital discord in the overall outcome of a program training parents in behavioral techniques (behavioral parent training) and (b) to assess the effects of an adjunctive treatment (partner support training [PST]) on outcome. The latter treatment focused on marital conflict, communication, and problem solving. Twenty-four families with a child diagnosed as oppositional or conduct disordered were assigned to either a marital-discord group (n = 12) or a no-marital-discord group (n = 12). Families within each group were then randomly assigned to either child management training (CMT) alone or CMT with PST. Measures of child deviance, parenting behavior, and marital satisfaction were collected at pre- and posttraining and at a 6-month follow-up. Results indicated a significant interaction between marital discord and treatment type on most measures at follow-up but not at posttraining. Although PST added little to the maintenance of change for the nondiscordant group, it produced significant gains over those who received CMT only for the discordant group. Further results highlighting the interaction of marital and treatment variables are discussed.

Considerable research has indicated that marital discord and child behavior problems, particularly conduct disorders in boys, covary in clinical samples and, to a lesser extent, in the general population (Emery, 1982). However, the role of marital variables in the treatment of conduct disorders has received far less attention. A number of authors have argued that, based on their clinical impressions, marital discord interferes with behavioral parent training programs (Cole & Morrow, 1976 ; Ferber, Keeley, & Shemberg, 1974 ; Kent & O'Leary, 1976 ; Patterson, Cobb, & Ray, 1973). Conceptual approaches, emphasizing the reciprocal relations between child and family variables, would certainly predict that marital discord will negatively effect behavioral treatment, with its emphasis on parents as agents of behavior change in the home.

We know of only two studies that have attempted to directly assess the role of marital discord in treatment outcome. Oltmanns, Broderick, and O'Leary (1977) found no correlation between marital satisfaction level and treatment outcome. However, their study suffers from a lack of observational measures of parent-child interaction and from the utilization of a mixed sample of childhood behavior disorders. Brody and Forehand (1985) compared treatment outcome across groups of maritally distressed and nondistressed mothers. Results indicated that although the distressed group performed more poorly on one measure of deviant child behavior, overall the groups were equally responsive to the behavioral treatment. However, the absence of husbands in this study could have minimized marital effects. Furthermore, the lack of a follow-up assessment raises questions about the durability of change for the two groups. Thus, although it appears certain that treatment dropout or failure is associated with negative parental perceptions of child behavior (Wahler & Afton, 1980), low socioeconomic status (SES), inadequate social support and single parenting (Dumas & Wahler, 1983 ;

Wahler, 1980 ; Webster-Stratton, 1985), and personal adjustment (e.g., depression; Greist & Wells, 1983), this association has not been demonstrated for parents' marital interactions and perceived marital satisfaction.

Although there are at present no strong data, some evidence suggests that extra training procedures may enhance the treatment effects of behavioral parent training. Early studies have utilized training in marital conflict resolution (Kelley, Embrey, & Baer, 1979) and self-management and self-control procedures (Sanders, 1982 ; Sanders & Glynn, 1981 ; Wells, Griest, & Forehand, 1980). Griest, Forehand, Rogers, Breiner, Furey, and Williams (1982) compared the effects of parent training alone with parent training plus parent enhancement training on parent and child behavior at posttreatment and at a 2-month follow-up. The adjunctive training focused on parents' perceptions of child behavior, personal and marital adjustment, and extrafamilial relationships. The results showed that the extra training was associated with better implementation of child management techniques by parents and with decreased levels of child noncompliance after treatment and at follow-up. This study supported the previous finding that focusing on broader parental variables such as marital adjustment, problem solving, and self-control would enhance long-term treatment effects.

All of these studies contain limitations that make their findings tentative. First, no study provided measures of parent implementation of the extra training procedures. Second, all studies used families that had no documented problems other than child management difficulties. Thus, it is possible that these families would have shown durable change without the extra training. Third, the Griest et al. (1982) study did not report whether the two groups were matched in therapist contact. Fourth, follow-up was limited to 3 months or less, which may not have been long enough to show a lack of durability.

A number of these problems were overcome in a recent study. Dadds, Sanders, Behrens, and James (in press) provided four families displaying marital discord as well as child behavior problems with child management training (CMT) plus partner support training (PST). The latter treatment was a structured program that focused on parents' immediate responses to problems and on communication and problem-solving skills. Direct observations of parent-parent interactions in the home revealed that parents were able to implement the partner support skills, which resulted in a decrease in aversive parental interchanges and an increase in problem-solving behaviors that were unaffected by child management training alone. Training effects were maintained at the 6-month follow-up. However, the omission of a control group and the small sample used make it impossible to attribute durable effects to the partner support training.

The aim of the present study was to evaluate the interacting effects of two factors (marital discord and brief marital therapy) on the durability of treatment gains in a behavioral parent training program. Families of conduct-disordered children were classified into either marital-discord or no-marital-discord groups prior to treatment to evaluate the effects of this factor on treatment outcome. Families within each group were randomly assigned to CMT alone or to CMT plus a brief marital intervention (PST) in order to evaluate the effects of the extra training. On the basis of previous research, the following hypotheses were made: (a) that maritally discordant and nondiscordant families would respond equally to behavioral parent training for their conduct-disordered child and (b) that the addition of PST would produce stronger treatment effects at posttreatment and at follow-up than the provision of CMT alone.

Method

Subjects and Settings

Subjects were 24 families who were self-referred or were referred by health agencies to the Psychology Clinic of the University of Queensland in response to a press release in local newspapers describing the project and calling for families who were experiencing child behavior problems. The

following criteria were used to select subjects: (a) each target child had to meet Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980) criteria for oppositional or conduct disorder as confirmed by a standardized clinical interview (Murphy, Hudson, King, & Remenyi, 1985) that examined psychological and medical history and present status and included informal prebaseline observations; (b) the child's behavior problem could not be associated with organic pathology (assessed by parental report of the most recent medical examination or by medical assessment if judged necessary); (c) the family could evidence no psychiatric pathology beyond the oppositional disorder and any associated marital discord (assessed by parental self-report or by medical assessment if judged necessary); (d) no family member could be undergoing other psychological therapy; and (e) subjects had to be willing to complete self-report and home observation procedures. Reliability checks on DSM-III diagnoses were not obtained. Seven families did not meet criteria and were not included. In the majority of these families, either the child evidenced no behavior problem or the problem was educational rather than behavioral.

The 24 included families were assigned to one of two groups according to their scores on the Locke Wallace Marital Adjustment Test, which was administered during prebaseline interviews. Twelve families with a mean score of 105 or more (M = 120.9) and who verbally acknowledged no marital problems comprised the no-marital-discord group, and 12 families with a mean score of 95 or less (M = 77.9) and who acknowledged marital problems comprised the marital-discord group. Families within each of these groups were randomly assigned to either CMT only or to CMT plus PST. Table 1 summarizes family demographic information for the overall sample and for each experimental group and includes a measure of SES (on a 7-point scale where 1 = high [Daniel, 1983]) based on fathers' occupations. No significant difference between groups was found on any of these measures using analysis of variance (ANOVA) comparisons.

Family Demographic Data, Combined and by Group

All interviews and treatment sessions were held in the university clinic. Observational data on family interactions were collected in the families' homes in the living room and kitchen areas. All family members were present and were requested to avoid scheduling visitors, watching television or using the telephone. Parents were asked to remain in the observation area, to ensure that the child remain in the area, and to interact as naturally as possible. All observational conditions (time of day, persons present) were kept constant throughout the study for each family.

Observation Procedure

Observers were undergraduate students at the University of Queensland who were naive to the goals of the studies and had received between 6 hr and 10 hr of training in the use of the time-sampling procedure. This training included coding videotapes of family interaction sequences that previously had been coded to a criteria level. Observers were required to reach 85% overall agreement with the prescored tape and with each other on an unscored tape. Discussion regarding only technical and administrative matters was permitted between the experimenter and the observers in order to minimize any influence from observer expectancies.

A time-sampling procedure was used to record mother-child interactions. These interactions were sampled on observation blocks of 40 s (25 s for observation and 15 s for recording). This observe-record cycle was repeated for approximately 25 min at each observation session. The instrument measured five categories of oppositional child behavior, nine categories of mother attending behavior, and two categories (correct or incorrect) of program implementation by mothers. Table 2 lists behavior categories and abbreviated definitions for all child and mother behaviors. 1 Observers sat in the corner of the lounge or kitchen area wearing a tape recorder ear piece that told the observer when to observe and when to record. Observers recorded the presence or absence of each of the behaviors for each 25-s interval. Four observations were conducted for each family at baseline, immediately

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following the termination of treatment, and at 6-month follow-up, totalling 12 observations for each family.

Table 1
Family Demographic Data, Combined and by Group

	Child's age (months)		Parent's age (years)		No. children		SES	
Group	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Marital discord								
CMT only	49.0	18.7	30.3	2.6	1.8	0.9	4.5	1.1
CMT & PST	53.0	11.6	31.8	4.4	2.0	0.6	4.0	1.3
M	51.0	15.0	31.0	3.6	1.9	0.8	4.2	1.1
No marital discord								
CMT only	48.8	16.7	32.3	3.9	1.8	0.4	3.9	1.0
CMT & PST	51.0	10.5	32.8	3.9	2.6	0.8	3.6	1.0
M	49.9	13.4	32.5	3.7	2.2	0.7	3.7	0.9
Combined								
CMT only	48.9	16.9	31.3	3.3	1.8	0.7	4.2	1.1
CMT & PST	52.0	10.6	32.3	4.0	2.3	0.7	3.8	1.1
M	50.4	13.9	31.8	3.7	2.1	0.8	4.0	1.1

Note. SES = socioeconomic status. CMT = child management training; PST = partner support training.

Reliability of Observations

Interobserver reliabilities were calculated on 20% of the observations for each category of child behavior, parent behavior, and parent accuracy of program implementation. Observers used extension ear plugs attached to the same cued audiotape and sat out of vision of each other's score sheets. Agreements and disagreements were gauged by the presence or absence of the behavior on an interval-by-interval basis. Overall occurrence and nonoccurrence reliabilities were calculated for the data and for its corresponding chance levels according to the formulas developed by Hopkins and Herman (1977) . Overall agreement (i.e., occurrence plus nonoccurrence) ranged from 82.0% for accurate program implementation to 95.8% for praise. All reliabilities for occurrences and nonoccurrences were above their corresponding chance levels.

Observation Measures

The following dependent measures were used to evaluate the effect of treatment on mother-child interactions.

- Child deviance was scored for any interval in which one or more of the deviant child behaviors was scored present. The number of deviant intervals was divided by the total number of intervals and multiplied by 100 to yield a percentage measure of child deviance for each observation.
- For correct implementation, the number of intervals in which the parent was scored as correctly implementing treatment were summed, divided by the total number of intervals in which the parent directed behaviors towards the child, and multiplied by 100. This produced a percentage measure of correct implementation for each observation.
- For maternal aversiveness, intervals containing one or more aversive parent behavior directed toward the child (Table 2) were summed, divided by the total number of intervals in which the mother directed behaviors toward the child, and multiplied by 100. This yielded a percentage measure of maternal aversiveness directed toward the child for each observation. Previous research has indicated that rates of maternal aversiveness may be predictive of the durability of treatment effects following parent behavioral training (Dadds, Sanders, & James, in press ; Dumas & Wahler, 1983).

Table 2
Summary of Observed Behavior Categories

	Parent- child behavior
Contact	Any contact deemed to be nonaversive (i.e., not causing or having the potential to cause pain or discomfort).
Aversive	Any contact causing or having the potential to cause pain or discomfort in the child.
Questions	Any nonaversive request for information from the child. e.
Aversive questions	Any request for information deemed aversive due to content or tone of voice
Instructions	Any verbal command presented nonaversively.
Aversive instruction	Any verbal command presented aversively
Social Attention	Any nonaversive attention, verbal or nonverbal, that cannot be scored under other categories.
Aversive social attention	Social attention deemed to be aversive due to content or voice presentation.
Correct implementation	Scored for any interval in which the parent did not engage in any aversive behavior and, if the child was scored deviant, the parent followed the appropriate correction procedure outlined in the child management training phase of treatment.
	Deviant child behavior
Noncompliance	Refusal to initiate compliance with specific instructions within 5 s (e.g., when child is told to go to his room, he runs outside).
Complaint	Verbal complaint involving whining, screaming, grizzling, vocal protest, or display of temper (excludes aversive commands).
Aversive commands	Instruction directed to another person by the child that is judged to be aversive or unpleasant (e.g., "Fix my dinner now!").
Physical negative	Actual or threatened physical attack or damage to another person or destruction of an object (e.g., punching, kicking, scratching, pinching, etc.).
Oppositional	Inappropriate behavior that cannot be classified in other categories (e.g., violating family rules, teasing, deliberate ignoring, humiliating).

Self-Report Measures

Self-report forms were used to assess parents' perceptions of their marital satisfaction and their child's behavior. The Child Behavior Problem Checklist (CBPC) lists 40 common problem behaviors found in young children and is based on the assessment materials developed by Patterson, Reid, Jones, and Conger (1975) . The CBPC has been found to be sensitive to changes in parents' perceptions of child behavior (Sanders & Dadds, 1982) and can be used to supplement direct observation of parent-child interaction. Parents complete the form by checking each listed problem behavior that has caused them difficulty over the last 2 weeks. A score is derived by totalling the number of problem behaviors checked. Parents also completed the Marital Adjustment Test (MAT; Locke & Wallace, 1959). This test has been found to be reliable across time and settings, to discriminate reliably between distressed and nondistressed couples (Spanier, 1976), and to be sensitive to clinical changes in marital satisfaction (Bornstein, Hickey, Schulein, Fox, & Scolatti, 1983). Parents completed both self-report measures at baseline, at termination of treatment, and at 6-month follow-up.

Design

A group design with crossed factors of marital type and treatment type was used, with six families in each of the resultant four cells. The dependent measures of parent and child behavior and the self-report measures, taken at pretreatment, posttreatment, and 6-month follow-up, were treated as repeated measures. The number of treatment and assessment contacts was held constant across families: That is, the CMT group received extended review of the CMT techniques while the CMT plus PST group underwent the PST training. Because the therapist was aware of the research aims, assignment to treatment conditions was made after four sessions of CMT. Thus, the possible effects of

the therapist's knowledge of group membership on the quality of CMT each family received were minimized. Therapy was contingent on both parents being present at each session, and apart from occasional cancelled sessions, all families adhered to this contingency. The aim was to elucidate the effects of PST beyond those of CMT; it was important that the results not be attributable to the provision of inadequate CMT training, and we sought to produce the best possible treatment effects likely to be associated with a behavioral child management training program. The CMT thus included planned activities training components (Sanders & Dadds, 1982) to enhance setting generalization.

The measure of marital satisfaction served as both an independent (between groups) and a dependent variable. Statistical analyses of marital satisfaction as a dependent measure were thus restricted to ANOVAS of treatment effects between the two marital-discord groups and between the two nondiscord groups but were not performed across discord and nondiscord groups. Assignment to different treatment groups within each marital group was random, and thus, marital satisfaction could be utilized as a dependent measure.

Procedure

Child management training (CMT). The first author acted as the therapist for all families. A training format identical to that described by Dadds, Sanders, Behrens, and James (in press) was used that included components to enhance setting generalization of parent implementation, that is, Planned Activities Training as described by Sanders and Dadds (1982) . Parents were instructed on the use of descriptive praise and other contingent consequences to increase appropriate behavior and were taught a correction procedure (including time-out) in response to five deviant child behaviors (demanding, aggression, tantrums, interrupting, and noncompliance).

Each family met at the clinic for 1-hr weekly feedback sessions. The child was given access to a range of toys, and parents interacted with the child while the therapist observed through a one-way screen. After 10 min, the child was left to play and the therapist provided feedback to parents on their performance of the behavior correction procedures. Parents also discussed with the therapist any problems regarding implementation of the procedures at home. These feedback sessions continued, up to a predetermined maximum of six sessions (M = 5.2), until parents reported satisfaction with their implementation of the procedures at home.

Parents were then instructed to select one or two community settings in which the child was causing problems. All families selected either shopping trips, travelling in the car, or visiting at other people's homes. Parents were taught to use a planned activities procedure (Sanders & Dadds, 1982) to engage children in activities in the target setting. The procedure involved the selection and arrangement of suitable activities, a discussion with the child regarding the rules for the situation, a discussion of the consequences for appropriate and inappropriate behavior, and a discussion with the child following the situation to review the child's behavior and to deliver any consequences. All families received three 1-hr training sessions in the use of the planned activities procedure.

Partner support training (PST). The PST treatment was provided adjunctive to CMT and was designed to facilitate the maintenance of parent and child behavior change by decreasing sources of coercion and by increasing supportive and problem-solving skills in parents. It's aim was similar to parent enhancement training (Griest et al., 1982) and mand review training (Wahler & Graves, 1983) but was different in that PST focused specifically on the parental relationship as a source of support or lack of support. The PST was divided into three treatment components, each containing two 1-hr sessions: problem responses, casual discussions, and problem solving. The treatment procedure has been described in detail elsewhere (Dadds, Sanders, Behrens, & James, in press).

Results

To assess the overall effects of marital discord and treatment type on treatment outcome, the dependent measures of child behavior and parent behavior were analyzed simultaneously using a 2 × 2 × 3 (Group × Treatment × Phase) multivariate analysis of variance (MANOVA ; Finn, 1980) with repeated measures on the last factor. Comparisons were made of pretreatment versus posttreatment, and of pretreatment versus follow-up. Comparisons between groups at different phases of treatment were performed by classifying individual families as either responders or nonresponders according to the criteria specified by Dumas and Wahler (1983) and by Webster-Stratton (1985) . That is, families were classified as responders if the level of deviant child behavior and maternal aversiveness was reduced by 50% under the baseline level. This classification was performed separately for measures of observed child deviance, maternal aversiveness, maternal perceptions of child deviance, and for a combined measure. Separate analyses were performed for both posttreatment and follow-up levels compared with the baseline level. For the measure of marital satisfaction, a separate 2 × 3 (Treatment × Phase) ANOVA was used for each of the two marital groups.

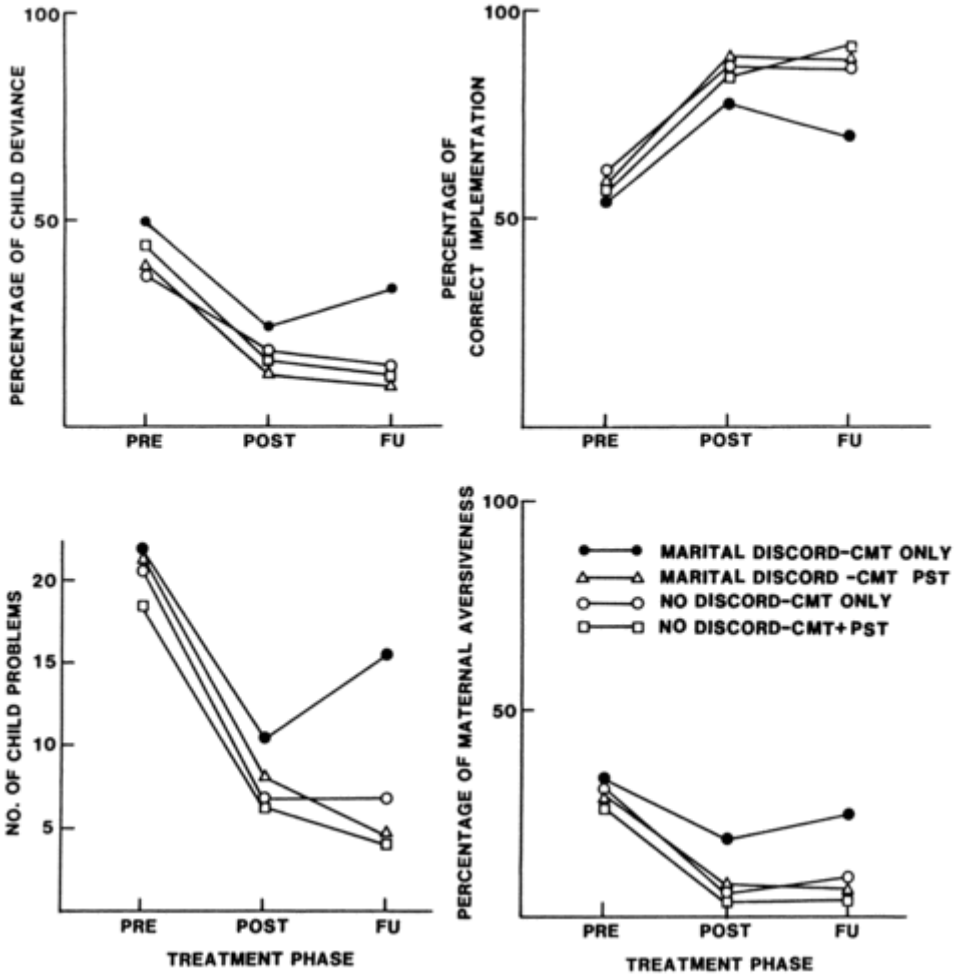

Figure 1. Mean levels of child deviance, correct implementation, number of child problems, and maternal aversiveness at pre- and posttreatment and at follow-up for the four treatment groups.

Changes in Parent and Child Behavior

Figure 1 shows the mean levels of correct implementation, maternal aversiveness, and child deviance and the number of child problems reported by mothers for each group across treatment phases. At baseline, groups were very similar on these measures. All groups showed improvements

from baseline to posttreatment on all measures. The MANOVA confirmed a significant main effect for phase, $F (4, 17) = 148.35$, $p < .0001$, but showed no significant interaction or main effect for treatment type or group membership using the pretreatment versus posttreatment comparison. Using the pretreatment versus follow-up comparison, the MANOVA revealed a significant phase effect, $F (4, 17) = 100.20$, $p < .0001$, and an interaction between treatment type and group membership, $F (4, 17) = 3.33$, $p < .05$. Treatment effects were maintained to follow-up for all groups except the marital discord—CMT only group.

Treatment Outcome Using Responder and Nonresponder Classification

Table 3 shows the frequency of responders and nonresponders by group for measures of child deviance, maternal aversiveness, parent perceptions of child deviance (assessed by the CBPC), and for a combined measure utilizing all of these criteria for comparisons of posttreatment and follow-up versus baseline.

At posttreatment assessment, using the most stringent combined criteria, 14 families responded to treatment (58.3%) and 10 families did not. Twice as many nonresponders came from the marital discord—CMT only group as from the other groups, and this difference was attributable to the difference in rates of maternal aversiveness. On measures of deviant child behavior and maternal perceptions of child behavior, the groups were not different, with a total of 18 (75%) and 20 (80%) families responding to treatment on each measure, respectively. However, on the measure of maternal aversiveness, the marital discord—CMT only group performed worse than the other groups, with only 2 families responding to treatment compared with 5 and 6 in the other groups.

Table 3
Number of Responders (R) and Nonresponders (NR) in Each Group Across Behavioral Measures

	Child behavior		Parent behavior		Parent perceptions		Combined	
Group	R	NR	R	NR	R	NR	R	NR
Pretreatment vs. posttreatment								
Marital discord								
CMT	4	2	2	4	4	2	2	4
CMT & PST	5	1	5	1	5	1	4	2
No marital discord								
CMT	4	2	5	1	6	0	4	2
CMT & PST	5	1	6	0	5	1	4	2
Pretreatment vs. follow-up								
Marital discord								
CMT	1	5	0	6	0	6	0	6
CMT & PST	6	0	6	0	6	0	6	0
No marital discord								
CMT	4	2	4	2	5	1	4	2
CMT & PST	5	1	6	0	6	0	5	1

Note. CMT = child management training; PST = partner support training. For both comparisons, $N = 24$.

At follow-up assessment, using the combined criteria, 15 families responded to treatment (62.5%) and 9 families did not. Six of the nonresponding families comprised the entire marital discord—CMT only group. On the other three measures, a similar picture emerged. For child deviance and maternal aversiveness, 16 families were responders (66.7%); of the 8 families that were nonresponders, 5 and 6 families came from the marital discord—CMT only groups for deviant child behavior and maternal

aversiveness, respectively. For maternal perceptions of child deviance, 17 families (70.8%) were responders and 7 families were not. Six of these families came from the marital discord—CMT only group.

From this data, it can be concluded that at posttreatment, the groups had responded similarly to treatment on all measures except maternal aversiveness. On this measure, the marital discord—CMT only group had responded poorly to treatment. At follow-up, the marital discord—CMT only group had done worse in treatment than either of the no-marital-discord groups and the marital-discord CMT plus PST group on all measures. The inclusion of PST appeared to have some extra benefits for the nondiscordant group who received it. However, the means presented earlier on these measures (Figure 1) indicate that, at a group level, this effect was negligible.

Mean levels of child deviance, correct implementation, number of child problems, and maternal aversiveness at pre- and posttreatment and at follow-up for the four treatment groups

Changes in Marital Satisfaction

Figure 2 shows the mean group level of marital satisfaction reported by mothers and fathers for each treatment phase. Separate statistical analyses were performed on each marital group. For the no-marital-discord group, an ANOVA revealed a significant main effect for phase, $F (2, 40) = 9.67$, $p < .001$. No differences between treatment type or sex were noted. A different pattern, however, emerged for the marital discord group. A Treatment × Phase interaction was observed, with CMT plus PST producing a stronger treatment effect than CMT only at follow-up, $F (2, 40) = 19.43$, $p < .001$. Fathers appeared to report greater increases in marital satisfaction than mothers for the group receiving CMT plus PST; however, this effect only approached significance ($p < .07$).

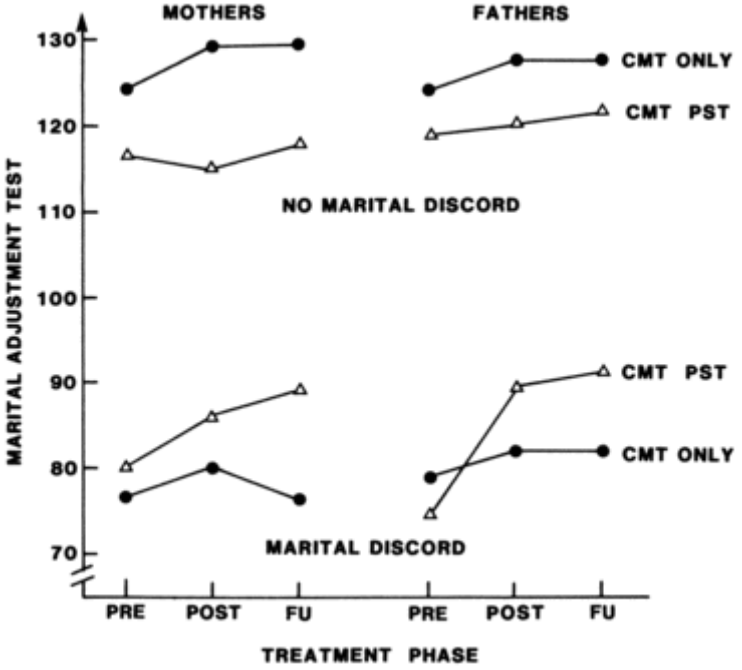

***Figure 2*. Mean levels of marital adjustment measured at pre- and Posttreatment and at follow-up for the four treatment groups**

Discussion

The major findings of this study concern the interacting roles of marital discord and a brief marital intervention on the long-term therapeutic success of behavioral treatments for conduct and

oppositional child disorders. On both objective measures and maternal perceptions of child behavior, the presence of marital discord and the inclusion of the marital intervention had little influence on treatment outcome as measured at treatment termination. The lack of influence of marital discord on treatment outcome supports the findings of Brody and Forehand (1985) . However, the measure of maternal aversiveness directed toward the child did differentiate between groups, with the maritally discordant group who received child treatment only evidencing the highest levels of aversiveness immediately following treatment. This supports previous research that has pointed to the predictive power of this measure (Dadds, Sanders, & James, in press ; Dumas & Wahler, 1983). At 6-month follow-up, the group of maritally discordant parents who had received CMT only evidenced significant relapse. By contrast, the maritally discordant group who also received PST and the two non-maritally-discordant groups had maintained treatment effects. This interaction between marital and treatment variables was more evident on parent's self-reports of child behavior and marital satisfaction than on observational measures of mother-child interaction. However, the interaction was evident at a group level for all measures, and analysis of the responses of individual families revealed the inflated relapse rates associated with marital discord and CMT only.

The negative impact of marital discord on treatment outcome found in this study supports the clinical impressions of various researchers (Kent & O'Leary, 1976 ; Patterson et al., 1973) and supports recent calls to broaden the focus of behavioral parent training (Griest & Wells, 1983 ; Wahler & Graves, 1983). However, our finding differs from the results of Oltmanns et al. (1977), who did not utilize observational measures and included a mixed sample of childhood disorders, and adds to the results of Brody and Forehand (1985), who did not include a follow-up assessment.

The results of the treatment comparisons indicate that the inclusion of a brief maritally focused treatment with parent training may overcome treatment failure for maritally discordant families. It should be noted that none of the families in this sample were actively pursuing separation or experiencing severe marital crises at the time of referral. Most were suffering from chronic marital discord but were committed to remaining together. It is unlikely that families in severe marital crisis would respond to the treatment, and in these cases more intensive marital therapy may be required. Partner support training is not a comprehensive marital therapy but instead targets parental interactions for change in the context of a successful child management program. Clinical impressions and previous research (Dadds, Sanders, Behrens, & James, in press) have indicated that the marital intervention has a major impact by increasing the rates of nonaversive father engagement with the mother in daily child care responsibilities. It is unlikely that parents who have presented for help with a child behavior problem would respond so favorably to marital therapy unless the child problem had been previously treated by the therapist.

Little difference was found between treatment outcomes for the two no-marital-discord groups who received different treatments. That is, the inclusion of PST did little to enhance treatment effects at follow-up. This is contrary to the findings of Griest et al. (1982), who found extra benefits associated with a similar adjunctive treatment provided to non-maritally-discordant families. It is possible that a ceiling effect occurred in this study in that CMT, incorporating the planned activities component, was sufficient to produce durable change. Alternatively, the Griest et al. (1982) training program could have been more relevant to nondiscordant families in that it was less directive and did not specifically focus on marital problems. This finding contradicts the speculations of some authors that marital problems are always associated with child behavior problems (e.g., Framo, 1975).

Previous research has indicated that marital discord may be correlated with level of child deviance in families presenting with a conduct disordered child. Although no correlation analyses were performed on a family-by-family basis, it was clear from the equality of groups at baseline that our results did not support this relation. Families with marital discord, as assessed by self-report and by the Locke Wallace Marital Adjustment Test did not differ from families with higher marital satisfaction on overall levels of observed child deviance, parent-reported child deviance, and maternal aversiveness. A number of explanations are possible.

First, the Marital Adjustment Test might not differentiate overt marital hostility from overall marital satisfaction. Porter and O'Leary (1980) found that only the former was related to level of deviance in their sample of children. However, this seems unlikely given that overt hostility and overall marital satisfaction do appear to correlate negatively (Porter & O'Leary, 1980) and that, in the course of therapy in this study, the discordant families reported more open fighting in the home. An alternative explanation might explore the factors that account for the variance in who does and does not seek clinical help with child behavior problems. The child's behavior might account fully for help seeking in nondiscordant families, whereas a combination of child behavior and marital variables might account for help seeking in discordant families. As such, one might expect more consistent problems of parent-child interaction in the nondiscordant families, with greater variance in the levels of child deviance and in aversive parent-child interactions in the discordant group. It would be useful to utilize some of the methods used by Forehand and associates (Rickard, Forehand, Wells, Griest, & McMahon, 1981), who assessed the relative contributions of maternal adjustment, parental cognitive variables, and child behavior to referral status, incorporating marital discord and open hostility as predictors.

It is clear from this study that pretherapy and posttherapy measures, such as those used by Brody and Forehand (1985), may not be sufficient to differentiate between responders and nonresponders to behavioral parent training. Researchers should continue to use follow-up assessments of at least 3–6 months.

The findings of this study are limited by the small sample size. However, the results indicate that clinically significant differences can emerge in a sample of this size. Although the inclusion of PST produced durable change in parent and child behaviors in the marital-discord group comparable to that observed in the no-marital-discord group, the overall levels of marital satisfaction were still lower after treatment for the marital-discord group. Further research will be needed to clarify the long-term effects of marital satisfaction on child development before it can be known whether this residual difference will have any impact.

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