

Comparisons of Behavior Transactions Between Conduct-Disordered Children and Their Mothers in the Clinic and at Home¹

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The effects of various degrees of structure during clinic observations and the location of the observation (home or clinic) on the behaviors of mothers and children were examined. Forty families with conduct-problem children between the ages of 3 and 8 years participated. Correlations indicated little relationship between behavior in structured and in unstructured clinic conditions. There was also a lack of correlation between the structured clinic and the home observations. However, there were high correlations between mothers' and children's behaviors in the unstructured clinic observation and the home observations. ANOVA further indicated that there were significant differences between the actual rates of behaviors observed in the home and clinic locations. Results are discussed in relation to the potential of structured clinic observations to provide more relevant and efficient information about mothers and conduct-problem children.

Direct behavioral observations of children and their families have become an important means of assessing the degree of normalcy or deviancy of family interactions as well as evaluating the outcome and progress of treatment.

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Bornstein, Bridgewater, Hickey, and Sweeney (1980) found that 72% of experimental articles published between 1970 and 1978 reported using direct observation procedures. Although observational assessments of families have been carried out in a wide range of settings, the most common settings have been in the clinic and in the home.

Considerable debate exists about the most reliable and valid choice of the observational setting in which to conduct the behavioral assessment. Proponents of home-based observations argue that such observations give a more valid and representative picture of family interaction because behaviors occur in a real-life situation. In addition, they emphasize the importance of imposing as little structure as possible in order to get an assessment of behaviors as they "naturally occur." Conversely, proponents of clinic observations argue that home observations are not practical, and are a time-consuming, inefficient way of observing parent-child interactions. Consequently, a wide range of structured clinic observation settings is recommended. In these structured clinic observational assessments, parent-child interactions are observed in analogue situations such as free play (e.g., Forehand, King, Reid, & Yoder, 1975; Kogan & Wimberger, 1971) and a variety of command-compliance structured situations such as the mother having the child clean up or put away play materials (Robinson & Eyberg, 1981). The use of such structured clinic observations is based on the assumption that the structured clinic situation efficiently elicits the behaviors of interest and the standard stimulus situation enables the clinician to make valid within- and between-subject comparisons (Hughes & Haynes, 1978).

Few studies have directly assessed the comparability of home and clinic observations of parent-child dyads. Those studies that have been conducted have yielded conflicting results (Belsky, 1980; Johnson & Bolstad, 1973; Kniskern, Robinson, & Mitchell, 1983; Sajwaj, 1973). Moreover, when a discrepancy in behaviors exists between home and clinic, the argument is frequently made that behavior in the clinic or laboratory is unrepresentative while the home behavior is more representative of the child's "true" behavior because it occurred in a natural setting. Mash and Terdal (1982, p. 58) have recently argued, "Assumptions that home observations are 'natural' and observations in the clinic are 'artificial' are oversimplifications" (p. 58). Home observations may, at times, produce artificial reactions in mothers and children to the presence of observers while clinic observations that use one-way mirrors may produce more "natural" responses in an artificial setting.

One of the reasons for conflicting results may be that researchers are comparing situations that vary in many ways besides location. In particular, there has been the tendency for existing studies to confound location with the potentially important variable of the structure or instructions and tasks given to parents during the observations. For example, Belsky (1980) gave

the mother instructions to have 30 minutes of free play with her infant in the clinic, whereas in the home she was told to go about her household activities. Zangwill and Kniskern (1982) compared home versus clinic observations of families with conduct-disordered children using the Dyadic Parent and Child Interactional Coding System (DPICS, Robinson & Eyberg, 1981). The clinic observation was a highly structured analogue situation with detailed instructions to the parents. However, during the home observation the mother was told to do what she would normally do. It does not seem particularly surprising that Belsky (1980) found increased rates of interaction during the clinic observation or that Zangwill and Kniskern (1982) found increased mother reinforcement and punishment behaviors and increased child non-compliance during the highly structured clinic observations as compared with home observations. It can be assumed that variation in results may be due in part to the variation in structure of the assessment situation.

In a follow-up study, Kniskern et al. (1983) again compared home versus clinic observations using the DPICS observational system, attempting to control for the effect of structure by observing in both settings with the same analogue structure. They concluded that there were high correlations between the behaviors of mothers and children in both settings and that the structure and presence of siblings during the observations was a more important factor than the location of the observation in determining parent-child behaviors. However, methodological problems limit the interpretability of these results. Rather than observing the same families in both settings, their sample included 40 families with normal children who were randomly assigned to either the home or laboratory observation. It is unknown how families with more deviant children would react in different structured situations as well as in different locations. Furthermore, an effort was made to make the home observation more like an analogue situation with extensive structure rather than making the clinic a more natural situation. This would seem counter to the original purpose of home observations—that is, to see families in the most natural way possible.

Furthermore, many other studies fail to provide descriptions of the structure or instructions given to parents during observational assessments. The paucity of research coupled with methodological limitations in existing research has resulted in a lack of understanding of the effect of location and structure on the behavior of family members. In order to understand more completely the meaning of behavioral assessments in the home or clinic, there is a need to examine the reactive effects of various amounts of structure on parent-child interactions. The purpose of this study is to examine (a) the effects of various degrees of structure during clinic observations and (b) the effects of location (clinic versus home observations) on the behavior of mothers and conduct-problem children.

METHOD

Subjects

Clients were recruited as part of a larger program involving the evaluation of a parent training program (Webster-Stratton, 1984). Children were screened during an intake telephone call followed by an office appointment and were included in the sample if they met the following criteria: (a) The child was between 3 and 8 years old; (b) the child had no debilitating physical impairment, intellectual deficit, or history of psychosis; (c) the primary referral problem was social aggression and noncompliance; and (d) parents agreed to home visits and videotape observations.

Forty families referred by pediatricians, psychiatrists, school or mental health personnel, nurses, or parents themselves were admitted to the study. Study children included 29 boys and 11 girls, with a mean age of 4 years 8 months. Twenty-four of the 40 children were from father-absent families. The mean age of mothers was 30 years. Family social class as determined by Hollingshead and Redlich's (1957) Two Factor Index of Social Position was 52.7, indicating that the average family was Social Class 4, lower middle to lower class.

Measures

Attitudinal Measures. The Eyberg Child Behavior Inventory (ECBI; Eyberg & Ross, 1978; Eyberg, 1980) is a 36-item inventory that measures parents' perceptions of their children's behavior problems and is applicable for children 2-12 years. Previous research with normative samples of 512 children has demonstrated reliability coefficients of the ECBI scales from .86 (test-retest) to .98 (internal consistency), indicating that the inventory is stable and homogeneous.

Observational Measures. All families were observed at home and at the clinic according to the Dyadic Parent-Child Interaction Coding System (DPICS; Robinson & Eyberg, 1981). The DPICS consists of 29 separate behavior categories covering parent and child behaviors that are coded every time they occur for each 5-minute segment. Since most of these families had only one parent living at home and only one child, only mother/problem-child dyadic interactions were analyzed.

From the 29 behavior categories, five separate variables were formed for mother behaviors: Total Praise (labeled and unlabeled praise), Critical Statements, Total Commands (direct plus indirect commands), No Opportunity Commands (commands given by parents in such a way that there is no opportunity for child to comply, and Direct Commands (clear and specific commands). For the target child there were two variables: Total Child Deviance (whine + cry + physical negative + smart talk + yell + destructive) and Noncompliance (failure to comply within 5 seconds of command being given).

Home and clinic observations were done by five trained observers who were blind to the hypotheses of the study. Initially the observers received extensive training and had to maintain 80% reliability with practice tapes before conducting observations. This training program was followed by weekly training and practice sessions to maintain accuracy. To assess reliability, two observers were used on approximately 50% of all home observations and 75% of clinic observations. Reliability was calculated in two ways: the ratio of percent of agreements to total number of agreements and disagreements and Pearson product-moment correlations between ratings for each separate behavior category. The percent agreement reliability was calculated for each 5-minute segment and was based only on occurrences of behavior noted, not nonoccurrences. Mean overall interrater agreement was 78.6%. The product-moment correlations calculated between observers for clinic observations and for home observations are shown in Table I. Whether the ob-

Table I. Interrater Reliability Coefficients for Each Behavior Dimension for Home and Clinic Observations^a

Behavior category	Reliability ^b coefficient home visits		Reliability coefficient clinic visits		
	Home visit #1	Home visit #2	CDI	PDI	UNS
Mother					
Total commands	.92	.98	.94	.97	.81
No opportunity commands	.73	.83	.91	.91	.61
Direct commands	.90	.84	.81	.88	.70
Critical statements	.98	.99	.86	.82	.87
Total praise	.93	.98	.76	.99	.96
Child					
Total deviancy	.95	.95	.65	.87	.68
Noncompliance	.94	.89	.85	.87	.99

^aUNS = unstructured; CDI = child-directed interaction mildly structured; PDI = parent-directed interaction highly structured.

^bReliability coefficients computed as the correlation between observers on both home visits.

servations were in the home or in the clinic, the reliability coefficients for each behavior category were quite comparable. The fact that the clinic observations were videotaped and later analyzed with the opportunity for coders to repeatedly review behaviors they were unsure about did not substantially improve reliability estimates over the home visits where there was no chance to review behaviors once they had occurred.

Procedures

Clinic observations of the mothers and children were conducted in a room equipped with a see-through mirror, remote control video equipment, and a large assortment of toys. There were three sets of observations in the clinic, each with varying amounts of structure imposed. For the unstructured clinic observations (UNS), which lasted 30 minutes, the mothers were given vague instructions, which paralleled the instructions given at home: "Make yourself at home and do what you would normally do." For the mildly structured clinic observation, called Child-Directed Interaction (CDI), the mother was instructed: "It's [child's name] turn to play. Let him/her choose whatever he/she wants to play with. You just follow his/her lead and play along with him/her." For the highly structured clinic observation, called Parent-Directed Interaction (PDI), the mother was instructed: "Now it's your turn. Choose whatever you want to play with and have [child's name] play with you." The CDI and PDI clinic observations each lasted 5 minutes and have been previously described by Robinson and Eyberg (1981).

The 30-minute home observations were conducted on two evenings during the week between 5:00 and 8:00 p.m., usually during the family's dinner hour. During these observations, an attempt was made to impose as little structure as possible and family members were asked to "do what you would normally do," except for the limitation that they were not to talk to the observers or watch television. For both sets of home observations, the procedures were the same.

RESULTS

For the purpose of analyses, the results from the two home observations were averaged to form one set of seven mean behavior scores. The results from the clinic observations were also averaged across the subjects to obtain the mean scores for the unstructured observation (UNS), and for each of the two structured observations, PDI and CDI. First, Pearson product-moment correlations were calculated between the mean scores for the three clinic observation conditions and the home observation condition. Because

Table II. Correlations Between Structured (CDI and PDI) and Unstructured Clinic Observations and Home Observations

	Clinic observations			Clinic and home observations		
	Correlation CDI vs. PDI	Correlation CDI and unstructured observations	Correlations PDI and unstructured observations	Correlation CDI and home visits	Correlation PDI and home visits	Correlation unstructured clinic and home visits
Mother						
Total commands	.02	.45 ^a	.40 ^a	.46 ^a	.03	.60 ^c
No opportunities	.04	.36	.47 ^a	.47 ^a	.04	.45 ^a
Direct commands	.40 ^a	.42 ^a	.35	.64 ^c	.33	.70 ^c
Critical statements	.17	.36	.13	.50 ^b	.07	.47 ^a
Total praise	.34	.32	.46 ^a	-.005	.36	.37 ^a
Child						
Noncompliance	.22	.10	.22	.14	.05	.54 ^c
Total deviancy	.18	.05	.22	.04	-.01	.61 ^c

^a*p* < .01.

^b*p* < .001.

^c*p* < .0001.

Table III. Comparisons of Mean Behavior Rates of Structured (PDI, CDI) and Unstructured (UNS) Clinic Observations with Each Other

Behavior variables	Clinic observations					
	Child-directed interaction (CDI) ^a		Parent-directed interaction (PDI) ^b		Unstructured interaction (UNS) ^c	
	rate/min	(SD)	rate/min	(SD)	rate/min	(SD)
Mother						
Total commands	1.06 ^e	(1.12)	3.65 ^e	(2.53)	1.74 ^f	(.20)
No opportunities	.43 ^e	(.75)	1.66 ^f	(1.70)	.89 ^f	(.79)
Direct commands	.43 ^e	(.47)	1.23 ^e	(.89)	.84 ^f	(.71)
Critical statements	.31	(.38)	.57	(.80)	.36	(.34)
Total praise	.14	(.23)	.14	(.24)	.23	(.21)
Child						
Deviancy	.22 ^f	(.32)	.90 ^f	(1.18)	.19	(.33)
Noncompliance	.19 ^f	(.30)	.67 ^e	(.67)	.22	(.24)
Noncompliance ratio ^d	.27	(.24)	.34	(.48)	.24	(.13)

^aComparisons CDI versus PDI.

^bComparisons PDI versus UNS.

^cComparisons UNS versus CDI.

^dRatio calculated as number of child noncompliance behaviors divided by total number of opportunities to comply.

^e $p < .05$.

^f $p < .01$.

^g $p < .001$; critical values from Dunn's Multiple Comparison Tables.

of the number of correlations, the alpha was set at .01 level. Next, a repeated-measures ANOVA was used to compare the means for each of the seven behavior scores (based on rate per minute) among the three clinic conditions and then between the home and the clinic situations. The Dunn-Bonferonni Tables were used to determine critical values in order to correct for the number of individual comparisons. Table II shows the correlations between the three types of clinic observations and the home visits, and Tables III and IV show the means and standard deviations of behaviors per minute and the results of the ANOVAS comparing the three clinic observations with each other and with the home observation.

Degree of Structure in Clinic

Pearson product-moment correlations between the two structured observations indicated very little correlation between the behaviors during PDI and CDI conditions in the clinic. Out of the five mother variables only one variable, mother direct commands, showed a modest correlation when observed under CDI and PDI conditions. For the two child variables there was

Table IV. Comparisons of Mean Behavior Rates of Structured (PDI, CDI) and Unstructured (UNS) Clinic Observations with Home Observations

Behavior variables	Clinic observations							
	Child-directed interaction (CDI)		Parent-directed interaction (PDI)		Unstructured interaction (UNS)		Home observations	
	rate/min	(SD)	rate/min	(SD)	rate/min	(SD)	rate/min	(SD)
Mother								
Total commands	1.06	(1.12)	3.65 ^d	(2.53)	1.74 ^d	(.20)	1.02	(.68)
No opportunities	.43	(.75)	1.66 ^d	(1.70)	.89 ^d	(.79)	.35	(.30)
Direct commands	.43	(.47)	1.23 ^d	(.89)	.84 ^c	(.71)	.56	(.44)
Critical statements	.31	(.38)	.57	(.80)	.36	(.34)	.42	(.44)
Total praise	.14	(.23)	.14	(.24)	.23 ^d	(.21)	.08	(.09)
Child								
Deviancy	.22	(.32)	.90	(1.18)	.19 ^d	(.33)	.48	(.55)
Noncompliance	.19	(.30)	.67 ^c	(.67)	.22	(.24)	.25	(.22)
Noncompliance ratio ^a	.27	(.24)	.34	(.48)	.24 ^b	(.13)	.35	(.16)

^aRatio calculated as number of child noncompliance behaviors divided by total number of opportunities to comply.

^b $p < .05$.

^c $p < .01$.

^d $p < .001$; significant difference when each clinic situation was compared with home visit; critical values from Dunn's Multiple Comparison Tables.

no correlation between child deviancy and child noncompliance in the CDI and PDI clinic conditions. Results from the repeated-measures ANOVA indicated that both mothers and children behaved at significantly different rates per minute in the two structured conditions. As compared to CDI, during PDI mothers gave significantly more total commands, $t(39) = -5.95, p < .001$, more commands with no opportunity to respond, $t(39) = -4.26, p < .001$, and more direct commands, $t(39) = -6.13, p < .001$. Although mothers tended to be somewhat more critical during PDI, this did not reach significant levels. In addition, the children were significantly more deviant, $t(39) = -3.69, p < .01$, and more noncompliant during PDI observations, $t(39) = -3.69, p < .01$, than during CDI observations.

The correlations between CDI observation and the unstructured clinic observation (UNS) also indicated little correspondence. Out of seven mother and child variables only mother total commands and direct commands showed a modest correlation between CDI and UNS observations. The ANOVAS indicated that there were significantly more total commands, $t(39) = 3.45, p < .01$, number of no opportunities, $t(39) = 3.34, p < .01$, and direct commands, $t(39) = 3.91, p < .01$, during the unstructured clinic observation than during the CDI observation. However, the rate of child deviancy and noncompliance per minute was very similar in the CDI and UNS clinic conditions.

The correlations between the PDI structured observation and the unstructured clinic observation (UNS) indicated that out of the five mother behaviors there were three significant correlations between mothers' total commands, commands with no opportunity to respond, and total praise. There also was no correlation between child deviancy and noncompliance across the two clinic situations. The ANOVAS indicated that the rate of total mother commands, $t(39) = 5.16, p < .001$, no opportunities, $t(39) = 3.24, p < .01$, direct commands, $t(39) = 2.68, p < .05$, child noncompliance, $t(39) = 4.16, p < .001$, and child deviancy, $t(39) = 3.92, p < .01$, was significantly higher during PDI clinic condition than during the unstructured clinic observation.

Clinic versus Home Observations

None of the seven mother and child behavior observations were correlated between the highly structured PDI clinic observation and the home observations. Results from ANOVA also indicated that mothers and children behaved at different behavior rates per minute in the two settings. During PDI, mothers gave significantly more total commands, $t(39) = 6.37, p < .001$, more no opportunity commands, $t(39) = 4.87, p < .001$, and more direct commands, $t(39) = 5.05, p < .001$, than in the home. Children were

also significantly more noncompliant, $t(39) = 3.73, p < .01$, during PDI condition than in the home. However, when the noncompliance ratio was calculated on the basis of number of commands given, there was no difference between PDI condition and home observations.

Four out of seven correlations between the mildly structured CDI clinic observations and the home observations were significant. Mother total commands correlated significantly between home and CDI observations, as did no opportunity commands, direct commands, and critical statements. Mother praise and child deviancy and noncompliance did not correlate between home and CDI observations. None of the mother or child behavior rates differed significantly between the CDI clinic and home observations.

Pearson correlation coefficients indicated a high degree of correlation between the unstructured clinic observation and the home observations. Observations in all seven categories were significantly correlated. Mother's total commands in the UNS clinic conditions correlated highly with total commands in the home, as did no opportunity commands, direct commands and critical statements, and praise. Children's noncompliance and deviancy in the UNS clinic condition also correlated highly with child noncompliance and deviancy in the home. Results from the ANOVAS again indicated higher rates of total mother commands per minute, $t(39) = 4.45, p < .001$, no opportunity commands, $t(39) = 4.85, p < .001$, direct commands, $t(39) = 3.60, p < .01$, and praise, $t(39) = 4.63, p < .001$, in the unstructured clinic condition than in the home. However, the rate of total child deviancy was significantly higher in the home, $t(39) = -4.22, p < .001$, than in the unstructured clinic condition, as was the noncompliance ratio, $t(39) = -2.66, p < .05$.

Correlations of Child Behavior Observations and Parent Perceptions

The mean and standard deviation of the number of behavior problems according to the mothers' reports on the Eyberg Child Behavior Inventory was 21.2 ± 7.0 , and the mean intensity score was 157.7 ± 28.5 . These means clearly fall within the range of clinic conduct-disordered children as described by Eyberg and Ross (1978). Pearson product-moment correlations were then calculated between the two child deviancy and noncompliance behavior scores recorded by the independent observers during the three sets of clinic observations and the home observations and mothers' reports of their children's behavior problems. The only significant correlations were found between child deviancy and noncompliance observed during the PDI clinic situation and mother's reports on the Eyberg Problem Score, $r(39) = .40, p < .01$.

CONCLUSIONS

The lack of correlation between the two sets of structured clinic observations (PDI and CDI) and the unstructured clinic observations (UNS) as well as the lack of correlation between the structured clinic observation and the unstructured home observations illustrates that mothers and conduct-disordered children react differently to different degrees of structure. Moreover, the high correlation between the unstructured clinic and the unstructured home observations illustrates the importance of structure rather than the setting of the observation. A previous study using the same DPICS observational system reported high correlations between the structured clinic and home observations. However, this would be expected in the Kniskern et al. study (1983) because they structured the home to create an analogue situation just like the clinic situation.

Behavioral observations in the clinic and home also revealed different rates of mother and child behaviors observed per minute depending on the task or degree of structure or setting of the observation. In the most highly structured clinic task situation, PDI, where the parent was asked to have the child follow her lead, there were significantly higher rates of parental commands of all types and significantly higher rates of child deviancy (.90 deviant behaviors/minute) and noncompliance (.67/minute) than during either the CDI or unstructured clinic observation, or the home observation. During the unstructured clinic observation there were significantly more commands and praise than on the home observations but significantly fewer child deviant behaviors and a lower noncompliance ratio (when number of commands was taken into account) than during the home observations. In fact, very little child deviancy occurred during the UNS clinic observation or during the CDI observation.

There are two important limitations of this study. First is the fact that the four different observational situations studied were uniformly presented in a fixed order: UNS interactions followed by CDI followed by PDI followed by home observations. A second related limitation of the study is the unequal time periods of the different sets of observations. The significant differences that were discussed as structure effects might therefore just as logically be interpreted as order or time effects. Future research should attempt to avoid this design problem by randomization and/or counterbalancing the order and by using equivalent time periods for each condition.

The question then remains as to which of the clinic or home observations gives the most valid and reliable assessment of parent and child behaviors. As was seen, the largest number and greatest magnitude of significant correlations were obtained between the unstructured clinic and home observations. There were very few correlations among the three sets of clinic ob-

servations and no significant correlations between clinic PDI and home observations. This finding would seem to imply a greater validity for the UNS clinic and home observations. However, support for the usefulness of the PDI clinic observations was provided when mother reports on the Eyberg Total Behavior Problem Score correlated highly with independent raters' observations of child deviancy and noncompliance during the PDI situation.

Thus, the researcher or clinician is faced with a perplexing problem in choosing an observational assessment procedure. As we have seen, different degrees of structure lead to differences in the frequencies and types of certain behaviors noted. It is unclear which is the most valid procedure. Perhaps what is most important is not so much that there be a one-to-one correspondence in behaviors between home or clinic or from one situation to another, but rather that we employ an observational procedure that is practical and provides meaningful and useful assessment information about the family. For example, the UNS and CDI less structured clinic situations provided little relevant information about the nature of child deviancy and noncompliance because these behaviors rarely occurred. During the home observations these deviant child behaviors occurred slightly more often, but a great deal of time and expense was necessary to obtain these data. However, the PDI seems to be an efficient if artificial way to accelerate the occurrence of the behaviors of interest that may not naturally occur without provocation (be it during a home or a clinic observation) unless the researcher is prepared to observe continuously over a long period of time. Perhaps the PDI clinic observations can be equated with the "challenge tests" used in medicine—that is, where families are first evaluated at baseline without structure and then are challenged with a great deal of structure. If there is a significant change in parental behavior and, most important, a significant increase in child deviancy and noncompliance, this could be taken as an indicator of a more seriously disturbed parent-child dyad. Some support for this challenge test hypothesis is found in the Kniskern et al. (1983) study with normal children, which found only .27 child-deviant behaviors/minute and .32 noncompliant behaviors/minute during PDI. In fact, they reported no difference between the rates of noncompliance and child deviance between PDI and CDI with normal children, even though the mothers did give more commands during PDI than during CDI. This again would seem to indicate that clinic children react differently to structure imposed by parents than do normal children. Further support for this hypothesis could be provided by a study comparing conduct-disordered children and normal children interacting with their parents in the home and clinic using both structured and unstructured situations.

Prior research has yielded mixed results concerning the ability of clinic observations to differentiate normal from deviant parent-child interactions.

Similarly, inconsistent data have been reported concerning the comparability of home versus clinic behaviors. It seems likely that the major reason for these inconsistent results has to do with the tasks of degree of structure imposed during the observations rather than location. Unfortunately, while many studies restrict the environment of subjects in some manner, few provide sufficient descriptions of the instructions or structure of the assessment environment, and few have examined the validity of such observational strategies. If we are to continue to use clinic or home observations as a method of family assessment and of evaluating treatment effectiveness, it would be important to understand the reactive effects of structure and setting on parent and child interactions. In addition to considering the validity of an assessment procedure, it is also important to consider its utility. Results of this study with the DPICS observational coding instrument seem to suggest that the structured PDI clinic observations may be a more relevant as well as efficient method of deriving important assessment information about mothers and conduct-disordered children.

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