



Feeling is Thinking:  
(FisT)ful Thinking or A Proven, Children's  
Mental Health Group Work Intervention.

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## Abstract

*'Feeling is Thinking' (FisT) is a mental health group work intervention for children 8 to 12 years of age and run over eight weeks. Developed by the Royal Children's Hospital Mental Health Service (RCH MHS) Community Group Program in Melbourne, Australia, it is run predominantly in school settings. It utilises a 'train the trainer' model, collaboratively running the program alongside school based welfare staff. The huge popularity of the program led to the development of a training package and a comprehensive evaluation of the intervention using clinically standardised measures over a 12 month period. The evaluation found several important symptomatic and behavioural improvements in children referred to the FisT program, and offers impetus for the development of a randomised controlled trial.*

## Introduction

In the late 1990's, Melbourne's Royal Children's Hospital Mental Health Service (RCH MHS) set about to better service the local western and north western metropolitan community. One of the initiatives commenced was the Community Group Program (CGP), run by a small team of its clinicians in collaboration with the Department of Education. The objective of the CGP then, and still today, is to address the mental health and well being of 'at risk' children and adolescents through an integrated, innovative and clinically evaluated group work treatment response.

Feeling is Thinking (FisT) is the most requested group offered by the CGP. It is targeted at children aged between 8-12 years who experience problems in expressing their strong feelings and who have difficulties in their interpersonal relationships (Pavlidis & Bunston, 2004). Typically, these children may be very aggressive in their interactions or, conversely, withdrawn and demonstrate a limited range of emotional expression and comprehension. They often have difficulties with externalizing as well as internalizing problems. Rather than manipulating the defense mechanisms of children who are considered to have developed dysfunctional intra and inter-relational patterning, the program has a strengths based focus. It endeavors to expand the emotional repertoire of children, building their capacity to problem solve, and extending their cognitive processing and interpersonal skills.

The FisT program has a Cognitive Behavioural Therapy focus; however an attention to the group processes is also prominent and warrants attention. The children referred into FisT are commonly marginalised within their social and educational setting and require reparative experiences in their relationships with both the adults and other children in the group.

We operate from an assumption that group work can offer children and adolescents a powerful therapeutic arena in which they can explore and experiment with a range of different situations that mirror the delicate and often difficult dynamics that operate within families and other intimate relationships. As one's image of self is more often than not derived from the reflection we see in the eyes of others, group work therapy can offer a very creative, intensive and personally exciting way of enhancing and strengthening one's sense of self. Enabling children and young people to have Growthful Relational Opportunities (GRO), is what we believe group work is all about" (Bunston, Pavlidis & Leydon, 2003, p: 41).

The FisT program runs for 8 weeks with each session lasting approximately ninety minutes each. A pre-group assessment session (ideally involving parents and/or

school staff) is held as well as providing post-group feedback sessions for parents (and teachers when requested). The maximum number of participants is 8 with a minimum of 2 facilitators. Issues of gender are considered when establishing the group with facilitators striving for either a 50/50 gender mix or selecting a same sex group.

Each session follows a similar format. Sessions begin with the introduction of a new theme, followed by a review of the previous week's work. A warm-up activity focuses the members on different types of feelings. This is followed by a game and reflection time. Each session ends with distribution of stickers and member feedback. For example the focus of session three is exploring anger. We brainstorm 'What is anger,' 'What happens when we get angry,' 'Is anger good or bad?' and 'What are the good and bad consequences of our anger?' We then move to an activity where pre-prepared cue cards (i.e. stay alone, walk away, smash something etc) are laid out for participants to then choose which best describes how they handle their anger. Further questions are asked to tease out how they deal with, feel about and handle their anger, as well as 'Does it work?', 'Who else handles anger this way (family, friends)?' and 'Is there a difference between how males and females show/handle their anger?'. This is followed by using a 'fact sheet' that explains that anger is a natural emotion, is not good or bad but the actions we choose as a result of our anger may have good or bad outcomes for ourselves or others and ask the participant to try and list these (Pavlidis & Bunston 2004).

The games used within the program are selected according to the unique presentation of each group, the developmental progress of the group over the eight weeks and the themes requiring illustration (Audette & Bunston, 2006). For example, games that play with a range of emotional expressions and enable participants to perhaps act out 'angry', 'happy', 'sad', 'lonely' and 'curious' animals, may complement the week where identifying feelings is being discussed.

## Parental Involvement

Much work is undertaken within the FisT program to involve parents in the pre-assessment sessions and individual feedback sessions at the conclusion of the groups. These sessions endeavour to brief parents on the strategies their children developed during the program in order to encourage parents to help them maintain and continue their progress. Additionally, parents are often contacted during the course of the group when difficulties arise or disclosures made that are better addressed outside of the group context. The commitment to sustainable outcomes led to a decision in 2004 to incorporate a parent component into the FisT program. Designed to compliment the work undertaken by the children's group, parent's participating in FisT undertake similar activities, exploring how they

themselves express strong emotions and what strategies enhance how both they and their child can manage conflict, their own sense of self and relating to others.

Requests for the child/parent version of FisT have failed to match requests for the stand alone child program. This may be explained by the general dilemma of involving significantly troubled parents in child/parent treatment programs. To date only a very small number of parent programs have been run. However, we are keen in the future to compare the outcomes of these two tiered groups with the 'children only' groups. The demand by schools, as well as our own mental health clinicians, led to the development of training workshops on 'how to run a FisT program' as well as the publication of a training manual (Pavlidis & Bunston 2004).

## A Comprehensive Evaluation

With over 70 FisT programs having now been run by the CGP in a variety of locations within Western and North Western Metropolitan Melbourne, and others being run by FisT training graduates who had participated in our 'train the trainer' program, attended training or through simply purchasing the manual, it was important to undertake a comprehensive evaluation of FisT to more fully measure and substantiate its true effectiveness. As a result we invested in some measures that were additional to what we already used and decided to undertake an intensive evaluation of FisT over a 12 month period in conjunction with the ongoing pre and post evaluation we have endeavoured to undertake with all our CGP groups since 1999 (Dileo 2006), using the 'Strengths and Difficulties Questionnaire' (SDQ - Goodman, 1999).

### Methodology

#### *Participants*

Participants comprised of 88 young people who participated in the FisT program. The age of these participants ranged from 8 to 12 ( $M=9.79$ ,  $SD=1.07$ ). 22 participants (25%) were female and 66 participants (75%) were male. 27 of these participants (31%) were referred from Victorian Child and Adolescent Mental Health Services (CAMHS), whilst 61 participants (69%) were referred from Victorian Schools in the western and north western metropolitan suburbs of Melbourne, Australia.

#### *Measures*

Brief parent, teacher and self report measures were used to assess key social, emotional and behavioural constructs before and after the FisT program. The following three measures were administered.

## Strengths and difficulties questionnaire

The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997) is a brief behavioural screening questionnaire that exists in several versions. This study used the parent, teacher and self informed questionnaires for children aged 6 to 11, requiring each informant to rate 25 questions on a 3-point Likert scale. This measure yields scores on 5 subscales: emotion symptoms; conduct problems; hyperactivity; peer problems; and prosocial behaviour, as well as a score for total difficulties. The SDQ has demonstrated strong correlations with the Child Behavioural Checklist (CBCL; Reynolds & Kamphaus, 1992), and claims strong discriminative validity (Goodman & Scott, 1999). The SDQ has recorded reasonable internal consistency and test-retest reliability at .76 and .75 respectively (Goodman, 1997). Heterogeneous normative data has been collected for the SDQ, and all scores can be plotted against borderline and abnormal ranges.

## Social skills rating scale

The Social Skills Rating Scale (SSRS) (Gresham & Elliott, 1990) is a broad, multi-informant assessment of child social behaviours that influence relationships at school and home. The SSRS is focused on positive behaviours or prosocial skills, with a brief assessment of problem behaviours and academic competence (academic competence was not assessed in this study). Teacher, parent and self report forms vary slightly, but collectively include subscales for co-operation, assertion, responsibility, empathy, self control, externalising problems, internalizing problems, and hyperactivity. The three forms include between 30 and 38 items where informants rate the frequency and importance of various behaviours on 3 point Likert scales. Normative data based on a large heterogeneous sample allows conversion of raw scores to standardized scores. Psychometric testing has found the SSRS to have adequate internal consistency (ranging from .73-.95 across scales), test-retest reliability (ranging from .48 to .88) and interrater reliability (ranging from .54 to .93) (Gresham & Elliott, 1990). The SSRS establishes content validity through the use of 'importance ratings' and previous research indicating the domains of social skills, problem behaviour and academic performance being important constructs in evaluating children's social behaviour (Gresham & Elliott, 1990)

## Children's inventory of anger

The Children's Inventory of Ander (ChIA) (Nelson & Finch, 2000) is a child informed, self report assessment, which explores various elements of anger: including intensity, relationship focus and expression. Children respond to 39 items outlining various home and school situations, and selects which place on a 4-point

Likert scale reflects the level of anger they feel. In addition to a total anger score, ChIA yields subscales for frustration, physical aggression, peer relationships and authority relations. Normative data from a large heterogeneous sample allows standardization of scores and the identification of individuals in the abnormal or clinical range. The ChIA has demonstrated strong internal consistency (.95), adequate test-retest reliability (.66) and split-half reliability (.83 to .95) (Nelson & Finch, 2000). This measure has also established content and discriminate validity via psychometric testing in clinical populations (Nelson & Finch, 2000).

### *Procedure*

All participants were referred to the FisT program from 12 schools in the north western suburbs of Melbourne. Upon acceptance into the program and signed consent from parents, pre-program assessment questionnaires (i.e.: the SDQ, SSRS and ChIA) were sent to the parents, teachers and individuals participating in the program. These were completed within 2 weeks of commencement of the program. Programs containing between 6 and 8 children per group were conducted at each school over an 8 week period, as outlined in the "FisT: Feeling is Thinking" manual (Pavlidis & Bunston, 2004). At the completion of the program, parents, teachers and participants were given the assessment questionnaires to complete for a second time. Overall, it is important to note that this evaluation was conducted post-hoc for exploratory purposes, and therefore, no control group was recruited for comparison.

### *Data Analysis*

All data was entered, scored, transformed and analysed in Statistical Package for the Social Sciences (SPSS version 13.0). All data at pre-program assessment was transformed to identify the clinical band in which each subscore fell, from which a clinical profile could be built. As only 6 self-report SDQ records were obtained, these were removed from the analysis. Due to missing data an uneven number of participants for various reports and subscales, the number of participants in the abnormal range for each subscale was converted to a percentage of total participants for each subscale. The total number of participants for each measure is noted on each presentation and analysis for reference. Preliminary data analysis was run to ensure the assumptions of subsequent statistical analysis were met. Box plots, histograms and normality Q-Q plots were used to identify univariate outliers. As a result of this analysis, three SSRS subscales were transformed with a squared transformation to address negative skewness. Differences between mean pre and post scores were via by a paired samples t-test with  $\alpha = .05$ , and  $d'$  was calculated to estimate the effect sizes. For exploratory purposes, a mixed repeated measures ANOVA's were conducted using subscales as the within-subjects and gender as the between subjects factor, with  $\alpha = .05$ , and  $\eta^2$  calculated to estimate

the effect sizes. Note, these mixed repeated measure ANOVAs are exploratory in nature and should be interpreted with caution due to small and unequal samples.

## Study Findings

### *Participant profile*

Eighty-eight children between the ages of 8 and 12 were recruited to FisT in 2005 ( $M=9.75$ ,  $SD=1.08$ ). 22 of these children were female, and 66 were male. 27 were recruited from Child and Adolescent Mental Health Services (CAMHS) whilst 61 were recruited from primary schools in the western and north western Melbourne metropolitan areas.

As illustrated in Table 1, parents, teachers and individuals self report a large number of FisT participants meeting the abnormal or problem range for SDQ, SSRS, and ChIA measures. Although parents and teachers appear to agree overall in terms of problem behaviours (indicated by SDQ – total difficulties and SSRS Problem Behaviours), the specific problem behaviours identified by informants differ. Whilst parents report more participants in the clinical range for internalising and emotion symptoms, teachers report more participants in the higher range for externalising and hyperactivity. Mixed results are presented for prosocial behaviour, with parents reporting a lower number of participants with prosocial behaviour deficits than teachers on the SDQ, and the reverse pattern is presented in the SSRS. *Strengths and Difficulties Questionnaire (SDQ) findings*

Forty-seven parents and 62 teachers completed the SDQ for children before and after the FisT program. Parents reported slight improvement on all subscales, but not at a significant level. When testing for gender differences using a mixed repeated measure ANOVA, a significant interaction was found between gender and parent report of peer problems  $F(1,46) = 4.73$ ,  $p = .03$ ,  $\eta^2 = .10$ . Females were reported to have significant reductions in peer problems, whilst male peer problems were reported near the same level.

In contrast to parents, teachers reported statistically significant improvement on all SDQ subscales. Strong improvements were reported on prosocial behaviour  $t(61) = 4.31$ ,  $p < .01$ ,  $d' = .45$ , total difficulties  $t(61) = 4.02$ ,  $p < .01$ ,  $d' = .52$ , peer problems  $t(61) = 3.97$ ,  $p < .01$ ,  $d' = .42$ , conduct problems  $t(61) = 2.93$ ,  $p < .01$ ,  $d' = .38$ , hyperactivity  $t(61) = 2.89$ ,  $p = .01$ ,  $d' = .36$ , and emotion symptoms  $t(61) = 2.36$ ,  $p = .02$ ,  $d' = .45$ . When testing for gender differences using a mixed repeated measure ANOVA, no significant interactions were found. Overall however, teachers reported male children to have significantly higher levels of hyperactivity  $F(1,62) = 23.50$ ,  $p < .01$ ,  $\eta^2 = .28$  than females, and females were reported to

have significantly stronger prosocial behaviour than males  $F(1,62) = 11.42, p < .01, \eta^2 = .16$ .

### *Social Skills Rating Scales (SSRS) Findings*

Thirty-eight parents, 35 teachers and 66 participants completed the SSRS questionnaire before and after the FisT program. Parents reported statistically significant improvement in cooperation  $F(1,37) = 2.72, p = .01, d' = .37$ , and overall social skills  $F(1,37) = 2.21, p = .02, d' = .30$ . Improvement on all other scales was also reported, but not at statistically significant levels. When testing for gender differences using a mixed repeated measure ANOVA, an interaction approaching statistical significance was reported for internalising problems  $F(1,37) = 3.09, p = .09, \eta^2 = .08$ . Whilst females were reported to have more internalising problems post FisT, males were reported to have fewer internalising problems. Overall, parents reported males to demonstrate more self-control  $F(1,37) = 4.66, p = .04, \eta^2 = .11$  than females.

Teachers reported statistically significant improvements in cooperation  $F(1,34) = 2.72, p = .03, d' = .26$ , self control  $F(1,34) = 1.99, p = .05, d' = .26$ , externalising problems  $F(1,34) = 2.54, p = .02, d' = .36$ , internalising problems  $F(1,34) = 2.42, p = .02, d' = .25$ , hyperactivity  $F(1,34) = 2.93, p < .01, d' = .34$ , and problem behaviours  $F(1,34) = 3.78, p < .01, d' = .44$ . When testing for gender differences using a mixed repeated measure ANOVA, no significant interactions were found. Overall, females were reported to have higher cooperation skills  $F(1,34) = 9.10, p < .01, \eta^2 = .22$ , self control  $F(1,34) = 7.40, p = .01, \eta^2 = .18$  and overall social skills  $F(1,34) = 5.47, p = .03, \eta^2 = .14$  than male children. Male children were reported to have significantly higher hyperactivity problems than females  $F(1,34) = 8.86, p = .01, \eta^2 = .21$ .

Children completing the SSRS reported slight improvement over the FisT program, but not of statistical significance. When testing for gender differences using a mixed repeated measure ANOVA, no significant interactions were observed. Overall, females reported themselves to have higher cooperation  $F(1,65) = 4.37, p = .04, \eta^2 = .06$ , self control  $F(1,65) = 4.18, p = .05, \eta^2 = .06$  and overall social skills  $F(1,65) = 3.96, p = .05, \eta^2 = .06$ , than male participants.

### *Children's Inventory of Anger (CHIA) Findings*

Twenty-five children completed the CHIA before and after the FisT program. Children did not report any change across any of the CHIA subscales following the FisT program. When testing for gender differences using a mixed repeated measure ANOVA, a significant interaction was observed for frustration  $F(1,25) = 4.36, p = .05, \eta^2 = .15$  and physical aggression  $F(1,25) = 7.25, p = .01, \eta^2 = .23$ .

Whilst females reported increased frustration and physical aggression after FisT, males reported decreased frustration and physical anger. Overall, females reported significantly less anger towards authority than males  $F(1,25) = 7.14, p = .01, \eta^2 = .23$ , a difference that was also found for total anger  $F(1,25) = 4.86, p = .05, \eta^2 = .06$ .

## Discussion

This evaluation found that children being referred to FisT program have a clinical profile characterised by maladaptive externalising behaviours, peer problems, anger, and limited prosocial behaviours. Following participation in the FisT program, teachers reported statistically significant improvement in these problem areas, whilst parents reported slight but less significant improvement. The analysis of self report data found no significant change after the program. Exploratory statistical analysis of gender effects found several significant differences between males and females before and after the FisT program, and some differential outcomes based on gender. In sum, this program evaluation found several results of statistical significance that warrant discussion.

More than half of the eighty eight children referred to the FisT program were reported by parents and teachers as having emotional and behavioural difficulties at levels that are found in clinical populations. While nearly a third of participants had been referred into the FisT programs by Child and Adolescent Mental Health Services (CAMHS), suggesting an already established clinical population in part, this high number indicates that referrals from the primary schools had appropriately identified students with significant social, emotional and behavioural difficulties. Schools typically refer children into the program who present with anger management/conduct problems as these children attract the most energy and attention from the school community broadly. It is sometimes only in discussion with facilitators from the CGP pre-program that school referrers consider including children with internalising difficulties and/or a potential role model to enhance the reparative properties that a diverse client mix can offer the group membership overall.

While teachers reported significant improvement overall, the most notable improvements were a reduction in overall behavioural difficulties, fewer hyperactivity symptoms, and an increase in prosocial behaviour. The higher levels of improvement noted by teachers over parents may reflect the greater investment schools have in the program as the predominant referrers/hosts for the group. Conversely, as the program operates most often within a school setting, changes experienced by the participants within the group may be more readily transferred into other areas of their school/peer exchange over their home environment. Participants are potentially given immediate opportunities to practice what has

been explored in the group in relation to assertive behaviours and problem solving skills as well as strategies to improve their social skills and relationships with others

The exploratory analysis of gender effects found some interesting results that are worthy of additional analysis. Overall, males had significantly higher levels of hyperactivity and total anger, and lower prosocial skills than females overall. Female participants reported significantly reduced peer problems following the program, while no change was noted for males. Furthermore, following the program, females reported higher levels of anger whilst males reported lower levels of anger. One hypothesis may be the primary aged girls are more preoccupied with establishing and maintaining friendships than boys. Their own personal goals within the group and the reason for schools referring them into FisT may have involved peer difficulties whereas boys may have self and school identified problems with managing their anger. An increase in girls identified levels of anger may reflect some levels of contagion, with exposure to others with clearly identified aggressive and/or conduct difficulties negatively impacting on them. Equally, it could be proposed that girls who may typically internalise their feelings may perceive a greater accessibility to their emotional expression as anger.

It is important to recognise that this paper is based on a retrospective program evaluation and there are some limitations that could be improved on in future research. Firstly, the limited sample size and poor statistical power may have introduced type two statistical errors. In other words, some additional changes may have occurred following participation in the FisT program, but could not be identified due to statistical limitations. In acknowledging this limitation, it is equally important to recognise and appreciate the nature of this clinical population, the FisT program, and the nature of the evaluation that was conducted. Even the most thoroughly planned and well orchestrated clinical research project will face similar difficulties in the recruitment and retention of participants due to the transient nature of the families of many children referred to this program. As such, investigators would be advised to develop recruitment and retention strategies in advance to maximise their statistical power. Secondly, due to resource limitations, FisT program facilitators also played the role in administering the assessment procedures, a situation which may have confounded informant responses due to expectancy bias. Future research could benefit from complementing self-report and informant measures with double-blind clinician administered assessments. Furthermore, a longitudinal design that would also assess children at 6, 12 and/or 24 month follow up could also explore the longer term effects of participation in the FisT program.

In summary, it is difficult to conclude that the FisT program is 'wishful thinking' or a proven children's mental health group work intervention. This evaluation found

several important symptomatic and behavioural improvements in children referred to the FisT program, and offers impetus for the development of a randomised controlled trial. Such endeavours will benefit from the insights offered in this paper with respect to the recruitment, assessment, and retention of this challenging and often transient population. Given the popularity of this school based intervention these results are at the very least encouraging as this is a client group that warrants an effective intervention that is strengths based and endeavours to expand the emotional repertoire of children, building their on capacities to problem solve, and expand their cognitive processing and interpersonal skills. At most, the evaluation of this program, as with the children who attend it, requires a further investment of time, energy and attention.

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Table 1

*Presentation of FisT participants who met the abnormal, clinical or problem range for the SDQ, SSRS and ChIA.*

Measure	Subscale	Parent Report	Teacher Report	Self Report
		x% (n)	% (n)	% (n)
<b>SDQ</b>	Emotional Symptoms	42% (74)	30% (78)	
	Conduct Problems	60% (74)	59% (78)	
	Hyperactivity	43% (74)	65% (78)	
	Peer Problems	57% (74)	51% (78)	
	Prosocial Behaviour	14% (74)	41% (78)	
	<b>Total Difficulties</b>	<b>55% (74)</b>	<b>59% (78)</b>	
<b>SSRS</b>	Cooperation	46% (56)	48% (42)	25% (73)
	Assertion	63% (56)	26% (42)	12% (73)
	Responsibility	63% (56)		
	Empathy			27% (73)
	Self Control	57% (56)	27% (42)	15% (73)
	<b>Social Skills</b>	<b>64% (56)</b>	<b>36% (42)</b>	<b>21% (73)</b>
	Externalising	63% (56)	67% (42)	
	Internalising	45% (56)	31% (42)	
	Hyperactivity	61% (56)	57% (42)	
	<b>Problem Behaviours</b>	<b>71% (56)</b>	<b>71% (42)</b>	
<b>ChIA</b>	Frustration			35% (26)
	Physical Aggression			13% (26)
	Peer Relationships			13% (26)
	Authority Relations			19% (26)
	<b>Total Anger</b>			<b>26% (26)</b>

*X% = percentage of participants in the abnormal or problem range*

*n = the number of participants in entire sample of reports received.*

Table 2

*Pre and Post Mean scores for SDQ, SSRS and ChIA subscales, with results from paired sample t-tests*

Measure	Informant	Subscale	Pre FIST		Post FIST		Difference			
			M	SD	M	SD	t	df	Sig.	d'
SDQ	Parent	<i>Emotional Symptoms</i>	3.89	2.45	3.81	2.41	0.26	46	0.79	
		<i>Conduct Problems</i>	4.38	2.52	4.26	2.34	0.43	46	0.67	
		<i>Hyperactivity</i>	6.02	2.76	5.6	2.87	1.49	46	0.14	
		<i>Peer Problems</i>	4.26	2.26	3.81	2.28	1.67	46	0.1	
		<i>Prosocial Behaviour</i>	6.13	2.17	6.49	2.03	-1.19	46	0.24	
		<b>Total Difficulties</b>	<b>18.55</b>	<b>7.48</b>	<b>17.47</b>	<b>7.06</b>	<b>1.27</b>	<b>46</b>	<b>0.21</b>	
	Teacher	<i>Emotional Symptoms</i>	3.1	2.73	2.37	2.3	2.36	61	<b>.02*</b>	0.29
		<i>Conduct Problems</i>	4.27	2.32	3.4	2.18	2.93	61	<b>.01***</b>	0.38
		<i>Hyperactivity</i>	7.18	2.87	6.15	2.79	2.89	61	<b>.01**</b>	0.36
		<i>Peer Problems</i>	3.94	2.36	3	2.02	3.97	61	<b>.01***</b>	0.42
		<i>Prosocial Behaviour</i>	4.89	2.26	5.89	2.1	-4.31	61	<b>.01***</b>	-0.45
<b>Total Difficulties</b>		<b>18.48</b>	<b>6.69</b>	<b>14.92</b>	<b>6.82</b>	<b>4.02</b>	<b>61</b>	<b>.01***</b>	<b>0.52</b>	
SSRS	Parent	<i>Cooperation</i>	7.71	3.76	9.05	3.28	-2.72	37	<b>.01**</b>	-0.37
		<i>Assertion</i>	12.24	3.32	12.61	2.74	-0.89	37	0.38	
		<i>Responsibility</i>	10.55	2.86	11.11	2.7	-1.29	37	0.2	
		<i>Self Control</i>	7.92	2.97	8.66	3.1	-1.7	37	0.1	
		<b>Social Skills</b>	<b>38.42</b>	<b>9.83</b>	<b>41.42</b>	<b>9.79</b>	<b>-2.21</b>	<b>37</b>	<b>.03*</b>	<b>-0.30</b>
		<i>Externalising Problems ^</i>	78.37	43.81	65.89	42.65	1.59	37	0.12	
		<i>Internalising Problems</i>	7.26	2.33	7.05	2.38	0.6	37	0.55	
		<i>Hyperactivity</i>	7.71	2.57	7.58	2.82	0.28	37	0.78	
		<b>Problem Behaviours</b>	<b>23.45</b>	<b>5.65</b>	<b>22.32</b>	<b>6.42</b>	<b>1.08</b>	<b>37</b>	<b>0.29</b>	
	Teacher	<i>Cooperation</i>	10.49	3.53	11.6	4.62	-2.27	34	<b>.03*</b>	-0.26
		<i>Assertion</i>	9.37	3.49	9.83	4.26	-0.73	34	0.47	
<i>Self Control</i>		10.71	4.3	11.97	5.05	-1.99	34	<b>.05*</b>	-0.26	
<b>Social Skills</b>		<b>30.57</b>	<b>9.33</b>	<b>33.4</b>	<b>12.17</b>	<b>-1.9</b>	<b>34</b>	<b>0.07</b>		
<i>Externalising Problems ^</i>		71.34	47.17	53.54	48.9	2.54	34	<b>.02*</b>	0.36	
<i>Internalising Problems</i>		4.86	2.59	4.2	2.45	2.42	34	<b>.02*</b>	0.25	

		<i>Hyperactivity</i> ^	73.17	44.69	56.74	49.11	2.93	34	<b>.01***</b>	0.34
		<b>Problem Behaviours</b>	<b>20.63</b>	<b>7.13</b>	<b>17.17</b>	<b>7.98</b>	<b>3.78</b>	<b>34</b>	<b>.01***</b>	<b>0.44</b>
<b>Self</b>		<i>Cooperation</i>	12.95	3.86	12.7	4.08	0.54	65	0.59	
		<i>Assertion</i>	13.24	3.21	12.5	3.77	1.59	65	0.12	
		<i>Empathy</i>	14	3.41	13.71	4.33	0.56	65	0.58	
		<i>Self Control</i>	11.05	3.71	11.44	4.03	-0.77	65	0.44	
		<b>Social Skills</b>	<b>51.24</b>	<b>12.03</b>	<b>50.35</b>	<b>14.82</b>	<b>0.56</b>	<b>65</b>	<b>0.58</b>	
<b>ChIA</b>	<b>Self</b>	<i>Frustration</i>	23.7	6.3	24	7.4	-0.252	25	0.803	
		<i>Physical Aggression</i>	26.8	6	26.6	7	0.259	25	0.798	
		<i>Peer Relationships</i>	19.8	4.5	19.9	7.2	-0.126	25	0.901	
		<i>Authority Relations</i>	25.8	6.8	25	6.7	0.662	25	1.154	
		<b>Total Anger</b>	<b>98.5</b>	<b>21.3</b>	<b>97.4</b>	<b>26.2</b>	<b>0.289</b>	<b>25</b>	<b>0.775</b>	
*	p < .05 (2-tailed)									
**	p = .01 (2-tailed)									
***	p < .01 (2-tailed)									
^	Paired samples t-test based on transformed data									

Table 3

*An analysis of gender effects on mean SDQ, SSRS and ChIA scores overall, and as an influence on the changes in mean scores following the FisT program.*

	Subscale	Female		Male		Gender Main Effect*		Interaction*		
		Pre	Post	Pre	Post	sig.	$\eta^2$	sig.	$\eta^2$	
<b>SDQ</b>	<b>Parent (n=47)</b>	<i>Emotional Symptoms</i>	4.67	4.40	3.53	3.53				
		<i>Conduct Problems</i>	4.53	4.67	4.31	4.06				
		<i>Hyperactivity</i>	5.27	4.67	6.38	6.03				
		<i>Peer Problems</i>	4.20	2.93	4.28	4.22			0.03	0.10
		<i>Prosocial Behaviour</i>	6.67	7.40	5.88	6.06				
		<b>Total Difficulties</b>	<b>18.67</b>	<b>16.67</b>	<b>18.50</b>	<b>17.84</b>				
	<b>Teacher (n=62)</b>	<i>Emotional Symptoms</i>	3.75	2.81	2.87	2.22				
		<i>Conduct Problems</i>	3.19	3.00	4.65	3.54				
		<i>Hyperactivity</i>	4.69	4.25	8.04	6.80	< .01	0.28		
		<i>Peer Problems</i>	4.81	3.13	3.63	2.96				
		<i>Prosocial Behaviour</i>	6.25	7.19	4.41	5.43	< .01	0.16		
		<b>Total Difficulties</b>	<b>16.44</b>	<b>13.19</b>	<b>19.20</b>	<b>15.52</b>				
<b>SSRS</b>	<b>Parent (n=38)</b>	<i>Cooperation</i>	6.91	8.55	8.04	9.26				
		<i>Assertion</i>	12.00	12.55	12.33	12.63				
		<i>Responsibility</i>	11.45	12.09	10.19	10.70				
		<i>Self Control</i>	6.45	7.27	8.52	9.22	0.04	0.11		
		<b>Social Skills</b>	<b>36.82</b>	<b>40.45</b>	<b>39.07</b>	<b>41.81</b>				
		<i>Externalising Problems ^</i>	99.18	77.91	69.89	61.00				
		<i>Internalising Problems</i>	7.27	8.00	7.26	6.67				
		<i>Hyperactivity</i>	7.36	8.64	7.85	7.30				
		<b>Problem Behaviours</b>	<b>24.36</b>	<b>23.91</b>	<b>23.07</b>	<b>21.67</b>				
	<b>Teacher (n=35)</b>	<i>Cooperation</i>	13.83	16.00	9.79	10.69	0.00	0.22		
		<i>Assertion</i>	9.33	10.33	9.38	9.72				
		<i>Self Control</i>	14.50	16.17	9.93	11.10	0.01	0.18		
		<b>Social Skills</b>	<b>37.67</b>	<b>42.50</b>	<b>29.10</b>	<b>31.52</b>	<b>0.03</b>	<b>0.14</b>		

		<i>Externalising Problems</i> ^	51.67	18.00	75.41	60.90		
		<i>Internalising Problems</i>	5.17	4.67	4.79	4.10		
		<i>Hyperactivity</i> ^	28.67	13.67	82.38	65.66	0.01	0.21
		<b><i>Problem Behaviours</i></b>	<b>16.17</b>	<b>11.33</b>	<b>21.55</b>	<b>18.38</b>		
	<b>Self (n=65)</b>	<i>Cooperation</i>	14.56	13.94	12.35	12.23	0.04	0.06
		<i>Assertion</i>	14.61	12.67	12.73	12.44		
		<i>Empathy</i>	15.17	14.78	13.56	13.31		
		<i>Self Control</i>	12.56	12.56	10.48	11.02	0.05	0.06
		<b><i>Social Skills</i></b>	<b>56.89</b>	<b>53.94</b>	<b>49.13</b>	<b>49.00</b>	<b>0.05</b>	<b>0.06</b>
<b>ChIA</b>	<b>Self (n=25)</b>	<i>Frustration</i>	17.14	20.86	26.11	25.11		0.05 0.15
		<i>Physical Aggression</i>	22.43	26.29	28.47	26.68		
		<i>Peer Relationships</i>	17.57	18.29	20.58	20.53		0.01 0.23
		<i>Authority Relations</i>	20.14	21.14	27.84	26.47	0.01	0.23
		<b><i>Total Anger</i></b>	<b>78.86</b>	<b>88.43</b>	<b>105.79</b>	<b>100.68</b>	<b>0.04</b>	<b>0.17</b>

^ Paired samples t-test based on transformed data

\* Only reported if a significant result was found