AN EVALUATION OF A BRIEF BEHAVIOURAL FAMILY INTERVENTION

MELISSA K. DAWKINS B.SC. (HONS)

AN EVALUATION OF A BRIEF BEHAVIOURAL FAMILY INTERVENTION

MELISSA K. DAWKINS B.SC. (HONS)

AN EVALUATION OF A BRIEF BEHAVIOURAL FAMILY INTERVENTION

MELISSA K. DAWKINS B.SC. (HONS)

This thesis is submitted in partial fulfillment of the requirements for the Master of Psychology (Clinical) degree, Department of Psychology, the University of South Australia, 2000.

DECLARATION

This thesis does not contain any material that has been previously offered for any degree or diploma at any University or other tertiary institution. This thesis does not contain previously published material from any other source, except where due reference is made in the text.

Melissa K Dawkins

Melissa K. Dawkins B.Sc. (Hons)

May 2000

ACKNOWLEDGMENTS

There are several people I need to mention here. Thanks to my supervisor, Greg Ireland, for helping my idea along and training me in the skills required to conduct Primary Care Triple P. Thanks to the staff at CAMHS - Eastern Region for their time and cooperation, particularly Pam Schofield. Without Pam, this thesis could not have happened. Thanks also for Pam thinking of me when a position became available at CAMHS - Northern Region. Thanks must also go to the families who participated in this study. Lastly, I would like to thank my family and everyone else who has given me much support and encouragement.

TABLE OF CONTENTS

DECLARATION ii

ACKNOWLEDGMENTS iii

LIST OF TABLES vii

ABSTRACT viii

CHAPTER 1: INTRODUCTION

1.1 Parent Education 1

1.1.1 History of Parental Involvement 1

1.1.2 Contribution of Behaviour Theories 2

1.2 Parenting Skills as a Risk/Protective Factor 5

1.2.1 Conduct Problems 7

1.3 Behavioural Family Intervention (BFI) 8

1.3.1 Effectiveness of BFI 10

1.4 The Positive Parenting Program (Triple P) 11

1.5 The Evaluation of Triple P 16

1.5.1 Development of the Core Intervention 17

1.5.2 Randomised Efficacy Trials 19

1.5.3 Effects of Self-Directed Variants 20

1.5.4 Evaluation of Group Triple P 21

1.6 Brief Interventions 22

1.6.1 Brief Primary Intervention 23

1.7 Aims 23

1.8 Hypotheses 24

CHAPTER 2: METHODS 25

2.1 Participants 25

2.2 Procedure 25

2.3 Measures 27

2.3.1 The Eyberg Child Behavior Inventory (ECBI) 28

2.3.2 The Parenting Scale 29

2.3.3 Parenting Sense of Competence (PSOC) Scale 29

2.3.4 The Parent Problem Checklist (PPC) 30

2.3.5 The Abbreviated Dyadic Adjustment Scale (ADAS) ... 31

2.3.6 The Depression-Anxiety Stress Scales (DASS) 31

2.3.7 The Parent Daily Report Checklist 32

2.3.8 The Client Satisfaction Questionnaire (CSQ) 33

2.3.9 Family Background Questionnaire 33

2.4 Statistical Analysis 34

CHAPTER 3: RESULTS 35

3.1 Participants 35

3.2 Adherence to Sessions 38

3.3 Comparisons Between Groups 39

3.4 Wait-listed Control Group 40

3.5 Experimental Group Improvements 41

3.6 Wait-listed Control Group Improvements 41

3.7 Overall Improvements as a Group 42

3.8 Client Satisfaction Questionnaire 43

3.9 Comparison to Community Samples 44

3.10 Attrition Rates 45

CHAPTER 4: DISCUSSION 46

4.1 Findings of the Present Study 46

4.1.1 The Initial Hypothesis 46

4.1.2 Other Findings in the Present Study 47

4.2 Comparing Present Study to Community Norms 50

4.3 Attrition Rates 51

4.4 Limitations 54

4.5 Conclusions & Recommendations 55

REFERENCES 58

LIST OF APPENDICES 71

Appendix A 72

Appendix B 74

LIST OF TABLES

TABLE 1: Marital Status of Participating Parents 36

TABLE 2: Educational Level of Participating Parents 37

TABLE 3: Employment Status of Participating Parents 38

TABLE 4: Average Number of Weeks Between Sessions 39

TABLE 5: Average Time of Each Session (in minutes) 40

TABLE 6: The Statistics for the Client Satisfaction Questionnaire .. 44

ABSTRACT

Behavioural Family Intervention (BFI) is an approach to parent education based on the behavioural modification model. Australian research by Matthew Sanders and his colleagues have repeatedly demonstrated that parent education and training is an effective intervention for young children at risk for developing conduct and other behavioural problems. The most researched version of family intervention developed by Sanders and his colleagues is Triple P - The Positive Parenting Program.

Triple P aims to prevent conduct problems in children by increasing the skills of their parents. It attempts to account for the differences in intervention required by having 5 levels of intervention, from a self-help level with no therapist contact to intensive family intervention. As there had been no controlled evaluations of Level 3 Primary Care Triple P (a brief 4-session intervention) it was decided to conduct a study evaluating this level of intervention.

This study was conducted with the parents of children on the waiting list for services at Child and Adolescent Mental Health Services (CAMHS) - Eastern Region, in Adelaide, South Australia. Twenty parents agreed to participate and were divided into 2 groups -

an Experimental (EX) group and a Wait-Listed Control (WL) group. The EX group received the intervention immediately, whereas the WL group waited 6 weeks before beginning the intervention. Families completed a series of questionnaires from Triple P at several points in the study - before (PRE) and after (POST) completing the intervention, and also at a 6-week follow-up (FU). Families in the WL group completed the questionnaires again, before the 6-week wait to begin the intervention (1-PRE).

The results of the study demonstrated positive effects on the participating parents, with milder positive effects on their children, compared to a wait-listed control group. The sample in the present study also reported higher levels of dysfunction than what would be expected in community samples, even after the completion of the intervention. Due to the low response rate and the high attrition rate in the present study, limited conclusions can be drawn, and it is recommended that further studies be carried out to help determine what type of intervention will help CAMHS clients. Further evaluations of Level 3 Triple P are also recommended.

CHAPTER 1: INTRODUCTION

1.1 Parent Education

Parent education has been defined as: "the formal attempt to increase parents' awareness and facility with the skills of parenting" (Lamb & Lamb, 1978, p. 14), with the broad goal to increase the skills of parents in the community (Lamb & Lamb, 1978).

1.1.1 History of Parental Involvement

Involving parents in the treatment of their children is not a new idea. Informally, parent education has existed for hundreds of years. In fact, when printing press was first introduced in the 1400's, information on parenting was one of the first topics published (Polster & Dangel, 1984).

Brim (1959; cited by Lamb & Lamb, 1978) reports that active parent training programs existed throughout Europe during the 18th century, and the interest increased during the early part of the 19th century. Brim discovered several magazines appearing between 1830 and 1850, including *Mother's Magazine, Mother's Assessment*, and *Parent's Magazine*, indicating the interest in parent education and training. Brim also traced group meetings of parents in the United States of America back to 1815, and 'maternal association' meetings throughout the United States of America around 1820. Between 1920

and the early 1930's various programs were developed, and parent education became professionalised due to increased financial support (Lamb & Lamb, 1978). Behavioural parent trainers began refining their methods in the 1950's, with the first formal account of behavioural parent training published in 1959 (Polster & Dangel, 1984). This study (Williams, 1959; cited by Bijou, 1984) illustrated that tantrum behaviour could be eliminated by an operant extinction procedure. The next important study was published in 1966 (Hawkins, Peterson, Schweid, & Bijou, 1966; cited by Bijou, 1984). This study was more exacting and more complicated in research design, both in terms of the parental training and in terms of the method of data collection

1.1.2 Contribution of Behaviour Theories

Ideas of behaviour modification grew out of the work of early learning theorists. Initial studies in basic learning were conducted on animals in the 1930's and 1940's. In the 1950's this focus shifted to humans, and behavioural modification techniques began to develop. One of the first experimental studies demonstrating that someone who is unskilled in behaviour modification could be taught to control certain behaviours in others by manipulating reinforcement contingencies was performed in the late 1950's. Behaviour modification extended to a variety of applied problem situations in the

early 1960's, including much work with parents and their children (O'Dell, 1974).

Parent education using the behavioural modification model focuses on increasing the parental skills of influencing, controlling and directing behaviour and development. Therefore, parents act as agents of change for their children. The essential goal of parent education with a behavioural modification focus is to have the parents - the most significant aspect of the child's environment - accept responsibility for changing their own child. This also assumes that parents can change by acquiring more skills. The behavioural modification model of parent education involves techniques including observation, functional analyses of behaviour, reinforcement, punishment, and extinction, development of good communication skills, contingency contracting and token economies, program generalisation and program maintenance, and program evaluation. The training procedures involved include didactic instruction, role playing, modeling, cuing, contingency contracting, and videotape feedback (Lamb & Lamb, 1978).

Possibly the first study using behaviour modification principles for parental education in a group process was conducted in 1965 (Pumroy, 1965; cited by O'Dell, 1974). Parents in this study attended lectures on behaviour modification principles and received advice on

applying these principles to specific problems. The findings encouraged others to research this area and investigate the extent these approaches could be applied to a variety of problems (O'Dell, 1974).

A review (O'Dell, 1974) of studies employing behaviour modification principles to assist parents in dealing with their children demonstrated that changing parental behaviours to reinforce desired behaviours and ignore or punish undesirable behaviours results in positive changes in children's behaviour. Due to the success of parent education and training in behaviour modification for a range of areas, including different child behaviour problems, a range of parents, and use with groups or individuals, O'Dell (1974) concluded that parent education was a promising area of preventative mental health.

Parent education programs for parents of children displaying behaviour management problems continued to become a popular form of intervention for families in the early 1980's. A wide range of training methods were employed to teach parents behaviour modification skills at both group and individual levels. Methods and techniques proven to be successful include using verbal and written instructions, lectures, modelling, behavioural rehearsal, and feedback (Sanders, 1982).

Parent education procedures based on behavioural modification approaches are by far the most popular and extensively

researched approach. Other approaches to parent education have been based on Alderian, Client-Centred, and Rational Emotive therapies (for further information on these other approaches, refer to Lamb & Lamb, 1978).

1.2 Parenting Skills as a Risk/Protective Factor

The quality of family life is fundamental to the well-being of children. Relationships within the family, most importantly the relationship between the parent and child, have a strong influence on the psychological, physical, social, and economic well being of children. Significant mental health, social, and economic problems have been associated with disturbances in family functioning and the breakdown of family relationships (Chamberlain & Patterson, 1995; Patterson, 1982; Sanders & Duncan, 1995). Families are important in the development, maintenance, and treatment of behavioural and emotional problems in children, as such problems are learnt through the interactions children have with their care-givers (Sanders & Dadds, 1993).

Although family relationships are important, parents usually receive little preparation beyond their own experience of themselves being parented. Most parenting skills are learned on the job - on a trial and error basis (Risley, Clark & Cataldo, 1976; Sanders, Tully, Dagae,

Lynch, Hetwood, Polland, & Youlden, in press, cited by Sanders, 1999). Demands of parenthood are further complicated when parents do not have access to extended family support networks (e.g., grandparents, close family friends), they do not have partners, or when they experience the stress of separation, divorce, or re-partnering (Lawton & Sanders, 1994; Sanders, Nicholson & Floyd, 1997).

Many of Australia's social and mental health problems are associated with disturbances in the functioning of families. Families have a profound influence on mental health because they supply the first, and most important, social, emotional, interpersonal, economic, and cultural context for human development. Dysfunctional family relationships are a risk factor for a wide variety of mental health problems in children and adults (Sanders & Duncan, 1995).

Parenting style risk factors associated with producing teenagers at risk for major behavioural and emotional problems including, criminality, substance abuse, and antisocial behaviour have been identified by several authors. Such risk factors include: poor supervision; harsh, inflexible, inconsistent, or rigid discipline style; insecure attachment; low involvement with child; marital conflict or breakdown; parental psychopathology; lack of social supports; financial stress; abuse or neglect; low socioeconomic status; and lack of a warm relationship (Coie, 1996; Loeber & Farrington, 1998; both

cited in Sanders, 1999; Sanders, 1995; Sanders & Dadds, 1993; and Simmons, 1999). The identification of risk factors such as these is important, so preventative programs can be implemented before children present with clinical and behavioural dysfunction. A preventative program has the potential for greater success than an intervention later in life (Sanders & Markie-Dadds, 1996).

Family protective factors have also been identified. These are factors likely to prevent the development of antisocial behaviour in children and direct them to more positive pathways in their development. Examples of protective factors include having supportive and caring parents, family harmony, having at least a two year gap between siblings, child responsibilities for chores, a secure and stable family environment, children having supportive relationships with other adults, small family size, and strong family norms and morality (Simmons, 1999).

1.2.1 Conduct Problems

Robins (1991) argued that conduct disorder is the most common referral to child psychiatrists and psychologists, and reported that it is likely there are many more unreported cases in the community. Children who have conduct problems are more likely to have problems with aggression, hyperactivity, delinquency, and specific learning disabilities (Robins, 1991).

Conduct problems in children are an important predictor for an antisocial type personality in later adulthood. Conduct problems in children have also been associated with later substance abuse, mania, schizophrenia, and obsessive compulsive disorder. Such problems in children are not only associated with psychiatric diagnoses in adulthood, but they also have wide-ranging effects on adult life, including later arrests, truancy and school failure, failure to complete schooling, joblessness and consequent financial dependency, poor interpersonal relationships, marital conflict, and parenting children with a greater risk of conduct problems (Robins, 1991).

Robins (1991) reported that one of the strongest correlates for conduct disorder in children is poor parental disciplinary practices. Parents of children with conduct problems are usually described as neglectful, erratic, and harsh in their punishment. Patterson (1982) asserts that treatments for conduct problems in children focusing on parent education and training have had success.

1.3 Behavioural Family Intervention (BFI)

One more recent approach to parent education based on the behavioural modification model is Behavioural Family Intervention (BFI). BFI was developed as a practical, process-orientated model for children with disruptive behaviour or conduct problems. BFI is an

approach to assist families with their concerns regarding children's behaviour and development. Sanders and Dadds (1993) describe BFI as: "a therapeutic process which aims to effect change in a child's behavior and adjustment through corresponding changes in those aspects of the family environment which are implicated in the maintenance of the child's problem behavior" (p. 26).

Sanders (1992; 1996) argues that the term BFI more accurately represents the role of family intervention in both treatment and prevention efforts and should be used in preference to other terms, such as behaviour parent training, child management training, or parent management training. The term BFI emphasises the targets as reaching more than parenting skills, rather encompassing the family system as a whole, and addressing parenting and child management issues, adult adjustment problems, and home-school problems. Sanders and Dadds (1993) also argue that the term BFI allows greater flexibility in tailoring the focus of the intervention to the requirements of individual families.

BFI is a skills oriented approach aimed at modifying maladaptive parenting through the use of instructions, modelling, practice, feedback, and goal setting procedures. BFI gives parents the skills and knowledge which will better equip themselves to the demands of caring for, supervising, educating, and managing children.

BFI aims to improve the quality of parent-child interactions, since conduct problems in children are closely related to poor parenting (Sanders & Markie-Dadds, 1992).

Essentially, BFI is "a flexible, action-orientated, educationally focussed intervention that attempts to equip family members with the skills and knowledge necessary for resolving pressing family problems with children" (Sanders & Dadds, 1993, p. 31). The focus of BFI is on the family, although this does not necessarily assume that the family causes the child's problems. Instead, the emphasis is on the role of the family in the maintenance and remediation of the problem (Sanders & Dadds, 1993).

1.3.1 Effectiveness of BFI

Several well controlled studies have been conducted that evaluate the effectiveness of family intervention programs such as BFI for preschool aged children who are considered at risk for later conduct and emotional problems. The majority of these intervention programs focus on improving parenting and enhancing the child's social and cognitive development to prevent conduct problems or learning difficulties (Committee on the Prevention of Mental Disorders, 1994; cited by Sanders, 1995). Sanders (1995) argues that parent education and training form the central focus in most successful intervention programs. Typically, these programs involve training

parents to use positive parenting techniques, for example, increasing positive attention and affection when the child is appropriately behaved, supplying engaging age-appropriate activities, and using effective discipline strategies. In the early 1990's several reviews of the literature (e.g., Kendziora & O'Leary, 1992; Webster-Stratton, 1993) demonstrated that parents could be trained to use more effective parenting skills, and that when this training occurs there is usually quick improvement in the child's behaviour and adjustment.

Australian research conducted by Matthew Sanders and his colleagues has repeatedly demonstrated that parent training is an effective intervention for young children with problems related to conduct disorders (Sanders, 1995). The most recent and most researched version of the family intervention system developed by Sanders and his colleagues is **Triple P** - The Positive Parenting Program.

1.4 The Positive Parenting Program (Triple P)

Triple P - The Positive Parenting Program - is essentially "a multilevel, preventively oriented parenting and family support strategy . . . The program aims to prevent severe behavioral, emotional, and developmental problems in children by enhancing the knowledge, skills, and confidence of parents. It incorporates five levels of

intervention on a tiered continuum of increasing strength . . . for parents of preadolescent children from birth to age 12" (Sanders, 1999, p. 72).

Triple P is a form of BFI based on the behavioural modification model. This approach to the treatment and prevention of childhood disorders has the strongest empirical support of any intervention with children, particularly children who have conduct problems (Sanders, 1999).

Family intervention methods must vary in complexity over a number of dimensions, including the strength, intensity and scope of the intervention, the setting in which it takes place, the target population, who delivers the intervention, and the cost of the delivery. The Triple P model accounts for these differences in its five levels of intervention which have been adapted from levels in BFI.

- Level 1 (Universal Triple P) is a universal parent information strategy, providing all interested parents access to information about parenting. Intervention at this level uses parenting tip sheets and videotapes demonstrating parenting strategies for managing specific problems. Level 1 should be applied when it appears that the parent has sufficient skills and motivation to implement the proposed strategies without intensive training, as there is no therapist contact.

- Level 2 (Selective Triple P), a brief, one to two session primary health care intervention designed to provide early anticipatory development guidance to parents of children with mild behaviour difficulties. This level incorporates brief behavioural counselling as an early intervention to managing a specific behavioural problem. Professional contact at this level is minimal, and would usually be telephone contact, or brief face-to-face contact, and aims to support the parents in using the positive parenting strategies.
- Level 3 (Primary Care Triple P) is a four-session intervention, targeting children with mild to moderate behaviour difficulties. This level includes some active skills training for parents on one or two specific problems. The parents are trained through performance based methods combining instructions, modelling, rehearsal, and feedback. Level 3 interventions are appropriate for family members who require more than information and support.
- Level 4 (Standard Triple P), an intensive 8 to 10 session parent training program which is run on an individual or group basis. This level targets children with more severe behavioural difficulties, under close therapist supervision, and may also include some home visits. The focus of the intervention is broader than the previous levels, aiming to solve a variety of problems. Level 4 also includes

training in antecedent stimulus control and contingency management techniques.

- Finally, Level 5 (Enhanced Triple P) is an enhanced BFI program designed for families where parenting difficulties are complicated by other sources of family distress, eg marital conflict, parental depression, lack of social supports, or high levels of stress. This level addresses problems at a broader systematic level and targets multiple problems within a family.

(Sanders, 1992; 1995; 1996; 1999; Sanders & Markie-Dadds, 1996; Sanders, Markie-Dadds, & Turner, 1995).

There are individual differences with parents who are concerned about their child's behaviour. These include differences in the severity of problems, the breadth of knowledge, motivation, access to support, and the presence of other family stresses. Therefore, it is unlikely that a single family intervention program will be equipped for the requirements of all parents. The Triple P model takes these differences into account, and assumes that the differing needs of parents require differing levels of support and tailors the strength of the intervention to the needs and preferences of individual families. The multilevel strategy maximises efficiency, reduces costs, avoids over servicing, and ensures the program reaches the wider community (Sanders, 1999; Sanders & Markie-Dadds, 1996).

Distinctive features of the Triple P model as a family intervention include the following. The first is understanding that parents differ in the strength of the intervention they require to manage a problem independently. The Triple P model aims to provide families the minimally sufficient level of support required. The second distinctive feature of the Triple P model is the ability for flexible tailoring to identified risk and protective factors. Triple P allows parents to receive parenting support in the most cost-effective way possible, due to the different levels of varying intensity. The varied delivery modalities are the third distinctive feature of the Triple P model. Most of the intervention levels can be delivered in a variety of formats, for example individual face-to-face contact, group programs, telephone assisted programs, or self-directed programs, or a combination. This flexibility means parents can participate in ways that best suit their individual circumstances. The fourth distinctive feature of the Triple P model, is its multi-disciplinary approach. Triple P was developed as a professional resource that can be used by a range of professionals, including psychologists, community nurses, family doctors, paediatricians, teachers, social workers, psychiatrists, and police officers (Sanders, 1999).

1.5 The Evaluation of Triple P

The evaluation of Triple P needs to be seen in the broader context of research into BFI, from which it emerged. Previous comprehensive literature reviews have shown the efficacy of BFI as an approach to helping children and their families (Lochman, 1990; McMahon, in press, cited in Sanders, 1999; Sanders, 1996; Sanders, 1998, cited in Sanders, 1999; Taylor & Biglan, 1998). BFI as an approach to parent education has been effective with such clinical problems as:

- oppositional defiant disorders (Forehand & Long, 1988; Webster-Stratton, 1994);
- attention deficit hyperactivity disorder (Barkley, Guevremont, Anastopoulos & Fletcher, 1992);
- conduct problems (Kendziora & O'Leary, 1993; McMahon, 1994; McMahon & Wells, 1989; Miller & Prinz, 1990; Patterson, Dishion, & Chamberlain, 1993; Webster-Stratton, 1993);
- persistent feeding difficulties and chronic food refusal (Sanders, Patel, Le Grice, & Shepherd, 1993; Turner, Sanders & Wall, 1994);
- pain syndromes and pain management (Miller & Kratochwill, 1979; Sanders, Rebgetz, Morrison, Bor, Gordon, Dadds, & Shepherd, 1989; Sanders, Shepherd, Cleghorn & Woolford, 1994);

- anxiety disorders (Barrett, Dadds & Rapee, 1997; Dadds, Heard, & Rapee, 1991);
- autism and developmental disorders (Schreibman, Kaneko & Koegel, 1991);
- infant sleep disturbance (France & Hudson, 1990);
- chronic illnesses (Miller-Johnson, Emery, Marvin, Clarke, Lovinger, & Martin, 1994);
- hostile marriages (Dadds, Schwartz & Sanders, 1987; Sayger, Horner & Glaser, 1993);
- remarried families (Lawton & Sanders, 1994); and
- achievement problems, habit disorders, and everyday problems of normal children (Sanders, 1996; Taylor & Biglan, 1988).

Maintenance of treatment gains is often reported, and the effects are seen to generalise to school settings (McNeil, Eyberg, Eisenstadt, Necomb & Funderbunk, 1991) and to various community settings (Sanders & Glynn, 1981).

1.5.1 Development of the Core Intervention

Research into BFI, that has since become known as Triple P, began in 1977, and the first findings were published in the early 1980's. Since then studies have been carried out to evaluate intervention methods used in Triple P, using both intrasubject replication designs and randomised control group designs. The early

studies (Sanders & Christensen, 1985; Sanders & Dadds, 1982; Sanders & Glynn, 1981) demonstrated that parents could be trained to administer behaviour change and positive parenting strategies in their homes, and that many parents also applied these strategies outside in the community. Not all parents, however, were able to generalise their skills to high risk situations, e.g., situations with competing demands, time constraints, or situations placing parents under stress in a social evaluative context, after their initial active skills training. For these parents the addition of self management skills were effective in teaching parents to generalise their skills (Sanders & Dadds; 1982; Sanders & Glynn, 1981). These children who received both the basic parenting skills and planned activities training had significantly lower levels of disruptive and oppositional behaviours. The parents also demonstrated increased positive parent-child interactions, and reduced levels of negativity. Sanders and Plant (1989) demonstrated that the same intervention methods were also effective with oppositional children who were mildly intellectually disabled. This research helped establish the core program of Triple P, as a 10 session individual parent training intervention, which is now known as Standard Level 4 Triple P Intervention.

After the initial research, a series of controlled outcome studies were developed in order to improve the outcomes of standard parent

training, by targeting other family risk factors, including marital conflict and parental depression. A study evaluating brief, four session marital communication intervention to complement parenting skills training (Dadds, Schwartz & Sanders, 1987) found that the provision of partner support training significantly improved outcomes on both child and parent observational measures for families with marital conflict, but not for parents without marital conflict. This suggested that when problems in child management are complicated by marital conflict, better outcomes can be achieved for both children and parents when marital communication is specifically targeted.

Studies have demonstrated that parent education and training is also effective with clinically depressed parents of children with oppositional disorders. McFarland and Sanders (1993; cited by Sanders, 1995) evaluated the effectiveness of BFI with clinically depressed mothers. The mothers who were randomly assigned to an enhanced BFI condition (specifically targeting the mothers' depression) achieved better results compared to the standard BFI condition.

1.5.2 Randomised Efficacy Trials

A recent large scale randomised controlled trial was conducted to compare the efficacy of three different variants (standard BFI - 12 weeks of child focused parent training, self-help BFI, and enhanced

BFI - additional interventions focusing on marital communication, mood management, and stress coping training) of Triple P intervention (Sanders & Markie-Dadds, 1994, cited by Sanders, 1995; Sanders, Markie-Dadds, Tully & Bor, 1999; cited by Sanders, 1999). Directly after the treatment, the three interventions were more effective than a wait-listed control group, and the two therapy assisted treatments showed greater treatment effects than the self-directed group. The Standard and Enhanced BFI groups were not significantly different from each other. The three interventions also all had high levels of consumer satisfaction. The main finding from these studies was that the provision of a generic enhanced family intervention should be reserved for those families who fail to make improvement after the standard BFI. It also suggested that self-directed program variants can be effective with some families.

1.5.3 Effects of Self-Directed Intervention

The self-directed intervention was developed for those families who can not regularly attend therapy sessions, such as those families in rural areas. A study evaluating the self-help program (Level 1), which combined self-help materials and back up telephone consultation found this to be highly effective with families who have traditionally had little access to mental health services (Connell, Sanders, & Markie-Dadds, 1997). After the intervention the families

treated with the self-help intervention demonstrated significant reductions in child behaviour problems, as reported by the parents. They also demonstrated improvements in parenting skills, a greater sense of parenting competence, and reduced levels of parenting stress, anxiety and depression. Parents also reported a high consumer satisfaction with the intervention (Sanders, Connell & Markie-Dadds, 1994; cited by Sanders, 1995).

Others studies examining the effectiveness of the self-directed variants of Triple P for parents with preschool-aged children with oppositional behaviour problems (Markie-Dadds & Sanders, 1999; Markie-Dadds, Sanders & Smith, 1997; both cited by Sanders, 1999) found that the standard self-directed program was effective with some families. The effects, however, were enhanced by providing brief telephone calls using a self-regulatory framework that encouraged parents to take control of the learning progress.

1.5.4 Evaluation of Group Triple P

The concern over mental health meant a search for more cost efficient ways of delivering family interventions within a population level prevention framework. The group version of Triple P was designed to deal with this and there have been a few studies (e.g., Williams, Silburn, Zubrick & Sanders, 1997, cited in Sanders, 1999) showing this group version of Triple P can be successful and effective.

Sanders (1999) reported that currently large scale population trials of group Triple P are being conducted, and results will be published as soon as they have been completed.

1.6 Brief Interventions

Brief interventions have become a practical necessity in therapy due to increased waiting lists (McGee, 1983). In addition, financial resources are at a low and brief interventions generally mean greater cost efficiency (Dryden, 1995; Quick, 1996). Brief interventions allow people to access therapy, who in the past were unable to because they did not have the personal and financial resources for long term treatments (McGee, 1983). As resources for interventions are decreasing, and more and more people seek help, a brief intervention becomes the more viable alternative. There are a number of individuals who actually benefit from short-term therapy, and do not require long term interventions (Dryden, 1995). Many clients also actually prefer brief therapy when given the choice of attending long term therapy (Quick, 1996). Overall, brief interventions can be more efficient, economical, and effective (Bauer & Kabos, 1987).

1.6.1 Brief Primary Intervention

At the time of writing his 1999 article, Sanders reported that there were two randomised controlled trials in progress. These trials involved primary care nurses in the implementation of Level 2 or Level 3 interventions. There was another study in process evaluating the effectiveness of training general medical practitioners to provide Level 2 and Level 3 consultation advice to parents, as appropriate.

Although there have been no controlled evaluations of Level 3 Triple P, several studies have targeted discrete problems such as sleep disturbances, feeding difficulties, and habit disorders, using similar intervention methods as in a brief consultation format (Christensen & Sanders, 1987; Dadds, Sanders, & Bor, 1984; Sanders, Bor, & Dadds, 1984). The trials currently in progress will help to provide a clearer basis for determining who responds best to which level of intervention.

1.7 Aims

The purpose of the present study is to evaluate the Level 3 version of the Triple P intervention model by comparing parents who complete this intervention with individuals on a wait-listed control group. More specifically the aims are:

1. To conduct the Primary Care Intervention (Level 3) of the Triple P model with the parents of children on a waiting list for services at the Child and Adolescent Mental Health Services (CAMHS), Eastern Region.
2. To determine the effectiveness of the Primary Care Intervention (Level 3) of the Triple P model with CAMHS clients by comparing families who complete the intervention with families in a wait-listed control group.

1.8 Hypotheses

1. Primary Care Triple P will significantly reduce parent reported child behaviour problems when compared to a wait-listed control group.

CHAPTER 2: METHODS

2.1 Participants

The participants in this study were the parents of children on the waiting list for services at the Child and Adolescent Mental Health Services (CAMHS), Eastern Region, in Adelaide, South Australia, during June 1999. Parents who were approached to participate in the study had a child aged between 3 and 8 years, inclusive, and had been on the CAMHS waiting list for a period of 3 months or less and were seeking assistance with child behavioural problems.

2.2 Procedure

Families who are referred to CAMHS receive an Initial Consultation interview with a trained CAMHS technician, to gather information regarding their concerns and determine the priority of the referral. Priority 1 children are allocated within 6 weeks, and includes those children who are at risk of harm from themselves or others. Priority 2 children are placed on the waiting list for services, which can be a 12 month wait.

Families on the Priority 2 waiting list were contacted by mail, to determine if they were interested in participating in the present study. An information sheet (Appendix A) and consent form

(Appendix B) were sent to the contact person for the child, with a letter asking them to contact the researcher via CAMHS if they had any questions, or wished to participate in this study. If they had not contacted the researcher or CAMHS within two weeks of receiving this information, the researcher contacted them by telephone to determine their level of interest and to provide answers to questions. If the family agreed to participate, they were randomly allocated to one of two groups. The first group received the brief intervention immediately (Experimental group - EX group), whereas the second group were placed on a 6-week waiting list before beginning the intervention (Wait-Listed Control group - WL group).

Parents completed questionnaires (outlined in *Section 2.3*) at several points throughout the study. Both groups of parents - the EX group and the WL group - completed the questionnaires at their first appointment, before beginning the Level 3 intervention. This was labelled the 'PRE' measure. Parents from both the groups also completed the same questionnaires at the conclusion of Session 4. This was labelled the 'POST' measure. Additionally, the parents from both the groups were sent out by mail (with a return envelope) these questionnaires again 6 weeks after they attended their last session. This was to follow-up how the parents had found things since they completed the intervention, and this was labelled the 'Follow-Up' or

'FU' measure. The parents in the WL group completed the questionnaires a further time - when they were first contacted to participate in this study, 6-weeks before beginning the intervention. This was labelled the '1-PRE' measure, as it occurred before the PRE measure.

Both groups completed the sessions as outlined in the Primary Care Triple P (Level 3) model (see Turner, Sanders, Markie-Dadds, 1999, for further details of the Session Outlines). Every attempt was made to make this type of treatment as similar as possible between the different families, although there were differences with the types of problems the families wished to work with. In the majority of families only one problem behaviour was targeted, although one parent had the opportunity to examine a second behaviour.

2.3 Measures

The questionnaires completed by parents in this study are the same ones which are routinely used in the Triple P intervention model. These questionnaires are from the more intensive Level 4 and Level 5 programs, rather than the Level 3 program. It was decided to use the questionnaires from Level 4 and Level 5 to be able to conduct a more comprehensive analysis of data, and also to be able to compare

outcomes with those achieved from evaluations of the Level 4 and Level 5 programs.

2.3.1 The Eyberg Child Behavior Inventory (ECBI)

The Eyberg Child Behavior Inventory (ECBI) is a 36-item, multidimensional measure investigating parental perceptions of current disruptive child behaviour (Eyberg, 1992). It assesses behaviours on two scales: an Intensity Scale, indicating how often the behaviours occur; and a Problem Scale, identifying the specific behaviours that are problems for the parent. The Intensity Scale has a frequency-of-occurrence rating for each item, ranging from *Never* (1) to *Always* (7). The Problem Scale provides a "YES-NO" identification rating for each item (Eyberg, 1992).

There is much data (see Eyberg, 1992) supporting the reliability and validity of the ECBI in the assessment of child behaviour problems. The validity of the ECBI as a concise measure of behavioural problems in childhood has been demonstrated (Boggs, Eyberg, Reynolds, 1990). There are 3 scales (plus a total score) relating to DSM descriptions of disruptive behaviour in children: Oppositional Defiant Disorder, Conduct Disorder, and Attention-Deficit Hyperactivity Disorder (Burns & Patterson, 1991).

2.3.2 The Parenting Scale

The Parenting Scale contains 30 items measuring dysfunctional discipline practices with parents. This scale was based on parental discipline "mistakes" relating to theoretically externalising problems. Each mistake is paired with its more effective counterpart to form the anchors for a 7-point scale. This format allows parents to characterise behaviour in a way that is less dependent on the rates of children's behaviours (Arnold, O'Leary, Wolff, & Acker, 1993).

Three stable factors of dysfunctional discipline style have been identified: Laxness, Over-reactivity, and Verbosity. Additionally, there are a few (4) items that do not fit into these factors, but have clear theoretical support for their importance, and also correlated significantly with the Total Parenting Scale scores, which have also been retained (Arnold et al., 1993).

The Parenting Scale has demonstrated adequate reliability and internal consistency, has strong validity and can discriminate between groups of clinic and non-clinic families. Most importantly, The Parenting Scale scores are related to observed discipline mistakes and child misbehaviour's (see Arnold et al., 1993).

2.3.3 Parenting Sense of Competence (PSOC) Scale

The Parenting Sense of Competence (PSOC) Scale - also known as the *Being a Parent Scale* - is a 16 item scale covering two

dimensions of parenting self esteem: Efficacy and Satisfaction. Efficacy refers to competence, problem solving ability, and the capability in the parenting role. Satisfaction reflects the extent of parenting frustration anxiety, and motivation in their role as a parent. Each item on the scale is answered on a 6-point scale ranging from *strongly disagree* (6) to *strongly agree* (1), with higher scores indicating greater self-esteem (Johnston & Mash, 1989).

Satisfactory levels of internal consistency for the Satisfaction scale and for the Efficacy scale have been reported previously, with reasonable 6-week test-retest correlations for the scales and total score (Gibaud-Wallston & Wandersman, 1978; cited by Johnston & Mash, 1989).

2.3.4 The Parent Problem Checklist (PPC)

The Parent Problem Checklist (PPC) has 16 items each of which the parents check if the item has caused problems over the last month. It investigates parents ability to cooperate and work together in family management. There are 6 items documenting the presence or absence of parental disagreements over rules and discipline for child misbehaviour, 6 items focusing on the occurrence of open conflict over child-rearing issues, and 4 items concerning whether the parents undermine each other's relationships with children. The PPC

has moderately high internal consistency and high test-retest reliability (Dadds & Powell, 1991).

2.3.5 The Abbreviated Dyadic Adjustment Scale (ADAS)

The Dyadic Adjustment Scale (DAS) was designed to measure the degree of satisfaction reported by individuals across aspects of marital interaction. An abbreviated form of the DAS was developed for quick classification of individuals and couples, providing an index of marital disharmony. The 7-item version (ADAS) represents a moderately reliable and valid instrument which is easily administrated and scored. The ADAS is able to differentiate between people who were dissatisfied with their marriages, according to external criteria, and those couples who remained together - distinguishing between high and low scorers on a measure of marital satisfaction or happiness (Sharpley & Rogers, 1984).

2.3.6 The Depression-Anxiety-Stress Scales (DASS)

The Depression-Anxiety-Stress Scales (DASS) contains 42 negative emotional symptoms in a self-report inventory for adults. Participants rate the extent to which they have experienced each symptom over the past week, on a 4-point severity/frequency scale. There are 3 scales: Depression, Anxiety, and Stress. The scores for these scales are reached by summing the scores for the relevant 14

items. This makes the DASS an easily administered and scored instrument (Lovibond & Lovibond, 1995).

The DASS has high reliability for the 3 scales, and good discriminant and concurrent validity. The DASS Anxiety scale has been highly correlated with the Beck Anxiety Inventory, and also the DASS Depression scale as been strongly correlated with the Beck Depression Inventory (Lovibond & Lovibond, 1995).

2.3.7 The Parent Daily Report Checklist

The Parent Daily Report Checklist is a 34-item parent daily observation and reporting measure that allows for repeated assessments of child problem behaviours. To administer the Parent Daily Report (PDR) Checklist, the parent initially identifies which items have been particular problems for their child. The parent then for 7 days checks any of the items that have occurred in that day. The parent is not asked to provide frequencies, only the occurrence or non-occurrence. The PDR checklist creates two scores: PDR Total Behaviours and Targeted Behaviours. The Total Behaviour score is the sum of all occurrences during a day, and the Target Behaviour score is the sum of all occurrences of events previously identified by the parents as problematic. The PDR also has moderate reliability and validity, as well as moderate concurrent validity (Chamberlain & Reid, 1987).

As only a few parents completed the PDR, this questionnaire was subsequently not included in any data analyses.

2.3.8 The Client Satisfaction Questionnaire (CSQ)

The Client Satisfaction Questionnaire (CSQ) (from the Primary Care Triple P outline) was adapted from the *Therapy Attitude Inventory (TAI)* developed by Eyberg (1993; cited by Turner et al., 1999) with specific questions related to Primary Care Triple P. The parents completed this questionnaire at the end of session 4, at the same time as the POST measures. Eyberg (1993; cited by Turner et al., 1999) established reliability, internal consistency and discriminant validity. The CSQ addresses the following: the quality to service provided; how well the program met the parents needs, increased the parent's skills and decreased the child problem behaviours; and whether the parent would recommend the program to others. The measure derived is a composite score from 13 items, where each is rated on a 7-point scale (range of 13 to 91). At the conclusion of the rating scales, there is space for parents to comment or make suggestions about any aspect of the program (Turner et al., 1999).

2.3.9 Family Background Questionnaire

Parents also completed the Family Background Questionnaire at the same time as the PRE measures during Session 1, from the Primary Care Triple P outline (Turner et al., 1999). This covered

essential biographical data, including contact details, the child's details (name, age, date of birth), marital status of the parents, relationship to child, current employment status and educational background. It also included other details such as, the names and ages of all family members, information on the family composition, whether they receive a government pension, use of other health services, and the child's health and development. A question regarding the family income was removed, in line with CAMHS policies.

2.4 Statistical Analysis

The data was analysed using t-tests, which were carried out with the SPSS for Windows computer program.

CHAPTER 3: RESULTS

3.1 Participants

A total of 40 families were sent information sheets and consent forms regarding this study. Eighteen families declined to participate. A further two families could not be reached by telephone, nor did they respond to letters, leaving a sample size of 20 and a response rate of 50%. Twelve parents were allocated to the EX group, and 8 were allocated to the WL group.

Five families (4 from the WL group and 1 from the EX group) dropped out before attending any sessions. One of these parents completed the questionnaire at the 1-PRE measure, the other 4 did not complete any questionnaires. As the study progressed, a further 6 parents dropped out, leaving final sample size of 9, meaning only 55% of participants attended the full four sessions. Two of these parents failed to complete the POST measure, so POST data is only available for 7 parents. Follow-up data, 6-weeks after the completion of Session 4, is available for 4 parents who returned the questionnaires.

The mean age of the children of the participating parents in this study was 7-0 years, with a range of 3-1 years to 9-0 years (N = 20). Fifty five percent of children participating were aged 7 or older. There were approximately equal numbers of male and female children

participating (55% males). The participating parents were almost exclusively mothers, with one couple attending the sessions together, however the father from this couple elected not to complete the questionnaires. One other father did attend one session with his wife. The martial status of the participating families is presented in Table 1, the Education Level in Table 2, and the Employment Status in Table 3. Of the 50% of parents who fully completed the *Family Background Questionnaire*, 70% were receiving a Government pension.

Table 1: Martial Status of Participating Parents

	N	%
Married	10	50
Divorced	2	10
Separated	2	10
Remarried	2	10
No Details Available*	4	20
TOTAL	**20**	**100**

*Data on some families are unavailable as they did not complete the *Family Background Questionnaire.*

Table 2: Educational Level of Participating Parents

	Mothers (N)	%	Fathers (N)	%
< Year 10	1	5	1	5.56
Year 10/11	5	25	3	16.67
Year 12	3	15	1	5.56
Uni Degree	1	5	1	5.56
TAFE	0	0	1	5.56
Trade/ Apprenticeship	0	0	1	5.56
No details*	10	50	10	55.56
TOTAL	**20**	**100**	**18**	**100**

*Data on some families are unavailable as they did not complete the *Family Background Questionnaire.*

Table 3: Employment Status of Participating Parents

Hrs/Week in Employment	Mothers (N)	%	Fathers (N)	%
< 10	1	5	0	0
10-15	2	10	0	0
16-40	4	20	4	22.22
> 40	0	0	3	16.67
Home Duties	2	10	0	0
Unemployed	1	5	1	5.56
No details*	10	50	10	55.56
TOTAL	**20**	**100**	**18**	**100**

*Data on some families are unavailable as they did not complete the *Family Background Questionnaire.*

3.2 Adherence to Sessions

It was planned for the first three sessions to be held on consecutive weeks, with the fourth session being held on the sixth week - consistent with the recommendations for Primary Care Triple P (Turner et al., 1999). Unfortunately, it was not possible for every family to attend on such a schedule; there was only one mother who attended all sessions as planned. The remaining families either rescheduled appointment times for sessions or failed to turn up. Some

sessions (4) were conducted over the telephone to avoid even longer delays between sessions. The statistics for the number of weeks between sessions are presented in Table 4. The sessions were intended to each run for 20 minutes (as set out by Turner et al., 1999), and again it was not possible to stick to such time restraints with the families in this sample, who tended to run over time. The statistics for the time each session ran for are presented in Table 5.

Table 4: Average Number of Weeks Between Sessions

1 & 2	2 & 3	3 & 4
1.68	1.45	3.83
Min = 1	Min = 0.5	Min = 2.5
Max = 4	Max = 4	Max = 6
Ideal[a] = 1	Ideal[a] = 1	Ideal[a] = 3
N = 14	*N = 11*	*N = 9*

[a] *Ideal* refers to recommendations set out by Turner et al. (1999).

3.3 Comparisons Between Groups

Comparisons were made between the first questionnaires completed by the parents, ie PRE for the EX and 1-PRE for the WL group. This was to ensure that the EX and WL groups entered the study at similar levels of clinical dysfunction. The results

Table 5: Average Time of Each Session (in minutes)

Session 1	Session 2	Session 3	Session 4
31.33	38.93	19.55	15.00
Min = 20	Min = 35	Min = 5*	Min = 10*
Max = 60	Max = 60	Max = 40	Max = 20
Ideal[a] = 20	Ideal[a] = 20	Ideal[a] = 20	Ideal[a] = 20
N = 15	*N = 14*	*N = 11*	*N = 9*

[a] *Ideal* refers to recommendations set out by Turner et al. (1999).
* Session conducted by telephone.

on these measures were similar, although the WL group had significantly higher parenting competence scores ($t = 3.531$, $df = 4$, $p = 0.024$) and parenting satisfaction scores ($t = 9.571$, $df = 4$, $p = 0.001$). Comparisons were also made for the EX and WL groups at the PRE measure, to ensure that they began the first session at similar levels of clinical dysfunction. Again, the results on the questionnaires were similar, apart from the WL group having significantly higher parenting competence scores ($t = 5.058$, $df = 3$, $p = 0.015$) and parenting satisfaction scores ($t = 8.668$, $df = 3$, $p = 0.003$).

3.4 Wait-listed Control Group

The WL group was compared for changes from the 1-PRE to PRE measures, to determine if they were worse off waiting 6 weeks

for an intervention compared to those who received an intervention immediately. Due to only 62.5% of participants in the WL group completing the 1-PRE measure, and only 50% completing the PRE measure, t-tests could not be calculated. Qualitative data analysis shows that the WL group did not improve during the 6-week wait for services, and generally did worse or stayed the same.

3.5 Experimental Group Improvements

In the EX group only, there was a significant decrease in the reported conduct problems on the ECBI for the mothers from the PRE to POST measures ($t = -3.896$, $df = 5$, $p = 0.011$). Additionally, there were significant decreases in the parents overall scores on *The Parenting Scale* ($t = 5.372$, $df = 2$, $p = 0.033$) and the Verbosity score on *The Parenting Scale* ($t = -6.397$, $df = 2$, $p = 0.024$) from the PRE to FU measures.

3.6 Wait-listed Control Group Improvements

No statistics could be calculated for the WL group to determine if they were any improvements over time, as only 1 parent from this group completed the questionnaires at the POST and FU measures. Therefore, the WL and EX groups were combined for further analyses.

3.7 Overall Improvements as a Group

When those who completed the intervention program from both the EX group and WL group are combined (N = 7), a few overall improvements were found. The anxiety reported by the parents in this study significantly decreased between the PRE and POST measures ($t = 2.5$, $df = 6$, $p = 0.047$), as did the degree of conduct problems reported by the parents ($t = -3.32$, $df = 6$, $p = 0.016$). Both the number of problems reported on *The Parent Problem Checklist* ($p = 0.058$) and the overall score on *The Parenting Scale* ($p = 0.052$) approached significance, with both these variables decreasing from the POST to the FU measure (N = 4).

The data for the 7 parents (6 from the EX group and 1 from the WL group) who completed both PRE and POST measures and the 4 (3 from the EX group and 1 from the WL group) who also completed the FU measures was examined further on a qualitative level. Generally, most parents improved on some, if not all variables, although many parents had mixed results, improving on some individual variables and not others. All parents showed a decrease in their reported conduct problems on the ECBI from the PRE to POST measures. Three out of four parents demonstrated an increase in reported conduct problems from the POST to FU measures, however only one of these parents reported more problems than their baseline (PRE) measure. All

parents also demonstrated a decrease on the Over-reactive factor on *The Parenting Scale* and a decrease in reported Oppositional Defiant Disorder symptoms on the ECBI from the POST to FU measures. No parent demonstrated an increase in reported anxiety symptoms from PRE to POST measures, although 3 parents remained on the same score. All but one parent demonstrated an increase in reported feelings of efficacy as a parent on *The Parenting Sense of Competence Scale* from the PRE to POST measures. The remainder of the variables present a somewhat mixed picture, and no conclusive outcomes for these variables can be determined.

3.8 Client Satisfaction Questionnaire

Only 7 parents completed the CSQ and their results are presented in Table 6. Essentially, they demonstrate that these parents thought favourably of the program. The comments by these parents in the question "Do you have any other comments about this program?", further reinforce this, with generally positive comments listed (two parents declined to make a comment:

1). "This program has helped me realise what I have been doing in the past was exactly what was recommended."

2). "Very good."

3). "Helped me to be aware that there are other strategies to handling situations than smacking."

4). "Yes, it was good to sit down and work out some different strategies. Also helped out some friends with there (sic) problems of there (sic) daughter."

5). "I felt the forms were intrusive and were over done. Thank you for your time and advice Melissa."

Table 6: The Statistics for the Client Satisfaction Questionnaire

	CSQ
Mean	59.71
Standard Deviation	12.51
Maximum	85
Minimum	46
	N = 7

3.9 Comparison to Community Samples

The scores from both the EX and WL groups in the present study were compared to current available norms for all of the questionnaires administered (Arnold et al., 1993; Dadds & Powell, 1991; Eyberg & Ross, 1978, cited by Eyberg, 1992; Johnston & Mash,

1989; Lovibond & Lovibond, 1995; Sharpley & Rogers, 1984). Overall, qualitative data analysis demonstrates almost all parents were above the community and clinic samples on most measures when entering the study, and the majority of parents still remained above these samples at the completion of the study.

3.10 Attrition Rates

With such a high attrition rate (45% from the original sample completed the PRE measure, and 20% of the original sample completed the FU measure), the data was examined to see if there were any factors in common with those parents who did not complete the program. Of the parents who did not complete the program, five dropped-out before completing any questionnaires, so partial data is only available for the remaining eight. The only demographic details available for all parents agreeing to participate is the gender of the child and the child's age. Sixty one and a half percent (61.54%) of those parents who dropped out or failed to complete the POST measure (N = 13), had male children. This was compared to 42.85% of males for those parents who completed the intervention (N = 7). On average, the families who dropped out or failed to complete the POST measure, had children who were approximately one year older than the children in the families who didn't drop-out (6-10 years [N =

13] compared to 5-11 years [N = 7]). Comparisons are unable to be made by comparing other demographic details, as of the parents who dropped out only three parents completed the *Family Background Questionnaire.*

On the questionnaires completed by the parents, a few differences are noticed. When the parents who completed the intervention are compared to those who did not attend all 4 sessions or failed to complete the questionnaires at the POST measure, are compared to those parents who completed the program, one significant difference is found. Parents who completed all sessions and questionnaires, reported significantly more Oppositional Defiant problems on the ECBI at the PRE measure ($t = 15.588$, $df = 2$, $p = 0.004$).

CHAPTER 4: DISCUSSION

4.1 Findings of the Present Study

4.1.1 The Initial Hypothesis

The hypothesis in the present study - that Primary Care Triple P will significantly reduce parent reported child behaviour problems when compared to a wait-listed control group - was supported. In the present study qualitative analysis demonstrated that the WL group was actually worse off waiting for the intervention compared to the EX group. The WL group did not improve or increased their dysfunction during the 6-week wait for the intervention, whereas the EX group demonstrated at least some improvements during the same time period. Quantitative statistical analyses were not able to be conducted because insufficient numbers completed the measures from the WL group.

4.1.2 Other Findings in the Present Study

The anxiety symptoms reported by the seven parents (from both the EX and WL groups) who participated in all four sessions in this study, decreased once the program was implemented, ie between the PRE and POST measures. This finding suggests that participation in Primary Care Triple P, a program designed to help their child, is of

some benefit to the parents who participate. In addition, six out of these seven parents reported increased feelings of efficacy as a parent between the PRE and POST measures. These findings further support the suggestion that participation in Primary Care Triple P is beneficial for parents through increasing their feelings of competence as a parent and reducing their reported anxiety symptoms.

These findings in the present study suggest that the Primary Care Triple P intervention produced few adverse side effects following parental participation. This suggestion is further supported by the results of the Client Satisfaction Questionnaire. Parents reported at least some positive benefits resulting from their participation (e.g., increasing awareness of parenting strategies), and generally had positive comments to report with regard to the program. The results of the present study are similar to Turner and colleagues (1994) who found that parental depression decreased, and that marital satisfaction increased following participation in a parent training and education program. Additionally, Huhn and Zimpfer (1989) demonstrated that participating in a parent education and training program increases parents confidence in themselves as parents, which appears also to be true in the present study, albeit on a smaller scale.

Furthermore, all four parents who completed the FU measure, demonstrated a decrease in reported Over-reactivity between the

POST and FU measures. An overall decrease in Over-reactivity suggests a decrease in a parents need for authoritarian discipline, displays of anger, meanness, and/or irritability, after completing the intervention.

Additionally, the six parents in the EX group demonstrated a decrease in their reported Verbosity, between the PRE and FU measures. This indicates that over the approximate 12 weeks between the recording of these measures, the parents reported decreased tendencies to give overly long reprimands and/or reduced their reliance on talking about their child's problems with their children.

The findings in the present study were not restricted to the parents. Primary Care Triple P is also beneficial to the children of the parents participating in the present study. The number of reported conduct problems reduced from the PRE to POST measures, suggesting that the program does have an influence on child behaviour problems. This is important since, as previously reported in *Section 1.2.1*, conduct problems in children have been associated with poorer outcomes during adolescence and adulthood. This decrease in reported conduct problems was not, however, maintained at the 6-week follow-up, with three out of four parents completing the FU measure reporting a slight increase in conduct problems. The four parents who completed the FU measure also demonstrated a decrease

in the number of reported Oppositional Defiant Disorder symptoms from the POST to FU measures, indicating that this is may be another area in which children are aided through intervention with their parents. These findings are important, in demonstrating that participation in Primary Care Triple P is not only beneficial for participating parents, but also their children.

It appears that in the present study, the Primary Care Triple P intervention had only a small effect on the children when compared with the parents. This difference could be attributed to the fact that the program is designed to target parental skills so that parents, changes in children may only occur through changes in parenting skills. It is likely that the impact on the children will be delayed (Huhn & Zimpfer, 1989). Perhaps a longer term study would demonstrate a greater effect on children.

4.2 Comparing Present Study to Community Norms

The parents in the present study reported more dysfunction than would be expected in a community sample (Arnold et al., 1993; Dadds & Powell, 1991; Eyberg & Ross, 1978, cited by Eyberg, 1992; Johnston & Mash, 1989; Lovibond & Lovibond, 1995; Sharpley & Rodgers, 1984). This finding suggests that when these families present to CAMHS, they may have reached a higher level of

dysfunction and have more significant problems, even when they are classified as Priority 2 according to the CAMHS classification system. Further studies are required to explore whether this level of dysfunction is typical of families classified as Priority 2, or restricted to the sample in the present study.

4.3 Attrition Rates

Only 55% of the original sample (combining both the EX and WL groups) in this study attended all four sessions, and only 45% of the original sample completed the POST measure. Such a high attrition rate was not expected, given the brevity of Primary Care Triple P. Due to the high attrition rate, the researcher considered contacting the parents to inquire about their reasons for discontinuing the study, but this was not feasible. The parents who dropped out did so by not turning up for scheduled sessions. The researcher attempted to contact these parents numerous times (via telephone and mail) to reschedule sessions or to find out if they wished to continue participating. However, only three parents responded. One parent was from the WL group and had not attended any sessions. This mother reported that her child had improved to the extent that they did not need the program any more. The other two parents from the EX group did attend sessions (one attended Session 1 and the other

attended both Session 1 and 2), and reported that they felt the Triple P model was not for them and their child. The parent who attended two sessions reported feeling disappointed that her son had not already improved his behaviour.

It is hard to draw many definite conclusions about why parents failed to complete the program, particularly as limited data is available for the families that failed to complete the intervention. Qualitative analyses demonstrated that the families who dropped out in this study were slightly more likely to have a male child and slightly more likely to have an older child. In a study investigating parents' perceptions and demographic variables in relation to attrition rates, Lochman and Brown (1980) found two demographic variables predicting a higher risk for dropping out: a lower family income and having an older child. The latter appears to qualitatively fit with the present study, however the difference in ages between the two groups in the present study was found to be small and not significant.

Statistical analyses investigating differences between the parents who completed all four sessions and the parents who did not complete Session 4 or complete the POST measure found that the parents completing the program reported significantly more Oppositional Defiant Disorder symptoms. This may indicate that parents at CAMHS are more likely to complete the program when

they perceive their children to have more Oppositional Defiant Disorder symptoms. This finding should be further explored in future studies to determine whether this is a factor predicting the likelihood of completing an intervention program such as Triple P.

Possible reasons for the high attrition rate in the present study include:

1). Participants were selected from a largely working class area, and so it is possible that the parents were not able to attend the sessions because they were not granted leave from work. This was mentioned to the researcher by some parents during the process of the study, although all the participating mothers (for whom only 50% of the data is available) reported working less than 40 hours a week on the Family Background Questionnaire.

2). As *Section 4.2* has outlined, parents in the present study have reported more dysfunction, when compared to community samples. It is suggested that because the children are viewed as very dysfunctional that the parents could be unable to attend.

3). The intervention in this study was carried out by a student, completing her Master in Psychology (Clinical). It is possible that the parents were not comfortable working with a 'student', and would have preferred to work with a paid CAMHS clinician.

4). The researcher is under the impression that some parents did not attend because they were under the false belief that if they attended these sessions, they would not receive the same services from CAMHS as compared to families who did not participate. The researcher clearly explained to all parents that their participation in the present study would not have an affect on their status on the waiting list at CAMHS, and was "intervention which may help in the meanwhile".

5). The original sample of 20 families in the present study attended an average of 2.45 sessions. However, by excluding the parents who dropped-out before attending any sessions, this average is increased to 3.27 sessions. This is actually typical of clients at CAMHS - Eastern Region, who in 1998 attended on average 2.43 sessions (D. Skene, personal communication, 8 May, 2000). This indicates that the low rate of attendance many not be restricted to the Primary Care intervention implemented in the present study, and rather may be typical of CAMHS clients in this region. Only 20.6% of clients in this region in 1998 attended four or more sessions (D. Skene, personal communication, 8 May, 2000), whereas in the present study 55% of parents attended 4 sessions - more than the average.

4.4 Limitations

The findings in the present study should be viewed with some caution, due to the small sample size and also the relatively small number of statistically significant comparisons. The interpretation of the results in this study is limited by the number of participants who agreed to participate in the study and also the number who attended the full program of four sessions. The interpretation of the results should be restricted to the sample from which the data was obtained - CAMHS - Eastern Region.

4.5 Conclusions & Recommendations

The main findings to emerge from the present study:

1). Parents participating in Primary Care Triple P are reported better better outcomes, e.g., decreased anxiety and conduct probems, when compared to a wait-listed control group.

2). There are positive benefits for parents participating in Primary Care Triple P.

3). There are also positive benefits for children whose parents participate in Primary Care Triple P.

4). The participating parents demonstrated higher levels of dysfunction when compared to community samples, even after the completion of the intervention.

5). The high attrition rate in the present study does not appear to be restricted to the Primary Care intervention, but appears typical of CAMHS clients in this region.

Although these results are positive, there were still many variables which remained unchanged by the Primary Care Triple P intervention and parents still reported a high rate of dysfunction, suggesting that such a brief intervention may not be the best option for CAMHS clients. It may be that CAMHS clients require a more intensive intervention, such as Level 4 or Level 5 Triple P interventions.

This study has added to growing literature on Triple P, demonstrating positive benefits of participation, however more research is required with Primary Care Triple P. Future research needs to explore Primary Care Triple P with larger numbers of participating families and with longer follow-up periods. Researching different populations would also help demonstrate which populations Primary Care Triple P best suits.

It is also recommended that further - larger scale - studies be carried out with different types of interventions with CAMHS

populations, in order to have more of an understanding of the attrition rate for CAMHS clients and to determine the effectiveness of interventions with CAMHS populations. As the waiting list for child mental health services is ever increasing, and the pressure builds to implement brief interventions, researching the type of intervention most valuable to clients presenting with child behavioural problems becomes more important. Understanding the attrition rate becomes important in determining which clients will be more likely to drop out, and how services can be beneficial to these clients.

REFERENCES

Arnold, D.S., O'Leary, S.G., Wolff., L.S., & Acker, M.M. (1993). The Parenting Scale: A Measure of Dysfunctional Parenting in Discipline Situations. *Psychological Assessment, 5*(2), 137-144.

Barkley, R.A., Guevremont, D.C., Anastopoulos, A.D., & Fletcher, K.E. (1992). A Comparison of Three Family Therapy Programs for treating Family Conflicts in Adolescents with Attention-Deficit Hyperactivity Disorder. *Journal of Consulting and Clinical Psychology, 60*, 450-462.

Barrett, P.M., Dadds, M.R., & Rapee, R.M. (1997). Family Treatment of Childhood Anxiety: A Controlled Trial. *Journal of Consulting and Clinical Psychology, 65*, 627-635.

Bauer, G.P., & Kobos, J.C. (1987). *Brief Therapy: Short-Term Psychodynamic Intervention.* Northvale, NJ, USA: Jason Aroson, Inc.

Bijou, S.W. (1984). Parent Training: Actualizing the Critical Conditions of Early Childhood Development. In R.F. Dangel & R.A. Polster (Eds.), *Parent Training: Foundations of Research and Practice* (pp. 15-26). New York, NY, USA: The Guilford Press.

Boggs, S.R., Eyberg, S., & Reynolds, L.A. (1990). Concurrent Validity of the Eyberg Behavior Inventory. *Journal of Clinical Child Psychology, 19*(1), 75-78.

Burns, G.L., & Patterson, D.R. (1991). Factor Structure of the Eyberg Child Behavior Inventory: Unidimensional or Multidimensional Measure of Disruptive Behavior? *Journal of Clinical Child Psychology, 20*(4), 439-444.

Chamberlain, P., & Patterson, G.R. (1995). Discipline and Child Compliance in Parenting. In M.H. Bornstein (Ed.), *Handbook of Parenting, Volume 4: Applied and Practical Parenting* (pp. 205-225). Mahwah, NJ, USA: Erlbaum.

Chamberlain, P., & Reid, L.B. (1987). Parent Observation and Report of Child Symptoms. *Behavioral Assessment, 9*, 97-109.

Christensen, A.P., & Sanders, M.R. (1987). Habit Reversal and DRO in the Treatment of Thumbsucking: An Analysis of Generalization and Side Effects. *Journal of Child Psychology and Psychiatry, 28*, 281-295.

Connell, S., Sanders, M.R., & Markie-Dadds, C. (1997). Self-Directed Behavioral Family Intervention for Parents of Oppositional Children in Rural and Remote Areas. *Behavior Modification, 21*, 379-408.

Dadds, M.R., Heard, P.M., & Rapee, R.M. (1991). Anxiety Disorders in Children. *International Review of Psychiatry, 3*, 231-241.

Dadds, M.R., & Powell, M.B. (1991). The Relationship of Interpersonal Conflict and Global Marital Adjustment to Aggression, Anxiety, and Immaturity in Aggressive and Nonclinic Children. *Journal of Abnormal Child Psychology, 19*(5), 553-567.

Dadds, M.R., Sanders, M.R., & Bor, B. (1984). Training Children to Eat Independently; Evaluation of Mealtime Management Training for Parents. *Behavioural Psychotherapy, 12*, 356-366.

Dadds, M.R., Schwartz, S., & Sanders, M.R. (1987). Marital Discord and Treatment Outcome in Behavioral Treatment of Child Conduct Disorders. *Journal of Consulting and Clinical Psychology, 55*(3), 396-403.

Dryden, W. (1995). *Brief Rational Emotive Behaviour Therapy.* West Sussex, England, UK: John Wiley & Sons, Inc.

Eyberg, S. (1992). Parent and Teacher Behavior Inventories for the Assessment of Conduct Problem Behaviors in Children. In L. VandeCreek, S. Knapp, & T.L. Jackson (Eds.), *Innovations in Clinical Practice: A Source Book (Volume 11)*, pp. 261-270.

Sarasota, FL, United States of America: Professional Resource Exchange, Inc.

Forehand, R., & Long, N. (1998). Outpatient Treatment of the Acting Out Child: Procedures, Long Term Follow-up Data, and Clinical Problems. *Advances in Behavior Research and Therapy, 10*, 129-177.

France, K.G., & Hudson, S.M. (1990). Behavior Management of Infant Sleep Disturbance. *Journal of Applied Behavior Analysis, 23*, 91-98.

Huhn, R.P., & Zimpfer, D.G. (1989). Effects of a Parent Education Program on Parents and Their Preadolescent Children. *Journal of Community Psychology, 17*, 311-318.

Johnston, C., & Mash, E.J. (1989). A Measure of Parenting Satisfaction and Efficacy. *Journal of Clinical Child Psychology, 18*(2), 167-175.

Kendziora, K.T., & O'Leary, S.G. (1993). Dysfunctional Parenting as a Focus for Prevention and Treatment of Child Behavior Problems. *Advances in Child Clinical Psychology, 15*, 175-206.

Lamb, J., & Lamb, W.A. (1978). *Parent Education and Elementary Counseling*. New York, NY: Human Sciences Press.

Lawton, J.M., & Sanders, M.R. (1994). Designing Effective Behavioral Family Interventions for Stepfamilies. *Clinical Psychology Review, 14*, 463-496.

Lochman, J.E. (1990). Modification of childhood aggression. In M. Hersen, R.M. Eisler, & P.M. Miller (Eds), *Progress in behavior modification* (Vol 25, pp. 47-85). New York, NY, USA: Academic Press.

Lochman, J.E., & Brown, M.V. (1980). Evaluation of Dropout Clients and of Perceived Usefulness of a Parent Education Program. *Journal of Community Psychology, 8*, 132-139.

Lovibond, P.F., & Lovibond, S.H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy, 33*(3), 335-343.

McGee, R.K. (1983). Crisis Intervention and Brief Psychotherapy. In M. Hersen, A.E. Kazdin, & A.S. Bellack (Eds.), *The Clinical Psychological Handbook* (pp. 751-781). Elmsford, NY, USA: Pergamon Press Inc.

McMahon, R.J. (1994). Diagnosis, Assessment and Treatment of Externalizing Problems in Children: The Role of Longitudinal

Data. *Journal of Consulting and Clinical Psychology, 62*, 901-917.

McMahon, R.J., & Wells, K. (1989). Conduct Disorders. In E.J. Marsh & R.A. Barkley (Eds.), *Treatment of Childhood Disorders* (pp. 73-134). New York, NY, USA: Guilford Press.

McNeil, C.B., Eyberg, S., Eisenstadt, T.H., Newcomb, K., & Funderbunk, B. (1991). Parent Child Interaction Therapy with Behaviour Problem Children: Generalization of Treatment Effects to the School Setting. *Journal of Clinical and Child Psychology, 20*, 140-151.

Miller, A.J., & Kratochwill, T.R. (1979). Reduction of Frequent Stomach Complaints by Time Out. *Behavior Therapy, 10*, 211-218.

Miller, G.E., & Prinz, R.J. (1990). Enhancement of Social Learning Family Interventions for Childhood Conduct Disorder. *Psychological Bulletin, 108*, 291-307.

Miller-Johnson, S., Emery, R.E., Marvin, R.S., Clarke, W., Lovinger, R., & Martin, M. (1994). Parent-Child Relationships and the Management of Insulin-Dependent Diabetes Mellitus. *Journal of Consulting and Clinical Psychology, 62*, 603-610.

O'Dell, S. (1974). Training Parents in Behavior Modification: A Review. *Psychological Bulletin, 81*(7), 418-433.

Patterson, G.R. (1982). *Coersive Family Process.* Eugene, OR, USA: Castalia.

Patterson, G.R., Dishion, T.J., & Chamberlain, P. (1993). Outcomes and Methodological Issues Relating to Treatment of Antisocial Children. In T.G. Giles (Ed.), *Handbook of Effective Psychotherapy* (pp. 43-87).

Polster, R.A., & Dangel, R.F. (1984). Behavioral Parent Training: Where It Came from and Where It's At. In R.F. Dangel & R.A. Polster (Eds.), *Parent Training: Foundations of Research and Practice* (pp. 1-12). New York, NY, USA: The Guilford Press.

Quick, E.K. (1996). *Doing What Works in Brief Therapy: A Strategic Solution Focussed Approach.* San Diego, CA, USA: Academic Press, Inc.

Risley, T.R., Clark, H.B., & Cataldo, M.F. (1976). Behavioral Technology for the Normal Middle Class Family. In E.J. Marsh, L.A. Hamerlynck, & L.C. Handy (Eds.), *Behavior Modification and Families* (pp. 34-60). New York, NY, USA: Brunner/Mazel.

Robins, L.N. (1991). Conduct Disorder. *Journal of Child Psychology & Psychiatry, 32*(1), 193-212.

Sanders, M.R. (1982). The Effects of Instructions, Feedback and Cueing Procedures in Behavioral Parent Training. *Australian Journal of Psychology, 34*(1), 53-69.

Sanders, M.R. (1992). Enhancing the Impact of Behavioural Family Intervention With Children: Emerging Perspectives. *Behaviour Change, 9*(3), 115-119.

Sanders, M.R. (1995). *Healthy Families, Healthy Nation.* Brisbane, QLD, Australia: Academic Press.

Sanders, M.R. (1996). New Directions in Behavioral Family Intervention with Children. In T.H. Ollendick and R.J. Prinz (Eds.), *Advances in Clinical Child Psychology, Volume 18* (pp. 283-330). New York, NY, USA: Plenum Press.

Sanders, M.R. (1999). The Triple P - Positive Parenting Program: Towards an Empirically Validated Multilevel Parenting and Family Support Strategy for the Prevention of Behavior and Emotional Problems in Children. *Clinical Child & Family Review, 2*(2), 71-90.

Sanders, M.R., Bor, B.,-& Dadds, M.R. (1984). Modifying Bedtime Disruptions in Children Using Stimulus Control and Contingency Management Procedures. *Behavioural Psychotherapy, 12*, 130-141.

Sanders, M.R., & Christensen, A.P. (1985). A Comparison of the Effects of Child Management and Planned Activities Training in Five Parenting Environments. *Journal of Abnormal Child Psychology, 13*(1), 101-117.

Sanders, M.R., & Dadds, M.R. (1982). The Effects of Planned Activities and Child Management Procedures in Parent Training: An Analysis of Setting Generality. *Behavior Therapy, 13*, 452-461.

Sanders, M.R., & Dadds, M.R. (1993). *Behavioral Family Intervention.* Needham Heights, MA, USA: Allyn and Bacon.

Sanders, M.R., & Duncan, S.B. (1995). Empowering Families: Policy, Training, and Research Issues in Promoting Family Mental Health in Australia. *Behaviour Change, 12*(2), 109-121.

Sanders, M.R., & Glynn, T. (1981). Training Parents in Behavioral Self-Management: An Analysis of Generalization and Maintenance. *Journal of Applied Behavior Analysis, 14*, 223-237.

Sanders, M.R., & Markie-Dadds. (1992). Towards a Technology of Prevention of Disruptive Behaviour Disorders: The Role of Behavioural Family Intervention. *Behaviour Change, 9*(3), 186-200.

Sanders, M.R., & Markie-Dadds, C. (1996). Triple P: A Multilevel Family Intervention Program for Children with Disruptive Behaviour Disorders. In P. Cotton & H. Jackson (Eds), *Early Intervention and Prevention in Mental Health* (pp. 59-85). Carlton South, VIC, Australia: Australian Psychological Society, Ltd.

Sanders, M.R., Markie-Dadds, C., & Turner, K.M.T. (1995). Childhood disruptive behaviour disorders. *General Practitioner, 2*, 18-21.

Sanders, M.R., Nicholson, J.M., & Floyd, F.J. (1997). Couples' Relationships and Children. In W.K. Halford & H.J. Markman (Eds.), *Clinical Handbook of Marriage and Couples Interventions* (pp. 225-253). Chichester, UK: Wiley.

Sanders, M.R., Patel, R.K., Le Grice, B., & Shepherd, R.W. (1993). Children with Persistent Feeding Difficulties: An Observational Analysis of the Feeding Interactions of Problem and Non-Problem Eaters. *Health Psychology, 12*, 64-73.

Sanders, M.R., & Plant, K. (1989). Generalization effects of Behavioral Parent Training to High and Low Risk Parenting Environments. *Behavior Modification, 13*, 283-305.

Sanders, M.R., Rebgetz, M., Morrison, M., Bor, W., Gordon, A., Dadds, M.R., & Shepherd, R.W. (1989). Cognitive-

Behavioral Treatment of Recurrent Nonspecific Abdominal Pain in Children: An Analysis of Generalization and Side Effects. *Journal of Consulting and Clinical Psychology, 57,* 294-300.

Sanders, M.R., Shepherd, R.W., Cleghorn, G., & Woolford, H. (1994). The Treatment of Recurrent Abdominal Pain in Children: A Controlled Comparison of Cognitive-Behavioral Family Interventions and Standard Pediatric Care. *Journal of Consulting and Clinical Psychology, 62*(2), 306-314.

Sayger, T.V., Horner, A.M., & Glaser, B.A. (1993). Marital Satisfaction and Social Learning Family Therapy for Child Conduct Problems: Generalization of Treatment Effects. *Journal of Marital and Family Therapy, 19,* 393-402.

Schreibman, L., Kaneko, W.M., & Koegel, R.L. (1991). Positive Affect of Parents of Autistic Children: A Comparison Across Two Teaching Techniques. *Behavior Therapy, 22,* 479-490.

Sharpley, C.F., & Rogers, H.J. (1984). Preliminary Validation of the Abbreviated Spanier Dyadic Adjustment Scale: Some Psychometric Data Regarding a Screening Test of Marital Adjustment. *Educational and Psychometric Measurement, 44,* 1045-1049.

Simmons, K. (1999). *Pathways to prevention: Developmental and early intervention approaches to crime in Australia.* National Crime Prevention, Attorney-General's Department, Canberra, Australia: Commonwealth of Australia.

Taylor, T.K., & Biglan, A. (1998). Behavioral family Intervention for Improving Child Rearing: A Review of the Literature for Clinicians and Policy Makers. *Clinical Child and Family Psychology Review, 1*, 46-60.

Turner, K.M.T., Sanders, M.R., & Markie-Dadds, C. (1999). *Practitioner's Manual for Primary Care Triple P.* Brisbane, Queensland, Australia: Families International Publishing Pty. Ltd.

Turner, K.M.T., Sanders, M.R., & Wall, C.R. (1994). Behavioural Parent Training Versus Dietary Education in the Treatment of Children with Persistent Feeding Difficulties. *Behaviour Change, 11*(4), 242-258.

Webster-Stratton, C. (1993). Strategies for helping Early School-Age Children with Oppositional Defiant Disorders: The Importance of Home-School Partnerships. *School Psychology Review, 22*, 437-457.

Webster-Stratton, C. (1994). Advancing Videotape Parent Training: A Comparison Study. *Journal of Consulting and Clinical Psychology, 62*, 583-593.

LIST OF APPENDICES

APPENDIX A: Information Sheet 72

APPENDIX B: Consent Form 74

INFORMATION SHEET.

School of Psychology, The University of South Australia

An Evaluation of a Brief Behavioural Family Intervention.

Behavioural Family Intervention has been a highly successful approach to helping parents with children who have behaviour problems. The majority of these programs are quite intensive, and require much time on behalf of the parents and the organisation conducting the program for participation. Many authors suggest that change can be effective in many instances with briefer Behavioural Family Interventions. In this research we are asking whether you would be willing to participate in a brief Behavioural Family Intervention program, which will be evaluated for its success in assisting you and your family.

If you agree to participate in this program, you will be randomly allocated into one of two groups. One group will complete the program immediately, whereas the other group will wait 8 weeks before completing the program. In these groups you will be required to participate in 4 sessions, each lasting approximately 20 minutes. The sessions are tailored to meet the needs of your family, and will be run on an individual basis at the CAMHS clinic. You will be required also to complete some forms before beginning the program, and also after its completion. Also, with your permission, you will be contacted approximately 8 weeks after you have competed the program to ask your views on how successful you felt this program was.

The current waiting list for programs of these sort at CAMHS is approximately up to 6 months. By agreeing to participate in this study, you will not lose your place in the waiting list, and will be still offered services at CAMHS as they arise.

The information that you provide will be kept strictly confidential. Any information reported from the data obtained in this study will be reported in a group format, and individual participants will not be identified. All information collected as part of this study will be retained for seven years, and stored securely in the School of Psychology at the University of South Australia.

You are free to withdrawn from this study at any time.

If you agree to participate, please sign and return the enclosed consent form.

This study has been given approval by the Women's & Children's Hospital's Ethics Committee, and the Human Research Ethics Committee at the University of South Australia.

If you have any further questions regarding this study, please feel free to contact me (8353 8157), my supervisor Greg Ireland (8302 1479) or Pam Schofield at Eastern CAMHS (8207 8999). If you have any concerns regarding the ethical approval of this study, please feel free to contact Ms Brenda Penny (8204 6521) at the Women's and Children's Hospital, or Dr. Brian Cheers (8302 4811, fax 8302 4377) at the University of South Australia.

Melissa K. Dawkins
Research Student

CONSENT FORM.

Project Title: **An Evaluation of a Brief Behavioural Family Intervention.**

Researcher's Name: **Melissa K. Dawkins**

Supervisor's Name: **Greg Ireland**

- I have read the Information Sheet, and the nature and the purpose of the research project has been explained to me. I understand and agree to take part.
- I understand that I may not directly benefit from taking part in the study.
- I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential.
- I understand that I can withdraw from the study at any stage and that this will not affect my status now or in the future.
- I understand that there will be no payment to me for taking part in this study.
- I am aware that I should retain a copy of the Consent Form, when completed, and the Information Sheet.
- I confirm that I am over 18 years of age.
- I understand that while my children are not directly involved with these sessions, I will receive advice on how their behaviour can be managed. I realise that if I choose to act upon this it may impact on my children.

Name of participant: .....

Signed: .....

Dated: .....

I have explained the study to the participant and consider that he/she understands what is involved.

Researcher's signature and date .....