An Evaluation of a Self-directed Parent Training Programme

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ABSTRACT

The aim of this thesis was to investigate the effects of a self-directed parent training programme for preschoolers externalising behaviour problems on child and parenting behaviours. The programme used was the Triple P self-help book and DVD. A non-concurrent multiple baseline design across five participants was used to examine changes in preschoolers externalising and prosocial behaviours over time and parents use of behaviour management strategies was also monitored at baseline and throughout using the self-help programme. A pre-post design was used to further test changes in preschoolers externalising behaviours and parents use of ineffective discipline, and to examine changes in parenting knowledge, competence, and depression, anxiety and stress symptoms. Significant and large effect sizes were found for increased prosocial behaviour, decreased externalising behaviour as shown by the multiple baseline data and parents' decreased ineffective discipline and increased parental competence as shown by the test battery. The pre- and post-measures showed non-significant improvements for parenting knowledge and depression, anxiety and stress symptoms. These findings are comparable to previous research. Parents were satisfied with the intervention, although some participants did not trial all of the strategies taught. This study supports the effectiveness of the self-directed Triple P intervention, without therapist assistance, and suggests that the preschool period may be a particularly important point in preventing the otherwise adverse developmental pathway of externalising behaviour problems. These results require further replication due to the small sample size in the study and the lack of a control group for the pre- post-comparisons. Future parent training research should examine changes in children's prosocial behaviours and parenting knowledge and monitor parents' use of and satisfaction with behaviour management strategies. This would be beneficial in clarifying the nature of these changes and relationship among these variables and to improve parent training programmes to maximise treatment gains.

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Children often exhibit behaviour that is of concern to their parents and behavioural disorders are among the most common chronic health problems; externalising behaviours are of particular concern (Church, 2003). There is also literature regarding the vital role of parenting to child mental health, with the first few years being especially important because it establishes patterns of functioning (Nock, Kazdin, Hiripi & Kessler, 2007).

This introduction will explore the usefulness of a self-help intervention for parents of preschoolers who have externalising behaviour problems. Specifically this review will discuss how childhood externalising behaviours are related to parenting behaviours and investigate the efficacy of existing parent training programmes for externalising behaviours. The Positive Parenting Programme (Triple P) (Sanders, Markie-Dadds, Tully & Bor, 2000), a specific parent training programme, will be discussed in depth. The Triple P intervention has recently been developed and has produced promising results (Sanders, Markie-Dadds, Turner & Ralph, 2004) in reducing childhood externalising behaviours thus far. The focus of this thesis is on using the self-help version of the Triple P programme for externalising behaviours in preschoolers. Therefore, this review will also discuss self-help interventions.

It is important to consider that the majority of this research has been conducted in America and Australia, where parent training programmes to combat externalising behaviour problems have been developed.

Externalising Behaviour Problems

Externalising behaviour is a broad term that encompasses behaviours such as non-compliance, aggression, impulsivity, over-activity, tantrums, and defiance (Montgomery, Bjornstad & Dennis, 2006). Such behaviour problems are more prevalent in boys (APA, 2000). These behaviours are a prevalent and serious problem and are becoming increasingly common (Webster-Stratton & Hooven, 1998). Externalising behaviours make up approximately two thirds of referrals for psychological services in childhood (Moore & Patterson, 2003) and are the primary developmental pathway for diagnosis of Attention Deficit-Hyperactivity

Disorder (ADHD), Oppositional Defiance Disorder (ODD) or Conduct Disorder (CD) (Scholer, Nix & Patterson, 2006). Furthermore, externalising behaviours in childhood are a serious problem as they may also lead to: substance abuse, relationship problems, criminality, and a range of psychiatric disorders (Reyno & McGrath, 2006). Early intervention is considered crucial in averting this otherwise adverse trajectory and also because these behaviours become increasingly difficult to treat with age (Webster-Stratton & Hooven, 1998). It has recently been recognised that the optimum time for early intervention in externalising behaviours is the preschool age. This is because during this stage; externalising behaviours tend to first emerge and occur at a high rate (Sanders et al., 2004), are stable over the long-term (Caspi & Silva, 1995; Heller, Baker, Henker & Hinshaw, 1996) and because parent and preschoolers' behaviours are likely to be less severe, less entrenched and more amenable to change (Williford & Shelton, 2008). Therefore, there is a need for effective interventions to ameliorate externalising behaviour in preschoolers.

Aetiology of Externalising Behaviours

Aetiology of externalising behaviours is viewed as a mixture of ineffective parenting, biology, socio-cognitive and environmental factors (Webster-Stratton & Hooven, 1998). In the past, child behaviour problems were treated by focusing on the child. This has shifted in recent years, particularly within behavioural frameworks, to focusing on parents as powerful agents of socialisation and on the family as the child's primary social context (Moore & Patterson, 2003). Biological, socio-cognitive and environmental factors are important areas to consider in the investigation of the development and treatment of externalising behaviours in childhood. However, these factors are beyond the scope of this thesis, which will focus on discussing the effects of parenting practices.

Research has shown that adverse parenting practices have a major influence in the development, maintenance and exacerbation of externalising behaviours by discouraging prosocial behaviours and inadvertently teaching negative behaviours through modelling and reinforcement (Kazdin & Weisz, 2003). Discipline may be inconsistent or overly permissive and it is harsh discipline in particular that is the strongest predictor of externalised child behaviour (Reyno & McGrath, 2006). This is evident with parents of children

with externalising behaviours, who are 1.25-3 times more likely to use coercive practices and 8 times more likely to abandon demands than parents of 'normal' children (Gardner, 1989). Conversely, children given clear, firm, consistent and appropriate consequences for misbehaviour exhibit fewer externalised behaviours (Arnold, O'Leary, Wolf & Acker, 1993). The strong influence of parental behaviours on externalised child behaviours has led to a focus on Parent Training (PT) as an intervention to ameliorate externalised child behaviour problems through modifying parenting practices. Thus, there is a need for PT interventions that can enhance parenting practices and reduce the externalising behaviours of preschoolers.

Parent Training for Externalised Child Behaviour Problems

Behavioural PT is the best researched of the varying PT orientations (Kazdin & Weisz 2003), and henceforth behavioural orientated PT, will be referred to as PT. Behavioural PT is grounded in behavioural principles and social learning theory and views disruptive behaviour as learned behaviour which is maintained by reinforcement (attention/escape). PT is based on the coercion cycle, which postulates that negative behaviours of both parent and child are reciprocally reinforcing in an escalating cycle of negative interactions, which are then repeated until habitual (Eyberg & Graham-Pole, 2005). Therefore, it is argued that child behaviour can be modified by modifying reinforcers of problematic behaviours (Dumas, 2005) and so PT aims to teach parents to increase positive interactions, consistently reinforce prosocial behaviours and reduce coercive or inconsistent parenting practices and ignore or punish aversive child behaviours (Webster-Stratton & Hooven, 1998). To achieve this PT applies operant conditioning, shaping, and successive approximation to produce effective parenting skills. Therapists use modelling, role play, didactic instruction, feedback, verbal reinforcement and provide homework exercises (McCart, Priester, Davies & Azen, 2006) to teach parents to use positive reinforcement contingencies (reward charts/token economies/differential attention), ignoring and punishment (time-out/response-cost). Consistent and correct implementation of these techniques is required for treatment gains (Dumas, 2005).

PT aims to promote prosocial behaviours and reduce externalising behaviours in children by developing parents' confidence and knowledge and

skills of effective behaviour management strategies and by enhancing the quality of parent-child interactions. In fact it has been argued that knowledge and parental competency play an important role in parenting practices. It is contended that increasing parenting knowledge about effective discipline may diminish the use of harsh discipline (Pinderhughes, Dodge, Bates, Pettit & Zelli, 2000). Parent's knowledge of behaviour management is also considered important, as parents are thought to be unlikely to use skills post-intervention, unless they comprehend the concepts that the intervention promotes (Matthews & Hudson, 2001). However, there is a dearth of research examining the role of parenting knowledge in ineffective parenting and child behaviour problems or indeed the effect of PT of parenting knowledge. The literature has focused on knowledge in relation to parent populations that have abused or are at risk of abusing their children (Palusci, Crum, Bliss & Bavolek, 2008; Showers, 1993). Measures of knowledge have also focused on child development (Landy & Menna, 2006) rather than knowledge of behavioural principles and child behavioural management strategies (Morawska, Winter & Sanders, 2009). Recent research with parents of preschoolers has found that parental knowledge of effective parenting strategies acts as a moderating factor in the relationship between parenting confidence and dysfunctional parenting (Morawska et al., 2009). Morawska et al., (2009) concluded that higher knowledge of effective parenting strategies resulted in less dysfunction than lower knowledge levels and those parents with both low levels of knowledge and confidence may exhibit dysfunctional parenting. Low levels of behavioural knowledge are also predictive of negative reactions in dealing with the challenging behaviours of children (Hastings & Brown, 2002). McLoughlin (1985) found that parents, who read a self-instructional guide of behaviour management strategies but not principles of behaviour management, increased their knowledge of behaviour principles after using the strategies. He concluded it is not necessary for parents to learn behaviour principles in order to successfully use behaviour management strategies. However, teaching parents principles of behaviour results in additional gains above that of PT alone (McMahon, Forehand & Griest,1981) and a significant increase in knowledge of behaviour principles at post-intervention (Zimerman & Popynick, 2003).

In their review of parenting self-efficacy, Jones and Prinz (2005) found a moderate negative relationship between parenting self-efficacy and child misbehaviour. Johnston and Mash (1989) found that those with low levels of efficacy are more likely to use ineffective parenting techniques and those with high conflict parenting style were less satisfied in their parenting. Similarly, Hastings and Brown (2002) found that caregivers who had greater self-efficacy in dealing with challenging behaviours in children reported fewer negative emotional reactions, such as anxiety and depression. However, knowledge and confidence in parenting does not automatically imply the use of effective parenting skills and strategies (Morawska et al., 2009; Matthews & Hudson, 2001). Morawska and Sanders (2006b) suggest PT efficacy studies should evaluate pre- and post-knowledge of behaviour management strategies.

Guidelines for Evaluating PT Programmes

Guidelines specifically for evaluating PT programmes have been proposed by Matthews and Hudson (2001). They state that PT should occur under 'real life' conditions as much as possible (Matthews & Hudson, 2001). The guidelines recommend using multiple direct and indirect assessment measures of parent and child behavioural outcomes before, during and after implementation, to best evaluate PT programmes.

The specific variables that Matthews and Hudson (2001) recommend for evaluation include assessment of parental knowledge of principles of behaviour, parent's acquisition of skills and strategies, and satisfaction with the strategies that the intervention teaches. It is also recommended to measure child behaviour problems and prosocial behaviours and to measure acceptability and social validity or satisfaction with the intervention. It is stressed that an effective PT intervention should result in child and parent behaviour changes. To evaluate this, Matthews and Hudson (2001) suggest that parent behaviour change can be assessed using measures such as the Parenting Scale (Arnold et al., 1993) and the Depression Anxiety Stress Scale (Lovibond & Lovibond, 1995), while child behaviour change can be measured by tools such as the Eyberg Child Behavior Inventory (ECBI) and Parent Daily Report (PDR), which uses parental observation of child behaviour. Additional support for the use of some of these measures is garnered by a review of parental discipline and nurturance measures

by Locke and Prinz (2002). These authors recommend using the Parenting Scale to assess ineffective discipline and the Parent Daily Report to measure the frequency of specific child behaviours, as among the most useful instruments. To assess satisfaction with the PT intervention, Matthews and Hudson (2001) recommend the administration of the Parent Consumer Satisfaction Questionnaire (PCSQ) (Forehand & McMahon, 1981). Therefore, these measures should be used as part of PT evaluations.

Observation is also considered important, particularly for treatments directed at children. However, problems with observation include parents interacting with their child in a non-typical manner due to being observed and child reactivity to observation (Hamilton & MacQuiddy, 1984) and observed parents differing on self-report of parent and child behaviours compared to unobserved parents (Morawska & Sanders, 2007). Therefore, caution needs to be taken with studies involving observation.

Efficacy of Parent Training

PT has been found to be an effective treatment for child externalising behaviours (Moore & Patterson, 2003), although much of the research has not included all the above measures. PT has been found to be more effective than therapists' treatment as usual and more effective based on observations of parent and child behaviours than family therapy (Webster-Stratton & Hooven, 1998). Additionally, more improvements in child behaviour at home, mothers' confidence, and client satisfaction have been found for PT than for eclectic treatment at a child mental health service (Webster-Stratton & Hooven, 1998). A meta-analysis comparing PT and cognitive-behavioural therapy (CBT) with antisocial youth found PT to have a significantly stronger effect for 6-12 year olds than for adolescents compared to CBT (McCart et al., 2006). Overall, PT has been effective in improving parent and child behaviours, communication, and parenting self-esteem (Reyno & McGrath, 2006). A meta-analysis found that PT resulted in 80% of children being 'better adjusted' compared to control groups (Serketich & Dumas, 1996). Furthermore, two-thirds of children whose parents participate in PT show clinically significant improvement at 1-year follow-up (Reid & Webster-Stratton, 2001).

There are, however, a number of factors which have been found to affect the efficacy of PT. Much of the research has been conducted with school-age children and PT has been found to be more effective with parents of children under 8 years old than for older children and adolescents (Moore & Patterson, 2003). It is suggested that younger children may require less intensive treatment because behaviours are less entrenched (Taylor & Biglan, 1998). PT packages that include video modelling have also been found to increase PT efficacy (Kazdin & Weisz, 2003). Additionally, improved parental discipline has been found to be a mediator for change in problem behaviour of children (Heinrichs, Bertram, Kuschel & Hahlweg, 2005). Effectiveness may also depend on training to generalise (Reid & Webster-Stratton, 2001).

There are a number of external factors that also affect PT efficacy. Reyno and McGrath (2006) found that self or external referral produced a statistically significant but moderate effect size on treatment outcome. While there have been some conflicting findings, generally, severe externalised behaviours, family conflict, parental psychopathology, higher levels of stressful events and low socio-economic status (SES) are associated with decreased benefit from PT (Sanders et al, 2004; Kazdin & Wassell, 2000; Reyno & McGrath, 2006). Indeed, antisocial behaviour in low SES schools in New Zealand is 3-6 times higher than in high decile schools (Bretherton, 2001). It is suggested that SES may indirectly affect parenting by increasing psychological distress (Reyno & McGrath, 2006).

While PT has been found to be the treatment of choice for child externalised behaviours (Church, 2003) it has largely focused on school-age children despite preschoolers behaviour considered to be more malleable and early intervention desirable. PT guidelines have been developed but thus far PT research has largely focused on parent outcomes such as dysfunctional parenting style (ineffective discipline), parenting stress and measures of relationships with partners and child outcome measures have focused on externalising behaviours rather than also measuring changes in prosocial behaviours (Sanders, Calam, Durand, Liversidge & Carmont 2008). Thus, there is a need to examine the effect of PT on prosocial behaviours in preschoolers and parenting knowledge and use of behaviour management strategies.

The majority of the research has focused on one of four PT packages: the Incredible Years (Webster-Stratton), the Oregon Social Learning Centre programme, the Forehand and McMahon programme, and the Positive Parenting Programme or Triple P programme (Sanders et al., 2000). All of these packages have been reported as effective PT packages in reviews (Church, 2003). Of these, the Triple P package was selected here for further review and the research relating to this will now be presented.

The Triple P Positive Parenting Programme

The Triple P Programme is a behavioural PT program developed by Sanders and colleagues at the University of Queensland, in Brisbane, Australia (Sanders, et al., 2004). The core is the Level 4 Triple P, which involves intensive training and is targeted at parents who have children with a broad range of behavioural problems (Sanders et al., 2004). It corresponds to typical PT programmes (Norwak & Heinrichs, 2008; Thomas & Zimmer-Gembeck, 2007). Specifically, the fundamental parenting practices taught in Triple P are: observation (monitoring of own and child's behaviour), encouraging desirable behaviour (quality time, affection, descriptive praise, attention), teaching new skills (modelling, behaviour charts, incidental teaching), managing misbehaviour (rules, planned ignoring/differential social reinforcement, giving instructions, logical consequences, quiet time/non-exclusionary time-out, time-out), and preventing problems (selecting engaging activities, risk reduction strategies) (Sanders et al., 2004). Level 4 Triple P has been used with a diverse range of populations, such as step-families, single parent families, families in socially disadvantaged areas, parents with children with diagnosis of an externalised behaviour, children at risk of developing a conduct problem or for parents who are concerned about their child's behaviour, and with parents of preschoolers (Sanders et al., 2004).

The effectiveness of Level 4 Triple P is evident in the meta-analyses that have been conducted. One meta-analysis on the effects of Level 4 Triple P on parenting, found that this intervention was effective in improving dysfunctional parenting (ineffective discipline) and parental competence (parental satisfaction and feelings of efficacy as a parent) (de Graaf, Speetjens, Smit, de Wolff, & Tavecchio, 2008b). These effects further improved at a follow-up period of up to

a year (de Graaf et al., 2008b). Another meta-analysis found that Level 4 Triple P results in decreased behavioural problems in children, which were maintained, and even enhanced at 6-12 month follow-up (de Graaf, Speetjens, Smit, de Wolff, & Tavecchio, 2008a).

Limitations of Parent Training

While Triple P and other PT packages are effective, their utility has been limited by difficulties accessing PT groups and problems recruiting and retaining families in PT. The reported enrolment of parents for PT is only approximately 20% of the eligible population (Garvey, Julion, Fogg, Kratovil & Gross, 2006). Additionally, approximately 50% of PT families attend half or less PT sessions (Kazdin & Weisz, 2003) and the drop-out rate is approximately 50% (Prinz & Miller, 1994). Services may also exclude those whose behaviours are not serious enough to warrant a diagnosis. This suggests that the majority of children with externalising behaviour problems are not receiving effective psychological interventions (Taylor & Biglan, 1998).

Families who have difficulties accessing services are typically characterised by: low income, social isolation (Sanders, et al., 2004), marital problems, parental depression, and single parenthood (Heinrichs et al., 2005). These factors, along with: transportation, proximity to an appropriate service, expense, child-care, intervention setting (Garvey et al., 2006) and acceptability (Borrego, Ibanez, Spendlove & Pemberton, 2007; Barkin, Scheindlin, Ip, Richardon & Finch, 2007) act as potential barriers to accessing services. Parents who have difficulties with their child's behaviour may also find it difficult to find an appropriate therapist and contend with waiting lists. They may fear that they will be blamed for their child's behaviour, feel stigmatised or want problems to remain private rather than discussed in a group. In fact, non-participation in PT is mostly due to concerns over intrusion of privacy such as being videotaped, observed and having home visits, as well as logistical issues such as scheduling conflicts, time constraints and the number of sessions required/program demands (Heinrichs et al., 2005). Non-participation in PT may lead to reliance on General Practitioners (GP's) who may not be able to treat psychological problems (Elgar & McGrath, 2008; Scholer et al., 2006) apart from prescribing medication. This

suggests that flexible PT programmes delivered in a variety of formats may be required in order to recruit and retain parents into PT.

Self-help Interventions

Self-help interventions (SHIs) reflect the changing social needs of consumers, and are a means of addressing many of the barriers to traditional therapy (Starker, 1989). SHIs not only aid access to interventions, but also have many advantages such as: being easily disseminated to a large and diverse audience, inexpensive, easily accessible, private, making few demands, and being convenient as SHIs can be consulted anytime or place (Starker, 1989). SHIs also allow individuals to help themselves at their own pace and the intervention can be re-referred to as necessary (Mains & Scogin, 2003). Furthermore, SHIs may reduce demands on services and allow for optimum usage of professionals and services (Ellis, 1993).

In terms of PT, SHIs have the potential to increase the confidence and competence of parents managing their child's externalising behaviour, and the anonymity of SHIs may ameliorate the potential stigma of being perceived as having a 'bad' child, being a 'bad' parent, or admitting difficulty in coping as a parent (Smith, Vartanian, De Frates-Densch, Van Loon & Locke, 2003). Additionally, the self-help format allows the child's natural environment to be utilised and enables the empowerment of families to take responsibility for, and control of, the management of their child's behaviour problems (Elgar & McGrath, 2008).

A wide range of SHIs for various problems are available in the form of video materials, audiotapes, computer programs, or books, or some combination of these formats (Elgar & McGrath, 2008). However, only a small proportion of the plethora of SHIs has been empirically validated, which limits the evidence base, particularly in regards to specific problems. Overall, the studies of the efficacy of SHIs have produced conflicting results and they have generally been found to be less effective than therapist directed interventions (Mains & Scogin, 2003). SHIs have been found to be more effective with a multimedia medium and with the inclusion of some level of therapist involvement rather than a completely self-administered intervention (Mains & Scogin, 2003). There also appears to be a great deal of individual variability in response to SHIs (Ellis, 1993). The

efficacy of SHIs for an individual may be dependent on their understanding, ability, or motivation to implement a SHI correctly and the severity of their problem. It may also be that an individual's motivation to change using a lengthy SHI wanes without therapist involvement (Rapee, Abbott & Lyneham, 2006).

Research on the efficacy of SHIs is difficult to compare as different problems, populations, measures, and treatments have been used, and varying amounts of therapist contact have been involved (Ellis, 1993). Even a completely self-administered intervention requires some degree and form of contact with a researcher to establish its efficacy. Despite these issues, it is argued that SHIs may have utility as a first step, before seeking therapist intervention in a stepped-care model of mental health service delivery (Mains & Scogin, 2003). SHIs may also be used as part of a treatment package or as a stand-alone treatment for less severe problems (Mains & Scogin, 2003). In their review of SHIs, Mains and Scogin (2003), conclude that further research with diverse problems and populations and varying levels of therapist contact are needed to be confident about the utility of SHIs. They also stipulate that monitoring should be part of all SHI evaluations.

Self -help Interventions for Child Problems

With regards to SHIs being used for children's problems, SHIs may involve the child self-administering treatment or the intervention being used by the parent/caregiver to administer treatment for a child's problem. In a review of parent and self-administered manual and multi-media SHI for childhood disorders, Elgar and McGrath (2008), found these to be generally effective, although the evidence base is limited. Parent-administered SHIs have been used effectively for children with problems such as anxiety (Rapee et al., 2006), enuresis (Nawaz, Griffiths & Tappin, 2002), and conduct problems in children (Webster-Stratton, 1990).

It is suggested, however, that parent-directed SHIs are particularly suitable for child externalising behaviour problems and may mitigate the limitations inherent in traditional PT (Elgar & McGrath, 2008). A study comparing PT videos alone to therapist contact found that they were equally effective, and the effects were maintained at one year follow-up (Webster-Stratton, Kolpacoff & Hollinsworth, 1988). The Webster Stratton et al., (1988) study is one of the few

studies to examine changes in children's prosocial behaviour and parenting strategies. They found that the self-administered videotape intervention resulted in significantly increased prosocial behaviour and a significant decrease in the use of time-out and spanking compared to a control group, as reported by mothers and also found, via observation, that mothers were less critical and had more positive affect in their interactions with their child compared to a control group. Kratochwill, Elliott, Loitz, Sladeczek & Carlson (2003) found that parents raised their voices less and they also found threats of punishment decreased after using a self-administered PT intervention compared to pre-intervention for children with externalising or internalising behaviour problems. Lending further weight to the possible efficacy of SHIs, Cedar and Levant (1990), using a meta-analysis, found a small positive effect size for a self-help parenting book on parents' attitudes, knowledge, and behaviour and on children's self-esteem.

Overall, a review of eleven studies, involving 943 participants using parent-administered cognitive-behavioural SHIs for behavioural problems in children, found that SHIs resulted in a moderate effect compared to no-treatment and as an adjunct to medication (Montgomery et al., 2006).

The Triple P Self-help Intervention

The Montgomery et al. (2006) review also included studies of the self-help version of the Triple P programme, which is also a Level 4 Triple P programme. It covers the same material as the standard programme but is in a self-help format (Sanders et al., 2004). This involves a work-book which is divided into 10 weekly sections, each of which has reading and homework tasks. In current practice, the self-help book *Every parent's Self-help Workbook* (Markie-Dadds, Sanders & Turner, 2007) is being used in conjunction with the DVD *Every Parent's Survival Guide* (Sanders, Markie-Dadds & Turner, 2008). In addition to reading the book, parents are expected to watch selected DVD segments, which are outlined in the workbook for each weekly section.

The Montgomery et al., (2006) review also examined just the studies on self-help PT to determine its efficacy and found that this intervention resulted in reliable clinically significant change for 30-60% of participants. This small body of evidence implies that self-help Triple P may be a useful intervention for externalised child behaviour problems.

There are also a number of noteworthy individual studies on Triple P with mothers of preschoolers who exhibit conduct problems. Morawska & Sanders (2006a) randomly assigned parents of preschoolers to either self-directed Triple P, telephone assisted self-directed Triple P, or to a wait-list condition. Telephone assistance occurred in the form of weekly phone calls which each lasted for an average of 10 minutes. They found that the self-directed Triple P resulted in significant difference from the wait-list in terms of improved child behaviour and dysfunctional parenting. The intervention conditions did not significantly differ on these measures; however, the self-directed condition did not result in clinically significant change for child behaviour problems. Additionally, the telephone assisted group resulted in greater confidence than the self-directed group. Although the self-directed intervention was less acceptable to parents than the telephone assisted version, there were no significant differences in attrition between these interventions (Morawska & Sanders, 2006a). In fact, no significant differences in attrition between the various Triple P formats has been a consistent finding (Sanders et al., 2000; Sanders, Bor & Morawska, 2007).

Morawska and Sanders (2006b), also conducted research on self-administered Triple P with telephone assistance with mothers of preschoolers, in the context of an existing telephone counselling service; they found that the self-directed programme with an average of four phone calls lasting an average of 18 minutes, resulted in reduced child behaviour problems, dysfunctional parenting, and anger and increased parenting confidence, which were still present at three month follow-up (Morawska & Sanders, 2006b). This intervention was acceptable to parents, with the more telephone calls the more acceptable. However, the lack of a control group means these finding could be attributed to factors other than the intervention. In general, these findings suggest that self-directed Triple P may provide more benefit in conjunction with some involvement from a therapist, which can be in the form of telephone contact only.

Self-directed Triple P without therapist assistance has also been compared to a wait-list control group for mothers of preschoolers. Markie-Dadds and Sanders (2006) found that self-directed Triple P resulted in significantly reduced child behaviour problems and dysfunctional parenting, and increased parenting competence for the self-directed group, which apart from parental competence,

were maintained at six month follow-up. This implies that this intervention may have utility as a stand-alone treatment.

In fact, a study comparing self-directed, standard, and enhanced Triple P, found that at one year follow-up, there were significant improvements for the self-directed condition (Sanders et al., 2000). However, the therapist-administered interventions were significantly more effective and considered more acceptable than the self-directed version (Sanders et al., 2000). Interestingly, a three year follow-up of this study found that all interventions had similar effects in terms of reduced child behaviour problems and there were no significant differences between the interventions (Sanders et al., 2007). This suggests that self-help Triple P may be as effective as interventions involving more intensive therapist assistance in the long-term.

Overall, greater confidence in results can be gained by the meta-analysis research of the effects of Level 4 Triple P on parenting. It was found that the self-help Triple P intervention resulted in moderate to large effects and was as effective as the Level 4 group and individual formats (de Graaf et al., 2008b). Nevertheless, most SHIs have actually involved minimal therapist assistance, rather than being truly self-administered.

In general, it is suggested that self-help Triple P may be most useful for families who do not have adversity risk factors, such as parental psychopathology (Sanders et al., 2007). It is also recommended that families be screened via a telephone interview before using self-help Triple P, to exclude factors such as children with developmental disorders, significant health impairments, or those receiving professional help for behavioural problems, and to exclude parents who cannot independently read (Markie-Dadds & Sanders, 2006).

A further limitation is that the use of randomised controlled pre-post studies has obscured individual change that occurs throughout using the intervention. This is important as SHIs have been found to have great individual variability and monitoring throughout using an SHI is recommended (Mains & Scogin, 2003). Additionally, knowledge and prosocial behaviour are variables that have been omitted from the existing research on this SHI, and most of the studies have involved some therapist assistance and the workbook, rather than the workbook and DVD. Thus, there is a need for research to investigate these

variables and individuals' change over the course of using the workbook and DVD, without therapist assistance.

Summary

In summary, PT is the treatment of choice for externalised child behaviour problems and is particularly crucial in preschoolers as this is likely to be the most successful stage to intervene to thwart the negative sequelae of externalising behaviours (Cunningham, Bremner & Boyle, 1995). Triple P is an established and effective PT intervention for parents of preschoolers with externalised child behaviour problems. However, most parents of children with externalising behaviour problems are not receiving validated PT treatments. The demands, inflexibility, intrusion into privacy, perceived stigmatisation and inaccessibility of PT for some families creates barriers to undertaking PT. SHI may be an advantageous means of overcoming these barriers.

While the research on SHIs appears promising, there have been contradictory findings and the body of evidence is limited. Further research is needed in order to draw definitive conclusions about the usefulness of SHIs for children and families (Elgar & McGrath, 2008). The effect of the type of contact, such as face-to-face or telephone, and amount of therapist assistance on SHIs, also needs further investigation. There is also a need for further research on SHIs for particular problems, as the research supporting some SHIs does not mean that all SHIs have utility.

The self-help Triple P PT intervention appears promising for externalised child behaviour problems. However, studies on PT have not closely examined how child behaviour, including prosocial behaviour, and parent behaviour, particularly parents' use of behaviour management strategies, changes throughout the course of the intervention. This is despite child behaviour being the desired object of change, which PT aims to achieve through parents use of effective behaviour management strategies. Also, research on PT has not only demonstrated the importance of parents use of effective behaviour management strategies and of children's' prosocial behaviours but also the importance of parents knowledge of behaviour management strategies. While self-directed Triple P also aims to increase parenting knowledge, this has not as yet been included in studies of this SHI.

In evaluating SHIs for child behaviour problems it is also important to note that behaviour may get worse before improving, due to the effects of events such as intermittent schedules of reinforcement (Montgomery et al., 2006).

The Present Study

Rationale

Research on self-help PT for externalising behaviours in preschoolers is important. Self-help Triple P is a type of PT where parents receive a standardised workbook augmented with a DVD to use without major support from a therapist. The studies that have been conducted on this intervention have some limitations. The studies have involved some degree of therapist assistance and involved randomised controlled designs using pre- post parental self-report of only child behaviour problems, parenting confidence, parenting style and parental symptoms of depression, anxiety and stress as outcome measures and have been based on the workbook, rather than the workbook and DVD. It is important to investigate changes over the intervention for those who self-select a SHI under real-life conditions to reflect normal usage on this SHI. It is equally important that such research incorporates prosocial child behaviour and parenting knowledge and use of behaviour management strategies, as these have been neglected in prior research. Therefore, this study attempted to address some of the previous limitations. It involved an evaluation of self-help Triple P (workbook and DVD), without therapist assistance but with regular contact with the researcher (for the purpose of data gathering), for parents of preschoolers who were concerned about their child's behaviour. Additionally, at the time of starting this study there were no published studies on this SHI conducted in New Zealand.

Aims

One purpose of this study, was, then, to assess the effects of the self-help Triple P intervention, a package consisting primarily of the self-help book *Every Parents self-help workbook* (Markie-Dadds, Sanders & Turner, 2007) augmented with the DVD *Every Parent's Survival Guide* (Sanders, Markie-Dadds & Turner, 2008) on parenting behaviour and child behaviour for parents who are concerned about their preschooler's externalising behaviour. This study aimed to contribute to conclusions about the efficacy of this SHI for externalising behaviours in preschoolers. Therefore, the main aim of this study was to address the question,

"Does using the Triple P self-help book and DVD decrease externalising behaviours, increase preschoolers prosocial behaviours and increase the knowledge, competence and use of effective behaviour strategies (i.e., the parenting practices) of parents who are concerned about their preschoolers behaviour?"

The aim was to have parents use the SHI as near as possible to the way they would have had they not been part of the study. However, in order to do the study at all the parents had to collect data and the researcher needed to interact with them to assess the programme and to monitor their progress.

Study Design

This study used a non-concurrent multiple baseline design to investigate the individual effects of the self-help Triple P programme on child behaviour problems and prosocial behaviours over the course of the intervention. This allowed monitoring of individual's change in using the self-help intervention, as there was likely to be individual variability in effects (Elgar & McGrath, 2008) and matched the purposes of SHIs that they are flexible and convenient for people to use, as participants may vary on the time taken to get through each section of the self-help workbook. The study design required participants to monitor and record measures regularly throughout the baseline and intervention periods. The data for this were recorded every weekday by parents. It was expected that child misbehaviour may get worse before improving, due to intermittent schedules of reinforcement. Parent's use of effective behaviour management strategies was also monitored by the PSC, which extended previous research. These regular measures are in line with Matthews and Hudson's (2001) recommendations and Elgar and McGrath's (2008) suggestion that individuals should be monitored throughout using a SHI.

To maximise real-world use and minimise threats to external validity and in consideration of SHI efficacy dependent on therapist level of involvement, the methodology selected was a completely self-administered intervention (parents reading the book and watching the DVD). To minimise researcher contact with the families the data on child behaviour and parenting strategies was collected by the use of daily and weekly reports respectively of the types of behaviour that occurred using a checklist format. No advice or feedback was offered when

contacting participants who were undertaking the intervention and no incentives were offered for participation.

The study replicated aspects of earlier research and also extended earlier research by using a different research design, the non-concurrent multiple baseline and some additional outcome measures. Participants collected the baseline data and completed a pre-intervention test battery as soon as they had been recruited into the study. Pre- and post-measures were used to examine the effects of the Triple P SHI on parental knowledge of behaviour management strategies (an extension on other studies), parental confidence, ineffective discipline, and parental depressive, anxiety and stress symptoms. Replicated studies that replicate findings increase confidence in the research findings. As well as the monitoring, the use of the pre- and post-intervention test battery also allowed some of the hypotheses to be tested, and allowed comparison to previous research on the self-help Triple P intervention.

It was hypothesised that parenting knowledge as measured on the Triple P Parenting Quiz, parenting style/dysfunctional discipline as measured on the Parenting Scale, and confidence and satisfaction as measured on the Parenting Sense of Competence, would improve on completion of the self-help intervention. In addition, the use of effective behaviour management strategies as assessed using the Parenting Strategies Checklist would improve throughout using this intervention. It was also hypothesised that child behaviour problems would decrease, as measured by the 'bad' behaviour score of the Parent Daily Report and on the Eyberg Child Behaviour Inventory and that children's prosocial behaviours would increase, as measured by the 'good' behaviour score on the Parent Daily Report. Given that previous research has found a lack of change of this SHI on parental depressive, anxiety and stress symptoms, it was not hypothesised that these symptoms as measured by the Depression Anxiety Stress Scale would improve. It was hypothesised that parents would consider this an acceptable intervention as measured by the Parent Consumer Satisfaction Questionnaire. Therefore, the following measures were used.

Measures

The measures used in this study will be discussed further in the measures section of the Method.

Multiple Baseline Measure. The Parent Daily Report (PDR) will be used as a regular measure for baseline and intervention data collection. The PDR is used as a checklist that gives a measure of the number of different daily child behaviour problems and prosocial behaviours. This measure will help to test the hypothesis that completing self-help Triple P will reduce problem behaviours and increase prosocial behaviours.

Monitoring Measures. Each week the Parenting Strategies Checklist was used to monitor the types of behaviour management strategies used and if parents are actually using the skills taught. This measure in conjunction with the Parenting Scale will test the hypothesis that completing the self-help Triple P intervention will result in greater use of effective behaviour management strategies and decrease use of ineffective behaviour management strategies. This form of monitoring of actual behaviour managed strategies used by parents throughout an intervention appears unique to this study.

There was also an 'Evaluation Questionnaire' regarding specific ideas in the book and of their acceptability to the reader following each section of weekly reading. This evaluated whether this intervention was acceptable and useful to parents.

Test Battery. A pre- and post-test battery was also used to assess change using the measures recommended by Matthews and Hudson (2001) and Locke and Prinz (2002) and because these measures among others have often been used in PT studies. Therefore, these measures enable comparisons to previous research and achieve the research aims.

The hypothesis of reducing child behaviour problems was also tested using the Eyberg Child Behavior Inventory (ECBI) (Eyberg and Pincus, 1999).

The Parenting Scale (PS) was used to test if dysfunctional discipline changed as a result of this intervention.

The Parenting Sense of Competence (PSOC) was used to evaluate if parental competence (satisfaction and efficacy) changed as a result of this intervention.

The Triple P Parenting Quiz was used to test if parents gained greater knowledge of behavioural principles as a result of this intervention. Greater knowledge has been found to reduce dysfunctional discipline (Morawska et al., 2009).

The Depression Anxiety Stress Scale was used to assess whether depression, anxiety or stress impacted on the effectiveness of this intervention. Parents with greater self-efficacy have also been found to have lower anxiety and depression (Hastings & Brown, 2002) and reduced behaviour problems have been found to reduce parental stress.

Following completion of the intervention the Parent Consumer Satisfaction Questionnaire (PCSQ) was used to assess if the intervention was acceptable and useful to parents.

METHOD

Ethical Approval

Ethical approval for this research was received through the University of Waikato Psychology Department Ethics Committee.

Participants

Participant Recruitment

Participants were caregivers of a child aged 2-5years who were concerned about that child's behaviour. Recruitment of participants involved a poster advertisement with contact details of the researcher (Appendix A) being displayed at various childcare centres, kindergartens, Kohanga Reo, medical centres, public libraries, supermarkets, and the university intranet and notice-boards. These advertisements gave information about the study and stated that it involved using a self-help book and DVD. Potential participants who contacted the researcher were initially asked about their child's development, involvement with professional services for the child's behaviour, and about the caregivers reading ability. Potential participants were excluded if their child had been diagnosed with a developmental disability (e.g. Autism, Global Developmental Delay) or if their child was currently receiving professional help for the child's behaviour such as from a Psychologist or Early Intervention Teacher. Participants were also excluded if caregivers were not able to read the Waikato Times (a local newspaper) without assistance. The exclusion criteria were selected based on the recommendations of Markie-Dadds and Sanders (2006) mentioned earlier, and to facilitate comparison with prior research regarding the self-help workbook, and to both ensure participants' safety and ensure that participants' would be able to understand and complete the weekly readings and exercises involved in the book.

Caregivers who were not the primary caregiver were included if they were able to consistently be the person who did the weekly exercises and readings. Following the initial pre-screening potential participants were given further information about the study, such as that it involved collecting daily data, were able to ask questions and were sent an information sheet (Appendix B). At this point potential participants were asked to make contact with the researcher after

reading the information sheet to proceed further. A meeting was then arranged with the potential participants at either the university library or Hamilton Public Library to review the information sheet and further discuss the research. Participants who agreed to participate signed the consent form (Appendix C). No incentives were offered for participation.

Settings

This study primarily took place in the participants' own homes. Participants' read the book, completed the exercises and behaviour checklists at home. The initial, concluding and weekly collection meetings (unless by telephone or email) were conducted at the university library or Hamilton Public Library.

Demographics

Ten participants from the Hamilton area met the criteria for the study and decided to take part in this study (see Table 1). All participants were the parent of the child whose behaviour they were concerned about. Three participants withdrew from the study. Participants 4 and 7 both completed the baseline period before withdrawing. Participant 4 had received the book and DVD but had not started using it. Participant 6 completed baseline and three weeks of using the book before withdrawing, due to serious health concerns in the family. Participant 2 completed baseline and undertook the intervention for 24 weeks but did not complete the intervention during this time and so did not complete the final assessments. After the 24 weeks, Participant 2 did not make or respond to telephone or email contact from the researcher. Participant 8 was still undertaking the intervention.

Table 1
The details for the participants who took part in this intervention.

Partic-ipant	Interven-tion Status	Relation -ship to Child	Age	Ethnicity	Marital Status	House Hold Income	Child's Age Years months	Child's Gender
1	Completed	Mother	30-40	NZ European	Married	80,000+	4.4	F
2	Withdrew	Mother	30-40	Maori	Married	50-60,000	4.7	F
3	Completed	Mother	30-40	British	Single	<30,000	4.9	M
4	Withdrew	Father	30-40	British	Married	80,000+	3.10	F
5	Completed	Mother	30-40	NZ European	Married	80,000+	3.9	F
6	Withdrew	Mother	30-40	NZ European	Married	70-80,000	3.3	M
7	Withdrew	Mother	30-40	NZ/ African	Married	30-40,000	4	F
8	Incomplete	Mother	30-40	Pakeha	Married	60-70,000	3.11	F
9	Completed	Mother	30-40	NZ European	Married	50-60,000	2.5	F
10	Completed	Mother	30-40	Australian	Married	50-60,000	4.6	F

Table 1 also shows the five participants (1, 3, 5, 9, and 10) who completed this study were all between 30 and 40 years old and were mothers of preschoolers ranging in age from 2 years 5 months to 4 years 9 months. The preschoolers were four females and one male. Four of the mothers had partners living in the same household, Participant 3 was single. Three participants were of New Zealand/European (Pakeha) descent, one was British and one was Australian. The household income ranged from under $30,000 to over $80,000.

Materials

The materials used in the study were:

- Advertisement (Appendix A)
- Information Sheet (Appendix B)
- Consent form (Appendix C)
- Baseline and intervention checklists (See Measures below and Appendix D)

Self-help Materials

The Triple P self-help book *Every Parent's Self-help workbook* (Markie-Dadds et al., 2007) was used in this study. The self-help book was divided into 10 sections of reading and exercises. The sections included; causes of problem behaviours, promoting desirable behaviour, managing misbehaviour, monitoring of strategies, practising implementing strategies using checklists, planned activities, revision and maintenance (Markie-Dadds et al., 2007). This was accompanied by the Triple P DVD *Every Parent's Survival Guide* (Sanders et al., 2008). A workbook, *Supplementary Materials Booklet,* was also created based directly on the self-help book so that participants were not writing in the self-help books which they were not able to keep. The *Supplementary Materials Booklet* had an introduction explaining how to use the programme and materials and also had the same commitment agreement, exercises, monitoring, and practice checklists as the self-help book (Appendix E). In addition, it contained Evaluation Questionnaires (Appendix E – within the booklet) to complete after finishing each section of the self-help workbook.

Measures

Multiple Baseline

The Parent Daily Report (PDR) (Chamberlain & Reid, 1987) is a checklist which assesses the total number of specific child behaviours that have occurred over the last 24 hours by parent observation of the occurrence or non-occurrence of the set behaviours. The PDR is a useful tool as it reduces memory bias and increases accuracy by assessing actual child behaviours soon after they have happened and is an alternative to direct observation. The PDR allows for examination of the typical level of a child's behaviours and variation in the levels of behaviour (Chamberlain & Reid, 1987). A 60-item version of the PDR incorporating 30 specific problematic child behaviours ('bad' behaviours) and their 30 prosocial opposites ('good' behaviours) was used for this study. This provided the Total Daily 'Bad' and 'Good' Behaviour scores (the sum of all occurrences of problem behaviour and prosocial behaviour respectively for the day). While the PDR has largely been used as a telephone-administered measure, it was used as a daily monitoring record of child behaviours over each weekday period throughout this study. Three to five administrations are considered

necessary to obtain a stable rate of a child's behaviour as observed by parents (Chamberlain, Price, Reid, Landsvark, Fisher & Stoolmiller, 2006).

Repeated Monitoring

The Parenting Strategies Checklist (PSC) assessed the frequency of actual parenting strategies that had recently been used. Participants rated their estimate of weekly frequency of use of the set strategies in fixed categories (0, 1-3, 4-6, 7-9, 10+ times). It encompassed effective strategies promoted by the self-directed Triple P programme as well as ineffective parenting strategies. This was created by the researcher for the purposes of this study. Items were phrased in a neutral manner in an effort to avoid participants endorsing items that appeared socially desirable and reflect actual strategies used.

Weekly Evaluation Questionnaire. This was based on a questionnaire devised by Beharry (2008). The self-help workbook used in this study was divided into 10 weekly sections. After reading each section, participants completed an evaluation questionnaire regarding that section of the book and accompanying DVD segment. Participants ranked six statements on a scale from 0 (not at all) to 10 (very much). These statements assessed whether the particular weekly section provided useful skills and important ideas, their intention to use the skills/techniques, the helpfulness of watching the DVD clip, and their enjoyment of the reading and DVD.

Pre- and Post-Intervention Measures

The Eyberg Child Behavior Inventory (ECBI) (Eyberg & Pincus, 1999) is a 36-item questionnaire measuring parental perceptions of disruptive behaviour in children aged 2 to 16 years old (Eyberg & Pincus, 1999). An Intensity score is derived by rating how often each of the 36 behaviours listed is currently occurring, on a 7-point likert scale, with 1 (never) to 7 (always). The Problem score assesses how many of the 36 behaviours that parents consider to be a problem with their child and is rated on a yes-no format. The Intensity and Problem scores demonstrate high internal consistency, r=.95 and r=.94 respectively. The test-retest reliability (r=.86) and validity are good (Eyberg & Pincus, 1999), with the ECBI able to discriminate between clinic and non-clinic referred children aged 2-6 years (Weis, Lovejoy, & Lundahl, 2005). Higher scores represent greater disruptive behaviour. The Clinical Range is an Intensity score of 131 or more (T=60) or a Problem score of 15 or more (T=60). An

Intensity score of 127 or more, or a Problem score of 11 or more has been suggested as an Elevated Range (Eyberg & Ross, 1978) and used in the literature.

The Parenting Scale (PS) (Arnold et al., 1993) is a 30-item self-report questionnaire that assesses the dysfunctional discipline styles of Laxness (permissive parenting), Overreactivity (authoritarian discipline) and Verbosity (overly long reprimands or explanations) (Arnold et al., 1993). Each item has two anchor points pertaining to ineffective and effective discipline. Parents rate which point, on a 7-point scale between these anchors, best fits their discipline practices (Arnold et al., 1993). Higher scores represent greater dysfunctional parenting. The PS Total score has adequate internal consistency .84, and test-retest reliability, r=.84 (Arnold et al., 1993). The scales have adequate internal consistency and good test-retest reliability respectively, Laxness (.83, r=.83), Overreactivity (.82, r=.82), and Verbosity (.63, r=.79). The PS is correlated with observations of parenting behaviour and child behaviour and is able to discriminate between non-clinic and clinic populations (Arnold et al., 1993). Recent research on the validity and reliability of the PS with mothers of preschoolers supports the original three factor structure and reliability and validity properties (Arney, Rogers, Baghurst, Sawyer & Prior, 2008). In particular, the Laxness and Overreactivity subscales have been found to have high reliability and validity and significant correlations with the Child Behaviour Checklist and the ECBI (Arney et al., 2008).

The Parenting Sense of Competence Scale (PSOC) was devised by Gibaud-Wallston and Wandersman in 1978 (Johnston & Mash, 1989). The PSOC is a 17-item questionnaire that assesses competence on two scales. These scales are Satisfaction with the parenting role (frustration, anxiety, motivation) and feelings of Efficacy as a parent (problem solving ability, capability in the parenting role). Parents were required to rate their level of agreement with a statement on a 5-point likert scale. Higher scores are indicative of greater confidence in the parenting role. The Total score has adequate internal consistency .79. Ohan, Leung, and Johnston (2000) recommend that only the first 16 items are used.

The Triple P Parenting Quiz. This is a 30-item multiple-choice questionnaire that assesses knowledge of effective parenting strategies that are promoted in the Triple P programme (Morawska et al., 2009). Higher scores

pertain to higher parenting knowledge of promoting development, understanding of causes of child misbehaviour, principles of effective behaviour management strategies, and using assertive discipline (Morawska et al., 2009).

The Depression Anxiety Stress Scale (DASS) (Lovibond & Lovibond, 1995) is a 42-item questionnaire that measures symptoms of depression, anxiety and stress in adults over the past week. It uses a 4-point scale from "did not apply to me" (0) to "applied to me very much or most of the time" (3). Scores on each of the three subscales can range from 0-42, which corresponds to a range from Normal to Extremely Severe for each scale. Higher scores indicate greater symptom severity. The DASS demonstrates high reliability for Depression .91, Anxiety .81, and Stress .89 and has good validity (Lovibond & Lovibond, 1995).

Post-intervention Measure

The Parent Consumer Satisfaction Questionnaire (PCSQ) (Forehand & McMahon, 1981). An adapted version of this questionnaire was used for this study to fit with the techniques taught in the self-help programme. The PCSQ assesses parent's perceptions about the programme overall, child behaviour improvement, difficulty and usefulness of the treatment format, and the difficulty and usefulness of the specific parenting techniques that were taught. This consisted of a 38-item questionnaire rated on a 7-point likert format, with 7 the most positive response. This questionnaire also allowed qualitative responses regarding what parents liked most and least about the programme and how the programme could be improved. This measure was administered when participants completed the self-help programme.

The measures listed above have been used in previous research using this workbook, so were repeated in this study for replication and comparison purposes. These measures all have adequate validity and reliability and have been used with parents of preschoolers. The Triple P Parenting Quiz was also used to take into account possible prior learning; participants were pre-tested on principles to be learned.

Study Design

This thesis used a non-concurrent multiple baseline design, with pre-intervention and post-intervention comparison. A non-concurrent multiple baseline design was chosen to look at the effects on individual participants over

time and can establish when change in behaviour may be attributed to treatment. Multiple baseline designs can be used across behaviours, settings and participants without having to withdraw treatment (Richards, Taylor, Ramasamy & Richards, 1999). This is appropriate as the intervention had irreversible effects and did not require counter therapeutic changes.

A non-concurrent multiple baseline across participants was used with the Parent Daily Report (PDR) as the dependent variable. This involved the intervention being applied in sequence to individual participants, wherever possible, while baseline data was collected for succeeding individuals (see Table 2). Thus, the intention was to have matched pairs of participants. Participants started collecting baseline data on weekdays as soon as each participant was recruited. Each participant's baseline lasted five weekdays or longer if required to establish stability. As soon as the data was considered to be stable for each participant, they were then able to start the intervention. Therefore, the study consists of a series of AB designs with staggered starts for participants. Participants also completed a battery of measures at the beginning and end of the study. The test battery consisted of measures of child behaviour, parenting style, parenting competence, parenting knowledge and depression, anxiety and stress symptoms. This enabled comparison to previous studies on the self-help intervention and generated additional measures of change from the PDR. The test battery also served to measure variables, such as knowledge, that were not conducive to multiple measurements.

Table 2

This table shows the timetable of the time taken for each participant (P) to complete the baseline period and each section of the intervention period. The dates and months are indicated at the top of the table. The numbers in the shaded areas of the table show the section of the intervention that the participants were working through over the corresponding weeks.

P No		2008 Dec				2009 Jan				Feb				Mar					Apr				May				Jun					July				Aug					Sep				Oct	
	1	8	15	22	29	5	12	19	26	2	9	16	23	2	9	16	23	30	6	13	20	27	4	11	18	25	1	8	15	22	29	6	13	20	27	3	10	17	24	31	7	14	21	28	5	12
1				1	2	3	4	5 6	7	8	9	10																																		
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3																				1	2		3		4		5		6		7		8		9		10									
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9																																1		2		3	4	5	6	7		8	9	10		
10																																			1	H		2	3	4	5	6	7	8	9	10

Baseline
Intervention

P No = Participant Number
H= Holiday (i.e. not working on the intervention at this time)
W= Withdrew
?= The participant was not able to be contacted/intervention incomplete.
1-10= The section of the book that participants were working on at the specified period.

The month is shown with the date of the start of the week underneath.

Procedure

After signing the consent form, participants completed the measures in the test battery and a weekly time was arranged for data collection if participants decided not to e-mail data. The Parent Daily Report (PDR) was used as a measure for baseline and intervention data collection, from the time of signing consent until completion of the intervention. The PDR is a checklist of the number of different types of daily problem behaviours and prosocial behaviours that occurred at least once during the day. Participants recorded the daily presence or absence of behaviours (the PDR) and recorded their weekly estimate of the frequency with which they used the behaviour management strategies included in the parenting strategies checklist (PSC) throughout the baseline and intervention periods.

Each week a week's supply of the PDR (i.e. 5 PDR's) and PSC (i.e. 1 PSC) was given to participants in one envelope and a spare envelope was given to place completed PDR's and PSC in. Participants were contacted weekly (by phone, e-mail, post or in person, whichever was the participant's preference) by the researcher to collect or to arrange collection of the PDR sheets and the PSC.

The PDR sheets were scored and the problem and prosocial behaviour totals were both plotted on a graph against days and the resulting data paths were inspected visually. Once the PDR was judged to be stable visually (i.e. the data paths were flat, not trending in any direction, or trending in a direction opposite to the desired change (prosocial behaviours trending downwards and/or problem behaviours trending upwards)), participants were instructed to begin the intervention.

At this point, participants were loaned a copy of the book *Every Parent's Self-Help Workbook* which has 10 sections of readings and exercises, which were suggested by the author and the researcher to be completed weekly. Participants were also given a copy of the DVD *Every Parent's Survival Guide*, which has segments to accompany the weekly sections of the workbook. Participants were also given a *Supplementary Materials Booklet* created by the researcher and based on the workbook, in which to complete the exercises that were detailed in the book (See Appendix E). Participants were able to keep both the supplementary booklet and the DVD, but were not told this until they had completed the intervention. The supplementary booklet contained an introduction sheet

reminding participants to write in the booklet not in the self-help workbook, and explaining the requirements of the study. The booklet was divided into 10 sections to match the self-help workbook. Each weekly section comprised the exercises, which were taken directly from the self-help workbook, and an Evaluation Questionnaire relating to the content for that week. Participants were instructed to begin the first week of the intervention straight after completing the baseline period. This meant reading the first section of the self-help workbook, completing the corresponding exercises in the booklet, watching the associated DVD segment, and filling in the Evaluation Questionnaire at the end of the workbook section.

The Evaluation Questionnaires asked open questions: 1) What was the most important thing you learned from the reading for this week? 2) What was the most important thing you learned from the DVD segment for this week? The Evaluation Questionnaire also required participants to give ratings, a 0 (not at all) to 10 (very much) rating of the following 6 statements: 1) This component provided useful information for understanding and/or managing my child's behaviour 2) I agree the ideas in this component are important 3) I am going to use the skills/techniques suggested 4) I enjoyed reading this section of the programme 5) I enjoyed watching the DVD section of this programme 6) I thought watching the DVD section of the programme was helpful.

The Evaluation Questionnaires were collected weekly along with the PDR and PSC. While, the intervention was expected to last 10 weeks, participants were allowed to take more time to complete sections if they needed it. If they required more time, they were asked to continue to fill in the PDR sheets every weekday and the PSC at the end of each week.

The researcher also met with participants at the completion of the study at either the university library or Hamilton Public Library to repeat the test battery and to complete the Parent Consumer Satisfaction Questionnaire (PCSQ), whereupon the intervention finished. The *Every Parent's Self-help Workbook* was collected and participants were thanked for their involvement in the study and were asked if they would like a summary of their results.

RESULTS

Multiple Baseline PDR Scores

Time lines showing the dates of the baseline and intervention period for each participants are shown earlier in Table 2 (in the Method section). Some participants took longer than planned. While Participant 1 took only 12 weeks to complete the baseline and intervention phases, Participant 5 took 28 weeks. Participants started the intervention in sequence; this was intended to provide a baseline while another participant started the intervention. However, the matched pair's analysis was not possible because of participants withdrawing. Table 2 shows that Participants, 1, 3, 5, 9, and 10 completed the intervention. The other participants withdrew and are hereafter referred to as the 'non-completers'. Of the non-completers, Participants 2 and 8 completed most of the intervention, Participant 4 completed the baseline but did not start the intervention, Participant 6 started the intervention and then withdrew and Participant 7 withdrew during the baseline phase. Of the participants that completed the intervention, the baseline for Participant 5 was extended and was the only one that overlapped with an intervention start (that of Participant 3).

Figure 1a shows the PDR data for each participant who completed the intervention, plotted against the number of weekdays. Figure 1b shows the PDR data for each non-completer participant, plotted against the number of weekdays. The end of the baseline phase is marked by the first solid vertical and the end of each section by dotted lines on the graph and the number of the section. Data are joined over small gaps in the data collection where the occasional data point was not recorded, such as if a child was not in the care of the parents for a day. However, if participants stopped using the programme for a period, such as going on holiday, then this is indicated by a gap in the data path. The maximum possible score for 'bad' or 'good' behaviour was 30. For 'bad' behaviour the higher number indicated more types of 'bad' or problem behaviour, for the 'good' behaviour a higher score indicated a higher occurrence of different good behaviours; i.e., an effective intervention would be seen if there were a decrease in the bad behaviour scores and an increase in the good behaviour scores.

In the following sections regarding the PDR scores over the intervention, only Participants 2 and 8 of the non-completers are referred to since they are the only non-completers whom undertook most of the intervention.

PDR problem behaviour scores (bad behaviour)

Figures 1a and 1b show that during baseline problem behaviour scores tended to fluctuate for most participants but did not show any upward or downward trend. Participant 9's baseline problem behaviour scores were the least variable. During the intervention there was a downward trend in the problem behaviour scores for most participants. For Participant 1 the problem behaviour scores were stable for a period, and then they fluctuated before trending downwards at the end of the intervention. The problem behaviour scores for Participant 3 and Participant 8 (non-completer) trended downwards with some variability over the intervention. For Participants 5 and 9 and Participant 2 (non-completer) the scores trended downwards throughout the intervention. For Participant 10 the problem behaviour scores decreased, then increased before decreasing over the intervention to lower levels than baseline. A scoring floor (that is, scores could not go below 0) meant that greater decreases could not be shown.

PDR prosocial behaviour scores (good behaviour)

During baseline the good behaviour scores were variable for most participants; they did not show any upward or downward trend. Participant 9's baseline good behaviour score was relatively stable. Over the intervention, the good behaviour scores increased for all the treatment completers and Participants 2 and 8 who completed most of the intervention. Participant 1 had high good behaviour scores over baseline which increased slightly over the intervention, although they were constrained by a ceiling effect (a maximum of 30). Participant 3 showed some variability in good behaviour scores throughout the intervention, with the good behaviour increasing to higher levels than baseline by the end of the intervention. For Participant 5, good behaviour scores increased steadily from baseline, then dropped briefly and then remained at a stable high rate over the last third of the intervention. The graph for Participant 9 shows that for approximately the first third of the intervention good behaviour scores remained at a similar level to baseline before increasing over the rest of the intervention period. The graph

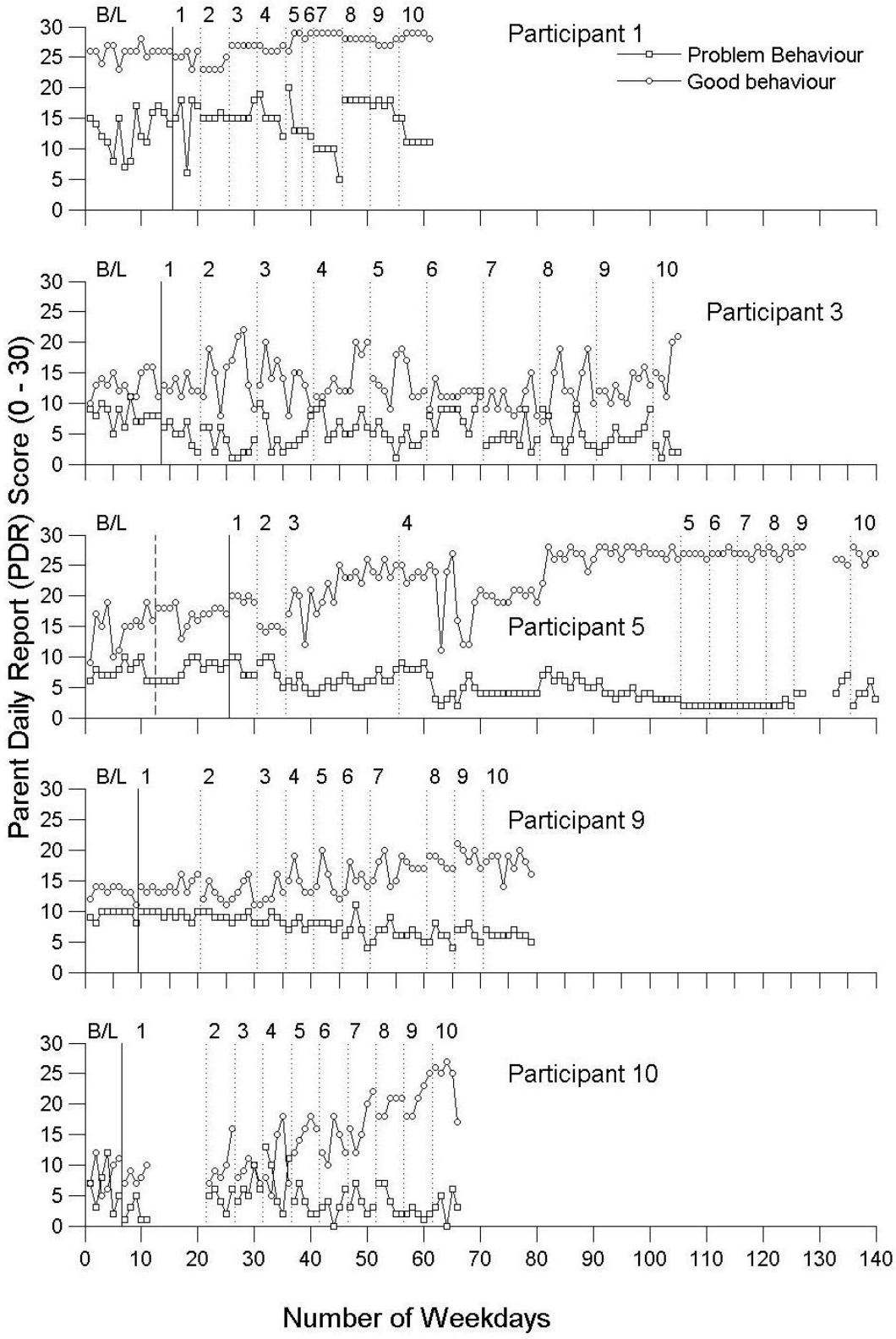

Figure 1a. The PDR scores for each weekday over baseline and intervention for each participant who completed the intervention. The solid vertical lines indicate the end of baseline and the dotted vertical lines the end of the various sections of the programme.

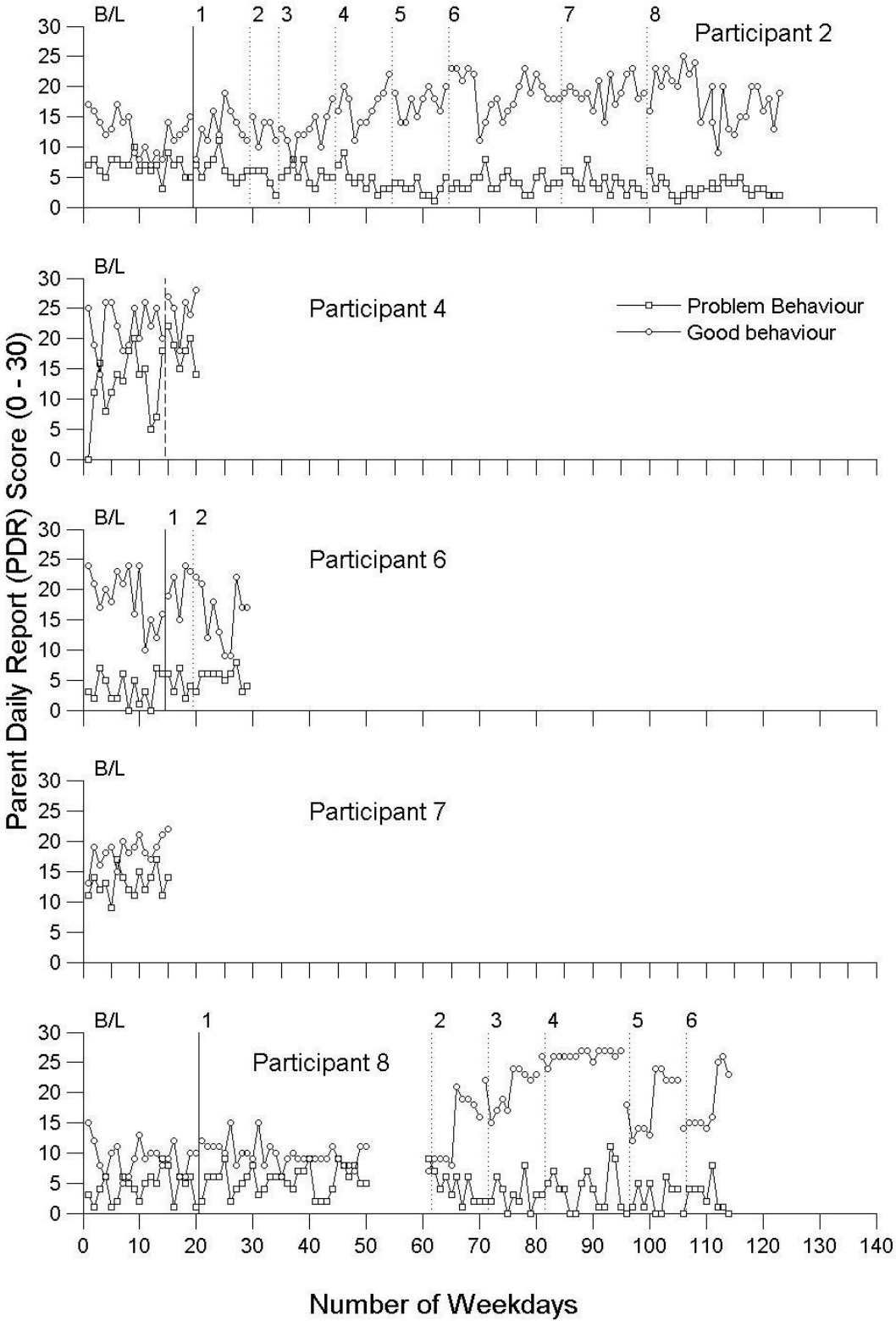

Figure 1b. The PDR scores for each weekday over baseline and intervention for each non-completer participant (participants who withdrew from the study and did not complete the intervention). The solid vertical lines indicate the end of baseline and the dotted vertical lines the end of the various sections of the programme.

for Participant 10 shows a steady increase in good behaviour scores over the intervention from low levels at baseline to high levels by the end of the intervention. For Participant 2 (non-completer), good behaviour scores increased steadily from baseline then decreased slightly during section 8 when they withdrew. For Participant 8 (non-completer), the good behaviour scores remained similar to baseline over the first section of the intervention, then increased to a generally high level over the rest of the intervention, i.e., until section 6 of the intervention when this participant withdrew.

Comparison of PDR good and bad behaviour scores

The upward trend in good behaviour scores and the downward trend in problem behaviour scores were particularly evident over the latter half of the intervention for all participants (treatment completers and Participants 2 and 8), apart from Participant 3, for which behaviour remained variable until the end of intervention. Over baseline good and problem behaviours scores were close together, whereas, at end of intervention, there was a greater divergence with higher good behaviour scores and lower problem behaviour scores; this was least clear for Participant 3. Participants 5, 9 and 10 and Participants 2 and 8 (non-completers) had the most consistently trending data over the programme and for these participants the trends in both scores appear to start after they finished section 4 of the programme. No other relations between the section of the programme and the upwards and downwards changes in either score are apparent. For Participant 1, the increase in good behaviour scores was slight (but the baseline was high), while the problem behaviour scores fluctuated but did decrease somewhat from baseline by the end of the intervention. For Participant 3, the problem behaviour scores decreased over the intervention, while the good behaviour scores fluctuated but increased slightly by the end of the intervention. Participant 5's problem behaviour scores decreased from a low level to a very low level over the intervention, while good behaviour scores increased from baseline to a high level over the intervention. The problem behaviour scores decreased slightly for Participant 9 over the intervention, while the good behaviour scores increased from baseline levels over the intervention. Participant 10 had low good and bad behaviour scores over baseline, the problem behaviour scores decreased and the good behaviour scores increased over the intervention. For Participant 2 (non-completer), the problem behaviour scores decreased from a low level to a

very low level over the intervention, while the good behaviour scores increased from baseline to a generally high level over the intervention. Participant 8's (non-completer) problem behaviour scores decreased slightly from a low level at baseline, while the good behaviour scores remained at a similar level to baseline and then increased over the intervention. Overall then, problem behaviour scores decreased and good or prosocial behaviours scores increased from baseline levels during the intervention period.

Mean PDR scores

In order to compare these data with the test battery data the baseline and end of intervention means were calculated for the treatment completers. The mean of the baseline PDR good and bad behaviour scores were calculated over all baseline data for each participant. The mean good and bad behaviour scores at the end of the intervention were calculated over the last five observations of the intervention for each participant. Figure 2 shows these means. The left graph shows that the bad behaviour scores for each child decreased and the right graph shows that the good behaviour scores for each child increased over the intervention. Participants 2 and 8 were not included in these calculations but would have followed the same pattern of decreased bad behaviour scores and increased good behaviour scores.

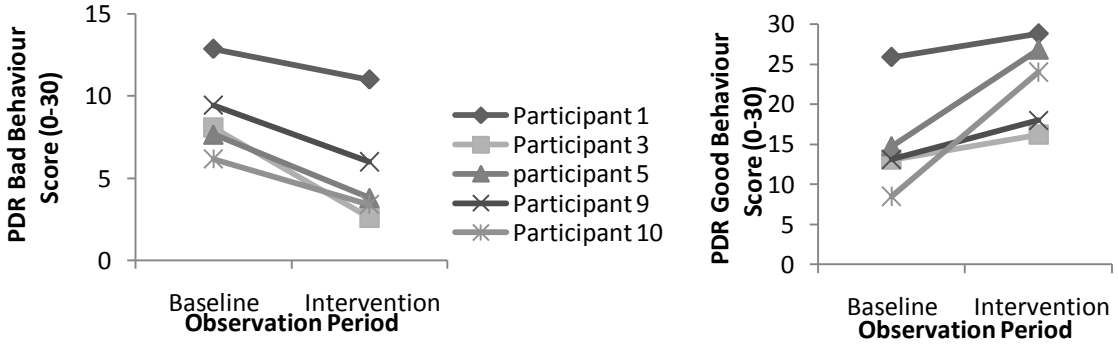

Figure 2. Participants' individual mean PDR scores over baseline and end of intervention. The PDR Bad behaviour scores are shown of the left graph and the PDR Good behaviour scores on the right graph.

The mean scores were compared using dependent t-tests and the effect sizes (Cohen's *d*) were calculated by dividing the difference between the means by the standard deviations of the differences between pairs of scores as suggested by Aron, Aron and Coups (2009) and Kinnear and Gray (2006). These results are shown in Table 3. Throughout this study, dependent t-tests results were considered significant if $p < .05$. Effect sizes (Cohen's *d*) are termed small if between 0.20 to 0.50, medium if between 0.50 and 0.80 and large if above 0.80 (Aron et al., 2009) throughout this study. There was a significant difference between the bad behaviour scores at baseline and at the end of intervention. The means at the end of intervention were lower, and there was a large effect size. The difference in the mean good behaviour scores was also significant, with the means at end of intervention larger, and this difference also gave a large effect size.

Table 3

The obtained *t* values, *df*, obtained *p* value and Cohen's *d* for dependent t-tests comparing the means of the bad and good behaviours (PDR) over the baseline to the means at the end of intervention for each participant

Variable	Mean Baseline	Mean Final	Mean Diff	SD Diff	*t*	*df*	*p*	Cohen's *d*
PDR Bad Behaviour	8.85	5.36	3.49	1.35	5.790	4	.004*	2.589
PDR Good Behaviour	15.06	22.76	-7.70	5.73	-3.003	4	.040*	-1.343

*=significant at the $p<.05$ level PDR=Parent Daily Report

Test Battery

Group and Individual Analyses

The test battery was administered pre- and post-intervention. The pre- and post-intervention test scores for each of the tests were analysed by dependent t-tests and effect sizes (Cohen's *d*) were also calculated. Table 4 shows the means of the test scores, the differences between these means (Diff.), the standard deviations of the differences between pairs of scores (SD Diff.), the t-test results and the effect sizes. Overall, for participants who completed the intervention, the

average post-intervention scores changed in the positive direction from the average pre-intervention scores on all the measures.

The participants' individual scores from pre-treatment to post-treatment were graphed for each measure in the test battery to investigate any changes across individual participants' scores. Where a measure has a clinical rating or category ratings then these are indicated on the graphs.

Table 4

The obtained *t* values, the obtained *p* value, and Cohen's *d* for dependent t tests comparing the means of the scores on the ECBI, DASS, PS, PSOC and Triple P Parenting Quiz from pre-intervention to post-intervention across the participants.

Variable	**Mean Pre**	**Mean Post**	**SD Pre**	**SD Post**	**Mean Diff**	**SD Diff**	***t***	***p***	**Cohen's *d***
ECBI Problem Score	15.20	8.00	9.20	4.36	7.20	6.38	2.524	.065	1.129
ECBI Intensity Score	131.00	102.60	29.79	11.39	28.40	21.56	2.946	.042*	1.317
DASS Depression	12.80	5.80	14.92	8.07	7.00	7.81	2.004	.116	0.896
DASS Anxiety	3.40	2.00	3.78	2.35	1.40	1.95	1.606	.184	0.782
DASS Stress	15.20	9.80	7.16	5.50	5.40	6.99	1.728	.159	0.773
PS Verbosity	24.40	18.60	3.29	5.41	5.80	6.34	2.046	.110	0.915
PS Overreactivity	28.40	23.60	8.65	6.47	4.80	3.19	3.361	.028*	1.503
PS Laxness	32.20	20.80	7.79	6.38	11.40	5.37	4.750	.009*	2.124
PS Total	92.60	66.60	16.46	13.24	26.00	10.51	5.531	.005*	2.473
PSOC Satisfaction	25.40	31.00	3.91	3.08	-5.60	4.83	-2.594	.060	-1.160
PSOC Efficacy	20.60	26.40	1.14	2.07	-5.80	3.11	-4.164	.014*	-1.862
PSOC Total	46.00	57.40	4.53	4.83	-11.40	7.27	-3.508	.025*	1.569
Triple P Quiz	25.60	27.80	1.14	2.28	-2.20	2.77	-1.773	.151	-0.793

*=significant at the $p<.05$ level
ECBI = Eyberg Child Behavior Inventory
DASS= Depression Anxiety Stress Scale
PS= Parenting Scale
PSOC= Parenting Sense of Competence

The Eyberg Child Behavior Inventory (ECBI). Table 4 shows that the mean Problem scores decreased from 15.20 (SD = 9.20), which is in the Clinical Range, to an average of 8.00 (SD = 4.36), which is in the Normal Range. Table 4 also shows that while the difference in the mean ECBI Problem scores was not significant, t (4) = 2.524, p= .065, there was a large effect size with the post intervention scores being lower. The ECBI Intensity scores decreased from a mean of 131.00 (SD = 29.79) which is in the Clinical Range to a mean of 102.60 (SD = 11.39) which is in the Normal Range. This difference was significant, t (4) = 2.946, p=.042, and there was a large effect size. The means at post-intervention were lower.

Figure 3 shows participants' individual scores on the pre- and post-administrations of the ECBI. This figure shows that all participants' scores decreased, on the ECBI Problem score (left graph) and the ECBI Intensity score (right graph), from pre- to post-administration.

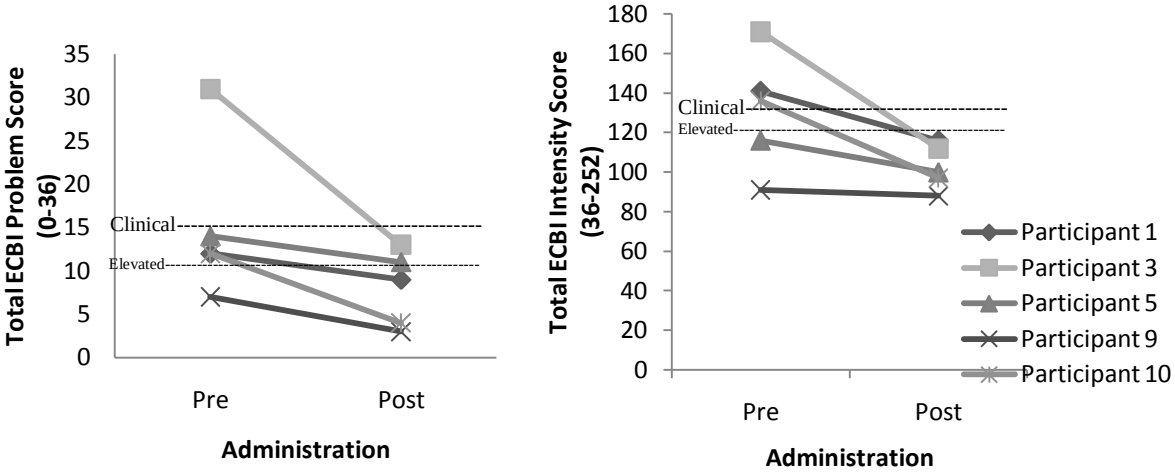

Figure 3. Participants' individual scores on the pre- and post-administrations of the ECBI. The ECBI Problem scores are shown in the left graph and the ECBI Intensity scores on the right graph.

Participant 3's Problem score was in the Clinical Range (Clinical≥ 15) and decreased to the Elevated Range (Elevated≥11). Participants 1, 5, and 10 had Problem scores in the Elevated Range which reduced to the Non-clinical Range, apart from Participant 5's score, which reduced but remained in the Elevated Range. Participants 1, 3 and 10 had Intensity scores in the Clinical Range (Clinical≥131) which all reduced to the Non-clinical Range. Participants 5 and 9's scores were in the Non-clinical Range.

The Depression Anxiety Stress Scale (DASS). Table 4 shows the DASS Depression Scale scores decreased from a mean of 12.80 (SD = 14.92), which is in the Mild Range, to a mean of 5.80 (SD = 8.07), which is in the Normal Range. This difference was not significant, t (4) = 2.004, p= .116, but gave a large effect size. The Anxiety Scale scores decreased from a mean of 3.40 (SD = 3.78) to a mean of 2.00 (SD = 2.35). These average pre and post-intervention scores for anxiety are both in the Normal Range. The difference was not significant, t (4) = 1.606, p =.184, and the effect size is medium. The Stress Scale scores decreased from a pre-intervention mean of 15.20 (SD = 7.16), which is in the Mild Range, to a mean of 9.80 (SD = 5.50), which is in the Normal Range. The difference was not significant, t (4) = 1.728, p =.159, and the effect size is medium.

Figure 4 shows participants' scores on the Depression, Anxiety and Stress Scales respectively. Figure 4 (top left graph) shows that most participants' Depression scores decreased from pre- to post-intervention, the exception was Participant 9, whose score remained the same. Participant 3 had a Depression score in the Extremely Severe Range, which reduced to the Moderate Range. Participant 5 had a Depression Score in the Mild Range which decreased to the Normal Range. All other scores were in the Normal Range.

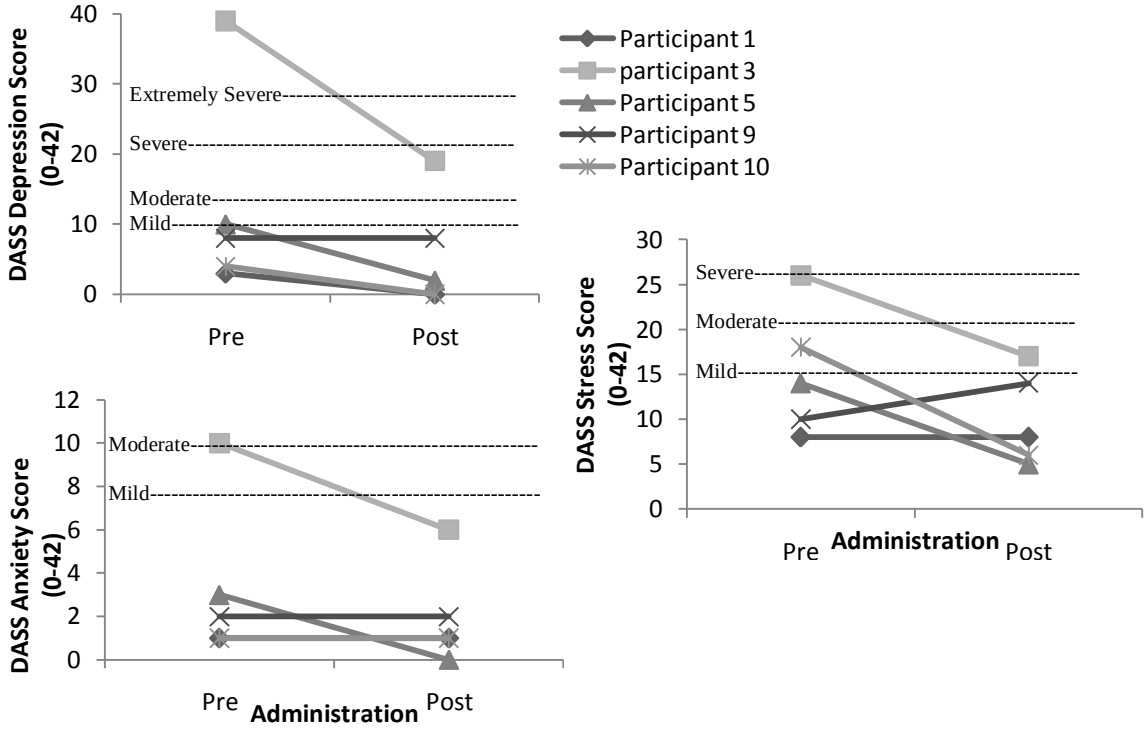

Figure 4. Participants' individual scores on the pre- and post-administrations of the DASS. The DASS Depression scores are shown in the top left graph, the Anxiety scores in the bottom left graph, and the DASS Stress scores on the right graph.

Figure 4 (bottom left graph) shows Participant 3 had an Anxiety score in the Moderate Range which decreased to the Normal Range. Participant 5's score remained in the Normal Range. Participant 1, 9 and 10's scores on this scale did not change and were all in the Normal Range.

Figure 4 (right graph) shows Participant 3 had a Stress score in the Severe Range which decreased to the Mild Range. Participant 5's score remained in the Normal Range. Participant 10 had a Stress score in the Mild Range which decreased to the Normal Range. Participant 1's score did not change, and for Participant 9 there was an increase in the Stress score. These scores remained in the Normal Range.

It should also be mentioned that three of the five treatment completers (Participants 3, 5 and 9) experienced serious personal issues for their families that only emerged in the midst of undertaking the SHI.

The Parenting Scale (PS). Table 4 shows that the PS Total scores decreased from a mean of 92.60 (SD = 16.46) at pre-intervention to a mean of 66.60 (SD = 13.24) at post-intervention. This difference was significant, t (4) = 5.531, p=.005 and was a large effect size. The Overreactivity Subscale scores decreased from a mean of 28.40 (SD = 8.65) to a mean of 23.60 (SD = 6.47) at post-intervention. This difference was significant, t (4) = 3.361, p=.028 and was a large effect size. The Laxness Subscale scores decreased from a mean of 32.20 (SD 7.79) at pre-intervention to a mean of 20.80 (SD = 6.38). This difference was significant, t (4) = 4.750, p =.009 and was a large effect size. The Verbosity Subscale scores decreased from a mean of 24.40 (SD = 3.29) to a mean of 18.60 (SD = 5.41). The change in the mean PS Verbosity Subscale score was not significant, t (4) = 2.046, p =.110, but the effect size was still large.

Figure 5 shows participants' PS Total Score, Verbosity, Overreactivity and Laxness Subscale scores respectively. This figure shows that all participants' Total scores, Verbosity, Overreactivity, and Laxness Subscale scores on the PS decreased from pre- to post-intervention.

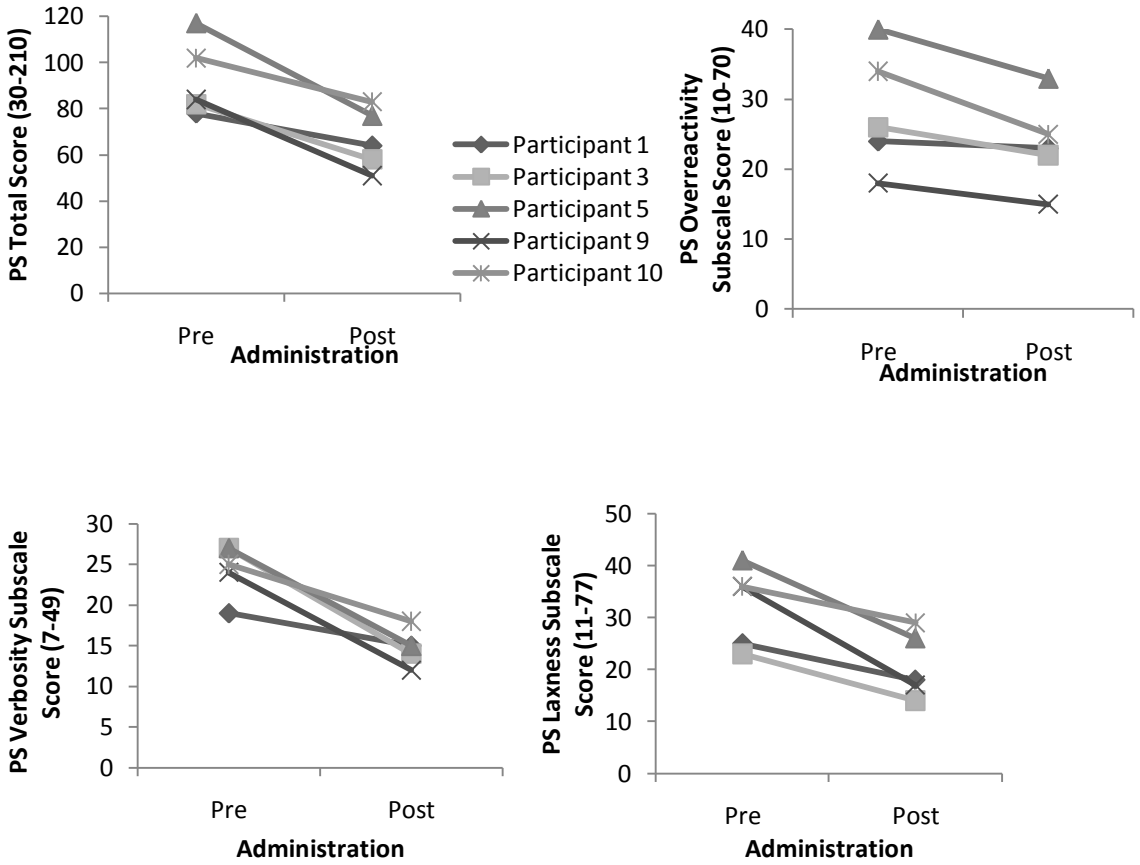

Figure 5. Participants' individual scores on the pre- and post-administrations of the PS. The PS Total Score, (top left), the PS Verbosity Score (bottom left), the PS Overreactivity Score (top right), the PS Laxness score (bottom right).

The Parenting Sense of Competence (PSOC). Table 4 shows the means and standard deviations of the PSOC Total scores and Satisfaction Subscale and Efficacy Subscale scores. The PSOC Total scores increased from a pre-treatment mean of 46.00 (SD = 4.53) to a post-treatment mean of 57.40 (SD = 4.83). Table 4 shows the difference in the PSOC Total scores was significant, t (4) = -3.508, p =.025, and that there was a large effect size. The Efficacy Subscale scores increased from a mean of 20.60 (SD =1.14) to a mean of 26.40 (SD =2.07). This difference was significant, t (4) = -4.164, p =.014, and there was a large effect size. The Satisfaction Subscale score increased from a mean of 25.40 (SD =3.91) at pre-intervention to a mean of 31.00 (SD = 3.08) at post-intervention. The difference in the mean PSOC Satisfaction Subscale scores was not significant, t (4) = -2.594, p=.060, but there was a large effect size.

Figure 6 show participants' Total scores on the PSOC Total Score and their Satisfaction and Efficacy Subscales scores. Figure 6 (top and bottom graph) shows that all participants PSOC Total and Efficacy subscale scores increased from pre- to post-intervention. Figure 6 (middle graph) shows that most participants scores increased on the PSOC Satisfaction subscale from pre- to post-intervention, the exception was Participant 1, whose score remained the same.

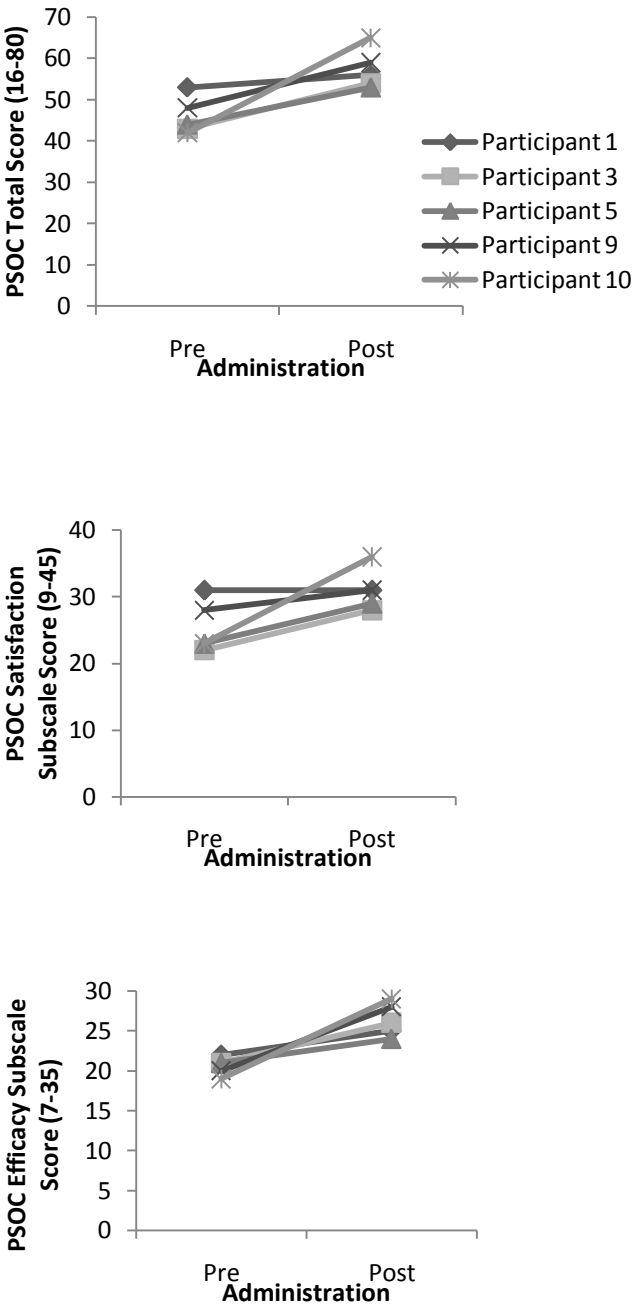

Figure 6. Participants' individual scores on the pre- and post-administrations of the PSOC. The figure shows the PSOC Total scores (top graph), the PSOC Satisfaction scores (middle graph), and the PSOC Efficacy scores (bottom graph).

The Triple P Parenting Quiz. Table 4 shows the means and standard deviations for the Triple P Parenting Quiz. The Triple P Parenting Quiz scores increased from a mean of 25.60 (SD = 1.14) at pre-intervention to a mean of 27.80 (SD = 2.28). Table 4 shows that this increase was not significant, t (4) = -1.773, p=.151, but that there was a medium effect size. A measurement ceiling on this measure may have concealed treatment effects.

Figure 7 shows the Total Triple P Parenting Quiz scores for individual participants. Most participants' scores increased slightly, the exception being Participant 5 whose score decreased from pre- to post-intervention. All participants had high initial scores which may have prevented demonstration of treatment effects.

Examination of participants' pre- and post-intervention responses to the items on the Triple P Parenting Quiz revealed that two of the participants responded incorrectly to the Triple P Quiz item of 'misbehaviour during time-out should be ignored'.

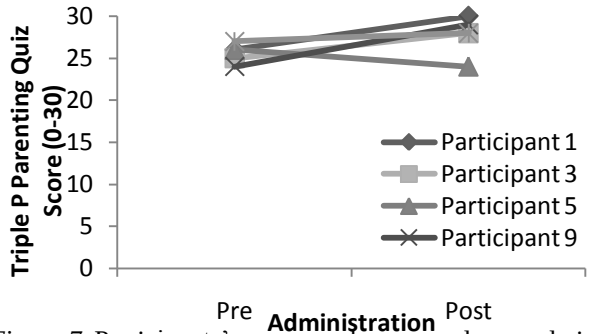

Figure 7. Participants' scores on the pre- and post-administrations of the Triple P Parenting Quiz.

Parenting Strategies Checklist

The Parenting Strategies Checklist (PSC) (Appendix D) gives the participants' estimates of the number of times each strategy was being used over a week. It was filled in weekly by participants throughout baseline and intervention. To summarise these data, the PSC data were first collated into tables to allow visual analysis of any trends. The trends in each participant's use of strategies for managing their preschooler's behaviour were then analysed and the

analysis is summarised in Table 5 (see raw data in attached CD). Changes in ratings over the weeks were examined and when the rating stayed roughly the same for each week (i.e., did not increase or decrease over time) this was classified as 'No Change', indicated on Table 5 as N. Some of the strategies were consistently rated as 'frequently used' and so the rating of their use could not have increased further even if they were being used more frequently, thus there was a measurement ceiling, and these data are indicated by N(c), some were rated consistently as 'rarely used' and the rating could not have decreased further (a measurement floor) and these are indicated by N(f). When the strategies were rated as 'never used', this is recorded as N(0). When the rating increased by at least one frequency category rating, i.e., an increase from 1-3 to 4-6, over at least half of the measurements during the intervention period, this was considered an 'increase', and is represented by a + in the table. When the data decreased by at least one frequency category rating over at least half of the measurements during the intervention period, this was considered a 'decrease', and is represented by a - in the table. When the data failed to meet any of these descriptions, that is changes were more variable, but showed some sign of an increase or a decrease overall, this was considered 'unclear' and is indicated by a ? in the table, i.e., a somewhat unclear decrease would be indicated by -?. The table groups the strategies into both ineffective and effective strategies for both managing misbehaviour and for encouraging prosocial behaviour. The heading 'other' represents strategies that could be either effective or ineffective depending on the context or how they were interpreted by participants.

Table 5

A summary of the analysis of trends for the Parent Strategies Checklist for each participants' use of both effective and ineffective strategies for managing their child's behaviour throughout the intervention. N indicates no change, c indicates ceiling, f indicates floor, 0 indicates never used, ? indicates somewhat unclear, - indicates a decrease, + indicates an increase in the use of a strategy. An increase/decrease required a shift of at least one category rating, e.g. 1-3 times to 4-6 times, over at least half of the time points during the intervention period

STRATEGY	**PARTICIPANT**				
Managing Misbehaviour	**1**	**3**	**5**	**9**	**10**
INEFFECTIVE STRATEGIES					
1. Raised Voice Raised your voice (growled, scolded or yelled)	N	N	-	-	-
2. No Action Noticed it but did **not** do anything about it	N(0)	N	N	N	-
4. Threats Threatened to punish him/her (but **did not really** punish him/her).	N (0)	- (f)	N	N	N
5. Warnings Gave several warnings for an incident of misbehaviour	-	N	N	N	-
11. Spanking Gave your child a spanking.	N (0)	N (f)	N (0)	N (0)	N (0)
12. Physical Force Used physical force but **not** spanking	N (0)	N (f)	N (f)	N (0)	N (0)
16. Retaliation Did the same back to them e.g. biting	N (0)	N (0)	N (0)	N (0)	N (0)
17. Delayed Consequences Gave a consequence for the behaviour a few hours later or the next day.	N (0)	N (0)	N(f)	N (0)	+
OTHER					
6. Grounding Grounded your child e.g. not allowed to play outside	N	N (f)	N (f)	N (0)	N (0)
9. Discussion Discussed the problem with your child or asked your child questions.	N	N	+?	-(f)	N
10. Offered another activity Offered another activity as child misbehaving with thing they were doing.	N	+	+?	+	N
EFFECTIVE STRATEGIES					
3. Planned Ignoring Ignored the behaviour on **purpose to not give attention to it.**	+?	N	+	N	+
7. Removed Privileges Took away privileges that were **not** involved in the inappropriate behaviour	-?	+	+?	+	N(0)
8. Logical Consequences Took away the toy or thing they were doing when they misbehaved.	N	+?	+	+	+
13. Correct problem Got your child to correct the problem or make up for his/her mistake	N	N	+?	N(f)	+
14. Quiet-time Removed to edge of activity for a few minutes	+?	N (0)	+?	N (f)	+
15. Time-out Removed **completel**y from situation to another area/room for few minutes.	N (c)	+?	+?	+	-?
Encouraging Prosocial Behaviour					
INEFFECTIVE STRATEGIES					
1. No Action Noticed it but **did not** do anything about it	-?	N (0)	N	N	-
6. Better than sibling Told them wished their brother/sister behaved as well as they did	N (0)	N	+ (c)	N (0)	+
11. Bribe Gave treat & made them promise to be good before any misbehav.	N (0)	N (0)	N (0)	N (0)	N
OTHER					
2. Stay up late Let them stay up late	N	N	N (0)	N(f)	-
3. General Praise General praise – e.g. *"good boy"*	N (c)	N (c)	+	+ (c)	N

EFFECTIVE STRATEGIES					
4. Descriptive Praise Praise describing behav, *I like that you put toys in box like I asked*	N (c)	+? (c)	+ ?(c)	+ (c)	N (c)
5. Affection Gave your child a hug, kiss, pat, handshake or "high five."	N (c)	N	N (c)	+	+
7. Gave Privilege Gave extra privilege, cake, special activity, extra time doing activity	N (c)	N	+	+	+
8. Public Praise Told others how well your child had behaved **in front of your child**.	N	+	N(c)	+	+
9. Gave Reward Bought something, food/small toy, **after** good behaviour happened	+?	N	+?	+	N
10. Gave Money Gave child money for good behaviour **after** the behaviour happened.	N	N (f)	N(f)	N(0)	+
12. Play Spent time with your child playing/doing fun things thru the day.	N (c)	+	N(c)	+	+(c)
13. Behaviour Chart **Behaviour Charts** Use of behaviour chart – yes/no	No	Yes	Yes	No	Yes

Overall, participants' use of effective strategies for managing misbehaviour increased. Participant 3 never tried using quiet-time. Ineffective strategies for managing misbehaviour were generally low or were never used and so there could be a measurement floor here. The ineffective strategy of using a raised voice generally decreased. Delayed consequences increased at a low level for Participant 10. Participants 3, 5 and 9 used the strategy of offering their child another activity when their child was not behaving with what they were doing; this increased over the intervention.

Overall, participants' use of effective strategies for fostering good behaviour also increased or showed ceiling effects. Participants 1and 9 never tried using a behaviour chart. Participant 10 and 5's (for Participant 5 this was high and could not increase further) use of the strategy of negatively comparing their target child to a sibling ('better than sibling') increased, when the target child displayed good behaviour. Participant 10 continued to give a low level of bribes. The strategies that increased, decreased, or remained unchanged were variable for each participant.

Programme Section Ratings

After completing reading each section of the self-help workbook and the corresponding DVD segment, participants rated the section of the programme in terms of the usefulness of the skills, importance of ideas, intention to apply the skills taught in the section, enjoyment of reading, enjoyment of DVD and helpfulness of watching the DVD segment. The ratings were based on a 0 (not at all) to 10 (very much) scale. Only programme sections 1 to 3 had specific DVD segments assigned. Thereafter, participants could review a DVD segment if they chose to do so but a particular segment was not required to be watched. Therefore, the DVD ratings were only included for sections 1-3 of the programme. However, the average rating of enjoyment of watching the DVD and helpfulness of the DVD was calculated based on each rating a participant gave to the DVD throughout the programme (i.e., if they watched it in sections 1 to 3 and section 10, all these ratings were used in calculating the average rating).

Figure 8 shows the mean of the skills, ideas, intention, enjoyment and helpfulness ratings that participants gave each section of the programme averaged over all ratings and participants. The ratings show a general trend downward throughout the intervention programme. Section 2 of the programme was rated the highest, then sections 3 and 4. Sections 6 and 10 were rated the lowest when enjoyment, helpfulness etc. were combined for each section.

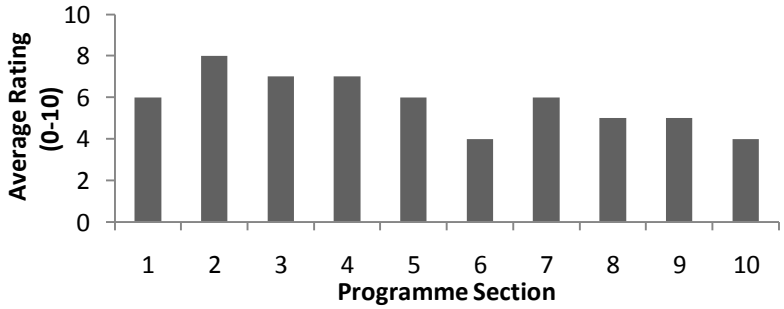

Figure 8. The skills, ideas, intention, enjoyment and helpfulness ratings on average across the participants' for each section of the intervention. The X-axis is the sections of the intervention while the Y-axis is the section rating.

Figure 9 shows the mean rating each participant gave for skills, usefulness of ideas, intention to use the skills, enjoyment of the reading and DVD and the helpfulness of the DVD averaged over the whole intervention programme. All participants gave intention to use the skills the lowest rating, except for Participants 9 and 10 who gave it equal ratings to the DVD components. The importance of the ideas, enjoyment of DVD and DVD helpfulness were generally rated higher than other components. Participant 9 gave the lowest ratings on average over the intervention. Participants 3 and 10 gave the highest average ratings.

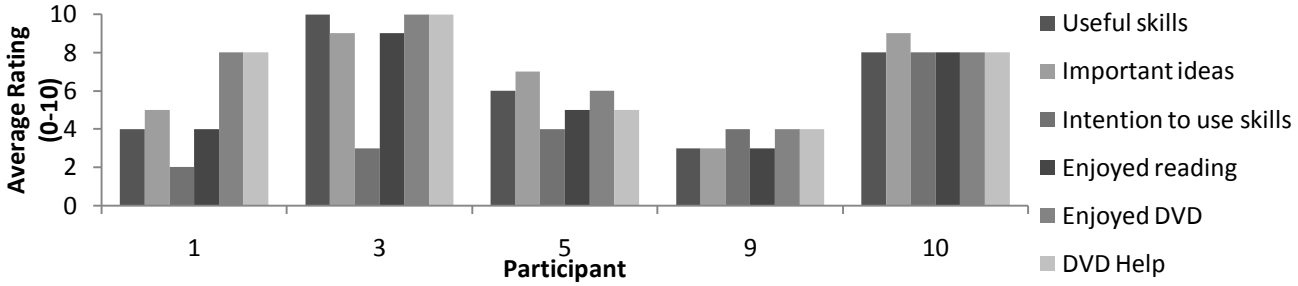

Figure 9. The individual participants' average skills, intention to use skills, enjoyment and helpfulness component ratings across the intervention sections. The X-axis is the participant while the Y-axis is the component rating.

Post-intervention Questionnaire

Parent Consumer Satisfaction Questionnaire (PCSQ). The PCSQ was administered at post-intervention. Figure 10 (left graph) shows participants' ratings of satisfaction of the programme (section A of the PCSQ) and Figure 10 (right graph) shows their total ratings of the ease and usefulness of the teaching format of the programme (section B of the PCSQ).

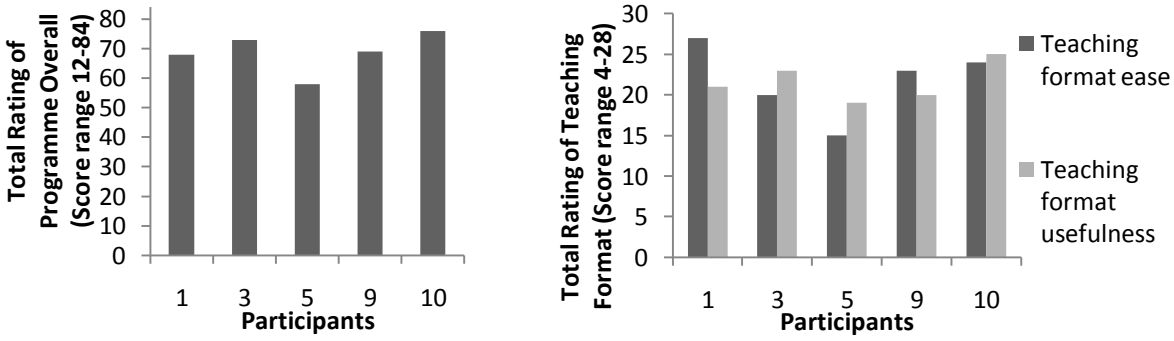

Figure 10. The individual participants' programme satisfaction ratings are shown on the left graph and total rating of the programme teaching format (ease and usefulness) on the right graph.

Figure 10 (left graph) shows that participants generally rated their satisfaction with the programme as high. Participant 5 had the lowest rating (approximately 60%) and Participants 3 and 10 had the highest ratings. The average rating was just over 75% (75%=66). Figure 10 (right graph) shows participants' ratings of the teaching format as generally easy and generally useful. Participant 5 had the lowest ratings (the lowest, ease rated at approximately 50%) and Participant 1 had the highest rating of ease of teaching format and Participant 10 had the highest rating of usefulness of the teaching format. The average rating of ease and usefulness were both approximately 75% (75%=22).

Figure 11 shows participants' rating of each specific type of teaching format in terms of ease and usefulness respectively (section B of the PCSQ). Figure 11 shows high ratings for workbook information in terms of both ease (top graph) and usefulness (bottom graph). Practice of the skills was rated the lowest for both ease and usefulness. The DVD was rated highly, apart from by Participant 5, for ease and usefulness.

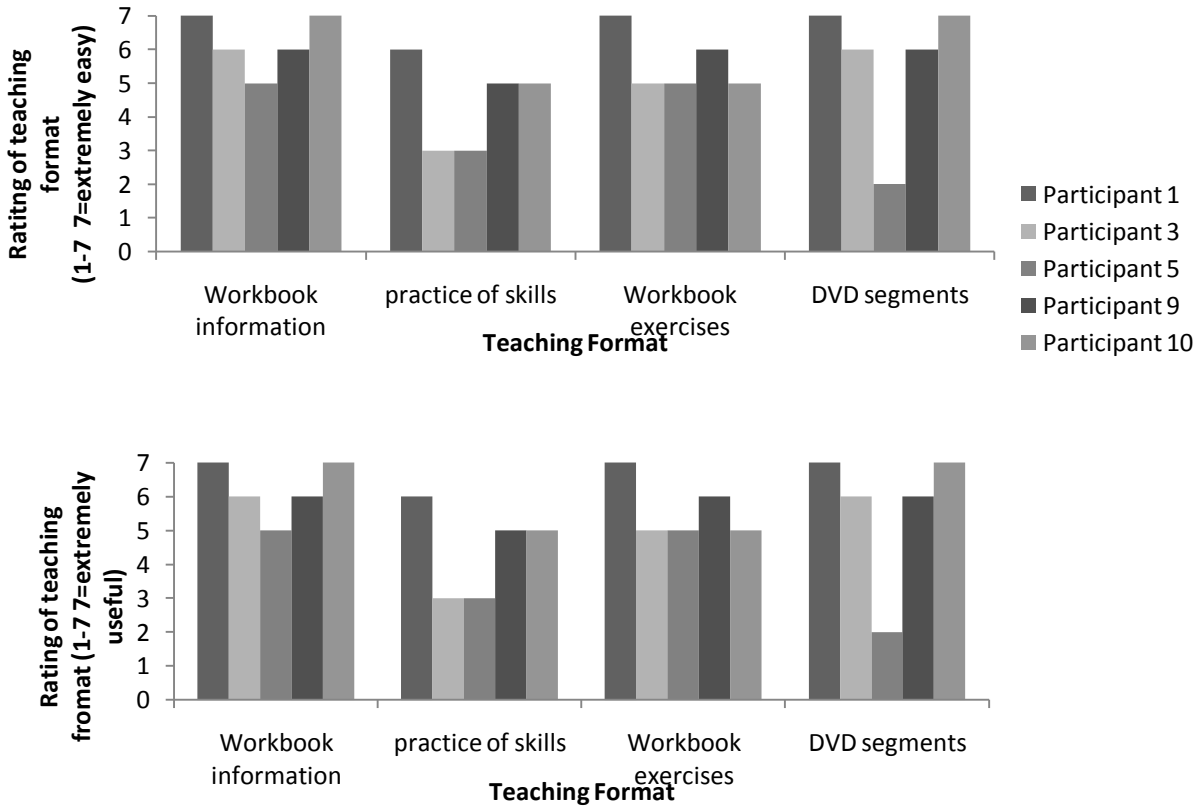

Figure 11. The rating of the ease (top) and usefulness (bottom) of following each type of teaching format for each participant. The X-axis shows the type of teaching format.

Figure 12 shows participants' total ratings of the ease and usefulness of the parenting skills/techniques taught in the programme (section C of the PCSQ). Figure 12 shows participants generally found the parenting techniques taught both easy and useful. Participant 5 had the lowest ratings and Participant 10 had the highest ratings for both the total ease and usefulness of the techniques taught in the programme. The average rating for usefulness and ease were both over 75% (75%=49.5). The average rating for usefulness of the techniques was slightly higher than the average for ease of the techniques.

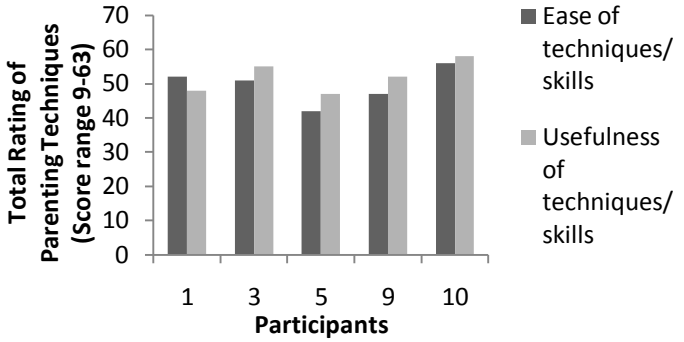

Figure 12. Individual participants total rating of the parenting techniques on a minimum of 9 to maximum of 63 score. The X-axis represents each participant, while the Y-axis represents the total rating of the parenting techniques.

Figure 13 shows participants rating of the ease (top graph) and usefulness (bottom graph) of each specific parenting technique taught in the programme. Figure 13 shows that of the specific techniques, behaviour charts were rated the lowest by participants in terms of usefulness and ease to use. Techniques rated easy were play and logical consequences and amongst the most useful was planned ignoring, while both descriptive praise and time-out were considered easy and useful.

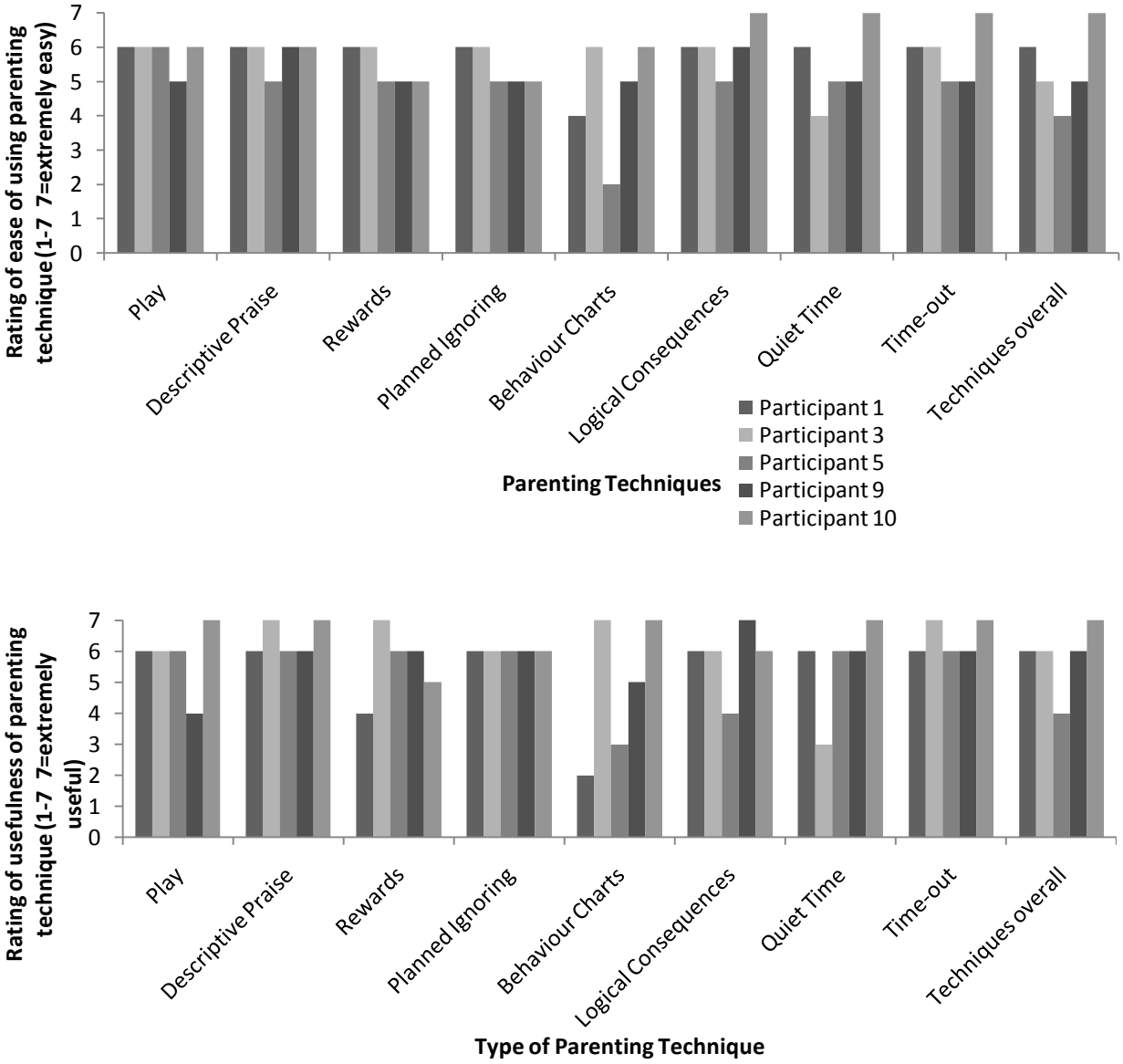

Figure 13. The rating of the ease of using each type of parenting technique for each participant (top graph) and the rating of the usefulness of using each type of parenting technique for each participant (bottom graph). The X-axis indicates the type of parenting technique.

Qualitative Information

Table 6 shows participants' responses to the qualitative sections of the Evaluation Questionnaires and the PCSQ, which are recorded verbatim. The phrases in brackets have been used to clarify the topic the participant is referring to. The comments are classified as negative and positive. Overall, participants who completed the programme felt that it had been worthwhile doing the programme. They stated it was useful to think about what you were doing as a

parent, gained insight into their parenting and stated that it was useful to pay close attention to children's prosocial behaviours as well as the behaviour problems. All participants felt that the book was too repetitive at times. There were also conflicting opinions, particularly regarding the DVD. Participant 3 found the DVD particularly useful, and Participant 1 thought the DVD reinforced the reading, while Participant 5 found the DVD idealistic and Participant 9 considered the situations in the DVD were contrived.

Summary over Treatment Completers

Participant 1. The PDR graph showed that the prosocial behaviour scores increased to a high level and the problem behaviours decreased over the intervention. The ECBI score, which was in the Elevated Range for Problem behaviours and the Clinical Range for Intensity score, decreased to the Non-clinical Range. Together, these results suggest that the intervention had a positive effect on the child's behaviour. The DASS Depression Scale score decreased while the Anxiety and Stress scores remained the same; however, these were all in the Normal Range. The PSOC Total, Verbosity, Laxness and Overreactivity subscale scores all decreased from pre-intervention, suggesting a less ineffective discipline style at post-intervention. The PSOC Satisfaction score remained the same and the Efficacy score increased suggesting that the participant had greater feelings of efficacy as a parent at post-intervention. The Triple P Parenting Quiz score also increased at post-intervention, suggesting an improved knowledge of effective parenting strategies. Participant 1 rated the DVD highly and rated her intention to use the skills as low and disliked the repetitiveness of some sections of the programme. However, the overall rating of the intervention at the end of the study was high.

Participant 3. The ratings of the amount of daily prosocial behaviour, although variable, increased and the rating of the problematic child behaviour decreased over the intervention as measured by the PDR. This was further supported by the average of the daily behaviour scores at baseline and at the end

Table 6

Participants' negative and positive comments about the programme.

Participant	Positive Comments	Negative Comments
1	DVD reinforced reading. Useful step by step instructions and DVD examples. Developmental stages, expectations (most important thing learnt)	Nothing new Repetitive ideas, overkill at this point. More examples on the DVD (improvement). Plans are too much.
3	My little devil has turned into a little angel. My kids are great really. I like the DVD best – all of it To be consistent and calm (most important thing learnt). I have the tools!	(Liked least) The workbook. All the charts (should not have been included). Some of the charts (were confusing).
5	Realised I reward her for bad behaviour and tend to escalate when bad behaviour occurs and usually gets worse. I have tried to use behaviour charts before but was probably targeting too many behaviours and she didn't understand. Got me to think about the behaviours and why to use the consequences. Using quiet time, time-out effectively (most important thing learnt)	Time to use monitoring forms (too much time required). DVD too idealistic. Don't feel have time to watch DVD, use techniques.
9	We were accidentally rewarding. It was helpful in viewing it as a natural/normal thing that requires management rather than a problem which I may have caused. (Liked) Practice exercises etc. The importance of consistency (most important thing learnt)	Not so much of the same at the end of the book – it felt like it was just more and more of the same, over and over. DVD contrived situations – not necessary to see it as techniques were clear in the book.
10	I gave accidental rewards. Great having checklists to assist in managing situation. We are on the right track. Broken down into week by week segments. Easy. Logical consequences (most important thing learnt).	Difficult to watch DVD without children around. Too much repetition. (improvement)Week 10 should be brought forward to week 9 and week 10 should be summaries

of the intervention. Likewise, the ECBI scores also suggest positive changes. The ECBI Problem pre-intervention score was in the Elevated Range and the Intensity Score was in the Clinical Range; both decreased to the Non-clinical Range at post-intervention, suggesting that the frequency of disruptive child behaviours decreased and there were fewer behaviours that were considered to be a problem. The DASS Depression score changed from the Extremely Severe Range to Moderate, the Anxiety score from Moderate to Normal and the Stress score from Severe to Mild at post-intervention. The PS Total score and subscale scores all reduced from pre-intervention to post-intervention, suggesting less ineffective parenting. The PSOC scores increased at post-intervention, suggesting greater satisfaction and efficacy as a parent than at pre-intervention. The Triple P Parenting Quiz score increased, suggesting greater knowledge of effective parenting strategies at post-intervention compared to pre-intervention. Participant 3 rated the different facets of the programme section ratings highly, apart from intention to use the skills. The satisfaction and teaching format and techniques were rated highly. However, this participant stated that just having the DVD would be useful.

Participant 5. For Participant 5, already low ratings of bad behaviour decreased over the intervention and the good behaviour scores increased. The ECBI results showed a decrease in Problem score (but it was still within the Elevated Range) and Intensity score. The DASS Depression score changed from Mild to Normal and the other scores were in the Normal Range and further decreased. The changes on the Parenting Scale indicate that this participant had an improved discipline style. The PSOC results suggest greater efficacy and satisfaction as a parent at post-intervention than pre-intervention. The Triple P Parenting Quiz scores decreased from pre-intervention to post-intervention, suggesting that there was greater knowledge of effective parenting strategies at pre-intervention. The components of the programme section ratings were rated at a medium level, 5 out of 10, with intention to use the skills the lowest. However, she was satisfied with the programme. The monitoring forms were considered too time-consuming to use.

Participant 9. For Participant 9, the good behaviour scores increased and the bad behaviour scores decreased over the intervention. This was confirmed by analysis of the average of the daily presence of good and bad behaviours at

baseline compared to the average scores at the end of the intervention. The ECBI Problem score and Intensity score were both in the Non-clinical Range at pre-intervention and further decreased at post-intervention. The DASS scales remained the same, from pre- to post-intervention, apart from the Stress score which increased but was still within the Normal Range. The greatest changes for this participant appear to be in the PS Total and subscale scores, which all decreased, suggesting the participant had an improved discipline style at post-intervention, and in the PSOC scores, which increased, suggesting greater efficacy and satisfaction in the parenting role at post-intervention compared to pre-intervention. The Triple P Parenting Quiz score only slightly increased at post-intervention. It is noteworthy that this participant rated the components of the intervention, such as useful skills etc., as low throughout using the programme but at the end of the intervention was satisfied with the programme, and rated the techniques and teaching format highly. This participant reported she had been accidentally rewarding her child. She considered the repetitiveness of the book as a negative facet of the programme.

Participant 10. For Participant 10, the low rate of bad behaviour decreased over the intervention and the good behaviour scores increased. The ECBI Problem score and Intensity scores also decreased, suggesting that disruptive behaviour occurred less frequently, a shift from the Clinical to the Non-clinical Range; and that there were fewer disruptive behaviours that were considered a problem, a change from the Elevated Range to the Non-clinical Range. The DASS Depression score was in the Normal Range and decreased further, the Normal Range Anxiety score remained the same and the Stress score was in the Mild Range at pre-intervention and decreased to the Normal Range at post-intervention. There was also an improved discipline style and greater confidence and efficacy as a parent at post-intervention than at pre-intervention. The Triple P Parenting score also increased slightly from pre-to post intervention. This participant rated all the components of the programme as useful, was highly satisfied with the programme, and the teaching format and techniques in terms of easiness to use and usefulness. The checklists were considered a positive feature of the book, although the repetitive sections were viewed as a negative feature of the book.

DISCUSSION

The aim of this study was to examine the effectiveness of the self-administered Triple P PT intervention (the workbook and DVD), without therapist assistance, for parents who were concerned about their preschooler's behaviour. The main hypotheses were that utilising the self-help programme would result in increases in parenting knowledge, and competence and children's prosocial behaviours and reductions in child externalising behaviours, and parents' ineffective discipline. It was not expected that parents' symptoms of depression, anxiety and stress would change. Overall, the findings suggest that child behaviour and parenting behaviours and wellbeing improved.

The results of this study provide support for the effectiveness of this intervention without therapist assistance and replicate and extend previous findings. All the variables measured trended in the expected direction, although the intervention added greater positive changes for some of the areas assessed than in others. The strongest finding of this study was that, for those who completed the intervention, there was a significant increase in their preschoolers' prosocial behaviour and a significant decrease in preschoolers externalising behaviour scores. The most significant finding in terms of parenting was that parenting competence increased and dysfunctional/ineffective discipline decreased at the end of the intervention. Each of the hypothesis and associated findings, together with relevance to the literature, will now be discussed.

Child Outcomes

Prosocial behaviours. The first hypothesis was that preschoolers' prosocial behaviour would increase, as measured by the good behaviour score on the PDR, which gives the number of different good behaviours that occurred each day. Both the individual data and group analysis demonstrated that all seven participants (completers and Participants 2 and 8 (non-completers)) had increases in the number of different daily prosocial behaviours present for their child. The prosocial behaviour significantly increased from baseline to end of intervention and the magnitude of this change was large as indicated by Cohen's *d*.

The individual analysis suggests that individuals have varying responses. However, the prosocial behaviour generally increased steadily from baseline over

the course of using the intervention. The prosocial behaviours did not trend during baseline when participants were not using the intervention suggesting that changes were not a function of simply starting measuring and observing and the increase in good behaviour happened for some participants while others were still in baseline (see Table 2 and Figure 1a) suggesting that change was not due to an external variable occurring at that time. This suggests that these changes are a result of this intervention.

The upward trend in the number of different good behaviours present was particularly evident after section 4 or over the latter half of the intervention for all participants (treatment completers and Participants 2 and 8 (non-completers)), apart from Participant 3, for whom the good behaviour remained variable until the end of intervention. This may have occurred at this stage because section 4 was the last section of specific skill teaching; sections 5 to 10 involved revision, practice, and troubleshooting. This may mean that mothers had learnt and were using all of the skills introduced in each previous section (monitoring, promoting good behaviour, managing bad behaviour, using checklists for specific behaviours) by section 5. This may have positively affected the daily observation of the presence of good behaviours i.e., parents were noticing more good behaviour due to monitoring and were using successful strategies to promote good behaviour and reinforcing good behaviour when it occurred by this stage. It also suggests that it takes time for positive changes in prosocial behaviour to occur. Furthermore the increase in the number of different good behaviour is in line with the strategies taught in this SHI, such as descriptive praise and with the aims of the SHI i.e., to encourage prosocial behaviour. As previously stated if the reported increase in good behaviour was an effect of measuring, then an increase in good behaviour score during baseline (or over section 1, which teaches parents to track child behaviours) should have been apparent, but this was not the case.

There is a paucity of research on the effects of PT on children's prosocial behaviour. However, these findings suggest that this intervention can have a positive effect on the number of different prosocial behaviours occurring. These findings are similar to those of a study investigating the effectiveness of self-administered videotape PT for 3-8 year old children whose behaviour was rated in the Clinical Range on the ECBI (Webster-Stratton et al., 1988). In that study the mean PDR prosocial behaviour scores increased significantly compared to a

control group (Webster-Stratton et al., 1988). The present study is promising as it shows similar results to that study which utilised a randomised-control group design.

The version of the PDR used in Webster-Stratton et al.'s (1988) study listed 19 prosocial behaviours as opposed to the 30 prosocial behaviours in the present study and it is unknown to what extent the behaviours listed in each differs. This makes it difficult to compare these results. The increased good behaviour that occurred with both of these studies does, however, support the proposition that self-help PT interventions can increase the number of different prosocial behaviours of children who have externalising behaviour problems. As the PDR had a set list of prosocial behaviours, it may be that other prosocial behaviours that were not on the PDR also occurred. It could also be that prosocial behaviours that were absent at baseline but occurred at the end of the intervention were also occurring frequently in the day at the end of the intervention. This could imply an undetected effect. To further examine changes in prosocial behaviour, it would be beneficial to also use a measure that gauges the frequency of preschoolers' prosocial behaviours pre- and post-intervention. As those with externalising behaviours are at risk of developing poor relationships with peers (Webster-Stratton & Hooven, 1998) these findings have important implications in potentially improving social skills with peers. Given that effective strategies for promoting prosocial behaviour also increased (the PSC) this may mean that as parents' model and reinforce prosocial behaviour, parent-child interactions improve, which in turn results in improved child prosocial behaviours, or a positive behaviour cycle.

Much of the literature seems to assume that a decrease in externalising behaviours means an increase in prosocial behaviours rather than actually assessing this. Over the course of the present intervention, there was generally an increase in prosocial behaviour and decrease in externalising behaviours, which appeared to occur simultaneously. This suggests that interventions that teach parents to both encourage prosocial behaviour and to manage misbehaviour effectively can both increase prosocial behaviour and reduce externalising behaviours in children. The findings of this study also support the idea that the child's behaviour during the preschool period is amenable to change and that early

intervention is likely to be successful in improving preschoolers' prosocial behaviour.

Externalising Behaviour. The second hypothesis was that preschoolers externalising behaviours would decrease. This was measured by the bad behaviour component of the PDR score and by the ECBI which yields the number of behaviours that parents consider to be a problem and the frequency of disruptive behaviours. As already mentioned changes in both individual and group data from both measures supports this hypothesis.

In terms of the PDR, this hypothesis was supported as all participants (completers and Participants 2 and 8 (non-completers)) had reductions in the number of different daily bad behaviours present for their child, which generally reduced steadily over the course of using the intervention. Like the good behaviour, this suggests that these changes are a result of this intervention as the bad behaviours were stable (did not trend) during baseline. Additionally, the analysis of the overall changes of averaged number of daily bad behaviours at baseline compared to the end of the intervention was significant and the effect size was large. These changes suggest that this intervention was successful in eliminating some of the different bad behaviours that occur each day.

The ECBI Problem and Intensity scores decreased from the Clinical to the Non-clinical Range. While pre- and post-measures alone without a control group do not definitively demonstrate the effectiveness of an intervention, these measures in conjunction with the PDR add further weight to the finding that externalising behaviours decreased. These findings suggest that this intervention was successful in reducing the number of behaviours that parents considered to be a problem with their child and that disruptive behaviours occurred significantly less frequently after the intervention.

Some participants had initial low scores for bad behaviour on the PDR but high scores for disruptive behaviour on the ECBI, but this does not mean that these measures are assessing different behaviours or are incompatible. Instead it seems that while there may be only a few different bad behaviours that are present each day, these behaviours occur frequently within the day and/or that these behaviours are considered to be a problem, resulting in Clinical or Elevated Range on the ECBI. Additionally, the PDR examines the daily occurrence of behaviours. Therefore, a reduction of bad behaviour means the non-occurrence of

some behaviours, which may have more meaning for parents than a reduction in the daily frequency of a behaviour.

The Problem scores changed less than the Intensity scores for some participants. This is consistent with Webster-Stratton et al. (1988) who found significant decreases in externalising behaviour as measured by the ECBI and the PDR compared to a control group but their Problem score was in the Elevated Range at post-intervention (Webster-Stratton et al., 1988). The present findings may mean the SHI needs to incorporate extra information, such as unrealistic child behaviour expectations, as Eyberg and Pincus (1999) suggest that a higher Problem score and lower Intensity score may mean that a parent has a low tolerance for normal behaviours, unrealistically high expectations, or there may be adversity factors.

The present findings that this intervention results in a significant decrease in disruptive behaviour and that the magnitude of the change is large are similar to previous studies (de Graaf et al., 2008a). Sanders et al. (2007) found the self-directed Triple P intervention resulted in a decreased PDR score at post-intervention. Markie-Dadds and Sanders (2006) study was similar to the present one in that it also involved a community sample of children aged 2-5 years. They found the self-directed intervention resulted in a significantly decreased mean PDR score and Problem and Intensity scores compared to the wait-list control group (WLC). In comparing the ECBI findings of this study to others, it is important to note that this study used a more rigorous determination of the ECBI Clinical Range whereas most studies deem the Elevated ECBI Range as Clinical. The three treatment completers who had an ECBI pre-intervention score in the more rigorous Clinical Range were no longer in the Clinical Range at post-intervention, suggesting that this SHI may have utility for a clinical population. Furthermore, disruptive behaviour did not increase for any of the participants. This is important as left untreated, clinical levels of externalising behaviour problems have been found to become worse (Nock et al., 2007).

The decreases in externalising behaviour that occurred across these studies supports the hypothesis that self-directed PT, by targeting parents, can decrease child's externalising behaviour and that the posited automaticity of the negative coercion cycle can be modified. The present study also shows that a self-

administered intervention, without therapist assistance, can be effective and the results are promising and are similar to those from a randomised-controlled study.

Parent Outcomes

Behaviour Management

Parenting Strategies Checklist. Parents' use of the strategies which were promoted in the SHI as well as ineffective strategies, were monitored throughout the intervention by the weekly PSC, which gave an estimate of the frequency of use of each strategy listed. The PSC findings could reflect actual usage, participants not filling in the form properly each week, or misunderstanding on an item or the difference between items, such as 'planned ignoring' versus 'not bothering to provide consequences for misbehaviour'. A limitation is that the PSC does not give information on how a strategy is used; some participants commented that they had learnt to give more realistic duration for a confiscated toy or that they had learnt not to give attention while their child was in time-out. That is, they had learned not only to try and use the strategy but also to use it effectively.

Generally participants' use of effective strategies for managing misbehaviour increased and ineffective strategies for managing misbehaviour decreased and likewise for strategies for fostering good behaviour. However, some of the participants did not try all of the recommended strategies e.g. quiet-time and time-out. Additionally, unexpectedly some participants' use of potentially ineffective strategies also increased during the intervention. The individual variability in strategies used suggests different strategies may be acceptable and effective for different people; therefore, it is important for PT interventions to promote a range of effective strategies. These findings also suggest that parents' use of behaviour management strategies needs further investigation, and information on inappropriate strategies may need to be included in the SHI to ensure that parents are not undermining strategies promoted in the programme by also using ineffective strategies. This issue may not be unique to this SHI but could be occurring across PT interventions as the use of strategies has not been monitored. Future research should monitor the usage of behaviour strategies. Therapists may need to be available to provide minimal assistance in terms of clarifying strategies on an as needed basis.

The Webster-Stratton et al. (1988) self-administered video study, in contrast to this study, found a significant decrease in the use of time-out compared to a control group. Similar to the present study, Kratochwill et al. (2003) found that parents raised their voices less and they also found threats of punishment decreased after using a self-administered PT intervention compared to pre-intervention. The Kratochwill et al. (2003) study must be interpreted cautiously as it also included parents of children who had internalising behaviour problems.

It is difficult to compare these studies as they used different measures. Indeed, it is difficult to measure and interpret parenting strategies. Strategies such as quiet time and time-out may be used infrequently because parents do not believe in or are not trying the techniques, rely on other techniques, or because behaviour has improved so a strategy is not required. The PSC looked at the frequency of use rather than which techniques parents were likely to use in which circumstances. Measuring the frequency of the use of strategies may be misleading because it depends on the rate of misbehaviour. Parents may use ineffective and effective techniques frequently if they have a child with a high rate of misbehaviour, while a parent of a child with less misbehaviour may not use effective techniques frequently. Additionally, a combination of effective and ineffective strategies may be used for one behaviour incident. In retrospect, a measure monitoring the use of strategies and the behaviour this was in response to would be more useful.

The Parenting Scale. The third hypothesis stated that ineffective discipline would decrease as measured by the PS. This hypothesis was supported as the PS Total score and subscale scores decreased at post-intervention. Participants varied as to which subscale decreased the most. The effect sizes were all large and the changes were significant for all, except the Verbosity subscale. Parents were less ambivalent and inconsistent in setting limits and responding to behaviour problems, the tendency to use threats, displays of anger and harsh punishment reduced, and parents were less likely to rely on talking when action would be more effective. However, there are some points to note about the PS. The Verbosity Subscale has been found to have the lowest reliability and validity of the subscales (Arnold et al., 1993), and some authors suggest it may have varying normative levels for different populations/cultures and should thus be used cautiously (Arney et al., 2008). Overall, the use of the PS is a strength of the

study, as it is behaviour focused and consistent with the premise of PT in regards to discipline being a maintaining factor in externalising behaviour problems.

These PS findings are similar to the typical findings of other PT studies. Markie-Dadds and Sanders (2006) used the PS subscale scores and found these were lower at post-intervention but only the Overreactivity scale was significantly lower for the self-administered Triple P intervention compared to the scores from mothers in a WLC. In comparing pre- and post-intervention effects for the self-directed Triple P programme Morawska and Sanders (2006a) found that the PS Total score reduced significantly compared to a WLC. Hahlweg, Heinrichs, Kuschel, and Feldmann (2008) in their therapist-assisted self-directed Triple P study, found large pre- to post-effect sizes for the PS Total and subscale scores, except for Laxness, which had a medium sized effect, and there were no significant changes for the WLC. Thus, the present study results are promising as they show similar large effects to the study using a randomised-control design and involving therapist-assistance.

The present study generally had significant changes and large effect sizes for externalising behaviours and for ineffective discipline. The Hahlweg et al. (2008) study similarly found large and significant effect sizes for ineffective discipline and for decreases in externalising behaviours. Overall, the PSC and PS findings in the present study suggests that mothers had improved discipline and used strategies to foster good behaviour and this was associated with fewer and less frequent externalising behaviours and more prosocial behaviours in their preschoolers, which supports the underlying premise of PT. It also suggests that despite a myriad of possible causes of externalising behaviour, changing just one environmental determinant of problem behaviours in children, i.e. parents' behaviour management, can have a substantial impact on improved child behaviour.

Parenting Knowledge. The fourth hypothesis stated that parenting knowledge would increase, as measured by the Triple P Parenting Quiz. This measure was specifically designed as a measure of knowledge for the Triple P Parenting Programme. This hypothesis was supported, knowledge did generally increase and the effect size was medium but the change was not significant. However, there was a measurement ceiling for all participants' initial scores which impinged on the demonstration of treatment effects. It deserves mention

that the participants in this study had generally been highly educated in relation to knowledge of behaviour. Only Participant 3 had not previously undertaken psychology or child development papers. It may be that a more complex test of parenting knowledge is required to adequately measure any changes. Examination of participants' responses to the items on the Triple P Parenting Quiz revealed that at both pre- and post-intervention some of the participants did not recognise the principle that 'misbehaviour during time-out should be ignored'. The intervention may need to make these principles more explicit, or there may be an underlying belief which needs to be challenged to change parents' response to this situation.

There is limited literature regarding parenting knowledge. McLoughlin (1985) found that parents, who read a self-instructional guide of behaviour management strategies but not principles of behaviour management, increased their knowledge of behaviour principles after using the strategies. However, teaching parents principles of behaviour results in additional gains above that of PT alone (McMahon et al.,1981) and a significant increase in knowledge of behaviour principles at post-intervention (Zimerman & Popynick, 2003). How knowledge relates to the use of effective strategies is unclear. The high rate of initial knowledge in this study, suggests that knowledge does not automatically translate into the effective use of strategies, as parents had high initial knowledge and initially used significantly more ineffective discipline as measured by the PS. This partially supports the argument that knowledge and use of effective behaviour management strategies are independent phenomena but an increase in one may lead to an increase in the other. It has not been satisfactorily determined what aspects of knowledge and parenting strategies were increased by specific sections of the intervention, but overall the intervention was effective. It may be that it is not necessary for parents to learn behaviour principles in order to successfully use behaviour management strategies or it may be that acquiring one or two new principles elicits greater change in parenting skills, or it may be that a certain level of knowledge is a necessary prerequisite for the effective use of behaviour management skills.

Further research on this measure and on the effects of PT on parent knowledge of the appropriate use of behaviour management strategies and possible moderator variables is needed. In retrospect, using both the Triple P

parenting Quiz and the short-form of the Knowledge of Behaviour Principles as Applied to Children (KBPAC) may help to clarify changes in knowledge. However, the threshold representing an acceptable level of knowledge is unclear and the predictive validity of such measures is unknown.

Parenting Competence

Parenting Competence. The fifth hypothesis was that parenting competence would increase after the intervention. This was measured by the PSOC, which yields Satisfaction and Efficacy subscales as well as a Total score. This hypothesis was supported, as these scores generally increased. The pre-post-changes produced large effect sizes and the changes for the PSOC Total Score and Efficacy Subscale score were significant. The finding that Satisfaction score changes were not significant is in contrast to Markie-Dadds and Sanders (2006), who found both the Satisfaction and Efficacy scores to have improved significantly compared to mothers in the WLC. The difference in these findings is most likely due to the sample size in the present study not being large enough to achieve statistical significance, especially considering there was a large effect size. Alternatively, the lesser changes on the Satisfaction scores may be because there is variability in the source of satisfaction. It has been suggested for non-clinical mothers, such as some of the participants in this study, satisfaction may derive from social comparison, while mothers of children with disruptive behaviour in the Elevated Range, i.e. those in the aforementioned study, acquire satisfaction from improvement in child behaviour (Ohan et al., 2000).

The results of the present study are consistent with previous research; effect sizes on the PSOC scales after PT are typically large (Ohan et al., 2000) and meta-analysis of the self-directed Triple P demonstrates medium to large effect sizes for PSOC Total score (de Graaf et al., 2008b). Overall, the present findings support the proposition that satisfaction and efficacy in the parenting role may improve through using this SHI. It is suggested that improved parenting self-esteem (satisfaction and self-efficacy) may be a function of both improved child behaviour and effective discipline (Ohan et al., 2000), which participants in this study also achieved. It appears that child behaviour, discipline strategies and competency are interlinked. As knowledge was initially high, the present findings imply that parenting competence may not be related to parenting knowledge.

Parental Wellbeing

Depression, Anxiety, and Stress Symptoms. Based on previous research and the SHI not directly targeting these symptoms, symptom reduction was not expected. However, as a group these symptoms all reduced, although most participants were in the Normal Range to start with. In general these results are promising, in consideration of the fact that three of the five treatment completers experienced serious issues for their families that only emerged in the midst of undertaking the SHI. Indeed it is somewhat surprising that despite these issues, depression, anxiety and stress symptoms either improved or did not deteriorate.

In relation to the literature, Cann, Rogers, and Worley (2003) found significant changes on all DASS scales, however, the mean pre and post DASS scales were low, within the Normal Range. In contrast, like this study, Morawska and Sanders (2006b) also found no significant changes on any of the DASS scores after the intervention and Markie-Dadds and Sanders (2006) and Morawska and Sanders (2006a) also reported no significant changes on any of the scales for the SHI in comparison to a WLC, although all the scores did decrease.

The present study tentatively suggests that this intervention may have an impact on parental depression, stress or anxiety symptoms, but further investigation is required to be confident about this. Individually, this study found also that for the mothers' who had initial symptoms of depression/stress/anxiety above the Normal Range prior to beginning the intervention, this did not prevent them from making gains in parenting and in child behaviour, and in fact the DASS scales all reduced by the end of the intervention. It may be that information on parenting and child behaviour and/or the use of parenting skills provided by the intervention can help to ameliorate some depression, anxiety and stress symptoms that are related to parenting, while the existence of personal problems (as reported in this study), such as health and financial concerns individuals experience besides child misbehaviour/parenting, which would not be expected to change by undertaking this SHI.

All of the aforementioned studies also reported floor effects. In the present study the low scores on these scales at pre-intervention also meant it was unlikely any treatment effects would be evident and may account for the lack of statistical significance. It has been suggested that the DASS may not be sensitive enough to demonstrate change in a normal population (Morawska & Sanders,

2006a). Previous research has found parents of preschoolers who have externalising behaviours experience more stress than parents of 'normal' children (Baker & Heller, 1996). However, stress measures have varied such as the Stress subscale on the DASS or specifically tapping stress related to child behaviour, such as the Parenting Stress Index (PSI). Studies examining the difference in scores on general measures like DASS and instruments pertaining to parenting, such as the PSI, would be useful to gain a better understanding of depression, anxiety and stress symptoms and PT.

The Triple P Self-help Intervention

Ratings of the Self-help Intervention. Each section of the programme was rated to monitor participants' perceptions as they worked through the programme. Overall, in comparing the average rating from all participants for the components of each section of the programme, the sections teaching the skills (sections 1-4) were rated the highest. While ratings were variable across sections of the book, no section achieved the maximum possible rating, suggesting that improvements could be made to the programme. Ratings taken together with participants' comments indicate that the sections of the programme that were solely practice based were rated the lowest. Despite rating the practice sections (the latter half of the programme) as lower, this is the period during which greater change on the PDR appeared to occur. This could mean that parents had accumulated the skills by these stages which were beginning to affect the child's behaviour positively, or that the disliked practice sections are actually necessary to achieve changes in preschoolers' behaviour. It could be that introducing some brief new information or a statement about the importance of practice, to sections based largely on practice, may enhance the perceived usefulness etc of the programme. Additionally, since the theme of repetition came in after section 4 of the programme and since positive changes were occurring by the end of section 4, a study looking at the effectiveness of just using the first 4 sections of the programme is indicated.

In comparing the ratings participants gave to each component, such as useful skills, to the intervention as whole (i.e., across sections), 'intention to use the skills' was given the lowest rating. However, this rating must be interpreted cautiously; it appeared misleading as participants reported they rated their

intention to fill out forms or use the checklists, rather than the skills per se. This could mean that the intention to use the skills was obscured, especially as parents used more effective discipline, as measured by the PS and PSC. It does not appear any other study has investigated the intention to use the skills taught in PT interventions. Further research is needed to clarify participants' intention to use the skills taught in a SHI and how this may align with the PS and with the ease and usefulness of the techniques in satisfaction measures.

Satisfaction with the SHI. It was hypothesised that parents would be satisfied with the SHI, as measured by the PCSQ. Mothers' ratings of the programme supported this hypothesis. The PCSQ results suggest that this intervention was acceptable, appropriate, helpful, and was recommended to others, which was also supported by anecdotal comments from participants. The rating of the programme overall, the usefulness and ease of the treatment format and usefulness and ease of the skills taught in the programme were all at approximately 75% of the total possible rating. The PCSQ (post-intervention) findings of the high rating of the workbook were similar to the findings from the part of the regular section evaluations regarding the workbook. This further supports the high rating of the workbook. In terms of teaching format 'practice of the skills' was rated the lowest. This could imply that the practice sections need to be reduced or greater emphasis needs to be placed on the importance of practice. There were conflicting views regarding the utility of either the DVD or book. This suggests individual variability in format preference and that it may be important to have both. Given the general high rating of the DVD it may be useful to have DVD clips to match the 10 sections on the workbook, rather than just the first sections.

These findings are comparable to those of Webster-Stratton et al., (1988), who found that mothers reported high satisfaction for child improvement, ease and usefulness of the treatment format and for overall ease of the parenting skills taught in the programme. The present study adds support to the argument that SHIs are an acceptable form of intervention (Kratochwill et al., 2003) and that the self-directed Triple P programme, in particular, is an acceptable means of intervention (Markie-Dadds and Sanders, 2006).

Behaviour charts were rated the lowest by participants in terms of usefulness and ease to use, which suggests this strategy may need further

explanation or tips on how to use it or that other strategies to promote good behaviour are needed. Mothers' rated all the techniques in terms of ease and usefulness on the PCSQ, but, again as monitored by the PSC, they did not all use these techniques e.g., two participants never used behaviour charts. Therefore, satisfaction ratings of techniques may be misleading as parents' may be rating their past experience of a technique or the acceptability of an untried technique rather than a technique used during the intervention. The reliance on satisfaction ratings of techniques rather than monitoring techniques is a possible flaw of the general PT research as it seems to be assumed that these satisfaction ratings means that a participant actually tried using the techniques. It is vital that in future research, the intention to apply a skill and use of the skill during an intervention is monitored and that the perception of the ease and usefulness of the actual skills used is then rated at post-intervention. Caution also needs to be taken in interpreting satisfaction ratings because previous research has found positive correlation between child improvement and treatment acceptability (MacKenzie, Fite, & Bates, 2004). It may be that techniques and teaching format were rated highly simply due to the experience of improved child behaviour.

Strengths and Limitations

Study design. A non-concurrent multiple baseline design was used as it allowed change over time to be examined which has been a limitation of previous research as well as flexibility in recruiting participants and in consideration of the time it may take participants to complete the programme. The intended matched pairs' analysis, with participants starting in pairs to allow overlapping concurrent baselines, was not possible due to participants withdrawing. A limitation is that there was no control group, so results should be interpreted with some caution. It could be that the PDR reflects change in parents' perception rather than actual behaviour. However, this is unlikely as the PDR was measured daily over the baseline period and the data during this time did not trend in any direction suggesting that changes were not a function of measuring. The behaviour scores generally changed steadily from baseline over the course of the intervention when participants were using the intervention. The behaviour score changes occurred for some participants while others were still in baseline suggesting that change was not due simply to some common external variable occurring at that time and

an extraneous variable evoking change among different participants at different times is unlikely (Hayes & Blackledge, 1998). Additionally, the findings of the present study are similar to studies of this SHI that have used randomised-control designs. It is also unlikely that maturation accounted for the effects given the stability of clinical and moderate externalising behaviours in the preschool period (Heller et al., 1996). Even if it was that parents were noticing more behaviour rather than actual behaviour change, this is what the intervention teaches, so is still an intervention effect but this is unlikely considering parents also used more effective behaviour management strategies. All these points suggest that these changes are a result of this intervention.

Measurements: A strength of this study is that it incorporated the PT evaluation recommendations wherever possible. Multiple child behaviour and parenting domains were assessed, including the tracking of both behaviour problems and prosocial behaviours using measures with sound psychometric properties, and parenting strategies were monitored. However, there were some measurement limitations, such as ceiling effects for parenting knowledge and floor effects on the DASS scales, which may have concealed treatment effects and are likely to explain the non-significant changes for these measures. It may be that the Triple P Parenting Quiz requires revision. A study using both the DASS and specific parenting measures such as the PSI, and a study of the Triple P Parenting Quiz and the KBPAC, would allow for clarification of treatment effects on these symptoms and parenting knowledge respectively. Additionally, a limitation was that changes in parent-child relationships were not measured; as a goal of this SHI is to enhance parent-child relationships, this should be measured in future research.

The use of the PDR is a strength of this study and the standardised list of behaviours enabled comparison between participants. However, future research should include a measure that assesses the frequency of preschooler's prosocial behaviours to further clarify these findings and behaviours listed on the PDR could be reviewed to ensure behaviours that parents are most concerned about are included and tracked, which would elucidate if these behaviours extinguish, emerge or increase/decrease over the intervention.

Future research should also administer the test battery midway through the programme or after each section is completed. This was not done in

consideration of the already heavy demands involved in the SHI and the research. However, this would allow temporal sequence of changes in knowledge, confidence and use of effective discipline strategies to be explored and aid the understanding of mechanisms of change in PT.

A limitation is that observation was not used to confirm the self-report measures used in this study, however, observation has been found to alter behaviour (Morawska & Sanders, 2007). Furthermore, observation was not feasible in terms of time and cost and the difficulty in collecting an adequate sample of behaviours that have a low base-rate. As intrusion of privacy is a reason for undertaking an SHI rather than standard PT, observation could also have impeded recruitment. The problems with observation were offset to a degree by parents' own observation of their child, via the PDR. Also, the ECBI and PS have been found to significantly correlate with observations of externalising behaviour and parenting behaviour, and the ECBI is sensitive to treatment effects and can differentiate between clinical and non-clinical populations; all of which adds strength to these findings.

Recruitment. Recruitment took longer than expected, which was possibly due to a number of PT programmes in operation in the area in which the study took place or to a lack of interest in a SHI. Just under half of the participants withdrew from the study, which is a typical rate reported in PT studies (Prinz & Miller, 1994). The small sample size (although it was only possible to have 10 participants because of the cost of materials) is a major limitation, which likely precluded changes in some of the measures to reach the significance level. The small sample size also restricted the type of statistical analysis that could be conducted. Dependent t-tests were conducted for all pre- and post-measures to test statistical significance and effect sizes were calculated. However, there was also a lack of power to detect effects because of the large variance and small sample size. Future studies should involve a larger sample size.

Population Utility. Participants self-selected to take part in the study, so they may have greater motivation and therefore better results than the typical parent population. However, this is how the book would normally be used, by parents buying it themselves. Therefore, this study may represent some of the typical population that would seek to use the book, which is a strength of the study. Future research could investigate the effectiveness of this SHI for parents

mandated to complete a parenting course, or for those who would prefer standard PT over the SHI.

Treatment completers were Pakeha, British or Australian mothers of children aged 2-5 year old; therefore, these findings may not generalise to caregivers, fathers, Maori or to children not in the 2-5year old bracket. Only two of the ten target children recruited and only one of the treatment completers was a male child, which is surprising considering the greater prevalence of externalising behaviours in males. Future research should investigate the utility of this SHI for Maori, fathers, and for children over 5 years old.

The SHI: In applying 'real life conditions', participants' took longer than the 10 weeks duration of the programme, but still had positive results. Future research could examine how the duration taken to complete the SHI affects treatment outcomes. Applying real life conditions also meant the SHI did not involve therapist assistance or incentives for participation. No advice or feedback was given to participants over the course of this study, which is a strength of the study, as it may have reduced potential response bias. However, the fact that there was necessary contact with the researcher may on one hand have aided motivation to complete the intervention. It is unknown how participants would respond without this contact and so it cannot therefore be ruled out that minimal contact may be necessary for a SHI to be effective. On the other hand contact may have been an extra demand that impeded the SHI, with some participants not utilising the forms and checklists in the SHI as they were already filling in materials for the research. An important consideration in future research is how to balance the demands of the intervention with the demands of research. A shortcoming of the utility of this SHI is that the workbook requires literacy. Future research should determine the effectiveness of the DVD for those that have literacy problems.

Conclusion

The aim of this study was to replicate and further explore the effects of self-administered PT on preschoolers' behaviours and parenting in New Zealand. A non-concurrent multiple baseline was used to examine changes over the course of using this SHI and it was hypothesised that the intervention would increase preschoolers' prosocial behaviours and parents' confidence and knowledge, and

decrease preschoolers' externalising behaviours and parents' use of ineffective discipline. It was also expected that parents would consider the SHI acceptable. Although there were limitations to the study and some individual response variability, the hypotheses were all supported. All participants self-reported short-term gains in all the expected directions, except one who decreased slightly on parenting knowledge, and the magnitude of the changes was medium to large for all measures. There were ceiling and floor effects on maternal knowledge of effective parenting strategies and maternal depression, anxiety and stress respectively. While monitoring showed that participants' use of a range of effective behaviour management strategies increased, unexpectedly some participants' use of potentially ineffective strategies also increased during the intervention. This should be monitored in future research. Overall, these finding suggest this SHI is an acceptable and effective intervention to significantly reduce mothers' use of ineffective discipline, ameliorate externalising behaviours in pre-schoolers and increase preschoolers' prosocial behaviours and mothers' satisfaction and efficacy in the parenting role. The intervention can also improve knowledge of effective behaviour management strategies and reduce depression, anxiety and stress symptoms. A mid-point re-administration of the test battery would have provided more information on the changes and may have strengthened these findings.

Future research should consider how to balance the demands of the SHI with the demands of research, investigate the temporal order of treatment effects, ascertain the characteristics of those families who are most likely to benefit from this SHI (Morawska, Stallman, Sanders, & Ralph, 2005), trial a version of the programme using sections1 to 4, and directly compare the efficacy of the SHI and standard PT with those who self-select to take part in each. This study adds to the body of evidence in support of SHIs as an effective alternative means of intervention, challenges the notion that SHIs are only effective for a specific problem, and provides support for the efficacy of this SHI without therapist assistance. These findings also support the tenet of PT, that child behaviour can be modified by changing parenting behaviour. This means this intervention is accessible, cost-effective, and beneficial for mothers who are concerned about their preschoolers externalising behaviour and self-select to undertake the self-directed Triple P intervention.

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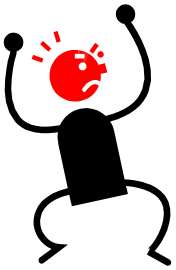
Appendix A

Recruitment Advertisement

Free

CONCERNED ABOUT YOUR PRE-SCHOOLER'S BEHAVIOUR?

- ☑ Tantrums
- ☑ Hitting
- ☑ Whining
- ☑ Fighting/Not sharing



- ☑ Interrupting
- ☑ Biting
- ☑ Arguing/Answering back
- ☑ Refusal/Not listening

Hi, Kia Ora, I am doing research to evaluate a **self-help parenting workbook**, as part of my Masters Thesis and am looking for participants. This project would be useful for any parents/caregivers who are concerned about their 2-5year old child's/tamaiti's behaviour.

The research is to see if such a self-help workbook can be helpful for parents/caregivers in managing their child's behaviour and any workbook improvements to better meet people's needs.

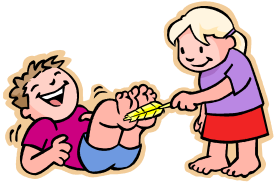
This project may be especially beneficial as you can read the workbook at your own time and in your own home! You will get to use a self-help workbook divided into weekly reading and exercises to do to **learn more about typical child behaviour problems & ways to manage your child's behaviour**. There is NO COST.

Interested & want to know more?

PH: 839 4499 or 021 0592241 E-mail: jmh15@waikato.ac.nz
Jenny Huxtable

Thanks

Supervisors: Professor Mary Foster & Dr Carrie Barber



Parenting Self-help workbook jmh15@ waikato.ac.nz 021 059 2241 839 4499	Parenting Self-help workbook jmh15@ waikato.ac.nz 021 059 2241 839 4499	Parenting Self-help workbook jmh15@ waikato.ac.nz 021 059 2241 839 4499	Parenting Self-help workbook jmh15@ waikato.ac.nz 021 059 2241 839 4499	Parenting Self-help workbook jmh15@ waikato.ac.nz 021 059 2241 839 4499	Parenting Self-help workbook jmh15@ waikato.ac.nz 021 059 2241 839 4499	Parenting Self-help workbook jmh15@ waikato.ac.nz 021 059 2241 839 4499

Appendix B

Information Sheet

Information Sheet: Self-Help Workbook for Child Behaviour Problems

Hi, Kia Ora, My name is Jenny and I'm doing some research on a self-help parenting workbook

Contact: *Jenny Huxtable, Department of Psychology, University of Waikato*
Telephone: *021 059 2241* Email: *jmh15@waikato.ac.nz*
Supervisors: *Prof Mary Foster,* m.foster@waikato.ac.nz *& Dr Carrie Barber,*
ccbarber@waikato.ac.nz *(University of Waikato,* 07 856 2889*)*

What is this study about?
You are invited to participate in a research project to evaluate the use of a self-help workbook and DVD used for parents/caregivers concerned about their child's behaviour. Participation is voluntary. The reason for the study is to see if the book and DVD may be helpful for parents/caregivers who are concerned about their child's behaviour. This research is important in improving programmes to better meet people's needs and helping to reduce problem child behaviour. This is especially relevant for people who are not involved with a professional regarding their child's behaviour or who would find it difficult to access services or parenting groups.

What is involved?
If you agree to take part in this research you will meet individually with the researcher on 2 occasions at Waikato University. Each visit will take approximately 1 hour at the University. The two main meetings will be an introduction and a conclusion for the intervention. At each meeting you will fill out some questionnaires which ask you to rate your child's behaviour and other aspects of parenting such as style, confidence, stress, depression and knowledge. The questionnaires should take approximately 30mins to complete. You will initially record the daily occurrence of behaviours over a short period before beginning the programme and throughout the intervention. During the 10 week intervention period you will be required to read through and do some written activities from the self-help book and watch a DVD. This is expected to take no more than two hours per week. During the 10 weeks you will be contacted weekly by the researcher to state the presence or absence of a list of child behaviours, and parenting strategies which should take approximately 10 minutes. At the end of the study you will meet with the researcher to record any completed exercises from the workbook and to repeat the initial questionnaires. There is NO COST, beyond time in using the workbook and DVD.

What will happen to my information?
The information you provide will remain completely confidential. Numbers will be used so you will not be identifiable in the use of the information. Completed questionnaires will be stored in a locked cabinet. The results will be anonymised and combined with others participating in the study and presented as part of my thesis. If you would like, you will be sent a summary of the findings at the end of the study.

Your rights. If you participate in the study the researcher will respect your rights to: ask any questions about the study at any time; decline to answer any questions; withdraw from the study at any time; be provided with information to ensure you will not be identified in the study findings; be given a summary of the findings.
If you have any queries/concerns regarding your rights as a participant in this study you may wish to contact the ethics committee: Dr Robert Isler: r.isler@waikato.ac.nz or 07 8384466.
This study has received University of Waikato Psychology Department ethical approval.

If you are interested in taking part in this research or have any further questions please contact Jenny Huxtable. Thank you.

Appendix C

Consent Form

University of Waikato
Psychology Department

CONSENT FORM

PARTICIPANT'S COPY

Research Project: Effects of self-directed parent training on child and parenting behaviour.

Name of Researcher: Jenny Huxtable

Name of Supervisor: Mary Foster & Carrie Barber

I have received an information sheet about this research project or the researcher has explained the study to me. I have had the chance to ask any questions and discuss my participation with other people. Any questions have been answered to my satisfaction.

I agree to participate in this research project and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact the convenor of the Research and Ethics Committee (Dr Robert Isler, phone: 838 4466 ext. 8401, e-mail r.isler@waikato.ac.nz)

Participant's Name:_____Signature:_____Date:_____

==========

University of Waikato
Psychology Department

CONSENT FORM

RESEARCHER'S COPY

Research Project: Effects of self-directed parent training on parenting knowledge

Name of Researcher: Jenny Huxtable

Name of Supervisor: Mary Foster & Carrie Barber

I have received an information sheet about this research project or the researcher has explained the study to me. I have had the chance to ask any questions and discuss my participation with other people. Any questions have been answered to my satisfaction.

I agree to participate in this research project and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact the convenor of the Research and Ethics Committee.

Participant's Name: _____Signature:_____ Date:_____

Appendix D

Baseline and Intervention Checklists

PARENT DAILY REPORT – 2 Sides

<u>Instructions:</u> Tick if the listed behaviour occurred at all during the last 24 hours. You don't need to record how many times it happened, just tick if it occurred at least once. Please make sure you write the date on the space provided.

Participant Code: _____ Day: M/T/W/T/F Week of__/__/__ to __/__/__

No.	Behaviour	Any Comments
1	Aggressiveness, hit ADULTS	
2	Argued, Back-Talked ADULTS	
3	Bedwetting, wet pants, soiled	
4	Was Competitive	
5	Complained, was irritable, negative	
6	Was Defiant, non-compliant, didn't listen	
7	Was destructive, purposefully damaged something	
8	Physically fought with other CHILDREN	
9	Interrupted ADULTS, demanded attention.	
10	Lied, didn't tell whole truth, broke promises	
11	Threw toys	
12	Quarrelled, argued with other CHILDREN	
13	Resisted being disciplined (tried to run away)	
14	Was Hyper-active, Boisterous, Noisy,	
15	Didn't eat meals, picked and fussed with food.	
16	Hurt self (e.g. pulling own hair)	
17	Swore/used bad language	
18	Whined/Cried/Pouted	
19	Teased/provoked other CHILDREN	
20	Was Sad, fearful	
21	Was Sluggish at doing tasks, did not complete tasks	
22	Was Jealous	
23	Played with matches/lighter	
24	Stole, snuck and hid things	
25	Abused animals (pulled cat's tail)	
26	Didn't settle at an activity	
27	Yelled, shouted	
28	Had Temper tantrums	
29	Was a Problem at childcare, kohanga reo, kindy	
30	Other	
Total		

 **PLEASE TURN OVER** 

PARENT DAILY REPORT

<u>Instructions:</u> Tick if the listed behaviour occurred at all during the last 24 hours. You don't need to record how many times it happened, just tick if it occurred at least once. Please make sure you write the date on the space provided.

Participant Code: _____ Day: M/T/W/T/F Week of__/__/__ to __/__/__

No.	Behaviour	Any Comments
1	Accepted disappointment well	
2	Accepted punishment	
3	Used appropriate language	
4	Complied to requests (minded)	
5	Said something to make another child feel good	
6	Was co-operative with other CHILDREN	
7	Spoke nicely to other ADULTS	
8	Played nicely with other CHILDREN	
9	Showed happiness, smiled, laughed	
10	Asked before taking things	
11	Thoughtful/considerate of another's feelings	
12	Waited for turn to speak, listened attentively	
13	Told truth when confronted, kept promises	
14	Willingly shared something	
15	Stayed dry at night, clean pants	
16	Spoke nicely to other CHILDREN	
17	Took care/looked after toys and property	
18	Ate meals without picking or throwing	
19	Kept hands to self with other CHILDREN	
20	Was quiet, used a calm voice	
21	Went to bed without problems	
22	Put toys away	
23	Kept away from matches/lighters	
24	Volunteered to help or work, completed tasks appropriately.	
25	Played nicely with animals	
26	Settled at an activity	
27	Kept hands to self with ADULTS	
28	Kept temper under control when didn't get own way	
29	Fine at childcare, kohanga reo, kindy	
30	Other	
Total		

The following is a list of things that parents/caregivers sometimes do when their child/tamaiti misbehaves (that is, does something s/he is not supposed to do) ☹

Parenting Strategies Checklist

How often in the <u>last week</u> did you use any of the following strategies?:

STRATEGY	**Never**	**1-3 Times**	**4-6 Times**	**7-9 Times**	**10+ Times**
1. Raised your voice (growled, scolded or yelled)					
2. Noticed it but did **not** do anything about it					
3. Ignored the behaviour on **purpose to not give attention to it.**					
4. Threatened to punish him/her (but **did not really** punish him/her).					
5. Gave several warnings for an incident of misbehaviour					
6. Grounded your child e.g. not allowed to play outside					
7. Took away privileges (like TV, playing with friends) or a toy that was **not** involved in the inappropriate behaviour.					
8. Took away the toy or thing they were doing when they misbehaved. *e.g. took the ball away for kicking the ball in the house.*					
9. Discussed the problem with your child or asked your child questions.					
10. Offered your child another activity since they weren't behaving properly with the thing that they were doing.					
11. Gave your child a spanking.					
12. Used physical force but **not** spanking.					
13. Got your child to correct the problem or make up for his/her mistake					
14. Removed to edge of activity for a few minutes					
15. Removed **completel**y from the situation to another area/room for a few minutes.					
16. Did the same back to them e.g. biting					
17. Gave them a consequence for the behaviour a few hours later or the next day.					
18. Other (Please state).....					

PLEASE TURN OVER

The following is a list of things parents might do when their child/tamaiti behaves well or does a good job at something.☺

How often in the last week did you use any of the following strategies?:

STRATEGY	**Never**	**1-3 Times**	**4-6 Times**	**7-9 Times**	**10+ Times**
1. Noticed it but **did not** do anything about it					
2. Let them stay up late					
3. General praise – e.g. *"good boy"*					
4. Praise that describes the behaviour, such as *"I really liked the way you listened to me straight away and put the toys in the box like I asked"*					
5. Gave your child a hug, kiss, pat, handshake or "high five."					
6. Told them wished their brother/sister behaved as well as they did					
7. Gave him/her an extra privilege (such as cake, special activity, extra time doing something e.g. pushes on the swing for good behaviour)					
8. Told partner/family/friends how well your child had behaved **in front of your child**.					
9. Bought something for him/her (such as special food, a small toy) **after** good behaviour happened					
10. Gave him/her money for good behaviour **after** the behaviour happened.					
11. Other (Please state).....					

These are other strategies that parents use that effect their child's behaviour

How often in the last week did you use any of the following strategies?:

STRATEGY	**Never**	**1-3 Times**	**4-6 Times**	**7-9 Times**	**10+ Times**
12. Gave your child a treat and made him/her promise to be good **before** any misbehaviour happened. *e.g. giving your child lollies before you have a visitor.*					
13. Spent time with your child playing or doing fun things throughout the day.					
14. Behaviour Charts Give points or stars on a chart Do you have a behaviour chart – yes/no	(If you have a behaviour chart did you it – please circle) **NO** **YES**				

Appendix E

Supplementary Materials Booklet

Supplementary Materials Booklet 2009

For “Every Parent’s Self-Help Workbook”

Compiled by:
Jenny Huxtable (jmh15@waikato.ac.nz)

Supervisors:
Mary Foster & Carrie Barber, University of Waikato

This booklet is based on the self-help publication by Markie-Dadds, Sanders and Turner (2007). The exercises are directly from the self-help book.

INTRODUCTION

Enclosed is the material you need to participate in this study. The study will take 10 weeks to complete and each week you are required to:

- Read the specified part of the book and watch the related DVD section.
- Do the exercises in that section (the exercises that are in the book are also provided here so you can fill them in – or if you would like extra copies of these please contact me).
- Answer questions to help me evaluate the book.

The exercises and evaluation questions are attached and are in the order that you are required to complete or look at them. The research has been designed to allow you to work through the book and complete the exercises at a steady pace. The questions are to prompt discussion about how you are finding the book and DVD. It doesn't matter if you like the book or DVD or not. I'm just interested in your thoughts and opinions!!

The exercises and the questions I will use to evaluate the book are attached.

I will contact (by the method agreed e.g. phone or e-mail) you once a week to collect the data from the Parent Daily Report and the evaluation questions.

The weekly time that we have arranged for you to be contacted is:
(Time): _____ on (day):_____by (phone/ face to face/ e-mail)

Here is a list of the weekly reading:

WEEK No.	START DATE	REQUIRED READING	TICK AS COMPLETE
1		Intro, commitment, Week 1	
2		Week 2	
3		Week 3	
4		Week 4	
5		Week 5	
6		Week 6	
7		Week 7	
8		Week 8	
9		Week 9	
10		Week 10, final meeting	

At the last meeting I will need the workbook returned, and will photocopy this supplementary materials booklet, but you can keep this booklet.

The agreed date for the final meeting is time: _____ date _____ .

Week 1: Positive Parenting

Reading: Introduction, How to use this workbook & Week 1Exercises

Introduction

Raising children can at times be challenging. This workbook and DVD will help develop your skills and knowledge to deal with your child's/tamariki's behaviour. The book *"Every Parent's Self-Help Workbook"* and DVD are part of the Positive Parenting Program (Triple P) which aims to make parenting easier and has been helpful for many parents.

How to use the workbook and this 'Supplementary Materials Booklet'.

The program has been designed to be used once a week for 10 weeks. Try to avoid reading lots and then doing the exercise all at once. Use the yellow *"Every parent's self-help workbook"* for the weekly readings. There are corresponding exercises to complete in the workbook but instead of writing in the workbook please make sure any exercises you do are written in this booklet. This is because all the '*Every parent's self-help workbook*s' and DVD's are University of Waikato property and have to be returned to the University. Thanks!

Your Commitment (page x)

I (name)_____ agree to play an active role throughout the program. I am able to...(tick boxes as apply)

☐ Set aside 1 hour or more a week to work through the program
☐ Complete readings & exercises (exercises in the 'Supplementary Materials Booklet')
☐ Complete the practice exercises suggested.
☐ Watch the corresponding DVD segment.

Signed:_____ Date:_____

READING: POSITIVE PARENTING (pg 1>)

Exercise 1: What you would like to get out of the programme (from page 2)

Think about why you are participating in this self-help programme and what you hope to get out of it. Write your ideas below.

_____
_____
_____
_____

Exercise 2: What is Positive Parenting? (from page 4)

Which of these positive parenting skills do you find easy? Why?

Which of the positive parenting skills do you find hard? Why?

What other things are important in helping children develop?

Exercise 3: Identifying causes of child behaviour problems (pages 5-13)

As you read this section:

Which causes apply to your child/tamariki?

Which factors are most important in explaining your child's behaviour?

Is there anything else you think is important that is not on the list?

What was your child like as an infant?

☐ Liked to be with people, demanded lots of attention
☐ Easily upset, difficult to settle, distressed by sudden change
☐ Very active, busy, energetic, difficult to control

Comments:

Do any of these accidental rewards occur in your family?

☐ Social attention ☐ Food rewards ☐ Material rewards ☐ Activity rewards

Comments:

Do either of these escalation traps occur in your family?

☐ Child escalates
☐ Parent/caregiver escalates

Comments:_____

Do you often fall into the trap of ignoring desirable behaviour?

Comments:_____

How do you give instructions?

☐ Too many ☐ Too few
☐ Too hard ☐ Poorly timed
☐ Too vague ☐ Confusing body language

Comments:_____

Do you give any of these emotional messages?

☐ Name calling or put-downs
☐ Guilt-inducing messages

Comments:_____

Do you have any of these difficulties with discipline?

☐ Threats not carried out
☐ Punishment given in anger
☐ Punishment as a crisis response
☐ Inconsistent use of punishment

Comments:_____

Do either of these apply to you?

☐ Unhelpful beliefs
☐ Unrealistic expectations

Comments:_____

Do any of these apply to your family/whanau?

☐ Parents/caregivers relationship with each other
☐ Parents/caregivers feelings
☐ Stress

Comments:_____

_____

_____

Are any of these a concern for your family/whanau?

☐ Peers and friends
☐ Kohanga Reo, Crèche, Kindergarten, Early Childhood Centre
☐ Media and Technology

Comments:_____

_____

_____

Are you aware of any other things that could be influencing your child's behaviour? If so, list them in the space below._____

_____

_____

Exercise 4: What skills would you like to encourage in your child/tamaiti? (page14)

_____

_____

_____

_____

Exercise 5: Setting Goals for Change (page 15)

List those changes that you would like to see in your child's behaviour and your own behaviour. Make sure your goals are specific and achievable.

GOALS FOR CHANGE IN YOUR CHILD'S BEHAVIOUR	GOALS FOR CHANGE IN YOUR OWN BEHAVIOUR

Exercise 6: Keeping Track (page 22)

Indicate what type of form could be used to keep track of each of the following behaviours. Give your reason for choosing a particular form. Often more than 1 form would be appropriate for the behaviours listed.

- How often a child bites others:_____
- How long a child takes to settle when left with other carers:_____
- How often a child whines, particularly in the afternoon before dinner:_____
- How often a child is destructive:_____
- How often a child answers back or uses a negative tone of voice:_____

SUMMARY OF ACTIVITIES - Practice Activities (page 23)

Select 1 or 2 of your child's problem behaviours for monitoring. Keep track of these behaviours for 7 days using a monitoring form from pages 24-27 (Copies of these forms are on the next few pages and spare forms in the appendix of this supplementary booklet). After 7 days, plot your data onto a behaviour graph (page 28 – use the graph following in this supplementary booklet). Jot down the behaviour/s you plan to track for the next 7 days.

Which type of monitory form will you use?_____

Remember to watch Part 1 and 2 of the 'Every Parent's Survival Guide' DVD!

BEHAVIOUR DIARY

Instructions: List the problem behaviour, when and where it occurred and what happened before and after the event.

*Problem Behaviour:*_____ *Day:*_____

PROBLEM EVENT	WHEN & WHERE DID IT OCCUR	WHAT OCCURRED BEFORE THE EVENT?	WHAT OCCURRED AFTER THE EVENT?	OTHER COMMENTS

TALLY SHEET

Instructions: Write the day in the first column, then place a tick in the successive square each time the behaviour occurs on that day. Record the total number of episodes for each day in the end column.

*Behaviour:*_____ *Starting Date:*_____

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	TOTAL

DURATION RECORD

Instructions: Write the day in the first column, then for each separate occurrence of the target behaviour, record how long it lasted in seconds, minutes or hours. Total the times at the end of each day.

*Behaviour:*_____ *Starting Date:*_____

DAY	SUCCESSIVE EPISODES										TOTAL
	1	2	3	4	5	6	7	8	9	10	

TIME SAMPLE

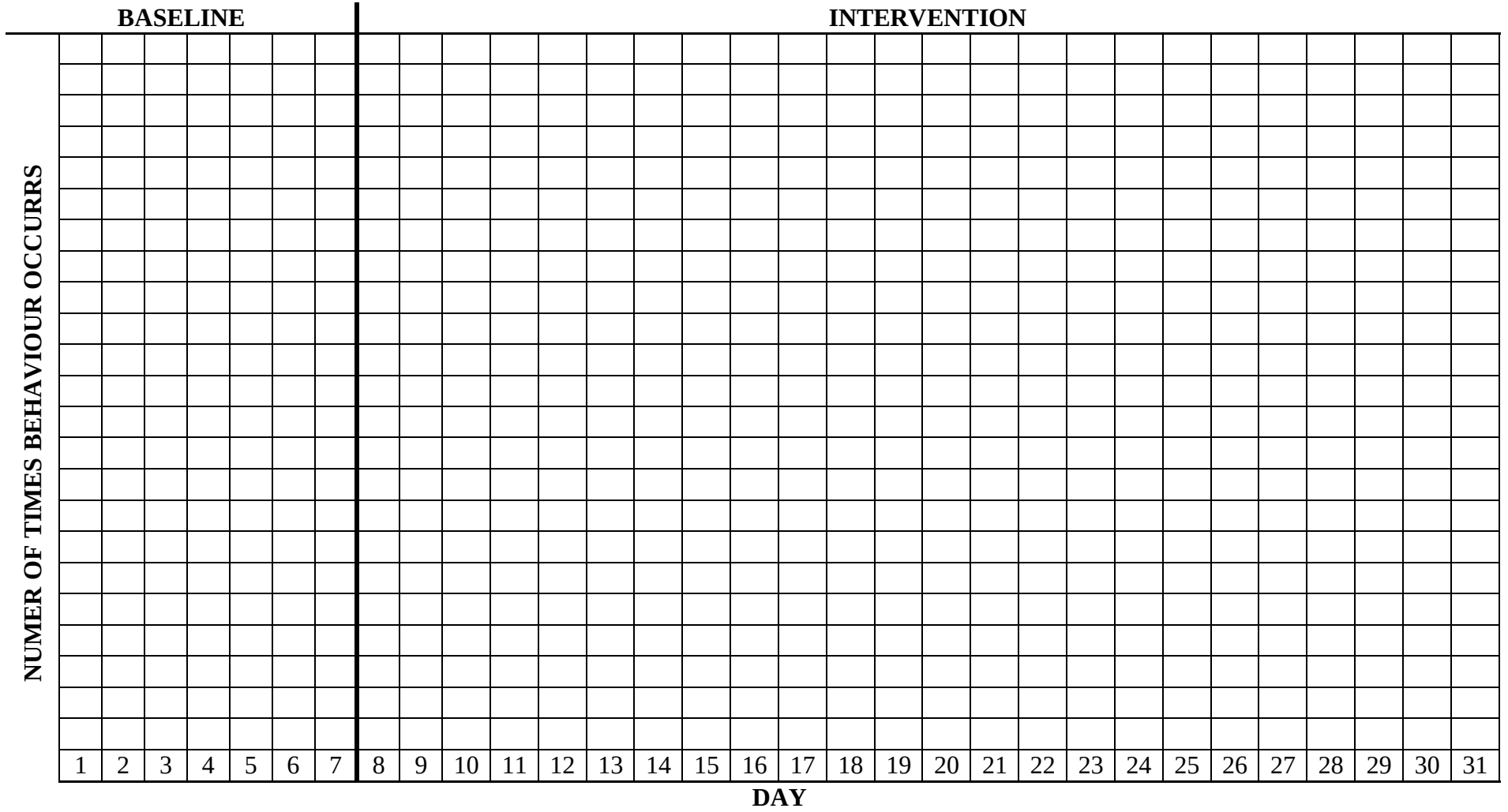
Instructions: Place a tick in the square for the corresponding time period if the target behaviour has occurred at least once.

*Behaviour:*_____ *Starting Date:*_____

TIME PERIOD	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
TOTAL																					

BEHAVIOUR GRAPH

Instructions: Plot the number of times the behaviour occurs each day by placing a cross or circle in the appropriate column, then join up the marks for each day. *Behaviour:*_____ *Month:*_____



Week 1: Evaluation Questions

1. What is the most important thing you learnt from the **reading** for this week?
   .....
   .....
   .....

Did you watch the **DVD** segment for this week? YES/NO

2. What is the most important thing you learnt from the **DVD** for this week?
   .....
   .....
   .....

Circle the number that represents how you feel:

This component provided useful skills for understanding and/or managing my child's behaviour.

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I agree the ideas in this component are important

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I am going to use the skills/techniques suggested e.g. monitoring forms

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed reading this section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed watching this DVD section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I thought watching this DVD section of the programme was helpful

Not at all Very much

0 1 3 4 5 6 7 8 9 10

Week 2: Promoting Children's Development

Reading, Exercises & Activities

Exercise 1: Ideas for Quality Time (page 31)
Quality time is different for all families/whanau. Write down some ideas about how you and your child/tamaiti can spend quality time together. Remember quality time is something that can happen every day, such as reading a story or playing a game, rather than special outings, such as trips to amusement parks.

_____
_____
_____
_____

Exercise 2: Things to Talk About (page 31)
List some things that your child is interested in or that you have been doing that you can talk about._____
_____
_____
_____

Exercise 3: Affection (page 32)
What kind of physical affection do you and your child/tamaiti both enjoy?

_____
_____
_____

Exercise 4: Descriptive Praise (page 33)
Look at your list of goals for things you would like your child to do more often (page 15). Write down the goal behaviours and some praise statements you could use to encourage these goal behaviours. Try to be as specific and descriptive as you can.

_____
_____
_____
_____
_____

Exercise 5: Ways to Give Attention (page 33)
Write down some ways you can give attention to your child._____
_____

Exercise 6: Engaging Activities (page 34)
Think of some fun new activities for your child/tamaiti. You may like to get some ideas from other parents/caregivers. You may also be able to borrow some books or children's games from your local library, childcare centre, kindergarten or church. List some games and activities for indoors and outdoors.

INDOOR GAMES AND ACTIVITIES	OUTDOOR GAMES AND ACTIVITIES

Exercise 7: Setting a Good Example (page 35)
From your list of goals for your child's behaviour (page 15), decide if there are any behaviours you can encourage by setting a good example. List them below.

_____
_____
_____
_____

Exercise 8: Incidental Teaching (page 36)
There are different types of teaching opportunities that occur frequently. Think of how you could use incidental teaching in the following situations.

- When your child asks you questions, particularly the common 'Why' questions (e.g. Why is the moon round tonight?)._____
_____
_____
- When your child/tamaiti mispronounces a word (e.g. sgetti instead of spaghetti)_____
_____
_____
- When your child/tamaiti is engaged in an activity and wants to show you something (e.g. come and look at my painting!)_____
_____
_____
- When your child/tamaiti is frustrated with an activity and asks for help (e.g. I can't do this puzzle!)_____
_____
_____

Exercise 9: Ask, Say, Do (page 37)
Pick a behaviour or skill that you would like your child/tamaiti to learn to do by themselves, such as tying shoelaces, using a fork and knife, using the potty or washing their body. Use Ask, Say, Do routine for the first three steps of your chosen task.
Behaviour or skill:_____

ASK	
SAY	
DO	

ASK	
SAY	
DO	

ASK	
SAY	
DO	

Exercise 10: Behaviour Charts (page 40)
Write down the behaviour for which you plan to use a chart. Make sure you phrase it positively. For example, the target behaviour would be *Doing as you are told* rather than *Not being disobedient* or *Talking nicely* rather than *Not swearing*. Make sure the behaviour is clear to your child._____
_____
_____
Think of what your child can receive for the desired behaviour/s (e.g. stickers, stamps, smiley faces, points, starts), and how many they need to earn to receive a back-up reward. Remember to set easy goals at first so your child is rewarded for their extra effort, then you can gradually make the goals harder to achieve. Ideally your child should earn a back-up reward on the first day of the chart._____
_____
_____
Describe the back-up rewards that your child can earn for a specified number of starts or stickers. Choose rewards that your child will enjoy, such as having a friend over to play, or choosing their favourite dinner. You can discuss this with your child to get their ideas on things they would like to work for._____
_____
_____
List anything you need to purchase or get organised before you can start using the chart (e.g. coloured paper to make the chart, stickers)._____
_____
_____

SUMMARY OF ACTIVITIES – Practice Exercises (page 43)
Choose 2 of the strategies introduced in Week 2 that you would like to practise with your child over the next week. Be as specific as possible (e.g. 1 goal may be to use descriptive praise statements with your child at least 5 times per day). Use the table below to record whether you reached your goals each day. Comment on what went well and list any problems that occurred.

GOAL 1:_____
_____
GOAL 2:_____
_____

DAY	GOAL 1 Y/N	GOAL 2 Y/N	COMMENTS
1			
2			
3			
4			
5			
6			
7			

Remember to watch Part 3 of the 'Every Parent's Survival Guide' DVD!

Week 2: Evaluation Questions

1. What is the most important thing you learnt from the **reading** for this week?
   .....
   .....
   .....

   Did you watch the **DVD** segment for this week? YES/NO
2. What is the most important thing you learnt from the **DVD** for this week?
   .....
   .....
   .....

Circle the number that represents how you feel:

This component provided useful skills for understanding and/or managing my child's behaviour.

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I agree the ideas in this component are important

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I am going to use the skills/techniques suggested e.g. monitoring forms

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed reading this section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed watching this DVD section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I thought watching this DVD section of the programme was helpful

Not at all Very much

0 1 3 4 5 6 7 8 9 10

Week 3: Managing Misbehaviour

Reading, Exercises & Activities

Exercise 1: Deciding on ground rules (page 47)
List 4 or 5 rules that you would like to use in your home.

_____
_____
_____
_____

Exercise 2: Directed Discussion (page 47)
Think of a rule that occasionally gets broken in your house or imagine that our child has just broken one of your new rules. Write down what you could say to your child at each step of a directed discussion to teach your child the correct behaviour.

Situation:

_____
_____

Gain your child's attention:

_____
_____

State the problem briefly, simply and calmly:

_____
_____

Briefly explain why the behaviour is a problem:

_____
_____

Describe or ask your child to suggest the correct behaviour:

_____
_____

Have your child practise the correct behaviour:

_____
_____

Praise you child for the correct behaviour:

_____
_____

Exercise 3: Ideas for using planned ignoring (page 49)
For which minor problem behaviours could you use planned ignoring?

_____
_____
_____
_____

When do you stop ignoring a minor problem behaviour?

What would stop you from using planned ignoring?

Exercise 4: Ideas for giving clear, calm instructions (page 50)
Write down some examples of clear, calm instructions you could use in the following situations. Indicate how many times you would give the instruction to your child:

It is time for your child's dinner:

Your child is jumping on the couch:

Your child's toys are scattered on the floor:

Your child is interrupting your telephone call:

It is time for your child to get ready to go out:

Exercise 5: Choosing Logical Consequences: (page 52)
Think of some logical consequences for the following situations and make a note of what you would say to your child.

Your child is playing with their drink at the dinner table:

Your child is playing roughly with a toy:

Your child is wandering away from you on a walk:

Your child is playing dangerously on the swings:

Your child is drawing on the wall:

Exercise 6: Preparing to use quiet time (page 54)

What space in your home could be used for quiet time?

What can you say to your child as you take them to quiet time?

What can you say to your child as you put them in quiet time?

How long will your child need to be quiet in quiet time?

When can you talk to your child again?

What can you say to your child when quiet time is over?

What can you do if your child is not quiet within 10seconds or does not stay seated in quiet time?

Exercise 7: Preparing to use time-out (page 57)

What room or space in your home could be used for time-out?

What can you say to your child as you take them to time-out?

What can you say to your child as you put them in time-out?

How long will your child need to be quiet in time-out?

When can you talk to your child again?

What can you say to your child when time-out is over?

What could you do if your child refused to come out of time-out when it was over?

What could you do if your child made a mess in the time-out room?

What could you do if your child came out of time-out before their time was up?

What could happen if you threaten to use time-out with your child?

What could happen if you let your child out of time-out while they are still upset?

Exercise 8: Using the compliance routine (page 62)
Read this page and try to practise this routine with another adult.

Exercise 9: Using the behaviour correction routine (page 65)
Choose a problem behaviour and in the space below, write what you would say or do for each of the main steps involved in stopping this problem using a behaviour correction routine.

Problem Behaviour:_____

1. Gain your child's attention. Tell them what to stop doing and what to do instead.

2. Praise your child if they do as you ask.

3. If your child does not do as you have asked, tell them the problem and the consequence and enforce the consequence.

4. Ignore any protests or complaints. Back up your consequence if needed.

5. When the consequence is over, set your child up in an activity and praise them for behaving well.

Exercise 10: Consequences for behaviour charts (page 66)
What could you do if your child fails to reach the set goal?

What could you do if your child misbehaves (e.g. throws a tantrum)

SUMMARY OF ACTIVITIES – Practice Exercises (page 67)

- Decide on 4 or 5 ground rules and discuss them with your family.
- Choose the strategies that you would like to try out with your child. If you choose to use time-out, keep track of how you go. Use the monitoring form on page 68 (below in this book). Additional copies in Appendix. Choose a time to talk to your child about your new strategies before you use them. If possible, start using your new strategies on a day when you are likely to be at home and when you do not have any time pressures or other tasks that must be completed. Jot down the strategies you plan to use over the next 7 days.

_____

_____

_____

_____

- Put into practice the behaviour chart you designed in week 2, with the consequences you have just decided upon.
- Continue to keep track of your child's behaviour and plot this data on your behaviour graph. As you start to use the strategies introduced this week and in week 2, look for changes in your child's behaviour.

Remember to watch Part 4 of the 'Every Parent's Survival Guide' DVD!

DIARY OF TIME-OUT

Instructions: Make a note of the day, the problem behaviour, when and where it occurred, and the total length of time your child was in time-out.
Set time for time –out: 2 minutes ☐ 3 minutes ☐ 4 minutes ☐ 5 minutes ☐

DAY	PROBLEM BEHAVIOUR	WHEN & WHERE IT OCCURRED	LENGTH OF TIME-OUT

Week 3: Evaluation Questions

1. What is the most important thing you learnt from the **reading** for this week?
   .....
   .....
   .....

   Did you watch the **DVD** segment for this week? YES/NO
2. What is the most important thing you learnt from the **DVD** for this week?
   .....
   .....
   .....

Circle the number that represents how you feel:

This component provided useful skills for understanding and/or managing my child's behaviour.

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I agree the ideas in this component are important

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I am going to use the skills/techniques suggested e.g. monitoring forms

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed reading this section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed watching this DVD section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I thought watching this DVD section of the programme was helpful

Not at all Very much

0 1 3 4 5 6 7 8 9 10

Week 4: Using Positive Parenting Strategies 1

Reading, Exercises & Activities

Exercise 1: Setting up a practice session (page 70)

Identify a time when you will be able to have a 20minute practice session.

Day..... Date..... Time.....

List your goals for the first practice session.

_____

_____

_____

Exercise 2: Planning your practice task (page 71)

Note down how you plan to organise the 20 minutes practice time (e.g. *I'll spend 10 minutes with Jack and his toys and then I'll spend 10 minutes ironing clothes and encouraging Jack to continue to play be himself*).

_____

_____

_____

_____

Exercise 3: Keeping track of what you do (page 71)

You may find it helpful to use the Practice Task checklist and the checklists on the following pages to remind yourself of the steps to follow when dealing with some common problem behaviours. You can also refer to them after the practice task to see how well you went. These checklists can help you work out which steps you follow well and any steps you many have forgotten or need to practise. This can help you set goals for change. You can also use the checklists at other times if any of these problem behaviours occur. Extra copies of these checklists are included in the Appendix section.

PRACTICE TASK CHECKLIST

Note down your goals for the practice task. Be as specific as possible. Use the table below to record whether you reached your goals. Comment on what went well and list any problems that occurred.

GOAL 1:

_____

_____

GOAL 2:

_____

_____

GOAL 3:

_____

_____

	GOAL ACHIEVED? Y/N	COMMENTS
GOAL 1		
GOAL 2		
GOAL 3		

CHECKLIST FOR MANAGING INTERRUPTING

Instructions: Whenever interrupting parents' conversations or activity occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1. Gain your child's attention.					
2. Tell your child what to stop doing and what to do instead – *Stop interrupting. Say "Excuse me" and wait until I am free.*					
3. If your child does as you ask, when there is a break in your activity, praise them for waiting and give them your attention.					
4. If your child does not do as you have asked, tell them what they have done wrong – *You are interrupting* – and the consequence – *Now go to quiet time*. If necessary, take them to quiet time. Do not argue or debate the point.					
5. If your child does not sit quietly in quiet time, tell them what they have done wrong – *You are not being quiet in quiet time* – and the consequence – *Now you must go to time-out.* Take them straight to time-out.					
6. When your child has been quiet for the set time in quiet time or time-out, set them up in an activity.					
7. As soon as possible, praise your child for behaving well.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

CHECKLIST FOR MANAGING FIGHTING OR NOT SHARING

Instructions: Whenever fighting or not sharing or taking turns with other children occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1. Gain your child's attention.					
2. Tell your child what to stop doing and what to do instead – *Stop fighting over the game. Take turns please*					
3. Praise the children if they do as you ask.					
4. If the problem continues, tell your child what they have done wrong and the logical consequence – *You are not taking turns, I'm putting the game away for 5 minutes.* Do not argue or debate the point.					
5. If your child protests or complains, use planned ignoring.					
6. When the time is up, return the activity.					
7. As soon as possible, praise the children for sharing and taking turns.					
8. If the problem happens again, repeat the logical consequence for a longer period or use quiet time.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

CHECKLIST FOR MANAGING AGGRESSION

Instructions: Whenever aggression occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1. Gain your child's attention.					
2. Tell your child what to stop doing and what to do instead – *Stop hitting. Keep your hands to yourself.*					
3. Praise your child if they do as you ask.					
4. If your child does not do as you have asked, tell them what they have done wrong – *You are still hitting* – and the consequence – *Now go to quiet time.* If necessary, take them to quiet time. Do not argue or debate the point.					
5. If your child does not sit quietly in quiet time, tell them what they have done wrong – *You are not being quiet in quiet time* – and the consequence – *Now you must go to time-out.* Take them straight to time-out.					
6. When your child has been quiet for the set time in quiet time or time-out, set them up in an activity.					
7. As soon as possible, praise your child for behaving well.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

CHECKLIST FOR MANAGING TEMPER OUTBURSTS

Instructions: Whenever temper outbursts (e.g. screaming, crying or stamping feet) occur, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
EITHER A) Use planned ignoring for toddlers under 2 years old **OR** B) Gain your child's attention as best you can and follow the steps below:					
1. Tell your child what to stop doing and what to do instead – *Stop screaming right now. Use a nice voice.*					
2. Praise your child if they do as you ask.					
3. If your child does not do as you have asked, tell them what they have done wrong – *You have not done as I asked* – and the consequence – *Now go to time-out.* If necessary, take them to quiet time. Do not argue or debate the point.					
4. When your child has been quiet for the set time in time-out, set them up in an activity.					
5. As soon as possible, praise your child for behaving well.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

CHECKLIST FOR MANAGING WHINING

Instructions: Whenever whining for something occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1. Gain your child's attention.					
2. Tell your child what to stop doing and what to do instead – *Stop whining for a piece of cake. Please ask nicely.*					
3. Praise your child if they do as you ask.					
4. If your child does not do as you have asked, tell them what they have done wrong – *You have not asked nicely* and the logical consequence – *The cake goes away for 10 minutes. Try again then.* Do not argue or debate the point.					
5. If your child protests or complains, use planned ignoring.					
6. When the time is up, if your child has stopped whining, praise them for being quiet and give them an opportunity ask nicely for what they want.					
7. If your child asks nicely, praise them for asking nicely and respond to their request.					
8. If the problem happens again, repeat the logical consequence for a longer period or use quiet time.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

EXERCISE 4: Reviewing the practice task (page 79)

What do you feel you did well during the practice task? Aim to identify at least two things that you did well *(e.g. I used descriptive praise 3 times, and followed through with the quiet time consequence for misbehaviour).* Refer to your goals listed in Exercise 1. Which goals did you achieve?

What do you feel you could have done differently to improve on this practice task? Be specific and think of one or two things you would do differently if you repeated this practice task *(e.g. I need to use more descriptive prise and tell Jack exactly what he had done that pleases me, and I need to stay calm and tell Jack why he is going to quiet time).* Think about the goals you set in Exercise 1. Was there a goal that you did not reach?

You may like to use the space below to make notes about any other issues that arose during the practice task.

SUMMARY OF ACTIVITIES – Practice Exercises

Make a note of the skills you would like to practise for the remainder of this week. Be specific and relate your goals to the areas you identified in your practice task *(e.g. I want to stay calm and explain why Jack is going to quiet time, and use more descriptive praise).*

_____
_____
_____
_____
_____
_____
_____
_____

You may like to review part 3 and 4 of the 'Every Parent's Survival Guide' DVD!

Week 4: Evaluation Questions

1. What is the most important thing you learnt from the **reading** for this week?
   .....
   .....
   .....

   Did you watch the **DVD** segment for this week? YES/NO
2. What is the most important thing you learnt from the **DVD** for this week?
   .....
   .....
   .....

Circle the number that represents how you feel:

This component provided useful skills for understanding and/or managing my child's behaviour.

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I agree the ideas in this component are important

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I am going to use the skills/techniques suggested e.g. monitoring forms

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed reading this section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed watching this DVD section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I thought watching this DVD section of the programme was helpful

Not at all Very much

0 1 3 4 5 6 7 8 9 10

Week 5: Using Positive Parenting Strategies 2

Reading, Exercises & Activities

Exercise 1: Setting up a practice session (page 84)

Identify a time when you will be able to have a 20minute practice session.

Day..... Date..... Time.....

List your goals for the first practice session.

_____

_____

_____

Exercise 2: Planning your practice task (page 85)

Note down how you plan to organise the 20 minutes practice time (e.g. *I'll start the exercise at 7pm when Jack is to start getting ready for bed. This will give me a chance to give 4 or 5 clear, direct instructions).*

_____

_____

_____

_____

Exercise 3: Keeping track of what you do (page 85)

During the practice task try to keep a record of when you are meeting your goals. You may find it helpful to use the Practice Task checklist and the checklists on the following pages to remind yourself of the steps to follow when dealing with some common problem behaviours. You can also refer to them after the practice task to see how well you went. These checklists can help you work out which steps you follow well and any steps you many have forgotten or need to practise. This can help you set goals for change. You can also use the checklists at other times if any of these problem behaviours occur. Extra copies of these checklists are included in the Appendix section.

PRACTICE TASK CHECKLIST

Note down your goals for the practice task. Be as specific as possible. Use the table below to record whether you reached your goals. Comment on what went well and list any problems that occurred.

GOAL 1:

_____

_____

GOAL 2:

_____

_____

GOAL 3:

_____

_____

	GOAL ACHIEVED? Y/N	COMMENTS
GOAL 1		
GOAL 2		
GOAL 3		

CHECKLIST FOR MANAGING INTERRUPTING

Instructions: Whenever interrupting parents' conversations or activity occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1. Gain your child's attention.					
2. Tell your child what to stop doing and what to do instead – *Stop interrupting. Say "Excuse me" and wait until I am free.*					
3. If your child does as you ask, when there is a break in your activity, praise them for waiting and give them your attention.					
4. If your child does not do as you have asked, tell them what they have done wrong – *You are interrupting* – and the consequence – *Now go to quiet time*. If necessary, take them to quiet time. Do not argue or debate the point.					
5. If your child does not sit quietly in quiet time, tell them what they have done wrong – *You are not being quiet in quiet time* – and the consequence – *Now you must go to time-out.* Take them straight to time-out.					
6. When your child has been quiet for the set time in quiet time or time-out, set them up in an activity.					
7. As soon as possible, praise your child for behaving well.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

CHECKLIST FOR MANAGING FIGHTING OR NOT SHARING

Instructions: Whenever fighting or not sharing or taking turns with other children occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1. Gain your child's attention.					
2. Tell your child what to stop doing and what to do instead – *Stop fighting over the game. Take turns please*					
3. Praise the children if they do as you ask.					
4. If the problem continues, tell your child what they have done wrong and the logical consequence – *You are not taking turns, I'm putting the game away for 5 minutes.* Do not argue or debate the point.					
5. If your child protests or complains, use planned ignoring.					
6. When the time is up, return the activity.					
7. As soon as possible, praise the children for sharing and taking turns.					
8. If the problem happens again, repeat the logical consequence for a longer period or use quiet time.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

CHECKLIST FOR MANAGING AGGRESSION

Instructions: Whenever aggression occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1. Gain your child's attention.					
2. Tell your child what to stop doing and what to do instead – *Stop hitting. Keep your hands to yourself.*					
3. Praise your child if they do as you ask.					
4. If your child does not do as you have asked, tell them what they have done wrong – *You are still hitting* – and the consequence – *Now go to quiet time.* If necessary, take them to quiet time. Do not argue or debate the point.					
5. If your child does not sit quietly in quiet time, tell them what they have done wrong – *You are not being quiet in quiet time* – and the consequence – *Now you must go to time-out.* Take them straight to time-out.					
6. When your child has been quiet for the set time in quiet time or time-out, set them up in an activity.					
7. As soon as possible, praise your child for behaving well.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

CHECKLIST FOR MANAGING TEMPER OUTBURSTS

Instructions: Whenever temper outbursts (e.g. screaming, crying or stamping feet) occur, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
EITHER A) Use planned ignoring for toddlers under 2 years old **OR** B) Gain your child's attention as best you can and follow the steps below:					
1. Tell your child what to stop doing and what to do instead – *Stop screaming right now. Use a nice voice.*					
2. Praise your child if they do as you ask.					
3. If your child does not do as you have asked, tell them what they have done wrong – *You have not done as I asked* – and the consequence – *Now go to time-out.* If necessary, take them to quiet time. Do not argue or debate the point.					
4. When your child has been quiet for the set time in time-out, set them up in an activity.					
5. As soon as possible, praise your child for behaving well.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

CHECKLIST FOR MANAGING WHINING

Instructions: Whenever whining for something occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1. Gain your child's attention.					
2. Tell your child what to stop doing and what to do instead – *Stop whining for a piece of cake. Please ask nicely.*					
3. Praise your child if they do as you ask.					
4. If your child does not do as you have asked, tell them what they have done wrong – *You have not asked nicely* and the logical consequence – *The cake goes away for 10 minutes. Try again then.* Do not argue or debate the point.					
5. If your child protests or complains, use planned ignoring.					
6. When the time is up, if your child has stopped whining, praise them for being quiet and give them an opportunity ask nicely for what they want.					
7. If your child asks nicely, praise them for asking nicely and respond to their request.					
8. If the problem happens again, repeat the logical consequence for a longer period or use quiet time.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

EXERCISE 4: Reviewing the practice task (page 92)

What do you feel you did well during the practice task? Aim to identify at least two things that you did well *(e.g. I stayed calm and gave clear, direct instruction, used descriptive praise when Jack followed instructions and told him why he needed to go to quiet time when he didn't follow instructions)*. Refer to your goals listed in Exercise 1. Which goals did you achieve?

What do you feel you could have done differently to improve on this practice task? Be specific and think of one or two things you would do differently if you repeated this practice task *(e.g. I need to stop repeating my instructions several times and follow through with a consequence after I have given an instruction 2 times, and I need to follow through with my plan rather than debating or arguing the point).* Think about the goals you set in Exercise 1. Was there a goal that you did not reach?

You may like to use the space below to make notes about any other issues that arose during the practice task.

SUMMARY OF ACTIVITIES – Practice Exercises (page 93)

Make a note of the skills you would like to practise for the remainder of this week. Be specific and relate your goals to the areas you identified in your practice task *(e.g. Only give an instruction 2 times before backing up with a consequence and follow through with consequences rather than arguing or debating the point with Jack).*

_____
_____
_____
_____
_____
_____
_____
_____

You may like to review Part 3 and 4 of the 'Every Parent's Survival Guide' DVD!

Week 5: Evaluation Questions

1. What is the most important thing you learnt from the **reading** for this week?
   .....
   .....
   .....

   Did you watch the **DVD** segment for this week? YES/NO
2. What is the most important thing you learnt from the **DVD** for this week?
   .....
   .....
   .....

Circle the number that represents how you feel:

This component provided useful skills for understanding and/or managing my child's behaviour.

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I agree the ideas in this component are important

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I am going to use the skills/techniques suggested e.g. monitoring forms

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed reading this section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed watching this DVD section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I thought watching this DVD section of the programme was helpful

Not at all Very much

0 1 3 4 5 6 7 8 9 10

Week 6: Using Positive Parenting Strategies 3

Reading, Exercises & Activities

Exercise 1: Setting up a practice session (page 96)

Identify a time when you will be able to have a 20minute practice session.

Day..... Date..... Time.....

List your goals for the first practice session.

_____

_____

_____

Exercise 2: Planning your practice task (page 97)

Note down how you plan to organise the 20 minutes practice time (e.g. *between 5pm and 5.30pm is a good time as the children have difficulty playing nicely with one another and keeping themselves entertained in this late afternoon period. I will be busy preparing dinner and the children will also need to do their chores)*.

_____

_____

_____

_____

Exercise 3: Keeping track of what you do (page 97)

During the practice task try to keep a record of when you are meeting your goals. You may find it helpful to use the Practice Task Checklist and the checklists on the following pages to remind yourself of the steps to follow when dealing with some common problem behaviours. You can also refer to them after the practice task to see how well you went. These checklists can help you work out which steps you follow well and any steps you many have forgotten or need to practise. This can help you set goals for change. You can also use the checklists at other times if any of these problem behaviours occur. Extra copies of these checklists are included in the Appendix section.

PRACTICE TASK CHECKLIST

Note down your goals for the practice task. Be as specific as possible. Use the table below to record whether you reached your goals. Comment on what went well and list any problems that occurred.

GOAL 1:

_____

_____

GOAL 2:

_____

_____

GOAL 3:

_____

_____

	GOAL ACHIEVED? Y/N	COMMENTS
GOAL 1		
GOAL 2		
GOAL 3		

CHECKLIST FOR MANAGING INTERRUPTING

Instructions: Whenever interrupting parents' conversations or activity occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1. Gain your child's attention.					
2. Tell your child what to stop doing and what to do instead – *Stop interrupting. Say "Excuse me" and wait until I am free.*					
3. If your child does as you ask, when there is a break in your activity, praise them for waiting and give them your attention.					
4. If your child does not do as you have asked, tell them what they have done wrong – *You are interrupting* – and the consequence – *Now go to quiet time*. If necessary, take them to quiet time. Do not argue or debate the point.					
5. If your child does not sit quietly in quiet time, tell them what they have done wrong – *You are not being quiet in quiet time* – and the consequence – *Now you must go to time-out.* Take them straight to time-out.					
6. When your child has been quiet for the set time in quiet time or time-out, set them up in an activity.					
7. As soon as possible, praise your child for behaving well.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

CHECKLIST FOR MANAGING FIGHTING OR NOT SHARING

Instructions: Whenever fighting or not sharing or taking turns with other children occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1. Gain your child's attention.					
2. Tell your child what to stop doing and what to do instead – *Stop fighting over the game. Take turns please*					
3. Praise the children if they do as you ask.					
4. If the problem continues, tell your child what they have done wrong and the logical consequence – *You are not taking turns, I'm putting the game away for 5 minutes.* Do not argue or debate the point.					
5. If your child protests or complains, use planned ignoring.					
6. When the time is up, return the activity.					
7. As soon as possible, praise the children for sharing and taking turns.					
8. If the problem happens again, repeat the logical consequence for a longer period or use quiet time.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

CHECKLIST FOR MANAGING AGGRESSION

Instructions: Whenever aggression occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1. Gain your child's attention.					
2. Tell your child what to stop doing and what to do instead – *Stop hitting. Keep your hands to yourself.*					
3. Praise your child if they do as you ask.					
4. If your child does not do as you have asked, tell them what they have done wrong – *You are still hitting* – and the consequence – *Now go to quiet time.* If necessary, take them to quiet time. Do not argue or debate the point.					
5. If your child does not sit quietly in quiet time, tell them what they have done wrong – *You are not being quiet in quiet time* – and the consequence – *Now you must go to time-out.* Take them straight to time-out.					
6. When your child has been quiet for the set time in quiet time or time-out, set them up in an activity.					
7. As soon as possible, praise your child for behaving well.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

CHECKLIST FOR MANAGING TEMPER OUTBURSTS

Instructions: Whenever temper outbursts (e.g. screaming, crying or stamping feet) occur, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
EITHER A) Use planned ignoring for toddlers under 2 years old **OR** B) Gain your child's attention as best you can and follow the steps below:					
1. Tell your child what to stop doing and what to do instead – *Stop screaming right now. Use a nice voice.*					
2. Praise your child if they do as you ask.					
3. If your child does not do as you have asked, tell them what they have done wrong – *You have not done as I asked* – and the consequence – *Now go to time-out.* If necessary, take them to quiet time. Do not argue or debate the point.					
4. When your child has been quiet for the set time in time-out, set them up in an activity.					
5. As soon as possible, praise your child for behaving well.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

CHECKLIST FOR MANAGING WHINING

Instructions: Whenever whining for something occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1. Gain your child's attention.					
2. Tell your child what to stop doing and what to do instead – *Stop whining for a piece of cake. Please ask nicely.*					
3. Praise your child if they do as you ask.					
4. If your child does not do as you have asked, tell them what they have done wrong – *You have not asked nicely* and the logical consequence – *The cake goes away for 10 minutes. Try again then.* Do not argue or debate the point.					
5. If your child protests or complains, use planned ignoring.					
6. When the time is up, if your child has stopped whining, praise them for being quiet and give them an opportunity ask nicely for what they want.					
7. If your child asks nicely, praise them for asking nicely and respond to their request.					
8. If the problem happens again, repeat the logical consequence for a longer period or use quiet time.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

EXERCISE 4: Reviewing the practice task (page 104)

What do you feel you did well during the practice task? Aim to identify at least two things that you did well *(e.g. I stayed calm and gave clear, direct instructions, I used descriptive praise when Jack and harry cooperated with instructions, and I only gave an instruction twice before backing it up with the consequence).* Refer to your goals listed in Exercise 1. Which goals did you achieve?

What do you feel you could have done differently to improve on this practice task? Be specific and think of one or two things you would do differently if you repeated this practice task *(e.g. I need to work on the timing of my instructions so that the boys have finished their activity or chore before I give an instruction).* Think about the goals you set in Exercise 1. Was there a goal that you did not reach?

You may like to use the space below to make notes about any other issues that arose during the practice task.

SUMMARY OF ACTIVITIES – Practice Exercises (page 105)

Make a note of the skills you would like to practise for the remainder of this week. Be specific and relate your goals to the areas you identified in your practice task *(e.g. Wait until the children have finished their activity before giving them an instruction).*

_____
_____
_____
_____
_____
_____
_____
_____

You may like to review part 3 and 4 of the 'Every Parent's Survival Guide' DVD!

Week 6: Evaluation Questions

1. What is the most important thing you learnt from the **reading** for this week?
   .....
   .....
   .....

   Did you watch the **DVD** segment for this week? YES/NO
2. What is the most important thing you learnt from the **DVD** for this week?
   .....
   .....
   .....

Circle the number that represents how you feel:

This component provided useful skills for understanding and/or managing my child's behaviour.

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I agree the ideas in this component are important

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I am going to use the skills/techniques suggested e.g. monitoring forms

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed reading this section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed watching this DVD section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I thought watching this DVD section of the programme was helpful

Not at all Very much

0 1 3 4 5 6 7 8 9 10

Week 7: Planning Ahead

Reading, Exercises & Activities

Exercise 1: Taking care of yourself (page 108)

Who do you rely on for support?

Family_____

Friends_____

Think about one person you could talk to or telephone at least once a week.

_____

What can you do to increase your support if needed?

_____

Make a note of things you like to do (on your own or with your partner or friends).

_____

_____

_____

Think about when you can have a break over the next week and who you can call on for child minding.

_____

_____

Exercise 2: Identifying high-risk parenting situations (page 110)

Think of situations which are high-risk for you. Tick those home and community situations listed below what can be high-risk times for your family. Fate how confident you are in deal8ing with your child's behaviour in each situation. Rate your confidence from 1 (not at all confident) to 10 (extremely confident).

HOME SITUATIONS	☑	**0-10 Rating**
• Waking, getting out of bed	☐	☐
• Getting dressed	☐	☐
• Eating breakfast, lunch or dinner	☐	☐
• Using the bathroom or toilet	☐	☐
• When you are busy doing chores	☐	☐
• Getting ready to go out (e.g. kindy)	☐	☐
• When visitors arrive	☐	☐
• Playing indoors or outdoors	☐	☐
• Watching television	☐	☐
• When you are on the telephone	☐	☐
• While you are preparing meals	☐	☐
• When siblings come home from school	☐	☐
• When a parent/caregiver comes home from work	☐	☐
• Undressing/getting ready for bed	☐	☐
• Bedtime	☐	☐
• _____	☐	☐
• _____	☐	☐
• _____	☐	☐

COMMUNITY SITUATIONS		
• Visiting friends or relatives	☐	☐
• Going on family outings (e.g. beach)	☐	☐
• Birthday/Christmas parties	☐	☐
• Weddings/ceremonies/funerals	☐	☐
• Annual holidays	☐	☐
• Dinner engagements	☐	☐
• Visiting the doctor/dentist	☐	☐
• Travelling in the car	☐	☐
• Travelling on public transport	☐	☐
• Shopping at the supermarket	☐	☐
• Going to the local shops	☐	☐
• Going to the bank	☐	☐
• Leaving your child at day care/Kohanga Reo	☐	☐
• Leaving your child with baby-sitters (or other carers)	☐	☐
• _____	☐	☐
• _____	☐	☐
• _____	☐	☐

Exercise 3: Developing a planned activities routine (page 113)

Now you have the chance to design you own planned activities routine. Work through one of the high risk situations you indicated in Exercise 2.

Identify the high-risk situation

_____

Specify details for a practise session (when, where, who should be present)

_____

List any advance planning or preparation

_____

_____

_____

Decide on rules

_____

_____

_____

Select engaging activities

_____

_____

_____

List rewards for appropriate behaviour

_____

_____

_____

List consequences for misbehaviour

_____

_____

_____

Note any goals from the follow-up discussion

SUMMARY OF ACTIVITIES – Practice Exercises (page 115)
Choose 2 of your own high-risk situations and develop planned activities routines for each of them. Try out your new routine for each situation at least once in the coming week. Use the Planned activities Routine forms and two monitoring forms from the appendix. To complete these forms, write down the steps of your routine and then note whether or not you completed it in the high-risk situation. Write down 2 high-risk situations you plan to try out this week.

Identify the high-risk situation

Specify details for a practise session (when, where, who should be present)

List any advance planning or preparation

Decide on rules

Select engaging activities

List rewards for appropriate behaviour

List consequences for misbehaviour

Note any goals from the follow-up discussion

PLANNED ACTIVITIES ROUTINE

Identify the high-risk situation

Specify details for a practise session (when, where, who should be present)

List any advance planning or preparation

Decide on rules

Select engaging activities

List rewards for appropriate behaviour

List consequences for misbehaviour

Note any goals from the follow-up discussion

PLANNED ACTIVITIES CHECKLIST

*Situation:*_____

Instructions: Whenever whining for something occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1.					
2.					
3.					
4.					
5.					
6.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

PLANNED ACTIVITIES CHECKLIST

*Situation:*_____

Instructions: Whenever whining for something occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1.					
2.					
3.					
4.					
5.					
6.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

Week 7: Evaluation Questions

1. What is the most important thing you learnt from the **reading** for this week?
   .....
   .....
   .....

2. Did you watch any of the **DVD** segments this week? YES/NO
   What did you learn from the **DVD** section that you watched?
   .....
   .....
   .....

Circle the number that represents how you feel:

This component provided useful skills for understanding and/or managing my child's behaviour.

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I agree the ideas in this component are important

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I am going to use the skills/techniques suggested e.g. monitoring forms

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed reading this section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed watching this DVD section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I thought watching this DVD section of the programme was helpful

Not at all Very much

0 1 3 4 5 6 7 8 9 10

Week 8: Using Planned Activities Routines 1

Reading, Exercises & Activities

Exercise 1: Reviewing your use of planned activities routines (page 122)
What were your practice exercises from last week?

What worked? Please be specific and think of at least 2 positive points. It may be helpful to look at your Planned Activities Checklist/s.

Is there anything that you could have done differently? You may notice some steps on your Planned Activities Checklist/s that you missed or could improve.

Exercise 2: Developing more planned activities routines (page 122)
Design another 1 or 2 planned activities routines for high-risk situations you indicated on the checklist.

PLANNED ACTIVITIES ROUTINE

Identify the high-risk situation

Specify details for a practise session (when, where, who should be present)

List any advance planning or preparation

Decide on rules

Select engaging activities

List rewards for appropriate behaviour

List consequences for misbehaviour

Note any goals from the follow-up discussion

PLANNED ACTIVITIES ROUTINE

Identify the high-risk situation

Specify details for a practise session (when, where, who should be present)

List any advance planning or preparation

Decide on rules

Select engaging activities

List rewards for appropriate behaviour

List consequences for misbehaviour

Note any goals from the follow-up discussion

SUMMARY OF ACTIVITIES – Practice Exercises (page 125)

List the main points that came up this week that require follow-up by you.

_____

_____

_____

Try out the planned activities routine/s that you have just developed at least once in the coming week. An additional copy of this form is included in the Appendix.

PLANNED ACTIVITIES CHECKLIST

*Situation:*_____

Instructions: Whenever whining for something occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1.					
2.					
3.					
4.					
5.					
6.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

PLANNED ACTIVITIES CHECKLIST

*Situation:*_____

Instructions: Whenever whining for something occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1.					
2.					
3.					
4.					
5.					
6.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

Week 8: Evaluation Questions

1. What is the most important thing you learnt from the **reading** for this week?
   .....
   .....
   .....

2. Did you watch any of the **DVD** segments this week? YES/NO
   What did you learn from the **DVD** section that you watched?
   .....
   .....
   .....

Circle the number that represents how you feel:

This component provided useful skills for understanding and/or managing my child's behaviour.

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I agree the ideas in this component are important

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I am going to use the skills/techniques suggested e.g. monitoring forms

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed reading this section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed watching this DVD section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I thought watching this DVD section of the programme was helpful

Not at all Very much

0 1 3 4 5 6 7 8 9 10

Week 9: Using Planned Activities Routines 2

Reading, Exercises & Activities

Exercise 1: Reviewing your use of planned activities routines (page 130)
What were your practice exercises from last week?

What worked? Please be specific and think of at least 2 positive points. It may be helpful to look at your *Planned Activities Checklist/s.*

Is there anything that you could have done differently? You may notice some steps on your *Planned Activities Checklist/s* that you missed or could improve.

Exercise 2: Developing more planned activities routines (page 130)
Design another 1 or 2 planned activities routines for high-risk situations you indicated on the checklist.

PLANNED ACTIVITIES ROUTINE

Identify the high-risk situation

Specify details for a practise session (when, where, who should be present)

List any advance planning or preparation

Decide on rules

Select engaging activities

List rewards for appropriate behaviour

List consequences for misbehaviour

Note any goals from the follow-up discussion

PLANNED ACTIVITIES ROUTINE

Identify the high-risk situation

Specify details for a practise session (when, where, who should be present)

List any advance planning or preparation

Decide on rules

Select engaging activities

List rewards for appropriate behaviour

List consequences for misbehaviour

Note any goals from the follow-up discussion

SUMMARY OF ACTIVITIES – Practice Exercises (page 133)

List the main points that came up this week that require follow-up by you.

_____

_____

_____

- Try out the planned activities routine/s that you have just developed at least once in the coming week. An additional copy of this form is included in the Appendix.
- Monitor the same behaviour you began monitoring in week 1. This will help you see what changes have happened in your child's behaviour since you began the program.

PLANNED ACTIVITIES CHECKLIST

*Situation:*_____

Instructions: Whenever whining for something occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1.					
2.					
3.					
4.					
5.					
6.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

PLANNED ACTIVITIES CHECKLIST

*Situation:*_____

Instructions: Whenever whining for something occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1.					
2.					
3.					
4.					
5.					
6.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

Week 9: Evaluation Questions

1. What is the most important thing you learnt from the **reading** for this week?
   .....
   .....
   .....

2. Did you watch any of the **DVD** segments this week? YES/NO
   What did you learn from the **DVD** section that you watched?
   .....
   .....
   .....

Circle the number that represents how you feel:

This component provided useful skills for understanding and/or managing my child's behaviour.

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I agree the ideas in this component are important

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I am going to use the skills/techniques suggested e.g. monitoring forms

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed reading this section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed watching this DVD section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I thought watching this DVD section of the programme was helpful

Not at all Very much

0 1 3 4 5 6 7 8 9 10

Week 10: Program Close

Reading, Exercises & Activities

Exercise 1: Reviewing your use of planned activities routines (page 138)
What were your practice exercises from last week?

_____
_____
_____
_____

What worked? Please be specific and think of at least 2 positive points. It may be helpful to look at your *Planned Activities Checklist/s.*

_____
_____
_____
_____

Is there anything that you could have done differently? You may notice some steps on your *Planned Activities Checklist/s* that you missed or could improve.

_____
_____
_____
_____

Exercise 2: Identifying changes that have been made (page 140)
Take a few minutes to complete the table below, outlining the changes that both you and your child have made since commencing the program. It may be helpful to look back at your goals from week 1.

CHANGES IN YOUR CHILD'S BEHAVIOUR	CHANGES IN YOUR OWN BEHAVIOUR

Exercise 3: Planning for future high-risk situations (page 144)
Spend a few minutes planning possible solutions to these situations. What would you do if....

Your 8year old has been in trouble the last 3 weekends at soccer matches for yelling at this team mates and for kicking the ball into the spectators if he misses a goal or causes a penalty. You are worried he will be removed from the team if his temper outbursts continue.

Your 11 year old is being bullied at school. Two children have started to call her names and exclude her from their games. She is coming home after school in tears and complains of feeling sick before school each day. She is also starting to call herself names (such as *Stupid* and *Ugly*) and saying she's not good at doing anything.

The summer holidays start in 3 weeks time. You will have your 3 school-age children home with you each day for the next 7 weeks and you expect family squabbles and complaints of being bored.

Exercise 5: Independent problem solving (page 145)
Devise a routine for dealing with one of the potential high-risk situations you have just identified.

PLANNED ACTIVITIES CHECKLIST

*Situation:*_____

Instructions: Whenever whining for something occurs, record Yes, No or NA (Not Applicable) for each of the steps below.

	DAY				
STEPS TO FOLLOW	**STEPS COMPLETED**				
1.					
2.					
3.					
4.					
5.					
6.					
NUMBER OF STEPS COMPLETED CORRECTLY:					

Exercise 6: Identifying future goals (page 147)
What further improvements would you like to see in your child's and your own behaviour? Remember to state your goals specifically (e.g. less talking back).

_____
_____
_____
_____

How could you achieve these goals? Think about the practice exercises you could set yourself to achieve the goals stated above.

_____
_____
_____
_____

SUMMARY OF ACTIVITIES – Practice Exercises (page 147)

- Continue to practise positive parenting strategies
- Continue to develop and implement planned activities routines for high-risk situations
- Write down your goals for the coming week.

_____
_____
_____
_____

List any material you feel you need to review this week.

_____
_____
_____
_____

Congratulations

You have now completed Every Parent's self-help workbook. Congratulations on staying motivated and interested throughout the program!

Week 10: Evaluation Questions

1. What is the most important thing you learnt from the **reading** for this week?
   .....
   .....
   .....

2. Did you watch any of the **DVD** segments this week? YES/NO
   What did you learn from the **DVD** section that you watched?
   .....
   .....
   .....

Circle the number that represents how you feel:

This component provided useful skills for understanding and/or managing my child's behaviour.

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I agree the ideas in this component are important

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I am going to use the skills/techniques suggested e.g. monitoring forms

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed reading this section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I enjoyed watching this DVD section of the programme

Not at all Very much

0 1 3 4 5 6 7 8 9 10

I thought watching this DVD section of the programme was helpful

Not at all Very much

0 1 3 4 5 6 7 8 9 10

THANK YOU – You have succeeded in finishing the program!