

# Self-Directed Behavioral Family Intervention: Do Therapists Matter?

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**ABSTRACT.** Behavioral family intervention is an effective form of intervention for the prevention and treatment of a wide range of emotional and behavioral problems in children. There is a growing need to address the accessibility of these services. This paper reviews the literature on self-directed interventions designed to help parents manage difficult child behaviors. Evidence regarding the efficacy of interventions is reviewed, and some of the difficulties associated with self-directed programs are discussed. The Self-directed Triple P and Teen Triple P—Positive Parenting Programs are highlighted as examples of efficacious and effective behavioral family interventions fitting into a larger multi-level model of family intervention. The discussion of the efficacy and effectiveness of self-directed Triple P has implications for service delivery of parenting programs. [*Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2005 by The Haworth Press, Inc. All rights reserved.*]

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Parenting interventions attempt to enhance a parent's understanding of child behavior management and the quality of the parent-child interactions, with the ultimate goal of optimising the child's developmental course (Cowan, Powell, & Cowan, 1998). When parents are taught to use consistent, moderate, and firm discipline, their children exhibit fewer behavior problems (Arnold & O'Leary, 1997; Forehand, Wells, & Griest, 1980; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988).

The purpose of this article is to examine the research focusing on the efficacy of self-directed parenting interventions for children, particularly examining the evidence for the efficacy of self-directed interventions alone, versus ones involving therapist assistance and support. A range of programs is currently available; however, empirically validated programs are in short supply, particularly ones available to the community. Cowan et al. (1998) suggested that while there are plenty of opportunities for parenting advice in books and magazines for low risk families, these are largely not backed by evidence of effectiveness. On the other hand, for high-risk families, interventions need to go beyond parenting skills and address issues of poverty, feelings of incompetence, and troubled relationships with others or institutions.

### BEHAVIORAL FAMILY INTERVENTION

Parents can be trained to use more effective parenting skills (Kendziora & O'Leary, 1993; Webster-Stratton, 1993). Behavioral family interventions (BFI) aim to effect change in children's behavior and adjustment by modifying aspects of the family environment that maintain and reinforce a child's problem behaviors (Sanders, 1992). BFI has well documented efficacy, is relatively inexpensive, and is generally considerably briefer than traditional child psychotherapy (Serkettich & Dumas, 1996).

There is substantial evidence that BFI, particularly therapist-directed BFI, produces significant changes in both parents and children immediately following treatment (Forehand, Griest, & Wells, 1979) and there is good maintenance of treatment gains and generalisation of these skills (Dadds, Sanders, & James, 1983; Forehand & Long, 1988). There is also evidence for the generalisation of intervention effects beyond the

specific behaviors and settings addressed during treatment (Sanders & Glynn, 1981; Serkettich & Dumas, 1996). Furthermore, BFI has effects ranging beyond improvements in child behavior. Effects have been shown for decreases in parental depression (Connell, Sanders, & Markie-Dadds, 1997; Forehand et al., 1980), anxiety, and stress (Connell et al., 1997). Finally, in general, parents report high levels of satisfaction with behavioral family interventions and find the programs socially acceptable (Forehand et al., 1980; McMahon & Forehand, 1983; Webster-Stratton, 1989).

While there is significant evidence to support the efficacy of BFI, there are a number of factors that limit its dissemination at a community level. Firstly, very few parents participate in any form of parent education (Sanders et al., 1999) and there is generally low participation by parents of children who have significant behavior problems (Zubrick et al., 1995) or whose children are believed to be at greatest risk of developing serious behavior or emotional problems (Harachi, Catalano, & Hawkins, 1997). In Australia, while approximately 18% of children experience an identifiable mental health problem, only 2% of these children receive any form of treatment from specialist mental health practitioners (Zubrick & Silbern, 1994) and only 10% of parents participate in parenting education (Sanders et al., 1999). Secondly, there is a range of psychological and cultural implications to seeking help, with great stigma attached to perceived difficulties with coping (Cunningham, 1996). The logistics of attending sessions, either individual or group, such as work schedules, extracurricular activities, difficulties arranging childcare, travel time, and transport costs may prevent many parents from participating in interventions (Cunningham, 1996; Pavuluri, Luk, & McGee, 1996; Spoth, Redmond, Hockaday, & Shin, 1996). Finally, families may simply live in areas where there are no services, such as rural and remote regions. For these families, accessing services is very difficult, if not impossible. Indeed, research indicates that children from low-income families or rural/remotely areas are less likely to receive psychological interventions (Hunsley, Aubry, & Lee, 1997), despite evidence of greater need for rural versus urban populations (Spoth & Redmond, 1996).

### SELF-DIRECTED INTERVENTIONS

The National Institute of Mental Health Psychosocial Intervention Development Workgroup recommended that non-traditional delivery

methods are needed to increase access to evidenced-based interventions to prevent the onset and recurrence of emotional problems in children (Hollon et al., 2002). Self-directed interventions have been proposed as one effective way for addressing some of the limitations and access problems identified for traditional BFI and for increasing the reach of services (Sanders, 2000). Such interventions overcome many of the barriers associated with accessing face-to-face services, as there is lowered stigma and significantly reduced or eliminated cost, transport requirements, and timing difficulties. Families can complete self-directed programs in their own homes, in their own time, and at their own pace. Furthermore, self-administered interventions are often very cost-effective and their use can ease the financial burden of mental health on the community.

Self-administered interventions have also been proposed as forming part of a stepped-care approach, where they are used as the most basic and least intrusive level possible. It may be efficient to screen individuals and on the basis of a number of factors, assign them to either more intensive treatment or to a self-directed intervention. Clients could be offered a self-directed intervention, followed by more intensive intervention if required, allowing the clinician to build on skills and knowledge which have been acquired through the self-directed intervention (Sanders, Montgomery, & Brechman-Touissant, 2000; Webster-Stratton, 1992).

There is a range of self-help materials available and they are highly acceptable means of gaining information and accessing services. There are thousands of self-help books on various topics available and increasingly, people are turning to the Internet for information and psychotherapy (Rabasca, 2000). Self-help materials constitute a major source of information and education in health care (Starker, 1990). Various types of self-help materials are used as adjuncts to therapy (Adams & Pitre, 2000; Campbell & Smith, 2003; Pardeck, 1991; Starker, 1988). In general, it has been suggested that self-directed programs that incorporate multimedia such as telephone calls, computers, audio or videotapes, as well as some level of therapist contact, are more effective than self-help materials alone (Mains & Scogin, 2003; Marrs, 1995). However, what much of the available self-help materials have in common is a lack of empirical support to provide evidence for their effectiveness (Ellis, 1993), and the statement by Anchor and Thomason (1977) that "with alarming frequency, authors of best-selling books are successful in circumventing the process of professional, scientific evaluation by

offering untried techniques directly to the consumer" (p. 135) remains true today.

There is limited research in the family intervention field focusing on self-directed interventions. Self-directed interventions have been used to target both specific problem behaviors, as well as more broad behavioral difficulties. For example, self-directed interventions have been successful in improving child compliance (Gmeinder & Kratochwill, 1998; Sloane, Endo, Hawkes, & Jenson, 1990), in reducing child tantrums (Endo, Sloane, Hawkes, McLoughlin, & Jenson, 1991), in reducing child sleep problems (Seymour, Brock, Doring, & Poole, 1989), providing better outcomes in the treatment of ADHD (Long, Rickert, & Ashcraft, 1993), treating nocturnal enuresis (van Londen, van Londen-Barensten, van Son, & Mulder, 1993), and delaying adolescent smoking onset (Bauman et al., 2001).

The broader self-directed interventions focus on parents developing skills to monitor and mediate ineffective parenting techniques, determine their own goals and performance standards, and identify actions they can take to produce change in their child's behavior. The work of Webster-Stratton and colleagues demonstrates an approach to examining self-directed programs with parents of young children. For example, Webster-Stratton, Kolpacoff, and Hollinsworth (1988) compared individually administered video modelling (IVM), to group discussion video modelling (GDVM), to group discussion (GD) and a wait-list control, for 114 multi-problem families. Parents in the IVM group attended a clinic on a weekly basis, where they watched successive parenting video segments and completed relevant assignments. All three treatment groups reported improvements in children's behavior on parent-report measures of child behavior, compared to the control group. While the GDVM group reported highest levels of improvement, IVM group outcomes were favorable, with lower drop-out compared to the GD group. The IVM intervention was very cost effective, requiring no therapist time, and a one-hour weekly commitment from the parents. Interestingly, the self-administered approach was found more effective when families accessed two brief consultations with a therapist during the course of the program (Webster-Stratton, 1990), suggesting that therapist involvement is an important element of therapeutic effectiveness.

Self-directed programs have also been found to have comparable effects to therapist directed programs. For example, Nicholson and Sanders (1999) compared therapist directed BFI to a self-directed BFI intervention for parents of 7 to 12-year-old children with significant oppositional or conduct problems. Both intervention conditions led to equivalent improvements,

compared to a wait-list control; however, there was more satisfaction with therapy in the therapist directed condition. Similarly, Sanders, Markie-Dadds, Tully, and Bor (2000) conducted a large scale clinical trial of 305 families with a 3-year-old child comparing two therapist-assisted versions of BFI and a self-directed BFI condition. Families completing any version of the program showed significant improvements on a variety of self-report and observational measures compared to a wait-list control group, however, there was more improvement in the therapist directed versions of the program, compared to the self-directed version. At one-year follow-up, families in the self-directed group continued to show improvements and were more comparable to the other two groups.

The empirical support for brief, self-directed interventions is hampered by methodological limitations. Most include some kind of practitioner support (e.g., Endo, Sloane, Hawkes, & Jensen, 1991; Hansen, Tisdelle, & O'Dell, 1984), small sample sizes (e.g., Connell et al., 1997; Gmeinder & Kratochwill, 1998; Hansen et al., 1984), an absence of control groups (e.g., Hunt & Adams, 1989), an absence of child behavior outcome measures (Flanagan, Adams, & Forehand, 1979; Hansen et al., 1984), and an absence of independent observations of child and parent behaviours (Connell et al., 1997). Furthermore, many practitioner assisted self-directed interventions have suffered from loosely structured treatment protocols (Bauman, 2001) and the absence of a self-regulatory framework (Lipkus et al., 2004).

In a review of self-administered treatments for children and families overall, Elgar and McGrath (2003) concluded that there is some evidence to support the use of self-administered interventions. However, more randomised controlled trials addressing various problem areas, long term effects, populations, and media need to be conducted. The authors emphasised the need to conduct effectiveness trials in naturalistic settings, in order to promote integration of programs into health care settings. Furthermore, they recommended that the role of therapist assistance in self-administered treatments needs to be clarified. The research to-date has not clarified the role of therapist involvement in self-directed interventions. While some studies have found that self-directed interventions are equivalent to therapist-directed intervention (Nicholson & Sanders, 1999; Sanders, Markie-Dadds et al., 2000), there is also evidence that therapist assistance enhances interventions effects (Webster-Stratton, 1990). One way in which therapist involvement may be influential is in promoting parents' self-regulatory skills, as well as motivating parents to implement new parenting strategies.

## SELF-REGULATION

Self-regulation is a central skill, and the ability to self-regulate has significant advantages for individuals over their lifetimes. It is a complex and multi-faceted concept (Baumeister & Heatherston, 1996) that refers to processes that enable an individual to guide his/her goal-directed activities. Carver and Scheier (1981; 1982) described a feedback model of self-regulation, whereby self-regulation involves three main concepts: standards (or goals), monitoring (or comparing current state to the standards), and operation (or acting on any discrepancy between current state and standards). Regulation involves modulation of thought, affect, behavior or attention and encompasses several different phases, including: (1) goal selection; (2) goal cognition; (3) directional maintenance; (4) directional change of reprioritisation; and (5) goal termination (Karoly, 1993).

Self-regulation is particularly relevant in the therapeutic context. Individuals generally access support when they are motivated to change some aspect of their functioning or environment, that is, there is a discrepancy between their goals or standards and their current state of functioning. In the therapeutic context self-regulatory skills are viewed as the key to successful implementation and generalisation of skills learned, without the need for ongoing practitioner support (Sanders, 1999). In this context, self-regulation is a process whereby individuals are taught skills to modify their own behavior. Thus, it is emphasised in the literature that interventions need to focus on enhancing individual levels of self-efficacy (Bandura, 1989) and self-regulatory skills (Baumeister & Heatherston, 1996; Sanders, 1999), in order to achieve long-term change. In particular, self-directed programs can enhance self-regulatory skills, leading to maintenance and generalisation of treatment gains.

## TRIPLE P-POSITIVE PARENTING PROGRAM

Triple P is an example of an empirically supported BFI (e.g., Sanders, Markie-Dadds et al., 2000), which was developed at the University of Queensland and has a considerable history of research and clinical application. It is a program that emphasises parental self-regulation as a means of achieving long-term change in child behaviour.

Triple P is a multi-level preventively oriented parenting and family support strategy. It aims to prevent behavioral, emotional and develop-

mental problems in children by enhancing the knowledge, skills, and confidence of parents. Triple P incorporates five levels of intervention on a tiered continuum of strength. Table 1 provides an overview of the levels of intervention encompassed by Triple P. In essence, Triple P is a behavioural family intervention based on social learning principles aiming to: (a) enhance the knowledge, skills, confidence, self-sufficiency and resourcefulness of parents; (b) promote more nurturing, safe, engaging, non-violent and low conflict environments for children, and; (c) promote children's social, emotional, language, intellectual and behavioural competencies through positive parenting practices (Sanders, 1999). The distinguishing features of Triple P are program sufficiency, flexible tailoring to identified risk and protective factors, varied delivery modalities, wide potential reach, and a multidisciplinary approach.

### SELF-DIRECTED TRIPLE P

Several research projects have recently examined the technological aspects of self-directed intervention, within the context of Triple P. Specifically, the research has examined the role of therapist involvement in enhancing the efficacy of self-directed behavioral family interventions. Morawska and Sanders (2005a) have examined the role of therapist assistance in BFI with parents of toddlers. Connell et al. (1997) examined the role of therapist assistance in BFI with parents of preschoolers, while Stallman, Ralph, and Sanders (2005) examined the role of therapist assistance in BFI with parents of young adolescents. The combined research helps clarify the role of therapist involvement in self-directed interventions.

Connell et al. (1997) provided a self-directed BFI intervention to 24 parents of preschoolers in regional areas, which included a parent book and workbook, as well as weekly telephone consultations with a therapist. In addition to providing specific advice and support, the telephone consultations also served to promote responsibility for changing parents' own and their child's behaviour. The self-directed program was effective in reducing levels of disruptive child behavior, based on self-report measures and changes were maintained at four months follow-up. There were also improvements in mothers' parenting practices at post-intervention and follow-up and there was greater satisfaction and competence in parenting skills and lower levels of dysfunctional parenting practices, compared to a wait-list control. Finally, mothers in the self-directed group also reported lower levels of depression, anxiety

TABLE 1. The Triple P Model of Parenting and Family Support

Level of Intervention	Target Population	Intervention Methods	Practitioners
<b>Level 1</b>			
<i>Universal Triple P</i> Universal prevention strategy including media-based parenting information campaigns	All parents interested in information about parenting and promoting their child's development.	Coordinated media and health promotion issues and encouraging participation in parenting programs. May involve electronic and print media (e.g., community service announcements, talk-back radio, newspaper and magazine editorials).	Typically coordinated by area media liaison officers or mental health or welfare staff.
<b>Level 2</b>			
<i>Selected Triple P</i> Health promotion/brief selective prevention strategy	Parents interested in parenting education or with specific concerns about their child's development or behavior.	Health promotion information or specific advice for a discrete developmental issue or minor child behavior problem. May involve group seminars or brief (up to 20 minutes) telephone or face-to-face clinician contact.	Parent support during routine well-child health care (e.g., child and community health, education, allied health and childcare staff).
<b>Level 3</b>			
<i>Primary Care Triple P</i> Narrow focus parenting skills training	Parents with a specific concern/s about their child's behavior or development who require consultations or active skills training.	A brief program (about 80 minutes over 3-4 sessions) combining advice with rehearsal and self-evaluation as required to teach parents to manage a discrete child problem behavior. May involve face-to-face or telephone contact with a practitioner.	As above.
<b>Level 4</b>			
<i>Standard Triple P</i> <i>Group Triple P</i> <i>Self-Directed Triple P</i> Broad focus parenting skills training	Parents wanting intensive training in positive parenting skills. Typically targets with behavior problems such as aggressive or oppositional behavior.	A broad focus program (about 10 hours over 8-10 sessions) focusing on parent-child interaction and the application of parenting skills to a broad range of target behaviors. Includes generalisation enhancement strategies for transfer of skills across settings and children. Program variants include individual, group or self-directed (with or without telephone assistance) options.	Intensive parenting interventions (e.g., mental health and welfare staff and other allied health and education professionals who regularly consult with parents about child behavior).
<i>Stepping Stones Triple P</i> Broad focus parenting skills training targeting child disabilities.	Families of children with disabilities who have or are at risk of developing behavioral or emotional disorders.	A parallel 10-session individually tailored program with a focus on disabilities. Sessions typically last 60-90 minutes (with the exception of 3 home practice sessions which last 40 minutes).	As above.
<b>Level 5</b>			
<i>Enhanced Triple P</i> Behavioral family intervention	Parents of children with concurrent child behavior problems and family dysfunction such as parental depression or stress or conflict between partners.	An intensive individually tailored program for families with child behavior problems and family dysfunction. Program modules include practice sessions to enhance parenting skills, mood management and stress coping skills, partner support skills, and attribution retraining (for parents at risk of child maltreatment).	Intensive family intervention work (e.g., mental health and welfare staff).

and stress following the intervention compared to the control group. This study demonstrated the efficacy of a therapist-assisted self-directed approach, however, it did not provide information about the minimally sufficient level of intervention required for change. It also did not provide information about the importance or otherwise of the telephone consultations with parents.

In order to address this limitation, Morawska and Sanders (2005a) compared a self-directed BFI (SD-BFI) for parents of toddlers, to a telephone-assisted self-directed (TASD-BFI) version and a wait-list control. There were significant short- and long-term effects of the self-directed intervention in terms of child behavior problems and maternal parenting style, confidence and anger. However, while participants in the SD-BFI condition made similar statistical gains to the TASD-BFI condition, the TASD-BFI conditions led to clearly superior outcomes in clinical terms. Participants in the TASD-BFI condition changed more reliably and there was a significant shift away from the clinical range for this group. While participants in the SD-BFI also made some gains, these were not as clinically meaningful as those in the TASD-BFI condition. These effects were maintained over a period of six-months. Finally, parents in the TASD-BFI group were more satisfied with the program than those in the SD-BFI condition.

A unique aspect of this study was that using a stringent methodological approach, it demonstrated that self-administered interventions can provide significant benefits in terms of child behaviour and parenting confidence and skills. Furthermore, it was also demonstrated that a tiered effect was evident, where parents who received a small amount of clinical input were able to make more significant, clinically meaningful improvements. It is important to note that the clinician input in this study was relatively minimal. Telephone consultations lasted an average of approximately 10 minutes, and overall on average each participant in the TASD-BFI received just over an hour of clinical input over the course of the program. What makes this hour unique, is that it is designed to enhance parents' self-regulatory skills—that is, enable them to make their own changes and be able to generalise these changes over time and situations. Parents set the agenda for these sessions and they are guided to solve their difficulties or concerns using the resources that have been provided to them, rather than the clinician providing advice or solutions.

Stallman, Ralph, and Sanders (2005) examined the role of therapist assistance in BFI with parents of adolescents. They compared a self-directed BFI, Teen Triple P, with a telephone-assisted self-directed pro-

gram, and a waitlist control group, for parents of young adolescents (12-14 year-olds). Short-term treatment gains were found for both adolescent behavior and parenting style for parents in the telephone-assisted condition only and these gains were maintained at 3-month follow-up. The treatment effects reported in this study were confirmed by intent-to-treat analyses. Parents in the telephone-assisted group were significantly more satisfied across all areas of the program than parents in the standard group. Satisfaction, however, was mediated by the number of program modules completed. On average, parents in the telephone-assisted group completed significantly more program modules (8 of a total of 10) than the standard group (2 out of 10). This study highlights that brief telephone contact plays a valuable role in the effectiveness of a self-directed intervention and highlights an important area for further investigation. Therapist-assistance may contribute to positive outcomes by building rapport, predicting and problem-solving parental resistance, and providing ongoing support and motivation for parents to complete the program in a timely manner. These results are similar to Morawska and Sanders (2005a), demonstrating that minimal therapist intervention using a self-regulatory framework results in significant intervention gains.

The combined results of these studies provide strong support for the use of telephone assisted self-directed versions of Triple P as a low cost, clinically effective intervention for children of all ages. Table 2 provides the details of the effects of the interventions on child behavior and parenting style. As can be seen from the Table, the self-directed Triple P interventions led to results that were not only statistically significant, but also clinically meaningful. These effects were evident particularly for the telephone-assisted versions of the program. While statistically significant effects were evident for the self-directed version alone, the effect sizes were very small, particularly for the Stallman et al. (2005) study. The studies provide a strong evidence base for self-directed interventions, which form an effective part of a behavioral family intervention suite that allows tailoring of strength of intervention to individual problems and families. Furthermore, there is clear evidence for the important role of therapist involvement and support.

#### TELEPHONE COUNSELLING SERVICES

A key setting where families, and particularly geographically isolated families, may be supported in completing self-administered inter-

TABLE 2. Outcomes of Self-Directed Telephone-Assisted Triple P Studies

Measure	Comparator	Mean (SD)			% Clinic Range (n/n)			% Reliable Change (n/n)			Effect Size	
		Pre	Post	Follow Up	Pre	Post	Follow Up	Post	Follow Up	Post		
ECBI Intensity/Problem	SD-BFI	118.27 (25.24)	111.89 (24.92)	111.59 (22.23)	35.71 (15/42)	26.47 (9/34)	18.74 (6/32)	19.35 (6/31)	20.83 (5/24)	.44	.47	
		123.48 (29.95)	105.86 (21.13)	108.64 (23.51)	39.53 (17/43)	14.63 (6/41)	19.51 (8/41)	40.0 (16/40)	23.68 (9/38)	.68	.58	
		12.02 (7.13)	6.41 (5.48)	5.98 (5.74)	34.88 (15/43)	14.63 (6/41)	14.63 (6/41)	43.59 (17/39)	39.02 (16/41)	.70	.68	
	WLC	119.90 (23.75)	123.40 (23.75)	-	39.02 (16/41)	35.14 (13/37)	-	13.51 (5/37)	-	-	-	-
		10.19 (6.01)	10.70 (6.79)	-	21.95 (9/41)	32.43 (12/37)	-	5.88 (2/34)	-	-	-	-
		2.98 (.72)	2.59 (.60)	2.52 (.59)	35.71 (15/42)	20.59 (7/34)	21.89 (7/32)	31.25 (10/32)	25.81 (8/31)	.50	.64	
TASD-BFI	3.16 (.55)	2.48 (.62)	2.58 (.66)	67.44 (29/43)	17.07 (7/41)	24.39 (10/41)	41.46 (17/41)	38.46 (15/39)	.69	.50		
	2.97 (.59)	2.88 (.53)	-	43.90 (18/41)	29.73 (11/37)	-	8.11 (3/37)	-	-	-		
	WLC	2.97 (.59)	2.88 (.53)	-	43.90 (18/41)	29.73 (11/37)	-	8.11 (3/37)	-	-	-	
Parenting Style	SD-BFI	2.98 (.72)	2.59 (.60)	2.52 (.59)	35.71 (15/42)	20.59 (7/34)	21.89 (7/32)	31.25 (10/32)	25.81 (8/31)	.50	.64	
		3.16 (.55)	2.48 (.62)	2.58 (.66)	67.44 (29/43)	17.07 (7/41)	24.39 (10/41)	41.46 (17/41)	38.46 (15/39)	.69	.50	
		2.97 (.59)	2.88 (.53)	-	43.90 (18/41)	29.73 (11/37)	-	8.11 (3/37)	-	-	-	
	WLC	10.19 (6.01)	10.70 (6.79)	-	21.95 (9/41)	32.43 (12/37)	-	5.88 (2/34)	-	-	-	
		2.98 (.72)	2.59 (.60)	2.52 (.59)	35.71 (15/42)	20.59 (7/34)	21.89 (7/32)	31.25 (10/32)	25.81 (8/31)	.50	.64	
		3.16 (.55)	2.48 (.62)	2.58 (.66)	67.44 (29/43)	17.07 (7/41)	24.39 (10/41)	41.46 (17/41)	38.46 (15/39)	.69	.50	
SDC Difficulties/Impact	WLC	11.69 (5.95)	12.50 (7.03)	-	17.6 (3/17)	100 (4/4)	-	0 (0/16)	-	-	-	
		2.38 (2.22)	2.08 (1.62)	-	52.8 (7/13)	80 (8/10)	-	6.7 (0/15)	-	-	-	
		12.94 (7.06)	10.15 (6.24)	11.00 (6.39)	41.2 (7/17)	16.7 (1/6)	40 (2/5)	15.4 (2/13)	10 (1/10)	.14	-.01	
	Standard	12.29 (7.05)	7.69 (3.61)	7.29 (3.68)	23.5 (4/17)	0 (0/3)	0 (0/2)	20.0 (2/10)	22.2 (2/9)	.74	.85	
		2.36 (1.69)	0.67 (1.12)	0.29 (0.76)	71.4 (10/14)	28.6 (2/7)	20 (1/5)	14.3 (1/7)	40.0 (2/5)	.78	.89	
		4.28 (1.01)	4.03 (0.89)	-	64.7 (11/17)	30 (3/10)	44.4 (4/9)	60.0 (6/10)	33.3 (3/9)	1.12	1.18	
Enhanced	4.63 (.88)	3.74 (1.11)	4.03 (0.92)	94.1 (16/17)	71.4 (10/14)	83.3 (10/12)	28.6 (4/14)	16.7 (2/12)	.13	-.15		
	3.96 (0.98)	3.00 (1.03)	3.03 (0.87)	64.7 (11/17)	30 (3/10)	44.4 (4/9)	60.0 (6/10)	33.3 (3/9)	1.12	1.18		
	Enhanced	3.96 (0.98)	3.00 (1.03)	3.03 (0.87)	64.7 (11/17)	30 (3/10)	44.4 (4/9)	60.0 (6/10)	33.3 (3/9)	1.12	1.18	
Parenting Style OR..	WLC	4.28 (1.01)	4.03 (0.89)	-	64.7 (11/17)	30 (3/10)	44.4 (4/9)	60.0 (6/10)	33.3 (3/9)	1.12	1.18	
		4.63 (.88)	3.74 (1.11)	4.03 (0.92)	94.1 (16/17)	71.4 (10/14)	83.3 (10/12)	28.6 (4/14)	16.7 (2/12)	.13	-.15	
		3.96 (0.98)	3.00 (1.03)	3.03 (0.87)	64.7 (11/17)	30 (3/10)	44.4 (4/9)	60.0 (6/10)	33.3 (3/9)	1.12	1.18	
	Standard	4.28 (1.01)	4.03 (0.89)	-	64.7 (11/17)	30 (3/10)	44.4 (4/9)	60.0 (6/10)	33.3 (3/9)	1.12	1.18	
		4.63 (.88)	3.74 (1.11)	4.03 (0.92)	94.1 (16/17)	71.4 (10/14)	83.3 (10/12)	28.6 (4/14)	16.7 (2/12)	.13	-.15	
		3.96 (0.98)	3.00 (1.03)	3.03 (0.87)	64.7 (11/17)	30 (3/10)	44.4 (4/9)	60.0 (6/10)	33.3 (3/9)	1.12	1.18	
Enhanced	4.28 (1.01)	4.03 (0.89)	-	64.7 (11/17)	30 (3/10)	44.4 (4/9)	60.0 (6/10)	33.3 (3/9)	1.12	1.18		
	4.63 (.88)	3.74 (1.11)	4.03 (0.92)	94.1 (16/17)	71.4 (10/14)	83.3 (10/12)	28.6 (4/14)	16.7 (2/12)	.13	-.15		
	3.96 (0.98)	3.00 (1.03)	3.03 (0.87)	64.7 (11/17)	30 (3/10)	44.4 (4/9)	60.0 (6/10)	33.3 (3/9)	1.12	1.18		

Study 2 (Stallman et al., 2005)

Study 1 (Morawska & Sanders, 2005a)

Study 3 (Morawska & Sanders, 2005b)

Pre = Pre-intervention; Post = Post-intervention; FU = follow-up; SD-BFI = Self-Directed Behavior Family Intensity Questionnaire; TASD-BFI = Telephone Assisted Self-Directed Behavior Family Intensity Questionnaire; OR = Parenting Scale Overreactivity Subscale

ECBI Intensity/Problem	TASD-BFI	Parenting Style	
		Standard	Enhanced
122.55 (24.45)	106.32 (24.89)	105.48 (29.54)	37.27 (41/110)
12.87 (6.07)	7.23 (6.18)	6.58 (7.06)	37.27 (41/110)
3.14 (.64)	2.60 (.70)	2.61 (.66)	47.27 (52/110)

ventions is through existing telephone counselling services. There has been a dramatic expansion of telephone counselling services in the past few decades, beginning in the 1960s (Lester, 1995), as well as widespread belief in their preventive and therapeutic value (Hornblow, 1986). Telephone counselling services are an integral part of community mental health care, as a result of their non-institutional orientation, easy accessibility and guaranteed anonymity (Coman, Burrows, & Evans, 2001; Hornblow, 1986).

Despite their wide acceptability, empirical evidence for the effectiveness of telephone counselling services is lacking, often as a result of difficulties in conducting research in this area (Coman et al., 2001; Hornblow, 1986; Lester, 1995). Older studies focused largely on crisis intervention and measures of the effectiveness of such services included suicide rates, counsellor performance, counsellor satisfaction, caller satisfaction, change in caller's knowledge or behavior, caller compliance with counsellors' recommendations or suggestions, utilisation rates, and administrative criteria (Auerbach & Kilmann, 1977; Hornblow, 1986). Currently, common ways of assessing telephone counselling services are through the use of simulated caller paradigms (e.g., Bryant & Harvey, 2000) or listening in to actual calls (e.g., Bonneson & Hartsough, 1987). Furthermore, services have been evaluated on the basis of client satisfaction with the service offered (e.g., Reese, Conoley, & Brossart, 2002). Hornblow (1986) concluded that telephone counselling services do appear to perform valuable listening, information giving and referral roles.

More recent research focuses on the effectiveness of telephone counselling in supporting clients in various specific contexts. For example, telephone counselling has been shown effective in promoting smoking cessation (e.g., Katz, Muehlenbruch, Brown, Fiore, & Baker, 2002), in increasing rates of mammography screening (Stoddard et al., 2002), for bulimia nervosa treatment (Hugo, Segwick, Black, & Lacey, 1999), with elderly people (Ko & Lim, 1996) and for increasing physical activity (Pinto et al., 2002).

Overall, there is evidence for the effectiveness of telephone counselling when offered as part of another service or when addressing a specific focus area such as smoking. However, this research has focused almost exclusively on non-real-world settings. Existing telephone services are supported by very little empirical research, the vast majority of which suffers from a range of methodological problems, as well as a focus on the service versus client outcomes. There is very limited infor-

mation available as to whether there are improvements in terms of specific client outcomes, as a result of receiving telephone counselling.

### EFFECTIVENESS OF TRIPLE P

Morawska and Sanders (2005b) recently examined the effectiveness of a telephone assisted self-directed Triple P within the context of a regular service provider, Parentline. Parentline is a confidential telephone counselling service for parents and/or primary care givers. Parentline is a joint initiative of BoysTown Family Care and Families, Youth and Community Care Queensland, operational since 1996. Parentline is staffed by paid counsellors who are professionally trained to understand and respond to the particular issues that concern parents. The service has three main aims, including: (1) maintaining a confidential and anonymous counselling service for all parents in Queensland which meets the highest standards of professional practice and management; (2) collecting, analysing and disseminating non-identifying information which supports research and reflects the issues and problems of parents, and; (3) assisting parents to have a direct voice on those policies or issues that affect them.

Parentline operates between the hours of 8:00am and 10:00pm, seven days per week. Non-identifying information is logged about each call and a comprehensive, computerised database has been developed that reflects the issues concerning parents and families. The most common types of issues concerning callers include: challenging behavior/discipline, parent-child relationship and parenting strategies. About half of callers are from regional or remote areas of Queensland.

Overall, the research results indicate that a BFI based on a self-regulatory model, delivered by trained telephone counsellors can have significant effects across a range of measures of family functioning. The intervention led to reductions in parental reports of child behavior problems, reductions in dysfunctional parenting for mothers, and increases in parenting efficacy and confidence for both parents. There were also reductions in parental conflict over parenting and maternal stress. These effects were evident not only in statistical terms, but also in clinical terms with a shift in the population norm towards lower levels of risk. Importantly, the effects were also maintained at follow-up, indicating that the intervention has not only immediate effects, but benefits continue over time. Similar effects were obtained for a smaller study conducted in another Australian state (Cann, Rogers, & Worley, 2003).



However, in addition to a smaller sample size, only post-intervention measures were obtained and there was no follow-up of the families participating in the intervention.

### CONCLUSIONS AND IMPLICATIONS

The review presented here indicates that methodologically sound, structured self-directed intervention approaches are in short supply. At the same time, there is a growing need to increase access to efficacious parenting interventions for parents who find it difficult to access traditional services. Triple P is a behavioral family intervention with significant empirical support, and the studies reviewed here provide considerable evidence for the efficacy of self-directed versions of the program. Furthermore, the studies provide support for the importance of therapist involvement in promoting clinically meaningful and reliable change in child behavior and family functioning. It was a clear finding across studies that therapist assistance in completing a self-directed parenting program led to greater positive change for families. While this therapist involvement was clearly important, it was very minimal and was focused on enhancing parents' self-regulatory skills. This emphasis on self-regulation enables parents to make successful, enduring changes for their children and families, and provides them with the structure and skills necessary to effectively problem-solve future difficulties.

There is growing evidence that self-directed behavioral family interventions based on a self-regulatory model provide a low-cost, effective intervention for families in the treatment of a range of behavioral difficulties across childhood. They allow parents who cannot access traditional services to access high quality evidence-based interventions. They also have the potential to form a valuable role in a multi-level intervention model. A therapist-assisted intervention socialises parents to the self-regulatory framework and key strategies that may be refined later in individual therapy if necessary, reducing demands on services. This review has provided evidence that therapist involvement is important and has considerable impact on the outcomes of behavioral family interventions across the spectrum of child development. While parents are able to make changes on their own, their ability to implement strategies and maintain these in the longer term is affected by whether or not they are supported in doing so. Parents who receive therapist support make greater changes in their parenting and thus report increased levels of improvement in their child's behavior. An area for future research is

to consider the mechanisms involved in this effect. We posit that the self-regulatory framework utilised by therapists is key to better outcomes for families participating in a self-directed program. In addition, a motivational effect may also play a role in increasing parents' implementation of strategies. Clarification of the mechanisms involved would be important to specify the nature of therapist involvement, the training therapists need to conduct telephone-consultations and thus, the most efficient way of delivering support to families.

Given the importance of therapist involvement and the ability to translate the outcomes into a regular service-delivery context, it is important to consider the role of telephone counselling services and how they may be shaped to most effectively benefit the community. These types of services are increasingly popular, and often provide the only support available to remote communities, and break down many of the barriers associated with help-seeking. Telephone counselling services are accepted by the community, offer a high level of convenience and cost-effectiveness, and the potential for greater self-determination by clients. They are also in high demand and governments often rely on such services, whether government-supported or otherwise, to provide services within the current policy context. Despite this there is a considerable paucity of research evaluating such services, and the findings presented here, contribute to filling this gap in knowledge. While Triple P was successfully implemented within a telephone counselling service (Morawska & Sanders, 2005b), an important question to consider, is what other interventions or types of interventions can also be examined. Potentially, there is a range of other child and family interventions, which may be successfully delivered using this format.

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## CASE STUDY

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# Response Blocking with Guided Compliance and Reinforcement for a Habitative Replacement Behavior: Effects on Public Masturbation and On-Task Behavior

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 Adam Weaver

**ABSTRACT.** There is limited empirical research regarding effective treatment for public masturbation. In the current case study, the relative and combined effects of reinforcement of an incompatible habitative replacement behavior and response blocking with guided compliance on masturba-

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