Help Yourself to Positive Parenting

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Being a report of an investigation submitted as partial requirement for the degree of Master of Clinical Psychology

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1997

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Abstract

This study examines the role of commercially available self-help parenting books in the treatment of preschool aged children with oppositional behaviour problems. Thirty parents of oppositional preschoolers were randomly assigned to either a self-help parenting condition (SH) or to a waitlist control group (WL). Parents in the SH condition received a self-help parenting book to use in the management of their children's behaviour problems. They did not receive any other advice or intervention. At the end of a 10-week period the results showed that the behaviour of the children in the SH condition had improved but was not significantly better than that of the children in the WL condition which had also improved. Mothers in both conditions reported lower levels of dysfunctional parenting practices, higher levels of parenting competency and improvements in affect at post-treatment. Improvements in the SH group were maintained at 3-month follow-up. Reasons for the lack of a significant difference between the conditions in the treatment effect were discussed.

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Introduction

Disruptive Behaviour Disorders (DBDs) are the most common, significant, and costly of childhood adjustment problems (Sanders & Markie-Dadds, 1992). According to DSM-IV (American Psychiatric Association [APA], 1994), DBDs include Conduct Disorder (CD), Oppositional Defiant Disorder (ODD) and Disruptive Behaviour Disorder Not Otherwise Specified. CD is characterised by a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated (APA, 1994). ODD is characterised by a recurrent pattern of negativistic, defiant, disobedient, and hostile behaviour toward authority figures (APA, 1994). Prevalence figures indicate that approximately 10-15% of preschoolers have mild to moderate behavioural problems (e.g., Cornely & Bromet, 1986; Koot, 1993). This suggests that an estimated 75 000 to 112 500 of Australian 3- to 5- year-olds exhibit mild to moderate levels of antisocial behaviour. These behaviour problems are much more common in boys than in girls (APA, 1994).

DBDs are associated with many problems including, ADHD (e.g., Campbell, 1990; Barrickman, et al, 1995); learning disorders (Campbell, 1995); reading difficulties (Sturge, 1982); low self-esteem and low frustration tolerance (APA, 1994); poor social skills and interpersonal relationships (Carlson, Lahey & Neeper, 1984); and depressive symptoms (e.g., Campbell, 1995; Patterson, DeBaryshe & Ramsey, 1989; Sanders, Dadds, Johnston & Cash, 1992). Additionally, children with DBDs are at greater risk of being abused by their parents (Burgess & Conger, 1978; Kaplan & Pelcovitz, 1982). DBDs persist into adulthood for a substantial proportion of

children and are predictive of a broad range of adult disorders. In the long term, they may develop marital, social or occupational adjustment problems (Kazdin, 1987), which may lead to adult criminality, alcoholism, drug abuse or psychiatric disorder (Lytton, 1990; Robins & Price, 1991; Rutter, 1989).

These problems are expensive for the individuals involved and the community at large. The cost of juvenile crime in Australia, such as car theft, burglary, shop-stealing, vandalism, arson and violent assault, is estimated to be $1.8 billion per year (Potas, Vining & Wilson, 1990). This does not include the even greater costs associated with the provision of mental health, educational or social services for perpetrators and their victims. The effective implementation of intervention strategies to prevent these problems depends upon knowledge of their developmental course.

Empirical evidence supports a dual model of aetiology, namely, the "early" versus "late starter" model. The "early starter" is characterised by the onset of problems in the early childhood years. This model proposes that ineffective parental management strategies lead to a pattern of negative reinforcement in which the parents and child are each reinforced by the other for increasingly negativistic and aggressive behaviours (Patterson, Reid & Dishion, 1992). The relatively less serious behaviours, such as noncompliance and temper tantrums in the early preschool and school years, progress to more serious ones, such as lying and stealing, in middle childhood. By adolescence the most serious behaviours, such as interpersonal violence and substance abuse have developed (e.g., Hinshaw, Lahey & Hart, 1993; Patterson, Capaldi & Bank, 1991).

The "late starter" is not believed to display problem behaviours until adolescence after a normal developmental history during the

school years (e.g., Hinshaw, et al., 1993; Moffitt, 1993; Patterson et al., 1991). This pathway is thought to result in less serious behaviour disorders which decline by early adulthood (e.g., McMahon, 1994; Webster-Stratton, 1993). It has been suggested that girls are more likely to be "late starters" whereas boys are more likely to start early on the path toward disruptive behaviour disorders (e.g., McGee, Feehan, Williams & Anderson, 1992; Trembley, et al., 1992).

In addition to the negative parent-child interaction processes which characterise the "early starter" model, characteristics of the family, parent and child have also been identified as risk factors for the subsequent development of children's conduct problems. Parental psychopathology, alcohol abuse, father criminality, marital discord, father absence, harsh and inconsistent punishment practices, poor supervision and monitoring of the child, large family size, child temperament and genetic characteristics, and socioeconomic disadvantage all prospectively predict disruptive behaviour problems in children (Kazdin, 1987; Rutter,1989). Rutter and Quinton (1984) found that the presence of two or more of these adverse family-environment factors significantly increased the chance of subsequent child psychopathology.

The prognosis for the "early starter" is poor due to the continuity and stability of the behaviours over time (e.g., Campbell, 1991; Campbell & Ewing, 1990; White, Moffitt, Earls, Robins & Silva, 1990). If left untreated, child conduct problems tend to worsen following entry into school (e.g., Kazdin, 1985; Loeber, 1985). Even with treatment, the prognosis is poor as often families seek treatment only when the child's problem is long-standing and severe (Kazdin, 1991). Severe cases are difficult to treat, fail to sustain treatment gains and are at increased risk for prematurely terminating therapy, particularly

families characterised by marital discord, parental depression, lack of social support or low socioeconomic status (Kazdin, 1987; 1990; 1991).

Since preschool-aged children are more dependent on adult authority and less able to sabotage treatment programs than school-aged children, it has been suggested that early intervention with preschool children and their families, whose behaviour patterns have not yet become firmly entrenched, may prove to be an effective strategy for the treatment of DBDs (Eyberg, 1992; Sanders & Markie-Dadds, 1992).

One approach which shows promise is Behavioural Family Intervention (BFI) which targets coercive family interactions known to contribute to the development and maintenance of children's conduct problem behaviour (Patterson et al., 1992). Parents are taught to use operant procedures when they interact with their child to change their child's behaviour. These techniques typically include positive reinforcement and mild punishment. Parents learn to use descriptive praise, social attention or tokens as rewards for positive behaviours and to administer effective consequences such as time-out or privilege-removal for problem behaviours.

Of all treatment approaches used with preschool children, parent-training intervention programs have received the greatest empirical scrutiny and have proved to be the most effective approach thus far, for helping parents reduce aggressive and oppositional behaviours in their children (e.g., Sanders & Dadds, 1993; Webster-Stratton, 1993; McMahon, 1994). In fact, the literature shows that if children displaying early signs of conduct problems are treated during the preschool years, BFI alone is sufficient to produce clinically significant improvements in behaviour over the long-term (e.g., McMahon &

Wells, 1989; Sanders, 1996). Improvements have been shown to persist at least up to one year post-treatment for two thirds of families (e.g., Horne & Van Dyke, 1983; Webster-Stratton, 1982) and in many cases for three years or more (e.g., Daly, Holland, Forrest & Fellbaum, 1985; Strain, Steele, Ellis & Timm, 1982).

Not only are there improvements in children's behaviour but also in that of the parents. Treatment effects have also been shown to generalise to untreated siblings and behaviours and to different settings (e.g., Dadds, Sanders & James, 1987; McMahon, 1994). Parents are generally satisfied with the parenting strategies learned (Webster-Stratton, 1989), and report increased feelings of parenting competence and reduced levels of depression (Sanders & Dadds, 1993). Whilst parent training is delivered in a variety of ways, one increasingly prevalent strategy is to present it in the form of self-help books.

Self-help books are a multimillion dollar publishing phenomenon. A bibliography of self-help books in psychology (Lorenz & Weiton, 1987) identifies more than 800 titles, whereas other estimates (Chaplin, 1989) suggest that more than 2000 new self-help books covering a range of topics, including parenting, are published each year. In recent years there has been a proliferation of how-to parent training books (eg., Faber & Mazlish, 1980; Schaefer, 1984) designed to address a diverse array of child-rearing difficulties (Rogers Wiese, 1992). The current proliferation of self-help books can be seen as one component of a larger change that is occurring in the mental health field. The need for mental health services far surpasses current capabilities. The provision of services through traditional modes of individual or group therapy by professionals cannot meet the ever-increasing demand for mental health care (Craighead,

McNamara & Horan, 1984). Given the extent of child behaviour problems and the limited number of child health care professionals, self-help books represent an alternative method of delivering behavioural parent training.

Parenting books have gained popularity within the community. Clarke-Stewart (1978) found that more than 44 % of a sample of mothers of 2- to 4-year-olds had read more than 5 childcare or parenting books. She also found that readers of childcare books were typically highly satisfied with them and would recommend them to others. Sixty-two percent of parents of 4- to 7-year-olds nominated "books" as an "important" source of information (Hunt, Hawkins & Goodlet, 1992). The more severe the child's behaviour problem, the more likely the parents were to rate books on children's problems as good sources of advice for parents of children with behaviour problems (Sonuga-Barke, Thompson & Balding, 1993). These data suggest that self-help books enjoy considerable acceptance among book-buying parents as an authoritative source of information on parenting.

The self-help approach appears to offer many advantages over traditional therapies. It is cost-effective, easily accessible and convenient (Starker, 1990). It also may be perceived as offering readers greater control over the behaviour change process. This may enhance their sense of self-efficacy and may improve generalisation and maintenance of treatment effects (e.g., Dow, 1982; McMahon & Forehand, 1980). The aforementioned authors maintain that greater behaviour change is possible when clients can attribute the ability to change to themselves and not to the therapist as can happen in a traditional client/therapist relationship. The

concept of self-help takes as its premise the notion that individuals utilise self-regulatory processes,

> "to guide ... goal-directed activities over time and across changing circumstances (contexts). Regulation implies modulation of thought, affect, behavior, or attention via deliberate or automated use of specific mechanisms and supportive metaskills." (Karoly, 1993, p.25).

Consequently the goal of self-help programs is to promote self-sufficiency by fostering individual problem-solving and self-management skills such as goal-setting, self-monitoring and self-evaluation. Studies which have attempted to operationalise and empirically test self-regulatory theory have suggested that training parents in self-regulatory skills enhances their capacity to generalise their implementation of parenting skills across different settings (e.g., Sanders & Glynn, 1981). However, further evidence is required in order to establish whether self-help books are effective in developing self-regulatory skills in their readers.

Whilst the results of outcome research have been inconclusive (e.g., Pardeck, 1990, 1991; Riordan & Wilson, 1989), self-help books have been considered by some as useful tools in the treatment of obesity (e.g., Black & Threlfall, 1986), insomnia (Bailey, 1982), chronic headaches (Cuevas, 1984), depression (Bowman, Scogin & Lyrene, 1995), panic disorder (Gould, Clum & Shapiro, 1995) and conversation skills (Black, 1981). Children's behaviour (Klingman, 1985) and the inappropriate behaviour of adolescents (e.g., Harbaugh, 1984; Swantic, 1986), have also been changed through the use of self-help books. Gould & Clum (1993), in their meta-analytic review, found self-help programs an effective tool in social skills training, fear reduction, parent-child training and in the

treatment of depression, headache and insomnia. It was less effective, however, for habit disturbances such as smoking, drinking, diet and exercise. Another meta-analysis concluded that there was no significant difference in treatment effect between self-help and therapist-assisted conditions (Scogin, Bynum, Stephens, & Calhoon, 1990).

A number of authors have commented on the lack of well-controlled empirical studies attesting to the effectiveness of self-help books (e.g., Clarke-Stewart, 1978; Rosen, 1987; McMahon & Forehand, 1980). Many of these books are written by practitioners who have taken procedures reported in the experimental literature in the context of a therapist/client relationship and incorporated them into clinical practice. Through trial-and-error the techniques are often modified or augmented to such an extent that they no longer resemble the original procedures which have been empirically validated. They are then assembled in book-form and promoted as a do-it-yourself treatment. Consequently, such programs may be empirically based but not necessarily empirically evaluated in their modified form. Data reported on these programs typically consist of anecdotal evidence from the author, but the effectiveness of the modified techniques used in the context of a self-help book is not directly evaluated (Craighead, et al, 1984). Evaluations conducted so far have been characterised by methodological flaws which have confounded the interpretation of any findings. A major shortcoming is ambiguity over the authors' use of the term "self-help". What many deemed "self-help" interventions, in fact, almost always incorporated some therapist contact, ranging in intensity from regular letters (e.g., Grossman, McNamara & Dudley, 1991) or telephone calls (e.g., Connell, Sanders & Markie-Dadds, in press), to face-to-face

counselling sessions (e.g., Cooper, Coker & Fleming, 1994) during which encouragement, elucidation and advice was often provided. Even in those studies where contact was minimised, subjects' coverage (Bowman et al., 1995), comprehension (e.g., Gould et al., 1993) and practice of the material (e.g., Spence & Sharpe, 1993) was assessed throughout the program. Such strategies risk prompting parents to read, use and retain the information when they otherwise might not. Ogles, Lambert and Craig (1991) addressed some of these methodological issues by giving their study participants one of four types of self-help books to read. They found that participants reported similar levels of improvement in psychological outlook regardless of the theoretical orientation of the book read. Furthermore, those who reported a higher expectation of receiving help from the books also reported greater improvements at post-treatment and were more likely to attribute improvements at post-treatment to the book. Spence & Sharpe (1993) concluded that the best predictor of non-compliance in a self-help pain management program was subjects' pre-treatment ratings of the credibility of the program.

In a well-controlled study by Markie-Dadds & Sanders (in press) a group design incorporated a no-treatment waitlist control group to evaluate a self-directed parenting program which consisted of a parenting book Every Parent (Sanders, 1992) and an accompanying workbook, Every Parent's Workbook (Sanders, Lynch & Markie-Dadds, 1994). Every Parent (Sanders, 1992) is a commercially available broad-focus parenting book which is designed to be completely self-administered. It presents a behavioural parent-training program which is suitable for empirical evaluation as it prescribes specific behavioural procedures to achieve change in

children's behaviour. The desired outcome is that the behaviour of children is not discriminable from that of children in the normal population at post-treatment (Sanders, 1982; Dadds & McHugh, 1992). Subjects in the Markie-Dadds & Sanders (in press) study were not allowed therapist contact. They found that the program was an effective strategy for reducing levels of disruptive child behaviour, increasing mothers' sense of competence and satisfaction in their parenting skills and lowering levels of dysfunctional parenting practices. Improvements in children's behaviour were maintained at 6-month follow-up and parents reported a high level of satisfaction with the parenting program and materials.

The present study attempted to establish whether the book, Every Parent (Sanders, 1992), alone, can be an effective minimal and cost-effective intervention for parents of children with disruptive behaviour problems. Because Markie-Dadds & Sanders (in press) did not evaluate the effectiveness of Every Parent (Sanders, 1992) without combining it with a structured workbook, it is unclear whether using Every Parent (Sanders, 1992) alone would produce similar results. Using an improved methodology the present study aimed to extend the Markie-Dadds & Sanders (in press) study in a number of ways. It incorporated a group design with a no-treatment control group and there was no contact between the program coordinator and participating families during the "treatment" phase. The book was evaluated under self-administered conditions. This design was adopted in order to ascertain whether Every Parent (Sanders, 1992) can be used effectively by parents without therapist support or a guided workbook. To further investigate the role of expectations in compliance and outcome as reported by Spence and Sharpe (1993) and Ogles et al (1991), measures of parental expectations of

treatment outcome and compliance were sought at pre-treatment and post-treatment, respectively. As recommended by McMahon and Forehand (1980), a variety of outcome measures (e.g. parental behaviour self-reports, child behaviour parental reports, parental attitude self-reports, consumer satisfaction measures) were used in an attempt to control any bias which might result from relying on one type of measure alone.

Like the Markie-Dadds and Sanders study (in press), the present study evaluated the impact of the intervention on measures of child behaviour, parenting style and parental adjustment. Based on previous research findings, it was predicted that compared to a waitlist control group at post-treatment, parents in the self-help group would report less disruptive behaviour in their children (e.g., McMahon, 1994); higher levels of parenting competence (e.g., Sanders & Dadds, 1993); and lower levels of dysfunctional parenting practices (Markie-Dadds & Sanders, in press) . Since high levels of parental anxiety, stress and depression have been linked with dysfunctional parenting and child behaviour problems (e.g., Kazdin, 1991),it was expected that reported improvements in child behaviour would be associated with improvements on measures of parental personal adjustment. Based on the findings of Ogles et al (1991) and Spence and Sharpe (1993), it was also predicted that self-help parents with higher expectations of a successful outcome would report greater satisfaction with Every Parent at post-treatment (Sanders, 1992). Finally, as behavioural parent training has been shown to be effective at 6- and 12-month follow-up (e.g., Sanders, 1996), it was anticipated that changes in measures of child behaviour and parenting skills and competence would be maintained at 3-month follow-up.

Method

Participants

Thirty preschool children and their families were recruited from South East Queensland. Families responded to media releases in state and local newspapers and flyers distributed to daycare centres (see Appendix A). A third recruitment strategy involved telephoning families who were on a waiting list for parenting courses conducted by the Parenting and Family Support Centre (PFSC) at The University of Queensland. These families were asked whether they would like to participate in the present study whilst waiting for a vacancy at the PFSC.

Eligible children were aged between 2 and 5 years of age at the time of recruitment, showed no evidence of developmental delay or significant health impairment, were not taking medication for behavioural problems, and were not currently having regular contact with another professional or government body for emotional or behavioural problems. Eligible parents were not currently receiving therapy for psychological or psychiatric problems, showed no evidence of intellectual disability, and reported that they had no difficulties reading, speaking or understanding English. Parents were further informed that participation would involve the reading of a parenting book written at Grade 7 level and the completion of a number of paper and pencil questionnaires. In addition, eligible parents reported concern about their child's behaviour.

Participants who met the initial selection criteria were mailed a pre-assessment package to determine the nature and severity of their child's behaviour problem. Mothers who rated their child's behaviour within the clinical range on the intensity or problem scales of the

Eyberg Child Behaviour Inventory (ECBI; Eyberg & Robinson, 1983) were eligible to participate in the study. Once recruited, parents were asked not to consult other health professionals about the project.

One hundred and thirty-three telephone interviews were completed. This yielded 78 potential participants, all of whom were mailed pre-assessment packages. A response rate of 63% yielded forty-nine completed assessment packages. Based on the results of the ECBI, 19 families were excluded. The remaining 30 families completed pre- and post-assessments. Nine families completed a 3-month follow-up assessment. Demographic characteristics of the sample are summarised in Tables 1 and 2. There was a predominance of male children which is consistent with prevalence data and, in most cases, both parents were present. Seventy-nine percent of mothers and 77% of fathers were educated to Year 12 level or better. Analyses revealed no significant differences between the groups on these characteristics.

Measures

The following self-report measures were completed at pre- and post-assessment and 3-month follow-up.

Eyberg Child Behaviour Inventory. (ECBI; Eyberg & Ross, 1978). The ECBI is a 36-item, multidimensional measure of parental perceptions of disruptive behaviour in children aged 2 to 17 years. The ECBI yields a measure of frequency of difficult behaviours (Intensity), and a score indicating whether difficult behaviours are a problem for parents (Problem). Standardisation data has revealed high internal consistency for both the Intensity (.95) and Problem (.94) scores and good test-retest reliability (.86) (Eyberg & Ross

1978; Robinson, Eyberg, & Ross, 1980). It is an easily administered instrument which discriminates Oppositional Defiant Disorder, Attention Deficit Disorder and Conduct Disorder as described by DSMIII-R (Burns & Patterson,1991) and is sensitive to the effects

Table 1

Demographic Characteristics of Sample (descriptives)

Variable	Self-Help Group (n = 15)		Waitlist Group (n = 15)	
	M	SD	M	SD
Child's Age (months)	41.3	11.36	45.33	8.53
Mother's Age (years)	33.5[a]	2.93	32.14[a]	4.77
Father's Age (years)	36.4[b]	3.33	35.33[c]	2.81
Father's Occupational Status*	4.0[a]	0.9	4.1[b]	1.5
Mother's Occupational Status*	4.1[d]	0.8	4.5[d]	1.1

* Based on a 7-point (1 = high SES, 7 = low SES) occupational prestige scale, (Daniel, 1983)

[a]n = 14. [b]n = 13. [c]n = 12. [d]n = 10

of intervention (Webster-Stratton, 1990).

Parenting Sense of Competency Scale. (PSOC; Gibaud-Wallston & Wandersman, 1978). The PSOC is a 17-item scale which taps two dimensions of parenting self-esteem: (i) Satisfaction, an affective

dimension reflecting the extent of parental frustration, anxiety and low motivation in the parenting role; and (ii) Efficacy, an instrumental

Table 2

Demographic Characteristics of Sample (frequencies)

	Self-Help Group (n = 15)		Waitlist Group (n = 15)	
Variable	n	%	n	%
Child's Gender				
Male	11	73.33	7	46.67
Female	4	26.67	8	53.33
Paternal Status				
Present	14	93.33	12	80.00
Absent	1	6.67	3	20.00
Mother's Education				
Grade 10 or 11	3	21.43	5	33.33
Grade 12	6	42.86	4	26.67
Tertiary	5	35.71	6	40.00
Father's Education				
Grade 10 or 11	3	23.08	3	23.08
Grade 12	4	30.77	3	23.08
Tertiary	6	46.15	7	53.85

dimension reflecting competence, problem-solving ability and familiarity with parenting. The total score (16 items), satisfaction score (9 items), and the efficacy score (7 items) show a high level of

internal consistency with Cronbach's alphas of .79, .75 and .76, respectively (Johnston & Mash, 1989). The affective dimension (Satisfaction) is thought to be particularly sensitive to the effects of deviant child behaviour (Johnston & Mash, 1989).

Parent Daily Report Checklist. (PDRC; Chamberlain & Reid, 1987). This checklist consists of 33 child problem behaviours and one adult behaviour (the use of physical punishment) which are rated daily over a 7-day period by the parent as present or absent. It is inexpensive, easy and relatively unobtrusive to use. Two scores are generated: (i) the Total Problem Behaviour Score is the sum of all occurrences of problem behaviours; and (ii) the Targeted Behaviour Score is the sum of all occurrences of behaviours previously identified by the parent as problematic. Each of these scores can be averaged to produce either a Mean Daily Problem Score or a Mean Daily Targeted Score. The Total Problem Behaviour Score has good temporal reliability (apart from on the first day which shows highly inflated scores); poor interparent reliability (r = .02, n.s.); and poor validity (r = .19, n.s.) (Chamberlain & Reid, 1987). The Targeted Behaviour Score however, shows high interparent reliability (r = .89) and adequate validity (r = .48) (Chamberlain & Reid, 1987). Consequently, in this study, only the Targeted Behaviour Score and Mean Daily Targeted Score were used. The measure represents a low-cost compromise between global parent reports and independent observations of child behaviour (Chamberlain & Reid, 1987).

Parenting Scale. (PS; Arnold, O'Leary, Wolff & Acker, 1993) The PS is a 30-item questionnaire designed to measure dysfunctional discipline practices of parents of young children. The scale is easy to administer and score. In addition to yielding a total score, the PS

measures three factors of dysfunctional discipline style: Laxness; Overreactivity; and Verbosity. The PS is internally consistent, with alpha coefficients of .83 for Laxness, .83 for Overreactivity, .63 for Verbosity and .84 for the Total Score (Arnold et al., 1993). Test-retest correlations are .83, .82 and .79 for the Laxness, Overreactivity and Verbosity factors respectively; and .84 for the Total Score (Arnold et al., 1993). The PS discriminates between clinic and non-clinic parents and children. Each of the factors correlates significantly with observational measures of parental discipline practices and child behaviour (Arnold et al., 1993).

Parent Problem Checklist. (PPC; Dadds & Powell, 1993). The PPC is a 16-item measure of parents' ability to cooperate and to act as a team in performing the executive parenting functions within the family. Six items focus on disagreement over rules and discipline for child misbehaviour, six on the occurrence of open conflict over child-rearing issues, and four on whether the parents undermine each other's relationships with the children. It has high test-retest reliability (r = .90) and moderately high internal consistency (alpha = .70) (Dadds & Powell, 1991).

Abbreviated Dyadic Adjustment Scale. (ADAS; Sharpley & Cross,1982). The ADAS is an abbreviated, 7-item form of the 32-item Dyadic Adjustment Scale (Spanier,1976). The scale is designed to measure the quality of adjustment between partners in a dyadic relationship. Respondents indicate the extent to which they agree or disagree with their partner on some items and on other items they rate how often they engage in various activities together. The ADAS is a quick and reliable (alpha = .76) method of classifying couples as high or low on the continuum of dyadic adjustment (Sharpley & Rogers, 1984)

Depression Anxiety Stress Scales. (DASS; Lovibond & Lovibond,1995). The DASS is a 42-item questionnaire designed to measure three affective dimensions. It is an easily administered and scored instrument which yields information on a broad range of symptoms of depression, anxiety and stress in adults. Factor analytic studies of the DASS have shown that it has satisfactory reliability with alpha coefficients of .83 (depression), .70 (anxiety) and .80 (stress). The three subscales have good discriminant and concurrent validity (Lovibond & Lovibond, 1995).

Expectancy Form. (EF). The EF is an instrument devised by the author. It poses the question: "At this stage, how confident do you feel that the program your family is about to receive will be effective?" Respondents rate their level of confidence on a 7-point scale ranging from "Not at all confident" to "Extremely confident".

The following questionnaire was administered at post-assessment only.

The Client Satisfaction Questionnaire. (CSQ). The CSQ is a 26-item instrument devised by the author which endeavours to elicit quantitative and qualitative information about parents' and children's responses to the program. It contains questions on parents' understanding, utilisation and satisfaction with the techniques described in Every Parent (Sanders, 1992) and is based, in part, on "The Therapy Attitude Inventory" (Brestan, Jacobs, Rayfield, & Eyberg, in press).

Procedure

The selection of eligible participants was conducted in two stages. Initially, a structured screening telephone interview was conducted with the primary caregiver to determine the eligibility of the family for

the project. Parents who expressed interest in the program completed a 10-minute telephone interview which established demographic details, a brief description of the child's behaviour problems and assessed the eligibility of the family to participate in the study. During this interview, the parent was given information about the program including the process of random allocation to experimental groups and the requirement to complete a series of questionnaires before and after the program was completed, including at a 3-month follow-up. Eligible families were then sent the pre-treatment package which consisted of the questionnaire booklet, a letter briefly outlining the study design and group allocation procedures, instructions on completing the questionnaires, and a reply paid envelope (see Appendices B-J). Once the assessment booklets were completed, returned and scored, families were randomly allocated to either the self-help (SH) or waitlist (WL) group according to a table of random numbers.

Waitlist condition. Families allocated to the WL condition were informed that they would be required to wait 10 weeks before receiving Every Parent (Sanders, 1992). At this stage, the primary caregiver was sent the EF and, if applicable, the secondary caregiver was sent the ECBI (Eyberg & Robinson, 1983) and PSOC (Gibaud-Wallston & Wandersman, 1978) to complete and return in a reply paid envelope. During the waiting period there was no contact between the parents and the principal investigator. At the end of 10 weeks, participants were mailed the post-treatment package. On receipt of the completed post-treatment packages, families were sent a copy of the parenting book. These families took no further part in the study.

Self-help condition. Families assigned to the SH condition were immediately mailed a copy of Every Parent (Sanders, 1992) free of charge. The primary caregiver completed an EF and the secondary caregiver (if applicable) completed the ECBI (Eyberg & Robinson, 1983) and PSOC (Gibaud-Wallston & Wandersman, 1978) and returned them in a reply paid envelope. Ten weeks after receiving the book, parents were sent the post-treatment package and a reply paid envelope. Three months after the post-assessment package was due, a follow-up assessment package was mailed to the SH families. Beyond the initial telephone interview, contact between participants and the principal investigator was minimal and there were no face-to-face meetings. All telephone calls were under three minutes in duration and the content restricted to requests for parents to complete and return the assessment packages. No reference was made to any of the material presented in Every Parent (Sanders, 1992). Letters accompanying program materials contained essential instructions on procedural matters such as when and how to complete and return questionnaires. Parents were not specifically directed to read the parenting book, or use the techniques described therein. Nor were they told that they would be questioned on their use and understanding of the book at the post-assessment. These procedures were adopted in order to minimise experimental effect and replicate as closely as possible the conditions prevailing upon an individual purchasing a copy of the text in a book store.

Results

Preliminary Analyses: Equality of Treatment Conditions

To check that random assignment led to equivalent sociodemographic groups, univariate analyses of variance (ANOVAs) for continuous variables, and chi square analyses for categorical variables, were conducted. No significant differences ($p > .05$) were found for any of the sociodemographic measures, for child behaviour ($p > .05$), parental adjustment ($p > .05$), or for all but one of the measures of parenting style and competence ($p > .05$). A significant difference between groups was found for the Verbosity scale of the Parenting Scale, $F(1,28) = 6.02$, $p < .05$, with the WL group scoring higher on this scale than the SH group at pre-treatment. Consequently, in any further analyses involving the PS, Analyses of Covariance (ANCOVAs) were performed using Verbosity as a covariate.

As the assumption of homogeneity of variance was violated and a large number of individual repeated ANOVAs were conducted during the data analysis, Pillai's correction, which has both power and robustness was used. This statistic is not liable to distortion in the face of such violations and is able to detect differences where they exist (Norusis, 1988). Power statistics were calculated as the small sample size may have reduced the sensitivity of the experiment to treatment effects. A significance level of .05 was adopted throughout the analyses.

One family allocated to the SH group and one allocated to the WL group did not return post-assessment measures and were not considered in any further analyses.

Child Behaviour

To determine the effects of intervention on the child's behaviour, a series of 2 (condition: SH vs WL) X 2 (time: pre- vs post-treatment) repeated measures ANOVAs were conducted. Table 3 presents the means, standard deviations, F and p values for the condition by time interaction for each of the measures of child behaviour. There were no significant time by condition interactions. Mean scores on mothers' ECBI and Mean Daily Targeted Scores on the PDRC were within the clinical range while fathers' mean ECBI scores and Targeted Behavior Scores were within the normal range. On the ECBI, mothers in both conditions reported a decrease in the number and intensity of problem behaviours at post-treatment. There was a significant main effect for time on Problem $F(1, 25) = 17.25$, $p < .001$ and Intensity scores $F(1, 25) = 7.81$, $p = .01$ and for condition on Intensity scores alone $F(1, 25) = 4.58$, $p < .05$. There were no other significant effects for mothers' ECBI scores ($p > .05$). An analysis of fathers' ECBI scores revealed a decrease from pre- to post-treatment which also was not significant ($p > .05$).

A significant main effect for condition was found for Mean Daily Targeted Score $F(1, 25) = 4.54$, $p < .05$. Mothers in the SH condition reported a lower mean number of targeted problem behaviours than mothers in the WL group at pre and post-treatment. There were no other significant effects for PDRC scores ($p > .05$).

Parenting Style

Due to the finding that there was a significant difference between the SD and WL groups on the Verbosity scale at pre-treatment with the WL group scoring higher than the SD group on Verbosity,

Table 3

Changes in Child Behaviour Over Time as Measured by Parental Reports

	Self-Help (n = 14)				Wait-list (n = 13)				Condition X Time	
	Pre-treatment		Post-treatment		Pre-treatment		Post-treatment			
Variable	M	SD	M	SD	M	SD	M	SD	F	p
Eyberg Child Behavior Inventory										
Mother Problem	13.36	5.06	9.14	6.88	17.54	7.11	13.39	5.30	.00	.98
Intensity	128.71	20.5	113.50	23.05	140.46	19.96	135.85	26.54	2.23	.15
Father Problem	8.18[a]	9.14	7.91[a]	9.57	15.30[b]	9.96	11.40[b]	6.90	1.10	.31
Intensity	127.55[a]	28.94	113.36[a]	29.05	134.00[b]	28.57	131.30[b]	29.71	1.22	.28
Parent Daily Report Checklist										
Mother										
Total Targeted Behavior Score	29.14	14.71	15.21	12.21	34.39	21.98	31.07	26.08	1.11	.30
Mean Daily Targeted Score	4.80	2.44	2.41	1.99	5.58	3.54	5.57	4.13	2.41	.13

[a] n = 11. [b] n=10.

2 (group) X 2 (time) repeated measures ANCOVAs were conducted using the Verbosity pre-treatment score as a covariate. The means, standard deviations, F and p values of the condition by time interaction for the three factor scores and the total score on the PS, as completed by mothers, appear in Table 4. Mean scores on Laxness and Verbosity were in the normal range at pre- and post-treatment whilst Over-reactivity and Total Scores fell within the clinical range. No significant time by condition interaction effects were found. A significant main effect for time was found for Laxness $F(1, 26) = 12.36$, $p < .01$ and Total scores $F(1, 26) = 14.90$, $p = .001$. From pre- to post-treatment, mothers in both conditions reported a decrease in lax parenting behaviour and in the total number of dysfunctional parenting behaviours. A significant effect for the Verbosity covariate was found for Laxness $F(1,25) = 9.95$, $p < .01$, Overreactivity $F(1, 25) = 9.53$, $p < .01$ and Total scores $F(1,25) = 20.36$, $p < .001$. Analysis of the Verbosity scores revealed significant main effects for condition and time with $F(1, 26) = 6.03$, $p < .05$ and $F(1, 26) = 13.79$, $p = .001$ respectively. Whilst mothers in both conditions reported a decrease in verbosity from pre- to post-treatment, there was a difference between the SH group and WL group in the nature of the decrease. There were no other significant effects for PS scores ($p > .05$).

Parenting Sense of Competency

Table 5 shows the means, standard deviations, F and p values for the condition by time interaction for the Satisfaction, Efficacy and Total scores on the PSOC Scale. All mean scores were in the normal range at pre- and post-treatment. A significant condition by time interaction was found for fathers' Total and Satisfaction scores

Table 4

Changes in Parenting Style Over Time as Measured by Mothers' Self-Reports

	Self-Help (n= 14)				Wait-list (n = 14)				Condition X Time	
	Pre-treatment		Post-treatment		Pre-treatment		Post-treatment			
Variable	M	SD	M	SD	M	SD	M	SD	F	p
Parenting Scale										
Mother										
Laxness	2.94	.88	2.55	.70	3.36	.91	3.08	.80	.96	.34[a]
Verbosity	3.37	.77	2.96	.72	3.94	.64	3.58	.65	.06	.80[b]
Over-reactivity	3.13	.53	2.86	.68	3.20	.68	3.14	.70	1.21	.28[a]
Total	3.15	.54	2.58	.80	3.42	.51	3.18	.59	2.45	.13[a]

[a]ANCOVA with Verbosity. [b]ANOVA

with $F(1, 19) = 4.35$, $p < .05$ and $F(1, 19) = 6.41$, $p = .05$ respectively. The WL fathers' group reported that their sense of parenting satisfaction improved from pre- to post-treatment whilst that of the SH group did not. However, post-treatment scores in both conditions were nearly identical and were within the normal range. There were no significant time by condition interactions for mothers' PSOC scores. Analysis revealed a significant main effect for time on mothers' Efficacy scores, $F(1, 26) = 6.34$, $p < .05$ with mothers in both groups reporting improvement in their sense of competency from pre- to post-treatment. There were no other significant results for this measure ($p > .05$).

Parental Affect

The means, standard deviations, F and p values for the condition by time interaction for mothers' DASS scores appear in Table 6. No significant time by condition interactions were found. At pre- and post-treatment, mean scores were within the normal range. A significant main effect for time on the Anxiety, Stress and Total scores was revealed with $F(1,26) = 4.76$, $p < .05$; $F(1,26) = 7.00$, $p = .01$; and $F(1,26) = 6.30$, $p < .05$ respectively. Mothers in both groups reported lower DASS scores at post-treatment than at pre-treatment, however, only the decreases in Anxiety and Stress scores were statistically significant. There were no other significant results for the DASS ($p > .05$).

Interpersonal Relationships

Table 7 presents the means, standard deviations, F and p values for the condition by time interaction for the mothers' PPC, and ADAS scores. All mean scores were within the normal range at pre- and

Table 5

Changes in Parenting Sense of Competency Over Time as Measured by Parental Self-Reports

		Self-Help (n=14)				Wait-list (n= 14)				Condition X Time	
		Pre-treatment		Post-treatment		Pre-treatment		Post-treatment			
	Variable	M	SD	M	SD	M	SD	M	SD	F	p
Parenting Sense of Competency											
Mother	Satisfaction	33.57	4.90	34.29	5.74	32.29	8.07	33.57	6.77	.10	.76
	Efficacy	25.93	3.89	28.36	3.30	23.43	6.04	23.79	6.24	3.51	.07
	Total	59.50	7.39	62.64	8.14	55.71	12.07	57.36	11.44	.37	.55
Father	Satisfaction	37.73[a]	5.31	35.55[a]	6.12	32.90[b]	6.90	35.00[b]	7.01	6.41	.02*
	Efficacy	26.82[a]	2.44	26.55[a]	3.08	26.30[b]	4.47	26.50[b]	4.28	.14	.71
	Total	64.55[a]	7.30	62.09[a]	8.32	59.20[b]	10.92	61.50[b]	10.75	4.35	.05*

*$p \leq .05$.

[a]$n = 11$. [b]$n = 10$

Table 6

Changes in Parental Affect Over Time as Measured by Mothers' Self-Reports

	Self-Help (n = 14)				Wait-list (n = 14)				Condition X Time	
	Pre-treatment		Post-treatment		Pre-treatment		Post-treatment			
Variable	M	SD	M	SD	M	SD	M	SD	F	p
Depression, Anxiety and Stress Scales										
Depression	4.79	4.78	2.50	2.31	6.50	8.07	5.57	5.93	.45	.51
Anxiety	2.14	3.13	1.29	1.82	3.43	4.77	1.57	1.74	.65	.43
Stress	10.29	4.43	6.36	3.52	12.71	8.03	10.64	8.25	.67	.42

post-treatment. There were no significant results for the ADAS or PPC. Mothers in both groups reported that they were generally satisfied with their marital relationship at pre- and post-treatment.

Consumer Satisfaction

On a 7-point scale where 1 is 'least satisfied' and 7 is 'most The mean rating for each of the consumer satisfaction questions reported by the SH group is presented in Table 8. Mothers reported satisfaction with Every Parent (Sanders, 1992) at or above the mean except on the question of whether their relationship with their partner had been improved as a result of having read Every Parent (Sanders, 1992). Their responses indicated that there had not been any change in their relationship as a result of reading the book. These data match those reported in Table 7 which indicate that mothers were generally happy with their marital relationships at the commencement of the study and remained so throughout the course of the study. Consequently, the lack of any significant improvement from pre- to post-treatment is likely to be due to a ceiling effect.

The SH group reported their highest level of satisfaction with the resource material contained in Every Parent (Sanders, 1992); its usefulness as a reference; and the improvement in their child's behaviour. In Table 9, correlations of the SH group's satisfaction ratings with measures of expectancy, socioeconomic status, child behaviour, parental conflict and parental adjustment are presented. Significant correlations were found between the response to the question 'In general, how satisfied are you with 'Every Parent' ?' and ratings for expectancy $r = .66$, $p < .05$; DASS Depression pre-treatment score $r = -.49$, $p < .05$; and satisfaction with child's progress $r = .48$, $p < 05$. Mothers who reported higher levels of

Table 7

Changes in Interpersonal Relationships Over Time as Measured by Mothers' Self-Reports

	Self-Help (n = 14)				Wait-list (n = 13)				Condition X Time	
	Pre-treatment		Post-treatment		Pre-treatment		Post-treatment			
Variable	M	SD	M	SD	M	SD	M	SD	F	p
Parent Problem Checklist										
Problem	5.00[a]	3.16	2.54[a]	1.20	4.55[c]	2.58	4.36[c]	2.29	2.98	.10
Intensity	30.15[a]	10.45	26.46[a]	6.91	32.73[c]	15.86	27.50[c]	7.12	.08	.78
Abbreviated Dyadic Adjustment Scale										
Total	22.00[a]	4.02	22.54[a]	3.38	21.64[c]	3.04	23.00[c]	4.29	.32	.58

[a]n= 13. [b]n = 12. [c]n= 11.

Table 8

Self-Help Group's Satisfaction Ratings*

Question	M	SD
How useful did you find the resource material ?	5.66	1.53
To what extent has EP helped you deal more effectively with your child's behaviour ?	4.20	1.54
To what extent has EP helped you deal more effectively with problems that arise in your family ?	4.10	1.83
To what extent do you think your relationship with your partner has been improved by reading EP ?	2.05	1.39
How satisfied are you with EP ?	4.52	1.63
If you experience parenting problems in the future, will you refer to EP ?	5.62	1.43
To what extent has EP developed skills that can be applied to other family members ?	4.62	1.72
To what extent has EP Increased your confidence in yourparenting skills ?	4.00	1.38
How is your child's behaviour at this point ?	5.48	.81
How satisfied are you with your child's progress ?	4.52	1.33

* 7-point scales (1 = low point, 7 = high point) based on the Therapy Attitude Inventory (Eyberg, 1993)

Table 9
Correlation of Satisfaction Rating with Other Ratings as Reported by Mothers' in the Self-Help Condition

Variable	Range	M	SD	N	r	p
Expectancy rating	1 low - 7 high	4.08	4.62	11	.66	.02*
Socio-Economic Status	1 high - 7 low	4.06	.84	8	.46	.13
PDRC Problem score	0 - 204	33.14	13.79	13	.04	.45
ECBI Intensity score	36 - 252	128.71	20.56	13	-.17	.29
ECBI Problem score	0 - 36	13.36	5.06	13	-.17	.29
PPC Intensity score	16 - 112	30.15	10.45	12	-.48	.06
PPC Problem score	0 - 16	5.00	3.16	12	.01	.49
DASS Depression score	0 - 42	4.79	4.78	13	-.49	.04*
DASS Anxiety score	0 - 42	2.14	3.13	13	-.46	.06
DASS Stress score	0 - 42	10.29	4.43	13	-.11	.36
Child's current behaviour	1 low-7 high	5.77	.73	13	.35	.12
Child's progress	1 low-7 high	5.08	1.04	13	.48	.05*

*$p \leq .05$.

depression and lower expectations of the effectiveness of the book at pre-treatment subsequently reported less satisfaction with the book. Those who reported greater satisfaction with their child's behaviour, expressed greater satisfaction with the book . The correlations between satisfaction and PPC Intensity pre-treatment scores, and DASS Anxiety pre-treatment scores were not significant but revealed a trend towards mothers reporting less satisfaction with Every Parent (Sanders, 1992) if they reported higher levels of anxiety and more intense conflicts with their partner on parenting issues at pre-treatment.

Three-Month Follow-Up

Complete data was available on 9 of the 14 mothers in the SH group at a 3-month follow-up. Seven of the 13 fathers provided follow-up data on the PSOC and eight on the ECBI. 1 X 3 repeated measures ANOVAs were conducted for each of the dependent variables.

Table 10 presents the means, standard deviations, F and p values for the time effects for each of the measures of child behaviour as reported by mothers and fathers. A significant main effect for time was found for mothers' ECBI Problem $F(2, 16) = 3.61$, $p = .05$ and Intensity $F(2, 16) = 5.87$, $p = .01$ scores. A significant main effect for time was also found for PDRC Targeted Behavior Score $F(2, 16) = 7.75$, $p < .01$; and Mean Daily Targeted Score $F(2, 16) = 8.74$, $p < .01$ scores.

Table 11 shows the means, standard deviations, F and p values for the time effects for PS. Analyses revealed a significant main effect for time for PS Laxness $F(2, 16) = 4.69$, $p < .05$; Overreactivity

Table 10

Changes in Child Behaviour Over Time as Measured by Self-Help Parental Reports at 3-Month Follow-Up

	Pre-treatment (n = 14)		Post-treatment (n = 14)		Follow-up (n = 9)			
Variable	M	SD	M	SD	M	SD	F	p
Eyberg Child Behavior Inventory								
Mother Problem	13.36	5.06	9.14	6.88	7.11	4.76	3.61	.05*
Intensity	128.71	20.56	113.50	23.05	111.67	18.01	5.87	.01*
Father Problem	8.18[b]	9.14	8.23[c]	8.92	11.38[a]	10.66	.84	.46
Intensity	127.55[b]	28.94	114.92[c]	27.44	118.88[a]	22.18	1.18	.35
Parent Daily Report Checklist								
Mother								
Total Targeted Behavior Score	29.14	14.71	15.21	12.21	12.00	12.90	7.75	.00**
Mean Daily Targeted Problem Score	4.80	2.44	2.41	1.99	2.00	2.15	8.74	.00**

*$p \leq .05$. **$p \leq .01$. ***$p \leq .001$.

[a] $n = 8$. [b] $n = 11$. [c] $n = 13$.

Table 11

Changes in Parenting Style Over Time as Measured by Mothers' Self-Reports at 3-Month Follow-Up

	Pre-treatment (n = 14)		Post-treatment (n = 14)		Follow-up (n = 9)			
Variable	M	SD	M	SD	M	SD	F	p
Parenting Scale								
Mother								
Laxness	2.94	.88	2.55	.70	2.31	.51	4.69	.03*
Verbosity	3.37	.77	2.96	.72	3.14	.43	5.35	.02*
Over-reactivity	3.13	.53	2.86	.68	2.57	.57	8.40	.00**

*p < .05. **p < .01.

$F(2, 16) = 8.40$, $p < .01$; Verbosity $F(2, 16) = 5.35$, $p < .05$; and Total $F(2, 16) = 4.68$, $p < .05$ scores.

Table 12 contains the means, standard deviations, F and p values for the time effects on parents' PSOC scores. Only Fathers' Efficacy scores on the PSOC revealed a significant main effect for time $F(2, 12) = 4.96$, $p < .05$.

Table 13 shows the means, standard deviations, F and p values for the time effects on the DASS. Mothers' Stress and Total scores showed a significant main effect for time with $F(2, 16) = 7.45$, $p < .01$ and $F(2, 16) = 5.15$, $p < .05$ respectively.

Table 14 contains the means, standard deviations, F and p values for the time effects for PPC and ADAS, neither of which were significant. Given that all of the scores were within the normal range at post-treatment, no further reductions were possible. Consequently, the lack of any further improvement is likely to be due to a floor effect.

Paired samples t-tests revealed that, apart from a few exceptions, mean scores on the dependent variables decreased from pre- to post-treatment and the changes were maintained at follow- up. Exceptions were the PS Overreactivity and Verbosity scores. Overreactivity scores did not decrease significantly from pre- to post-treatment, $t (1,13) = -1.99$, $p > .05$, but did from pre-treatment to follow-up, $t (1,8) = -4.34$, $p < .01$. Verbosity decreased between pre- and post-treatment, $t (1,13) = -2.56$, $p < .05$, but reverted to pre-treatment levels by follow-up $t (1,8) = -3.73$, $p < .01$. Fathers' PSOC Efficacy scores did not decrease significantly between pre- and post-treatment, $t (1,10) = .35$, $p = > .05$, but increased significantly between post-treatment and follow-up, $t (1,6) = -3.75$, $p < .01$. A post-hoc chi-square analysis of the clinical change in SH mothers' ECBI scores from post-treatment to follow-up revealed a significant

Table 12

Changes in Parenting Sense of Competency Over Time as Measured by Parental Self-Reports at 3-Month Follow-Up

	Pre-treatment (n = 14)		Post-treatment (n = 14)		Follow-up (n = 9)			
Variable	M	SD	M	SD	M	SD	F	p
Parenting Sense of Competency								
Mother Satisfaction	33.57	4.90	34.29	5.74	35.78	6.48	1.07	.37
Efficacy	25.93	3.89	28.36	3.30	27.33	4.87	2.02	.17
Father Satisfaction	36.77[a]	5.83	36.25[b]	6.33	36.29[c]	7.21	3.18	.08
Efficacy	27.31[a]	3.01	26.83[b]	3.10	27.86[c]	4.53	4.96	.03*

*$p < .05$.

[a]$n = 13$. [b]$n = 12$. [c]$n = 7$.

Table 13

Changes in Affect Over Time as Measured by Mothers' Self-Reports at 3-Month Follow-Up

	Pre-treatment (n = 14)		Post-treatment (n = 14)		Follow-up (n = 9)			
Variable	M	SD	M	SD	M	SD	F	p
Depression, Anxiety and Stress Scales								
Depression	4.79	4.78	2.50	2.31	2.11	2.15	2.90	.08
Anxiety	2.14	3.13	1.29	1.82	.89	1.17	1.52	.25
Stress	10.29	4.43	6.36	3.52	5.11	3.98	7.45	.01*

*$p < .05$.

Table 14

Changes in Interpersonal Relationships Over Time as Measured by Mothers' Self-Reports at 3-Month Follow-Up

	Pre-treatment (n = 14)		Post-treatment (n = 13)		Follow-up (n = 8)			
Variable	M	SD	M	SD	M	SD	F	p
Parent Problem Checklist								
Problem	5.00	3.16	2.54	1.20	5.63	5.10	2.67	.10
Intensity	30.15	10.45	26.46	6.91	28.88	10.71	1.83	.20
Abbreviated Dyadic Adjustment Scale								
Total	22.00	4.02	22.54	3.38	22.13	3.04	.27	.77

difference for the direction of change, $\chi^2 = 9.00$, $\underline{df} = 3$, $\underline{p} < .05$. One of the children had remained in the clinical range throughout the study, two had reverted to the clinical range at follow-up after moving into the non-clinical range at post-treatment, four had maintained the non-clinical status which they had achieved at post-treatment into follow-up, and two who were still in the clinical range at post-treatment had moved into the non-clinical range at follow-up.

Discussion

Child Behaviour

Contrary to predictions, the SH group of mothers, compared to a WL control group did not report significantly less disruptive behaviour in their children at post-treatment. Rather, mothers in both the SH and WL conditions reported a decrease from pre- to post-treatment which, in the SH group, was maintained at 3-month follow-up. Fathers' ECBI scores did not change from pre- to post-treatment. Overall, fathers' ratings indicated that they found their childrens' behaviour less problematic than did the mothers. This finding is consistent with previous research and has been explained by fathers' limited exposure to children due to work commitments and the possibility that children behave differently with fathers and mothers (Webster-Stratton, 1988). Although there were decreases in ECBI scores between pre- and post-treatment for mothers in the SH group, these decreases were not significantly greater than those that occurred over time in the WL group.

Parenting Style

It was predicted that, at post-treatment, the SH group would report a lower level of dysfunctional parenting practices than the WL group. However, both groups of mothers reported a significant drop in Laxness, and Verbosity between pre- and post-treatment and at post-treatment there was no significant difference between the two conditions. Whilst the decrease in Laxness was maintained by the SH group at a 3-month follow-up, the change in Verbosity was not.

Parenting Sense of Competency

It was predicted that the SH group of mothers would report higher levels of parenting competency than the WL group at post-treatment, but all mothers improved significantly over time, regardless of condition. These changes were maintained by the SH group at follow-up. A surprising finding, however, was that the WL group of fathers reported a statistically significant increase in their sense of satisfaction whilst the SH group reported no change. It is important to note that the mean scores only increased by 2.10 points from pre- to post-treatment, and both of these scores fall within one standard deviation of the mean for non-clinic families. Consequently, although statistically significant the change does not appear to be clinically significant.

Parental Affect

All mothers reported a significant decrease in scores on measures of anxiety and stress between pre- and post-treatment and there was no significant difference between the conditions. The scores were subject to a "floor effect" as scores were well within the normal range at pre-, post- and follow-up assessments, giving little opportunity for improvement. The reductions in anxiety and stress may have reflected improvement in the children's behaviour. However, the changes were not clinically significant.

Interpersonal Relationships

The lack of change in mothers' relationships with their partners from pre- to post-treatment was again largely due to a "floor effect" as the scores on measures of satisfaction and conflict were in the

normal range at pre-treatment. Respondents indicated that they were satisfied with their relationships and that conflict over parenting issues was contained within the normal range.

Consumer Satisfaction

Mothers' responses on the Satisfaction Questionnaire showed, along with previous research (Ogles, et al, 1991; Spence & Sharpe, 1993), that the best predictor of satisfaction with a self-help program is the degree of confidence they have in the effectiveness of the program. Consequently, the more confidence mothers had in the effectiveness of a self-help book prior to commencing the program, the more likely they were to express satisfaction with the program. Mothers who reported more parental conflict and higher levels of depression and anxiety were likely to be less satisfied with the outcome. The finding that mothers' satisfaction was unrelated to the children's behaviour at post-treatment was surprising. One possible explanation is that mothers have an internal set of criteria, established prior to commencing a self-help program, which they use to determine the success or failure of the program. The degree of success that they expect may be one of the factors which influences their evaluation.

Study Limitations

The present study was limited by four major factors. First, the sample size was limited to 30 due to budget restrictions and the difficulty of attracting eligible participants. In addition, there were a number of dropouts which meant that some analyses were conducted with very small numbers. For example, only nine families were

available for the follow-up analyses. This resulted in a reduction in the power of the experiment (rarely reaching 0.8) so that the risk of Type II errors increased. Consequently significant effects may have been incorrectly rejected on statistical grounds. Second, selection criteria were strictly applied in order to minimise the effect of extraneous variables. Consequently, parents and children with a range of physical, mental or developmental disorders were excluded which severely restricted the selection pool. This reduced the generality of any experimental findings. Third, the fact that the participants fell within the non-clinical range on all measures, apart from the ECBI, lead to a floor effect. Statistically significant changes from pre- to post-treatment, were usually minute and remained within the normal range throughout the study on measures of parenting and personal adjustment. Consequently, it was difficult to evaluate the clinical significance of any movement in the scores. A further complication was that the WL group tended to show significant improvements over time, along with the SH group, a result not previously found in similar research (e.g., Connell, Sanders & Markie-Dadds, in press; Markie-Dadds & Sanders, in press). Therre are a number of possible explanations for this finding. Firstly, the children's behaviour may improve with maturation, regardless of any actions their parents may have taken. Secondly, there may have been a placebo effect from completing the initial selection questionnaires. Merely responding to the questions may have been sufficient to heighten mothers' awareness to the many aspects of parenting which are associated with child behaviour outcomes. This may have been enough to prompt changes in their behaviour which, in turn, produced a decrease in their perception of their children's problem behaviours.

Certainly many mothers mentioned in their post-assessment questionnaires that simply completing the questionnaire made them look at their parenting behaviour and its relationship to their children's behaviour problems. Subsequently they may have changed their behaviour without recourse to books or other sources of advice. Perhaps these parents, by virtue of self-selecting for a self-help reading program may already have highly developed self-regulatory processes which were triggered by the initial assessment process. Certainly, there is evidence to suggest that those who are self-help readers by choice, implement changes suggested in the books they read, and have a strong belief in their ability to change themselves and their behaviour (Delin & Delin, 1994). A third reason may relate to the unique design of this study in which there was little contact between the researcher and the participants during the course of the study. Unlike the Connell, Sanders & Markie-Dadds (in press) study, participants were not contacted regularly to ensure that they were reading the book or implementing the strategies advocated therein. Such contact risks introducing such non-specific factors as self-monitoring, approval seeking and treatment compliance into the experimental equation thereby creating a placebo effect in the self-help treatment group which may confound statistical findings. In the present study, however, the SH and WL conditions were psychologically identical and provided a more appropriate method for determining valid effect sizes. Bowers & Clum's (1988) finding that treatment effect sizes are reduced when a psychological placebo control group rather than a no-treatment control group is used may explain the small effect sizes in the present study.

Conclusions and Future Directions

This study fails to provide conclusive statistical evidence that a self-help parenting book promoting BFI strategies, is a more effective minimal intervention for reducing levels of disruptive child behaviour or in changing parental behaviour than the passage of time. Others have also found that parent training does not produce clinically significant changes in children's behaviour in an estimated 30-50% of cases (Patterson, Dishion & Chamberlain, 1993; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989). In addition, BFI may not be suitable for delivery within a truly self-help format.

Methodological problems such as small sample size and the homogeneity of the sample may have obscured significant statistical and clinical effects and will need to be addressed in future studies. It is also recommended that clinical and non-clinical experimental and control groups be utilised in order to clarify the extent of experimental effect, regression to the mean and placebo effects. Mothers reported considerable satisfaction with the book and its usefulness as a parenting aide. Unfortunately, it is beyond the scope of this study to discover why mothers should have reacted so favourably to the book. In order to answer this question, future research must examine further the role and mechanics of expectancy and self-regulation in the evaluation of task performance and outcome. Clearly, such investigations have wider implications than just in the field of BFI self-help intervention programs. Given the economic advantages of a minimalist, early intervention/prevention approach such as a self-help book, should one unequivocally be shown as effective, further research in this area would appear to be warranted.

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Appendix A

Introductory Letter: Pre-Assessment Package

Dear

Thankyou for agreeing to participate in the **Positive Parenting of Preschoolers 'Every Parent' Self-Help Program**. As I mentioned on the phone, in this study, you will be randomly allocated to one of two groups: Group 1 receives the program immediately; Group2 receives the program after a 10-week waiting period.

The waiting period for Group 2 is necessary in order to discover whether any chamges in the families who complete the program are due to the material presented or to the passage of time alone.

Families are not allocated to a group until all of their assessment booklets have been completed and returned. Therefore, the sooner you can complete the enclosed assessment booklet an return it via the reply paid envelope, the sooner you can begin the program. The instructions for completing each questionnaire are at the top of each form. Please read the instructions carefully and if you have any questions, please call me on (07) 38511159 or (07) 3655366.

I have attached a questionnaire to the front of your assessment bookleyt which needs to completed each day for seven days. Please start completing this form as soon as you receive this letter.

As soon as I receive your completted asessemnt booklet, I will let you know to which group you have been allocated.

Yours sincerely,

Fiona Sandilands

Appendix B

Eyberg Child Behavior Inventory

EYBERG CHILD BEHAVIOUR INVENTORY

rections: Below are a series of phrases that describe children's behaviour. Please (1) circle the mber describing **how often** the behaviour **currently** occurs with your child, and (2) circle either s" **or** "no" to indicate whether the behaviour is **currently a problem.**

		How often does this occur with your child?							Is this a problem for you?	
		Never	Seldom	Sometimes		Often		Always		
.	Dawdles in getting dressed	1	2	3	4	5	6	7	YES	NO
.	Dawdles or lingers at mealtime	1	2	3	4	5	6	7	YES	NO
.	Has poor table manners	1	2	3	4	5	6	7	YES	NO
.	Refuses to eat food presented	1	2	3	4	5	6	7	YES	NO
.	Refuses to do chores when asked	1	2	3	4	5	6	7	YES	NO
.	Slow in getting ready for bed	1	2	3	4	5	6	7	YES	NO
.	Refuses to go to bed on time	1	2	3	4	5	6	7	YES	NO
.	Does not obey house rules on own	1	2	3	4	5	6	7	YES	NO
.	Refuses to obey until threatened with punishment	1	2	3	4	5	6	7	YES	NO
0.	Acts defiant when told to do something	1	2	3	4	5	6	7	YES	NO
1.	Argues with parents about rules	1	2	3	4	5	6	7	YES	NO
2.	Gets angry when doesn't get own way	1	2	3	4	5	6	7	YES	NO
3.	Has temper tantrums	1	2	3	4	5	6	7	YES	NO
4.	Answers back to adults	1	2	3	4	5	6	7	YES	NO
5.	Whines	1	2	3	4	5	6	7	YES	NO
6.	Cries easily	1	2	3	4	5	6	7	YES	NO
7.	Yells or screams	1	2	3	4	5	6	7	YES	NO
8.	Hits parents	1	2	3	4	5	6	7	YES	NO
9.	Destroys toys and other objects	1	2	3	4	5	6	7	YES	NO
0.	Is careless with toys and other objects	1	2	3	4	5	6	7	YES	NO
1.	Steals	1	2	3	4	5	6	7	YES	NO
2.	Lies	1	2	3	4	5	6	7	YES	NO
3.	Teases or provokes other children	1	2	3	4	5	6	7	YES	NO
4.	Verbally fights with friends own age	1	2	3	4	5	6	7	YES	NO

		How often does this occur with your child?							Is this a problem for you?	
		Never	Seldom		Sometimes		Often	Always		
5.	Verbally fights with sisters and brothers	1	2	3	4	5	6	7	YES	NO
6.	Physically fights with friends own age	1	2	3	4	5	6	7	YES	NO
7.	Physically fights with sisters and brothers	1	2	3	4	5	6	7	YES	NO
8.	Constantly seeks attention	1	2	3	4	5	6	7	YES	NO
9.	Interrupts	1	2	3	4	5	6	7	YES	NO
0.	Is easily distracted	1	2	3	4	5	6	7	YES	NO
1.	Has short attention span	1	2	3	4	5	6	7	YES	NO
2.	Fails to finish tasks or projects	1	2	3	4	5	6	7	YES	NO
3.	Has difficulty entertaining self alone	1	2	3	4	5	6	7	YES	NO
4.	Has difficulty concentrating on one thing	1	2	3	4	5	6	7	YES	NO
5.	Is overactive or restless	1	2	3	4	5	6	7	YES	NO
6.	Wets the bed	1	2	3	4	5	6	7	YES	NO

Appendix C

Parenting Sense of Competency Scale

BEING A PARENT SCALE

On this questionnaire are 16 items relating to your feelings about being a parent. Please read each item carefully and rate whether you feel it applies to you, by circling a number from 1 (strongly agree) to 6 (strongly disagree) on the scale.

The rating scale is as follows:

1. Strongly agree
2. Agree
3. Mildly agree
4. Mildly disagree
5. Disagree
6. Strongly disagree

1. The problems of taking care of a child are easy to solve once you know how your actions affect your child, an understanding I have acquired.	1	2	3	4	5	6
2. Even though being a parent could be rewarding, I am frustrated now while my child is at his/her present age.	1	2	3	4	5	6
3. I go to bed the same way I wake up in the morning, feeling I have not accomplished a whole lot.	1	2	3	4	5	6
4. I do not know why it is, but sometimes when I'm supposed to be in control, I feel more like the one being manipulated.	1	2	3	4	5	6
5. My father was better prepared to be a good father than I am.	1	2	3	4	5	6
6. I would make a fine model for a new father to follow in order to learn what he would need to know in order to be a good parent.	1	2	3	4	5	6
7. Being a parent is manageable and any problems are easily solved.	1	2	3	4	5	6
8. A difficult problem in being a parent is not knowing whether you're doing a good job or a bad one.	1	2	3	4	5	6
9. Sometimes I feel like I'm not getting anything done.	1	2	3	4	5	6
10. I meet my own personal expectations for expertise in caring for my child.	1	2	3	4	5	6

11. If anyone can find the answer to what is troubling my child, I am the one.	1	2	3	4	5	6
12. My talents and interests are in other areas, not in being a parent.	1	2	3	4	5	6
13. Considering how long I've been a father, I feel thoroughly familiar with this role.	1	2	3	4	5	6
14. If being a father were only more interesting, I would be motivated to do a better job as a parent.	1	2	3	4	5	6
15. I honestly believe that I have all the skills necessary to be a good father to my child.	1	2	3	4	5	6
16. Being a parent makes me tense and anxious.	1	2	3	4	5	6

Appendix I

The 'Every Parent' Self-Help Program Expectancy Form

THE 'EVERY PARENT' SELF-HELP PROGRAM

EXPECTANCY FORM

Client No._____ Date:_____

At this stage, how confident do you feel that the program your family is about to receive will be effective ?

Please circle the number below that best corresponds to your opinion.

1	2	3	4	5	6	7
Not at all confident			Reasonably confident			Extremely confident

Appendix J

The Client Satisfaction Questionnaire

Client No:
Date: / /
Mo/Fa:

THE 'EVERY PARENT' SELF-HELP PROGRAM

CLIENT SATISFACTION QUESTIONNAIRE

This questionnaire will help evaluate the book 'Every Parent'. I am interested in your honest opinions, both positive and negative. Please answer all questions and thanks for helping.

Please circle the letter corresponding to your response.

1 What type of help were you seeking from the 'Every Parent' Self-Help Program ? *(Please specify)*

.....

.....

.....

.....

.....

2 Which of your child's needs were you hoping to meet through the program ? *(Please specify)*

.....

.....

.....

.....

.....

3 Which of your needs were you hoping to meet through the program ? *(Please specify)*

.....

.....

.....

.....

.....

4 How much of 'Every Parent' have you read so far ?

a. None of it
b. All of it
c. Only the sections relevant to my child
d. Briefly skimmed through
e. Other *(Please specify)*

.....

.....

If you circled (a), go straight to Q 24.

5 What was your approach to reading 'Every Parent'?

a. Read it as soon as I received it and haven't looked at it since
b. Read it as soon as I received it and have occasionally referred to it since
c. Read it as soon as I received it and have often referred to it since
d. Read small amounts at regular intervals over the last 10 weeks
e. Other *(Please specify)*

.....

.....

6 Did you use any of the strategies described in 'Every Parent'?

a. No
b. Yes

If you circled (b) go straight to Q 8.

7 Why didn't you try any of the strategies described in 'Every Parent' ?

You may circle more than one response.

a. I didn't have time.
b. I couldn't be bothered
c. The strategies seemed to take too much time and effort to implement
d. My partner wouldn't support me
e. I didn't have the materials required
f. My house isn't suitable
g. None of the strategies are suitable for my child's particular problem behaviours
h. I wasn't sure that I would use the strategies correctly and was afraid of 'harming' my child if I used them incorrectly
i. They weren't explained clearly enough
j. I've tried them all before and they didn't work
k. Other *(please specify)*

.....

.....

.....

8 Using the chart below, please specify which strategies you used for particular problem behaviours; whether you explained to your child what you were going to do; whether you conducted a practice run or role play with your child; rate how successful you found the strategy*; and give possible reasons why some strategies may have been less successful than others.

**** Rating scale is provided below chart.***

PROBLEM	STRATEGY	EXPLAINED	PRACTISED	RATING	REASONS
Example:					
Not eating dinner	Behaviour chart	yes	no	3 (no change)	Rewards not attractive enough; made it too hard for him to earn a reward; he lost interest

***RATING SCALE**

1	2	3	4	5
Problem behaviour **worsened markedly**	Problem behaviour **worsened somewhat**	Problem behaviour **unchanged**	Problem behaviour **lessened**	Problem behaviour **ceased**

9 Did you use any of the resource materials provided at the back of the book ?

a. Yes
b. No

If you circled (b), go straight to Q 11.

Please <u>circle the number</u> corresponding to the response that best describes how you feel.

10 How useful did you find the resource materials ?

1	2	3	4	5	6	7
Not at all useful		Not very useful		Quite useful		Extremely useful

11 Did you receive the type of help you wanted from the program ?

7	6	5	4	3	2	1
Yes definitely		I suppose so		Not really		No, definitely not

12 To what extent has the program met your child's needs ?

1	2	3	4	5	6	7
No needs were met		Some needs were met		Most needs were met		All needs were met

13 To what extent has the program met your needs ?

7	6	5	4	3	2	1
All needs were met		Most needs were met		Some needs were met		No needs were met

14 To what extent has 'Every Parent' helped you deal more effectively with your child's behaviour ?

1	2	3	4	5	6	7
It did not help at all		It helped a little bit		It helped quite a lot		It helped enormously

15 To what extent has 'Every Parent' helped you deal more effectively with problems that arise in your family ?

7	6	5	4	3	2	1
It helped enormously		It helped quite a lot		It helped a little bit		It did not help at all

16 To what extent do you think your relationship with your partner has been improved by reading 'Every Parent' ?

1	2	3	4	5	6	7
Not at all		A little bit		Quite a lot		Enormously

17 In general, how satisfied are you with 'Every Parent' ?

7	6	5	4	3	2	1
Extremely satisfied		Quite satisfied		Somewhat satisfied		Not at all satisfied

18 If you experience parenting problems in the future, will you refer to 'Every Parent' ?

1	2	3	4	5	6	7
No, definitely not		No, probably not		Yes, probably		Yes, definitely

19 To what extent has the program helped you develop skills that can be applied to other family members ?

7	6	5	4	3	2	1
It helped a great deal		It helped quite a lot		It helped a little bit		It did not help at all

20 To what extent has 'Every Parent' increased your confidence in your parenting skills ?

1	2	3	4	5	6	7
Not at all		A little bit		Quite a lot		Enormously

21 In your opinion, how is your child's behaviour at this point ?

1	2	3	4	5	6	7
Considerably Greatly worse		Slightly worse		Slightly improved		improved

22 At this point, how satisfied are you with your child's progress ?

7	6	5	4	3	2	1
Extremely satisfied		Quite satisfied		Somewhat satisfied		Not at all satisfied

23 Since beginning this program, if you have sought further assistance from any other source in changing the behaviour of either yourself, your child or other members of your family please provide details below (ie. source; family member; reason why).

.....

.....

.....

24 Have you had any other problems with your child which you feel may be related to the original difficulty ?

.....

.....

.....

25 Do you have any further comments about the book ?

.....

.....

.....

.....

26 Why didn't you read the book ?

You may circle more than one response.

a. Lack of time
b. Too tired
c. Book looked too boring
d. Lost the book
e. Forgot
f. None of the topics in the index looked relevant to my particular problem(s)
g. Other *(please specify)*

.....

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If you have any further comments that you would like to make about 'Every Parent' or this study, please feel free to do so in the space provided below.

.....

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ONCE AGAIN,

THANKYOU FOR YOUR TIME IN PARTICIPATING IN THIS PROJECT

****

Appendix D

Parent Daily Report Checklist

PARENT DAILY REPORT CHECKLIST

1. Place an asterisk beside any of the behaviours listed on the left side of the form that are currently a problem for you.

   A good rule of thumb is to ask yourself whether your child is engaging in a particular behaviour more than an average child of the same age.

2. For each day of the week, place a tick in the correct column if a particular behaviour occurred during that day.

   Go right through the list each day.

3. The checklist must be completed for seven days, although it is not necessary for these seven days of monitoring to be consecutive.

   If your child is absent for only part of the day, for example while at day care or kindy, continue monitoring as usual. Fill in the checklist based on the behaviour you saw in the morning before your child leaves, and in the evening after your child returns.

   However, if your child is not under your direct care for 24 hours or longer, for example if your child is visiting or staying with relatives or friends, do not monitor this day. Instead continue monitoring when your child returns home.

(*) Asterisk problem behaviours in the left hand column.
For each day, place a tick (√) next to any problem behaviour that occurred.

Behaviour	(*)	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Aggressiveness								
Arguing								
Bedwetting								
Competitiveness								
Complaining								
Crying								
Defiance								
Destructiveness								
Fearfulness								
Fighting w/sibs								
Firesetting								
Hitting others								
Hyperactiveness								
Irritableness								
Lying								
Negativism								
Noisiness								
Noncomplying								
Not eating meals								
Pants wetting								
Pouting								
Running around								
Running away								
Sadness								
Selling								
Stealing								
Talking back-adult								
Teasing								
Temper tantrum								
Whining								
Yelling								
Police contact								
School contact								
Parents seen								
Total daily								
Total targeted								

Total Number of Problem Behaviours = _____ Total Number of Targeted Behaviours = _____

Daily Mean of Problem Behaviours = _____ Daily Mean of Targeted Behaviours = _____

Appendix E

Parenting Scale

PARENTING SCALE

At one time or another, all children misbehave or do things that could be harmful, that are "wrong", or that parents don't like. Examples include:

hitting someone	whining	throwing food
forgetting homework	not picking up toys	lying
having a tantrum	refusing to go to bed	wanting a cookie before dinner
running into the street	arguing back	coming home late

Parents have many different ways or styles of dealing with these types of problems. Below are items that describe some styles of parenting.

For each item, circle the number that best describes your style of parenting during the past two months with your child.

SAMPLE ITEM

At meal time...

I let my child decide how much to eat.	1	2	3	4	5	6	7	I decide how much my child eats.

---

1. **When my child misbehaves...**

I do something right away.	1	2	3	4	5	6	7	I do something about it later.

2. **Before I do something about a problem...**

I give my child several reminders or warnings.	1	2	3	4	5	6	7	I use only one reminder or warning.

3. **When I'm upset or under stress...**

I am picky and on my child's back.	1	2	3	4	5	6	7	I am no more picky than usual.

4. **When I tell my child not to do something...**

I say very little.	1	2	3	4	5	6	7	I say a lot.

5. **When my child pesters me...**

I can ignore the pestering.	1	2	3	4	5	6	7	I can't ignore the pestering.

6. **When my child misbehaves...**

I usually get into a long argument with my child.	1	2	3	4	5	6	7	I don't get into an argument.

7. **I threaten to do things that...**

I am sure I can carry out.	1	2	3	4	5	6	7	I know I won't actually do.

8. **I am the kind of parent that...**

sets limits on what my child is allowed to do.	1	2	3	4	5	6	7	lets my child do whatever he or she wants.

9. **When my child misbehaves...**

I give my child a long lecture.	1	2	3	4	5	6	7	I keep my talks short and to the point.

10. **When my child misbehaves...**

I raise my voice or yell.	1	2	3	4	5	6	7	I speak to my child calmly.

11. **If saying no doesn't work right away...**

I take some other kind of action.	1	2	3	4	5	6	7	I keep talking and trying to get through to my child.

12. **When I want my child to stop doing something...**

I firmly tell my child to stop.	1	2	3	4	5	6	7	I coax or beg my child to stop.

13. **When my child is out of my sight...**

I often don't know what my child is doing.	1	2	3	4	5	6	7	I always have a good idea of what my child is doing.

14. **After there's been a problem with my child...**

I often hold a grudge.	1	2	3	4	5	6	7	things get back to normal quickly.

15. **When we're not at home...**

I handle my child the way I do at home.	1	2	3	4	5	6	7	I let my child get away with a lot more.

16. **When my child does something I don't like...**

I do something about it every time it happens.	1	2	3	4	5	6	7	I often let it go.

17. **When there's a problem with my child...**

things build up and I do things I don't mean to do.	1	2	3	4	5	6	7	things don't get out of hand.

18. **When my child misbehaves, I spank, slap, grab, or hit my child...**

never or rarely.	1	2	3	4	5	6	7	most of the time.

19. **When my child doesn't do what I ask...**

I often let it go or end up doing it myself.	1	2	3	4	5	6	7	I take some other action.

20. **When I give a fair threat or warning...**

I often don't carry it out.	1	2	3	4	5	6	7	I always do what I said.

21. **If saying no doesn't work...**

I take some other kind of action.	1	2	3	4	5	6	7	I offer my child something nice so he/she will behave.

22. **When my child misbehaves...**

I handle it without getting upset.	1	2	3	4	5	6	7	I get so frustrated or angry that my child can see I'm upset.

23. **When my child misbehaves...**

I make my child tell me why he/she did it.	1	2	3	4	5	6	7	I say "No" or take some other action.

24. **If my child misbehaves and then acts sorry...**

I handle the problem like I usually would.	1	2	3	4	5	6	7	I let it go that time.

25. **When my child misbehaves...**

I rarely use bad language or or curse.	1	2	3	4	5	6	7	I almost always use bad language.

26. **When I say my child can't do something...**

I let my child do it anyway.	1	2	3	4	5	6	7	I stick to what I said.

27. **When I have to handle a problem...**

I tell my child I am sorry about it.	1	2	3	4	5	6	7	I don't say I'm sorry.

28. **When my child does something I don't like, I insult my child, say mean things, or call my child names...**

never or rarely.	1	2	3	4	5	6	7	most of the time.

29. **If my child talks back or complains when I handle a problem...**

I ignore the complaining and stick to what I said.	1	2	3	4	5	6	7	I give my child a talk about not complaining.

30. **If my child gets upset when I say "No"...**

I back down and give in to my child.	1	2	3	4	5	6	7	I stick to what I said.

Appendix F

Parent Problem Checklist

PARENT PROBLEM CHECKLIST

Directions: Below are a list of issues over child-rearing which parents often discuss. Please (1) circle either "yes" **or** "no" to indicate whether or not each issue has been a problem for you and your partner over the **last 4 weeks**, and (2) circle the number describing the **extent** to which each issue has been a problem for you and your partner in the **last 4 weeks**.

		Has this issue been a problem for you and your partner?		To what extent has this issue been a problem for you and your partner?						
				Not at All	A little		Somewhat		Much	Very Much
1.	Disagreement over household rules (e.g., bedtime, play areas)	YES	NO	1	2	3	4	5	6	7
2.	Disagreement over type of discipline (e.g., smacking children)	YES	NO	1	2	3	4	5	6	7
3.	Disagreement over who should discipline the children	YES	NO	1	2	3	4	5	6	7
4.	Fighting in front of the children	YES	NO	1	2	3	4	5	6	7
5.	Inconsistency between parents	YES	NO	1	2	3	4	5	6	7
6.	Children preventing parents from being alone	YES	NO	1	2	3	4	5	6	7
7.	Disagreement about sharing child care workloads	YES	NO	1	2	3	4	5	6	7
8.	Inability to resolve disagreements about child care	YES	NO	1	2	3	4	5	6	7
9.	Discussions about child care turning into arguments	YES	NO	1	2	3	4	5	6	7
10.	Parents undermining each other, i.e., not backing each other up	YES	NO	1	2	3	4	5	6	7
11.	Parents favouring one child over another	YES	NO	1	2	3	4	5	6	7
12.	Lack of discussion between parents about child care	YES	NO	1	2	3	4	5	6	7
13.	Lack of discussion about anything	YES	NO	1	2	3	4	5	6	7
14.	One parent 'soft' one parent 'tough' with children	YES	NO	1	2	3	4	5	6	7
15.	Children behave worse with one parent than the other	YES	NO	1	2	3	4	5	6	7
16.	Disagreement over what is naughty behaviour	YES	NO	1	2	3	4	5	6	7

Appendix G

Abbreviated Dyadic Adjustment Scale

ABBREVIATED DYADIC ADJUSTMENT SCALE

Most people have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each of the following three items. Please circle the number which best fits your answer.

	Always agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
1. Philosophy of life	5	4	3	2	1	0
2. Aims, goals and things believed to be important	5	4	3	2	1	0
3. Amount of time spent together	5	4	3	2	1	0

How often would you say the following events occur between you and your partner?

	Never	Less Than Once a Month	Once or Twice a Month	Once or Twice a Month	Once a Day	More Often
4. Have a stimulating exchange of ideas	0	1	2	3	4	5
5. Calmly discuss something	0	1	2	3	4	5
6. Work together on a project	0	1	2	3	4	5

The dots on the following line represent different degrees of happiness in your relationship. The middle point, "happy" represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

0	1	2	3	4	5	6
•	•	•	•	•	•	•
Extremely Unhappy	Fairly Unhappy	A little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

Appendix H

Depression Anxiety Stress Scales

DEPRESSION–ANXIETY–STRESS SCALE

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0. Did not apply to me at all
1. Applied to me to some degree, or some of the time
2. Applied to me a considerable degree, or a good part of the time
3. Applied to me very much, or most of the time

1.	I found myself getting upset by quite trivial things.	0	1	2	3
2.	I just couldn't seem to get going.	0	1	2	3
3.	I had a feeling of faintness.	0	1	2	3
4.	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness) in the absence of physical exertion.	0	1	2	3
5.	I felt sad and depressed.	0	1	2	3
6.	I found it hard to calm down after something upset me.	0	1	2	3
7.	I perspired noticeably (e.g., hands sweaty) in the absence of high temperatures or physical exertion.	0	1	2	3
8.	I found myself getting impatient when I was delayed in any way (e.g., lifts, traffic lights, being kept waiting).	0	1	2	3
9.	I found myself in situations which made me so anxious I was most relieved when they ended.	0	1	2	3
10.	I tended to over–react to situations.	0	1	2	3
11.	I found myself getting upset rather easily.	0	1	2	3
12.	I felt that I had nothing to look forward to.	0	1	2	3
13.	I couldn't seem to experience any positive feeling at all.	0	1	2	3
14.	I found that I was very irritable.	0	1	2	3
15.	I was aware of dryness of my mouth.	0	1	2	3
16.	I felt that I had lost interest in just about everything.	0	1	2	3
17.	I could see nothing in the future to be hopeful about.	0	1	2	3
18.	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat).	0	1	2	3
19.	I felt scared without any good reason.	0	1	2	3

20. I felt that life wasn't worthwhile.	0	1	2	3
21. I felt that I was rather touchy.	0	1	2	3
22. I felt that I was using a lot of nervous energy.	0	1	2	3
23. I couldn't seem to get any enjoyment out of the things I did.	0	1	2	3
24. I had a feeling of shakiness (e.g., legs going to give way).	0	1	2	3
25. I felt down-hearted and blue.	0	1	2	3
26. I found it difficult to work up the initiative to do things.	0	1	2	3
27. I found it hard to wind down.	0	1	2	3
28. I was intolerant of anything that kept me from getting on with what I was doing.	0	1	2	3
29. I had difficulty in swallowing.	0	1	2	3
30. I feared that I would be "thrown" by some trivial but unfamiliar task.	0	1	2	3
31. I felt I was pretty worthless.	0	1	2	3
32. I was unable to become enthusiastic about anything.	0	1	2	3
33. I was worried about situations in which I might panic and make a fool of myself.	0	1	2	3
34. I was in a state of nervous tension.	0	1	2	3
35. I felt I was close to panic.	0	1	2	3
36. I felt I wasn't worth much as a person.	0	1	2	3
37. I found it difficult to relax.	0	1	2	3
38. I felt terrified.	0	1	2	3
39. I experienced trembling (e.g., in the hands).	0	1	2	3
40. I found myself getting agitated.	0	1	2	3
41. I felt that life was meaningless.	0	1	2	3
42. I found it difficult to tolerate interruptions to what I was doing.	0	1	2	3