



Preliminary evaluation of the Group Teen Triple P program for parents of teenagers making the transition to high school

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Abstract

Group Teen Triple P is a brief group parenting program for parents of teenagers. It is based on the successful Triple P – Positive Parenting Program for parents of children aged from 0 to 12, with a focus on helping parents manage the transition from late childhood to early adolescence. This paper describes the initial evaluation of a universal trial of the program offered to all parents of students entering their first year of high school at age 12 in a regional north Queensland school. Twenty-seven parents completed a battery of self-report questionnaires immediately before and after participating in the 8-week program. Participating parents reported significant reductions in conflict with their teenager, and on measures of laxness, over-reactivity, and disagreements with their partner over parenting issues. These are well-established parenting risk factors. In addition, parents reported significant improvements on measures of self-regulation, including self-efficacy, self-sufficiency, and self-management, and reductions on measures of depression, anxiety, and stress. It was concluded that a preliminary evaluation of the Group Teen Triple P program achieved its goals of reducing targeted risk factors associated with the development of behavioural and emotional problems in teenagers. The paper concludes with an examination of issues around parent recruitment and engagement which are crucial for the successful provision of effective and timely advice and support for parents of teenagers.

Keywords

Parenting, Triple P, family intervention, early adolescence

Introduction

The research literature in the area of child and adolescent behavioural and emotional problem behaviour now strongly supports refocusing a significant proportion of resources toward an early intervention/prevention model that provides parents with appropriate support and assistance during children's early years (Sanders, 1999). One question that follows is whether there is also a case for splitting this effort by separately targeting the period of early adolescence.

The Australian Temperament Project (ATP), a large scale, longitudinal study that has followed approximately 1600 Victorian children from infancy to 17-18 years of age, recently released data supporting two different pathways associated with the development of antisocial behaviour in adolescents (Vassallo, Smart, Sanson, Dussuyer, McKendry, Toumbourou, Prior & Oberklaid, 2002). During adolescence, three groups were identified on the basis of self-reported involvement in antisocial behaviour. These groups were designated low/non

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antisocial, persistent, and experimental. The latter two groups follow similar trajectories to the early and late starter groups identified by Patterson (Patterson, 1982; Patterson, Capaldi & Banks, 1991) and others (McMahon & Estes, 1997) to describe children whose problem behaviour becomes entrenched in the pre-school years, and those who do not exhibit problem behaviour in early childhood, but become part of a 'late starter' group, with problems emerging in early adolescence. Those in the ATP study who belonged to the persistent group began to exhibit antisocial behaviour at a significantly higher rate than the other two groups from the age of 5-6 years, with these differences increasing until the age of 11-12 when they began to plateau. Those in the experimental group did not begin to exhibit antisocial behaviour at a significantly higher rate than those in the low/non antisocial group until age 12-13, with these differences increasing until the age of 15-16, after which there was a slight downward trend. A similar, but not as extensive, downward trend was also observed for the persistent group when all participants were surveyed at age 17-18. However, as no data have yet been gathered beyond this age, it is not possible to tell whether these downward trends will continue into early adulthood. The authors concur with current thinking that there should be a focus on the early primary school years to prevent the development of persistent antisocial behaviour (the early starter pathway). However, they also go on to conclude that interventions targeting experimental antisocial behaviour should focus on the early secondary school years (the late starter pathway).

A recent survey of parents about their teenagers' behaviour revealed that issues around family conflict and management of emotions featured strongly and were identified as areas where parents wanted assistance (Ralph, Toumbourou, Grigg et al., 2003, this issue). Two recent studies have provided perhaps the clearest picture yet of the parenting constructs that should be targeted when developing early interventions to prevent severe adolescent problems. Metzler, Biglan, Ary and Li (1998), built on work by Dishion, Li, Spracklen et al., (1998) to investigate the association between six parenting constructs (positive family relations, parent-child conflict,

parental rule-making, consistent enforcement of rules, positive reinforcement for desirable behaviour, and parental monitoring), and three adolescent criterion variables (association with deviant peers, antisocial behaviour, substance use). Results showed that parent-child conflict, positive family relations, and parental monitoring were most highly related to the criterion variables. Conflict with parents was strongly associated with contact with deviant peers, substance use, and engaging in antisocial behaviour. High levels of positive family relations, parental monitoring, rule setting, and positive reinforcement for appropriate behaviour were associated with less contact with deviant peers, less engagement in antisocial behaviour, and less substance use.

This paper reports the adaptation of the successful Triple P – Positive Parenting Program developed by Sanders and colleagues at the University of Queensland (Sanders & Markie-Dadds, 1992; Sanders, Markie-Dadds, Tully & Bor, 2000; Sanders & McFarland, 2000) to produce an early intervention program, known as Teen Triple P, for the late starter or experimental group. The intervention features specific strategies that are introduced to parents that aim to enhance the protective factors and reduce the risk factors identified above.

The Triple P model features a five-tiered system of intervention of increasing strength, ranging from media- and information-based strategies, to brief consultation primary care interventions, and on to more intensive parent training and enhanced behavioural family interventions. The enhanced intervention targets parenting skills together with other family adversity factors such as marital conflict, depression and high levels of parenting stress. Triple P's unique features include its universality, use of multiple levels of intervention to facilitate matching of intensity to need, its multidisciplinary nature, the use of flexible delivery modalities (group, individual, self directed and telephone assisted), the promotion of a self-regulatory approach to facilitate maintenance and generalisation, and its targeting of destigmatizing access points. Triple P is designed as an intervention for all parents and its use of the mass media involves saturated exposure and easy access to the program. An

integrated series of controlled outcome studies has been conducted in Australia and more recently overseas which has demonstrated the effectiveness of Triple P for toddlers, preschool and primary school-aged children with conduct problems (the early starter or persistent group). These studies have included both efficacy and effectiveness trials, using both traditional randomised group designs and intra-subject replication designs (Sanders, 1999; Sanders et al., 2000).

Teen Triple P aims to more adequately prepare parents for their child's transition to the teenage years by focusing on the all-too common difficulties for children (and parents) of making a successful transition to high school. Schools provide a potentially convenient and appropriate community-based contact point where parenting issues can be legitimately discussed.

Teen Triple P can be delivered universally; as an indicated prevention program for teenagers who are identified as having detectable problems, but who do not yet meet full diagnostic criteria for a behavioural disorder; and also as an early intervention program for those teenagers who meet diagnostic criteria, with the aim of preventing progression of problem behaviour and severe impairment. It should also be noted that this level of intervention can target parents of individual teenagers thought to be at risk, or an entire population as a preventive approach to risk-reduction. In the current study, a group version of the program is offered universally to all parents in a high school intake, with the aim being to conduct a preliminary trial of the program's efficacy as a universal intervention to reduce risk factors known to be associated with the development of emotional and behavioural problem behaviour for teenagers.

Method

Procedure

Potential participants were 169 parents with 12- to 13-year-old children from a high school servicing a low socio-economic area of a regional city in north Queensland. All participation by parents and their children was entirely voluntary throughout.

At the commencement of the school year, letters were mailed to all parents of newly enrolled Year 8 students advising them about the Group Teen Triple P program and a registration form was included inviting them to register to participate in one of several different group time slots during the coming weeks. Group sessions were offered in the school library at times such as 10am-12 noon, 1-3pm, 4-6pm, and 7-9pm. Parents were also telephoned personally by staff from the schools and the research team and invited to participate in the group program.

Of the 169 families who were contacted, 68 parents indicated they were interested in attending a group, 37 attended at least one group session, and 26 completed the program. In three-quarters of cases only one parent from a family attended, with the remaining quarter of cases being both parents, although they did not always attend all sessions together. Of the 37 parents who attended at least one session, there were only two who were fathers attending without the mother. Four couples attended, and the remainder were mothers.

Five parenting groups were delivered at the commencement of Term 3 (July and August) and were facilitated by one of the principal investigators (2 groups), a clinical psychologist experienced in delivering Group Triple P for parents of younger children (2 groups), and two school guidance staff (2 groups). One of the groups was co-facilitated by the clinical psychologist and one of the school guidance staff, and the other 4 groups were facilitated singly. Groups comprised between 3 and 11 parents. A training day was held prior to the groups being conducted to allow the principal investigator to ensure the facilitators were familiar with the materials, structure, and process of facilitating the groups.

All facilitators were provided with a Facilitator's Kit containing the *Facilitator's Manual for Group Teen Triple P* (Sanders & Ralph, 2002), a copy of the *Teen Triple P Group Workbook* (Ralph & Sanders, 2002) that all participating parents would receive, and a set of overhead transparency slides that are used to present aspects of the group program. In addition, each

facilitator was given a copy of the videotape *Every Parent's Guide to Teenagers* (Ralph & Sanders, 2001) which illustrates much of the content of the Teen Triple P program for parents. After each session, facilitators were required to complete session checklists. These were regularly inspected by the principal investigators to ensure program integrity had been maintained.

Assessment

On arrival at the first group session, and immediately prior to the beginning of the group intervention, parents were asked to complete an assessment booklet. They were advised that they would be requested to complete it again after the completion of the program 8 weeks later. The assessment was designed to compile data on a number of relevant domains as follows.

Parent – teenager conflict. The Conflict Behaviour Questionnaire (CBQ: Prinz, Foster, Kent & O'Leary, 1979; Robin & Foster, 1989) has a number of versions of varying length. The shorter CBQ-20 was selected for this study. The longer measure appears to have adequate validity and reliability, and the shorter form correlates .96 with scores from the longer version. Mean scores for families with distressed status are significantly higher ($p < .001$) than those with nondistressed status. There are two versions of the CBQ-20: one for the parent to complete, and another for the teenager. Statements are rated *True/False* with high scores indicating higher levels of conflict. The teenager was asked to complete one version of the form for their interactions with their father, and another for their interactions with their mother, depending on which parent/s formed the parenting team. Parents were asked to take the teenager forms home and ask their teenager to complete them. An option was provided for the teenager to mail their completed form/s directly to the facilitator, or to seal it separately in an envelope for their parent to return at the following session. Teenagers from 22 of the 27 (81%) families returned completed usable questionnaires.

Parenting style. The Parenting Scale for Adolescents (PS-A) is an adaptation by Irvine, Biglan, Smolkowski and Ary (1999) of the Parenting Scale by Arnold, O'Leary, Wolff and

Acker (1993). The original 30-item questionnaire measures three dysfunctional discipline styles in parents and yields a Total score and three factors: Laxness (permissive discipline); Over-reactivity (authoritarian discipline, displays of anger, meanness and irritability); and Verbosity (overly long reprimands or reliance on talking). The PS-A retains 13 items from the original 30. Factor analysis of the revised items resulted in the Verbosity sub-scale being omitted, leaving two subscales: Laxness, and Over-reactivity. Statements are rated on 6-point Likert scales with higher scores indicating higher levels of parental dysfunction. The revised scale has adequate internal consistency for the Total score ($\alpha = .84$), Laxness ($\alpha = .82$), and Over reactivity ($\alpha = .83$), and has good test-retest reliability ($r = .86, .82$ and $.82$ respectively). The scale has been found to discriminate between parents of clinic and non-clinic children.

Parenting beliefs. The Parenting Beliefs Scale (PBS) is a 22-item questionnaire developed by Sanders (2002) to measure parents' reports of personal agency (10 items), self-efficacy (4 items), self-management (4 items), and self-sufficiency (4 items). Statements are rated on 6-point Likert scales with higher scores indicating higher levels of parental dysfunction.

Conflict over parenting. The Parent Problem Checklist (PPC: Dadds & Powell, 1991) is a 16-item questionnaire which measures inter-parental conflict over child rearing. It rates parents' ability to cooperate and work together in family management. Six items explore the extent to which parents disagree over rules and discipline for child misbehaviour, six items rate the amount of open conflict over child-rearing issues, and a further four items focus on the extent to which parents undermine each other's relationship with their children. The PPC has moderately high internal consistency ($\alpha = .70$) and high test-retest reliability ($r = .90$) (Dadds & Powell, 1991). To obtain a score out of 16, the number of areas of disagreement which the family has experienced in the last month are summed. A revision of the checklist has been made (with the permission of the authors) to include an intensity rating from 1 to 7 for each issue, which provides useful clinical information.

Parental adjustment. The Depression-Anxiety-Stress Scales (DASS-21: S.H. Lovibond & P.F. Lovibond, 1995) comprise a 21-item questionnaire which assesses symptoms of depression, anxiety, and stress in adults. The DASS-21 is a shorter version of the DASS which has high reliability for the Depression ($\alpha = .91$), Anxiety ($\alpha = .84$), and Stress ($\alpha = .90$) sub-scales, and good discriminant and concurrent validity (S.H. Lovibond & P.F. Lovibond, 1995; P.F. Lovibond & S.H. Lovibond, 1995). The DASS-21 has a number of advantages over the DASS including having fewer items, a cleaner factor structure, and smaller interfactor correlations (Antony, Bieling, Cox et al., in press).

Consumer satisfaction. The Client Satisfaction Questionnaire (CSQ) is an adaptation of the Therapy Attitude Inventory (TAI) developed by Eyberg (1993) to measure consumer satisfaction with parent training programs. The TAI has established reliability, internal consistency and discriminant validity (Eyberg, 1993). The CSQ addresses the quality of service provided; how well the program met the parent's needs, increased the parent's skills and decreased the child's problem behaviours; and whether the parent recommend the program to others. The measure derived is a composite score of program satisfaction ratings on 7-point scales (a maximum score of 91 and a minimum score of 13 are possible). For the purposes of program development, parents are also prompted to make general comments or suggestions about any aspect of the program. This instrument was only included at post-test.

Program implementation

Group Teen Triple P is an eight-session program, optimally conducted in groups of 10–12 parents. It employs an active skills training process to help parents acquire new knowledge and skills. The program consists of four two-hour group sessions that provide opportunities for parents to learn through observation, discussion, practice and feedback. Segments from a videotape *Every Parent's Guide to Teenagers* (Ralph & Sanders, 2001) are used to demonstrate positive parenting skills. These skills are then practised in small groups. Parents

receive constructive feedback about their use of skills in an emotionally supportive context. Between sessions, parents complete homework tasks to consolidate their learning from the group sessions. Following the group sessions, four 15–30 minute follow-up telephone sessions provide additional support to parents as they put into practice what they have learned in the group sessions. Although delivery of the program in a group setting may mean parents receive less individual attention than in individual consultation, there are several benefits for parents. These include support, friendship and constructive feedback from other parents as well as opportunities for parents to normalise their parenting experience through peer interactions.

During the group sessions, parents are taught a variety of behaviour management skills including: monitoring problem behaviour; providing brief contingent attention following desirable behaviour; arranging engaging activities; using directed discussion for minor problem behaviour; making clear, calm requests; and backing up instructions with logical consequences. Parents are also taught how to set up behaviour contracts to deal with more resistant or established problem behaviours, and to use family meetings to plan how to make necessary changes to family routines. Specific strategies are used to help parents prepare their teenager to deal with risky behaviours that might put their health or well-being at serious risk and to promote the generalisation and maintenance of parenting skills across settings and over time. This level of intervention combines the provision of information with active skills training and support. However, it also teaches parents to apply parenting skills to a broad range of target behaviours in both home and community settings with the target teenager and siblings.

Results

The analyses tested whether parents who participated in the group parenting programs subsequently reported reductions on measures of targeted family risk factors, and improvements on measures of family functioning. At post-test, usable questionnaires were obtained from 27 parents although there were occasional missing data in some of these. As there was only one

couple who completed both pre- and post-test questionnaires, it was decided to only enter one data set per family, and as there was only one father who completed both pre- and post-test questionnaires, the mother's data were entered for that couple. The parent sample for analysis therefore comprised 25 mothers and one father (see Table 1). As the study was a preliminary trial of the efficacy of the group program, the significance level was set at $p < .05$. As the hypotheses to be tested predicted improvements for the parents who participated in the program, analyses were one-tailed. Exceptions to these criteria will be noted where relevant.

Parent-teenager conflict. Parent-teenager conflict as reported by parents (measured by the CBQ-20) was reduced significantly post-treatment. However, the reduction in teenagers' mean scores was non-significant.

Parenting style. Parental laxness and over-reactivity (measured by the PS-A) both improved significantly at post-treatment. Pre-treatment, these parents were reporting mean scores in excess of parents of clinic-referred children, with these post-treatment scores falling below the scores of parents of non-clinic children on Laxness, but less so on Over-reactivity.

Parental beliefs. Parents reported significant improvements following the group treatment on measures of self-efficacy, self sufficiency, and self-management (measured by the PBS), but not on personal agency.

Parental conflict. On disagreements over their parenting strategies (measured by the PPC), parents reported a significant reduction post-treatment (just above the non-clinical group

Table 1: Mean parent self-report scores at pre- and post-intervention (N=26)

Self-report instrument	Pre M (SD)	Post M (SD)	ANOVA F (time effect)
<i>Conflict Behaviours (Parent)</i>	6.96 (6.02)	4.50 (5.67)	9.76**
<i>Conflict Behaviours (Youth)</i>	3.80 (4.26)	3.05 (4.06)	1.55
<i>Parenting Scale (PS-A)</i>			
Laxness subscale	17.29 (5.84)	13.46 (6.00)	15.99**
Over-reactivity subscale	20.46 (6.85)	17.08 (6.93)	8.91**
Total score	39.71 (10.77)	32.25 (12.42)	15.76**
<i>Parenting Beliefs Scale (PBS)</i>			
Personal agency subscale	38.09 (9.53)	35.46 (11.11)	2.33
Self-efficacy subscale	10.96 (2.46)	8.68 (2.40)	14.34**
Self-sufficiency subscale	12.96 (2.87)	11.27 (2.35)	6.45*
Self-management subscale	9.86 (2.17)	8.14 (2.05)	9.05**
Total score	71.86 (11.10)	63.55 (14.43)	10.24**
<i>Parent Problem Checklist (PPC)</i>			
Problem subscale	5.28 (4.20)	3.11 (3.53)	8.84**
Intensity subscale	26.11 (12.30)	23.17 (12.08)	2.47
<i>Depression-Anxiety-Stress (DASS-21)</i>			
Depression subscale	2.00 (2.15)	1.26 (2.40)	3.35
Anxiety subscale	0.91 (1.51)	0.48 (0.85)	4.87*
Stress subscale	3.39 (2.82)	2.48 (2.97)	4.80*
Total score	6.30 (5.91)	4.22 (5.78)	6.56*
<i>Client Satisfaction Questionnaire (CSQ)</i>	-----	69.87 (9.29)	-----

Note ** $p < .01$. * $p < .05$

mean). However there was no change on the mean intensity scores.

Parental adjustment. Although pre-treatment measures of depression, anxiety, and stress (measured by the DASS-21) revealed non-clinical mean scores, nevertheless, all showed significant improvements post-treatment.

Parent satisfaction. At the completion of the group program, all parents were asked to complete a questionnaire that measured their satisfaction with the group program (measured by the CSQ) and their views on whether it had helped meet their goals for change. Most item mean scores were at 5 or above on the 7-point Likert scales indicating high levels of satisfaction.

Discussion

Preliminary analysis of the Teen Triple P group parenting program shows positive outcomes for most participating parents with significant reductions of targeted risk factors. Mean scores at pre-test support the view that, as a group, these parents were not clinically elevated on the measures employed, although some parents did score in the elevated range. However, as an early intervention/prevention program it is still important to record reductions in the mean scores on measures of identified risk factors and comparable increases in the mean scores of protective factors.

With regard to parent-teenager conflict, although the mean score indicated this was not a very high-conflict group at pre-test, at post-test the group more closely resembled a non-distressed group. On the teen measure of parent-teenager conflict, the pre-treatment mean of 3.80 was within 1 SD below the mean for distressed teenagers ($M = 8.4$, $SD = 6.0$) but also within 1 SD above the mean for non-distressed teenagers ($M = 2.0$, $SD = 3.1$). While at post-test the teenagers more closely resembled a non-distressed group, the change was not significant, partly due to the large variance in the scores. This raises the issue of whether teenagers perceive and/or report lower levels of conflict than their parents, or whether

the instrument is less valid or reliable when used with teenagers. These questions require further investigation.

Laxness and over-reactivity are both parenting styles that are associated with increased risk for teenagers. A lax style tends to allow teenagers access to potentially risky activities without effective parental control or monitoring. An over-reactive style of parenting often leads to serious conflict between the parent and teenager that can lead to family breakdown that also results in teenagers being without effective parental control and monitoring. The mean reductions on both these sub-scales are therefore positive signs that should contribute toward reducing these risks for the teenagers concerned.

One key aspect of the Triple P model, particularly as it relates to the generalisation and maintenance of the gains made during the program, is the promotion of parental self-regulation. Significant improvements in parental self-efficacy, self-sufficiency, and self-management are therefore important indicators that this goal was achieved for these parents, at least in the short-term. Clearly further studies are now needed to determine whether these gains are maintained at follow-up, and whether they correlate with sustained improvements in other areas of parenting.

A further risk factor is inconsistency between parents in relation to rules, expectations, and disciplinary practices. The significant reduction in the mean number of problems identified between parents reduces the impact of this risk factor. Finally, although mean parental adjustment scores were not clinically elevated, there were nevertheless significant improvements on depression, anxiety and stress which can be anticipated to enhance the parents' capacity to be available to their teenagers.

These findings are necessarily only preliminary as the study reports on a small sample of parents. The completion rate of 27 parents (16%) from an initial pool of 169 may appear low but in fact compares favourably with similar studies of parenting groups, especially with this age cohort. In addition, the lack of a

control group makes it difficult to draw firm conclusions about the possible link between parents' participation in the program and the reported changes on the outcome measures. Clearly these findings are encouraging but further studies are now necessary to demonstrate that the improvements can be replicated under controlled conditions. A larger scale trial of the Group Teen Triple P program is now underway and early reports indicate that similar effects are being observed. These findings will be reported after the trial has been completed.

Group facilitators reported anecdotal evidence that many parents enjoyed participating in the group program and parents also reported good consumer satisfaction indicating that the program was appropriate for their needs and helped them to achieve their goals. However there is a clear challenge to be more successful with regard to recruitment and engagement. A level of community awareness was achieved prior to the groups being offered through several features by local newspapers, radio and television. However, these were somewhat brief and a more coordinated and sustained media promotion program would probably have helped to 'seed the ground' more effectively to the point where greater parental awareness and interest could have been generated and perhaps translated into greater participation. Research is badly needed to test this hypothesis as improved strategies for the engagement of parents clearly need to be part of any community-based intervention in the future.

Initial recruitment of parents was accomplished by a letter from the principal, followed by a personal telephone invitation by members of the research team to all parents. The telephone calls seemed to be a very effective way of gaining parents' interest and resulted in 40% of parents expressing interest in participating in a parenting group. However, these calls required a considerable investment of time and effort which may be difficult to sustain. Although the current study was only a preliminary investigation it became clear that greater ownership of the program by the participating school is desirable to maximise parent

engagement, both with the parenting program and with the school more broadly.

However, while 40% of parents expressed interest in participating, only a little over a half of these attended at least one group session. There is thus a clear gap between interest and participation. One possible issue in this regard was the difficulty of organising a close fit between recruitment and program delivery at the very beginning of the school year. Optimising the delivery of the group program by engaging parents at the time their children actually made the transition into high school was thought to be a critical aspect of the intervention. More lead up time to prepare schools at the end of the preceding year would have helped to better test this hypothesis by allowing groups to commence in Term 1. In the event, groups did not commence until Term 2 and several had to be held over until Term 3.

The final aspect of parental engagement is retention throughout the course of the group program. The retention rate for the parenting groups was 75% and although this was below the target set, it still represented a far better retention rate than many other group programs have reported.

In summary, this research study reports a preliminary empirical validation of an early intervention and prevention strategy addressing risk factors associated with behavioural and emotional problems in teenagers. Furthermore, it demonstrates that these results can be obtained by briefly trained school guidance staff. More comprehensive research trials are currently underway to further evaluate the implementation of Teen Triple P, building on the successful efficacy and effectiveness studies already conducted with Triple P for parents of pre-adolescent children.

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