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Preliminary evaluation of a self-directed video-based 1-2-3 Magic parenting program: A randomized controlled trial

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ABSTRACT

The current study examined the effectiveness of a self-directed video-based format of the 1-2-3 Magic parenting program in reducing dysfunctional parenting and child problem behaviors. Eighty-four parents of children aged 2-10 were randomly assigned to either the intervention group (n = 43) or the waitlist control group (n = 41). Participants in the intervention group reported significantly less problem behaviors for their children, and significantly less dysfunctional parenting, at post-intervention when compared to the control group. The results were maintained at 6-month follow-up. There was no significant change on measures of parental adjustment for either group. The current results provide preliminary support for the conclusion that the video-based self-directed format of the 1-2-3 Magic parenting program is suitable as an entry-level intervention in a multi-level intervention model and is suitable for inclusion in a population approach to parenting program delivery.

The link between dysfunctional parenting and child problem behavior, and child abuse and children's social adjustment and mental health, have been well documented (Bayer et al., 2011; Gershoff, 2010; Odgers et al., 2008; Saul et al., 2014; Scott, Doolan, Beckett, Harry, & Cartwright, 2011). These findings suggest that an early intervention public health approach targeting parenting skills and a reduction in child problem behavior would be worthwhile (Kirp, 2011; Sanders, 2010; Saul et al., 2014; Webster-Stratton & Taylor, 2001). Parenting interventions that effectively reduce child problem behaviors and dysfunctional parenting are based on a combination of cognitive, social learning, and behavioral models. Their key components include: (1) psycho-education about underlying maladaptive parental thinking patterns; (2) parental emotional self-regulation; (3) adaptive parental communication styles in interactions with their child; and (4) an emphasis on controlling children's externalizing behaviors. It is thought that the latter, such as temper tantrums, can be better managed through consistency in responding and correctly applied time-out (Aunola & Nurmi, 2005; Centers for Disease Control and Prevention [CDC], 2009; Tully, 2008; Wade, Macvean, Falkiner, Devine, & Mildon, 2012). All of these together should, in the longer term, improve outcomes for parent and child.

Several evidence-based early-intervention parenting programs that address the above parenting skills are available for parents with children aged 2–12. These programs include *1-2-3 Magic Effective Discipline for Children* (Phelan, 2014, 2010b); *Communication Method* (*Comet*; Kling, Forster, Sundell, & Melin, 2010); *Helping the Noncompliant Child* (McMahon & Forehand, 2003); *Incredible Years* (*IY*; Webster-Stratton, 1984); *Parent Management Training - Oregon Model* (*PMTO*; Forgatch & Patterson, 2010); *Parent Child Interaction Therapy* (*PCIT*; Eyberg, 1988); *Systematic Training for Effective Parenting* (*STEP*; Dinkmeyer & McKay, 1976); and the *Triple P – Positive Parenting Program* (*Triple-P*; Sanders, 1999). Despite this choice, engagement in parenting programs is generally low (Koerting et al., 2013; Nix, Bierman, McMahon, & the Conduct Problems Prevention Research Group, 2009; Thornton & Calam, 2011). A number of barriers to accessing therapist-assisted parenting programs have been identified. There are practical barriers, such as distance, cost, conflicting work schedules, and lack of child care (Flaherty & Cooper, 2010; Mytton, Ingram, Manns, & Thomas, 2014; O'Brien & Daley, 2011) as well as service

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availability barriers, such as a limited amount of low-cost programs offered in community settings, long waiting lists, and insufficient referrals (Koerting et al., 2013). In addition, there are also psychological barriers, such as concerns about confidentiality and stigma (Koerting et al., 2013; O'Brien & Daley, 2011) and parental preference for self-administered programs (Metzler, Sanders, Rusby, & Crowley, 2012).

Parenting programs that are entirely self-directed – without any help from a therapist – can overcome most of these barriers and are, therefore, well suited to reach parents who might otherwise not engage in a parenting program. This makes parenting programs that are entirely self-directed particularly well placed for inclusion in a public health delivery approach. In addition, parenting programs that are entirely self-directed can function as the entry-level intervention in a multi-level delivery approach, providing the lowest level of intervention in terms of intensity and cost (Enebrink, Högström, Forster, & Ghaderi, 2012; Sanders, Baker, & Turner, 2012). Phelan (2010b) states that only 50% of parents need to move on to a more intensive level of intervention, making self-directed parenting programs a cost-effective component in a multi-level intervention model. Finally, self-directed parenting programs may be helpful for caregivers who are waitlisted to participate in a therapist-assisted parenting program in a community setting but who may need help more urgently (Phelan, 2010b). For all of theses reasons, self-directed parenting programs are well suited for integration into multi-level intervention models and a public-health approach to parenting program delivery, with the aim to increase effective parenting skills, reduce child problem behavior, and prevent child abuse.

Self-directed programs come in many delivery formats – print-media (books, manuals, or workbooks), audio (CD or downloadable), video (DVD or TV-program) as well as online internet-based programs (Montgomery, Bjornstad, & Dennis, 2006). Several of the parenting programs mentioned above are available in such self-directed formats. A number of parenting programs that are entirely self-directed have been evaluated: (1) the 7-session, internet-based Comet (Enebrink et al., 2012); (2) the 10-session, video-based IY (Webster-Stratton, 1990) and workbook-based IY (Lavigne et al., 2008); (3) the 10-session, workbook-based Self-directed Triple-P (Markie-Dadds & Sanders, 2006) and Self-help Triple-P (Sanders, Dittman, Farruggia, & Keown, 2014); (4) the 6-episode, TV-based Triple-P (Calam, Sanders, Miller, Sadhnani, & Carmont, 2008); and (5) the 8-module internet-based Triple-P Online (Sanders et al., 2012). All of these have shown to be effective in reducing child problem behaviors and dysfunctional parenting.

The self-directed video-based format of the 1-2-3 Magic parenting program, which consists of two videos (Booth & Phelan, 2004a, 2004b), has not been evaluated as yet. This is surprising because, with a combined viewing time of less than 4 h, it is one of the shortest self-directed parenting programs available and is well suited for parents who would not engage in therapist-assisted parenting programs, or in longer self-directed parenting programs. The parenting strategies illustrated in the two videos (Booth & Phelan, 2004a, 2004b) are based on cognitive, social learning, and behavioral models. The programs contain psycho-education about children's cognitive developmental stages and parental erroneous beliefs, as well as parental modeling of emotion self-regulation. They also teach parents how to enable their child to self-regulate emotions (through observing their parents and through having time to adjust while parents use the 1-2-3 counting system). In addition, the program helps parents to use praise and other incentives to encourage desirable behaviors and time-out or time-out alternatives to stop persistent problem behaviors (Phelan, 2014). The 1-2-3 Magic videos (Booth & Phelan, 2004a, 2004b), or excerpts from them, have been used in a range of evidence-based therapist-assisted delivery formats of the 1-2-3 Magic parenting program. In small-group formats, this has included using video material and discussion (Bradley et al., 2003) and using excerpts of the videos and a manualized presentation based on the Australian version of the program (Flaherty & Cooper, 2010; based on Hawton & Martin, 2006). In large-group formats, we have previously used video material and discussion based on the speed-delivery format of the program (Porzig-Drummond, Stevenson, & Stevenson, 2014; based on Phelan, 2010b) as well as using video excerpts and manualized presentation (Porzig-Drummond et al., 2014; based on Hawton and Martin, 2011). However, the 1-2-3 Magic videos (Booth & Phelan, 2004a, 2004b) are not only shown during therapist-assisted program delivery. They are also widely used as a basis for independent self-instruction (Phelan, 2014, 2010b), with almost 300,000 copies of the videos sold (T.W. Phelan, personal communication, July 2014). Despite the extensive use of the 1-2-3 Magic videos as a self-directed program, their effectiveness in reducing child problem behaviors and dysfunctional parenting has not been evaluated.

In summary, there are several reasons for evaluating the self-administered video-based 1-2-3 Magic parenting program. First, the program is considerably shorter than other self-directed parenting programs that target child problem behavior and dysfunctional parenting. The combined viewing time for both videos is less than 4 h, which compares favorably with 6–10 h required for completion of the self-directed programs outlined earlier. Its brevity makes the self-directed video-based 1-2-3 Magic program particularly suited for parents who would not engage in longer programs and, because of this, it would be beneficial to include the self-directed program as an option in a public health delivery approach. Second, the self-directed video-based program is suitable as an entry-level intervention in a multi-level intervention model. Third, the self-directed video-based 1-2-3 Magic program can serve as an 'emergency intervention' for caregivers who are waiting to attend a therapy-assisted 1-2-3 Magic program but who urgently need help with children displaying problem behaviors. Finally, the self-directed video-based 1-2-3 Magic program is commercially available and widely used without input from a therapist, but its effectiveness has not been evaluated.

Thus the aim of this study was to investigate whether the brief and entirely self-directed video-based format of the 1-2-3 Magic parenting program (Booth & Phelan, 2004a, 2004b) would reduce problem behaviors in children aged 2–12 and dysfunctional parenting. There is currently favorable evidence for both self-directed parenting programs, and for therapist-assisted formats of the 1-2-3 Magic parenting program. Consequently, we hypothesized that the self-directed video-based 1-2-3 Magic parenting program would be effective in decreasing both dysfunctional parenting and child problem behavior relative to a waitlist control group.

Method

Sampling procedure

Recruitment from metropolitan and rural areas of New South Wales (NSW), Australia, was conducted via advertisements on parenting websites, and emails to NSW child-care centers and primary schools. To be eligible for participation, caregivers had to live with a 2–12 year-old child, and consider their child to be behaving disruptively. As the 1-2-3 Magic program is already being used within the community and would be suitable for inclusion in a public health delivery approach, this study aimed to assess it in a cross-section of the caregiver population, regardless of the level of parental psychological adjustment or level of child disruptive