

QUESTION # 1: I think the data provided in terms of “less is more” may be being over-interpreted. Are the short term interventions associated with longer term parenting outcomes, or with (more importantly) child development outcomes? One major problem that doesn’t seem to be accounted for when comparing the number of sessions is the length of time between pre and post. I can see a very short, very intensive parent sensitivity training that leads to some very measureable changes in behavior (short term). Also, this type of intervention is less likely to have attrition (which may be associated with larger effect sizes). But longer interventions with somewhat smaller overall effects may lead to longer-term changes that are more likely to be associated with improved child development outcomes.

So, my question is this: Are there any studies that look long term at parenting outcomes that compare fewer vs. more intervention sessions?

The follow-up periods for these studies are equivalent, and are measured as time post-treatment. There is no evidence that longer treatments result in more persistent changes; nearly all interventions—at best—lead to moderate positive changes. Changes seen, if any, tend to decrease over time no matter what the approach. It’s difficult to absorb, but the truth is that the relationship between duration and outcomes is simply not as linear and clear-cut as we have all assumed. Of course, this is not to say that there are never situations in which duration or intensity does help. I’m sure there are.

The decrease in attrition for the briefer treatments is indeed a major advantage. All such studies are—or should be—analyzed using an intent to treat model, such that those who drop out are still included as treatment group participants. I don’t see this is a reason to discount findings such as those I reviewed today; I in fact see it as more reason to take brief approaches very seriously.

Further, there is substantial evidence that single-session brief interventions can have effects as long as one year later. Change may be much more unpredictable and sudden than it is cumulative and linear; see some of the work by Ken Resnicow on chaos theory and the work by Bill Miller on “quantum leaps” for examples.

QUESTION #2: We were really excited and interested by the call, but listening in a conference room and not by our computers!

1. What does the software look like? Cartoons? What kind of visuals, etc. Music? See the papers that were sent for a full description of the interactive software.

2. Does the FSW become involved in the "coaching" aspect at all, or is the "coaching" to skill all done via the computer?

I personally would love for FSW's to do more coaching to criterion (as in SafeCare), but out of a desire to make the intervention easily disseminated, and requiring no special training, we do not ask FSW's in this study to do anything different than they usually do.

Thanks and we look forward to the results and will be ready to be a pilot site whenever it is time to expand! Thank you!

QUESTION # 3: Have you looked at outcomes for Nurse Family Partnership (NFP) and any thoughts about NFP in relation to your model.

The NFP has certainly shown the strongest results of all the models tested thus far. I will be delighted if it becomes clear that those results—particularly in terms of maltreatment outcomes, and especially as measured by CPS reports—can be replicated when the NFP is conducted in community settings without intensive University support in place. If so, the questions will still remain: Can technology make this better? Can technology help it to be just as good, in a briefer format? Should we utilize a stepped-care model, such that families receive a low-intensity treatment first, and then are moved to a higher intensity intervention if they do not respond? Can we tell, at baseline, who needs the high-intensity intervention and who might respond to a briefer approach?

QUESTION #4: Do you think the possible success of computerized home visiting is a result of this upcoming generation's comfort with virtual realities such as is characterized by social interaction in such computer domains as Facebook and Myspace?

Technically, virtual reality is a particular approach involving immersion into an alternate “world” in which the participant sees, hears, feels, and even smells only things from that alternate world, and can interact with it directly. It's being used in many ways, such as anxiety disorders or cravings. I'm not convinced that it is going to help much beyond existing approaches—but it sure is cool!

Regarding social networking sites and interaction with the internet in general, such familiarity certainly can only help projects like the EPP. Having said that, the novelty of interacting with a computer does seem to be a big plus for participants who are not familiar with such technology. I like to imagine a world in which there are many efficacious self-change/ “homework” modules available online, for the many (and growing) number of parents with access to the internet, at home, work, libraries, etc.

QUESTION # 5: With much emphasis being put into Responsible Fatherhood, why are we only using this system to interact with mothers in the program.

Fathers are important, and are not included in this study. Teen parents, Spanish-speaking parents, higher-SES parents, Arab-American parents, Asian-American parents, etc. are also very important, and are also not included in this study. To include adequate numbers with all of these groups right off the bat would be prohibitively expensive and irresponsible (quite an investment on something that may not work). If results suggest that it's worth pursuing with other groups, we will certainly begin that process.