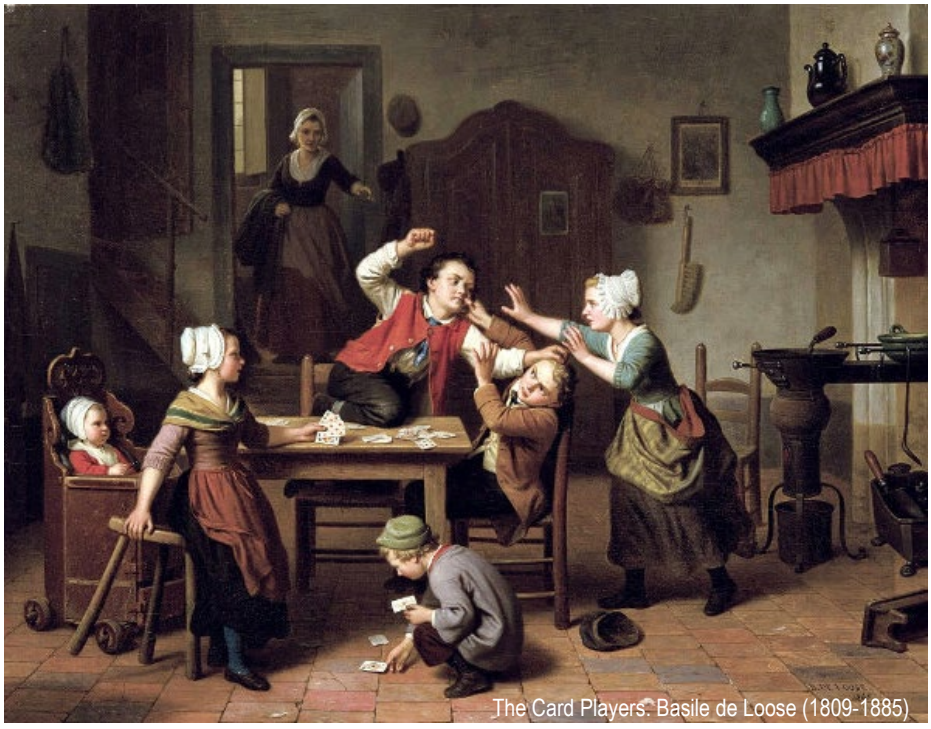
PARENTING PROGRAMS

Divna Haslam, Anilena Mejia, Matthew R. Sanders & Petrus J. de Vries



The Card Players. Basile de Loose (1809-1885)

Divna Haslam PhD

Parenting and Family Support Centre, University of Queensland, Australia

Anilena Mejia PhD

Parenting and Family Support Centre, University of Queensland, Australia & Institute for Scientific Research and Technology (INDICASAT), Panama

Matthew R Sanders PhD

Parenting and Family Support Centre, University of Queensland, Australia

Conflict of interest: Dr Sanders and Dr Haslam are authors of various *Triple P* resources. The *Triple P – Positive Parenting Program* is owned by the University of Queensland (UQ). UQ through its main technology transfer company, UniQuest Pty Ltd, has licensed

Suggested citation: Haslam D, Mejia A, Sanders MR & de Vries PJ. Parenting programs. In Rey JM (ed), *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2016.

The importance of growing up in a nurturing and supportive family environment cannot be underestimated. Raising children in a warm, loving environment sets them on a positive developmental trajectory for later life success (Biglan et al, 2012). Conversely, children raised in homes with inconsistent and harsh parenting or with high levels of conflict can be adversely impacted.

Parenting programs have been developed to support parents and equip them with effective disciplinary skills to manage current parenting challenges, with the hope of protecting children from later life adversity. In this chapter you will learn about parenting programs, their theoretical foundations, for what kind of problems they are recommended, how to evaluate their impact, and the main issues you might face when delivering parenting interventions, particularly in low and middle income countries and other low resource settings.

Triple P International Pty Ltd to publish and disseminate the program worldwide. Royalties stemming from published *Triple P* resources are distributed to the Faculty of Health and Behavioral Sciences at UQ, Parenting and Family Support Centre, School of Psychology at UQ, and contributory authors. No author has any share or ownership in Triple P International Pty Ltd. Dr Mejia is an honorary researcher at UQ but receives no royalty from *Triple P* dissemination

Petrus J de Vries MBChB, MRCPsych

Division of Child & Adolescent Psychiatry, University of Cape Town, South Africa

Conflict of interest: none disclosed

THEORETICAL BACKGROUND OF PARENTING PROGRAMS

Before the 1960s, problematic child behaviors were typically addressed using therapeutic methods directed at the child or adolescent (e.g., individual psychoanalysis/psychotherapy or child institutionalization). The late 1960s were marked by a shift in the field of child psychology and psychiatry. Around this time, interventions started to focus on changing parents' behaviors and making them active participants in therapeutic interventions. This shift was due to a growing understanding of how parents can influence children's behavior. Theories on *behavioral modification* (Skinner, 1965), *social cognitive models* (Bandura, 1977) and those having to do with *coercive family interactions* (Patterson, 1982) shaped the development of what became known as *parenting programs*. Table A.12.1 presents a brief synthesis of each of these theories and their contribution to the development of parenting programs.

Parenting programs have proliferated since the 1960s with different programs focusing on developing different types of skills in parents (e.g., behavior management, self-efficacy, and/or knowledge). There are now several meta-analyses on the effectiveness of these interventions and comparing those with different theoretical orientations (e.g., Lundahl et al, 2006). However, the programs most widely used are those based on behavioral and social cognitive models (i.e., the theories described in Table A.12.1). Typically these programs are manualized and have manuals, training materials and accreditation systems. They are commonly known as "behavioral family interventions" or "parenting training programs". Examples include *The Incredible Years* (Webster-Stratton & Reid, 2015), *The Triple P—Positive Parenting Program* (Sanders, 2012), and *Parent Management Training—The Oregon Model* (Forgatch, 1994).

TYPES OF PROBLEMS THAT CAN BE TARGETED WITH PARENTING PROGRAMS

Parenting programs are recommended for the prevention and treatment of externalizing (e.g., oppositional, aggressive, or impulsive behaviors, such as non-compliance, disobedience, fighting, aggression and answering back) (Furlong et al,

Table A.12.1 Theoretical foundations of parenting programs

BEHAVIORAL THEORIES (Skinner, 1953)	SOCIAL COGNITIVE MODELS (Bandura, 1977)	COERCION THEORY (Patterson, 1982)
Main contribution: There are contingencies involved in the parent-child interaction. • Parents influence children's behavior through positive reinforcement or consequences, such as attention and praise • Children's difficult behavior can be inadvertently reinforced by parents' attention to it, while positive behavior can be eliminated by parents' inattention	**Main contribution:** Parental cognitions, such as attributions, expectancies and beliefs, determine parents' behavior. • Parental cognitions will influence parental confidence, their decision-making and their behavioral intentions • Parents need to understand the interactional explanations they have for their child's behaviour and their own • Interventions should target self-efficacy	**Main contribution:** There are coercive interactions in families. • The aversive behavior of each person in family interactions is terminated by the aversive behavior of the other person, but the long-term effect is an increase in the likelihood that the aversive behavior will occur again • If a child whines when asked to do something and the parent stops demanding, the whining will stop. However, both the whining and the demand (aversive behavior) are more likely to occur again • Parents need to be taught strategies for positive child management as alternative to coercive parenting practices

Click on the image to preview the *Incredible Years* parenting program (20:01)

Click on the image to view families completing group *Triple P* (4 video clips by Brighton & Hove City Council). It shows some of the techniques that *Triple P* teaches, and the effect it has on children's behavior.

2012), and internalizing problems (e.g., depression, anxiety) in children (Kendall et al., 2008). Research suggests that both sub-clinical and clinical levels of problems decrease when these interventions are properly implemented (Dretzke et al, 2009). Many clinical presentations, such as oppositional defiant disorder and conduct disorder, can be treated with focused parenting interventions (Kazdin, 1997).

Parenting programs can also be very useful as adjunctive treatment for children with attention deficit hyperactivity disorder (ADHD), mood disorders, or neurodevelopmental and learning disorders (Petrenko, 2013; Skotarczak & Lee, 2015). In these cases, they typically focus on managing behavioral problems associated with the primary condition. For example, a child with ADHD may benefit from a combined therapeutic approach comprising medication for the child (if required) and a parenting program. Similarly, a child with a diagnosis of an autism spectrum disorder may benefit from a combination of individually applied behavioral therapy and social skills training, while their parents may benefit from

parenting training (Tellegen & Sanders, 2013). The parenting component would focus on teaching parents skills to manage behavioral problems (e.g., difficulty with change in routines) that occur in the context of the primary disorder.

In addition to the prevention and treatment of childhood disorders, many parenting programs are also used to prevent the development of more serious problems in adolescence and early adulthood. Some problems that might be prevented include teenage delinquency, truancy, antisocial behavior in adolescence, early sexual activity, risky sexual behavior, substance misuse, and adult criminality (Haggerty et al, 2013). For example, some parenting programs have been used as part of broader population interventions to reduce risky sexual activity and the prevalence of HIV-AIDS (Prado et al, 2007). Note that in this example the intervention is not intending to change the primary outcome (e.g., HIV-AIDS), but rather used to halt negative developmental trajectories that might result in becoming infected later on.

TYPES OF PARENTING PROGRAMS

Parenting programs are interventions that aim to improve child and family outcomes by equipping parents with effective parenting skills. They differ from parent education training or psychoeducation—which focus on increasing parent knowledge about developmental stages or certain conditions—in that parenting programs include active skills training. They are designed to increase competence and confidence in parents, allowing them to raise children in a loving, consistent, predictable, and non-harmful environment. Research suggests that improvements in parenting style are associated with reductions in child socio-emotional and behavioral problems (Sanders & Woolley, 2005). Effective programs aim to reduce known risk factors for poor child and family outcomes such as harsh disciplinary practices, and strengthen protective factors (i.e., factors that predict positive family outcomes). See Table A.12.2 for the typical goals of most programs.

According to their primary focus, they can be broadly divided into prevention, treatment, and blended programs:

- ***Prevention programs*** are designed to avoid the development of serious behavior or emotional problems in children through the acquisition of parenting skills *before problems develop or at the first sign of problems*.

Table A.12.2 Common goals of parenting programs

PRIMARY INTERVENTION GOALS
• Improve parent-child relationships • Reduce negative, coercive or violent discipline practices • Teach parents effective, non-violent parenting practices
SECONDARY INTERVENTION GOALS
• Reduce parental stress, depression, and anxiety • Increase parental confidence and competence • Reduce violence towards children

Typically, these are lower intensity interventions, thus easier and cheaper to implement. They work in a way similar to regular tooth brushing to prevent cavities. When parents are taught effective, safe, non-violent discipline strategies, children are less likely to develop emotional and behavioral problems (Forgatch & DeGarmo, 1999).

- ***Treatment programs*** seek to reduce problem behaviors after they have developed. To continue with the dental hygiene analogy, these are similar to going to the dentist to get a cavity filled. Like with prevention programs, they are most effective when implemented as early as possible (before the cavity becomes large or the tooth is lost), but they can also be effective even when problems are longstanding or severe. They are often more intensive in terms of time and cost than prevention programs given that they cover more content and provide additional support to families. These programs are best suited to families with higher levels of need or with many risk factors (Kazdin & Whitley, 2003).
- ***Blended approaches*** are broader than focused prevention and treatment programs; they can be conceptualized as *suites of interventions*. Blended programs often have a range of variants that can be deployed as needed. For example *The Incredible Years* has a school-based variant aimed at preventing problems in the classroom, as well as intensive parenting interventions for implementation at home. *Triple P* is also a blended program with five levels of intervention, ranging from media strategies targeting whole populations to intensive individual services for families with complex comorbidities (Prinz et al, 2009).

Most research on the topic has targeted treatment-focused programs for children with behavioral or emotional problems at the clinical level or those at high risk for the development of such problems. Allowing for between-country variance, only 10% to 15% of children have problems at this level (Jaffee et al, 2005). Without early intervention, subclinical levels of problems may escalate into clinical presentations that are harder to treat. For this reason, prevention programs and blended approaches can be beneficial in reducing the number of cases at a whole population level.

KEY COMPONENTS

Research indicates that programs that include a number of *key active ingredients* are most likely to work. For a review of key components of parenting interventions see the meta-analysis by Kaminski and colleagues (2008). Components can be broadly classified in those that:

- Teach parents to respond consistently (e.g., praising their child)
- Teach parents strategies to manage difficult behavior (e.g., use of time out), and
- Use active parent participation during training (e.g., role play for parents to practice skills).

A summary of key ingredients that seem to contribute to the effectiveness of these programs is listed in the Box.

KEY COMPONENTS OF EFFECTIVE PROGRAMS

The program:

- Provides strategies for increasing positive parent-child interactions
- Focuses on parental consistency
- Allows parents to practice new skills with their own child
- Teaches the appropriate use of consequences, such as time-out (i.e., the temporary withdrawal of parental attention in response to problem behavior)
- Teaches problem solving to parents
- Increases parental sensitivity and nurturing
- Models (or shows) positive behavior
- Provides opportunities for parents to practice strategies in the session via role play
- Teaches emotional communication skills

Most researchers agree that corporal punishment is associated with adverse outcomes, particularly behaviour problems, later in life.

EVALUATING EFFECTIVENESS

In the previous section key elements or active ingredients of parenting programs were discussed. However, it is important to keep in mind that many programs are promoted or implemented without evidence that they work. Those with evidence of efficacy gathered through a body of empirical research (usually including randomized controlled trials) are known as *evidence-based programs*. Clinicians have the ethical responsibility to ensure that interventions offered to families have some evidence of effectiveness—a core principle of evidence-based practice. However, it is also necessary to maximize resources, particularly when working in low-income settings. It can be tempting to *make programs up* (i.e., develop them from scratch), with the risk that they might be ineffective and a waste of resources.

Click on the image to view the United Nations Office on Drugs and Crime (UNODC) list of evidence-based parenting interventions

A number of programs have been found to be effective after rigorous evaluation (Haggerty et al, 2013). These include *The Incredible Years* (Webster-Stratton & Reid, 2015); *Parent-Child Interaction Therapy* (Brinkmeyer & Eyberg, 2003); *Triple P—Positive Parenting Program* (Sanders, 2012); *Nurse Family Partnership* (Olds et al, 2003); and *Strengthening Families Program* (Kumpfer et al, 1996). More information about these can be found in Table A.12.3. Many international bodies, such as the United Nations Office on Drugs and Crime (UNODC, 2009), have lists of evidence-based parenting interventions.

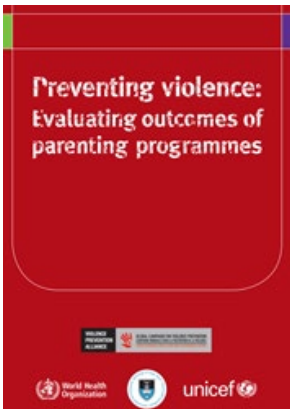
Table A.12.3 Summary of selected evidence-based parenting programs*

NAME**	SUMMARY	TARGET AUDIENCE	TARGET OUTCOMES
Strengthening Families	Involves 14 two-hour group sessions focusing on parenting skills, children's social skills, and family life skills • It can be implemented for pre-schoolers, elementary school children, early teens (10-14), high school teens (12-16), and as group classes (7-17) • There is a home DVD with ten 30-minute lessons	• Children with high risk for drug abuse, crime and other delinquent behavior • Different versions of the program contain age-group specific activities • SFP 10-14 is aimed at low-risk families	• Reduced substance abuse and delinquency • Improved family relationships • Reduced risk factors for problem behaviors in high risk children
Parent-Child Interaction Therapy	Typically used for the treatment of oppositional defiant disorder or conduct disorder. Has two stages of intervention: • Child-directed interaction and • Parent-directed interaction Average of 14 sessions (10-20) of one to two hours per week.	• Parents of children aged 2-7 with behavioral problems	• Improved parent-child relationship • Effective parenting skills • Effective discipline
The Incredible Years	• There is a treatment version and a prevention version • The program is split into differing ages: babies, toddlers, pre-schoolers, and school age children • Each program has a different method of delivery	• Families with children aged 0-12 years	• Reduction in child conduct problems and hyperactive behavior • Improved parenting skills • Reduced negative parenting strategies • Increased child compliance and positive affect
Nurse Family Partnership	• Delivered by registered nurses to low-income first-time mothers • One-to-one home visits from pregnancy until the child is two years old • The nurse visits every one or two weeks, depending on the schedule decided by the parent and nurse • Nurses use professional knowledge, judgement and skill while applying guidelines	• Low-income first-time mothers • The program is most effective with parents and children who are at high-risk	• Improved pregnancy outcomes • Improved health and development of the child • Positive life course in parents
Triple P—Positive Parenting Program	• A parenting and family support system aimed at prevention and treatment of behavioral and emotional problems in children and teenagers • The intensity varies from light to highly targeted interventions depending on the needs of each family • Delivery may include personal consultation, group or online courses, self-help interventions or public seminars	• Can target any age from birth to sixteen years. • Specialist program also target parents of children with a disability, health or weight concerns, parents going through divorce and Indigenous families	• Reduced behavioral and emotional problems • Improved parental wellbeing and parenting skills • Reduction in negative parenting strategies

*All these programs require payment of a licensing fee for training and materials.

**Click on the name of the program to access the website.

It is beyond the scope of this chapter to review the key concepts of evidence-based practice. However, guidelines on how to judge effectiveness of interventions can be found in Chapter A.6 of the IACAPAP Textbook. Listed in the Box 3 are some questions that can assist you in judging if the program you are considering is likely to be effective. More information about how to assess evidence of effectiveness can also be found in a summary by the World Health Organization (2013) available here.



Click on the image to access the WHO report "Preventing Violence: Evaluating Outcomes of Parenting Programmes"

QUESTIONS WORTH ASKING WHEN CHOOSING A PARENTING PROGRAM

- Is the program grounded in a strong theoretical framework?
- Does the program target known risk and protective factors?
- Does the program include most of the key components associated with effective parenting?
- Has the program been evaluated scientifically and shown to improve the target outcomes using:
  - Randomized controlled methodology
  - Strong quasi-experimental trials
  - Designs in real world delivery settings
  - Population trials (if the target audience is a whole population)?
- Can the program focus in the population you are seeking to treat?
- Are gains maintained after the conclusion of the program?
- Have positive findings been replicated independently of the original research team?
- Has the program been evaluated in contexts similar to the one where you will be implementing the program?
- Are appropriate resources, training and implementation support available?

PRACTICAL ISSUES IN THE DELIVERY OF PARENTING PROGRAMS

While parenting programs can be very useful, there are other aspects to consider, such as whether a parenting program is the treatment of choice, as well as delivery issues. These include:

- ***Child protection and safeguarding of children.*** It is possible that either during assessment or delivery of a parenting program, concerns about child safety may be raised. Safeguarding and protecting children has to be of paramount importance. Where child protection becomes a concern, this has to be dealt with as a priority. Facilitators will need to discuss concerns with their supervisor and, if appropriate, with parents, and swiftly take the necessary action.
- ***Parental mental health problems.*** There is much evidence that parental mental illness (e.g., depression) can adversely affect their ability to parent (Oyserman et al, 2000). However, when it is clear that a parent has a serious mental illness, such as a psychotic disorder, severe depression or anxiety, it may not be appropriate to offer a parenting program until the mental illness has been assessed and stabilized. Supporting parents to find appropriate treatment should therefore be the priority in these cases. On the other hand, if a parent has a low-level mood or anxiety disturbance they may still be able to participate in the program while also seeking additional assistance. Clinicians should monitor parents' mood and reactions throughout the course

of the program and take appropriate action. For example, if a parent appears to be getting upset or teary in a group session, the practitioner should speak to the parent privately outside the group to determine if additional support is necessary.

- ***Privacy and confidentiality.*** It is important to conduct sessions in a room where discussions are private and where confidentiality can be maintained. When parenting programs are delivered in a group format, it is useful to explicitly state privacy expectations at the start of the group. This will allow parents to share their thoughts and experiences and facilitate group discussion. It is important to make clear that personal information discussed in a session should not be shared with others outside the session. Parents should also be informed that privacy and confidentiality will be upheld unless there is concern about risk to their children's safety, to themselves or to others. This is part of the duty of care of all child health professionals.
- ***Parenting programs and specific child problems.*** While the general principles of parenting programs are helpful for all children, there are specialized programs where highly specific targets are included. For instance, in some programs for autism spectrum disorder, parents might be provided with specific training in turn-taking, stepping into the "attentional spotlight" of the child, how to arrange the environment to encourage communication and so on. For a review of "naturalistic developmental behavioral interventions", many of which use parents as active treatment partners and include parent coaching, click here.

  In these programs there is often an emphasis on learning to understand the function of a particular behavior. For instance, a child with autism spectrum disorder may use a particular behavior not to get attention, but rather to avoid attention. A time-out strategy would therefore not

A Triple P program session in Kenya

be appropriate in that instance. There is also a specialized approach to functional analysis of behavior in children with intellectual disability and specific genetic disorders, such as fragile X, Prader-Willi, Angelman or Cornelia de Lange syndromes, for instance. In many of these genetic disorders, specific behaviors may be associated with sensory sensitivities, pain, cognitive inflexibility, avoidance behaviors, or exaggerated need for behavioral reinforcement with eye contact. These are specialized scenarios for which specific modules or parenting approaches are required. For example, the *Stepping Stones Triple P* program has been evaluated with parents of children with a range of specific neuro-developmental disorders (Tellegen & Sanders, 2013).

- ***Poverty and low socio-economic status.*** It is crucial to note that, particularly in low- and middle-income countries, parents may arrive at a parenting program with an empty stomach. Just as children can't learn if they are hungry, parents can't make use of training if they are hungry or thirsty. A drink and a biscuit can go a long way to help parents concentrate. Likewise, ensuring that parents have access to printed materials, baby sitting or transport will be helpful. For example, provide notepads, pens and copies of monitoring forms parents need to use at home rather than expecting them to make their own copies.
- ***Stigma and shame.*** Many come to the program having received the overt or covert message that they are not good enough parents or that they need to be "trained". It is important that group leaders and facilitators keep in mind that parents may feel stigmatized and ashamed. It is important to acknowledge such feelings, and to use parents' knowledge and experiences to assist in the program, rather than for facilitators to assume a position of exclusive expertise. The facilitator should explicitly acknowledge the expertise of the parents and empower them to achieve their own family goals. Many people would say that parenting is the most difficult job any parent will ever do!

Click on the image to view a clip that illustrates the life and resilience of women in the high-risk Panamanian neighborhood of San Joaquin

TESTING A PARENTING PROGRAM IN A LOW-RESOURCE SETTING

In 2012, the government of Panama funded a research project to explore the cultural relevance and efficacy of *Triple P* in low-resource communities in Panama. The research team explored the acceptability of the program to parents and practitioners in those communities, and conducted a trial to test if the program was effective in reducing behavioral problems in children aged 3 to 12. The program was considered culturally acceptable and the parents who participated in the intervention were less stressed and less hostile towards their children who, in turn, were better able to follow instructions.

Few studies of parenting programs have been conducted in low income countries. See Mejia et al (2012) for a review.

Matters relevant to low and middle-income countries

This section discusses how to ensure parenting interventions are relevant to specific cultures, the adaptations that can be made to fit the context of low income countries, and how to enhance their value-for-money.

Most parenting interventions have been developed, evaluated and implemented in western, English-speaking, high-income countries. However, meta-analytic reviews have indicated that evidence-based parenting programs implemented in other countries are at least as effective as in the country where they had originated (Gardner et al, 2015); only minimal adaptations being required. There are, however, a number of low-risk cultural and contextual adaptations that can help increase engagement and improve cultural appropriateness.

Cultural relevance

Parenting interventions have been tested in different countries and cultures (See Table A.12.4 for examples). Some of them have also been adapted following rigorous and systematic procedures to improve the fit for the target population. An example can be found in Baumann et al (2014) for the adaptation of the

CASE EXAMPLE

BEING A PARENTING PRACTITIONER IN EL SALVADOR

Josefa is a social worker at a community center in one of the most violent neighborhoods in San Salvador.

Most fathers in this neighborhood are in prison, and mothers are under considerable stress trying to raise their children without support. There is one child, Gabriel, who is 8 years old and has severe behavioral problems. He does not follow instructions and is aggressive towards his mother and peers. He is at high risk of gang involvement and antisocial behavior later in life. Josefa undertook some training on a parenting program some time ago. However, she faces several barriers for delivering the program in this context:

- Gabriel's mother cannot read or write, so she can't complete assessments, read the workbook or follow the videos (which are only available in English with subtitles)
- Gabriel and his mother come from a rural town and recently moved to the city. Josefa is not sure if the strategies from this parenting program will be appropriate to their traditions and values
- Like Gabriel, there are many children in the neighborhood with severe difficulties. Josefa does not have capacity to see all parents. She will ask one of the mothers in the community to assist her in delivering the intervention
- Josefa was trained more than 10 years ago and does not have anybody to supervise her cases

Table A.12.4 Examples of evidence-based parenting programs implemented around the world*

PARENTING PROGRAM	ORIGINALLY DEVELOPED IN	EVALUATED OR IMPLEMENTED IN
Incredible Years	United States	• Jamaica (Baker-Henningham et al, 2009) • Netherlands (Posthumus et al, 2012) • Norway & Sweden (Axberg & Broberg, 2012 • Forgatch & Degarmo, 2011) • UK
Parent Management Training-Oregon Model	United States	• Iceland (Sigmarsdottir et al, 2013) • Norway (Forgatch & Degarmo, 2011)
Parent-child Interaction Therapy	United States	• Hong Kong (Leung et al, 2007) • Puerto Rico
Strengthening Families Program	United States	• Canada • Chile • Costa Rica • El Salvador • Netherlands • Norway • Panama (Mejia et al, 2015b) • Peru • Puerto Rico (Matos et al, 2009) • Spain (Orte et al, 2013) • Sweden • UK (Seggrott et al., 2014)
Triple P—Positive Parenting Program	Australia	• China • Curaçao • Germany • Hong Kong (Leung et al, 2003) • Indonesia (Sumargi et al, 2015) • Japan (Matsumoto et al, 2010) • Netherlands • Panama (Mejia et al., 2015a) • UK

*Not an exhaustive list.

Parent Management Training—Oregon Model in Mexico. If you are intending to use a parenting intervention that has not been tested or adapted for the population you are working with, it might be beneficial to start by reflecting on the cultural relevance of the program. If you are familiar with the target group, make sure you anticipate potential cultural barriers in the implementation of specific strategies. For example, in some cultures, promoting independent problem solving in young children might not be accepted by parents. If you are not familiar with the target group, you could ask parents how they feel about implementing behavioral strategies such as time-out or descriptive praise. Does this strategy contradict their cultural values or typical communication practices? If so, how can the strategy be adapted to fit their culture?

Context-appropriate assessment

Before delivering a parenting intervention, it is recommended to get a sense of the main difficulties your target group is facing. This will allow you to tailor the intervention to their specific needs. In addition, parents around the world face very different challenges, thus a one-size-fits-all-approach will not work. Some parents might be facing other complex issues apart from their child's behavioral and emotional difficulties, such as child maltreatment or domestic violence. These families should be referred to other services, if available; most parenting programs are not recommended for problems such as severe parental psychopathology, domestic violence, or child maltreatment.

In relation to child behavioral and emotional difficulties, parents might be struggling with disobedience, aggression, tantrums or conflict between siblings, for example. There are standardized questionnaires to help you assess the difficulties parents might be struggling with. Some of these questionnaires have been translated into different languages. For example, the *Strengths and Difficulties Questionnaire* (SDQ) has been translated to most languages and is available free. The SDQ provides information on both emotional problems, such as anxiety and depression, and behavioral problems, such as tantrums and aggressiveness (Goodman, 1997). The *Eyberg Child Behavior Inventory* (ECBI) is also widely-used also but requires payment of a licensing fee.

Two instruments for parent reports have been developed recently: the *Child Adjustment and Parent Efficacy Scale* (CAPES) (Morawska et al, 2014), and the *Parenting and Family Adjustment Scale* (PAFAS) (Sanders et al, 2014). The English version of these instruments can be found in Appendix A.12.2; there are also versions in Spanish, Portuguese, Turkish and Chinese, all freely available for use. Please contact the first author to receive a copy of these measures.

It is important to know that literacy levels in many low-income countries range from 30% to 80%. If parents are illiterate or if it is difficult to collect written data from them, the program leader can give parents a tally sheet (such as the one in Appendix A.12.1) so that parents can monitor their children's behavior for a certain period of time and obtain an estimate of how frequently certain problem behavior occur. It is best to introduce monitoring before introducing strategies to obtain an accurate level of baseline behavior. Many programs ask parents to monitor child behavior between the first and second sessions. The parent can also complete a monitoring form after the intervention is complete to check problems have decreased. Alternatively you can ask parents to move stones from one jar to

another each time a problem behavior occurs and then count the stones in each jar at the conclusion of the week to capture how frequent behavior problems occur. You can also collect in-depth information through an interview. Make sure to gather information on:

- The target problem
- Where and when is it most likely to occur (i.e., contextual details about the problem)
- Parent's explanation of the cause of the problem
- Strategies tried in the past without success
- Parent's current goals.

Program fidelity

Most evidence-based parenting programs include a practitioner manual (and often a certified training component). For this reason, they are known as "manualized" programs. Sticking to the manual in relation to the key concepts, content, and structure is known as *program fidelity*. Ensuring fidelity is important because programs are most effective when delivered as prescribed and might not work at all if not delivered with fidelity. However, it is also important to ensure a good fit between the content of the program and parents' needs. Thus, it is crucial that practitioners achieve a balance between fidelity and flexibility during delivery (Mazzucchelli & Sanders, 2010). Later in this section we present examples of low and high risk adaptations that can be made to a program to achieve a balance between fidelity and flexibility.

Adaptations to content

When one has a clear understanding of the target problem, it is acceptable to make minor adaptations to the content of an existing manual to fit parents'

CASE EXAMPLE

LOW-RISK ADAPTATIONS TO ENGAGE MOTHERS IN KENYA

A practitioner was delivering a parenting program in an informal settlement (slum community) in the outskirts of Nairobi. Some changes made included spending time in small groups explaining the parenting questionnaires rather than expecting parents to do them without assistance.

Parents were very shy at the start of the intervention. After noticing this, the practitioner asked parents how group meetings would typically start in Kenya. Parents reported that they would usually start with a praise song and a prayer. As a result, from then on, sessions started with a praise song and prayer led by one of the parents.

Another change made was to spend extra time discussing the benefits and challenges of physical affection---not a common practice among Kenyan parents. Discussions covered the type of affection parents themselves had received as children and how this influenced their own parenting. In this way, parents were able to consider the potential benefits of showing their children affection in a manner that was consistent with cultural expectations. For example, mothers of boys were able to consider forms of affection other than kissing, which was not seen as appropriate.

These low-risk adaptations (i.e., they did not change the content of the intervention itself or undermine the fidelity of the program) allowed mothers to be more open and confident in discussing their concerns in the group and had a profound impact on the group atmosphere and attendees cooperation.

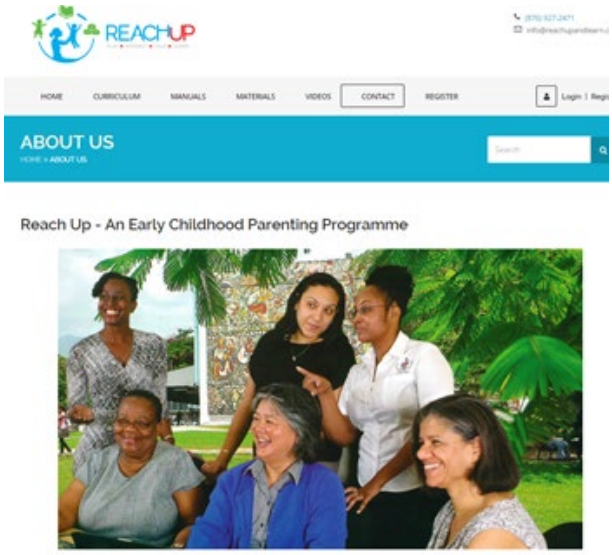
Table A.12.5 Low and high risk adaptations

LOW RISK	HIGH RISK
• Language translations done by a certified translator with a back translation procedure and reviewed by a qualified practitioner	• Changing the order of sessions
• Simplifying written materials for parents with low literacy levels (i.e., using videos, role-plays or making workbooks easier to read)	• Changing specific strategies and the way they are implemented (i.e., suggesting parents to assist the child to calm down when they are in time out)
• Modifying examples (e.g., using local examples or stories)	• Changing the order in which strategies are introduced to parents
• Including icebreaking activities in group sessions	• Not structuring sessions with an agenda
• Showing video segments more than once	• Removing strategies to be taught in a session
• Doing individual exercises as a large group	• Adding inconsistent strategies
• Adding additional break in between sessions	• Removing homework
• Dividing one long session into two shorter ones	
• Providing more sessions when additional support is required	
• Increasing or shortening the length of sessions or particular exercises	
• Slowing down the pace of the intervention	
• Including additional spaces for discussion	

specific needs and cultural expectations. However, it is important that you are clear about which changes are low risk and which may be high risk. Low risk adaptations include minor changes that make the content locally relevant, such as modifying examples or including ice-breaking activities, which will not affect the core ingredients of the intervention. High risk adaptations are those that change core components of the intervention, such as excluding training in a particular skill (e.g., praise or time-out). See Table A.12.5 for guidelines and examples.

Given that most parenting interventions rely on written materials, it is also important to consider parents' literacy level. Trials indicate that parents with low literacy or intellectual disability can benefit from modified parenting interventions (e.g., Glazemakers & Deboutte, 2013). When working with illiterate parents, consider using a program that relies on video materials dubbed into the local language. If you do not have access to videos, consider using role-plays to train parents on a particular skill and allow additional time for group discussion. You may also integrate key examples into family stories to make it easier for parents from storytelling cultures to remember. Where parents are literate but with low

levels of education (i.e., primary school only) written materials can be adapted to make them briefer and easier to read.



Click on the image to access the *Reach Up* website

TRAINING OF FACILITATORS

Most parenting interventions have a well-established training to accredit professionals to deliver them. Only professionals that undergo this training (usually lasting 3 or 4 days) are accredited to deliver the intervention. This requirement aims to ensure the quality and fidelity of the intervention.

There are parenting interventions freely available online that do not require facilitators to be accredited by attending a course. One example is *Reach Up,* an early childhood parenting program. To be able to deliver the program, potential facilitators must go through a free online training. *Reach Up* is quite intensive and is delivered as part of home visits to help parents enhance their child's development. There are several trials showing that *Reach Up* has been effective in Jamaica and there are versions available in English, Spanish, French and Bangla (Grantham-McGregor & Walker, 2015).

While most programs based on social-cognitive and behavioral theories only allow health professionals to be trained as facilitators, there are several examples documented in the literature of other parenting interventions that can be delivered by para-professionals or educated members of the community. There is no evidence that health professionals achieve better outcomes than para-professionals. Using para-professionals (also referred to as *task-sharing*—see Chapter J.5 of the Textbook) might be particularly attractive in low income countries where health professionals are scarce. A decision on the credentials needed for those who will deliver the intervention should be made based on the:

- Intervention chosen (e.g., whether the program requires that only health professionals be trained)
- Available resources (e.g., whether there are funds to pay facilitators)
- Number of families that need to be reached (e.g., if the aim is to reach a large number of families, using para-professionals or lay facilitators might be more feasible)
- Severity of the target population (e.g., psychologists, psychiatrists and health workers might be better equipped to deal with children with severe problems).

Value for money

Programs that are cost neutral (i.e., the costs of implementation are similar to the savings made by reducing children's problems) or cost positive (i.e., the costs of implementation are lower than the savings made by reducing children's problems) should be the first choice. The costs and return on investment of implementing specific parenting interventions can be found in websites such as Blueprints. However, these costs have been calculated for a specific set of programs

in the US. To our knowledge, no cost-effectiveness studies have been conducted in low income countries. In the absence of such information, the following strategies can be used to maximize the impact of programs and increasing their value for money:

- Some programs can be offered as large seminars in schools and community settings. Providing parenting information to as many parents as possible in a single session reduces costs and can be a good strategy to identify those who need more intensive support
- Self-directed learning materials, such as brochures and videos, could also be used to reach parents with mild difficulties
- Some parenting interventions can be delivered by para-professionals

CONCLUSIONS

Parenting programs are increasingly perceived as a cost-effective means of preventing and treating emotional and behavioral problems in children. Their effectiveness is supported by a growing body of empirical research. When considering using a parenting program:

- Consider each family's unique situation through a comprehensive assessment to determine if a parenting program will be helpful or appropriate
- Make sure the parenting program you choose targets known risk factors
- It is preferable to offer interventions to parents that are appropriate to their level of difficulty. In other words, if they have mild difficulties, you can offer a light-touch intervention of few sessions (i.e. brief and focused). If they have more severe difficulties, then you can offer individual support for several sessions.
- Make minor or low-risk adaptations to ensure cultural and contextual fit
- Monitor families' progress throughout the course of the intervention using clinical judgment and appropriate measurement tools
- Provide additional assistance or refer those with other significant problems (e.g., parental depression, domestic violence) to other services
- Access peer support and supervision.

- Do you have questions?
- Comments?

Click here to go to the Textbook's Facebook page to share your views about the chapter with other readers, question the authors or editor and make comments.

REFERENCES

Axberg U, Broberg AG (2012). Evaluation of "The Incredible Years" in Sweden: the transferability of an American parent-training program to Sweden. *Scandinavian Journal of Psychology,* 53:224-232

Baker-Henningham H, Walker S, Powell C et al (2009). A pilot study of the Incredible Years Teacher Training program and a curriculum unit on social and emotional skills in community pre-schools in Jamaica. *Child: Care, Health and Development,* 35**:**624-631

Bandura A (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological Review,* 84**:**191-215.

Baumann AA, Domenech Rodriguez MM, Amador NG et al (2014). Parent Management Training-Oregon Model (PMTO) in Mexico City: Integrating cultural adaptation activities in an implementation model. *Clinical Psychology: Science and Practice,* 21:32-47

Biglan A, Flay BR, Embry DD et al (2012). The critical role of nurturing environments for promoting human well-being. *American Psychologist,* 67**:**257-271

Brinkmeyer MY, Eyberg SM (2003). Parent-child interaction therapy for oppositional children. In Weisz JR, Kazdin AE (eds) *Evidence-Based Psychotherapies for Children and Adolescents.* New York, NY: Guilford Press

Dretzke J, Davenport C, Frew E et al (2009). The clinical effectiveness of different parenting programs for children with conduct problems: a systematic review of randomised controlled trials. *Child and Adolesc Psychiatry and Mental Health,* 3:7

Forgatch M (1994). *Parenting Through Change*: *A Training Manual*. Eugene: Oregon Social Learning Centre.

Forgatch MS, Degarmo DS (2011). Sustaining fidelity following the nationwide PMTO implementation in Norway. *Prevention Science,* 12:235-246

Forgatch S, Degarmo S (1999). Parenting through change: An effective prevention program for single mothers. *Journal of Consulting and Clinical Psychology,* 67:711-724

Furlong M, Mcgilloway S, Bywater T et al (2012). Behavioural and cognitive-behavioural group-based parenting programs for early-onset conduct problems in children aged 3 to 12 years. *Cochrane Database Syst Rev,* 2**,** Cd008225

Gardner F, Montgomery P, Knerr W (2015). Transporting evidence-based parenting programs for child problem behavior (age 3–10) between countries: Systematic review and meta-analysis. *Journal of Clinical Child & Adolescent Psychology***,** 18:1-14

Glazemakers I, Deboutte D (2013). Modifying the 'Positive Parenting Program' for parents with intellectual disabilities. *Journal of Intellectual Disability Research,* 57:616-626

Goodman R (1997). The Strengths and Difficulties Questionnaire: a research note. *Journal of Child Psychology and Psychiatry,* 38:581-586

Grantham-Mcgregor S, Walker S (2015). The Jamaican early childhood home visit intervention. *Early Childhood Matters.* The Hague: Bernard van Leer Foundation.

Haggerty KP, Mcglynn-Wright A, Klima T (2013). Promising parenting programs for reducing adolescent problem behaviors. *Journal of Children's Services,* 8:229-243

Jaffee SR, Harrington H, Cohen P et al (2005). Cumulative prevalence of psychiatric disorder in youths. *Journal of the American Academy of Child & Adolescent Psychiatry,* 44:406-407

Kaminski JW, Valle LA, Filene JH et al (2008). A meta-analytic review of components associated with parent training program effectiveness. *Journal of Abnormal Child Psychology,* 36:567-589

Kazdin AE (1997). Parent management training: evidence, outcomes, and issues. *Journal of the American Academy of Child & Adolescent Psychiatry,* 36:1349-1356

Kazdin AE, Whitley MK (2003). Treatment of parental stress to enhance therapeutic change among children referred for aggressive and antisocial behavior. *Journal of Consulting and Clinical Psychology,* 71:504-515

Kendall PC, Hudson JL, Gosch E et al (2008). Cognitive-behavioral therapy for anxiety disordered youth: a randomized clinical trial evaluating child and family modalities. *Journal of Consulting and Clinical Psychology,* 76:282-297

Kumpfer KL, Molgaard V, Spoth R (1996). The Strengthening Families Program for the prevention of delinquency and drug use. In: Peters RDeV, McMahon RJ (eds) *Preventing Childhood Disorders, Substance Abuse, and Delinquency.* Thousand Oaks, CA: Sage Publications, Inc

Leung C, Heung K, Yiu I et al (2007). Evaluation of the effectiveness of the Parent Child Interaction Therapy (PCIT) in treating families with children with behavior problems in Hong Kong. *7th National Parent-child Interactive Therapy (PCIT) Conference.*

Leung C, Sanders MR, Leung S et al (2003). An outcome evaluation of the implementation of the Triple P-Positive Parenting Program in Hong Kong. *Family Process,* 42**:**531-544

Lundahl BW, Nimer J, Parsons B (2006). Preventing child abuse: A meta-analysis of parent training programs. *Research on Social Work Practice,* 16**:**251-262

Matos M, Bauermeister JJ, Bernal G (2009). Parent-child interaction therapy for Puerto Rican preschool children with ADHD and behavior problems: a pilot efficacy study. *Fam Process,* 48**,** 232-52

Matsumoto Y, Sofronoff K, Sanders MR (2010). Investigation of the effectiveness and social validity of the Triple-P Positive Parenting Program in Japanese society. *Journal of Family Psychology,* 24:87-91

Mazzucchelli TG, Sanders MR (2010). Facilitating practitioner flexibility within an empirically supported intervention: Lessons from a system of parenting support. *Clinical Psychology: Science and Practice,* 17**:**238-252

Mejia A, Calam R, Sanders MR (2012). A review of parenting programs in developing countries: Opportunities and challenges for preventing emotional and behavioral difficulties in children. *Clinical Child and Family Psychology Review, 15*: 163-175.

Mejia A, Calam R, Sanders MR (2015a). A pilot randomized controlled trial of a brief parenting intervention in low-resource settings in Panama. *Prevention Science,* 16:707-717

Mejia A, Ulph F, Calam R (2015b). An exploration of parents' perceptions and beliefs about changes following participation in a family skill training program: A qualitative study in a developing country. *Prevention Science,* 16**:**674-684

Morawska A, Sanders MR, Haslam D et al (2014). Child Adjustment and Parent Efficacy Scale: Development and initial validation of a parent report measure. *Australian Psychologist,* 49**:**241-252

Olds DL, Hill PL, O'Brien R et al (2003). Taking preventive intervention to scale: The nurse-family partnership. *Cognitive and Behavioral Practice,* 10:278-290

Orte C, Ballester L, March MX et al (2013). The Spanish adaptation of the Strengthening Families Program. *Procedia - Social and Behavioral Sciences,* 84:269-273

Oyserman D, Mowbray CT, Meares PA et al (2000). Parenting among mothers with a serious mental illness. *American Journal of Orthopsychiatry,* 70:296-315

Patterson GR (1982). *Coercive Family Process.* Eugene, OR: Castalia Publishing Co

Petrenko CL (2013). A review of intervention programs to prevent and treat behavioral problems in young children with developmental disabilities. *Journal of Developmental and Physical Disabilities,* 25

Posthumus J, Raaijmakers MJ, Maassen G et al (2012). Sustained effects of Incredible Years as a preventive intervention in preschool children with conduct problems. *Journal of Abnormal Child Psychology,* 40**:**487-500

Prado G, Pantin H, Briones E et al (2007). A randomized controlled trial of a parent-centered intervention in preventing substance use and HIV risk behaviors in Hispanic adolescents. *Journal of Consulting and Clinical Psychology,* 75:914-926

Prinz R, Sanders M, Shapiro C et al (2009). Population-based prevention of child maltreatment: The U.S. Triple P System Population Trial. *Prevention Science,* 10:1-12

Sanders MR (2012). Development, evaluation, and multinational dissemination of the Triple P-Positive Parenting Program. *Annual Review of Clinical Psychology,* 8**:**345-379

Sanders MR, Morawska A, Haslam DM et al (2014). Parenting and Family Adjustment Scales (PAFAS): validation of a brief parent-report measure for use in assessment of parenting skills and family relationships. *Child Psychiatry & Human Development,* 45:255-272

Sanders MR, Woolley ML (2005). The relationship between maternal self-efficacy and parenting practices: implications for parent training. *Child: Care, Health and Development,* 31:65-73

Segrott J, Gillespie D, Holliday J et al (2014). Preventing substance misuse: study protocol for a randomised controlled trial of the Strengthening Families Program 10-14 UK (SFP 10-14 UK). *BMC Public Health,* 14:49

Sigmarsdottir M, Degarmo DS, Forgatch MS et al (2013). Treatment effectiveness of PMTO for children's behavior problems in Iceland: assessing parenting practices in a randomized controlled trial. *Scandinavian Journal of Psychology,* 54**:**468-476

Skinner BF (1965). *Science And Human Behavior*. Free Press

Skotarczak L, Lee GK (2015). Effects of parent management training programs on disruptive behavior for children with a developmental disability: a meta-analysis. *Research in Developmental Disabilities,* 38:272-287

Sumargi A, Sofronoff K, Morawska A (2015). A randomized-controlled trial of the Triple P-Positive Parenting Program seminar series with Indonesian parents. *Child Psychiatry & Human Development,* 46**:**749-761

Tellegen CL, Sanders MR (2013). Stepping Stones Triple P-Positive Parenting Program for children with disability: a systematic review and meta-analysis. *Research in Developmental Disabilities,* 34**:**1556-1571

UNODC, United Nations Office on Drugs and Crime (2009). *Compilation of Evidence-Based Family Skills Training Programs*

Webster-Stratton C, Reid MJ (2015). The Incredible Years parents, teachers and children training series: A multifaceted treatment approach for young children with conduct problems. In: weisz AE and Kazdin JR (eds) *Evidence-Based Psychotherapies for Children and Adolescents.* 2nd ed New York: Guilford Publications

World Health Organisatiom (2013). *Preventing violence: Evaluating outcomes of parenting programs*

Behavior Tally Sheet

Instructions : Each day the specific behavior occurs on a given day make a mark in the box. At the end of the day count how many marks have been made. Choose only one behavior at a time to monitor and be clear exactly what the behavior is in advance.

Behaviour: Refusing to follow clear instructions

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Total
Monday	✔	✔	✔	✔	✔	✔	✔	✔	✔							9
Tuesday	✔	✔	✔	✔	✔	✔	✔									7
Wednesday	✔	✔	✔	✔	✔	✔	✔	✔								8
Thursday	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔						10
Friday	✔	✔	✔	✔	✔	✔										6
Saturday	✔	✔	✔	✔												4
Sunday	✔	✔	✔	✔	✔											5
															Weekly Total	49

This type of tally sheet can be used to assess how frequently certain behaviours occur. In this example tally sheet the parent is tracking how often the child fails to follow instructions. Each time the child says “no” or refuses to do what the parent asked (eg Get dressed) the parent has placed a tick in the box. In this example we can see that the child failed to follow instructions 9 times on monday, 7 times on tuesday and so forth. A weekly total is calculated at the bottom showing that over the whole week the child failed to follow instructions 49 times in the week. In this example the child said failed to follow instructions 49 times in the week. At the end of the parenting program we would expect to see this number drop dramatically.

Behaviour Tally Sheet

Instructions : Each day the specific behaviour occurs on a given day make a mark in the box. At the end of the day count how many marks have been made. Choose only one behaviour at a time to monitor.

Behaviour: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Total
Monday																
Tuesday																
Wednesday																
Thursday																
Friday																
Saturday																
Sunday																

Weekly Total: _____

Appendix A.12.2

Child Adjustment and Parent Efficacy Scale (CAPES)*

Please read each statement and select a number 0, 1, 2 or 3 that indicates how true the statement was of your child (aged 2-12) **over the past four (4) weeks**. Then, using the scale provided, write down the number next to each item that best describes how confident you are that you can successfully deal with your child's behavior, even if it is a behavior that rarely occurs or does not concern you.

There are no right or wrong answers. Do not spend too much time on any statement.

Example:

My child:							
Gets upset or angry when they don't get their own way	0	1	2	3		***9***	

The rating scale is as follows:

0. Not true of my child at all
1. True of my child a little, or some of the time
2. True of my child quite a lot, or a good part of the time
3. True of my child very much, or most of the time

Child Adjustment and Parent Efficacy Scale (CAPES)*

	How true is this of your child?				Rate your confidence		
My child:	Not at all	A little	Quite a lot	Very much	1 = Certain I can't do it 10 = Certain I can do it		
1. Gets upset or angry when they don't get their own way	0	1	2	3			
2. Refuses to do jobs around the house when asked	0	1	2	3			
3. Worries	0	1	2	3			
4. Loses their temper	0	1	2	3			
5. Misbehaves at mealtimes	0	1	2	3			
6. Argues or fights with other children, brothers or sisters	0	1	2	3			
7. Refuses to eat food made for them	0	1	2	3			
8. Takes too long getting dressed	0	1	2	3			
9. Hurts me or others (e.g., hits, pushes, scratches, bites)	0	1	2	3			
10. Interrupts when I am speaking to others	0	1	2	3			
11. Seems fearful and scared	0	1	2	3			
12. Has trouble keeping busy without adult attention							
13. Yells, shouts or screams	0	1	2	3			
14. Whines or complains (whinges)	0	1	2	3			
15. Acts defiant when asked to do something	0	1	2	3			
16. Cries more than other children their age	0	1	2	3			
17. Rudely answers back to me	0	1	2	3			
18. Seems unhappy or sad	0	1	2	3			
19. Has trouble organizing tasks and activities	0	1	2	3			
20. Can keep busy without constant adult attention	0	1	2	3			
21. Cooperates at bedtime	0	1	2	3			
22. Can do age appropriate tasks by themselves	0	1	2	3			
23. Follows rules and limits							
24. Gets on well with family members	0	1	2	3			
25. Is kind and helpful to others	0	1	2	3			
26. Talks about their views, ideas and needs appropriately	0	1	2	3			
27. Does what they are told to do by adults	0	1	2	3			

*Sanders et al, 2014.

Scoring Key for the CAPES

Child Emotional and Behavioral Problems Scale: 27 items (rating scale 0–3). Note that shaded items (in bold) must be reverse scored (i.e., 0=3, 1=2, 2=1, 3=0). To obtain an *Emotional Problems Subscale Score*, sum items 3, 11, 18, with a possible range from 0-9. To obtain a *Behavioral Problems Subscale Score* sum all remaining items, with a possible range from 0-72. To obtain a *Total Intensity Score* add the *Emotional Problems Subscale* and the *Behavioral Problems Subscale Scores* together, with a possible range from 0-81. Higher scores indicate greater levels of child emotional or behavioral problems.

Parent Efficacy Scale: sum all parent confidence ratings (rating scale 1–10). Note that there are no parent confidence ratings for shaded items. Possible range for the *Total Score* is 19–190, with higher scores indicating greater levels of parent efficacy.

ITEM	Reverse score shaded items (i.e. 0=3, 1=2, 2=1, 3=0)	PARENTAL SELF- EFFICACY
Emotional maladjustment		
3		
11		
18		
Behavioural Problems Subscale		
1		
2		
4		
5		
6		
7		
8		
9		
10		
12		
13		
14		
15		
16		
17		
19		
20		
21		
22		
23		
24		
25		
26		
27		
Total Intensity Score		

Parenting and Family Adjustment Scales (PAFAS)*

Please read each statement and select a number 0, 1, 2 or 3 that indicates how true the statement was of you **over the past four (4) weeks**. There are no right or wrong answers. Do not spend too much time on any statement.

Example:				
If my child doesn't do what they're told to do, I give in and do it myself.	0	1	2	3

The rating scale is as follows:

0. Not true of me at all
1. True of me a little, or some of the time
2. True of me quite a lot, or a good part of the time
3. True of me very much, or most of the time

	How true is this of you?			
	Not at all	A little	Quite a lot	Very much
1. If my child doesn't do what they're told to do, I give in and do it myself	0	1	2	3
2. I give my child a treat, reward or fun activity for behaving well	0	1	2	3
3. I follow through with a consequence (e.g. take away a toy) when my child misbehaves	0	1	2	3
4. I threaten something (e.g. to turn off TV) when my child misbehaves but I don't follow through	0	1	2	3
5. I shout or get angry with my child when they misbehave	0	1	2	3
6. I praise my child when they behave well	0	1	2	3
7. I try to make my child feel bad (e.g. guilt or shame) for misbehaving to teach them a lesson	0	1	2	3
8. I give my child attention (e.g. a hug, wink, smile or kiss) when they behave well	0	1	2	3
9. I spank (smack) my child when they misbehave	0	1	2	3
10. I argue with my child about their behavior / attitude	0	1	2	3
11. I deal with my child's misbehavior the same way all the time	0	1	2	3
12. I give my child what they want when they get angry or upset	0	1	2	3
13. I get annoyed with my child	0	1	2	3
14. I chat / talk with my child	0	1	2	3
15. I enjoy giving my child hugs, kisses and cuddles	0	1	2	3
16. I am proud of my child	0	1	2	3
17. I enjoy spending time with my child	0	1	2	3
18. I have a good relationship with my child	0	1	2	3
19. I feel stressed or worried	0	1	2	3
20. I feel happy	0	1	2	3
21. I feel sad or depressed	0	1	2	3
22. I feel satisfied with my life	0	1	2	3
23. I cope with the emotional demands of being a parent	0	1	2	3
24. Our family members help or support each other	0	1	2	3
25. Our family members get on well with each other	0	1	2	3
26. Our family members fight or argue	0	1	2	3
27. Our family members criticize or put each other down	0	1	2	3
	How true is this of your child?			
If you are in the relationship, please answer the following 3 questions	Not at all	A little	Quite a lot	Very much
28. I work as a team with my partner in parenting	0	1	2	3
29. I disagree with my partner about parenting	0	1	2	3
30. I have a good relationship with my partner	0	1	2	3

*Morawska et al, 2014.

Scoring Key for the PAFAS

All 30 items are rated from 0 to 3. Note that items in bold in the scoring key below must be reverse scored (i.e. 0=3, 1=2, 2=1, 3=0) before summing the Total Score for each subscale. Please see Table 2 below for further information regarding coding the items. PAFAS consist of two scales Parenting and Family Adjustment. PAFAS Parenting consists of four subscales and PAFAS Family Adjustment consists of 3 subscales which can be interpreted using the table below.

SCALE	ITEMS	INTERPRETATION	POSSIBLE RANGE
PAFAS Parenting			
Parental consistency	1,3,4,11,12	Higher scores indicate lower level of consistency	0-15
Coercive parenting	5,7,9,10,13	Higher scores indicate more coercive parenting	0-15
Positive Encouragement	2,6,8	Higher scores indicate lower level of positive encouragement	0-9
Parent-child relationship	14,15,16,17,18	Higher scores indicate worse parent-child relationship	0-15
PAFAS Family adjustment			
Parental adjustment	19,20,21,22,23	Higher scores indicate worse parent adjustment	0-15
Family relationships	24,25,26,27	Higher scores indicate worse family relationships	0-12
Parental teamwork	28,29,30	Higher scores indicate worse parental teamwork	0-9

Item coding

Item	Item
PAFAS Parenting	**PAFAS Family Adjustment**
1	19
2	20
3	21
4	22
5	23
6	24
7	25
8	26
9	27
10	28
11	29
12	30
13	
14	
15	
16	
17	
18	

Appendix A.12.3

SELF-DIRECTED LEARNING EXERCISES AND SELF-ASSESSMENT

MCQ A.12.1 Which of the following is a key component in effective parenting programs?

A. Time out
B. Telephone follow-up
C. Involving children in the intervention
D. A workbook for parents
E. Parental literacy

MCQ A.12.2 A mother who has a son who is generally well behaved but occasionally answers back may benefit from what type of parenting program?

A. Treatment-focused
B. Prevention-focused
C. Blended
D. Home visiting
E. Psychoeducation

MCQ A.12.3 Effective parenting programs are typically based on which of the following?

A. Coercion theory
B. Self-actualization theory
C. Psychoanalytic theory
D. Cultural responsiveness theory
E. Cognitive theory

MCQ A.12.4 In a parenting group, a father is taught about the importance of showing children physical affection. The father says he cannot kiss his daughter as it is not culturally appropriate. What should the practitioner do?

A. Advise to kiss his daughter even if he doesn't feel comfortable
B. Validate his concern and tell him not to show affection if he doesn't feel comfortable
C. Prompt the father to think of culturally appropriate forms of physical affection that he would be comfortable in using
D. Ask if the mother could show affection instead
E. To seek advice from elders

MCQ A.12.5 Which of the following would be considered a high-risk change when implementing a parenting program

A. Leaving out the section of the course that teaches parents about time out
B. Changing the examples from the ones in the work book to make them more applicable to local parents
C. Spending extra time on particular topics
D. Adding extra sessions
E. Shortening some sessions.

ANSWERS

MCQ A.12.1 Answer: A

MCQ A.12.2 Answer: B

MCQ A.12.3 Answer: A

MCQ A.12.4 Answer: C

MCQ A.12.5 Answer: A