WITHOUT A PADDLE: UTILIZING OARS WITHIN AN ONLINE PROBLEM-

SOLVING COMMUNICATION PROGRAM TO IMPROVE THE

PARENT-CHILD RELATIONSHIP

by

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ABSTRACT

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Although parent-child conflict is a normative feature in adolescence, it may result in negative outcomes when it occurs frequently and at high intensity. Parental support behaviors (e.g., warmth, communication, reinforcement) are important during adolescent development to shape appropriate behaviors, while providing opportunities to reinforce the adolescent's autonomy. While behavioral parent training interventions are effective for helping parents manage parent-child conflict that emerges during this developmental period, engagement and retention for face-to-face therapy are problematic. These concerns become more apparent for underserved populations. Efforts to increase accessibility of parenting interventions (e.g., I-PCIT, Triple-P Parenting Program) through online platforms have generated support for internet interventions with younger children. Far fewer studies have investigated online behavioral interventions for parents of adolescents. The aims of this study are to pilot the feasibility and acceptability of an

online parenting intervention for parent-adolescent conflict, as well as assess program outcomes for both caregivers and their adolescents (ages 11 to 14). The self-directed program was adapted from components of Problem-Solving/Communication Training (PSCT), an evidence-based parent management intervention for parents of adolescents. Didactic skills, modeling, and practice assignments translated core PSCT components, and specific communication strategies were added to the model (OARS: Open Questions, Affirmations, Reflections, Summaries). Feasibility data indicate participants perceived the intervention to be accessible and acceptable. Preliminary treatment outcome findings indicate improvements in multiple domains (i.e., relationship quality, involvement, communication, and conflict) following program completion.

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CHAPTER I:

INTRODUCTION

Navigating relationships with children and establishing boundaries, while maintaining appropriate communication as they develop, are tasks that parents may struggle to manage. In fact, parent-child conflict in the United States occurs across cultural boundaries, though it appears more prevalent in white families than minoritized groups (i.e., Black, Hispanic, Asian; Barber, 1994; Parra-Cardona et al., 2017). Parental characteristics (e.g., negative perception of child's personality, warmth; Barber, 1994; de Haan et al., 2012; Goldstein et al., 2005; Heaven et al., 2004) appear to affect the trajectory of early adolescent development. Positive parent-child relationships improve children's well-being, self-esteem, self-control, and internalizing and externalizing symptomatology (Armsden & Greenberg, 1987; Branje et al., 2010; Brody et al., 2005; Gullone & Robinson, 2005; Moore et al., 2011). However, early adolescence is a tumultuous time, as adolescents seek autonomy (Goldstein et al., 2005; Smetana & Asquith, 1994), resulting in conflicts surrounding various topics, such as school, chores, and independence seeking (Barber, 1994; Moed et al., 2015; Laursen, 1995).

Problem-solving communication training (PSCT) is an evidence-based approach for the treatment of parent-child conflict (Barkley et al., 2001; Barkley & Robin, 2014; Foster et al., 1983; Robin, 1981). The approach integrates elements of operant and social learning theories, with an emphasis on communication and problem-solving processes within a family systems context (Barkley & Robin, 2014; Robin & Foster, 1984). Although PSCT demonstrates strong efficacy for increasing parent-child relationship quality and reducing parent-child conflict, engagement in treatment is problematic due to inconsistent attendance and attrition in therapy. These attendance and attrition issues often occur because of multiple barriers, such as low socioeconomic status, negative

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parent expectations, parental stress, inappropriate parenting, and child symptom severity (Chacko et al., 2016; Kazdin et al., 1997; Nock & Kazdin, 2001). Thus, treatment must address these barriers before communication patterns become entrenched. One type of treatment to address these issues may be self-directed and online interventions.

Self-directed and online interventions can appeal to interested clients due to the accessibility of treatment, as well as the reduction of barriers to treatment, such as cost, scheduling, transportation, and stigma (Tarver et al., 2014). In fact, multiple studies have shown that self-directed (e.g., Triple P and Incredible Years), online interventions (e.g., Triple P; Baker & Sanders, 2017; Sanders et al., 2014; Webster-Stratton, 1992) can effectively manage a range of externalizing behaviors. PSCT is a generalizable treatment option to address important foundations in the parent-child relationship in this self-directed framework. Interventions that include components of PSCT (e.g., behavioral family systems therapy) are a strong fit for early adolescence, as the family-systems framework emphasizes problem-solving and communication skills important for autonomy and navigating conflict (Barkley & Robin, 2014; Foster et al., 1983; Robin, 1981, Wysocki et al., 2008). Further, PSCT demonstrates strong applicability to normative (Robin, 1981) and clinical populations (Barkley et al., 2001; Barkley & Robin, 2014), and a self-directed framework may provide additional resources for use in primary care settings, schools, or other settings, where early intervention may prevent later, more costly interventions (Baker & Sanders, 2017; Sanders et al., 2012; Walker et al., 1998).

Therefore, the primary goals of the current study were to examine the pilot feasibility and acceptability outcomes of an online, self-directed intervention that adapts the core tenets of PSCT. Additionally, the study examined preliminary caregiver and child outcomes related to parent-child relationship quality, conflict, and communication following involvement in the intervention.

Parent-Child Conflict

Prior to early adolescence (ages 11–14), parents and children possess a hierarchical relationship that is maintained by the parents (Hartup, 1989; Laursen & Bukowski, 1997; Omer et al., 2013). Research suggests there is a shift in early adolescence, when the adolescent begins to desire a more egalitarian relationship (Laursen & Collins, 2009; McGue et al., 2005); however, parents are observed to struggle during this time with negotiating the appropriate level of individuation for their child's current developmental level (Blos, 1967; Goldstein et al., 2005; McElhaney et al., 2009). Seminal works note that conflict during adolescence approximates an inverted "U" shape, where conflict increases from early to mid-adolescence, is maintained throughout mid-adolescence, and declines in later adolescence (Montemayor, 1983; Steinberg, 1987). Contrary to this original hypothesis, meta-analyses conducted by Laursen and colleagues (1998) revealed that a shift occurs during early adolescence, where conflict intensity may increase through mid-adolescence, while the trajectory of total conflict and conflict rate appears to linearly decline from early to late adolescence. The adolescent's desire to promote more equality in the parent-child relationship, coupled with the potential for parents to struggle to adapt the relationship with their child in a developmentally appropriate manner, can lead to conflict. Smetana (1996) derived three types of family conflict patterns based on conflict frequency and severity; these patterns include 'frequent squabblers' (frequent, low intensity conflict), 'placid' (rare, moderate intensity conflict) and 'tumultuous' (frequent, high intensity conflict; Nelson et al., 2014).

Per expectancy violations theory, individuals develop expectations for how interactions will proceed based on multiple characteristics (e.g., demographics, personality, degree of familiarity, privacy, formality; Burgoon, 1993). When an individual interacts in a manner that is perceived as negative and violates established

expectations, distress may occur (Burgoon, 1993; Dixson et al., 2014). This may translate to the parent-child relationship, as adolescents' desire for autonomy is a violation of previously held parental expectations regarding how their child responds. Thus, when adolescents attempt to assert autonomy in areas they previously did not possess independence, there is a risk of fission within the parent-child relationship (Collins & Luebker, 1994). Fission may result in conflict, as previous communication patterns are disrupted. Adolescents who experience lower levels of autonomy and family connectedness may exhibit increased maladaptive behaviors (e.g., behavioral problems or depressive affect; Eccles et al., 1997). While conflict is normative throughout early adolescent development, longstanding negative patterns of communication and negative parent expectations can exacerbate tension and increase the likelihood for continued distress for both parent and child (Collins & Luebker, 1994; Laursen & Collins, 2004; Laursen & Collins, 2009). Negative parental reactions (e.g., anger, rejection) to their child's disclosures (i.e., sharing about their daily activities) are associated with decreased adolescent connectedness and disclosures; in contrast, positive parental reactions (e.g., attempted understanding, warmth) are linked to increased adolescent connectedness and disclosures (Tilton-Weaver et al., 2010). Families experiencing high rates and intensity of conflict may have adolescents who are at-risk for developing psychopathology (Bradford et al., 2008; Burt et al., 2005; Marmorstein & Iacono, 2004).

Parent-Child Relationship Quality

Relationship quality appears to moderate the relation between conflict and adolescent outcomes (e.g., delinquency, school grades, and withdrawal), where increased conflict, coupled with poor relationship quality, results in poor parent-child outcomes (Adams & Laursen, 2007). Various components that comprise parent-child relationship quality influence closeness between parent and child. Balancing the domains of

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communication, power, and support are important in facilitating positive parent-child relationships.

Parent-Child Communication

Baumrind's (1966) depiction of authoritative parenting is based on communication patterns that set expectations for the child, while facilitating discussion between parent and child, and affirming individual qualities of the child. Specifically, open communication involves the interchange of instrumental and emotional information (i.e., discussion of needs and problems) between parents and children and is exhibited by levels of agreement and sympathetic behaviors (De Goede et al., 2009; Hadiwijaya et al., 2017). Literature has well established the role of parent-child communication in predicting psychosocial child outcomes and family functioning (Davidson & Cardemil, 2009). Positive communication patterns can support healthy family relationships and adolescent emotional functioning (Hart et al., 1997), prevent the development of adolescent delinquent behaviors (Kapetanovic et al., 2019), and serve as prototypes for the adolescent to emulate in other relationships (e.g., listening and problem-solving behaviors; Shomaker & Furman, 2009). However, in early adolescence, communication can be disrupted through increasing negative interactions (e.g., hostility or negative affect) that result in increased conflict and decreased cohesion (Conger & Ge, 1999). The ability for families to communicate openly leads to higher levels of trust and perceived support (Caprara et al., 1998), which may minimize the amount and intensity of conflict experienced in early adolescence, as well as deter the development of psychopathology.

Power in the Parent-Child Relationship

Power, in the parent-child relationship, is described as the balance of authority compared to equality (De Goede et al., 2009; Hadiwijaya et al., 2017). When power is unequal, there is a unidirectional relationship that impairs collaboration, while the

bidirectional relationship associated with equal power facilitates collaboration due to the shared responsibility for outcomes of interactions (Laursen & Bukowski, 1997). Parent-child relationships commonly involve vertical relationships, where parents possess the power to provide guidance, as well as assist in decision-making, and it is often parents who are in control of the progression to horizontality in the relationship throughout adolescence (Branje et al., 2002). Therefore, ensuring parents engage in appropriate autonomy-granting and communication regarding negotiations of autonomy are important in promoting an adolescent's psychological adjustment.

Parental Support

Support within the parent-child relationship is represented by aspects of affection, companionship, nurturance, instrumental provision, intimacy, and the reliability of the alliance (De Goede et al., 2009; Furman & Buhrmester, 1985; Stice & Barrera,1993). Adolescents' perception of support from their parents is crucial to promoting confidence in relationships (Collins & Laursen, 2004). As they age, adolescents tend to increase time spent alone and spend less time with the family (Larson & Richards, 1991). While spending a moderate amount of time alone may have benefits for adolescents (e.g., improved well-being), excessive time spent alone may result in negative consequences, such as unhappiness, reduced alertness, and isolation (Larson & Csikszentmihalyi, 1978). Such results highlight the need for parents to appropriately balance granting autonomy and power to their adolescents while still providing adequate support. Research suggests that decreases in perceived parental support (Helsen et al., 2000; Furman & Buhrmester, 1992), as well as relationship quality (McGue et al., 2005), occur during early to middle adolescence. Compared to pre-adolescence, parents and children often report less frequent positive expression of emotions followed with an increase in the expression of negative emotions during early adolescence (Collins & Laursen, 2004), which can impact

how children perceive support from their parents. Decreases in parental support during early adolescence may result in negative outcomes, such as poorer physical health (Wickrama et al., 1997), emotional as well as behavioral problems (Bradford et al., 2008; Branje et al., 2010; Gerard et al., 2006; Helsen et al., 2000), and decreased academic performance (Cutrona et al., 1994; Wong, 2008).

Developmental Considerations in Parent-Child Relationships

Parents and adolescents appear to have different perspectives regarding when the hierarchy should shift, with adolescents often seeking autonomy earlier than parents may feel is appropriate (Feldman & Quatman, 1988). Collins and colleagues (1997) identified the ages of 13 to 15 as a time where adolescent and maternal expectations regarding autonomy are most discrepant. These discrepancies occur due to the evolution of power throughout this period of early adolescent development. Early adolescence is marked by a shift from hierarchical (Fiske, 1992) to more equitable (Clark & Mills, 1979) relationships. Parents may struggle with this shift because the relationship moves from one in which the child is more dependent on their parent to one in which there are more reciprocal interactions between child and parent (Hartup & Laursen, 1991; Laursen & Bukowski, 1997). Such changes require parents and children to form a mutual relationship in which they are more collaborative in discussions (Laursen & Bukowski, 1997).

Communication patterns in early adolescence are likely to continue throughout adolescence, with negative patterns potentially worsening and parent-child closeness decreasing in response (Collins & Laursen, 2004). Per the expectancy violation-realignment model described by Collins and Luebker (1995), early adolescence is when adolescents begin to assert their autonomy and expect their parents to respond favorably to these assertions; however, parents expect to maintain a hierarchical relationship. In this

situation, the adolescent has their expectations for increasing autonomy violated as the parent attempts to maintain the hierarchy of the previous relationship. Both children and parents perceiving violations to their current expectations may result in distress and conflict (Collins & Laursen, 2004). Emotional variability between parent and child is an important aspect during conflictual interactions. When mothers and adolescents can flexibly express a range of positive and negative emotions throughout their interactions, research indicates this results in less adjustment difficulties, higher relationship quality, and decreases in maternal control (Van der Giessen et al., 2013; Van der Gieseen et al., 2014). Research suggests that an adolescent's feelings regarding communication are correlated with well-being, self-esteem, and coping (Jackson et al., 1998). Such evidence emphasizes the importance of communication as a vehicle for improved adolescent outcomes. The relationship quality components of support, power, and communication are important to address because varying levels of each can affect another domain and either strengthen or weaken the parent-child relationship (Hadiwijaya et al., 2017).

Interventions to Enhance Parent-Child Relationship Quality

Various treatment modalities have been shown to improve parent-child relationships, such as multisystemic therapy (MST; Henggeler et al., 1999; Henggeler & Schaffer, 2016), parent management training (PMT; Eyberg & Robinson, 1982), and problem-solving communication training (PSCT; Barkley & Robin, 2014; Robin,1981). Although all three treatments target reduction in disruptive behaviors and improvement in the parent-child relationship, the mechanism for improvement of relationship quality is different for each. PSCT explicitly emphasizes modeling and practicing of communication skills, as a mechanism for relationship change (Robin, 1979). PSCT is a family-based approach that can apply to general problem-solving and communication difficulties that underlie negative parent-child relationships and a variety of child clinical

concerns. PSCT typically consists of cognitive restructuring, problem-solving, communication training, and optimization of the family structure (Robin & Foster, 1984). However, other models of PSCT have focused primarily on problem-solving, communication training, and cognitive restructuring (Barkley, et al., 2001; Foster et al., 1983). As with PMT, PSCT emphasizes the parent's role in learning and implementing warmth and structure with their child; yet PSCT additionally provides families with the tools to resolve disputes and reduce conflict in the home (Robin & Foster, 1984) to improve the overall parent-child relationship. PSCT appears as effective as PMT in addressing parent-child conflict (Barkley et al., 1992; Barkley et al., 2001;) and may enhance PMT (Spaccarelli et al., 1992), though PSCT may exhibit higher rates of attrition than PMT (Barkley et al., 2001). The length of PSCT can vary from as few as 7 sessions to as many as 18 sessions depending on a family's needs (Barkley et al., 2001; Robin et al., 1994; Robin & Foster, 1984). However, the high dropout rates with PSCT (Barkley et al., 2001) are concerning when considering the importance of treatment engagement for successful outcomes.

Problem-Solving Communication Training

PSCT addresses family processes through the combined approaches of behavioral and systems models to target both behavioral patterns of family members, as well as the problematic structures (e.g., coalitions, hierarchies) within families (Robin & Foster, 1989). The behavioral tradition emphasizes the role of operant conditioning (Skinner, 1981), social learning theory (Bandura, 1977), and social exchange theory (Homans, 1958) on family processes. Systems theory focuses on altering existing cybernetic systems to impact family processes (Ekeh, 1974). The blend of both theories enables therapists to provide a more comprehensive treatment tailored to meet the varying needs of families and their problematic interaction patterns (Robin, 1989).

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Operant conditioning posits that behavior is modifiable based on the reinforcements and punishments that follow, to either encourage or reduce behavior (Skinner, 1981). Clinically, therapists teach parents how to provide appropriate consequences for their child's behavior, such as removal of attention when their child is misbehaving or the provision of a reward and praise for desired behaviors. Social learning theory expands on operant conditioning by exploring learning that occurs through modeling of, rather than via the consequences of, behavior. Bandura (1971) stated that learning occurs via modeling of and experimenting with behavior, where people observe a behavior and then imitate a behavior and will either continue or discontinue the behavior depending on the consequences. Parents serve as powerful models of behavior for their children on how to appropriately manage distress, as well as how to interact with others (Ramsden & Hubbard, 2002). Social exchange theory examines the behaviors of interactants and how individual characteristics of the actors (e.g., powers, coalition formation, emotion) impact the consequences the individuals believe will result from the interaction (Ekeh, 1974). These various learning principles are integral components of parent-child interactions and highlight the importance of modeling and reinforcement of critical skills in childhood necessary to appropriately navigate conflict in adolescence.

Family systems theory targets problematic family functioning that contributes to familial discord. The core targets of family systems theory include family structures, roles, communication patterns, power relations, and boundaries (Rothbaum et al., 2002). Bowen's theory is unique among family systems theories, as it emphasizes the family as an emotional unit in which the relationships between family members are affected by the cognitions, emotions, and behaviors of others in the unit (Kerr & Bowen, 1988). In adolescence, the family system is disrupted due to the varying cognitive, emotional, and

behavioral changes brought about during this time that affect the unit (Robin et al., 1994). Thus, PSCT integrates family systems theory by addressing the family structure (i.e., cohesion, alignment, coalitions, triangulation) and functions of interactional events to improve family functioning (Robin & Foster, 1984).

PSCT is an approach that seeks to ameliorate parent-child conflict through the modeling of appropriate problem-solving and communication skills. Similar to PMT, PSCT emphasizes the importance of parents learning skills, engaging in positive interactions with their child (e.g., making eye contact, using a neutral tone, validating), and providing structure for their child to allow for more autonomy while under their guidance. Robin and colleagues (1984) proposed a 12-session version of PSCT that consists of an engagement phase, skill-building phase, intense conflict resolution phase, and termination. The first three sessions comprise the engagement phase and consist of assessment of the family members, building rapport, and developing a therapeutic contract to prepare the family for change (Robin et al., 1984). During the skill-building phase, problem-solving and communication skills are developed, and then utilized in the conflict resolution phase after the family is introduced to cognitive restructuring (Robin et al., 1984).

Foster and colleagues (1983) consolidated their PSCT treatment program into an intake session with an additional six sessions dedicated to problem-solving and communication skill development and practice. During PSCT, both the parents and the children are present to develop skills in session (Barkley et al., 2001). Homework activities are assigned to promote the practice of PSCT skills during times of family conflict (Barkley et al., 1992). The three primary skills exhibited in PSCT protocols include problem-solving skills, communication skills, and cognitive restructuring (Barkley et al., 2001; Barkley & Robin, 2014; Robin & Foster, 1984). While Robin and

Foster (1984) acknowledge the need to assess and address the family structure (e.g., cohesion, alignments), other PSCT models (e.g., Barkley et al., 2001; Barkley & Robin, 2014; Foster et al., 1983) do not incorporate it within their protocol.

Family Structure

Throughout sessions, the clinician observes family interactions to determine existing family structures. Identification of the family structure allows the therapist to conceptualize the family's behaviors and consider interventions to target problematic structures (e.g., coalitions, triangulation, adolescent behavior interfering with marital conflict, overprotection-rebellion escalator; Robin & Foster, 1989).

Communication skills

Communication skills training is conducted throughout family interactions as communications arise in therapy (Barkley & Robin, 2014; Foster et al., 1983; Robin & Foster, 1984). Communication targets include reducing accusations, interruptions, insults, and lecturing, while attempting to improve attention to family members (e.g., through use of reflections), participation in discussions, and tone of voice (Barkley, et al., 2001; Foster et al., 1983; Robin, 1981). Such skills allow for appropriate discussion of ideas and feelings, as well as proper attending (i.e., verbally, nonverbally) to other family members' actions (Robin, 1979).

Problem-Solving Skills

Typically, problem-solving skills training utilizes a step-by-step process consisting of problem definition, creating alternative solutions, weighing the consequences, selecting a mutually satisfactory solution, and detailing the implementation of the agreed upon solution that families utilize to resolve conflicts (Barkley, et al., 2001; Foster et al., 1983; Robin, 1981; Robin & Foster, 1984). Communication skills are important for problem-solving, because family members must

maintain non-accusatory speech while also utilizing proper assertiveness to facilitate appropriate interactions that minimize conflict at each step (Robin, 1979).

Cognitive Restructuring

Cognitive restructuring assists families in identifying unreasonable beliefs, challenging the beliefs (e.g., with direct feedback, humor, reframing), determining a more rational belief, testing the validity of the belief, and devising a plan to experiment with the new belief (Barkley et al., 2001; Robin, 1981; Robin & Foster, 1984). When there is conflict, family members typically process information based on individual cognitions (e.g., perceptions, beliefs, attributions). Such cognitions may lead to inaccurate or biased processing of information that influences their emotional and behavioral response as well as their ability to engage in effective communication and problem-solving (Robin & Foster, 1989).

Shortcomings of PSCT

While research supports the use of PSCT as a treatment for parent-child conflict, notable dropout rates influence the treatment's relevance to families. Barkley and colleagues (2001) compared the treatment outcomes of PSCT, as a standalone treatment, to a combined treatment program of PMT and PSCT. The researchers found that PSCT had the highest dropout rates (i.e., 38% in PSCT compared to 23% in the combined condition). Further, they hypothesized this stark contrast may exist due to the requirement for teens to attend all sessions in the PSCT condition, while teens only attend the latter half of the combined treatment (Barkley et al., 2001). Additionally, the researchers noted that the considerations Robin (1998) presented regarding the engagement of only parents with PMT may provide the parents with a sense of control over disruptive behaviors that facilitates improved engagement with problem-solving and communication skills. Other factors that appear to impact engagement in treatments involving PSCT include lower

child full-scale IQ (Kazdin et al., 1992), higher disruptive behavior symptom severity (Barkley et al., 2001; Spaccarelli et al., 1992), and lower SES (Nguyen et al., 2016).

Reducing attrition is key to promoting engagement in therapy and improving family outcomes. Ingoldsby (2010) conducted analyses of 17 studies to assess engagement and attrition in family treatments and noted that addressing perceived barriers to treatment (e.g., scheduling, financial concerns), development of parental coping skills, and motivational interviewing techniques may serve as facilitators of engagement and retention in family therapy. Perceived barriers are especially salient to families and the ability to address or reduce barriers (e.g., transportation, financial burden, scheduling) attenuates the risk for dropout (Kazdin et al., 1997).

One such facilitator of change within family interventions relates to the use of motivational interviewing skills (Ingolsby, 2010; Smeerdijk et al., 2011). Studies have successfully trained parents in motivational interviewing in conjunction with problem-solving and communication skills as a family-based intervention to reduce substance use with their children (Smeerdijk et al., 2011; Smeerdijk et al., 2014). While communication skills are addressed in PSCT through psychoeducation of negative communication habits, as well as in session practice (Robin et al., 1994), there is not a structured way to provide concrete skills to caregivers. Motivational interviewing techniques of open-ended questions, affirmations, reflections, and summaries (OARS; Miller & Rollnick, 2002) may provide caregivers with behavioral anchors to ensure mastery of learned skills (Smeerdijk et al., 2011, Smeerdjik et al., 2014).

When combined with parenting interventions, motivational interviewing serves to increase family engagement in treatment (e.g., González-Del-Castillo-McGrath et al., 2014, Sibley et al., 2016). The techniques are typically integrated with session content and focus on parental ambivalence and barriers to engagement. Forrester and colleagues

(2008) demonstrated that motivational interviewing techniques improved the clinicians'

ability to convey empathy, which led to decreased resistance and increased disclosure of

information. Such results highlight the importance of appropriate communication

techniques (e.g., open-ended questions compared to closed questions) during interactions.

Similarly, parents may benefit from improved communication techniques to bolster their

interactions with their children. In fact, Smeerdijk and colleagues (2014) found that

training parents in motivational interviewing skills led to parents exhibiting increased

empathy compared to baseline and the control group. Smeerdijk and colleagues (2011)

also found that the use of motivational interviewing techniques decreased substance use

of young adults with schizophrenia; however, the researchers' findings did not indicate

significant changes in the functioning of young adults, or the stress and burden

experienced by the parents. Thus, motivational interviewing skills are helpful for

improving communication, though appear to require combination with other techniques

to alleviate other difficulties

Creating online interventions may serve as a second avenue to further improve

engagement and retention by reducing barriers (Kazdin et al., 1997) and allowing for

flexibility in treatment participation. Online treatment aims to address potential barriers

to treatment discussed earlier (e.g., attendance, affordability). In fact, it is suggested that

socioeconomic status and levels of child symptomatology may not influence engagement

in treatment, though attendance to sessions serves as a potential barrier to successful

treatment outcomes (Dittman et al., 2014). Beyond enhancing attendance, online

interventions provide an opportunity for enhancing engagement in the intervention

(DuPaul et al., 2018). For example, online interventions allow caregivers to view peer

modeling of skills (e.g., implementation of OARS skills) that may increase

generalizability compared to a face-to-face intervention. Additionally, the time-limited

nature of online interventions appears to promote parent engagement due to the reduced time needed to complete treatment (DuPaul et al., 2018).

The Triple P – Positive Parenting Program and Incredible Years program are two existing parent management training approaches with online self-help adaptations (Baker & Sanders, 2017; Dittman et al., 2014; Sanders et al., 2012; Taylor et al., 2008). Initial efforts to promote dissemination of parenting interventions via the internet utilized a hybrid approach (i.e., web-delivery of content coupled with additional professional coaching) and indicated that the intervention had high participation rates, assisted in participant goal attainment, and appeared satisfactory to participants (Taylor et al., 2008). Participants in a web-based intervention of the Triple P program typically demonstrate improvements in both child and parenting behaviors (Sanders et al., 2012; Sanders et al., 2014). Parenting programs utilizing a self-help format online appear effective in improving parent and child behaviors (Antonini et al., 2014; Baker & Sanders, 2017; Enebrink et al., 2012; Sanders et al., 2012). Further, Dittman and colleagues (2014) found that typical barriers to engagement in parent training (i.e., low SES, parental depression, low parental education, high levels of child disruptive behavior) did not impair treatment effectiveness in their review of self-help online parenting interventions. The results are promising evidence for emerging online mental health treatments that aim to reduce barriers to treatment and broaden their reach. An online, self-directed intervention utilizing PSCT strategies expands on such programs by focusing on problem-solving and communication.

Current Study: A Pilot Trial of Online Problem-Solving Communication Training

The current study aimed to develop and examine the preliminary effectiveness of a self-directed, online PSCT treatment program in reducing the intensity of parent-child conflict and improving parent-child relationship quality. Accessibility may also promote

dissemination of PSCT and provide parents with additional resources and skills to manage family conflict in the home. Utilization of online modules was hypothesized to improve accessibility due to reduced demands on transportation, finances, and scheduling conflicts.

The Without a Paddle program incorporated the problem-solving skills, communication training, and cognitive restructuring typical of PSCT programs. While the structural analysis (i.e., determining family difficulties with cohesion and alignment) of the family unit was not possible with a self-directed, online module, the program incorporated psychoeducation regarding various family dynamics (e.g., types, consequences) and strived to aid parents in identifying their family structure to promote awareness of their parenting style. Further, the program incorporated additional content to bolster PSCT, including psychoeducation regarding adolescence, active training in OARS competencies within communication skills, and coping strategies for parents. A novel aspect of the program was the focus on training the parent without directly including the children in intervention coursework. Instead, the program aimed to ensure parents understood and acquired the skills necessary to model desirable behaviors for their children.

Aims of the Present Study

The current study was a single group, pre-post design. The following aims and hypotheses were examined in the proposed research:

1. The feasibility of an online, self-directed intervention was examined as evidenced by (a) compliance (i.e., via percent of modules completed), (b) perceived usefulness (i.e., via participant ratings; see Appendix L for Client Satisfaction Measure), (c) ability to recruit a sufficient sample of participants, and (d) the

completion of baseline and post-intervention assessments by those enrolled in the study (see Table 1 for feasibility outcomes).

Table 1

Summary of Proposed Feasibility Outcomes

Study Component	Feasibility Quantification	Method Obtained
Screening/Recruitment	Proportion of screen eligible who enroll	Enrollment data
Retention	Number of completed sessions, drop-out rate	Clinical data
Engagement	Number & percent of consecutively completed modules	Clinical data
PSCT Module Adherence	Percentage of completed lessons	Electronic survey database
Weekly Survey Adherence	Rate of completed surveys (% compliant)	Electronic survey database
Acceptability - Convenience	Time surveys were completed	Electronic survey database
Acceptability - Usability	User-friendly rating of survey program; selection of most user-friendly element	Electronic survey database

2. The acceptability of the Without a Paddle program was assessed through participant self-report of satisfaction with the program, as well as feedback regarding the format of the program, following completion of the intervention (see Appendix L for the Client Satisfaction Measure and Table 1 for additional acceptability outcomes).

3. It was predicted that caregivers receiving the intervention would demonstrate significantly higher levels of (a) parental monitoring, (b) positive parenting, (c) involvement, and (d) lower levels of inconsistent discipline as well as (e) corporal

punishment (measured on the Alabama Parenting Questionnaire; See Appendices H and I) compared to baseline.

4. It was predicted that caregivers receiving the intervention would report lower rates of child symptomatology (e.g., emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems) and increased prosocial behavior compared to baseline (measured on the Strengths and Difficulties Questionnaire; See Appendix J).

5. It was predicted that higher levels of parental acceptability would correlate with higher levels of parental engagement (e.g., completion of modules, lower rates of missed sessions).

6. It was predicted that caregivers receiving the intervention, as well as their children, would report higher rates of parent-child relationship quality relative to baseline (measured on the Quality of Relationship forms; See Appendices F and G).

7. It was predicted that caregivers receiving the intervention, as well as their children, would report higher openness of parent-child communication relative to baseline (measured on the Parent-Child Communication Scale; See Appendices D and E).

8. It was predicted that caregivers receiving the intervention, as well as their children, would report lower levels of conflict relative to baseline (measured on the Parental Environment Questionnaire and Issues Checklist; See Appendices B and C).

CHAPTER II:

METHOD

Participants

Participants included a diverse group of 18 caregivers and their children ages 11 to 14. Participants were recruited from online forums (e.g., Facebook and Craigslist), university settings (e.g., from undergraduate classrooms), and mental health facilities. The caregivers who completed the program completed pre- and post-program measures and module content. Children only participated in pre- and post-program measure completion.

Procedures

Participants who viewed the flyer at an in-person site (i.e., university or mental health setting) contacted the study coordinator via email to discuss scheduling a 10-minute video screener via Zoom. Online participants were first provided a link to three pre-screening questions through Qualtrics that assessed their eligibility (i.e., U.S. residence, parent/legal guardian status, and child age) and interest in being contacted to schedule a video screener via zoom. These participants were excluded if they entered the pre-screening multiple times from the same IP address or if the geographic location indicated they did not reside in the U.S. Eligible participants were then scheduled for a Zoom screening. A graduate student conducted the screening to determine participant eligibility. Graduate students conducting Zoom screenings provided a brief overview of the study, asked caregivers questions to verify eligibility status, and answered caregiver questions. Eligibility criteria were as follows: child between the ages of 11 to 14, normal intellectual functioning (IQ > 85), no current parental divorce/custody proceedings, no diagnoses of CD or ASD, and U.S. residency. If eligible, the caregiver and child provided consent through online signatures when completing pre-program measures.

If the caregiver and child consented, the caregiver and child individually completed pre-treatment measures (i.e., Strengths and Difficulties Questionnaire, Issues Checklist, Quality of Relationship questionnaire, Alabama Parenting Questionnaire, Parent-Child Communication Scale, Parental Environment Questionnaire) on Qualtrics to evaluate their beliefs on communication, conflict, and parent-child relationship quality. Then, the caregiver was assigned a participant number, given instructions on how to register an account online, and provided with a link to log in to the Without a Paddle program website. Participants could access the program from any device (e.g., cellphone, tablet, computer) when completing modules. Once the caregiver registered for their account, they completed a training module to familiarize themselves with the Without a Paddle program format.

Caregivers completed weekly measures for seven weeks in conjunction with completion of weekly modules (2-week baseline + 5-week intervention). If caregivers did not complete their weekly content, they remained on their current module and completed the same measures for the following week. Weekly email prompts were sent out to remind caregivers to complete modules. If a caregiver missed a week of modules, they were prompted via email to complete the module within the next week. Once the caregiver completed two weeks of baseline measures and five weeks' worth of content, they were provided a link to complete post-treatment measures along with their child. They received a $50 gift card payment for their participation in the study (see study flowchart in Figure 1).

Figure 1

Participant Flow from Baseline to Completion

```
┌─────────────────────────────────────────────┐
│      Expressed Interest in Participating      │
│                   n = 101                     │
└─────────────────────────────────────────────┘
                      │
┌─────────────────────────────────────────────┐
│      Assessed for Eligibility and Consented   │
│                   n = 41                      │
└─────────────────────────────────────────────┘
                      │
┌─────────────────────────────────────────────┐
│        Completed Pre-treatment Measures       │
│                   n = 35                      │
└─────────────────────────────────────────────┘
                      │
┌─────────────────────────────────────────────┐
│            Registered for Website             │
│                   n = 28                      │
└─────────────────────────────────────────────┘
                      │
┌─────────────────────────────────────────────┐
│         Participated in Online Modules        │
│          •  Baseline 1 (n = 26)               │
│          •  Baseline 2 (n = 25)               │
│          •  Module 1 (n = 25)                 │
│          •  Module 2 (n = 21)                 │
│          •  Module 3 (n = 19)                 │
│          •  Module 4 (n = 18)                 │
│          •  Module 5 (n = 18)                 │
└─────────────────────────────────────────────┘
                      │
┌─────────────────────────────────────────────┐
│        Completed Post-treatment Measures      │
│                   n = 18                      │
└─────────────────────────────────────────────┘
```
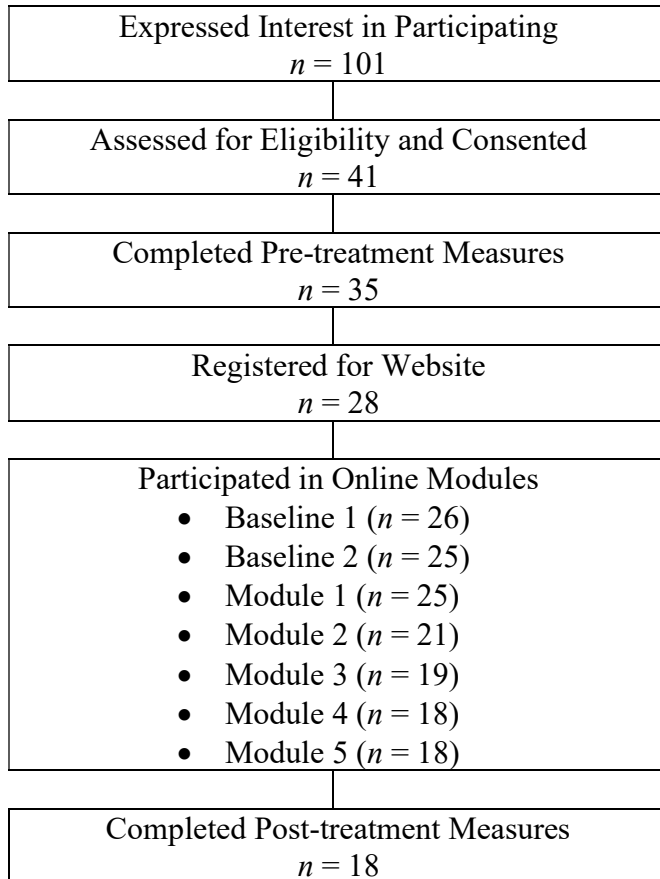
Online Intervention

The online modules for the Without a Paddle program were adapted from the PSCT intervention as described by Robin and colleagues (1994) and Barkley and Robin (2014). OARS communication strategies were adapted from Motivational Interviewing texts (Miller & Rollnick, 2002). The current intervention consisted of two baseline modules (survey only) and five content modules completed on a weekly basis. Content modules required approximately 20–45 minutes to complete. At the beginning of each module, caregivers completed a measure related to characteristics of the parent-child relationship (e.g., conflict, communication, quality). In the content modules, caregivers

received a didactic description of the weekly skill (e.g., psychoeducation, communication skills, problem-solving skills), an activity to reflect on or interact with the skill (e.g., identify the errors in the video interaction you viewed), and an assignment to assist in reinforcement of learned skills. Caregivers participated in the modules and could complete them at any time during the week. Once a module was completed, the next module did not become available until seven days had elapsed. This structure ensured caregivers were given ample time and opportunities to engage in skills practice.

Module 1

  The initial module began with a brief overview of the program and a review of expectations for participation prior to discussing program content. Additionally, psychoeducation was provided to parents regarding normal changes in adolescence, typical developments that occur throughout adolescence, and that the desire for autonomy is a developmental challenge for adolescents. Parents began by completing a 'Myths and Facts' questionnaire to debunk common misconceptions regarding adolescence and provide knowledge regarding appropriate developmental changes taking place. Additionally, parents received information regarding various family structures and were encouraged to identify which dynamics occurred in their own family to promote self-awareness of potential areas for development throughout the course of the intervention.

Module 2

  Differential attending was presented in the second module. Caregivers were provided with strategies to attend to positive behaviors of their child while ignoring undesirable behaviors. Psychoeducation and modeling of skills assisted caregivers in learning the concept.

Module 3

Communication skills are typically integrated throughout a PSCT intervention, as the therapist addresses communication skills in the moment to correct problematic communication patterns (Robin & Foster, 1989). Due to the nature of the modules, communication skills were programmed towards the beginning of the intervention to facilitate appropriate problem-solving skills. The module provided parents training in communication through teaching OARS skills from the motivational interviewing literature (Miller & Rollnick, 2002). OARS skills bolstered the PSCT intervention by providing formal communication strategies for parents to practice. Caregivers learned the OARS acronym and viewed demonstrations of each skill (i.e., open-ended questions, affirmations, reflections, summaries). Following the didactic presentation, caregivers observed inappropriate (e.g., closed questions) interactions and submitted the errors they noticed. They received feedback on what should change and then viewed an appropriate (e.g., open-ended questions) demonstration of skills. Caregivers then received interactive prompts based on the OARS skills learned.

Module 4

Problem-solving training included psychoeducation regarding the steps to problem-solving and how to progress through each step. Further, communication skills (i.e., OARS) were integrated to promote appropriate problem-solving discussions. Parents created a plan for problem-solving and how to implement solutions.

Module 5

Cognitive restructuring built upon previously learned skills to increase parents' awareness of the impact of cognitive processes on emotional experiences during conflict. Further, the module provided information on methods to identify and challenge cognitive distortions. Parents were encouraged to identify frequent cognitive distortions that

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occurred in the home and to begin reframing communication to eliminate such cognitive errors. The module concluded with a brief review regarding concepts learned throughout the program.

Measures

Demographic form

Caregivers completed a 21-item demographic form (See Appendix A) to collect parent and child information including ethnicity, gender, biological sex, and age. Parent-specific questions included languages spoken in the home, marital status, estimated annual income, mental health concerns, and the site where the participant heard about the study. Questions regarding the child included current diagnoses, medications prescribed, and history of mental health services.

Parental Environment Questionnaire (PEQ)

The PEQ (See Appendix B) is a measure of both caregiver and child perceptions of conflict with caregiver, involvement with caregiver, child's regard for caregiver, caregiver's regard for child, and structure (Elkins et al., 1997). Elkins and colleagues (1997) specifically observed the relationship between caregivers and their children in creation and validation of the measure. As conflict was one of the primary targets of the intervention, only the 12-item Conflict with Caregiver subscale was used for the purposes of this study (e.g., "I often lose my temper with my child," "Often there are misunderstandings between my child and myself," and "My child and I often get into arguments."). Internal consistency for the PEQ Conflict with Caregiver subscale is adequate (.81–.86) based on prior literature, and the PEQ demonstrated construct validity with the Family Environment Scale (FES) via high correlations between the PEQ Conflict and FES Conflict (r = .53–.55; Elkins et al., 1997). The internal consistency for caregivers in the current sample was good (n = 35, α = .89) for pre-program measures and

acceptable ($n = 18$, $\alpha = .78$) for post-program measures. Reliability for children in the current sample was good ($n = 30$, $\alpha = .89$) for pre-program measures and high ($n = 18$, $\alpha = .92$) for post-program measures.

Issues Checklist

The Issues Checklist (IC; See Appendix C) was used to assess the severity of parent-child conflict. It consists of 44 issues that prompt the respondent to indicate whether this disagreement occurred in the home over the past 4 weeks and, if so, the respondent rates the anger intensity of the discussion on a scale from 1 (*calm*) to 5 (*angry*), as well as the frequency with which the topic arises (Robin & Foster, 1989). The internal consistency for caregivers in the current sample was high for pre-program measures ($n = 35$, $\alpha = .90$) and for post-program measures ($n = 18$, $\alpha = .92$). Reliability for children in the current sample was high for pre-program measures ($n = 30$, $\alpha = .91$) and for post-program measures ($n = 18$, $\alpha = .94$).

Parent-Child Communication Scale (PCCS)

The Parent-Child Communication Scale consists of Caregiver (See Appendix D) and Child (See Appendix E) reports of parent and child communication adapted from the Pittsburgh Youth Study (Loeber et al., 1998; Thornberry et al., 1995). The Conduct Problems Prevention Research Group (CPPRG, 1994a; CPPRG, 1994b) adapted a 20-item caregiver report measure and a 10-item child report measure to specifically assess for perceptions of the caregiver's openness to communication, as well as the caregiver's perception of their child's communication skills. The subscales of the child form include Parent Communication and Child Communication; while the subscales of the parent form include Parent Communication, Parent Restricted Topics (comprised of two items), Child Empathy/Listening, and Child Emotional Expression. Items are rated on a scale of 1 (almost never) to 5 (almost always). The CPPRG (1994b) demonstrated adequate

reliability for the child report with a Cronbach's alpha ranging from .70–.86. While the parent report showed low internal consistency for the Restricted Topics subscale ranging from .34–.43, the remaining subscales demonstrated adequate internal consistency from .69–.75 (CPPRG, 1994a). The internal consistency for caregivers in the current sample was acceptable ($n = 35$, $\alpha = .76$) for pre-program measures and good ($n = 18$, $\alpha = .84$) for post-program measures. Reliability for children in the current sample was questionable ($n = 30$, $\alpha = .68$) for pre-program measures and low ($n = 18$, $\alpha = .29$) for post-program measures.

Quality of Relationship

The Quality of Relationship with Caregiver (QRC; See Appendix F), and Parent-Child Relationship (PCR; See Appendix G) questionnaires assess the child's and caregiver's perceptions regarding the quality of the parent-child relationship, as well as recent level of parental involvement (Resnick et al., 1997). The QRC is adapted from the Quality of Relationship with Mother (QRM) and Quality of Relationship with Father (QRF) measures (Resnick et al., 1997). Items in the QRC were adapted by changing "mother" or "father," from the QRM and QRF, respectively, to say "caregiver" to ensure the child answers items regarding only the caregiver participating in the intervention modules. The QRC consists of the 25 items included in both the QRM and QRF, while the caregiver form is comprised of 21 items. Each item requires a rating from 1 (never; not at all) to 5 (always; very much). The internal consistencies in the literature range from average to good for the QRF ($\alpha = .71$–$.75$), QRM ($\alpha = .68$–$.69$), and PCR ($\alpha = .59$–$.60$; Resnick et al., 1997). The internal consistency for caregivers in the current sample was poor ($n = 35$, $\alpha = .53$) for pre-program measures and good ($n = 18$, $\alpha = .83$) for post-program measures. Reliability for children in the current sample was poor ($n = 30$, $\alpha = .68$) for pre-program measures and good ($n = 18$, $\alpha = .84$) for post-program measures.

Alabama Parenting Questionnaire

The APQ was used to assess the perceptions of the child and their caregiver regarding both positive and negative parenting behaviors. It is a 42-item questionnaire with both caregiver (See Appendix H) and child (See Appendix I) forms to evaluate perceptions of parenting behaviors by rating items on a scale of 1 (*never*) to 5 (*always*; Frick, 1991). Subscales include parental monitoring and supervision, inconsistent punishment, corporal punishment, positive parenting, involvement, and other discipline practices (Dadds et al., 2003). Internal reliability of subscales ranges from .55–.75 and test-retest reliability estimates range from .62–.96 (Dadds et al., 2003). The internal consistency for caregivers in the current sample was good ($n = 35$, $\alpha = .80$) for pre-program measures and high ($n = 18$, $\alpha = .90$) for post-program measures. Reliability for children in the current sample was good ($n = 30$, $\alpha = .85$) for pre-program measures and high ($n = 18$, $\alpha = .93$) for post-program measures.

Strengths and Difficulties Questionnaire (SDQ)

The SDQ (See Appendix J) was used to assess both the child's and caregiver's perceptions of child behavioral concerns that may impact family functioning. It is a 25-item questionnaire with both caregiver and child forms that assess emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behavior on a scale of 0 (*Not True*) to 2 (*Certainly True*; Goodman, 1997; Goodman et al., 1998). The reported internal consistencies for the subscales are acceptable and range from .61 to .82 (Goodman et al., 1998). The internal consistency for caregivers in the current sample was acceptable for pre-program measures ($n = 35$, $\alpha = .72$) and for post-program measures ($n = 18$, $\alpha = .78$). Reliability for children in the current sample was acceptable ($n = 30$, $\alpha = .77$) for pre-program measures and good ($n = 18$, $\alpha = .86$) for post-program measures.

Weekly Module Measure

The Weekly Module Measure (see Appendix K) is a 13-item questionnaire created for the present investigation based on several of the previously discussed measures (i.e., PEQ, PCCS, QoR, SDQ) that are the primary targets of the intervention. The purpose of the measure was to evaluate individual trajectories of symptom change. Additionally, acceptability and feasibility questions included in the measure examined the impact of each module. Caregivers were asked to rate parent-child conflict on a scale of 1 (*Definitely True*) to 4 (*Definitely False*), communication on a scale of 1 (*Almost Never*) to 5 (*Almost Always*), relationship quality on a scale of 1 (*Not at all*) to 5 (*Very Much*), and behaviors their child exhibits on a scale of 1 (*Not True*) to 2 (*Certainly True*). The three items from the Parental Environment Questionnaire are derived from the Conflict subscale and had the highest factor loadings (.68–.76; Elkins et al., 1997) in the literature. The factor loadings for these items in the current sample for caregivers ranged from .70–.86 pre-program and from .76–.87 post-program. For children, the factor loadings for these items in the current sample ranged from .65–.83 pre-program and from .78–.83 post-program. The three items from the Parent-Child Communication Scale are part of the Parent Communication subscale (Conduct Problems Prevention Research Group, 1994; Loeber et al., 1998; Thornberry et al., 1995), and the Quality of Relationship items are representative of the domains of the construct described in the introduction (Resnick et al., 1997). The items for these measures have high factor loadings and, theoretically, appear to best reflect the constructs. The three items selected from the Strengths and Difficulties Questionnaire reflect both externalizing and internalizing symptoms (Goodman, 1997). Additional open-ended questions regarding usefulness of the module were used to assess acceptability of the particular intervention content delivered in that week.

Adapted Client Satisfaction Questionnaire (CSQ)

The CSQ (See Appendix L) is an eight-item questionnaire used to assess general satisfaction with the psychotherapy intervention provided (Larsen et al., 1979). Items are rated on a scale of 1 (indicating either disagreement or low satisfaction) to 4 (indicating either agreement or high satisfaction). The CSQ was reworded to match the phrasing for the Without a Paddle program (e.g., 'service' changed to 'program'), and an item regarding perceived usefulness (i.e., How satisfied are you that the lessons in the program were useful?) was added to assess acceptability. Additionally, there is an area for the participants to provide qualitative feedback regarding the program. Larsen and colleagues (1979) reported a coefficient alpha of .92 for this 8-item acceptability scale, which is consistent with literature regarding the internal consistency of longer versions of the CSQ. Authors also note that this scale correlates with positive psychotherapy outcomes (Attkisson & Zwick, 1982). The internal consistency for the current sample completed at post-treatment was good (.97).

Data Analytic Plan

Datasets were exported from Qualtrics into an SPSS file, and analyses were conducted using SPSS Statistics 27. The study examined the perceived feasibility and acceptability of a web based, self-directed PSCT intervention. Pilot caregiver and child outcomes from baseline to post-program were also examined.

Descriptive statistics were computed for compliance (i.e., via percent of modules completed), number recruited vs. number enrolled and completed, and perceived usefulness (i.e., via participant ratings) following completion of the intervention. To examine the acceptability of the Without a Paddle program, descriptive statistics were computed for participant self-report of satisfaction with the program (i.e., Client Satisfaction Questionnaire). Qualitative feedback regarding the format of the program

was reviewed and organized thematically following completion of the intervention. Bivariate correlations were conducted to assess the relations between parental acceptability and levels of parental engagement (e.g., completion of modules, lower rates of missed sessions).

Separate repeated measures multivariate analyses of variance (MANOVAs) were conducted to examine whether the caregivers demonstrated significantly higher levels of (a) parental monitoring, (b) positive parenting, (c) involvement, and (d) lower levels of inconsistent discipline and (e) corporal punishment following the intervention compared to baseline based on caregiver and child reports. Additionally, MANOVAs were used to assess whether caregivers and children reported improvements in parent-child relationship quality and openness of parent-child communication from baseline to post-program.

Paired samples t-tests were used to assess rates of child symptomatology (e.g., emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems) and changes in child prosocial behaviors from baseline to post-program as indicated by caregiver and child reports. Three paired samples t-tests were conducted to examine changes in conflict, amount of conflict, and conflict intensity between caregivers and children from baseline to post-program.

CHAPTER III:

RESULTS

Participant Characteristics

A total of 41 caregivers were recruited from various sites (e.g., offices of mental health professionals, university settings, online recruitment) and, of those participants, 18 caregivers completed the study. Participation was active between September 2020 and October 2021. Of the participants, 30 (85.7%) identified as female, 31 (88.6%) were biological parents, 23 (65.7%) identified as Caucasian, and 6 (17.1%) identified as African American. All participants endorsed having internet access and indicated their preferred method to participate via either computer ($n = 28$, 68.3%), phone ($n = 6$, 14.6%), or both ($n = 7$, 17.1%). When examining the demographic characteristics of the 18 participants who completed the study, 16 (88.9%) identified as female, 16 (88.9%) were biological parents, 9 (56.3%) identified as Caucasian, and 6 (37.5%) identified as African American. Sample sizes and percentages of demographic information collected for the participants prior to beginning the program are presented in Table 2.1, and the demographic information for participants who completed the study are presented in Table 2.2.

Table 2.1

Participant Demographics

Demographic	n	%	Demographic	n	%	Demographic	n	%
Caregiver Race/Ethnicity			Annual Household Income			Diagnostic Status		
African American	6	17.1	<$20,000	4	11.4	Diagnosis*	8	22.9
Latino	2	5.7	$20,000-$40,000	4	11.4	ADHD	5	62.5
Caucasian	23	65.7	$41,000-$60,000	5	14.3	Anxiety	5	62.5
Asian	2	5.7	$61,000-$80,000	6	17.1	Depression	3	37.5
Native American	1	2.9	>$81,000	16	45.7	Learning Disability	1	12.5
Biracial	1	2.9				OCD	1	12.5
						No Diagnosis	27	77.1
Relationship to Child			Caregiver Gender			Child Gender		
Biological Parent	31	88.6	Female	30	85.7	Female	21	60
Adoptive Parent	2	5.7	Male	5	14.3	Male	14	40
Stepparent	1	2.9						
Custodial Grandparent	1	2.9						
Caregiver Marital Status			Caregiver Age			Child Age		
Never Married	6	17.1	24-34	6	17.1	11	12	34.3
Married	23	65.7	35-44	21	60	12	11	31.4
Divorced/Separated	6	17.1	45-54	7	20	13	6	17.1
			>54	1	2.9	14	6	17.1

Note: N = 35, which included those who completed pre-treatment measures; *Specific diagnoses total to more than 8 due to children having comorbid diagnoses

Table 2.2

Completed Participant Demographics

Demographic	n	%	Demographic	n	%	Demographic	n	%
Caregiver Race/Ethnicity			Annual Household Income			Diagnostic Status		
African American	6	33.3	<$20,000	2	11.1	Diagnosis*	5	27.8
Latino	1	5.6	$20,000-$40,000	2	11.1	ADHD	2	11.1
Caucasian	9	50.0	$41,000-$60,000	3	16.7	Anxiety	2	11.1
Asian	1	5.6	$61,000-$80,000	4	22.2	Depression	2	11.1
Biracial	1	5.6	>$81,000	7	38.9	OCD	1	5.6
						No Diagnosis	13	72.2
Relationship to Child			Caregiver Gender			Child Gender		
Biological Parent	16	88.9	Female	16	88.9	Female	6	33.3
Adoptive Parent	1	5.6	Male	2	11.1	Male	12	22.5
Stepparent	1	5.6						
Caregiver Marital Status			Caregiver Age			Child Age		
Never Married	4	22.2	24-34	3	16.7	11	6	33.3
Married	11	61.1	35-44	12	66.6	12	6	33.3
Divorced/Separated	3	16.7	45-54	3	16.7	13	2	11.1
						14	4	22.2

Note: $N = 18$, which included those who completed all modules and post-treatment measures; *Specific diagnoses total to more than 5 due to children having comorbid diagnoses

Feasibility

Descriptive statistics were computed for the ability to recruit a sufficient number of participants, compliance (i.e., via percent of modules completed), perceived usefulness (i.e., via weekly participant ratings), and the completion of baseline and post-program measures.

Recruitment

There were 101 caregivers who contacted the study coordinator to schedule a Zoom screener. Of those caregivers, 52 (51.5%) did not present for the screening, 42 (41.6%) were eligible to participate, and 41 (40.6%) consented to participate. The caregiver who declined to participate cited concerns with lack of monetary compensation for the time investment required by the study. This caregiver stated, "$50 is not enough compensation for five to six hours of my time." Of the consented caregivers, 35 completed pre-treatment measures. Caregivers were recruited from several sites including Facebook ($n = 60\%$), Craigslist ($n = 8.6\%$), mental health professionals ($n = 5.7\%$), university professors ($n = 5.7\%$), research forums ($n = 11.4\%$), Amazon Mechanical Turk ($n = 5.7\%$), and friend referral ($n = 2.9\%$).

Compliance

Compliance rates are based on a total of 26 participants who registered on the website. These rates indicated that 18 (69.2%) participants completed all seven modules, 1 (3.8%) participant completed up to module three, 2 (7.7%) participants completed up to module two, 4 (15.4%) participants completed up to module one, and 1 (3.8%) participant completed one baseline module.

Perceived Usefulness

For modules two through five, participants were asked what was most useful from the previous module's content, the frequency with which they enacted strategies from the

previous module, how effective the strategies seemed, and whether a co-caregiver utilized the strategies. Ratings for module five were not provided as participants did not have the opportunity to rate their use of module five content following study completion. Percentages provided were based on the number of caregivers that provided responses to the items listed above. Rates of participant completion for the content modules are as follows: 20 completed ratings for module one, 18 completed ratings for module two, 18 completed ratings for module three, and 18 completed ratings for module four.

Module One Ratings

Caregivers identified the ABC chart activity from module one as helpful for reflecting on problematic behaviors and how they are maintained. Participants reported using the strategies from module one between one ($n = 36.89\%$) to three times ($n = 26.3\%$) in the last week. Content from module one was generally viewed as effective by participants ($n = 80\%$) and most participants ($n = 60\%$) did not have a co-caregiver use the strategies.

Module Two Ratings

Both one-on-one time and effective commands were viewed as useful strategies from module two. Caregivers reported using these strategies five or more times within the last week ($n = 50\%$) and they viewed these strategies as effective ($n = 83.3\%$). Most participants did not have a co-caregiver use the strategies ($n = 66.7\%$).

Module Three Ratings

Caregivers found various aspects of OARS from module three were helpful. Some participants listed specific skills that were useful (e.g., active listening, affirmations, open-ended questions) while some participants thought the skills were useful for reflecting on their communication styles (e.g., "The video examples made me realize how much I criticize"). Most participants used these skills one ($n = 29.4\%$) to three times ($n =$

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29.4%) during the week, considered these skills effective (*n* = 88.2%), and had a co-caregiver implement the strategies (*n* = 64.7%).

Module Four Ratings

Participants found the problem-solving steps useful, and some noted the collaboration between caregiver and child was helpful. Caregivers employed these strategies once (*n* = 38.9%) or twice (*n* = 27.8%). Most participants (*n* = 83.3%) found the strategies were effective and most (*n* = 55.6%) reported a co-caregiver did not use the strategies.

Measure Completion

At baseline, 35 (85.4%) caregivers who consented to participate and 25 (61%) of their children completed pre-program measures. Participants who did not complete both pre-program measures (*n* = 4) and participants who did not register for the website (*n* = 3) were dropped from the study if they did not respond to email prompts. A total of 18 (43.9%) caregivers and children completed post-program measures.

<center>**Acceptability**</center>

Acceptability was measured by participants' post-program completion of the Adapted Client Satisfaction Questionnaire. A total of 18 participants completed post-program acceptability measures. The responses to these questions were grouped thematically for analysis.

Perception of Program Quality

The mean rating of the quality of the program (*M* = 3.33) reflected caregiver satisfaction with the quality of the lessons provided. Most of the participants rated the quality as either "excellent" (*n* = 44.4%) or "good" (*n* = 44.4%), and a few participants as "fair" (*n* = 11,1%). Generally, participants expressed favorable views of the program with most participants rating that they "definitely" (*n* = 44.4%) or "generally" (*n* =

44.4%) received the expected services from the program. A participant described "look[ing] forward to practicing the skills I learned when I interact with my child and his siblings." Caregivers believed the program "helped a great deal" ($n = 55.6\%$) in dealing with their problems more effectively. Participants cited feeling 'most' ($n = 50\%$) to 'almost all' ($n = 38.9\%$) of their needs were met.

Attitudes Towards Referral

Caregivers believed they would 'definitely' ($n = 50\%$) return to the program, or likely consider returning ($n = 38.9\%$) if they needed to seek help again. Similarly, they indicated they would likely ($n = 44.4\%$) or 'definitely' ($n = 50\%$) recommend the program to a friend if they needed similar help. A participant described themselves as "excited to share with friends and family what I learned in order to help them as well."

Satisfaction with Program Components

Overall participant satisfaction was reported as "very satisfied" ($n = 44.4\%$) and "mostly satisfied" ($n = 44.4\%$). Caregivers indicated similar levels of satisfaction with the amount of help they received from the program. One participant expressed that "more scenarios acted out" would be helpful, as the included scenarios in each module assisted with skill implementation. Caregivers reported they were 'mostly' ($n = 44.4\%$) to 'very' ($n = 50\%$) satisfied with the usefulness of the lessons within the program. One participant noted that "the program itself was good, but the delivery system was poor." They followed-up with specific concerns to address including "no checklist of weekly activities" causing the program to remain locked longer because the participant was unaware that they had not completed all module components prior to receiving an email reminder. The participant described the resulting delays in completing future modules due to this lack of clarity as "difficult." Another participant described the program as

"disjointed" and expressed some of the skills seemed inappropriate, particularly that the effective command section "seemed too authoritarian."

Program Outcomes

Separate repeated measures multivariate analyses of variance (MANOVAs) were used to examine changes from baseline to post-program on five dependent measures related to caregivers' and children's perceptions of parental monitoring, positive parenting, parental involvement, inconsistent punishment, and corporal punishment. Results indicated statistically significant changes in parenting behaviors reported by caregivers from pre-program to post-program, $F(5,13) = 4.46$, $p = .014$, $\eta_p^2 = .63$. There were no statistically significant changes in any of the dependent variables from baseline to post-program in the child ratings, $F(5,6) = 2.97$, $p = .109$, $\eta_p^2 = .11$. The effect sizes for caregiver reports of parental involvement and inconsistent discipline fell within the large effect size indicating that, while the results were not statistically significant, there was improvement observed from baseline to post-program. The effect size for positive parenting indicated a moderate effect size, while the effect sizes for poor monitoring/supervision demonstrated a small effect size. Child reported changes in positive parenting and parental involvement were within the moderate range. Inconsistent discipline demonstrated a large effect size. The means, standard deviations, effect sizes, and observed power for the dependent variables are provided in Table 3.

Table 3

Means, Standard Deviations, and Effect Sizes for Alabama Parenting Questionnaire (APQ) Subscales

Caregiver Ratings	Baseline			Post-Program			η_p^2	$1-\beta$*
	Range	*M*	*SD*	*Range*	*M*	*SD*		
Poor Monitoring/Supervision	28	19.06	7.38	24	17.67	7.45	.05	.15
Positive Parenting	13	22.79	2.67	12	23.43	2.87	.07	.19
Parental Involvement	31	34.29	6.73	24	37.64	6.23	.18	.45
Inconsistent Discipline	18	16.57	3.67	13	13.92	3.29	.20	.48
Corporal Punishment	7	5.64	2.41	10	5.57	1.83	.01	.07
Child Ratings	Baseline			Post-Program			η_p^2	$1-\beta$
	Range	*M*	*SD*	*Range*	*M*	*SD*		
Poor Monitoring/Supervision	30	21.27	5.46	19	21.27	6.78	.00	.05
Positive Parenting	17	20.90	4.48	17	22.09	4.98	.13	.20
Parental Involvement	25	34.54	6.73	24	36.56	8.10	.10	.17
Inconsistent Discipline	17	16.64	4.84	15	14.36	3.75	.37	.59
Corporal Punishment	10	6.09	1.97	6	6.18	2.23	.00	.05

Note: $N = 18$; *$1-\beta$ represents observed power

Dependent samples t-tests were used to assess whether caregivers and their children reported lower rates of child symptomatology (i.e., emotional problems, conduct problems, hyperactivity/inattention, peer relationship problems) and increased prosocial behavior following the program compared to baseline. There were no significant decreases in child symptomatology domains or prosocial behavior per caregiver and child ratings from baseline to post-program (see Table 4). However, caregiver reports indicated emotional problems had a small effect size, while child-reported emotional problems, conduct problems, and peer problems demonstrated small effect sizes. Caregiver reports suggested a small effect size for prosocial behaviors. Children did not report a significant increase in prosocial behavior from baseline to post-program, though the changes demonstrated a small effect size. The means, standard deviations, paired-samples t-test statistics, and effect sizes for specific child symptomatology measures from the dependent t-tests are included in Table 4.

Table 4

Means, Standard Deviations, Paired-Samples T-test Statistics, and Effect Sizes for Strengths and Difficulties Questionnaire (SDQ) Child Symptomatology Subscales

Caregiver Ratings	Baseline			Post-Program			Paired Samples T-test		
	Range	*M*	*SD*	*Range*	*M*	*SD*	*t*	*p*	*d*
Emotional Problems	8	2.39	2.17	8	2.83	1.54	-1.17	.260	-.28
Conduct Problems	6	2.39	1.54	8	2.50	2.46	-.22	.826	-.05
Hyperactivity	10	4.94	3.04	9	4.72	2.72	.51	.614	.12
Peer Problems	7	2.61	2.25	7	2.67	2.09	-.18	.859	-.04
Prosocial Behaviors	10	5.83	2.50	10	6.61	2.48	-1.94	.069	-.46
Child Ratings	Baseline			Post-Program			Paired Samples T-test		
	Range	*M*	*SD*	*Range*	*M*	*SD*	*t*	*p*	*d*
Emotional Problems	9	4.06	2.80	9	4.67	2.79	-1.22	.238	-.29
Conduct Problems	7	3.56	2.50	7	3.17	2.30	1.20	.248	.28
Hyperactivity	10	4.61	2.43	10	4.39	2.64	.66	.521	.16
Peer Problems	6	3.33	1.84	7	2.83	2.20	1.28	.217	.30
Prosocial Behaviors	7	6.33	2.06	6	6.67	1.88	-1.14	.269	-.27

Note: N = 18; *df* = 17

Bivariate correlations were conducted to assess the relation between caregiver acceptability and levels of caregiver engagement (i.e., timely completion of modules and lower rates of missed sessions). Timely completion of modules was calculated by determining the number of weeks it took participants to complete the study from baseline one to module 5. The rate of missed sessions was calculated by the number of weeks participants took between modules. For each week that was missed following the reminder email, participants received a make-up module, and it was counted as a missed session. There was not a statistically significant relation between overall caregiver acceptability ($M = 30.39$, $SD = 5.30$) of the program and amount of time taken to complete modules in the program ($M = 8.77$, $SD = 2.44$; $r = .21$, $p = .405$), though the results indicated a small effect size. Similarly, there was not a statistically significant relation between caregiver acceptability ($M = 30.39$, $SD = 5.30$) and rate of missed sessions ($M = 1.61$, $SD = 2.15$; $r = .17$, $p = .502$).

Separate repeated measures MANOVAs were used to assess caregiver and child reported improvements in parent-child relationship quality and openness of parent-child communication following the intervention compared to baseline. Caregiver-reported baseline relationship quality and involvement were not significantly different from post-program relationship quality and involvement, $F(2,16) = .596$, $p = .563$, $\eta_p^2 = .07$. Caregiver-reported relationship quality involvement demonstrated small effect sizes. Similarly, child-reported baseline relationship quality and involvement were not significantly different from post-program relationship quality and involvement, $F(2,16) = .22$, $p = .809$, $\eta_p^2 = .97$. Child-reported relationship quality did not demonstrate a notable effect size and involvement demonstrated a small effect size. Regarding communication, there were no significant changes found for caregiver reports, $F(4,14) = .1.70$, $p = .206$, $\eta_p^2 = .33$, or child reports, $F(2,16) = .17$, $p = .844$, $\eta_p^2 = .02$, from baseline to post-

program. Caregiver-reported parent communication and parent-restricted topics fell within the large effect size range, while child empathy/listening and child emotional expression was within the medium range. Child-reported parent communication and child communication exhibited small effect sizes. The means, standard deviations, effect sizes, and observed power for the dependent measures of relationship quality and communication are provided in Table 5.

Table 5

Means, Standard Deviations, and Effect Sizes for Quality of Relationship and Parent-Child Communication Scales (PCCS)

	Quality of Relationship Questionnaire							
Caregiver Ratings	Baseline			Post-program				
	Range	*M*	*SD*	*Range*	*M*	*SD*	η_p^2	*1-β**
Relationship Quality	2.33	3.81	.63	2.50	3.93	.58	.03	.11
Involvement	8.00	6.11	2.14	6.00	6.50	2.01	.03	.11
Child Ratings	Baseline			Post-program				
	Range	*M*	*SD*	*Range*	*M*	*SD*	η_p^2	*1-β*
Relationship Quality	2.33	3.70	.76	2.83	3.72	.74	.00	.05
Involvement	7	5.22	2.62	9	5.67	2.47	.03	.10
	Parent-Child Communication Scales							
Caregiver Ratings	Baseline			Post-Program				
	Range	*M*	*SD*	*Range*	*M*	*SD*	η_p^2	*1-β*
Parent Communication	3.50	3.53	.71	2.67	3.85	.71	.15	.36
Parent Restricted Topics	3	2.14	.89	3	1.75	.83	.14	.36
Child Empathy/Listening	4	3.26	.91	2.33	3.59	.75	.10	.25
Child Emotional Expression	3.40	3.56	.85	2.40	3.66	.68	.09	.23
Child Ratings	Baseline			Post-Program				
	Range	*M*	*SD*	*Range*	*M*	*SD*	η_p^2	*1-β*
Parent Communication	2.60	3.64	.73	2	3.54	.96	.01	.06
Child Communication	3.67	3.53	.96	3	3.43	.98	.02	.08

Note: $N = 18$; **1-β* represents observed power

Dependent t-tests were conducted to examine differences in perceived conflict based on caregiver and child ratings from baseline to post-program. There were no significant differences in caregiver-reported conflict improving from baseline, though results demonstrated a small effect size (See Table 6). Per child ratings, there was not a significant difference in conflict from baseline to post-program; however, the changes fell within the small effect size range. Similarly, caregivers and children did not report significant changes in the quantity of problems on the Issues Checklist from baseline to post-program, though caregiver results demonstrated a small effect size. Caregivers reported a significant difference in the intensity of problems from baseline to post-program that demonstrated a medium effect size. Child ratings did not demonstrate a significant difference from baseline to post-program, and the change did not demonstrate a notable effect size. The means, standard deviations, paired-samples t-test statistics, and effect sizes for specific conflict measures from the dependent t-tests are included in Table 6.

Table 6

Means, Standard Deviations, Paired-Samples T-test Statistics, and Effect Sizes for Parental Environment Questionnaire (PEQ) and Issues Checklist (IC)

		Parental Environment Questionnaire							
Caregiver Ratings		Baseline			Post-Program		Paired Samples T-test		
	Range	*M*	*SD*	*Range*	*M*	*SD*	*t*	*p*	*d*
Conflict		33.33	6.63		36.67	4.58	-1.96	.066	-.46
Child Ratings		Baseline			Post-Program		Paired Samples T-test		
	Range	*M*	*SD*	*Range*	*M*	*SD*	*t*	*p*	*d*
Conflict		32.61	7.88		34.28	8.01	-1.45	.164	-.34
		Issues Checklist							
Caregiver Ratings		Baseline			Post-Program		Paired Samples T-test		
	Range	*M*	*SD*	*Range*	*M*	*SD*	*t*	*p*	*d*
Quantity of Issues		24.83	10.10		21.50	9.28	1.95	.068	.46
Intensity of Issues		2.15	.62		1.76	.43	3.28	.004	.77
Child Ratings		Baseline			Post-Program		Paired Samples T-test		
	Range	*M*	*SD*	*Range*	*M*	*SD*	*t*	*p*	*d*
Quantity of Issues		22.06	8.32		20.50	10.83	.64	.533	.15
Intensity of Issues		2.08	.91		2.08	.84	-.01	.990	.00

Note: N = 18; *df* = 17

CHAPTER IV:

DISCUSSION

Adapting parenting interventions to online formats may assist with dissemination of evidence-based treatments, particularly to underserved families. Further research into adapting such interventions is necessary for adolescents, as this developmental period is characterized by changes in the parent-child relationship that potentially exacerbate conflict and can impact both caregiver and child outcomes. This pilot study explored the feasibility and acceptability of a self-directed, online parenting program designed to improve the parent-child relationship and communication and decrease parent-child conflict. Additionally, the study compared program outcomes (i.e., caregiver-child relationship quality, communication, and child behaviors) at baseline and post-program.

Feasibility and Acceptability

Retention of consented participants was low ($n = 21$ out of 41, 51.2%). It is unclear why participants did not continue participating in the study, as most participants who dropped out ($n = 7$) did not respond to further email communication either prior to completing pre-program measures or registering on the program's website. The participants who formally withdrew from the study ($n = 2$) and completed at least one module (e.g., baseline modules) cited concerns with the time commitment despite the higher accessibility and self-pacing of this program. While attrition rates were higher than other online parenting interventions, those programs recruited from samples of parents with children exhibiting high levels of behavioral problems (Baker & Sanders, 2017; Sanders et al., 2012; Sanders et al., 2014), and our study exhibited lower levels of conflict and symptomatology in comparison. Due to some complaints regarding the low compensation, some participants may have lacked a desired incentive to continue the study, as their primary motive was compensation rather than investing time to learn and

practice skills while managing other daily activities. COVID-19 likely impacted caregiver involvement in the study, as caregiver burnout is an emerging issue amid the pandemic (Kerr et al., 2021) and may have prevented caregivers from enrolling in the study due to the resources (e.g., time commitment, attention, energy) required for participation. Additionally, caregivers exhibit higher levels of stress during the week when balancing work activities and childcare due to the demands placed on them during the pandemic (Freisthler et al., 2021). The self-directed nature of the study may have deterred caregivers who were seeking services during this time, as increased stress during a pandemic may lead to seeking connection with a therapist through telehealth or face-to-face therapy services. Participants who completed the study expressed satisfaction with the program and their ability to implement what they learned. These findings indicate a need to improve engaging caregivers in the program. Expanding recruitment to clinical sites could engage participants who need services and are primarily focused on the potential benefits of the program rather than compensation. Further, successful recruitment of low-income families for technology-based treatment requires targeted advertising in areas (e.g., retail outlets, workplaces) where low-income families are overrepresented, facilities that provide care to low-income families, and schools in low-income areas (Jones et al., 2014).

Caregivers reported satisfaction with the overall quality of the program and stated the program met their needs. They reported satisfaction with module components and noted the skills were relevant to their goals. While most participants were pleased with the program, one participant stated the program was not cohesive and noted specifically disliking the effective commands section. Another participant expressed satisfaction with the program, though added the website itself (e.g., lack of clarity regarding completion of module components) was a barrier to the program. Such feedback indicates a need to

ensure that future versions of the program are contained within the website, as the current program used Qualtrics to store participant data regarding activities (e.g., module measures, homework assignments) to ensure HIPAA compliance. Additionally, the website could be constructed to have automated reminders programmed to send at the time modules unlock to improve efficiency. The current study sent reminders individually by monitoring participant completion of modules and sending out weekly emails. Further, the website could prevent participants from pressing the 'Complete' button at the end of the module until all components are verified, as some participants required email reminders to return to the module and complete content prior to moving into new content. Streamlining the website would help reduce confusion around the program and allow participants to progress through modules more easily.

Caregiver Engagement

Participant engagement varied throughout the program, and there were no statistically significant differences for participants who demonstrated higher acceptability. Evidence suggests a relation between younger child age and a higher likelihood for parents to complete the minimum dose of an intervention (Baker & Sanders, 2017); thus, older child age in the current study may have reduced participant engagement. Another factor found to impact participant engagement is participation quality (i.e., interest in program and skills, engagement with program and skills, and quality of skill implementation), with higher quality of participation related to higher levels of positive parenting outcomes regardless of participant attendance (Nix et al., 2009). Qualitative analysis of weekly activity responses could provide insight into quality of caregiver engagement and the corresponding outcomes from the program. Caregiver motivations to complete the interventions were not assessed, though there were comments from a non-consenting caregiver and those inquiring about the study

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expressing dissatisfaction with study compensation. These observations, paired with a largely non-clinical sample of participants consenting to the program, suggest that some caregivers were engaged for the monetary incentive and were less engaged during the self-paced program. Similar trends were observed in another study where caregivers exhibited higher rates of engagement for assessment completion sessions where there was a monetary benefit and lower rates of engagement for parenting sessions where there was no compensation (Kern et al., 2007).

It is also important to explore the impact of additional variables besides acceptability, as there is evidence to suggest sociodemographic factors (e.g., socioeconomic status and minority group membership) predict dropout rates in parenting programs (Calam et al., 2008; Lavigne et la., 2010). It may be that other factors increase engagement to a greater extent such as feasibility of completing modules (e.g., module content duration, number of siblings or daily activities to manage), having a child with a clinical diagnosis, or severity of problem behaviors (i.e., caregivers with a child with severe disruptive behaviors or parent-child conflict might be more engaged than those without). A similar self-paced study (i.e., Triple P Online) noted higher scores for problematic child behaviors at baseline predicted greater improvement post-program (Baker & Sanders, 2017). Research suggests that perceiving a higher need for services may increase engagement in the parenting intervention (Shenderovich et al., 2018); therefore, future studies should focus on recruiting from outpatient clinics and community centers. Finally, studies examining online parenting interventions suggest greater participation when participants understand that module content is also accessible via smartphone (Love et al., 2016). Future trials of this intervention may increase engagement by offering multiple formats for accessibility.

Skill Acquisition and Implementation

Specific highlights of the program included satisfaction with modeling of skills via video demonstrations. Additionally, caregivers found the weekly skills were generally effective when implemented. Effective commands and one-on-one time were the highest utilized skills (i.e., five or more times in the week after the module) from the program and were introduced during module two. This reinforces the importance of these skills, because of the ability to implement them multiple times throughout the week and their salience in daily caregiver-child interactions. The skills that were rated as most effective included OARS skills from module three and problem-solving steps from module four. Communication skills presented using OARS are a novel part of this intervention as PSCT typically relies on encouraging active listening skills and positive communication through systematic communication training with the therapist providing in vivo modeling and feedback (Barkley & Robin, 2014).

The presentation of OARS skills in the self-paced program provides caregivers with concrete active listening skills to practice, modeled through video demonstrations of each skill. Though they are not able to receive feedback for their implementation of skills, it is encouraging that parents considered these skills the most effective. Such findings may highlight potential caregiver beliefs regarding the importance of communication and problem-solving skills, as parent-child interactions can have contentious outcomes when communication is ineffective. OARS skills were also the most implemented by a co-caregiver, which suggests the caregiver completing the program finds them relevant and has the necessary understanding to teach these skills to a co-caregiver. In contrast, lower ratings of co-caregiver use were exhibited in module one, which was primarily a didactic module. Overall, caregivers appeared to implement skills each week and reported they were generally effective.

The findings imply that an online intervention has the potential to serve as a cost-effective modality for problem-solving communication training and can increase treatment dosage from the enlistment of a co-caregiver. Future studies of the program may also measure co-caregiver outcomes to determine the potential of the program to improve other variables in the household. While the sequencing of skills was similar to an established model of parent training (Barkley & Robin, 2014), communication training was presented prior to the introduction of problem-solving skills to provide a foundation for communication skills to implement when problem-solving. The presentation of skills appeared appropriate for this program's model, though modules could benefit from encouraging the caregiver completing the program to involve a co-caregiver in skills practice. Reviews of co-parenting programs provide evidence suggesting small, yet significant, effect sizes in parent outcomes for both at-risk families and nonclinical samples when co-parents are involved in treatment (Eira Nunes, 2021). This could be done through tasking the caregiver to complete homework activities with a co-caregiver and having caregivers work together to practice weekly skills. Additionally, module one content could expand to include an assessment of caregivers' interactions with each other and their child as well as video demonstrations of common problems caregivers face when implementing parent training together. Aside from promoting co-caregiver involvement, this type of reflection could assist caregivers with reducing barriers that may result from problematic partner interactions and provide additional targets for communication and problem-solving skills modules.

Program Outcomes

Overall, program outcomes indicated significant increases observed by caregivers in children's prosocial behaviors and significant decreases in caregiver-child conflict. While other outcomes were not considered statistically significant, the observed effect

sizes of multiple child symptomatology variables (e.g., conduct problems, hyperactivity, and peer problems), caregiver-child relationship (e.g., poor monitoring/supervision, positive parenting, parental involvement, inconsistent discipline, corporal punishment), and communication outcomes (e.g., parent communication, parent-restricted topics, child empathy/listening, child emotional expression) demonstrated improvements from baseline to post-program. Although these results are not statistically significant, effect sizes are consistent with past research on in-person behavioral parent training (Baruch et al., 2011; Hagen et al., 2011). It is notable that this self-directed, online model of intervention demonstrated these trends with a much briefer model (5 sessions compared to 12–20) and with only indirect modeling of skills (compared to clinician directed implementation of communication and problem-solving skills). The results of the program also indicate positive preliminary results similar to other online parenting interventions (e.g., Triple P, Sanders et al., 2012).

There were also some notable differences in the current sample and that of other online parenting interventions. Research examining the outcomes of the online parenting intervention, Triple-P, recruited samples of children typically exhibiting clinically significant disruptive behaviors (Love et al., 2016; Sanders et al., 2012). The participants in the current sample did not have clinically significant or diagnosed disruptive behaviors and displayed lower baseline ratings of severity compared to the Sanders et al. (2012) study. In another study examining the Triple P sample, parent-child relationship quality significantly improved in a sample of parents with children who exhibited higher levels of disruptive behaviors at baseline (Sanders et al., 2014). There are also data to suggest parents of children with higher severity of behavior problems are more accepting of parenting interventions (Chase & Peacock, 2017). Thus, recruitment of participants in greater need of services may demonstrate further potential of the program among clinical

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populations through both greater improvement on clinical measures from baseline to post-program and higher levels of engagement. Examining weekly data could also provide valuable information for the mechanisms that encourage higher amounts of participation in each module and inform how to adapt modules where caregivers exhibit lower levels of engagement.

From the children's perspectives, there were no statistically significant changes observed across multiple program outcomes; however, there were outcomes that demonstrated small to large effect sizes from baseline to post-program. This suggests that children witness some levels of improvement, though they may not observe as many changes as caregivers because they are indirectly involved in the program through their caregivers practicing the skills with them. Discrepancies between caregivers and children occur frequently and highlight the importance of multi-informant reporting when assessing outcomes (De Los Reyes & Kazdin, 2005). To further elucidate the sequence of parenting and child behavior change during the program, assessing weekly data could determine how caregiver and child behaviors influence each other and if there is a bidirectional relation between the two. Additionally, utilizing the program as an adjunct for caregivers in a setting where the child is receiving individual therapy services may allow caregivers to gain useful skills, self-pace their learning, and receive clinician feedback when necessary while their child benefits from individualized sessions. This could also increase caregiver engagement in the program, as a positive parent-clinician alliance is shown to increase treatment engagement with child-focused services (Flicker et al., 2008; Thompson et al., 2007). Further, using this program in conjunction with, or as a waitlist for, clinical services could allow for implementation with a higher clinical population (e.g., Conduct Disorder).

Limitations

While recruitment was conducted across the U.S., our sample was limited by a few demographic factors. Most participants fell within the middle-income range, with some participants in the low-income range. Though online recruitment strategies were successful, recruitment may have missed individuals who do not use social media frequently. Recruitment of low-income families is important in assessing the feasibility of the program for caregivers of various socioeconomic statuses. Second, caregivers primarily identified as female, and few caregivers had children with clinical diagnoses. Additionally, many of the participants and their children reported lower levels of conflict at baseline, which could impact the significance of the changes observed when compared to a clinical sample. The ability to recruit a more diverse sample of participants with varying levels of conflict could provide more support for the generalizability of our findings for caregivers with various child presentations. Further, our sample was small and lacked sufficient power to produce statistically significant results and make more general claims about treatment outcomes, though the results appear promising. This initial design is consistent with current recommendations for pilot intervention studies, which highlight emphasis on examining acceptability and feasibility over effectiveness with small samples (Kraemer et al., 2006; Leon, Davis, & Kraemer, 2010). Future iterations of the program should add a control group to investigate the impact of the program compared to a group who does not receive the program and a clinical population to compare the effects across child symptomatology. Additionally, follow-up surveys in the months after the delivery of the program could provide insight into skill acquisition/retention, long-term use of skills, and the longitudinal consequences of the program. While participants expressed satisfaction with the program, the attrition rate was high and reflects continued concerns with retention in parent training programs

(Chacko et al., 2016). Regarding the modules, we did not collect data regarding module acceptability and skills implementation for module five. We are unsure if there were differences (e.g., SES, marital status, ethnicity, etc.) in participants who presented for their screening session and those who did not, as demographic data were not collected until participants completed pre-program measures. Further, demographic data were not collected for participants who consented to participate and ceased responding to emails prior to completing pre-program measures.

Conclusions

The Without a Paddle program was a pilot feasibility and acceptability study that examined preliminary program outcomes for caregivers and their children. The program expanded upon the typical problem-solving communication training model through the integration of OARS skills to provide caregivers with concrete communication skills to implement. While the program could not incorporate feedback that occurs in face-to-face therapy and did not include the child in the program, the results indicated potential for the program to assist parents with developing and modeling skills that are associated with improved caregiver and child outcomes. Additionally, the accessibility of the program could increase the number of families that receive services, particularly for those that would otherwise not have access to services. Results indicated that caregivers endorsed high feasibility and acceptability ratings, which is encouraging for the continued development of a program that is easily accessible and self-paced. The findings of the current study are positive indications that the Without a Paddle program has potential as a highly accessible, low-cost program to assist with the development of effective parenting skills for early adolescence.

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APPENDIX A:

DEMOGRAPHIC FORM

Instructions: Please complete the following questions regarding you and your child. If you have multiple children, please answer the questions regarding the child you wish to target with the intervention who is between the age of 11 to 14.

1. Please indicate your relationship to child:
    a. Biological parent
    b. Adoptive parent
    c. Stepparent
    d. Legal guardian
    e. Custodial grandparent
    f. Other (please specify) _____

2. Please identify your ethnicity:
    a. Black (African American, Caribbean)
    b. Latino
    c. Caucasian (White, Not of Latino or Asian descent)
    d. Asian
    e. Native American
    f. Arab
    g. Bi-Racial
    h. Other (please specify) _____

3. Please identify your child's ethnicity
    a. Black (African American, Caribbean)
    b. Latino
    c. Caucasian (White, Not of Latino or Asian descent)
    d. Asian
    e. Native American
    f. Arab
    g. Bi-Racial
    h. Other (please specify) _____

4. Your gender:
    a. Male
    b. Female
    c. Transgender (Male to Female)
    d. Transgender (Female to Male)
    e. Other (please specify) _____

5. Your child's gender:

a. Male
b. Female
c. Transgender (Male to Female)
d. Transgender (Female to Male)
e. Other (please specify) _____

6. Your child's biological sex:
    a. Male
    b. Female
    c. Other (please specify) _____

7. Your age: _____

8. Your child's age: _____

9. Is English your first language?
    a. Yes
    b. No

10a. Does your child have any mental health diagnoses?
    a. Yes
    b. No

10b. If yes, select the diagnoses your child has received.
    a. Attention-Deficit/Hyperactivity Disorder (ADHD)
    b. Learning Disability (e.g., Reading, Math, Written Expression, etc.)
    c. Anxiety
    d. Depression
    e. Bipolar
    f. Other (please specify) _____

11. What type of medications (if any) does your child take? Check all that apply.
    a. None
    b. Stimulant/Typical ADHD Medications (Ritalin, Adderall, Daytrana, Concerta, Metadate, Focalin, etc.)
    c. Atypical ADHD medications (Stratera, Clonidine)
    d. Anti-depressant (Zoloft, Prozac, Wellbutrin, etc.)
    e. Other (please specify) _____

12. How many people are living in your home at present (including yourself)? _____
    a.
13a. How many children do you have total? _____

13b. If you have more than 1 child, what number is the child in the sibling order?
_____

13c. What are the ages of your other children? _____

14. Your current marital status?
    a. Never married
    b. Married
    c. Divorced/Separated
    d. Other (please specify) _____

15. What is your highest level of education?
    a. Less than High School
    b. High School Diploma
    c. Specialized Trade/Technical Degree
    d. Undergraduate University Degree
    e. Master's Degree
    f. Doctorate or Professional Degree

16. Highest education level of spouse?
    a. Less than High School
    b. High School Diploma
    c. Specialized Trade/Technical Degree
    d. Undergraduate University Degree
    e. Master's Degree
    f. Doctorate or Professional Degree

17. Please estimate your annual household income:
    a. Less than $20,000 per year
    b. $20,000 to $40,000 per year
    c. $41,000 to $60,000 per year
    d. $61,000 to $80,000 per year
    e. Over $80,000 per year

18a. Do you (or your partner) have any current or past mental health needs/concerns (e.g., ADHD, Depression, Anxiety Disorder, Learning Disorder)?
    a. Yes
    b. No

18b. If yes, please describe. _____

19a. Has your child ever received any mental health services (at school or elsewhere)?
_____

19b. If yes, how long did your child receive these services? _____

19c. If yes, what kind(s) of services? Check all that apply.
    a. Individual Therapy
    b. Group Therapy
    c. Family Therapy
    d. School Counseling/Clinical Intervention
    e. Home-based Counseling
    f. Diagnostic Evaluation
    g. Medication Support
    h. Not applicable
    i. Other (please specify) _____

20. Where did you hear about this study? _____

____

PARENTAL ENVIRONMENT QUESTIONNAIRE – PARENT FORM

Parental Environment Questionnaire (Parent Form)

		Definitely True	Probably True	Probably False	Definitely False
1.	**Often lose temper with child**	1	2	3	4
2.	**Often have misunderstandings with child**	1	2	3	4
3.	**Child and I often argue**	1	2	3	4
4.	**Often criticize child**	1	2	3	4
5.	**Child often angers or annoys me**	1	2	3	4
6.	**Often hurt child's feelings**	1	2	3	4
7.	**Often irritate child**	1	2	3	4
8.	**Sometimes hit child in anger**	1	2	3	4
9.	**Child has been really scared of me**	1	2	3	4
10.	**Often interrupt child**	1	2	3	4
11.	**Child respects others more than me**	1	2	3	4
12.	**Often do not trust child's decisions**	1	2	3	4
13.	Don't know how child does in school	1	2	3	4
14.	Don't know about child's hobbies	1	2	3	4
15.	Don't have much to talk about with child	1	2	3	4
16.	Don't know how child spends spare time	1	2	3	4
17.	Comfort child when they're discouraged	1	2	3	4
18.	Child shares concerns with me	1	2	3	4
19.	Try to keep up with child's performance	1	2	3	4
20.	Child doesn't feel close to me	1	2	3	4
21.	Praise child when they do well	1	2	3	4
22.	Child doesn't want friends to meet me	1	2	3	4
23.	Child doesn't talk about problems with me	1	2	3	4
24.	Don't do much together with child	1	2	3	4
25.	Child is proud of me	1	2	3	4
26.	Child wants to be like me in many ways	1	2	3	4
27.	Child respects me	1	2	3	4

28. Give good advice to child	1	2	3	4
29. Child can learn a lot from me	1	2	3	4
30. Child really likes me	1	2	3	4
31. Have taught child useful things	1	2	3	4
32. Make good impression on child's friends	1	2	3	4
33. I am proud of child	1	2	3	4
34. Don't think highly of child	1	2	3	4
35. Like others in family better than child	1	2	3	4
36. Love child no matter what they do	1	2	3	4
37. child knows I love them	1	2	3	4
38. Want child to do what's right	1	2	3	4
39. Important that child obeys the law	1	2	3	4
40. Make clear what I want child to do or not do	1	2	3	4
41. Expect child to finish job by himself	1	2	3	4
42. Want child to have fixed bedtime	1	2	3	4

PARENTAL ENVRIONMENT QUESTIONNAIRE – CHILD FORM

Parental Environment Questionnaire (Child Form)

	Definitely True	Probably True	Probably False	Definitely False
1. **My parent often loses their temper with me**	1	2	3	4
2. **Often there are misunderstandings between my parent and myself**	1	2	3	4
3. **My parent and I often argue**	1	2	3	4
4. **My parent often criticizes me**	1	2	3	4
5. **I anger or annoy my parent**	1	2	3	4
6. **My parent often hurts my feelings**	1	2	3	4
7. **My parent often irritates me**	1	2	3	4
8. **My parent sometimes hits me in anger**	1	2	3	4
9. **I have been really scared of my parent**	1	2	3	4
10. **My parent often interrupts me**	1	2	3	4
11. **I respect others more than my parent**	1	2	3	4
12. **My parent often does not trust my decisions**	1	2	3	4
13. My parent doesn't know I do in school	1	2	3	4
14. My parent doesn't know about my hobbies	1	2	3	4
15. My parent doesn't have much to talk about with me	1	2	3	4
16. My parent doesn't know how I spend my spare time	1	2	3	4
17. My parent doesn't comfort me when I'm discouraged	1	2	3	4
18. I share concerns with my parent	1	2	3	4
19. My parent tries to keep up with my performance	1	2	3	4
20. I don't feel close to my parent	1	2	3	4
21. My parent praises me when I do well	1	2	3	4
22. I don't want friends to meet my parent	1	2	3	4

23. I don't talk about problems with my parent	1	2	3	4
24. My parent doesn't do much together with me	1	2	3	4
25. I am proud of my parent	1	2	3	4
26. I want to be like my parent in many ways	1	2	3	4
27. I respect my parent	1	2	3	4
28. My parent gives me good advice	1	2	3	4
29. I can learn a lot from my parent	1	2	3	4
30. I really like my parent	1	2	3	4
31. My parent has taught me useful things	1	2	3	4
32. My parent makes good impression on my friends	1	2	3	4
33. My parent is proud of me	1	2	3	4
34. My parent doesn't think highly of me	1	2	3	4
35. My parent likes others in the family better than me	1	2	3	4
36. My parent loves me no matter what I do	1	2	3	4
37. I know my parent loves me	1	2	3	4
38. My parent wantsme to do what's right	1	2	3	4
39. My parent thinks it's important that I obey the law	1	2	3	4
40. My parent makes it clear what they want me to do or not do	1	2	3	4
41. My parent expects me to finish jobs by myself	1	2	3	4
42. My parent wants me to have fixed a bedtime	1	2	3	4

APPENDIX D:

ISSUES CHECKLIST

Issues Checklist (Abridged)

DIRECTIONS
Circle "yes" for topics you have discussed with your parents/son or daughter during the last 4 weeks, and "no" for topics that have not come up. For each issue answered "yes," circle a number between 1 (calm) and 5 (angry) to answer the question, "How did you feel when you discussed this topic?"

Source: Adapted, with permission, from Robin AL, Foster SL. 1989. *Negotiating Parent-Adolescent Conflict: A Behavioral-Family Systems Approach.* New York, NY: Guilford Press.

Have You Discussed?			Calm		A little angry		Angry
1. Telephone calls	yes	no	1	2	3	4	5
2. Bedtime	yes	no	1	2	3	4	5
3. Cleaning bedroom	yes	no	1	2	3	4	5
4. Doing homework	yes	no	1	2	3	4	5
5. Putting away clothes	yes	no	1	2	3	4	5
6. Using the television	yes	no	1	2	3	4	5
7. Cleanliness (washing, showers, brushing teeth)	yes	no	1	2	3	4	5
8. Which clothes to wear	yes	no	1	2	3	4	5
9. How neat clothes look	yes	no	1	2	3	4	5
10. Making too much noise at home	yes	no	1	2	3	4	5
11. Table manners	yes	no	1	2	3	4	5

(The column header "How Did You Feel When You Discussed This Topic?" spans the Calm, A little angry, and Angry columns.)

12. Fighting with brothers and sisters	yes	no	1	2	3	4	5
13. Cursing	yes	no	1	2	3	4	5
14. How money is spent	yes	no	1	2	3	4	5
15. Picking books or movies	yes	no	1	2	3	4	5
16. Allowance	yes	no	1	2	3	4	5
17. Going places without parents (shopping, movies, etc.)	yes	no	1	2	3	4	5
18. Playing stereo or radio too loudly	yes	no	1	2	3	4	5
19. Turning off lights in house	yes	no	1	2	3	4	5
20. Using drugs	yes	no	1	2	3	4	5
21. Taking care of records, games, bikes, pets, and other things	yes	no	1	2	3	4	5
22. Drinking beer or other alcoholic beverages	yes	no	1	2	3	4	5
23. Buying records, games, toys, and other things	yes	no	1	2	3	4	5
24. Going on dates	yes	no	1	2	3	4	5
25. Who friends should be	yes	no	1	2	3	4	5
26. Selecting new clothes	yes	no	1	2	3	4	5
27. Sex	yes	no	1	2	3	4	5
28. Coming home on time	yes	no	1	2	3	4	5
29. Getting to school on time	yes	no	1	2	3	4	5
30. Getting low grades in school	yes	no	1	2	3	4	5

31. Getting in trouble at school	yes	no	1	2	3	4	5
32. Lying	yes	no	1	2	3	4	5
33. Helping out around the house	yes	no	1	2	3	4	5
34. Talking back to parents	yes	no	1	2	3	4	5
35. Getting up in the morning	yes	no	1	2	3	4	5
36. Bothering parents when they want to be left alone	yes	no	1	2	3	4	5
37. Bothering adolescent when he/she wants to be left alone	yes	no	1	2	3	4	5
38. Putting feet on furniture	yes	no	1	2	3	4	5
39. Messing up the house	yes	no	1	2	3	4	5
40. What time to have meals	yes	no	1	2	3	4	5
41. How to spend free time	yes	no	1	2	3	4	5
42. Smoking/spit tobacco	yes	no	1	2	3	4	5
43. Earning money away from the house	yes	no	1	2	3	4	5
44. What adolescent eats	yes	no	1	2	3	4	5

PARENT-CHILD COMMUNICATION SCALE – PRIMARY CAREGIVER FORM

Parent-Child Communication Scale (Primary Caregiver)

Please use the child's name in the blanks below.

How often…	Almost Never	Once in a While	Sometimes	Often	Almost Always
1. Can you discuss your beliefs with _____ without feeling restrained or embarrassed.	1	2	3	4	5
2. Is _____ a good listener?	1	2	3	4	5
3. Can _____ tell how you are feeling without asking you?	1	2	3	4	5
4. Are you satisfied with how you and _____ talk together?	1	2	3	4	5
5. Does _____ try to understand your point of view?	1	2	3	4	5
6. Are there things you avoid discussing with _____?	1	2	3	4	5
7. Do you discuss child-related problems with _____?	1	2	3	4	5
8. Does _____ insult you when he/she is angry with you?	1	2	3	4	5
9. Do you think you can tell _____ how you really feel about some things?	1	2	3	4	5
10. Does _____ tell you about his/her personal problems?	1	2	3	4	5
11. Does _____ keep his/her feeling to him/herself rather than talk about them with you?	1	2	3	4	5
12. Does _____ hide being angry?	1	2	3	4	5
13. Do you encourage _____ to think about things and talk about them so that he/she can establish his/her own opinion?	1	2	3	4	5
14. If _____ is upset, is it difficult to figure out what he/she is feeling?	1	2	3	4	5
15. Does _____ let things pile up without talking or dealing with them until they are more than you and he/she can handle?	1	2	3	4	5
16. Does _____ let you known what is bothering him/her?	1	2	3	4	5
17. Are there certain topics which you do not allow _____ to discuss with you?	1	2	3	4	5
18. Does _____ admit mistakes without trying to hide anything?	1	2	3	4	5
19. Can _____ have his/her say even if you disagree?	1	2	3	4	5
20. Do you and _____ come to a solution when you talk about a problem?	1	2	3	4	5

PARENT-CHILD COMMUNICATION SCALE – CHILD FORM

Parent-Child Communication Scale (Child)

Please fill in the blanks with the name of the relationship that the primary caregiver has to the child (e.g., mom, grandma, father).

How often…	Almost Never	Once in a While	Sometimes	Often	Almost Always
1. Is your _____ a good listener?	1	2	3	4	5
2. Can you _____ tell how you are feeling without asking you?	1	2	3	4	5
3. Does your _____ try to understand what you think?	1	2	3	4	5
4. Are there things that you do not discuss with you _____?	1	2	3	4	5
5. Do you discuss problems with your _____?	1	2	3	4	5
6. Does your _____ insult you when she/he is angry with you?	1	2	3	4	5
7. Do you think that you can tell your _____ how you really feel about some things?	1	2	3	4	5
8. Can you let your _____ know what is bothering you?	1	2	3	4	5
9. Are there certain things which your _____ does not allow you to discuss her/him?	1	2	3	4	5
10. Can you have your say even if your _____ disagrees with you?	1	2	3	4	5

APPENDIX G:

QUALITY OF RELATIONSHIP - PARENT FORM

Quality of Relationship: Caregiver-Child Relationship (Parent Form)

	Not at all	Very little	Somewhat	Quite a bit	Very much
1. How close do you feel to your child?	1	2	3	4	5
2. How much do you care about your child?	1	2	3	4	5
How often…	*Never*	*Seldom*	*Sometimes*	*Often*	*Always*
3. How often does your child interfere in your activities?	1	2	3	4	5
4. How often do you trust your child?	1	2	3	4	5
5. How often do you feel you understand your child?	1	2	3	4	5
6. How often do you and your child get along well?	1	2	3	4	5
7. How often do you and your child make decisions together about things in their life?	1	2	3	4	5
8. How often do you feel that you are interfering with your child's activities?	1	2	3	4	5
In the past 4 weeks…	*No*	*Yes*			
9. Have you gone shopping with them?	0	1			
10. Have you played a sport with them?	0	1			
11. Have you gone to a religious service or church-related event with them?	0	1			
12. Have you talked with child about things they were doing with their friends?	0	1			
13. Have you gone to a movie, play, museum, concert, or sports events with them?	0	1			
14. Have you talked with them about a personal problem they were having?	0	1			
15. Have you had a serious argument with them about their behavior?	0	1			
16. Have you talked to your child about their grades?	0	1			
17. Have you worked on a project for school with them?	0	1			
18. Have you talked with them about other things they're doing in school?	0	1			

APPENDIX H:

QUALITY OF RELATIONSHIP – CHILD FORM

Quality of Relationship: Caregiver-Child Relationship (Child Form)

<u>Instructions</u>: Please complete the following items regarding the caregiver that attended the session with you today. If both parents attended the session, please choose one parent in answering these questions. Indicate the gender of the caregiver who attended today on the following line: _____.

	Not at all	*Very little*	*Somewhat*	*Quite a bit*	*Very much*
1. How close do you feel to your caregiver?	1	2	3	4	5
2. How much do you think they care about you?	1	2	3	4	5
How often…	*Never*	*Seldom*	*Sometimes*	*Often*	*Always*
3. How often do they interfere in your activities?	1	2	3	4	5
4. How often do they trust you?	1	2	3	4	5
5. How often do they understand you?	1	2	3	4	5
6. How often do you get along well?	1	2	3	4	5
7. How often do you make decisions together about things in your life?	1	2	3	4	5
8. How often do you feel that you are interfering with their activities?	1	2	3	4	5
In the past 4 weeks…	*No*	*Yes*			
9. Have you gone shopping with them?	0	1			
10. Have you played a sport with them?	0	1			
11. Gone to a religious service or church-related event with them?	0	1			
12. Have you talked about your friends or things you were doing with friends?	0	1			
13. Have you gone to a movie, play, museum, concert, or sports events with them?	0	1			
14. Have you talked with them about a personal problem you were having?	0	1			
15. Have you had a serious argument with them about your behavior?	0	1			
16. Have you talked about your schoolwork or grades with them?	0	1			
17. Have you worked on a project for school with them?	0	1			
18. Have you talked with them about other things you're doing in school?	0	1			

APPENDIX I:

ALABAMA PARENTING QUESTIONNAIRE – PARENT FORM

Alabama Parenting Questionnaire (APQ; Parent Form)

<u>Instructions</u>: The following are a number of statements about your family. Please rate each item as to how often it TYPICALLY occurs in your home. The possible answers are <u>Never</u> (1), <u>Almost Never</u> (2), <u>Sometimes</u> (3), <u>Often</u> (4), <u>Always</u> (5). PLEASE ANSWER ALL ITEMS

	Never	*Almost Never*	*Sometimes*	*Often*	*Always*
1. You have a friendly talk with your child.	1	2	3	4	5
2. You let your child know he they are doing a good job with something.	1	2	3	4	5
3. You threaten to punish your child and then do not actually punish them.	1	2	3	4	5
4. You volunteer to help with special activities that your child is involved in (such as sports, boy/girl scout, church youth groups)	1	2	3	4	5
5. You reward or give something extra to your child for obeying you or behaving well.	1	2	3	4	5
6. You child fails to leave a note or to let you know where they are going.	1	2	3	4	5
7. You play games or do other fun things with your child.	1	2	3	4	5
8. You child talks you out of being punished after they have done something wrong.	1	2	3	4	5
9. You ask your child about their day in school.	1	2	3	4	5
10. Your child stays out in the evening past the time they are supposed to be home.	1	2	3	4	5
11. You help your child with their schoolwork.	1	2	3	4	5
12. You feel that getting your child to obey you is more trouble than it's worth.	1	2	3	4	5
13. You compliment your child when they do something well.	1	2	3	4	5
14. You ask your child what their plans are for the coming day.	1	2	3	4	5
15. You drive your child to a special activity.	1	2	3	4	5

16. You praise your child if they behave well.	1	2	3	4	5
17. Your child is out with friends you don't know.	1	2	3	4	5
18. You hug or kiss your child when they do something well.	1	2	3	4	5
19 Your child goes out without a set time to be home.	1	2	3	4	5
20. You talk to your child about their friends.	1	2	3	4	5
21. Your child is out after dark without an adult with them.	1	2	3	4	5
22. You let your child out of a punishment early (like lift restrictions earlier than you originally said)	1	2	3	4	5
23. Your child helps plan family activities.	1	2	3	4	5
24. You get so busy that you forget where your child is and what they are doing.	1	2	3	4	5
25. Your child is not punished when they have done something wrong.	1	2	3	4	5
26. You attend PTA meetings, parent/teacher conferences, or other meetings at your child's school	1	2	3	4	5
27. You tell your child that you like it when they help out around the house.	1	2	3	4	5
28. You don't check that your child comes home at the time they were supposed to.	1	2	3	4	5
29. You don't tell your child where you are going.	1	2	3	4	5
30. Your child comes home from school more than an hour past the times you expect them.	1	2	3	4	5
31. The punishment you give your child depends on your mood.	1	2	3	4	5
32. Your child is at home without adult supervision.	1	2	3	4	5
33. You spank your child with your hand when they have done something wrong.	1	2	3	4	5
34. You ignore your child when they are misbehaving.	1	2	3	4	5
35. You slap your child when they have done something wrong.	1	2	3	4	5

36. You take away privileges or money from your child as a punishment.	1	2	3	4	5
37. You send your child to their room as a punishment.	1	2	3	4	5
38. You hit your child with a belt, switch, or other object when they have done something wrong.	1	2	3	4	5
39. You yell or scream at your child when they have done something wrong.	1	2	3	4	5
40. You calmly explain to your child why their heavier was wrong when they misbehave.	1	2	3	4	5
41. You use time out (make them sit or stand in a corner) as a punishment.	1	2	3	4	5
42. You give your child extra chores as a punishment.	1	2	3	4	5

APPENDIX J:

ALABAMA PARENTING QUESTIONNAIRE – CHILD FORM

Alabama Parenting Questionnaire (APQ; Child Form)

<u>Instructions</u>: The following are a number of statements about your family. Please rate each item as to how often it TYPICALLY occurs in your home. The possible answers are <u>Never</u> (1), <u>Almost Never</u> (2), <u>Sometimes</u> (3), <u>Often</u> (4), <u>Always</u> (5). If your dad or mom is not currently living at home with you, then skip the questions that ask about that person.

	Never	*Almost Never*	*Sometimes*	*Often*	*Always*
1. You have a friendly talk with your mom.	1	2	3	4	5
A. How about your dad?	1	2	3	4	5
2. Your parents tell you that you are doing a good job.	1	2	3	4	5
3. Your parents threaten to punish you and then do not do it.	1	2	3	4	5
4. Your mom helps with some of your special activities (such as sports, boy/girl scouts, church youth groups).	1	2	3	4	5
A. How about your dad?	1	2	3	4	5
5. Your parents reward or give something extra to you for behaving well.	1	2	3	4	5
6. You fail to leave a note or let your parents know where you are going.	1	2	3	4	5
7. You play games or do other fun things with your mom.	1	2	3	4	5
A. How about your dad?	1	2	3	4	5
8. You talk you parents out of punishing you after you have done something wrong.	1	2	3	4	5
9. Your mom asks you about your day in school.	1	2	3	4	5
A. How about your dad?	1	2	3	4	5
10. You stay out in the evening past the time you are supposed to be home.	1	2	3	4	5

11. Your mom helps you with your homework.	1	2	3	4	5
A. How about your dad?	1	2	3	4	5
12. Your parents give up trying to get you to obey them because it's too much trouble.	1	2	3	4	5
13. Your parents compliment you when you have done something well.	1	2	3	4	5
14. Your mom asks you what your plans are for the coming day.	1	2	3	4	5
A. How about your dad?	1	2	3	4	5
15. Your mom drives you to a special activity.	1	2	3	4	5
A. How about your dad?	1	2	3	4	5
16. Your parents praise you for behaving well.	1	2	3	4	5
17. Your parents do not know the friends you are with.	1	2	3	4	5
18. Your parents hug or kiss you when you have done something well.	1	2	3	4	5
19. You go out with a set time to be home.	1	2	3	4	5
20. Your mom talks to you about your friends.	1	2	3	4	5
A. How about your dad?	1	2	3	4	5
21. You go out after dark without an adult with you.	1	2	3	4	5
22. Your parents let you out of a punishment early (like lift restrictions earlier than they originally said).	1	2	3	4	5
23. You help plan family activities.	1	2	3	4	5
24. Your parents get so busy that they forget where you are and what you are doing.	1	2	3	4	5
25. Your parents do not punish you when you have done something wrong.	1	2	3	4	5
26. Your mom goes to a meeting at school, like a PTA meeting or parent/teacher conference	1	2	3	4	5
A. How about your dad?	1	2	3	4	5

27. Your parents tell you that they like it when you help out around the house.	1	2	3	4	5
28. You stay out later than you are supposed to and your parents don't know it.	1	2	3	4	5
29. Your parents leave the house and don't tell you where they are going.	1	2	3	4	5
30. You come home from school more than an hour past the time your parents expect you to be home.	1	2	3	4	5
31. The punishment your parents give depends on their mood.	1	2	3	4	5
32. You are at home without an adult being with you.	1	2	3	4	5
33. You parents spank you with their hand when you have done something wrong.	1	2	3	4	5
34. Your parents ignore you when you are misbehaving.	1	2	3	4	5
35. Your parents slap you when you have done something wrong.	1	2	3	4	5
36. Your parents take away a privilege or money from you as a punishment.	1	2	3	4	5
37. Your parents send you to your room as punishment.	1	2	3	4	5
38. Your parents hit you with a belt, a switch, or other object when you have done something wrong.	1	2	3	4	5
39. You parents yell or scream at your when you have done something wrong.	1	2	3	4	5
40. Your parents calmly explain to you why your behavior was wrong when you misbehave.	1	2	3	4	5
41. Your parents use time out (makes you sit or stand in a corner) as a punishment.	1	2	3	4	5
42. Your parents give you extra chores as a punishment.	1	2	3	4	5

APPENDIX K:

STRENGTHS AND DIFFICULTIES QUESTIONNAIRE

For each item, please mark the box for Not True, Somewhat True, or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of this young person's behavior over the last six months or this school year.

	Not True	*Somewhat True*	*Certainly True*
Considerate of other people's feelings	1	2	3
Restless, overactive, cannot stay still for long	1	2	3
Often complains of headaches, stomach-aches, or sickness	1	2	3
Shares readily with other youth, for example books, games, food	1	2	3
Often loses temper	1	2	3
Would rather be alone than with other youth	1	2	3
Generally well behaved, usually does what adults request	1	2	3
Many worries or often seems worries	1	2	3
Helpful if some is hurt, upset, or feeling ill	1	2	3
Constantly fidgeting or squirming	1	2	3
Has at least one good friend	1	2	3
Often fights with other youth or bullies them	1	2	3
Often unhappy, depressed, or tearful	1	2	3
Generally liked by other youth	1	2	3
Easily distracted, concentration wanders	1	2	3
Nervous in new situations, easily loses confidence	1	2	3
Kind to younger children	1	2	3
Often lies or cheats	1	2	3
Picked on or bullied by other youth	1	2	3
Often offers to help others (parents, teachers, children)	1	2	3
Thinks things out before acting	1	2	3
Steals from home, school, or elsewhere	1	2	3
Gets along better with adults than with other youth	1	2	3
Many fears, easily scared	1	2	3
Good attention span, sees work through to the end	1	2	3

APPENDIX L:

WEEKLY MODULE MEASURE

Instructions: Answer these questions based on interactions with your child in the last week.

Conflict	Definitely True	Probably True	Probably False	Definitely False
1. I often lost my temper with my child.	1	2	3	4
2. Often there were misunderstandings between my child and myself.	1	2	3	4
3. My child and I often got into arguments.	1	2	3	4

Communication	Almost Never	Once in a While	Sometimes	Often	Almost Always
4. Could you discuss your beliefs with your child without feeling restrained or embarrassed?	1	2	3	4	5
5. Were you satisfied with how you and your child talked together?	1	2	3	4	5
6. Did you and your child come to a solution when you talked about a problem?	1	2	3	4	5

Quality of Relationship	Not at all	Very Little	Somewhat	Quite a bit	Very much
7. How close did you feel to your child?	1	2	3	4	5
	Never	Seldom	Sometimes	Often	Always
8. How often did you and your child get along well?	1	2	3	4	5
9. How often did you feel you and your child made decisions together about things in their life?	1	2	3	4	5

Behavior	Not True	Somewhat True	Certainly True
10. Your child often lost their temper.	1	2	3
11. Your child had many worries or often seemed worried.	1	2	3
12. Your child was often unhappy, depressed, or tearful.	1	2	3

Acceptability & Feasibility

	Yes	No
13. Did you utilize the strategies from last week?	Yes	No

14. What was the most useful aspect of last week's content?

15. How often did you use the strategies?	Once	Twice	Three times	Four times	Five or more times
16. Did the strategies seem effective?		Yes			No
17. Did a co-parent use the strategies?		Yes			No

ADAPTED CLIENT SATISFACTION QUESTIONNAIRE

1. How would you rate the quality of the program you received?

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
Poor	Fair	Good	Excellent

2. Did you receive the kind of service you wanted?

1	2	3	4
No, definitely not	No, not really	Yes, generally	Yes, definitely

3. To what extent has our program met your needs?

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
None of my needs have been met	Only a few of my needs have been met	Most of my needs have been met	Almost all of my needs have been met

4. If a friend were in need of similar help, would you recommend our program to him/her?

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of help you received?

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. Has the program you received helped you to deal more effectively with your problems?

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
No, it seemed to make things worse	No, it really didn't help	Yes, it helped somewhat	Yes, it helped a great deal

7. Overall, how satisfied are you with the program?

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

8. If you were to seek help again, would you come back to our program?

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

9. How satisfied are you that the lessons in the program were useful?

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

<u>Write comments below</u>: