

April 2020

## Parent Perceptions of the Acceptability, Effectiveness, and Experience of Engaging in the Group Stepping Stones Triple P Intervention for Parents of Children with Disabilities

Tara B. Delach  
*University of South Florida*

Follow this and additional works at: <https://digitalcommons.usf.edu/etd>



Part of the [Other Education Commons](#), and the [Psychology Commons](#)

---

### Scholar Commons Citation

Delach, Tara B., "Parent Perceptions of the Acceptability, Effectiveness, and Experience of Engaging in the Group Stepping Stones Triple P Intervention for Parents of Children with Disabilities" (2020). *USF Tampa Graduate Theses and Dissertations*.

<https://digitalcommons.usf.edu/etd/8181>

This Dissertation is brought to you for free and open access by the USF Graduate Theses and Dissertations at Digital Commons @ University of South Florida. It has been accepted for inclusion in USF Tampa Graduate Theses and Dissertations by an authorized administrator of Digital Commons @ University of South Florida. For more information, please contact [digitalcommons@usf.edu](mailto:digitalcommons@usf.edu).

Parent Perceptions of the Acceptability, Effectiveness, and Experience of Engaging in the Group  
Stepping Stones Triple P Intervention for Parents of Children with Disabilities

by

Tara B. Delach

A dissertation submitted in partial fulfillment  
of the requirements for the degree of  
Doctor of Philosophy  
Department of Educational and Psychological Studies  
College of Education  
University of South Florida

Major Professor: Kathy Bradley-Klug, Ph.D.  
Linda Raffaele-Mendez, Ph.D.  
John Ferron, Ph.D.  
Amanda Keating, Psy.D., BCBA-D

Date of Approval:  
April 2, 2020

Keywords: parent training, disability, GSSTP, parenting

Copyright © 2020, Tara B. Delach

## Table of Contents

List of Tables .....	vi
List of Figures .....	vii
Abstract .....	viii
Chapter One: Introduction .....	1
Background .....	1
Parenting Interventions.....	2
Statement of the Problem.....	3
Purpose and Significance of The Study .....	4
Research Questions .....	6
Theoretical framework.....	6
Limitations .....	7
Terminology.....	8
Developmental disability .....	8
Challenging behavior .....	8
Parent.....	8
Parent Management Training (PMT).....	8
Group Stepping Stones Triple P (GSSTP).....	9
Summary .....	9
Chapter Two: Literature Review .....	10
Developmental Disabilities .....	10
The Individuals With Disabilities Education Act .....	11
Prevalence and Characteristics of Developmental Disabilities .....	12
Mental Health and Behavior Challenges Among Children with Disabilities .....	14
Family Functioning and Mental Health of Parents of Children with Disabilities .....	15
Parent beliefs and expectations.....	15
Parenting Interventions for Children with Challenging Behavior .....	16
Parent-Child Interaction Therapy .....	18
The Incredible Years.....	18
Triple P.....	19
Current Literature on Parenting Interventions for Children with Disabilities .....	20
Stepping Stones Triple P.....	23
Theoretical Basis of Stepping Stones Triple P .....	26
Stepping Stones Triple P Research to Date .....	31
Summary .....	45

Chapter Three: Method .....	47
Overview .....	47
Participants.....	47
Recruitment.....	48
Setting .....	50
Intervention.....	52
Design .....	55
Data Collection .....	57
Quantitative Data .....	57
Child Measures .....	58
Strengths and Difficulties Questionnaire (SDQ) .....	58
The Child Adjustment and Parent Efficacy Scale- Developmental Disability (CAPES-DD) .....	59
Individual Parent Measures.....	59
Parenting Tasks Checklist(PTC).....	59
The Parenting Scale (PS) .....	60
The Depression Anxiety and Stress Scale-42 (DASS-42).....	61
Parent Relationship Measures.....	61
Parenting Problem Checklist(PPC).....	61
The Relationship Quality Index .....	62
Qualitative Data.....	62
Family Experience Questionnaire.....	62
Interviews.....	62
Observations .....	65
Permanent Products .....	66
Data Analysis .....	66
Quantitative.....	66
Descriptive Statistics.....	66
Clinically Significant Change .....	67
Reliable Change .....	67
Qualitative.....	68
Reliability and Validity.....	70
Confidentiality .....	73
Ethical Considerations .....	73
Researcher Reflexivity.....	74
Chapter Four: Results .....	76
Participant Descriptions .....	76
Noelle.....	76
Selena.....	76
Maria .....	77
Kevin and Lisa .....	77
Debby .....	78
Roger and Joe.....	78

Attrition.....	79
Quantitative Results.....	80
Descriptive Statistics.....	80
Clinically Significant and Reliable Change.....	81
Strengths and Difficulties Questionnaire (SDQ).....	85
The Child Adjustment and Parent Efficacy Scale-Developmental Disability (CAPES-DD).....	87
Parenting Tasks Checklist(PTC).....	87
The Parenting Scale (PS).....	88
The Depression Anxiety and Stress Scale-42 (DASS-42).....	88
Parenting Problem Checklist(PPC).....	89
The Relationship Quality Index.....	89
Thematic Analysis.....	90
Question 1: What led parents to engage in the GSSTP program and what did they hope to gain from participating?.....	93
Theme 1: Word of Mouth.....	93
Theme 2: Informed About GSSTP by a Professional.....	94
Theme 3: Seeking New Skills.....	95
Theme 3a: Skills for Helping Children Develop.....	95
Theme 3b: Skills to Help Manage Challenging Behavior.....	96
Theme 4: Parenting is Hard Work and You Never Get a Break.....	98
Theme 4a: Overwhelmed by the Level of Care Required.....	99
Theme 4b: Difficulty Knowing How to Respond to Challenging Behavior.....	104
Theme 4c: Challenges in School/Community.....	107
Theme 4d: Lack of Support from Partner or Not on the Same Page as Partner.....	108
Theme 4e: Other Parenting Challenges.....	109
Question 2: What aspects of the GSSTP program do parents perceive to be most beneficial/least beneficial, and why?.....	111
Theme 5: Learned New Skills.....	112
Theme 5a: Learned New Skills (general).....	115
Theme 5b: Learned New Skills (specific).....	115
Theme 6: Received Support.....	117
Theme 6a: Received Support from Other Parents.....	117
Theme 6b: Received Support from the Facilitators.....	120
Theme 7: Improved Co-Parent Relationships.....	121
Theme 8: Suggestions for Changes in the Group.....	123
Theme 8a: Length of Group was a Barrier.....	123
Theme 8b: Suggested Changes to the Format or Content of Sessions.....	124
Theme 8c: Suggested Grouping Classes Based on Specific Characteristics.....	125
Question 3: What specifically do parents learn as a result of participating in the GSSTP program and how has this new knowledge impacted them and their child(ren)/family?.....	127
Theme 9: Learned How to Talk to Their Children.....	127
Theme 10: Learned How to Plan Ahead.....	129

Theme 11: Learned How to Implement Rewards .....	130
Theme 12: Learned Other Strategies to Strengthen Parent-Child Relationship and Prevent Challenging Behavior .....	131
Theme 13: Learned Other Ways to Manage Challenging Behavior.....	133
Theme 14: Implementing New Strategies Has Helped.....	134
Question 4: How do parents perceive their relationship with their child and how has this changed as a result of participating in the GSSTP program? .....	135
Theme 15: Positive Parent-Child Relationships .....	135
Theme 15a: Good Relationship with Child/Love Them.....	135
Theme 15b: Enjoy Sharing Experiences with Their Child, Teaching Them, and Learning from Them .....	136
Theme 15c: Children are Funny .....	138
Theme 15d: Want to Give Them Everything/Prepare Them for the Future .....	139
Theme 16: Strained Parent-Child Relationships.....	140
Additional Theme Not Related to a Specific Research Question .....	141
Theme 17: Cultural Differences.....	141
 Chapter Five: Discussion .....	 145
Research Question 1: What led parents to engage in the GSSTP program and what they hoped to gain from participating .....	145
Research Question 2: What aspects of the GSSTP program do parents perceive to be most beneficial/least beneficial, and why .....	149
Research Question 3: What specifically do parents learn as a result of participating in the GSSTP program and how this impacted them and their child(ren)/family ....	156
Research Question 4: How do parents perceive their relationship with their child and how this changed as a result of participating in the GSSTP program.....	159
Additional Theme .....	161
Implications for Practice .....	162
Role of the Psychologist/School Psychologist.....	164
Contributions to the Literature.....	165
Limitations .....	165
Directions of Future Research .....	167
Summary .....	169
 References.....	 174
 Appendices .....	 192
Appendix A: Description of Case Study.....	193
Appendix B: Family Experience Questionnaire .....	195
Appendix C: Recruitment Email.....	196
Appendix D: Recruitment Flyer.....	197
Appendix E: Adult Minimal Risk Informed Consent .....	197
Appendix F: Parent Interview Questions .....	202
Appendix G: Standard Deviation and Reliability Estimates Used to Calculate Reliable Change .....	204
Appendix H: Researcher’s Journal .....	207

Appendix I: GSSTP Member Checks .....	210
Appendix J: Triple P Permission to Use Form .....	213

## **List of Tables**

Table 1.	Stepping Stones Triple P Interventions for Parents of Children with Disabilities .....	24
Table 2.	Principles of Positive Parenting and Associated Skills Taught in GSSTP .....	30
Table 3.	Overview of GSSTP Session Content for Current Intervention .....	54
Table 4.	Stepping Stones Strategies and Ages for Which Each Strategy is Recommended.....	64
Table 5.	Demographic Characteristics of GSSTP Study Participants and Target Child .....	80
Table 6.	Means and Standard Deviations of Outcome Measures .....	81
Table 7.	Reliable and Clinical Change on Outcome Measures .....	83
Table 8.	Summary of Themes and Subthemes.....	90



## **List of Figures**

Figure 1. Stepping Stones Triple P Strategy Pyramid.....	28
Figure 2. Phases of Data Analysis.....	70

## **Abstract**

The challenges associated with parenting are often compounded for parents of children with developmental disabilities. Children with developmental disabilities are at increased risk for exhibiting mental health concerns and challenging behavior compared to their typically developing peers. Parents who are raising a child with a disability tend to experience increased demands, higher levels of stress, and greater challenges associated with the physical, emotional, and behavioral needs of their children than do parents of typically developing children. Parent training interventions grounded in social learning theory and behavioral principles have proven to be effective in improving both child and parent outcomes in these families.

One evidence-based parent training intervention that targets parents of children with disabilities is the Group Stepping Stones Triple P (GSSTP) intervention. Research supports the effectiveness of GSSTP for decreasing children's challenging behavior, decreasing parent stress, improving parental self-efficacy and competence, and increasing positive interactions between parents and their children, among other positive outcomes. Despite the extensive research on the efficacy of the GSSTP, few studies have examined the qualitative accounts of parents who have participated in this group intervention. The purpose of this study was to explore the perceptions that parents of children with disabilities or developmental delays have about the acceptability, effectiveness, and overall experience of engaging in Group Stepping Stones Triple P. Using a case study approach, this study attempted to gain an in-depth account of the experiences of parents of children with a disability who participated in the GSSTP intervention. Findings from

the present study suggest that the parents who engaged in GSSTP were experiencing numerous challenges related to parenting one or more children who have a disability. The majority of parents described positive parent-child relationships with some improvements noted post-intervention. Parents who enrolled in GSSTP expressed a desire to learn new strategies for helping their children develop new skills and they also were seeking help with preventing and manage their children's challenging behavior. Overall, parents found the GSSTP intervention to be acceptable and they reported that the most beneficial aspect was learning new parenting strategies, such as new ways of communicating with their child, planning ahead to prevent and manage challenging behavior, and using rewards to encourage desirable behavior. Other benefits parents noted were the support they received from other parents as well as GSSTP facilitators and improvements in their co-parenting relationships. Parents provided recommendations for changes to the content and delivery of the intervention, as well as suggestions for grouping participants according to specific characteristics, such as marital status and cultural background.

Based on the findings of the present study, future research should examine parent perceptions and outcomes following a shortened GSSTP intervention, such as a 4- or 5-week class. Future research also should examine the impact of various formats of the intervention, such as briefer sessions or multiple sessions per week. It also would be of interest to compare outcomes of participants who receive GSSTP alone and those who receive GSSTP enhanced with some level of Partner Support. Lastly, future studies would benefit from examining the outcomes and qualitative perceptions of parents from various cultural groups who have completed GSSTP as well as parent perceptions at 6 months or 1 year following the intervention.

## **Chapter One: Introduction**

### **Background**

Although nearly all parents experience difficulties related to parenting and childrearing at one time or another, those challenges can be compounded for parents of a child with a disability. From day-to-day stressors and financial burdens to longer-term worries, parents raising a child with a disability experience increased demands and emotional stressors compared to parents of typically developing children (Dyches et al., 2016; Hutchison et al., 2016; Lecavalier Leone, & Wiltz, 2006; Lee, 2013). Examples of the extraordinary challenges that parents of children with a disability may face include: added financial burdens and time constraints due to their child's ongoing medical and therapy appointments, difficulty finding reliable child care or appropriate educational settings, increased stress related to their child's challenging behavior or other impairments, and/or additional worries regarding their child's future and overall well-being (McCann, Bull, & Winzberg, 2012; Plant & Sanders, 2007; Resch et al., 2010; Sawyer et al., 2010; Whittingham et al., 2006; Zechella & Raval, 2016).

Given these increased demands and added stressors, it is not surprising that parents of children with disabilities are at a greater risk of experiencing mental health problems (i.e. stress, depression, anxiety) and other adverse outcomes, such as marital discord and limited social support, than are parents of typically developing children (Hastings & Beck, 2004; Sawyer et al., 2010; Singer, Ethridge & Aldana, 2007). The added stress that parents of children with disabilities experience can adversely impact parenting practices, leading to a cycle of negative parent-child interactions (Beckerman et al., 2017; Norlin et al., 2014; Shawler & Sullivan, 2017).

For example, parenting stress has been associated with increased family dysfunction, including coercive parenting practices and an increased risk for child maltreatment (Murphy, 2011). In fact, it is estimated that children with disabilities are 3 to 4 times as likely to be abused than are their typically developing peers (Murphy, 2011).

**Parenting Interventions.** Parent training interventions have proven to be successful in reducing ineffective parenting practices, increasing parent self-efficacy, reducing and preventing problem behaviors in children, and improving parent-child relationships in parents of typically developing children as well as parents of children with disabilities (Kaminski et al., 2008; Shawler & Sullivan, 2017; Tully & Hunt, 2016). Those interventions that emphasize responding consistently to children's behavior and that include training in creating positive parent-child interactions, implementing time-out, and actively practicing new skills in training sessions, tend to have larger effect sizes, particularly on externalizing behavior (Kaminski et al., 2008).

One evidence-based parenting intervention, which is available in 25 countries and at least 34 states in the United States, is The Triple P system of parenting interventions (Shapiro et al., 2014; The World of Triple P, n.d.). Triple P uses a public health approach to provide quality parenting information and supports to parents, with the goal of increasing their knowledge and use of effective parenting strategies (Shapiro et al., 2014). Triple P interventions provide parents with strategies for teaching their children new skills and preventing problem behaviors from occurring, as well as behavior management strategies for addressing misbehavior. The Triple P system of parenting interventions has proven to be effective in terms of improving parent-child relationships, increasing parents' competence and confidence in parenting, improving their ability to manage their children's behavior, reducing the use of ineffective parenting strategies, and a variety of other positive outcomes for both parents and youth (Nowak & Heinrichs, 2008;

Ralph & Sanders, 2002, 2003, 2006; Salari, Ralph & Sanders, 2014). The Triple P Stepping Stones intervention also has proven to be effective at meeting similar outcomes for parents of children with disabilities (Ruane & Carr, 2018; Shapiro, Kilburn, & Hardin, 2014; Tellegen & Sanders, 2013) and parents who have participated in Stepping Stones and other Triple P interventions tend to report high levels of satisfaction with participation as reported on the Client Satisfaction Questionnaire (Ralph & Sanders, 2003; Salarai, Ralph & Sanders, 2014).

### **Statement of the Problem**

Despite the extensive research supporting the effectiveness of the Stepping Stones Triple P intervention for parents of children with disabilities, less is known about the specific experiences of participants, including what they liked/disliked about the program, which aspects of the intervention were most helpful, or how their participation in the program impacted their parent-child relationship. The majority of studies that have measured parent satisfaction with the Stepping Stones intervention have used The Client Satisfaction Questionnaire (CSQ), which provides mostly quantitative data in the form of ratings (Whittingham et al., 2009). On the CSQ, parents are asked to rate their satisfaction with various aspects of the program, such as the quality, type and amount of help they received, the extent to which the program met their needs and their child's needs, and their overall satisfaction with the program (Whittingham et al., 2009). The CSQ does include 3 open-ended questions that ask parents whether they have had any other problems with their child since beginning the program, if they have sought further assistance from any other source since participating in program, or if they have any other comments about the program (Whittingham et al., 2009). Although rating scales such as the CSQ provide an indication of overall satisfaction, they do not provide qualitative insight into the

thoughts, emotions, and beliefs that parents have regarding their experiences of this intervention and its impact on their family.

There are few studies to date that have analyzed qualitative data regarding parent perceptions of the Group Stepping Stones (GSSTP) intervention. Four studies were identified in the literature that report outcomes in English and include some type of qualitative feedback from parents regarding satisfaction with GSSTP. Of those four studies, only one included feedback from parents who participated in GSSTP (Roux, Sofronoff, & Sanders, 2013). The other studies were either based on a partial-group administration of SSTP (Whittingham et al., 2009-b), individually administered Standard SSTP (Hodgetts, Savage, & McConnell, 2013), or feedback ratings from parents who did not participate in SSTP but who viewed a DVD of the SSTP strategies (Whittingham, Sofronoff, & Sheffield, 2006). Of the four qualitative studies that were identified, three included only parents of children with autism but not parents of children with other disabilities (Whittingham et al., 2006; Whittingham et al., 2009; Hodgetts, Savage, & McConnell, 2013) and only one included parent interviews (Hodgetts et al., 2013). The one study that did include parent interviews involved parents of children with autism who participated in Standard SSTP rather than Group SSTP.

### **Purpose and Significance of the Study**

The purpose of the present study was to examine the perceptions that parents of children with disabilities or developmental delays have about the acceptability, effectiveness, and overall experience of engaging in Group Stepping Stones Triple P, an evidence-based parenting intervention for parents of children with a disability (Sanders, Mazzucchelli, & Studman, 2009). The study was a qualitative case study, through which the researcher attempts “to describe and understand the world from the point of view” of the participants (Sipe & Constable, 1996, p. 158).

The GSSTP intervention provided in this study was modified to include portions of the Triple P Partner Support intervention, which was hypothesized to impact parent satisfaction.

This study adds to the literature regarding the Group Stepping Stones Triple P program by providing a qualitative account of the experiences of parents who have participated in this program. The current literature suggests that Group Stepping Stones Triple P is an effective parenting intervention (Skotarczak & Lee, 2015; Ruane & Carr, 2018) and this study adds insight into the particular aspects of the program that parents perceive to be beneficial or unhelpful. It was expected that gaining a better understanding of the specific aspects of the program that are favorable to parents and obtaining information about how acceptable they perceive the intervention to be may inform how GSSTP and other parent management training interventions are delivered in the future.

In addition, it was expected that gaining qualitative feedback from parent participants also may provide valuable insights for practitioners who are working with this population and for researchers who are interested in parent-child relationships among families of children with disabilities. For example, if parents indicate that they did not like particular aspects of the group, practitioners/researchers may choose to make changes to those aspects of the program and then evaluate the effectiveness of these changes. Likewise, if participants report that specific components of intervention were most effective, practitioners and researchers can avoid removing these components if alterations are made to shorten the length of the program, for example.

This is the only known study to date to obtain feedback from parents who have participated in GSSTP supplemented with the Triple P Partner Support intervention, which is designed to improve communication and relationships between parents. Given the increased risk



for marital distress and decreased marital satisfaction among parents of children with challenging behaviors (Brobst, Clopton, & Hendrix, 2009; Fox, Dunlap, & Powell, 2002; Robinson & Neece, 2015; Sim et al., 2016), of interest was whether or not parents would report the Partner Support component as one of the beneficial aspects of the GSSTP parenting intervention.

### **Research Questions**

With the assumption that there are multiple truths and each parent has a unique interpretation of any given experience, this study attempted to answer the following questions related to participation in the Group Stepping Stones Triple P (GSSTP) program:

1. What led parents to engage in the GSSTP program and what did they hope to gain from participating?
2. What aspects of the GSSTP program do parents perceive to be most beneficial/least beneficial, and why?
3. What specifically do parents learn as a result of participating in the GSSTP program and how has this new knowledge impacted them and their child(ren)/family?
4. How do parents perceive their relationships with their child and how has this changed as a result of participating in the GSSTP program?

As recommended by Yin (1981) when conducting case studies, the narrative of this case study is organized around specific research questions with “flexibility for modifying these topics as analysis progresses (Yin, 1981, p. 60).” With this in mind, it was possible for additional topics or research questions to be added throughout the process of data collection and analysis.

### **Theoretical Framework**

This study was interpretivist/constructivist in nature, operating under the assumption that truth and reality are subjective and are constructed by individuals in interaction with one another

(Lincoln, Lynham, & Guba, 2011). This view assumes that “there is no single observable reality” but instead, each individual constructs their world based on “the meaning they attribute to their experiences” (Merriam, 2010, p. 457). Under the assumption that each parent has their own unique perspective and perceptions about this intervention, and these perceptions may differ among parents, each parent was interviewed individually even if they participated in the intervention as a couple. Participants included mothers, fathers, or any caregiver who assumes a primary role in caring for the child (e.g. grandparent, step-parent, foster parent). Information provided by participants was viewed as individual truths, without expectations or judgments about what is right, wrong, true or false, good vs. bad, etc. Instead, accounts provided by each participant were taken at face value in an attempt to understand and describe their experiences.

### **Limitations**

There are several limitations to the present study. First, this study was conducted in conjunction with an intervention that was being delivered as part of the day-to-day operations of a community organization. As such, the researcher did not have control over all aspects of intervention delivery or factors outside of the parenting intervention that may have influenced parenting practices or perceptions. Furthermore, participants were selected from a small group of parents of children with disabilities who voluntarily agreed to participate in a parenting intervention. This small and potentially biased sample of participants limits generalizability of the findings. No follow-up data were collected beyond postintervention, so this study cannot provide insight into the longer-term impact of GSSTP on parents of children with disabilities.

## **Terminology**

The following terms are defined for purposes of this study:

**Developmental Disability.** A developmental disability generally refers to a delay in 1 or more of the areas of cognitive development, physical development, communication development, social or emotional development, or adaptive development (IDEA, 2004).

Developmental disabilities may include impairment in physical, learning, language, or behavior areas and they tend to impact day-to day functioning (Centers for Disease Control and Prevention, 2018).

**Challenging behavior.** Defined by Emerson (1995, 2001), challenging behavior includes “culturally abnormal behaviour(s) of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behavior which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities (Emerson, 2001, p. 7).

**Parent.** For purposes of this study, “parent” will be defined as any caregiver who has legal custody of a child and/or assumes primary parenting responsibilities. As such, this may include biological or adoptive caregivers, step-parents, grandparents, and foster parents.

**Parent management training/Parent training. (PMT)** Parent management training refers to an intervention in which parents are taught social learning techniques to change the behavior of their children or adolescents. In PMT, parents are taught specific skills through practice, role play, and other active methods of training based on a social learning conceptualization of how to change social, emotional and behavioral problems. PMT also integrates assessment and evaluation in treatment and treatment decision-making (Kazdin, 2008).

For purposes of this study, the terms “parent management training” and “parent training” will be used interchangeably.

**Group Stepping Stones Triple P (GSSTP).** GSSTP is a group-based parent training intervention for parents or caregivers of children with disabilities who require or are interested in learning a broad-based range of parenting skills to promote child development and to manage mild to moderate level challenging behavior (Triple P International, 2017; Sanders, Mazzucchelli, & Studman, 2009).

### **Summary**

The present study adds to the literature regarding the experiences of parents of children with disabilities who are participating in GSSTP, a group-based parent training program designed specifically for this population. Based on the increased risks that these parents and their children face and the extensive research indicating that parent training is an effective intervention for improving both parent and child behaviors and interactions, it is important to understand what aspects of this particular intervention parents find most and least helpful. This information may be beneficial to researchers as well as parents and practitioners who have an interest in GSSTP or other group-based parent training interventions. Using a qualitative case study approach, this study sheds light on the experiences of parents of children with disabilities who have participated in an evidence-based group parent training intervention.

## **Chapter Two: Literature Review**

The purpose of this chapter is to review the literature on developmental disabilities, some of the challenges associated with developmental disabilities, and current parenting interventions for children with disabilities. This chapter begins with an overview of developmental disabilities, including definitions, prevalence, and characteristics. Next, some of the mental health and behavioral challenges associated with having a developmental disability are discussed, as well as the impact of these challenges on family functioning and parents' health. Following a description of the mental health and behavioral challenges, research on parenting interventions for children with challenging behavior is reviewed. Finally, the literature on parenting interventions for children with disabilities is discussed with a particular focus on Stepping Stones Triple P, which is the intervention of interest in the present study.

### **Developmental Disabilities**

Developmental disability is a broad category that encompasses both intellectual and physical disabilities, which are evident before age 22 years and tend to be lifelong (U.S. Department of Health and Human Services, National Institutes of Health, n.d.). Intellectual disabilities are evident before the age of 18 years and are characterized by deficits with both intellectual functioning (including the ability to learn, reason, problem solve, and other skills) and adaptive behavior (including everyday social and life skills) (U.S. Department of Health and Human Services, National Institutes of Health, n.d.). Exact definitions of developmental disability and intellectual disability vary depending on the context (i.e. education, health, Social Security Administration) and also may vary by state but generally describe conditions that are

“usually present at birth and that negatively affect the trajectory of the individual’s physical, intellectual, and/or emotional development” (U.S. Department of Health and Human Service, 2016). Some of the most common types of developmental disabilities include attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder (ASD), cerebral palsy, hearing loss, intellectual disability, vision impairment, language and speech disorders, fetal alcohol spectrum disorders, Fragile X Syndrome, and Muscular Dystrophy (Centers for Disease Control and Prevention, 2018).

**The Individuals with Disabilities Education Act (2004).** The Individuals with Disabilities Education Act (IDEA) is a federal law that affords protections to children with disabilities and those at risk for developmental delays. IDEA provides guidance and regulations to early intervention programs, schools, and states for identifying and delivering intervention services to children ages birth through 21 years; however, states have autonomy to decide how they define and measure disabilities and developmental delays. As a result, states differ greatly in their eligibility criteria as well as in the percentages of children identified for early intervention (IDEA Part C) and school-age special education (IDEA Part B). According to IDEA (2004), an infant or toddler with a disability is:

an individual under 3 years of age who needs early intervention services because the individual (i) is experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in 1 or more of the areas of cognitive development, physical development, communication development, social or emotional development, and adaptive development; or (ii) has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay; and (B) may also include, at a State’s discretion— (i) at-risk infants and toddlers; and (ii) children

with disabilities who are eligible for services under section 619 and who previously received services under this part until such children enter, or are eligible under State law to enter, kindergarten or elementary school.”

A child with a disability, as defined in Part B of IDEA (2004), includes a child ages 3-21 years:

(ii) with mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance (referred to in this title as 'emotional disturbance'), orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities; and (ii) who, by reason thereof, needs special education and related services.

**Prevalence and Characteristics of Developmental Disabilities.** According to the most recent National Health Interview Survey conducted by the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics, approximately 15% of children ages 3 to 17 years in the United States have one or more developmental disabilities (Zablotsky, Black, Maenner, Schieve, & Blumberg, 2015). The lifetime prevalence of a parent-reported diagnosis of Autism Spectrum Disorder (ASD) was 2.24%, or 1 in 45 children. The estimated prevalence of intellectual disabilities was 1.10% and the prevalence of any other developmental disabilities was 3.57%. The majority of children diagnosed with ASD were male (75%), non-Hispanic white (59.9%), living in families in large metropolitan statistical areas (MSAs) (54.7%), living with two parents (68%), and living with at least one parent who had more than a high school level of education (67.7%). Demographic characteristics of children with other developmental disabilities were similar to those of children with ASD: mostly male, non-Hispanic white, living in two-parent households, living in large metropolitan statistical areas (MSA's), and living with at least one parent who has more than a high school level of education (Zablotsky et al., 2015).

In the same National Health Interview Survey, parents of children with autism and other developmental disabilities were asked to report on their child's co-occurring conditions, functional limitations, and service utilization (Zablotsky et al., 2015). Many children with ASD also had a co-occurring learning disability (62.6 %), diagnosis of ADHD (42.8%), or other developmental delay (22.9%). Some children with ASD also had a co-occurring intellectual disability (16.7%), history of stuttering/stammering within the past year (8.1%), or history of seizures within the past year (3.1%). A large majority (78.2%) of children with ASD experienced some type of functional limitation (e.g. trouble hearing, seeing, or walking; difficulty remembering; needing help with personal care). The majority (69.9%) of these children had received either special education or early intervention services (Zablotsky et al., 2015).

Many children diagnosed with other developmental delay also had a co-occurring learning disability (56.5%) or diagnosis of ADHD (27.4%) (Zablotsky et al., 2015). Other co-occurring conditions among children with other developmental delay included ASD (14.4%), history of stuttering/stammering within the last year (13.1%), intellectual disability (12.9%), or history of seizures within the past year (5.8%). Over half (61.7%) of children with other developmental delay experienced some type of functional limitation and 56.4% were receiving either special education or early intervention services (Zablotsky et al., 2015).

Learning disability was the most common co-occurring condition (58.3%) among children aged 3-17 years who had ever been diagnosed with an intellectual disability, ASD, or any other developmental delay (Zablotsky et al., 2015). The next most common co-occurring condition among this population was ADHD (32.7%). Approximately 66% of children who had ever been diagnosed with an intellectual disability, ASD, or any other developmental delay had



experienced some type of functional limitation and over half (59.9%) were receiving special education or early intervention services (Zablotsky et al., 2015).

### **Mental Health and Behavioral Challenges Among Children with Disabilities.**

Children with disabilities are much more likely to experience emotional and behavior problems than are typically developing children (Emerson et al., 2001; Rojahn & Meier, 2009). Although minor behavior challenges are a typical part of child development, these behaviors are often more persistent, more frequent, and/or more severe in children with developmental disabilities (Emerson et al., 2001; Lowe et al., 2007). Examples of these types of behaviors include non-compliance, physical tantrums, aggression, rocking, head banging, and destructiveness (Emerson & Bromley, 1995; Emerson et al., 2001; Roberts et al., 2003). Other behaviors of concern include those that may be harmful to themselves, such as self-injury or eating inedible objects, or behaviors that are unpleasant to others, such as self-stimulation or regurgitating food (Emerson & Bromley, 1995). Some of the factors that tend to increase the risk of behavior problems in children with disabilities include intellectual impairments, deficits in adaptive behavior, communication difficulties, delayed emotional development, or having multiple disabilities (Emerson et al., 2000, 2001; De Bildt et al., 2005; Felce et al., 2009; Holden and Gitleson, 2006; Mazzucchelli & Sanders, 2012; Sappok et al., 2014).

Challenging behaviors can lead to a variety of negative outcomes for children with disabilities, including physical health concerns, restrictions to educational environments, difficulty with peer interactions, and strained parent-child relationships (Emerson, 2001; Lecavalier Leone, & Wiltz, 2006). Left untreated, behavior challenges in childhood are likely to persist into adulthood, which can lead to more severe consequences, such as reduced

occupational opportunities or involvement in the criminal justice system (Emerson et al., 2001; Holland, 2004; Sappok et al., 2014; Tsagaris et al., 2015).

**Family Functioning and Mental Health of Parents of Children with Disabilities.**

Parents, especially mothers, of children with disabilities are particularly at risk for increased psychological distress, such as stress, anxiety, and depression (Eisenhower, Baker, & Blacher, 2009). The increased demands placed on parents of children with disabilities and the added concerns regarding their child's development and behavior can lead to significant worry, stress, and impaired sleep (Sawyer et al., 2010; McCann, Bull, & Winzenberg, 2012). As parenting stress increases, behavior problems increase, and as child behavior problems increase, so does stress. This bidirectional relationship can lead to a cycle in which both the parent and child are experiencing increasing levels of distress and the problem behaviors of both the parent and child are shaped and maintained (Hassall et al., 2005; Lecavalier, Leone, & Wiltz, 2006; Shawler & Sullivan, 2017). Some of the factors known to impact parental stress include level of support, parenting satisfaction, confidence, internal locus of control, and child disruptive behavior problems (Eyberg, Boggs, & Rodriguez, 2008; Hassel, Rose, & McDonald, 2005; Moreland et al., 2016; Plant & Sanders, 2007; Shawler & Sullivan, 2017).

***Parent beliefs and expectations.*** Parents' beliefs and expectations of their children can influence their parenting practices in both positive and negative ways (Jones & Prinz, 2005; Moreland et al., 2016). For example, when parents have greater self-efficacy and believe that they have the ability to influence their children's behavior, they are more likely to implement positive and effective parenting strategies (Chavira et al., 2000; Whittingham et al., 2006). On the other hand, when parents attribute responsibility for their child's behavior to their child, they are more likely to experience negative emotions towards their child and use harsh disciplinary

practices (Beckerman et al., 2017; Chavira et al., 2000). Parents of children with disabilities who attribute their child's challenging behavior to stable or unchangeable factors (i.e. genetic, biological), may lower their expectations for their child and/or put less effort into trying to change their child's behaviors (O'Brien, 2006). They also may place fewer demands on their child or be more lenient with rules. Since parents of children with disabilities report being "at a loss regarding milestones they expect the child might achieve," it can be challenging for them to set realistic goals for their child (Weisleder, 2011, p. 1052). When parents lower their expectations, set unrealistic goals, or fail to try to change their child's behavior, they can then be reinforced for their beliefs when their child's behavior and development do not improve.

### **Parenting Interventions for Children with Challenging Behaviors**

Parents are uniquely positioned to impact the trajectory of their child's behavior and overall development, given the reciprocal and symbiotic relationship between parents and children. Positive, healthy parent-child interactions can reduce or prevent children's challenging behavior and the potential negative consequences that result from persistent challenging behavior. On the other hand, unhealthy and dysfunctional parent-child interactions can lead to, or exacerbate, behavior problems and can lead to mental health concerns for both children and parents (Kuppens & Ceulemans, 2018; Piquart & Kauser, 2018; Schroeder & Mowen, 2012). Given this reciprocal relationship between parents and children and the increased risk of behavior challenges among children with disabilities, it is important for parents of children with disabilities to be equipped with effective parenting practices and strategies for addressing challenging behavior.

There is a strong evidence base to support parent training as an intervention for reducing and preventing challenging behavior, increasing parent self-efficacy, and improving parent-child

relationships, among other positive outcomes (Ruane & Carr, 2018; Kaminski et al., 2008; Piquero et al., 2016; Shawler & Sullivan, 2017; Tully & Hunt, 2016). In a recent meta-analysis of 78 randomized controlled studies of parent training interventions for young children, Piquero et al. (2016) found parent training to be an effective intervention for reducing child behavior problems and deterring antisocial behavior. The overall mean effect size of the 78 studies was .37, with several specific brands of parent training having larger effect sizes. This particular meta-analysis did not include any studies with parents of children with disabilities; however, it provides support for parent training as an intervention for parents of children with challenging behavior (Piquero et al., 2016). Even parenting interventions consisting of as few as 2 to 4 sessions have been shown to positively impact dysfunctional parenting practices and reduce child behavior problems (Tully & Hunt, 2016).

Examples of evidence-based parenting interventions that target challenging behavior include Parent-Child Interaction Therapy (PCIT) (Eyberg, 1988), The Incredible Years (Webster-Stratton, 1998), STAR Parenting (Fox & Fox, 1992), Systematic Training for Effective Parenting (STEP) (Brock, Oertwein, & Coufal, 1993), Parent-Management Training Oregon (PMTO) (Patterson, 2005), and Triple P (Sanders, 1999). In their meta-analysis of 78 parenting intervention studies, Piquero et al. (2016) calculated the mean effect sizes for three of the most popular parent training programs and found PCIT to have the greatest effect (mean effect size=.98), followed by the Triple P Parenting Program (mean effect size=.56) and The Incredible Years Parenting Program (mean effect size=0.31).

**Parent-Child Interaction Therapy.** Parent-child interaction therapy (PCIT) is an individually-administered behavioral family intervention designed specifically for preschool-age children and their parents (Ruane & Carr, 2018; Eyberg, 1988). PCIT consists of between 12

and 20 sessions in which parents are provided with didactic instruction as well as coaching by a therapist as they play with their child (PCIT International, [www.pcit.org](http://www.pcit.org)). Using a bug-in-ear device, a trained therapist provides real-time feedback to the parent regarding their interaction with their child. The goal is to “establish a warm, loving relationship between parent and child in which parents can teach their child desirable prosocial skills and behaviors and decrease inappropriate and maladaptive behaviors” (Eyberg, 1988, p. 35). PCIT has a strong evidence base and has been shown to significantly improve parent-child relationships, increase parenting skills, decrease child behavior problems, and reduce the risk of abuse and neglect (Ruane & Carr, 2018; Cooley et al., 2014; Kennedy et al., 2016; Ward, Theule, & Cheung, 2016).

**The Incredible Years.** The Incredible Years (IY) is another well-known, evidence-based program that aims to “prevent and treat young children’s behavior problems and promote their social, emotional, and academic competence” ([www.incredibleyears.com](http://www.incredibleyears.com)). IY targets children ages birth through 12 years and consists of 3 comprehensive curricula for parents, teachers, and children. In each program, trained facilitators use video vignettes to stimulate group discussion, elicit problem-solving, and prompt practices related to participants’ goals during group sessions. The IY program is implemented around the world and has proven to strengthen parent and teacher management skills, improve children’s social and emotional competence and school readiness, and reduce behavior problems (Menting, de Castro, & Matthys, 2013; Pidano & Allen, 2015; Webster-Stratton, 2001; [www.incredibleyears.com](http://www.incredibleyears.com)).

**Triple P.** Triple P, which is the subject of the present study, is one of the most evidence-based parenting interventions in the world and is based in social learning theory, operant theory, coercion theory, and applied behavior analysis (Sanders, 1999; [www.triplep.net](http://www.triplep.net)). Triple P consists of 5 levels of intervention, which increase in intensity from universal promotion of

positive parenting practices to individualized, intensive intervention for parents at risk of abuse and neglect. The Triple P systems targets children ages birth through 16 years and provides families with “simple and practical strategies to help them build strong, healthy relationships, confidently manage their children’s behavior and prevent problems from developing” (www.triplep.net). Triple P also offers flexible service delivery based on a family’s need or level of dysfunction and has specialized interventions for parents of children with a disability, parents of children with health or weight concerns, parents going through a divorce or separation, and indigenous populations.

Extensive research on Triple P has shown it to be an effective parenting intervention for addressing challenging behavior (Nowak & Heinrichs, 2008; Ralph & Sanders, 2002, 2003, 2006; Tully & Hunt, 2016). A meta-analysis conducted in 2008, which incorporated 55 intervention studies involving 11,797 families, found that participation in Triple P led to positive outcomes, including increased parenting skills, decreased child problem behavior, and increased parent well-being (Nowak & Heinrichs, 2008). Effect sizes were highest for the more intensive levels of Triple P (levels 4 and 5) and for the individual format of the intervention (vs. group or self-directed delivery) (Nowak & Heinrichs, 2008). The studies included in this meta-analysis incorporated different applications of the Triple P program, and therefore targeted a variety of age groups and target concerns including, but not limited to, children with disabilities (Nowak & Heinrichs, 2008).

### **Current Literature on Parenting Interventions for Children with Disabilities**

Few studies have examined the overall effectiveness of parenting interventions for parents of children with developmental disabilities. Some studies, such as a recent meta-analysis by Van Aar et al. (2017), have examined the effects of parent interventions on child disruptive

behavior for children with and without disabilities. Criteria for inclusion in this meta-analysis were: studies that (1) reported on a parenting intervention aimed at preventing or reducing child disruptive behavior, (2) included pretest, posttest and a follow-up of at least one month, (3) had a randomized intervention and control condition at pretest, posttest and follow-up consisting of at least 5 participants, (4) targeted parents or caregivers of children aged 1 to 15 years with a maximum mean age of 12 years, (5) did not specifically target parents/caregivers of children who were developmentally delayed, (6) involved parenting interventions that consisted of at least one face-to-face meeting, (7) used the same parent report measures of child disruptive behavior across occasions, and (8) were written in English. Forty studies were included in the meta-analysis and a variety of different parenting interventions were included. Triple P Positive Parenting Program was the most frequently evaluated, with 9 trials, followed by The Incredible Years (7 trials) and Parent Management Training Oregon (2 trials). The other 22 parenting interventions were evaluated once. When evaluated together, there was a significant, small to moderate effect of parenting interventions on child disruptive behavior from pretest to immediate posttest, as well as from pre-test to follow-up (up the three years posttest). The effect of parenting interventions on child disruptive behavior generally remained stable from pre-test to post-test and this was true regardless of participant characteristics (e.g. child's age, gender, or initial severity of behavior problems) or intervention characteristics (e.g. number of sessions, delivery format, or use of booster sessions). There was substantial variance across trials in terms of sleeper effects and fade-out effects, suggesting that there may be moderators that impact changes in child disruptive behavior post-intervention but that were not examined in the study.

In order to examine the effects of parent management training (PMT) on disruptive behaviors of children with a developmental disability, Skotarczak and Lee (2015) conducted a

meta-analysis involving eleven studies and 540 participants across four countries (Australia, The United States, Ireland, & China). Studies included in the meta-analysis were those that: (1) evaluated interventions that met the operational definition of PMT program, (2) were evaluated using RCTs, (3) had pre-test and post-test measures that were administered immediately before and immediately after the intervention, respectively, (4) had control groups that were either no treatment or TAU but not a specialized treatment such as medication, and (5) were conducted no earlier than 1990. Studies were only included if they (6) examined the behavior of children with a developmental disability (7) which originated before age 18 years, (8) the impairment affected functioning in the areas of conceptual, social, practical, and intellectual functioning, (9) and the impairments caused difficulties in many areas of daily living (Scotarczak & Lee, 2015). The eleven studies included 3 different PMTs, including Parents' Plus, Stepping Stones Triple P, and The Incredible Years. The overall main effect of PMTs on the behavior of children with disabilities was significant, suggesting that PMTs are an effective intervention for reducing disruptive behavior in this population. Several moderators also were identified, including the type of PMT, the delivery type, the setting in which the intervention was delivered, and the education level of the facilitator. Both Stepping Stones Triple P and The Incredible Years PMTs were moderators of child behavior, whereas Parents Plus did not have a significant effect on child behavior. A combined individual and group delivery had a significant effect on child behavior whereas a solely individual or solely group delivery did not. Service delivery in both the home and agency setting (combined) had a larger effect on child behavior than service delivery solely at an agency. The facilitator's education level also was a significant moderator, with facilitators who held a graduate degree having a larger effect on child disruptive behavior than those who did not. Additional moderators, including child age, session number, and session



duration, were examined but were not significant. Findings in this meta-analysis were based on post-test measures but did not include any long-term or follow-up measures.

The other two known meta-analyses conducted on parent management training for parents of children with disabilities have examined a specific intervention, Stepping Stones Triple P (SSTP). These studies examined the effectiveness of the various levels of SSTP including both controlled and uncontrolled studies (Tellegen & Sanders, 2013; Ruane & Carr, 2018). In the first meta-analysis of SSTP, Tellegen and Sanders (2013) examined the effects of all levels of SSTP across 12 studies, which were mostly conducted in Australia and included 659 families. Studies that were published in English or German, that contributed original data, and had sufficient data for analysis were included in the meta-analysis. When analyzing all levels of SSTP together, significant effects were found on all outcome variables except observed parent behavior. All levels of SSTP demonstrated significant effects for reducing child behavior problems, and effect sizes increased in size as the intensity of the intervention increased. There also were significant medium to large treatment effects for parent satisfaction, parenting style, and parent self-efficacy for levels 3-5 of SSTP when analyzed by level. Observed child behaviors were significantly reduced following levels 4 and 5 of SSTP. The authors noted that findings for analyses conducted at each individual level of SSTP should be interpreted with caution given the small number of studies included in these analyses. For this reason, the analyses that combined all levels of SSTP might be more representative and robust. Ruane and Carr (2018) conducted a larger meta-analysis of SSTP, consisting of 19 studies conducted in four different countries (Australia, the United States, the Netherlands, and Ireland) with over 900 families. Both published and unpublished controlled outcome studies were included, and analyses were conducted for all levels of SSTP combined, as well as for each

individual level separately. When examining the combination of levels 1-5 of SSTP, significant overall effects were found for parent-reported child behavior problems, researcher observed child behavior problems, parental adjustment, coparental relationship, parenting satisfaction, parenting style, and parent self-efficacy. Significant effects were not found for researcher-observed parent behavior. The majority of studies (12) included SSTP level 4 and the strongest treatment effects were found for this level of intervention. The small number of studies available for levels 1, 2, 3, and 5 limited the confidence that could be placed on findings for these levels of intervention.

Given the extensive positive research supporting SSTP, the present study focused on the experiences of parents who have participated in this particular parent training intervention. Additional details about the SSTP intervention are provided in the remainder of this chapter.

**Stepping Stones Triple P (SSTP).** Stepping Stones Triple P is a multi-level, prevention oriented system of family interventions designed to reduce the prevalence of emotional and behavioral challenges in children with disabilities (Mazzucchelli & Sanders, 2012). Using a combined prevention/treatment approach, Stepping Stones “aims to both prevent the development of severe behavioral and emotional problems and provide targeted interventions for existing problems” (Mazzucchelli & Sanders, 2012, p. 5). The main goals of the SSTP program are to “(a) enhance the knowledge, skills, confidence, self-sufficiency and resourcefulness of parents; (b) promote nurturing, safe, engaging, non-violent and low conflict environments for children; and (c) promote children’s social, emotional, language, intellectual and behavioral competencies through positive parenting practices” (Mazzucchelli & Sanders, 2012, p. 7).

SSTP is offered in varying formats and 5 levels of intensity in order to meet the unique needs of parents of children with disabilities. The goal is to identify the minimally sufficient intervention needed in order to prevent children with disabilities from experiencing serious

emotional and behavioral challenges (Mazzucchelli & Sanders, 2012). The rationale behind this is that some parents may benefit from advice on how to manage specific concerns or behaviors (Level 1), while others may require a more intensive intervention that targets multiple child behavior problems and family risk factors and/or includes active skills training (Levels 3-5). Table 1 provides an outline of the 5 levels of Triple P interventions available for parents of children with disabilities, including the methods used in each and the target populations.

**Table 1: Stepping Stones Triple P Interventions for Parents of Children with Disabilities**

<p><b>Level 1: Universal Stepping Stones Triple P</b>  <i>Universal prevention strategy targeting an entire population; aims to prevent adverse outcomes</i></p>	
<ul style="list-style-type: none"> <li>• Uses health promotion and social marketing strategies to raise awareness of parent issues and encourage participation in parenting programs</li> <li>• Electronic and print media</li> </ul>	<ul style="list-style-type: none"> <li>• For all parents interested in information about parenting and promoting their child’s development</li> </ul>
<p><b>Level 2: Selected Stepping Stones Triple P</b>  <i>Health promotion/brief selective intervention; management of discrete child behavior problems in the absence of other major behavior management challenges or family dysfunction</i></p>	
<ul style="list-style-type: none"> <li>• Health promotion information or specific advice for a discrete developmental issue or minor behavior problem</li> <li>• May include 90- minute group seminar or brief (up to 20 min.) telephone or face-to-face clinician contact</li> <li>• Can be provided by general practitioners and family doctors, day care centers, schools</li> <li>• Uses parenting booklets and a DVD</li> </ul>	<ul style="list-style-type: none"> <li>• For parents of children with a disability who are interested in parenting education or have specific concerns about their child’s development or behavior</li> </ul>

(Table 1, continued)

---

<b>Level 3: <i>Primary Care Stepping Stones Triple P</i></b> <b><i>Narrow-focus parent training for the management of discrete child behavior problems in the absence of other major behavior management challenges or family disfunction</i></b>	
<ul style="list-style-type: none"><li>• Brief program (approx. 80 min. over 4 sessions) combining advice, rehearsal, and self-evaluation to teach parents to manage a discrete child problem behavior.</li><li>• Includes active skills training and generalization enhancement strategies</li><li>• May include telephone or face-to-face contact or group sessions</li><li>• Utilizes DVD: <i>Stepping Stones Triple P: A survival guide for families with a child who has a disability</i></li></ul>	<ul style="list-style-type: none"><li>• For parents of children with disabilities who have specific concerns about their child's behavior and who require consultation or active skills training</li></ul>
<hr/> <b>Level 4: <i>Standard Stepping Stones Triple P, Group Stepping Stones Triple P, Self-Directed Stepping Stones Triple P</i></b> <b><i>Broad-focus parent training; combines the provision of information with active skills training and support and teaches parents to apply parenting skills to a broad range of target behaviors in both home and community settings</i></b>	
<ul style="list-style-type: none"><li>• Broad-focus program (approx.. 9-16 hours over 9-10 sessions) focusing on parent-child interaction and the application of parenting skills to a broad range of target behaviors seen in a disability context</li><li>• Includes strategies to increase generalization and maintenance of parenting skills across setting and over time</li><li>• May be self-directed or involve telephone or face-to-face clinician contact or group sessions</li><li>• Utilizes DVD: <i>Stepping Stones Triple P: A survival guide for families with a child who has a disability</i></li></ul>	<ul style="list-style-type: none"><li>• For parents of children who want to promote their child's development, or whose children have or are at risk of developing behavioral or emotional disorders</li></ul>

---

(Table 1, continued)

---

<b>Level 5: Enhanced Triple P</b> <i>Intensive family intervention modules for parents in need of further assistance following a Level 4 intervention</i>	
<ul style="list-style-type: none"><li>• Includes modules for changing dysfunctional attributions, improving home safety, modifying disturbances in attachment relationships, and coping with anger</li><li>• Can be delivered individually or in groups</li></ul>	<ul style="list-style-type: none"><li>• For parents of children with behavior problems and concurrent family dysfunction (e.g. parental depression or stress) or conflict between partners</li></ul>
<b>Pathways Triple P</b> <i>Level 5 intervention specifically targeting parents at risk for maltreating their children</i>	
<ul style="list-style-type: none"><li>• Includes modules for changing dysfunctional attribution, improving home safety, modifying disturbances in attachment relationships, and coping with anger</li><li>• Can be delivered individually or in groups</li></ul>	<ul style="list-style-type: none"><li>• Designed for parents who are involved in the child protection system and are at risk of maltreating their children</li><li>• May be beneficial for any family in conflict</li></ul>

---

(Mazzucchelli & Sanders, 2012, p. 6)

### ***Theoretical basis of SSTP***

The SSTP program draws on a number of theories including social learning theory, child and family behavior therapy, applied behavior analysis, child development, social information processing theory, developmental psychopathology, and public health (Mazzucchelli & Sanders, 2012). Research to date suggests that parenting interventions that incorporate social learning and family management practices (Patterson, 1982; Patterson & Stouthamer-Loeber, 1984) tend to be effective for children with developmental disabilities, particularly in managing early onset behavior problems (Matson, Mahan, LoVullo, 2009; Roberts, Mazzucchelli, Taylor, & Reid, 2003). SSTP is strongly rooted in Patterson's (1982) social learning model of parenting, which highlights the reciprocal and bi-directional relationship of parent-child interactions. This model identifies learning processes that maintain coercive and dysfunctional patterns of family

interaction, which predict future antisocial behavior in children (Reid, Patterson, & Snyder, 2002).

SSTP attempts to decrease coercive parenting practices by teaching positive behavior management strategies and helping parents understand their child's behavior within the context of the environment, such as in interactions between the child and other family members. SSTP also teaches antecedent-based behavioral strategies that reduce the incidence of problem behavior by providing more positive and engaging environments for children (Mazzucchelli & Sanders, 2012). SSTP teaches parents to use strategies, such as incidental teaching, to develop their children's language, social skills, and problem solving within their day-to-day interactions. This type of strategy is rooted in developmental research that links social competence and intelligence to early parent-child interactions (Hart & Risley, 1995). Parents also receive active skills training to help them effectively deal with their child's misbehavior and avoid "parenting traps," which involve patterns of escalating, negative parent-child interactions (Mazzucchelli & Sanders, 2012, p. 104). Figure 1 provides a visual representation of the strategies taught in Stepping Stones Triple P. The strategies at the bottom of the pyramid are aimed at preventing misbehavior, by teaching new skills and reinforcing desirable behavior, whereas the more intensive strategies at the top are aimed at managing misbehavior.

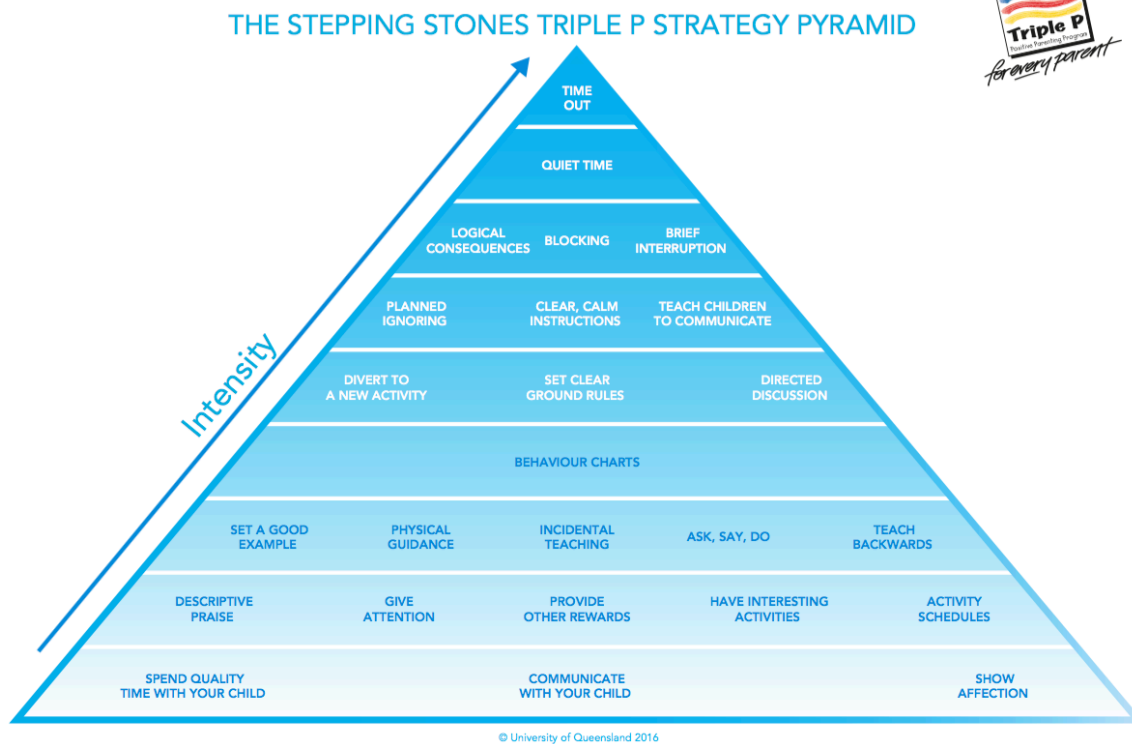


Figure 1: Stepping Stones Triple P Strategy Pyramid  
(University of Queensland, 2016)

In addition to teaching specific skills for improving parent-child interactions, SSTP targets factors known to impact parenting practices, such as parental attributions, couple relationship conflict, and parental distress (Mazzucchelli & Sanders, 2012). With regard to parental attributions, SSTP aims to help parents recognize and change unhelpful expectations and beliefs about their child's behavior and their own behavior. This is accomplished by helping parents recognize the impact that negative attributions have on their own self-efficacy, decision-making, and behavior, and then examining alternative, more helpful explanations for their child's behavior (Bandura, 1977; Mazzucchelli & Sanders, 2012). Using this cognitive-behavioral approach, SSTP also targets parental distress, including depression, anger, anxiety, and stress associated with parenting. SSTP teaches and encourages strategies for collaboration,

communication and teamwork between parents/caregivers, since parent discord is a known risk factor for child and adolescent psychopathology.

As with all Triple P interventions, the Stepping Stones program aims to develop parents' capacity for self-regulation (Mazzucchelli & Sanders, 2012). The goal is for parents to learn to solve problems independently and modify their own behavior through a process of self-reflection and self-evaluation. This self-regulatory process, which includes the stages of self-sufficiency, self-efficacy, self-management, personal agency, and problems solving, is a hallmark of Triple P. As parents move through the various stages, they become increasingly independent problem solvers (Mazzucchelli & Sanders, 2012). SSTP encourages self-regulation and problem-solving skills by teaching parents how to: select developmentally appropriate goals for their child and/or personal goals as a parent, monitor their own behavior as well as that of their child, choose appropriate methods of intervention for particular problems, implement solutions, monitor their implementation, self-evaluate their performance, and set goals for future action (Mazzucchelli & Sanders, 2012). The hope is that parents will, in turn, foster self-regulation and resilience in their children.

SSTP is based on seven principles of positive parenting that address specific risk and protective factors that are known to predict positive developmental and mental health outcomes in children, including: (1) having a safe engaging environment, (2) a positive learning environment, (3) assertive discipline, (4) adaptation to a child with a disability, (5) realistic expectations, (6) community participation, and (7) parental self-care. A description of each principle and the associated parenting skills taught in SSTP are outlined in Table 2, which is adapted from Mazzucchelli & Sanders (2012).



Table 2: Principles of Positive Parenting and Associated Parenting Skills Taught in SSTP

Principle of Positive Parenting	Parenting Skills
<p><b>Safe and engaging environment</b>  <i>Providing a safe, supervised, and therefore protective environment that provides opportunities for children to explore, experiment, and play</i></p>	<ul style="list-style-type: none"> <li>● Spending brief quality time</li> <li>● Communicating with children</li> <li>● Showing affection</li> <li>● Giving descriptive praise</li> <li>● Giving nonverbal attention</li> <li>● Providing other rewards</li> <li>● Providing engaging activities</li> </ul>
<p><b>Positive learning environment</b>  <i>Educating parents in their roles as their child’s teacher and teaching them to respond positively and constructively to child-initiated interactions (e.g. requests for help, information, advice, and attention) using techniques that assist children to generalize and learn to solve problems for themselves</i></p>	<ul style="list-style-type: none"> <li>● Setting a good example</li> <li>● Using physical guidance</li> <li>● Using incidental teaching</li> <li>● Using ask-say-do</li> <li>● Teaching backwards</li> <li>● Using behavior charts</li> </ul>
<p><b>Assertive discipline</b>  <i>Teaching parents specific child management and behavior change strategies that are alternatives to coercive and ineffective discipline practices (such as shouting, threatening, or using physical punishment)</i></p>	<ul style="list-style-type: none"> <li>● Using diversion to another activity</li> <li>● Establishing ground rules</li> <li>● Using directed discussion</li> <li>● Using planned ignoring</li> <li>● Giving clear, calm instructions</li> <li>● Teaching children to communicate what they want</li> <li>● Using logical consequences</li> <li>● Using blocking</li> <li>● Using brief interruption</li> <li>● Using quiet time</li> <li>● Using time-out</li> </ul>

(Table 2, continued)

---

<p><b>*Adaptation to a child with a disability</b> <i>Parents coming to terms with their child's disability, finding a balance between the demands and stresses of parenting and the resources they have to cope, and staying optimistic about the future. Parents may need to acknowledge any sense of grief or sense of loss they feel. They may also find it helpful to decrease demands and stressors, increase their coping resources, and find personal meaning and sense of control.</i></p>	<ul style="list-style-type: none"><li>• Catching unhelpful thoughts</li><li>• Relaxing and managing stress</li><li>• Developing personal coping statements</li><li>• Challenging unhelpful thoughts</li><li>• Developing coping plans for high-risk situations</li><li>• Improving personal communication habits</li><li>• Giving and receiving constructive feedback</li><li>• Having casual conversations</li><li>• Supporting other parents/caregivers when problem behavior occurs</li><li>• Solving problems</li><li>• Improving relationship happiness</li></ul>
<hr/> <p><b>Realistic expectations</b> <i>Exploring with parents their expectations, assumptions, and beliefs about the causes of children's behavior and choosing goals that are developmentally appropriate for the child and realistic for the parent.</i></p>	<ul style="list-style-type: none"><li>• Monitoring children's behavior</li><li>• Setting developmentally appropriate goals</li><li>• Setting practice tasks</li><li>• Self-evaluating strengths and weaknesses</li><li>• Setting personal goals for change</li></ul>
<hr/> <p><b>*Community participation</b> <i>Every individual with a disability has a right to a full and rewarding life that includes employment or meaningful activities throughout the day; living independently in the community; a meaningful social life with friends and family members; and recreation, hobbies and leisure time. Creating this life begins in childhood by families regularly using facilities and participating in activities in the community.</i></p>	<ul style="list-style-type: none"><li>• Planning and advanced preparation</li><li>• Discussing ground rules for specific situations</li><li>• Selecting engaging activities</li><li>• Providing incentives</li><li>• Providing consequences</li><li>• Holding follow-up discussions</li></ul>

---

(Table 2, continued)

---

**Parental self-care**

*Parenting is affected by a range of factors that impact on a parent's self-esteem and sense of well-being. All levels of Stepping Stones Triple P specifically address this issue by encouraging parents to view parenting as part of a larger context of personal self-care, resourcefulness, wellbeing and by teaching practical parenting skills that both parents are able to implement.*

---

- Same as for all principles listed above

(Mazzucchelli & Sanders, 2012)

\*Core principles that are unique to SSTP (i.e. not included in other Triple P interventions)

***Stepping Stones Research to Date.*** The efficacy of Stepping Stones Triple P program has been established through years of research, conducted across many countries, in a variety of settings, with diverse populations, and at varying levels of intensity. Research to date supports the efficacy of the SSTP program as an intervention for parents of children with disabilities and the few qualitative studies that have been conducted indicate that parents view SSTP to be an acceptable and useful intervention. Although SSTP studies have been conducted in multiple languages, only those published in English are included in this review.

The first randomized, controlled trial of Standard Stepping Stones Triple P was conducted by Roberts, Mazzucchelli, Studman, and Sanders in 2006. In this study, parents of 48 preschool children with developmental disabilities were randomly assigned to the treatment group or waitlist control group. Parents in the treatment group participated in 10 individual treatment session, including clinic sessions which lasted 120 minutes and 3-4 home visits that lasted 40-60 minutes. Parents who were experiencing relationship conflict or high levels of stress and depression also participated in either the Partner Support or Coping Skills module from Enhanced Triple P. The 21 families in the waitlist control group received early intervention services as usual, such as OT, Speech, PT, etc. Mothers who participated in SSTP reported

significant reductions in child behavior problems from pre-intervention to post-intervention as well as from pre-intervention to 6-month follow-up. These findings also were supported by independent observations, which noted reductions in oppositional behavior and non-compliance from pre-test to post-test for children in the intervention group, but no changes in oppositional behavior and non-compliance for children in the control group. Independent observations confirmed that the positive changes observed in the intervention group were maintained at 6-month follow-up. In addition to changes in child behavior, parents in the intervention group reported significant decreases in maternal stress and as well as improvements in maternal and paternal parenting style. Independent observations indicated that intervention parents successfully implemented behavior management strategies across multiple settings after participating in the intervention, whereas no improvements were observed in the parenting practices of parents in the waitlist control group.

In 2007, Plant and Sanders conducted a randomized control trial to examine the effects of SSTP-E, an intervention consisting of Standard Stepping Stones Triple P (SSTP-S) plus 6 sessions focused specifically on stress reduction and helping parents cope with caring for a child with a developmental disability. In this study, 74 families with a preschool child with a developmental disability were randomly assigned to receive either SSTP-S, SSTP-E, or waitlist control. Children in this study had a variety of diagnoses, including ASD, Global Developmental Delay, Down Syndrome, Cerebral Palsy, and Chromosomal abnormality other than Down Syndrome. Parents who received the SSTP-S and SSTP-E interventions had similar outcomes, with reductions in observed negative child behavior and reductions in the number of problematic caregiving tasks compared with the waitlist control group. Negative child behaviors also decreased significantly from post-intervention to 1-year follow-up for both intervention

groups, with more significant reductions noted in the SSTP-E group. There were no significant differences on measures of parenting skills and competence between the two intervention groups at post-intervention or 1-year follow-up. Mothers in both groups reported satisfaction with the intervention. The authors concluded that since SSTP-E is more cost-prohibitive than SSTP-S and both interventions were deemed effective, SSTP-E should be reserved for families who may have additional risk factors.

Whittingham, Sofronoff, Sheffield, and Sanders (2009a, 2009b, 2009c) conducted the first RCT of Stepping Stones with families of children with ASD and, in conjunction, examined the acceptability of the intervention for this population. Fifty-nine parents of children with autism (ages 2-9 years) were randomly assigned to either a partial-group format of SSTP (5 group sessions, 4 individual sessions) or waitlist control. Parents in the treatment group reported significant reductions in child behavior problems and dysfunctional parenting styles (i.e. laxness, over-reactivity, verbosity) as compared with the waitlist group. These changes, with the exception of reductions in lax parenting style, maintained at 6-month follow-up. Whittingham et al. (2009a, 2009b, 2009c) also found that parents who participated in the SSTP intervention were more likely to attribute their child's misbehavior to external, alterable factors rather than factors intrinsic to the child (e.g. disposition). Parents in the intervention group also were less likely to believe that their child's autism-related behaviors would persist over time. Parents in the intervention group reported noticing significant improvements in their child's behavior as well as in their own parenting skills and confidence. Qualitative data also were obtained from the Client Satisfaction Questionnaire and the Strategies Questionnaire and themes were identified based on parent input. Parents indicated that participation in SSTP normalized their experience and they appreciated being able to share ideas with other parents. They found the groups to be supportive

and reported wanting more group time. Only a small percentage (6.78%) of parents indicated that they felt uncomfortable in their group or working in groups in general. In terms of suggestions for improvements, parents requested having more information specifically about ASD as well as information about how to promote emotion regulation in their child.

In addition to Standard Stepping Stones, which is individually administered, Group Stepping Stones Triple P has proven effective as a parent training intervention for parents of children with disabilities. GSSTP was developed by Sanders, Mazzucchelli, and Studman in 2009 as a more cost-effective approach to parent training than Standard SSTEP. In 2013, Roux, Sofronoff and Sanders published the first RCT of GSSTP, in which they examined its effectiveness with 52 families of children ages 2-9 years with ASD, Down Syndrome, Cerebral Palsy, or an intellectual disability. Parents who participated in the study completed a variety of ratings scales at pre-, post-, and 6-month follow-up and also provided qualitative feedback about their goals and their satisfaction with the program. Parents who participated in GSSTP reported significant reductions in child behavior problems as compared with parents in the waitlist group, and those changes were maintained at the 6-month follow-up. Intervention parents also reported significant improvements in their parenting style and significant decreases in the number of parenting issues that they disagreed about.

Roux et al. (2013) also used the Goal Attainment Scale, which was created specifically for the study, to determine the goals for change that parents set at the beginning of the intervention and the degree to which those goals were attained. Three main themes were identified for the types of goals parents set for their children, including (1) decreasing challenging behavior, (2) increasing skills of self-care and independence, including communication, and (3) decreasing emotional behavior. Following the intervention, parents in

the treatment group reported high levels of goal attainment and 93% reported that there had been significant changes in their child's behavior that they attributed to the intervention. Overall, parents who participated in GSSTP reported high rates of satisfaction with the intervention. Parents' feedback from the Client Satisfaction Questionnaire was analyzed and three main themes were identified regarding the aspects of the program that parents liked, including: (1) positive improvements in child's behavior and skills, (2) feeling more confident and skilled as parents, and (3) enjoyment of the group setting, in particular learning about the experiences of parents of children with different disabilities.

VanVoorhis and colleagues (2015) examined the effectiveness of GSSTP with parents/caregivers of children diagnosed with ASD. Random sampling resulted in the identification of 8 participants for the waitlist control group and 10 participants for the intervention group. The GSSTP intervention consisted of 5 group sessions, followed by 3 individual telephone sessions and a final group session, as outlined in the GSSTP manual. Parents who participated in GSSTP reported a more functional parenting style compared with parents in the waitlist control group, but improvements were not maintained at 6-month follow-up, with the exception of improved scores on the Verbosity subscale. Parents in both groups reported increased confidence in their parenting abilities, which the authors hypothesized may be due to the fact that both groups were receiving support from teachers and administrators at a university autism center, in addition to the services they received through the study. Similarly, parents in both the intervention group and waitlist control group reported significant decreases in depression and reduced conflict over parenting issues at posttest. Overall, parents who participated in Group Stepping Stones reported high levels of satisfaction with the intervention.

Less intensive levels of the SSTP intervention, including Seminar Stepping Stones (Level 2) and Primary Care Stepping Stones (Level 3) also have proven to be effective (Sofronoff, Jahnel, & Sanders, 2011; Tellegen & Sanders, 2014). In 2011, Sofronoff, Jahnel, and Sanders conducted the first randomized controlled efficacy trial of Primary Care Stepping Stones Triple P. Participants included 53 parents of a child (aged 2-10 years old) with a disability, over half of whom had multiple disabilities. The children's diagnoses included intellectual disability, developmental delay, specific learning difficulty, acquired brain injury, cerebral palsy, vision impairment, and Maroteaux-Lamy Syndrome. Parents were randomly assigned to one of two 2-hour seminars or a waitlist control group and parents in the waitlist group participated in seminars 6 weeks later. Parents who participated in the seminars reported significant reductions in child behavior problems, the use of dysfunctional parenting styles (overreactive and verbose), and parental conflict as compared with parents in the waitlist control group. These changes maintained at 3 months and there was a sleeper effect for parenting confidence, with parenting confidence improving between post-test and follow-up.

Tellegen and Sanders (2014) conducted a RCT of Primary Care Stepping Stones with 64 parents of children ages 2-9 years old who were diagnosed with ASD. Parents were randomly assigned to either Primary Care SS or treatment as usual and they completed measures pre-intervention, post-intervention, and at 6-month follow-up. Parents who participated in the intervention reported significant short-term improvements in child behavior problems, dysfunctional parenting styles, parenting confidence, parental stress and conflict, and relationship happiness compared with parents in the waitlist control group. These short-term effects were mostly maintained at 6-month follow-up. There were, however, no significant effects on parental depression, parental anxiety, observed child disruptive behavior, or observed



parent aversive behavior. Overall, parents reported high levels of goal achievement and satisfaction with the program.

In addition to RCTs and pre-post designs, several qualitative studies have been conducted to examine parent perceptions of the strategies used in SSTP (Whittingham, Soffronoff, & Sheffield, 2006; Whittingham et al., 2009) as well as the experience and perceived outcomes of participating in SSTP (Hodgetts et al., 2013). In 2006, Whittingham et al. (2013) conducted a pilot study to evaluate the acceptability of the SSTP strategies for parents of children with autism. In this study, 42 parents of children ages 3-13 watched a video depicting the strategies used in SSTP and then participated in a focus group to discuss their opinions regarding the acceptability and usability of each strategy as well as their intention to use the strategies. Parent perceptions of control over their children's behavior as well as attributions about the causes of their child's behavior were also measured. Parents were then followed two weeks after the focus group to determine how many of the strategies they had tried and how helpful they found them to be. In general, parents rated SSTP highly in terms of acceptability, usability and behavioral intention (i.e. their intention to use the strategies). The higher their ratings for behavioral intention, the greater the number of strategies they had attempted in the two weeks following the focus group. Likewise, the higher their rating for the usability of the strategies, the greater the number of strategies that they found helpful. Parents were more likely to give lower ratings of usability if they attributed their child's behaviors to stable factors, such as ASD, and they were more likely to give higher ratings of usability if they perceived their child's behavior to be uncontrollable.

In 2009, Whittingham et al. (2009-b) conducted another qualitative study of SSTP, also involving parents of children with autism. In this study, Whittingham et al. (2009-b) used

qualitative data from questionnaires that parents filled out during a randomized controlled trial of a partial-group format of Stepping Stones (5 weeks of group format; 4 weeks individual) (Whittingham et al., 2009-a). Fifty-nine parents of children ages 2-9 years with ASD completed a Client Satisfaction Questionnaire at the conclusion of the 9-week group as well as a Strategies Questionnaire at 6-months post-intervention. The Client Satisfaction Questionnaire asked questions regarding parents' satisfaction with the intervention and the Strategies Questionnaire asked parents to report on which strategies they had utilized during the post-intervention period. Qualitative data were analyzed from these two questionnaires and themes were identified based on parent reports. The four themes identified from the Client Satisfaction Questionnaire indicated that parents felt the SSTP program was acceptable, they felt that they had developed rapport with their therapists, and they perceived improvements in their child's behavior as well as in their own parenting skills and confidence. Four additional themes were identified based on parent responses to the Strategies Questionnaire, including parents' perception of the group as being supportive, their appreciation for being able to share ideas with other parents, their feeling of being understood and believing the experience normalized their own challenges, and their desire for having more group time. Parents did provide some recommendations for improving the SSTP program, such as providing longer group sessions, giving longer breaks between sessions, offering more specific information about ASD, and providing strategies for how to promote emotional regulation in their children (Whittingham et al., 2009-b).

Hodgetts, Savage, and McConnell (2013) conducted an in-depth, mixed-methods, multiple case study investigating the experience and perceived outcomes of Standard SSTP (individual format) for parents of children ages 5-12 years old with autism. Participants were recruited through two agencies that provided services to children with autism. Families who had

already decided to participate in SSTP through one of these agencies were asked if they would also like to participate in the study. Ten families enrolled in the study and data were collected over a period of 18 months. Parents completed a variety of questionnaires and also participated in pre-, post-, and follow-up interviews. Parent interviews were designed to obtain information from parents about their child with autism, their family life, their interpretation and understanding of their child's behaviors, their expectations of SSTP, and their experience of participating in SSTP. All ten parents were interviewed prior to participating in SSTP and the 6 who completed the intervention were interviewed post-intervention. Four of the six parents who completed the intervention were also interviewed at 3-month follow-up. The three practitioners who provided SSTP were also interviewed post-intervention regarding their experience delivering SSTP and their perceptions of participants' responses to the intervention. Results of a thematic analysis identified three main themes from the parent interviews, which the authors named "Attribution of cause, Who's the boss?, and Rewarding is rewarding!" (Hodgetts et al, 2013). The first theme, Attribution of cause, reflected a change in parents' attributions of their children's behavior, from believing that at least some of the behaviors were a symptom of autism and that there was nothing they could do to change them, to believing that the behaviors served a function for their child and were amenable to change. The second theme, Who's the boss?, reflected a change from parents "giving in" and feeling as if their daily activities revolved around their child's demands and routines, to expecting positive behavior from their children and feeling empowered and more in charge of their daily activities and routines. The third theme, Rewarding is Rewarding!, reflected a change in parents' approach from feeling as if they were constantly managing negative behaviors to focusing on reinforcing positive behaviors, which in turn led to positive outcomes for their child and their family.

Hodgetts et al. (2013) also transcribed and analyzed practitioner interviews using thematic analysis. These themes reflected practitioners' beliefs that the time commitment for participating in the 10-week Standard SSTP may be too demanding for some parents of children with disabilities, particularly those who received other therapeutic services. The practitioners noted that completing the homework and participating in weekly sessions was challenging for these parents given their other commitments. Practitioners indicated that they believed parents appreciated the first 4 sessions the most, because they learned new strategies during these sessions. Getting parents to complete the program and obtaining post-assessment data, however, was challenging as parents had competing commitments and time constraints that prevented them from following through with the intervention. Practitioners reported feeling that Standard SSTP was less useful for parents who were at a point of crisis or who already had multiple service providers working with their family. Lastly, practitioners all expressed concern that there are no regulations on the level of training required to administer Stepping Stones, aside from the standard Triple P provider training. Practitioners indicated that training in counseling is beneficial for providers of SSTP, given the complex needs that families of children with disabilities encounter, including the potential for co-morbid mental health disorders or marital issues. Overall, participation in SSTP was associated with improvements in parental self-efficacy, parental psychological well-being, and a reduction in the perceived need for behavioral services for some families (Hodgetts et al, 2013). Participation in SSTP was not associated with reduced parental stress in this particular study, which the authors noted may be due to the many other factors, aside from children's disruptive behaviors, that contribute to parental stress in parents of children with disabilities.

Prior research has also examined the effectiveness of SSTP when delivered through alternative methods, such as delivery in family homes (Shapiro, Kilburn, & Hardin, 2014) and online delivery through a telehealth intervention (Hinton et al., 2017). Shapiro et al. (2014) conducted two separate RCTs of Standard SSTP delivered individually in family homes of children under 2 years of age who were receiving early intervention services (IDEA Part C). In the first study, 49 families of children with a variety of disabilities were randomly assigned to early intervention services as usual or early intervention services in combination with SSTP. Although most of the parents and children were not in the clinical range on any measures prior to treatment, children in the intervention group did demonstrate a significant decrease in behavior problems from post-intervention to follow-up. No other significant between-group differences were noted. There was a high attrition rate (52%) in this study, which the authors hypothesized may be due to the extra burden and time constraints placed on parents of young children with disabilities, who already have multiple service providers meeting with them on a regular basis. In the second study, 40 families were randomly assigned to PCAN-enhanced early intervention as usual or PCAN-enhanced early plus SSTP (Shapiro et al., 2014). The PCAN (Preventing Child Abuse and Neglect: Parent-Provider Partnerships in Child Care) curriculum is designed to help practitioners promote effective parent-child relationship, to enhance practitioners' understanding of the impact of abuse and neglect on infants and toddlers, and to help supervisors support staff in efforts to reduce risk for abuse and neglect. Parents who participated in the PCAN-enhanced early intervention plus SSTP showed positive trends towards improved mood, parenting style, and quality of parent-child relationships. Attrition rates were lower (20%) in this study than in the first study; however, fidelity to the SSTP intervention was somewhat low (66%). The authors noted the challenges of increasing retention and maintaining fidelity with

multiple providers delivering services within an existing service system. They recommended that future research examine a service delivery model that supports reduced attrition and enhanced treatment adherence while delivering services in family homes.

Hinton et al. (2017) conducted an RCT examining the efficacy of Triple P Online-Disability (TPOL-D), a telehealth intervention for parents of children with a disability. Ninety-eight parents of children with a variety of disabilities (physical, intellectual, and/or physical) were randomly assigned to treatment as usual (TAU) or TPOL-D, which consisted of online modules as well as access to the parent workbook and DVD that are typically provided in Stepping Stones interventions. At the conclusion of the intervention, parents who received the intervention demonstrated improvements in parenting self-efficacy as well as actual parenting practices. There was not a significant change in parent-reported child behavior problems post-intervention as compared with the TAU group; however, there was a significant decrease in parent-reported child behavior problems at 3-month follow-up, and all other changes were maintained and/or enhanced at 3-month follow-up. Overall, parent satisfaction was high and all except for two parents indicated that the intervention helped them to deal more effectively with their child's challenging behaviors.

SSTP has also been evaluated in combination with other interventions, such as Acceptance and Commitment Therapy (ACT; Brown et al., 2014, 2015; Whittingham et al., 2014). Brown et al. (2014, 2015) conducted an RCT examining the effectiveness of Primary Care SSTP plus ACT compared with treatment as usual. Fifty-nine parents or caregivers of children diagnosed with Acquired Brain Injury (ABI) were randomly assigned to either Primary Care SSTP plus ACT (9 sessions SSTP + 2 sessions ACT) or treatment as usual, which was described as the child's typical rehabilitation services. The Primary Care SSTP plus ACT

intervention was delivered in groups of 3 to 4 parents. Fifty-two parents completed post-assessment measures and 31 parents completed the post-intervention follow-up. Parents in the treatment group reported significant reductions in child behavior and emotional problems, as well as improvements in the parenting styles of laxness and overreactivity, compared with parents in the CAU group (Brown et al., 2014). The majority of improvements were maintained at 6-month follow-up, with the exception of child emotional problems, which returned to baseline levels. Parents in the intervention group also reported significant improvements on measures of psychological distress, psychological flexibility, confidence in managing their children's behavior, family adjustments, and number of disagreements between parents compared to CAU parents (Brown et al., 2015). Most of these improvements also were maintained at 6 months. Parents who received the intervention did not report significant improvements (compared with CAU parents) in depressive symptoms, confidence in managing children's behavior in different situations, or relationship satisfaction in 2-parent families.

Whittingham et al. (2014) examined the additive effects of SSTP plus ACT with parents of children with cerebral palsy (CP). Sixty-seven parents of children with CP were randomly assigned to either SSTP alone, SSTP plus ACT, or waitlist control, and interventions were delivered in groups of 3-10 families. SSTP alone consisted of 6 (2-hour) group sessions plus 3 (30-minute) telephone consultations. SSTP plus ACT consisted of two 2-hour group sessions of ACT prior to the SSTP sessions. The three groups (SSTP, SSTP plus ACT, and waitlist control) were compared on various measures postintervention and then parents in the waitlist control group were offered SSTP at postintervention. Those waitlist parents who did complete SSTP also completed postintervention measures as well as 6-month follow-up, as did parents in the SSTP alone and SSTP plus ACT groups. Both interventions (SSTP alone as well as SSTP plus

ACT) were associated with decreased parent-reported child behavior problems. At 6-month follow-up, parents who received SSTP plus ACT reported decreased child behavior problems and dysfunctional parenting compared to parents who received SSTP alone (Whittingham et al., 2014). SSTP plus ACT showed a benefit specifically for parenting styles of overreactivity, laxness, and verbosity, as well as child hyperactivity.

Whittingham et al. (2016) examined secondary outcomes, including parental adjustment, child quality of life, and child functional performance, from the Whittingham et al. (2014) study of SSTP plus ACT. Parents who received the SSTP plus ACT intervention reported increases in child functional performance (i.e. mobility) and quality of life, as well as decreases in parent psychological symptoms of stress and depression compared with the SSTP only and waitlist groups. The results of both studies (Whittingham et al., 2014, 2016) provided preliminary evidence of the added benefit of ACT with SSTP for children with cerebral palsy. However, the authors noted that future research should include more direct measures (rather than parent report alone), to determine whether intervention effects were due to true changes in child functioning and behavior rather than parent perception.

## **Summary**

In summary, the literature to date suggests that children with disabilities are at increased risk for mental health concerns and challenging behaviors. These challenges as well as other concerns unique to parents of children with disabilities place these parents at an increased risk for stress, anxiety, marital discord, and other adverse outcomes. Parenting interventions that incorporate social learning principles have proven effective at preventing and improving children's challenging behaviors as well as decreasing parent stress and improving parenting practices. One well-established parenting intervention designed specifically for parents of



children with disabilities is Stepping Stones Triple P. Research studies indicate that Stepping Stones Triple P is effective at changing parental attributions for child behavior, increasing positive interactions between parents and their children, reducing reported and observed use of ineffective parenting styles, and decreasing reported and observed problem behavior. SSTP also has demonstrated positive effects on parent perceptions, including enhanced parental self-efficacy, parental competence, and parental satisfaction. (Sanders, Mazzucchelli, & Studman, 2014). Parents, particularly mothers, who have participated in SSTP also have shown reduced parental stress. Furthermore, many of the gains that parents have reported following participation in SSTP have maintained over time. Despite the abundance of research demonstrating that SSTP is an effective intervention and that it is generally viewed as acceptable and beneficial by families of children with disabilities, few qualitative studies have examined parent perceptions of the GSSTP intervention, including the specific aspects of the intervention that parents deem to be most or least beneficial and how the intervention has impacted their relationship with their child. The purpose of this proposed study was to address the gap that currently exists in the literature regarding parents' qualitative accounts of their experiences in the GSSTP intervention.

## **Chapter Three: Methods**

### **Overview**

This chapter describes the methods and procedures used in this qualitative case study. The chapter begins with a description of the participants and the inclusion criteria that were used to determine eligibility for the study. Next, a description of the setting, the intervention, and the design of the study is provided. The data collection procedures and measures are then described in detail. Following the list of measures, an explanation of the data analyses procedures is provided, as well as strategies for increasing the reliability and validity of the study, maintaining participants' confidentiality, and addressing potential ethical issues. The chapter concludes with a researcher reflexivity statement, which explains the filter through which data were collected, constructed, and analyzed in this qualitative research study.

### **Participants**

Participants originally included 12 parents who elected to participate in the Group Stepping Stones Triple P (GSSTP) intervention at a nonprofit agency in the southeastern United States, and eight of those participants completed the intervention and were included in the final data analysis. Of the four participants who were not included in the final data analysis, three participants did not complete the intervention, post-measures, or interview and one participant completed the intervention but then could not be reached in order to conduct the final interview. Of the three participants who did not complete the intervention, two ceased participation due to a death in their family and the other participant reported that it became too difficult to attend the classes due to her children's school schedule. She explained that her children "have a different

schedule since they are in private school so sometimes they were out of school when there was class.” The four participants who were not included in the final data analysis did not differ significantly from other participants in terms of demographics, with the exception of education level. Three of the four participants who were not included in the final data analysis had a lower level of education than the parents who were included in the final data analysis.

Inclusion criteria for participation were (1) being an adult parent (21 years or older) of a child (ages 1-18 years) with a developmental delay or diagnosed disability, (2) being enrolled in the Group Stepping Stones Triple P program, and (3) being able to speak and understand English. Because participants of the GSSTP program sometimes have children who are experiencing developmental delays but who have not been formally evaluated, parent report of a child’s delay or suspected disability would have been considered sufficient in order to determine eligibility when a formal diagnosis had not been made. In this particular study, however, all participants reported that their children had been formally diagnosed with a disability.

**Recruitment.** After receiving approval from the University of South Florida’s Institutional Review Board (IRB), recruitment for this study occurred through a purposive sampling procedure, whereby parents who had signed up to participate in the free GSSTP parent training program at a local nonprofit agency were offered the option to participate in this research study. In order to recruit participants, an employee of the nonprofit agency emailed a flyer to parents that provided information about the study and included the Primary Investigator’s (PI’s) contact information (see appendix C and D). The informed consent was attached to the email as well, and parents were encouraged to read the flyer and contact the PI if they were interested in participating (see appendix E). The Stepping Stones group facilitator also handed out flyers during the first group session and encouraged interested participants to meet with the

PI, who was available on site, to review informed consent. The PI then reviewed the Informed Consent with interested participants.

Recruitment was to continue until up to 12 parents had participated, or saturation was reached. In this case, recruitment ceased once 12 participants had joined the study. This particular sampling method was chosen in order to obtain a sample of parents who fit within the bounds of the case study, which included parents of children with diagnosed or suspected developmental delays or disabilities who are participating in the SSTP Group. Given the specific inclusion criteria, a purposive sample was the most practical method for recruiting participants who met these requirements. Although this method did limit the external validity of the study, generalizability to other groups of participants is not one of the goals of this qualitative research study.

SSTP groups are typically designed for up to 12 parents per group; however, some SSTP Groups at this particular agency have historically had as few as 2 to 5 parents complete the group. Based on the numbers of participants in a given SSTP group and the fact that the present study included an in-depth analysis based on multiple data sources, a sample size of 12 was chosen as a feasible number of participants to answer the research questions. Only parents who participated in at least 7 out of 9 (78%) GSSTP sessions were included in the final data analysis. A maximum of 2 out of the 8 treatment sessions (Session #1 is intake only) could be make-up sessions, which were provided individually either over the phone or in person as determined by the parent and group facilitator. An outline of the content for each session is provided in Table 1 in the Intervention section. The number of required sessions and maximum number of make-up sessions were chosen based on PST requirements. Typically, participants who miss more than 2 sessions at PST are asked to sign up for a different group, because it is difficult to catch up on

missed content and also the group dynamic may be impacted when participants miss multiple sessions.

Parents who did not complete the group intervention did not participate in interviews, but were contacted by the PI via phone or email to determine why they withdrew from the intervention. The PI asked these parents whether there were any barriers that prevented them from completing and this information is reported in the final product of the case study. It is expected that this information will provide insight into some of the reasons why participants may not complete the Group Stepping Stones intervention.

### **Setting**

This study took place at a non-profit organization in the Southeastern United States. The Stepping Stones group intervention occurred at the non-profit agency office. The Triple P parenting courses offered by this agency take place in a variety of settings including, but not limited to, community agencies, schools, children's museums, and pediatricians' offices. Some data collection for the present study occurred at the intervention site; however, pre- and post-interviews were conducted at various locations based on each participant's preference (e.g., non-profit agency office, participant's home, bookstore).

The program where the intervention took place is a multi-faceted program that utilizes a public health approach to strengthen families. In order to protect the identity of participants, a pseudonym will be used for the name of the program throughout this document. The Parenting Support and Training (PST) program offers a variety of interventions that aim to promote positive parenting skills and confidence, co-parenting relationships, marriages, and financial health. The PST program consists of a multidisciplinary team of family educators and case managers who provide group-based parenting and relationship classes, case management, and

financial education free of charge. The case management and financial services are individualized to parents based on a needs assessment that is conducted during the first session of each parenting group. The parenting classes offered by PST utilize an evidence-based curriculum called the Triple P Positive Parenting Program. All classes are offered free of charge and most classes offer free child care and food for participants. Participants also receive incentives, in the form of gift cards to local stores and restaurants, for completing pre/post assessments as well as for continued participation in the group.

The PST program utilizes a variety of marketing strategies to recruit parents, including a website, social media posts, informational presentations and community outreach. The agency where the intervention took place has a marketing department which assists with creation of the informational flyers for each class and PST staff is responsible for distributing the flyers throughout the community. PST staff also is tasked with posting information about each class on the program website as well as social media sites (e.g. Facebook). PST serves parents throughout a large county in the Southeastern United States. The county has a population of over 1.4 million residents and the majority of residents are White (74.5%), followed by Black/African American (17.8%), Asian (4.3%) and Multiple races (2.7%). Over one-fourth (28.6%) of residents are Hispanic. In 2016, the median household income the county was \$51,681 and 15% of the population was living in poverty (U.S. Census Bureau, n.d.). Given the purposive sampling procedure that was used for recruitment, it was not expected that the present study sample would necessarily be representative of the population of the county where the intervention took place.

## **Intervention**

The GSSTP intervention was provided by the Parent Support and Training (PST) program at a non-profit agency and was delivered as part of the typical daily operations of the program. SSTP Group Facilitators were current employees of the agency who have been trained and accredited by the Triple P organization to facilitate this intervention. Facilitator training for GSSTP consists of three days of instruction, which is provided by the Triple P Organization. At the conclusion of the training, participants are required to pass a test and demonstrate competencies related to the intervention in order to obtain certification. In addition to having training and certification in SSTP, PST group facilitators each hold a minimum of a Bachelor's or Master's degree in psychology, social work, counseling, or a related discipline.

The GSSTP intervention offered through PST consists of nine total sessions, including an intake session, a closure session, and seven content sessions. During the intake and closure sessions, participants complete a variety of pre- and post- assessments, which will be discussed in detail within the Measures section of this proposal. In addition to the session content outlined in the Group Stepping Stones Manual, the intervention for this study included consultation with a case manager and financial coach, as well as 3 Triple P Partner Support modules. The original study design incorporated the Partner Support Tip Sheet during week 8 rather than 3 full modules of Partner Support, however; the facilitators noted that they decided to implement the full Partner Support modules since they had enough time and felt it would be beneficial for participants. Table 3 provides an overview of each session, including the content covered and the duration of the session. Session content was delivered through a combination of didactic teaching, group discussions, informational videos, role-plays, and other exercises/activities.

Fidelity of the intervention was assessed based on completed session checklists, which are provided by the Triple P organization and were completed by the facilitator and/or an observer during each session. The session checklists provide a task analysis of the topics and activities to be covered during each session and they follow the outline of each session as it is presented in the *Facilitator's manual for Group Stepping Stones Triple P (Edition II): For families with a child who has a disability* (Sanders, M., Mazzucchelli, T., & Studman, L., 2015). In general, session checklists include an agenda, a review of the previous session (if applicable) and homework, new topics and activities, a review of the main points covered in the session, and homework for the next session. Each of these areas are further broken down into specific tasks and a recommended session length is provided on the form as well. Triple P facilitators typically use these checklists as a means for keeping track of the activities and topics covered during each session. If checklists were incomplete or it appeared that portions of the intervention were not delivered, for example, the PI verified this information with the facilitator and requested an explanation. Triple P allows for flexibility in service delivery, so it was possible that some portions of the intervention may not be delivered within the designated session but may be delayed until the following session, for example. Facilitator's verbal explanations or notes written on the session checklists were used to help develop a more complete picture of the intervention that was delivered. This information was helpful in terms of understanding challenges associated with delivering the intervention as well as understanding which portions of the intervention that parents actually received. Parents were encouraged to attend all group sessions, however; a maximum of 2 make-up sessions were offered either in person or via phone for participants who missed a session. It is important to note that the intervention delivered in this study deviated from the intervention as it is outlined in the Group Stepping Stones Triple P



Facilitator’s Manual. For example, the current intervention consisted of all group sessions whereas GSSTP typically consists of five group sessions followed by three individual sessions and a final group or individual session. In addition, the Partner Support portion of the current intervention is typically provided as an addition to GSSTP for parents experiencing relationship distress, rather than being included in GSSTP for all parents. These deviations to the intervention in the present study are a result of the grant requirements of the PST program. Deviations from the typical GSSTP intervention are noted in Table 3.

Table 3: Overview of Group SSTP Session Content for Current Intervention

Week/ Session	Topic	Content	Session Duration
1	Intake/Assessments/Intro to Group*	<ul style="list-style-type: none"> <li>• Introductions</li> <li>• Outline of group sessions</li> <li>• Group rules</li> <li>• Complete intake assessments</li> <li>• Intro to case management and financial services*</li> </ul>	2.5 hours*
2	Positive Parenting	<ul style="list-style-type: none"> <li>• Working as a group</li> <li>• What is positive parenting</li> <li>• Why do children behave as they do?</li> <li>• Goals for change</li> <li>• Keeping track of children’s behavior</li> </ul>	2.5 hours*
3	Helping Children Develop	<ul style="list-style-type: none"> <li>• Developing good relationships with children</li> <li>• Encouraging good behavior</li> </ul>	2.5 hours*
4	Teaching New Skills; Managing Misbehavior Part 1	<ul style="list-style-type: none"> <li>• Teaching new skills and behaviors</li> <li>• Managing misbehavior part 1</li> </ul>	2.5 hours
5	Managing Misbehavior Part 2	<ul style="list-style-type: none"> <li>• Managing misbehavior part 2</li> <li>• Developing parenting routines</li> <li>• Finalizing your behavior chart</li> </ul>	2.5 hours

(Table 3, continued)

6	Planning Ahead	<ul style="list-style-type: none"><li>• Family survival tips</li><li>• High-risk situations</li><li>• Planned activities routines</li></ul>	2.5 hours*
7	Using Positive Strategies 1 (Check-in on Planning Ahead)* Partner Support I*	<ul style="list-style-type: none"><li>• Update on practice</li><li>• Partner support*</li></ul>	2.5 hours*
8	Using Positive Strategies 2 (Check-in on Planning Ahead)* Partner Support II*	<ul style="list-style-type: none"><li>• Update on practice</li><li>• Other issues</li><li>• Partner support*</li></ul>	2.5 hours*
9	Using Positive Strategies 3 (Check-in on Planning Ahead)* Partner Support III* Closure/Assessments	<ul style="list-style-type: none"><li>• Update on practice</li><li>• Partner Support*</li><li>• Phasing out the program</li><li>• Progress review</li><li>• Keeping up the good changes</li><li>• Problem solving for the future</li><li>• Future goals</li><li>• Final assessment</li></ul>	2.5 hours*

(Sanders et al., 2009)

*Note:* \*Indicates that a modification has been made to the content, duration, and/or format (group vs. individual) of the typical Stepping Stones Triple P Group curriculum.

## Design

The design of this study was a qualitative case study, which consists of an in-depth study of a phenomenon that exists within a bounded system (Merriam, 1995). This type of study allows for a thorough and comprehensive inquiry into a particular phenomenon, with the goal of being able to better understand and describe the experience of those who exist within the bounds of the case. According to Merriam (1985), case studies “result in an intensive, holistic description and analysis of the phenomenon or social unit being studied (p. 206)” and “the final product...is an intensive, thick description and interpretation of the phenomenon (p. 207).” In the present study, the phenomenon being studied was the experience of parents of children with disabilities who are participating in an evidence-based parenting group intervention.

As recommended by Merriam (1995), information for the case study was gathered via interviews, observations, and written products. Written products included questionnaires/rating scales, session checklists, homework checklists, and facilitator notes regarding homework completion and participation. This qualitative case study results in a written report, which is part of the process, as well as the product of the case study. In addition to interviews and observations, the PI planned to audio record the final session of the group(s), pending written permission from all group members, because this session typically includes a recap of the intervention and provides parents with an opportunity to share what they have learned in the program. It was planned that the researcher would observe the group and write down notes from the session if all group members did not agree to have the final session audio recorded. However, during the intervention there was an unexpected change to delivery of the final session, which prevented the PI from observing or recording. During the last week of the intervention, facilitators reported that they made a last minute decision to deliver the final session content and questionnaires one week early because a large portion of group participants had indicated that they could not attend the final session for various personal reasons (e.g. children out of school that day and no childcare). Since this was an unexpected change and the PI had not been observing during the second to last session, the PI was unable to attend or plan for audio recording. A full list of the components of the present case study are provided in Appendix A.

The main advantages of the case study design are that it allows the researcher to study a particular group of participants in depth, using multiple methods of data collection. The researcher becomes “the primary instrument of data collection and analysis,” conducting observations, interviews, and analyzing written products to construct an interpretation of the experience of those individuals who are a part of the case (Merriam, 2010, p. 457). The

disadvantages of this type of design are that it cannot be used to determine the effectiveness of the GSSTP group, but rather the perceptions of those individuals in the group. Since there was no random selection, random assignment, or comparison to a control group, the results of this study cannot be generalized beyond this particular group or case. That being said, there is some knowledge that can only be gained about a particular phenomenon (i.e. the experience of participating in an evidence-based intervention for parents of children with developmental delays or disabilities) through an in-depth analysis of experiences.

## **Data Collection**

### **Quantitative Data**

Parents completed a variety of rating scales during the intake session as well as immediately following the completion of the program, as this is standard procedure in the Triple P curriculum (Sanders, Mazzucchelli, & Studman, 2015) and the PST program. These assessments are built into the Triple P program as a way to measure child behavior and adjustment, parenting style and confidence, conflict over parenting, relationships functioning, conflict with children, and parents' personal adjustment (Sanders, Mazzucchelli, & Studman, 2015). All parent participants completed pre- and post-measures including the Strengths and Difficulties Questionnaire-Extended Version (SDQ), the Child Adjustment and Parent Efficacy Scale- Developmental Disability (CAPES-DD), the Parenting Tasks Checklist, the Parenting Scale, and the Depression Anxiety Stress Scales-21 (DASS-42). Parent participants who lived in a two-parent household also completed the Parent Problem Checklist (PPC) and the Relationship Quality Index (RQI). As a typical part of the Stepping Stones Triple P program, assessment results were shared with parents and used to establish and modify goals. The PI planned to have all participants complete the Client Satisfaction Questionnaire (CSQ) in addition to the other post

measures at the conclusion of the intervention; however, due to unexpected changes to the final session of the intervention, parents were not asked to complete the CSQ. During the second to last session, a large portion of participants informed the facilitators that they would be unable to attend the final session due to various scheduling conflicts. In order to ensure that parents received the complete intervention, facilitators decided to provide the content from the final session on that same day, one week earlier than planned. Facilitators also asked parents to complete the post questionnaires as is typical practice following PST groups; however, parents were not given the CSQ since it is not typically administered in the PST program. The PI was not in attendance during the 2<sup>nd</sup> to last session to ensure that this questionnaire was provided to participants. The PI learned that the CSQ was not administered after some post-interviews had already been completed, so attempts were not made to have parents complete the CSQ at that point.

#### *Child Measures*

***Strengths and Difficulties Questionnaire*** (Goodman, 1997, 1999). The SDQ is a measure of parents' perceptions of their child's problematic behavior. It consists of 25 items regarding children's positive and negative behaviors, and parents are asked to rate the frequency of each behavior on a 3-point scale. The SDQ consists of 5 subscales including Emotional Symptoms, Conduct Problems, Hyperactivity, Peer Problems, and Prosocial Behavior, which are computed by adding the scores of 5 items within each scale. Scores on each scale range from 0-10 and a Total Difficulties score can be calculated by summing each scale score except Prosocial Behavior. In addition to scale scores and the Total Difficulties score, a Total Impact score can be calculated based on 5 additional questions which assess the number of different areas in the

child's life that are impacted by the difficult behavior. Severity ratings of Normal, Borderline, and Abnormal can be applied to each scale score and overall score (Goodman, 1997, 1999).

The SDQ has been widely used with typically developing children and it correlates highly with the Achenbach Child Behavior Checklist (Achenbach, 1991, 1992), which assesses similar constructs. The SDQ has shown to discriminate between low-risk and high-risk samples of typically developing children (Goodman & Scott, 1999) and is considered to be sufficiently reliable for children with and without disabilities (Kaptein, Jansen, Vogels, & Reijneveld, 2008).

***The Child Adjustment and Parent Efficacy Scale- Developmental Disability*** (CAPES-DD; Emser, Mazzucchelli, Christiansen, & Sanders, 2016). The CAPES-DD is a 24-item questionnaire that assesses behavioral and emotional problems as well as prosocial skills of children with developmental disabilities ages 2-16 years. The CAPSES-DD also assesses caregivers' self-efficacy in managing their children's behaviors. Caregivers are asked to rate how true each statement is of their child over the past 4 weeks (0=Not at all, 1= a little, 2= quite a lot, 3= very much, or most of the time). Parents are then asked to rate their confidence, on a scale from 1 to 10 (1=Certain I can't manage it, 10=Certain I can manage it), in being able to successfully manage each behavior. The CAPES-DD provides three subscale scores (Behavioral Problems, Emotional Problems, Prosocial Behavior) and two scale scores (Self-Efficacy Scale and Total Problems Scale). The CAPES-DD has moderate to good internal consistency (Total Problems,  $\alpha=.80$ ; Self-Efficacy,  $\alpha=.89$ ) as well as very good convergent and predictive validity (Emser et al., 2016; Hinton et al., 2017).

#### *Individual Parent Measures*

***The Parenting Tasks Checklist*** (PTC; Sanders & Woolley, 2005). The PTC is a 25-item checklist used to assess parents' confidence and competence in managing their child's

challenging behavior in common parenting situations. Parents rate their confidence on a scale from 0 (Certain I cannot do it) to 100 (Certain I can do it), with higher scores indicating greater confidence. Parent ratings result in scores on two dimensions, behavioral self-efficacy and setting self-efficacy. Behavioral self-efficacy refers to confidence in dealing with specific child behavior and setting self-efficacy refers to confidence in dealing with difficult behavior in different settings. Both scales have shown good internal consistency (Behavioral Self-efficacy,  $\alpha=.97$ ; Setting Self-efficacy,  $\alpha=.91$ ). The PTC also has been shown to discriminate between mothers in a clinical sample versus a community sample, with mothers in a clinical sample showing significantly lower setting self-efficacy and behavioral self-efficacy than mothers in a community sample (Sanders & Woolley, 2005). Scores less than 68.44 for behavioral self-efficacy and less than 79.30 for setting self-efficacy are considered to be in the clinical range.

***The Parenting Scale*** (PS; Arnold, O'Leary, Wolff, & Acker, 1993). The PS is a 30-item questionnaire that measures dysfunctional parenting styles. It results in scores on three scales, which represent parenting styles of Laxness (permissive, inconsistent discipline), Over-reactivity (harsh, emotional, authoritarian discipline and irritability), and Hostility (use of verbal or physical force). The PS requires parents to rate items on a 7-point scale ranging from 1 through 7 based on their parenting style. The PS has been found to have good test-retest reliability and to correlate with self-report measures of child behavior, marital discord, and depressive symptoms as well as with observational measures of dysfunctional discipline and child behavior (Arnold et al., 1993). The PS also has good internal consistency and has been shown to discriminate between parents of clinic (Total score  $M=3.1$ ,  $SD=.07$ ) and non-clinic children (Total score  $M=2.6$ ,  $SD=.06$ ) (Arnold et al., 1993; Freeman & DeCoursey, 2007). Mothers' scores greater

than 3.55, 4.04, and 2.40 on the Laxness, Over-reactivity and Hostility respectively are considered to be in the clinical range. Fathers' scores greater than 3.43, 3.87, and 2.45 on the same scales are considered to be in the clinical range.

***The Depression Anxiety and Stress Scale-42*** (DASS: Lovibond & Lovibond, 1995). The DASS-42 is a 42-item self-report questionnaire that assesses adult symptoms of depression, anxiety, and stress. Respondents are asked to rate how much each statement has applied to them over the last week, on a scale from 0 to 3 (0= did not apply to me at all, 3= applied to me very much, or most of the time). Ratings result in a score ranging from 0 to 42 on each of 3 scales (Depression, Anxiety, and Stress) with higher scores indicating greater symptomology. Severity descriptors, including Normal, Mild, Moderate, Severe, and Extremely Severe can then be applied to the scores on each scale (Lovibond & Lovibond, 1995). The DASS-42 has shown high internal consistency for each of the scales, Depression (alpha=.91), Anxiety (alpha=.84) and Stress (alpha=.90), and it also has good convergent and discriminant validity (Brown, Chorpita, Korotitsch, & Barlow, 1997; P. Lovibond & S. Lovibond, 1995).

*Parent Relationship Measures (for participants in a partner relationship)*

***Parent Problem Checklist (PPC; Dadds & Powell, 1991)***. The PPC is a 16-item questionnaire that measures couples' conflict over child-rearing issues. Items reflect common parenting issues including: disagreement over rules and discipline for child misbehavior, the amount of conflict over child-rearing issues, and the extent to which parents undermine each other's relationship with their children. Parents are asked to indicate whether each item is an issue for them and then they are asked to rate the intensity of each issue. The PPC provides a problem score, which ranges from 0-16, as well as an intensity score, which ranges from 16-112.



The PPC has moderate internal consistency ( $\alpha=.70$ ) and a high test-retest reliability ( $\alpha=.90$ ). Scores of 5 or more on the problem scale are considered to be in the clinical range.

***The Relationship Quality Index (RQI; Norton, 1983).*** The RQI is a 6-item measure of relationship quality and satisfaction between parents. Five of the items are rated on a 7-point scale and the last item, which is a global measure of happiness in the relationship, is rated on a 10-point scale. Scores on the RQI range from 6 to 45, with higher scores indicating a more positive relationship. The RQI has high internal consistency ( $\alpha=.97$ ), concurrent validity, and discriminant validity (Heyman, Sayers, & Bellack, 1994). Scores of 29 or less on the RQI are considered to be in the clinical range (Heyman et al., 1994; Norton, 1983).

### **Qualitative Data**

***Family Experience Questionnaire (FEQ).*** The Family Experience Questionnaire is a measure developed specifically for this study in order to obtain information about participants and their families (Appendix B). The FEQ was completed by each participant in person, within two weeks of the intervention start date. Most participants completed it on the day that they signed consent. One participant chose to answer the questions over the phone, so her responses were recorded verbatim on the questionnaire by the PI. Participants were asked to share demographic information about the members of their household (e.g. age, race/ethnicity, relationship to participant, type of disability or delay if applicable) as well as information about their experiences as a parent. Participants' responses are incorporated into the analysis and final product of the case study.

***Interviews.*** Interviews were conducted with each participant within 2 weeks of completion of the group. These in-depth semi-structured interviews were recorded and later transcribed during data analysis. Throughout these interviews, participants were asked to reflect

on their experiences of being parents and participating in the GSSTP program. Interviews covered topics such as positive and negative aspects of parenting, perceived quality of parent-child relationships, factors that influenced parents to attend GSSTP and what they hoped to gain from the experience, level of satisfaction with the intervention, most helpful/unhelpful aspects of the training, and changes in relationships, skills, or other aspects of parenting following the intervention. The PI utilized an interview protocol to guide the parent interviews (see Appendix F). The interviews lasted an average of 28 minutes each, with the shortest being 17 minutes and the longest being 40 minutes. Parents who did not complete the group intervention did not participate in interviews, but were contacted via phone or email and asked why they did not complete the intervention and whether there were any barriers that prevented them from completing.

The interview style I used was “romantic” in nature, as I attempted to develop rapport and build trust with the interviewees while attempting to gain an in-depth account of their experiences (Roulston, 2010). Based on this conception of interviewing, I relied on conversational interviewing techniques and attempted to be “friendly, open, honest, and forthcoming with interviewees” (Roulston, 2010, p. 206). I expect that my own interview style and ability to develop rapport impacted the study and the accounts that interviewees shared. This perspective on interviewing makes several assumptions, including that the interviewees are able to understand and describe their feelings and experiences, and that I as the interviewer was able to understand the perspectives and experiences of interviewees based on the information that they share with me (Roulston, 2010).

Following each interview, I wrote field notes, documenting who was present for the interview, where it took place, how long it lasted, as well as any reflections about the interview

and any discussions or themes that stood out during the interview. Because parents did not always know the names of particular strategies that they found to be most/least beneficial, I referenced a list of all the parenting strategies used in GSSTP and identified, based on parent description, which strategies they referenced during the interview. I used this same process to identify any patterns in terms of the exercises and teaching strategies that parents reported as being helpful or unhelpful. A list of the SSTP strategies and ages for which they are recommended are provided in Table 4.

Table 4. Stepping Stones Triple P Strategies and Ages for Which Each Strategy is Recommended

<b>Purpose of strategy</b>	<b>Strategies (recommended ages)</b>
<b><i>Developing good relationships</i></b>	<ol style="list-style-type: none"> <li>1. Spending quality time (ALL)</li> <li>2. Communicating with children (ALL)</li> <li>3. Showing affection (ALL)</li> </ol>
<b><i>Encouraging good behavior</i></b>	<ol style="list-style-type: none"> <li>1. Using descriptive praise (ALL)</li> <li>2. Giving attention (ALL)</li> <li>3. Providing other rewards (ALL)</li> <li>4. Having interesting activities (ALL)</li> <li>5. Setting up activity schedules (3+)</li> </ol>
<b><i>Teaching new skills and behaviors</i></b>	<ol style="list-style-type: none"> <li>1. Setting a good example (ALL)</li> <li>2. Using physical guidance (1y+)</li> <li>3. Using incidental teaching (1+)</li> <li>4. Using ask-say-do (3+)</li> <li>5. Teaching backwards (3+)</li> <li>6. Using behavior charts (2+)</li> </ol>

(Table 4, continued)

<b><i>Managing misbehavior</i></b>	<ol style="list-style-type: none"><li><b>1. Using diversion to another activity (ALL)</b></li><li><b>2. Ground rules (3+)</b></li><li><b>3. Directed discussion (3+)</b></li><li><b>4. Planned ignoring (1+)</b></li><li><b>5. Clear, calm instructions (2+)</b></li><li><b>6. Teaching children to communicate (3+)</b></li><li><b>7. Logical consequences (2-12)</b></li><li><b>8. Blocking (ALL)</b></li><li><b>9. Brief interruption (1+)</b></li><li><b>10. Quiet time (18m-10y)</b></li><li><b>11. Time-out (2-10)</b></li></ol>
------------------------------------	--

(Sanders, Mazzuchelli, & Studman, 2015)

**Observations.** Observations took place during selected weeks throughout the SSTP group based on the specific content that was covered during those weeks. For example, since participants were drawn from two different GSSTP cohorts, the PI observed the first session of each group in which parents were prompted to reflect on their goals for themselves and for their children. Additionally, the PI observed session 4 of each cohort's group, in which parents were asked to share the strategies they had implemented for developing a good relationship with their child and encouraging desirable behavior. The PI also attended session 5 of each cohort's group, in which parents learned strategies for managing misbehavior. Finally, the PI observed session 9 of each cohort's group, in which parents are typically asked to reflect on the changes they have noticed in themselves and their children since the beginning of the intervention. For one cohort, the content was different on the day that the PI observed due to facilitators making changes to accommodate families' needs, as mentioned previously. In total, the PI observed 8 total sessions across the two group cohorts.

It was expected that information gained through the observations would inform some of the interview questions post-intervention. For example, if the PI observed that a participant did not speak during a session or did not participate in some of the exercises, the PI could ask the

participant about their comfort level in the group or any factors that may have impacted their level of involvement in the group. Following observations, the PI asked the group facilitator(s) if there was any noticeable difference in parents' interactions during observations vs. typical group sessions, in order to determine if the observations were representative of the typical parent interactions in the group. Facilitators reported that they did not notice any differences in the group dynamic or participant interactions on days when the PI was present vs. typical group sessions.

***Permanent Products.*** Permanent products included session checklists, attendance records, and facilitator notes, that were completed by the group facilitators during and after group sessions. The session checklists provided an outline and task analysis of activities and topics covered during each session. The attendance records included a list of participants who were present during each session. Because there were several participants of the group who did not agree to participate in the study, only the attendance records of study participants were provided to the researcher. Facilitator notes consisted of any notes that the facilitator chose to write down during the session and included information regarding parent participation, parents' concerns and successes, or goals discussed during group. Group facilitators only disclosed information to the researcher regarding parents who agreed to participate in the study.

## **Data Analysis**

### **Quantitative**

***Descriptive Statistics.*** Descriptive statistics were calculated in order to provide a clearer picture of the participants' demographic characteristics as well as their outcomes on the various measures. Demographic characteristics of parents and children are reported. Parent characteristics include age, gender, race/ethnicity, relationship status (i.e. married, divorced,

single/never married, widowed), relationship to child (i.e. mother, father, step-mother, step-father, foster mother, foster father), number of children, and highest level of education. Child characteristics include age, gender, race/ethnicity, and type of diagnosed or suspected disability or delay. Descriptive statistics are reported in terms of parents' scores on various measures, which will be described in detail in the Measures section of this document.

*Clinically significant change.* Participants' pre- and post-scores were compared to the clinical cutoffs recommended by each measure in order to determine clinically significant change. More specifically, participant scores were entered into Triple P's Automatic Scoring and Reporting Application (ASRA) database, which automatically scores Triple P standardized assessment measures and provides a printout describing participant scores. In this study, the GSSTP facilitators entered participant scores into ASRA as part of the normal operations of the PST program and then provided the PI with the score summary for each participant. Participant scores were then used to establish four change groups, including those scores that were in the clinical range pre-intervention but not post-intervention (clinically significant positive change), scores that were in the clinical range pre-and post-intervention (not clinically significant change), scores that were not in the clinical range pre-intervention, but were in the clinical range post-intervention (clinically significant negative change), and scores that were not in the clinically significant range pre-or post-intervention (not clinical pre/post),

*Reliable change.* In order to determine whether parents' clinically significant improvements between pre- and post-measures were reliable and not due to the standard error of the measures themselves, the Reliable Change Index (RC), as described by Jacobson and Truax (1991), was calculated. The RC is found by calculating the difference in pre-test ( $x_1$ ) and post-test ( $x_2$ ) scores divided by the standard error of the difference ( $S_{diff}$ ) between the two scores.  $S_{diff}$

refers to the spread of the distribution of change scores that would be expected if no change occurred between pre and post. If the RC is greater than 1.96, then the change is considered to be reliable and not merely due to the standard error of the measure. If the RC is less than 1.96, however, then the change from pre- to post-test is not considered to be reliable and may be due to the standard error of the measure itself (Jacobson & Truax, 1991). In order to calculate  $S_{diff}$ , it is necessary to have standard deviation and reliability estimates for each scale and subscale of the measures used. In the present study, standard deviation and reliability values were obtained from the normative sample for each measure whenever possible, in order to calculate reliable change for each participant. In instances where the PI was unable to obtain standard deviation and reliability estimates from the normative sample for a particular measure, these estimates were obtained from other studies that administered the measures to a large sample that was reported to be representative of the population. Appendix G includes a table of the standard deviation and reliability estimates used to calculate reliable change, as well as the corresponding references for where those estimates were obtained.

### **Qualitative**

Upon completion of the parent interviews, the PI engaged in thematic analysis, “a method for identifying, analyzing, and reporting patterns (themes) within data (Braun & Clarke, 2006, p. 6).” Each interview was transcribed and coded in order to identify themes among and between parent interviews. Initial codes were identified “a priori” based on the interview protocol questions, the research questions, and the literature related to parent perceptions of Triple P or other parent training programs (Dey, 1993, p. 106). This deductive approach reflects the questions that were discussed with participants during the interviews as well as the PI’s personal interests in the topic (Braun & Clarke, 2006; Miles, Huberman, and Saldana, 2013). As the PI

began to transcribe and then read through the interviews, an inductive approach was used to identify additional codes based on the data available in the interviews. The PI first read through each transcription multiple times and noted any topics that reoccurred within individual interviews (Ryan & Bernard, 2000). These terms or topics were added to the list of a priori codes and were highlighted and labeled using a word processing software (i.e. Microsoft Word and Excel). Although codes were first identified within individual interviews, similarities and differences between interviews became apparent as individual interviews were being analyzed. As these similarities and differences became apparent, they were noted on a separate list and the PI returned to them once she began comparing codes across interviews.

Once codes were identified within each individual parent interview, comparisons were made between all of the parent interviews. Through this process, themes were identified across parent interviews, and then subthemes were identified using a cutting and sorting technique (Ryan & Bernard, 2000). Rather than physically cutting and pasting quotes onto index cards as described by Ryan and Bernard (2000), the PI cut and pasted quotes and phrases using word processing software.

After themes and sub-themes were identified across parent interviews, the PI engaged in a process of reviewing and refining themes, whereby some themes were discarded and others were combined or expanded (Braun & Clarke, 2006). At the conclusion of this phase, the PI created a “thematic map” and analyzed how each theme fits together in a larger pattern (Braune & Clarke, 2006, p. 21). Once the PI was satisfied that all themes and sub-themes were identified and thoroughly analyzed, she began to define each theme. In order to keep track of the definitions of each code and theme, a codebook was kept throughout the data-analysis process. As recommended by Miles, Huberman, & Saldana (2013), the PI jotted down ideas and



reactions that she had as she was coding data and she wrote memos to synthesize and further analyze her thoughts and reactions to the data as they occurred. It was expected that this process would occur throughout data analysis from beginning to end, as the PI read, re-read, and moved back and forth between interviews (Braun & Clarke, 2006). The final phase of data analysis involved synthesizing and interpreting the data while developing a written report. The written report reflects both the process of data collection and analysis as well as the PI's final interpretation of the data. See Figure 2 for a visual depiction of the data analysis process.

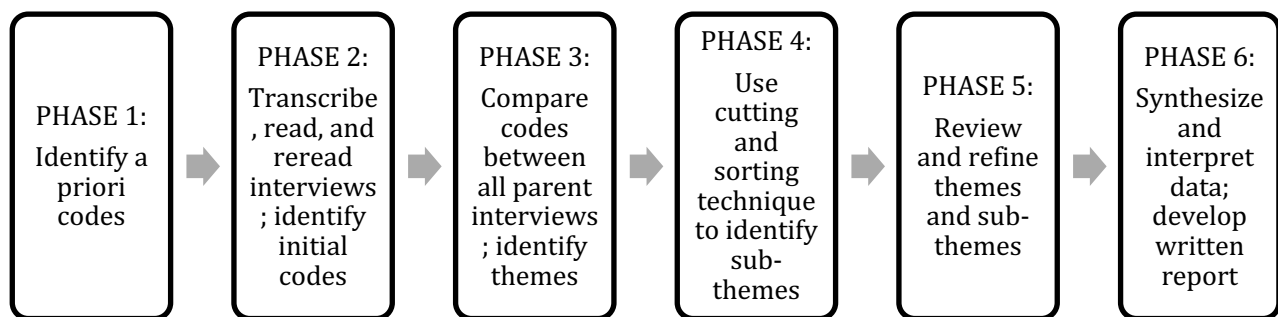


Figure 2: Phases of Data Analysis

### **Reliability & Validity**

In order to increase reliability and validity of the study, the PI engaged in a variety of practices throughout data collection and analysis. As recommended by Denzin (1978), the PI used multiple data sources (triangulation) such as parent interviews, permanent products, observations, and results of pre-post data. In order to ensure treatment integrity, the PI collected completed session checklists for each session of the SSTP group as well as attendance records, in order to track who participated in the treatment and whether or not each aspect of the intervention was delivered.

During data analysis, the PI had two additional coders assist in coding transcripts and identifying themes. All three coders (including the PI) came to agreement about the final themes

in an attempt to ensure that the experiences of the participants were not misunderstood or misconstrued. In the event that coders disagreed, each coder provided their rationale for a particular theme or code, and all three coders discussed their interpretation until consensus was reached. The PI also made the research process transparent and accessible to the reader, as recommended by Roulston (2010) for researchers conducting romantic interviews. To achieve this, I have included my interview guides as appendices to this document and also kept a journal throughout the study. The PI used this journal to reflect on her own bias, beliefs, and overall subjectivity in an attempt to keep her thoughts separate from those of the participants as she reported on their experiences. The researcher's journal is provided in Appendix H. The PI also included a researcher reflexivity statement, which discloses her own personal biases, beliefs, and assumptions, which may influence the PI's involvement in this study. Lastly, the PI engaged in "member checking" with participants to determine the degree to which her interpretations align with theirs, and also to provide opportunities for them to note any disagreements they may have with the data or interpretation (Roulston, 2010). Participants were contacted via phone and provided with an opportunity to meet in person to review the researcher's written interpretation of their experience. Parents were given the option of reading the portion of the document that pertains to them or having the PI read it to them. If a participant chose not to meet in person, the researcher offered to read the interpretation to them over the phone or via video conferencing (e.g. Skype or Zoom). Participants were asked whether the researcher's interpretation accurately depicts their individual experience and participants were given an opportunity to provide feedback and clarification if they felt any portion of their experience had been misinterpreted. The researcher then included participants' feedback into the final product. Six of the eight participants participated in member checks . All 6 of the participants who participated in

member checks reported that the researcher's descriptions and interpretations were accurate representations of their experience. One other participant scheduled to meet with the PI, but cancelled due to having to fly out of town for a family emergency. The PI attempted to reschedule with her the following week but did not receive a return call. The other participant who did not engage in member checks did not respond to several phone calls from the PI and therefore could not be reached to schedule a time to meet. Summaries of the completed member checks are provided in Appendix I. It was expected that the aforementioned strategies (i.e. triangulation, member checks, researcher reflexivity, and researcher engagement in the research situation), would strengthen the internal validity of the study (Merriam, 1995). These strategies also helped to ensure that the results of the present study are consistent with the data that were collected, which is "essential for qualitative research (Merriam, 1995, p. 56)."

In terms of external validity, the goal was to gain a deep understanding of the experiences of parents of children with disabilities rather than to generalize findings to the population as a whole or even to parents in general. In an effort to make the results more generalizable to the population of parents of children with disabilities, the PI attempted to include parents from varying demographic backgrounds as well as parents of children with varying types of disabilities. The PI also provided a thick description within the written product in order to allow the reader to determine the extent to which the experience of the participants in this study can be transferred or generalized beyond this case. It was expected that these strategies would help the PI and the reader to gain a deeper understanding of experience of parents of children with disabilities participating in an evidence-based parenting intervention (Merriam, 1995).

## **Confidentiality**

The PI maintained confidentiality of all participants by using pseudonyms rather than their real names on all transcribed interviews. The PI used these pseudonyms on all permanent products and kept them in a locked cabinet. Physical data, including informed consent documents, pre/post measures, study notes, and checklists, were transported from the study site in the PI's locked briefcase and then stored at USF in a locked cabinet. Electronic records were all stored in a USF Box account. All study related data will be kept for 5 years at which time electronic data will be deleted and physical data will be shredded.

## **Ethical Considerations**

Prior to interviewing parents and prior to their participation in the SSTP group, the PI reviewed informed consent with them in person. The PI notified them of any potential risks and benefits. The informed consent, provided in Appendix E, included information about incentives, including a \$10 gift card that was provided to them at the first meeting with the PI prior to the intervention as well as a \$10 gift card that was provided to them at the conclusion of the final interview. These gift cards were provided in addition to the incentives that are already offered to every SSTP Group participant at the non-profit agency as part of the daily operations of the program (i.e. gift cards following pre/post assessments, a gift card mid-way through the intervention, and food/child care provided at each session).

In terms of potential risks, the PI informed parents that they did not have to answer any questions that they were not comfortable with and they were welcome to leave the study at any time. Withdrawing from the study would not impact their ability to continue participating in the SSTP Group. Because this is a group intervention, there was the potential that other group members would share personal information about a participant outside of group. This risk was

not unique to parents in this study, as they would be participating in the group intervention regardless of their participation in this study. All PST group participants are encouraged to keep information of other group members confidential and this was true for participants in this study as well.

Because the PI is a part-time employee of the agency where the present study took place, there was a potential for ethical issues to arise. In an attempt to avoid any ethical dilemmas, the PI made her role as an employee evident to participants prior to the start of the study.

### **Researcher Reflexivity**

In this study, data were collected, constructed, and analyzed primarily through the filter of one researcher. I am a mother of three children and a School Psychology doctoral student who has worked with children and families in a variety of capacities over the span of approximately nineteen years. Through my professional work with children and families, I have seen how issues such as mental health concerns, medical problems, behavioral challenges, poverty, abuse/neglect, and trauma can impact the well-being of children and families.

In many ways, my professional experiences have exposed me to cultures, practices, and situations very different from my own. At the same time, they have helped me to reflect on my own experiences and to find similarities that parents and children face regardless of culture, socioeconomic status, race/ethnicity, or other demographic characteristics. Both my personal experiences as a mother and my professional experiences working with children and families have shaped the way that I view the world, and in particular how I view family relationships. These experiences have taught me that there is often a gray area and there are typically multiple perspectives through which any given situation can be viewed. In line with these beliefs, my philosophical views about parent-child relationships tend to be interpretivist in nature,

identifying with the view that “the world is constructed by each knower/observer according to a set of subjective principles peculiar to that person” (Sipe & Constable, 1996, p. 158). I am fascinated by others’ experiences of the world and how their interactions with others impact their construction of truth and reality.

My goal in this study was to acknowledge and embrace my own bias, while striving to understand the experiences of others as unique and separate from my own. One of my beliefs, or biases, is that healthy parent-child relationships are beneficial for all parents and children, and that children deserve to feel safe, loved, and cared for at all times. I also recognize that parent-child relationships are diverse, multi-faceted, and often complicated. Perhaps most relevant to the present study, I believe that both parents and children benefit when parents have the knowledge and skills to create positive relationships with their children and to manage their children’s challenging behaviors. Given that I am a parent as well as a facilitator of the Stepping Stones group intervention, it was particularly important for me to continuously reflect on any assumptions or judgments that I may be making based on my own values and beliefs throughout this process. In an attempt to be cognizant of my own bias, I kept a reflexive journal throughout this study. I used this journal to both document and process my assumptions and beliefs as they became apparent and then tried to separate these from the thoughts and beliefs of the participants.

## Chapter Four: Results

This chapter presents the results of the case study based on data collected from the eight participants who completed the GSSTP intervention and final interview. The chapter begins with a description of the participants and their child(ren), followed by the results of the quantitative data analysis and an explanation of the themes and sub-themes that emerged during data analysis. Data were analyzed through rating scales as well as thematic analysis of interviews, questionnaires, and observations in order to answer the four research questions.

### Participant Descriptions

*Noelle.* Noelle is a 31 year-old Hispanic female. She is a single mother of three children, all of whom have a diagnosed disability. Her oldest son, Carter, is 13 years old and in 7<sup>th</sup> grade. He has been diagnosed with Autism, Anxiety, Attention Deficit Hyperactivity Disorder (ADHD), and Speech Apraxia. Noelle's middle son, Anthony, is 12 years old and in 6<sup>th</sup> grade. Anthony has been diagnosed with Autism, Anxiety, and Bipolar Disorder. Noelle's youngest son, Lucas, is 4 years old and is in PreK. Lucas has been diagnosed with Autism, ADHD, and Developmental Delay, and he also is nonverbal. Noelle reported that all three of her children were diagnosed with Autism around age 2 years. Noelle reports that her children currently see a neurologist, a neuropsychologist, and a geneticist. She said that Lucas is on a waitlist to receive speech therapy. Noelle reported that her hopes and aspirations for her children are "for them to be independent and successful."

*Selena.* Selena is a 40 year-old Hispanic female and she is married to Manuel (age 46), who participated in the GSSTP intervention, but was not a participant in the present study.

Selena and Manuel have 2 children, Carla and Miguel. Carla is a 14 year-old female and she is in 7<sup>th</sup> grade. Miguel is a 7 year-old boy and he is in 1<sup>st</sup> grade. Miguel has been diagnosed with ADHD, Speech Delay, and Sensory Processing Disorder. Selena reported that Miguel's neurologist suspected that Miguel has Oppositional Defiant Disorder (ODD); however, this has not been diagnosed. Selena said that Miguel has had developmental delays since birth and he was diagnosed with ADHD at age 5 years. Selena reported that Miguel received Early Steps interventions from ages 0 to 3 years and he currently receives behavior therapy outside of school and speech therapy in school. When asked about her hopes and aspirations for Miguel, Selena stated, "He is very very very intelligent. I hope he can express more his feelings and learn to control himself and do better in school." When asked prior to the intervention if there is anything else she would like to share about her child or family, Selena wrote, "I visualize that my son needs some help but my husband is in denial. He thinks he's a normal kid, that his behavior will get better as he gets older."

*Maria.* Maria is a 37 year-old Hispanic female. She is married to Carlos (age 47), who did not participate in the GSSTP intervention. Maria and Carlos have two children, Leah and Sophia. Leah is 10 years old and is in 4<sup>th</sup> grade. Leah was diagnosed with autism at age 2 years. She has been diagnosed with ADHD, Sleep Disorder, and an eating disorder. Leah has received applied behavior analysis ABA therapy at home as well as case management. Sophia is 8 years old and does not have any diagnosed or suspected disabilities. Maria indicated that her hope for Leah is that she will be "independent, brave," and "have a voice of her own".

*Kevin and Lisa.* Kevin is a 38 year-old white male and his wife, Lisa, is a 37 year-old Asian female. Kevin and Lisa both participated in the GSSTP intervention and were participants in this study. Kevin and Lisa have two children, Hanna and David. Hanna is 3 years old and



was diagnosed with Autism at age 2 years. Hanna also has a diagnosed Speech Delay. Hanna has received Early Steps interventions as well as ABA therapy in a preschool setting. Lisa said that her hopes for Hanna are that she will be “happy, healthy, and able to communicate and fit in the society”. Kevin and Lisa’s son, David, was an infant at the time of the intervention and they did not express any concerns regarding his health or development. Kevin indicated that he hopes for both of his children to be “happy and successful in what they choose to do.”

*Debby.* Debby is a 50 year-old black female and a single mother of one son, Jason. Jason is 10 years old, is in 4<sup>th</sup> grade, and he was diagnosed with autism this year. He also was diagnosed with ADHD around age 7 or 8 years. Debby shared that Jason received speech therapy at age 3 or 4 years for “clarity and sound pronunciation” as well as play therapy at age 6-7 years. Jason is currently receiving medication therapy as well as ABA. Debby shared that she hopes Jason will be successful with his career and have strong friendships and relationships with others. When asked if there is anything else she would like to share about her son or her family, Debby wrote, “my son is fantastic and I want to strengthen our bond and problem-solving skills”.

*Roger and Joe.* Roger is a 42 year-old white male and he is married to Joe, who also is a 42 year-old white male. Roger and Joe have one adopted son, Jake, who is 14 years old and is in a special education program working at a 1<sup>st</sup> grade level. Roger and Joe adopted Jake approximately 9 months before they started participating in GSSTP. Jake has been diagnosed with Autism, ADHD, Post Traumatic Stress Disorder, ODD, Mood Disorder, Anxiety, and low IQ. Joe and Roger reported that Jake was first diagnosed with a developmental disability at birth. Jake currently receives occupational therapy, medication management, pelvic floor rehab, ABA therapy, and family therapy. He also sees a urologist and GI doctor. In terms of their hopes for Jake, Joe and Roger both hope for increased independence. Joe said he hopes that Jake

“will grow up, live on his own and hopefully [be] able to hold a job.” Roger said that he would like to see Jake “not stuck in a group home, become capable of caring for himself with guidance, and become an employed, contributing member of society.” When completing the Family Experience Questionnaire (FEQ) prior to the intervention, Roger and Joe both shared insight into the challenges they were facing. Joe wrote, “Every day is a challenge and everything is a struggle.” Similarly, Roger wrote, “Every day is a battle and a struggle.”

**Attrition.** In addition to the eight participants who completed the study, there were four participants who enrolled in the study but either did not complete the intervention or did not participate in the final interview. These participants were not included in the final data analysis. Participants who were not included in the final analysis included a married couple (50 year-old white male, 38 year-old white female) who missed a large portion of the intervention following the death of a family member, a single father (age 37, white male) who completed the intervention but did not complete the post assessments or interview, and a single mother (age 46, Hispanic female) who reported that she could not continue participating because she did not have child care. These participants were not significantly different from other participants in terms of age, gender, race/ethnicity, relationship status, relationship to their child, number of children, or their child’s disability type. However, these participants were somewhat different than other participants in terms of their highest level of education. Of the four participants who were not included in the final data analysis, one completed 10<sup>th</sup> grade, two completed high school, and one completed college, whereas all participants who were included in the data analysis completed at least some college. The single father who was not included in the final analysis also differed from other participants in the fact that he was the only single father in the intervention and his child did not live with him.

## Quantitative Results

### *Descriptive Statistics*

Descriptive statistics were calculated for participants' demographic characteristics as well as those of each target child. Table 5 provides an overview of participant demographics (i.e., age, gender, race/ethnicity, relationship status, relationship to child, number of children, and highest level of education) as well as child demographics (i.e., age, gender, race/ethnicity, and type of disability or delay).

Table 5. Demographic Characteristics of GSSTP Study Participants and Target Child

Variable	Parents (n=8)	Children (n=6)
Age in years	31-50 ( $M=39.63$ )	3-14 ( $M=6$ )
Gender		
Male (%)	3 (37.5)	4 (66.7)
Female (%)	5 (62.5)	2 (33.3)
Race/Ethnicity		
White/Caucasian (%)	3 (37.5)	1 (16.7)
Black/African American (%)	1 (12.5)	0 (0)
Hispanic (%)	3 (37.5)	3 (50)
Asian (%)	1 (12.5)	0 (0)
Mixed/Multiple (%)	0	2 (33.3)
Type of Disability (Child)		
Autism only (%)	-	0 (0)
Autism co-morbid with others (%)	-	5 (83.3)
ADHD co-morbid with others (%)	-	1(12.5)
Relationship status		
Married or in a relationship (%)	6 (75.0)	-
Single (%)	2 (25.0)	-
Relationship to child		
Mother (%)	5 (62.5)	-
Father (%)	3 ( 37.5)	-
Step-Parent (%)	0 (0)	-
Foster Parent (%)	0 (0)	-
Number of Children	1-3 ( $M=1.4$ )	-
Highest Level of Education		
Master's Degree (%)	2 (25.0)	-
Bachelors (%)	3 (37.5)	-
AA/Vocational (%)	3 (37.5)	-

Note:  $M$ =mean

Descriptive statistics were also calculated for participants' scores on each outcome measure. The means and standard deviations of all outcome variables are summarized in Table

Table 6. Means and standard deviations of outcome measures.

<b>Outcome Measure</b>	<b>Pre- Intervention</b>	<b>Post- Intervention</b>
<b><i>Child Measures</i></b>		
SDQ		
Emotional Symptoms	4.38 (2.83)	4.38 (3.60)
Conduct Problems	5.34 (2.93)	5.13 (3.30)
Hyperactivity	6.63 (2.45)	5.13 (3.33)
Peer Problems	4.75 (1.56)	3.56 (2.36)
Prosocial Behavior	5.13 (1.76)	4.50 (2.12)
Total Difficulties	21.34 (9.25)	17.38 (12.65)
CAPES-DD		
Behavioral Problems	16.00 (9.62)	16.25 (8.35)
Emotional Problems	4.25 (2.54)	3.75 (1.98)
Prosocial Behavior	15.50 (5.36)	14.25 (3.63)
Self-Efficacy	104.13 (44.67)	112.63 (47.19)
Total Problems	24.00 (14.08)	23.88 (10.95)
<b><i>Individual Parent Measures</i></b>		
Parenting Tasks Checklist (PTC)		
Behavioral Self-efficacy	76.72 (11.14)	76.85 (18.94)
Setting Self-efficacy	75.81 (13.70)	81.64 (14.82)
Parenting Scale (PS)		
Laxness	2.95 (0.75)	2.65 (0.86)
Over-reactivity	3.32 (0.49)	2.75 (0.71)
Hostility	1.96 (0.68)	1.71 (0.92)
Total	3.35 (0.41)	2.84 (0.36)
DASS-42		
Depression	6.00 (6.78)	2.75 (4.44)
Anxiety	7.63 (5.31)	3.13 (4.08)
Stress	12.75 (9.91)	7.75 (5.61)
Total	26.38 (20.41)	13.63 (12.51)
<b><i>Parent Relationship Measures</i></b>		
Parenting Problem Checklist (PPC)		
Problem	6.00 (4.16)	7.83 (3.89)
Relationship Quality Index (RQI)		
Total	33.67 (9.32)	35.17 (7.43)

*Note: Standard deviations in parenthesis*

### **Clinically Significant and Reliable Change**

In order to determine whether participants experienced a clinically significant change from pre-test to post-test on each outcome measure, participants' pre-and post-scores were first

evaluated using the recommended clinical cutoffs provided by each questionnaire. For the Strengths and Difficulties Questionnaire, the following subscale and total scores are considered to be in the abnormal or clinical range: Prosocial behavior, 0-4; Hyperactivity, 7-10; Emotional Symptoms, 5-10; Conduct Problems: 4-10; Peer Problems, 4-10, Total Difficulties, 17-40. For The Parenting Tasks Checklist, Setting self-efficacy scores less than 79.3 and Behavioral self-efficacy scores less than 68.4 are considered to be in the clinical range. On the Parenting scale, scores greater than or equal to the following cutoff scores are considered to be in the clinical range: Over-reactivity (Mothers=4.0, Fathers =3.9); Laxness (Mothers=3.6, Fathers=3.4); Hostility (Mothers=2.4, Fathers=2.5). Clinical cutoffs for the DASS include scores greater than or equal to the following: (Stress, 19; Anxiety, 10; Depression, 14). For the parent relationship measures, scores greater than 5 on Parent Problem Checklist Problem scale and scores less than 29 on the Relationship Quality Index are considered to be in the clinical range. One of the measures, the CAPES-DD, provides a recommended clinical cutoff of 9 for the total problem score, although this cutoff score is based on preliminary analysis and should be interpreted with caution. For the remaining subscales of the CAPES-DD, there are no clinical cutoffs provided but higher scores indicate greater levels of child behavior problems (range= 0-30), emotional problems (range= 0-9), prosocial behavior (range= 0-24), and self-efficacy (range= 16-160).

After comparing participant scores to the clinical cutoffs for each measure, their scores were then classified into four categories based on their pre-and post-scores for each subscale. The first category, *Non-clinical range pre/post*, consists of participant scores that were not in the clinical range prior to the intervention or following the intervention. The next category, *Clinically significant positive change*, includes participant scores that were in the clinical range prior to the intervention but were no longer in the clinical range following the intervention,

indicating a positive change. The third category, *Not clinically significant change*, includes participant scores that were in the clinical range prior to the intervention and remained in the clinical range on the post measure. The fourth category, *Clinically significant negative change*, includes participants scores that were not in clinical range prior to the intervention but were in the clinical range post intervention, indicating a significant negative change. Participant scores were not categorized for the subscales of the CAPES-DD because no recommended clinical cutoffs are provided.

Finally, in order to determine the reliability of participants' clinically significant improvements between pre- and post-measures, reliable change indexes were calculated using the formula described by Jacobson and Truax (1991). Reliable change index scores greater than 1.96 indicate that the changes in scores from pre to post were reliable, while reliable change index scores lower than 1.96 indicate that the change from pre to post may be due to the standard error of the measure itself rather than a reliable change from pretest to posttest. Table 7 provides an overview of participants' clinical and reliable change categorizations for each outcome measure.

**Table 7. Reliable and Clinical Change on Outcome Measures**

<b>Outcome Measure</b>	<b>Subscale</b>	<b>Reliable Change</b>	<b>Non-clinical range pre/post</b>	<b>Clinical range pre/Non-clinical range post</b>	<b>Clinical range pre/Clinical range post</b>	<b>Non-clinical range pre/Clinical range post</b>	<b>No clinical cutoff for scale</b>
<b>Child Measures</b>							
SDQ	Emotional Symptoms	Reliable change	1 (12.5%)	0 (0%)	0 (0%)	0 (0%)	-
		No reliable change	4 (50%)	0 (0%)	2 (25%)	1 (12.5%)	-
	Conduct Problems	Reliable change	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
		No reliable change	3 (38%)	0 (0%)	4 (50%)	1 (12.5%)	-
	Hyperactivity	Reliable change	1 (12.5%)	1 (12.5%)	0 (0%)	0 (0%)	-
		No reliable change	1 (12.5%)	1 (12.5%)	2 (25%)	2 (25%)	-
	Peer Problems	Reliable change	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
		No reliable change	1 (12.5%)	3 (38%)	3 (38%)	1 (12.5%)	-

(Table 7, continued)

CAPES-DD	Prosocial Behavior	Reliable change	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
		No reliable change	6 (75%)	0 (0%)	2 (25%)	0 (0%)	-
	Total Difficulties	Reliable change	2 (25%)	1 (12.5%)	0 (0%)	0 (0%)	-
		No reliable change	1 (12.5%)	0 (0%)	3 (38%)	1 (12.5%)	-
	Behavioral Problems	Reliable change	-	-	-	-	3 (38%)
		No reliable change	-	-	-	-	5 (62.5%)
	Emotional Problems	Reliable change	-	-	-	-	0 (0%)
		No reliable change	-	-	-	-	8 (100%)
	Prosocial Behavior	Reliable change	-	-	-	-	0 (0%)
		No reliable change	-	-	-	-	8 (100%)
	Self-Efficacy	Reliable change	-	-	-	-	4 (50%)
		No reliable Change	-	-	-	-	4 (50%)
	Total Problems	Reliable change	0 (0%)	0 (0%)	2 (25%)	1 (12.5%)	-
		No reliable change	0 (0%)	0 (0%)	5 (62.5%)	0 (0%)	-
<b>Individual Parent Measures</b>							
Parenting Tasks Checklist PTC	Behavioral Self-efficacy	Reliable change	1 (12.5%)	0 (0%)	1 (12.5%)	0 (0%)	-
		No reliable change	4 (50%)	0 (0%)	1 (12.5%)	1 (12.5%)	-
	Setting Self-efficacy	Reliable change	0 (0%)	3 (38%)	1 (12.5%)	0 (0%)	-
		No reliable change	2 (25%)	0 (0%)	2 (25%)	0 (0%)	-
Parenting Scale (PS)	Laxness	Reliable change	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
		No reliable change	4 (50%)	1 (12.5%)	3 (38%)	0 (0%)	-
	Over-reactivity	Reliable change	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
		No reliable change	7 (87.5%)	1 (12.5%)	0 (0%)	0 (0%)	-
DASS-42	Hostility	Reliable change	0 (0%)	0 (0%)	0 (0%)	0 (0%)	-
		No reliable change	5 (62.5%)	1 (12.5%)	1 (12.5%)	1 (12.5%)	-
	Depression	Reliable change	2 (25%)	0 (0%)	0 (0%)	0 (0%)	-
		No reliable change	5 (62.5%)	0 (0%)	1 (12.5%)	0 (0%)	-
Anxiety	Reliable change	0 (0%)	1 (12.5%)	0 (0%)	0 (0%)	-	
	No reliable change	5 (62.5%)	1 (12.5%)	1 (12.5%)	0 (0%)	-	
Stress	Reliable change	1 (12.5%)	2 (25%)	0 (0%)	0 (0%)	-	
	No reliable change	4 (50%)	1 (12.5%)	0 (0%)	0 (0%)	-	

(Table 7, continued)

Parent Relationship Measures							
Parenting Problem Checklist (PPC)	Problem	Reliable change	0 (0%)	1 (12.5%)	1 (12.5%)	2 (25%)	-
		No reliable change	1 (12.5%)	0 (0%)	1 (12.5%)	0 (0%)	-
Relationship Quality Index (RQI)	Total	Reliable change	1 (12.5%)	1 (12.5%)	0 (0%)	1 (12.5%)	-
		No reliable change	2 (25%)	0 (0%)	1 (12.5%)	0 (0%)	-

***Strengths and Difficulties Questionnaire- Extended Version (SDQ).*** Parents were asked to identify behaviors that their child exhibited over the last six months using the SDQ. Parent ratings of their child’s challenging behavior varied by subscale. On the *Emotional Symptoms* subscale, only two of the eight participants rated their child in the clinically significant range pre-intervention. Neither of those parent ratings significantly improved from pre to post. Of the remaining six participants whose ratings were not in the clinical range pre-intervention, four remained in the non-clinical range post-intervention and one reported a clinically significant negative, or worsening, change; however, this change was not considered to be reliable.

On the *Conduct Problems* subscale, four participants rated their child in the clinical range pre-intervention and none of them reported clinically significant or reliable positive change post intervention. Of the four participants who rated their child in the non-clinical range prior to the intervention, three maintained ratings in the non-clinical range post intervention and one participant reported a significantly negative (i.e. worsening) but unreliable change.

On the *Hyperactivity* subscale, four participants rated their child in the clinical range pre-intervention. Of those, two participants reported clinically significant positive change and one of those was considered reliable change. The other two participants maintained ratings in the clinical range post-intervention, however; their change from pre- to post-intervention was not considered to be reliable. Of the four participant ratings that were not in the clinical range pre-



intervention, two remained in the non-clinical range post intervention and the other two participant ratings showed clinically significant negative (i.e. worsening) change, however; this negative change was not considered to be reliable for either participant.

On the *Peer Problems* subscale, six participants rated their child in the clinical range pre-intervention. Of those, three participants reported clinically significant positive change but the change was not reliable for any of those participants. The remaining three participants who rated their child in the clinical range pre-intervention maintained ratings in the clinical range post-intervention and their changes from pre- to post-intervention were not considered reliable. Of the two participants who rated their child in the non-clinical range pre-intervention, one maintained a rating in the non-clinical range post intervention and the other reported a clinically significant negative (i.e. worsening) but unreliable change.

On the *Prosocial Behavior* subscale, only two participants rated their child in the clinical range pre-intervention and neither of them reported a clinically significant positive change post intervention. The remaining six participants rated their child in the non-clinical range pre-and post-intervention. None of the participant scores on this subscale showed reliable change from pre- to post-intervention.

On the *Total Difficulties* scale, four participants rated their child in the clinical range pre-intervention. Of those four, one participant reported clinically significant positive and reliable change and the remaining three participants did not report significant or reliable improvement. Of the four participants who rated their child in the non-clinical range pre-intervention, three maintained ratings in the non-clinical range post-intervention and one participant reported a clinically significant negative (i.e. worsening) but unreliable change.

***Child Adjustment and Parent Efficacy Scale- Developmental Disability (CAPES-DD).***

Parents were asked to rate how true various statements were related to their child's behaviors over the last four weeks. Parent ratings of their child's behavioral concerns, emotional problems, and prosocial skills were obtained for all subscales of the CAPES-DD; however, only the Total Problems Scale was analyzed for clinical and reliable pre-post change, because there are no recommended clinical cutoffs provided for the other subscales. On the *Total Problems Scale*, seven of the eight participants rated their child in the clinical range pre-intervention. All seven of those parents maintained ratings in the clinical range post intervention and the changes from their pre- to post-scores were considered unreliable. The one participant who rated their child in the non-clinical range pre-intervention reported a clinically significant negative (i.e. worsening) change post intervention, however, this negative change was not considered to be reliable.

***Parenting Tasks Checklist.*** Parents' ratings of confidence and competence in managing their child's challenging behavior were rated in terms of behavioral self-efficacy and setting self-efficacy. Behavioral self-efficacy refers to confidence in dealing with specific child behavior and setting self-efficacy refers to confidence in dealing with difficult behavior in different settings. On the *Behavioral self-efficacy* subscale, only two participants had pre-intervention ratings in the clinical range and both of them maintained ratings in the clinical range post-intervention. Of the six parents who reported pre-intervention ratings in the non-clinical range on the Behavioral self-efficacy subscale, five maintained ratings in the non-clinical range and one reported a clinically significant negative (i.e. worsening) change; however, this change was not considered reliable.

Parent ratings on the *Setting self-efficacy* subscale were quite different than their ratings on the Behavioral self-efficacy subscale. Six of the eight participants reported Setting self-efficacy scores in the clinical range pre-intervention. Of those, three reported clinically

significant positive (i.e., improved) and reliable change post-intervention and three remained in the clinical range post-intervention. The two parents who rated their setting self-efficacy in the non-clinical range pre intervention maintained ratings in the non-clinical range post intervention.

***Parenting Scale.*** Participants were asked to answer questions about their parenting style over the past two months. Their answers were rated on the *Laxness*, *Overreactivity*, and *Hostility* scale. On the *Laxness* scale, four of the eight participants were in the clinical range pre-intervention. Of those four, one had clinically significant positive change from pre-intervention to post-intervention but it was not considered to be reliable change. The other three participants who were in the clinical range pre-intervention remained in the clinical range post-intervention and did not show clinically significant or reliable change. The four participants who were in the non-clinical range pre-intervention remained in the non-clinical range post-intervention.

On the *Over-reactivity* scale, only one participant was in the clinical range pre-intervention. That participant reported a clinically significant positive (i.e., improved) but unreliable change post intervention. Of the participants who were not in the clinical range pre-intervention, all seven remained in the non-clinical range post-intervention.

On the *Hostility* scale, two participants were in the clinical range pre intervention. Of those two, one participant reported a clinically significant positive but unreliable change while the other did not report a clinically significant change. Of the six participants who were not in the clinical range pre-intervention, five remained in the non-clinical range post-intervention and one reported a clinically significant negative (i.e., worsening) change; however, this negative change was not considered to be a reliable change.

***Depression Anxiety Stress Scales-42 (DASS-42).*** Participants were asked to rate their symptoms of depression, anxiety, and stress over the past week. For the *Depression* subscale,

seven of the eight participants were not in the clinical range pre- or post-intervention. The one participant who was in the clinical range pre-intervention did not report clinically significant or reliable change post intervention. For the *Anxiety* subscale, three participants reported scores in the clinical range prior the intervention and two of those reported clinically significant positive change post-intervention. This positive (i.e., improved) change was considered reliable for one of those participants but not the other. The five participants who reported Anxiety scores in the non-clinical range pre-intervention maintained scores in the non-clinical range post-intervention. For the *Stress* subscale, three participants reported ratings in the clinically significant range pre-intervention and all three of those participants reported clinically significant positive (i.e., improved) change post intervention. This positive change was considered reliable for two of those three participants. The remaining five participants reported ratings in the non-clinical range pre- and post-intervention.

***Parent Problem Checklist (PPC).*** Six of the eight participants completed the PPC, which measures couples' conflict over child-rearing issues. Three of those parents reported pre-intervention ratings in the clinical range. Of those two, one reported clinically significant and reliable positive change post intervention. The other two parents maintained ratings in the clinical range post-intervention. Of the three parents whose pre-intervention ratings were in the non-clinical range, only one remained in the non-clinical range post intervention and the other two reported clinically significant negative (i.e., worsening) change post-intervention. That negative change was considered to be reliable for both of those participants.

***Relationship Quality Index (RQI).*** Six of the eight participants completed the RQI measure of relationship quality and satisfaction between parents. Two of the six participants reported ratings in the clinical range pre-intervention and one of those showed clinically

significant and reliable positive (i.e., improved) change post-intervention. The other parent remained in the clinical range post intervention and their pre-post change was not considered to be reliable. Four participants provided ratings that were not in the clinical range pre-intervention and three of those maintained ratings in the non-clinical range post-intervention. One of the participants who had been in the non-clinical range pre-intervention reported a clinically significant and reliable negative (i.e., worsened) change post-intervention.

### Thematic Analysis

Results of the thematic analysis are summarized in Table 8, followed by a description of participants' statements as they relate to the research questions.

Table 8. Summary of Themes and Subthemes

<b>Theme/Subtheme Name</b>	<b>Description of Theme/Subtheme</b>	<b>Participants who endorsed theme</b>
<b>1. Word of mouth</b>	Parents were referred to the intervention by a friend, partner, or acquaintance	Noelle, Selena, Lisa, Kevin, Joe
<b>2. Informed about GSSTP by a professional</b>	Parents were referred to the intervention by a professional (i.e. medical/mental health professional, school staff, agency staff)	Roger, Debby, Maria
<b>3. Seeking new skills</b>	Parents joined the GSSTP intervention with hopes of learning new skills.	Kevin, Lisa, Noelle, Selena, Joe, Debby, Maria, Roger
<b>3a. Skills for helping children develop</b>	Parents hoped to learn new skills to help their child develop.	Kevin, Lisa, Noelle, Selena, Joe, Debby, Maria
<b>3b. Skills to help manage challenging behavior</b>	Parents hoped to learn new skills for managing their child's challenging behavior.	Debby, Noelle, Selena, Roger, Joe
<b>4. Parenting is hard work and you never get a break</b>	Parents described a number of challenges that they experience related to parenting, including feeling overwhelmed by the daily demands of caring for their child, not knowing how to manage their child's challenging behaviors, experiencing problems in their child's school/in the community, or lacking support from their partner.	Roger, Joe, Noelle, Lisa, Kevin, Maria, Noelle, Selena
<b>4a. Overwhelmed by level of care required</b>	Parents reported feeling overwhelmed by the constant demands of caring for their child.	Roger, Joe, Noelle, Lisa, Kevin, Selena

(Table 8, continued)

<b>4b. Difficulty knowing how to respond to challenging behavior</b>	Parents reported that it can be hard to know how to respond to their children’s challenging behavior, which makes parenting especially difficult.	Selena, Roger, Lisa
<b>4c. Challenges in school/community</b>	Parents shared challenges that they face in schools and other places in the community, including difficulty accessing effective services and scrutiny from other people.	Kevin, Selena, Roger, Joe, Debby
<b>4d. Lack of support from partner/not on same page as partner</b>	Parents reported challenges related to their partner, including lack of support from their partner or not being on the same page as their partner.	Maria, Noelle, Kevin
<b>4e. Other parenting challenges</b>	Parents described a variety of other challenges that they face related to their children, including safety concerns, the high cost of care, worry about the future, and lack of resources.	Roger, Joe, Noelle
<b>5. Learned new skills</b>	Parents listed new skills that they learned as being the most beneficial aspects of the intervention.	Selena, Debby, Roger, Joe, Noelle, Maria, Kevin, Lisa
<b>5a. Learned new parenting strategies (general)</b>	Parents reported that one of the most beneficial aspects of GSSTP was the new strategies that they learned, but they did not describe the specific strategies.	Selena, Debby, Roger, Joe, Noelle, Maria, Kevin, Lisa
<b>5b. Learned new parenting strategies (specific)</b>	Parents named specific strategies that they learned, which they found to be the most beneficial aspect of GSSTP.	Lisa, Debby, Maria, Joe, Roger
<b>6. Received support from others</b>	Parents reported that one of the most beneficial aspect of participating in the GSSTP group was the support that they received from other parents and the facilitators.	Lisa, Kevin, Selena, Joe, Debby, Roger, Joe
<b>6a. Received support from other parents</b>	Parents reported that one of the most beneficial aspect of participating in the GSSTP group was the support that they received from other parents.	Lisa, Kevin, Selena, Joe, Debby
<b>6b. Received support from GSSTP facilitators</b>	Parents reported that one of the most beneficial aspect of participating in the GSSTP group was the support that they received from the facilitators	Lisa, Roger, Joe

(Table 8, continued)

<b>7. Improved co-parent relationship</b>	Parents reported that participating in the intervention positively impacted their co-parent relationship.	Lisa, Kevin, Joe, Roger, Selena
<b>8. Suggestions for changes in group</b>	Participants provided recommendations for changes to GSSTP, including the length, format, and participant groupings.	Debby, Kevin, Lisa, Maria, Roger, Selena, Noelle
<b>8a. Length of group was a barrier</b>	Parents reported that it was difficult to attend all of the sessions of GSSTP because it lasted so many weeks.	Debby, Kevin, Lisa, Maria
<b>8b. Changes to the format/content of sessions</b>	Parents recommended changes to the format and content of the sessions, including the types of activities and topics covered.	Debby, Roger, Selena, Kevin
<b>8c. Suggested grouping classes based on specific characteristics</b>	Parents recommended grouping GSSTP classes based on participant characteristics, such as the age of the child, single parents vs. married, Hispanic vs. Non-Hispanic.	Kevin, Maria, Noelle, Selena
<b>9. Learned How To Talk To Their Children</b>	Parents said they learned new ways to talk to their children, such as reducing the number of instructions, using positively stated language, getting within close proximity, and giving clear, calm instructions.	Joe, Kevin, Debby, Maria, Lisa, Noelle
<b>10. Learned How To Plan Ahead</b>	Parents described learning how to implement a planned activities routine in order to plan for challenging situations.	Roger, Kevin, Debby, Selena
<b>11. Learned how to implement rewards</b>	Parents reported that they learned to implement rewards in order to encourage the behaviors that they want to see.	Joe, Debby, Maria
<b>12. Learned Other Strategies to Strengthen Parent-Child Relationships And/Or Prevent Challenging Behavior</b>	Parents described a number of other strategies they learned for strengthening parent-child relationships and/or preventing challenging behavior, such as giving their child attention, implementing a visual schedule, choosing interesting activities, reducing stimulation, and remaining calm.	Noelle, Roger, Joe, Debby, Maria, Lisa
<b>13. Learned other ways to manage challenging behavior</b>	Parents indicated that they learned new strategies for managing misbehavior, such as taking breaks, using physical guidance and blocking, and implementing quiet time and time out.	Joe, Kevin, Lisa, Debby

(Table 8, continued)

<b>14. Implementing New Strategies Has Helped</b>	Parents reported that they have noticed positive changes in themselves or their children since they began implementing the strategies that they learned in GSSTP.	Roger, Selena, Kevin, Maria, Debby, Joe, Noelle
<b>15. Positive parent-child relationships</b>	Parents described having positive parent-child relationships.	Maria, Noelle, Selena, Roger, Lisa, Debby, Joe, Kevin
<b>15a. Good relationship with child/love them</b>	Parents stated that they have a good relationship with their child and/or that they love them.	Maria, Noelle, Selena, Roger, Lisa
<b>15b. Enjoy sharing experiences with their child, teaching them, and learning from them</b>	Parents described enjoying spending time with their children, sharing experiences with them, teaching them, and learning from them.	Selena, Debby, Roger, Joe, Kevin, Debby, Maria
<b>15c. Children are funny</b>	Parents described their children as being funny and making them smile/laugh.	Roger, Kevin, Debby
<b>15d. Want to give them everything/prepare them for the future</b>	Parents said that they want to give their children everything and/or that they want to prepare them for the future.	Kevin, Joe, Selena, Debby, Maria
<b>16. Strained parent-child relationships</b>	Parents described having a strained parent-child relationship.	Roger, Joe, Debby
<b>17. Cultural Differences</b>	Parents discussed cultural differences between their own culture and that of other participants, or cultural differences between their culture's parenting practices and those of the U.S. or those taught by Triple P.	Noelle, Maria, Selena, Lisa

**Question 1: What led parents to engage in the GSSTP program and what did they hope to gain from participating?**

**Theme 1: Word of Mouth.** Five of the eight participants interviewed indicated that they heard about the GSSTP intervention through someone they knew, such as a friend, partner, or acquaintance. For example, Lisa reported that she heard about the class through an acquaintance that she had met at a different service provider:



I met this mom at a behavior consulting place and then she introduced the Stepping Stones to me so we decided to get involved.

Another participant, Noelle, shared that a friend informed her about the group:

My friend told me about the class. Even though I have a case manager because I'm in the Healthy Start program with (oldest son) since he was a baby. But she didn't mention anything about the class.

Selena shared that she was told about the class by a friend who works for the agency where the GSSTP intervention was offered:

I have a friend that works there and she's from church and she knew that I was struggling with my son. We are friends so I called her, I feel frustrated. I don't know what I'm going to do and she told me, "Okay, I work at this place. I think you need to take these classes. It's going to be helpful for you, for the family." And I'm like, I'm going to do whatever I need to do to help my son, specifically. He has ADHD.

Joe reported that his partner, Roger, initially told him about the class:

Honestly I can't remember because (Roger) actually came to me and said, "I signed us up for this class we're going to start taking on Saturdays," and I'm like, "What is it about?" and he's like, "better parenting techniques and stuff." I don't know who really recommended it to him but I think it may have been our family therapist or something.

**Theme 2: Informed about GSSTP by a Professional.** The remaining three participants indicated that they heard about the GSSTP class from a professional or at an outreach event. For example, Joe's partner, Roger, indicated that their psychiatrist told them about the class:

We have a psychiatrist that we are working with just as a couple, as one of the many people that we see that I think when we started having some difficulty just handling (our

son), we thought it was a good thing to kind of try, at the recommendation of a lot of people actually, to go and seek help for ourselves and stuff like that too and they had recommended us to that particular program.

Debby and Maria both shared that they were informed about the class at separate outreach events. Maria reported that she learned about the class at a resource fair and Debby recalled attending an event at her son's school where someone shared information about the class:

There had been some outreach some months ago, maybe mid-last spring where I had attended an introduction session and then they kept me on the waiting list and I told them I'd be interested in some of the other programs and then I was called by (agency) and they said we have this program, it's coming up, and I thought that would be a good match...

**Theme 3: Seeking New Skills.** Participants described a variety of things that they hoped to gain from participating in GSSTP, with the major theme being "Seeking New Skills." This theme included two subthemes, "Skills For Helping Children Develop" and "Seeking Help With Challenging Behavior." Parents reported having a desire to learn new parenting skills to help their children develop and also wanting to receive help with their children's challenging behavior.

**Theme 3a: Skills for Helping Children Develop.** Seven of the eight parents shared that they hoped to learn new skills to help with their children's development. Some parents listed specific skills that they hoped to learn, while others made more general statements. For example, during his interview following the intervention, Kevin explained that there was not a specific incident that inspired him to sign up for GSSTP but rather a desire to preemptively learn skills that may help him and his wife help their daughter:

I mean there wasn't really a tipping point, in my opinion. It was more of a, you know, we need to do everything we can to help our daughter, you know, overcome the challenges that she's facing, and also help us as parents to be better equipped to deal with certain situations and scenarios that we can potentially foresee and kind of get into. We know a lot of other parents that have children that are older who have autism and you know, the struggles that they face, and we're just trying to, you know, not get into those if we can help it.

Kevin's wife, Lisa, indicated prior to the intervention that her goal was to gain "better communication with [her] daughter." Noelle and Selena both wrote that they hoped to learn new skills that would help them to support their children. Noelle noted that her goal was "learning new skills on how to work with my boys." Similarly, Selena wrote:

I want to understand and want to help my son better, to learn some techniques that I can help him and to help me help him.

Maria had a very specific skill that she was hoping to help her daughter develop. She shared that her daughter has a hard time talking and expressing her feelings and she wanted to learn how to help her daughter express herself at home:

My big concern with (daughter), my girl, is because she doesn't talk. She talk. She talk very well but she don't express herself, her feelings...that's my big concern is how to she express herself...I don't know if she's afraid of something or she doesn't want to talk.

**Theme 3b: Skills to Help Manage Challenging Behavior.** Five out of the eight participants reported that one of their goals in signing up for GSSTP was to learn strategies for dealing with their child's challenging behavior. Some of the target behaviors that parents identified at the beginning of the intervention were hitting, screaming, crying, self-harming

(hitting self), urinating, and emotional outbursts (i.e. cursing, yelling). Prior to starting the class, Debby noted on her Family Experience Questionnaire that she hoped to learn “strategies for helping others work with [her son]” and “strategies for helping us at home to increase cooperation and reduce frustration.” During her interview following the intervention, Debby described her goal in more detail:

The goal was to find something that worked with disciplining him and guiding him. He’s very oppositional and he will try to talk you out of whatever thing you want him to do, so he’s really smart in that way so I needed some techniques to help discipline and discipline stick. And to get him back on routines and then also to learn what I could share with his teachers to help them manage their classrooms, manage him in the classroom better.

Noelle shared a similar sentiment and noted that the goal was not just to change her children’s behavior but also to change her own behavior. When asked what she hoped to gain from participating, Noelle said:

I think to learn, like she said (referring to a friend), for behavior and helping moms. It was for moms and not for the kids, so it was like, yeah, we need a little bit of help sometimes.

Roger and Joe both indicated on their Family Experience Questionnaires that they hoped to learn to better handle their son’s challenging behavior. Roger noted that he hoped to learn “effective strategies for managing and reducing the intensities of our child’s behaviors” and Joe wrote that he hoped to learn “how to handle his meltdown better”. Joe shared that he and his partner had received many differing opinions from various providers regarding their son’s challenging behaviors and he hoped that taking this class would provide them with some direction with

regard to how to parent their child. When asked about what he hoped to gain from participating, he said:

Maybe just to get a little more consistency and sanity into our home. I mean, literally since our adoption it's just been literally all over the place with his behaviors and him needing motivation to accomplish goals and to get to school on time and you know, we've had so many people coming and going from the home just to give us advice and everybody has their own opinions about things and I'm like, okay, if we just go to a professional class maybe, you know, maybe something that's been tried and guaranteed it can give us a little bit of, you know, proper guidance, then maybe we can get something out of it.

**Theme 4: Parenting is Hard Work and You Never Get a Break.** Parents reported a number of challenges that they experience related to parenting, including feeling overwhelmed by the daily demands of caring for their child, not knowing how to manage their child's challenging behaviors, and experiencing problems in their child's school or in the community. Parents also reported that parenting can be especially difficult when they are lacking support from their partner or are not on the same page as their partner. Participants indicated that parenting a child who has a disability can be especially challenging. For example, during one of the classes, Maria stated:

It is hard to be a good parent. Can you imagine with a child with a disability, trying to be a good parent? This is no something bad. It's something that we're going to have to work a little bit harder. We have to work to help them be successful.

Some parents specified these challenges as the reasons that they decided to sign up for GSSTP. For other parents, the challenges of parenting emerged as a theme throughout their interviews

and the class observations, even though they may not have specifically identified these challenges as one of their reasons for joining GSSTP.

**Theme 4a: Overwhelmed by the Level of Care Required.** Parents reported feeling overwhelmed by the daily demands of caring for their child. Parents described both the physical and emotional burden they feel due to the constant care and attention they provide for their children. Some parents indicated that they feel exhausted and never get a break.

Roger expressed this when describing the challenges of parenting:

If I haven't gone into the fact that I just, we've had very little support and you never get a break from it. So, it takes over your life (laughs). I would say that is the most challenging thing. The only time in which I have gotten any kind of break at all is when I've gotten away from the situation and the only times I've really gotten to do that for the most part is whenever I've gone to, I've had to make like a business trip for work or something like that and you're not off having fun, you know.

Roger indicated that both he and his partner are in need of a break but it is hard for either of them to get one:

It's constant. Yeah, I mean I think as a working parent, as a working parent for somebody like this, it really is because you spend a full day at work and then when you get home, your partner's like, "Here (laughs), it's your turn (laughs)." It's like, "Oh, when's my break (laughs)? Never. When you're asleep."

Kevin shared a similar experience as a working parent, noting during one of the classes that the most challenging thing about being a parent is "always being on." He explained:

You're never off the clock. I go to work and then come home and it's like, I should've stayed at work. Then my wife is frazzled because she's been with them and then she's like, "Okay, you're on."

Roger shared that he and his partner have attempted to get respite care for their son so that they can have a break, but finding a respite provider has been challenging:

We were having difficulty as it is trying to find a respite provider that, just looking at his case would want to go and return the phone call and, or was you know anywhere fit to handle somebody that had as extreme behaviors as [our son]...

Despite having some support from a family friend, Roger explained that he or his partner are always present when the respite provider is there due to their son's challenging behavior, so they never get a true break:

We've not gotten to the point of actually leaving her alone with him. I think in some ways she's kind of a little bit afraid of that...just knowing how angry he can get and how he acts when he gets into one of the angry episodes, I think to some degree she's, she's afraid of that, and that's why it's been difficult just finding somebody that can look after him.

At the time of the interview, Roger and his partner had become so overwhelmed by the level of care that their son required that they had begun looking into placing him in a group home:

But yeah and I guess that also kind of feeds into why we're looking at a group home arrangement, just simply because it's, it's tough finding the support that we need.

Noelle shared a similar challenge with regard to caring for her children, noting that "sometimes [she] could use a little break." Noelle added that she felt her situation was unique from the other parents in the group because she does not have the support of a partner or anyone else:

I'm full-time mom and dad...like, I have no support here...like I have no support. I have my kids twenty-four seven. Even my dating life, it's like not an option. They are with me 24 seven. I can't go out.

She expressed the same concern during one of the group sessions, stating, "It's hard to get a sitter for 3 kids with autism." Noelle noted that other group participants talked about having free time or a getting a break from the demands of caring for their children, but that is not an option for her :

Yeah, because all the moms had the opportunity many times, and they said themselves that they had free time. I can't go out. I can't even go pee by myself (laughs) because the baby. The older ones too...I'm like, "Oh dear Lord, give me two seconds...I'll be out."

Lisa shared a similar experience of not having enough time for herself and also feeling exhausted. She stated, "Sometimes I just feel so tired that I kind of just want to have some 'me time' to take care of myself before I can take care of her." She also indicated that one of the hardest parts of being a parent is the "lack of sleep."

Several parents mentioned challenges related to caring for their child, particularly with regard to toileting issues. For example, Kevin described how it can be challenging to remain patient when he is tired and his daughter urinates in the bed:

Maintaining a level of patience that, you know, is unexpected. I mean, just the amount of patience you have to have. Right now we're dealing with her taking her clothes off at night when she goes to bed. Anytime we put her down, she'll take all her clothes off. All the way down to just everything. And then she'll just wet the bed, wet everything in the room...So you have to go in there and change her and now everything is wet and you're tired, you know, and you're not mad. You can't be mad. You can be frustrated. And you



know, that to me is, that's what it is to be a parent. You're always just a little bit more patient than you thought you could be, I guess.

Roger and Joe indicated that their son's toileting concerns were an unexpected challenge that they learned about after adopting him and Joe reported that the care their child requires due to toileting accidents impacts their quality of life:

It was a surprise, I mean we were informed that he had nighttime enuresis where he just urinated on occasion in the bedroom but we didn't know it was every single night and now it's kind of evolved into more of where he's soiling himself every day, so, and it can be multiple times a day so at 14 years old he's still wearing pull-ups and we have several pull-up changes throughout the day, so it's very challenging and it kind of, it kind of prevents us from being able to take like trips or do vacations or you know, do too much too far from the house...

Roger shared the same concern regarding their son's toileting accidents and explained that "this toileting issue has just absolutely taken over our lives at this point":

But yeah this has become our life now, just dealing with multiple pull-up changes a day and, you know, it's controlling pretty much what we can do as a family because we have to think, okay, are we going to be in a place where we can go and handle a pull-up change or an accident or something like that if that surfaces? It's taking control of our life and that's been a real rough thing for us.

Several parents also discussed their child's medical needs as an added stressor. Noelle noted that in addition to all three of her sons having a developmental disability, one of them also has a severe allergy that require special attention:

But my situation is different because he has, he's autistic but also has severe food allergy so even when his dad takes him it's like a struggle because he's going to have a bad reaction or something and his dad doesn't like taking him much because he's like, "What does he need? What do I have to give him? He's flaring up." So I'm like, more like a helicopter mom with this one.

Joe reported that he and his partner often get sick now because their son will get sick and then they will get whatever illness he has. He indicated that it is difficult to keep up with his son's hygiene. Joe's partner, Roger, discussed how time consuming it can be to keep up with the various medical appointments and therapies that their son needs:

It's like a full-time job just dealing with all of the specialist providers, all of his therapists and everything, yeah...it requires one of you to be like his personal secretary and then you know, making appointments, contacting providers, filling out- I can't tell you how many paperwork packets I have filled out throughout all this time.

**Theme 4b. Difficulty Knowing How to Respond to Challenging Behavior.** Several parents described dealing with their child(ren)'s challenging behaviors as being one of the most difficult aspects of parenting. For example, Selena described feeling "frustrated" by her child's behavior and unsure of how to manage it since everything she had tried did not seem to work. Roger described a similar frustration and explained that there are many situations in which he feels as if any response to his son's behavior will lead to a negative result:

So you end up in these no-win situations because if you let him sleep it's a reward to him. If you get him up, it's still kind of a reward to him because he's getting all of this attention. It doesn't matter that it's all negative attention. He is very very attention driven so...he's full of these kind of conundrums where either way, you lose, whether that be

just completing aspects of his daily routine or schooling or anything like that. You get into these things where, either way you lose.

Lisa expressed worry about not being able to manage her daughter's behavior and keep up with her daughter's energy level as she gets older:

She is a ball of energy and I feel like, I'm afraid I'm not going to be able to catch up because she's growing so fast and I'm growing so old so fast. Yeah it's difficult but we are still hanging in there...I think comprehensionally she's about 2 (years old), but she looks like she's 5, like she's as tall as 5, so yeah. She's also as strong as 5 so it's hard to get her to do things without giving so much effort.

**Theme 4c. Challenges in School/Community.** Parents reported experiencing challenges in schools and other places in the community. Some parents reported having a hard time accessing services or finding effective supports for their children, while other parents described the added stress or scrutiny that they experience when taking their child into the community. For example, Kevin talked about having to just maintain composure in public and learning not to worry about what other people think:

You know, just holdin' it together...there's a point when you're like, "I just don't care. I don't care that my hands are covered in urine and there's poop on my shirt or that she vomited on me and we're in public."

Selena described the judgment that she experiences from others while out in the community and she shared that it is especially difficult when other people make the assumption that her son's misbehavior is her and her husband's fault:

It's when he can't control. He don't have any patience. In school sometimes the people don't understand. They think, the people think that he's like that because we don't, you

know, we don't educate him, and it's not. And when you're going out and he starts screaming, he starts yelling for something, the people look at us like, you know... 'do something.' And I'm like, 'We can't do nothing.'

During group, Selena shared that other parents also give her advice when she is in stores and other places in public. She said that she wished other people would "mind their own business because they don't understand."

Roger shared that his son's behaviors were so challenging that it became a struggle to find a school that could support him:

He has been effectively kicked out of public school just because his behaviors were that strong. They were unable to go and support him and yeah, effectively, he really engages in problem behaviors both at school and just trying to avoid school so in some ways it's been a bit of a victory for us just getting him into a school environment and having him in a classroom there, because we had tried homeschooling him at the, in the early days of our adoption, and that ended up not so great.

Roger and his partner both discussed the challenges that they encountered when trying to get assistance from their son's school. They indicated that one of the major problems they dealt with day-to-day was their son's toileting issues, but they felt that the school was not very helpful with addressing this issue:

We still have problems with the toileting in school and I think the problem is that he does not, he has such poor wiping behavior that he does not properly clean himself or anything like that and there's nobody there that seems to be able to support him in that kind of way, and so inevitably what that means is that you know, he's soiling pull-ups at school and then when we get him he's still very much soiled and unclean and we have to go and

spend a lot of time, you know, first thing when we get home, you know getting him cleaned up and showered and all of that, so yeah, it's, and we've been having I would say lackluster participation in that particular program at school.

Debby discussed a similar challenge with her son's school, noting that the school is not always able to provide the supports that her son requires:

I think we came up with a good IEP and what I found was that the inconsistency is a real trigger for him. So anything out of the ordinary routine is where we have problems so I was able to share some of those things with the teachers. We talked about what needs to be done, moving him from really high stimulus, stimulating environments....but the issue is, he needs consistency. This program teaches consistency and sometimes they're not able to deliver that level of consistency.

Joe shared that he often receives phone calls or emails from his son's school informing him that his son is self-harming or having a meltdown:

It's hard because we're trying to get him into a new perspective and get him engaged in learning and we have such a wonderful school that he goes to, and I just see the struggles that they have with him and the fact that he's always in the de-escalation room. The ABAs are constantly calling and emailing us saying your son's in this position now, he's you know, doing self-harm. He's hurting himself. He's cussing at the teachers and all this other stuff.

Joe and his partner, Roger, both expressed disappointment in the way they were treated by some service providers, including the ABA therapists that work with their son at school. Roger shared:

...I do have some issues with how the ABAs kind of treat us sometimes because they're a younger group of kids right out of school and they haven't really been in our home too much so they're constantly correcting us on how we should parent.

Debby shared that she has tried many different types of interventions for her son and while some of them led to short-term improvements in her son's behavior, none have led to the long-term changes that she was hoping for. When asked what other interventions she has tried, Debby said:

A lot of more therapeutic interventions, behavioral counseling. We've done neuro therapy, so biofeedback. We've done, we do medication therapy, some talk therapy but nothing that really long-term affected how he behaved and how people can interact with him. So we'd do these therapies, it'd work for a while but when he'd go into the classroom with the teacher, it wouldn't stick. Or at home, if he'd had a bad week or a bad day at school, I couldn't get him to kind of turn it around, re-focus him.

Several parents indicated that they had difficulty finding appropriate supports in the community. Debby, for example, reported that she had difficulty finding service providers for her son due to the limited options available in the area of town where she lives:

I live in the eastern part of the county. There's not a lot of supports or therapies in anything in that area.

Roger shared that he and Joe had to wait a long time to get their son access to the services that he currently receives, including ABA therapy:

And it took a long time to get that just simply because he had to qualify through Medicaid and there's a shortage of providers and we had to wait in line for services for quite some time.

Like Roger, Noelle shared that she had been waiting a long time to receive ABA services.

During one of the group sessions, she said that her son has been on a waitlist for ABA for over a year.

#### **Theme 4d. Lack of Support from Partner or Not on the Same Page as Partner.**

Another parenting challenge that several parents brought up was a lack of support that they receive from their partner/co-parent and/or lack of consistency between them and their partner when it comes to parenting. Maria and Noelle both shared that they receive little to no support from their children's fathers when it comes to parenting. Maria explained that although she is married and lives with her husband, she is the primary caretaker for her daughter:

I have my husband and everything but he doesn't get that much involved so I'm with her twenty-four/seven...

Noelle, a single mom of three, explained that her children's fathers are not involved in their day-to-day lives, so she is "full-time mom and dad." Referring to her older two children, she said:

They have their dads in their lives but the older two, their dad is in the army, active military, so he travels. Right now he's leaving to Afghanistan again. So he sees the boys once a year, and his dad (points to youngest son) is more loose cannon...

Kevin shared a different challenge related to his partner/co-parent, noting that they are not always on the same page or in agreement about parenting. He shared that this is one of the areas that they hoped to improve in as a result of participating in GSSTP. When discussing his experience of attending the class with his wife, Kevin shared:

I mean it was kind of funny because there were times in class where, you know, I would say something to the group and then like we'd leave and my wife would be like, "You don't really think that, do you?" And I'm like, "I wouldn't of said it to everybody if I

didn't think that," and she's like, "See, I knew you felt like that." So, and there were times also when we were in class where I'm like, "I'm gonna say this" and I look at my wife and I'm like, "I'm not gonna say this."

Kevin went on to say that he felt he and his wife needed to make sure they are both on the same page before trying to address an issue with their daughter:

Cause I feel like that kind of needs to happen before you start delving into, you know, what are the issues that you're facing with your child? And some of that's...that gets back to the whole, I see some issues in our family versus my wife seeing things and I feel like sometimes that's cause we're not always on the same page...about stuff.

**Theme 4e: Other Parenting Challenges.** In addition to the challenges mentioned above, there were several other challenges that parents reportedly faced, although only one or two parents mentioned each one. For instance, Roger and Joe both discussed how safety is a concern for their son, who has been Baker Acted four times due to being a harm to himself or others. Although this concern was unique to Roger and Joe, it seemed to be a significant challenge in their lives. Roger shared that they have had to call the police to their home several times due to the severity of their son's behavior and they do not have the tools to keep him safe:

We still have these periods in which, you know, he gets angry and really violent. You know, we still, you know, don't really have the tools in order to really keep him safe. He's big, you know, so when he starts participating in self-injurious behavior, there's really not a whole lot that the two of us can do. It's been recommended that we will, that it would be good that we at least be PCM (Professional Crisis Management) compliant but he's getting to where it takes more than two people to go and safely restrain him.



Joe indicated that they had initially tried homeschooling their son after they adopted him but he nearly hit his teacher in the back of the head with a key and it was no longer safe to have him at home. Joe shared the lengths they have had to go to in order to keep themselves and their son safe at home:

You know, we have a lot of precautions at the house that we do to try to prevent him from doing any harm to himself. We've got all the knives and scissors and everything locked up. We have alarms on the house, on all the windows. We have, you know, emergency contacts if we need them. So, it's just like, always out of the corner of my eye, just having that anxiety of making sure he's not going to hurt himself or try to hurt us. You know, it's real hard.

Joe reported that the stress and anxiety of worrying about their safety and their son's safety has become "unbearable at times":

You know, it's gotten to the point where it's unbearable at times at home...and you know, we see the harm he's done to himself. He's literally bitten himself, punched himself to the point that he's broken the brackets on his braces and you know, he's scraping his fingernails on his face and making marks all the time, and trying to gouge his eyes, and I'm just like, what can we do to get this child to understand that he's loved and he doesn't have to harm himself? And you know, he's threatened us a lot. He's threatened to kill us. It's a constant fear and anxiety that we live with in our house. You know, we keep our door locked and keep everything sharp away from him. You know, his obsession with guns and violence and stuff like that is just, it's very disturbing.

Another parenting challenge, which was only discussed by Roger and Joe, was the cost of care for a child who has special needs. Roger shared that it was very expensive to pay for their son's

private school (which was the only environment they could find to support him) in addition to the other services that he needs:

He requires a tremendous amount of money in terms of his care, you know, what we get as a subsidy does not cover him, so unfortunately it just, in terms of everything that he needs...

Several other parenting challenges were mentioned by only one parent each, including worry about his child's future (Joe) and lacking resources (Noelle). Joe indicated that he worries about how his son will make it in the world and be able to hold a job since he currently does not seem to have any interest in his education. Noelle discussed the challenges associated with having limited resources, such as not having a car to take her children places. Another challenge, reported only by Roger, was the time constraints that they experience as a result of going to their son's various medical and therapeutic appointments:

He's, his routine is just, in terms of a typical week, we are so filled with therapist visits, doctor visits, specialist visits that the time to go and implement something new is just very very difficult.

**Question 2: What aspects of the GSSTP program do parents perceive to be most beneficial/least beneficial, and why?**

Several themes emerged with regard to the aspects of GSSTP that parents reported to be most beneficial. These themes included "Learned New Skills," "Received Support," and "Improved Co-Parent Relationships". The theme "Learned New Skills" included the subthemes of "Learned New Parenting Strategies (general)" and "Learned New Parenting Strategies (specific)." The theme "Received Support" included the subthemes "Received Support From Other Parents" and "Received Support From GSSTP Facilitators."

The aspects of the program that parents reported to be least beneficial were described by the theme “Suggestions For Changes In Group.” This theme contained three subthemes, including “Length of Group Was a Barrier”, “Changes To The Format/Content of Sessions,” and “Suggested Grouping Classes Based On Specific Characteristics.”

**Theme 5: Learned New Skills.** All eight parents reported that that learning new skills and strategies was one of the most beneficial aspects of participating in GSSTP. All parents reported that the skills, concepts, or techniques that they learned were helpful and five parents listed specific skills that they found to be most beneficial.

**Theme 5a: Learned New Skills (general).** Some parents expressed that they learned new parenting strategies or techniques but did not explicitly state which ones were most beneficial. For example, Selena stated, “I love the techniques that they showed us and also the books,” without elaborating on the specific techniques that were most helpful. Similarly, Debby reported, “The experience was very good. I learned some new techniques and strategies for working with my son.” Roger described how the class taught him new parenting skills and made him more aware of his own behaviors:

I believe it’s given me some information and tools that I didn’t have before. There are things that we did learn and some of the stuff that we did apply whenever we were doing our parenting and it has helped...I mean there were little things here and there that I think the class made us realize, ‘ooh, we do this...maybe we shouldn’t do that.’

Roger noted that while he and his partner did benefit from the class, he believes that it could be more helpful for parents of children who are not experiencing the extreme level of behaviors that their child exhibits:

I think it's worthwhile. I think it depends on what your situation really is on that obviously. Like I said, I think we've had a pretty extreme case but I could see this being very useful for someone who hasn't had the kind of background that we have and everything.

Roger's partner, Joe, also mentioned learning new skills as being one of the benefits of the class. He also echoed Roger in pointing out that their situation was unique compared to that of the other parents in the group due to the extreme challenges that they were facing with their son:

I think the largest one is trying to implement new ideas and new plans to incentivize a child to behave properly, you know, or to, you know, just do daily routine type tasks, because, and there were times when we were in the actual class where I felt like, and I hate to say this, but I feel like we dominated the class a lot because we just had so many issues going on compared to the other parents and they were, you know, constantly calling on us to, you know, "What's your perspective?" And then it turned into this big long, "this is what we're doing..."

Joe recalled feeling motivated to try new strategies after participating in GSSTP:

I felt like every time I came home, I was gung-ho on trying to implement something new or trying a change that they recommended or something, so...you know at least it helps, you know, give you some new incentive ideas, give you some ideas for getting them engaged in doing their daily routines. Yeah I would definitely recommend it.

Noelle reported that it was helpful to "hear new strategies, hear new concepts and ways how to deal different from how I deal". In discussing the aspects of the program that she viewed to be most valuable, Noelle said:

I think the concepts were most beneficial for me...yeah, I think some of them were good. Like different methods for the boys, like with anger issues for the little one. Could I try them all? No.

Noelle added that the class was especially beneficial for her since all three of her children have autism:

I think that what the class was supposed to be, intended to be for Mom's help with special needs kid, in my case, I need it like three times over (laughs), so it was helpful.

Maria shared that the class helped her to change some of her own parenting behaviors. She indicated that she would recommend this class for other parents and would tell them to be open to the new strategies that they will learn:

Oh, yes. It's so helpful. It is so helpful and be open to learn and get all the information you can get to help yourself and your kids. Because sometimes they say, "Oh, they have classes for kids with autism and those kind of stuff...they are going to teach you how to deal with your kid." But no, they're going to teach you how to deal with yourself (laughs).

Kevin expressed relief that he was able to take this class and learn new strategies that will hopefully prevent some of the behaviors that the parents of older children are experiencing.

Kevin's wife, Lisa, shared how learning new tactics in general was the most beneficial aspect of participating in GSSTP, however, she also listed some specific strategies that she found to be helpful:

The aspect I find most beneficial is the tactics that they teach in the class that how can, for different scenarios, like how to redirect the kids, like quiet time, what is appropriate for kids with disabilities or special needs, that what works for them compared to

neurotypical kids. And, like, that is the most major thing that I learned and beneficial to me.

**Theme 5b: Learned New Skills (specific).** Several parents shared specific skills that they learned and viewed to be the most beneficial aspect of participating in GSSTP. For example, as mentioned previously, Lisa noted that “quiet time” and learning “how to redirect kids” were some the strategies that she found to be most helpful. Some parents, including Lisa, identified strategies that are part of the Triple P curriculum, whereas others mentioned specific strategies that they learned in the class but that are not necessarily described in the Triple P curriculum. In terms of strategies that are taught as part of the Triple P curriculum, parents mentioned the following as being most beneficial: identifying behaviors and consequences, providing feedback for consequences, pre-planning for high-risk situations, implementing the Start Routine, giving clear, calm instructions, gaining your child’s attention, and talking to your child. Debby described some of the Triple P strategies that had been most helpful with her son:

I’ve been able to work with the behavioral intervention- two attempts, and then choosing an appropriate consequence and something that really I knew but needed to be reinforced for me was the physical proximity. That I can’t be in the kitchen and he’s in the family room, I can’t say, “Hey do this.” I have to go to him, look him straight in the eye or maybe even touch his shoulder and say, “It’s time to do X,” and be more specific about what “X” is.

Debby described how using the Start Routine has helped with gaining compliance from her son:

I’m getting much greater compliance. Usually first or second asks or prompts and usually it would be multiple prompts and then I wasn’t giving a true consequence, but now that

I'm giving him two attempts, two prompts and then an immediate consequence, I've seen a lot of movement.

Debby also shared that learning to give an immediate consequence for behaviors, providing feedback to her son, and planning ahead for challenging situations has been very helpful:

I don't know specifically which session it was but there were a couple sessions that focused on the consequences of identifying behaviors and consequences and immediate feedback for those consequences, and then that session on pre-planning for high risk or situations that are often difficult. Those were really impactful for me.

Maria discussed how she learned to get her daughter's attention and give brief instructions:

But with so many things I learn how to get her attention and talk to her. That help me a lot. They help me. They teach me some strategies for the way to talk to her or just getting that attention. Sometimes I talk a lot. And no, you don't have to talk that much. So, be just straight, simple, and done...it's just more simple and right in the point.

Roger and Joe both mentioned strategies that they found to be beneficial but that were not part of the Triple P curriculum. For example, Joe shared that the strategy of creating a visual schedule for daily routines and involving his son in using it was very beneficial:

And getting him to take more responsibilities and visual cues from like creating like visual aids and charts around the home to get him to do things that he should be doing on a daily basis. So we created these step by step charts of, you know, daily routines.... We have him pull them off one by one as he completes each task, so instead of us just blindly saying, "Okay it's time to brush your teeth, it's time to, you know, brush your hair, put on deodorant," he actually has the ability to use these visual aids to pull one off and get excited about the fact that he actually accomplishes each thing....I would say

about 90% of the time those visual aids and cues have actually helped us get him on the right path each morning to getting to school on time.....Yeah, definite improvement.

Joe's partner, Roger, shared a strategy that one of the facilitators recommended to them, which has helped prevent them from having to discuss their son's history and challenges in front of him every time they go to a new doctor or therapist:

You know, every time we come to one of these therapist visits we have to go rehash his past and it's terrible doing this in front of him, you know, but you're in a doctor's office. You've got a limited amount of time. You're trying to give them enough information for them to realize that there really is a problem here...one of the things I ended up starting to do, beyond that point, you know, realizing it and talking about it in class, is now I'm starting to write out the dissertation of what kind of problems he has and what we are seeking and then handing that to the nurse as we come in....so "please have the doctor read this before he or she comes and sees us".....So we've done that in the last several visits here and it's kinda helped us cut to the chase without rehashing a bunch of stuff.

**Theme 6: Received Support.** All but one participant mentioned that one of the most beneficial aspects of participating in GSSTP was the support that they received from other parents in the class and/or from the facilitators.

**6a. Received Support From Other Parents.** Five of the eight participants reported that they appreciated the support that parents in the group gave one another and/or that they learned new ideas from other parents. For example, Lisa described participating in the group as "eye widening" and discussed how valuable it was to hear from other parents as well as the instructors. She also noted that she appreciated the support she received from the group:



I learned so much that, by just listening to other parents that is in the program and the instructor, like it give me a different perspective of how I can relate to my kids...and it also kind of serves as a support group, like I don't feel like I need to find or look for answers all by myself.

During her interview, Lisa expressed her gratitude for the other parents in the group, noting that parenting can be hard for anyone, but especially for parents of children with disabilities:

I just feel, I already said that I want to go back and I just want the instructor and the other parents to know how amazing they are because we are facing, like, I think neurotypical kids, it's hard sometimes already, like everyone has their temper tantrums but special needs definitely more challenging and so I am thankful that I got an opportunity to participate in the class.

Lisa's husband, Kevin mentioned that listening to other parents was one of his favorite things about participating in the class:

...And the majority of the session was spent probably just talking, you know, everyone kind of has their own stories and everyone listens to what their stories are, and honestly that's kind of the best part.

Kevin reported that hearing what other parents were going through put things in perspective for him and he liked being able to offer encouragement to other parents:

(Hearing from)...other family and hearing the troubles they're having and you just kind of get the sense that, oh it could be much worse, or you can help offer perspective about things that they haven't thought of or even just offering encouraging, you know, sentiments.

Like Kevin, Selena said that hearing from other parents in the group helped her to see that she was not the only one experiencing parenting challenges and it put the difficulties that she was experiencing in perspective:

...we are not the only ones that were struggling with our kids. That I learned from other parents that they have more situations than us. And sometimes I feel like I'm the only one and I'm not. I'm not...Sometimes I feel like I have the worst situation and it's not. Some parents, they are going through worse situations than us and I know we are blessed for that (laughs). Thank God.

Joe described how helpful it was to hear suggestions from other parents and to hear how other parents have handled similar situations with their children:

And we got ideas from other parents too that had children with the same special needs and stuff, and what their ideas were and how they dealt with certain situations and you know, there were suggestions from other parents towards us, like, "Have you guys tried XYZ? This is what I do with my son or my daughter." And I'm like, "Oh, we never thought of that," so not only do we feel like we got stuff out of the class but we got stuff out of you know, just being there in the environment with other parents in the same situation.

Like Joe, Debby indicated that hearing what other parents have tried with their children was beneficial:

It was really good to have an opportunity to talk with other parents and learn about the resources and other things that they've done to work with their children, being that they were all different ages.

Parents were often observed sharing ideas and resources with one another during group sessions. For example, when one family was planning a trip, other parents shared ideas for flying on an airplane with a child who has autism. Parents also shared information with one another about accessing services, such as respite care.

**6b. Received Support From the Facilitators.** Three of the participants reported that their interactions with the GSSTP facilitators and the personalized support they received from the facilitators were some of the most beneficial aspects of participating in the group. Roger emphasized how helpful it was to get feedback from the facilitators regarding the specific issues that he and his partner were experiencing:

I think one thing I probably failed to mention that I really did like, was some of the personalized attention. I think some of that was really good to just being able to kind of talk through with another person some of the problems that we were having and trying to find solutions to those particular problems that were very specific to our child... Yeah, working with (facilitator) was really really good.

Roger's partner, Joe, also noted that he "appreciated the fact that, you know, they would take the extra time after class and stuff to kind of go over our particular situation." Another participant, Lisa, indicated that hearing the instructors talk with other parents about their unique situations was beneficial because "it might be helpful applied in [her] case." During group sessions, the GSSTP facilitators were often observed sharing ideas and feedback with parents. For example, when one family noted that the incentive plan they had been using did not seem to be working, one facilitator recommended changing the schedule of reinforcement so that their child would not have to wait a whole week to access the reward.

**Theme 7: Improved Co-Parent Relationships.** Five of the participants reported that participating in the intervention had a positive impact on their co-parenting relationship. Kevin and Lisa both shared that their communication with one another improved as a result of participating in GSSTP. Lisa said that the class helped her and her husband to get on the same page with their parenting and improved their interactions with each other:

It's definitely helping. It's definitely helping just by, like talking about each other's day and then there's a different style between us, like it kind of helped us to be on the same page, and then through the exercises and activities that we do in the class, it helped us to communicate better with each other too.

Kevin reported that the Partner Support portion of the GSSTP group helped him and Lisa to recognize and then talk through some of the things that they had been doing differently from one another. Kevin also described how he and Lisa discussed the strategies that they wanted to implement and then they were able to hold one another accountable and remind each other of their parenting plan:

Yeah, we spent a lot of time talking about the best approach for stuff and then it was also nice because when we go to put things into action...we're constantly reminding each other like, "We're not supposed to yell across the room. We need to get in front of her," you know, try and, "Let's do the reward system for this part here. Let's get this behavior kind of under control." So just reminding each other like how we're supposed to be doing things sometimes helps.

Joe talked about how he and Roger used to blame one another when their son would misbehave but now they listen to one another's ideas and work together to try new things, including strategies that they learned in GSSTP:

You know, it's like if we throw an idea at each other and say, "I thought about this, can we give it a try? We saw this in class. Let's try it." You know, we're on board with the other's ideas.

Selena recalled that she and her husband viewed her son's challenges differently than one another prior to taking the class and that her husband did not have the same concerns that she had. She explained that she had to convince her husband to take the class with her because she knew that if she tried to implement new strategies without his support, they would not make progress with their son. Selena indicated that since taking the class together, she and her husband now understand their son better and they also understand one another better:

...we can understand some of the feelings and actions of my son, my son's actions and feelings, and we're still working because, you know, like I told them in the class, "We need to do it together like parents because if I do it alone and I learn and I try to do the techniques and I try to do everything different, if you don't do it with me we're not, we're gonna be in the same place."

Selena shared that she and her husband are working together as parents now:

Everything between us, now we can understand together everything that we're going through. Now he can understand what I see and I can understand what he sees. It's, we have a good connection like parents and we're doing better like parents for my son...we're doing better decisions together for my son.

In terms of how her co-parenting relationship has changed, Selena said:

Everything. Everything is different. He sees what I see now and he's supporting me more.

**Theme 8: Suggestions for Changes in the Group.** When participants were asked what aspects of the GSSTP program that they disliked or changes that they would recommend, participants noted that they disliked or would recommend changes to the length of the group, the format of the group, or participant groupings for the GSSTP intervention.

**Theme 8a: Length of Group was a Barrier.** Half of the participants reported that the length (i.e. number of weeks) of the group was difficult to commit to. For example, Debby, who lived across town from where the group was held, said that it was hard to miss out on participating in activities with her son every Saturday for two months while participating in GSSTP:

I live kind of far away so it's always a challenge. The timing, you know I guess it was alright... It was kind of hard to miss every Saturday morning for, you know, two months but I was able to at least do a little, make breakfast in the morning, but it did mean that some of the activities we would have done, we didn't end up doing.

Kevin said that he felt that the material covered in class could be condensed:

I mean, I didn't think the material that they covered, you know, warranted that much of a spacing. I thought it could be condensed a little bit more from what it was.

Kevin also recommended meeting twice a week for a shorter number of weeks rather than once a week. Kevin's wife, Lisa, shared that it was difficult to make it to every session because of work and family commitments. Another participant, Maria, indicated that she missed one class due to not having childcare and then there were two weeks where they did not have class because of holidays, so missing that many weeks of class made it difficult to keep up:

Because we have the holiday it was kind of, two weeks, and then when we came back to the classes I can feel myself kind of lost.

**Theme 8b: Suggested Changes to the Format or Content of Sessions.** When asked about aspects of the intervention that parents did not like or that they would suggest changing, half of the parents mentioned wanting to change the format or content of sessions. Debby, who teaches workshops as part of her career, offered advice on how to improve the format of the classes:

I would tighten (the beginning of class) up with more defined activity, not just a circle time sharing time but giving people a chance to pair and share first and then share with the entire group. The entire program could be compressed for each session. There's some lag time in there and I would like to see a little bit more parent involvement.

There's a lot of watching, listening and then the activities are good, they're individual but some greater interaction between parents or families might be helpful.

Like Debby, Roger also recommended having more hands-on activities during class:

I would probably like to make it a little bit more hands-on and maybe part of that is just how well we learn. You know there was a lot of stuff that was just kind of going through the book and watching videos and stuff like that.

Similarly, Selena said that she thought that it would have been helpful if the facilitators were more interactive with participants rather than teaching from the front of the room most of the time:

...and the only thing is I think they need to be more, like active, more- because there is always, okay they say different things, different techniques, but they're always in the front. They need to be, for me, more interactive with us.

Kevin provided recommendations for changing the format of the group, including separating the classes into a didactic portion and another portion where parents can discuss their attempts to implement the strategies:

It almost needs to be separated into like two different things, like one is like, here's class- we're going to teach you what you need to know and then the other side of it is, okay let's kinda do like this group therapy discussion thing and talk about what's going on in your attempts to do XYZ and how do you overcome these challenges. Yeah, cause they lay out like a very formulaic approach in terms of how you were supposed to like handle your child and you watch the examples and you go, "My child's not going to do that."

Kevin also thought it would be helpful to change the format of the group in order to offer the partner support portion of the intervention at the beginning, rather than at the end:

You know, you can't really do the parenting unless you've got parents who are in it so I would like to kind of see more of that on top of it...the parenting portion of it starts off with like teaching you how to be a parent, you know, how to handle things and to do things, but I kind of feel like there should've been like a precursor to that that was about working as a partner, you know, how to get that alignment set up before you kind of get into, what are your goals and everything for your child?

Another change to the format of the group, which was recommended by Debby, was the inclusion of observation and feedback. Debby said that she wished the facilitators could have observed participants with their children and provided feedback on implementation of the strategies that they learned in class.

**Theme 8c: Suggested Grouping Classes Based on Specific Characteristics.** Half of the parents offered suggestions for dividing the groups based on participant characteristics, such



as the age group of their children, single parents vs. couples, or dividing classes based on cultural factors. For example, Kevin recommended separating each member of a couple into separate classes for part of the group. He explained that there were times in class when he did not want to speak up because he knew that his wife would disagree with what he was saying. Although he acknowledged that taking the class together helped him and his wife learn more about one another's views, he said that he wished there was a portion of the group where they were in separate classes:

So on one hand it's nice because we're able to talk about what we learned in class, but at the same time it's kind of like I wish they'd split us up a little bit so that way, you know, I would feel a little more comfortable saying my side of how I see things in our family vs. how she sees things in our family.

Maria, who is also married, indicated that she did not really enjoy the "partner support" portion of the intervention. Maria shared that although she is married, she is the main caretaker for her daughter and she does not receive much support from her husband. She indicated that since some of the parents in the group were either single or were not coparenting, it was not necessary to spend so much time discussing partner support:

Yes, you can talk about it but don't give it, it was too much time. Some other topic, they need more time instead

Noelle said that she felt judged because she was the only single mom in her group and she recommended having separate classes for single parents:

I don't think they do it [judge] with that purpose but it's like, it happened that way...I think it's just what they think like a household is supposed to be, but I think they need to be a little more open, like the class single moms or single dad's would be good.

Noelle also indicated that she thought she might connect better in a class that was geared specifically towards Hispanic moms.

In addition to the length, format/content, and participant characteristics of the group, there were several other aspects of the GSSTP intervention that parents reportedly disliked or did not find to be helpful, however, these things did not emerge as themes since only one or two participants mentioned them. For example, two participants (Maria and Noelle) indicated that it would be helpful to have separate classes geared towards young children vs. older children and they also reported that they felt judged by or felt different than the other parents in the group. Maria indicated that she felt judged by a particular parent in the group and she felt that it was due to cultural differences in their parenting styles and also the different ways that they express themselves. Noelle, on the other hand, indicated that she felt like she was singled out because she does not have a partner or co-parent. One parent, Roger, noted that some of the information in the group re-iterated many things that he already learned in other parenting classes and he noted that he and Joe had a somewhat unique situation due to the severity of their son's behavior.

**Question 3: What specifically do parents learn as a result of participating in the GSSTP program and how has this new knowledge impacted them and their children/family?**

**Theme 9: Learned How to Talk to Their Children.** Seven of the eight participants mentioned that they learned how to better communicate/talk with their children. For example, Selena described how she learned to use directed discussion with her son when he breaks a rule and Kevin described learning to use positively stated instructions, rather than telling his daughter what not to do:

Well one of the things for me was trying to phrase things in a more positive nature. You know, not always saying “no” and “stop” but just kind of using a more redirective approach with how I want her to behave I guess.

Kevin said he also learned to get close to his daughter when giving instructions and to give single-step instructions rather than listing multiple instructions at once:

Keeping her hands to herself, stuff like that, and then the other thing was, is how we give her instructions, making sure that we’re not just spouting instructions from the far side of the room but really kind of getting right in her face and kind of saying exactly what we want tends to get a little bit more of a response. And we’re, you know we’re getting a little bit more compliance out of her on one-step instructions now. That’s been very helpful.

Debby described the strategy of giving clear, calm instructions when telling her son to do something and she said that she realized the importance of keeping the instructions brief:

And then a couple strategies that I thought were really important for me was really thinking about when I would ask him to do something...thinking about the situation. Am I giving him too many instructions? So, thinking about one clear instruction, complete the task, second clear instruction, complete that task. So instead of giving multiple-slowness that down. So I’ve really thought about that considerably.

Maria also described the strategy of giving clear, calm instructions and, like Debby, she mentioned realizing that she needed to keep her instructions brief. She described learning “how to talk less and be more straight to the point” when giving her daughter instructions.

Noelle described learning to talk to her children more and be more affectionate with them, which has been new for her. She indicated that she used to feel the need to be tough and

less affectionate towards her sons in order to make sure they knew that she was the authority figure. During group, Noelle shared that she had been making a point to “fist bump” one of her sons who typically does not like affection and then she noticed he was “actually seeking out kisses which he didn’t do before.”

**Theme 10: Learned How To Plan Ahead.** Half of the participants reported that they learned how to plan ahead for high risk situations. Roger said that he and his partner had not had a chance to implement the Planned Activities Routine yet, but he was looking forward to trying it:

I feel like there are suggestions that we’ve gotten in class that we just have not had the time and opportunity in order to go and implement that I’m kind of a little bit excited about trying to actually do. There was one particular lesson I recall where basically you go and kind of rehearse this whole thing in terms of a particular activity...the planned activities. We still have not gotten to the point of doing that...I think that one is going to also be a useful thing we just haven’t been able to.

Kevin explained that the planned activities routine helped them to think through situations in advance in order to prevent problem behaviors:

One of the ones that wasn’t super, you know, I guess, it wasn’t like rocket science, you know...just kind of planning, you know, planning to mitigate issues before they start...for us it was really taking the time to sit down and think through some of the bigger, bigger items that we’re doing, like we’re taking a trip overseas or visiting a relative and staying overnight...Really laying out, okay what will [we] be doing on the car ride? Let’s start at the very beginning...we’re gonna get in the car, we’re gonna be in there for several hours. Okay, what will happen when we get there? What about food? Is

there gonna be food along the way?... you're thinking about all of the possibilities that you could end up running into and that was interesting, you know. It's more like goal planning I guess. The behavior you want is this...how do you get to that?

Debby also described the planned activities routine as one of the things she learned and she noted how this provided a more systematic way of planning for how to prevent and manage challenging behavior. Selena shared that she and her husband had also been trying to implement the planned activities routine. She explained that she learned to "be proactive, do something before going to the someplace or like a restaurant."

**Theme 11: Learned How to Implement Rewards.** Three participants mentioned that they learned to implement rewards and incentives. Joe described how the facilitators assisted him and his partner with developing a plan to reward their son for using the toilet:

And that was another thing that was brought to our attention from the class is, they literally pulled us aside when they heard about our issues and like, "Have you guys tried implementing an incentive plan to get him to try to go to the bathroom?" We're not saying that he should go to the bathroom but it's basically, he gets a coin...and for every coin he gets, he gets so many minutes of pool time, and that's his big incentive. So once he accumulates an hour worth of coins, he can have an hour of pool time...

Debby shared that she learned how to use a wider variety of rewards when incentivizing her son:

Definitely one activity that I thought was helpful and thinking about it now was to identify the rewards and as I was going through that long list, I was like, you know, I have not been using the full arsenal of all the rewards that I could use and so I've been trying to include those. Not just the ones that are easy but the ones that might take a little effort for me to deliver.

Maria indicated that some of the specific things she learned were how to manage misbehavior and implement rewards, but she noted that overall, she learned how to handle her own behavior:

Yeah the misbehaving and the reward class. It was the more important for me in the moment, but overall I just learned how to handle myself because the strategies, I know a lot of them because my daughter, she's been in therapy at home, but the class helped me more how to handle myself instead of how the strategies to do with her.

In addition to the specific strategies that three or more participants mentioned learning (i.e. how to talk to kids, how to plan ahead, and how to implement rewards) there were a variety of other prevention and intervention strategies that participants reportedly learned from participating in GSSTP. Those strategies are described by the themes “Learned Other Strategies For Strengthening Parent-Child Relationships” and “Learned Other Ways To Manage Challenging Behavior.”

**Theme 12: Learned Other Strategies to Strengthen Parent-Child relationships and Prevent Challenging Behavior.** Four parents mentioned that they learned some type of strategy that strengthened their parent-child relationship or prevented challenging behavior. For example, Noelle shared that she learned to talk to her boys more and to give them more attention:

...just talk to them, the little times that they have, just give it more attention individually to each of them and that will make a difference and it has made a difference.

Roger described how he and his partner learned to implement a visual schedule, which prevented them from having to constantly tell their son what he needed to be doing:

I think, and I've probably forgot the term for it, but the picture routine. There was a particular suggestion they had of going and putting his routine on little bitty cards that had like a simple picture and what it was, and laminating that and having it to where he

could go and pull those down in the routine. And that one thing alone finally got it to where he is now at least some of the time, you know, participating in his routine, and sometimes without prompting.

Joe described how he learned to find interesting activities for his son to do, which helped motivate his son to do things that had previously been a struggle. Debby reported that she learned to reduce stimulation when trying to get her son to complete a task:

Overall reducing stimulation, so I've really been thinking about the environment he's in, so kind of a quiet home environment but making sure that if I'm asking him to do something, if we are trying to work on a skill, that it's really focused on that. I'm not trying to ask him to do something when he's distracted by electronics or playing or anything...so really focusing on keeping everything very quiet and really focused.

Maria and Lisa both described how they learned to be calmer in their approach to parenting.

Maria explained that in her culture and in the way she was raised, she learned to raise her voice and become more emotional as a parent. She indicated that she realized while taking the class that she often gets frustrated as a parent and she had to calm herself down first before setting expectations with her children:

With the class I said I had to go and I need to calm down myself first and then I approach to my kids...I need to understand sometimes if I'm angry or frustrated or stressful, whatever... I had to realize that I had to just calm down and...some strategies just for me. It's just not to working with my kid, for me.

Like Maria, Lisa indicated that she learned how to stay calm and she noted that "the class helped [her] to not to get upset too much (laughs)."

**Theme 13 : Learned Other Ways to Manage Challenging Behavior.** Four parents reported that they learned new strategies for how to handle their child’s challenging behavior. For example, Joe shared that he learned how to redirect his son to a different activity before he begins to have a meltdown, and also to avoid arguments or attempts to explain things while his son is upset. Similarly, Kevin said he learned to use physical guidance and blocking in order to redirect his daughter rather than lecturing her about misbehavior:

You know, using guiding hands, you know, blocking her when she’s trying to do something that she shouldn’t be doing and just kind of resetting her and not really getting into a whole big discussion about why you shouldn’t be doing this or that. I think that’s been the biggest improvement.

Kevin’s wife, Lisa, stated that “quiet time” was one of the strategies that she learned to implement in the class. Joe reported that he learned how to implement “time out” in order to allow his son an opportunity to calm down when he gets upset.

Debby shared that she learned more about her son’s disability and also how to handle his behavior in crisis and social situations:

I think that I am more educated on his disability and then also I feel more confident in some approaches to handling some of those crisis situations and then just more positive about his, about his outcome in, or his interactions in social situations, that I can handle those...because sometimes I would not participate in things because I was always afraid about how he was going to react and now I have better control and more confidence in how I would be able to guide those situations and avoid some of situations that were challenging for us and others.



**Theme 14: Implementing New Strategies Has Helped.** Seven of the eight participants specifically mentioned that they have noticed positive changes in their child or relationships since implementing the new skills that they learned in GSSTP. For example, Noelle reported that she and her children are “bonding” more since she began to show more affection and give more attention to each of her boys. Maria indicated that she has noticed that her daughter is able to relax and express herself better now since she began talking to her in more simple and direct sentences. Maria indicated that the strategies she learned have helped her “a lot” as a Mom and she said she would recommend this course to other parents. Debby said that she would encourage other participants of the Stepping Stones class to try the practice activities because she has seen positive changes as a result of trying new strategies, including ones that she did not think would work for her:

There were certain things that I thought maybe wouldn't work in my situation but I gave them a try and saw some positive results.

Roger said that he still feels tired and worn out as a parent but that he has learned some more effective techniques, which have helped. Kevin described being more aware of his own actions and how those actions align with the goals that his family is trying to accomplish:

I'm more aware now I think. I think about it more often in terms of goal setting I guess, in terms of what we're trying to achieve as a family. Just trying to keep some of the tools and some of the processes in my mind, like I find myself doing it without really thinking about doing it.

Kevin indicated that he has seen the “biggest improvement” from using guiding hands, redirection, and blocking rather than lecturing his daughter. Like Kevin, Selena described being more aware of her own parenting practices. She explained that she has a better understanding of

how to handle her children's behavior and when she realizes something is not working, she is able to make a change.

**Question 4: How do parents perceive their relationship with their child and how has this changed as a result of participating in the GSSTP program?**

Prior to starting the GSSTP intervention, participants completed the Family Experience Questionnaire and answered questions about their relationship with their child. At that time, five of the eight participants described having a good/great relationship with their child and the other three described having a good but somewhat strained relationship.

**Theme 15: Positive Parent-Child Relationship.** Parents reported having good relationships with their children and they described things that they enjoy about their relationship such as spending time with their children and sharing experiences with them. Parents also described traits that they like about their children, such as their children being funny. This theme is divided into two subthemes, "Good Relationship/Love Them" and "Enjoy Sharing Experiences With Their Child."

**15a: Good Relationship with Child/Love Them.** Participants described loving their children and having close relationships with them. For example, prior to the GSSTP intervention, Maria described her relationship with her daughter as "close" and she reiterated this same sentiment following the intervention:

Ah, it's good. I think it's great. We are so close. That's why I just want to encourage her to talk to me more and get out from that bubble.

Similarly, Noelle described her relationship with her children as being “extremely close,” noting, “we only have each other.” Selena indicated that she loves both of her children but she described having a special relationship with her son:

He’s my prince. he’s my blessing. I love my kids. I love my daughter and my son but my son is, is my miracle baby. He born 1 pound and 4 ounces. Yes, so I am going to do whatever I need to do for him and he’s a lovely boy.

Roger described his love for his son, his empathy for what his son has been through, and his desire for his son to succeed:

I would say that I do love him and I really want the best things for him and everything. He’s had a really rough life and, you know, I really want to see the best for him and I really want him to want to succeed in life and have everything.

Prior to taking the GSSTP class, Lisa described her relationship with her daughter as “good.” Following the intervention, she described loving her daughter “with all [her] heart” and she indicated that one of the things she enjoys most about parenting is the affection and love that she receives from her daughter:

I definitely like this kisses and hugging and then she recently started say, “I love you Mommy.”...Yeah, I think that’s partially, that’s why I wanted to have kids. I want the intimacy because in my culture we don’t hug or kiss each other.

**15b: Enjoy Sharing Experiences with Their Child, Teaching Them, and Learning from Them.** Parents reported that they enjoy spending time with their children, sharing experiences with them, teaching their children things, and watching them learn. For example, prior to attending GSSTP, Selena described her relationship with her son as “wonderful” and

noted, “We love to play together, be together, eat together.” Following the intervention, Selena shared a similar love of spending time with her children and sharing experiences with them:

I love my kids and I enjoy every moment to spend with them. I enjoy everything. We like to play, go out to eat, go to church, everything.

Prior to the GSSTP intervention, Debby noted that the things she enjoys most about parenting her son are “sharing new experiences, learning about his interests. Just having fun playing games.” Following the intervention, she described how she enjoys learning along with her son and being able to teach him new things:

There’s so many things. He’s just a lot of fun to play games with. I like when we learn new things, when he learns new things, I can teach him new things or we learn new things together. So that’s always fun. He just really, he’s a really cool person. If I were not his mother and we met and we were the same age, I would say, oh that’s a great person. I want to be that person’s friend.

Like Debby, both Joe and Roger described how enjoyable it is when they are able to teach their son new things and watch him experience new things. Prior to the GSSTP intervention, Joe wrote that one of the things he enjoys most about parenting is “showing a child something for the first time, Disney, zoo, etc.” and he reiterated this after the intervention as well. Roger said:

I think I enjoy, I guess there’s probably a few things I kind of delight in. Number one, I like it when he’s open and wanting to learn, and being able to teach him stuff that he just hasn’t seen before, you know... it’s really cool to see when he’s really, really engaged like that and asking questions and, you know, I enjoy being able to go and share both my experiences of traveling around and also, you know, just information about different places and stuff like that.

Kevin described how he likes to sit back and watch as his daughter experiences the world around her and he said the joy that his daughter gets from everyday experiences puts things in perspective for him:

And you know when she finds such joy in really small, really simple things, that to me is kind of cool. Like going swimming. I remember when I was a kid and going swimming was like *the* thing. It was like so much fun and then as you get older it's like, "It's hot, there's nothing to do." What are you gonna do at the pool? Before, you never had to think about it. You just went and it was stuff to do...and all of a sudden at some point none of that was fun anymore. So like for her, it's still fun.

**15c: Children Are Funny.** Several parents reported that they enjoy their child's humor and how funny they are. For example, when describing what she likes most about parenting, Noelle wrote, "The funny moments we have together, there smart, there jokes, how caring they are and protective of each other." Roger also noted that his son is funny and this is one of the things he enjoys most about him:

...and overall, he's, he's a funny kid, you know, he likes to smile, he likes to, you know, he likes to try to make you smile and make you feel good so that's some of the things I really do like about him, so...

Prior to the intervention Kevin described his relationship with his daughter as "good/great" on the FEQ. During his interview following the intervention, Kevin described his daughter as being "hilarious" and indicated that this is one of the things that he enjoys most about parenting:

It's like the little things, you know? When she makes a, you know she makes a statement that's out of character for her, you know, that you know she's heard it from you and she's saying it but she's saying it in her way and you're just like, "That's just hilarious."

Prior to the intervention, Debby also described her relationship with her son as “good” and added, “We have challenges but are able to overcome them after a time.” During her interview, she described her relationship with her son more in depth and noted that he is funny:

I think we have a good relationship. He is very funny. He loves to tell me jokes and I love to hear them... he thinks he’s the funniest guy ever.

**15d: Want to Give Them Everything/Prepare Them for the Future.** Parents described having a desire to give their children everything and prepare them for the future. Kevin described his daughter as “a legacy” and indicated that he wants to make sure that he does not hinder her in any way:

To me, she’s more like a legacy I guess. I don’t know, I just want to give her everything and not, you know, hinder her in any way, so I feel like sometimes I just, I don’t know, I find myself just watching a lot of times because I’m just fascinated to just watch.

Selena became emotional when describing her aspirations for her son, noting that she wants to help prepare him for the future :

So, like mother (crying), like mothers I’m going to do whatever I need to do to help him so he can be better, you know, be a better person, someone in the future. He’s only seven years old, I know, but he need to learn how to control himself and I’m here to help him.

Debby shared during group that it has been a challenge “adapting to a child with a disability because I just see so much potential.” She explained, “I just think, ‘What is his life going to be like? Is he going to be able to take care of himself and have a family?’” During her interview, Debby described a desire to prepare her son for the future and to teach him independence:

What I’d like to be able to do is teach him greater independence. So that’s one area that I need to work on and not doing so much for him because it’s so easy, you know, I always

want to, ah here's little something special. And those things are fine but I also have to prepare him. So, I'm enjoying this time where I'm preparing him for the future and I'm anxious to see what he's going to become.

Like Debby, Maria indicated that she hopes to prepare her daughter for the future. She said that she also wants her daughter to be able to come to her and confide in her as she gets older.

**Theme 16: Strained Parent-Child Relationships.** Three parents, Roger, Joe, and Debby, all expressed frustration or discontent over their children's behavior and the strain that this places on their parent-child relationship. For example, although Debby described having a good relationship with her son, she also indicated that when her son is confrontational or uncooperative, it is especially difficult because she does not have support in dealing with his behaviors:

He's my only child so what I find most challenging is that when there are problems or challenges, it's just me to deal with all of those. So not only do I have the regular issues of being an adult and adulting in the world, I don't have a great deal of support with addressing his challenges and I find it very difficult when he is confrontational with me or he is obstinate or uncooperative. Like it's just us, so that's really, that's really hard because we have to work together for our family to run and when he doesn't, that's a real dissatisfier.

Joe and Roger described having good but also somewhat conflicted relationship with their son. For example, Joe described their relationship with their son as an "off and on love/hate sort of relationship" and Roger noted that his relationship with their son is "good, but still developing, with our child still learning how to be a participating member of our family." Roger described how he loves his son but that his son's behavior puts a strain on their relationship:

I think in general we really do love each other but his behaviors make it very very difficult to go and do that sometimes and I can very much see in my partner, it impacts his overall relationship with him period, too. It's difficult, you know. On one hand you love him, on the other hand you don't love what he does, you don't love his behaviors, you don't love some of the things that he values that goes against your values as a person...

Throughout the interview with Joe, he described his frustration with his son's behavior and indicated that he wished that their relationship was better. While describing their relationship, Joe said:

I would say it's very strained and I'm frustrated the fact that we went into this adoption with such high hopes of, you know, I had my vision of how raising a son would be and I have not achieved hardly any of that. It's just been day after day of, you know, constant struggles, feeling like you know, I'm a nurse to him, you know dealing with the urination issues and, you know, constantly taking him to medical appointments all the time, so it's very strained.

Joe indicated that his relationship with his son has taken a toll on his physical and mental health:

And we have very few moments of him really showing that much love or affection for us. It's a lot of hate and anger and tantrums and stuff so, I know it takes, I mean I can tell it's taken a huge toll on me mentally and physically, you know. I've gained like 30lbs since he moved into the house.

### **Additional Theme Not Related to a Specific Research Question**

**Theme 17: Cultural Differences.** An additional theme that emerged from the interviews but that was not directly related to the research questions was the impact of culture on



participants' experiences in the group. Two participants noted differences between their own culture and that of other participants and two participants noted differences between their own culture's parenting practices and those of the U.S. or those taught in Triple P. Both Maria and Noelle described feeling different than other parents in the group because their culture's parenting practices were different than those of other participants. In describing the other participants in the group, Maria stated:

Yes, they were different cultures and very different backgrounds and their experience in some points they are similar of us but we um, I mean me, myself, I manage with my girls so different and in some point it's just like, "You don't get it." It's kind of, "okay...I respect your things" but I feel some point they don't respect and they, "Oh my God, this and that..."

Noelle indicated that she felt like she did not identify with the other parents in the group because their parenting views were so different:

I'm not there to make friends but at least identify, like I have no one, that's what I felt with the other ones, like, oh my God I'm super strict on my kids and I'm not going to change my way. I even called my dad after the classes sometimes because he raised me. I was raised by a single dad so I was like, "Papi they're telling me this and this," and he was like, "Oh that doesn't work." He's like, "You cannot be your child's friend, at all. That doesn't work."

Noelle indicated that she liked being able to learn from parents from other cultures but she also did not want to change things that she felt were working for her family:

The thing is that what I liked also with the English, we are all different cultures so we learn from each other and I like that, but I've noticed too that we Hispanic are really strict

with our kids. We are extremely strict and I'm like, why are you changing it if it's not broken? I'm like, if it's working, it's working.

Selena and Lisa both described difference in their own culture's parenting practices and those of the U.S. culture or Triple P strategies. Selena reported that she often feels judged as a parent and that even her family judges her because they are from a different culture and have different views about parenting:

Yes, and we are judged by, sometimes our family judges us. My parents, especially mine, my father, he don't understand why he's like that (referring to her son).

Selena explained that her father is very strict and thinks that she and her husband are not strict enough with their son.

Lisa, who is from Taiwan and speaks Chinese, said that she thinks that the language that the GSSTP class is delivered in makes a difference in terms of the parenting style that is taught. She explained that when she reads articles in Chinese, there is a very different parenting style than here in the U.S. Lisa also explained that when she talks with people she knows in Taiwan, they have different views about parenting than she does and she sees a cultural difference between there and the U.S.:

...even when I talk with my friend...like the other day, this is actually funny, cause I was talking with my friend, that she is a high school teacher and she has encountered kids with special needs and I was just like venting to her, like, "Sometimes she does this...I am so mad," like just talking, I'm not actually going to do it. I'm like "Oh I just want to slap her" and she's like, "No you cannot slap her because if you slap her it will damage the ear. You can hit as hard on another part like the butt or something," and I'm like, "No we don't do that." So it's funny to me now because I live in the states, and then the,

it kind of like, the difference in parenting, the how we parent our kids. You can tell, it's very obvious what's acceptable in my culture and what's acceptable here.

Lisa explained that she was just venting to her friend and was not actually intending to slap her daughter, so she was surprised by her friend's response. She said that she had to explain to her friend, "It's just like an expression, like just describing how mad I am but no, I'm not going to punish my kids like that (laughs)."

## **Chapter Five: Discussion**

This chapter begins with a summary of the findings of the present case study and provides comparisons of these findings with those of the extant literature where applicable. Following a review of the findings, the implications for practice and the role of the psychologist/school psychologist are reviewed. Lastly, contributions to the literature, limitations of the study, and directions for future research are explored.

### **Research Question 1: What Led Parents to Engage in the GSSTP Program and What Did They Hope to Gain from Participating?**

Themes related to the first research question included “Word of Mouth”, “Informed About GSSTP By A Professional”, “Seeking New Skills” (including the subthemes “Skills for Helping Children Develop” and “Skills to Help Manage Challenging Behavior”), and “Parenting is Hard Work and You Never Get a Break” (which includes the subthemes “Overwhelmed by The Level of Care Required,” “Difficulty Knowing How to Respond to Challenging Behavior,” “Challenges in School/Community,” “Lack of Support From Partner or Not on The Same Page As Their Partner,” and “Other Parenting Challenges”).

Most parents in this study learned about the GSSTP intervention through friends, acquaintances, and family members, as illustrated by the theme “Word of Mouth.” Although several parents heard about the group through someone in a professional role, as described in the theme “Informed About GSSTP By A Professional,” only one parent heard about it from a service provider with whom they had a professional relationship (e.g. psychiatrist). This was

somewhat surprising since most parents had regular, ongoing contact with multiple professionals, such as therapists, doctors, and case managers. Several parents noted that they wished they had known about the intervention sooner and they were surprised to learn that there was a free intervention specifically for parents of children with disabilities and they had never heard of it before. This is consistent with what other parents of children with disabilities have reported with regards to the obstacles and barriers they face in finding and accessing appropriate supports (Resch et al., 2010). These findings highlight the importance of increasing community awareness about the availability of services such as GSSTP, particularly with other providers in the area who work with children with disabilities and could serve as a potential referral source.

The parents in this study were eager to learn new ways to work with their children and they hoped to learn strategies to improve their own parenting skills. In general, parents recognized challenges that their children were facing and they wanted to be able to teach their children new skills to overcome those challenges. The theme “Seeking New Skills” reflects parents’ recognition that in order to see changes in their child’s behavior, they would need to make changes to their own behavior. The goals that parents expressed within the subthemes “Skills for Helping Children Develop” and “Skills to Help Manage Challenging Behavior” mirror those of the parents of children with autism who participated in the first RCT of GSSTP (Roux et al., 2013). In the Roux et al. (2013) study, parents set goals for decreasing challenging behavior, increasing independence and communication, and decreasing emotional behavior. Similarly, parents in the present study hoped to help their children communicate more effectively, become more independent, and decrease challenging behaviors. Parents in this study described struggling with children’s behaviors such as hitting, screaming, self-harming, enuresis/encopresis, and emotional outbursts. These types of externalizing behaviors have been

associated with increased parenting stress in children with autism and other developmental disabilities (Hastings et al., 2004; Lecavalier et al., 2006; Zaidman-Zait et al., 2017), so it is fitting that parents would prioritize this as a goal.

Although most parents did not specifically identify parenting exhaustion as their reason for enrolling in GSSTP, a theme that emerged throughout participants' interviews, observations, and questionnaires was "Parenting is Hard Work and You Never Get a Break". The sheer number of subthemes within this theme (i.e. "Overwhelmed by The Level of Care Required," "Difficulty Knowing How to Respond to Challenging Behavior," "Challenges in School/Community," "Lack of Support From Partner or Not on The Same Page As Their Partner," and "Other Parenting Challenges"), reflects the multitude of challenges that these parents were facing. Overall, the parents who participated in GSSTP echoed what many parents of children with autism and other developmental disabilities have reported, including an increased burden related to caregiving duties and a lack of time for themselves (DePape & Lindsay, 2015; McCann, Bull & Winzenberg, 2012; Safe, Joosten, & Molineux, 2012; Sawyer et al., 2010). The theme "Overwhelmed by The Level of Care Required," which was endorsed by seventy-five percent of parents in this study, exemplifies the pure exhaustion that parents feel due to providing constant care for their child, with little to no opportunity for a break. Many parents discussed this as an ongoing challenge and they did not foresee that these circumstances would change anytime soon.

The subtheme "Difficulty Knowing How to Respond to Challenging Behavior" reflects parents' thoughtfulness in terms of wanting to respond to their child's behavior in the most effective manner while recognizing the complexity of children's behavior, which makes this task less straightforward. Most of the children in this study possessed characteristics that have been

shown to increase the risk of challenging behavior in children with disabilities, such as deficits in adaptive behavior, communication delays, having multiple disabilities, and/or having an intellectual impairment (Emerson et al., 2001; Mazzucchelli & Sanders, 2012; Sappok et al., 2014). Parents in this study did not only describe their children's challenging behavior in terms of goals for change in GSSTP, but they reported feeling conflicted about how to address their child's challenging behavior, which added to the stress of parenting.

Other challenges that parents reported, such as difficulties related to schools and other places in the community (i.e. experiencing scrutiny from others, difficulty accessing effective services, and disappointment in the services they received), are consistent with the findings of other qualitative studies that have examined the experiences of parents of children with autism and other disabilities (DePape & Lindsay, 2015; Makintosh et al., 2012; Resch et al, 2010; Safe, Joosten, & Molineux, 2012). These barriers, which are summarized in the theme "Challenges in School/Community", can add to the burden of parents who are already facing challenges related to caring for their child or managing their child's behavior (Lecavalier et al., 2006; Makintosh et al., 2012). Additional factors that parents identified as increasing the burden of parenting were related to co-parenting, as described by the subtheme, "Lack of Support from Partner or Not on The Same Page As Their Partner". Prior research has found that not having the support of a partner can exacerbate the challenges that parents of children with disabilities are already facing, leading to increased stress and overwhelm (Dyches et al., 2016). Findings from the present study support this and suggest that the absence of partner support as well as disagreements about parenting practices amongst co-parents can be added stressors for parents of children with disabilities. The range of "Other Parenting Challenges" that parents in this study faced with regard to parenting their child who has a disability (i.e. safety concerns, the high cost of care,

worry about the future, and lack of resources) have also been reported by many other parents of children with disabilities (McCann, Bull, & Winzberg, 2012; Resch et al., 2010; Sawyer et al., 2010; Whittingham et al., 2006; Zechella & Raval, 2016).

### **Research Question 2: What Aspects of the GSSTP Program do Parents Perceive to be Most Beneficial/Least Beneficial and Why?**

Themes related to the second research question were divided into aspects of the GSSTP intervention that parents found to be most beneficial and those that they found to be least beneficial. The themes describing the most beneficial aspects of GSSTP included “Learned New Skills” (which included the subthemes “Learned New Parenting Strategies (General)” and “Learned New Parenting Strategies (Specific)”), “Received Support From Others” (which included subthemes “Received Support From Other Parents” and “Received Support From GSSTP Facilitators”), and “Improved Co-Parent Relationships”. The theme that described the least beneficial aspects of GSSTP was “Suggestions For Changes In The Group” and this theme was further divided into the subthemes, “Length of Group Was a Barrier”, “Suggested Changes to The Format Or Content of Sessions”, and “Suggested Grouping Classes Based on Specific Characteristics”.

Given that one of the main goals of Triple P groups is to teach parents positive parenting skills, it is reassuring that parents identified learning new skills as being the most beneficial aspect of the group. Within the theme, “Learned New Skills”, there did not seem to be any particular skill or strategy that the majority of parents viewed to be the most helpful, which was somewhat surprising. Instead, the strategies that each parent identified depended on the usefulness of that particular strategy for them and their child. This finding highlights the importance of Triple P’s focus on the self-regulatory process, in which parents are encouraged to



self-select the strategies that they would like to practice and implement rather than choosing a one-size-fits-all plan for every parent (Mazzucchelli & Sanders, 2012). Perhaps the benefit of each strategy to parents depends on where they are in their parenting journey, the skills that they already utilize, and the particular areas of concern that they are experiencing. It also is of note that several of the things that parents found to be beneficial within the subtheme “Learned New Parenting Strategies (Specific)”, including planning ahead and using the Start Routine, involve using multiple strategies in a systematic way. It may be that providing parents with a step-by-step approach for implementation increases their ability to apply the skills they learned, thereby making those skills more beneficial to them. This finding adds to the limited body of research regarding parent’s perceptions about the usefulness of the Triple P Stepping Stones strategies. Although prior research has reported positive parent feedback regarding the GSSTP strategies (Whittingham et al., 2009), the current study is the only known qualitative study of GSSTP in which parents self-identified strategies as being one of the most helpful aspects of the intervention.

The theme “Received Support From Others” which was endorsed by seven of the eight participants, highlights the importance of social support for parents of children with disabilities. Parents in the present study reported that GSSTP served as a support group through which they could share stories with other parents and offer encouragement to one another. Parents’ enjoyment of the group setting and their appreciation for learning about the experiences of others mirror what other participants of GSSTP have said that they enjoyed most about the program (Roux et al., 2013). Parents in the present study also reported that hearing what other parents were going through helped them to feel that they were not alone and it normalized their experience. This normalization of their experience has also been described by other parents who

have participated in GSSTP, including other parents of children who have autism (Whittingham et al., 2009b). In addition to receiving support from other parents, participants appreciated the individualized support and attention that they received from the group facilitators in the form of resources, ideas, and recommendations. The theme, “Received Support From GSSTP Facilitators”, highlights the impact that facilitators of the program can have on parents’ experience in the intervention. Facilitators of the Stepping Stones intervention have previously discussed the need for practitioners to have knowledge and experience beyond what is taught through the Triple P certification process due to the complex needs of Stepping Stones participants (Hodgetts et al., 2013). In the present study, several of the facilitators had advanced training in psychology and/or ABA as well as extensive experience working with children who have disabilities, which may have provided an added benefit in terms of being able to support the unique needs of parents.

In addition to learning new strategies and receiving support from others, parents in the present study appreciated the changes that occurred within their co-parenting relationships following the intervention. The theme “Improved Co-Parent Relationships” is consistent with prior studies in which parents have described improved co-parent relationships following the GSSTP intervention (Roux, Sofronoff, & Sanders, 2013; VanVoorhis et al., 2015). For the parents in the present study, improving communication with their partner and/or increasing support from their partner were some of the most impactful aspects of participating in GSSTP.

In addition to the aspects of the GSSTP program that parents found to be most beneficial, parents openly shared feedback regarding the aspects of the program that they disliked, as reflected in the theme “Suggestions For Changes In The Group”. Parents reported that, due to other competing demands such as work, extracurricular activities, unexpected childcare needs,

and family commitments, it became difficult to attend every session of group. The subtheme “Length of Group Was a Barrier ” is consistent with the findings of a prior qualitative study of Standard Stepping Stones (Hodgetts et al., 2013), in which practitioners reported that it was difficult for parents to attend weekly sessions and complete homework due to their other commitments such as therapeutic appointments. Parents in the present study offered suggestions for reducing the length of the group, such as offering multiple sessions per week for a shorter number of weeks and condensing the material in order to reduce the total the number of sessions. These suggestions for shortening the number of sessions is in contrast with a prior study in which parents of children with autism reported that they wished the Stepping Stones group sessions had been longer (Whittingham et al., 2009). It is important to note, however, that parents in the Whittingham et al. (2009) study attended a shorter number of group sessions to learn new strategies and the remaining sessions were individual sessions with a practitioner for observation, practice, and feedback of the strategies. It is possible that parents’ preference for group length depends on their level of need, their desire for social support, or other personal factors.

In addition to changing the length of the group, half of the parents offered recommendations for changing aspects of the group delivery, as described by the subtheme, “Suggested Changes to The Format Or Content of Sessions.” Parent suggestions included having more interactive and hands-on and activities during the sessions, moving the Partner Support content to the beginning of the group, adding in an observation of parents interacting with their children, and splitting sessions into a didactic portion as well as a portion to problem-solve challenges related to implementation. Because this is the only known study to obtain parent feedback regarding the content and delivery of GSSTP, it is not known whether these perceptions are unique to the participants in this particular case study.

The final change that parents recommended regarding the GSSTP intervention, which was characterized by the subtheme, “Suggested Grouping Classes Based on Specific Characteristics”, appears to be unique to the participants of the present study. Half of the parents in this study mentioned that it might be beneficial to group parents based on commonalities such as cultural background or marital status, and one parent recommended separating partners into different groups for a portion of each class. These recommendations differ from those that parents have offered in prior studies regarding GSSTP. For example, in both the Whittingham et al. (2009) study and the Roux et al. study (2013), parents who completed GSSTP later said that they would have liked for participants to have been grouped differently; however, they recommended grouping participants based on the child’s disability type rather than parents’ cultural group or marital status as recommended by parents in this study.

### **Research Question 3: What Specifically do Parents Learn as a Result of Participating in the GSSTP Program and How Has Impacted Them and Their Child(ren)/Family?**

Themes related to the third research question include “Learned How to Talk to Their Children,” “Learned How to Plan Ahead”, “Learned How to Implement Rewards”, “Learned Other Strategies to Strengthen Parent-Child Relationships And Prevent Challenging Behavior”, “Learned Other Ways to Manage Challenging Behavior”, and “Implementing New Strategies Has Helped”. Overall, when parents were asked what they learned in GSSTP, they described different strategies and concepts that they learned and found to be helpful. As such, there are some similarities between the themes described in this section and those related to Research Question 2, in which parents identified new skills and strategies as one of the most beneficial aspects of GSSTP. Most of the things that parents described learning were prevention strategies. For example, a majority of parents endorsed the theme “Learned How to Talk to Their

Children,” in which they reported learning more effective communication strategies (e.g. reducing the number of instructions, using positively stated language, getting within close proximity, and giving clear, calm instructions). Half of the parents also described learning a more strategic way to proactively prevent their child’s challenging behavior as depicted in the theme “Learned How to Plan Ahead”, and some parents described learning how to use rewards to encourage and reinforce desirable behavior (“Learned How to Implement Rewards”). These findings, along with the theme “Learned Other Strategies to Strengthen Parent-Child Relationships And Prevent Challenging Behavior”, highlight parents’ desire to learn a more proactive, rather than reactive, approach to parenting and the findings are somewhat unique given that this is the first known study to ask parents to self-report what they learned in GSSTP. Other parents of children with disabilities have, however, mentioned “rewarding” as one of the most beneficial things that they learned in Stepping Stones (Hodgetts et al., 2013, p. 2580), which underscores the idea that sometimes the most simple and straightforward strategies have the most impact on parents.

Parents in this study also reported learning strategies for addressing their child’s difficult behaviors when they do occur, as reflected in the theme, “Learned Other Ways to Manage Challenging Behavior.” As mentioned previously, parents in this study experienced added stress and burden due to their children’s challenging behavior and they appreciated learning to use behavioral strategies such as physical guidance, blocking, quiet time, and time-out. These findings are similar to those of Whittingham et al. (2009) who reported that a majority of parents who participated in Stepping Stones indicated that they used blocking, physical guidance, and time-out, and they found them to be effective.

Overall, parents in the present study reported noticing positive results in their child or family since implementing the new strategies that they learned in GSSTP. These results, which are summed up in the theme “Implementing New Strategies Has Helped,” are consistent with other research supporting parents’ acceptability of the Group Stepping Stones intervention (Roux, Sofronoff, & Sanders, 2013; Whittingham et al., 2009). Similar to other parents who have participated in Stepping Stones interventions, including parents of children with autism, the participants in the present study reported improvements in their own style of interaction with their child(ren) (Roberts et al., 2006; Roux et al., 2013; Whittingham, et al. (2009). In particular, they noted that implementing new strategies and making changes to their own behavior has helped prevent arguments between them and their children and has led to more positive parent-child interactions.

Despite reporting in their interviews that they noticed positive changes in themselves and their parent-child interactions, parent ratings on the various rating scales were mixed. For example, in terms of parents self-efficacy in handling their children’s challenging behavior, some parents reported increased self-efficacy related to *setting* on the Parenting Tasks Checklist, but not related to *behavior*. These results may be partly due to the fact that parents entered the program with higher behavioral self-efficacy than setting self-efficacy, as evidenced by only two of the parents rating themselves in the clinical range for *Behavioral self-efficacy* pre-intervention compared with six rating themselves in the clinical range for *Setting self-efficacy*.

Of the six parents who rated themselves in the clinical range for *Setting self-efficacy*, half reported a clinically significant and reliable positive improvement post intervention, suggesting that half of the parents felt more confident and competent in managing their child’s behavior in different settings after participating in GSSTP. The two parents who rated themselves in the

clinical range for *Behavioral self-efficacy* pre-intervention did not report significant or reliable positive improvement post intervention and those were also two of the parents who did not report improvements on the *Setting self-efficacy* scale. These two parents described experiencing the most challenging and persistent child behaviors of all of the participants, so it may be that the intensity of the GSSTP intervention did not match their level of need.

In terms of parenting style, few parents rated themselves as having overly hostile or overreactive parenting styles pre-intervention, but half of them reported being overly lax. Only one of those parents reported a clinically significant positive improvement and that improvement was not considered to be reliable, meaning that the change was not greater than would be expected due to chance. The one parent who rated themselves in the clinically significant range on the Overreactivity scale did report a clinically significant positive improvement post intervention; however, this change also was unreliable. Similarly, one of the two parents who rated themselves in the clinical range on the Hostility scale pre-intervention reported improvement in their hostile parenting style post-intervention but this change was considered to be unreliable as well. Findings from the present study differ from those of other studies which have shown improvements in parents' dysfunctional parenting styles following participation in Stepping Stones (Roux et al., 2013; Vanvoorhis et al. (2015); Whittingham et al. (2009). In each of those studies, caregivers participated in an all or partially individual group format, meaning that they had time to individually practice their parenting skills and receive feedback from practitioners. It may be that the all-group format of the present study did not provide sufficient opportunities for parents to practice and modify their skills.

In terms of well-being, more parents reported clinical levels of stress and anxiety than depression pre-intervention, and most of those parents reported improvements in anxiety and

stress post intervention. The three participants who reported clinical levels of stress pre-intervention reported clinically significant improvements post-intervention and that change was reliable for two of those parents. Of the three participants who reported clinical levels of anxiety pre-intervention, two reported improvement in symptoms following GSSTP and this change was reliable for one of them. The one participant who reported clinical levels of depression pre-intervention did not report a significant improvement in symptoms and she was also the one parent who did not report an improvement in anxiety. This parent may have benefited from additional intervention, such as the Coping Skills modules of Enhanced Triple P, to more directly target her symptoms of depression and anxiety.

In terms of co-parent relationships, parent ratings on the PPC and RQI were also mixed. For example, on the Parent Problem Checklist, three out of the six parents surveyed rated clinical levels of conflict related to childrearing pre-intervention and only one of those parents showed clinically significant and reliable improvement following GSSTP. Two of the parents who were not in the clinical range pre-intervention actually reported higher levels of conflict post-intervention. Similarly, only one of the two parents who reported clinical levels on the Relationship Quality Index pre-intervention reporting clinically significant and reliable improvement in their relationship quality following GSSTP. As with the Parent Problem Checklist, one participant actually reported a clinically significant and reliable decline in their relationship quality. Interestingly, one of the parents who did not report improvement on either co-parenting measure also did not report improvement in depression, anxiety, parenting confidence, or the parenting style of laxness. This highlights the complex nature of parenting and its interrelationship with other factors such as mental health and partner relationships. For



parents who are experiencing a range of problems including mental health concerns, it may be necessary to provide more individualized or targeted supports to meet those needs.

In general, parents did not report significant improvements in their children's behavioral or emotional symptoms on the SDQ or CAPES-DD. A majority (n=6) of parents rated their child in the clinical range on the Peer Problems scale of the SDQ pre-intervention and half (n=4) of the parents rated their child's behavior in the clinical range on the Conduct Problems, Hyperactivity, and Total Difficulties scales pre-intervention. Of those, only three parents reported significant improvements for their child's Peer Problems, two reported significant improvements for Hyperactivity, and one reported a significant improvement for Total Problems. Those changes were only considered reliable for one of the parents, on both Hyperactivity and Total Difficulties scales. None of the parents reported clinically significant positive changes in their child's behavior on the Conduct Problems subscales, Emotional Problems, or Prosocial Behavior subscales and one parent reported a clinically significant but unreliable negative change on the Emotional Symptoms and Conduct Problems scales. Two participants also reported worsening symptoms on the Hyperactivity scale and one parent reported worsening symptoms on the Peer Problems and Total Difficulties scales, however, none of these negative changes were considered to be reliable. Parent ratings on the SDQ seem discrepant with their reports of changes in their children's behavior during interviews. One possible explanation for this may be that since the SDQ asks parents to rate their child's behavior over the last 6 months, post ratings would include ratings of children's behavior that occurred up to four months prior to the intervention, before any improvements occurred.

On the Total Problems scale of the CAPES-DD, seven of the eight participants initially rated their child in the clinical range and none of those parents reported a clinically significant

improvement. One parent, who initially rated their child in the non-clinical range pre-intervention reported that their child worsened, however, this change was not reliable. This was the same parent who rated worsening, but unreliable, changes on four of the six scales of the SDQ. Since parent ratings on the CAPES-DD applied to the past 4 weeks, their post-ratings included behaviors that were present partway through the intervention. As with the SDQ, the timeframe in which they were asked to rate their child's behavior may not have provided enough opportunity to report significant change.

#### **Research Question 4: How do Parents Perceive Their Relationship with Their Child and How Has This Changed as a Result of Participating in the GSSTP Program?**

Themes related to the fourth research question include "Positive Parent-Child Relationships" and "Strained Parent-Children Relationship". The first theme is divided into subthemes including, "Good Relationship With Child/Love Them," "Enjoy Sharing Experiences With Their Child, Teaching Them, And Learning From Them," "Children Are Funny," and "Want To Give Them Everything/Prepare Them For The Future." In terms of how parents perceive their relationship with their child, all eight parents shared things that they love or enjoy about their child and their parent-child interactions, as highlighted in the theme "Positive Parent-Child Relationships."

The majority of parents specifically described having a good relationship with their child before and after GSSTP, or they stated that they love their child, as characterized by the subtheme "Good Relationship With Child/Love Them." In addition to feeling close and loving towards their children, seven of the eight participants reported that they appreciated the experiences that they share with their children. This sentiment is characterized by the theme, "Enjoy Sharing Experiences With Their Child, Teaching Them, And Learning From Them."

Parents described enjoying every day experiences such as playing together, going out to eat, and spending time together in general. They also described finding enjoyment in teaching their children new things and watching as they learn and experience the world. The theme, “Children Are Funny,” highlights parents’ appreciation of their children’s humor and the laughter that they share with their child. The final subtheme illustrating positive parent-child relationships, “Want To Give Them Everything/Prepare Them For The Future,” demonstrates parents’ desire to ensure that their children have everything they need to be successful in the future. This theme is particularly salient in light of DePape & Lindsay’s (2015) research on parents of children with autism. In their thematic synthesis of qualitative studies, DePape & Lindsay (2015) found that parents of children with autism tended to have worries about their child’s future, particularly related to their child’s ability to live independently. Parents in the current study tended to have similar concerns and it was important to them to do everything they can to ensure that their children will be prepared for the future.

Despite having positive views about their relationships with their children, three parents also described negative aspects of their parent-child relationship, as described by the theme, “Strained Parent-Child Relationships.” All three parents shared that while they love their child, their child’s challenging behavior can be a source of strain on their relationship. Given that child behavior problems have been associated with increased levels of parenting stress (Lecavalier et al., 2006; Zaidman-Zait et al., 2017), it is not surprising that parents would identify challenging behavior as a source of strain on their parent-child relationship. The two parents in this study who described the most challenging child behaviors also reported the most strained parent-child relationships. Few, if any, studies have examined qualitative accounts of parent perceptions of their parent-child relationships before and after GSSTP, so these findings provide insight into

how these parents perceive their relationships with their children. Overall, parents did not report drastic differences in their parent-child relationship from pre- to post- intervention, however, some parents did note improvements, such as feeling closer to their children and having increased communication.

### **Additional Theme**

During the post-intervention interviews, half of the participants mentioned cultural factors that influenced their experience in GSSTP. The theme “Cultural Differences” highlights the dissonance that parents experienced when their own culture’s parenting practices seemed to contradict the parenting practices taught in GSSTP or when their parenting practices were different than those of other GSSTP participants. For example, Noelle, who was resistant to use some of the strategies taught in the class, explained that Hispanic parents are “extremely strict” and she did not see a reason to change this if it is working. Noelle’s views about parenting are consistent with the views of other Latino parents who have participated in focus groups about parenting practices (Calzada, Fernandez, & Cortes, 2010). In this study of Latino parenting practices, Calzada et al. (2010) found that the Latino cultural value of *respeto*, which emphasizes respect and obedience of authority, aligns with parenting practices that are incongruent with some positive parenting practices. For example, parents who value *respeto* may view harsh discipline as an effective means for teaching children to respect authority, whereas strategies such as positive reinforcement and planned ignoring may be incongruent with *respeto*. It makes sense then, that some parents may resist strategies that go against their cultural parenting values. On the other hand, other parents in the present study noted that while their friends and family members subscribe to more harsh parenting practices that are acceptable within their culture, they themselves disagreed with those practices and instead valued the positive parenting

practices that were taught in GSSTP. In either case, it is important to be aware of each parents' cultural values and how these influence their experience in parenting interventions.

### **Implications for Practice**

The results of this case study have several implications for practice. First, the experiences of the parents in the present study emphasize the need for increased access to parent training as an early intervention service for parents of children with a disability. Parents of older children indicated that they had tried many different types of therapy over the years and they wished they had known about GSSTP sooner, whereas parents of younger children said that they were hoping to prevent foreseeable challenges related to their child's disability. Triple P practitioners have previously noted that Stepping Stones was less useful for parents who were already at a point of crisis (Hodgetts et al., 2013), which further supports the need for a proactive approach. Parents in the present study appreciated the preventive strategies that they learned in GSSTP and overall, they reported that these strategies were effective. Considering the widespread negative consequences that result from challenging behavior (e.g. parent stress, strained parent-child relationships, challenges in the school/community, etc.), it is important to offer parent training as a preventive measure, not just as a reactive approach to challenging behavior.

Another clear need identified by the parents in this case study is the need for increased access to respite care for parents of children with a disability. The present study supports what prior research has shown, which is that "high parenting demands and limited respite opportunities can leave the parents of children with disabilities overwhelmed and unable to cope (Murphy, 2011, p. 1055)." Given the bi-directional relationship between parenting stress and ineffective parenting practices, it is crucial that parents get "a break" from the constant demands

of parenting. For the parents in the present study, respite care was hard to come by and the informal supports that parents had were often not equipped to manage the level of needs that these children required. Increasing access to trained and qualified respite providers may help relieve some of the ongoing stress and overwhelm that can happen when parenting a child who has a disability.

In addition to the implications that this study has for the needs of parents of children with disabilities, there are several implications specifically for the implementation of GSSTP. Half of the parents in the present study indicated that a 9-week course was difficult to commit to and most parents were not able to attend every session. For parents who are already attending various therapeutic and medical appointments related to their child's disability, it may be beneficial for providers to offer more flexible delivery options such as brief versions of the intervention or a virtual class for parents who have to miss an in-person session.

Another implication for practice is that some parents may prefer to attend group interventions with parents who are similar to them with regard to cultural factors and/or marital status. Several parents in the current study shared that they identified more with other participants who shared similar cultural beliefs or marital status as theirs, and in some instances, parents felt judged or misunderstood by other participants who differed with regard to these characteristics. Although it may not always be possible or even preferred to group GSSTP participants according to cultural factors, this does highlight the importance of providing culturally competent service delivery, particularly when serving parents from different cultural backgrounds. One suggestion would be for GSSTP facilitators to facilitate a more in-depth group dialogue about participants' cultural parenting values towards the beginning of the group

intervention in order to give parents a voice and offer multiple perspectives related to implementation of parenting strategies.

A final implication for practice is the importance of matching the intervention to the particular needs of parents. Due to the constraints of grant requirements, there were several aspects of the current intervention that were not tailored to the needs of individual participants as is typically done in Group Stepping Stones Triple P. For example, the current intervention included Partner Support modules for all parents, regardless of their co-parenting status, which may have led some parents to feel different than other group members or unable to relate to the rest of the group. For groups that include both single parents and those who have a co-partner, the Partner Support modules should be offered as an addition to the GSSTP curriculum rather than imbedding them with the other content. This would allow parents to choose whether or not to attend the Partner Support portion of the intervention without missing other aspects of the intervention. Additionally, there were several parents in this study who were experiencing either greater challenges related to their child's behavior or more intense negative emotions than other parents in the group. For the one parent who did not show improvement in depression and anxiety symptoms, for example, it may have been helpful to offer the Coping Skills modules of the Enhanced Triple P curriculum in addition to GSSTP. Similarly, those parents who reported the most intense child behaviors likely would have benefited from additional support beyond the group setting in order to meet their unique needs.

### **Role of the Psychologist/School Psychologist**

Whether working in clinic or school settings, school psychologists and psychologists are well-positioned to collaborate with parents who are involved in the Group Stepping Stones intervention or other Triple P parent training interventions. Psychologists and school

psychologists might provide direct training to parents using the Triple P curriculum or they may serve as an information and referral source for parents who are seeking or are in need of parent training. In this particular study, participants noted that they did not hear about the GSSTP intervention through the other providers with whom they were working, so it is important for psychologists/school psychologists to be aware of this type of resource in their community. With appropriate education and experience, psychologists and school psychologist may also provide training and/or supervision to practitioners who provide Triple P interventions. In addition to implementing interventions and supervising practitioners, psychologists and school psychologists are in a unique position of being able to evaluate the effectiveness of interventions, such as GSSTP.

### **Contributions to the Literature**

This study expands the current literature on the Triple P Group Stepping Stones intervention by adding insight into the experience of parents who participated in the intervention. Using multiple sources of data (i.e. observations, rating scales, and interviews), this case study provides a window into the experience of parents of children with disabilities who engage in Group Stepping Stones. As one of the only known studies to include parent interviews following participation in GSSTP, this study provides rich data on the specific aspects of GSSTP that parents find to be beneficial and offers suggestions for improving the intervention based on parent input. This is also the first known study to examine parent perceptions of GSSTP combined with the Triple P Partner Support modules.

### **Limitations**

There are several limitation with the present study, both with regard to the study design and also implementation of the intervention. One limitation to the study is that children's



diagnoses and behavioral challenges were taken at face value based on parent report alone, which could be biased. Also, one-third of the participants (4 out of 12) either did not complete the intervention or did not complete post data. It is possible that those four parents differed in some way from the parents who were included in this case study.

Since the GSSTP intervention in this study was delivered as part of the day-to-day operations of a community organization, the researcher did not have control over all aspects of intervention delivery or factors outside of the intervention that may have influenced parenting practices or perceptions. The researcher also did not have control over most of the pre- and post-measures, which were administered to participants as part of the typical operations of the program where the study took place. These rating scales may not have been sensitive enough to capture the small but significant changes that parents experienced over a short amount of time. These scales also did not measure variables such as hope, social connectedness, and social support, which may have a significant impact on parents' well-being.

Another limitation of the present study is that there was no follow-up to determine how parent perceptions and outcomes changed over time. On one hand, parents may experience increased gains over time as they continue to implement newly learned strategies and on the other hand, it is possible that their use of strategies or their fidelity of implementation decreases over time. The lack of follow-up procedures in the present study limits the researcher's ability to make inferences about these and other possible longer-term outcomes of GSSTP.

In addition to the limitations related to study design, there were several limitations with regard to implementation of the GSSTP intervention in this study. For example there were several holidays that occurred during the time that the intervention took place and class was held on one of the holidays but not the other. One couple indicated that they missed one class

because they did not realize that class would be held on a holiday and another parent reported that having a week off of class made it difficult to remember the class material once they returned the following week. This interruption in delivery of the intervention may have impacted parent perceptions and/or outcomes. There was also an unexpected change to the final class of the intervention which prevented the PI from attending the session or administering the CSQ questionnaire. This change was made at the last minute when facilitators decided to complete the final session content one week early due to a large number of parents indicating that they would be missing the planned final session. This change in the delivery of the intervention impacted data collection as well as the fidelity with which GSSTP was administered, since the content from two sessions was provided on one day.

Another potential limitation related to implementation was that facilitators completed the full Partner Support module, rather than just the Partner Support tip sheets as originally planned. Facilitators reported that they realized that there was enough time in the sessions to complete the full module so they chose to deliver three full modules. While this does not present any issues with fidelity since the Partner Support Modules were delivered as recommended by Triple P, there were some parents who indicated that they would have liked for there to be less focus on partner support. There were also several parents, however, who reported that the partner support was one of the most helpful aspects of the intervention. The real limitation, then, may be that the partner support portion of this intervention was not tailored to the specific needs of each participant, as is recommended by Triple P.

### **Directions for Future Research**

Taking into account the opinions and recommendations of the GSSTP participants, future research should examine effects of changing the format and/or length of the GSSTP

intervention. Parents in the present study recommended a variety of different format options, such as offering classes twice a week for a shorter number of weeks, grouping participants based on marital status or cultural background, and separating group sessions into a didactic portion and a portion to process implementation issues. Comparing different format options may provide insight for providers who wish to increase the feasibility and acceptability of the intervention for parents. Parents of children with a variety of disabilities have reported reductions in child behavior problems, parent conflict, and dysfunctional parenting styles following participation in as few as two 2-hour Stepping Stones Seminars (Sofronoff, Jahnel, & Sanders, 2011; Tellegen & Sanders, 2014). These findings, in combination with participant feedback from the present study, suggest that it is worth examining the impact of shortened versions of GSSTP.

Future research would also benefit from examining parent perceptions of the longer-term impact of GSSTP, such as 6 months to a year after completing the intervention. It would also be beneficial to examine other variables that may impact parents' well-being, such as hope, social connectedness, and social support. Parents in the present study described at length the challenges that they were facing as parents, the aspects of GSSTP that they deemed to be most and least beneficial, and the changes they saw in themselves, their children, and their parent-child relationship following GSSTP. It would be beneficial to see how parents describe their experience in GSSTP, their use of strategies, and any changes in their relationships and parent-child interactions 6-12 months after completing the intervention.

Another area that warrants additional research is the comparison of co-parents' perceptions and outcomes after completing GSSTP alone vs. GSSTP plus Partner Support modules vs. GSSTP plus the Partner Support Tip Sheet. Although parents in the present study

described benefits to their co-parenting relationships following the intervention, it is not clear whether these same outcomes would have occurred regardless of the Partner Support modules being included or not. It may be that providing parents with a Partner Support Tip Sheet and briefly discussing strategies with them is just as helpful to parents as participating in three Partner Support modules. Considering the added time commitment of the Partner Support modules, it is important to know how valuable parents find them to be.

Finally, future research should compare the outcomes and qualitative perceptions of parents from various cultural groups who have completed GSSTP. Several parents in the present study disliked aspects of the group that they deemed to be in conflict with their culture's parenting values. Gaining a better understanding of the specific aspects of GSSTP that parents from various cultural groups deem to be acceptable and unacceptable may provide insight about how GSSTP could be modified to improve acceptability and social validity for diverse groups of parents.

## **Summary**

Parents of children with disabilities experience increased demands and stressors compared to parents of typically developing children (Dyches et al., 2016; Hutchison et al., 2016; Lecavalier Leone, & Wiltz, 2006; Lee, 2013). Parents, and in particularly mothers, of children with disabilities, also have an increased risk of experiencing stress, depression, anxiety and other adverse outcomes compared with parents of typically developing children (Eisenhower, Baker, & Blacher, 2009; Hastings & Beck, 2004; Sawyer et al., 2010; Singer, Ethridge & Aldana, 2007). The increased stress that parents of children with disabilities experience can have an adverse impact on parenting practices and parent-child interactions (Beckerman et al., 2017; Norlin et al., 2014; Shawler & Sullivan, 2017). Fortunately, parent

training has proven to be a useful intervention for reducing ineffective parenting practices, increasing parent self-efficacy, reducing and preventing problem behaviors in children, and improving parent-child relationships (Kaminski et al., 2008; Shawler & Sullivan, 2017; Tully & Hunt, 2016). Group Stepping Stones Triple P (GSSTP) is one parent training intervention that has proven to be effective for parents of children who have a disability (Ruane & Carr, 2018; Skotarczak & Lee, 2015); however, few studies have analyzed qualitative data regarding parent perceptions of the intervention.

This study adds to the extant literature regarding the Group Stepping Stones Triple P program by providing an in-depth qualitative account of the experiences of parents who have participated in GSSTP. Using interviews, observations, and written products including a variety of questionnaires/rating scales, this qualitative case study examined the experiences of eight parents who participated in GSSTP at a non-profit agency in the southeastern United States. Using thematic analysis of parent interviews, 17 themes and 18 subthemes were identified. Parents who engaged in GSSTP were mostly referred by people they knew, such as friends and acquaintances, as described in theme “Word of Mouth,” or they were informed about the intervention by someone in a professional role, as described in the theme “Informed About GSSTP By A Professional.” These parents were experiencing a multitude of challenges related to parenting one or more children who have a disability and they expressed a desire to learn new parenting skills, as evident in the theme “Seeking New Skills.” The subthemes “Skills for Helping Children Develop” and “Skills To Help Manage Challenging Behavior” further describe parents’ desire to learn new strategies that would help their children develop new skills and also help them prevent and manage challenging behavior.

Parents described numerous challenges that they face related to parenting a child who has a disability, most notably the lack of ever having a break or time to themselves, as highlighted in the theme “Parenting is Hard Work and You Never Get a Break.” This theme is divided into five subthemes representing the aspects of parenting that parents find challenging: “Overwhelmed by The Level of Care Required,” “Difficulty Knowing How to Respond to Challenging Behavior,” “Challenges in School/Community,” “Lack of Support From Partner or Not on The Same Page As Their Partner,” and “Other Parenting Challenges.”

Following participation in GSSTP, parents reported that learning new parenting strategies was the most beneficial aspect of the intervention. The theme “Learned New Skills” encompasses two subthemes, “Learned New Parenting Strategies (General)” and “Learned New Parenting Strategies (Specific).” Some of the strategies that parents found helpful were learning more effective ways to communicate with their child, learning how to plan ahead to prevent and manage challenging behavior, and learning how to use rewards to encourage desirable behavior. In addition to the benefit of learning new skills, parents indicated that they “Received Support From Others.” The subthemes “Received Support From Other Parents” and “Received Support From GSSTP Facilitators” further describe the types of support that parents found to be beneficial. Parents also appreciated the positive changes that they saw in their partner relationships as explained by the theme, “Improved Co-Parent Relationship.”

Aspects of the intervention that parents found to be less beneficial are summarized by the theme, “Suggestions For Changes In The Group.” While describing aspects of GSSTP that they disliked, parents made recommendations for improving the group. The subthemes, “Length of Group Was a Barrier,” “Suggested Changes To The Format Or Content of Sessions,” and “Suggested Grouping Classes Based on Specific Characteristics,” highlight the particular facets

of the intervention that parents recommended changing. In general, parents found aspects of the intervention to be less acceptable if they deemed them to be irrelevant to their particular situation or in contrast with their cultural values. For example, parents who were in a co-parenting relationship tended to report having positive views of the Partner Support modules, whereas those who were not in a co-parenting relationship reported more negative views about Partner Support. Likewise, parents whose cultural values of parenting differed than those taught in GSSTP found portions of the intervention to be less acceptable. The various ways that cultural factors influenced parents' experience in GSSTP are described in the theme, "Cultural Differences."

In terms of what parents learned in GSSTP, four themes emerged, including, "Learned How To Talk To Their Children," "Learned How To Plan Ahead," "Learned How to Implement Rewards," "Learned Other Strategies To Strengthen Parent-Child Relationships And Prevent Challenging Behavior," and "Learned Other Ways To Manage Challenging Behavior." Parents described the changes that they noticed in themselves and their child since participating in GSSTP, as summarized by the theme "Implementing New Strategies Has Helped."

Overall, parents described having positive parent-child relationships both pre- and post-intervention, as highlighted in the theme "Positive Parent-Child Relationships." Within this theme, four subthemes emerged, including, "Good Relationship With Child/Love Them," "Enjoy Sharing Experiences With Their Child, Teaching Them, And Learning From Them," "Children Are Funny," and "Want To Give Them Everything/Prepare Them For The Future." Although parents mostly described having good relationships with their children, the theme "Strained Parent-Child Relationships" represents several parents' assertions that their child's challenging behavior put a strain on their parent-child relationship.

Results of this study provide insight into parent perceptions of the acceptability, effectiveness, and experience of engaging in Group Stepping Stones Triple P. These findings may be used to inform future research on GSSTP and also to improve implementation and accessibility of GSSTP for parents of children with disabilities.



## References

- Achenbach, T. M. (1992). *Manual for the Child Behavior Checklist/2-3 and 1992 profile*.  
Department of Psychiatry, University of Vermont.
- Achenbach, T. M., & Edelbrock, C. (1991). *The child behavior checklist manual*. Burlington, VT: The University of Vermont.
- Arnold, S., O'Leary, S., Wolff, S., & Acker, M. (1993). The parenting scale: a measure of dysfunctional parenting in discipline situations. *Psychological Assessment, 5*(2), 137-144.
- Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological review, 84*(2), 191.
- Bandura, A., & Walters, R. H. (1971). Social learning theory.
- Baumrind, D. (1966). Effects of authoritative parental control on child behavior. *Child development, 37*, 887-907.
- Beckerman, M., van Berkel, S. R., Mesman, J., & Alink, L. R. (2017). The role of negative parental attributions in the associations between daily stressors, maltreatment history, and harsh and abusive discipline. *Child abuse & neglect, 64*, 109-116.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101.
- Brobst, J. B., Clopton, J. R., & Hendrick, S. S. (2009). Parenting children with autism spectrum disorders: The couple's relationship. *Focus on Autism and Other Developmental Disabilities, 24*(1), 38-49.

- Brock, G. W., Oertwein, M., & Coufal, J. D. (1993). Parent education: Theory, research, and practice. In M. Arcus, J. Schvaneveldt, & J. Moss (Eds.), *Handbook of family life education: The practice of Family Life Education* (Vol. 2, pp. 87-114). Newbury Park: SAGE Publications.
- Brown, F. L., Whittingham, K., Boyd, R. N., McKinlay, L., & Sofronoff, K. (2015). Does Stepping Stones Triple P plus Acceptance and Commitment Therapy improve parent, couple, and family adjustment following paediatric acquired brain injury? A randomised controlled trial. *Behaviour research and therapy*, *73*, 58-66.
- Brown, F. L., Whittingham, K., Boyd, R. N., McKinlay, L., & Sofronoff, K. (2014). Improving child and parenting outcomes following paediatric acquired brain injury: a randomised controlled trial of Stepping Stones Triple P plus Acceptance and Commitment Therapy. *Journal of child psychology and psychiatry*, *55*(10), 1172-1183.
- Brown, T.A., Chorpita, B.F., Korotitch, W., & Barlow, D.H. (1997). Psychometric properties of the depression anxiety stress scales (DASS) in clinical samples. *Behaviour Research & Therapy*, *35*(1), 79-89.
- Calzada, E. J., Fernandez, Y., & Cortes, D. E. (2010). Incorporating the cultural value of respeto into a framework of Latino parenting. *Cultural Diversity and Ethnic Minority Psychology*, *16*(1), 77.
- Centers for Disease Control and Prevention (2018). Facts about developmental disabilities. Retrieved from <https://www.cdc.gov/ncbddd/developmentaldisabilities/facts.html> on December 15, 2018.

- Chavira, V., López, S. R., Blacher, J., & Shapiro, J. (2000). Latina mothers' attributions, emotions, and reactions to the problem behaviors of their children with developmental disabilities. *Journal of Child Psychology and Psychiatry, 41*(2), 245-252.
- Cooley, M. E., Veldorale-Griffin, A., Petren, R. E., & Mullis, A. K. (2014). Parent–Child Interaction Therapy: A meta-analysis of child behavior outcomes and parent stress. *Journal of Family Social Work, 17*(3), 191-208.
- Dadds, M. R., & Powell, M. B. (1991). The relationship of interparental conflict and global marital adjustment to aggression, anxiety, and immaturity in aggressive and nonclinic children. *Journal of abnormal child psychology, 19*(5), 553-567.
- Denzin, N. K. (1978). Triangulation: A case for methodological evaluation and combination. *Sociological methods, 339-357*.
- DePape, A. M., & Lindsay, S. (2015). Parents' experiences of caring for a child with autism spectrum disorder. *Qualitative Health Research, 25*(4), 569-583.
- Dey, I. (1993). *Qualitative data analysis: A user friendly guide for social scientists*. Routledge.
- Dyches, T. T., Christensen, R., Harper, J. M., Mandelco, B., & Roper, S. O. (2016). Respite care for single mothers of children with autism spectrum disorders. *Journal of autism and developmental disorders, 46*(3), 812-824.
- Eisenhower, A. S., Baker, B. L., & Blacher, J. (2009). Children's delayed development and behavior problems: Impact on mothers' perceived physical health across early childhood. *Social Science & Medicine, 68*(1), 89-99.
- Emerson, E. (1995, 2001). *Challenging behaviour: Analysis and intervention in people with learning disabilities*. Cambridge University Press, 40 West 20th Street, New York, NY 10011-4211.

- Emerson, E., & Bromley, J. (1995). The form and function of challenging behaviours. *Journal of Intellectual Disability Research, 39*(5), 388-398.
- Emerson, E., Kiernan, C., Alborz, A., Reeves, D., Mason, H., Swarbrick, R., Mason, L., Hatton, C. (2001). The prevalence of challenging behaviors: a total population study. *Research in Developmental Disabilities, 22*, 77-93.
- Emsler, T.S., Mazzucchelli, T.G., Christiansen, H., & Sanders, M.R (2016). Child adjustment and parent self-efficacy scale-developmental disability (CAPES-DD): First psychometric evaluation of a new child and parenting assessment tool for children with a developmental disability. *Research in Developmental Disabilities, 53-54*, 158-177.
- Eyberg, S. (1988). Parent-child interaction therapy: Integration of traditional and behavioral concerns. *Child & Family Behavior Therapy, 10*(1), 33-46.
- Eyberg, S. M., Boggs, S. R., & Rodriguez, C. M. (2008). Relationships between maternal parenting stress and child disruptive behavior. *Child & Family Behavior Therapy, 14*(4), 1-9.
- Fox, L., Dunlap, G., & Powell, D. (2002). Young children with challenging behavior: Issues and considerations for behavior support. *Journal of Positive Behavior Interventions, 4*(4), 208-217.
- Fox, R. A., & Fox, T. A. (1992). Leader's guide: STAR parenting program. *Bellevue, Washington: STAR Parenting.*
- Freeman, K., & DeCoursey, W. (2007). Further analysis of the discriminate validity of the parenting scale. *Journal of Psychopathology and Behavioral Assessment, 29*(3), 169-176.
- Goodman, R. (1997). The strengths and difficulties questionnaire: a research note. *Journal of Child Psychology and Psychiatry, 38*, 581-586.

- Goodman, A., & Goodman, R. (2009). Strengths and difficulties questionnaire as a dimensional measure of child mental health. *Journal of the American Academy of Child & Adolescent Psychiatry, 48*(4), 400-403.
- Goodman R., & Scott (1999). Comparing the strengths and difficulties questionnaire and the child behavior checklist. Is small beautiful? *Journal of Abnormal Child Psychology, 27*, 17-24.
- Hart, B., & Risley, T. R. (1995). *Meaningful differences in the everyday experience of young American children*. Paul H Brookes Publishing.
- Hassall, R., Rose, J., & McDonald, J. (2005). Parenting stress in mothers of children with an intellectual disability: The effects of parental cognitions in relation to child characteristics and family support. *Journal of intellectual disability research, 49*(6), 405-418.
- Hastings, R. P., & Beck, A. (2004). Practitioner review: Stress intervention for parents of children with intellectual disabilities. *Journal of child psychology and psychiatry, 45*(8), 1338-1349.
- Heyman, R. E., Steven, L.S, & Bellack, A.S. (1994). Global marital satisfaction versus marital adjustment: an empirical comparison of three measures. *Journal of Family Psychology, 8*(4), 432-446.
- Hinton, S., Sheffield, J., Sanders, M.R., & Sofronoff, K. (2017). A randomized controlled trial of a telehealth parenting intervention: a mixed disability trial. *Research in Developmental Disabilities, 65*, 74-85.

- Hodgetts, S., Savage, A., & McConnell, D. (2013). Experience and outcomes of stepping stones triple P for families of children with autism. *Research in developmental disabilities, 34*(9), 2572-2585.
- Holland, A. J. (2004). Criminal behaviour and developmental disability: An epidemiological perspective. *Offenders with developmental disabilities, 23-34*.
- Hutchison, L., Feder, M., Abar, B., & Winsler, A. (2016). Relations between parenting stress, parenting style, and child executive functioning for children with ADHD or autism. *Journal of Child and Family Studies, 25*(12), 3644-3656.
- Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*, 12-19.
- Jones, T. L., & Prinz, R. J. (2005). Potential roles of parental self-efficacy in parent and child adjustment: A review. *Clinical psychology review, 25*(3), 341-363.
- Kaminski, J. W., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. *Journal of abnormal child psychology, 36*(4), 567-589.
- Kaptein, Jansen, Vogels & Reijneveld (2008). Mental health problems in children with intellectual disability: use of the strengths and difficulties questionnaire. *Journal of Intellectual Disability Research, 52*, 125-131.
- Kazdin, A. E. (2008). *Parent management training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents*. Oxford University Press.
- Keller, D., & Honig, A. S. (2004). Maternal and paternal stress in families with school-aged children with disabilities. *American Journal of Orthopsychiatry, 74*(3), 337.

- Kennedy, S. C., Kim, J. S., Tripodi, S. J., Brown, S. M., & Gowdy, G. (2016). Does Parent–Child Interaction Therapy reduce future physical abuse? A meta-analysis. *Research on social work practice, 26*(2), 147-156.
- Kuppens, S., & Ceulemans, E. (2018). Parenting styles: A closer look at a well-known concept. *Journal of Child and Family Studies, 1-14*.
- Lecavalier, L., Leone, S., & Wiltz, J. (2006). The impact of behaviour problems on caregiver stress in young people with autism spectrum disorders. *Journal of Intellectual Disability Research, 50*(3), 172-183.
- Lee, J. (2013). Maternal stress, well-being, and impaired sleep in mothers of children with developmental disabilities: A literature review. *Research in developmental disabilities, 34*(11), 4255-4273.
- Lichtman, M. (2013). *Qualitative Research in Education: A User's Guide*. Sage.
- Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. *The Sage handbook of qualitative research, 4*, 97-128.
- Lovibond, P.F., & Lovibond, S.H. (1995). The structure of negative emotional states: comparison of the depression anxiety stress scales (DASS) with the beck depression and anxiety inventories. *Behaviour Research & Therapy, 33*(3), 335-343.
- Lowe, K., Allen, D., Jones, E., Brophy, S., Moore, K., & James, W. (2007). Challenging behaviours: Prevalence and topographies. *Journal of Intellectual Disability Research, 51*(8), 625-636.

- Makintosh, V.H., Goin-Kochel, R.P., & Myers, B.J. (2012). What do you like/dislike about the treatments you're currently using? A qualitative study of parents of children with autism spectrum disorder. *Focus on Autism and Other Disabilities*, 27(1), 51-60.
- Matson, J. L., Mahan, S., & LoVullo, S. V. (2009). Parent training: A review of methods for children with developmental disabilities. *Research in Developmental Disabilities*, 30(5), 961-968.
- Mazzucchelli, T. G., & Sanders, M. R. (2012). Stepping Stones Triple P: a population approach to the promotion of competent parenting of children with disability. *Parenting Research and Practice Monograph*, 2, 1-35.
- Mazzucchelli, T. G., & Sanders, M. R. (2011). Preventing behavioural and emotional problems in children who have a developmental disability: A public health approach. *Research in developmental disabilities*, 32(6), 2148-2156.
- McCann, D., Bull, R., & Winzenberg, T. (2012). The daily patterns of time use for parents of children with complex needs: A systematic review. *Journal of Child Health Care*, 16(1), 26-52.
- Menting, A. T., de Castro, B. O., & Matthys, W. (2013). Effectiveness of the Incredible Years parent training to modify disruptive and prosocial child behavior: A meta-analytic review. *Clinical Psychology Review*, 33(8), 901-913.
- Merriam, S. (2010). Qualitative case studies. In 'International encyclopedia of education'. 3<sup>rd</sup> edn. (Eds P Peterson, E Baker, B McGaw) pp. 456-462.
- Merriam, S. (1995). What Can You Tell From An N of 1?: Issues of validity and reliability in qualitative research. *PAACE Journal of lifelong learning*, 4, 50-60.



- Merriam, S. B. (1985). The case study in educational research: A review of selected literature. *The Journal of Educational Thought (JET)/Revue de la Pensée Educative*, 204-217.
- Miles, M. B., Huberman, A. M., & Saldana, J. (2013). *Qualitative data analysis: A methods sourcebook*. SAGE Publications, Incorporated.
- Moreland, A. D., Felton, J. W., Hanson, R. F., Jackson, C., & Dumas, J. E. (2016). The relation between parenting stress, locus of control and child outcomes: predictors of change in a parenting intervention. *Journal of Child and Family Studies*, 25(6), 2046-2054.
- Murphy, N. (2011). Maltreatment of children with disabilities: The breaking point. *Journal of Child Neurology*, 26(8), 1054-1056.
- Norlin, D., Axberg, U., & Broberg, M. (2014). Predictors of harsh parenting practices in parents of children with disabilities. *Early child development and care*, 184(9-10), 1472-1484.
- Norton, R. (1983). Measuring marital quality: A critical look at the dependent variable. *Journal of Marriage and the Family*, 45, 141-151.
- Nowak, C., & Heinrichs, N. (2008). A comprehensive meta-analysis of Triple P-Positive Parenting Program using hierarchical linear modeling: Effectiveness and moderating variables. *Clinical child and family psychology review*, 11(3), 114.
- O'Brien, G. (2006). Young adults with learning disabilities: a study of psychosocial functioning at transition to adult services. *Developmental medicine and child neurology*, 48(3), 195-199.
- Patterson, G. R. (1982). *Coercive family process*. Eugene, OR: Castalia
- Patterson, G. R. (2005). The next generation of PMTO models. *The Behavior Therapist*, 28(2), 25-32.

- Patterson, G. R., & Stouthamer-Loeber, M. (1984). The correlation of family management practices and delinquency. *Child development*, 1299-1307.
- Phillips, B. A., Conners, F., & Curtner-Smith, M. E. (2017). Parenting children with down syndrome: An analysis of parenting styles, parenting dimensions, and parental stress. *Research in developmental disabilities*, 68, 9-19.
- Pidano, A. E., & Allen, A. R. (2015). The Incredible Years series: A review of the independent research base. *Journal of Child and Family Studies*, 24(7), 1898-1916.
- Pinquart, M., & Kauser, R. (2018). Do the associations of parenting styles with behavior problems and academic achievement vary by culture? Results from a meta-analysis. *Cultural Diversity and Ethnic Minority Psychology*, 24(1), 75.
- Piquero, A. R., Jennings, W. G., Diamond, B., Farrington, D. P., Tremblay, R. E., Welsh, B. C., & Gonzalez, J. M. R. (2016). A meta-analysis update on the effects of early family/parent training programs on antisocial behavior and delinquency. *Journal of Experimental Criminology*, 12(2), 229-248.
- Plant, K. M., & Sanders, M. R. (2007). Predictors of care-giver stress in families of preschool-aged children with developmental disabilities. *Journal of intellectual disability research*, 51(2), 109-124.
- Ralph, A., & Sanders, M. (2006). The 'Teen Triple P' Positive Parenting Program: A Preliminary Evaluation. *Youth Studies Australia*, 25(2), 41.
- Ralph, A., & Sanders, M. R. (2003). Preliminary evaluation of the Group Teen Triple P program for parents of teenagers making the transition to high school. *Australian E-journal for the Advancement of Mental Health*, 2(3), 169-178.

- Ralph, A., & Sanders, M. R. (2002). The Positive Parenting Program: An early intervention to improve personal relationships between teenagers and their parents. In *International perspectives on child and adolescent mental health* (Vol. 2, pp. 101-131). Elsevier.
- Reid, J. B., Patterson, G. R., & Snyder, J. E. (2002). *Antisocial behavior in children and adolescents: A developmental analysis and model for intervention*. American Psychological Association.
- Resch, J. A., Mireles, G., Benz, M. R., Grenwelge, C., Peterson, R., & Zhang, D. (2010). Giving parents a voice: A qualitative study of the challenges experienced by parents of children with disabilities. *Rehabilitation psychology, 55*(2), 139.
- Roberts, C., Mazzucchelli, T., Studman, L., & Sanders, M. R. (2006). Behavioral family intervention for children with developmental disabilities and behavioral problems. *Journal of Clinical Child & Adolescent Psychology, 35*(2), 180-193.
- Roberts, C., Mazzucchelli, T., Taylor, K., & Reid, R. (2003). Early intervention for behaviour problems in young children with developmental disabilities. *International Journal of Disability, Development and Education, 50*(3), 275-292.
- Robinson, M., & Neece, C. L. (2015). Marital satisfaction, parental stress, and child behavior problems among parents of young children with developmental delays. *Journal of Mental Health Research in Intellectual Disabilities, 8*(1), 23-46.
- Rojahn, J., & Meier, L. J. (2009). Epidemiology of mental illness and maladaptive behavior in intellectual disabilities. In *International review of research in mental retardation* (Vol. 38, pp. 239-287). Academic Press.
- Roulston, K. (2010). Considering quality in qualitative interviewing. *Qualitative Research, 10*(2), 199-228.

- Roux, G., Sofronoff, K., & Sanders, M. (2013). A randomized controlled trial of group Stepping Stones Triple P: A mixed-disability trial. *Family Process, 52*(3), 411-424.
- Ruane, A., & Carr, A. (2018). Systematic Review and Meta-analysis of Stepping Stones Triple P for Parents of Children with Disabilities. *Family Process*.
- Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes. *Field methods, 15*(1), 85-109.
- Ryan, G. W., & Bernard, H. R. (2000). Techniques to identify themes in qualitative data. *Handbook of Qualitative Research. 2nd ed. Thousand Oaks, CA: Sage Publications*.
- Safe, A., Joosten, A., & Molineux, M. (2012). The experiences of mothers of children with autism: Managing multiple roles. *Journal of Intellectual and Developmental Disability, 37*(4), 294-302.
- Salari, R., Ralph, A., & Sanders, M. R. (2014). An efficacy trial: Positive parenting program for parents of teenagers. *Behaviour Change, 31*(1), 34-52.
- Sanders, M. R. (2010). Adopting a public health approach to the delivery of evidence-based parenting interventions. *Canadian Psychology/Psychologie canadienne, 51*(1), 17.
- Sanders, M. R. (1999). Triple P-Positive Parenting Program: Towards an empirically validated multilevel parenting and family support strategy for the prevention of behavior and emotional problems in children. *Clinical child and family psychology review, 2*(2), 71-90.
- Sanders & Woolley (2005). The relationship between maternal self-efficacy and parenting practices: implications for parent training. *Child: Care, Health, & Development, 31*(1), 65-73.

- Sanders, M., Mazzucchelli, T., & Studman, L. (2015). *Facilitator's manual for Group Stepping Stones Triple P (Edition II): for families with a child who has a disability*. Triple P International Pty Ltd.
- Sanders, M., Mazzucchelli, T., & Studman, L. (2014). *Participant Notes for Standard Stepping Stones Triple P Provider Training*. Triple P International Pty Ltd.
- Sanders, M., Mazzucchelli, T., & Studman, L. (2012). *Practitioner's manual for standard Stepping Stones Triple P: for families with a child who has a disability*. Triple P International Pty Ltd.
- Sanders, M., Mazzucchelli, T., & Studman, L. (2009). *Facilitator's manual for Group Stepping Stones Triple P (Edition II): for families with a child who has a disability*. Triple P International Pty Ltd.
- Sanders, M., Mazzucchelli, T., & Studman, L. (2003). *Practitioner's manual for Standard Stepping Stones Triple P: for families with a child who has a disability*. Triple P International Pty Ltd.
- Sappok, T., Budczies, J., Dziobek, I., Bölte, S., Dosen, A., & Diefenbacher, A. (2014). The missing link: Delayed emotional development predicts challenging behavior in adults with intellectual disability. *Journal of autism and developmental disorders*, *44*(4), 786-800.
- Sawyer, M. G., Bittman, M., La Greca, A. M., Crettenden, A. D., Harchak, T. F., & Martin, J. (2010). Time demands of caring for children with autism: What are the implications for maternal mental health?. *Journal of Autism and Developmental Disorders*, *40*(5), 620-628.

- Schroeder, R. D., & Mowen, T. J. (2014). Parenting style transitions and delinquency. *Youth & Society, 46*(2), 228-254.
- Shapiro, C. J., Kilburn, J., & Hardin, J. W. (2014). Prevention of behavior problems in a selected population: Stepping Stones Triple P for parents of young children with disabilities. *Research in developmental disabilities, 35*(11), 2958-2975.
- Shawler, P. M., & Sullivan, M. A. (2017). Parental stress, discipline strategies, and child behavior problems in families with young children with autism spectrum disorders. *Focus on Autism and Other Developmental Disabilities, 32*(2), 142-151
- Sim, A., Cordier, R., Vaz, S., & Falkmer, T. (2016). Relationship satisfaction in couples raising a child with autism spectrum disorder: A systematic review of the literature. *Research in Autism Spectrum Disorders, 31*, 30-52.
- Singer, G. H., Ethridge, B. L., & Aldana, S. I. (2007). Primary and secondary effects of parenting and stress management interventions for parents of children with developmental disabilities: A meta-analysis. *Developmental Disabilities Research Reviews, 13*(4), 357-369
- Sipe, L., & Constable, S. (1996). A chart of four contemporary research paradigms: Metaphors for the modes of inquiry. *Taboo: The Journal of Culture and Education, 1*(Spring), 153-163.
- Skotarczak, L., & Lee, G. K. (2015). Effects of parent management training programs on disruptive behavior for children with a developmental disability: A meta-analysis. *Research in developmental disabilities, 38*, 272-287.

- Sofronoff, K., Jahnel, D., & Sanders, M. (2011). Stepping Stones Triple P seminars for parents of a child with a disability: A randomized controlled trial. *Research in developmental disabilities, 32*(6), 2253-2262.
- Stake, R. E. (2013). *Multiple case study analysis*. Guilford Press.
- Stake, R. E. (1978). The case study method in social inquiry. *Educational researcher, 7*(2), 5-8.
- Tellegen, C. L., & Sanders, M. R. (2014). A randomized controlled trial evaluating a brief parenting program with children with autism spectrum disorders. *Journal of consulting and clinical psychology, 82*(6), 1193.
- Tellegen, C. L., & Sanders, M. R. (2013). Stepping Stones Triple P-Positive Parenting Program for children with disability: A systematic review and meta-analysis. *Research in developmental disabilities, 34*(5), 1556-1571.
- The World of Triple P (n.d.) Retrieved from <https://www.triplep.net/glo-en/find-out-about-triple-p/the-world-of-triple-p/> on December 31, 2018.
- Triple P International Pty Ltd (2017). *Group Stepping Stones Triple P Course Summary*. Retrieved from [https://www.triplep.net/files/5315/2886/8005/ENG\\_Standard\\_Stepping\\_Stones\\_Triple\\_P\\_LTR.pdf](https://www.triplep.net/files/5315/2886/8005/ENG_Standard_Stepping_Stones_Triple_P_LTR.pdf) on December 19, 2018.
- Tsagaris, G. S., Seck, M. M., Keeler, J., & Rowe, R. (2015). Characteristics of adult offenders with developmental disabilities in large urban environments. *Best Practices in Mental Health, 11*(2), 60-72.
- Tully, L. A., & Hunt, C. (2016). Brief parenting interventions for children at risk of externalizing behavior problems: a systematic review. *Journal of Child and Family Studies, 25*(3), 705-719.

- U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs. (2007). *Archived: Twenty-five years of progress in educating children with disabilities through IDEA*. Washington, D.C.
- U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs (2014). *36th annual report to congress on the implementation of the individuals with disabilities education act*. Washington, D.C.
- U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs (2015). *37th annual report to congress on the implementation of the individuals with disabilities education act*. Washington, D.C.
- van Aar, J., Leijten, P., de Castro, B. O., & Overbeek, G. (2017). Sustained, fade-out or sleeper effects? A systematic review and meta-analysis of parenting interventions for disruptive child behavior. *Clinical psychology review, 51*, 153-163.
- VanVoorhis, R., Miller, K., Miller, S., & Stull, J. (2015). Impact of Stepping Stones Triple P on parents with a child diagnosed with autism spectrum disorder: Implications for school psychologists. *School Psychology Forum: Research in Practice, 9* (2), 121-142.
- Ward, M. A., Theule, J., & Cheung, K. (2016, October). Parent-child interaction therapy for child disruptive behaviour disorders: A meta-analysis. In *Child & Youth Care Forum* (Vol. 45, No. 5, pp. 675-690). Springer US.
- Webster-Stratton, C. (2001). The incredible years: Parents, teachers, and children training series. *Residential treatment for children & youth, 18*(3), 31-45.
- Webster-Stratton, C. (1998). Wally's detective manual for solving problems at home. *Incredible years parents, teachers, and children training series*. Seattle, WA: Seth Enterprises.



- Weisleder, P. (2011). Family interventions to prevent maltreatment of children with disabilities. *Journal of Child Neurology*, 26(8), 1052-1053.
- Whittingham, K., Sanders, M., McKinlay, L., & Boyd, R. N. (2014). Interventions to reduce behavioral problems in children with cerebral palsy: an RCT. *Pediatrics*, 133(5), e1249-e1257.
- Whittingham, K., Sanders, M. R., McKinlay, L., & Boyd, R. N. (2016). Parenting intervention combined with acceptance and commitment therapy: A trial with families of children with cerebral palsy. *Journal of pediatric psychology*, 41(5), 531-542.
- Whittingham, K., Sofronoff, K., Sheffield, J., & Sanders, M. R. (2009). Stepping Stones Triple P: An RCT of a parenting program with parents of a child diagnosed with an autism spectrum disorder. *Journal of abnormal child psychology*, 37(4), 469.
- Whittingham, K., Sofronoff, K., Sheffield, J., & Sanders, M. R. (2009). Behavioural Family Intervention with parents of children with ASD: What do they find useful in the parenting program Stepping Stones Triple P?. *Research in Autism Spectrum Disorders*, 3(3), 702-713.
- Whittingham, K., Sofronoff, K., Sheffield, J., & Sanders, M. R. (2009). Do parental attributions affect treatment outcome in a parenting program? An exploration of the effects of parental attributions in an RCT of Stepping Stones Triple P for the ASD population. *Research in Autism Spectrum Disorders*, 3(1), 129-144.
- Whittingham, K., Sofronoff, K., & Sheffield, J. K. (2006). Stepping Stones Triple P: a pilot study to evaluate acceptability of the program by parents of a child diagnosed with an Autism Spectrum Disorder. *Research in Developmental Disabilities*, 27(4), 364-380.

- Whittingham, K., Wee, D., Sanders, M., & Boyd, R. (2011). Responding to the challenges of parenting a child with cerebral palsy: a focus group. *Disability and rehabilitation*, 33(17-18), 1557-1567.
- Yin, R. K. (1981). The case study crisis: Some answers. *Administrative science quarterly*, 26(1), 58-65.
- Zablotsky, B., Black, L. I., Maenner, M. J., Schieve, L. A., & Blumberg, S. J. (2015). Estimated prevalence of autism and other developmental disabilities following questionnaire changes in the 2014 National Health Interview Survey. National health statistics reports; no 87. Hyattsville, MD: National Center for Health Statistics.
- Zaidman-Zait, A., Mirenda, P., Duku, E., Vaillancourt, T., Smith, I., Szatmari, P., Bryson, S., Fobonne, E., Volden, J., Waddell, C., Zwaigenbaum, L., Georgiades, S., Bennett, T., Elsabaggh, M., & Thompson, A. (2017). Impact of personal and social resources on parenting stress in mothers of children with autism spectrum disorder. *Autism*, 21(2), 155-166.
- Zechella, A. N., & Raval, V. V. (2016). Parenting children with intellectual and developmental disabilities in Asian Indian families in the United States. *Journal of Child and Family Studies*, 25(4), 1295-1309.

## Appendix A: Description of Case Study

This case study was analyzed primarily through a qualitative lens with the inclusion of both quantitative and qualitative components. Data analysis occurred at both the individual parent level and group level, with the goal of gaining an in-depth understanding of the experiences of parents who participated in the intervention. The various aspects of data collection and analysis are listed in the table below:

Qualitative Components	Quantitative Components
<ul style="list-style-type: none"> <li>• Observations of GSSTP sessions</li> <li>• Interviews with individual participants</li> <li>• Thematic analysis of interviews</li> <li>• Qualitative data from:               <ul style="list-style-type: none"> <li>○ Observations</li> <li>○ Family Experience Questionnaire</li> <li>○ Triple P session checklists/facilitator notes</li> <li>○ Attendance records</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Descriptive statistics of parents and children</li> <li>• Analysis of individual participants' pre/post data on various measures including:               <ul style="list-style-type: none"> <li>• Strengths and Difficulties Questionnaire</li> <li>• The Child Adjustment and Parent Efficacy Scale-Developmental Disability</li> <li>• Parenting Tasks Checklist</li> <li>• The Parenting Scale</li> <li>• The Depression Anxiety Stress Scale</li> <li>• Parenting Problem Checklist</li> <li>• The Relationship Quality Index</li> </ul> </li> </ul>





## Appendix C: Recruitment Email

The following email will be sent to potential participants by a [REDACTED] staff member other than the PI:

Good [Morning/Afternoon] [Participant Name],

I am writing to inform you of a research study that is being conducted at [REDACTED] by a researcher from USF. This study will be examining the experiences of parents of children with developmental disabilities or delays. I am sending you information about this study because you have signed up to participate in the Group Stepping Stones Triple P intervention at [REDACTED]. Participation in this research study is completely voluntary, and you will still be able to participate in the Group Stepping Stones class at [REDACTED] regardless of whether or not you choose to participate in the study. Attached is an informational flyer about the study as well as an Informed Consent document. If you would like more information or would like to participate in the study (Pro00039153), please contact the Primary Investigator, Tara Delach, at [REDACTED] regarding this study.

## Appendix D: Recruitment Flyer

UNIVERSITY of SOUTH FLORIDA

### ARE YOU THE PARENT OF A CHILD WITH A DIAGNOSED OR SUSPECTED DEVELOPMENTAL DISABILITY OR DELAY WHO IS PARTICIPATING IN THE GROUP STEPPING STONES TRIPLE P INTERVENTION?

If so, we'd like to hear from you.

**Who:** Parents of a child (ages 1-12 years) with a developmental delay or diagnosed disability who (a) have enrolled in the Stepping Stones Triple P Group program and (b) are able to speak and understand English.

**When:** Whatever time is best for you. You will participate in one brief meeting (30 minutes or less) prior to the intervention and will complete one interview lasting approximately 30-60 minutes following the intervention.

**Where:** Interviews will take place in a private location agreed upon with the interviewer.

**Why:** We are conducting a study of the experiences of parents of children with a diagnosed or suspected disability who are participating in the Group Stepping Stones Triple P intervention. This research study is being conducted by a graduate student researcher (Tara Delach) from the University of South Florida.

**Note:** What you share with us is confidential. It will not be linked directly with you when we publish our findings. You will choose a fake name for the interviews, and we will use that name to refer to you when we write up the study.

**Incentive:** After completing the first meeting, you will receive a \$10 gift card to a local store or restaurant. You will receive a second \$10 gift card after completing the interview following the intervention.

**Research Contact:** If you have any questions, please contact Tara Delach, M.A. at (813) 501-5502.



IRB# PRO 00039153

## Appendix E: Adult Minimal Risk Informed Consent



UNIVERSITY OF  
SOUTH FLORIDA

### Informed Consent to Participate in Research Involving Minimal Risk

Information to Consider Before Taking Part in this Research Study

**Title: Parent Perceptions of the Acceptability, Effectiveness and Experience of Engaging in the *Group Stepping Stones Triple P* Intervention for Parents of Children with Disabilities**  
**Pro # 00039153**

---

**Overview:** You are being asked to take part in a research study. The information in this document should help you to decide if you would like to participate. The sections in this Overview provide the basic information about the study. More detailed information is provided in the remainder of the document.

**Study Staff:** This study is being led by Tara Delach, M.A. who is a doctoral student at/in The University of South Florida. This person is called the Principal Investigator. She is being guided in this research by Dr. Kathy Bradley-Klug. Other approved research staff may act on behalf of the Principal Investigator.

**Study Details:** This study is being conducted at [REDACTED]. The purpose of the study is to obtain information from parents about their experience participating in the Group Stepping Stones Triple P Intervention. The Principal Investigator will obtain background information from parents prior to the intervention and will interview participants at the conclusion of the intervention. The Principal Investigator will use information obtained from these interviews as well as information from participants' pre- and post- assessment measures to gain a better understanding of the overall experience of participating in this intervention.

**Participants:** You are being asked to take part because you have signed up to participate in a Triple P Stepping Stones Group intervention. We want to find out more about the experience of parents who participate in this intervention.

**Voluntary Participation:** Your participation is voluntary. You do not have to participate and may stop your participation at any time. There will be no penalties or loss of benefits or opportunities if you do not participate or decide to stop once you start. Alternatives to participating in the study include: participating in the Group Stepping Stones intervention that you signed up for, but not participating in the research study.

**Benefits, Compensation, and Risk:** We do not know if you will receive any benefit from your participation. There is no cost to participate. You will be compensated up to \$20 in gift cards for your participation. This research is considered minimal risk. Minimal risk means



that study risks are the same as the risks you face in daily life.

Confidentiality: Even if we publish the findings from this study, we will keep your study information private and confidential. Anyone with the authority to look at your records must keep them confidential.

---

## Study Procedures:

You will be asked to spend about 3 months in this study, beginning with this meeting in which you sign consent and ending with one meeting which will occur within 2 weeks following the Stepping Stones Group intervention. You will be asked to answer questions regarding your household and demographic information either over the phone, via video conference, or in person prior to the group intervention and you will be asked to participate in one interview at the conclusion of the intervention. The first meeting (over the phone, via video conferencing, or in person) is expected to take less than 30 minutes and the interview following the intervention is expected to take approximately 1 hour and no more than 90 minutes. Each of these sessions, which are separate from the Stepping Stones group sessions, will take place on a date and time agreed upon by you and the Principal Investigator. These two sessions are the only activities you are being asked to participate in as part of the research. All other activities, such as attending group sessions and completing pre/post assessments, are activities that you would normally participate in as part of the Group Stepping Stones intervention, even if you were not participating in this study. If you do not complete the Group Stepping Stones intervention, the researcher will contact you via phone or email to ask questions regarding your experience and any barriers that prevented you from completing the intervention.

At each visit, you will be asked to:

- Answer questions about your family, your relationship with your child, and your experiences as a parent.

At the second/final visit, you will be asked:

- your opinions regarding the Group Stepping Stones intervention.
- **Audio Recording.** The final interview between you and the Principal Investigator will be audio recorded. The purpose of this is to allow the Principal Investigator to transcribe this interview and analyze it along with the interviews of other participants. Only the Principal Investigator and other study members will have access to the audio recordings. Additional study members might include up to 3 researchers who may assist the Principal Investigator with transcribing the audio recordings and/or analyzing the data obtained from the transcribed interviews. The audio recordings and typed transcriptions will not include your name, your child's name, or your contact information. False names will be used. After data are collected from the recordings, the data will be transferred to a USF Box Account and then immediately destroyed/deleted from the audio recording device. You will not have access to the audio recordings. The recordings are for research purposes only. The Principal Investigator will keep the digital recordings saved in a USF

Box Account for five years after the study is completed, at which time they will be deleted.

## **Total Number of Participants**

About 6 to 12 individuals will take part in this study at USF.

## **Alternatives / Voluntary Participation / Withdrawal**

You do not have to participate in this research study.

You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study.

## **Benefits**

The potential benefits of participating in this research study include:

- You will have an opportunity to share your story regarding being a parent and the aspects of the Group Stepping Stones intervention that you liked/disliked.
- You will also have an opportunity to provide recommendations for changes to the program
- You will have an opportunity to contribute to research regarding the experience of parents who participate in the Group Stepping Stones intervention.

## **Risks or Discomfort**

This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study. However, you may experience mild discomfort resulting from the discussion of potentially difficult topics such as parenting challenges you have experienced.

## **Compensation**

You will be compensated \$20 in gift cards if you complete all the scheduled study visits. If you withdraw for any reason from the study before completion you will be compensated a \$10 gift card for each study visit you complete.

## **Costs**

It will not cost you anything to take part in the study.

## Privacy and Confidentiality

We will do our best to keep your records private and confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. Certain people may need to see your study records. These individuals include:

- The research team, including the Principal Investigator and all other research staff.
- Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety.
- Any agency of the federal, state, or local government that regulates this research. This includes the Department of Health and Human Services (DHHS) and the Office for Human Research Protection (OHRP)
- The USF Institutional Review Board (IRB) and its related staff who have oversight responsibilities for this study, and staff in USF Research Integrity and Compliance.

We may publish what we learn from this study. If we do, we will not include your name. We will not publish anything that would let people know who you are.

## You can get the answers to your questions, concerns, or complaints.

If you have any questions, concerns or complaints about this study, call Tara Delach at [REDACTED]. If you have questions about your rights, complaints, or issues as a person taking part in this study, call the USF IRB at (813) 974-5638 or contact by email at [RSCH-IRB@usf.edu](mailto:RSCH-IRB@usf.edu).

## Consent to Take Part in Research

I freely give my consent to take part in this study. I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form to take with me.

---

Signature of Person Taking Part in Study

---

Date

---

Printed Name of Person Taking Part in Study

## Statement of Person Obtaining Informed Consent

I have carefully explained to the person taking part in the study what he or she can expect from their participation. I confirm that this research participant speaks the language that was used to explain this research and is receiving an informed consent form in their primary language. This research participant has provided legally effective informed consent.

---

Signature of Person Obtaining Informed Consent

---

Date

---

Printed Name of Person Obtaining Informed Consent

## Appendix F: Parent Interview Questions

*Thank you for taking the time to meet with me today. As both an employee of [REDACTED] who sometimes facilitates this intervention and also as a researcher, I am interested in understanding what it is like for parents who participate in the Group Stepping Stones Intervention. Every parent is different and has a unique perspective, and I am interested in knowing what your real experience was like.*

1. Tell me about your experience participating in the Stepping Stones Group Triple P program.
  - a. What led you to sign up to participate in this program?
    - i. Was there a “tipping point” or specific experience that motivated you to seek this intervention?
  - b. What were your goals when you started the program?
  - c. If there is a partner or co-parent, did they participate as well?
  - d. What aspects of the program were most beneficial?
  - e. What aspects of the program did you dislike, or what changes would you recommend?
2. Have you noticed any changes in yourself as a parent since participating in this program?
  - a. To what do you attribute the change (if any)?
  - b. What new information, skills, or strategies did you learn in this program?
3. Describe your relationship with your child.
  - a. What do you enjoy most about being a parent?
  - b. What do you find most challenging about being a parenting?
4. What would you tell other parents who are thinking about participating in the program?
  - a. Would you recommend this program to others, and if so, what would you tell them about this program?
  - b. What advice would you offer to other parents?
5. Is there anything else you would like to add about your experience in the Stepping Stones Program?

### Supplemental Questions

If the parent is in a relationship but has not mentioned their relationship at this point, ask....

1. How would you say this experience impacted your relationship with your partner?

If English is not their first language, ask...

2. How do you think having the information delivered in English influenced your experience?

If parent was absent for any sessions....

3. What contributed to you missing a session/sessions?

### Appendix G: Standard Deviation and Reliability Estimates Used to Calculate Reliable Change

Child Measures	Scale	Standard Deviation of Raw Scores	Internal Consistency Reliability	Source	SEmeas	Sdiff
SDQ	Emotional Symptoms	1.8	0.67	SD from USA normative sample <a href="https://www.sdqinfo.com/g0.html">https://www.sdqinfo.com/g0.html</a> manual); reliability from Goodman (2001), nationwide British sample (not listed in Bourdon study of US sample)	1.03	1.46
	Conduct Problems	1.6	0.63	SD from USA normative sample <a href="https://www.sdqinfo.com/g0.html">https://www.sdqinfo.com/g0.html</a> manual); reliability from Goodman (2001), nationwide British sample (not listed in Bourdon study of US sample)	0.97	1.37
	Hyperactivity	2.5	0.77	SD from USA normative sample <a href="https://www.sdqinfo.com/g0.html">https://www.sdqinfo.com/g0.html</a> manual); reliability from Goodman (2001), nationwide British sample (not listed in Bourdon study of US sample)	1.2	1.7
	Peer Problems	1.5	0.46	SD from USA normative sample <a href="https://www.sdqinfo.com/g0.html">https://www.sdqinfo.com/g0.html</a> manual); reliability from Bourdon et al (2005), US normative data	1.1	1.56
	Prosocial Behavior	1.8	0.65	SD from USA normative sample <a href="https://www.sdqinfo.com/g0.html">https://www.sdqinfo.com/g0.html</a> manual); reliability from Goodman (2001), nationwide British sample (not listed in Bourdon study of US sample)	1.06	1.5
	Total Difficulties	5.7	0.83	SD from USA normative sample <a href="https://www.sdqinfo.com/g0.html">https://www.sdqinfo.com/g0.html</a> manual); reliability from Bourdon et al (2005), US normative data	2.35	3.32
CAPES-DD	Behavioral Problems	7.53	0.89	SD from Hinton et al. (2016) study of parents who participated in triple p online (since only SD ranges listed in Emser; reliability from Emser et al (2016), first psychometric evaluation	2.5	3.53
	Emotional Problems	1.61	0.71	SD from Hinton et al. (2016) study of parents who participated in triple p online (since only SD ranges listed in Emser; reliability from Emser et al (2016), first psychometric evaluation	0.87	1.23
	Prosocial Behavior		0.82	unable to find study with SD; no one in clinical range in current sample		
	Self-Efficacy	21.93	0.94	SD from Hinton et al. (2016) study of parents who participated in triple p online (since only SD ranges listed in Emser; reliability from Emser et al (2016), first psychometric evaluation	5.37	7.59

	Total Problems	8.24	,90	SD from Hinton et al. (2016) study of parents who participated in triple p online (since only SD ranges listed in Emser; reliability from Emser et al (2016), first psychometric evaluation	2.61	3.69
<b>Individual Parent Measures</b>						
Parenting Tasks Checklist PTC	Behavioral Self-efficacy	16.66	0.89	SD and reliability from Tellegen & Sanders (2014) study sample of 64 parents of children with autism (original psychometric study by Wooley & Sanders (2006)only included mothers)	5.53	7.8
	Setting Self-efficacy	12.43	0.89	SD and reliability from Tellegen & Sanders (2014) study sample of 64 parents of children with autism (original psychometric study by Wooley & Sanders (2006)only included mothers)	4.12	5.83
	Laxness-male	0.85	0.69	Rhoades & O'Leary (2007)- more representative sample of males and females (original normative data all mothers)	0.47	0.66
Parenting Scale (PS)	Laxness-female	0.92	0.74	Rhoades & O'Leary (2007)- more representative sample of males and females (original normative data all mothers)	0.47	0.66
	Over-reactivity-male	0.9	0.66	Rhoades & O'Leary (2007)- more representative sample of males and females (original normative data all mothers)	0.52	0.74
	Over-reactivity-female	0.91	0.67	Rhoades & O'Leary (2007)- more representative sample of males and females (original normative data all mothers)	0.52	0.74
	Hostility-male	0.82	0.59	Rhoades & O'Leary (2007)- more representative sample of males and females (original normative data all mothers)	0.52	0.74
	Hostility-female	0.75	0.52	Rhoades & O'Leary (2007)- more representative sample of males and females (original normative data all mothers)	0.52	0.74
DASS-42	Depression	6.54	0.91	SD from Lovibond & Lovibond (1995 evaluating psychometric properties (couldn't obtain manual), reliability from normative sample (Lovibond & Lovibond, 1993)	1.96	2.77
	Anxiety	4.83	0.84	SD from Lovibond & Lovibond (1995 evaluating psychometric properties (couldn't obtain manual), reliability from normative sample (Lovibond & Lovibond, 1993)	1.93	2.73
	Stress	6.94	0.9	SD from Lovibond & Lovibond (1995 evaluating psychometric properties (couldn't obtain manual)  reliability from normative sample (Lovibond & Lovibond, 1993)	2.19	3.1
<b>Parent Relationship Measures</b>						
Parenting Problem	Problem	3.77	0.82	Stallman et al (2009)- normative Australian sample (original psychometric properties	1.6	2.26



Checklist (PPC)				from Dadds & Powell 1991 were for mothers only		
Relationship Quality Index (RQI)	Total	7.39	0.96	Tellegen & Sanders (2014)- 64 parents of children with ASD (could not find data in Norton, 1983)	1.48	2.1

## Appendix H: Researcher Journal

Friday, 4/5/19, 10:00am-12:30pm (PST Session 2/Triple P Session 1)

- Holding back tears when mother (Selena) tearing up, talking about feeling alone, husband not supportive and not believing that something is wrong with their child
- Mom sharing the importance of self-care and I was thinking how wise she is, how we can all learn from her
- I can relate to them as a parent on many levels, many of the things they are talking about, but also can't fully- haven't experienced all of the same things
- really feel for these parents, have so much respect for them. Even taking the time to be here is so commendable
- Feel emotional thinking about what they go through on a daily basis and also feeling happy that they have formed a connection with one another and feel supported.

Saturday, 4/6/19, 10:00am-12:30pm (PST Session 2/Triple P Session 1)

- Wish that participants in this group and the Friday group could share resources with one another
- Notice some of the difference between this group and yesterday's group which was all women. Yesterday's group emphasized feeling protective of their children, having had feelings of incompetence as a parent. Today's group emphasized wanting to teach their child new skills/behavior
- Again, have a feeling of empathy and respect for these parents, acknowledging that I cannot fully understand what they go through on a daily basis. Parenting is challenging even with typically developing children so adding challenging behavior, less independence, etc. would be very stressful, exhausting

Friday, 4/26/19, 10:00am-12:30pm (PST Session 4/Triple P Session 3)

- Selena and husband both participating today. Mom previously shared that dad felt uncomfortable attending because he felt like this was a group for children with disabilities and he did not believe that their child had a disability. Nice to see that dad is now attending. I'm wondering what changed his mind and how he is feeling about the class now. Dad participated and gave input and was also participating in the exercises.
- I felt happy for Selena, as I know it was important for her to have her husband participate. Hoping that he finds the class useful.
- Even though the class is small today (3 participants), I think parents are finding it useful and getting even more 1-on-1 feedback regarding the use of strategies for their particular children

Saturday, 4/27/19, 10:00am-12:30pm (PST Session 4/Triple P Session 3)

- Glad to see that everyone was able to attend today. Parents were very involved and seem comfortable sharing with one another. This group has children of different ages and varying needs so it is interesting to hear the different skills and behaviors that they want to teach their children. I wonder how this impacts the group dynamic.

Friday, 5/3/19, 10:00am-12:30pm (PST Session 5/Triple P Session 4)

- The two GSSTP participants who attended this session missed last week when the group discussed strategies for encouraging behavior they want to see more of. This week they discussed managing misbehavior so I wonder how missing last week's session will impact the effectiveness of the class. They may implement strategies for managing misbehavior without putting the other strategies in place.
- Can tell that these parents truly want to learn new ways to manage their children's challenging behavior. They provide a lot of examples and ask for ways to react in specific situations. I can relate to just wanting someone to tell me exactly how to handle a particular behavior or situation.
- Felt like parents were very receptive to start routine and wanted to understand it, but I feel like they would benefit from in-home, in the moment coaching.

Friday, 5/31/19, 10:00am-11:00am (PST Session 9/Triple P Session 8)

- Only 3 parents present at final session. Parents seem committed to implementing changes but also overwhelmed with life stressors (medical issues, end of school year, etc.). I can relate as a parent and my children don't have special needs, which adds a whole other layer to life stressors

Tuesday, 6/4/19 (Interviews with 3 participants), first Selena at her home, then Noelle and Maria at Noelle's home

- Interviewed three participants from one group. All participants reported positive feelings about the group and said they learned new ways to interact with their children. Two of the parents mentioned feeling judged by other participants when they would discuss their parenting style/strategies and they did not feel a sense of closeness with other group members. The other group member indicated that she liked being part of the group and learning/hearing from others. Two participants did not like the 3 weeks of partner support and I wish they had only done the one day/tip sheet rather than the 3 full weeks. The class really needs to be tailored to the individuals in the class. It would be nice to have a singles group separate from couples.

6/9/19- Interviewed 2 more participants (Roger & Joe) at Barnes & Noble.

- Noticing themes of needing a break/not enough respite, exhaustion and never ending challenges. Also noticing themes of participants learning from one another and appreciating the fact that other people are going through similar things. This particular couple has been having extreme challenges and the situation is sad all around. They are trying so hard and are not able to get the support and resources they need to keep their son safe and to keep him from harming others. I can't imagine the physical and

emotional exhaustion that must come from the level of care and support that their son requires.

6/11/19- Interviewed Kevin and Lisa in their home.

- They both seemed very appreciative of being able to participate in GSSTP. Kevin gave several suggestions for changing the group. He really seemed to like the partner support aspects. Lisa expressed feeling very tired and exhausted. She really liked hearing from other parents and she had positive things to say about the intervention overall. Both of them seem motivated to make changes in order to help their family.

9/17/19- looking at strategies that participants identified as being helpful. Some just noted strategies in general. Others noted things that were not on my original list, such as start routine, giving immediate feedback for consequences. A few listed specific strategies recommended by the facilitators that are not specific to Triple P (e.g. writing down child's history to give to doctor rather than restating it in front of child every time).

10/1/19- while coding and finding themes, found myself feeling heartbroken for parents as well as children, particularly when reading about how the relationship is strained due to the child's behavior or physical needs

10/21/19- reading back through Family Experience Questionnaires- Sense a feeling of parents being worn down by challenges of parenting. Taken aback at description of "love/hate" relationship that Joe described. Felt his statement "everyday is a challenge and everything is a struggle" was very powerful.

10/29/19- Have been revising themes and subthemes and creating code book over the past week. Hearing how these parents describe their kids and also their hopes and aspirations, I can relate but also know that my insight is limited to what other parents tell me or what I see. I can't truly know what it is like for them. Their daily struggles and challenges are much greater than what I experience with my own children. It makes me reflect on my own parent-child relationships and wonder how those would be impacted by challenging behavior, constant medical/therapy appointments, etc. It is hard to imagine.

1/4/20- I have been in the process of writing the results of my thematic analysis. Reviewing all of the quotes and organizing them has helped me see patterns more clearly. It seems like benefits that parents receive from GSSTP depend on how challenging their situation was prior to starting the class. For parents whose children exhibit extremely difficult behaviors (e.g. Roger and Joe) and parents who have multiple children who have special needs (Noelle), the class seemed to be helpful but perhaps not as impactful.

## **Appendix I: GSSTP Member Checks**

### Noelle

The interviewer met with Noelle for 1 hour approximately 9 months after she completed GSSTP. Noelle reported that the descriptions and quotes in the document were representative of her and her opinions. She shared that she still feels the same way regarding her views about parenting and her parenting practices, such as a belief that parents should be strict with their kids and that spanking is an effective means of discipline. Noelle shared that she and her friend attended a Spanish Stepping Stones class following the study and she was able to relate more with the parents in that class. She said, “In the Spanish class, everyone spanked their kids,” and she reported that she did not feel as judged by those parents. She also liked the book that they used in the Spanish class and said that it was “more in depth” than the book that was used in the English class. Noelle reported that she felt that it would be helpful to have a class geared towards parents of children whose disabilities are “more severe.” She explained that her youngest son has more severe disabilities than a child who “just has ADHD,” for example, and she felt that some of the strategies were not practical for him.

Noelle also shared some updates regarding her family. She now has a car, which has made it easier to get her sons to their appointments and activities. Her younger son has started talking more but it is “more echolalia.” She said that he no longer receives OT because the therapist said that she could no longer work with him due to his meltdowns and tantrums. Noelle expressed frustration with this, stating that the therapist moved the appointments to a later time when her son is tired and more likely to have meltdowns. Noelle said that her son still receives speech therapy, although she said he has had three different providers in the last year due to therapists leaving. Noelle reported that her son is still on a waitlist for ABA services, meanwhile his behavior is “just getting worse.” Noelle shared that her son has also experienced more medical issues. She explained that he had to have surgery related to the tubes in his ear, he had to be put under anesthesia to have 7 crowns placed on his teeth, and he recently had to have an MRI. She shared that her son also has had strep, and he was allergic to 4 of the antibiotics that they used to treat the strep. Noelle reported that her son’s doctor was concerned he may have PANDAS due to the changes that occurred in his behavior around the time he had strep. Noelle also expressed worry that her son may have some type of autoimmune disorder. She explained that he has gone into anaphylactic shock three times in the last 2 months and two of the times occurred first thing in the morning when he had not been exposed to food or any other known allergens.

### Kevin and Lisa

The interviewer met with Kevin and Lisa for 1 hour approximately 9 months after their completion of GSSTP. Kevin and Lisa both indicated that the descriptions and the quotes used in document were representative of them and their thoughts and opinions. The said that it was

nice to hear the quotes because it reminded them of their time in the group. The both acknowledged that they still try to implement some of the strategies that they learned in GSSTP but they noted how easy it is to revert back to some of their old habits, such as yelling. Kevin said that raising his voice is effective at getting his daughter's attention so he will sometimes resort to that after he has told her something calmly multiple times and she does not comply. Kevin said that it can be hard to not yell when it seems to work better than other strategies. Like Noelle, Kevin and Lisa mentioned that it might be beneficial to group GSSTP classes based on the type of disability or intensity of problem behaviors. They recalled that there were some parents in their group who were experiencing severe challenges and they felt that those parents probably would have liked to be able to talk to others who were experiencing similar challenges. Kevin and Lisa indicated that they would like to attend another GSSTP class in the future. They both reiterated how nice it was to talk with other parents who were experiencing similar concerns and they talked about how isolating it can feel when you have a child who has a disability. Lisa explained that "friends stop inviting you to things." She indicated that they do not spend time with friends like they used to before they had children.

Kevin and Lisa provided updates regarding their family. They said that their daughter is talking much more now and they are able to communicate with her much better now. They also said that their co-parenting relationship is better and they are more on the same page than they were prior to GSSTP.

#### Deborah

The interviewer met with Deborah for one hour approximately 9 months after the GSSTP intervention completed. After reviewing the descriptions and quotes in the document Deborah reported that they were all representative of her experience. Deborah indicated that she is still using some of the strategies that she learned in GSSTP such as the Planning Ahead Routine, the Start Routine, clear, calm instructions, rewards, etc. She indicated that her son has been doing better with maintaining routines since she broke them down into tasks. She recalled using the Planned Activities Routine when they took a trip to Europe over the summer, which she said was very helpful. Deborah reported that she has been able to increase her son's independence by being very clear about her expectations, breaking things into smaller tasks, and being intentional about the rewards that her son can earn. Although Deborah has noticed positive changes at home, she described continued challenges with her son's behavior at school. She shared that he was moved to a different school in order to be in a smaller classroom because he was having increasingly challenging behavior issues in school. She indicated that it has been difficult to find a setting that can meet his behavioral needs as well as his needs related to giftedness. Deborah reported that her son still struggles with transitions and that unfortunately he does not like school at all. Deborah said her son has had behavioral difficulties when engaging in activities such as scouting, so he stopped attending but she has started taking him to art classes and he seems to do better there. Deborah shared that she is still looking for another activity for him to participate in and she is thinking of something like tennis or biking since he tends to get competitive and have behavioral challenges with team activities.

### Roger and Joe

The interviewer met with Roger and Joe via Zoom (virtual teleconference) approximately 9 months after the intervention completed. Roger and Joe shared that their son, Jake, has been living in “a behavioral group” as of approximately 2 months after the intervention ended. They said that he is also attending a new “ESE school” for students with special needs. Roger and Joe said that they have seen significant improvement in Jake’s behavior since he started living in the group home. They explained that his “toileting behaviors are better” and he is “actually engaging in school” and working on a 2<sup>nd</sup> grade level. They explained that Jake still has toileting accidents but they are not occurring as frequently and he now has an ABA therapist to assist with toileting. Roger reported that they ended their relationship with the prior ABA company that was working with Jake at his school. He explained that prior to Jake moving to the group home, his school was sending Jake home daily due to behavioral concerns but the ABA therapists “would not work with him at home.” He reported that they have seen positive improvements in Jake’s behavior since they switched ABA companies. Roger reported that Jake “still has tremendous issues in terms of managing anger” but that the staff at the group home are better equipped to manage those behaviors in order to keep him safe. Roger and Joe reported that they are still able to see Jake and take him on outings and to his doctor appointments, etc. They also reported that Jake’s behavior is much better now when they take him out in public. Roger and Joe both said that it was an incredibly hard decision to place Jake in a group home but they felt they had exhausted all resources and they were unable to get the level of support that they needed at home. They said that Jake likes being at the group home because he has friends and playmates. They reported that he gets to spend a lot of time outside playing and exercising, which has been good for him. They reported that Jake gets very excited to see them and they think it is good for him to see that they “are still in the picture, [they] still care about him, and [they] haven’t stepped out of the picture.” In terms of their own well-being, Roger and Joe reported noticing positive changes in their own physical and mental health since Jake moved to the group home.

## Appendix J: Triple P Permission to Use Form



### PERMISSION TO USE FORM

Tara Delach is a doctoral student at the University of South Florida in Tampa, Florida. She has recently completed her dissertation study (the 'Work') on the experience of parents participating in the Group Stepping Stones Triple P intervention.

Tara Delach has requested permission to include several Triple P images and tables, which she has copied or produced based on the Triple P curriculum. Before submitting her dissertation to her school's electronic thesis and dissertation platform, she has requested permission to include these tables and images, which are attached ('Attachment'). Each one has been included in her dissertation in order to help the reader understand the intervention and the background behind her study. She will be including references for each one and will not be presenting them as her own work.

In response to the request made by Tara Delach, I, John Raymond Robins, Head of Licensing and Strategic Alliances, of Triple P International P/L, the Exclusive Global Licensee for the dissemination of the Triple P- Positive Parenting Program ('Triple P'), being duly authorized to do so, give my permission to include the tables and images as shown in the Attachment. Collectively, the tables and images in the Attachment are referred to as 'the Material'.

I hereby grant Tara Delach the right to use this Material as follows:-

- in the Work and in any related derivative and ancillary Works published by her;
- for non-commercial distribution in print and/or electronic delivery platforms related to the University of South Florida in Tampa, Florida;
- on the understanding that the source(s) of the included Material will be fully identified in the Dissertation; and
- on the undertaking that any use of the Work will be for non-commercial purposes.

SIGNED BY:

John Raymond Robins LL.B



Head of Licensing and Strategic Alliances  
Triple P International Pty Ltd

Triple P International Pty Ltd ABN 17 09 03 817

11 Market Street North, Indooroopilly Qld 4068 PO Box 1300 Milton Qld 4064 Australia tel: +61 7 3236 1212 fax: +61 7 3878 5510 web: www.triplep.net