Summer 2023

The Strong Families Program: Utility of Telehealth Parenting Skills Psychoeducation

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THE STRONG FAMILIES PROGRAM:

UTILITY OF TELEHEALTH PARENTING SKILLS PSYCHOEDUCATION

by

GRACE PROSPERI

(Under the Direction of C. Thresa Yancey)

ABSTRACT

Externalizing behaviors in children are a common problem experienced by many parents. If untreated, externalizing behaviors are associated with more serious consequences (Hann, 2012). Parents of children with behavior issues also report higher levels of stress (Dumas et al., 2009). Parenting stress is related to lower life satisfaction for parents and increased negative outcomes for children living in the home. Parent training programs, incorporating attachment building and discipline strategies, combat childhood externalizing behaviors in clinical settings. While reducing childhood externalizing behaviors is the main aim of parent training, there are other benefits to gaining parenting skills such as increased familial problem-solving and coping skills. Group delivered interventions reach more individuals and provide services more easily than individually delivered interventions for underserved and rural communities. Seventeen parents (including biological, adoptive, foster, and other caregivers) completed a 6-week parent training program provided in a group setting via telehealth. Results indicate the program resulted in reductions in externalizing behaviors, but no significant changes occurred for parental stress or family problem solving skills, possibly due to underpowered analyses. Future studies should continue to examine the utility of this and similar programs to better understand the usefulness of their implementation with larger sample sizes.

INDEX WORDS: Parent training, Externalizing behaviors, Parent, Attachment, Discipline, Familial problem solving, Parenting stress, Telehealth for families, Rural parent training, Group parent training, Rural telehealth

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B.S., Missouri State University, 2018

M.S., Georgia Southern University, 2020

A Dissertation Submitted to the Graduate Faculty of Georgia Southern University

in Partial Fulfillment of the Requirements for the Degree

DOCTOR OF PSYCHOLOGY

COLLEGE OF BEHAVIORAL AND SOCIAL SCIENCES

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Electronic Version Approved:
May 2022

DEDICATION

This dissertation is dedicated to the foster and parenting community of South Georgia. Your passion to raise strong families and happy children made this study possible. It was an honor to work alongside you.

ACKNOWLEDGMENTS

First, I would like to thank my parents, Vince and Susan Prosperi, who taught me the best way to parent is with unconditional love. Thank you for always believing in me and supporting my dreams.

I express my sincerest appreciation for my mentor Dr. Thresa Yancey. You were always there to support with wisdom, kindness, and cheesecake. Thank you for always keeping an open door just in case I needed advice, encouragement, or just a good laugh. I couldn't be more grateful to have had you on my side for all these years. Special thanks to Sara, some of my fondest memories will always be sitting in front of the computer with you as my co-therapist. Thank you for always coming to session with so much joy and patience.

To Lindsey and Kayleigh who made Statesboro feel like home. Thank you for laughing with me through the good and stressful times. To Evan, I couldn't have made it through the long days without your love and constant support. Thank you for always being there to cheer me on.

Finally, I would like to thank the members of Bulloch County who helped bring our study to the community. Thank you for sharing our study with your friends, neighbors, and colleagues. This study took a village, and we had a great one.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

INTRODUCTION

Purpose of the Study

The purpose of the current study was to examine the impact of a short term, group formatted parent training program in a telehealth format. The parent training program examined in the study (the Strong Families Program) intends to reduce externalizing behaviors in children by training parents to use attachment and evidence based discipline in their homes (Slusher, 2019). If it is efficacious to deliver the program via telehealth in a shortened group, format it would minimize cost and provide accessibility to rural and underserved communities. Additionally, the current study examined the program's impact on familial problem solving and parenting stress overall through the course of the group. Externalizing behaviors and parenting stress were expected to decrease and familial problem solving was expected to increase over the course of the program.

Externalizing Behavior

Externalizing Behaviors include defiant or aggressive behaviors (Ni et al., 2019) and are relatively common in children over the age of two. For example, temper tantrums, failing to comply with instructions, and mild aggression are commonly reported behaviors by parents of young children (Liu, 2006). Certain externalizing behaviors at mild levels are typical in the normal development of children and vary in frequency and severity from child to child (Miner & Clarke-Stewart 2008). As many as 50% of parents with children in the three- to seven-year age group report some form of externalizing behavior in their children (Achenbach & Edelbrock, 1981; Broidy et al., 2003). Typically, most parents see a decline in externalizing behaviors around age 7, lasting through adolescence (Bogner, 2007).

While externalizing behaviors are typical for most children, if they are left unaddressed, they may lead to more serious behavioral concerns. In some cases, externalizing behaviors may develop into a diagnosable behavioral disorder such as Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD; Bardone et al., 1998). Oppositional Defiant Disorder is a prevalent childhood psychological disorder

involving severe externalizing behaviors such as defiance, disobedience, and hostility toward authority figures (Erford et al., 2014). Five to six percent of children aged eight to 16 develop ODD (Fraser & Ray, 2008). If left untreated, ODD behaviors may exacerbate and meet criteria for Conduct Disorder (Freitag et al., 2018). Specifically, children with ODD who display defiant, argumentative, and vindictive symptoms have the highest risk for developing conduct disorder (APA, 2013). CD, with a prevalence rate of two to 10% (APA, 2013), impacts adolescents and children and is characterized by behaviors such as aggression, hostility, deceitfulness, violence, destruction of property, and serious violations of the law (Lillig, 2018). CD is typically diagnosed in later childhood and adolescence, and, for some children, ODD can be a precursor to a diagnosis of CD (Lillig, 2018). Most children diagnosed with CD displayed externalizing behaviors earlier in their development (Pardini & Frick, 2013).

A common trajectory for people who display antisocial behavior as adults begins in their childhood with externalizing behaviors escalating to oppositional defiance disorder and then into conduct disorder (Rowe et al., 2011). Behavioral disorders, such as conduct disorder and oppositional defiant disorder, are associated with a higher risk for adult psychiatric disorders such as major depressive disorder, bipolar disorder, and antisocial personality disorder (Bardone et al., 1998). Predicted outcomes for children with diagnosable behavioral disorders also include a higher risk for suicide and non-suicidal self-injury in adulthood (Bardone et al., 1998).

Children with behavior issues also experience higher rates of social consequences, such as educational loss, occupational difficulties, and substance use, as they become adults (Bettencourt et al., 2016). Atypical externalizing behavior not only impacts achievement but can affect an individual's ability to connect with others and create relationships later in life. Decreased prosocial behavior in adulthood is correlated to increased levels of externalizing behavior during childhood, leading to a lack of social network and, in some cases, isolation (Memmott et al., 2020).

Externalizing behavior can not only predict negative outcomes in adulthood, but these outcomes are observed as soon as adolescence. Social consequences for prolonged externalizing behavior start in adolescence and can last throughout a lifetime. Children with higher rates of externalizing behavior in

childhood are more likely to display antisocial behaviors in adolescence such as underage alcohol consumption, deviant sexual behavior, and violence toward peers (Regan et al., 2020). Childhood externalizing behaviors are also associated with a lack of concern for negative consequences of substance use in adolescence (Regan et al., 2020). Furthermore, childhood externalizing behaviors are associated with a risk for juvenile delinquency and crime later in life (Hann, 2012). Without intervention, behavioral issues tend to become pervasive throughout a child's life.

In some cases, typical parenting practices are not enough for more serious externalizing behaviors (Reynolds & McGrath, 2005). Early intervention for behavioral concerns can change the course of the child's behavior as they grow, enhancing resiliency, and increasing prosocial behavior (Reynolds & McGrath, 2005). Furthermore, early interventions for behavioral concerns have higher success rates than interventions for externalizing behaviors that have exacerbated into more serious antisocial behavior (e.g., law breaking, violence, vandalism; Tully & Hunt, 2015). Behavioral interventions utilizing parenting skills training are effective at reducing externalizing behaviors in the short term as well as through the lifespan (Nowak & Hendrichs, 2008). Early intervention for behavioral problems reduces the need for later interventions and prevents the negative consequences associated with childhood behavioral problems, including those associated with diagnoses of ODD and CD. Using psychoeducation to implement parenting interventions gives parents the tools to extinguish a variety of externalizing behaviors as they occur throughout childhood. Externalizing behavior may manifest in different forms as the child develops but implementing interventions for parenting instead of treating the child's behavior alone provides parents with the skills to manage different behaviors and these interventions may generalize to other issues that arise (Nowak & Hendrichs, 2008). While externalizing behaviors are associated with serious consequences later in life, there are effective interventions to adjust behavior and reverse negatives outcomes (for further details, see Rationale for Parent Training section below).

Family Problem Solving

Familial problem-solving strategies are an important coping factor for most families. When there is a lack in familial problem-solving skill, negative consequences can ensue, such as marital problems,

interpersonal negativity, and substance use (Rueter & Conger, 1995). These consequences can result in exacerbated externalizing behaviors in children (Pindershughes, 2000). Problem solving skills can help families cope with everyday stressors as well as larger crises. Utilizing familial problem-solving strategies helps families bond through teamwork and group empathy (Keyzers, 2019). Families working together to solve problems can bond over that work and use their resources to resolve concerns. Increasing problem-solving strategies used in family systems allows families easily accessible coping strategies during times of stress. Furthermore, strong family coping strategies in times of stress are associated with fewer child externalizing behaviors (Frank et al., 1996). Strong familial coping is also associated with lower risk of externalizing behaviors in adolescence, preventing behaviors such as risky sexual behaviors, substance use, and academic trouble (Modeki et al., 2017).

Family problem solving skills are typically developed by parents and then learned by their children (Kieran et al., 1996). These problem-solving skills are used not only in the family home by children but are adapted and used outside of the home. The more robust a family's problem-solving skills, the more resilient a child may be to problems they face in their own lives, separate from the family unit (Kieran et al., 1996). Parents showing children proficient problem-solving skills gives children a model for developing their own problem-solving skills. Children whose parents have stronger problem-solving skills typically have better problem-solving skills than children whose parents have less robust problem-solving skills. (Jewsbury Conger et al., 2009). Having more developed problem-solving skills leads to greater positive outcomes for children when they reach adulthood (Jewsbury Cogner et al., 2009).

While problem solving skills are beneficial to parents and their children, a lack of them is associated with externalizing behaviors. Children diagnosed with conduct disorder, a disorder categorized by severe externalizing behaviors, often have families displaying lower rates of positive problem-solving skills (Sanders, Dadds, Johnston, & Cash, 1992). Additionally, children experiencing externalizing behaviors early in childhood who were later taught problem-solving skills had better outcomes than children who were not taught these skills (Stratton et al., 2003). Introducing problem solving skills at a

young age is related to more positive outcomes (Stratton et al., 2003). If a child sees problem solving skills utilized in the family unit, they develop those skills for use outside the family unit.

<div align="center">**Parenting Stress**</div>

Parents of children with behavior issues also experience increased stress compared to parents of children without behavior issues (Dumas et al., 2009). High levels of parenting stress contribute myriad consequences for parents including an increased risk of psychological disorders, substance use, and social isolation (Crnic et al., 2005). These consequences impact not only the affected parent, but the entire family unit. Children with parents experiencing psychological disorders, substance use, or social isolation experience negative outcomes with education, income, and substance use themselves (Pindershughes, 2000). A lack of social support and feelings of control are cited by many parents of children with behavioral issues (Offord & Bennett, 1994). These parents report feeling they lack the skills to handle the problem and have no one to turn to for support.

Many parents do not seek help for parenting stress related to child misbehavior due to fear of judgment from their peers and mental health professionals (Jones et al., 2017). Parents of children with behavior issues may see their child's misbehavior as a parenting failure and blame themselves for the stress they are enduring as a result of that misbehavior. When parents decide to engage in therapy for their child's behavior issues, they are likely experiencing high levels of parenting stress over an extended period (Jones et al., 2017). Parents in treatment for childhood behavior problems reporting higher levels of parenting stress have higher attrition rates than parents experiencing lower levels of stress, undermining treatment efforts (Friars & Mellor, 2007). Higher parenting stress correlates with more severe behavior issues in children, meaning higher stress in those parents could prevent children needing behavioral intervention the most from accessing professional services to ameliorate the problem (Friars & Mellor, 2007).

Inadvertently, parents' behaviors may be related to the development of child behavior problems. Patterson's (1982) coercive process theory explains how child behavior problems develop and are maintained through inadvertent parental reinforcement (i.e., negative attention and escape from demands

following child misbehavior or noncompliance). This coercive process reinforces noncompliance, which causes parents to escalate their demands until the child is forced to comply, reinforcing the parents' escalation of demands. This process creates a cycle that continually escalates child misbehavior and, consequentially, parental stress. Therefore, there are numerous consequences to childhood behavior problems for both the child and the parent which are often developed and maintained through a coercive process of demands and reinforcement.

Rationale for Parent Training

The coercive process theory explains how, without intervention, children's problematic behaviors may increase. Fortunately, empirically informed parent training programs show good results in treating externalizing behavior problems. Parent training programs, such as Parent-Child Interaction Therapy (McNeil & Hembree-Kigin, 1995, 2010), Triple P Parenting (Sanders, 2001), and Helping the Non-Compliant Child (McMahon & Forehand, 1981), among others, apply strategies outlined in the Hanf Model (McMahon & Forehand, 2005). The Hanf model was created by Dr. Constance Hanf at the Oregon Social Learning Center (Hanf, 1969) and uses attachment, behaviorism, and social learning strategies to diminish child externalizing behaviors. The original intervention by Hanf focused on differential attention for desired and undesired behaviors in phase one of treatment and teaching clear direction giving and consistent consequences for compliance/non-compliance in phase two of treatment (Hanf, 1969). Dr. Sheila Eyberg built on Hanf's intervention to be more inclusive of Baumrind's parenting theories (Eyberg, Boggs, Algina,1995) – leading to current parenting interventions using traditional play therapy techniques (taught to parents) in Phase One and consistent direction giving and behavioral consequences for compliance/noncompliance in Phase Two (Eyberg et al., 1995; Forehand & McMahon, 1981; McNeil & Hembree-Kigin, 2010). Current parent training programs for children's externalizing behaviors enhance child and parent bonds (via teaching play therapy skills to parents to strengthen the parent child relationship) and increase consistent discipline utilizing differential attention for misbehavior (noncompliance) and acceptable behavior (compliance; Eyberg et al., 1995, Forehand & McMahon, 1981; McNeil & Hembree-Kigin, 2010).

The underpinnings for teaching parent training skills go back to the beginnings of behaviorism, attachment, and social learning theories. John Bowlby's attachment theory (1969) emphasizes the influence a parent's attention to their child through warmth and responsiveness has on the child's behavior and development. This is highlighted in parent training programs through time dedicated to developing and strengthening bonds between the parent and the child. This typically takes the form of child-led play between the parent and child (e.g., special play, Child Directed Interaction, Child's Game) which in turn builds and enhances secure attachment between the child and caregiver (Eyberg, 2004; Forehand & McMahon, 1981; McNeil & Hembree-Kigin, 2010).

In 1938, B. F. Skinner used rats and pigeons to investigate the use of operant conditioning to modify behavior. He found, through positive and negative reinforcement, we can not only predict the behavior of animals, but influence the behavior as well. In 1977, Bandura took operant conditioning a step further and proposed there was a cognitive element involved. Bandura stated children do not just adhere to pure behaviorism but observe the environment and behaviors of others, including their caregivers, to model their own behaviors (social learning). Bandura (1977) reported children cognitively process consequences and rewards to their behavior and learn to respond to stimuli based on these cognitive processes. Parent training programs apply a similar theory to adjusting children's externalizing behavior. Parents attend to their children's behaviors with differential reinforcement, so the child learns to associate either a consequence (e.g., time out) or a reward (e.g., parental attention) with their behavior. Consequences come in the form of a strict discipline procedure following every incident of child misbehavior (i.e., consistent consequences). Soon, children learn to associate the consequence with their behavior and adjust their behavior to avoid the consequence (Hanf, 1969).

The inclusion of both relationship-building components (attachment) and consistent expectations and consequences (behaviorism) leads to a less coercive parent-child relationship. Diana Baumrind researched parenting styles and the impact of those styles on children's outcomes. She found children not only had a need for boundaries and discipline, but also a need for warmth and care (1966). The balance between nurturing and discipline is referred to as Authoritative parenting. When parents attend to their

children by giving them attention, they are showing their child they will be available when the child needs them. While behavioral techniques work to shape the behavior of the child, building attachment solidifies those behaviors by creating a stronger parent and child bond (Baumrind, 1968). Including both attachment and discipline in a treatment training program lays the strong relationship foundation so the child adjusts to the new discipline protocol (McNeil & Hembree-Kigin, 2010). Parent training programs for externalizing behaviors in children teach parents to use an Authoritative style of parenting (Eyberg et al., 1995, McNeil & Hembree-Kigin, 2010).

Rural Accessibility to Treatment

Behavior management treatment for children with externalizing behaviors are effective and well researched, but there are roadblocks to accessing them for some populations (Smalley et al., 2012). A shortage of professionals trained in behavioral management therapies exists, with a particular scarcity in rural areas. This necessitates families to travel long distances to receive treatment or go without professional help (Kazdin, 2008). Psychotherapy services can be expensive, resulting in lower income families being unable to obtain services even when they are available. Low income families from rural areas may be particularly unable to access resources to alleviate externalizing behavior in children, putting their families at higher risk for negative consequences of untreated behavioral issues.

One way to ease financial impediments to receiving care is to offer services in group format as group therapies are generally less expensive per person (Smalley et al., 2012). Parent training programs delivered in a group setting are more cost effective compared to individual delivery (Sampioa et al, 2018). More people accessing the same care at the same time also cuts down on the use of resources needed for treatment. Instead of the same resources being used repeatedly by different individuals, they are shared in one setting. This allows a therapist to treat more families over the same time frame. Translating therapies into a group format is also a popular way for rural professionals to provide access to therapeutic services to a larger group of people, as more individuals can receive services in areas where there are few available providers (Smalley et al., 2012).

While there is less research on the utility of offering behavioral management therapies in group vs. individual formats, the available literature suggests translating individual parent training programs into a group format does not diminish treatment gains related to child externalizing behaviors (Lyon & Budd, 2010; Niec et al., 2016). In addition, group treatments with shorter delivery times also show promise (Slusher, 2019). Reducing the number of sessions needed for effectiveness may be particularly helpful to reach underserved families in rural areas. This study aims to further investigate the utility of a six-week group format for a behavioral management therapy (i.e., The Strong Families Program; Slusher, 2019) to provide a lower cost alternative to individuals seeking treatment for their family.

As a further burden, families living in rural communities can encounter extensive travel distances to receive care (Celaya et al., 2006). Travel for psychological services can create unique challenges. Traveling requires time and money, resources individuals living in rural communities may have less access to (Smalley et al., 2012). Providing therapy in a telehealth format can offer more accessibility for those in rural areas (Morland et al., 2015). Using a telehealth format removes travel barriers because parents are able to access care in their own homes by connecting virtually with treatment providers.

Recent research investigated the utility of translating parent training programs into remotely accessible formats. Comer et al. (2017) examined parent training services via video conferencing and found no significant difference between in person and virtual implementation of parent training. Using a virtual delivery also gives therapists a unique view into a family's home life and delivering skills to parents directly in their home may benefit in generalizing these skills to the environment where problematic child behaviors normally occur (Comer et al., 2015). Telehealth gives therapists the ability to see parents' responses to their children's externalizing behavior in the environment where they typically manifest. In turn, the therapist and parent can troubleshoot implementation of skills right in the moment they happen (Comer et al., 2015). While using a telehealth format for parent training programs is becoming more prevalent, there is still a shortage of research for this type of delivery, especially in a group setting. Using telehealth to provide care for families needing help managing externalizing behavior can enhance accessibility by eliminating travel barriers and reducing cost associated with care. The

current study examined the utility of delivering via telehealth a brief (6-session) group format parent behavior management program with demonstrated utility using an in-person delivery (Slusher, 2019).

Current Study

Externalizing behaviors left untreated can result in a variety of negative consequences for not only the child but the family unit as well (Crnic et al., 2005). Parent training reduces externalizing behaviors in children and can result in added benefits for the family unit such as increased problem solving and coping skills and reduced parenting stress (Eyberg et al., 1995, Forehand & McMahon, 1981; McNeil & Hembree-Kigin, 2010). Increasing coping and problem skills helps improve family bonds which can lead to lower risk for negative outcomes for children (Jewsbury Cogner et al., 2009; Keyzers, 2019). Decreased parenting stress positively impacts the parent's and child's overall wellbeing (Jones et al., 2017). While parent training is effective, it can be difficult to provide care to underserved and rural populations (Kazdin, 2008; Lyon & Budd, 2010; Niec et al., 2016). Utilizing a short group format reduces treatment length and provides care to more individuals at the same time making it more accessible for families. A virtual delivery further provides accessibility for people who have transportation difficulties or are located in areas far from providers. Examining the effectiveness of a shortened parent training group with a virtual delivery may result in evidence of the utility of methods of delivery providing more available care for more individuals needing help reducing their child's externalizing behaviors.

Using the Strong Families Program, a manualized 6-week group treatment with documented success in reducing child externalizing behaviors and parental stress (Slusher, 2019), the current study modified the parent training to a telehealth format. In addition, family problem solving skills changes were evaluated to ascertain if these skills, which research indicates are related to externalizing behaviors, were also impacted via the parent behavior management program. Parents were expected to report a decrease in their child's behavior problems and their own parental stress and an increase in positive familial coping and problem solving strategies following engaging in the 6-week group program via telehealth.

The current study explored the following hypotheses:

Hypothesis 1 - Externalizing behaviors in children were hypothesized to decrease with implementation of the Strong Families Program.

Hypothesis 2 - Parenting stress was hypothesized to decrease with implementation of the Strong Families Program.

Hypothesis 3 – Familial problem ratings were expected to increase with implementation of the Strong Families Program.

CHAPTER 2

METHOD

Context of the Current Study

The current study used the Strong Families Program manual, with minimal changes (Slusher, 2019). The original manual included two group types (Standard and Resilience); however, findings indicated no difference in children's externalizing behaviors or parental stress between the two group formats (Slusher, 2019). Therefore, the current study utilized only the Standard group manual. Further, the original Strong Families Program was created for in-person delivery. The current study used a telehealth format, but used the manual as written for in-person delivery (no changes were made aside from live telehealth vs. in person delivery). The original program had caregivers who were not being individually coached practicing skills independently in a room with other caregivers also awaiting individual coaching (see Appendix for program outline). For telehealth delivery, participants were placed in individual virtual waiting rooms, and thus did not have this shared space/time with other caregivers in the program. No other alterations were made to the manualized program.

Procedure

Participants self-selected to attend the Strong Families Program (see below for details). The psychoeducational group met via telehealth once a week for six weeks with a one-week break, generally occurring between the third and fourth sessions. Doctoral students in a clinical psychology program, supervised by a licensed psychologist, conducted the program. A total of four therapists across five rounds delivered the program for the current study. Rounds one through four were conducted by the same pair of student therapists, including the program director. Round five was conducted by another pair of student therapists supervised by the same licensed clinician and trained by the two previous therapists. All participants met with the program director prior to starting the group to complete informed consent paperwork. Weekly meetings were 90 minutes duration. Caregivers completed the self-report measures about their children's behavior, parenting stress, and their family interactions at pre-treatment, mid-point, and end of treatment via an online survey.

The group followed the Strong Families Program Treatment Manual, outlined in the Appendix (Slusher, 2019). Therapists were trained by a licensed supervisor with experience implementing the Strong Families Program. The first session introduced families to the treatment and taught and demonstrated relationship-building skills to enhance the parent-child bond. In Session 2, participants received individual *in vivo* coaching while practicing the relationship-building skills with their child. Participants who were not being coached by the therapists were encouraged to practice learned skills in their homes while waiting in a zoom breakout room for their individual coaching time. Session 3 introduced discipline skills; participants learned to give effective instructions, determine compliance, and differentially respond to compliant (praise) and noncompliant (time out sequence) behaviors. In Sessions 4 and 5, participants received individual *in vivo* coaching while practicing the discipline skills with their child. Session 4 led caregivers to develop new "house rules" for their children to follow. Session 6 (final session) included practice of previously learned discipline skills, delivery of individualized recommendations for further amelioration of externalizing behaviors, and education on adapting the discipline skills to situations outside of the home. Further, at the final group participants were debriefed and, if needed, provided referrals for continued treatment.

<div align="center">**Participants**</div>

Participants were 17 parents or caregivers of children (ages two to six years) displaying externalizing/oppositional behaviors. This research program was implemented in a rural community in the southeast United States. Participants self-selected to attend a six-session group psychoeducational treatment focused on learning behavioral parenting skills to assist with reducing oppositional behaviors (The Strong Families Program). Recruitment occurred via flyers posted in local pediatricians' offices, online communities, local schools, and foster parent coordinators. Participants were over the age of 18 and were the parent/caregiver for at least one child between the ages of two and six years who displayed oppositional behaviors (e.g., noncompliance, disruptive behaviors). No other inclusion/exclusion criteria were utilized.

For the current study, groups were conducted between October 2020 and November 2021 with 4 to 6 participants in each round of group psychoeducation. Most participants (16; 94.1%) completed all six sessions, with one participant (5.8%) missing the last session. Three participants (17.6%) missed one session with the group but attended a make-up session individually with one of the co-therapists prior to the subsequent session with the group. While some partners/spouses also attended the group sessions, all participants who completed assessments identified as the mother role in their family ($N = 17$). Most participants identified as women ($n = 16$; 94.1%), with one participant identifying as non-binary (5.8%). Interestingly, there was some diversity in the type of parent enrolled in the study. Eight participants (47%) reported they were biological or adoptive parent of the child with oppositional behaviors who prompted attendance, eight participants (47%) identified as the foster parent of the child with oppositional behaviors who prompted attendance, and one participant (5.8%) identified as another caregiver of the child with oppositional behaviors who prompted attendance (e.g., a grandparent, aunt, or other relative). The large foster parent enrollment is attributed to recruitment from the foster family community.

While most participants identified as Caucasian ($n = 13$; 76.5%), three participants identified as African American (17.6%), and one identified as Asian American (5.8%). Most participants had a college degree or some college credits ($n = 12$; 70.6%) and three participants had an advanced degree (masters or doctorate degree; 17.6%). One participant had a high school diploma (5.8%) and one participant chose not to respond to questions about education history (5.8%). While the program and study were designed for parents and caregivers of children ages two through eight years, participants' identified children's ages ranged from two to five years. Most of the children whose behaviors prompted participation were boys ($n = 12$; 70.6%). See Table 1 for full demographic information.

Participants were compensated with a $10 gift card for each assessment period (pre, mid, and post) completed. While participants were also offered a $10 gift card for a follow up survey (1 month post treatment), no participants completed the post treatment assessment. Additionally, foster families who participated earned nine hours of parent training to submit to the Georgia Department of Child and Family Services (DFCS) toward their required annual continuing education.

Table 1

Table 1. Participant Demographics

Variables	Frequency	Percentage
Household Income		
$10,001-$20,000	2	12%
$20,001-$40,000	3	18%
$40,001-$60,000	1	5%
$60,001-$80,000	2	12%
$80,001-$100,000	3	18%
Above $100,000	4	23%
Child Age		
Two years (2)	3	18%
Three years (3)	5	29%
Four years (4)	4	24%
Five years (5)	5	29%

Note. Two participants chose not to disclose their household income.

Measures

Behavior Assessment System for Children, Third Edition (BASC-3; Reynolds & Kamphaus, 2015). The BASC-3 measures functioning in individuals aged two to 25 years. The Parent Rating Scales (PRS), where caregivers of children answer questions related to their child's functioning, were used for this study. The BASC-3 PRS provides clinical scales (e.g., Aggression, Conduct Problems, Hyperactivity) and composite scales (e.g., Externalizing Problems, School Problems). For the current study, the Externalizing Problems composite scale was used to measure the participant's perceptions of their children's externalizing behavior in three areas (Aggression – nine items, Hyperactivity – 11 items, and Conduct Problems – ten items). Items on the PSR are answered on a 4-point Likert scale ranging from *Never* to *Almost Always*. The externalizing behaviors domain includes questions such as how often does your child "listen to directions" and "lose control when angry" (Reynolds & Kamphaus, 2015). The PRS

shows strong internal consistency ($\alpha = .90$) and test-retest reliability ($\alpha = .72$ to $.92$), as well as convergent, divergent, and concurrent validity when tested with groups of children with behavioral difficulties.

Parenting Stress Index, Fourth Edition – Short Form (PSI-4-SF; Abidin, 2012). The PSI-4-SF is a 36-item self-report inventory to assess parental/caregiver stress. Items are rated on a 5-point Likert scale (1 = *Strongly Agree* to 5 = *Strongly Disagree*). There are three subscales included in the PSI-4-SF evaluating parental stress in different areas: Parental Distress (PD), Parent-Child Dysfunctional Interaction (P-CDI), and Difficult Child (DC), as well as an overall score. The current study used the overall score as a general measure of parental stress. Sample questions include, "My child seems to cry more than most children" and "I often have the feeling that I cannot handle things very well" (Abidin, 2012). The PSI-SF has adequate test-retest reliability ($\alpha = .78$), internality consistency ($\alpha = .87$), and construct and content validity. The current study found high internal consistency for the PSI ($\alpha = .91$).

Family Crisis Oriented Personal Evaluation Scale (F-COPES; McCubbin et al. 1987). The F-COPES is a 29-item self-report inventory utilizing a 5-point Likert scale (1 = *Strongly Disagree* and 5 = *Strongly Agree*). The F-COPES evaluates family problem solving strategies in times of crisis. Five subscales are included: acquiring social support, reframing, seeking spiritual support, mobilizing family to acquire and accept help, and passive appraisal, as well as an overall score. The current study used the overall score as a measure of family problem solving. Participants indicate level of agreement with their use of problem-solving strategies such as "Seeking advice from relatives" and "Facing problems "head-on" and trying to get solutions right away" (McCubbin et al., 1987). The F-COPES has high internal consistency ($\alpha = .86$), as well as adequate to high test-retest reliability ($\alpha = .61$ to $.95$). The current study found high internal consistency for the F-COPES ($\alpha = .80$).

Demographics. Participants provided demographic information about who lives in the home as well as ages, race/ethnicity, and relationship to the identified child for treatment. Participants also provided information regarding their income, educational level, mental health history, and current mental health diagnoses, services, or concerns for their child.

CHAPTER 3

RESULTS

Preliminary Analysis

Due to the variability in parenting types, a preliminary Two-Way Multivariate Analysis of Variance (MANOVA) analysis was conducted to determine whether there were group differences among the three different types of parents involved in the study (biological/adoptive, $n = 8$; foster, $n = 8$; other caregiver, $n = 1$) at the start of the program. Findings indicated no significant differences in externalizing behaviors, parental stress, or familial coping by parenting type at pretreatment (Wilks' $\Lambda = .581$, $F(6, 22) = 1.44$, $p = .371$).

Hypothesis 1. It was expected that the main effect of time-point on externalizing behaviors would be significant, such that symptoms of externalizing behaviors would significantly decrease from pretreatment to posttreatment. A repeated measures multivariate analysis of variance was conducted. Time-point served as the independent variable with three levels (pretreatment, midtreatment, and posttreatment). The Externalizing Behaviors Scale (BASC-3) served as the dependent variable. A significant decrease in externalizing behaviors was observed from pretreatment to post treatment, Wilks' $\Lambda = .493$, $F(2, 14) = 7.204$, $p = .007$, partial $\eta^2 = .507$. A smaller, non-significant decrease was also seen from pretreatment ($M = 64.25$, $SD = 7.72$) to midtreatment ($M = 59.94$, $SD = 6.07$). See Table 2.

Table 2

Table 2. Means and Standard Deviations of Externalizing Behaviors Scale Scores by Time

Variables	Mean	Standard Deviation
Pre-Treatment:	64.25 [a]	7.72
Mid-Treatment	62.44[a, b]	7.11
Post-Treatment:	59.94[b]	6.07

Note. A one-way repeated measures multivariate analysis of variance showed a main effect for Time on Externalizing Behaviors scores. Wilks' Λ = .493, $F(2, 14)$ = 7.204, p = .007. Means with different superscripts are significantly different at the p < .05 level.

Hypothesis 2. It was expected that the main effect of time-point on parenting stress would be significant, such that reported parenting stress would significantly decrease from pretreatment to posttreatment. A one-way repeated measures multivariate analysis of variance was conducted with time-point serving as the independent variable with three levels (pretreatment, midtreatment, and posttreatment). Parenting Stress (PSI-4-SF) total score served as the dependent variable. Analyses found no significant change in parenting stress from pre to post treatment (Wilks' Λ = .834, $F(2, 14)$ = 1.39, p = .281). While the findings did not reach significant levels, examining the effect size indicates significance was likely hampered by a small sample size (partial η^2 = .16). See Table 3. In addition, while no hypotheses were made regarding subscale scores on the PSI-4-SF, these are included in Table 4 to provide further context to the findings.

Table 3

Table 3. Means and Standard Deviations of Parenting Stress Index Scores by Time

	Mean	Standard Deviation
Pre-treatment:	117.00	24.88
Mid-Treatment	116.25	26.08
Post-Treatment:	109.06	24.17

Note. A one-way repeated measures multivariate analysis of variance was conducted on parenting stress. No significant results were found. Wilks' $\Lambda = .834$, $F(2, 14) = 1.39$, $p = .281$.

Table 4

Table 4. Means and Standard Deviations of the Parenting Stress Index Subscales

Variables	Mean	Standard Deviation
Parenting Distress:		
Pre-treatment:	3.27	.82
Mid-Treatment	3.27	.82
Post-Treatment:	3.19	.85
Parent-Child Dysfunctional Interaction (P-CDI):		
Pre-treatment:	3.05	1.00
Mid-Treatment	3.15	1.1
Post-Treatment:	2.95	.98
Difficult Child (DC):		
Pre-treatment:	3.27	.60
Mid-Treatment	3.29	.63
Post-Treatment:	2.94	.577

Hypothesis 3. To test the hypothesis that reliance on familial problem solving would increase over a 6-week treatment program with implementation of a behavior management treatment program in the home, a one-way repeated measures multivariate analysis of variance was conducted. Time-point served as the independent variable with three levels (pretreatment, midtreatment, and posttreatment) and familial problem-solving strategies (F-COPES) total score served as the dependent variable. It was expected that the main effects of time-point on familial problem-solving strategies would be significant, such that group reliance on familial problem-solving skills would significantly increase from pretreatment to posttreatment, but analyses did not support this hypothesis (Wilks' $\Lambda = .942$, $F(2, 14) = .434$, $p = .656$). It is relevant to note that average scores at each assessment round were in the high range for coping/problem solving (pre $M = 94.56$, $SD = 14.18$; mid $M = 97.06$, $SD = 12.77$; post $M = 95.12$, $SD = 15.13$). This indicates families had high levels of coping/problem solving abilities before they participated in the group, with little room for observed improvement due to ceiling effects of the F-COPES measure. While the findings did not reach significance, examining the effect size indicates significance was hampered by a small sample size (partial $\eta^2 = .05$). See Table 5.

Table 5

Table 5. Means and Standard Deviations of F-COPES scores

	Mean	Standard Deviation
Pre-treatment:	94.56	14.17
Mid-Treatment	97.06	12.77
Post-Treatment:	95.25	15.31

Note. A one-way repeated measures multivariate analysis of variance was conducted on familial problem solving. No significant results were found. Wilks' $\Lambda = .942$, $F(2, 14) = .434$, $p = .656$.

Satisfaction Survey

Participants completed a satisfaction survey at the conclusion of the treatment program to provide information on their experience. Ten participants completed the satisfaction survey (58.8%). See Table 6 for full satisfaction survey data. Most participants had positive feedback for the program, finding their therapists to be "extremely" supportive ($n = 8$), knowledgeable ($n = 7$), and prepared ($n = 8$). The other participants who completed the survey found their therapists to be "very" supportive ($n = 2$), knowledgeable ($n = 3$), and supportive ($n = 2$).

In terms of the program's format, while some participants felt the sessions were "a little too long" ($n = 3$), most participants felt the sessions were "just the right length of time" ($n = 7$). All participants felt six sessions was "just the right" number of sessions to learn the information ($N = 10$). All participants felt they were "very" ($n = 3$) or "extremely" ($n = 7$) engaged in each session.

Most participants felt their child was "much" ($n = 5$) or "a little" ($n = 3$) better than when the group started, with one participant feeling their child was the same ($n = 1$). All participants felt their own stress as a parent was "much" ($n = 6$) or "a little" better ($n = 4$). Overall, participants reported they felt the group was "extremely impactful" ($n = 7$), "impactful" ($n = 2$), or "somewhat impactful" ($n = 1$)

In terms of the telehealth format, most participants reported the virtual format made the group "much more accessible" ($n = 7$), while the other participants reported it was "slightly more accessible" ($n = 1$) or "the same amount of accessible" ($n = 2$) when compared to the idea of in person sessions. Participants also reported the virtual format was "much more convenient" ($n = 6$), "slightly more convenient" ($n = 2$), or "the same amount of convenience" ($n = 2$) when compared to the idea of in person sessions.

Participants also provided open-ended feedback on the group's impact on their overall functioning. Participants generally found the group to be helpful and beneficial to their families. Many participants commented on the convenience of the telehealth format and reported enjoying the ability to connect with other parents in a group format. For example, one participant noted "We were able to get supper on the table for the kids and fold laundry all while learning in the program. We still use the

timeout but less now because she listens better." Another participant reported "Everyone was transparent about their situation, the therapist really empathized with the parents and the children." Most participants who completed the written section felt the group helped their child's behavior and indicated they were still using the skills learned. For areas of improvement, participants recommended more handouts and "zoom rules" to make sure other participants had their microphone silenced and cameras on during the program sessions. One participant stated "I wish ground rules regarding the use of Zoom had been established, like muting yourself when you're not speaking. That was incredibly distracting!"

Table 6
Table 6. Means and Standard Deviations of Satisfaction Survey

Item	*M*	*SD*
How supportive were your therapists? (1=Extremely Supportive; 6=Extremely Unsupportive)	1.2	0.40
How knowledgeable were your therapists? (1=Extremely Knowledgeable; 6=Extremely Unknowledgeable)	1.4	0.66
How well prepared for assessment and therapy sessions did you find your therapists? (1=Extremely Prepared; 6=Extremely Unprepared)	1.3	0.46
How did you feel about the length of each session? (1=Too Short; 6=Too Long)	2.7	0.46
How do you feel about the number of sessions offered? (1=Too little; 6=Too Many)	3.0	0.0
How relevant were the topics to you and your family's situation? (1=Extremely Relevant; 6=Extremely Irrelevant)	1.5	0.75
How engaged were you in learning and participating? (1=Extremely Engaged; 6=Extremely Unengaged)	1.48	0.42
How convenient was the weekly homework that you completed with your child? (1=Extremely Convenient; 6=Extremely Inconvenient)	2.0	0.54
There were 3 assessment periods to monitor your family's progress. How do you feel about the number of assessment sessions? (1=Too little; 6=Too Many)	3.0	0.0
How would you rate the Strong Families Program's impact on your child? (1=Extremely Impactful; 6=Not impactful at all)	1.6	0.66
How would you rate the Strong Families Program's impact on yourself? (1=Extremely Impactful; 6=Not impactful at all)	1.4	0.49
How would you rate the Strong Families Program's impact on your family? (1=Extremely Impactful; 6=Not impactful at all)	1.4	0.66
How did the virtual format contribute to your accessibility of the group vs. in person? (1=Extremely Convenient; 6=Extremely Inconvenient)	1.5	0.81

Note. Ten participants (58.8%) completed the survey following their participation in the program.

CHAPTER 4

DISCUSSION

The current study aimed to better understand the effect of a short (6-week) parent training group in a telehealth format on child externalizing behaviors, parental stress, and family problem solving. Participants rated their child's behavior, their own parenting stress, and family coping abilities at pre, mid, and post treatment to measure gains through the program. Across time, a decrease in child externalizing behaviors and parenting stress, and an increase in familial problem-solving skills were expected.

Externalizing Behaviors

As expected, results demonstrate a significant main effect of time on children's externalizing behaviors. Parents reported children demonstrated fewer externalizing behaviors from pretreatment to post treatment. A minor, non-significant decrease was seen from pretreatment to mid treatment indicating a possible decline in externalizing behaviors after the first half of treatment. The larger change was noted from pretreatment to post treatment, showing the main decrease in externalizing behaviors occurred after participating in the entire six-week program. These decreases in externalizing behaviors are consistent with literature on other, similar parent behavior management programs (e.g., PCIT, Eyberg et al., 1995; McNeil & Hembree-Kigin, 2010; Positive Parenting Program, Sanders et al., 2001), including those delivered in a group format (e.g., Strong Families Program, Slusher, 2019; Group PCIT, Niec et al., 2016). Because there was no wait list control group, it is impossible to determine if the change in externalizing behaviors is due to the program alone or children's externalizing behaviors otherwise decreasing over time. Furthermore, most of the children whose caregivers participated were similar ages (i.e., 3-5years old). With a more diverse age range of children, different results may have been observed. Similar studies show age of child relates to declines in externalizing behaviors (Slusher, 2014).

Childhood externalizing behaviors are a pervasive problem for many parents (Achenbach & Edelbrock, 1981; Broidy et al., 2003), but parent training programs are often long and require a significant time commitment. Studies show parenting training programs delivered in group format (Lyon

& Budd, 2010; Niec et al., 2016), short format (Slusher, 2014), and telehealth format (Comer et al., 2015) effectively decrease childhood externalizing behaviors. Combining these factors not only helps with high attrition rates due to greater affordability and attendance, it also diminishes service disparities in rural and underserved areas. With parent training difficult to access in underserved and rural areas (Kazdin, 2008, Lyon & Budd, 2010; Niec et al., 2016), utilizing more accessible formats (i.e., short-term, telehealth delivery) allows greater availability for these populations. The current study shows utilizing multiple forms of accessibility still led to effective decreases in children's externalizing behaviors, demonstrating the utility of adapting treatment delivery to be cost effective and accessible.

Parenting Stress

Results indicate a nonsignificant main effect of time on parenting stress, contrary to expectations. While mean PSI scores decreased over time, the change was not significant. Although not reaching significance, parental stress did decline over the course of the program. However, at each time point participants continued to report clinically high levels of parenting stress. The decrease in parental stress, while not reaching significance, is consistent with findings from other, similar parent behavior management programs showing decrease in parenting stress (e.g., PCIT, Eyberg et al., 1995; McNeil & Hembree-Kigin, 2010; Positive Parenting Program, Sanders et al., 2001), including those delivered in a group format (e.g., Strong Families Program, Slusher, 2019; Group PCIT, Niec et al., 2016). While results indicated a nonsignificant change, effect size analyses showed low power due to small sample size. It is possible with a larger sample size, a significant change in parenting stress would be observed.

Because participation in a follow up assessment was not successfully implemented, possible gains occurring after the program ended were unable to be assessed. Because the intervention was short (six weeks), group members were only assessed over a short time. Studies find that parent training programs do reduce parenting stress, but declines can take time to develop (Eyberg et al., 1995; Forehand & McMahon, 1981; McNeil & Hembree-Kigin, 2010). While a reduction in externalizing behaviors for children was reported, it might take caregivers more time to feel the residual decrease in parenting stress. During the six weeks of the program, parents received concentrated and intense psychoeducation and

coaching from therapists. At the last assessment period, caregivers were still receiving help fine tuning the skills learned during the program. Participants were not expected to be experts by the end of their six weeks in the program and were advised on how to continue gains via consistently practicing skills following the end of the program. With more practice and mastery of the skills learned in the program and as their child's externalizing behaviors continue to decrease, participants may experience more observable changes in parenting stress. It is also possible that parents' stress would stay the same or increase, if they discontinue using the skills or if the lack of therapist presence for a longer time hampers their ability to continue to use the skills effectively.

Furthermore, although participants' PSI scores did not indicate significant decreases in parenting stress, their responses on the satisfaction survey indicated they found the program helpful. Not only did participants report they had gained skills, the group dynamic allowed them to connect with other parents experiencing similar concerns, adding a level of support for their roles as caregivers. Further, participants reported feeling more equipped to handle parenting difficulties. Therefore, it is possible a decrease in parental stress could be observed if progress were tracked post-intervention.

Familial Problem Solving

Results also indicate a non-significant effect of time on family problem solving skills. Interestingly, there was minimal change in scores across time. Effect size analyses showed a lack of power due to small sample size indicating results may differ if data were available from a larger sample. Across all assessment periods, scores of family problem solving were high for most participants indicating they arrived to the program with strong familial problem-solving skills. While an increase in familial problem-solving skills was expected, because participants started pretreatment with high levels, the program may not have impacted problem-solving skills or that participants were hitting the ceiling on the measure of family problem solving skills. It is possible individuals with a deficit in familial problem-solving skills prior to engaging in parent training for children's externalizing problems may experience a greater change in family problem solving skills after learning those skills.

Furthermore, a large portion of the sample size identified as foster parents. With a high pressure to be a "model" parent within the foster community (Bergsund, Wentzel-Larson, & Jacobsen, 2019) it is possible parents reported high problems solving skills to meet community expectations. Social desirability may have impacted the results with parents inflating their ratings of family problem solving skills.

<div align="center">**Limitations**</div>

Notably, the current study had several limitations. The small sample size contributed to a lack of power shown through effect size analyses which may impact results. A larger sample size might show more changes over time through the program. Furthermore, the sample was drawn from a rural, majority Caucasian identifying population from a relatively small area with most participants identifying as mothers. Additionally, participants had similar education and socioeconomic statuses. The lack of diversity in the sample makes it impossible to generalize the findings to more geographically, ethnically, and racially diverse populations with more variability in parent role identification. Utilizing a more diverse population in the future would increase generalizability of results and provide evidence for effectiveness across a larger scope.

Another limitation in the current study was the lack of a wait list control group. Without a control, it is unclear if significant decreases in externalizing behaviors for the children of participants were due to the program or other factors. This limitation is compounded by data collection occurring at different times throughout the year (the program was conducted in several sessions between October 2020 and November, 2021). Parents experience variable stress throughout the year which may influence responses to the study measures (i.e., children are typically at home more with their parents during the summer months, children spend more time indoors during the winter months). Examining these variables further may show changes in parenting stress due to extenuating circumstances. Future studies should control for possible confounding variables via a wait list control. Furthermore, valuable information on the impact of the program may be discovered via additional assessment, specifically a follow up

assessment. While a follow up assessment (one month post treatment) was attempted, there was a lack of participant response. It is possible changes may be observed in a post-treatment assessment period.

Lastly, all data collection was based on participant self-report. Parents with children experiencing externalizing behaviors generally report more stress than other parents which may influence how a parent perceives their child's behavior (McNeil & Hembree-Kigin, 2010). Because the current study showed stability in parenting stress throughout all assessment periods, it is possible reporting of children's behaviors was influenced by that stress. In the future, using other reporters (e.g., teachers, clinicians) may provide more information on the child's overall functioning.

Strengths

While there were limitations in the current study, there are notable strengths as well. First, there was stability in therapists across the program. In all rounds of the program but one, the same two student therapists conducted program sessions. During the last round of the program, different co-therapists (trained by the previous therapists and supervised by the same licensed clinician) conducted the program sessions. Furthermore, the same manual and telehealth procedures were used across all rounds of the program delivery, ensuring standardization across all participants.

Furthermore, while the participant pool was not diverse in some ways due to recruitment from a small, rural area, it was diverse in parenting type. Because foster family groups were included in recruitment strategies, parenting types included foster parents and other nontraditional caregivers (e.g., grandparents). This increases generalization to those other than the traditional nuclear family and allows for evaluation of the impact of parent training on families with nontraditional parenting situations. While there were no differences observed in preliminary analyses by parenting type, it is useful for future clinicians to know parent training delivered via telehealth in a short (6-week) format is effective for a variety of groups of parent identifiers.

Additionally, attrition for this program was very low, allowing for three rounds of assessment data from all participants. Out of the entire participant pool, only one participant did not attend one session of the program and three participants, who missed a group session, made up the session on

another day in a rescheduled individual session with one of the co-therapists. Every make-up session was scheduled prior to the next group session to keep each participant on track. The lack of attrition ensured data were fully available from every participant.

Finally, this program provides low-cost, empirically supported (Slusher, 2019) parent training for families in a rural area where a shortage of mental health professionals makes finding appropriate services difficult. Participants reported previous difficulty finding parent training to help with their child's externalizing behaviors. Because participants accessed the program directly from their home via the internet, they were able to participate even if they lived in isolated rural areas. This program made parent training affordable and accessible for the population from which we were recruiting, providing a needed clinical service to the area.

<center>**Future Directions**</center>

Further research should continue to observe the impact of short parent training program delivered via telehealth. The current study examined rural populations in response to the shortage of mental health resources in those areas (Smalley et al., 2012), but there are underserved populations in non-rural areas who would benefit from further accessibility through adaptations to existing parent training models (group format, short format, telehealth). Future research should expand the participant pool to investigate other underserved populations and examine treatment gains within those populations.

Moreover, a more diverse participant pool including factors such as race, gender identity, and culture would improve generalizability. The current study included only participants who identified as mothers, but fathers in America are increasingly taking on parenting roles that in years past were primarily held by mothers (Schoppe-Sullivan, et al., 2021). With fathers experiencing similar parenting stress and concerns, future studies can evaluate the utility of similar programs for fathers of children with externalizing behaviors.

Lastly, while no differences were observed between parenting types (biological/adoptive, foster, grandparent), these were not directly assessed in the current study. In satisfaction surveys, foster parents did indicate the parenting group was helpful in transitioning children from previous placements to their

home. By examining factors related to parent identity (e.g., biological vs. other caregivers) and impacting foster parents (e.g., child/parent bonding and attachment), research can determine whether parent training improves other areas of concerns for non-traditional parents.

Clinical Implications/Rurality

The current study offers useful clinical implications. First, the use of parent training appears effective in decreasing child externalizing behaviors in the home. With childhood externalizing behaviors a concern in 50% of homes, the use of parent training programs like the Strong Families Program is a possible solution for these behaviors (Achenbach & Edelbrock, 1981; Broidy et al., 2003). Utilizing a short, group, telehealth format provides accessibility for parents by making treatment available in-home, negating the need to spend time in travel or acquire childcare. Further, a group format diminishes treatment costs and allows more clients to be served at a time (Sampioa et al., 2018). A short length of treatment provides parenting skills faster to families in need and can improve attrition rates leading to more successful treatment.

Additionally, these added elements can provide accessibility to underserved and rural communities needing assistance for childhood externalizing behaviors. With underserved populations experiencing a shortage in mental health providers, utilizing a telehealth format can eliminate the barrier of transportation expenses (Smalley et al., 2012). Using telehealth to deliver effective interventions diminishes unique barriers faced by rural populations such as isolation and lack of mental health providers in the area. Previous studies show telehealth to be an effective format for parent training programs (Comer et al., 2015). Combining telehealth with a group format and short time frame allows even more accessibility and lower costs, serving more people without additional clinician time. Utilizing a telehealth, group, short-term parent training program like the Strong Families Program is an effective way to provide services to more populations including rural and underserved individuals.

Conclusion

The current study aimed to better understand the effect of a short parenting training program delivered in a group telehealth format. A previously developed, short, group format parenting training

manual (Slusher, 2019) was converted to be delivered via telehealth. The hypothesis of decreasing externalizing behaviors over time was supported; however, there were no significant effects regarding parenting stress or familial coping. This may be due to the brief assessment period. While these findings need to be studied further, they provide support for the use of telehealth delivered short-term parenting training programs in a group format for increased accessibility for family populations.

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APPENDIX

TREATMENT OUTLINE

Topic	Homework
Session 1: PRIDE Skills, Selective Ignoring	Special Play Time for 5 minutes/day
Session 2: Practice skills with coaching	Special Play Time for 5 minutes/day
Session 3: Practice skills with coaching and discipline introduction	Special Play Time for 5 minutes/day
Session 4: Practice discipline skills with coaching	Special Play Time for 5 minutes/Time out Practice
Session 5: Practicing discipline skills with coaching & house rules	Special Play Time for 5 minutes/ Time out Practice
Session 6: Practice discipline skills with coaching, individual recommendations, discipline away from home	Special Play Time for 5 minutes/ Time out Practice