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Promoting School Readiness in At-risk Children: An Evaluation of a Behavioral Parent Training Program in an Early Childhood Community Setting

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PROMOTING SCHOOL READINESS IN AT-RISK CHILDREN: AN EVALUATION OF A BEHAVIORAL PARENT TRAINING PROGRAM IN AN EARLY CHILDHOOD COMMUNITY SETTING

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Randi J. Cheatham-Johnson

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To: Dean Michael R. Heithaus
College of Arts, Sciences, and Education

This dissertation, written by Randi J. Cheatham-Johnson, and entitled Promoting School Readiness in At-Risk Children: An Evaluation of a Behavioral Parent Training Program in an Early Childhood Community Setting, having been approved in respect to style and intellectual content, is referred to you for judgment.

We have read this dissertation and recommend that it be approved.

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The dissertation of Randi J. Cheatham-Johnson is approved.

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Florida International University, 2020

DEDICATION

Breonna Taylor. George Floyd. Alexia Christian. Eric Garner. Korryn Gaines. Michael Brown. Michelle Cusseaux. Tony McDade. Sandra Bland. Walter Scott. Aiyana Stanley-Jones. Jordan Davis. Charleena Chavon Lyles. Laquan McDonald. Natasha McKenna. Tamir Rice. Mya Hall. Botham Jean. Atatiana Jefferson. Ahmaud Arbery. Meagan Hockaday. Trayvon Martin. Janisha Fonville. Oscar Grant. Aura Rosser. John Crawford III. Sheneque Proctor. Samuel Dubose. Pearlie Golden. William Chapman II. Gabriella Nevarez. Darius Stewart. Yvette Smith. Brendon Glenn. Miriam Carey. Christian Taylor. Kyam Livingston. Amadou Diallo. Kayla Moore. Willie Tillman. Shelly Frey. Brian Keith Day. Malissa Williams. Stephon Clark. Alesia Thomas. Philando Castille. Shantel Davis. Freddie Gray. Sharmel Edwards. Michael Sabbie. Rekia Boyd. Alonzo Smith. Dominique Clayton. Pamela Turner. Quintonio Legrier. Shereese Francis. Albert Joseph Davis. Tarika Wilson. Paul O'Neal. Kathryn Johnston. Matthew Ajibade. Alberta Spruill. Keith Harrison McLeod. Kendra James. Randy Nelson. LaTanya Haggerty. Jordan Edwards. India Kager. Aaron Bailey. Margaret LaVerne Mitchell. Jamar Clark. Tyisha Miller. Antwon Rose II. Danette Daniels. Terril Thomas. Frankie Ann Perkins. Alton Sterling. Sonji Taylor. David Joseph. Eleanor Bumpurs. Christopher Whitfield. And countless others. BLACK LIVES MATTER.

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ABSTRACT OF THE DISSERTATION

PROMOTING SCHOOL READINESS IN AT-RISK CHILDREN: AN EVALUATION OF A BEHAVIORAL PARENT TRAINING PROGRAM IN AN EARLY CHILDHOOD COMMUNITY SETTING

by

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Behavioral parent training (BPT) is the gold standard for the treatment of externalizing behavior problems in young children. However, many programs have failed to consistently replicate positive outcomes in economically and socially disadvantaged populations. Given the lasting negative impact of early behavioral problems on youth, families, and society as well as the heightened risk such families face, it is important to examine BPT within particularly vulnerable populations. A pilot open trial of a novel BPT, the School Readiness Parenting Program (SRPP), was conducted to examine the acceptability, feasibility, and promise of the manualized treatment as a standalone intervention for economically and socially disadvantaged families implemented within early childhood education settings, and generate feedback regarding the SRPP in order to refine future iterations. In addition, a qualitative study of the program was also conducted to examine caregiver acceptability of SRPP and the adaptation and implementation of the program during the school year. The open trial consisted of six Black caregivers and their preschool-aged children who completed a pretreatment assessment, received the SRPP,

completed a posttreatment assessment, and participated in a focus group or individual interview. Results indicated sufficient feasibility and acceptability of the SRPP. The qualitative study consisted of 35 caregivers (68% Black) who participated in focus groups or interviews. Results indicated that while many caregivers found some of the evidence-based strategies acceptable (e.g., planned ignoring, praise), time-out as a discipline strategy was often seen as culturally incongruent. Strengths and weaknesses of the present studies are discussed, and considerations for future research directions are noted. Findings from the current studies provide a foundation for informing intervention efforts and treatment adaptations to meet the needs of overrepresented and underserved communities.

Keywords: parent training; at-risk; behavior problems; school readiness; preschool; young children; treatment outcome; treatment acceptability; ethnic minority parents

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ABBREVIATIONS AND ACRONYMS

ADHD	Attention-Deficit/Hyperactivity Disorder
BPT	Behavioral Parent Training
CD	Conduct Disorder
CDI	Child-Directed Interaction
COPE	Community Parent Education Program
DBD	Disruptive Behavior Disorder
DPICS	Dyadic Parent Interaction Coding System
EBP	Externalizing Behavior Problem
HNC	Helping the Noncompliant Child
IY	Incredible Years
ODD	Oppositional Defiant Disorder
PCIT	Parent-Child Interaction Therapy
PDI	Parent-Directed Interaction
SRPP	School Readiness Parenting Program
TO	Time Out
Triple P	Positive Parenting Program

I. INTRODUCTION

Externalizing behavior problems (EBPs), such as aggression, defiance, inattention, hyperactivity, and impulsivity in preschool-aged youth have received significant attention (Broidy et al., 2003; Campbell, 2002; Campbell, 2006; Campbell & Ewing, 1990; Dodge & Pettit, 2003; Hinshaw, 2002; Lavigne et al., 2009; Moffitt, 1993). In addition to accounting for over half of all referrals for mental health services (Loeber et al., 2000; Morgan et al., 2002), empirical work has demonstrated that these early difficulties often do not remit and are predictive of other, more concerning mental health disorders (i.e., externalizing and internalizing) later on (Frick & Nigg, 2012; Mesman et al., 2001; Moffitt et al., 1996; Olson et al., 2002; Tremblay, 2000). Research has shown that an alarming proportion of preschoolers (50% to 75%) with significant behavior problems continue to exhibit these difficulties up to six years later (Campbell & Ewing, 1990; Marakovitz & Campbell, 1998; Nixon, 2002; Richman et al., 1985; Speltz et al., 1999), which underscores the importance of intervening early on to reduce later risk of more serious mental health problems.

Parenting children with EBPs is particularly challenging with caregivers reporting significantly higher levels of parenting stress than caregivers of children who do not display externalizing behaviors (Barkley et al., 1989; Beck et al. 1990; Eyberg et al. 1993; Fischer, 1990; Gillberg et al., 1983; Johnson & Reader, 2002; Lee et al., 2012 Mash & Johnston 1983; Morgan et al., 2002; Ross et al. 1998; Webster- Stratton, 1988). Caregiver stress has been shown to account for other mental health disorders such as depression (Donenberg & Baker, 1993; England & Simon, 2009). Studies show that caregivers of children with externalizing disorders display significantly elevated levels of

distress associated with their child's disorder (Kashdan et al., 2004). Empirical work has established that caregivers of children who display externalizing difficulties often view themselves as having less parenting knowledge, less parental competence, and fewer supports than caregivers of children who do not display externalizing behaviors (Mash & Johnston 1990). Thus, treatment approaches should equip caregivers with the knowledge and tools necessary to manage their children's difficulties across domains (e.g., home, public, school).

Early EBPs also have significant implications for children's school readiness and early school success (Denham, 2006; McClelland et al., 2006; Webster-Stratton et al., 2008), placing these children at heightened risk for school failure, school dropout, and eventual delinquency (McGee et al., 2002; Webster-Stratton et al., 2008). For instance, 66% of preschool children with significant behavior problems have been found to later be diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD) or a related disorder by the time they are nine years old, allowing these children to qualify for costly special education services (Graziano et al., 2013). In recent years, there has been a sharp increase in young children being expelled from preschool and childcare programs at an alarming rate, often because of aggression, tantrums, and noncompliance (Perry et al., 2011). The first national study of preschool expulsions found that prekindergartners are expelled at rate more than three times that of K-12 students and preschool-aged boys are four times as likely to be expelled as girls (Gilliam, 2005). These statistics are particularly concerning considering the vast literature documenting the benefits of children receiving quality prekindergarten, which extends far beyond the first years of school (e.g., assessments of language, literacy, mathematics and science, and reductions in grade

retention and special education placement; Bania et al., 2014; Barnett et al., 2013; McCoy et al., 2017). Preschool suspensions and expulsions have both an immediate and lasting negative impact on children's overall emotional and social development as well as risk of subsequent school dropout (Horowitz, 2015; Upshur et al., 2009). When left untreated, the long-term consequences for youth with behavior problems extend beyond youth and families, taking an enormous financial toll on society, including schools and public health agencies.

In addition to negative educational outcomes, EBPs often result in unemployment (Maughan & Rutter, 2001), and mental health difficulties including depression, anxiety, addiction, and antisocial personality disorders (Oldehinkel & Ormel, 2014). Early onset of externalizing behavior has also been found to be a significant risk factor for later juvenile offending, crime as an adult, and interpersonal violent behavior, including anti-social behavior and substance abuse (Liu, 2004; McCord et al., 2001). Such negative consequences lead to increased costs for educational, mental health, law enforcement, and social services, which are estimated to be ten times higher for children with externalizing disorders than for children without such difficulties (Scott et al., 2001). One study purports an estimated $2.6 to $5.3 million in savings per child by successfully implementing interventions for high-risk youth who exhibit externalizing behaviors (Cohen & Piquero, 2009). Furthermore, research suggests we could reduce the rate of criminal offenses and number of justice-involved youth through early identification and treatment of externalizing behaviors in children (Christenson et al., 2016). An examination of the implications of early externalizing problems by race and ethnicity and socioeconomic status (SES) uncover crippling disparities.

Children from racial/ethnic minority and economically disadvantaged backgrounds are especially vulnerable in the abovementioned domains. For example, ethnic/racial minority children and children from low SES groups are three times more likely to have behavior problems (Briggs-Gowan et al., 2001) than their Non-Hispanic/Latino, middle to upper class counterparts. Students from low SES groups and ethnic minorities are often overrepresented in the special education population (Arnold & Lassmann, 2003; Dunn, 1968; Parrish, 2002). Moreover, according to the U.S. Department of Education ([DOE]; 2016), Black preschoolers are disproportionately impacted by out of school suspensions, with these children being almost four times as likely to receive one or more suspensions compared to their White counterparts. This discrepancy is particularly unsettling considering Black children make up only 19% of preschool enrollment but comprise nearly half of preschoolers suspended one or more times. Given the high prevalence and stability of serious behavioral challenges and the costly trajectories of the youth displaying such behaviors, the high level of early EBPs in economically and socially disadvantaged children is considered a significant public health concern. In order to reduce the likelihood of negative developmental consequences and high societal costs, early intervention is critical for young children with externalizing behavior problems.

Behavioral parent training (BPT) is one of the most popular and effective behavioral interventions for caregivers of children with behavioral difficulties (Comer et al., 2013; Evans et al., 2018; Eyberg et al., 2008; Maughn et al., 2005). Behavioral Parent Training, or training caregivers in the use of behavior modification, uses therapists to teach caregivers to accurately define behavior problems, implement assessment measures

that elucidate the problem and its intensity, and teach caregivers the appropriate treatment plan for such problems within their individualized context (Breismeister & Shaefer, 1998). At its core, BPT is rooted in the empirical and applied concepts of behavior modification and the principles of social learning theory (e.g., Eyberg, 1988; Forehand & McMahon, 1981, Forgatch & DeGarmo, 1999; Hanf, 1969; Patterson, 1969; Webster-Stratton, 1981). Behavioral Parent Training reasons that children's behaviors (i.e., appropriate and inappropriate) are reinforced by "social agents," often caregivers, who give important cues and consequences for behavior (Miller, 1975). Behavioral Parent Training, which targets caregivers as the primary vehicle of change, has proven to be the most efficacious approach to correct the course of children with externalizing behavior problems who would otherwise have unfavorable trajectories (Eyberg et al., 2008; Weisz & Kazdin, 2010), and is recommended as the first line treatment for young children under six years of age with ADHD (AAP, 2011). The accumulating empirical support for manualized BPT programs has resulted in their rapid worldwide dissemination in recent years. There is also increasing interest in the application of BPT programs in clinical practice under real-world conditions (e.g., mental health, primary care, schools, and welfare settings, and in the non-profit sector, and in community settings for at-risk preschoolers; Gardner et al., 2010). However, delivery of BPTs in uncontrolled environments is convoluted, which has called into question the compatibility of such interventions in routine care settings (Weisz et al, 2015). Accordingly, focused efforts are needed to ensure proper service utilization and engagement for early behavior problems among economically and socially disadvantaged families.

The present work begins with a review of the behavioral parent training literature and a review of the most empirically supported programs, along with a discussion of the limitations of existing BPTs, which informed the development of the BPT at the center of the current study. Then the BPT, SRPP, is described, along with a review of prior evaluations of the program. In the present study, an open pilot trial of SRPP was conducted to examine the acceptability, feasibility, and promise of school year implementation for ethnic/racial minority families living in urban poverty, to explore predictors of treatment engagement, and generate feedback regarding caregiver's experience to inform future iterations. Finally, focus groups and individual interviews were conducted with a subset of caregivers who previously completed SRPP as part of their child's participation in a 7-week intensive summer camp program for prekindergartners with ADHD and associated behavioral, social-emotional, and learning difficulties.

II. BEHAVIORAL PARENT TRAINING

In response to the growing prevalence of children's behavior problems, behavioral parent training (BPT) programs emerged in the 1960s, when a number of programs of research began to focus on caregivers as primary change agents during treatment for the disruptive behaviors of their young children (Bernal et al., 1968; Hanf, 1969; Patterson & Brodsky, 1966; Wahler et al., 1965). While there was a degree of variability amongst interventions, behavior remained at the center of each, specifically changing parent behavior in order to change child behavior (Forehand et al., 2013). This behavioral focus directly opposed the popular approach at the time, which was play therapy and psychodrama with the child to treat underlying anxiety that was purportedly causing the child's externalizing behavior (Patterson, 1982).

At the outset, the groundwork laid by Bernal, Hanf, Patterson, Wahler and colleagues were comprised of case studies and uncontrolled group designs; however, these cumulative lines of research are responsible for a key intervention approach expanding over the next 60 years (Forehand, 2013). Behavioral Parent Training has now been meticulously examined with stringent research designs and is perceived as the foremost intervention for externalizing behavior disorders [i.e., ADHD, Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD)] (for reviews, see Chorpita et al., 2011; Dretzke et al., 2009; Evans et al, 2018; Eyberg et al., 2008; Lundahl et al., 2006; Maughan et al., 2005; McMahon et al., 2006; Weisz & Gray, 2008). The continued efforts of the field's experts have advanced our understanding of the complex role parents play in the lives of children who display EBPs and underscored gaps in current approached to treating youth and families.

Current Approaches to Addressing EBPs

Having outlined the need for renewed prevention and intervention approaches aimed at reducing externalizing behavior problems in young children, it is important to first examine existing strategies to treat early externalizing problems and their strengths and weaknesses. BPT is widely viewed as the 'gold standard' for fostering wellbeing in youth and preventing problem behaviors, as well as reducing parental stress, increasing positive parenting skills, and preventing maltreatment (Ciesielski et al., 2020; Furlong et al., 2013; McCabe & Yeh, 2009; Sanders et al., 2014; Thomas & Zimmer-Gemeck, 2011; United Nations, 2009; World Health Organization, 2009). Popular programs, such as the Incredible Years Program (Webster-Stratton, 1998), Helping the Noncompliant Child (McMahon & Forehand, 2003), Parent–Child Interaction Therapy (Zisser & Eyberg, 2010), and The Triple P Positive Parenting Program (Sanders, 2012) all have a universal conceptual foundation in Social Learning Theory (Bandura & Walters, 1963), and integrate behavioral, cognitive and developmental principles and theories. As such the aforementioned programs will be reviewed in detail below.

Summary of Existing Programs

Because of the important role caregivers play with regard to developmental trajectories, a number of programs have been developed to aid caregivers in managing their children's difficult behaviors and improving dyadic interactions. In a recent meta-analysis to evaluate the overall effect of psychosocial treatments on EBPs in young children, Comer and colleagues (2013) identified The Incredible Years, Helping the Noncompliant Child, Parent-Child Interaction Therapy, and Triple P as the most frequently studied BPTs. As such, the abovementioned BPTs will be

reviewed along with their evidence base, particularly with respect to effectiveness with ethnic minority children and families. Additionally, given its influence on SRPP, the COmmunity Parent Education Program (COPE; Cunningham et al., 1998) will be reviewed as well as empirical support for its effectiveness with economically and socially disadvantaged communities.

Parent-Child Interaction Therapy (PCIT)

With nearly 50 years of rigorous empirical support, parent–child interaction therapy (PCIT) is a best practice method developed for caregivers and children (2 – 6 years) who are exhibiting a range of behavioral, emotional, and family challenges (Herschell et al., 2002; Niec, 2018). Parent-Child Interaction Therapy consists of two phases: Child-Directed Interaction (CDI) and Parent-Directed Interaction (PDI). Child-Directed Interaction focuses on strengthening the parent-child relationship as a precursor for PDI, which stresses the importance of establishing a structured and consistent approach to discipline. During treatment, the focus of attention is placed on interactions between caregivers and their children because of underlying theoretical beliefs about the development and maintenance of externalizing behaviors. Parent-Child Interaction Therapy procedures are assessment driven and not bound by a set number of sessions as progress with regard to parent-child interactions is coded at each session. Completion of treatment is contingent upon caregivers mastering CDI and PDI skills and the child's behavioral functioning being rated within normal limits (Eyberg & Funderburk, 2011).

In both phases of treatment (i.e., CDI and PDI), caregivers attend one didactic session during which the clinician teaches the skills of the interaction and provides psychoeducation regarding their use. Clinicians rely heavily on modeling and role-play to

promote skills acquisition. Following the initial didactic session, caregivers and their child attend weekly sessions together. Outside of sessions, parents are asked to dedicate at least five minutes a day practicing the skills with their child at home. As part of CDI, clinicians teach caregivers to use the PRIDE skills (i.e., **P**raise, **R**eflection, **I**mitation, **D**escription, and **E**nthusiasm) and to avoid questions, commands, and criticism while they play with their child. The play situation at home and in the clinic is set up such that the child is allowed to select the toy(s) they would like to play with, and the caregiver is instructed to join in play with the child, following the child's lead. During these sessions, it is common for caregivers to wear a bug-in-the-ear device and receive in-vivo coaching on their use of the skills by a clinician who is observing the dyad from behind a one-way mirror. The second phase of PCIT (i.e., PDI) begins when the caregiver meets mastery criteria for CDI skills, usually 10 praise, 10 reflections, and 10 description and no more than a total of 3 questions, commands, and criticisms. In PDI, the focus of treatment emphasizes discipline strategies while continuing to strengthen the parent-child relationship through the use of PRIDE skills. Caregivers learn to provide specific, developmentally appropriate, commands and to follow up with consistent consequences for compliance (i.e., praise) and noncompliance (i.e., timeout). To address noncompliance, clinicians teach caregivers to implement a time-out sequence. Caregivers receive opportunities to practice using these skills in-session during play by issuing commands and responding accordingly. On average, most families graduate from PCIT within 10 to 16 weeks of weekly, 60 minute sessions. An extensive PCIT intervention includes the following steps:

(a) a baseline assessment of child functioning and parent-child interactions

(b) feedback, CDI skills teaching and coaching

(c) PDI skills teaching and coaching

(d) generalization of skills

(e) a posttreatment assessment of child functioning and parent-child interactions

It is recommended families complete follow-up evaluations and attend booster sessions, as needed.

Treatment outcomes research has demonstrated substantial empirical support for improvements in caregiver interactional style and with regard to child behavioral functioning across settings (i.e., home and school; Eisenstadt et al., 1993; McNeil et al., 1991; Schuhmann et al., 1998). Moreover, work has found PCIT is successful in helping caregivers manage their child's behavior, caregivers report high levels of satisfaction with the content and process of PCIT, less distress as their child's behavior improves, and increased confidence in their ability to manage their child's behavior (Schuhmann et al., 1998). Of note, the benefits of PCIT have been shown to generalize to other family members, including the behavior of siblings of target children and the mental health of the caregiver (Brestan et al., 1997; Eyberg & Robinson, 1982). Regarding controls, investigations of PCIT have included the comparisons of numerous groups, from treated children to waitlist controls (McNeil et al., 1999; Schuhmann et al., 1998), normal classroom controls, untreated classroom controls (McNeil et al., 1991), modified treatment groups (Nixon et al., 2003), treatment dropouts (Boggs et al., 2005), to control groups with varying severity of behavior problems (Funderburk et al., 1998). Each examination has substantiated the superiority of PCIT over diverse comparison conditions (Herschell et. al., 2002). After undergoing decades of empirical scrutiny, it is

evident PCIT improves the patterns of interaction between caregivers and children and establishes new patterns that are healthy, warm, and supportive (Niec, 2018). However, particularly relevant for the current studies, little research has examined the utility of PCIT for economically and socially disadvantaged families. Evidence suggests PCIT may result in positive behavior changes for minority families who complete treatment (e.g., Fernandez et al., 2009; Leung et al., 2015, Lyon & Budd, 2010). However, existing studies are limited by external validity. Only two of the abovementioned studies documenting the efficacy of PCIT have been conducted within community settings (e.g., schools), with no work examining PCIT delivered by community providers. Research commonly includes predominately White non-Hispanic, clinic-referred children from two parent households who receive services from graduate/trainee-level clinicians. Thus, the extent to which these studies demonstrate the accurate value of PCIT, particularly for ethnic minority families living in urban poverty is scant.

Helping the Noncompliant Child (HNC)

Helping the Noncompliant Child is a training program focused on teaching caregivers how to increase compliance in their children (three-eight years). The objective is to enhance caregiver-child interactions to decrease the worsening of behavior problems into serious mental health disorders (e.g., conduct disorder). At its core, HNC is built upon the theoretical premise that difficulty adhering to adult requests or rules is at the crux of the development of conduct problems. Furthermore, ineffective parent-child interactions play a significant role in the development and maintenance of such problems. HNC includes the training of five core skills (i.e., giving attends, giving rewards, use of active ignoring, issuing clear instructions, and implementing time outs; McMahon &

Forehand, 2003). Similar to PCIT, skills are sequential and taught in two phases (i.e., phase I: differential attention and phase II: compliance training). The program employs a variety of teaching methods, including instruction, handouts, modeling and role play to aid caregivers in generalizing new skills to the home. Of note, caregivers must also meet specific performance criteria for a skill (i.e., mastery) before moving on to the next skill.

During the Differential Attention phase (i.e., Phase I), caregivers are taught to increase the frequency and range of social attention to the child and decrease the frequency of competing verbal behavior. A key objective is to disrupt the coercive cycle of interaction by establishing a positive, mutually reinforcing relationship between the caregiver and child. First, the caregiver learns to attend to and describe the child's appropriate behavior. Moreover, the caregiver is required to refrain from all commands, questions, and criticisms directed to the child during session. The second segment of Phase I consists of teaching the caregiver to use verbal (e.g., praise) and physical (e.g., hugs) attention contingent upon compliance and other appropriate behaviors (rewards). Specifically, the caregiver is instructed to use praise statements in which the child's desirable behavior is labeled (e.g., "You are a good boy for picking up the blocks"). Throughout Phase I, the clinician emphasizes the use of contingent attention to increase child behaviors that the caregiver considers desirable. The caregiver also learns to actively ignore minor inappropriate behaviors (e.g., whining). At home, the caregiver is required to structure daily 10- to 15-minute Child's Game sessions to practice the skills that were learned in session. Toward the end of Phase I, with the help of the clinician, the caregiver develops a list of child behaviors that they wish to increase. The contingent use of attends and rewards to increase these behaviors is also reviewed.

The caregiver develops programs for use outside of the sessions to increase at least three child behaviors using the new skills.

In Phase II of the parent training program (i.e., Compliance Training), the primary caregiver skills are taught in the context of clear instructions sequence which consists of three paths:

a) clear instruction → compliance → positive attention (e.g., reward/praise)

b) clear instruction → noncompliance → warning → compliance → positive attention (e.g., reward/praise)

c) clear instruction → noncompliance → warning → noncompliance → time out

The therapist first teaches the parent to use appropriate commands to increase child compliance. In the context of the Parent's Game, the clinician teaches the caregiver to give direct, concise instructions one at a time and to allow the child sufficient time to comply. If the child initiates compliance within five seconds of the clear instruction, the parent is taught to reward and attend to the child within five seconds of the compliance initiation (Path A). If the child does not initiate compliance, the caregiver is taught to implement a brief time out (TO). Compliance is followed by contingent attention from the caregiver. In practice with the child during the Parent's Game in session, the caregiver is instructed to give a series of clear instructions and to provide appropriate consequences for compliance and noncompliance. At home, the caregiver is expected to practice the use of clear instructions, positive consequences for compliance, and, finally, the use of the TO procedure for noncompliance. When the caregiver is using the clear instructions sequence successfully in the home, the caregiver is taught to use standing rules as an occasional supplement to the clear instructions sequence. Standing rules are

"if...then" statements that, once stated and explained to the child, are permanently in effect. Finally, the clinician teaches the caregiver ways to implement the various Phase I and Phase II skills in settings outside the home (e.g., grocery store).

In an ideal situation, the playroom is equipped with a one-way window and a "bug-in-the-ear" device, giving the clinician the ability to communicate with the caregiver from behind the window while the caregiver interacts with the child. However, the setup is not necessary for the successful implementation of HNC (McMahon & Forehand, 2003). Sessions are held one to two times per week, with sessions ranging between 75 and 90 minutes. The number of sessions necessary for the completion of each phase of HNC is contingent upon the speed with which the caregiver demonstrates competency in the skills and the child's response to treatment. The number of sessions for each family necessary for the completion of the entire program has ranged between 5 and 14 sessions. The average number has been approximately 8–10 intervention sessions.

A number of studies have been conducted to examine the efficacy or effectiveness of HNC in treating children's oppositional behaviors (for a review see Forehand et al., 2014). However, very few report ethnic/racial demographics of participating families and those that do include predominately Caucasian samples (Abikoff et al., 2015; Forehand et al., 2016; Forehand et al., 2017).

Incredible Years (IY)

Incredible Years is a set of three distinct, multifaceted, and developmentally focused curricula for caregivers, teachers, and children. Developed to promote emotional and social competence as well as prevent and treat early behavioral and emotional difficulties, IY programs (i.e., caregiver, teacher, and child) can be implemented as a

package or separately. The Basic Parent Program is intended for caregivers who have children that fall within one of four age ranges: 0 –1 year (Baby Program; 8 –9 sessions), 1–3 years (Toddler Program; 12 sessions), 3– 6 years (Preschool or Early Childhood Program; 18–20 sessions), or 6–12 years (Early school age or Preadolescent Program; 12–16 sessions; Borden et al., 2010). The primary goal of the IY program is to enhance parenting skills as a mechanism for fostering child social competence, emotion regulation, academic achievement, and subsequently reduce children's current and future risk for negative outcomes (e.g., conduct problems, substance abuse, and violence; Borden et al., 2010).

In the Early Childhood Program, groups are structured such that 10–14 caregivers participate and weekly sessions lasts 2 to 2.5 hours. To reduce common barriers to engagement, food, childcare, and transportation are typically provided. Groups are led by two trained masters-level or higher professionals who have experience engaging caregivers and/or families, and knowledge of child development and social learning theory (Borden et al., 2010). Similar to other BPT, program skills and session content are grounded in social learning theory principles as well as decades of research which has outlined the common developmental sequence of child conduct problems (e.g., Patterson et al., 1989; Shaw et al., 1994).

Across IY programs, caregivers view videotapes showing parent models interacting with their children in various scenarios. Using an empowering approach (i.e., making caregivers active partners in the session), group leaders engage caregivers in discussion about the video vignettes and facilitate in-session practice of techniques using role-plays. During discussions, caregivers process their experience and observations

which provides a critical opportunity to test out skills and consider how to integrate them into their own parenting style. Furthermore, group leaders promote cognitive reframing to help parents with challenging their unhelpful and/or negative thoughts and substituting them for more positive, coping thoughts that will increase their likelihood of successfully implementing new strategies. Recognizing the importance of self-praise and self-care, group leaders repeatedly encourage such practices as significant components of positive parenting. Group discussions and buddy calls are designed to facilitate a support network for skills practice and problem solving barriers and challenges. Moreover, group leaders check in individually on a weekly basis to process and problem solve (Borden et al., 2010). Lastly, homework is assigned to promote in-home skills practice.

The IY program consists of four stages with skills and content building upon each other. Early stages encourage the development of skills related to key promotive factors and positive adjustment before advancing to effectively managing externalizing behaviors. During stage one, caregivers begin by learning skills to enhance children's social competence, school readiness, and emotion regulation. Vignettes and role-plays are utilized to model and facilitate skills practice during child-directed play through descriptive commenting in addition to coaching across several domains (e.g., academic, social, emotional, and persistence; see Webster-Stratton & Reid, 2010). These activities are designed to counteract or prevent a coercive cycle while encouraging positive interactions and skills. Coaching is at the center of these sessions, which includes using strategic comments to model and promote behaviors associated with resilience and positive development (i.e., calm and focused persistence through challenging conversations, positive communication, emotion language, and perspective taking;

Borden et al., 2010). During stage two, the program shifts attention toward promoting desired behavior through the use of positive attention, encouragement, and praise. Group leaders teach caregivers to encourage their children by using behavior-specific praise when children are exhibiting appropriate behaviors. Additionally, parents develop skills aimed at modeling positive self-talk and self-praise. The use of such skills equips caregivers with the necessary tools to provide support for their children and nurture self-esteem. In the final stages of IY (i.e., three and four), sessions emphasize the use of positive discipline including clear, developmentally appropriate commands, predictable household rules and routines, effective limit setting, and managing misbehaviors via ignoring, time-out, and rational consequences. Resilience related components are encouraged by teaching children problem-solving and self-regulation skills through the abovementioned discipline strategies. Children learn to self-regulate when upset, think about the consequences of their emotions and behaviors, and reflect on situations with empathy (Borden et al., 2010).

In an effort to address the impact of behavior problems on children's early school readiness and success, the developer of IY adapted a small group treatment program (i.e., The Incredible Years Dinosaur Social Skills and Problem Solving Child Training Program; Webster-Stratton et al., 2001) for young children (3 – 8 years) diagnosed with ODD and CD for use by teachers as a preventative school-based approach to promote socioemotional and academic development and reduce EBPs of all students in the classroom (Webster-Stratton & Reid, 2004). The adapted classroom-based version of the social skills program (i.e., Dina Dinosaur Social Skills and Problem-Solving Curriculum), is comprised of over 64 lesson plans and has versions for preschool/kindergarten and

primary grade youth. Teachers use the lesson plans to teach students specific skills two to three times per week in a brief (15 – 20 minute) large group circle followed by practice activities in smaller groups (20 minutes). Teachers are instructed to look for opportunities outside of groups (e.g., during recess, free choice, meal, or bus times) to encourage skills specific to the unit being taught. Children are assigned dinosaur home activity books to complete with caregivers to increase involvement and information about concepts covered in class is sent home. Moreover, caregivers are encouraged to help facilitate small group activities in the classroom. The school-based curriculum includes seven units: "learning school rules and how to be successful; emotional literacy, empathy or perspective taking, interpersonal problem solving; anger management; and friendship and communication skills" (p. 100; Webster-Stratton & Reid, 2004). Teachers complete four days of training in the content and methods of implementation and use comprehensive manuals with outlined lesson plans (Webster-Stratton & Reid, 2004).

The IY meets criteria for a well-established evidence-based intervention. Implemented domestically and internationally, IY has a wealth of empirical support demonstrating its effectiveness as a treatment for children with externalizing problems, improving parenting skills, and as a preventative intervention for high-risk populations (e.g., Bauer & Webster-Stratton, 2006; Brestan & Eyberg, 1998; Bywater et al., 2009; Menting et al., 2013; Reid et al., 2001; Scott et al., 2001; Webster-Stratton, 1984; Webster-Stratton & Hammond, 1997). In terms of ethnic minority status, IY has demonstrated its ability to improve parenting behavior and reduce child problem behaviors in Black, Asian, Hispanic, and multiracial youth in the U.S. (Gross et al., 2003;

Kim et al., 2008; Reid et al., 2004) and in the Netherlands, England, and Wales (Hutchings et al., 2007; Leitjen et al., 2015; Scott et al., 2010a; Scott, et al., 2010b).

Positive Parenting Program (Triple P)

Developed over twenty years ago as a public health strategy, Triple P (Sanders, 1999) is a multi-tiered system developed to prevent and treat severe behavioral, emotional, and developmental challenges in children (0 – 16 years) by building the knowledge, skills, and confidence of caregivers. This intervention also utilizes various service delivery modalities (e.g., group, individual, and self-directed). Triple P is comprised of five levels of education and support with increasing intensity at each level. The justification for this stepped-care approach is that there are different levels of challenging behaviors children display and as such caregivers may have different needs and desires concerning the type, intensity, and mode of treatment they require (Sanders, 1999).

Similar to a universal prevention approach, Level 1 provides psychoeducational information regarding parenting skills to interested caregivers. Level 2 is a brief intervention providing 1-2 time support for caregivers of children with mild behavioral problems who are generally coping well but have some concerns. Level 3 is a four-session intervention, designed to treat children with mild to moderate behavioral challenges, and includes active skills training for caregivers. Level 3 can be implemented with caregivers of children (0 – 12 years) and caregivers of teenagers. Sessions, each lasting 15 to 30 minutes, can be facilitated in-person or via telephone. Alternatively, 2hr small group sessions targeting a specific behavior problem or issue can be arranged (e.g., handling disobedience, managing fighting, developing good bedtime routines). Level 4 is

an intensive, 8- to 10-session parent training program for children with more severe behavioral difficulties or who are at risk of developing such problems. Sessions, which can be held individually or in a group format, teach caregivers a variety of child management skills. Level 4 is a form of selective or indicated prevention meaning youth are at elevated risk of developing behavioral problems and offers three delivery formats (i.e., individual, group, and web-based). Finally, level 5 is an enhanced behavioral family intervention program for families in which parenting difficulties are complicated by other sources of family distress (e.g., marital conflict, parental depression, or high levels of stress; Clarke, 2019; de Graaf et al., 2008; Sanders, 1999).

Triple P has undergone a variety of evaluations to examine its effectiveness and several studies have demonstrated that the parenting skills training employed produced a predictable decline in child behavior problems and this reduction in problem behaviors was generally maintained over time (Sanders et al., 2003). Moreover, clinically meaningful and statistically reliable outcomes for both caregivers and their children have been demonstrated for multiple modalities (i.e., the standard, self-directed, telephone-assisted group, and enhanced interventions). Triple P has also been successfully implemented within diverse family contexts, including two-parent families, single parents, stepfamilies, “maternally depressed” families, “maritally discordant” families, and families with a child with an intellectual disability (Sanders et al., 2003). Finally, with regard to ethnic minority status, findings from previous international investigations provide support for the program. For instance, Matsumoto and colleagues (2007) investigated the efficacy of Triple P with 50 Japanese parents living in Australia to assess the feasibility and acceptability of the program and the parenting skills taught in a cross-

cultural context. Using a randomized group comparison design with two conditions (i.e., Triple P group and waitlist control group), results demonstrated significant reductions in parent report of child behavior problems, parental over-reactivity and laxness, and parental conflict as well as increases in parental competence. Furthermore, Triple P was found to be highly acceptable. In another study conducted in Australia, Morawska and colleagues (2011) examined the cultural acceptability of program materials, preferences for delivery methods, and barriers to use of Triple P in an ethnically diverse sample of caregivers (e.g., White Australian, South-East Asian, European, African, Pacific Islander, Southern/Central Asian). Findings indicate high acceptability amongst parents with regard to the strategies and their utility. Moreover, participants were likely to use the strategies and reported currently using the strategies often. Program materials were also rated as very culturally appropriate.

Community Parent Education Program (COPE)

Developed by Cunningham and colleagues (1998), COPE is a Canadian program that aligns itself with other BPTs (Barkley, 1997; Forehand & McMahon, 1981; Webster-Stratton, 2005) by emphasizing strategies grounded in social learning theory and teachers use interactive strategies (i.e., modeling and role-play), goal setting and self-monitored homework strategies to encourage new skills (Cunningham, 2006). Additionally, COPE integrates several different theoretical orientations and treatment modalities including social-cognitive psychology, family systems theory, small-group interventions, as well as larger support-group-based programs (Thorell, 2009).

The most notable difference between COPE and other BPTs is that it is a nondidactic, large-group, community-based program. In establishing a training program

in neighborhood schools or community centers and by organizing the program within the community rather than through a psychiatric clinic, community-based programs proactively address potential barriers (e.g., logistic and psychological) that clinic-based programs may create (Thorell, 2009). In one such study, Cunningham and colleagues (1995) were able to demonstrate that economically disadvantaged families and families with children with more severe behavior problems were more likely to enroll in and complete community-based than clinic-based parent training programs. A cost analysis also showed that with groups of 18 families, community-based groups are more than six times as cost effective as clinic-individual programs (Cunningham et al., 1995).

Regarding treatment effectiveness, there are few published studies investigating the effectiveness of COPE (e.g., Cunningham et al., 1995; Cunningham et al., 2000; Tamm et al., 2005). Still, Cunningham and colleagues have found COPE to be effective in reducing externalizing problems in a community sample of children with high initial levels of such problems. Additionally, in the first European evaluation of COPE, results demonstrate that the program was effective in reducing conduct problems, hyperactivity/impulsivity, daily problem behaviors, parental stress, and lack of perceived parental control. However, COPE was not effective in reducing inattention, social competence deficits, or peer problems (Thorell, 2009).

Limitations of existing BPT programs

BPT has come to be one of the most successful and empirically supported interventions thus far in the treatment and prevention of child and adolescent externalizing behavior problems (e.g., aggression and noncompliance). In addition to the overall effectiveness of BPTs, several common treatment components (e.g., increasing

positive parent-child interactions, promoting consistency and use of time out) are associated with large effect sizes (Kaminski et al., 2008). Nonetheless, parent training success is variable, and the field has much to learn about the host of factors that affect the implementation of this treatment modality (Forehand & Kotchick, 2002).

For example, many of the benefits of receiving quality mental health services are not representative of economically and socially disadvantaged families (Eyberg et al., 2008; Fernandez et al., 2011). Furthermore, less than one-quarter of youth who need BPT receive treatment, and the proportion is even smaller for the most vulnerable populations, including low-income families who are overrepresented in statistics for externalizing problems (Farahmand et al., 2011; Kazdin et al., 1997; Khaeler et al., 2016). Parents and other caregivers serve as critical gatekeepers to children's utilization of mental health services. Recent studies approximate that 35-68% of parents who have children with externalizing behavior problems decline supported parent-training services (Barkley et al., 2000; Cunningham et al., 2000). In fact, minority families are less likely to seek and engage in treatment for externalizing problems than White families (Bussing et al., 1998; Garland et al., 2005; Padgett et al., 1994). These trends are doubly concerning for minority youth who receive fewer and poorer quality of services than their White peers (Alegría et al., 2015; Alegría et al., 2010; Kataoka et al., 2002). These disparities are associated with perceptions about the legitimacy of the ADHD diagnosis, stigma associated with receiving mental health treatment services, mistrust of treatment providers, and perceived cultural incongruence of treatment strategies with normative family processes (Dempster et al., 2015; Liang et al., 2016; Lindsey et al., 2012; Olanyian et al., 2007). When families do seek services for externalizing problems,

economically and socially disadvantaged families are more likely to have poor participation, retention and outcomes (Gross et al., 2014; Kazdin & Wassell, 1998; Lavigne et al., 2010; Leijten et al., 2013). Further widening this gap is the amount of time spent waiting for treatment, with the median length between seeking and receiving services being four years (Wang et al., 2005).

As demonstrated in the review of parent training programs above, racial and ethnic minority children are grossly underrepresented in controlled investigations (McMahon & Frick, 2005), even though minority children may show higher rates of behavioral problems than their White counterparts (Fabrega et al., 1993; Fantuzzo et al., 1999; Huaqing Qi & Kaiser, 2003). Given the exclusion of minority populations from such studies in relation to the overall evidence base, at present it is unclear to what degree many of the families most in need of effective care engage in and benefit from empirically supported treatments. In an effort to address mental health disparities and increase access to care for ethnic minority children and families, the field has sought to culturally adapt existing interventions and develop novel behavioral parent training programs to recruit, retain, and engage members of high-risk communities. Preventative interventions intended for low-income families often include a large number of African American and Latino families, as these ethnic minority groups are overrepresented among those living in poverty (Gross et al., 2009). Still, several empirically-supported interventions used to help economically and socially disadvantaged caregivers were originally developed and tested on middle-income and non-Hispanic White samples (Coard et al., 2004; Forehand & Kotchick, 1996; Gorman & Balter, 1997). As previously mentioned, research shows that low income families tend to benefit less from parent

training compared to families from higher SES backgrounds (Lundahl et al., 2006), a finding some have linked to the various correlates of economic disadvantage (Dumas & Wahler, 1983). However, reduced parent training effectiveness is potentially linked to low social validity and the belief among economically disadvantaged caregivers that such programs are not suitable for their immediate concerns (e.g., basic needs; Gottfredson et al., 2006) as caregivers responsible for parenting young children in multiply stressed environments (Gross et al., 2009). Previous work has highlighted contextual pressures and limitations such as low SES, unemployment, and health that effect BPT engagement (Prinz & Miller, 1996). For example, Fox and Gottfredson (2003) examined characteristics associated with program non-completion among predominantly Black families recruited for a family-based program offered in the metropolitan Washington, D.C. area. Analyses from survey responses revealed that caregivers who did not complete the program were misinformed about program content (e.g., not fully aware of program's expectations) and lacked transportation. Additionally, program content, family illness, and scheduling conflicts also contributed to non-attendance.

The complex contexts in which economically and socially disadvantaged caregivers raise their children may be exacerbated by traditional parent training principles, skills and approaches which can be viewed as culturally incongruent. Researchers have called attention to discrepancies between views held by Latino families and their services providers regarding the presence of mental health problems, their causes and solutions (Alegría et al., 2002; Calzada et al., 2012). As previously discussed, parent training programs ascribe the development and maintenance of behavior problems to social learning theory and target culturally influenced caregiver goals (Dumas et al.,

2010). Still critical differences in parenting exists across cultural groups (Calzada et al., 2012). Calzada and colleagues (2010) demonstrated this variation in their examination of the cultural values of Dominican and Mexican mothers of preschoolers. They found in comparison to non-Latino White caregivers, Latino caregivers tend to value obedience and respect above assertiveness and independence in children, and tend to rely on physical discipline and hierarchical parent-child relationships to instill these values (Calzada et al., 2010). Research has also shown that the same parenting behaviors could have different effects on children of different racial/ethnic backgrounds. In one such study, physical discipline used by Black caregivers was found to decrease child externalizing behaviors, though it increased externalizing behaviors among White children (Lansford et al., 2004). In another study, researchers found that in contrast to White caregivers, an authoritarian parenting style is associated with low levels of child misbehavior among Black caregivers (Bradley et al., 2001).

The aforementioned evidence documenting the differential impact of parenting practices on youth challenges the relevance of some core components of traditional BPT models. Moreover, the literature indicates a prescriptive approach for or against certain parenting practices may be perceived by caregivers as naïve, judgmental, or disempowering (Moodie & Ramos, 2014; Ortiz & Del Vecchio, 2013). Because both standard and culturally adapted versions of EBTs have proven to be effective with ethnic minorities, it is difficult to ascertain in what context cultural modifications to EBTs are innocuous, favorable, or unfavorable. To address this, McCabe & Yeh (2009) suggest that research compare culturally adapted versions of EBTs both to standard versions and treatment as usual or no-treatment controls.

Notable BPTs developed and/or adapted include Guiando a Niños Activos (GANA; McCabe & Yeh, 2009), The Chicago Parent Program (CPP; Gross et al., 2009), and the Strategies to Enhance Positive Parenting (STEPP) program (Chacko et al., 2009). The GANA program (McCabe et al., 2005) is a cultural adaptation of PCIT and the product of quantitative and qualitative information collected on Mexican American families' preferences for their children's treatment. Fifty-eight Mexican American families of children between 3 and 7 years with clinically significant behavior problems were randomly assigned to receive GANA, standard PCIT, or treatment as usual (TAU; McCabe & Yeh, 2009). McCabe & Yeh (2009) found that all three treatment approaches yielded significant pre-post improvement in conduct problems. Treatment outcomes for families who received GANA were significantly greater than those who received TAU across both parent report and observation; however, GANA and PCIT did not differ significantly from one another. PCIT was superior to TAU on two of the parent-report measures and nearly all of the observational indices. Lastly, there were no significant differences between the three groups on dropout, and both GANA and PCIT received higher satisfaction ratings than TAU (McCabe & Yeh, 2009).

Gross and colleagues (2009) developed a novel 12-session BPT (i.e., CPP) influenced by the Incredible Years BASIC Program's (IYP; Webster-Stratton, 1998) use of videotaped vignettes, group discussion format, and a collaborative interpersonal style to engage caregivers. Of note, a distinct component of the development of CPP was its partnership with a parent advisory council of seven African American and five Latino parents from different Chicago neighborhoods. The council advised the program authors on a number of issues, including difficult situations they encountered as parents,

scenarios they would like to see on videotape, and how to adequately depict parenting strategies in a way that is congruent with their values, lifestyle, and culture (Gross et al. 2007b). The perspectives of the advisory council regarding the acceptability and effectiveness of various discipline strategies, about how stress impacts their parenting, and about why strategies such as time out and dyad play are sometimes viewed as a White, middle-class value provided important insights in the development of the CPP (Gross et al., 2009). Additionally, once finished, the advisory council reviewed and evaluated CPP's content and videotaped scenes for their utility and pertinence and only those rated as such were retained in the program (Gross et al. 2009; for more information on the development of the CPP, see Gross et al. 2007b). Gross and colleagues (2009) tested the efficacy of the CPP in a sample of 253 parents of two- to four-year old children enrolled in several daycare centers serving low-income families. Center were matched and randomly assigned to intervention and wait-list control conditions. Parents assigned to CPP used less corporal punishment and issued fewer commands with their children at 1-year follow-up. Children who received the intervention displayed fewer behavior problems during observed play and clean-up sessions than controls. Additional group differences emerged when dosage was considered in the analytic model. Parents who attended at least half of the CPP sessions also reported greater improvements in parenting self-efficacy, more consistent discipline, greater warmth, and decreases in child behavior problems when compared to ratings from controls (Gross et al., 2009).

Beyond race/ethnicity and SES, researchers have also examined other risk factors for poor treatment outcomes, such as being a single mother, which has historically constituted risk in BPT (Chacko et al., 2007). For example, studies have shown that

single-mothers are less likely to participate in BPT (Cunningham et al., 2000), complete treatment (Kazdin & Mazurick, 1994; Kazdin et al., 1993), demonstrate improvement posttreatment assessment (Dumas & Wahler, 1983; Lundahl et al., 2006; Webster-Stratton & Hammond, 1990), or maintain treatment gains over time (Bagner & Eyberg, 2003; Webster-Stratton, 1985) compared to two-parent families. Given the risk factors for single mother families, Chacko and colleagues conducted a series of studies to investigate the efficacy of an enhanced BPT intervention targeting single mothers of children specifically diagnosed with an externalizing disorder. First, a pilot study was launched to determine the feasibility and preliminary efficacy of the STEPP program with single mothers of children with ADHD diagnoses (Chacko et al., 2008). The STEPP program focused on enhancing traditional BPT in the areas of format, delivery, and content including (a) an enhanced intake procedure that addressed practical barriers to treatment participation, maternal cognitions regarding expectations for treatment, and attributions regarding their children's behavior; (b) incorporating a subgroup, coping-modeling, problem-solving format within the traditional large group format to improve social support between parents and to increase participation among parents; and (c) incorporation of a systematic, problem-solving treatment to address parent-initiated problems (e.g., time management, conflicts with relative; Chacko et al., 2008). The aforementioned enhancements to traditional BPT were incorporated to address numerous key areas recognized in the literature as significant to target with multiply stressed, single mothers: practical barriers to participation, unhelpful beliefs regarding their child and treatment, depression, social support, and life stressors (Chronis et al., 2004; Miller & Prinz, 1990). Findings from the pilot investigation indicated that the STEPP program

reduced child problem behaviors, parental stress and psychopathology; and yielded high rates of treatment attendance, completion, and consumer satisfaction with the program. However, results also suggest the STEPP program had less impact on children's overall levels of impairment and resulted in relatively small effect size findings across most measures. While results of the pilot study were encouraging, they also underscored a need to improve the potency and delivery of certain aspects of the STEPP program (Chacko, et al., 2008). Quantitative and qualitative data gathered from the pilot study were used to adapt the STEPP program. Specifically, the intensity, content, and program activities were modified to lead to additional improvements in treatment outcomes. In a subsequent examination, Chacko and colleagues (2009) randomly assigned cohorts of 120 single mothers of children (ages 5–12 years) with ADHD to a waitlist control group, a traditional behavioral parent training program, or an enhanced behavioral parent training program (i.e., STEPP). Intent-to-treat analysis indicated benefits of participating in BPT, in general, and the STEPP program more specifically at immediate posttreatment on child and parent functioning. Further, the STEPP program yielded increased engagement in treatment. Nonetheless, findings suggest that BPT does not normalize behavior for most children of single mothers and treatment gains are not maintained.

In summary, despite adaptations of several existing BPTs for vulnerable populations (e.g., McCabe & Yeh, 2009), the field has still faced significant challenges with consistently demonstrating comparable effectiveness. While there is an unmet mental health burden that disproportionately impacts children and families of color, the field appears to be split between those who strongly advocate for the adaptation of evidence-based treatments to ensure their fit for specific ethnic communities and those

who caution against culturally tailored treatments given the limited evidence supporting their effectiveness or lack thereof with minorities (Miranda et al., 2005; Weisz et al., 1998). According to Lau (2006), "the first priority is to proceed with deployment to ensure minorities have access to evidence-based care and evaluate parity within inclusive effectiveness trials" (p. 296). Some researchers believe focusing on culturally responsive adaptations may result in unsystematic or misguided modifications that could compromise the fidelity of the interventions and their effectiveness (Castro et al., 2004; Elliot & Mihalic, 2004). Equally important, the likely limitless iterations of adapted treatments for different clinical problems for various communities is a poor use of resources (Lau, 2006). As such, future investigations should continue to strive to increase access to care for ethnic minorities.

Parenting and Children's School Readiness

While caregivers play a critical role in parenting children with EBPs, parenting practices are also key for children's school readiness (Graziano et al., 2017). In particular, research has identified aspects of parental involvement, such as parent-child book reading, homework involvement, and attending parent-teacher conferences as predictive of positive social and academic outcomes (Durand, 2011; Epstein, 2001; Epstein, 1987; Grolnick & Slowiaczek, 1994; Hill & Craft, 2003; McWayne et al., 2004; Wilder, 2014). Similarly, the literature also underscores the importance of the caregiver-child relationship which is predictive of the acquisition of early academic skills and academic success (Graziano et al., 2017). To date, the majority of existing BPT do not specifically address academic concerns despite a substantial amount of literature documenting the co-occurrence of academic underachievement and externalizing

behavior problems (Hinshaw, 1992; Reid et al., 2004; Trout et al., 2003). Since the emergence of the No Child Left Behind Act of 2001 (NCLB, 2001), kindergarten classrooms across the country have become increasingly similar to first grade, with increased academic demands, suggesting that children entering the classroom for the first time are encountering higher expectations in terms of their academic, behavioral, and socio-emotional preparedness for school (Bassok, 2016). Given the role that caregivers may play with regard to school readiness outcomes, it is crucial to investigate parenting outcomes for BPTs designed to treat populations particularly vulnerable to early school challenges such as preschoolers with EBP.

III. OVERVIEW OF THE SCHOOL READINESS PARENTING PROGRAM

The School Readiness Parenting Program (SRPP; Graziano et al., 2013) was designed to address several of the limitations of existing BPT by not only targeting preschoolers' behavioral problems, but by also helping parents increase their school involvement and promote their children's school readiness skills. The School Readiness Parenting Program has been successfully implemented in clinical practice in recent years in conjunction with the Summer Treatment Program for Prekindergartners (STP-PreK; for intervention description see Graziano et al., 2014), an 8-week intensive summer treatment program for preschool children with EBP, modeled after the Children's Summer Treatment Program (Fabiano et al., 2014; Pelham et al., 2005) for elementary-aged children with ADHD and related disorders. While SRPP incorporates standard aspects of behavior management strategies (e.g., positive reinforcement and time out) that have historically been implemented in BPTs, it aims to be a hybrid model in its delivery system- merging two efficacious BPT programs: COPE (Cunningham, 1998) and PCIT (Zisser & Eyberg, 2010).

The School Readiness Parenting Program integrates elements of COPE and PCIT by presenting didactic information on different skills in a large group format (10-15 parents), then providing opportunities for skills practice in smaller groups. Research has demonstrated the initial efficacy and promise of SRPP in improving the early academic and behavioral functioning of young children with and at-risk for externalizing behavior problems (Graziano & Hart, 2016; Graziano et al, 2018). For example, Graziano and Hart (2016) systematically evaluated three combinations of interventions targeting school readiness in a sample of 45 preschool-aged children with externalizing behavior

problems. During the summer prior to the transition to kindergarten, children and their caregivers were randomized to receive eight weeks of SRPP, a combination of SRPP and STP-PreK, or SRPP and STP-PreK Enhanced (including social-emotional and self-regulation training). They found significant improvements in children's behavioral functioning across all groups in a similar magnitude. However, children who received SRPP and STP-PreK Enhanced demonstrated greater growth across time (i.e., baseline, postintervention, and 6-month follow-up). While findings suggest a comprehensive approach (i.e., behavioral modification, social-emotional and self-regulation, and parent training) to promoting children's school readiness will yield superior improvements across a range of domains predictive of school success, they also highlight the utility and cost effectiveness of SRPP as a standalone intervention to address early behavioral difficulties. In a subsequent study, Graziano and colleagues (2018) examined, via open trial, the promise of the SRPP and STP-PreK in improving parenting outcomes. Data (i.e., caregiver ratings and observations) from a sub-sample of 90 predominately Hispanic participating families indicate significant improvements in parenting stress and discipline strategies post-intervention with all effects being maintained at six to nine month follow-up. While the researchers were limited in their ability to conduct a comprehensive cost-analysis, SRPP was estimated to cost approximately $350 per family considering therapists, child care, meals for families, and supplies; a fraction of the cost of traditional PCIT (Graziano et al., 2008). Given the structure of SRPP as a PCIT adaptation, these findings highlight the initial promise of this BPT in targeting multiple aspects of parenting while producing similar skills acquisition compared to traditional PCIT.

Program Structure

When implemented in conjunction with STP-PreK Enhanced, participating caregivers attend 8 weekly sessions, each lasting between 1.5 to 2 hours. Caregivers are given the choice to attend one of two evening sessions with about 15–20 people in each group facilitated by two clinicians. These clinicians are trained in both individual PCIT and group parent training, typically deliver sessions in English or Spanish, and tend to be advanced clinical psychology graduate students. Clinicians receive weekly supervision by a licensed clinical psychologist. In addition, dinner and childcare are provided during all sessions.

School Readiness Parenting Program sessions are divided into two parts (Graziano et al., 2013), with the first half of each session focusing on common behavior management strategies (e.g., improving the parent-child relationship, use of reinforcement, time-out) implemented within a group PCIT framework (Zisser & Eyberg, 2010). Group leaders encourage caregivers to participate in didactic discussions via a COPE (Cunningham, 1998) style of problem solving, which involves providing space for families to actively contribute and guide the group discussion. By using a COPE model of problem solving, caregivers are encouraged to offer suggestions and potential solutions to one another as opposed to only relying on didactic information provided by the group leaders. Content related to behavioral management models PCIT with four sessions (one teach and 3 coach sessions) dedicated to child-directed interaction (CDI) skills (e.g., increasing use of PRIDE skills, while refraining from criticisms, commands, and questions) during special time (i.e., child led play). The final four sessions (one teach and 3 coach sessions) focus on parent-direct interaction (PDI) skills (e.g., effective

commands, time out; Graziano et al., 2018). Six out of eight sessions include the administration of a quiz, which reviews content learned in previous sessions and provides opportunities for caregivers to assess their knowledge of skills and receive corrective feedback.

After a didactic discussion, families engage in small group activities which involves caregivers practicing newly acquired skills with their own children for 10–15 minutes. During in-session skills practice, other caregivers in the subgroup observe (using a coding sheet, records frequency of types of verbalizations such as praise and questions) while group leaders rotate among the subgroups to provide live coaching to each caregiver. After each round, caregivers in the subgroup provided positive feedback to the caregiver who was practicing their skills; sessions include three rotations for a total of 45 minutes of practice. Next, the entire group reconvenes to discuss their progress, problem solve any issues that came up in the session, as well as discuss the potential benefits of continuing to practice the skills at home. Of note, all caregivers are coached by a clinician at least once during CDI and once during PDI. Hence, SRPP's large group PCIT model differs from traditional individual or small group PCIT in not only its capacity to serve a larger group of families but also that it:

a) is short-term (8 sessions)

b) does not require mastery criteria

c) involves only brief coaching twice during treatment compared to weekly extensive coaching

d) takes advantage of observing other caregivers practicing with their children

During the second half of each SRPP session, group leaders engage caregivers in discussions concerning several school readiness topics including, how to appropriately manage behavior problems during homework time and in public settings, how to promote children's social-emotional functioning, how to promote early literacy and math skills, dialogic reading, how to implement a home-school communication plan with teachers (i.e., daily report card), and how to prepare their child for the transition to kindergarten (Graziano et al., 2018). For select topics (e.g., dialogic reading), caregivers are provided with opportunities to role play the use of skills with appropriate materials (e.g., picture books). Regarding school readiness skills, participants observe group facilitators introduce and model skills in one session and practice with other caregivers and/or their children in the following session for one practice session. Caregivers who do not have the resources or did not have access to developmentally appropriate books conducive to dialogic reading are able to check out a book from the program's library (Graziano et al., 2018).

Making the Case for School-Based Implementation

In the United States, an estimated four million children enroll in kindergarten each year (U.S. DOE, 2015). Moreover, one in four children who enter the classroom, specifically youth from low-SES backgrounds, lack the foundational skills necessary to keep up with the increased demands of formal school early on (Pritzker et al., 2015). Given the integration of school readiness skills (i.e., behavioral, social-emotional, adaptive, academic) to help caregivers prepare at-risk children for the transition to formal school, SRPP lends itself well to implementation within educational settings. However, the idea of schools and mental health services merging to meet the needs of youth is far

from a novel concept. Mental health services were initially offered in schools in the mid-1980s (Dolan, 1992). Since then, the Surgeon General's Report (U.S. Department of Health and Human Services, 1999) has described schools as a key setting for the identification and treatment of mental disorders in children and youth (Faramand et al., 2011). For economically disadvantaged youth, school-based mental health services can take advantage of schools' capacity to promote development and connect home and neighborhood ecologies (Cappella, et al., 2008). However, such services are often not sensitive to the cultural values or needs of minority communities (Guo et al., 2014). The literature has demonstrated poverty's significant and predictable association with children's cognitive abilities, physical health, and socioemotional development (for reviews see Bradley & Corwyn, 2002; Brooks-Gunn & Duncan, 1997; McLoyd, 1998). Given the fact that schools represent a bridge between home and community, as well as a setting in which youth spend significant time, they have the ability to foster positive outcomes despite risk (Allen-Meares, 2006; Boyd & Shouse, 1997). However, evidence suggests public schools in low-income communities struggle to realize this potential (Cappella et al., 2008). As a result of how public schools are funded, facilities and resources in underserved communities are often insufficient, with lack of space, poor environmental quality and educational materials (see Evans, 2004). Considering the number of obstacles schools in low-income communities face, quality care is desperately needed in order to strengthen the promise of schools to foster children's wellbeing (Cappella et al., 2008).

As such, a school-based mental health movement surfaced, to a great extent to combat barriers to services (Atkins et al., 2006). For instance, Brindis and colleagues

(2003) examined trends and changes in school-based health centers (SBHC) using data from a national survey. Findings indicated that over half of school-based clinics offered mental health services as compared to just 30% seven years prior. Schools were widely accepted as the *de facto* providers of mental health services for children and adolescents (Atkins et al., 2006.; Cappella et al., 2008), responsible for providing a staggering proportion of services (70-80%) to those youth who engage in them (Rones & Hoagwood, 2000). While earlier work highlighted a limited understanding of information regarding the quality or type of services offered given the low number of available empirical evidence (Rones & Hoagwood, 2000), recent meta-analyses provide support for the benefits of school-based mental health services (Sanchez et al. 2018; Franklin et al., 2012).

Of particular relevance to the current investigation, Hart and colleagues (2016) evaluated two early intervention packages (i.e., group 1 [high intervention group] – four-week intensive summer program before kindergarten, weekly parent workshops, and monthly school consultation and group 2 [low intervention group] – parent workshops alone) to promote successful transitions to kindergarten for 50 preschoolers (98% minority; low SES) with behavior problems enrolled in Head Start centers. Findings indicated that children in the high intervention group demonstrated more rapid improvement in their behavior between the end of preschool and the fall of kindergarten per teacher ratings of child behavior problems and had less conflict with their teachers than did children in the low intervention group. However, it is important to note that although these improvements were maintained across the kindergarten year, no significant differences emerged between groups during the spring, suggesting that

children in the low intervention group were functioning at the same level as children in high intervention group by the end of the kindergarten year. Moreover, there were no significant effects of either intervention group on caregiver ratings of child behavior problems or on caregiver and teacher report of functional impairment. Regarding objective measures of behavioral and academic outcomes, results demonstrated that children in high intervention group had marginally fewer disciplinary actions and out-of-school suspensions across the kindergarten year than children in the low intervention group. Hart and colleagues (2016) also found that children in the low intervention group were at marginally greater odds of retention referral than children in the high intervention group, and that children in the high intervention group demonstrated greater improvement on kindergarten achievement measures than children in the low intervention group. Findings from this evaluation of two early intervention packages to promote school readiness informed successive iterations of both SRPP and STP-PreK.

Aims of the Present Studies

The purpose of the present investigation was to leverage ongoing partnerships with two early childhood centers to evaluate SRPP as a standalone treatment for economically and socially disadvantaged children and their families during the academic year. The present investigation represents preliminary steps toward adapting, evaluating, and implementing the SRPP as a standalone BPT for economically and socially disadvantaged families:

Study 1. The first study was a pilot open trial and the first to examine SRPP for racial/ethnic minority families living in urban poverty during the school year. In study 1, the author sought to evaluate the acceptability, feasibility, and promise of SRPP for

economically and socially disadvantaged children and their families (**Aim 1)**. Additionally, the aim of the first study sought to explore and predictors of treatment engagement among minority families participating in SRPP, such as stress- and trauma-related factors, stigma-related concerns about mental health services, and logistical barriers and their associations with response to intervention (**Aim 2)**. Following completion of SRPP, participants were invited to attend a focus group or individual interview to share their experiences.

Study 2. A qualitative study of the treatment acceptability component and social validity of SRPP with Black/African American and Hispanic caregivers of young children who previously completed the program as part of their child's participation in an intensive summer camp program for children with EBPs. Study 2 examined transcriptions of focus groups and interviews regarding program design and implementation (**Aim 1**).

IV. STUDY 1: A PILOT OPEN TRIAL OF THE SCHOOL READINESS PARENTING PROGRAM

Study 1 was a pilot open trial of the School Readiness Parenting Program (SRPP) as a standalone intervention during the 2018 – 2019 academic year. Primary goals of the open trial were to examine the acceptability, feasibility, and promise of the behavioral parent training program (BPT) for families living in urban poverty. The acceptability of the SRPP was assessed via caregiver ratings of parent training satisfaction and caregiver feedback regarding their experiences. The feasibility of the program was assessed via caregiver attendance and homework compliance. The promise of the program was assessed by pre- and posttreatment caregiver- and teacher-report of children's behavioral functioning, and by examining caregiver skills via structured observation posttreatment. Finally, a preliminary descriptive examination of predictors of engagement were conducted. For a conceptual model of the proposed shared relationships among program components, outcomes, and impact of SRPP, see Figure 1.

Method

Recruitment and Participants

Prospective families were actively recruited over the course of three months during fall 2018 and two months during spring 2019 at four Head Start programs serving ethnically and linguistically diverse children and families across a large urban Southeastern city. Recruitment activities included disseminating program flyers during daily drop-off/pick-up, posting flyers on school grounds, teacher/administrative referrals, and attending open houses, parent workshops, staff meetings, and community events to provide a brief

overview of the program. Interested parents were asked to provide their contact information on a sign-in sheet in order to be contacted by the author or call to have the study explained to them and complete a phone screen to determine eligibility. No more than three calls were made per week over a two week span before study staff suspended attempts to contact caregivers. Figure 2 illustrates recruitment for the study. Participants were six caregivers (75% mothers; 100% Black) and their three- to five-year old children, who were rated as exhibiting elevated behavior problems at home and/or school on a comprehensive screener of social-emotional functioning (see Tables 1 and 2). According to caregivers' and teachers' combined report on the Disruptive Behavior Disorders Rating Scale (DBDRS; Pelham et al., 1992), at baseline, three children met symptom criteria for ADHD (i.e., hyperactive/impulsive presentation, inattentive presentation, or combined presentation). One child met symptom criteria for ODD, one child met symptom criteria for comorbid DBD diagnoses, and one child did not meet symptom criteria for a DBD diagnosis.

For study 1 inclusion, caregivers and/or teachers had to rate participating children above the clinical cut off (i.e., T – score ≥ 60 or Intensity Scale score ≥ 131) on the Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999) or Sutter-Eyberg Student Behavior Inventory – Revised (SESBI-R; i.e., T – score ≥ 60 or Intensity Scale score ≥ 151; Eyberg & Pincus, 1999). Consistent with previous PCIT research (e.g., Fernandez, Butler, & Eyberg, 2011; Fernandez & Eyberg, 2009), the Peabody Picture Vocabulary Test, Fourth Edition (PPVT-4; Dunn & Dunn, 2007) was used as a proxy for cognitive ability to screen children in the current study; children had to achieve a standard score of at least 70. Additional inclusion criteria included enrollment in

preschool during the 2018-2019 academic year, proficiency in English, and ability to attend weekly parent training sessions over the course of an 8-week period.

During the recruitment period, 11 caregivers at two of four Head Start Programs were either referred or requested to be contacted by the author to be screened (see Figure 2 for recruitment and allocation plan for this study) . Two families contacted by the author were deemed ineligible due to conflicting work schedules and two did not return calls to complete an initial phone screen. Of the seven families participating in the initial screening process, none were screened out because of behavior problems below the clinical cut-off on the ECBI and SESBI-R, and no children were screened out because of scores on the PPVT-4. One caregiver provided an incorrect date of birth for their child and was subsequently consented but did not meet the age criteria (i.e., three to five years). The author subsequently screened another child of the caregiver's who was determined eligible. However, the caregiver did not return calls to complete intake procedures. It is important to note that one of the partnering schools, which has historically served predominately Black/African American children and families, has experienced an influx of Hispanic students in recent years. Thus, potentially eligible families were excluded from the pool as a result of limited English proficiency among the caregivers of these Hispanic preschoolers.

Screening Measures

Disruptive Behavior Disorders Rating Scale (DBDRS)

Symptomology was measured via caregiver- and teacher-report using the DBDRS (Pelham et al., 1992), a 45-item rating scale of behaviors that map onto *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., text rev.; *DSM-III-R;* American

Psychiatric Association [APA], 1987) and *DSM-IV* (APA, 1994) diagnostic criteria for EBPs (i.e., ADHD, CD, and ODD). Items are rated on a 4-point Likert scale ranging from 0 ("Not at All") to 3 ("Very Much"). The DBDRS demonstrates excellent internal consistency for caregiver- (α = .95) and good internal consistency for teacher-report (α = .87) in the current sample.

Peabody Picture Vocabulary Test – Fourth Edition (PPVT-4)

Children's receptive vocabulary was assessed using the Peabody Picture Vocabulary Test, fourth edition (PPVT-4; Dunn & Dunn, 2007) at pretreatment and posttreatment. A trained undergraduate-level research assistant administered the PPVT-4 to each child at pretreatment. The author administered the PPVT-4 at posttreatment. All children were tested in English, as English was the mode of instruction for SRPP. The PPVT-4 is a measure of receptive vocabulary and is correlated with standardized verbal IQ measures (Bell et al., 2001). The PPVT-4 includes two standard battery forms (Form A and Form B), each containing 228 items. Test items involve two stimuli, a target word spoken by the examiner and four pictures on a single card; the examinee selects the picture that best represents the target word (Campbell & Dommestrup, 2010). It is a well-validated and reliable assessment of receptive vocabulary that is appropriate for individuals between ages 2.5-90 years and can be completed within 10 to 15 minutes. In the current study, raw scores were translated into age-based standard scores (i.e., M = 100; SD = 15).

Bracken School Readiness Assessment (BSRA)

As part of intake procedures, participating children were each administered the Bracken School Readiness Assessment (BSRA; Bracken, 2002), a popular assessment of

kindergarten readiness which consists of five subtests evaluating children's understanding of basic concepts. The BSRA consists of 85 concepts across five subtests: colors, letters, numbers/counting, size/comparison, and shapes. Studies support the BSRA's strong psychometric properties and validity as a significant predictor of children's academic performance (Bracken, 2002; Panter & Bracken, 2009). The BSRA was also administered during the posttreatment evaluation. Overall school readiness composite standard scores at pre- and posttreament were utilized for the purposes of this study.

Measures of Acceptability and Feasibility

Therapy Attitudes Inventory (TAI)

Upon completing SRPP, caregivers provided ratings for the TAI (Eyberg, 1993), a 10-item questionnaire that measures caregiver satisfaction with the process and outcome of treatment. Previous work has demonstrated the psychometric properties of the TAI, including test-retest reliability and correlations between the TAI and both parent-rating scales and observational measures of treatment change (Brestan et al., 1999). The TAI demonstrates adequate internal consistency among items ($\alpha = .83$) in the current sample. The TAI total score was used in the current study to demonstrate treatment acceptability.

SRPP Caregiver Satisfaction Survey

Caregivers also provided ratings of treatment satisfaction for the SRPP at posttreatment by answering a standard satisfaction questionnaire developed for the current study by the author. Caregivers indicated their degree of satisfaction across 4- and 7-point Likert scales whether they would recommend the program to other caregivers, expectations for good results from the program, as well overall feelings about achieving

their goal(s) for their child and family. Additionally, two qualitative items asked caregivers to provide information regarding what they liked best about the program and what they wished they could change about the program. The mean level of satisfaction was calculated by item.

Focus Groups and Interview

Following completion of SRPP, participating caregivers were invited to share their intervention experiences. Questions were intended to stimulate dialogue regarding caregivers' opinions on various facets of the intervention: (a) program expectations and impressions; (b) help/unhelpful aspects of SRPP; (c) elements that were liked/disliked; (d) changes to SRPP content and/or structure (e.g., "What would you keep/remove/add?"); (e) what potential participants should know coming into the program; (f) acceptability of topics covered; (g) acceptability of discipline strategies presented (e.g., "How did you feel about the discipline strategies presented"); and (h) prospective ways to enhance the SRPP for school year implementation (e.g., "In what ways can the program be improved to be implemented during the school year?").

Attendance

Session attendance was measured from sign-in sheets completed by caregivers. The author noted absences including reasons for missing a session.

Homework completion

Consistent with the SRPP protocol, homework compliance was measured using SRPP homework sheets that were administered weekly. Caregivers were encouraged to engage in daily skills practice in between sessions at home, including five minutes of child-led special play time to practice using the Do Skills (i.e., praise, reflections, and

behavioral descriptions) and refrain from using the Don't Skills (i.e., questions, commands, and criticisms). During the Parent-Directed Interaction (PDI) phase, caregivers were also instructed to practice effective commands and implement the time-out sequence within the context of play and other situations. Homework sheets provided space for caregivers to record the number of days that they practiced these skills on a weekly basis. When caregivers did not bring the homework sheet to session, the author facilitated a discussion regarding barriers to homework completion, skills practice, and problem-solving ways to complete assignments for future sessions using Motivational Interviewing (MI) techniques. When caregivers missed a session, these data were collected retrospectively at the following session, if available. Weekly homework completion percentages were averaged to calculate a homework completion percentage over the course of treatment (i.e., total of number of days practiced divided by duration of treatment).

Measures of Intervention Promise

Child Behavior Outcomes

The Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999) is a commonly used 36-item caregiver-report measure of externalizing child behavior (2-16 years). Specific child behaviors are rated on two scales: the Intensity Scale and the Problem Scale. The Intensity Scale assesses the frequency of the child's behavior on a 7-point Likert scale ranging from 1 ("Never") to 7 ("Always"), and the Problem Scale measures whether the caregiver views the specific behavior as problematic (i.e., 1 = "Yes", 0 = "No"). According to the professional manual (Eyberg & Pincus, 1999), the published cut-off scores are ≥131 for the Intensity Scale, and ≥15 for the Problem Scale.

The ECBI has demonstrated acceptable internal consistency and convergent validity (Gross et al., 2007a), as well as test-retest reliability (Fernandez et al., 2011), with African American Preschoolers. Furthermore, the questionnaire is sensitive to intervention effects for treatments for disruptive disorders (e.g., PCIT; Eisenstadt et al., 1993; Nixon et al., 2003). Total raw Intensity Scale scores were used in the current study as one of the main outcomes for children's behavioral functioning (α's = .93 - .95).

In addition, teacher ratings of behavioral functioning were measured using the Sutter-Eyberg Student Behavior Inventory-Revised (SESBI-R; Eyberg & Pincus, 1999). The SESBI-R is a 38-item questionnaire for children between the ages of 2 and 16 mirrors the format of the ECBI (i.e., Intensity and Problem Scales). Sutter-Eyberg Student Behavior Inventory-Revised Intensity and Problem Scales have been found to demonstrate adequate internal consistency, test-retest reliability, and inter-teacher agreement with preschool-aged children (Querido & Eyberg, 2003). Similar to the ECBI, total raw Intensity Scale scores at pre- and posttreatment were used in analyses as a primary outcome for children's behavioral functioning. The ECBI Intensity Scale demonstrates excellent internal consistency across time points (α's = .95 and .95, respectively) in the current sample. Similarly, the SESBI-R Intensity Scale demonstrates good internal consistency (α's = .90 and .89, respectively)

Parenting Skills

The quality of caregiver-child interactions and parenting skills were evaluated using a behavioral coding system, the Dyadic Parent-Child Interaction Coding System – Fourth Edition (DPICS-IV; Eyberg et al., 2013). The DPICS is used as a progress monitoring tool for parenting skills during treatment and provides an objective, well-

validated measure of changes in child compliance posttreatment. Caregiver-child dyads were video recorded for a total of 20 minutes, which includes a 5-minute warm-up and coding during three 5-minute play scenarios (child directed play, parent directed play, and clean-up). Caregiver codes are accordant with content presented in the intervention, including praise ("a verbalization expressing a favorable judgement of an attribute, product, or behavior of the child" p. 33), reflection ("a declarative phrase or statement that has the same meaning as a child verbalization" p. 45), behavior description ("a non-evaluative, declarative sentence or phrase in which the subject is the child and the verb describes the child's ongoing or immediately completed observable verbal or nonverbal behavior." p. 51), criticisms, and commands (Eyberg et al., 2013). In line with existing PCIT studies (Bagner et al., 2013; Graziano, 2018; Graziano et al., 2015; Matos et al., 2006) in assessing change in caregiver skills, the author created two composite categories: "do" skills (i.e., praises, reflections, and behavior descriptions) and "don't" skills (i.e., questions, commands, and criticisms) consistent with behaviors caregivers are taught to use/refrain from using during child directed play. Child compliance (%) to caregiver commands was also assessed during the clean-up task. The author and a bachelor-level research assistant were trained in DPICS skills to 80% reliability. The research assistant coded all videos and the author coded half of the observations at pretreatment a second time for reliability. Inter-rater reliability was excellent and ranged from 90 to 95%.

Measures of Predictors of Caregiver Engagement

Demographics

A demographic questionnaire was developed to gather information on caregiver biological sex, age, ethnicity, and race during intake procedures. Caregivers also reported on child demographic information and both caregivers' (if applicable) marital status, employment, and educational attainment.

Stress

The impact that child behaviors have on their family was assessed using the Family Impact Questionnaire-Revised (FIQ-R; Donenberg & Baker, 1993), a 50-item scale of caregiver perceptions of the impact of caring for children with respect to six areas of family functioning which include positive and negative feelings toward the child as well as the perceived impact of the child on caregiver's social life and partner (if applicable), finances and sibling relationships. Items on the FIQ are rated on a 4-point Likert scale ranging from 1 ("Not at All") to 4 ("Very Much"). The FIQ has been validated through research and has demonstrated reliability and validity (Donenberg & Baker, 1993). Four of six scales were examined in the present study: positive ($\alpha = .67$) and negative feelings ($\alpha = .57$), social life ($\alpha = .92$), and finances ($\alpha = .86$).

Exposure to Trauma

Caregivers completed the Life Stressor Checklist-Revised (LSC-R; Wolfe et al., 1997), a 30-item index of lifetime trauma exposure, as part of intake procedures to screen for degree and/or type of exposure to potentially traumatic events (e.g., neglect, abuse, natural disaster, abortion or miscarriage). For endorsed events, respondents are asked to provide additional information including age when event began, age when event ended,

belief that they were in harm (yes/no), and feelings of helplessness (yes/no). Additionally, respondents are asked to rate the effect endorsed events have had on their life in the past year and how upsetting the event was at the time on a five-point Intensity Scale (1 = "Not at All or Never" to 5 = "Extremely"). Regarding scoring, the LSC-R is valid using multiple methods (e.g., overall life stressor score, a weighted score, positively endorsed stressors that reflect *DSM-IV* [APA, 1994] Posttraumatic Stress Disorder [PTSD] criteria A). Studies have found the LSC-R to have good to moderate test–retest reliability and good criterion-related validity with diverse populations of women (Brown et al., 1999; Kimerling et al., 1999). For the purposes of the current study, overall life stressor scores (i.e., the total number of positively endorsed stressors) were examined. The scores range from 0 – 30 with higher scores indicating greater levels of life stressors and cumulative trauma. The LSC-R demonstrates good internal consistency ($\alpha = .83$) in the current sample.

Mental Health Attitudes

The author administered the Parental Attitudes Toward Psychological Services Inventory (PATPSI; Turner, 2012) as part of intake procedures to assess caregiver beliefs about mental health service use and stigma-related concerns. The measure consists of 21 items assessing help-seeking attitudes, help-seeking intentions, and mental health stigma, and is scored on a 6-point Likert scale from 0 ("strongly disagree") to 5 ("strongly agree"). The measure contains three subscales: Help-Seeking Attitudes (HSA), which reflects individuals recognizing that a psychological problem exists and that they are open to the possibility of seeking professional help (used to measure attitudes), Help-Seeking Intentions (HSI), which reflects the extent to which individuals believe they are

willing and able to seek professional psychological help, and Stigmatization, which reflects the extent to which individuals are concerned about how others might think should they find out they were seeking professional help for psychological problems (used to measure perceptions of stigma). Higher scores on each subscale indicate more positive attitudes, higher likelihood of seeking services, and more stigma toward services (Turner et al., 2015). The PATPSI measure has demonstrated good internal reliability and discriminate validity (Turner, 2012). For the purpose of the current study, scale scores for HSA (α = .83) and stigmatization (α = .87) were calculated and examined at pretreatment.

Procedure

The author completed initial phone screens with interested caregivers to determine the presence, frequency, and severity of common child behavior problems as measured by the ECBI. Once eligibility was confirmed, an in-person evaluation was scheduled with the caregiver during school hours at the child's school.

Participation consisted of two 1.5 hour study evaluations (i.e., pre- and posttreatment) scheduled prior to the start of SRPP and one to two weeks after the final session. During the intake assessment, the author provided a description of the study and written informed consent was obtained from the child's caregiver before proceeding with the assessment. The author administered a semi-structured background interview. Information regarding presenting problems, household structure, and academic, behavioral, and developmental history was collected. An undergraduate-level research assistant concurrently administered assessments of children's receptive vocabulary (i.e., PPVT-4) and school readiness (i.e., BSRA-3). The order of the tasks was standardized

and children were given small breaks at the end of each task to ensure that there were no carry over effects from one task to another. Eligible families completed a structured parenting skills assessment facilitated by the author and completed measures of family stress, beliefs about mental health and stigma, and exposure to trauma. Lastly, using MI techniques, the author engaged caregivers in discussion regarding parenting and child goals, motivations, self-efficacy, and expectations related to participation in SRPP. Families then received the intervention weekly for eight sessions, all of which were conducted by the author at the school in which the child was enrolled. The author was trained to facilitate SRPP by the co-developer. Participating families received weekly phone calls and text message reminders regarding sessions; missed sessions were not re-scheduled. Although data were primarily collected from mothers, fathers and other caregivers living in the home were invited to participate in the intervention. Consistent with criteria for SRPP completion within the context of STP-PreK, caregivers were considered program completers if they received critical dose (i.e., 75% of the intervention or 6 of 8 sessions). Following the intervention, families were seen for the posttreatment assessment at their child's school, which included a reduced battery of measures completed at pretreatment with two additional measures of program satisfaction (i.e., TAI and SRPP caregiver satisfaction survey). Finally, caregivers were also invited to participate in a follow-up focus group (1 – 1.5 hrs) or individual interview (30 minutes) to share their intervention experience. Focus groups and an individual interview were facilitated using a semi-structured format. Refreshments were provided for families during the focus groups and interview. Discussions were facilitated by the author whose ethnic/racial background matched those of all participants. Families received gift cards

(i.e., $15 and $20, respectively for completing study evaluations and $100 after the focus group) totaling $135 for their involvement in the entire study. The protocol was approved by Florida International University's Institutional Review Board and the partnering school district's Research Review Committee (IRB-18-0354-CR01).

SRPP Intervention Description

The School Readiness Parenting Program took place one day per week during the 2018-2019 academic year for 60 – 90 minutes (i.e., Monday through Friday) during the morning or afternoon (e.g., 9:00 – 10:30AM and 1:00 – 2:30PM) to accommodate varying caregiver work schedules. At the beginning of the first session, each caregiver received a binder with all necessary materials for the duration of the program. An outline of each session structure was provided along with the objectives, materials necessary to run the session, handouts, as well as homework and tracking sheets. The beginning of each session was generally spent reviewing the previous week's homework assignment (15min). Next, the therapist introduced a new skill/topic of the session (30min). Caregivers practiced the skill with their child (who was brought into the room at this time) while other parents observed, if applicable (45min). Finally, once the practice period was completed, the group would reconvene. At that point, the therapist would elicit from the caregivers how the practice went as well as the observing. Following the 8 core sessions, families were assessed for response to treatment. It is important to note that while SRPP was designed to be implemented in a large group format, given recruitment challenges, 60% of participating families received all of their session via one-on-one meetings. School Readiness Parenting Program fidelity was completed by a doctoral level licensed psychologist, who completed treatment fidelity checklists on 31% of SRPP

sessions. Treatment integrity coding involved evaluating for the frequency, duration, and inclusion of all appropriate session content. For example, the coder evaluated whether the author followed the treatment manual's session protocol (e.g., providing session overview, collecting and assigning homework, coaching parent practice with children, reviewing caregiver practice) as well as content topics (e.g., reward systems, positive parenting strategies, timeout system, sleep routines). Additionally, the coder rated the author on a 1- to 7- point Likert scale ranging from 1 ("Superior") to 7 ("Inadequate") concerning how effective they were in engaging caregivers during the session and providing social reinforcement and support to caregivers.

Data Analysis Plan

Descriptive data were provided to establish the feasibility and acceptability of the SRPP. To examine the preliminary efficacy of the SRPP and given the pilot open trial nature of the current study, the author conducted a series of paired sample *t*-tests to measure pre- to posttreatment improvement. Cohen's *d* effect size estimates were provided for main outcomes analyses. Effect size was calculated to show the extent of intervention effect on outcome measures. Effect sizes were computed by subtracting the pretreatment mean score minus the posttreatment mean score and dividing by the standard deviation of the posttreatment mean (see Tables 3 – 5 for means, standard deviations, and effect size calculations). A reliable change index (RCI) was also calculated employing the commonly used method proposed by Jacobson and Truax (1991; see *Overview* for more information), which takes into account measurement error. Finally, focus group data were audio- and videotaped, transcribed verbatim, and analyzed using thematic analysis software, NVivo 12 (QSR International, 2018). A priori questions

and codes were developed based on the aims of the study similar to other qualitative studies of evidence-based parenting practices (Calzada et al., 2012). Structural codes included: program content (i.e., congruent/incongruent); program modifications; overall program views (i.e., pros/cons); engagement (e.g., recruitment, retention, and barriers). First, responses were coded by speaker using the automatic code technique in NVivo. Next, the author identified quotes from the group (or interview) transcripts that linked to the structural codes and categorized these. The author ran a query on all qualitative data and examined codes would the highest number of references. Consistent with guidelines for analyzing focus group results, especially in small samples, the author examined the occurrence of codes by participant so as not to misrepresent the data (Krueger and Casey (2015). In light of the modest sample, case examples are presented below.

Results

SRPP Acceptability and Feasibility

Five families completed SRPP, attending, on average, 73% of the number of parent training sessions (5.8 out of 8 sessions), however, no caregivers attended all eight sessions. Two caregivers attended seven sessions; two caregivers attended six sessions, and one caregiver attended three sessions. As indicated earlier, one family failed to attend a single session and was excluded from all analyses.

Caregivers reported high satisfaction and acceptance with the intervention on the TAI (*M* = 45.20 out of a possible 50, range from 41 to 49). Specifically, caregivers reported high overall treatment satisfaction (*M* rating of 4.8 out of 5) as well as high satisfaction in terms of having learned discipline strategies (*M* rating of 4.6 out of 5), improved relationship with their child (*M* rating of 4.4 out of 5), and improved

confidence in disciplining their child (*M* rating of 4.4 out of 5). Similarly, families endorsed high satisfaction with the SRPP on the caregiver satisfaction survey. All caregivers indicated they would recommend the program to others (*M* rating of 6 out of 6), as well as an improvement in the bond/attachment with their child (*M* rating of 5.2 out of 6), high confidence in parenting posttreatment (*M* rating of 5.6 out of 6), high optimism regarding expectations for good results from SRPP (*M* rating of 5.4 out of 6), and very positive feelings about achieving their goals in the program for their child and family (*M* rating of 5.4 out of 6). Lastly, homework completion ranged from 10% to 76% over the course of treatment (*M* = 36%, *SD* = 24.85%) and appeared to be related to attendance, indicating that participants who attended more sessions had higher completion rates.

Treatment Fidelity

Treatment fidelity ranged from 86% to 100% per session (*M* = 97%) indicating that the author implemented the SRPP with very strong fidelity. The author was also highly rated in how effective they were in engaging parents during the session (*M* rating of 1 out of 7) and providing social reinforcement and support to parents (*M* rating of 1 out of 7).

SRPP Promise

Outcome Trends for Caregiver Skills

Two paired samples *t*-tests were conducted to examine changes in observed caregiver skills (i.e., Do Skills and Don't Skills) during child-led play between pretreatment and posttreatment assessment. Dyadic Parent-Child Interaction Coding System codes at pre- (Do *M* = 5.60; *SD* = 2.19; Don't *M* = 42.20; *SD* = 16.51) and

posttreatment (Do *M* = 16.60; *SD* = 10.11; Don't *M* = 17.00; *SD* = 10.30) suggested significant increase in Do Skills $t(4) = -2.88$, ($p = .045$), and decrease in Don't Skills, $t(4) = 3.01$, ($p = .040$). As shown in Table 3, changes in frequency counts of Do and Don't Skills between pre- and post-assessments were statistically significant in the predicted direction.

Outcome Trends for Behavioral Functioning

Three paired samples *t*-tests were performed to assess changes in mean caregiver- and teacher-report of child externalizing behavior from pretreatment to posttreatment. Scores on the ECBI Intensity Scale at pre- (*M* = 126.20; *SD* = 52.69) and posttreatment (*M* = 100.80; *SD* = 37.22) yielded a non-significant trend in the predicted direction (i.e., decrease) with regard to child externalizing problems, $t(4) = 2.25$, ($p = .088$). Moreover, three of the six children were rated above the clinical cutoff (i.e., ≥*131*) at pretreatment, while at posttreatment assessment, only one child was rated above the clinical cutoff. As shown in Table 4, changes between pretreatment and posttreatment approached significance. In addition, comparison of mean scores on the SESBI-R Intensity Scale at pre- (*M* = 191.80; *SD* = 25.19) and posttreatment (*M* = 174.60; *SD* = 26.80) did not yield statistically significant differences, $t(4) = 1.75$, $p = .155$). Furthermore, all six children were rated above the clinical cutoff (i.e., ≥ 151) at pretreatment, with four children rated above the clinical cutoff at the postintervention assessment. Lastly, a comparison between child response to caregiver commands during the clean-up task at pre- (*M* = 29.78; *SD* = 8.85) and posttreatment (*M* = 32.57; *SD* = 13.65) did not yield statistically significant improvements in child compliance, $t(4) = -.61$, ($p = .575$).

Outcome Trends for Children's School Readiness

Two paired samples *t*-tests were conducted to examine changes in children's school readiness skills (i.e., receptive vocabulary and concept knowledge) between pretreatment and posttreatment assessment. A comparison between pre- (M = 87.60; SD = 16.44) and posttreatment (M = 87.40; SD = 5.73) mean PPVT-4 Standard Scores did not yield statistically significant improvements in receptive vocabulary, $t(4) = -.03$, (p = .976). Similarly, a comparison between pre- (M = 91.40; SD = 14.88) and posttreatment (M = 93.60; SD = 16.47) mean standard scores for overall school readiness did not yield statistically significant improvements in concept knowledge, $t(4) = -.73$, (p = .507).

Effect Sizes

Effect size calculations were determined for the main outcome measures. As detailed in Tables 3 – 5, effect sizes ranged from .01 to 2.07, indicating scores were within the very small effect to large effect of treatment (Cohen, 1988).

Case Examples and Individual Results

Overview

Given the size of the sample, case descriptions (names changed for participant privacy) are presented below in order of enrollment in the current study. The Reliable Change Index (RCI; Jacobson & Truax, 1991) was calculated to examine clinically meaningful changes among outcome measures, which is consistent with previous pilot studies of PCIT with small samples (e.g., Bagner et al., 2013; Chu et al., 2009; see Tables 2 and 3). According to Jacobson and Truax (1991), the RCI $= \frac{x_1 - x_2}{Sdiff}$, where x_1 is the pretreatment score, x_2 = the posttreatment score, and $Sdiff = \sqrt{2(SE)^2}$, the standard error (SE) of the difference between the two scores. The $SE = s1\sqrt{1 - r_{xx}}$, where s1 is the

standard deviation of the normal population, and r_{xx} = the reliability of the measure. An RCI ≥ 1.96 signifies a reliable change at $\alpha = .05$. To date, no study has examined the normative data and the psychometric properties of the DPICS among Black families. As such, normative and reliability data for the DPICS-III were drawn from the only study examining this measure with ethnic minorities (i.e., Mexican American families; McCabe et al., 2010) and were as follows: s1 = .83 and r_{xx} = .73 for Do Skills and s1 = 5.57 and r_{xx} = .77 for Don't Skills. For the ECBI and SESBI-R, normative and reliability data were from the standardization samples (Gross et al., 2007a; Querido & Eyberg, 2003) and were as follows: ECBI Intensity Scale: s1 = 33.20 and r_{xx} = .94 and SESBI-R Intensity Scale: s1 = 37.91 and r_{xx} = .98. All children demonstrated clinically meaningful changes on at least one measure following treatment; however, one in the opposite direction and 80% demonstrated positive reliable change across all outcomes. However, 60% of the families that made reliable change did not have a posttreatment scores on the ECBI and/or SESBI-R Intensity Scales below the clinical cut-off (see Tables 3 and 4).

Child 1*: *Reid. Reid was a 3-year-old African American boy, who lived with his biological mother (41 years) and his brother (18 years). His mother was single, had completed 11th grade and reported an annual income of less than $11,720. While Reid's mother did not report any academic concerns and only minimal behavioral concerns at school, she stated he was "real bad at home," often engaging in challenging behaviors (e.g., trouble sitting still, yelling, and hitting). Reid's mother and teacher reported scores above the clinical cutoff on the both scales (i.e., Intensity and Problem) of the ECBI and SESBI-R, respectively. Moreover, Reid's mother used nine Do Skills and 61 Don't Skills

during the child-led play at pretreatment, indicating a high frequency of questions, commands, and/or criticisms.

Reid's mother participated in three of eight sessions and completed homework 10% of the time. At posttreatment, Reid's mother displayed statistically reliable increases in her use of Do Skills and decreases in her use of Don't Skills (see Table 3). She also reported statistically reliable change on the ECBI Intensity Scale with scores below the clinical cutoff at posttreatment. Regarding the SESBI Intensity Scale, Reid's teacher did not report statistically reliable change and his score remained above the clinical cut-off at posttreatment. Finally, Reid's mother reported very high satisfaction of the SRPP on the TAI with a score of 46.

Child 2: Devon. Devon was a 5-year-old African American boy, who lived with his biological mother (21 years) and his two younger sisters (3- and 1-years). His mother was single, had earned an Associate's degree and reported an annual income between $18,285 and $23,492. During the eligibility evaluation, Devon's mother reported concerns about his behavior, including distractibility, hyperactivity, getting upset when denied his way, and becoming destructive when upset. Regarding Devon's school functioning, his mother did not report any academic concerns, however, she noted that Devon had to be the classroom helper or he would not listen, had a short attention span, and became possessive over items (e.g., toys). Devon's teacher reported scores above the clinical cutoff on the SESBI-R intensity and problem scales. Conversely, his mother reported scores below the clinical cutoff on the ECBI intensity and problem scales. Additionally, Devon's mother used zero Do Skills and 18 Don't Skills during the child-led play at

pretreatment, demonstrating a lack of positive statements made during the five minute interaction and relatively low frequency of verbalizations overall.

This family did not complete the intake evaluation and did not return calls to schedule subsequent appointments.

Child 3: Taylor. Taylor was a 4-year-old African American girl, who lived with her biological parents (35 and 37 years, respectively), her brother (five years), and sister (three weeks). Her parents were married, both completed high school, and her mother reported an annual income of $11,720. Taylor's mother did not report any concerns; however she did note discrepant behavioral reports between two classroom teachers. Taylor's mother expressed the desire to address her classroom behaviors (e.g., "being a follower" and "following directions"). Taylor's teacher reported scores above the clinical cutoff on the SESBI-R intensity and problem scales. Conversely Taylor's mother reported scores below the clinical cutoff on the ECBI intensity and problem scales. Additionally, her mother used five Do Skills and 27 Don't Skills during the child-led play at pretreatment, indicating disproportionate use of positive and negative statements.

Taylor's mother participated in four of eight sessions and completed homework 24% of the time. Taylor's father attended two sessions. At posttreatment, Taylor's mother displayed statistically reliable increases in her use of Do Skills, but not decreases in her use of Don't Skills. While Taylor's mother did not report statistically reliable change on the ECBI Intensity Scale at posttreatment, her teacher reported statistically reliable change on the SESBI-R Intensity Scale. However, Taylor's score remained above the clinical cut-off at posttreatment on the SESBI-R. It is important to note that Taylor's

pretreatment ECBI intensity score was well below the clinical cut-off. Finally, Taylor's mother reported very high satisfaction of the SRPP on the TAI with a score of 48.

Child 4: Miles. Miles was a 3-year-old African American boy with no significant medical history or developmental concerns, who lived with his great aunt (52 years), his brother (4 years), and cousin (30 years). His caregiver was single, had completed high school, and reported an annual income of less than $11,720. Miles' caregiver reported concerns with his behavior including, short attention, "storytelling," frequent whining, and lack of self-control. Caregiver and teacher ratings on the ECBI and SESBI-R were above the clinical cutoff on the both scales (i.e., Intensity and Problem). At pretreatment, Miles' caregiver used three Do Skills and 31 Don't Skills during the child-led play, indicating disproportionate use of positive and negative statements.

Miles' caregiver participated in six of eight sessions and completed homework 27% of the time. At posttreatment, Miles' caregiver displayed statistically reliable increases in her use of Do Skills and statistically significant decreases in her use of Don't Skills. She also reported statistically reliable change on the ECBI Intensity Scale, despite Miles' score remaining above the clinical cut-off. Similarly, on the SESBI-R Intensity Scale, Miles' teacher reported statistically reliable change although his score remained above the clinical cut-off at posttreatment. Finally, the caregiver reported high satisfaction with the SRPP on the TAI with a score of 42.

Child 5: Riley. Riley was a 3-year-old, African American girl, who lived with her great grandmother (68 years), biological mother (21 years), aunt (25 years), uncle (27 years), and cousin (three years). Consent was obtained from Riley's biological mother in order to participate in the study, however, Riley's great grandmother serves as her primary

caregiver and thus engaged in treatment. Riley's caregiver was widowed, had completed high school and reported an annual income between $35,744 and $39,688. Riley's caregiver expressed interest in learning strategies to address Riley's behavior problems (e.g., tantrums and aggression), noting that she had recently run off from the playground at school when she was upset. Caregiver and teacher ratings on the ECBI and SESBI-R were above the clinical cutoff across scales (i.e., Intensity and Problem) at pretreatment, Riley's caregiver used five Do Skills and 34 Don't Skills during the child-led play demonstrating a tendency to use questions, commands, and/or criticisms in relation to positive statements (e.g., praise).

Riley's caregiver participated in seven of eight sessions and completed homework 41% of the time. At posttreatment, Riley's caregiver displayed statistically reliable increases in her use of Do Skills and statistically reliable decreases in her use of Don't Skills. She also reported statistically reliable change on the ECBI Intensity Scale and Riley's score was below the clinical cut-off at posttreatment. Conversely, Riley's teacher did not report statistically reliable change on the SESBI-R Intensity Scale and her score remained above the clinical cut-off at posttreatment. Finally, the caregiver reported high satisfaction of the SRPP on the TAI with a score of 41.

Child 6: **Jaida.** Jaida was a 3-year-old African American girl, who lived with her biological parents (37 and 38 years, respectively), her sister (15 years), and brother (12 years). Her parents were married. Both parents had completed high school and reported an annual income between $31,427 and $35,743. Jaida's mother reported minimal concerns with her child but acknowledged her pattern of becoming frustrated when denied her own way. Jaida's teacher reported a score above the clinical cutoff on the

SESBI-R intensity, but not the problem scale. Her mother reported scores below the clinical cutoff on the ECBI intensity and problem scales. Additionally, Jaida's mother used six Do Skills and 58 Don't Skills during the child-led play at pretreatment, indicating a high frequency of questions, commands, and/or criticisms and low frequency of positive statements (e.g., praise).

Jaida's mother participated in seven of eight sessions and completed homework 76% of the time. At posttreatment, Jaida's caregiver displayed statistically reliable increases in her use of Do Skills and statistically significant decreases in her use of Don't Skills. Jaida's mother did not report statistically reliable change on the ECBI Intensity Scale at posttreatment. Conversely, her teacher reported statistically reliable change on the SESBI-R Intensity Scale, but not in the predicted direction; Jaida had a higher score at posttreatment and it remained above the clinical cut-off. Of note, Jaida's pretreatment ECBI Intensity Scale score was well below the clinical cut-off. Finally, her mother reported very high satisfaction of the SRPP on the TAI with a score of 49.

Descriptive Statistics

Given the small sample size, the author was unable to explore predictors of treatment engagement among participating families, such as stress- and trauma-related factors, stigma-related concerns about mental health services, and logistical barriers and their associations with response to intervention. However, descriptive information regarding the contexts in which caregivers raise their children is reviewed as these factors likely impact engagement and treatment outcomes (Chacko et al., 2009; Chung et al., 2009; Lavigne et al., 2010; Turner et al., 2015).

Stress

At pretreatment, average ratings of children's impact on their families across domains on the FIQ were reported as follows: Negative Feelings (*M* = 5.67, *SD* = 3.67), Positive Feelings (*M* = 18.17, *SD* = 1.72), Social Life (*M* = 4.00, *SD* = 6.96), and Finances (*M* = 1.5, *SD* = 3.21).

Exposure to Trauma

On average, caregivers reported experiencing approximately nine traumatic/stressful life events (*M* = 8.8, *SD* = 5.54), with number of events ranging from 3 to 15.

Mental Health Attitudes

At pretreatment, caregivers indicated high levels of HSA (*M* = 32.50, *SD* = 7.29), high levels of HSI (*M* = 24.67, *SD* = .52), , and low levels of Stigmatization (*M* = 2.50, *SD* = 4.18), which correspond to more positive attitudes towards mental health services, a higher propensity to seek mental health services, and low stigma.

Focus Group and Interview

Following the completion of SRPP, caregivers who participated in the open trial were invited to participate in a follow-up focus group or individual interview. These platforms provided opportunities to examine participant feedback to inform ongoing development of the intervention. Several topics designed to facilitate discussion of the acceptability of SRPP and assist in program refinement. Of the four possible codes, the majority of discussions focused on the following three: program content, engagement, and overall views of program. Table 6 summarizes the occurrence of references to specific codes.

Program Content

Program content was discussed in terms of what families considered to be culturally congruent or incongruent. All caregivers appeared to view the use of praise and most viewed planned ignoring and as acceptable parenting practices to increase desired behaviors and decrease undesired behaviors. However, caregiver experiences with and views regarding time out as a discipline strategy were less uniform. For example, one caregiver commented on her reaction to time out being introduced in-session, stating, "At first, I used to be like 'only white people put they [*sic*] child in timeout' **(Bio-mother, 3 year old boy)**. Another caregiver reflected on the parenting practices her mother used and how she adopted similar views regarding discipline stated:

> "...how I came up, I'm just gon be totally honest, we didn't have no time out. Whatever your mama said that's what goes. If you didn't, she whooped your [expletive]- excuse me, she whooped your butt [laughs]. And I raised mine the same, and my grandkids, and other than that, I mean I understand you say…some people look at it as 'oh, you shouldn't be beating on them' or whatever, but sometimes, I mean 'cause like I explain to my grandkids, even as adults we have rules that we have to follow, and if we don't, we go to prison or whatever the case may be. So, when you…and you know better, it's consequences, oh yes…and no, it's not no time out room or no corner. Well, yeah the big kids, you know, they can't go outside or something like that, but not stand in the corner for 3 minutes or nothing, no" **(Great-aunt, 4 year old boy)**.

Conversely, one caregiver shared she was initially conflicted about using time out,

> "I'm like 'time out?! No, I can't put my baby in time out! She's not going to time out' it really broke my heart-.: it really did. It broke my heart but I had to like fight it, fight it and then, I did it at home and I was like 'I got this'" **(Bio-mother, 4 year old girl).**

Caregivers also discussed which program elements should be retained, removed, or potential additions. Of note, SRPP was developed to be implemented in a large group format, however, due to recruitment challenges, nearly all sessions were one-on-one. All caregivers in the focus group expressed satisfaction with individual sessions. This

preference was attributed to concerns about not having the opportunity to share their opinions and the ability to focus in a large group.

> **Bio-mother, 3 year old boy:** "...Because everybody in the group- like when you have a lot of people in a group, you cant really focus with everybody saying so much. You- I focus more when its probably about two or three, but about 8? This person talking, that person talking and you can't..."
>
> **Bio-mother, 4 year old girl**: "you won't have a chance to say your opinion."

Engagement

Second, caregivers discussed engagement, including the ways in which facilitators can make the program more engaging for families, desired characteristics of the clinician leading sessions (e.g., be willing to help, a "concerned person"), and recruitment. Given the small sample, this topic led to caregivers sharing their views on lack of participation of other caregivers at their children's respective schools, which extends outside of SRPP as the majority of the group noted low attendance at parent meetings at the school more broadly. One participant stated,

> "They probably thinking they could do a better job at home. They don't want like people to tell them how to be a parent, you know? But a lot of people are closeminded, and they feel like their way is the right way" **(Bio-mother, 4 year old girl)**.

While another caregiver highlighted the embarrassment some families may feel participating in a BPT:

> "Some parents like me at first I was kind of embarrassed like 'cause its like- I felt like they were labelling my child like 'oh she has behavioral issues.' I'm like she not- she not bad, but I guess the social skills [inaudible] so maybe they like embarrassed like they don't want to label their child." **(Bio-mother, 4 year old girl)**.

Caregivers also offered recruitment strategies to engage potentially eligible families, such as having previous participants speak to potential families about their experience in the program.

Overall Program Views

Lastly, many caregivers noted positive benefits of participating, including feeling less stressed, "yeah, before this program, I really- I think my [blood] pressure was going up a lot, I think- Ima be honest- [laughter]. I was hollering a lot and I- It was getting frustrating. Now, I'm more [*sic*] calmer" **(Bio-mother, 3 year old boy)** Similarly, other caregivers observed behavioral changes in the children as a result of implementing the strategies,

> "...and see we came through a different time, my mom raised her voice all the time, so I felt that was the way to do it…but, its not and I- I loved it. How- it really calmed my granddaughter- great granddaughter down, because what you- she feeling what I'm feeling…that's what it is and you can't expect a child to do nothin better than what you are telling them anyway" **(Great-grandmother, 4 year old girl).**

In summary, SRPP was largely accepted by participants who noted improvements in themselves and their children as a result of the strategies learned from the program. Further, caregivers also highlighted culturally incongruent practices and perceptions that may prevent economically and socially disadvantaged families from engaging or completing the program. As such, these issues will be discussed in brief below and then more generally discussed in Chapter 6.

Discussion

Study 1 was a pilot open trial of a novel behavioral parent training program, the SRPP, which was developed to address several limitations of existing BPT by not only

targeting behavior problems in young children, but by also helping parents increase their school involvement and promote their children's school readiness skills. The purpose of the study was to examine the acceptability, feasibility, and promise of the SRPP as a standalone program for families living in urban poverty conducted during the school year, and to generate feedback from participating caregivers in order to inform future iterations of SRPP. An additional aim was to explore predictors of treatment engagement, including stress- and trauma-related factors, stigma-related concerns about mental health services, and logistical barriers and their associations with treatment outcomes.

With regard to the acceptability of the SRPP, caregivers' reported satisfaction with the SRPP via the TAI was quite high, indicating that participating families felt they learned many useful techniques, their relationships with their children improved, and their confidence in their ability to discipline their child increased. Similarly, caregivers endorsed high satisfaction with the SRPP on the caregiver satisfaction survey. Specifically, all caregivers reported they would recommend the program to others. Additionally, participating families observed an improvement in the bond/attachment with their child, high confidence in parenting after completing SRPP, high optimism regarding expectations for good results from the program, and very positive feelings about achieving their goals in the program for their child and family. Qualitative data collected during the focus group and individual interview also suggest high social validity regarding praise and planned ignoring, however acceptance of time out as a discipline strategy was mixed.

With regard to the feasibility of SRPP, two aspects of the open trial were examined: attendance and homework compliance. However, rates of attendance and

homework completion demonstrated high variability. Still, only one caregiver did not complete the program (17%), which is significantly lower than traditional PCIT (42%; Boggs et al., 2005) and other clinic-based BPTs (approaching 50%; Reyno & McGrath, 2006). Of note, the caregiver did not attend any SRPP sessions thus she was lost to pretreatment attrition. A recent review conducted by Chacko and colleagues (2016) examined rates of attendance and adherence associated with engagement in the empirical literature on BPT for externalizing problems. The average rate of pretreatment attrition was 13% (*SD* = 15%) and studies with lower SES families consistently had higher attrition rates (34%) than those with higher SES participants (Chacko et al., 2016). Moreover, it is no surprise that caregivers tend to struggle to complete homework in BPTs. The average completion rate in the current study (36%) is in line with previous work reporting comparable homework completion rates (i.e., 30% to 48%; Chacko et al., 2009; Danko et al., 2016; Fabiano et al., 2009). The retention rates in the present evaluation are particularly encouraging due to the fact that the current sample is comprised of economically and socially disadvantaged families who are at an increased risk for drop out from traditional BPT to begin with (Bagner et al., 2013). However, it is important to note that in line with previous BPT studies with economically and socially disadvantaged samples, recruitment was a significant and persistent challenge (Fernandez et al., 2011; Heinrichs et al., 2005). Despite SRPP being designed for a large group format, nearly all sessions were facilitated one-on-one with very high fidelity.

Lastly, regarding the promise of the SRPP, three aspects of the current pilot were evaluated: caregiver skills, child compliance, and caregiver and teacher ratings of participating children's behavioral functioning and school readiness following the

intervention. In addition to the feasibility and acceptability, caregivers demonstrated statistically significant improvements in their interactions with their child immediately following the program. Specifically, they were more positive and better able to follow their child's lead during play. Of note, all but one caregiver demonstrated reliable change in Don't Skills. Furthermore, a high proportion of families who completed the program demonstrated clinically reliable change in skills acquisition from the pretreatment to posttreatment assessments, which is consistent with previous PCIT research indicating treatment completers report improvements in child functioning across measures (Bagner et al., 2013) and especially, child behavior (Fernandez et al., 2011).

Caregiver and teacher ratings of externalizing problems on the ECBI and SESBI-R immediately following the intervention were mixed. Caregivers endorsed significant reductions in child externalizing problems, while teachers did not. On the ECBI, 3 of the 6 children were still exhibiting clinically significant behavioral concerns at pretreatment, while at postintervention assessment, only 1 child was rated above the clinical cutoff. On the SESBI-R, all 6 children were rated above the clinical cutoff at pretreatment, with 4 children rated above the clinical cutoff immediately following the program. These findings suggest that while caregivers may be able to successfully acquire the skills required to manage difficult behaviors, a proportion of children will continue to have challenges, with previous studies demonstrating that clinically elevated behavior problems persist for one-third of children following treatment (Drugli et al., 2010). Consistent with previous work evaluating SRPP, there were no improvements in children's school readiness skills at posttreatment (Hart et al., 2016). Findings suggest the potential positive benefits of implementing SRPP as a standalone may not extend beyond

the caregiver-child relationship. Lastly, observations of children's compliance within the context of dyad interactions during a clean-up task did not significantly improve following completion of SRPP. Caregivers were observed to issue a higher frequency of direct commands posttreatment, however, children did not have sufficient time to comply before another command was issued thus underestimating compliance.

In terms of the second aim of the study, given the small sample, the author was unable to explore predictors of treatment engagement and their associations with response to intervention. However, preliminary descriptive information was presented regarding participating caregivers' levels of stress, exposure to trauma, stigma-related concerns about mental health services, and logistical barriers. Related to stress, on average, caregivers rated low negative impact on social life, finances, and feelings toward parenting and high positive feelings toward parenting. Regarding trauma exposure, caregivers endorsed a moderate to high number of stressful events. Findings from a recent national survey estimate 61% of adults had at least one ACE and 16% had four or more types of ACEs. Demographic variables (i.e., sex, race/ethnicity, and age group) were also independently associated with ACE exposure. In particular, women and racial/ethnic minorities (e.g., American Indian/Alaska Native, Black, Hispanic) were more likely to endorse four or more type of ACEs compared to male and White respondents. Similarly, younger adults reported higher exposure rates than individuals 65 years or older (Merrick et al., 2019).

The number of stressful events caregivers in the current sample have experienced are particularly sobering considering the literature documenting the devastating impact of adverse childhood experiences (ACEs) on physical, psychological and social outcomes

(Feliitti, et al., 1998; Gilbert et al., 2009). Adults who endorsed four or more ACEs, compared to those who did not endorse any, were found to have 4 to 12 times increased health risk for alcoholism, drug abuse, depression, and suicide attempt; a 2 to 4 times increased risk in smoking, poor self-rated health, risky sexual behaviors, and sexually transmitted disease; and a 1.4 to 1.6 increased risk in physical inactivity and severe obesity (Felitti, et al., 1998). Moreover, six or more ACEs is associated with premature death by 20 years compared to adults with no ACEs (Brown et al., 2009). Given the psychological risks associated with ACEs, there has been increasing interest in the study of the impact of caregiver's early adverse experiences on subsequent parenting practices. Both qualitative and quantitative investigations demonstrate links between child trauma history and negative parenting behaviors and beliefs (e.g., decreased maternal sensitivity and responsivity, harsh punishment, difficulty implementing behavior management strategies, relating children's negative behaviors to own past experiences, and prolonged unsupervised periods for children; Bert et al., 2009; Kistin et al., 2014; Pereira et al., 2012; Wright et al., 2012). Considering caregivers behaviors serve as the vehicle by which BPTs influence children's behavior, it is imperative that future work aim to expand our understanding of the associations between caregiver trauma exposure and subsequent parenting practices and the ways in which those factors impact engagement and treatment outcomes. Findings from such work may provide insight regarding the ways in which program components (e.g., coaching, psychoeducation, role play, etc.) can adopt a trauma-informed approach to address caregiver's specific needs.

Finally, caregiver ratings of views regarding psychological services indicate recognition of the existence of psychological problems and being receptive to the

possibility of seeking help from a mental health professional, higher likelihood of seeking service, and low concern regarding what others may think if they knew the caregiver was seeking mental health services. On average, there are large discrepancies between HSA and Stigmatization scale scores in the current sample and those previously reported by Black caregivers recruited from Head Start programs and community schools (Turner et al., 2015). While the attitudes of caregivers in the current sample contrast findings from previous studies, they provide further support for the association between stigma and help-seeking in low-income Black caregivers (Dempster et al., 2015). These findings suggest a shift in views regarding mental health services and utilization and may be indicative of the increased prioritization of mental health in larger society.

The execution of the current study presented several challenges, particularly with regard to recruitment and retention. Efforts to recruit potentially eligible families included approximately 22 visits across four sites. In addition to passing out program flyers at pick-up and drop-off, the author attended Head Start parent workshops, staff meetings, community events (i.e., Christmas Show, Moms & Muffins), and met with site administrators. Of note, the author was approached by the Head Start family liaison regarding interest from at least seven potentially eligible Spanish speaking caregivers. However, due to the author's limited proficiency in Spanish, monolingual Spanish speaking families were deemed ineligible to participate.

Within the context of the current findings, difficulties to recruit, retain, and engage economically and socially disadvantaged families continues to limit the ability to evaluate the promise of SRPP in a manner consistent with the majority of the literature. However, this mixed methods examination elucidates the complexity of meeting the

needs of a high-needs and underserved community. Caregiver ratings on measures of engagement suggest that despite family risk (e.g., ethnic/racial, socioeconomic, marital status, trauma exposure), perceptions of their circumstances are not as grim as one might expect or existing research suggests (Nam et al., 2015). Drawing upon the literature regarding resilience, self-efficacy and family/social support may serve as potential buffers for multiply stressed minority caregivers and their families (Raikes & Thompson, 2005; Cardoso et al., 2010).

Strengths and Limitations

A strength of this study was its systematic assessment of acceptability, feasibility, and promise of the SRPP as a standalone, school year BPT. However, limitations must also be noted. First, the very small sample size reduces statistical power and thereby limits generalizability of the findings to the larger population. Second, due to the small sample size, we were unable to examine predictors of treatment engagement and their subsequent influence on response to treatment. However, the current study included other factors (e.g., attendance and homework completion), which have been used to evaluate treatment engagement in prior work (Chacko et al., 2007) and has previously demonstrated sensitivity to differences in parent engagement in treatment (Cunningham et al., 1993; Prinz & Miller, 1994). A third limitation of this study is the absence of a control group of families randomly assigned to a group not treated with SRPP. Given SRPP was implemented during the academic year, the absence of a control prohibited the ability to examine the intervention's influence on children's school readiness above and beyond school enrollment. This pilot study provides valuable findings which warrant further examination of economically and socially disadvantaged preschoolers with

elevated externalizing problems and their caregivers. Fourth, to the author's knowledge, there is no DPICS normative data for African American families. As such, available norms for Mexican American families (McCabe & Yeh, 2010) were used to calculate RCIs and may have produced results that are not reflective of accurate changes in the current sample. However, previous studies have used available DPICS norms in samples with different cultural background when necessary (e.g., Bagner et al., 2013). Finally, the current open trial did not include a follow-up assessment and was unable to ascertain the maintenance of treatment gains over time. However, consistent with previous pilot studies (e.g., Chacko et al., 2007), SRPP still demonstrated improvements in observed caregiver skills and caregiver ratings of child functioning posttreatment.

Conclusions

This study was an open pilot trial of a novel BPT for economically and socially disadvantaged families. Six children and their caregivers enrolled in the intervention. Of those six families, five completed the pre- and posttreatment assessments and 80% received a therapeutic dose of the intervention, indicating preliminary feasibility of the intervention protocol for recruiting and retaining participants. While SRPP has been evaluated under a number of conditions (e.g., open trial in conjunction with STP-PreK, randomized pilot trial), future efforts should more rigorously examine SRPP as a standalone school year BPT, perhaps as first line treatment utilizing an adaptive design. In routine care settings, the treatment or prevention of child and adolescent mental health disorders often requires an individualized, sequential approach to intervention, whereby treatments are adapted overtime based on the youth's evolving status (e.g., adherence; Almirall & Chronis-Tuscano, 2016). Adaptive interventions are intended to provide a

replicable guide for the delivery of individualized sequences of intervention in routine care settings (Collins et al., 2004; Lavori et al., 2008; Lavori et al., 2000; Murphy et al., 2007a; Murphy et al., 2007b). In recent years, adaptive interventions have garnered the interest of researchers within the field of child and adolescent mental health as a novel approach to addressing challenges related to the field (Almirall & Chronis-Tuscano, 2016). According to Gunlicks-Stoessel and colleagues (2016), adaptive treatment strategies "have the potential to have a significant public health impact as they can simultaneously improve treatment outcomes and conserve resources by delivering treatments when and for whom they will do the most good" (p. 481). Innovative service delivery components, such as adaptive treatment strategies, can overcome existing challenges with engaging ethnic minority populations in traditional BPTs. Specifically, adaptive treatment strategies provide scientific guidelines for step-by-step clinical decision making via decision rules that suggest when, how, and for whom treatments should be applied (Gunlicks-Stoessel et al., 2016), however, this approach is still in its infancy, thus research on these fronts is lacking. Finally, a number of potential modifications can be made to future iterations of the SRPP based on feedback provided by caregivers and examination of families' responses to the intervention, which will be expanded upon in Chapter 6.

Table 1. Demographic Characteristics of Caregivers Focus Group and Interview Participants

	Focus Group *M (SD)*	Interview
Child age (years)	3.25 (.50)	3
Caregiver's age (years)	45.75 (15.06)	52
	%	%
Child gender – Male	25	100
Caregiver ethnicity/race		
Black/African American	100	100
Income < $11,720	50	100
Marital status - Single	50	0
Level of education ≤ HS Diploma/GED	100	--
Employed	0	0

Note. HS = high school; GED = General Education Development.

Table 2. Child Characteristics

Item	Reid	Devon	Taylor	Miles	Riley	Jaida
Age (years)	3.49	5.02	4.07	3.95	3.82	3.92
Parent DBDRS						
ADHD – inattentive symptoms endorsed	2	6	1	6	0	0
ADHD – hyperactive/impulsive symptoms endorsed	2	9	1	7	1	0
ODD items endorsed	2	3	0	3	2	0
CD items endorsed	0	0	0	3	1	0
Teacher DBDRS						
ADHD – inattentive symptoms endorsed	5	3	8	8	2	2
ADHD – hyperactive/impulsive symptoms endorsed	5	5	4	9	1	0
ODD items endorsed	3	2	3	6	5	3
CD items endorsed	0	1	0	3	2	0

Note. PPVT-4 = Peabody Picture Vocabulary Test, Fourth Edition (Dunn & Dunn, 2007); BSRA = Bracken School Readiness Assessment (Bracken, 2002); DBDRS = Disruptive Behavior Disorder Rating Scale (Pelham et al., 1992).

Table 3. Caregiver Outcomes at Pretreatment and Posttreatment Assessments

Caregiver	Age (years)	Pretreatment			Posttreatment		
		Do Skills	Don't Skills	Compliance (%)	Do Skills	Don't Skills	Compliance (%)
1	42	9	61	16	25$_R$	31$_R$	20
2	26	0	18	36	--	--	--
3	35	5	27	35	17$_R$	24	50
4	52	3	31	26	5$_R$	14$_R$	25
5	68	5	34	36	8$_R$	10$_R$	24
6	37	6	59	36	28$_R$	6$_R$	44
Mean	43.67	4.67	38.33	29.78	16.60†	17.00*	32.57
SD	14.73	3.01	17.64	8.85	10.11	10.30	13.65
d	--	--	--	--	-1.18	2.07	-.27

Note.
$_R$RCI < .05;
† $p < .10$;
* $p < .05$.

Table 4. Child Behavior Outcomes at Pretreatment and Posttreatment Assessments

Child	Age (years)	Pretreatment		Posttreatment	
		ECBI-Int	SESBI-R-Int	ECBI-Int	SESBI-R-Int
Reid	3	169	199	118$_R$	197
Devon	5	110	151	--	--
Taylor	4	59	175	57	133$_R$
Miles	3	179	216	155$_R$	179$_R$
Riley	3	140	212	89$_R$	198
Jaida	3	84	157	85	166$_R$
Mean	4.05	126.20	185	100.80$_\dagger$	174.60
SD	0.52	47.59	28.02	37.22	26.80
d	--	--	--	.61	.39

Note. ECBI-Int = Eyberg Child Behavior Inventory Intensity Scale raw score; SESBI-R-Int = Sutter-Eyberg Student Behavior Inventory- Revised Intensity Scale raw score
$_R$RCI < .05;
$_\dagger$ $p < .10$.

Table 5. Children's School Readiness Outcomes at Pretreatment and Posttreatment Assessments

Child	Age (years)	Pretreatment		Posttreatment	
		PPVT-4	BSRA	PPVT-4	BSRA
Reid	3	86	86	80	79
Devon	5	108	111	--	--
Taylor	4	75	77	88	88
Miles	3	78	103	90	104
Riley	3	116	111	95	117
Jaida	3	83	80	84	80
Mean	4.05	91	94.67	87.40	93.60
SD	0.52	16.90	15.53	5.73	16.47
d	--	--	--	.01	-.33

Note. PPVT-4 = Peabody Picture Vocabulary Test, Fourth Edition (Dunn & Dunn, 2007); BSRA = Bracken School Readiness Assessment (Bracken, 2002)

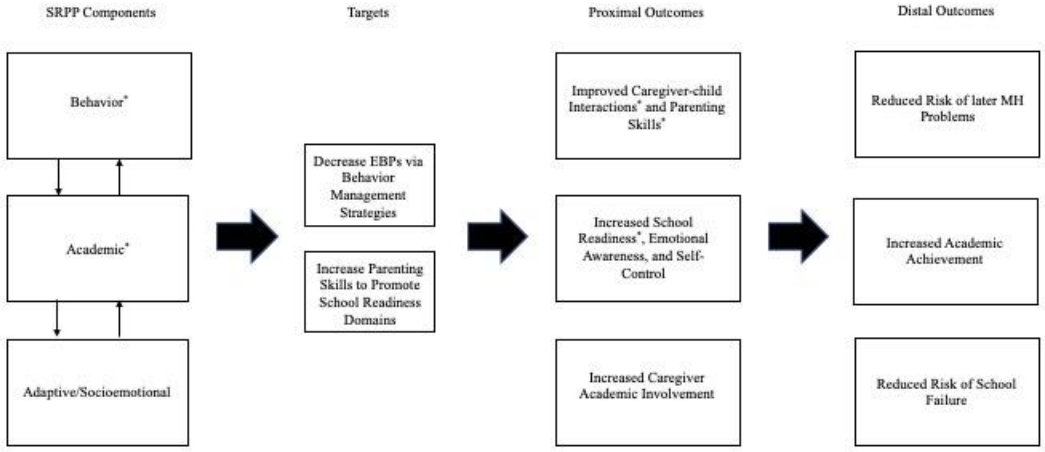
* $p < .05$;

† $p < .10$.

Table 6. References to SRPP Codes for 5 Participants

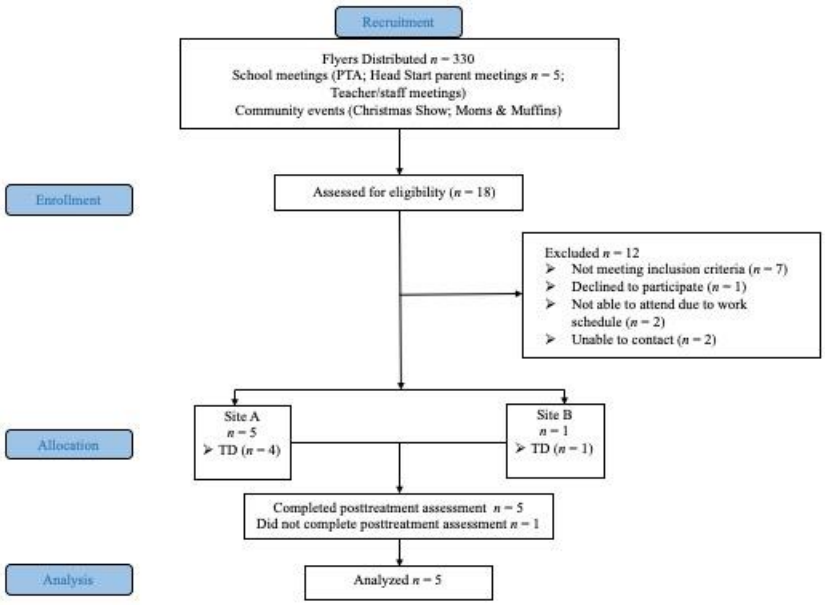
	Program Content			Overall Program Views			Engagement	
Caregiver	Praise	Ignoring	Time Out	Stress	Dyad Relationship	Barriers	Therapist	Recruitment
1	X	X	X	X	X		X	X
2	X	X					X	X
3	X	X	X	X	X		X	
4	X	X	X	X		X	X	X
5	X		X		X	X		X
n	5	4	4	3	3	2	4	4

Figure 1. A Conceptual Model of the Shared Relationships Among Program Components, Outcomes, and Impact of SRPP



Note. ∗Factors included in the current examination.

Figure 2. CONSORT Flow Diagram



Note. CONSORT = CONsolidated Standards of Reporting Trials (Schulz et al., 2010); PTA = Parent Teacher Association; TD = Therapeutic Dose.

V. STUDY 2: A QUALITATIVE STUDY OF THE SCHOOL READINESS PARENTING PROGRAM ACCEPTABILITY

Study 2 was a qualitative study of the SRPP. As part of ongoing refinement of SRPP, caregivers who previously completed the program within the context of an intensive behavioral summer camp (i.e., STP-PreK SRPP alumni) were invited to a semi-structured focus group or interview to provide additional suggestions regarding the content, delivery, format, and process of the program. Additionally, the author explicitly solicited feedback from participants regarding modifying SRPP to be implemented during the school year as a standalone BPT.

Method

Participants and Recruitment

Focus group participants were 35 caregivers (approximately 26% of eligible pool) who enrolled their children in an adapted STP-PreK (Graziano et al., 2014) for seven weeks from mid-June to early-August between 2016 and 2019, Monday through Friday (8:00AM. – 3:00PM). As part of their child's participation in the summer program, caregivers were required to attend a weekly parenting skills group (i.e., SRPP) held in conjunction with the program. Demographic characteristics of focus group and interview participants are presented in Table 1. Children of caregivers in the focus groups were 4- and 5-years old during the summer they were enrolled in the summer program and over two-thirds (69%) were male. The majority of caregivers were mothers (83%) and on average, focus group participants were 36.75 years of age (*SD* = 9.81), were single (60%), had relatively low levels of formal education (40% had a high school diploma/GED), and were not working outside the home (54%). Over one-third (37%)

reported an annual income below $11,720. Participants were predominately Black (68%). On average, length of time between completing STP-PreK and participation in focus groups/interviews was approximately 13 months (range: .10 – 34.06; *SD* = 12.09).

Procedure

Caregivers who previously completed the SRPP within the context of an adapted STP-PreK (Graziano et al., 2014) between summers 2016 and 2018 were contacted by the author via phone or text message to determine interest in participating in a focus group or individual interview. Caregivers who completed the program between summers 2016 and 2018 were offered three dates focus groups were being held or allowed to arrange an individual interview with the author. Caregivers who completed the program during summer 2019 were given the option of attending a focus group one week after completing the program. Interested caregivers came to their respective appointments, where they were provided written informed consent before the focus group or interview began. One individual interview and four focus groups were conducted at the school site where parenting sessions were held, with 4 to 12 caregivers (*M* = 8.50; *SD* = 3.42) in each group. All focus groups were conducted in English. The author facilitated the individual interview and all but one focus group. A doctoral-level graduate student facilitated the final focus group. Both moderators identify as ethnic minorities (Black and Hispanic, respectively). The individual interview lasted approximately 30 minutes and focus groups lasted between 44 to 70 minutes (*M* = 57.75; *SD* = 12.29); all caregivers were paid $100 for their participation. The interview and focus groups followed a semi-structured format with questions designed to elicit caregivers' views on a range of topics: (a) expectations for/impressions of the SRPP; (b) aspects of the program that were

help/unhelpful; (c) aspects that were liked/disliked; (d) modifications to program content and/or structure (e.g., "What would you keep/remove/add?"); (e) what incoming caregivers should be aware of; (f) views on topics covered; (g) views on discipline strategies presented (e.g., "How did you feel about the discipline strategies presented"); and (h) potential ways to improve the SRPP to be implemented during the school year (e.g., "In what ways can the program be improved to be implemented during the school year?"). Given the length of time between completing of STP-PreK and focus group participation, caregivers received a handout outlining topics covered in SRPP sessions to promote recall. The protocol was approved by Florida International University's Institutional Review Board and the partnering school district's Research Review Committee.

Data Analysis

Focus groups and interviews were video- and audiotaped and transcribed. The author analyzed the data using NVivo 12 (QSR International, 2018). A priori questions and codes were developed based on the aims of the study similar to other qualitative studies of evidence-based parenting practices (Calzada et al., 2012). Structural codes included: program content (i.e., congruent/incongruent); program modifications; school year implementation; overall program views (i.e., pros/cons); and engagement (e.g., recruitment, retention, and barriers). First, responses were coded by speaker using the automatic code technique in NVivo. Next, the author identified quotes from the group (or interview) transcripts that linked to the structural codes and categorized these. The author ran a query on all qualitative data and examined codes with the highest number of references. In line with recommendations for analyzing focus group results, the author

examined the occurrence of themes by participant within each focus group/interview to accurately illustrate the findings (Krueger and Casey (2015). Table 2 summarizes the occurrence of references to specific codes.

Results

Alumni of SRPP implemented within the context of STP-PreK were invited to participate in a focus-group or individual interview. The current study is meant to serve as an initial step toward tailoring SRPP to meet the needs of economically and socially disadvantaged families. These discussions provided opportunities for caregivers to inform future iterations of the program as a standalone intervention to be implemented during the school year. Several topics developed to facilitate discussion of the acceptability of SRPP and assist in program evaluation. Four of the five possible codes (i.e., program content, engagement, overall views of program, and program modifications) had the highest frequency of references. Table 2 summarizes the occurrence of references to specific codes.

Program Content

Similar to study 1, SRPP program content was discussed in terms of what families considered to be acceptable or unacceptable. In reviewing the evidence-based strategies presented during sessions, many caregivers seemed to view the PRIDE skills, specifically praise as an acceptable parenting practice despite initial views regarding compliance:

> "I think it helped a lot because it made us more aware of how we should like talk to them more or say certain things like you- we talk to them normally but I think like with me, it made me like praise my son more like I was saying thank you more than I usually do 'cause some like- in my mind I think you should know to do this or I asked you to do it, you need to do it. It ain't no if, ands, or buts, but actually saying thank you, actually showing appreciation and doing all the extra

> praising, I think that made him be more alert to really 'Ok, let me do it- make sure I do it right 'cause I know...' So, it did help..." (FG1; mother, 28 years).

Despite that fact that most caregivers were nearly a year or more removed from SRPP, some indicated continued use of certain strategies:

> "Even praising them with doing certain things that um you wouldn't even expect them to do. Letting them know "oh ok. I do see what you're doing. I know you're doing a good job." Or "thank you for you know behaving when we're out in public." And you know and rewarding them for something that you know should be rewarded for you know sometimes we don't feel like we should reward our kids 'cause we buy them whenever we- you know- So rewarding them still to let them know I acknowledge what you're doing and that's a great job for doing it, for me, you know. It's still good 'cause I have to still do it [laughter]" (FG1; mother, 29 years).

While caregivers found the elimination of yelling and planned ignoring to be generally acceptable, the use of time-out was variable and appeared to be dependent upon successful implementation:

> "My time out didn't work. He used to lean off the seat and slide down the chair. That's how they told me he used to be so I tried it. He used to have to use the bathroom and cry. His shirt was itchy, it was a mess. I just took it away" (FG2; mother, 39 years).

> "Time out worked for me. Um, I implemented time out since they were younger. I started time out and I started with me daughter as well, and shes only 1. So, I implemented time out from the beginning. The only thing that I think that helped me more was managing my anger from screaming 'cause I don't like screaming so my kids know that about me so like I would tell them you know, I don't wanna get mad right now" (FG2; 31 years).

Overall Program Views

Second, caregivers discussed their overall views of the program, noting pros and cons. For example, one participant observed increased patience,

> "Um, the experience for me was um great because it teach [*sic*] you a lot. It gives you more patience to learn what they know and what they don't know. As well as you learning the same thing too. Getting to know your child better. And the whole program it wasn't just like um "we're gonna teach you this." and it just, it was all

> type of different skills and you can pick from different parents, from you know, work methods, that worked for them. To come together as one to know your child as best as possible throughout the whole experience, it was really great" (FG3; mother, 29 years).

While another caregiver highlighted a difference in interactions with their child during play,

> "I think it kind of helped with me like actually opening up and interacting with him, because all day he could play with his toys and I'll be like right there and I'll be playing too but I'm always quiet like I let him do his own imagination and him rambling on what he…but I still just be there playing with him. But I think with the skills you guys taught us, I'm actually talking more. I'm making him learn more because I'm asking him questions or like with the opening sentences, making him want to say more and explain more, rather just being in his own imagination" (FG1; mother, 28 years).

Regarding in-session coaching, some caregivers expressed discomfort given the size of some groups ("because you know somebody watching what you bout to say [Laughter]"; FG1; mother, 28 years), and the way in which skills were modeled ("...especially if somebody know you and they know how you be around your child like 'she know she don't be doing that!' [Laughter]" (FG1; mother, 31 years).

Engagement

Third, participants discussed how to engage future families in SRPP. In particular, caregiver had suggestions for group leaders regarding mode of contact ("use text reminders", "group message"; FG4, mother, 40 years), and the use of humor in session ("...cause if they not funny...and they not down, then nobody gon come [laughs]"; FG1; mother, 31 years).

SRPP Modifications

Finally, caregivers weighed in on components of SRPP, indicating those that should be kept, eliminated, or added. The majority of participants suggested a reduction in the size of groups (~6 participants):

> "…because it was- you know like the ones I was coming to, the sessions I was coming to, it was like a whole bunch of parents and it was like 8 or 9 kids, and we was hearing what y'all said, but then again, it was so much going on and then we had to rush and go and do like our own separate groups, which y'all was walking around and like monitoring and helping us but I feel like if it was like half of the people that was there, then y'all could literally focus more- and like we could have more time and y'all could give us more tips. 'cause its like its smaller people so its like you work with us and then you all could work with them. Like 'cause- I would've felt like I would've got more tips 'cause I did know y'all was helping, but if you was like right there, like some moments I'm like 'you aint catch what he just did,' you know?" (FG1; mother, 28 years).

By and large, this suggestion was attributed to concerns about not having enough in-session coaching and the ability to pay attention in a large group setting. During the discussion regarding the ways in which caregiver's felt the program could be modified, two caregivers were *observed* to be particularly vocal about parenting Black children and promoting child safety in a dangerous community context.

> "...what I find myself doing lately is I [*sic*] been educating my kids on, you know, the violence and the realness thats really out here in society...he needs to be learning um you know how to deal with police, he needs to be learning some laws, you know, how to protect hisself [*sic*], things like that. How to *respond* to police, stuff like that... I think that we should be telling our kids the truth, little bit and bits and pieces as they are really growing up. Um, I think that, um, the young- like I have a problem with [child name] trusting police now because things have really changed and really shifted in the last three years, you know? So, he- 'I wanna say hi to the police!' and this and that, but I don't think that in five to ten years from now, when he's 15 or however old he is that it *might* not be ok. It might be too scary for him to talk to police and trust them. So, when we're at this junction [*sic*] I think he should be more educated as a young Black child, you know? I wanted to grow his hair in dreads and yesterday, I second guessed myself like 'ok, if he grow these dreads for ten years, its gonna be a 15-16 year old boy with dreads' and that might scare a police officer in the next 15 years. So, I think

> that's [*sic*] some issues we need to be thinking about as parents with young kids" (FG3; mother, 40 years).
>
> "...I don't sugarcoat nothing from my kids, even my five year old. She knows everything. Like, um, one of the movies I let them watch with me was *The Hate U Give*. I don't know if y'all saw [*sic*] that movie before but that's like one of the- you know, about police brutality and all that stuff like that. Um, they know if we [*sic*] driving and the police stop, stay- im sorry- stay yo [expltive]- don't move, listen, and um like I tell my son since he's the oldest, he's 10, if you're like- when you get up in age and you start driving, police stop you, keep yo hands on that wheel, don't move nothin'. If they tell you to get it, you tell them to get it 'cause they- you know, like as soon as you move or whatever, they can shoot you" (FG3; mother, 31 years)

In summary, SRPP was generally accepted by caregivers who also noted improvements across multiple domains from completing the program. Moreover, discussions also illustrated the continued use of strategies beyond the transition to kindergarten for many caregivers. Caregiver's also provided insight into the complex contexts in which their children are being raised. As such, these findings will be further discussed.

Discussion

Study 2 was the first qualitative examination of the social validity of a novel behavioral parent training program, the SRPP. In order to inform ongoing program development, the author invited STP-PreK SRPP alumni to participate in a focus group or be individually interviewed to share their experiences and provide feedback on a number of topics related to SRPP (e.g., content, delivery, format). Of note, STP-PreK SRPP alumni were provided the opportunity to discuss how to implement a school year version of the SRPP and ways to recruit, retain, and engage families. Many families reported continued use of strategies one to three years post intervention.

Based on qualitative data collected using a semi-structured format, caregivers' intervention experiences and views regarding the social validity of the SRPP were examined. Consistent with previous research, the majority of caregivers found value in using the PRIDE skills, specifically praise to reinforce desired behaviors (Calzada et al., 2012) and expressed a continued understanding of why praise is a valuable strategy for increasing positive behaviors (Matsumoto et al., 2007; Morawaska et al., 2011). However, caregivers showed greater variability with regard to their acceptance of the discipline strategies presented, with a portion of caregivers finding time-out less acceptable and/or effective for their family. For example, the elimination of yelling and planned ignoring was thought to be useful, yet caregivers were mixed regarding views on time-out; some participants highlighted cultural incongruences and perceptions that time-out was a tool better suited for White families. Previous work has demonstrated such discrepancies in acceptability in promotive (e.g., praise and social rewards) versus preventive strategies (e.g., time out, planned ignoring, and spanking) in minority samples (e.g., Calzada et al., 2012; Ho et al., 2012). Finally, caregivers provided feedback regarding modifications to the program and many suggested reducing the size of groups in order to ensure participants receive adequate in-session coaching and feel comfortable contributing to group discussions. While the implementation of large groups (10 – 15) increases access to high-quality, evidence-based care for vulnerable populations and it is more cost effective, some studies have found small group (four to five) PCIT to be effective in treating families (Nieter et al., 2013).

Strengths and Limitations

A strength of this study was the diverse sample of participants spanning four cohorts of STP-PreK SRPP alumni. Moreover, focus group moderators were of a similar racial/ethnic background to participants, which is thought to reduce moderator bias. Having a moderator of concordant cultural background could have facilitated the discussion in making participants feel more comfortable sharing their experience (Smithson, 2000). Furthermore, moderators facilitated groups in which they had established a therapeutic relationship with participants, which can be seen as a strength.

However, findings should be discussed in light of the limitations. First, focus groups are prone to the presence of dominant participants during discussions which is a common challenge (Smithson, 2000). Caregivers with strong opinions or those that speak often can potentially bias qualitative data. Moreover, participants that attempt to disagree or provide an alternative view point may be inadvertently ignored. However, moderators made every attempt to allow each participant to contribute to the discussion. A second limitation of the study is the fact that one of the focus groups had a different moderator. The literature underscores the utility of having the same moderator across groups to ensure that the same issues are addressed in all groups (Smithson, 2000). However, in order to ensure a degree of uniformity amongst discussions, moderators followed the same semi-structured format and asked the same questions. The approach served to ensure research questions were addressed, while flexibly exploring participants' views which tend to have an important influence on the discussion (Morgan, et al., 2011). It is important to note caregivers participated in SRPP as their children were simultaneously participating in an intensive summer treatment program. Thus, it is difficult to

disentangle improvements in children's functioning from camp participation. While a proportion of caregiver's reported continued use of skills learned (e.g., praise, time out) following completion of SRPP, the examination of skill maintenance via objective measures was outside the scope of the current study. Thus, it is unclear whether caregiver report of ongoing enthusiasm regarding learned skills is predictive of ongoing or effective use of said skills.

Finally, unlike previous evaluations of the social validity of parenting strategies (Calzada et al., 2012), the present work was unable to analyze qualitative data in terms of rates of agreement. Nonetheless, focus groups were structured similar to previous pilot studies (Chacko et al., 2007) and provide rich qualitative data. Caregivers demonstrated their acceptability (or lack thereof) of program content and shared their views of how a school year implementation of the SRPP can be enhanced to recruit, retain, and engage economically and socially disadvantaged families.

Conclusions

This study was a qualitative examination of an 8-week school readiness BPT targeting children experiencing elevated levels of externalizing problems and their caregivers. Thirty-five STP-PreK SRPP alumni participated in four focus groups and one individual interview to share their intervention experiences and provide feedback on the program. The qualitative data reviewed offers valuable insight and a number of potential modifications to SRPP, which will be discussed in Chapter 6.

Table 1. Demographic Characteristic Focus Group and Interview Participants

	Focus Groups *M (SD)*	Interview
Child age	6.32 (2.31)	6
Caregiver's age	37.06 (9.79)	27
# of years since completing SRPP	12.94 (12.09)	1
	%	%
Child gender – Male	69	100
Caregiver ethnicity/race		
Black	67.6	100
White/Hispanic	5.9	--
Afro-Caribbean	23.5	--
Other	2.9	--
Income < $11,720	37.1	0
Marital status - Single	60	0
Level of education ≤ HS	52.9	100
Employed	46	100

Note. HS = high school; GED = General Education Development.

Table 2. References to SRPP Codes for 35 Participants

	Focus Groups (FG; *n* = 34)				Interview (I; *n* = 1)
	FG1	FG2	FG3	FG4	I1
PROGRAM CONTENT					
Praise	X (*n* = 4)	X (*n* = 1)	X (*n* = 3)		X
Ignoring	X (*n* = 3)	X (*n* = 4)	X (*n* = 1)	X (*n* = 3)	X
Time Out	X (*n* = 2)	X (*n* = 5)	X (*n* = 5)	X (*n* = 12)	X
Behavior System	X (*n* = 2)	X (*n* = 3)			
OVERALL PROGRAM VIEWS					
Dyad Relationship	X (*n* = 4)	X (*n* = 2)	X (*n* = 5)	X (*n* = 4)	X
Expectations	X (*n* = 2)		X (*n* = 4)	X (*n* = 5)	
ENGAGEMENT					
Recruitment	X (*n* = 2)	X (*n* = 3)			X
Barriers	X (*n* = 4)		X (*n* = 2)	X (*n* = 4)	X
Therapist	X (*n* = 4)	X (*n* = 4)		X (*n* = 3)	
PROGRAM MODIFICATIONS					
Safety			X (*n* = 4)		
Structure	X (*n* = 4)	X (*n* = 6)	X (*n* = 7)	X (*n* = 6)	X
Family Resources			X (*n* =5)		

IV. GENRAL DISCUSSION

Summary of the Present Work

Youth who exhibit externalizing behavior problems account for a significant proportion (33% to 50%) of all child and adolescent clinic referrals. Moreover, persistent externalizing difficulties emerge during the preschool years, especially in boys (Fisher & Sexton, 2016). While these statistics are concerning, the trends are particularly grim for children from economically and socially disadvantaged backgrounds who are often overrepresented and underserved. In 2017, more than half of Black (57%) and Hispanic (54%) children lived in low-income families (Child Trends, 2019). Longitudinal work shows that, children of low SES have higher rates of caregiver-reported mental health problems and higher rates of unmet mental health needs (Hodgkinson et al., 2017). Furthermore, Black and Hispanic youth receive significantly less outpatient mental health and substance abuse care than their White counterparts, even after controlling for other demographic differences, impairment, income, and health coverage (Marrast et al., 2016).

To date, however, few BPTs address the impact of externalizing behavior problems on children's school readiness. A review of the extant literature on BPT identified a need for brief, culturally responsive, low cost approaches to address early externalizing behavior problems in economically and socially disadvantaged communities. This led to the examination of a novel BPT, as a standalone intervention, implemented within early childhood education settings.

The SRPP is an eight-week behavioral parent training program designed to address some limitations of traditional BPT. While the primary goal of the SRPP is to help caregivers manage early externalizing behavior, it also equips caregivers with tools

for a successful transition to kindergarten and encourages home-school communication. In the SRPP, preschoolers with elevated levels of externalizing problems and their caregivers participate in weekly sessions that provide a guided skills-based training including psychoeducation, role-play, in-session coaching, and the use of behavior management and early literacy/numeracy strategies to reduce problem behaviors and increase children's school readiness.

First, an open pilot trial of the SRPP was conducted to examine the acceptability, feasibility, and promise of the manualized BPT and to generate feedback caregivers experience, social validity, and potential modifications. Results of the open trial indicated overall high acceptability and feasibility of the intervention protocol, however the promise of the SRPP as a standalone intervention is unclear. SRPP resulted in significant reductions in caregiver ratings of children's behavioral functioning and improvements in caregiver-child interactions during child-led play, however, positive benefits did not extend beyond behavior.

Subsequently, a qualitative study of the program was conducted to examine treatment acceptability and to solicit caregiver feedback regarding school year implementation. Discussions illustrated general acceptance of behavior management strategies taught to promote desired behaviors and mixed acceptance of discipline strategies presented to decrease negative behaviors. Cultural incongruences were identified regarding program content. Of note, discussions largely excluded skills targeting promotion of early academic skills. Additionally, discussions produced a number of potential modifications to enhance future iterations of the SRPP for school year implementation to meet the needs of particularly vulnerable communities and

increase access to quality, culturally responsive evidence-based care. Taken together, findings underscore the need for a re-examination of the relevance of underlying theories of BPT programs to reduce early externalizing behaviors, especially those focusing on feasibility and acceptability within overrepresented and underserved communities.

Future Directions

This investigation provides initial evidence for the acceptability and feasibility of the SRPP as a standalone program offered during the school year for families from economically and socially disadvantaged backgrounds. While SRPP was not specifically designed for individual sessions nor was it designed to be implemented by professionals outside of the mental health field, the program is suited for implementation and evaluation within a variety of contexts given low costs and resources (Graziano et al., 2017) associated with implementation compared to existing BPTs (Olchowski et al., 2007). Nonetheless, it is difficult to ignore the persistent challenges faced regarding recruitment, retention, and engagement of low-income and racial/ethnic minority children and families that mirror those seen in the bulk of the BPT literature. Moreover, qualitative data suggests cultural incongruences with a hallmark component of traditional BPTs (i.e., time out). Engagement in BPT has crippled the field's ability to reduce disparities in access to quality evidence-based mental health services, particularly for economically and socially disadvantaged children and their families. In a recent systematic review, Chacko and colleagues (2016) raise that a notable proportion of attrition occurs before BPT enrollment, with at least one-quarter of those identified as eligible for intervention not enrolling in such programs. Furthermore, another 26% of families start, but discontinue prior to completing treatment. That being said, a 51%

attrition rate indicates no more than approximately half of eligible caregivers will complete BPT (Chacko et al., 2016). In the current study, despite the author's efforts to recruit families by passing out flyers, attending community events, and speaking at various meetings (i.e., parent, teacher/administrative), only a modest number of families were assessed for eligibility and an even smaller number of families enrolled and completed SRPP. To date, a significant proportion of studies evaluate attrition in a retroactive manner that prohibits the ability to identify what types of contextual factors prevent a family from participating in real time. Future work should include tools to assess pretreatment attrition in a more nuanced manner (e.g., focus groups/individual interviews). Moreover, given the potential utility of technology in dissemination of mental health services for families, recruitment can leverage indigenous resources schools utilize to disseminate information to caregivers (e.g., automated text messages) to recruit eligible families for treatment (Jones et al., 2013). Doing so could potentially reduce stigma associated with having other families observe a caregiver interacting with a service provider or receiving a flyer. Finally, future studies should take note of existing evidence in support of community models of research which seek to involve community stakeholders in all aspects of the program, such as development and evaluation (e.g., ParentCorps; Caldwell et al., 2005) and implementation (Calzada et al., 2005).

Findings from the current study also highlight a number of common missteps in transporting BPTs to routine care settings that future work should address. While pilot trials are recommended prior to implementing evaluations on a larger scale, it is also beneficial to conduct pipeline studies to determine if the expected population is available (Gottfredson et al., 2006). Taking such an approach will conserve resources and identify

difficulties early on. Difficulty recruiting families for the current study further support previous research which suggests that the field should cease "installing" programs into settings and instead endeavor to create a fit between the literature on effective practices and specific settings (Gottfredson et al., 2006). Lastly, considering traditional BPTs largely ignore culture and context, identifying and involving stakeholders early may be integral to determining if program goals align with the pressing needs of the community.

The present work was limited in its ability to examine SRPP's utility in fostering children's school readiness in other domains (e.g., self-regulation, socioemotional). Given the fact that SRPP was developed to address gaps in existing BPT by teaching caregivers' skills to promote their children's successful transition to formal school entry across domains, future studies should aim to evaluate response to treatment on children's social-emotional and adaptive functioning utilizing measures that are more reflective of the cultural contexts in which they live. Of note, participation did not produce statistically significant improvements in teacher ratings of child behavioral functioning posttreatment. These findings may underscore the extent to which SRPP as a standalone is able to improve functioning outside of the home. Furthermore, these findings may call attention to the reality that the theory that increased caregiver knowledge and skill are what is needed by economically and socially disadvantaged families may fall short, and that more effective interventions might appropriately focus on social organization or family financial requirements (Gottfredson et al., 2006). This is evidenced by qualitative data suggesting SRPP be modified to include resources to address family needs and the inclusion of content that addresses how to help caregiver's navigate conversations about interactions with the police and safety. Previous work has highlighted the prevalence of

culture-based parenting practices (i.e., racial socialization) and therefore their potential value in the development and implementation of evidence-based parent training programs with Black families. Black caregivers of young children from low-income, urban neighborhoods practice racial socialization and view such lessons as unique, routine, and critical aspects of raising Black children (Coard et al., 2004). As such, future work should seek to increase the cultural competence of interventions for economically and socially disadvantaged families in order to deepen our understanding of the influence of racial socialization in preventing externalizing problems and related negative outcomes in racial/ethnic minority youth.

Conclusions

Overall, despite challenges and limitations, school year implementation of the SRPP demonstrated initial acceptability, feasibility, and promise as a standalone, low-cost, intervention program for reducing externalizing behaviors among economically and socially disadvantaged preschoolers. The positive treatment outcomes produced in study 1 adds to the existing literature by further supporting the notion that BPT is effective in reducing behavior problems and improving caregiver skills immediately following treatment. This highlights the promise of involving schools to increase access to mental health services in order to intervene early on and promote academic success. However, there is still much work to be done regarding the effectiveness BPTs for ethnic minority youth and their families in order to fully understand the utility of existing programs, the impact of race/ethnicity on treatment outcomes, and the extent to which such factors warrant adapting interventions to meet the needs of specific communities.

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APPENDIX

Note. The following research measures were excluded from the appendix due to copyrights: Eyberg Child Behavior Inventory, and Sutter-Eyberg Student Behavior Inventory.

SCHOOL READINESS PARENTING PROGRAM
FAMILY REGISTRATION

Caregiver Last Name _____, **First** _____ **MI** ____

Date of Birth (mo/day/yr) ☐☐ ☐☐ ☐☐☐☐ **Gender** ☐ Male ☐ Female

Are you a Parent, Guardian or Primary Caregiver? ☐ Yes ☐ No

What is your relationship to the child?

☐ Biological mother ☐ Biological father ☐ Adoptive mother

☐ Adoptive father ☐ Step mother ☐ Step father

☐ Grandmother ☐ Grandfather ☐ Aunt

☐ Uncle ☐ Other _____

How many children are in your care? ☐☐

Are you proficient in English? ☐ Yes ☐ No

Is your child proficient in English? ☐ Yes ☐ No

Other language(s) spoken in the home ☐ Spanish ☐ Haitian-Creole ☐ Other:_____ ☐ None

Street Address _____ **City**_____ **Zip Code** _____

Primary Phone Number _____ **Secondary Phone Number** _____

Email _____

Ethnicity ☐ Hispanic ☐ Haitian ☐ Non-Hispanic ☐ Other, please specify: _____

Race ☐ American Indian or Alaskan ☐ Asian ☐ Black/African American

☐ Pacific Islander ☐ White ☐ Other ☐ Multiracial

What is the Highest Grade You Completed? Grade ☐☐ ☐ HS Diploma/GED

__ Some College __ Associate's Degree __ Bachelor's Degree __ Graduate Degree

What is your occupation (e.g., nurse, clerk) _____

What is your annual income?

__ Less than $11,720 __ $11,721 - $14,937 __ $14,938 - $18,284

__ $18,285 - $23,492 __ $23,493 - $27,827 __ $27,828 - $31,471

__ $$31,427 - $35,743 __ $35,744 - $39,688 __ $39,689 - $47,297

__ $47,298 - $75,000 __ $75,000 - $100,000 __ $100,000 +

What is your marital status?

__ Single, never married __ Living with partner __ Married

__ Separated __ Divorced __ Widowed

Child's Last Name _____, **First**_____ **MI** ____

Child's Date of Birth (mo/day/yr) ☐☐ ☐☐ ☐☐☐☐

Child's Gender __ Male __ Female

Child's Current School _____ Child's Current Grade ☐☐

Child's Ethnicity __ Hispanic __ Haitian __ Non-Hispanic __ Other, please specify: _____

Child's Race __ American Indian or Alaskan __ Asian __ Black/African American

__ Pacific Islander __ White __ Other

__ Multiracial

SEMI-STRUCTURED BACKGROUND INTERVIEW

I. CLIENT DATA

Child's Initials_____ Informant(s) _____
ID Number _____ _____
Date _____ Interviewer _____

II. REFERRAL INFORMATION

Reason for Referral:

_____
_____
_____
_____
_____
_____
_____
_____

Goals for Treatment:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Referred by: _____ at _____

III. SCHOOL HISTORY

1. Preschool Experience

Has child ever attended:	**Yes or No? (If yes, indicate when, where, and for how long.)**
Early Intervention	
Daycare	
Head Start Program	
Regular Preschool	
Developmental Preschool	
Special Education Preschool	

B. School Performance and Behavior

Current School: _____
Type of Classroom: _____
Grade-level: _____

Academic performance & behavioral difficulties at current school:

_____
_____
_____

Previous School (s): _____
Type of Classroom: _____
Grade-level: _____

Academic performance & behavioral difficulties at previous school(s):

_____
_____
_____

Has Child ever:	**Yes OR No? (If yes, indicated when and get detailed information)**
Had IEP/SPED	
Retained in grade	
Been suspended	
Been expelled	

C. Special Services at School or Out-of-School
Currently have an IEP or receiving Special Education services: NO YES
(Arrange for Copy of IEP or 504 plan)

Has child ever received:	**Yes OR No? (If yes, indicated when, where, how often, and by whom?)**
Resource room (part time)	
Self-contained LD room (full time)	
Behavior Disorders classroom	
Speech/Language Therapy	
Occupational Therapy	
Physical Therapy	
School counseling	
Has child ever received:	**Yes OR No? (If yes, indicated when, where, how often, and by whom?)**
Gifted	
Other	

Classroom accommodations (Describe)	

IV. FAMILY HISTORY
A. Family Composition

Child is currently living with:

Biological	Mother _____	Father _____
Step	Mother _____	Father _____
Adoptive	Mother _____	Father _____
Foster	Mother _____	Father _____
Other: _____		

	Relationship to child	Age
Other children in immediate family:	_____	_____
	_____	_____
	_____	_____
	_____	_____
Other children in the home:	_____	_____
	_____	_____
Other siblings outside of the home:	_____	_____
	_____	_____

Nature of relationship with parents: Below average Typical Above Average

Nature of relationship with siblings: Below average Typical Above Average

B. Current Marriage/Caretaker Relationship
Number of years married/together: _____
Parents/Caretakers' current relationship is:
Generally stable _____ Sometimes stable _____ Often unstable _____

C. Biological Parents
Child's biological parents:
____ Never married, currently together ____ Currently Married
____ Never married, currently apart ____ Once Married, currently, separated

____ Once Married, currently divorced ____ Once Married, now widowed

(If applicable) **Number of years married/together:** _____
(If applicable) **Number of years separated/divorced:** _____ **Age of Child**: ____

Custody of Child is held: Jointly Mother only Father Only DSS Other

D. Recent Lifestyle Changes/Psychosocial Stressors *(Write details as needed in margins)*

_____Pregnancy _____ Medical Problems _____ Job termination
_____ New Sibling _____ Psychiatric Problems _____ Layoff
_____ Marriage _____ Death of relative/friend _____ Financial Problems
_____ Marital Tensions _____ Change in residence _____ Legal problems
_____ Separation/Divorce _____ Change in work schedule _____ Other

E. Prenatal + early toddlerhood period

Pregnancy: _____ full term _____ early or late

Delivery: natural c-section (reason:_____)

Complications: none yes (details):
_____

Hospital stay after birth: normal 2 days Other (reason):_____

Major illnesses/hospitalizations in childhood:
_____
_____
_____
_____

Major accidents in childhood:
_____
_____
_____
_____

Temperament:

Eating:	

Sleeping:	
Mood:	
Transitions:	

Developmental Milestones:

Crawling	on time	early or late	
Walking	on time	early or late	
Talking	on time	early or late	
Toilet trained	on time	early or late	

Do you have any concerns about your child's developmental functioning?

_____
_____
_____
_____

G. Psychiatric/Medical History of Biological Relatives

Past/Present Hx of	**Siblings**	**Mother**	**Father**	**Extended Maternal**	**Extended Paternal**
AD/HD Diagnosis (Dx)					
ODD Dx					
CD Dx					
Antisocial Behavior					
LD Dx					
Developmental Delay					
Past/Present Hx of	**Siblings**	**Mother**	**Father**	**Extended Maternal**	**Extended Paternal**
Schizophrenia/Psychosis					

Bipolar/Manic Depression					
Depression/Suicide					
Anxiety Disorders					
Phobias					
Tics/Tourettes					
Alcohol Abuse					
Substance Abuse					
Physical Abuse					
Sexual Abuse					
Seizures/Epilepsy					
Other Medical					
Other Psychiatric					
Outpatient Treatment					
Inpatient Treatment					

Details:

V. CHILD'S EVALUATION AND TREATMENT HISTORY

A. Prior Evaluations

Has child ever undergone:	**NO**	**YES (Date, Provider)**
Psychological or Psychiatric Evaluation		
Pediatric evaluation for AD/HD		
Neurological Evaluation		
Has child ever undergone:	**NO**	**YES (Date, Provider)**
Neuropsychological Testing		
Intelligence Testing		

Academic Achievement Testing		
Speech/Language/Hearing Evaluation		

Results/Scores *(Ask for copy of any previous evaluations)***:**

_____

_____

Previous Diagnoses:

_____

_____

B. Psychological/Psychiatric Treatment

Has child ever received:	**NO**	**YES (Dates, Provider)**	**Current**
Individual Therapy			
Play Therapy			
Family Therapy			
Group Therapy			
Inpatient Treatment			
Residential Treatment			
Parent Training			
Social Skills Training			

Details:

C. Pharmacotherapy

Has child ever taken:	**NO**	**YES (Dates, Dosage Prescribing Physician)**	**Current**
Ritalin			
Ritalin LA or SR			
Focalin			
Concerta			
Metadate ER or CD			
Adderall			
Adderall XR			
Vyvance			
Dexedrine			
Dexedrine Spansules			
Cylert			
Clonidine/Tenex			
Wellbutrin			
Other: _____			

Current medication:
Schedule:
Time(s) medicine is taken: _____
How many days a week is medicine take: _____
Is medication taken on the weekends? Y N
Is medication taken during the summer? Y N

Any improvements? None at all Somewhat Very much

Any side effects? None at all Somewhat Very much

Past medications:
Any improvements? None at all Somewhat Very much

Any side effects? None at all Somewhat Very much

Does your child take any other medications?
Medication: _____ Dosage: _____Reason: _____
Medication: _____ Dosage: _____Reason: _____

Have you done anything else to try to help your child cope with his/her difficulties?
_____
_____
_____
_____
_____
_____
_____

VI. HOME MANAGEMENT
A. Compliance
How often does your child do what you ask on the first request?
_____ Almost never _____ Some of the time _____ Most of the time

How often does your child eventually do what you want them to do?
_____ Almost never _____ Some of the time _____ Most of the time

B. Strategies

Have you used:	Never	Previous	Present	**Outcome**

Privilege Removal				
Isolation/Time out				
Grounding				
Spanking/Physical Punishment				
Verbal Reprimands				
Yelling				
Allowance System				
Special Privileges/Rewards				
Star Chart/Token System				
Verbal Praise				
Other				

Overall, how effectively do you manage your child's behavior?
_____ Not very well _____ Moderately well _____ Very well

Overall, how effectively does your spouse/partner manage your child's behavior?
_____ Not very well _____ Moderately well _____ Very well _____ Not Applicable

How often do you and your spouse/partner agree on which behaviors to discipline?
_____ Almost never _____ Some of the time _____ Most of the time _____ Not Applicable

How often do you and your spouse/partner agree on how to discipline?
_____ Almost never _____ Some of the time _____ Most of the time _____ Not Applicable

If parent is separated or divorced from child's biological parent and the secondary parent is actively involved in the caretaking responsibilities, ask parent to describe any differences between households.

_____
_____
_____
_____
_____

Finally, what are your child's strengths? What do they like to do? What motivates them?

_____
_____
_____
_____
_____

Parent / Teacher DBD Rating Scale

Child's Name: _____ Form Completed by:_____

Grade: _____ Date of Birth: _____ Sex: _____ Date Completed: _____

	Not at All	Just a Little	Pretty Much	Very Much
1. often interrupts or intrudes on others (e.g., butts into conversations or games)				
2. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)				
3. often arg2ues with adults				
4. often lies to obtain good or favors or to avoid obligations (i.e. "cons" others)				
5. often initiates physical fights with other members of his or her household				
6. has been physically cruel to people				
7. often talk excessively				
8. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)				
9. is often easily distracted by extraneous stimuli				
10. often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking), e.g., runs into street without looking				
11. often truant from school, beginning before age 13 years				
12. often fidgets with hands or feet or squirms in seat				
13. is often spiteful or vindictive				
14. often swears or uses obscene language				
15. often blames others for his or her mistakes or misbehavior				
16. has deliberately destroyed others' property (other than by fire setting)				
17. often actively defies or refuses to comply with adults' requests or rules				
18. often does not seem to listen when spoken to directly				
19. often blurts out answers before questions have been completed				

	Not at All	Just a Little	Pretty Much	Very Much
20. often initiates physical fights with others who do not live in his or her household (e.g., peers at school or in the neighborhood)				
21. often shifts from one uncompleted activity to another				
22. often has difficulty playing or engaging in leisure activities quietly				
23. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities				
24. is often angry and resentful				
25. often leaves seat in classroom or in the other situations in which remaining seated is expected				
26. is often touchy or easily annoyed by others				
27. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)				
28. often loses temper				
29. often has difficulty sustaining attention in tasks or play activities				
30. often has difficulty awaiting turn				
31. has forced someone into sexual activity				
32. often bullies, threatens, or intimidates others				
33. is often “on the go” or often acts as if “driven by a motor”				
34. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)				
35. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited be subjective feelings or restlessness)				
36. has been physically cruel to animals				
37. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)				
38. often stays out at night despite parental prohibitions, beginning before age 13 years				
39. often deliberately annoys people				
40. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)				

	Not at All	Just a Little	Pretty Much	Very Much
41. has deliberately engaged in fire setting with the intention of causing serious damage				
42. often has difficulty organizing tasks and activities				
43. has broken into someone else's house, building, or car				
44. is often forgetful in daily activities				
45. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)				

Child's Name: _____

Date: _____

Family Impact Questionnaire-R

Being a parent can be difficult, and children have different effects on the family. We would like to know what impact your child has had on the family compared to the impact other children his/her age have on their families. The following questions attempt to understand children's impact on different areas of family functioning. Please check the category that best describes your situation in terms of how things have been in general for you with reference to the child who is participating in the program.

Your feelings and attitudes about your child	Not at all	Somewhat	Much	Very much
COMPARED TO CHILDREN AND PARENT WITH CHILDREN THE SAME AGE AS MY CHILD… 1. My child is more stressful.				
2. I enjoy the time I spend with my child more.				
3. My child brings out feelings of frustration and anger more.				
4. My child brings out feelings of happiness and pride more.				
5. When I am with my child, I feel less effective and competent as a parent.				
6. It is easier for me to play and have fun with my child.				
7. My child's behavior bother me more.				
8. My child makes me feel more loved.				
9. I feel like I am working alone in trying to deal with my child's behavior.				
10. My child makes me feel more energetic.				
11. I feel like I could be a better parent with my child.				
12. My child makes me feel more confident as a parent.				
13. I feel like I should have better control over his/her behavior.				
14. My child does what I tell him/her to do most of the time.				
15. I feel like I know how to deal with my child's behavior most of the time.				

Your feelings and attitudes about your child	Not at all	Somewhat	Much	Very much
The impact of your child on your social life COMPARED TO CHILDREN AND PARENTS WITH CHILDREN THE SAME AGE AS MY CHILD… 16. My child's behavior embarrasses me in public more.				
17. My family avoids social outings more (e.g., restaurants, public events) because of his/her behavior.				
18. It is more difficult to find a baby-sitter to stay with him/her.				
19. My family visits relatives and friends less often than I would like to because of my child's behavior.				
20. My child interferes more with my opportunity to spend time with friends.				
21. I feel more tense when my family goes out in public, because I am worried about his/her behavior.				
22. I need to explain my child's behavior to others more.				
23. I participate less in community activities because of my child's behavior.				
24. I have guests over to our house less often than I would like to because of my child's behavior.				
25. I take my child shopping and on errands less.				
The financial impact of your child COMPARED WITH OTHER CHILDREN MY CHILD'S AGE… 26. The cost of raising my child is more.				
27. The cost of childcare is more.				
28. The cost of food, clothes, and/or toys is more.				
29. The cost of home alterations and/or fixing and replacing items in the home is more.				

Your feelings and attitudes about your child	Not at all	Somewhat	Much	Very much
30. The cost of medication, medical care and/or medical insurance is more.				
31. The cost of education and psychological services is more.				
32. The cost of recreations activities (e.g., music, swimming, gymnastics) is more.				
IF YOU ARE MARRIED, COMPLETE THE FOLLOWING SECTION. OTHERWISE, SKIP TO QUESTION NUMBER 40. The impact of your child on your marital relationship				
COMPARED TO PARENTS WITH CHILDREN THE SAME AGE AS MY CHILD… 33. My spouse and I disagree more about how to raise this child.				
34. My spouse is more supportive of the way I deal with my child's behavior.				
35. This child pits my spouse and me against each other more.				
36. Raising this child has brought my spouse and me closer together.				
37. My child causes more disagreements between my spouse and me.				
38. My spouse is less supportive of the way I deal with my child's behavior.				
39. Raising this child has pushed my spouse and me farther apart.				
IF YOU HAVE OTHER CHILDREN, COMPLETE THIS SECTION. OTHERWISE, SKIP TO QUESTION NUMBER 49. The impact of your child on his/her siblings				
COMPARED WITH OTHER CHILDREN MY CHILD'S AGE… 40. The other children in the family help take care of him/her more.				
41. My child prevents his/her siblings from participating in activities more.				
42. The other children in the family complain about his/her behavior more.				

Your feelings and attitudes about your child	Not at all	Somewhat	Much	Very much
43. The other children in the family feel more embarrassed by his/her behavior.				
44. My child is more rejected by his/her siblings.				
45. The other children in the family invite friends over to the house less often because of his/her behavior.				
46. The other children in the family enjoy spending time with him/her more.				
47. My child uses his/her siblings' toys without asking permission more.				
48. My child breaks or loses his/her sibling's toys more.				

General Questions

49. Compared with other children my child's age, the degree of difficulty living with him/her is:

Much Easier	Easier	Slightly Easier	About the same	Slightly More Difficult	More Difficult	Much More Difficult

50. Compared with other children my child's age, the impact of my child on our family is:

Much Easier	Easier	Slightly Easier	About the same	Slightly More Difficult	More Difficult	Much More Difficult

Life Stressor Checklist - Revised

Please fill in today's date: _____

READ THIS FIRST: Now we are going to ask you some question about events in your life that are frightening, upsetting, or stressful to most people. Please think back over your **whole life** when you answer these questions. Some of these questions may be about upsetting events you don't usually talk about. Your answers are important, but **you do not have to answer any questions that you do not want to.** Thank you.

1. Have you ever been in a serious disaster (for example, an earthquake, hurricane, large fire, explosion)?

__ YES __ NO

a. How old were you when this happened? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? __ YES __ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? __ YES __ NO

e. How much has this affected your life in the past year?

__ 1 __ 2 __ 3 __ 4 __ 5
not at all some extremely

2. Have you ever seen a serious accident (for example, a bad car wreck or an on-the-job accident)?

__ YES __ NO

a. How old were you when this happened? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? __ YES __ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? __ YES __ NO

e. How much has this affected your life in the past year?

__ 1 __ 2 __ 3 __ 4 __ 5
not at all some extremely

3. Have you ever had a very serious accident-related injury (for example, a bad car wreck or an on-the-job accident)?

__ YES __ NO

a. How old were you when this happened? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? __ YES __ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? __ YES __ NO

e. How much has this affected your life in the past year?

__ 1 __ 2 __ 3 __ 4 __ 5
not at all some extremely

4. Was a close family member ever sent to jail?

__ YES __ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? __ YES __ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? __ YES __ NO

e. How much has this affected your life in the past year?

__ 1 __ 2 __ 3 __ 4 __ 5
not at all some extremely

5. Have you ever been sent to jail?

__ YES __ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? __ YES __ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

___ 1 ___ 2 ___ 3 ___ 4 ___ 5
not at all some extremely

6. Were you ever put in foster care or put up for adoption? ___ YES ___ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? ___ YES ___ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

___ 1 ___ 2 ___ 3 ___ 4 ___ 5
not at all some extremely

7. Did your parents ever separate or divorce while you were living with them? ___ YES ___ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? ___ YES ___ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

___ 1 ___ 2 ___ 3 ___ 4 ___ 5
not at all some extremely

8. Have you ever been separated or divorced? ___ YES ___ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? ___ YES ___ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

___ 1 ___ 2 ___ 3 ___ 4 ___ 5
not at all some extremely

9. Have you ever had serious money problems (for example, not enough money for food or place to live)?

___ YES ___ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? ___ YES ___ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

___ 1 ___ 2 ___ 3 ___ 4 ___ 5
not at all some extremely

10. Have you ever had a very serious physical or mental illness (for example, cancer, heart attack, serious operation, felt like killing yourself, hospitalized because of nerve problems)?

___ YES ___ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? ___ YES ___ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

__ 1 __ 2 __ 3 __ 4 __ 5
not at all some extremely

11. Have you ever been emotionally abused or neglected (for example, being frequently shamed, embarrassed, ignored, or repeatedly told that you were "no good")?

__ YES __ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? __ YES __ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? __ YES __ NO

e. How much has this affected your life in the past year?

__ 1 __ 2 __ 3 __ 4 __ 5
not at all some extremely

12. Have you ever been physically neglected (for example, not fed, not properly clothed, or left to take care of yourself when you were too young or ill)?

__ YES __ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? __ YES __ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? __ YES __ NO

e. How much has this affected your life in the past year?

__ 1 __ 2 __ 3 __ 4 __ 5
not at all some extremely

13. WOMEN ONLY: Have you ever had an abortion or miscarriage (lost your baby)?

__ YES __ NO

a. How old were you when this happened? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? ___ YES ___ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

___ 1 ___ 2 ___ 3 ___ 4 ___ 5
not at all some extremely

14. Have you ever been separated from your child against your will (for example, the loss of custody or visitation or kidnapping?

___ YES ___ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? ___ YES ___ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

___ 1 ___ 2 ___ 3 ___ 4 ___ 5
not at all some extremely

15. Has a baby or child of yours ever had a severe physical or mental handicap (for example, mentally retarded, birth defects, can't hear, see, walk)?

___ YES ___ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? ___ YES ___ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

___ 1 ___ 2 ___ 3 ___ 4 ___ 5
not at all some extremely

16. Have you ever been responsible for taking care of someone close to you (not your child) who had a severe physical or mental handicap (for example, cancer, stroke, AIDS, nerve problems, can't hear, see, walk)?

__ YES __ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? __ YES __ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? __ YES __ NO

e. How much has this affected your life in the past year?

__ 1 __ 2 __ 3 __ 4 __ 5
not at all some extremely

17. Has someone close to you died suddenly or unexpectedly (for example, sudden heart attack, murder or suicide)?

__ YES __ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? __ YES __ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? __ YES __ NO

e. How much has this affected your life in the past year?

__ 1 __ 2 __ 3 __ 4 __ 5
not at all some extremely

18. Has someone close to you died (do NOT include those who died suddenly or unexpectedly)?

__ YES __ NO

a. How old were you when this happened? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? ___ YES ___ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

___ 1 ___ 2 ___ 3 ___ 4 ___ 5
not at all some extremely

19. When you were young (before age 16). did you ever see violence between family members (for example, hitting, kicking, slapping, punching)?
___ YES ___ NO

a. How old were you when this happened? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? ___ YES ___ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

___ 1 ___ 2 ___ 3 ___ 4 ___ 5
not at all some extremely

20. Have you ever seen a robbery, mugging, or attack taking place?
___ YES ___ NO

a. How old were you when this happened? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? ___ YES ___ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

___ 1 ___ 2 ___ 3 ___ 4 ___ 5
not at all some extremely

21. Have you ever been robbed, mugged, or physically attacked (not sexually) by someone you did not know?
___ YES ___ NO

a. How old were you when this happened? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? ___ YES ___ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

___ 1 ___ 2 ___ 3 ___ 4 ___ 5
not at all some extremely

22. *Before* age 16, were you ever abused or physically attacked (not sexually) by someone you knew (for example, a parent, boyfriend, or husband, hit, slapped, choked, burned, or beat you up?

___ YES ___ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? ___ YES ___ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

___ 1 ___ 2 ___ 3 ___ 4 ___ 5
not at all some extremely

23. *After* age 16, were you ever abused or physically attacked (not sexually) by someone you knew (for example, a parent, boyfriend, or husband hit, slapped, choked, burned, or beat you up)?

___ YES ___ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? ___ YES ___ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

__ 1 __ 2 __ 3 __ 4 __ 5
not at all some extremely

24. Have you ever been bothered or harassed by sexual remarks, jokes, or demands for sexual favors by someone at work or school (for example, a coworker, a boss, a customer, another student, a teacher)?

__ YES __ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? __ YES __ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? __ YES __ NO

e. How much has this affected your life in the past year?

__ 1 __ 2 __ 3 __ 4 __ 5
not at all some extremely

25. *Before* age 16, were you ever touched or made to touch someone else in a sexual way because he/she forced you in some way or threatened to harm you if you didn't?

__ YES __ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? __ YES __ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? __ YES __ NO

e. How much has this affected your life in the past year?

__ 1 __ 2 __ 3 __ 4 __ 5
not at all some extremely

26. *After* age 16, were you ever touched or made to touch someone else in a sexual way because he/she forced you in some way or threatened to harm you if you didn't?

__ YES __ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? __ YES __ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? __ YES __ NO

e. How much has this affected your life in the past year?

__ 1 __ 2 __ 3 __ 4 __ 5
not at all some extremely

27. *Before* age 16, did you ever have sex (oral, anal, genital) when you didn't want to because someone forced you in some way or threatened to hurt you if you didn't?

__ YES __ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? __ YES __ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? __ YES __ NO

e. How much has this affected your life in the past year?

__ 1 __ 2 __ 3 __ 4 __ 5
not at all some extremely

28. *After* age 16, did you ever have sex (oral, anal, genital) when you didn't want to because someone forced you in some way or threatened to harm you if you didn't?

__ YES __ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? ___ YES ___ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

___ 1 ___ 2 ___ 3 ___ 4 ___ 5
not at all some extremely

29. Are there any events we did not include that you would like to mention?
___ YES ___ NO

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? ___ YES ___ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

___ 1 ___ 2 ___ 3 ___ 4 ___ 5
not at all some extremely

30. Have any of the events mentioned above ever happened to someone close to you so that even though you didn't see it yourself, you were seriously upset by it?
___ YES ___ NO

What was the event? _____

a. How old were you when this happened? _____

b. How old were you when this ended? _____

c. At the time of the event did you believe that you or someone else could be ***killed*** or seriously ***harmed***? ___ YES ___ NO

d. At the time of the event did you experience feelings of ***intense*** helplessness, fear, or horror? ___ YES ___ NO

e. How much has this affected your life in the past year?

___ 1	___ 2	___ 3	___ 4	___ 5
not at all		some		extremely

Parental Attitudes Toward Psychological Services Inventory – PATPSI

Directions: For each item, indicate whether you *strongly disagree (0), disagree (1), somewhat disagree (2), somewhat agree (3), agree (4),* or *strongly agree (5)*. The term "psychological problems" refer to reasons one might visit a professional. Similar terms include: mental health concerns, emotional problems, mental troubles, and personal difficulties. The term "professional" refers to individuals who have been trained to deal with mental health problems (e.g., psychologist, psychiatrist, social workers, and physicians).

0 strongly disagree	1	2	3	4	5 strongly agree

1.	I would not want others (friends, family, teachers, etc.) to know if my child has a psychological or behavior problem.	0	1	2	3	4	5
2.	To avoid thinking about my child's problems, doing other activities is a good situation.	0	1	2	3	4	5
3.	Having been mentally ill carries with it feelings of shame.	0	1	2	3	4	5
4.	If my child were experiencing a serious psychological or behavior problem at this point in my life, I would be confident that I could find relief in professional help.	0	1	2	3	4	5
5.	If my child were to experience a psychological or behavior problem, I would get professional help if I wanted to.	0	1	2	3	4	5
6.	Important people in my life would think less of my child if they were to find out that he/she had a psychological or behavior problem.	0	1	2	3	4	5
7.	Psychological problems tend to work out by themselves.	0	1	2	3	4	5
8.	It would be relatively easy for me to take my child to see a professional for help.	0	1	2	3	4	5
9.	I would want to get professional help if my child were worried or upset for a long period of time.	0	1	2	3	4	5
10.	I would be uncomfortable seeking professional help for my child because people (friends, family, coworkers, etc.) might find out about it.	0	1	2	3	4	5
11.	I would not want to take my child to a professional because what people might think.	0	1	2	3	4	5
12.	There is something admirable in the attitude of people who are willing to cope with their conflicts and fears without seeking professional help.	0	1	2	3	4	5

0 strongly disagree	1	2	3	4	5 strongly agree

13. If I believed my child were having a mental breakdown, my first decision would be to get professional help.	0	1	2	3	4	5
14. I would feel uneasy going to a professional because of what some people would think.	0	1	2	3	4	5
15. Strong willed individuals can handle emotional or behavior problems without needing professional help.	0	1	2	3	4	5
16. Had my child received treatment for a psychological or behavior problem, I would feel that it should be "kept secret"	0	1	2	3	4	5
17. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with mental health concerns.	0	1	2	3	4	5
18. People should work out their own problems instead of getting professional help.	0	1	2	3	4	5
19. There are things that happen in my family I would not discuss with anyone.	0	1	2	3	4	5
20. Seeking professional help is a sign of weakness.	0	1	2	3	4	5
21. Strong willed parents can handle problems without professional help.	0	1	2	3	4	5

THERAPY ATTITUDE INVENTORY*

(Please circle the response for each question which best expresses how you honestly feel)

I. Regarding techniques of disciplining, I feel I have learned

1. nothing	2. very little	3. a few new techniques	4. several useful techniques	5. very many useful techniques

II. Regarding techniques for teaching my child new skills, I feel I have learned

1. nothing	2. very little	3. a few new techniques	4. several useful techniques	5. very many useful techniques

III. Regarding the relationship between myself and my child, I feel we get along

1. much worse than before	2. somewhat worse than before	3. the same as before	4. somewhat better than before	5. very much better than before

IV. Regarding my confidence in my ability to discipline my child, I feel

1. much less confident	2. somewhat less confident	3. the same	4. somewhat more confident	5. much more confident

V. The major behavior problems that my child presented at home before the program started are at this time

1. considerably worse	2. somewhat worse	3. the same	4. somewhat improved	5. greatly improved

VI. I feel that my child's compliance to my commands or requests is at this time

1. considerably worse	2. somewhat worse	3. the same	4. somewhat improved	5. greatly improved

VII. Regarding the progress my child has made in his/her general behavior, I am

1. hindered much more than helped	2. hindered slightly	3. neither hindered nor helped	4. helped somewhat	5. helped very much

VIII. To what degree has the treatment program helped with other general personal or family problems not directly related to your child in the program?

1. hindered much more than helped	2. hindered slightly	3. neither hindered nor helped	4. helped somewhat	5. helped very much

IX. I feel the type of program that was used to help me improve the behaviors of my child was

1. very poor	2. poor	3. adequate	4. good	5. very good

X. My general feeling about the program I participates in, is

1. I disliked it very much	2. I disliked it somewhat	3. I feel neutral	4. I liked it somewhat	5. I liked it very much

SRPP Caregiver Satisfaction Survey

1. I would recommend this program to others

- ○ Strongly agree
- ○ Agree
- ○ Agree somewhat
- ○ Neutral
- ○ Disagree somewhat
- ○ Disagree
- ○ Strongly disagree

2. What do you like best about the program?

_____
_____
_____
_____
_____

3. What do you wish you could change about the program?

_____
_____
_____
_____
_____

4. The bonding/attachment that I feel with my preschooler since I took this program is:

- ○ Considerably Worse
- ○ Worse
- ○ Slightly worse
- ○ the same
- ○ Slightly improved
- ○ Improved
- ○ Greatly improved

---

5. My expectations for good results from the School Readiness Parenting Program are:

- ○ Very doubtful
- ○ Doubtful
- ○ Slightly doubtful
- ○ Neutral
- ○ Slightly hopeful
- ○ Hopeful
- ○ Very hopeful

---

6. How confident are you in parenting at this time?

- ○ Very unconfident
- ○ Unconfident
- ○ Slightly unconfident
- ○ Neutral
- ○ Slightly confident
- ○ Confident
- ○ Very confident

---

7. My overall feelings about achieving my goal in this program for my child and family is:

- ○ Very negative
- ○ Negative
- ○ Slightly negative
- ○ Neutral
- ○ Slightly positive
- ○ Positive
- ○ Very positive

School Readiness Parenting Program
Focus Group/Individual Interview

Introduction script

*modify based on whether or not the session is one-on-one or group

Good [morning/afternoon] and welcome. Thanks for taking the time to join our discussion about the weekly parenting group you all participated in [insert month]. The purpose of today's discussion is to get information from you about how to make sure we can make the parenting strategies group meaningful for future families. You were invited because you successfully completed the program and we value your dedication to helping your child prepare for the transition to kindergarten. There are no right or wrong answers to the questions I am about to ask. We expect that you will have differing points of view. Please feel free to share your point of view even if it differs from what others have said. If you want to follow up on something that someone has said, you want to agree, disagree, or give an example, feel free to do that. Don't feel like you have to respond all the time. Feel free to have a conversation with one another about these questions. I am here to ask questions, listen, and make sure everyone has a chance to share. We're interested in hearing from each of you. So, if you're talking a lot, I may ask you to give others a chance. And if you aren't saying much, I may call on you. We just want to make sure we hear from all of you. Feel free to get up and get more refreshments if you would like. I will be taking notes to help remember what is said. We are also audio recording the session because we don't want to miss any of your comments. I know some of you attended the same weekly session, but it's been awhile since we were all in the same room, so I'd like to begin by having each person in the room tell us their name and their child's name.

Questions

1. What were your expectations for/impressions of the parenting group? Were they met?

2. What did you find helpful/unhelpful? Why?

3. What did you like/dislike? Why?

4. What would you keep/remove/add?

5. How could group leaders make the parenting strategies group more engaging?

6. Having completed the parenting strategies group, what do you think incoming parents need to know?

7. How did you feel about the school readiness topics covered (e.g., socioemotional, adaptive, academic)?

8. How did you feel about the discipline strategies presented (e.g., ignoring, time-out)?

9. How did the timing/day of week of sessions impact your ability to participate?

10. In what ways can the program be improved to be implemented during the school year?

VITA

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2018	Center for Child and Families (CCF) Seed Fund Grant Florida International University Miami, Florida
2017 – Present	Doctoral Candidate in Clinical Psychology Florida International University Miami, Florida
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SELECTED PUBLICATIONS AND PRESENTATIONS

Hart, K. C., Poznanski, B., Cheatham-Johnson, R., Gregg, D., Zambrana, K., Villodas, F., & Villodas, M. (2019, November). Evaluating the Transportability of the STP-PreK to an Authentic Early Childhood Education Setting for Children Living in Urban Poverty. Paper presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, Atlanta, GA.

Zambrana, K. A., Hart, K. C., Maharaj, A., Cheatham-Johnson, R. J., & Waguespack, A. (2019). Latino parent involvement and associations with home literacy and oral reading fluency. *School Psychology Quarterly*. http://dx.doi.org/10.1037/spq0000298

Cheatham-Johnson, R. J. & Hart, K. C. (2017, November). *Engaging families living in urban poverty in behavioral parent training*. Symposium presented at the Association for Behavioral and Cognitive Therapies Annual Meeting, San Diego, CA.

Cheatham-Johnson, R. J., Hart, K. C., Waguespack, A.M., & Nichols-Lopez, K. A. (2017, April). *The role of culturally and linguistically diverse home literacy environments in the development of children's school readiness*. Poster presented at the Society for Research in Child Development Biennial Meeting, Austin, TX.

Bahrick, L., McNew, M., Todd, J., Martinez, J., Mira, S., Cheatham-Johnson, R. J., & Hart, K. C. (2017, April). *Individual differences in intersensory processing predict pre-literacy skills in young children*. Poster presented at the Society for Research in Child Development Biennial Meeting, Austin, TX.

Cheatham-Johnson, R., Poznanski, B., Scaramutti, C., & Hart, K.C. (2016, September). *Examination of associations between oral reading fluency and inattention/overactivity and opposition/defiant symptoms in young children at-risk for learning and behavior disorders*. Poster presented at the National Conference in Clinical Child and Adolescent Psychology Biennial Meeting, Lawrence, KS.

Hart, K. C., Graziano, P. A., Waguespack, A., & Cheatham-Johnson, R. (2015, March). *Evaluation of a summer school readiness parenting program for culturally and linguistically diverse families*. Poster presented at the Society for Research in Child Development Biennial Meeting, Philadelphia, PA.

Fite, P. J., Becker, S. P., Rubens, S. L., & Cheatham-Johnson, R. (2014). Anxiety symptoms account for the link between reactive aggression and sleep problems among Latino adolescents. *Child & Youth Care Forum*, *44*(3), 343-354. https://doi.org/10.1007/s10566-014-9288-4

Cheatham-Johnson, R. & Fite, P. J. (2014, October). *Potential factors contributing to attrition in after-school care programs*. Poster presented at the National Conference in Clinical Child and Adolescent Psychology Biennial Meeting, Lawrence, KS.