A Mixed-Methods Evaluation of a Universal Group Parenting Programme for Parents of Adolescents

Joanna Ting Wai Chu

2014

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy, The University of Auckland, 2014.

Abstract

Scholars and policy makers have repeatedly advocated for the need to adopt a public health approach to supporting parents of adolescents in order to improve family functioning and prevent or reduce rates of adolescent problem behaviours. The aim of the approach is to enhance parenting practices, competencies, and adjustment for all parents, and to promote the well-being of their adolescent at the population level. However, there remain many gaps in the current literature that need to be addressed before moving towards a successful public health approach. These include a lack of evidence-based parenting programmes for parents of adolescents, the lack of adolescent input in parenting intervention research, and finally a lack of social validation on parenting programmes. To justify the need for a public health approach to supporting parents of adolescents, this study aimed to fill gaps in the literature in relation to the efficacy and social validity of parenting programmes for parents of adolescents. A mixed-methods design was utilised to evaluate the impact of a universal group parenting programme designed specifically for parents of adolescents – Group Teen Triple P (GTTP). First, a randomised controlled trial was conducted to examine the efficacy of the programme with 72 families drawn from the community. Data on parent- and adolescent-related outcomes were collected from parents and adolescents at three time points (pre-, post-, 6-month follow up). The findings demonstrated that GTTP was effective in promoting positive parenting practices, reducing adolescent problem behaviours, and enhancing family functioning. Second, discussion groups were utilised to obtain parents' and adolescents' perspectives on the social validity of GTTP. The findings indicated that GTTP was beneficial and of value to parents and adolescents. Collectively, the findings suggest that parenting programmes such as GTTP are effective and socially valid for parents of adolescents. Implications for moving towards a public health approach are discussed in this thesis.

Acknowledgements

It is impossible to start … PhD was never part of my life plan; it was for 'clever' people. But as I have learnt through the years, hardly anything goes according to plan. I would not have been able to complete this journey without the support of countless people over the past years.

I owe a great debt of gratitude to my supervisors, Dr Pat Bullen and Associate Professor Robyn Dixon for agreeing to come on-board halfway through my PhD journey. Pat, you have provided the vision, encouragement, and advice necessary for me to complete this thesis. I could not have asked for a better role model; inspirational, supportive, and patient. Thank you for having faith when I didn't and for the many, many more that you have done. Robyn, thank you for your constant guidance and support, for keeping me on track, asking insightful questions, and offering invaluable advice. Thank you both for your dedication and encouragement that made this thesis possible.

I extend heartfelt thanks to Dr Susan Farruggia and Dr Cassandra Dittman, my former supervisors, who started me on this PhD journey. Both of you have helped and guided me through so many challenges of this research. Sue, your knowledge, passion, and energy, have always been a source of inspiration. I am forever grateful that you have been and still a part of this amazing journey. Cassy, your statistical knowledge, attention to detail, thoughtful suggestions, and continuous guidance have all made this thesis possible. I would also like to express my sincere gratitude to Professor Matthew Sanders, for his support and invaluable advice. Your work has been an inspiration as to what research can achieve.

I am sincerely grateful to the families that participated in this research. They have enlightened my knowledge of the field and illuminated the greater importance of supporting parents of adolescents. Their openness and willingness to inform this study is of significant value to others who will benefit from their contributions, my heartfelt thanks.

I have been very fortunate to be surrounded by an incredibly nice and collegial group of individuals in the Parenting Research Group, at the Faculty of Education. Dr Louise Keown and Dr Jenny Vaydich, their guidance and helpful suggestions have served me well and I own them my sincere appreciation. Tenille, Melanie, and Nike, you have all made

surviving this journey not only possible, but also one that is much more enjoyable. I look forward to findings ways to work together in the future.

In addition to the aforementioned colleagues, I would like to express my gratitude to all the academics and doctoral students that I have collaborated and worked with over the years. All of your enthusiasm and wealth of knowledge have broadened my eyesight beyond my own area of interest and provided me with ample research and work opportunities. Thank you so much.

Special thanks to the people at Triple P New Zealand and Triple P International, for their time and resources. A warm thank you goes to Margaret Weston for being extremely giving with her time and support. Her kindness and enthusiasm is deeply appreciated.

I would like to acknowledge the research support provided by the Auckland Council, funded by the Alcohol Advisory Council of New Zealand. Special thanks to Anna-Jane Jacob, Emma Solomon, Susie Trinh for their dedication and vision. Thanks also to Jane, Versity, and Sacha, for contributing their time and support to this research. A big thank you goes to all the organisations and professionals who assisted in distributing information about my research to families. This thesis was also made possible by the financial support provided through the University of Auckland Doctoral Scholarship.

On a personal note, thank you to all my friends whom have kept me sane and believed in me over the past years. I like to thank especially my dear friend Mei who has walked this journey with me. I cannot begin to express my gratitude and feeling for her. We've laughed, cried, drank, and among other things, cursed together. You know every fold of this journey, perhaps better than myself. For all these reasons and many, many more, I am forever grateful. Thank you for your constant reassurance that I am not alone. I also like to thank Margaret for her friendship, love, and support. We have been through so much together; no matter near or far, you have always stuck with me through thick and thin, wind and rain. Thank you for keeping me in your heart.

My deepest love and gratitude goes to the people closest to my heart – my family. For my mum, who instilled within me a love of education, science, and research. For giving me the freedom, support, and love that made this thesis possible. I owe you more thanks than I can ever put into words, as I do to the rest of my family - Aunt Collia, Carmana, Dexter,

Anthony, and Parker, for taking such good care of me, and for always being there. In particular, my second sister, Angie, it is without doubt that the tears you and I have shed in the past year can probably fill up a river, yet through the toughest of time; your unconditional love carries me through always. Thank you for keeping me strong. I also like to thank my darling Potato, for always greeting me with joy and never a word of complaint. You have made a place in my heart only you will ever occupy. Toffee, even though you have left, you have given me so much and I thank you for bringing so much joy and love into my life. Finally, thank you to my fiancé, Henry. Your tolerance of my frequent mood swings is a testament in itself of your unyielding devotion and love. You remind me daily of all that is yet to be.

The efforts of many were involved in this thesis, and it is my hope that the culmination of these efforts will result in taking one small step closer to supporting all parents of adolescents and promoting and shaping a better and healthier society for our future generations.

Table of Contents

List of Figures and Tables

Chapter 4

Chapter 5

Co-Authorship Form

This form is to accompany the submission of any PhD that contains research reported in published or unpublished co-authored work. **Please include one copy of this form for each co-authored work.** Completed forms should be included in all copies of your thesis submitted for examination and library deposit (including digital deposit), following your thesis Acknowledgements.

Please indicate the chapter/section/pages of this thesis that are extracted from a co-authored work and give the title and publication details or details of submission of the co-authored work.

Chapter 3 - Chu, J. T. W., Farruggia, S. P., Sanders, M. R., & Ralph, A. (2012). Towards a public health approach to parenting programmes for parents of adolescents. Journal of Public Health, 34(s1), i41-i47

Nature of contribution by PhD candidate	Conception and design, write up of manuscript
Extent of contribution by PhD candidate (%)	80
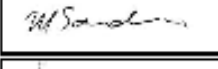
CO-AUTHORS

Name	Nature of Contribution
Dr Susan Farruggia	Conception and design, edited paper and provided feedback
Professor Matt Sanders	Conception and design, editied paper and provided feedback
Associate Professor Alan Ralph	Conception and design, editied paper and provided feedback

Certification by Co-Authors

The undersigned hereby certify that:
❖ the above statement correctly reflects the nature and extent of the PhD candidate's contribution to this work, and the nature of the contribution of each of the co-authors; and
❖ in cases where the PhD candidate was the lead author of the work that the candidate wrote the text.

Name	Signature	Date
Dr Susan Farruggia		13/02/2014
Professor Matt Sanders		25/02/2014
Associate Professor Alan Ralph		4/02/2014
		Click here
		Click here
		Click here

Co-Authorship Form

This form is to accompany the submission of any PhD that contains research reported in published or unpublished co-authored work. Please include one copy of this form for each co-authored work. Completed forms should be included in all copies of your thesis submitted for examination and library deposit (including digital deposit), following your thesis Acknowledgements.

Please indicate the chapter/section/pages of this thesis that are extracted from a co-authored work and give the title and publication details or details of submission of the co-authored work.

Chapter 5 - Chu, J. T. W., Bullen, P., Farruggia, S., Dittman, C., & Sanders, M. (2014). Parent and Adolescent Effects of a Universal Group Programme for th Parenting of Adolescents. Manuscript submitted for publication.

Nature of contribution by PhD candidate	Conception and design, data collection and anlysis, write up of manuscript
Extent of contribution by PhD candidate (%)	80
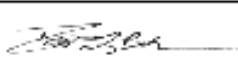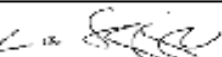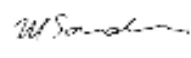
CO-AUTHORS

Name	Nature of Contribution
Dr Pat Bullen	Edited paper and provided feedback
Dr Susan Farruggia	Conception and design,edited paper and feedback
Dr Cassandra Dittman	Conception and design, statistical advice, edited paper and feedback
Professor Matt Sanders	Conception and design, edited paper and provided feedback

Certification by Co-Authors

The undersigned hereby certify that:
❖ the above statement correctly reflects the nature and extent of the PhD candidate's contribution to this work, and the nature of the contribution of each of the co-authors; and
❖ in cases where the PhD candidate was the lead author of the work that the candidate wrote the text.

Name	Signature	Date
Dr Pat Bullen		10/02/2014
Dr Susan Farruggia		13/02/2014
Dr Cassandra Dittman		18/02/2014
Professor Matt Sanders		25/02/2014
		Click here
		Click here

Graduate Centre
ClockTower – East Wing
22 Princes Street, Auckland
Phone: +64 9 373 7599 ext 81321
Fax: +64 9 373 7610
Email: postgraduate@auckland.ac.nz
www.postgrad.auckland.ac.nz

THE UNIVERSITY OF AUCKLAND
SCHOOL OF GRADUATE STUDIES

Co-Authorship Form

This form is to accompany the submission of any PhD that contains research reported in published or unpublished co-authored work. **Please include one copy of this form for each co-authored work.** Completed forms should be included in all copies of your thesis submitted for examination and library deposit (including digital deposit), following your thesis Acknowledgements.

Please indicate the chapter/section/pages of this thesis that are extracted from a co-authored work and give the title and publication details or details of submission of the co-authored work.

Chapter 6 - Chu, J. T. W., Bullen, P., Dixon, R., & Sanders, M. (2013). Evaluating the social validity of a universal group parenting programme for parents of adolescents. Manuscript in preparation

Nature of contribution by PhD candidate	Conception and design, data collection and analysis, write up of manuscript
Extent of contribution by PhD candidate (%)	80
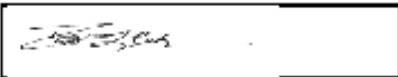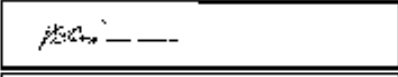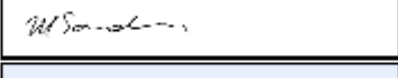
CO-AUTHORS

Name	Nature of Contribution
Dr Pat Bullen	Conception and design, edited paper and provided feedback
Associate Professor Robyn Dixon	Conception and design, editied paper and provided feedback
Professor Matt Sanders	Conception and design, editied paper and provided feedback

Certification by Co-Authors

The undersigned hereby certify that:
❖ the above statement correctly reflects the nature and extent of the PhD candidate's contribution to this work, and the nature of the contribution of each of the co-authors; and
❖ in cases where the PhD candidate was the lead author of the work that the candidate wrote the text.

Name	Signature	Date
Dr Pat Bullen		10/02/2014
Associate Professor Robyn Dixon		20/02/2014
Professor Matt Sanders		25/02/2014
		Click here
		Click here
		Click here

Chapter 1 – Introduction

Parenting adolescents is one of the most rewarding, yet demanding roles in our society. Parents are fundamental in influencing adolescent development, and the breakdown of family processes have consistently proved to be strongly associated with adolescent problem behaviours. The complexity of adolescent development, adolescent's propensity for risk taking, and vulnerability to problem behaviours clearly speaks to the need for supporting parents of adolescents (Steinberg, 2001). Importantly, the concerning rates of adolescent problem behaviours and the damaging consequences of such behaviours warrant effective prevention and intervention measures to be in place. Many scholars (e.g., Henricson & Roker, 2000; Steinberg, 2001) and policy makers (e.g., National Research Council and Institute of Medicine, 2009) have identified the need to support parents as a way of improving outcomes for adolescents. However, research has shown that this need often remains unmet and that there are very few evidence-based parenting programmes available for all parents of adolescents. This means that the majority of young people who are at risk of developing adolescent problem behaviours and the majority of parents who have concerns about everyday parenting issues, are left without support (Sanders, 2012; Bennett, Kang, Alperstein, & Kakakios, 2004; Spoth & Redmond, 2002). Therefore, the aim of this thesis is to evaluate the impact of a universal group parenting programme for parents of adolescents and to justify the need for a public health approach to parenting support.

This chapter provides a general introduction to the thesis. Firstly, it contains a broad overview of adolescent development including some of the developmental characteristics that are unique to the adolescent period. Secondly, it reports on the concerning prevalence rates of adolescent problem behaviours and argues that such behaviours constitute a public health concern. Thirdly, it highlights the need for effective prevention and intervention strategies to be instigated and advocates the need to adopt a public health approach to parenting support. The chapter concludes with the statement of the problem and an outline of the thesis.

1.1. Adolescent Development

In order to understand the issues faced by parents of adolescents there is a need to consider some of the developmental characteristics unique to the adolescence period. Adolescent development is a complex process and a time that involves multi-dimensional changes in the adolescent: biological, psychological, and social (Steinberg, 2008; Steinberg & Morris, 2001).

Biologically, adolescents experience pubertal changes. Trigged by the release of hormones, the onset of puberty is an intense developmental period. A cascade of hormones signals the development of primary sex characteristics (genitalia) and secondary sex characteristics (e.g., breast development in girls; facial hair in boys) during this period (Steinberg & Morris, 2001). These highly visible changes and disparate rates of maturity can cause many young adolescents to feel uncomfortable about the changes in physical appearances (Steinberg, 2005). Evidence from self-report data suggests that children seem to become progressively self-conscious and concerned with other people's opinions as they go through puberty (Steinberg, 2005).

Another important aspect to note is that the age of onset of puberty in Western society has markedly declined over the past two decades (Biro et al., 2010). The challenge with the rapid fall in the age of puberty is that, there is an increasing mismatch with those aspects of maturation (e.g., cognitive and social) which are independent of sex hormone effects (Gluckman, Low, & Franko, 2011). The perception that an individual looks mature and is advanced in puberty can lead to inappropriate assumptions about other aspects of their maturity and behaviour. This presumption can occur both in how others perceive the young individual and how the young individual perceives himself or herself (Gluckman et al., 2001). This has a number of implications for parents of adolescents which are discussed in later sections.

In addition to biological changes, psychological changes form another critical component to adolescent development. Psychosocially, identity formation is a key developmental task of adolescence (Erikson, 1972). As individuals begin their progression from childhood toward emerging adulthood, they may experience insecurity in their understanding of themselves or feel confused by interpretations of who they are that no longer match with previous notions of the self. Achievement of an individual's identity seems

to be a particularly complex task given the varying choices to be contemplated and the multitude of domains (i.e., profession, sexual, spiritual, etc.) from which these choices arise (Crocetti, Jahroi, & Meeus, 2012).

Although there are individual differences in cognitive development, adolescent develop greater capacity for complex thought processes (e.g., critical thinking, and reasoning; Steinberg, 2008). Recent advances in neuroscience on brain development indicate that the adolescent brain is less developed and more malleable than once assumed (Blakemore & Choudhury, 2006; Albert, Chein, & Steinberg, 2013). The late-maturing regions of the brain underpin the processes required for a range of cognitive activities, including attention span, perseverance, planning, problem solving, and critical thinking (Blakemore & Choudhury, 2006). Researchers argued that these late developmental changes in the brain regions seem to have consequences for adolescents' engagement in risk behaviours (Albert et al., 2013; Smith, Chein, & Steinberg, 2013). Steinberg (2008) further concluded that "heightened risk-taking (in adolescent) is likely to be normative, biologically driven and, to some extent, inevitable" (p. 100). These developmental changes suggest that compared with adults, adolescents decision making is more vulnerable to the influence of momentary emotions or social context (e.g., peers), and as a result adolescents are more prone to discounting the negative consequences of risky behaviours (Cauffman et al., 2010; Albert et al., 2013).

Finally, as children transit into adolescence, their social networks become wider and more complex encompassing the individual, peers, family, school, and community (Carter, McGee, Taylor, & Williams, 2007). Peer relationships take on greater importance and individuals increasingly conforms to peers' attitudes and behaviours (Brown, Bakken, Ameringer, & Mahon, 2008). Social maturity often lags behind biological and psychological development (Kellough & Kellough, 2008). Consequently, adolescents are often more socially vulnerable, than adults, to negative interactions with these social networks. Problematic behaviours can develop from, and be maintained by, these social network and lead to serious problem behaviours (Kellough & Kellough, 2008).

Owing to the unique confluence of biological, psychological, and social changes, adolescence can be a challenging period of life, not only for the adolescent but also for parents adjusting to the changing needs of the adolescent (Steinberg, 2001). Further, parenting influences all aspects of adolescent functioning (Dekovic′, Janssens, & van As, 2003). Consequently, when parenting deteriorates the likelihood of adolescent engaging in

problematic behaviours greatly increases (Ralph & Sanders, 2002; Dekovic′ et al., 2003). While only about one to ten percent of youth in the general population are estimated to meet diagnostic criteria for conduct disorder, many adolescent exhibit problem behaviours that impact their own well-being and other family related functioning (National Research Council and Institute of Medicine, 2009; Clark et al., 2013). Moreover, problem behaviours have powerful and damaging consequences on individuals, families, communities, and the society as a whole. These serious and costly adolescent problem behaviours are potentially preventable (Bennett et al., 2004; Chu, Farruggia, Sanders, & Ralph, 2012). The following section reports on the concerning prevalence rates of adolescent problem behaviours.

1.2. Adolescent Emotional and Behavioural Problems as a Public Health Issue

As noted previously, among the many changes that occur as children transit into adolescence is an increase in vulnerability to risk-taking and problem behaviour (Steinberg, 2001). Examples of externalising problem behaviours include: underage drinking, substance abuse, early initiation of sex, unprotected sex, self-harm, delinquency, violence, and truancy. Although experimentation with some of these behaviours may be considered part of a normative developmental process in which adolescents strive to assert their autonomy and gain peer acceptance, these behaviours maybe regarded as problematic by society because of the potential compromise to health and psychological well-being (Greenberg & Lippold, 2013; Steinberg, 2008). Many researchers have asserted that problem behaviours show a strong pattern of co-variation in adolescence (Greenberg & Lippold, 2013; Mann, Brima, & Stephenson, 2010). Adolescents who engage in one type of problem behaviour are likely to be involved in other types of problem behaviour. In addition, a vast body of research shows that internalising and externalising problems are closely related and often co-occur (Beyers & Loeber, 2003; Gilliom & Shaw, 2004). Internalising problems such as depression and anxiety in adolescents can result in significant impairments in functioning across a range of psychosocial domains, including social, academic, interpersonal relationships, and extracurricular functioning (Naghavi & Redzuan, 2012). Moreover, adolescents who exhibit internalising and externalising behaviours are at greater risk of subsequent extended and chronic patterns of physical, social, emotional, and behavioural problems in adulthood (Greenberg & Lippold, 2013; Mann et al., 2010).

By international standards, problem behaviours among New Zealand adolescents are high (OECD, 2011). The Youth '12 National Survey of the Health and Well-being of New Zealand Secondary School Students reported that 8% of students drink on a weekly basis or more, and about 23% reported binge drinking in the past 4 weeks, where binge drinking was defined as drinking more than five alcoholic drinks in four hours (Clark et al., 2013). Around 11% of students reported smoking at least occasionally, and almost 5% of students reported smoking weekly or more often. Cannabis is the most commonly used illicit drug in New Zealand and longitudinal studies reported that by the age of 21, an estimate of around 80% of young people would have used cannabis on at least one occasion, with 10% developing a pattern of heavy dependent use (Boden, Fergusson, & Horwood, 2011). New Zealand also has problematic social-health issues in relation to adolescent sexual behaviour, ranking fifth among OECD countries for rates of teenage pregnancy (OECD, 2011). There is also mounting concern about the level of self-harm (i.e., 29% of female students and 18% of male students had deliberately harmed themselves in the past year; Clark et al., 2013), and suicidal attempts among young people in New Zealand, with teenage suicide rate ranking high among other OECD countries (OECD, 2011). Finally, depressive disorder in adolescence is common, affecting at least a fifth of young people by the age of 18 (OECD, 2011).

Although recent New Zealand and International statistics have shown a decrease in some adolescent problem behaviours (e.g., substance abuse), their prevalence rate remains high, and taken together, represent a major public health concern (Clark et al., 2013; Johnston, O'Malley, Bachman, & Schulenberg, 2009; Miller, Levy, Spicer, & Taylor, 2006; Zagar, Zagar, Bartikowski, & Busch, 2009). Short and long term consequences of such problem behaviours during adolescence are particularly significant in terms of health and social integration (Johnston et al., 2009; National Research Council and Institute of Medicine, 2009; Miller et al., 2006). These consequences are reflected in significant emotional costs to families and individuals, and in major costs for many government agencies including social welfare, justice, education, police, and corrections (National Research Council and Institute of Medicine, 2009; Zagar et al., 2009). Given the significance of the problem, finding effective ways to reduce and prevent adolescent problem behaviour is a matter of high priority for scholars, policy makers and government agencies (Chu et al., 2012). Parents, who have repeatedly been shown to play a significant role in adolescent development, are important targets for prevention and intervention programmes aiming to

reduce problem behaviours and improve the well-being of adolescents (Ralph & Sanders, 2002; Steinberg, 2001).

1.3. The Need to Support Parents of Adolescents

Adolescent development is a complex process and represents a time of significant change for adolescents (Steinberg & Morris, 2001). For parents, this period can be stressful as they adjust to the changing needs of their adolescent. Parents are confronted with developmental and social challenges that are not present or relevant when children are young (Odgers, Caspi, Russell, Sampson, Arsenault, & Moffitt, 2012; Steinberg, 2001). Parents, also come with their own vulnerabilities that may interfere with the parenting process. This section focuses on the unique challenges of parenting adolescents.

1.3.1. Developmental characteristics

During adolescence, parents are required to adjust to their child's developmental transition within the context of their own personal lives (Silverberg & Steinberg, 1990). Studies reported that many parents have at least some difficulty coping with the developmental challenges posed by their adolescent, regardless of the extent to which their adolescent is experiencing difficulty themselves (Grotevant, 1998; Morris, Cui, & Steinberg, 2012). Research has pointed to a minefield of potential sources of psychological stress for parents of adolescents (Grotevant, 1998). These include but are not limited to adolescents' striving for independence, increased vulnerabilities to risk taking, and increased peer influence.

1.3.1.1. Striving for autonomy

Adolescent development (i.e., biological, psychological, and social) occurs simultaneously and creates varying demands on parents at varying times (Steinberg, 2001). For example, adolescents desire a high level of support from parents and at the same time want parents to be adaptive and responsive to their changing needs (Nucci, Hasebe, & Lins-Dyer, 2005). Adolescents naturally strive to become more independent from their parents and establish their own identity by seeking a greater amount of control over their lives and decision making. Often this individuation process involves adolescents' challenging parents' authority, de-idealisation of parents, and increased emotional separation (Nucci et al., 2005).

During this period, parents may go through a process of diminishing worth and respect from the perspective of their adolescent, which might be difficult for many to cope with (Morris et al., 2012).

1.3.1.2. Regulating emotions

The prevalence of various forms of psychopathology that are characterised by deficits in emotional processing (e.g., depression) increases dramatically during the adolescent period (Naghavi & Redzuan, 2012). Adolescents adapting to the changes from academic (e.g., transiting into high school), peers (e.g., forming new relationships), and family (e.g., renegotiating family relationships) can create a heavy emotional burden for the individual. The skill of emotional regulation is therefore necessary in order for adolescents to regulate their emotional processes to effectively respond to a range of situations (Gar, Hudson, & Rapee, 2005). Parents remain as one of the most influential sources by which adolescents learn to label, identify, and interpret emotions (Naghavi & Redzuan, 2012). Parents can influence the socialisation of adolescent emotion regulation through their direct reactions to adolescent emotions, parents' own expression of emotions, and parental conversations with adolescents about emotions (Eisenberg, Cumberland, & Spinard, 1998). Family factors such as lack of parental warmth and involvement, serious and prolong family conflict, and negative parent-adolescent relationship has further been associated with deficits in emotional processing and the development of internalising problems (Gar et al., 2005). Parents, therefore, play an important role in promoting and fostering emotional competence in adolescents (Naghavi & Redzuan, 2012).

1.3.1.3. Increased vulnerabilities to risk taking

Although increased propensity for risk behaviours is a general feature of adolescence, epidemiologic studies indicate that certain parenting practices can further elevate risk (See Chapter 2). Researchers have divided adolescent problem behaviours into two different patterns based on onset, persistence, and desistance (Moffitt, 1993; Moffitt, Caspi, Harrington, & Milne, 2002). Life-course-persistent individuals start to engage in problem behaviour as young children and continue to elevate in problem behaviour as they age. During adolescence, these individuals often engage in serious delinquent acts and problem behaviours. These behaviours do not subside and continue onto adulthood. On the other hand, adolescent-limited, describes individuals that do not have a history of childhood problem

behaviours but only engage in problematic behaviours during adolescence. Moffitt hypothesised that the life-course-persistent pathway is predicted by the combination of early individual vulnerability (i.e., executive control deficits of self-regulation) and disrupted early parenting processes, whereas the adolescent-limited pathway is predicted primarily by disrupted family processes and peer relationship risks (Frick & Viding, 2009; Moffitt, 1993). Dysfunctional parenting practices such as poor parental monitoring and inconsistent discipline have been shown to be strong predictors of problem behaviours during adolescence (Dishion & Patterson, 2006; Kerr, Stattin, & Burk, 2010; Morris et al., 2012). Given strong evidence for an adolescent-onset trajectory to problem behaviours (Frick & Viding, 2009), the task of adequately monitoring adolescent behaviours becomes simultaneously more difficult and more important for parents.

1.3.1.4. Increased peer influence

It is often proposed that during adolescence, peers become increasingly important, while parental influence diminishes. Adolescents often search for their social position within their peer group and conform to the expectations of their peers. This may include experimenting with and engaging in risky behaviours (Laursen, Hafen, Kerr, & Stattin, 2011). Numerous researchers have documented the influence of peers with adolescent problem behaviours (e.g., Albert et al., 2013; Laursen et al., 2011; Steinberg, Fletcher, & Darling, 1994). Nonetheless, research continues to show that parents remain instrumental in adolescent development, particularly as a source of supervision, guidance, and protection (Morris et al., 2012; Williams et al., 2009; Ryan, Jorm, & Lubman, 2010). For example, studies have revealed that peer influence become particularly powerful when there is inadequate level of parental monitoring and supervision (Lausen et al., 2011; Steinberg et al., 1994). Efforts of parents to monitor and set limits and boundaries to peer activities are therefore important in delaying or reducing exposure to risky peer contexts (Kerr et al., 2010; Morris et al., 2012).

1.3.2. Social challenges

Adding to the complexity of developmental changes, the societal context in which parent and adolescent redefine their relationship also undergoes changes that possess unique challenges to parents. The section below presents some of these challenges.

1.3.2.1. Negative portrayal of the adolescent years

Studies by Buchanan and Holmbeck (1998), among others (Duffet, Johnson, & Farkas, 1999; Hines & Paulson, 2006), have found that the general public, including parents of adolescents, view adolescence as a period of strife. There is an overwhelmingly negative stereotype attributed to adolescence in many Western societies, particularly through the media, in which problematic behaviours are seen as the norm for the adolescent population (Faucher, 2009). This has a range of unfortunate consequences. For example, parents may create assumptions and expectations about the adolescent period, focusing predominantly on problem behaviours, which can lead to greater parental anxiety and undermine parental competence (Hines & Paulson, 2006). Furthermore, problematic behaviours have often been portrayed by the popular culture as a result of 'failed' parenting. This can create significant stress for parents of adolescents and a culture of blame, in which parents are seen as the cause of adolescent problem behaviours (Corrigan, Watson, & Miller, 2006).

1.3.2.2. Increasing diversity of family structures

There is an increasing diversity in family structures over the last century that presents further challenges for parents today. These include but are not limited to, increase in divorce families, increase in the number of single-parent families, and increase in the number of step-parent families (Cavanagh & Huston, 2008). Although many adolescent may never experience family transitions, those who experience one family transition are at a greater risk for subsequent transitions and their associated stress (Wu & Thomson, 2001). Studies have shown that family transitions are associated with increased problematic behaviours across all stages of child development (Cavanagh & Huston, 2008; Cavanagh, Crissey, & Raley, 2008; Wu & Thomson, 2001). These diversities that exist in regard to family dynamics can all have pervasive implications for parent and adolescent outcomes (Cavanagh et al., 2008).

1.3.2.3. Changing nature of the adolescents' social world

In addition to changes in family structures, new information technology has also created new contexts in which parent-adolescent relations are being influenced (i.e., internet access, instant communication). For example, the internet creates extraordinary informational freedom and changes the nature of social interaction among individuals (Gross, Juvonen, & Gable, 2002; Livingstone & Helsper, 2010). As a social context, the internet enables multiple

communication functions (e.g., email, instant messaging, and blogs), and provides tremendous opportunities for adolescent socialisation (Livingstone & Helsper, 2010). However, several researchers have reported negative association between internet use and the quality of parent-adolescent relationships. Adolescents who spend more time on the internet were associated with less family time, poorer quality of parent-adolescent relationships, and greater paternal alienation (Richards, McGee, Williams, Welch, & Hancox, 2010; Lei & Wu, 2007).

In addition, as discussed earlier, adolescents are now experiencing earlier onset of puberty, and evidence suggest that the brain regions affecting cognitive development are less well developed than once assumed (Blakemore & Choudhury, 2006; Smith et al., 2013; Albert et al., 2013). This makes marketing and media that are aimed directly or indirectly at young people particularly worrisome for adolescents and parents. Studies have demonstrated that the media contains a high content of risk behaviours, such as alcohol consumption and sexuality that have a significant influence on adolescents' behaviour (Strasburger, 2010; Anderson, de Bruijn, Angus, Gordon, & Hastings, 2009) and have led to greater ambiguity regarding boundaries of socially acceptable behaviours among adolescents. Parents are faced with greater responsibility in monitoring and supervising adolescent media use. The role of parents in fostering adolescent cognitive development (i.e., moral reasoning and ethical judgements) in counteracting the negative or harmful content introduced by the media that can lead to engagement in risky adolescent behaviours becomes more important.

1.3.3. Additional Stressors

Even within families with few risk factors (i.e., well-functioning families), parents can struggle with striking a balance in fostering autonomy and independence, and at the same time setting limits and monitoring adolescents' behaviours. For some parents, the developmental challenges are coupled with additional life stressors that can lead to negative implications not only for the parent, but the family as a whole (Eamon, 2002; Odgers et al., 2012). For example, economic hardship and parent antisocial behaviours, can impact on parents' ability to parent adolescents (Eamon, 2002; Odgers et al., 2012).

Yoshikawa and colleagues (2012) discussed the critical role of poverty in increasing stress and producing a range of negative outcomes for parents and adolescents. More specifically, impoverished circumstances often perpetuate multiple problems, such as

unstable family relationships, social isolation, unemployment, and poor parental mental health (Forehand et al, 1991; Yoshikawa, Lawrence, & Bewardslee, 2012). These multiple adversities, along with the on-going strain of financial worries, increase the frequency of arguments between parents, as well as between parents and their adolescents. These conflicts, in turn, amplify the stress parents and their children face on a day-to-day basis (Johnston et al, 2009; Yoshikawa et al., 2012; Macmillan, McMorris, & Krutschnitt, 2004).

Moreover, adolescent with parents exhibiting antisocial behaviours are at significantly higher risk for developing antisocial behaviours themselves (Dishion, Owen, & Bullock, 2004). Adolescents may learn and engage in problem behaviours through modelling or even reinforcement of problem behaviours through parents (e.g., parents providing easy access to alcohol; Dishion et al., 2004). In addition, antisocial behaviours in parents can interfere with parenting process and their capacity to provide appropriate care for their children (Keijsers, Frijns, Branje, & Meeus, 2009). For example, studies have found an association between parental substance abuse and negative adolescent behaviours (e.g., adolescent substance abuse and depression; Ross & Hill, 2001; Ohannessian, Hesslebrock, Kramer, Kuperman, Bucholz, Schuckit, & Numberger, 2004).

1.4. Putting it All Together – What is Needed

The widespread concern about the rates of adolescent problem behaviours coupled with the challenges that parents are confronted with points to the need to support parents of adolescents. Many of the challenges that parents of adolescents face are universal, hence, all parents of adolescents are likely to benefit from support that provides information and skills to enhance family functioning and well-being (Steinberg, 2001). Adolescent problem behaviours are also more likely to be prevented or reduced when parents are provided with support and information that enables them to be optimally responsive to their adolescent (Kumpfer & Alvarado, 2003). In addition, for some families, additional stressors (e.g., poverty) may further undermine parents' parenting ability, and subsequently increases the risk for adolescents to engage in problematic behaviours (Odgers et al., 2012). Adolescence is therefore a key period during which the introduction of effective prevention and intervention strategies is of paramount importance (Morris et al., 2012; Ralph & Sanders, 2002). As Steinberg (2001) concluded in his presidential address to the Society for Research on

Adolescence, it is "time to be as vigorous and serious in our efforts to educate parents of teenager as we have been in past efforts to educate parents of infants" (p. 16).

1.5. Parenting Programmes for Parents of Adolescents

Effective parenting is the most powerful way in preventing and reducing adolescent problem behaviours (Kumpfer & Alvarado, 2003; Steinberg, 2001). Thus, the provision of parenting programmes represents an important pathway to improving outcomes for adolescents (Spoth, Trudeau, Guyll, Chungyeol, Redmond, 2009; Ralph & Sanders, 2002; Henricson & Roker, 2000). Parenting programmes can target those family and parenting factors that play an important role in determining the development and maintenance of behavioural problems during adolescence (Spoth et al., 2009). A slowly growing body of research on parenting programmes have attested to the value of such programmes (See Chapter 2).

However, despite its effectiveness, parenting programmes reach only a small percentage of the parenting population (Sanders, 2012). There appears to be a common perception by the society that parents are naturally equipped to take on the task of parenting. Thus, many parents receive little or no preparation for parenthood other than their personal experience with their family (Sanders, 2012). Furthermore, as stated previously, the stereotyping of adolescence as problematic is pervasive (Faucher, 2009). This emphasis on young people as problems have often led to research focusing on high risk behaviours and subsequently less research aimed at parents in general, with everyday concerns. Many parents of adolescents are left without the support and information on the normative changes and parenting issues of adolescence that they need (Heneghan, Mercer, & DeLeone, 2004; Sayal et al., 2010). Surveys conducted with a diverse population suggest that all parents report a desire to learn about parenthood, and that many families would welcome additional support on the task of parenting (Sayal et al., 2010; Ralph, Toumbourou, Grigg, Mulcahy, Carr-Gregg, & Sanders, 2003). The challenge then is to improve the reach and participation of families in parenting programmes at a population level thereby to enhance the competence and confidence of parents in raising their children (Biglan, Mrazek, Carnine, & Flay, 2003; Sanders, 2012).

1.6. Towards a Public Health Approach to Supporting Parents of Adolescents

One recommended strategy for parenting programmes to maximise population reach, is to adopt a public health approach (Sanders, 2012; Spoth, Greenberg, & Turrisi, 2008; Prinz, 2009). The rationale and need for this approach is discussed in Chapter 3. The following section briefly describes some key features of a public health approach to parenting support for parents of adolescents. These include a focus on the entire population, an emphasis on prevention, a comprehensive model (universal, selected, and indicated interventions), and firmly grounded in an evidence-based framework.

The notion of prevention for supporting parents of adolescents argues that even if adolescents are not presently engaged in problem behaviours, this does not mean that they would not engage in problem behaviours in the future (Pittman & Irby, 1996). Addressing and modifying risk factors using a preventative approach can therefore lead to greater health outcomes (Spoth et al., 2008). Universal programmes are designed for all members of an eligible population regardless of their risk status and level of concerns (e.g., all parents in a community). This strategy targets the entire population with the aim of preventing the development of adverse adolescent outcomes. Research repeatedly suggests that preventative universal services are far more likely to improve adolescent trajectories than targeted crisis interventions, since problems are often deeply entrenched once interventions are required (Kumpfer & Alvarado, 2003; Ralph & Sanders, 2002). Furthermore, offering universal programmes are more likely to reduce the potential of stigma attached to programmes for parents who are deemed to be failing (Spoth, Kavangh, & Dishion, 2002).

Nonetheless, selected and indicated services are equally important for families with elevated risk. When serious problems do develop, they often require intensive levels of support which are flexible and responsive to a wide range of needs. Selected interventions are designed for specific subgroups of the general population that are believed to be at greater risk than others for developing problems (e.g., families living in an impoverished neighbourhood). In addition, indicated parenting programmes are delivered to families with adolescents showing severe emotional and/or behavioural problems which are often complicated by additional family adversity factors. Hence, a public health approach that includes multiple levels (universal, selected, and indicated) of parenting support will better serve the needs of a diverse population. This will also increase the reach of parenting

programmes to the entire populations rather than solely targeting individuals (Sanders, 2012; Prinz, 2009).

A public health approach to parenting support is also based on the premises that parenting programmes implemented at the population level are evidence-based (Small, Cooney, & O'Connor, 2009). Programmes should be subjected to rigorous evaluations and demonstrated effectiveness in improving outcomes for parents and adolescents. Evaluations should be designed to provide a clear, rigorous, and critical assessment of the impact and effect of the programme (Powell, 2013). In the absence of an evidence-based framework to inform the implementation of parenting programmes, such programmes are typically not based on evidence, and have not been rigorously evaluated. This means that a considerable amount of time and resources may have been wasted as a result of services delivering potentially ineffective parenting programmes (Kumpfer & Alvarado, 2003).

1.7. Statement of the Problem

Scholars and policy makers have repeatedly advocated for the need to adopt a public health approach to supporting parents of adolescents in order to improve family functioning and prevent or reduce rates of adolescent problem behaviours (e.g., Sanders, 2012; Shek & Yu, 2011; Biglan et al., 2003; Prinz, 2009). However, there remain many gaps in the current literature that needs to be addressed before moving towards a successful public health approach. The present thesis attempts to address these gaps and to justify the need for a public health approach to parenting programmes for parents of adolescents.

1.8. Outline of the Thesis

This chapter has set out the premises of the study. Chapter 2 begins with a review of the literature on family and parenting factors that are associated with adolescent outcomes. The current evidence base for parenting programmes for parents of adolescents is then presented. The chapter concludes with a discussion on a challenging issue on parenting programmes, namely, low population reach. Chapter 3 presents a manuscript that argues for the importance of a public health approach to parenting programmes for parents of adolescents. Chapter 4 outlines the overall methodology. A background of the chosen parenting programme for evaluation - Triple P (Positive Parenting Program) is presented, including the Teen component of the programme. Chapter 5 presents the second manuscript

that addresses a randomised controlled trial (RCT) to examine the efficacy of a universal group parenting programme - Group Teen Triple P (GTTP). The short term and follow up intervention effects of GTTP on parent and adolescent self-reported outcomes are presented and implications are discussed. Chapter 6 builds on the previous study utilising a qualitative approach to examine both parent' and adolescent' perspectives on GTTP and gather information that are otherwise not captured through the first quantitative study. This study is presented as the third manuscript. The final discussion chapter integrates the findings of both studies and examines their contribution to the wider literature. Limitations and suggestions for future research are also discussed.

Chapter 2 – Literature Review

The previous chapter provided a broad overview of adolescent development including some of the developmental characteristics unique to the adolescence period. It reported on the concerning rates of adolescent problem behaviours and the damaging consequences of such behaviours to the individual, family, and the society. It also presented the challenges that parents are confronted with during their child's transition into adolescence. Together, the information highlighted the need for effective prevention and intervention strategies to be in place and provided a rationale for the need to support parents of adolescents.

In order to identify support strategies for parents, it is essential to have an understanding of the factors that place adolescents at risk of, or contribute to the development of problem behaviours in the first place. This chapter begins with a discussion on family and parenting factors that are associated with negative adolescent outcomes. This is then followed by a review of the literature concerning family-based interventions for parents of adolescents. Evaluations of prevention and intervention programmes that target parenting specifically are presented. The chapter concludes with a discussion on a challenging issue in family-based intervention: low population reach.

2.1. Why Parents Matter: A Brief Review of the Literature

Literature indicates that there are many factors that protect against the engagement in problem behaviours, or that escalate problem behaviours in the absence of protective factors (Flannery, Hussey, & Jefferis, 2005; Dishion & Patterson, 2006). Although many social and environmental factors (e.g., peers and school) play an important role in adolescent development, the family is the most prominent, persistent, and proximal developmental influence for adolescents (Steinberg, 2001). Certain patterns of parenting practice and quality of family relationships have been systematically linked with adolescent outcomes (Kiesner, Poulin, & Dishion, 2010; Kotchick, Shaffer, Miller, & Forehand, 2001). More specifically, family relationships including parent-adolescent relationship and marital relationship, parenting practices, parental monitoring, parental self-efficacy, and parental adjustment are well-established predictors of youth developmental outcomes (Dishion & Patterson, 2006;

Flannery et al., 2005; Shanahan, Mchale, Osgood, & Crouter, 2007; Kiesner et al., 2010). These factors can impact a range of adolescent risk behaviours such as association with deviant peers (Dishion, Patterson, Stoolmiller, & Skinner, 1991), onset and escalation in deviant behaviours (Dishion & Patterson, 2006), early onset of substance use and substance abuse (Keisner et al., 2010; Ryan et al., 2010), increased conflict in romantic relationships (Andrews, Capaldi, Foster, & Hops, 2000), poor academic performance and completion (Dumka, Gonzales, Bonds, & Millsap, 2009), and engagement in sexual risk behaviours (Kotchick et al., 2001). Due to their salience to adolescent development, these family factors are given specific attention in the following section.

2.1.1. Quality of family relationships

As briefly stated in Chapter 1, the transition from child to adolescent represents a time of significant change in family relationships (Steinberg, 2001). For healthy development to occur, adolescents need to establish a greater sense of self-sufficiency by renegotiating family rules and the degree of supervision and monitoring by parents (Steinberg, 2001; Dishion, Nelson, & Kavanagh, 2003; Petrie, Bunn, & Byrne, 2007). For parents too, this developmental period is often a time of apprehension and anxiety, involving negotiation of changing relationships with adolescents and also dealing with increased risk taking and vulnerability to adolescent problem behaviours (Ralph & Sanders, 2003). This change in family relationships is often accompanied by an increase in conflict within the family, including parent-adolescent conflict and marital conflict (Shanahan et al., 2007).

2.1.1.1. Parent-adolescent relationship

The emergence and escalation of conflict is often normative during adolescence, and most occurrences of conflict tend to focus on daily issues (e.g., chores, talking back, and engaging in undesirable behaviour; Ralph & Sanders, 2003). Conflict in parent-adolescent relationships serves an important developmental function and provides adolescents with opportunities to enhance interpersonal negotiation skills, think logically and critically, and consider alternative and or opposing points of view (Steinberg, 2005). However, researchers have shown that even normal levels of mild to moderate parent-adolescent conflict, when dealt with ineffectively, may have negative implications for parent and adolescent outcomes (Shanahan et al., 2007; Allison & Schultz, 2004). For instance, parents are more likely than their adolescents to become distressed by the arguments, not because of the minor content,

but because of their frequency and repetitiveness (Steinberg, 2001; Silverberg & Steinberg, 1990). Tomlinson (1991) further asserted that parents may become more reactive overtime in situations involving adolescent defiance. Parent-adolescent conflict is therefore likely to increase in frequency and intensity in the absences of adequate intervention and support. Negative communication patterns may also be exchanged between parents and adolescents during conflict and this in turn can lead to negative self-perceptions, resulting in lower self-esteem among adolescents (Allison & Schultz, 2004; Lau & Kwok, 2000).

Moreover, conflict can become intense and prolonged, and may present unique challenges to parents, youths, and the family as a whole (Shanahan et al., 2007; Dekovic′, 1999). Research consistently shows that serious and prolonged parent-adolescent conflict is a strong predictor of delinquent behaviours and is related to a wide variety of adverse developmental and behavioural outcomes (Lim, Tormshak & Dishion, 2005; Collins & Laursen, 2004; Shek & Yu, 2011). A vicious cycle may also result, in that adolescent problem behaviours can lead to increased parent-adolescent conflict and vice-versa (Collins & Laursen, 2004).

2.1.1.2. Marital relationship

Another aspect of family relationships that has been associated with adolescent problem behaviours is the quality of marital relationships. Marital conflict can interfere with the ability of parents to discipline effectively and consistently, as well as reducing parents' capability to be emotionally responsive to their children (Lindsey, Chambers, Frabutt, & Mackinon-Lewis, 2009). Evidence suggests that adolescents whose parents have a supportive marital relationship are more likely to be socially competent and less likely to develop behaviour problems (Cui, Donnellan, & Conger, 2007).

It is further proposed that children and youth repeatedly exposed to high levels of marital conflict respond with heightened emotionality and physiological arousal which results in long-term difficulties with emotion regulation (Fosco, Caruthers, & Dishion, 2012). Fosco and colleagues (2012) argued that marital conflict may lead adolescents to blame themselves or feel responsible for solving parents' arguments. In addition, adolescents that perceived themselves as being caught in the middle of marital conflict have reported a more negative parent-adolescent relationship and higher levels of parent-adolescent conflict (Fosco et al.,

2012; Cui et al., 2007). Riggio (2004) further reported that both marital and parent-adolescent conflicts are related to poorer adolescent adjustment.

2.1.2. Parenting practices

Parenting is seen as one component of family functioning which can increase risk or resilience to the development and maintenance of problem behaviours in adolescents (Kumpfer & Alvarado, 2003; Morris et al., 2012; Hawkins, Catalano, & Miller, 1992; Hoeve, Dubas, Eichelsheim, Van der Laan, Smeenk, & Gerris, 2009; Johnson, Smailes, Cohen, Kasen, & Brook, 2004). Hawkins and colleagues (1992) suggested that while positive parenting is more closely related to the child's prosocial behaviour, dysfunctional parenting is more closely related to the child's problem behaviour. For example, dysfunctional parenting practices such as laxness, over reactivity, and inconsistency of discipline can undermine the adolescent's independence, self-esteem, and other competencies that adolescents need to prevent risk taking behaviours (Steinberg, 2001; Patterson & Strouthamer-Leber, 1984; Dishion & Patterson, 2006).

Lax parenting incorporates aspects of permissiveness and inconsistency and occurs when parents allow rules to go unenforced, provide positive consequences for misbehaviour, fail to set limits, and 'give in' to children's coercive behaviour (Harvey-Arnold & O'Leary, 1997). On the contrary, over-reactive parental practices are characterised by high levels of parental anger, irritation and frustration in response to child misbehaviour (Harvey-Arnold & O'Leary, 1997), and the use of power-assertive techniques including physical punishment, yelling, and threats (Harvey-Arnold & O'Leary, 1997).

The impact of dysfunctional parenting skills on adolescent outcomes is well documented (e.g., Hoeve et al., 2009; Johnson et al., 2004). In particular, lack of discipline or inconsistency increases the likelihood and/or further exacerbates adolescents' problem behaviours such as substance abuse, mental health problems, and poor academic performance (Johnson et al., 2004; Patterson & Strouthamer-Leber, 1984; Morris et al., 2012). Conversely, effective non-violent discipline skills and consistent parenting strategies have been shown to be important, at multiple developmental stages, for preventing and reducing problem behaviours (Dishion & Patterson, 2006).

2.1.3. Parental monitoring

Parental monitoring has been consistently identified as an important factor in influencing youth outcomes (Kerr et al., 2010; Keijsers et al., 2009). It has been defined variously as a parental behaviour, a child's perception of parental knowledge, and the by-product of parent-adolescent communication (Kerr et al., 2010; Dishion & McMahon, 1998). Whereas a debate continues in the literature regarding the best definition of parental monitoring, research has proven it to be a robust construct associated with adolescent outcomes (Kerr et al., 2010; Kiesner et al., 2009). For example, parental monitoring, defined as the appropriate level of parental control and rule setting, has been found to lower the risk of adolescent substance use (Kiesner et al., 2009). Given increasing autonomy and independence demands from adolescents, the task of adequately monitoring and supervising adolescent behaviours can become simultaneously more difficult and more important for parents (Dishion & McMahon, 1998). The level of control and supervision by parents may provoke tension between the parent and adolescent as the adolescent negotiates the struggle between developing autonomy and continuing close bonds with their parents (Luthar, 2006).

Likewise, parental monitoring as defined by an adolescent's perception of parental knowledge has been found to influence adolescent outcomes. Several studies have shown that adolescents who perceive inadequate levels of parental monitoring by their parents are more likely to become involved in problematic behaviours such as substance use (Rodgers-Framer, 2000), early risky sexual activity (Metzler, Noell, Biglan, Ary, & Smolkowski, 1994), school truancy (Brown et al., 1993), and violence (Bacchini, Miranda, & Affuso, 2011). On the contrary, adolescents who perceive themselves to be well monitored are more likely to do better in school and report greater satisfaction with the parent-adolescent relationship (Fletcher, Steinberg, & Williams-Wheeler, 2004).

According to Kerr and colleagues (2010), parental monitoring incorporates adolescent's voluntary disclosure of information to parents, as well as parent-adolescent communication. As adolescents have an increasing need for autonomy and independence from their parents (Steinberg, 1990) and spend less leisure time under direct supervision, voluntary disclosure toward parents becomes an increasingly important facet in parent-adolescent relationships (Kerr et al., 2010; Soenens, Vansteenkiste, & Sierens, 2009). That is, parents can become dependent on these voluntary disclosures to find out about their adolescent's activities, whereabouts, and associates (Kerr et al., 2010). Studies have

consistently found that the less a parent knows about factors such as their child's whereabouts, their peers, and their activities, the more likely the child is to exhibit delinquent behaviours (Soenens et al., 2009; Kerr et al., 2010; Keijsers et al., 2009). The most effective form of parental monitoring has been reported to occur when adolescents felt supported and able to discuss issues with parents in an open and honest way (Soenens et al., 2009). Where parents used surveillance alone, without open communication, parental monitoring was found to be less effective (Sherriff, Cox, Coleman, & Roker, 2008). Parental monitoring is more likely to be effective if it occurs within the context of a positive parent-adolescent relationship.

Although outside the scope of the current review, a great deal of debate continues in the literature regarding the definition and measurement of parental monitoring, and further studies are warranted. Given the variety of definitions, terms, and measures used in the literature, it is important that studies measuring parental monitoring define the behaviours represented by the particular measure employed. In the present study, parental monitoring is defined as adolescent's voluntary disclosure of information to parents about their whereabouts and activities. In this respect, parental monitoring reinforces the open communication established within the context of a positive parent-adolescent relationship.

2.1.4. Parental self-efficacy

Parental self-efficacy refers to parents' beliefs in their ability to handle tasks and issues related to parenting (Jones & Prinz, 2005). Studies suggest that parental self-efficacy is closely linked with parenting practices and confidence in implementing parenting techniques (Jones & Prinz, 2005; Sevigny & Loutzenhiser, 2009). Parental self-efficacy has been found to directly and indirectly influence adolescent adjustment, adolescent behaviour, child maltreatment, and parental adjustment (Shumow & Lomax, 2002; Porter & Hsu, 2003). Ardelt and Eccles (2001) suggested that parental self-efficacy can produce a direct influence on an adolescent's self-efficacy and academic success through modelling of attitudes and beliefs. For example, parents with high levels of self-efficacy are more likely to exhibit positive attitudes, outlooks, and beliefs. This may result in his or her child adopting these attitudes and beliefs, and applying them to their own behaviour which leads to positive child outcomes (Ardelt & Eccles, 2001).

Parental self-efficacy may also have an indirect effect on adolescent behaviour. A higher sense of parental self-efficacy is associated with more persistent use of effective parenting strategies that are associated with desirable outcomes (Jones & Prinz, 2005). Parents who engage in more competent parenting behaviours experience less stress and more cooperation in their relationships with their adolescents. Furthermore, Bogenschneider and colleagues (1997) found that high levels of parental self-efficacy were associated with higher levels of parental monitoring and parental involvement with their adolescent. On the contrary, a low sense of parental self-efficacy has been shown to significantly predict harsh, permissive, and inconsistent parenting practices, which are associated with negative adolescent outcomes (Shumow & Lomax, 2002).

2.1.5. Parental well-being and adjustment

Parental negativity and depressive symptoms are significant variables that influence parenting quality (Waylen & Stewart-Brown, 2010; Sameroff, Gutman, & Peck, 2003). Both paternal and maternal depression poses risks for adolescents, but maternal depression appears to have a stronger relationship with problem behaviours than paternal depression (Connel & Goodman, 2002). Maternally depressed mothers are more likely than well-adjusted mothers to experience difficulties in parenting (Bor & Sanders, 2004; Waylen & Stewart-Brown, 2010). Mothers who experience great distress in their parenting role have been shown to place greater value on physical punishment to direct their children's behaviour and to be less empathetic to their children's needs (East, Matthews, & Felice, 1994). They are also more likely to use neglectful, punitive, and harsh parenting strategies when compared to less distressed, more confident mothers (Barlow, Smailagic, Huband, Roloff, & Bennett, 2012). Clearly then, poor parental well-being can lead, through dysfunctional parenting practices, to negative outcomes in adolescent development (Barlow et al., 2012).

To summarise, many adverse developmental outcomes in adolescents are associated with the quality of family relationships and parenting factors that are potentially modifiable (Morris et al., 2012; Flannery et al., 2005; Bullock & Dishion, 2007). Numerous studies have indicate that there is an association between adolescent behaviours, quality of family relationships, parenting practices, parental self-efficacy, and parental adjustment (e.g., Dishion & Stormshak, 2009; Bullock & Dishion, 2007). This body of work suggests that family-based interventions targeting family factors and parenting behaviours would prove an important approach to preventing and reducing adolescent problem behaviours (Bullock &

Dishion, 2007; Ralph & Sanders, 2002; Morris et al., 2012; Dishion & Stormshak, 2009). The following section provides a general review of the literature concerning family-based interventions for parents of adolescents.

2.2. Behavioural Family Intervention for Parents of Adolescents

The engagement of adolescents in problem behaviours poses significant cost to the individual, family, and society as a whole, and thus the reduction and prevention of risk taking behaviour has been the focus of research and intervention. As parents retain significant influence over adolescents' social and emotional development, they are important targets for prevention and intervention programmes (Fletcher, Elder, & Mekos, 2000). Research has found that interventions that incorporate parents can reduce adolescent problem behaviours more than an intervention targeting the adolescent alone (Stanton et al., 2004). The hypothesis that strengthening parenting practices results in increased positive outcomes in youth is a central tenet in behavioural family interventions (BFI; Bullock & Dishion, 2007).

BFI that are based on social learning models emphasise the bidirectional nature of parent-adolescent interactions and identify learning mechanisms which maintain coercive and dysfunctional family interactions (Patterson, 1982). By changing the antecedents and consequences of child behaviour, parents can influence the likelihood of behaviours occurring again in the future. BFI that are targeted specifically for parents of adolescents acknowledge the developmental and social challenges associated with adolescence, and support parents to involve their adolescent more directly in the negotiation and development of behaviour change strategies (Ralph & Sanders, 2002; Fletcher et al., 2000).

BFI form the foundation for most of the available evidence-based parenting programmes (Bullock & Dishion, 2007). In these programmes, parents are considered to be an important agent for reducing the risk factors and enhancing the protective factors that are associated with adolescent problem behaviours (Ralph & Sanders, 2002). These programmes teach parents to make use of developmentally appropriate discipline strategies and emphasise the importance of effective monitoring of their adolescent's behaviour and activities, such as contact with peers, class attendance and schoolwork, and social events outside the home (Kumpfer & Hansen, 2014; Ralph & Sanders, 2002). These programmes address adolescent problem behaviours by actively teaching parents a repertoire of skills such as the use of positive reinforcement to support the development of appropriate behaviours, non-punitive

consequences for negative behaviours, and enhancing the quality of the parent-adolescent relationship (Kumpfer & Hansen, 2014; Fletcher et al., 2000).

Parenting programmes can be delivered in a number of different formats including self-directed, individual, or group programmes (Ralph & Sanders, 2002). Self-directed programmes involve parents working through materials on their own, without guidance from a facilitator. Individual and group parenting programmes can be delivered in a range of settings including the home, and clinic or community settings such as schools or neighbourhood centres. Individual programmes have distinct advantages in terms of individualisation of services, and group formats are more cost-effective. Parenting programmes also vary in intensity and duration and can range from brief self-directed programmes that involve the provision of written material alone to facilitator-guided interventions that last several months (Kumpfer & Hansen, 2014). Programmes can be implemented as universal prevention programmes serving all youth and families to prevent the onset of problems, or to selected and indicated programmes to ameliorate the severity of existing problems in high risk youth (Kumpfer & Hansen, 2014; Spoth, Redmond, & Shin, 2001).

Parenting programmes can concurrently address multiple concerns including a variety of adolescent risk and protective behaviours and associated health outcomes (Ralph & Sanders, 2003; Spoth et al., 2001). The slowly increasing evidence of parenting programmes for parents of adolescents suggests that targeting a critical set of risk and protective factors will increase the likelihood of sustained positive results, beyond the narrow focus of one or a few risk behaviours. By targeting changes in parenting practices such as parental monitoring, consistency, positive reinforcement, and establishment of clear boundaries, parenting programmes have been shown to result in positive outcomes. Some of these outcomes include reductions in adolescent problem behaviours, increase in parental confidence, improvements in parental adjustment (including stress, depression, and anxiety), increased use of positive parenting practices, increased levels of parental monitoring, and improvement in parental-adolescent relationship quality (Ralph & Sanders, 2003, Stallman & Ralph, 2007; Spoth et al., 2001; Spoth et al., 2002; Barlow et al., 2012).

An increasing number of studies are appearing that support the use of parenting programmes for parents of adolescents (Spoth, Trudeau, Guyll, & Shin, 2012; Spoth et al., 2009; Ralph & Sanders, 2003; Doherty, Calam, & Sanders, 2013; Spoth et al., 2001; Gates,

McCambridge, Smith, & Foxcroft, 2006). The following section describes a number of parenting programmes that target parenting processes and have demonstrated effectiveness in addressing some of the problems facing adolescents. The programmes described below are selected based on a review conducted by the United Nations Office of Drugs and Crime (UNODC, 2009) which reviewed over 150 family-based programmes for children and adolescents. For the purpose of this research, the following review is limited to parenting programmes specifically designed for parents of adolescents. Many studies evaluating BFI include parents of both younger children and adolescents; however, these programmes do not specifically target parents of adolescents and are therefore not included. In addition, only programmes that have been reported as effective or promising are included (i.e., have demonstrated positive results in at least two randomised controlled trials, a clearly defined targeted population, and use of psychometrically sound and reliable measures). Some of these programmes target the parent only while others target the family and involve the adolescent in some or all of the interventions.

2.2.1. Programmes that focus solely on parents

The following section presents programmes that work exclusively with parents in addressing the well-being of adolescents. The assumption is that targeting parents solely may by itself be sufficient to produce positive outcomes for adolescents.

2.2.1.1. Family Matters

Family Matters (Bauman, Foshee, Ennett, Hicks, & Pemberton, 2001) is a universal programme intended to reduce the prevalence of substance use among adolescents ages 12-14. It is intended for use with a broad range of parents and can be delivered in the home. Parents receive a series of health booklets, delivered successively through the mail, and follow-up telephone calls from health educators. Each booklet contains information and activities to be completed by the parent. The content of the booklets is based on social and behavioural theories, and includes a combination of information on: parenting skills, such as supervision, communication, and monitoring; the importance of family and family influences; rule setting; and peer and media influence. Follow-up phone calls by a health educator are intended to ascertain the status of completion of each booklet and to answer questions or provide additional information about the programme.

Studies have demonstrated the programme to be effective in reducing the prevalence of smoking and alcohol use among adolescents in the United States (e.g., Bauman, Ennett, Foshee, Pemberton, King, & Koch, 2000; Bauman, Foshee, Ennett, Hicks, Pemberton, King, & Koch, 2001). Furthermore, the onset of smoking was reported to have reduced by 16.4% at 12 months following programme participation compared with the control condition (Bauman et al., 2001). However, only small effect sizes were found. In addition, none of the studies reported on any parent-related outcomes. It should also be noted that all evaluation studies of the programme were conducted prior to 2002, with no further examination of the programme available in recent literature.

2.2.1.2. Teen Positive Parenting Program (Teen Triple P)

A full description of the Positive Parenting Program (Triple P) and Teen Positive Parenting Program (Teen Triple P) is given in Chapter 4, hence, only a review of the evidence base for the Teen programme will be presented here. Triple P has been extensively researched with young children (e.g., Mejia, Calam, & Sanders, 2012; Leung, Fan, & Sanders, 2013; Jones, Calam, Sanders, Diggle, Dempsey, & Sandhani, 2013; Glazemakers & Deboutte, 2012; Tellegen & Sanders, 2013; de Graaf, Speetjens, Smit, & de Wolff, 2008; Nowak & Heinrichs, 2008). Teen Triple P is an upward extension of Triple P, designed specifically for parents of adolescents (12 to 16 years of age). Preliminary studies on variant forms of Teen Triple P have demonstrated the programme to be a promising intervention for parents of adolescents (Stallman & Ralph, 2007; Ralph & Sanders, 2003; Doherty, Calam, & Sanders, 2013; Chand, Farruggia, Dittman, Chu, & Sanders, 2013).

For example, one study examined two variants of a self-directed version of Teen Triple P with a sample of 51 Australian parents, who reported experiencing difficulties with their adolescent's behaviour (Stallman & Ralph, 2007). Families were randomly assigned to either a Standard self-directed programme consisting of a 10-module workbook programme supplemented by a video; Enhanced Standard self-directed programme which in addition to the Standard programme, ten, fifteen-minute weekly telephone session were offered; or a waitlist control group (Stallman & Ralph, 2007). Short term intervention effects were reported in the enhanced condition with parents reporting significantly fewer adolescent behavioural problems and less use of dysfunctional parenting practices (e.g., over-reactivity) than parents in either the Standard or waitlist control conditions. These positive changes were

maintained at the 3-month follow-up (Stallman & Ralph, 2007). Although the study showed promising results, the small sample size limited the generalisability of the findings.

Another Teen Triple P study evaluated the group version of Teen Triple P - GTTP amongst Australian parents of teenagers in their first year of secondary school. Ralph and Sanders (2003) found improvements from pre- to post-intervention in a number of risk factors for adolescent conduct problems. The 26 participating parents reported reductions in parent-adolescent conflict, inter-parental conflict, dysfunctional parenting, and increases in parental well-being and parental confidence. Six-month follow-up revealed some evidence for improvements being sustained (Ralph & Sanders, 2003). The study was replicated with 303 parents of students entering their first year of high school, over a 3-year period. Preliminary results revealed similar findings to previous evaluations with parents reporting significant improvements in adolescent problem behaviours, parenting practices, reduction in parent-adolescent conflict, inter-parental conflict, and parental stress and depression (Ralph, Stallman, & Sanders, in prep). However, neither study employed a control condition.

A mixed-methods evaluation was conducted on a brief preventative version of Teen Triple P - Teen Seminar Series on a community sample within Auckland, New Zealand. The Seminar Series was a brief, light touch intervention that included a series of tip sheets and parenting seminars delivered to a large group of parents. Of the 21 families that participated, parents reported an increase in parental monitoring, parental confidence, decrease in inter-parental conflict, and lower levels of parent-adolescent conflict following participation. Qualitative findings further revealed that adolescents perceived positive changes in family relationships and adolescent well-being following parents' participation. For example, adolescents reported increased sense of caring towards others (e.g., siblings and peers) and less engagement in risky behaviour (e.g., smoking; Chand et al., 2013). Despite promising findings, no comparison condition was employed and no long term follow-up data were reported.

Finally, a recent study provided preliminary support for the efficacy of self-directed Teen Triple P for families of adolescents with Type 1 Diabetes in the United Kingdom (T1D; Doherty et al., 2013). Compared to care as usual condition ($n = 37$), parents in the intervention ($n = 42$) reported reduced T1D-related family conflict at post-intervention (Doherty et al., 2013). Parents in the intervention group further reported significant improvements in

adolescent behaviour and parenting practices (Doherty et al., 2013). The study, however, only obtained parent-reported data and no long term follow-up data were reported.

2.2.2. Programmes that involve parents and adolescents

There are two types of parenting programmes that involve adolescents. One type of parenting programme involves a youth component parallel to the parent component. Both parents and adolescents are important targets within the intervention. The other type of parenting programme focuses on the parent, but adds a secondary component that involves the adolescent and parent learning together. This type of programme focuses on the parent and does not directly train or educate the adolescent.

2.2.2.1. Strengthening Families Programme 10-14 (SFP 10-14)

The Strengthening Families Programme 10-14 (SFP 10-14; Molgaard & Spoth, 2001) is a universal programme designed to reach the entire population of families with children between the ages of 10 to 14 years. The 7-week programme (with four additional booster sessions) assists families in the prevention of substance use. The programme is based on the principle that family influences the young person's perceptions of school, self-esteem, and peer influence. Building strong and positive relationships between the parent and the adolescent holds the key to creating a supportive and transactional process between parents and youth that in turn reduces the vulnerability to drug use. Programme activities include a combination of parent skill development (anger and stress management, discipline, use of rewards, and communication), adolescent skill development (social skills, coping, and communication), and family skill development (problem-solving, practicing communication skills, and use of family meeting times). Three group leaders facilitate the programme, one for the parent session and two for the youth session.

The programme has been well evaluated (e.g., Molgaard, Spoth, & Redmond, 2000; Spoth, Redmond, Shin, & Azevedo 2004; Spoth et al., 2009; Spoth et al., 2012) and a systematic review suggested that the programme has the potential to prevent substance and drug use in adolescents (Gates et al., 2006). A multi-method, multi-informant longitudinal study of 446 American families living in areas of high risk for drug problems revealed that families in the intervention condition reported significantly lower rates of substance use and increased family functioning (e.g., improved parent-adolescent relationship) then those who

did not receive the programme (Molgaard et al., 2000). Qualitative findings further revealed that parents perceived the programme to be useful and meaningful (Molgaard et al., 2000). The findings also showed economic benefits of preventive intervention for drinking among adolescents in avoiding future costs to society (Spoth et al., 2002). Spoth and colleagues (2002) estimated that the long-term effects ranged from $7.80 to $9.60 for every dollar invested. Long term effects of the programme were reported in a 10-year follow up study. Spoth and colleagues (2012) demonstrated that young adults who participated in the programme during adolescence reported lower levels of drug use (27.5%) then those in the control group (38.3%). It is important to note that SFP 10-14 offers parent training alongside other components of the programme. However, studies evaluating SFP 10-14 have not differentiated the effects of the different components, making it difficult to establish that it is the parent component exclusively that accounted for the intervention effects. In addition, most of the studies evaluating SFP 10-14 on adolescent outcomes, report only effects concerning substance use (e.g., Spoth et al., 2009; Spoth et al., 2004).

2.2.2.2. Adolescent Transitions Programme (ATP)

The Adolescent Transitions Programme (ATP; Dishion & Kavanagh, 2002) is a multi-level, family-centred, school-based intervention that aims to promote adaptation in the adolescent years (11-13 years of age). ATP consists of three levels of intervention in a tiered continuum: universal, selected, and indicated. At the universal level, family resource centres (FRC) operate in schools and target all families within the school regardless of their risk status. Printed and visual resources on effective parenting strategies are available for parents. In addition, adolescents work through a six week classroom curriculum on promoting success and well-being (Dishion & Kavanagh, 2002).

At the selected level, the Family Check-Up (FCU) is offered to parents with youth who are showing moderate to serious signs of risk for problem behaviours. The intervention is designed to enhance parental monitoring and family management. The FCU involves three sessions of motivational interviewing: 1) the facilitator explores parent concerns and motivates involvement in a family assessment; 2) the family participates in a home visit assessment; and 3) the facilitator provides feedback to explore potential intervention services that support family management practices (Dishion et al., 2003; Dishion & Stormshak, 2009). In a randomised controlled trial (RCT) with 71 American families with high risk youth, parents in the intervention condition reported enhanced monitoring from one- to two-year

follow up compared to the control condition (Dishion et al., 2003). At two-year follow-up, young people in the control group were more likely to self-report substance use than those in the FCU group. It should be noted that while the FCU was developed to be delivered prior to a 12-week parenting programme, many parents declined to participate in a more intensive programme, preferring participation in the brief FCU at periodic intervals (Dishion et al., 2003). The authors suggested that this was likely due to the barriers perceived by parents in participating in parenting programmes (e.g., stigma, work/family commitments). This selected level of intervention also relies on the identification of at-risk adolescents during home visit assessment, a feature that requires specialised interview and clinical skills for the practitioner (Kumpfer & Hansen, 2014). This intensive type of training may require greater resources than other programmes.

The indicated level of intervention is aimed at families of adolescents with clinically significant problem behaviours. The Family Management Curriculum (FMC) is a 12 week programme that can be delivered in groups or tailored for individual families. The programme consists of three components: 1) using incentives to promote positive behaviour change, 2) limit-setting and monitoring, and 3) family communication and problem solving. An initial randomised trial of FMC was conducted with 158 American families of young people who had four or more risk factors from a list of ten, such as problem behaviours, stressful life events, and peer substance use (Dishion & Andrews, 1995). Families were randomly allocated to one of four 12-week programmes: parent only group, teen only group, parent plus teen group, or a self-directed programme. The parent only group showed significant reduction in behavioural problems at post-intervention and a trend for reductions in adolescent tobacco use at follow-up. Of concern, the two interventions that included teens (teen only and parent plus teen group) showed escalations in tobacco use and teacher-rated problem behaviour at follow-up. This finding suggests that including high-risk young people in groups may serve to increase risk behaviour via contact with deviant peers, a process which has been described by Dishion and Tipsord (2011) as 'deviancy training'. Additional analyses revealed that adolescents with the highest initial level of problem behaviours were most susceptible to this effect. Furthermore, at the three-year follow-up, negative effects of youth self-reported tobacco use and teacher reported adolescent problem behaviours continued (Dishion, McCord, & Poulin, 1999). The effects for the inclusion of an adolescent component in parenting programmes remain inconclusive. While the programme in general

has been shown to be effective, research has not yet determined the relative importance of the different components they contain.

2.2.2.3. Guiding Good Choices (GCC)

The Guiding Good Choices programme (GCC; formerly known as Preparing for the Drug Free Years; Haggerty, Kosterman, Catalano, & Hawkins, 1999) is a five session universal programme designed to assist families of children (9 to 14 years of age) in reducing risk factors and increasing protective factors related to substance use. Many of the programme activities are attended by parents only, and include family conflict management, education on the extent of substance use and its connection to family and peer factors, and parent communication skill building. The sessions are interactive and skill-based, with opportunities for parents to practice new skills and receive feedback from workshop facilitators and other parents. There is also a session attended by parents and adolescents together that focuses on the development of substance use refusal skills (Haggerty et al., 1999).

A large study conducted in the Midwestern States of America, randomly assigned 667 (generally well-functioning) families to GCC, SFP 10-14, or a control group. The study demonstrated that both programmes had a significant effect on parenting practices (such as enhancement of positive adolescent involvement in family activities) and parent-adolescent relationship quality, compared with the control group (Spoth et al., 1999). These positive intervention effects were also maintained one year following the interventions, and by two-year follow-up, the likelihood of substance use initiation was significantly lower in the two interventions than the control group (Spoth et al., 1999). At the four-year follow-up, young people in both groups reported lower alcohol use compared with controls and the SFP group also showed reduced use of cigarettes (Spoth et al., 2001). At the six-year follow-up, both interventions had a significant impact on cigarette use and the SFP 10-14 also impacted on marijuana and alcohol use (Spoth, et al., 2004). GCC has been shown to be effective both in the short and long term. It is worth noting that most of the articles published on GCC have used data from different cohorts of the same sample identified above. Moreover, effect sizes reported in most of the GCC studies were generally small to medium (0.12 to 0.45; e.g., Mason, Kosterman, Hawkins, Haggerty, & Spoth, 2003; Spoth et al., 2001).

2.2.3. Parenting programme as part of multi-component programme

In addition to the above reviewed programmes, parenting programmes have also been delivered as part of a treatment package and adolescents and parents receive several different interventions alongside parenting programmes. Most of the available multi-component programmes are targeted at families with severe difficulties.

2.2.3.1. Multi Systematic Therapy (MST)

Multi Systematic Therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998) is an intensive support programme for young people aged 10 to 17 and their families targeting the multiple risk factors for delinquency and problem behaviours. Parents and adolescents receive several interventions that are directed towards various systems and subsystems in family, peers, school, and community. MST targets multiple factors and promotes approaches such as: encouraging young people not to spend time with peers who are a bad influence, building stronger bonds with family, school, and other conventional groups, enhancing parenting skills such as monitoring and discipline, and developing greater social and academic competence in the young person. The approach views individuals as part of a complex network of interconnected systems that encompass individual, family, and extra familial factors (school, peers, and neighbourhood). Several domains within the family including parenting, marital conflict, parental stress, parental unemployment, parental psychopathology, or any other family-related issues can be addressed when necessary (Henggeler et al., 1998). RCTs involving chronic and violent juvenile offenders have demonstrated the capacity of MST to reduce long term rates of criminal activity, incarceration, and concomitant costs (Curtis, Ronan, & Borduin, 2004; Henggeler, Clingempeel, Brondino, & Pickrel, 2002). Conversely, some studies revealed no significant differences in treatment effects between MST and care as usual control condition (Sundell, Hansson, Andrée Löfholm, Olsson, Gustle, & Kadesjö, 2008; Littell, 2006). The lack of significant findings was attributed to poor treatment fidelity across intervention (Sundell et al., 2008). In addition, a meta-analysis conducted by Littell and colleagues (2005) summarised a number of methodological limitations (e.g., unclear randomisation procedures, subjective definition of treatment completion, and failure to mention reasons for the exclusion of cases) of MST studies which led the authors to conclude that the evidence regarding the superiority of MST compared to care as usual control condition as inconclusive.

2.3. Summary of Evidence and Limitations

It is clear from the above studies that BFI directed at parents of adolescents are promising in the prevention and/or reduction of adolescent problem behaviours and in improving family functioning. However, although the programmes have demonstrated effectiveness, several limitations can be identified.

First, a majority of the programmes (e.g., Family Matters, SFP 10-14, GCC, and ATP) focused on the prevention of substance use. Hence, many of these programmes utilised a narrow set of outcome measures (e.g., self-report on drug use). The impact of the programmes on other adolescent-related outcomes (e.g., adolescent autonomy and self-esteem) is therefore less clear. Using a more comprehensive set of measures is required to determine the scope and magnitude of changes generated by a parenting programme in both adolescents and parents.

Second, several of the parenting programmes (e.g., SFP 10-14, GCC, ATP, and MST) reviewed included multiple components and it was therefore difficult to discern the degree to which the parent component resulted in changes among families. While some research indicated that interventions with both parent and adolescent component can be effective (e.g., Cotter, Bacallao, Smokowski, & Robertson, 2013), other research, however, raised concerns about the effects of such programmes. For example, an intervention (ATP) that involved both parents and adolescents led to escalations, rather than reductions, in adolescent tobacco use and problem behaviour at school, when compared to a parent-focused only intervention (Dishion & Andrews, 1995). Alongside the potential for targeted interventions to generate feelings of labelling and stigmatisation (Bayer, Hiscock, Morton-Allen, Ukomunne, & Wake, 2007), a key concern is that bringing together groups of high-risk youth may inadvertently produce harmful effects through peer contagion. Although the findings were from a high risk sample, at present there is insufficient information that can be used to draw conclusions for involving youth with low levels of problem behaviours.

Furthermore, while some of these programmes have shown to be effective, programmes with multiple components are often time consuming and labour intensive (Sundell et al., 2008). It is also noteworthy that the effects with regard to the impact of programmes working exclusively with parents are less well established. It is possible that such programmes may provide a minimally sufficient solution to the prevention and

reduction of adolescent problem behaviours, compared with programmes with multiple components. Thus, future studies testing the efficacy of such programmes are warranted.

Another shortcoming of the reviewed parenting programmes is heavy a reliance on single informant self-reports as indicators of programme effectiveness. Few studies simultaneously examine outcomes from multi-informants (e.g., parent, adolescent, and teachers). This practice creates a common methodological limitation due to the use of a single reporter, and, hence, may exaggerate or understate the true impact of the programme. Morsbach and Prinz (2006) pointed out that multiple informants will provide the most accurate information about parenting as each provides a unique perspective. Furthermore, the use of multi-informant reports can be tailored and utilised by scholars and clinicians to help meet the needs of individual families, adolescents, and parents.

Finally, of all the reviewed programmes, only two of the programmes (Teen Triple P and MST) have been trialled in a New Zealand context (e.g., Chand et al., 2013; Curtis, Ronan, Heiblum, & Crellin, 2009). There are very few studies that evaluated parenting programmes outside of their country of origin. As a result there is a lack of information on the impact of parenting programmes for parents of adolescents in New Zealand (Youthline, 2007). Studies to identify parenting programmes that are effective and beneficial for parents of adolescents in the New Zealand context are therefore needed.

2.4. Research Gap: What is Lacking?

In addition to the limitations of the reviewed programmes, many gaps can be identified in the general parenting literature on programmes supporting parents of adolescents. These include a lack of evidence-based parenting programmes that target parents of adolescents, a paucity of research that rigorously evaluates parenting programmes, a lack of adolescent voice and input in parenting programme research, and a lack of studies assessing social validity in parenting programmes. Each of these areas is given specific attention below.

2.4.1. Lack of evidence-based parenting programmes targeting parents of adolescents

There is a strong need for evidence-based parenting programmes to support parents of adolescents; however, this need continues to remain unmet. Within the literature, studies examining the effectiveness of parenting programmes have predominantly targeted infancy and early childhood (e.g., Hayes, Matthews, Copley, & Welsh, 2008; Bayer, Hiscock, Ukoumunne, Scalzo, & Wake, 2010). Although parenting programmes for parents with young children have repeatedly been shown to be effective in improving a range of outcomes including parent and child well-being, quality of parent-child relationship, decreased maternal depression and stress, and child problematic behaviour (e.g., Comer, Chow, Chan, Cooper-Vince, & Wilson, 2013; Dretzke et al., 2009), such programmes are not necessarily expected to prevent all future difficulties. Adolescence brings with it a range of new developmental and social challenges that are not present in young children (Steinberg, 2001). Thus for programmes to be effective, they must be developmentally timed to be relevant to the parent's needs (Ralph & Sanders, 2002).

The lack of attention directed towards support for parents of adolescents may be due to the beliefs that parental influence diminishes over time as adolescent's behaviour becomes increasingly individually-determined (Kazdin, 2008). Hence, there are comparatively few evidence-based programmes available that target parents of adolescents. Most of the current available programmes that are aimed at improving adolescent outcome have a primary focus on working with individual adolescents, or at the school level with minimal or no involvement of parents (Biehal, 2006; Kaslow, Broth, Smith, & Collins, 2012). Parents are thus by and large left with the task of parenting very much on their own (Chu, Bullen, Farruggia, Dittman, & Sanders, under review). Of concern is that a majority of these adolescent-focused or school based programmes have not been evaluated systematically for effectiveness or have been found disappointing (Dryfoos, 1991; Foxcroft, Ireland, Lister-Sharp, Lowe, & Breen, 2003; Lilienfeld, 2007). For example, school-based prevention programmes for substance abuse directed at adolescents alone are popular and politically enticing, but studies have repeatedly shown these programmes to be largely ineffective (Lilienfeld, 2007; Dryfoos, 1991; Foxcroft et al., 2003). These programmes focused on modifying individual characteristics through curriculum-based interventions, often overlook and fail to address the importance of parenting and family factors that impact adolescent

substance use (Foxcroft et al., 2003). For example, inadequate level of parental monitoring is strongly associated with the onset of substance use (Rodgers-Framer, 2000). Several studies demonstrate that the effects of family-focused interventions are far greater than interventions that focus solely on the adolescent (e.g., Diamond & Josephson, 2005; Carr, 2009). These findings suggest that programmes targeting parenting may be a more effective approach to improving adolescent outcome (Tobler & Kumpfer, 2000; Kumpfer & Alvarado, 2003).

2.4.2. Lack of rigorous evaluations of parenting programmes for parents of adolescents

Although parenting programmes aimed at adolescents exist, the evidence base to support their effectiveness has not yet been built to the same extent that it has for younger children (Chu et al., 2012; Tully, 2007). Systematic reviews of parenting programmes reveal a lack of evidence-based programmes that address risk behaviour problems among adolescents (Dretzke et al., 2009; Eyber et al., 2008). The call for increasing evidence-based parenting programmes and practices is based on the recognition that many practices and policies implemented in the communities at present do not work, or even have unintended negative effects (Spoth & Redmond, 2000; Small et al., 2009; Shapiro, Prinz, & Sanders, 2010). Parents that participate in programmes that have not been evaluated and proven effective are potentially at risk of not getting their needs met and it can be a waste of time and resources (Kumpfer & Alvarado, 2003).

In general, programmes that are considered evidence-based are built on solid scientific theoretical foundations, have been carefully implemented, and have been evaluated using rigorous scientific methods. These methods usually include a longitudinal design, well-established measures and a control or comparison group. Ideally, the programmes have been evaluated in a variety of settings with a range of samples (Flay et al., 2005). However, at present, many studies evaluating parenting programmes for parents of adolescents are subjected to several methodological shortcomings (Spoth et al., 2008).

The rates of families recruited for parenting programme studies are typically very low (Heinrichs, Bertram, Kuschel, & Hahlweg, 2005). Small intake samples create issues for evaluation analyses and conclusions. These include the ability to detect between group differences in the analysis and concerns about establishing causality (internal validity) and generalisation (external validity). In addition, some efficacy and evaluation studies have

relied on samples of convenience when testing programmes, such as parents who are already enrolled in a local parenting education programme (e.g., O'Neill & Woodward, 2002). As a result findings may only hold for parents who self-select into a parenting education programme (Powell, 2013).

Moreover, in the absence of a control group or a strong comparison group, it is unclear how much of the observed change in parent and adolescent outcomes can be attributed to the programme (Powell, 2013). Without such information, it is difficult to generalise over time, across settings, or across people. This undermines the internal and external validity of the research results (Powell, 2013). Finally, long-term follow up is essential in determining whether the effects of the programme are sustained over time or whether positive effects of the programme only emerge after a significant period of time has elapsed (Spoth et al., 2009). Long-term follow-up is also important in demonstrating any negative effects of the intervention. This information is important in guiding decisions on the duration and intensity of the programme as well as the programme's cost effectiveness. At present, there is insufficient information on the long term effects of parenting programmes for parents and adolescents (Spoth et al., 2008; Tully, 2007).

Together these methodological limitations influence conclusions that are drawn from the studies and have the potential to affect intervention effectiveness, and its application to policy and practice. There is a need to conduct more methodologically rigorous evaluation to examine the effects of parenting programmes for parents of adolescents.

2.4.3. Lack of adolescent voice and input

In addition to the above, at present, very little evidence exist in the literature that adolescents have participated at any level in developing the content, assessments of their value, and perceived impact of parenting programmes. Although there is increasing recognition for the need to include adolescents in parenting programme research, research in this area continues to be scarce (Kirby & Sanders, 2012). By, and large, adolescents have been seen as the objects of research and intervention rather than as active participants in the research process (Galambos & Leadbeater, 2000). Existing research has often relied solely on parents' self-reports for programme evaluation. While many programmes theoretically link improved family relationships with improved outcomes for adolescents, few actually measure adolescent self-reported outcomes directly. Parenting is an interactive process in which

parents not only influence their adolescent, but also are likewise, influenced by their adolescent (Smetana, 1995). Studies have assumed that as parents perceive improvement in their parenting skills following an intervention, that the adolescent too is experiencing similar improvement and/or benefiting from the changes (Hawthorn, Jessop, Pryor, & Richards, 2003; Gomby, Culross, & Behrman, 1999). However, this is an empirical question and should not be routinely assumed.

Moreover, adolescents are rarely asked to give their opinion and perspective about the parenting they receive and experience following parents' participation in parenting programmes. Only two of the studies reviewed in Section 2.2 sought qualitative data from the perspectives of adolescents (i.e., SFP 10-14, Teen Triple P – Seminar Series). This is important to note as research reveals that parents and young people can hold quite divergent perceptions of parenting (Smetana, 1995; Scott, Briskman, & Dadds, 2011). For example, Cottrell and colleague (2003) found that parent perceptions of parental monitoring efforts did not relate to adolescent perception of parental monitoring. Parents generally perceived themselves to have more information about their adolescents' whereabouts and activities than their adolescents reported (Cottrell et al., 2003). Paulson (1994) argued that adolescents' perceptions of parenting are better predictors of behaviour and psychosocial development than parents' self-reports. This is further supported by Scott and colleagues (2011) who demonstrated that adolescent reports of parenting was more congruent with independently observed parenting than parent reports. Adolescents' voice and opinion therefore have much to offer to our understanding of parenting processes and implications for development of future parenting interventions.

2.4.4. The need for social validity

Finally, despite increasing recommendations to assess social validity of parenting programmes, researchers continue to omit reporting and evaluating these important data. Social validity is a subjective measurement of the effectiveness of interventions including the social significance and importance of a programme or intervention (Romer & Umbreit, 1998). Social validity also includes assessing the acceptability of an intervention (Wolf, 1978). The lack of research on social validity for parenting programmes raises important questions such as whether programmes adequately address the needs of parents and adolescents.

Most parenting programmes have been evaluated in terms of their outcomes and researchers have been primarily interested in assessing whether programmes produced significant and reliable changes in behaviour (e.g., Bauman et al., 2001; Curtis et al., 2004). However, these evaluations do not necessarily provide insights about the preferences of consumers (Owens, Richerson, Murphy, Jageleweski, & Rossi, 2007). Very few studies reviewed in section 2.2 reported on the social validity of the programme evaluated. This is important to note as effectiveness is not the only criterion for programme engagement and uptake (Kirby & Sanders, 2012). Several researchers agree that the parents' perception of the significance and relevance of the programme is an important variable in predicting their potential utility of parenting programmes (Kazdin & Wassell, 1999; Solish & Perry, 2008; Whittingham, Sofronoff, Sheffield, & Sanders, 2009). This can include the extent to which parents consider that a parenting programme or specific parenting strategies provided are useful, and or relevant. As such, social validity is important because endeavouring to seek out consumer opinion sets the foundation for empowering consumer to be more involved in the development, implementation, evaluation, and dissemination of parenting programmes (Sanders & Kirby, 2011).

Although consumer satisfaction measures have been used in some studies (e.g., Stallman & Ralph, 2007), and provide some indication of the viability of the programme, these are not the only data relevant to intervention acceptability. Daud (2006) posited that the biggest gap in the literature stems from researchers being neglectful of the voices of consumers instead of seeing and utilising them as a significant resource. Just as in the evaluation utilising specific measures on treatment outcomes to demonstrate meaningful changes, the evaluation of social validity should include multiple informants whenever possible (Foster & Mash, 1999). Parents' concerns and insights are broad in scope and their perspectives and experiences with parenting programmes can help to design and implement more effective programmes as well as reduce barriers to accessing services (Sanders & Kirby, 2011). It is the subjective experience or meaning which an individual attaches to a programme that is most important to the utilisation of such programme. Adolescents too, can make a significant contribution to further inform the social validity of parenting programmes. By viewing adolescents as consumers and seeking their opinions, a more comprehensive evaluation can be sought. Understanding these may inform how families' experience of a programme and the personal value of these experiences such that intervention can be revised or adjusted to optimise programme participation (Sanders & Kirby, 2011). Parenting

programmes that identify what matters most to consumers can help bridge the gap between research and practice (Kazdin, 1977).

2.5. The Challenge of Behavioural Family Intervention

Scholars and policy makers have repeatedly advocated for interventions that target common risk and protective factors because of their potential to have broad positive impact across domains of adolescent functioning (Dishion & Andrews, 1995; Sanders, 2012; Steinberg, 2001; Biglan et al., 2003). As the aforementioned evidence suggests, implementing BFI that target risk and protective factors in the family environment have the potential to lead to better outcomes for both parents and adolescents (Dishion & Andrews, 1995; Stallman & Ralph, 2007; Spoth et al., 2000a). Importantly, researchers have suggested that BFI are the most cost effective approach to reducing and preventing adolescent problem behaviours (Dishion & Andrews, 1995).

While BFI have been found to be effective, their impact is limited by their poor uptake (Heinrichs et al., 2005; Baker, Arnold, & Meagher, 2011; Spoth & Redmond, 2000). Typically, only a small percentage (i.e., 20% of eligible population) of parents participate in evidence-based parenting programmes (Sanders, Markie-Dadds, Rinaldis, Firman, & Baig, 2007; Baker et al., 2011; Spoth et al., 2000b). Various epidemiological surveys show that most parents concerned about their children's behaviour or adjustment do not receive professional assistance (Sanders et al., 2007). For example, studies have shown that a high percentage of parents are concerned about the issue of adolescent drunk driving (e.g., Beck, 1990; McKnight, 1990). However, the data on parental willingness to actively participate in such programmes is somewhat discouraging. McKnight (1990) sent out a mail solicitation to more than 2000 parents inviting them to participate in a 1-hour programme on parent-teen alcohol use; however, only about 3.5% of the invitees participated.

Research suggests that recruitment for universal programmes is challenging (Kumpfer & Hansen, 2014; Prinz, Smith, Dumas, Laughlin, White, & Barron, 2001; Dumas, Nissley-Tsiopinis, & Moreland, 2007). Parents may not perceive concerns within their family and therefore do not perceive the need to participate in parenting programmes. Recruitment for selected and indicated programmes also face a number of challenges such as poverty, unemployment, low education, and socio-economic disadvantages that affect parents decision in participating in programmes (Heinrichs et al., 2005; Kumpfer & Hansen, 2014). Families

who have difficulties accessing preventative or treatment-based parenting services are typically characterised by demographic variables such as low income, unemployed parents, and single parenthood (Sanders et al., 2007; Heinrichs et al., 2005; Prinz et al., 2001). Unfortunately, these families who are expected to benefit from parenting interventions often do not participate.

One identified factor that poses a significant barrier for families to participate in parenting programme is stigma (Bayley, Wallace, & Choudhry, 2009; Koerting et al., 2013). Studies reveal that parents associate using such services with admitting to being a failure as a parent, as well as a concern about being labelled (Koerting et al., 2013; Harachi, Catalano, & Hawkins, 1997). Seeking support from outside of the family network was found to be associated by parents with embarrassment or shame, as it can be seen as a sign that the family is not functioning well and is experiencing difficulties with coping. This was particularly relevant to members of close-knit communities (i.e., rural areas or religious communities; Harachi et al., 1997).

Parenting has often been considered as a private matter rather than a community responsibility, which often leads to difficulties in parents asking for and accepting help. The general public tends to perceive parenting programmes as a last resort or that of a special need for particular at-risk populations (Bayley et al., 2009; Miller & Darlington, 2002). Miller and Darlington (2002) found that the majority of parents relied on family (i.e., parents, siblings, and other family members) and friends for emotional support and to a lesser extent, for information support. Neighbours and community agencies were considered to be less important by parents in the study in terms of meeting their various support needs (i.e., practical, emotional, and informal support). These perceptual barriers have important implications as research indicates that engagement and continuity of services may be compromised if the perception of barriers by families is high (McKay & Brannon, 2004). These findings point to the need to identify strategies to avoid social stigma attached to parenting programmes, where parents are not labelled as 'failed' parents for participating (Koerting et al., 2013; Harachi et al., 1997).

In addition to stigma, several practical barriers such as time constraints, conflict with other activities, lack of childcare facilities, location of a programme, and transportation restraints have all been consistently identified as factors that hinder parents' participation (Owens et al., 2007; Heinrichs et al., 2005; Koerting et al., 2013; Spoth & Redmond, 2000).

Providing strategies to overcome these barriers is needed to increase parents' participation in parenting programmes. For example, delivering the programme at a location that is easily accessible by parents, providing childcare facilities, and organising transport to and from the venue if needed (Heinrichs et al., 2005).

Another important consideration regarding the underutilisation and low participation in parenting support services is the general lack of programmes that are available for parents of adolescents (Biglan et al., 2003; Spoth, 2007). As discussed previously, support for parents of adolescents has received much less attention than meeting concerns around support for parents of younger children. Given that there are limited parenting programmes available, it is not surprising that low participation may reflect a lack of awareness regarding the availability and applicability of these services. Johnson and colleagues (2005) found that a large percentage (62%) of parents with primary school children in their UK sample ($n = 428$) were not aware of any formal parenting services available to them. Asmussen and colleagues (2007) also noted that parents reported a lack of information about adolescent development and about where to go for information or advice. This issue has clear public health implications, as engaging parents in parenting programmes is an essential step that may lead to the reduction and prevention of adolescent problem behaviours.

2.6. Summary

In summary, powerful risk and protective factors for adolescent problem behaviours originate in the family environment. Given the damaging consequences of adolescent problem behaviours, there is a need to consider ways to ensure that all parents have access to effective parenting support. BFI that target parenting have been shown to be effective in reducing adolescent problem behaviours, decreasing dysfunctional parenting practices, and improving family functioning, with many studies demonstrating maintenance of positive changes over time (Stallman & Ralph, 2007; Cotter et al., 2013; Gates et al., 2006; Spoth et al., 2002). Despite the promising results, many parents do not participate in evidence-based parenting programmes, thus limiting the potential impact of such programmes. The challenge then, is to have an effective strategy to ensure that all parents can easily access and participate in parenting programmes. The following chapter discusses the need for a public health approach to parenting support for parents of adolescents.

Chapter 3 - A Public Health Approach to Parenting Adolescents

There is now a considerable amount of evidence about the specific family and parenting factors that influence the development of adolescent problem behaviours. Providing support for parents is therefore recognised as a key strategy to address and prevent many of the problem behaviours adolescents may engage in, and to enhance and sustain positive family functioning for healthy youth development (Steinberg, 2001; Spoth et al., 2008; Sanders, 2012). The slowly increasing evidence suggests that behavioural family interventions (BFI) for parents of adolescents are promising in improving outcomes for both parents and adolescents (Carr, 2009). The previous chapter reviewed a number of BFI and highlighted that although such programmes exist, few parents participate in these programmes. While there has been much concern about this low population reach, the fact is that very few evidenced-based parenting programmes are available and accessible. Clearly, an important task for policy makers and researchers is to increase the availability of evidence-based programmes to achieve population level impact in reducing and preventing adolescent problem behaviours. One strategy for parenting programmes to maximise population reach is to adopt a public health approach to parenting support for parents of adolescents (Sanders, 2012; Spoth et al., 2008). This approach focuses on the population as a whole, emphasises prevention, utilises comprehensive models rather than a one-size fits all approach, and is based on solid and empirical evidence. Given the importance of parents during adolescence, the focus of this chapter is to argue for a public health approach to the delivery of parenting programmes for parents of adolescents. This chapter consists entirely of a manuscript published in the *Journal of Public Health.*

3.1. Abstract

Poor parenting practices have been associated with adolescent emotional and behavioural problems which are potentially preventable. Parenting interventions that are based on behavioural and social learning theories have been repeatedly shown to be effective. However, few evidence-based parenting programmes are implemented and sustained at a population level. Little research is available on supporting the general population of parents during the adolescent years. Further, a substantial research-practice gap exists regarding the impact of a universal approach to parenting programmes for parents of adolescents. This article will first examine the effects of parenting practices on adolescent outcomes. Next, it addresses the effectiveness of parenting programmes for parents of adolescents. Finally, it discusses the need for a public health approach to parenting programmes.

Keywords: parenting programmes, parenting, adolescence, public health, intervention

3.2. Towards a Public Health Approach to Parenting Programmes for Parents of Adolescents

Adolescent emotional and behavioural problems result in great personal, social, and monetary cost (Miller, Levy, Spicer, & Taylor, 2006; Zagar, Zagar, Bartikowski, & Busch, 2009). The most serious, costly, and widespread adolescent problems – suicide, delinquency, violent behaviours, and unintended pregnancy – are potentially preventable (Bennett, Kang, Alperstein, & Kakakios, 2004). In addition to high risk behaviours, such as the use of alcohol, tobacco, and other drug; parents of adolescents, also express concerns in everyday parenting issues such as fighting with siblings, talking back to adults, and not doing school work (Ralph, Toumbourou, Grigg, Mulcahy, Carr-Gregg, & Sanders, 2003). These parental concerns are often perceived as normative during adolescence and the impact on family dynamics such as parental stress, negative parent-adolescent relationship, are often undermined. In addition to family factors, adolescent risk behaviours are influenced by peers, school, neighbourhood, and broader cultural contexts (Roth & Brooks-Gunn, 2003). The family plays a central role in potentiating or protecting against risk within and across these contexts (Fletcher, Elder, & Mekos, 2000).

Parenting interventions that are delivered during this developmental period are necessary in order to capture the groups of youth and families that are: 1) currently experiencing problems, but who did not receive an intervention during early childhood; 2) those who received an intervention in early childhood, but who continue to experience problems and, 3) those who are not currently experiencing problems, but are at risk for developing problems later in adulthood (Tully, 2007). In Steinberg's 2001 presidential address to the Society for Research on Adolescence, a concluding remark was made for the need to develop a systematic, large scale, multifaceted, and on-going public health campaign for parenting programmes for parents of adolescents. Despite the wealth of knowledge that has been generated over the past decade on the importance of parents in adolescent development, a substantial research gap still exists in the parenting literature in regards to interventions that support parents of adolescents. In addition, little attention has been given to wide-scale prevention programmes (Bennett et al., 2004; Sanders, 2010; Sanders & Prinz, 2008). The majority of prevention research involving parenting programmes has been conducted using indicated or selective prevention approaches that target individuals at high risk for developing behavioural and emotional disorders (Sanders, 2008). Little is known

about the potential impact of adopting a public health approach to the parenting of adolescents. The present article makes the case that parenting practices have an important impact on adolescent development and that the delivery of parenting programmes using a public health approach has the greatest potential to positively influence multiple risk behaviours of adolescents.

3.3. Effects of Parenting Practices on Adolescent Outcomes

Much has been written about parenting and adolescent development, and evidence suggest parents influence many diverse aspects of adolescents' lives including a wide range of social, emotional, and behavioural problems. There is strong evidence to demonstrate that an authoritative parenting style characterised as high in parental demand and parental responsiveness, that takes into account the changing needs of adolescents are associated with healthy adolescent psychological development. Findings indicate that, regardless of age, children of authoritative parents perform better in school, display fewer conduct problems, and show better emotional adjustment than those raised in non-authoritative homes (Simons & Conger, 2007). Adolescents with authoritative parents who balance appropriate levels of supervision, nurturance, and democratic decision-making tend to achieve better psychosocial outcomes. Studies reveal that adolescents with authoritative parents are associated with less psychological distress, higher self-esteem, higher academic achievements, lower levels of delinquency, and less substance use (Gray & Steinberg, 1999). Gray and Steinberg (1999) found that emotional and behavioural problems tended to be associated with the degree of behavioural control and supervision or monitoring. The more behavioural control parents exerted, the less likelihood there was that young people would engage in antisocial behaviours. Parenting practices also play a prominent role in adolescent autonomy development (Peterson, Madden-Dedich, & Lenoard, 2002), an important issue during adolescence. Parental autonomy granting is associated with various positive outcomes for adolescents, including improved academic achievement, enhanced work orientation, positive self-concept, and higher psychosocial maturity (Aquilino & Supple, 2001; Silk, Morris, Kanaya, & Steinberg, 2003). In addition to social, emotional, and behavioural problems, positive parenting has been associated with children's physical health and well-being as reflected by adequate nutrition (Rhee, 2011), active lifestyles (Bradley, McRitchie, Houts, Nader, & O'Brien, 2011), less computer and television screen exposure (Valcke, Bonte, De Wever, & Rots, 2010), and how they cope with chronic health problems such as asthma,

diabetes or obesity (West, Sanders, Cleghorn, & Davies, 2010). Parents continue to be an important influence on adolescent despite increasing peer and social involvement. Research clearly indicates that parenting practices have profound effects on adolescent development. Good parenting typically includes high levels of monitoring and involvement, as well as being warm, accepting, and nurturing, and these can promote the social and emotional competence of adolescents. Suboptimal parenting, however, may contribute to youth participation in high risk behaviours that may lead to poor long term outcomes (Johnson, Smailes, Cohen, Kasen, & Brook, 2004; Kerr, Stattin, & Burk, 2010; Moore, Rothwell, & Segrott, 2010). By providing an environment that is nurturing, protective, stimulating, and supportive, parents contribute significantly to the healthy development of adolescents.

3.4. Parenting Programmes for Parents of Adolescents

In recognition of the importance of parenting practices on adolescent development, a number of parenting programmes have been developed. A growing body of research conducted over the past 30 years on the efficacy and effectiveness of these family-based programmes provides promising support for the value of such programmes (Petrie, Bunn, & Byrne, 2007; Spoth, Redmond, & Shin, 2001). A number of meta-analyses on parenting interventions also attest to the benefits that children and adolescents derive from their parents when they learn positive parenting skills with positive effect sizes ranging from moderate to large effects post-treatment (i.e., parenting style, 0.68; parental competences 0.65; de Graaf, Speetjens, Smit, Wolff, & Tavecchio, 2008).

Parenting programmes can concurrently address multiple concerns leading to better outcome and lifestyles for both parents and adolescents. Programmes that strengthen family relationships and improve parenting skills are considered to be among the most effective strategies for addressing youth problems such as delinquency and substance abuse (Moore et al., 2010; Petrie et al., 2007). Studies have shown that parent interventions can decrease negative disciplinary behaviour in parents and increase the use of a variety of positive attending and other relationship-enhancing skills to improve child behaviour (Spoth, Redmond, & Shin, 2000; Sanders, 1999).

Improvements in parent-adolescent relationships have been achieved through training parents to be supportive and involved (Stallman & Ralph, 2007). Communication and problem-solving training have also been found to help families of adolescents manage

conflict and increase positive influence and mutual support (Moore et al., 2010). Family management practices, including clear family rules and standards, prohibiting adolescent alcohol and other drug use, and parents/carers' monitoring and supervision have been found to reduce youth substance use (Toumbourou, Blyth, Bamberg, & Forer, 2001). Parenting programmes that emphasised positive parenting techniques for monitoring activities, praising appropriate behaviour, and applying moderate and consistent discipline that enforces defined family rules have reported reductions in problem behaviours in adolescents (Petrie et al., 2007). In addition to impacting on these family-level risk and protective factors, parenting interventions have demonstrated success in preventing early adolescent involvement in alcohol use, tobacco use, and conduct problems (Dishion, Nelson, & Kavanagh, 2003). Benefits following exposure to parenting programmes for parents of adolescents have been demonstrated to persist post-intervention to two years (Spoth, Redmond, & Lepper, 1999) and four years (Spoth et al., 2000b).

Parenting interventions that are based on behavioural and social learning theories have repeatedly been shown to be effective in reducing risk factors and promoting protective factors for youth with emotional and behavioural problems (Spoth et al., 2001; Stallman & Ralph, 2007; Irvine, Biglan, Smolkowski, Metzler, & Ary, 1999). Behavioural and social learning theories propose that children and youths' externalising behaviours are attained and maintained via interaction processes and modelling from others in the environment (Wierson & Forehand, 1994). Parenting programmes typically have a core parenting skills training component where parents are encouraged to increase their positive interactions with their children, increase rewards for good behaviour, ignore unwanted behaviour, and improve communication with clear requests and consequences.

Parenting programme sessions frequently include review of homework, video presentations of more or less effective ways of parenting, short lectures and discussions to elicit parenting principles, interactive exercises, and modelling and role plays of direct practice (Kumpfer & Alvarado, 2003). Parenting programmes also vary in intensity and duration and can range from brief self-directed programmes that involve the provision of written material alone to facilitator-guided interventions that last several months. Intervention research has shown that there is considerable variability in the duration and intensity of the parenting interventions offered. Linear associations are common, with higher duration and intensity leading to better outcomes (Aber, Jones, Brown, Chaudry, & Samples, 1998). While

some parents and families require intensive interventions, brief targeted methods can also be effective (Dishion, Spracklen, Anderws, & Patterson, 1996). There are increasing evidence that low intensity interventions are also effective and can be delivered to large numbers of parents and their families (e.g., Lim, Tormshak, & Dishion, 2005).These interventions may have a more pervasive impact than intensive interventions that target high risk individuals (Dishion et al., 1996).

3.5. The Need for a Public Health Approach

Positive outcomes have been reported in many randomised clinical trials. This work has recently been extended by the adoption of a public health model for the delivery of parenting support with parents of younger children (Sanders, 2008, 2010, 2012). Various epidemiological surveys show that most parents concerned about their children's behaviour or adjustment do not receive professional assistance for these problems and when they do, they typically consult family doctors or teachers who rarely have specialised training in parent consultation skills (Sanders & Prinz, 2008). Most of the family-based programmes targeting adolescents are only available to selective subpopulations of adolescents (those who have identified risk factors) and/or indicated subgroups of youth (those who already possess negative symptoms or detectable problems). Fewer programmes are available to those that encompass all youth (i.e., universal programmes). According to Geoffrey Rose, the distribution of risk levels follows a continuum in which the high risk individuals are at the extreme end. A large number of individuals with moderately increased risk levels contribute more cases than a small number with extreme risk levels (Rose, 1992). Parenting programmes that target high-risk populations therefore miss a substantial number of families who develop the problem even though they are not currently in the elevated risk group (Bennett et al., 2004; Sanders, 2008, 2010). The potential impact of such programmes at the population level is therefore minimal as only a small proportion of families in the general population participate in evidence-based programmes (Sanders & Prinz, 2008; Sanders, 2008). As Geoffrey Rose emphasised more than a decade ago, strategies that focus on high risk individuals will deal only with the margin of the problem and will not have impact on the general population. A linear association exists between exposure and outcome (Rose, 1992) and that a relatively small increase in parental exposure to an evidence-based programme can have significant population level effects.

A population approach to parenting programmes for parents of adolescents aims to modify parenting behaviours to produce multiple beneficial health and developmental outcomes for young people at the population level (Bennett, 2004; Sanders, 2010; Steinberg, 2001). A population approach can normalise and de-stigmatise parenting experiences. It seeks to break down parents' sense of isolation, increase social and emotional support from others in the community, and publicly acknowledge the importance and difficulties of parenting (Sanders, 2010; Steinberg, 2001). For parenting programmes to be well received and accepted at a population level, self-regulation should be promoted. Parents' fundamental rights to making decisions on how they raise their children should be protected rather than judged and prescribed. Parents should be taught the skills to change their own behaviour and become independent problem solvers in a broader social environment that supports parenting and family relationships (Sanders, 2012).

In recognition of the potential value of evidence-based parenting programmes, policy makers and scholars, in recent years, have taken a proactive stance to promote an increase in the availability of parenting programmes at the population level (Bennett et al., 2004; Sanders, 2010; Steinberg, 2001). For example, the National Research Council and Institute of Medicine (2009) recommended in their report on *Preventing Mental, Emotional and Behavioural Disorders Amongst Young People* that parenting programmes should be more widely disseminated and accessible. Similar initiatives have been made by the World Health Organization (2009), American Psychological Association (APA) Task Force (2009), and a number of European countries to increase dissemination of evidenced-based parenting programmes (Sanders, 2008).

A large scale population-level study conducted by Prinz and colleagues (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009) in 18 South Carolina countries using Triple P (Positive Parenting Program) for families with children between 0 to 8 years old demonstrated positive impact on reduction in child maltreatment, declined levels of in out-of-home foster care placement, and reduced numbers of emergency room visits and hospital admissions resulting from child maltreatment. Findings from the study were particularly important as it demonstrated population-wide effects for reducing child maltreatment. The study further illustrated that using a population approach was cost effective. Given the high public cost associated with child maltreatment, the researchers estimated that communities implementing Triple P were able to recoup their investments (media campaign and training

for child and youth workers) in less than one year (Prinz et al., 2009). This population-level study on younger children shed a light on the fact that similar findings might result if a population approach is used on parents with adolescents. Reducing the prevalence of adolescent behaviour problems will require that a large proportion of the population be reached with effective parenting strategies (Sanders, 2010; Sterinberg, 2001). A population approach to parenting programmes for parents of adolescents seeks to optimise impact and reach a larger proportion of the general population.

3.6. An Ecological Approach to Support Better Parenting

In the Strategic Review of Health Inequalities in England by Michael Marmot and others (2010), Marmot discussed the concept of proportional universalism, whereby focusing solely on the most disadvantaged will not reduce health inequalities and that actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. What is required will be a population wide parenting intervention to prevent and/or reduce adolescent problem behaviours but also targeted interventions that may be needed for high risk families. When considering the reach of public health approaches to parenting support, it is important that families that are most in need of intervention actually receive it. It is often the case that the most advantaged families are often better resourced to take advantage of population wide interventions. Dissemination of parenting interventions can be strengthened by attending to several key factors and principles: 1) ensuring interventions are used that match families' needs and preferences, 2) strong scientific evidence is available to support intervention components used in a population based approach, 3) multiple de-stigmatised access points are provided for families, and 4) cost effective strategies are used (Prinz, 2009). Poor participation and engagement by parents in parenting programmes stands as one of the most difficult barriers to widespread effective implementation of parenting programmes (Spoth, Clair, Greenberg, Redmond, & Shin, 2007; Spoth et al., 2000a). Parental willingness to participate in a parenting programme depends on several interacting variables. These include the nature of the programme offered, how it is delivered, perceptions of the parents as to whether the programme is culturally appropriate and potentially useful for dealing with their concerns, how much time they will need to invest, and the payoff they anticipate relative to other uses of their time (Sanders & Prinz, 2008; Sanders, 2008; Kumpfer & Alvarado, 2003; Spoth et al., 2007). Most parenting programmes usually are delivered in only one format (e.g., parent groups), have fixed length (e.g., between 8-15 sessions), and are designed

for one particular setting (e.g., clinic, school). This fixed delivery format may not be suitable for all families and can create a potential barrier to participation in parenting programmes.

A comprehensive population approach that includes multiple levels (universal, selected, and indicated) of parenting support will better serve the needs of a diverse population. This will mean that families can receive the minimally sufficient level of intervention they require (Prinz, 2009). This multilevel strategy recognises that there are differing levels of dysfunction and behavioural disturbances in adolescents, and that parents' have differing needs and desires regarding the type, intensity and mode of assistance they require (Sanders, 2008; Prinz, 2009; Foster, Prinz, Sanders, & Shapiro, 2007). While some families may require intensive programmes, others may require minimal assistance. In accordance with the population perspective which involves the core principle of minimal sufficiency, the multilevel strategy allows for broad dissemination of parenting programmes in a cost effective manner (Sanders, 2008; Prinz, 2009; Foster et al., 2007).

One of the causes of inadequate dissemination is restricted access to services. Universal preventive approaches to parenting programmes are generally designed to reduce family-related risk factors and enhance family protective factors by targeting an entire population (e.g., national, local community, neighbourhood or school). The mass media can play an important role in providing health information and related issues for parents and caregivers (Sanders & Prinz, 2008). However, adolescents are typically portrayed in the media as hostile, violent, delinquent, alienated from parents and families, and resistant to any assistance (Bennett et al., 2004; Faucher, 2009; Kidd-Hewitt, 2002). In news and television coverage, content analyses found that adolescents are depicted as perpetrators or victims of crime and violence, problem-ridden, and disruptive (Faucher, 2009; Kidd-Hewitt, 2002). In addition to the mass media images, public attitudes toward adolescents are predominately negative (Faucher, 2009). A population approach to build a climate of public interest and responsiveness will require actively working towards counteracting the predominantly negative media coverage of adolescents (Bennett et al., 2004). Media messages can raise parents' awareness and willingness to attend parenting programmes by normalising their experiences of receiving professional support. These messages should be based not only on research about adolescence, parenting, and effective communications, but also on research about what actually supports, rather than undermines, parents in their efforts to be better parents (Bennett et al., 2004; Sanders & Prinz, 2008; Steinberg, 2001).

In addition to universal interventions, a system of selected and indicated parental support is required for high risk families (Sanders, 2010; Foster et al., 2008). Although high risk families are also likely to benefit from universal services that promote positive parenting, it is highly probable that they will need more intensive support over longer periods of time. It is unlikely that the kind of support offered through universally available service will meet the need of highly vulnerable families. Intervention strategies that target high risk families or the general population are more likely to be complementary to one another rather than alternatives. A comprehensive model that blends universal, selected, and indicated levels of intervention in a set of parenting programme will increase flexibility and options for parents to access parental support.

3.7. Conclusion

A decade from Steinberg's 2001 presidential address, effective evidence-based parenting interventions and approaches exist in the research literature; however, the dissemination from research to practice has been relatively slow and the difficulty in achieving this has been apparent. The literature includes little research on supporting the general population of parents through their child's transition into adolescence and a substantial research-practice gap exists regarding the impact of a universal approach to parenting programmes for parents of adolescents. Parenting programmes directed at families with adolescents provide a promising direction for promoting positive youth development (Stallman & Ralph, 2007; Kumpfer & Alvarado, 2003; Steinberg, 2001; Prinz et al., 2009), yet, there remain several challenges that hinder their wide-scale dissemination. The requirements for a public health approach to parenting support to be effectively implemented at the population level are flexible tailoring of evidence-based programmes, increased accessibility to cost-efficient, low-intensity interventions, and evaluation of impact at a whole of population-level rather than solely tracking of individual outcomes (Sanders, 2010; Prinz, 2009; Foster et al., 2000). Effectively addressing these challenges is potentially achievable so that public health approaches to parenting support gain the acceptance they deserve and potential for population level benefit turns into reality.

3.8. References

Aber, J. L., Jones, S. M., Brown, J. L., Chaudry, N., & Samples, F. (1998). Resolving conflict creatively. Evaluating the developmental effects of a school-based violence prevention programme in neighbourhood and classroom context. *Development and Psychopathology,* 10, 187-213. doi:10.1017/s0954579498001576

American Psychological Association. (2009). *Effective strategies to support positive parenting in community health centers: Report of the Working Group on Child Maltreatment Prevention in Community Health Centers:* Washington, DC: American Psychological Association.

Aquilino, W. S., & Supple, A. J. (2001). Long-term effects of parenting practices during adolescence on well-being outcomes in young adulthood. *Journal of Family Issues,* 22, 289-308. doi: 10.1177/019251301022003002

Bennett, D. L., Kang, M., Alperstein, G., & Kakakios, M. (2004). Collaborative strategies for improving the health of young people. *Hong Kong Journal of Pediatrics,* 9, 295-302.

Bradley, R. H., McRitchie, S., Houts, R. M., Nader, P., & O'Brien, M. (2011). Parenting and the decline of physical activity from age 9-15. *International Journal of Behavioural Nutrition Physical Activity,* 8, 33-43. doi:10.1186/1479-5868-8-33

De Graaf, I., Speetjens, P., Smit, F., Wolff, M, de., & Tavecchio, L. (2008). Effectiveness of the Triple P Positive Parenting Program on Parenting: A Meta-Analysis. *Family Relation,* 57, 553-566.

Dishion, T. J., Spracklen, K. M., Andrews, D. W., & Patterson, G. R. (1996). Deviancy training in male adolescent friendships. *Behaviour Therapy,* 27, 373-390.

Dishion, T. J., Nelson, S. E., & Kavanagh, K. (2003). The Family Check-Up with high-risk young adolescents: Preventing early-onset substance use by parent monitoring. *Behaviour Therapy,* 34, 553-571. doi:10.1016/s0005-7894(03)80035-7

Faucher, C. (2009). Fear and loathing in the news: A qualitative analysis of Canadian print news coverage of youthful offending in the twentieth century. *Journal of Youth Studies,* 12, 439-456. doi: 10.1080/13676260902897426

Fletcher, A. C., Elder, G. H., & Mekos, D. (2000). Parental infleunces on adolescent involvement in community activities. *Journal of Research on Adolescence,* 10, 29-48.

Foster, E. M., Prinz, R. J., Sanders, M. R., & Shapiro, C. J. (2008). The costs of a public health infrasture for delievering parenting and family support. *Children and Youth Services Review,* 30, 493-501. doi:10.1016/j.childyouth.2007.11.002

Gray, M. R., & Steinberg, L. (1999). Unpacking authoritative parenting: Reassessing a multidimensional construct. *Journal of Marriage and Family,* 61, 574-587.

Irvine, A. B., Biglan, A., Smolkowski, K., Metzler, C. W., & Ary, D. V. (1999). The effectiveness of a parenting skills programme for parents of middle school students in small communities. *Journal of Consulting and Clinical Psychology,* 67, 811-825. doi: 10.1037/0022-006X.67.6.811

Johnson, J. G., Smailes, E., Cohen, P., Kasen, S., & Brook, J. S. (2004). Anti-social parental behaviour, problematic parenting and aggressive offspring behaviour during adulthood: A 25-Year longitudinal investigation. *British Journal of Criminology,* 44, 915-930. doi: 10.1093/bjc/azh041

Kerr, M., Stattin, H., & Burk, W. J. (2010). A reinterpretation of parental monitoring in longitudinal perspective. *Journal of Research on Adolescence,* 20, 39-64. doi: 10.1111/j.1532-7795.2009.00623.x

Kidd-Hewitt, D. (2002). Crime and the media: a criminological perspective. In Y. Jewkes & G. Letherby (Eds.), *Criminology: A Reader* (pp. 116-129). London: SAGE.

Kumpfer, K. L., & Alvarado, R. (2003). Family-strengthening approaches for the prevention of youth problem behaviours. *American Psychologist,* 58, 457-465. doi: 10.1037/0003-066x.58.6-7.457

Lim, M., Tormshak, E. A. S., & Dishion, T. J. (2005). A one-session intervention for parents of young adolescents. *Journal of Emotional and Behavioural Disorder,* 13, 194-199. doi:10.1177/10634266050130040101

Marmot, M. (2010). Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post.

Miller, T. R., Levy, D. T., Spicer, R. S., & Taylor, D. M. (2006). Societal costs of underage drinking. *Journal of Studies on Alcohol,* 67, 519-528.

Moore, G. F., Rothwell, H., & Segrott, J. (2010). An exploratory study of the relationship between parental attitudes and behaviour and young people's consumption of alcohol. *Substance Abuse Treatment Prevention and Policy,* 5. doi: 10.1186/1747-597x-5-6

Morawska, A., Haslam, D., Milne, D., & Sanders, M. R. (2011). Evaluation of a brief parenting discussion group for parents of young children. *Journal of Developmental and Behaviour Pediatrics,* 32, 136-145. doi:10.1097/DBP.0b013e3181f17a28

National Research Council and Institute of Medicine. (2009). *Preventing mental, emotional, and behavioural disorders among young people: Progress and possibilities.* Washington, DC: National Academic Press.

Peterson, G. W., Madden-Derdich, D., & Leonard, S. A. (2002). Parent-child relations across the life-course: Autonomy within the context of connectedness. In S. J. Price, P. C. McKenry, & M. J. Murphy (Eds.), *Families Across Time: A Life Course Perspective.* (pp. 187-203). Los Angeles, CA: Roxbury Publishing Co.

Petrie, J., Bunn, F., & Byrne, G. (2007). Parenting programmes for preventing tobacco, alcohol or drugs misuse in children < 18: a systematic review. *Health Education Research,* 22, 177-191. doi: 10.1093/her/cyl061

Prinz, R. J. (2009). Dissemination of a multi-level evidence-based system of parenting interventions with broad application to child welfare populations. *Child Welfare,* 88, 127-132.

Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-based prevention of child maltreatment: the U.S. Triple P system population trial. *Prevention Science,* 10, 1-13. doi: 10.1007/s11121-009-0123-3

Ralph, A., Toumbourou, J. W., Grigg, M., Mulcahy, R., Carr-Gregg, M., & Sanders, M. R. (2003). Early intervention to help parents manage behavioural and emotional problems in early adolescent: what parents want. *Australian e-Journal for the Advancement of Medical Health (AeJAMH),* 2.

Rhee, K. (2008). Childhood overweight and the relationship between parent behaviours, parenting style, and family functioning. *American Academy of Political Social Science,* 615, 12-37. doi:10.1177/0002716207308400

Rose, G. (1992). *The strategy of preventive medicine.* Oxford: Oxford University Press.

Roth, J., & Brooks-Gunn, J. (2003). Youth development programmes: risk, prevention, and policy. *Journal of Adolescent Health,* 32, 170-182.

Sanders, M. R. (1999). Triple P-Positive Parenting Program: towards an empirically validated multilevel parenting and family support strategy for the prevention of behaviour and emotional problems in children. *Clinical Child and Family Psychology Review,* 2, 71-90. doi: 10.1023/A:1021843613840

Sanders, M. R. (2008). Triple P-positive parenting program as a public health approach to strengthening parenting. *Journal of Family Psychology,* 22, 506-517. doi: 10.1037/0893-3200.22.3.506

Sanders, M. R. (2010). Adopting a public health approach to the delivery of evidence-based parenting interventions. *Canadian Psychology/Psychologie canadienne,* 51, 17-23. doi: 10.1037/a0018295

Sanders, M. R., & Prinz, R. J. (2008). Using the mass media as a population level strategy to strengthen parenting skills. *Journal of Clinical Child and Adolescent Psychology,* 37, 609-621. doi: 10.1080/15374410802148103

Silk, J. S., Morris, A. S., Kanaya, T., & Steinberg, L. (2003). Psychological control and autonomy granting: Opposite ends of a continuum or distinct constructs? *Journal of Research on Adolescence,* 13, 113-128. doi:10.1111/1532-7795.1301004

Simons, L. G., & Conger, R.D. (2007). Linking mother-father differences in parenting to a typology of family parenting styles and adolescent developmental outcomes. *Jounral of Family Issues,* 28, 212-241. doi:10.1177/0192513X06294593

Spoth, R., Clair, S., Greenberg, M., Redmond, C., & Shin, C. (2007). Toward dissemination of evidence-based family interventions: Maintenance of community-based partnership recruitment results and associated factors. *Journal of Family Psychology,* 21, 137-146. doi: 10.1037/0893-3200.21.2.137

Spoth, R., Redmond, C., & Lepper, H. (1999). Alcohol initiation outcomes of universal family-focused preventive interventions: one- and two-year follow-ups of a controlled study. *Journal of Studies on Alcohol,* 13, 103-111.

Spoth, R., Redmond, C., & Shin, C. (2000a). Modeling factors influencing enrollment in family-focused preventive intervention research. *Prevention Science,* 1, 213-225. doi: 10.1023/A:1026551229118

Spoth, R., Redmond, C., & Shin, C. (2000b). Reducing adolescents' aggressive and hostile behaviours - Randomised trial effects of a brief family intervention 4 years past baseline. *Archives of Pediatrics & Adolescent Medicine,* 154, 1248-1257.

Spoth, R., Redmond, C., & Shin, C. (2001). Randomised Trial of brief family interventions for general populations: adolescent substance use outcomes 4 years following baseline. *Journal of Consulting & Clinical Psychology,* 69, 627-642. doi: 10.1037/0022-006X.69.4.627

Stallman, H. M., & Ralph, A. (2007). Reducing risk factors for adolescent behavioural and emotional problems: A pilot randomised controlled trial of a self-administered parenting intervention. *AeJAMH (Australian e-Journal for the Advancement of Mental Health),* 6, 1-13.

Steinberg, L. (2001). We know some things: parent and adolescent relationships in retrospect and prospect. *Journal of Research on Adolescence,* 11, 1. doi: 10.1111/1532-7795.00001

Toumbourou, J. W., Blyth, A., Bamberg, J., & Forer, D. (2001). Early impact of the BEST intervention for parents stressed by adolescent substance abuse. *Journal of Community & Applied Social Psychology,* 11, 291-304. doi: 10.1002/casp.632

Tully, L. (2007). *Early intervention strategies for children and young people 8 to 14 years – A literature review*. New South Wales: Department of Community Services.

Valcke, M., Bonte, S., De Wever, B., & Rots, I. (2010). Internet parenting styles and the impact on internet use of primary school children. *Computer and Education,* 55, 454-464. doi:10.1016/j.compedu.2010.02.009

West, F., Sanders, M. R., Cleghorn, G. J., & Davies, P. S. W. (2010). Randomised clinical trial of a family-based lifestyle intervention for childhood obesity involving parents as the exclusive agents of change. *Behaviour Research and Therapy,* 48, 1170-79. doi:10.1016/j.brat.2010.08.008

Wierson, M., & Forehand, R. (1994). Parent behaviour training for child noncompliance: Rationale, concepts, and effectiveness. *Current Direction in Psychological Science*, 3, 146-150.

World Health Organization. (2009). *Preventing violence through the development of safe, stable and nurturing relationships between children and their parents and caregivers. Series of briefings on violence prevention: The evidence.* Geneva, Switzerland: World Health Organization.

Zagar, A. K., Zagar, R. J., Bartikowski, B., & Busch, K. G. (2009). Cost comparisons of raising a child from birth to 17 years among samples of abused, delinquent, violent, and homicidal youth using victimisation and justice system estimates. *Psychological Reports,* 104, 309-338. doi: 10.2466/PR0.104.1.309-338

Chapter 4 - Methodology

If the ultimate goal is to adopt a public health approach whereby all parents of adolescents have access to evidence-based parenting programmes, first and foremost, a range of effective parenting programmes need to be available. These include programmes not only for families who are already experiencing difficulties, but also for families in the community that are dealing with everyday concerns with parenting. As stated in Chapter 3, a comprehensive approach, which includes multiple levels of interventions (universal, selected, and indicated) can have the greatest impact on families as they reach out to and meet the needs of more individuals than a single parenting intervention (Sanders, 2012; Tully, 2007). Each level of the intervention should be developed and rigorously evaluated in isolation (Collins, Chakraborty, Murphy, & Strecher, 2009). The goal of such an approach is to ensure that each level of the intervention is effective and has an evidence base to justify inclusion in a public health model, with supporting evidence for each level (Collins et al., 2009; Sanders, 2012). Efficacy trials are therefore a useful and necessary step in building a multilevel system of parenting support for parents of adolescents.

However, as discussed previously, there is a lack of evidence-based parenting programmes available for parents of adolescents. Many of the studies available suffer from a number of methodological shortcomings. Moreover, a noticeable gap in almost all of the programmes evaluated is the perspectives and input of adolescents. Given the fact that improving the outcome of adolescents is a major goal of parenting programmes, involving and consulting adolescents to obtain their input would seem to be an important research priority. Finally, families are the major decision-makers in regard to the use of services; however, at present there are few studies that examine their perceptions and experiences of such services. Input from parents and adolescents about the social validity of parenting programmes is therefore an important aspect of evaluating the services provided. The inclusion of parental and adolescent voices in evaluation may also empower individuals and lead to increased participation in programmes (Kirby & Sanders, 2012).

The present study was therefore designed to address the gaps in the literature through the evaluation of a universal group parenting programme for parents of adolescents - Group

Teen Triple P (GTTP). This chapter discusses the overall methodology of this research. A background of the chosen parenting programme for evaluation – Triple P, and the Teen component of the programme is also presented.

4.1. The Present Study

The aim of the present study is twofold. First, it contributes to the current limited evidence base on parenting programmes by examining the efficacy of a universal group programme designed specifically for parents of adolescents - GTTP. Second, it addresses the lack of research on the social validity of parenting programmes by examining the acceptability and usefulness of GTTP from the perspectives of parents and adolescents.

Before describing the methodological approach chosen for the study, it is necessary to provide an explanation of what Positive Parenting Program (Triple P) is and why the group Teen component of the programme was chosen to be evaluated.

4.2. Triple P – Positive Parenting Program

The selection of the Triple P system as the parenting intervention to be evaluated was based in part on the existence of a large number of well controlled outcomes studies that show the intervention is effective in reducing behavioural and emotional problems in young children. In addition, consistent with a public health approach, the idea and structure for the implementation of Triple P focuses on the explicit recognition of the parental role in the broader ecological context, by normalising parental experiences, breaking down their sense of social isolation, and by encouraging social and emotional support from others in the community (Sanders, 2012). Triple P provides support along a continuum of services – universal, selected, and indicated interventions, and has the flexibility to be applicable in the context of both treatment (Sanders & Prinz, 2005) and prevention (Prinz, 2009). The following presents an overview of the Triple P system and Teen Triple P.

Triple P is a multilevel intervention that aims to prevent and treat social, emotional, and behavioural problems in children by enhancing the knowledge, skills, and confidence of parents (Sanders, 2012). It is developed for parents of children aged from birth to sixteen and targets the specific developmental stages of infancy, early childhood, school age, and adolescence. The Triple P system comprises five levels of intervention of increasing intensity

and narrowing population reach. Both universal and targeted interventions are included in the system and a range of variants have been developed to meet the differing needs of parents and thereby provide a comprehensive system of parenting support (Sanders, 2012). The system is designed to maximise efficiency, contain costs, avoid waste and over-servicing, and ensure that the programme has a wide reach in the community (Sanders, 2012). Table 4.1. summarises the key features of the Triple P multilevel model.

Table 4.1.

The Triple P multilevel intervention model of parenting and family support

Level of Intervention	Target Population	Intervention Method	Practitioners
Level 1: *Universal Triple P* Media-based parent information campaign	All parents interested in information about promoting their child's development and parenting information.	Coordinated media and health promotion campaign raising awareness of parent issues and encouraging participation in parenting programmes. May involve electronic and print media (e.g., community service announcements, talk-back radio, newspaper and magazine editorials).	Typically coordinated by area media liaison officers or mental health or welfare staff.
Level 2: *Selected Triple P Selected Teen Triple P* Health promotion strategy/brief selective intervention	Parents interested in parenting education or with specific concerns about their child's behaviour or development.	Health promotion information or specific advice for a discrete developmental issue or minor child behaviour problem. May involve a group seminar process or brief (up to 20 mins) telephone or face-to-face clinician contact.	Parent support during routine well-child health care (e.g., child and community health, education, allied health and child care staff).
Level 3: Primary Care Triple P Primary Care Teen Triple P Narrow focus parent skills training	Parents with specific concerns about their child's behaviour or development who require consultations or active skills training.	Brief programme (80 mins over 4 sessions) combining advice, rehearsal, and self-evaluation to teach parents to manage discrete child problem behaviour. May involve telephone or face-to-face clinician contact or group sessions.	Same as above for level 2.

Level 4[1]:			
Standard Triple P Group Triple P Standard Teen Triple P Group Teen Triple P Self-Directed Triple P Broad focus parent skills training	Parents wanting intensive training in positive parenting skills. Typically children with more severe behaviour problems such as aggression or oppositional behaviours.	Broad focus programme (about 10 hours over 8-10 sessions) focusing on parent-child interaction and the application of parenting skills to a broad range of target behaviours. Includes generalisation enhancement strategies. May be self-directed or involve telephone or face-to-face clinician contact or group sessions.	Intensive parenting interventions (e.g., mental health and welfare staff, and other allied health and education professionals who regularly consult with parents about child behaviour).
	Families of preschool aged children with disabilities or at risk of developing behavioural or emotional disorders.	A parallel 10-session, individually tailored programme with a focus on disabilities. Sessions typically last 60-90 mins (except for 3 practice sessions which are 40 mins each)	
Stepping Stones Triple P Specialist disorders			Same as above.
Level 5:			
Enhanced Triple P Behavioural family intervention	Parents of children with concurrent child behaviour problems and family dysfunction such as paternal depression, stress or conflict between partners.	Intensive individually tailored programme with modules (sessions last 60-90 min) including practice sessions to enhance parenting skills, mood management and stress coping skills, and partner support skills.	Intensive family intervention work (e.g., mental health and welfare staff).
Pathways Triple P	Parents at risk of maltreating their children. Targets anger management problems and other factors associated with abuse.	Modules include attribution retraining and anger management.	Same as above.

Note. Adapted from "Triple P-Positive Parenting Program as a public health approach to strengthening parenting" by M. R. Sanders, 2008, Journal of Family Psychology, 22, p. 508. Copyright 2008 by the American Psychological Association.

---

[1] It should be noted that this level of intervention can be used to target individuals at risk or an entire population. For example, a group version of the programme may be offered universally to serve a diverse range of families.

The programme's fundamental strategies are derived from social learning principles and bidirectional effects of parent-child interactions to reduce known family risk factors associated with problem behaviours, as well as to promote parental competence through increased parenting knowledge, skills, and self-efficacy (Sanders, Markie-Dadds, & Turner, 2003; Sanders, 2012). Through providing parents with positive child management skills and consistent disciplinary methods, the programme aims to eliminate coercive interaction patterns and create positive family relationships and functioning. The programme aims to build on the parent's capacity for self-regulation, modify self-management tools to change their child's behaviour, and encourage self-sufficient parenting practices (Sanders, 2008; Sanders et al., 2003).

The evidence base for Triple P with young children includes efficacy, effectiveness, and dissemination studies across countries, cultural groups, socioeconomic strata, and prevention and treatment contexts (e.g., Mejia et al., 2012; Leung et al., 2013; Jones et al., 2013; Glazemakers & Deboutte, 2012; Turner, Richards, & Sanders, 2007; Prinz et al., 2009). A number of randomised controlled trials (RCT) and independent meta-analyses indicate that various formats of Triple P, including group programmes, individual clinic-based therapy, telephone-based programmes, and self-directed programmes, are effective in improving parenting practices, parental well-being, and children's behaviour and adjustment (e.g., Tellegen & Sanders, 2013; de Graaf et al., 2008; Markie-Dadds & Sanders, 2006; Nowak & Heinrichs, 2008; Thomas & Zimmer-Gembeck, 2007; Leung et al., 2013). Sanders and colleagues (under review) conducted a meta-analysis of116 evaluations studies on Triple P and found positive effects for both parenting and child problem behaviour measures, with effect size ranging between 0.23 and 0.58. Analysis of follow-up scores also indicated that intervention effects were maintained (Sanders, Kirby, Tellegen & Day, 2013).

4.2.1. Teen Triple P

The programme for parents of teenagers, known as Teen Triple P, mirrors those for parents of younger children, but with a stronger emphasis on the importance of parents acknowledging and encouraging the growing autonomy and independence of teenagers relative to younger children (Ralph & Sanders, 2003). Recognition is also given to the likelihood of teenagers engaging in risky behaviour that may put their current or future health, education and general well-being in jeopardy, and providing parents with ways of assisting their teenagers to negotiate and manage these challenges effectively (Ralph &

Sanders, 2003). Teen Triple P is built upon five core principles of Triple P which are explored throughout the programme. These include ensuring a safe, engaging environment; creating a positive learning environment; using assertive discipline; having realistic expectations; and taking care of oneself as a parent (Sanders et al., 2003).

The Teen programme also echoes Triple P's key feature in adopting a self-regulatory framework and training for generalisation of parenting skills (Ralph & Sanders, 2003). Teen Triple P aims to promote self-regulation by fostering the following skills and abilities in parents: self-sufficiency, self-efficacy, self-management, personal agency, and problem solving. When parents are self-sufficient, they are able to use their knowledge, skills, and resources to solve new problems when they arise. Self-efficacy refers to parents being confident that they can manage the daily tasks of parenting. Self-management is taught through an active skills training process. Parents learn to set their own goals, monitor and evaluate their success, and implement their own parenting plans. Teen Triple P creates personal agency by helping parents attribute improvements to their own efforts and/or their adolescent's efforts. Finally, Teen Triple P develops problem solving skills in parents so they can apply knowledge and skills to new parenting challenges in the future (Sanders & Mazzucchelli, 2013). Through promoting self-regulation, GTTP enhances generalisation and maintenance of parenting skills.

Like the suite of programmes for younger children, Teen Triple P is available as a multi-level intervention and can be delivered in a range of formats, including large group seminars, small group or individual programmes, or as a self-directed programme. This study focuses on the group variant of Teen Triple P, which falls within level 4 of the system.

4.2.1.1. Group Teen Triple P (GTTP)

Group based parenting programmes are the most cost effective as this delivery context is able to reach a larger number of families (Powell, 2005). Although group programme may mean parents receive less individual attention, benefits include support, friendship, and constructive feedback from other parents as well as opportunities for parents to normalise their parenting experience through peer interactions. Studies further demonstrate that parents are more likely to comply with parenting programmes in a group setting within the community (Sanders, 2012; Powell, 2005).

GTTP is an early intervention strategy that aims to increase parental competence and confidence in raising teenagers. It is designed as a universal parenting support for a diverse population of parents. GTTP consists of eight-sessions for parents that employ an active skills training process (i.e., observation, discussion, practice, and feedback) to help parents acquire new knowledge and skills (Ralph & Sanders, 2002).

4.2.1.1.1. Session content

The first four two-hour group sessions cover content including identification of their own goals for change, understanding common adolescent behaviour and emotional problems, developing good relationships with their teenagers, promoting positive behaviour in their teenager, managing difficult behaviours, and planning ahead for high risk situations. Segments from a DVD *Every Parent's Guide to Teenagers* (Ralph & Sanders, 2001) are used to demonstrate positive parenting skills. Between sessions, parents complete tasks to consolidate their learning from the group sessions. Three 15-30 minute individual telephone sessions follow the group session to assist parents to fine-tune the implementation of the parenting strategies, and problem-solve any implementation difficulties. One final group session is held following the telephone consultations to cover additional skills to facilitate generalisation and maintenance of positive changes (Ralph & Sanders, 2002). Table 4.2. provides an overview of the programme content.

Table 4.2.

Overview of programme content in Group Teen Triple P

	Weekly Topic	Session Content	Duration
1)	Positive Parenting	What is positive parenting? Factors influencing teenagers' behaviour Goals for change Keeping track of problem behaviour	120 Minutes
2)	Encouraging Appropriate Behaviour	Developing positive relationships with teenagers Increasing desirable behaviours Teaching new skills and behaviours Holding family meetings	120 Minutes
3)	Managing Problem Behaviour	Developing family rules Dealing with non-compliance Dealing with emotional behaviour Using behaviour contracts	120 Minutes
4)	Dealing with Risky Behaviours	Identifying risk situations Routine for dealing with risky behaviour Family survival tips Preparing for telephone sessions	120 Minutes
5)	Phone Call Session – Implementing Family Routines-1	Update on progress Collaborative problem solving Other issues	15-30 Minutes
6)	Phone Call Session – Implementing Family Routines-2	Update on progress Collaborative problem solving Other issues	15-30 Minutes
7)	Phone Call Session – Implementing Family Routines-3	Update on progress Collaborative problem solving Other issues	15-30 Minutes
8)	Programme Review and Close	Update on progress Maintaining changes Problem solving for the future	120 Minutes

4.2.1.1.2. Specific parenting strategies

The parenting strategies that are taught during the group sessions fall into five main skills-based categories, including: skills to strengthen positive parent-adolescent relationships; skills to encourage desirable behaviour; skills for teaching adolescent new behaviours and skills; skills to manage problem behaviours; and skills for teaching adolescents how to avoid or deal with high-risk situations. These skills promotes family cohesiveness, reduces parent-adolescent conflict, and foster positive adolescent development. Table 4.3. summarises the specific parenting skills taught in GTTP.

Table 4.3.

Parenting strategies promoted through Group Teen Triple P

	Strategy	Application	Description
Developing Positive Relationships	Spending time with a teenager	Spending frequent, small amounts of time when there is no pressure to get other things done	Opportunities for teenagers to enjoy parent contact and maintain positive relationship
	Talking to a teenager	Having brief conversations about topics that are of interest to them	Promoting opportunity to voice opinions and to discuss issues important to them
	Showing affection	Adult-to-teenager displays of affection that don't cause public embarrassment	Demonstrates appropriate ways if showing affection
Increasing Desirable Behaviour	Using descriptive praise	Providing encouragement and approval by describing the behaviour that is appreciated	Encouraging appropriate behaviour
	Giving attention	Providing positive non-verbal approval	Encouraging appropriate behaviour
	Providing opportunities for engaging activities	Creating opportunities for teenagers to explore and try out new social and recreational activities	Encouraging independence; identifying activities that teenagers can participate in and develop new skills and interest
Teaching New Skills and Behaviours	Setting a good example	Demonstrating desirable behaviour by parental modelling	Showing teenagers how to behave app especially in relation to interpersonal i moral issues
	Coaching problem-solving	Helping teenagers to deal with a problem in a constructive and effective way	Promoting independence; assisting wit decisions, dilemmas, and challenges
	Using behaviour contracts	Negotiating an agreement to deal with an issue which is causing dispute or distress	Assisting a teenager to develop person
	Holding a family meeting	Organising a set time for family members to work together to set goals for change	Teaching compromise, decision makir responsibility

Managing Problem Behaviour	Establishing family rules	Negotiating in advance a set of fair, specific, and enforceable rules	Clarifying expectations and avoiding casual conflict
	Using directed discussion	The identification and rehearsal of the correct behaviour following occasional rule breaking	Correcting occasional rule breaking or initial violations following a new rule being applied
	Making clear, calm requests	Making a specific request to start a new task, or stop a problem behaviour and start a alternative behaviour	Initiating an activity, or terminating a problem behaviour and saying what is required instead
	Backing up with logical consequences	The provision of a specific consequence which involves the removal of an activity or privilege from the teenager for a set time	Dealing with noncompliance, mild problem behaviours that do not occur often
	Dealing with emotional behaviour	Helping a teenager to deal with unpleasant or intense emotional responses that interfere with effective problem-solving or cause increased conflict and/or distress	Promoting emotional management assisting a teenager to cope with events that cause distress; modelling arousal-reduction techniques to avoid unpleasant conflict
Dealing with Risky Behaviour	Identifying risky situations in advance	Anticipating events a teenager is likely to engage in that may be risky	Preventing unexpected demands from leading to conflict or decision-making under pressure
	Obtaining useful information	Ensuring important decisions are not taken on the basis of inaccurate assumptions	Demonstrating information seeking to reduce the risk of undesirable outcomes
	Explaining concerns and risks	Share concerns with teenager and explain nature of perceived risk	Explaining parents' concerns and motivation for rules; identifying the nature of risk
	Selecting risk reduction strategies	Problem-solving and negotiating in advance a set of fair, specific, and enforceable rules	Establishing the best possible plan to reduce or avoid risky situations while still participating in peer activities
	Holding a review session	Organising a set time to review how well the strategies worked	Teaching compromise, decision making, and personal responsibility
	Monitoring teenagers	Establish a parent or community network	Establishing communal responsibility to share load among parents

Triple P has been studied extensively with parents of young children, however, only limited studies have been conducted on the varying levels of Teen Triple P. These included studies on the Seminar Series (level 2), Self-Directed Teen Triple P (level 4), and GTTP (level 4) and were reviewed in Chapter 2. Although preliminary evaluation of GTTP demonstrated effectiveness with a school sample (e.g., Ralph & Sander, 2003), in the absence of a control group, it is unclear how much of the observed change in parent and adolescent outcomes can be attributed to the programme. Given the potential benefits the programme has for both parents and adolescents, there is a need for more rigorous study to build the evidence base and strengthen conclusions for the impact of the programme.

4.3. A Mixed-Methods Approach

To evaluate the impact of GTTP, a mixed-methods approach utilising sequential explanatory design was employed. First, a quantitative evaluation of parent and adolescent outcomes was conducted, followed by a qualitative examination of the social validity of GTTP. The following section presents a brief review of mixed-methods as a research approach. It considers the advantages of utilising mixed-methods in programme evaluation, and supports the appropriateness of using such methodology in the present research.

Mixed-methods research involves the collecting, analysing, and integrating of quantitative and qualitative data in a single study (Creswell, Fetters, Plano Clark, & Morales, 2009). A primary assumption in using this approach is that the use of a quantitative or qualitative method in isolation is insufficient in understanding the research issue and that the mixing of the methods results in a more comprehensive understanding of the research problem. Combining quantitative and qualitative methods can be used to: develop the method of one by using the results of the other; to complement one another; to recast results from one method as questions or results in another; or to expand the range of inquiry by using different methods for different routes of inquiry (Creswell et al., 2009). In addition, mixed-methods have been viewed as beneficial in addressing the complex questions arising in family and intervention research (Andrew & Halcomb, 2006).

4.3.1. Mixed-methods and programme evaluation

Mixed-methods designs have opened a new avenue for researchers interested in intervention programmes across various fields in health and social science (Palinkas,

Horwitz, Chamberlain, Hurlburt, & Landsverk, 2011). Effectiveness of parenting programmes has often been examined based on quantitative methods such as statistical analyses of significant and reliable changes of targeted outcomes. Although critical to effectiveness, researchers are increasingly aware that such evaluations do not necessarily provide insights about the preference of consumers (Owens et al., 2007; Kirby & Sanders, 2012). This is important as the extent to which a programme is socially accepted by consumers is essential to its long term utility (Schwartz & Baer, 1991; Palinkas et al., 2011). Thus qualitative methods are increasingly included in intervention research to add detail, depth, and meaning to quantitative findings that may inform the development and implementation of the programme (Creswell et al., 2009). Quantitative research does not take into account context or setting, and participant voice is generally not heard in the research. Similarly, without corresponding survey research and quantitative analysis, qualitative methods may not reliably indicate the representativeness of particular outcomes. Mixed-methods therefore provide the flexibility to fill in gaps in the available information and to provide different perspectives on complex, multi-dimensional phenomena (Palinkas et al., 2011).

In light of the above, a sequential explanatory mixed-methods design was utilise in the present research. This design consisted of two distinct phases, quantitative followed by qualitative. In this design, the researcher first collected and analysed the quantitative data. The qualitative data were then collected and analysed in the second sequence. The advantages of this mixed-methods design include straightforwardness and opportunities for the exploration of the quantitative results in more detail. This design can be especially useful when unexpected results arise from a quantitative study (Morse, 1991). In contrast, the disadvantages include lengthy time and feasibility of resources to collect and analyse both types of data (Ivankova, Creswell, & Stick, 2006). The following section describes each phase of the study.

4.4. Phase 1: Quantitative Approach

The first phase of the study involved an RCT to examine the efficacy of GTTP. This included examining the short and long term efficacy of the programme on a number of parent and adolescent self-reported outcomes. Quantitative data were collected for statistical analyses on the effectiveness of the programme.

The Society for Prevention Research specified several criteria for designing and testing efficacious intervention programmes (Flay et al., 2005). These include but are not limited to, the research design comprising at least one comparison condition; assignment to conditions that maximise confidence that the intervention, rather than other alternative explanations, caused the reported outcomes; the use of psychometrically sound and reliable measures; the use of multiple unbiased reporters; and examining follow-up effects with a minimal follow-up period of 6 months (Flay et al., 2005). Based on these recommendations, a 2 (group: GTTP, Care as Usual - CAU) X 3 (time: pre- and post-intervention and 6-month follow up) RCT was conducted to examine the efficacy of GTTP.

RCTs provide the highest level of evidence for intervention questions and have become the 'gold standard' on which intervention recommendations are based (Torgerson & Torgerson, 2008). Three core principles or assumptions in RCTs are randomisation, control, and comparison. More specifically, treatments are assigned randomly to subjects, treatments are controlled, and comparison of control and treatment groups enables researchers to detect a treatment effect, or the lack thereof (Torgerson & Torgerson, 2008). The strengths of RCT include a decreased chance for bias in group assignment, increased odds of balanced groups receiving and not receiving the intervention, and increased confidence that outcomes are a function of the intervention (Matthews, 2000).

Gardner and colleague (2013) further suggest that for interventions to be considered as efficacious, the quality of the reporting of designs and outcomes must be addressed. Poor reported RCTs (e.g., insufficient detail on methods and procedures) of family interventions have led to shortcomings in the reliability and utility of evidence for improving family functioning (Gardner et al., 2013). To this end, the present study closely follows the criteria set out in the Consolidated Standards of Reporting Trials (CONSORT) Statement (See Appendix A) adopted by the journals of the American Medical Association for reporting intervention evaluation (Schulz, Altman, & Moher, 2010). The reporting of the RCT is presented as a manuscript in Chapter 5. The following section details the information and rationale of the study procedures that are otherwise not captured in the following Chapter.

4.4.1. Sampling

GTTP as a universal programme was intended to serve a diverse population of parents in the community. A self-selection sampling approach was chosen for this study. This

allowed families to 'self-select' into the study. Through a community outreach approach (e.g., school flyers, newspaper stories, radio announcement, distribution of flyers through community organisation and events) parents of adolescents living in the Auckland region were invited to participate in the research. The procedures for recruitment and criteria for selecting the participants are described in Chapter 5 (See Appendix B for advertising material and screening material, and Appendix C for participant information sheets, and consent forms).

4.4.2. Measurement tools

The measurement tools utilised for this study were standardised and validated measures. Powell (2013) stated that parenting intervention studies that assess both parent and child outcomes "make a significantly stronger contribution to the field than studies that assess parenting outcomes alone" (p. 272). Therefore, measures used in this study measured both parents' and adolescents' outcomes. It has also been recommended that intervention studies should contain multiple sources of information. Reliance on single informant to measure parent- and adolescent-related outcome variables is likely to yield biased results (e.g., Okagaki & Bingham, 2005). To this end, data were collected from parents and adolescents in this study.

As reviewed in Chapter 2, the quality of family relationships and parenting factors can have an effect on adolescent outcomes. The effects of GTTP were therefore examined on a number of family, parent, and adolescent-related outcomes. This included measures on family relationships, parenting practices, parental well-being and adjustment, adolescent problem behaviours, and adolescent well-being and adjustment. Demographic information was also collected from parents at pre-intervention. Details of the measures are described in Chapter 5.

The measures selected for this study were chosen based on four general principles set out by Pfeiffer and colleagues (1992). These include practicality, or ease of use; sensitivity to change; suitability for the target population (i.e., developmental appropriateness); and psychometric quality. Moreover, all of these measures were chosen to be comparable with previous studies evaluating Teen Triple P (e.g., Chand et al., 2013; Chand, 2012; Stallman & Ralph, 2007; Ralph & Sanders, 2003).

4.4.3. Data collection

Data were collected from parents and adolescents in both conditions (GTTP and control group) at 3 time points (pre, post, and 6-month follow up). A number of steps were taken to minimise the challenges of collecting data at the 6-month follow up. These included clearly presenting the programme at intake as involving both post- and follow-up; the option of completing the assessments online or as hard copies; having participants provide additional contacts that could be utilised to find participants should their phone/email/address change; friendly reminder emails to complete assessments; and, offering the programme to the control condition upon completion of follow up assessment.

4.4.4. Intervention integrity and fidelity promotion

Fidelity refers to the extent to which a programme is delivered as originally developed (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005). It is a broad construct that includes adherence (i.e., extent to which programme components are delivered according to the protocols indicated in the programme modules), exposure (i.e., number and length of sessions), quality of delivery (i.e., facilitators preparedness), and participant responsiveness (Dane & Schneider, 1998).

Four female facilitators, including the researcher, delivered the programme. All facilitators were trained in GTTP and had worked with a diverse range of adolescent families, including within educational, community, and/or private settings. All facilitators had a background in social work, counselling, or psychology.

Group facilitators were provided with a kit containing a facilitator's manual, a copy of the Teen Triple P group workbook that all participating parents would receive, and a disc containing power point slides that are used to present aspects of the programme. In addition, each facilitator was given a copy of the DVD *Every Parent's Guide to Teenagers* (Ralph & Sanders, 2001), which illustrates much of the content of GTTP for parents.

To ensure intervention fidelity, following each group and telephone session, facilitators were required to complete session checklists. In addition, a weekly telephone peer supervision session was held between facilitators to address any issues regarding the sessions

and to provide feedback on the strengths and weaknesses of the session. An additional supervised meeting with trainers of Triple P was available for facilitators when needed.

4.4.5. Data analysis

The aims of data analysis in this phase were to 1) examine the efficacy of GTTP on a number of family, parent, and adolescent outcomes compared with the control condition and 2) identify whether these effects were maintained at 6-month follow up. A number of considerations were taken into account when deciding the statistical methods to be employed for evaluating the programme. This section sets out the reason for the chosen statistical methods and Chapter 5 reports on the statistical analyses conducted.

4.4.5.1. Analysis of covariance (ANCOVA) and multivariate analysis of covariance (MANCOVA)

It has been shown that ANCOVA has a greater statistical power than analysis of variance (ANOVA) and gives a more precise estimation of intervention effects (Twisk & Proper, 2004). Although randomisation was used in this study, it is still possible that differences arise between intervention and control groups on a range of variables at pre-intervention. Therefore, ANCOVAs enable the researcher to account or control for differences in groups not associated with the independent variable (e.g., intervention). Covariates serve to reduce the variability of the outcome measures and, hence, increase the power of the statistical tests. This is further supported by a study conducted by Van Breukelen (2006) noting that if intervention assignment is by randomisation ANCOVAs have more power than ANOVAs. Consequently ANCOVAs were used in this study.

As there were multiple dependent variables, MANCOVAs were used to examine group differences between intervention and control conditions. Using multiple ANCOVAs can inflate Type 1 error rates and thus the use of MANCOVAs can help control for the inflation. By including multiple dependent variables, MANCOVAs takes into account of the relationship between outcome variables (Field, 2009).

4.4.5.2. Missing data

Missing data is a common problem in statistical analysis. Missing value analysis in the SPSS software was used to deal with missing data. First, the pattern of missing data was

identified (e.g., missing completely at random or missing at random). Given the percentage of missing data was less than 10% and was missing completely at random, expectation maximisation (EM) was utilised to impute missing data. EM has been argued to be the optimal method for estimating missing values (Schlomer, Bauman, & Card, 2010), compared with more traditional strategies such as deleting cases with missing data or mean substitution. It uses non-missing data to estimate the distributional characteristics of, and relationships between, variables in data set. It then uses those estimated relationships to impute missing values. The primary advantage of using EM is simplicity (Dempster, Laird, & Rubin, 1977). Subsequently, EM was used to analyses and replace missing data in this study.

4.4.5.3. Intent-to-treat

Participant attrition can pose threats to both external and internal validity of the study (Barry, 2005). Specifically, if only participants who completed the intervention were assessed at post- and 6-month follow up, results may be artificially inflated as they fail to account for participants who did not complete the intervention. In order to control for this, an intent-to-treat approach was used for analysis. This approach analyse all available data from outcome measures for participants regardless of the extent of involvement in the intervention (Flay et al., 2005). The use of intent-to-treat analysis ensured that the most conservative and reliable results were reported. This approach is also consistent with the CONSORT statement.

In summary, a quantitative approach was utilised in this phase of the study to examine the efficacy of GTTP. The strength of utilising a quantitative approach included the ability to replicate the research, generalised finings to a larger population, objectively tested specific hypotheses, and enabled the capability of working with a large sample population (Holton & Burnett, 2005).

In addition to examining whether GTTP produced significant and reliable changes, the researcher recognised the shortcomings of assessing purely on the basis of quantitative data. For example, although it was hypothesised that participation in GTTP might teach parents parenting strategies that would lead to positive changes in parenting practices and adolescent behaviours, which specific strategy or what aspects of the programme prompted these changes was difficult to assess through quantitative methods. Moreover, these evaluations do not necessarily provide insights on the social validity of GTTP. Hence, this led to the second phase of the research, utilising qualitative methods to collect more in depth data

from the perspectives of parents and adolescents in order to fully evaluate the impact of GTTP.

4.5. Phase 2: Qualitative Approach

It is becoming increasingly recognised that the impact of behavioural family interventions is incomplete unless the needs and subjective experience of the targeted population can be comprehended (Goodman, Adler, Kawachi, Frazier, Huang, & Colditz, 2001; Rust & Cooper, 2007). Utilising qualitative methods can contribute in several ways to the evaluation of parenting interventions including exploring reasons for the quantitative findings of the trial, examining the acceptability of the intervention, and also to generate further questions or hypotheses with regards to the utilisation and sustainability of the intervention (Shepperd et al., 2009; Fletcher, Bonell, Sorhaindo, & Strange, 2008). At present, most of the qualitative studies in parenting research are conducted before the intervention trial and therefore opportunities to understand how the intervention is experienced by participants are not being fully utilised. Qualitative data collected following an intervention trial can provide important information regarding the social validity of the intervention (Shepperd et al., 2009).

Discussion groups were therefore utilised to gather qualitative data 6-12 months following intervention completion. Discussion groups are commonly used in social science research with the assumptions that interaction among participants in a group produces data and insights that are less accessible without the interaction found in the group (Morgan, 1988). Discussion groups encourage interaction among participants, as well as free and open disclosure in a group context (Beck, Trombetta, & Share, 1986). It enables the researcher to have direct contact with key informants and allows researchers to gain substantive information in an easy and efficient manner. The data collected are helpful in disclosing themes and topics that are otherwise not addressed by quantitative methods (Kitzinger, 1994). Given parenting is a common shared experience, the use of discussion group provided the opportunity for participants to interact and share rich source of information that would otherwise not be obtained through individual interviews (Webb & Kevern, 2001).

Although there are advantages to using discussion groups, there are also disadvantages in their use. This includes the discussion groups not being a representative sample, therefore caution must be made when generalising findings. Further, as with other

qualitative methods, it may be difficult to interpret qualitative data, as results are based on subjective evaluation of what was said during the discussion group (Acocella, 2012). Despite the disadvantage, discussion group was considered to be an appropriate tool to capture parents' and adolescents' perspectives on the social validity of GTTP. The reporting of this study is presented in Chapter 6. The following section details information that is otherwise not captured in the manuscript.

4.5.1. Sampling

The sampling for this study was self-selected. Parents and adolescents volunteered to participate in the discussion group in response to an invitation sent to families in the GTTP condition. Chapter 6 details the recruitment procedures and characteristics of the sample (See Appendix C for participant information sheets and consent/assent forms).

4.5.2. Group size

There is no consensus on how many people should be in each discussion group. Larger groups may limit productivity as it is generally more difficult to manage the discussions, with groups breaking up into small conversations and all talking at once. This means large groups typically require higher levels of moderator involvement which is not desirable for some research purposes (Morgan, 1988). Nonetheless, if participants have a low level of involvement with the topic, an active discussion may be difficult to maintain in a smaller group. Small groups also run the risk of being less productive because they are sensitive to the dynamics among the individual participants. Small groups thus work best when the participants are likely to be both interested in the topic and respectful of each other (Morgan, 1988). For this study, group sizes ranged from 2 to 7 people and most participants were able to partake actively in the discussion. In addition, to ensure that parents and adolescents perspectives were not influenced by each other, separate discussion groups were conducted for parents and adolescents.

4.5.3. Data collection

Prior to the discussion group, a topic guide was designed to assist the focus of the discussion. The topic guide was designed to promote participant freedom in giving a range of responses. The same topic guide were used for each parent and adolescent discussion group

but not necessarily in the same order, and in some cases the topics were reached without the question needing to be asked. Furthermore, there was the opportunity to ask questions that were relevant to each group and that had been unanticipated.

The parent topics focused on the structure and content of the programme (e.g., helpful and less helpful aspects of GTTP and recommendations) and the impact of the programme (e.g., perceived changes to family, parents, and adolescents). The adolescent topics focused on the impact of the programme. Given adolescents were the intended beneficiaries of parenting programmes, parents and adolescents were also asked specifically to comment on adolescents' involvement in parenting programmes. See Appendix D for topic guide.

4.5.4. Data analysis

A general inductive approach to analysis was used to analyse findings from discussion groups. Inductive analysis incorporates methods concerned with reading and interpreting raw data in order to develop themes, theories, and models (Thomas, 2006). This approach allows the researcher to look for themes from the data without being tied to one methodology in particular. According to Thomas (2006) there are three intents of the general inductive approach, 1) to condense raw text data into a summary format; 2) to form links between the research objectives and the summary data and to ensure these links are transparent and defensible; and 3) to develop a model representative of the process that is apparent in the raw data (2006, p. 238).

The initial stage of data analysis included the audio-recordings being transcribed verbatim and the transcripts were subsequently audited for the quality of transcription. This was achieved by having the researcher listening to the audio-recordings whilst reading the transcriptions. During this procedure, a code was attached to each response to anonymously identify the participant responsible. The transcripts were then read a number of times so that the researcher became immersed in the data. Analysis of the data involved the researcher searching the data for similar patterns, concepts, and themes (Thomas, 2006). Segments of text were coded for similarities and organised into categories. The coded segments were placed collectively under categories to enable data to be managed more easily and to be analysed as aggregate data. This process was done by using various coloured highlighter pens in sorting and cataloguing. The categories form the basis for identification of emerging themes (Thomas, 2006).

4.5.5. Trustworthiness

In qualitative research, emphasis is placed on establishing the trustworthiness of the findings. Four criteria of trustworthiness are addressed 1) credibility, 2) transferability, 3) dependability, and 4) confirmability (Morrow, 2005).

4.5.5.1. Credibility

Credibility is concerned with the degree to which the findings represent reality (Merriam, 2009). Qualitative research is valid to the researcher and not necessarily to others due to the possibility of multiple realties that people construct within social contexts. It is upon the reader to judge the extent of its credibility based on his or her understanding of the study. In this study, credibility was addressed through inter-coded agreement. A second coder reviewed the transcript statements and coded these statements into the pre-determined themes. Both lists of codes were compared and contrasted, and adjustments were made as needed. This step helped to ensure that the raw data coded and placed into themes created were free of any bias or prior hypothesis that the researcher may have had.

4.5.5.2. Transferability

Transferability is concerned with examining how applicable the research findings may be to other contexts (Morrow, 2005). Seale (1999) advocates that transferability may be achieved by providing a detailed, rich description of the settings studied to provide the reader with sufficient information to be able to judge the applicability of the findings to other settings that they know. Thus in this study, the researcher provided detailed information about the participants, research methods and procedures. This study also included participants' quotations when reporting the findings in order to enhance transferability. However, given the sample was self-selected, and may be highly motivated, transferability of the findings may be limited.

4.5.5.3. Dependability

Dependability ensures that the study is carried out in a reliable and consistent manner (Morrow, 2005). This is important as it demonstrates that the study and results are dependable and make sense in light of the data collected (Merriam, 2009). According to Seale (1999), dependability can be achieved through auditing which consists of the researcher's

documentation of data, methods and decision made during the research as well as its end products. Auditing for dependability requires that the data and descriptions of the research should be elaborate and rich. In this study, an audit trail (Lincoln & Guba, 1985) was established, which encompassed a detailed account of the raw data, data analysis, informed consent documents, and development of discussion group protocols.

4.5.5.4. Confirmability

Finally, confirmability is the degree to which the research findings can be confirmed or corroborated by others (Morrow, 2005). It is analogous to objectivity, that is, the extent to which researcher is aware of or accounts for individual subjectivity or bias. Seale (1999) argues that auditing could also be used to establish confirmability in which the researcher makes the provision of a methodological self-critical account of how the research was done. In this study, confirmability was established by 1) clarifying researcher bias by positioning the researcher's preconceived notions or experiences from the beginning of the study; and 2) an audit trail where all collected data are organised and retrievable.

4.6. Data Integration

Integration between the quantitative and qualitative methods is a key element in conducting mixed-methods research. Morse and Field (1995) have contended that quantitative and qualitative data sets need to be analysed separately because they are derived from very different data collection techniques. The data should come together once both aspects of the study are complete and the results, not the actual data, get triangulated. This makes intuitive and practical sense since confusion abounds as to the best way to combine data that is both numerical and literal in the analysis. Therefore results from quantitative and qualitative studies were integrated in the last chapter (Chapter 7) and findings were further explained in relation to both aspects of the study. By linking the findings from the two studies, insights were gained into how these data inform each other, how one helps to clarify the other, and how the finding were contrasted with one another (Bryman, 2006). Overall the findings provided a basis for discussing future research.

In summary, the studies aimed to fill an important gap in the existing literature by adopting a mixed-methods approach to examine the impact of a parenting programme for parents of adolescents. Both the quantitative and qualitative phases of this study were

important for answering the research questions. The utilisation of both quantitative and qualitative data is that it produces a more comprehensive understanding required to inform decision making regarding the implications and effectiveness of parenting programmes for parents of adolescents. Examining the efficacy of parenting programmes and exploring parents' and adolescents' perspectives on parenting programmes may be a critical beginning to refining and evaluating the success of intervention programmes implemented at the population level. It is anticipated that the present study will strengthen and justify the argument towards a public health approach to parenting support for parents of adolescents. The following chapters (Chapter 5 and Chapter 6) present the quantitative and qualitative phase of the studies, respectively.

Chapter 5 - Group Teen Triple P: An Efficacy Trial

Summarising the previous Chapters, there is a compelling argument for the potential benefits of adopting a public health approach to parenting programmes for parents of adolescents. This argument is supported by 1) epidemiological data indicating that a concerning number of adolescents engage in problematic behaviours; 2) etiological studies demonstrating the significant role parents play in fostering healthy adolescent development; 3) promising results from BFI attesting to the efficacy of parenting programmes in improving parent and adolescent outcomes; and 4) successful population trials with parents of younger children demonstrating the feasibility that similar population effects can occur with the adolescent population. The ultimate goal of delivering parenting programmes at the population level is to enhance parenting practices, competent and adjustment for all parents, and to promote the well-being of their adolescent. However, while there have been growing concerns about the high prevalence rates of adolescent problem behaviours and a parallel realisation for the importance of supporting parents during adolescence, there continues to be few evidence-based parenting programmes available. The lack of evidence-based parenting programmes poses a significant barrier for moving towards a successful adoption of a public health approach.

The need to evaluate in order to find out what works for families cannot be overstated and should be part of any programmes intended for widespread implementation. Researchers indicate that efficacy needs to first be established under controlled conditions before testing the programme for effectiveness in real services. This includes demonstrating the programme to have a positive impact on the targeted parent and adolescent outcomes, that the positive changes are maintained over time, and that the programme is effective relative to other comparison conditions. Efficacy trials therefore provide the basic evidence and are essential for successful adoption of a public health approach. This chapter examined the efficacy of a universal group programme for parents of adolescents and consists entirely of a paper published in *Prevention Science.*

5.1. Abstract

There is growing support for the large-scale implementation of parenting programmes for the prevention of child behaviour disorders and child maltreatment in younger children. However, there is only limited evidence on the efficacy of parenting programmes in modifying risk and protective factors relating to adolescent behaviour problems. This study examined the efficacy of Group Teen Triple P (GTTP), an eight-session parenting programme specifically designed for parents of young adolescents. Seventy-two families with adolescents aged between 12 to 15 years were randomly assigned to either GTTP ($n = 35$) or a care as usual (CAU) control condition ($n = 37$). Compared to CAU parents, parents who received GTTP reported significant improvements in parenting practices, parenting confidence, the quality of family relationships, and fewer adolescent problem behaviours at post-intervention. Several of the parent-reported effects were corroborated by reports from adolescents, including decreases in parent-adolescent conflict and increases in parental monitoring. Adolescents whose parents participated in GTTP also reported significantly fewer behavioural problems than adolescents in the CAU condition. Many of these improvements were maintained at 6-month follow up.

Keywords: parenting programme, parenting, adolescence, problem behaviour

5.2. Parent and Adolescent Effects of a Universal Group Programme for the Parenting of Adolescents

There have been increasing calls from both researchers and policy makers for the large-scale implementation of evidence based parenting programs prevent behavioural disorders among children and to reduce child maltreatment (e.g., National Research Council and Institute of Medicine, 2009). Such widespread recognition of the central role of parenting support based on social learning principles has stemmed from decades of carefully conducted trials attesting to the efficacy of programs based on social learning theory (e.g., Eyberg, Nelson & Boggs, 2008), alongside more recent population trials demonstrating the public health benefits of universal implementation of evidence-based parenting support (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009). However, the evidence base for parenting programs stems primarily from work with parents of preadolescent children. Systematic reviews of the parenting literature indicate that there is very little evidence that programs designed specifically for parents of adolescents can reduce negative adolescent outcomes, such as delinquency and school failure, and promote positive adolescent development (e.g., Eyber et al., 2008). Given strong evidence for an adolescent-onset trajectory to conduct disorder (Frick & Viding, 2009) population-based parenting approaches are an alternative to clinic-based treatment models for reducing prevalence rates of problem behaviours among adolescents.

Family factors, including the quality of parent-adolescent relationships, appropriate levels of parental monitoring, and positive parenting practices, have been identified as being central to the prevention of negative developmental outcomes for adolescents (Dishion & McMahon, 1998). Evidence further suggests that parental conflict and poor parental adjustment can interfere with the ability of parents to discipline effectively and consistently (Sameroff, Gutman, & Peck, 2003). Yet, in spite of the strength of evidence for the importance of parenting, prevention and intervention programs for adolescent problem behaviours generally have a primary focus on working with individual adolescents or at the school level, with minimal or no involvement of parents (Kaslow, Broth, Smith, & Collins, 2012). This lack of attention directed towards support for parents of adolescents may be due to the beliefs that parental influence diminishes over time as adolescent's behaviour become increasingly individually-determined (Kaslow et al., 2012). Hence, there are comparatively few controlled trials testing the efficacy of programs for parents of adolescents.

A small number of programs targeting the parents of adolescents have been shown to produce positive changes in adolescent behaviour, parenting, and the parent-adolescent relationship (e.g., Strengthening Families Program 10-14, Spoth, Trudeau, Guyll, Chungyeol, Redmond, 2009; Adolescent Transitions Program, Connell, Dishion, Yasui, & Kavanagh, 2007; Guiding Good Choices, Haggerty, Kosterman, Catalano, & Hawkins, 1999). Some of these programs (e.g., Strengthening Families Program 10-14, and Guiding Good Choices) include additional components (e.g., adolescent skills training) making it difficult to determine the degree to which the parenting component alone was responsible for the improvements reported. Programs with multiple components are typically more time consuming and labour-intensive than parenting programs alone (Sanders, 2012). Working exclusively with parents provides an effective yet minimally-sufficient solution to the prevention and reduction of adolescent problem behaviours, compared to multi-component programs.

One example of a program that works exclusively with parents of adolescents is the Teen Triple P-Positive Parenting Program (Ralph & Sanders, 2003), a specially adapted version of the well-established Triple P program for children under the age of 12 (Sanders, 2012). Like the program for parents of younger children, Teen Triple P is based on social learning principles and aims to target those modifiable family risk and protective factors associated with negative adolescent outcomes. Teen Triple P, however, places a stronger emphasis on the importance of parents acknowledging and encouraging the growing autonomy and independence of the adolescent relative to younger children. Recognition is given to the likelihood of adolescents engaging in risky behaviour that may put their current or future well-being in jeopardy, and providing parents with ways of assisting their adolescent to negotiate and manage these challenges effectively. The Teen program also echoes Triple P's key feature in adopting a self-regulatory framework that involves teaching skills to parents that enable them to become independent problem solvers and promote generalization of parenting skills (Ralph & Sanders, 2003). Teen Triple P is available as a multilevel intervention and can be delivered in a range of formats (i.e., large group seminars, small group or individual programs, self-directed program). A growing number of trials on variants of Teen Triple P have demonstrated the program to be a promising intervention for parents of adolescents (e.g., Ralph & Sanders, 2003; Stallman & Ralph, 2007).

This study focused on the group version of the program - Group Teen Triple P (GTTP). Group-based programs are an integral component of population approaches to parenting as this delivery context is able to reach a larger number of families than those that are individually-delivered (Sanders, 2012). Preliminary evaluation of GTTP with a secondary school sample demonstrated that participation in the program is associated with improvements in adolescent well-being, parenting practices, and the quality of parent-adolescent relationship (Ralph & Sanders, 2003). However, this uncontrolled trial precluded attributing observed changes in parent and adolescent outcomes to the program. Given GTTP is part of a multilevel system; evaluation of each variant of the intervention is required prior to testing the synergistic benefits of implementing multiple levels within the system as a whole.

The present study evaluates the efficacy of GTTP as a universal intervention to reduce family risk factors known to be associated with the development of adolescent problem behaviours. The universal approach involved recruiting parents of adolescents aged between 12 and 15 years without placing restrictions on the level of seriousness of parents concerns about the behaviour of their adolescent. A multi-informant (parents and adolescents) approach was utilized to evaluate the effectiveness of GTTP. It was hypothesized that, relative to the control condition at post-intervention, parents participating in GTTP would report a) improved family relationships including the parent-adolescent relationship; b) improved parental relationship quality; c) decreased use of dysfunctional parenting practices; d) decreased adolescent problem behaviour; and e) improved parental adjustment. For adolescent-reported outcomes, it was hypothesized that, relative to the control condition at post intervention, adolescents of parents who received GTTP would report a) improved family and parent-adolescent relationships; b) increased perceived parental monitoring; c) decreased problem behaviour; and d) improvement in adolescent adjustment. It was predicted that these intervention outcomes would be maintained at 6-month follow up. A six-month follow up period was selected as it is considered to be the minimal follow-up period required for testing efficacious interventions by the Society for Prevention Research (Flay et al., 2005).

5.3. Method

5.3.1. Participants

Families were recruited from throughout Auckland, New Zealand between January 2011 and April 2012. A community outreach approach was utilised involving recruitment through intermediate and secondary schools, media outlets (i.e., newspaper stories, radio announcement), and the distribution of flyers at a number of community events. A standardised telephone interview informed families about the research trial, obtained their consent to participate, and screened for eligibility. Families were eligible if 1) their child was in the target age range of 12-15 years; 2) their child did not have a developmental or intellectual disability; 3) the child or parent was not currently seeing a professional for the target adolescent's behaviour or emotional problems; and 4) the parent was not currently receiving assistance for their own psychological or emotional problems. The criteria were used to reduce the influence of confounding factors and to help strengthen our conclusions that any positive changes observed at post-intervention were in fact due to GTTP and non external factors, such as participation in a different intervention.

Power analysis indicated that for a large effect size of 0.8 (predicted based on previous Group Triple P research), 26 participants were needed per group, giving a total of 52 participants. In total, 107 parents were screened for eligibility for the study. Nineteen families did not meet the eligibility criteria and a further 16 chose to withdraw from the study before the completion of the pre-intervention assessment. Reasons for withdrawal included work and life commitments, difficulties with transportation and/or childcare, and the parents had sought other professional help. Seventy-two families completed pre-intervention assessments and were randomly allocated to a condition (GTTP $n = 35$; CAU $n = 37$). The flow of participants through each stage of the study is detailed in Figure 5.1.
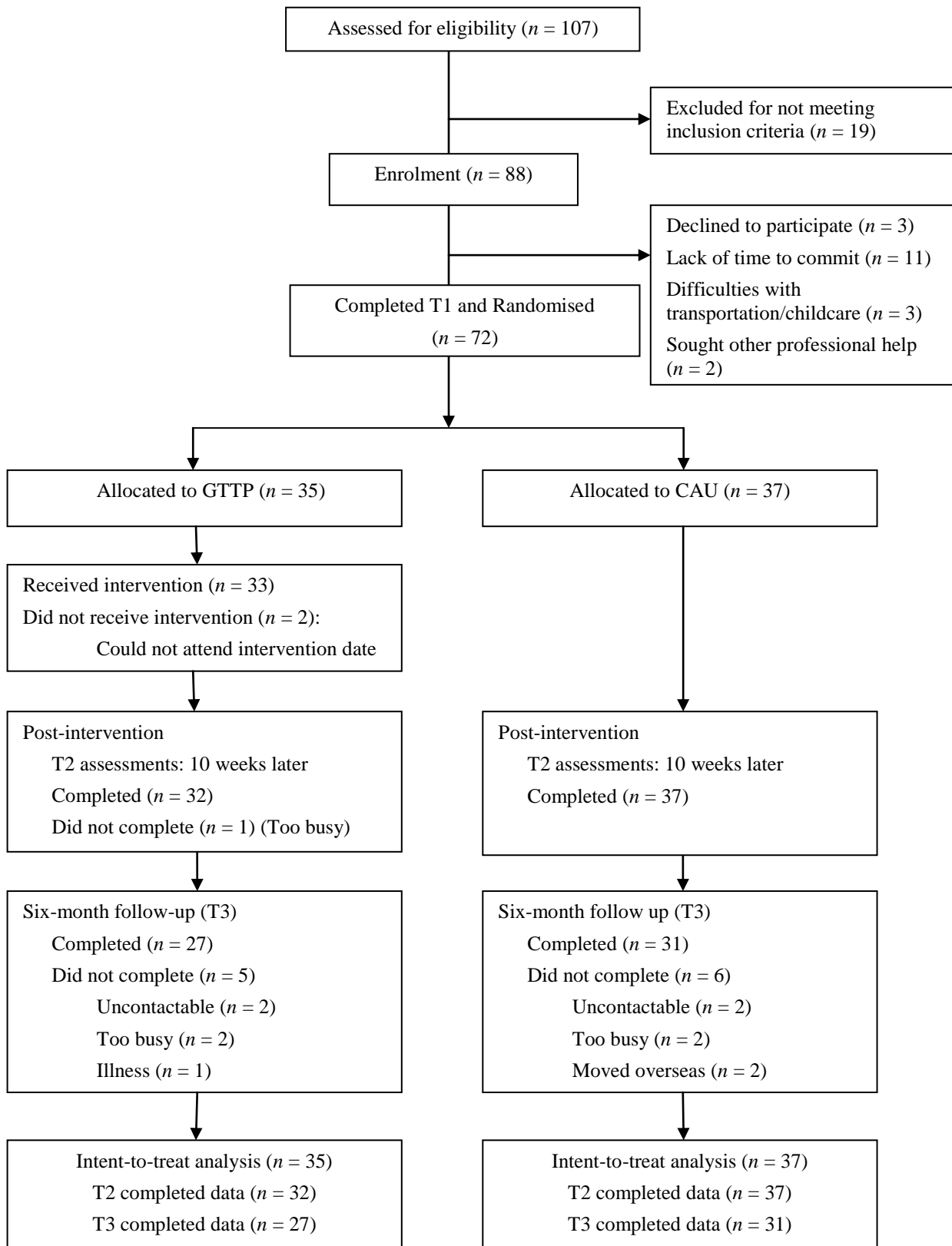
Figure 5.1. CONSORT diagram showing the flow of participants through each stage of the randomised controlled trial, and reasons for drop out.

Although both parents from two-parent household were encouraged to complete assessments, only mother's assessments were used. A more complete set of data was obtained from mothers than fathers. In this sample, mothers were predominately married (66.7%), with an average age of 44.71 years ($SD = 4.99$). For family composition, 65.2% of families were from an original family (both parents), with 31.9% being sole-parent families, and 2.9% as step-families. More than half of the mothers had obtained a university degree (52.2%) and were in paid employment (81.2%). Around one third of families (34.7%) earned above the average New Zealand household income of $81, 067 (Statistics New Zealand, 2013). A majority of the families (70%) reported no major difficulties in paying for household expenses in the past 12 months. Adolescents were mostly male (59.4%) and were an average of 12.85 years ($SD = 0.66$). The majority of mothers reported their child's ethnicity as Pakeha/European (72.5%), with the remaining reporting their children as Māori (Indigenous New Zealanders, 10.1%), Pacific Islander (8.7%), or Asian (8.7%); this ethnic breakdown is similar to the New Zealand population as a whole (Statistics New Zealand, 2013). Demographics of the sample are shown in Table 5.1.

Table 5.1.

Demographic characteristics of the sample

Variable	Group Teen Triple P (N = 35)		Control (N = 37)	
	M	*SD*	*M*	*SD*
Child age (years)	12.85	0.66	12.84	0.68
Mother age (years)	45.50	5.05	44.00	4.89
	n	%	*n*	%
Child Gender				
Male	21	60.0	22	59.4
Female	14	40.0	15	40.6
Family Type				
Original family	23	65.7	24	64.9
Sole parent	11	31.4	12	32.4
Step family	1	2.9	1	2.7
Marital Status				
Married/Defacto	24	71.9	23	62.2
Divorced/Separated	11	28.1	14	37.8
Ethic Group				
New Zealand	24	68.6	28	75.7
Māori	3	8.6	5	13.5
Pacific Islander	4	11.4	2	5.4
Asian	4	11.4	2	5.4
Education				
Year 13 or less	10	28.6	14	37.8
TAFE/College Certificate	3	8.6	6	16.2
Trade/Apprenticeship	2	5.7	1	2.7
University	20	57.1	16	43.3

5.3.2. Measures

Mothers completed all measures of demographics, family relationships, marital relationships, parenting, and parental adjustment. Of the measures on adolescent adjustment, mothers only completed the measure on adolescent problem behaviours (SDQ). Single mothers did not complete measures that assessed marital relationships. Adolescents completed all measures on family relationships and adolescent adjustment as well as the measure that assessed parental monitoring (PMS).

5.3.2.1. Demographics

Family Background Questionnaire (FBQ; Zubrick et al., 1995). This instrument collected family demographic information including parent marital status, employment and education, family composition, and income.

5.3.2.2. Family relationships

Family Environment Scale (FES; Moos & Moos, 1994). Two of the 10 subscales, cohesion and conflict, were selected for this study. Each subscale consisted of nine items rated on a 6-point scale (0 = *Strongly disagree* through to 5 = *Strongly agree*). Internal consistencies for the cohesion subscale and conflict subscale were both .84 and .83 in the present sample, for parents and adolescents at T1 respectively. Internal consistencies for the cohesion subscale and conflict subscale were .83, .84, and .83, .83, at T2, and .84, .81, and .82, 82, at T3, for parents and adolescents, respectively.

The Parent Conflict Questionnaire (PCQ; Greenberger, Chen, & Beam, 1998). The PCQ consists of eight items which measure parent-adolescent conflict. Parents and adolescents rate the frequency of parent-adolescent disagreements about different topics, such as chores, in the previous month. Items were rated on a 5-point scale (0 = *Never* and 4 = *Almost every day)*. In this study, the PCQ had high internal consistency for parents (α = T1: .82, T2: .84, and T3: .84) and adolescents (α = T1: .84; T2: .85; and T3: .84).

5.3.2.3. Marital relationships

Parent Problem Checklist (PPC; Dadds & Powell, 1991). The 16-item PPC measures inter-parental conflict over child rearing. The measure provides an index of the number of

disagreements, and the frequency of occurrence of such disagreements. Parents rated on a response scale (1 = *Yes* or 0 = *No*) to specify whether or not each item had been a problem for themselves and/or their partner within the previous month. Parents then indicated the degree to which each item had been a problem on a 7-point rating scale (1 = *Not at all*, through to 7 = *Very* much). Both the problem scale at T1, T2, and T3, (α = .82, .84, and .84, respectively); and extent scale at T1, T2, and T3 (α = .84, .84, and .85, respectively) had good internal consistencies.

Relationship Quality Index (RQI; Norton, 1983). The RQI is a questionnaire examining marital relationship satisfaction, with six items determining marital or relationship quality using global items. The first five items are scored on a 7-point scale from 1 = *Very strongly disagree* to 7 = *Very strongly agree*. The last item is a global measure of happiness in the relationship rated on a 10-point scale from 1 = *Unhappy* to 10 = *Perfectly Happy*. The RQI had a high internal consistency for this sample across all three time points (α =.93).

5.3.2.4. Parenting

Parenting Scale – Adolescent version (PSA; Irvine, Biglan, Smolkowski, & Ary, 1999) The PSA is an adaptation of the Parenting Scale (PS) by Arnold, O'Leary, Wolff, and Acker (1993). The measure consists of 13 items each scored on a 7-point scale measuring laxness and over-reactivity. A score of 1 indicates effective discipline and a score of 7 indicates dysfunctional discipline. The internal consistencies of the scales were .89, .88, and .88, for laxness and .61, .68, and .71, for over-reactivity at T1, T2, and T3, respectively.

Parental Monitoring Scale (PMS; Greenberger, Chen, Beam, Whang, & Dong, 2000). This scale consists of eight items measuring the level of parental monitoring (e.g., how often teenager tells them about their whereabouts). Items were rated on a 5-point scale with 1 = *Never* to 5 = *Always*. In this sample, the internal consistencies were high for both parent (α = T1: .91, T2: .88, and T3: .92) and adolescent (α = T1: .91, T2: .91, and T3: .89).

Parental Self-efficacy (PSE; Bandura, 2006). Thirteen items were selected from the original 35-item Parental Self-efficacy scale. The items focused on efficacy in setting limits, influencing peer association, and monitoring tasks by parents. For each item, parents rated how certain they were to carry out each item on a scale of 0 = *Cannot do it at all* through to

100 = *Highly certain I can do it*, to demonstrate their confidence level with their adolescents. The internal consistencies of the scale were .92, .91, and .91 at T1, T2, and T3, respectively.

5.3.2.5. Adolescent adjustment

Strengths and Difficulties Questionnaire (SDQ; Goodman, 1999). The SDQ were used to measure parental perceptions of difficult behaviours in their adolescent. Adolescents also completed the self-report version of the SDQ. The items are rated on 3 point scales (0 = *Not true*, 1 = *Somewhat true*, 2 = *Certainly true*), and cover four domains of problem behaviour: emotional symptoms, conduct problems, hyperactivity, and peer problems. Each of these scales contains five items which sum to yield a Total Difficulties score. High internal consistencies were found for the Total Difficulties score for parents (α = T1: .79, T2: .82, and T3: .79) and adolescents (α = T1: .81, T2: .81, and T3: .79).

Adolescent Problem Behaviour Checklist (PBC; Greenberger, et al., 2000). The PBC consists of 22 items measuring adolescent problem behaviour. Multiple domains of problem behaviour are assessed (e.g., school-related deviance, and risk-taking). Items are rated on a 4-point scale, from 1 = *Never* to 4 = *Most often*. Adolescents answered each item based on the frequency to which they have engaged in these behaviours in the past month. Internal consistencies of the scale were .72, .88, and .71 at T1, T2, and T3, respectively.

Autonomy Scale (AS; Greenberger, et al., 2000). The AS measures autonomy in adolescent decision making with regard to 12 adolescent-relevant topics, such as appearance, peers, leisure activity, and school work. Items were rated on a 5-point scale where 1 = *Parents making the decision alone* through to 5 = *Adolescent making the decision alone*. The AS had good internal consistency in this sample across all three time points (α = T1: .73, T2: .78, and T3: .78).

Rosenberg Self-Esteem Scale (SES; Rosenberg, 1965). The SES consists of 10 items to assess adolescents' self-reported self-esteem. Items were rated on 6-point scale with 1 = *strongly disagree* to 6 = *strongly agree*. Internal consistencies of the scale were .89, .90, and .88, at T1, T2, and T3, respectively.

Positive Youth Development (PYD; Lerner et al., 2005). The PYD measure comprised of five scales that measure Competence, Confidence, Connection, Caring and

Character. The subscale for *Caring* was used in the present study to measure adolescent's sense of sympathy and empathy for others. Nine items were scored on a 4-point scale with 0 = *Not well* through to 3 = *Very well*. Internal consistencies of the scale were .75, .76, and .76 at T1, T2, and T3, respectively.

5.3.2.6. Parental adjustment

Depression Anxiety Stress Scales-21 (DASS-21; Lovibond & Lovibond, 1995). The DASS-21 contains 21 items assessing the symptoms of depression, anxiety, and stress in adults. Symptoms are measured through a 4-point scale from 0 = *did not apply to me at all* to 3 = *applied to me very much*. The internal consistencies at T1 were .87, .59, and .83 for the subscales depression, anxiety and stress, respectively. Since internal consistency for the anxiety subscale was inadequate, it was not used in any of the analyses. Both the subscales for depression (α = .88 and .87); and stress (α = .85 and .87) had good internal consistencies at T2 and T3, respectively.

5.3.3. Design

The study was a 2 (group: GTTP, CAU) X 3 (time: pre- and post-intervention and 6-month follow up) longitudinal randomised controlled trial.

5.3.4. Procedure

Ethical clearance for the study was obtained in accordance with the ethical review processes of the University of Auckland. After families were deemed eligible to be a part of the study, hardcopies or online links for the pre-intervention assessments were sent out. Parents were randomly assigned to either the GTTP or CAU conditions once the pre-intervention assessments were completed by their adolescent and themselves. Randomisation was implemented using a list of computer generated random numbers and families were assigned sequentially to condition according to the list. An independent researcher allocated participants to condition to ensure blind assignment. Parents and adolescents in both conditions completed assessments at three time points: pre-intervention (on enrolment in the study), post-intervention (approximately 12 weeks later), and at 6-month follow up. Participants in the CAU condition were offered the programme after completing 6-month follow up assessment.

5.3.5. Intervention

Group Teen Triple P. Parents allocated to the GTTP condition attended the eight-week programme. The programme was delivered in community locations across Auckland to accommodate parents' preferences in location and increase ease of accessibility. The programme consists of four two-hour group sessions that provide parents opportunities to learn and refine the use of positive parenting strategies through observation, discussion, practice and feedback. Segments from a DVD *Every Parent's Guide to Teenagers* (Ralph & Sanders, 2001) are used to demonstrate positive parenting skills. Between sessions, parents complete take home tasks to consolidate their learning from the group sessions. Three 15-30 minute individual telephone sessions follow the group session to assist parents to fine-tune the implementation of the parenting strategies, and problem-solve any implementation difficulties. One final group session was held following the telephone consultations to cover additional skills to facilitate generalisation and maintenance of positive changes.

Care as Usual. Families allocated to CAU received no intervention or support from the research team and could access alternative services if they so desired but no specific guidance was provided.

5.3.6. Intervention integrity and fidelity promotion

GTTP was delivered by four female accredited Triple P facilitators, who had worked with a diverse range of adolescent families, and within educational, community, and/or private settings. Group facilitators were provided with a programme kit, containing a programme manual, DVD, and a disc containing power point slides to facilitate presentation of programme content to parents. Following completion of each group and telephone session, facilitators completed session checklists to ensure treatment integrity and reduce protocol drift during the trial.

5.3.7. Statistical analyses

To evaluate short-term intervention effects, differences between the GTTP and CAU conditions were examined using a series of two-group multivariate and univariate analyses of covariance (MANCOVAs and ANCOVAs), with post-intervention scores as dependent variables and pre-intervention data included as covariates. MANCOVAs were conducted on

each set of conceptually-related dependent variables: family relationship (FES Conflict and Cohesion, and PCQ); marital relationship (PPC Problem and Extent, and RQI); parenting (PSA Laxness and Over-reactivity, PMS, and PSE); adolescent related-outcome (problem behaviour: SDQ and PBC; adjustment: AS, SES, and PYD); and parental adjustment (DASS-21 Depression and Anxiety). In cases where multivariate effects were found, ANCOVAs were conducted and univariate F values examined to determine which variables contributed to the multivariate effect. Univariate ANCOVAs were conducted on mother reports on adolescent problem behaviour (SDQ) and adolescent reports on parenting (PMS). Maintenance of intervention effects were analysed by a series of MANCOVAs and ANCOVAs using 6-month follow up assessments as the dependent variable, and pre-intervention assessments as the control variable[2]. Significant effect sizes were calculated using Cohen's d. An effect size was considered to be meaningful, but small, when d was between 0.20 and 0.49, medium, when d was between 0.50 and 0.79, and large, when d was greater than 0.80 (Cohen, 1992). For those measures showing statistically significant change at 6-month follow up, clinical significance of change was examined using two methods: chi-square analyses of the proportion of participants moving from the clinically elevated to non-clinical range, and chi-square analyses of the extent to which changes were reliable or unlikely to be due to chance (i.e., through calculation of a Reliable Change Index; Jacobson & Traux, 1991).

5.4. Results

5.4.1. Data screening

All data were screened for missing values (including missing data due to participant attrition). There were a minimal proportion of values that were missing (< 10%). An analysis of missing values indicated that data points were missing completely at random (MCAR), with Little's MCAR test not reaching significance for both mother ($\chi 2$ (12061) = 548.751, p = 1.000) and adolescent ($\chi 2$ (3182) = 164.852, p = 1.000) data. Accordingly, expectation-maximisation was used to estimate values for the intent-to-treat sample on which all further calculations are based.

---

[2] It should be noted that repeated measures analyses across all time points revealed no significant difference to that of the main analyses.

5.4.2. Preliminary analyses

To check for adequate randomisation, a series of independent sample t-tests and chi-square analyses were conducted to identify any pre-intervention differences between the GTTP and CAU conditions on all of the socio-demographic and outcome variables. A significant pre-intervention difference was observed in mother-reported outcome measures. Mothers in the GTTP condition reported higher levels of parenting over-reactivity than mothers in the CAU condition (t (70) = 2.01, p = .048). No significant differences were observed in socio-demographic variables, or any other mother-reported, and adolescent-reported measures. Differences observed at pre-intervention were controlled by using ANCOVAs and MACOVAs where relevant.

5.4.3. Attrition

Of the 72 families assigned to GTTP (n = 35) or CAU (n = 37), 69 families completed post-intervention (GTTP n = 32, and CAU n = 37), representing a very high retention rate of 96%. Out of the original 72 families, 58 families (GTTP n = 27, and CAU n = 31) completed the 6-month follow up assessment, with a retention rate of 77% for the GTTP condition and 84% for the CAU condition, representing a moderately high retention rate. A series of one-way ANOVAs revealed no significant differences at pre-intervention between completers and non-completers of the 6-month follow up on any of the dependent variables.

5.4.4. Short-term intervention effects

Table 5.2. shows descriptive statistics for conditions at pre- and post-intervention, as well as univariate F values and effect sizes (Cohen's d) for all mothers and adolescents self-report measures.

Table 5.2.

Descriptive statistics and effect sizes for short-term intervention effects for all measures

	Group Teen Triple P (N = 35)		Control (N = 37)		Univariate *F* for group	*p*	Effect size *d*
	Pre *M (SD)*	Post *M (SD)*	Pre *M (SD)*	Post *M (SD)*			
Mother reported outcomes							
Family relationships							
FES-Conflict	1.83 (0.85)	1.36 (0.73)	1.87 (0.72)	1.76 (0.77)	11.11	.001	0.85
FES-Cohesion	3.50 (0.60)	3.76 (0.42)	3.27 (0.69)	3.24 (0.72)	14.89	.000	0.99
PCQ	1.17 (0.71)	0.79 (0.54)	1.02 (0.60)	1.05 (0.64)	7.74	.007	0.71
Marital relationships							
PPC-Problem	5.88 (4.45)	3.85 (3.52)	4.54 (3.71)	4.35 (3.48)	1.97	.168	0.41
PPC-Extent	26.27 (17.59)	16.94 (13.25)	24.76 (13.36)	17.70 (17.62)	1.83	.184	0.39
RQI	25.15 (7.49)	24.12 (9.34)	25.35 (5.85)	23.57 (6.33)	0.58	.811	0.22
Parenting							
PSA-Laxness	3.13 (0.77)	2.58 (0.78)	3.45 (1.16)	3.44 (1.11)	10.34	.002	0.82
PSA-Over-reactivity	4.01 (0.63)	3.19 (0.54)	3.70 (0.71)	3.54 (0.75)	12.33	.001	0.90
PMS	2.65 (0.51)	2.84 (0.51)	2.72 (0.60)	2.46 (0.78)	8.29	.005	0.74
PSE	68.66 (15.17)	75.18 (11.30)	69.96 (14.50)	62.05 (18.48)	16.66	.000	1.05
Adolescent problem behaviour							
SDQ-Total Score	9.60 (6.17)	7.30 (5.40)	9.24 (6.64)	10.24 (3.35)	12.93	.001	0.90
Parental adjustment							
DASS-Depression	5.01 (3.88)	3.86 (1.97)	6.62 (3.51)	5.57 (3.49)	1.73	.193	0.34
DASS-Stress	8.97 (6.93)	5.24 (4.46)	7.30 (6.45)	6.15 (4.83)	1.61	.208	0.32
Adolescent reported outcomes							

					F	p	d
Family relationships							
FES-Conflict	2.13 (0.88)	1.47 (0.79)	1.92 (0.93)	1.87 (0.86)	8.70	.004	0.76
FES-Cohesion	2.91 (0.84)	3.38 (0.70)	2.90 (0.73)	2.89 (0.69)	13.07	.001	0.93
PCQ	1.07 (0.81)	0.81 (0.74)	1.12 (0.73)	1.22 (0.68)	8.94	.004	0.77
Parenting							
PMS	2.53 (0.85)	2.69 (0.69)	2.30 (0.82)	2.28 (0.74)	4.32	.041	0.53
Adolescent problem behaviour							
SDQ-Total Score	11.89 (7.26)	8.54 (4.49)	9.76 (6.10)	7.18 (3.58)	2.06	.156	0.37
PBC	3.37 (4.32)	2.96 (4.74)	3.14 (2.39)	3.48 (2.47)	0.73	.395	0.22
Adolescent adjustment							
AS	3.28 (0.55)	3.28 (0.51)	3.22 (0.64)	3.23 (0.66)	0.28	.868	0.14
SES	2.27 (0.50)	2.30 (0.43)	2.23 (0.31)	2.16 (0.30)	2.05	.157	0.37
PYD-Caring	1.64 (0.59)	1.75 (0.42)	1.59 (0.41)	1.54 (0.35)	5.52	.022	0.60

Note. F = ANCOVA univariate effect for condition; *d* = effect size; FES = Family Environment Scale; PCQ = Parent Conflict Questionnaire; PPC = Parent Problem Checklist; RQI = Relationship Quality Index (N.B. GTTP *n* = 24 and Control *n* = 24 due to single family status); PSA = Parenting Scale-Adolescent version; PMS = Parental Monitoring Scale; PSE = Parental Self-Efficacy; SDQ = Strengths and Difficulties Questionnaire; DASS =Depression Anxiety Stress Scales; PBC = Problem Behaviour Checklist; AS = Autonomy Scale; SES = Rosenberg Self Esteem Scale; PYD = Positive Youth Development.

Family relationship. Multivariate intervention effects were found for the group of family relationship measures for both mothers (F (3, 65) = 6.10, p = .001) and adolescents (F (3, 65) = 5.344, p = .002). Follow-up ANCOVAs revealed a significant intervention effect on both subscales of the FES. Mothers and adolescents in the GTTP condition reported lower levels of family conflict and higher levels of family cohesion, compared to the CAU condition at post-intervention. Less parent-adolescent conflict was reported by mothers and adolescents in the GTTP condition at post-intervention compared to mothers and adolescents in the CAU condition. Medium to large effect sizes were found.

Marital relationship. No multivariate intervention effect was found for the group of marital relationship measures (F (3, 41) = .738, p = .535), nor were there any individual univariate effects on these measures.

Parenting. Multivariate intervention effect was found for the group of parenting-related measures based on mother-self reports (F (4, 63) = 6.62, p <.001). Follow-up ANCOVAs revealed a significant intervention effect on the PSA for parental laxness and parental over-reactivity, with mothers in the GTTP condition reporting lower use of dysfunctional parenting practices compared to the CAU condition at post-intervention. Mothers in the GTTP condition also reported increased level of parental monitoring and improved parental confidence at post-intervention compared to parents in the CAU condition. Consistent with mother-self reports, adolescents in the GTTP condition reported increases in parental monitoring at post-intervention, which was not evident in adolescents whose parents were in the CAU condition. The reported changes from parents and adolescents were associated with medium to large effect sizes.

Adolescent problem behaviour. The behaviour problems as measured by the Total Difficulties score on the SDQ reported by mothers and adolescents were in the normal range across both conditions at pre-intervention. Results from univariate ANCOVAs revealed a significant intervention effect on the SDQ as reported by mothers. Less problematic behaviours were reported by mothers in the GTTP at post-intervention than mothers in the CAU condition. This was associated with a large effect size. However, no significant multivariate intervention effect was found for the adolescent-reported measures on problem

behaviours (F (2, 67) = 1.02, p = .367), nor were there any individual univariate effects on these measures.

Adolescent adjustment. No multivariate intervention effect was found for the adolescent-reported measures on adolescent adjustment (F (3, 65) = 1.93, p = .133). However, follow-up ANCOVAs revealed a significant intervention effect on Caring with adolescents in the GTTP condition reporting higher levels of caring at post-intervention compared to adolescents in the CAU condition. This change was associated with medium effect size.

Parental adjustment. No multivariate intervention effect was found on measures of parental adjustment based on mother-self reports (F (2, 67) = 1.07, p = .348), nor were there any individual univariate effects on the subscales.

5.4.5. Six-month follow up intervention effects

Table 5.3. reports the descriptive statistics, results of univariate ANCOVAs, and effects sizes at 6-month follow up.

Table 5.3.

Descriptive statistics and effect sizes for 6-month follow up intervention effects for all measures

	Group Teen Triple P (N = 35)		Control (N = 37)		Univariate F for group	p	Effect size d
	Pre M (SD)	Post M (SD)	Pre M (SD)	Post M (SD)			
Mother reported outcomes							
Family relationships							
FES-Conflict	1.83 (0.85)	1.43 (0.73)	1.87 (0.72)	1.67 (0.77)	0.45	.506	0.16
FES-Cohesion	3.50 (0.60)	3.74 (0.75)	3.27 (0.69)	2.69 (0.97)	19.69	.000	1.05
PCQ	1.17 (0.71)	0.78 (0.51)	1.02 (0.60)	1.21 (0.71)	8.71	.004	0.70
Marital relationships							
PPC-Problem	5.88 (4.45)	4.22 (3.53)	4.54 (3.71)	4.20 (3.04)	1.10	.301	0.38
PPC-Extent	26.27 (17.59)	18.59 (10.73)	24.76 (13.36)	20.99 (15.03)	3.58	.065	0.55
RQI	25.15 (7.49)	25.33 (7.93)	25.35 (5.85)	25.00 (4.10)	3.74	.549	0.56
Parenting							
PSA-Laxness	3.13 (0.77)	2.56 (0.73)	3.45 (1.16)	3.31 (1.23)	12.84	.001	0.84
PSA-Over-reactivity	4.01 (0.63)	3.36 (0.50)	3.70 (0.71)	3.58 (0.62)	5.92	.018	0.57
PMS	2.65 (0.51)	2.84 (0.63)	2.72 (0.60)	2.27 (0.70)	10.72	.002	0.77
PSE	68.66 (15.17)	75.72 (15.56)	69.96 (14.50)	56.81 (21.46)	1.05	.309	0.24
Adolescent problem behaviour							
SDQ-Total Score	9.60 (6.17)	5.35 (4.88)	9.24 (6.64)	8.34 (4.92)	4.45	.039	0.50
Parental adjustment							
DASS-Depression	5.01 (3.88)	5.01 (3.89)	6.62 (3.51)	6.62 (3.51)	0.15	.702	0.09
DASS-Stress	8.97 (6.93)	6.11 (5.71)	7.30 (6.45)	5.68 (4.04)	0.65	.800	0.19
Adolescent reported outcomes							

					F	p	d
Family relationships							
FES-Conflict	2.13 (0.88)	1.23 (0.63)	1.92 (0.93)	1.18 (0.67)	17.85	.000	1.00
FES-Cohesion	2.91 (0.84)	3.35 (0.62)	2.90 (0.73)	2.84 (0.57)	19.26	.000	1.03
PCQ	1.07 (0.81)	0.87 (0.74)	1.12 (0.73)	1.17 (0.61)	13.32	.001	0.86
Parenting							
PMS	2.53 (0.85)	2.71 (0.47)	2.30 (0.82)	2.13 (0.61)	21.58	.000	1.10
Adolescent problem behaviour							
SDQ-Total Score	11.89 (7.26)	7.79 (5.77)	9.76 (6.10)	11.22 (6.25)	15.09	.000	0.92
PBC	3.37 (4.32)	2.34 (2.32)	3.14 (2.39)	3.76 (2.03)	11.97	.001	0.82
Adolescent adjustment							
AS	3.28 (0.55)	3.34 (0.36)	3.22 (0.64)	3.36 (0.67)	0.17	.680	0.10
SES	2.27 (0.50)	2.32 (0.57)	2.23 (0.31)	2.18 (0.26)	1.97	.165	0.33
PYD-Caring	1.64 (0.59)	1.62 (0.52)	1.59 (0.41)	1.22 (0.36)	6.78	.011	0.61

Note. F = ANCOVA univariate effect for condition; d = effect size; FES = Family Environment Scale; PCQ = Parent Conflict Questionnaire; PPC = Parent Problem Checklist; RQI = Relationship Quality Index (N.B. GTTP n = 24 and Control n = 24 due to single family status); PSA = Parenting Scale-Adolescent version; PMS = Parental Monitoring Scale; PSE = Parental Self-Efficacy; SDQ = Strengths and Difficulties Questionnaire; DASS =Depression Anxiety Stress Scales; PBC = Problem Behaviour Checklist; AS = Autonomy Scale; SES = Rosenberg Self Esteem Scale; PYD = Positive Youth Development.

Follow-up analyses show a similar pattern to post-intervention findings with most improvements maintained over time. For mother-reported measures, multivariate intervention effects were found for the groups measuring family relationship (F (3, 65) = 7.66, $p < .001$), and parenting (F (4, 63) = 5.74, $p = .001$). Follow up ANCOVAs revealed significant condition effects for family cohesion and parent-adolescent conflict, parental laxness and over-reactivity, parental monitoring, and adolescent problem behaviour; these ranged from medium to large effect sizes. However, no significant differences were observed in mother-reported measures at 6-month follow up on family conflict, and parental confidence despite significant effect at post-intervention. No multivariate intervention effects were observed for the group of measures on marital relationship (F (3, 41) = 1.63, $p = .197$) and parental adjustment (F (2, 67) = 0.93, $p = .912$), at 6-month follow up.

On adolescent reports, all significant intervention effects observed at post-intervention were maintained at 6-month follow up. These included multivariate intervention effects for the groups measuring family relationship (F (3, 65) = 10.03, $p < .001$), and univariant ANCOVAs on parental monitoring. Additional multivariant intervention effects were found at 6-month follow up on adolescent problem behaviour (F (2, 67) = 10.68, $p < .001$) and adolescent adjustment (F (3, 65) = 4.01, $p = .011$). Adolescents in the GTTP condition reported significantly less behavioural problems as measured by the Total Difficulties score on the SDQ as well as on the PBC, at 6-month follow up compared to adolescents in the CAU condition. Adolescents in the CAU condition also reported significantly lower levels of caring at 6-month follow up compared to adolescents in the GTTP condition. These changes were associated with medium to large effect sizes.

5.4.6. Reliable and clinically significant change

Table 5.4. reports the results of reliable and clinically significant change analyses and shows the proportion of families from the GTTP and CAU conditions who showed reliable and clinically significant improvement from pre- to 6-month follow up.

Table 5.4.

Reliable change and clinically significant change results for each significant measure for the intervention and care-as-usual conditions

Measure	Group Teen Triple P		CAU		Reliable change		Clinical change	
	Reliably improved %(n/n)	Clinically improved %(n/n)[a]	Reliably improved %(n/n)	Clinically improved %(n/n)[a]	χ^2	p	χ^2	p
Mother reported outcomes								
FES-Cohesion	17.14 (6/35)	50.00 (3/6)	0.00 (2/37)	0.00 (0/5)	2.51	0.146	3.44	0.182
PCQ	14.29 (5/35)	100.00 (5/5)	2.70 (1/37)	50.00 (2/4)	3.15	0.102	3.21	0.167
PSA-Laxness	34.29 (12/35)	60.00 (12/20)	8.11 (3/37)	15.00 (3/20)	7.47	0.006[**]	8.64	0.003[**]
PSA-Over-reactivity	28.57 (10/35)	62.50 (15/24)	10.81 (4/37)	39.13 (9/23)	3.62	0.057	2.57	0.148
PMS	22.86 (8/35)	N/A	10.81 (4/37)	N/A	13.51	0.000[**]		
SDQ-Total Score	17.14 (6/35)	100.00 (7/7)	10.81 (4/37)	71.43 (5/7)	0.603	0.509	2.33	0.462
Adolescent reported outcomes								
FES-Conflict	34.29 (12/35)	60.00 (3/5)	18.92 (7/37)	57.14 (4/7)	4.06	0.044[**]	1.66	0.293
FES-Cohesion	11.43 (4/35)	20.00 (1/5)	5.41 (2/37)	25.00 (1/4)	0.85	0.423	0.32	1.000
PCQ	5.71 (2/35)	66.67 (2/3)	2.70 (1/37)	0.00 (0/4)	0.41	0.609	3.73	0.143
PMS	11.43 (4/35)	N/A	0.00 (0/37)	N/A	4.48	0.034[**]		
SDQ-Total Score	34.29 (12/35)	100.00 (9/9)	18.92 (7/37)	50.00 (4/8)	2.19	0.139	5.89	0.029[**]
PYD-Caring	0.00 (0/35)	N/A	0.00 (0/37)	N/A				

Note. χ2 = Pearson's chi-square (where expected cell frequencies are too low for chi-square, 2-sided significance for Fisher's Exact Test is reported); N/A = there are no published clinical cut-offs for these measures; FES = Family Environment Scale; PCQ = Parent Conflict Questionnaire; PSA = Parenting Scale-Adolescent version; PMS = Parental Monitoring Scale; PSE = Parental Self-Efficacy; SDQ = Strengths and Difficulties Questionnaire; PYD = Positive Youth Development; [a] n for denominator represents the number of participants in the clinical range at pre-intervention; * $p < .05$, ** $p < .01$

Significantly more mothers reliably improved in the GTTP condition compared to the CAU condition on parental laxness and parental monitoring. In addition, more mothers in the GTTP condition moved out of the clinical range in parental laxness compared to the CAU mothers. A significantly higher proportion of GTTP adolescents reported reliable improvements in family conflict and parental monitoring compared with CAU adolescents. Finally, more adolescents in the GTTP condition reported shifts out of the clinical range of problem behaviour compared to the CAU condition.

5.5. Discussion

There is a clear recognition by policy makers and researchers that the cost of adolescent problem behaviour is high, and effective evidence-based parenting programs are needed and worth implementing. However, a lack of well-conducted randomized trials that document the efficacy of parenting programs for parents of adolescents hinders large-scale implementation of such programs. This study provided empirical support for the efficacy of GTTP as a universally offered intervention for parents of adolescents. Overall, the findings were promising with medium to large effects sizes comparable to other published efficacy trials of Triple P with younger children (Nowak & Heinrichs, 2008). There was also a tendency for a larger proportion of families in the GTTP condition to experience reliable and clinically meaningful improvements, compared to the CAU condition.

Mothers in the GTTP condition at post-intervention reported significant improvements in family relationship quality, including decreased family conflict, increased family cohesion, and decreased levels of parent-adolescent conflict; decreased use of dysfunctional parenting practices; increased parental monitoring; improved parental confidence; and decreased adolescent problem behaviour. However, no short-term intervention effect was found for mothers' parental relationship satisfaction and parental adjustment. The present findings are consistent with the results of other studies evaluating Triple P for younger children. These studies found Triple P to be consistently associated with decreased use of dysfunctional parenting practices and reduction of problem behaviours, but not necessarily related to

improvements in parental relationships and/or parental adjustment as reported by parents (e.g., Sanders, Markie-Dadds, Tully, & Bor, 2000). The extent of impact depends on the level of parental conflict and severity of symptoms of parental adjustment reported prior to intervention. In this study, baseline scores on these variables were in the non-clinical range.

Adolescents whose parents attended GTTP reported significant improvements in family relationships including decreased family conflict, increased family cohesion, and decreased levels of parent-adolescent conflict; increased levels of perceived parental monitoring; and improvement in adolescent adjustment in caring for others. However, contrary to predictions, no short-term intervention effects were found for either adolescent reported problem behaviours or adolescent self-esteem and autonomy in decision making. One possible explanation is that pre-intervention scores as reported by adolescents were well below the clinical range and therefore floor effects made it difficult to detect intervention effects. Alternatively, the effects of the parenting strategies implemented by parents in the GTTP condition may require a longer time period to result in changes in adolescent adjustment and behaviour.

Finally, at six-month follow up, several improvements reported by mothers were maintained: family cohesion, parent-adolescent conflict, dysfunctional parenting practices including over-reactivity, and parental monitoring. However, mother-reported outcomes on family conflict and parental confidence were not maintained. A possible explanation for non-significant intervention effects is scores at pre- and post-intervention were not within the clinical range. For adolescent-reported outcomes, all short-term intervention effects were maintained at 6-month follow up. In addition, significant intervention effects on adolescent problem behaviours were observed which were previously not found at post-intervention. Adolescents whose parents attended GTTP reported significantly lower levels of problem behaviour than adolescents in the CAU condition. This delayed condition effect suggest that parenting skills implemented by GTTP parents required a longer period of time then immediate post-intervention to have a detectable effect on their adolescents. The finding highlights the importance of follow up assessments in intervention studies in order to fully capture the effects of the intervention. Moreover, the findings suggest that changes in parenting practices and improvements in the

quality of family relationships have the potential to reduce or prevent adolescent reported problem behaviours in the long term.

The present findings are important because very few studies have documented adolescent-reported outcomes and of those available, mixed findings have been reported as to the presence of improvements in family relationships and adolescent behaviour from the point of view of the adolescent (Chand et al., 2013). As evident in the present study, mothers changes in their specific parenting practices appear to be accompanied by broader changes in how they relate to their adolescent (e.g., decrease parent-adolescent conflict), resulting in enhanced family relationships. For adolescents, improvements in family functioning, can lead to better communication between parents and adolescents, which is an important determinant of the quality of the parent-adolescent relationship (Maximo et al., 2011). Where parent-adolescent relationships are perceived to be positive by adolescents, there is a greater likelihood that higher monitoring would be reported by both parents and adolescents and therefore less likely for adolescents to engage in problem behaviours (Dishion & McMahon, 1998). Although the small sample size did not allow examination of moderators and mediators of intervention effects, the present findings found that adolescents whose parents participated in GTTP reported higher levels of parental monitoring and decreased parent-adolescent conflict as well as a reduction in problem behaviours.

The above findings are consistent with the framework of Teen Triple P in which it aims to bring about change in families by teaching parents to use positive adolescent management practices, to eliminate or reduce coercive interaction patterns, and to create positive family relationships and functioning. It seeks to accomplish this through the use of active skills training within a self-regulation framework (Sanders, 2012). Similar to findings on previous variants of Teen Triple P, GTTP was effective in reducing adolescent problem behaviours, parent-adolescent conflict, and dysfunctional parenting (e.g., Stallman & Ralph, 2007). In addition, these findings are consistent with results from other programmes developed for parents of adolescents (e.g., Strengthening Families Program 10-14; Spoth et al., 2009).

The present findings need to be interpreted in light of the study's strengths and limitations. Strengths included use of a randomized controlled design with follow up, multi-informant assessment, use of intent-to-treat analyses, and reliable, validated outcome assessment tools. A number of limitations are important to consider. Firstly, socioeconomically disadvantaged families were underrepresented limiting the generality of the findings to the more vulnerable parent and adolescent populations. In addition, families were generally well-functioning. Despite extensive efforts to use social marketing strategies to raise community awareness, participation rates were low. This is consistent with other international research on parenting interventions regarding challenges in recruiting parents in general as well as parents of lower socioeconomic status (Sanders, Markie-Dadds, Rinaldis, Firman, & Baig, 2007). Future research is needed with more diverse populations to assess the generalisability of the results. Secondly, we assessed intervention outcomes through self-report measures only. Although the measures had strong psychometric properties and utilized multiple informants, no observational data was collected. As with many studies where parents volunteer and consent to participate it is unknown to what extent differential positive expectancy effects may have contributed to observed group differences. Moreover, few father data were collected in the present sample. Future research would benefit from collecting multiple sources of data, particularly fathers and adolescents, given the current lack of father and adolescent input in parenting intervention research. For example, consulting with both parents (where applicable) and adolescents on how programs can be tailored to meet the needs of families, and to determine whether programs involving adolescents are considered acceptable and relevant to parents and adolescents.

Large-scale community based implementation of parenting programmes to prevent and reduce adolescent problem behaviours will require a number of effective programmes to be available to avoid a "one size fits all" approach. The current findings demonstrated the efficacy of GTTP in reducing adolescent problem behaviours, improve parent-related outcomes, and improve family relationships and functioning for families. Demonstrating efficacy of GTTP is a useful and necessary step towards the ultimate goal of having a multilevel system of parenting support available across childhood and adolescence within a public health framework that ultimately make a difference in the lives of youth and their families.

112

5.6. References

Bandura, A. (2006). Guide for constructing self-efficacy scales. In F. Pajares & T. Urdan (Eds.), *Self-efficacy beliefs of adolescents*. Greenwich, CT: Information Age Publishing.

Chand, N. L., Farruggia, S. P., Dittman, C. K., Chu, J. T. W., & Sanders, M. R. (2013). Positive youth development and Teen Triple P: Promoting positive youth development through a brief parenting intervention programme. *Youth Studies Australia,* 32, 29-36.

Cohen, J. (1992). A power primer. *Psychological Bulletin,* 112, 155-159.

Connell, A. M., Dishion, T. J., Yasui, M., & Kavanagh, K. (2007). An Adaptive Approach to Family Intervention: Linking Engagement in Family-Centered Intervention to Reductions in Adolescent Problem Behavior. *Journal of Consulting and Clinical Psychology,* 75:568–79.

Dadds, M. R., & Powell, M. B. (1991). The relationship of interparental conflict and global marital adjustment to aggression, anxiety, and immaturity in aggressive and nonclinic children. *Journal of Abnormal Child Psychology,* 19, 553-567. doi: 10.1007/BF00925820

Dishion, T. J., & McMahon, R. J. (1998). Parental monitoring and the prevention of child and adolescent problem behaviour: a conceptual and empirical formulation. *Clinical Child and Family Psychology Review,* 1, 61-75.

Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Evidence-based psychosocial treatments for children and adolescents with disruptive behaviour. *Jounral of Clinical Adolescent Psychology,* 37, 215-237. doi: 10.1080/18374410701820117

Flay, B. R., Biglan, A., Boruch, R. F., et al. (2005). Standards of evidence: criteria for efficacy, effectiveness and dissemination. *Prevention Science,* doi: 10.1007/s11121-005-5533-y

Frick, P. J., & Viding, E. (2009). Antisocial behaviour from a developmental psychopathology perspective. *Development and Psychopathology,* 21, 1111-1131. doi: 10.1017/s0954579409990071

Greenberger, E., Chen, C., & Beam, M. R. (1998). The role of "very important" nonparental adults in adolescent development. *Journal of Youth and Adolescence,* 27, 321-343. doi: 10.1023/A:1022803120166

Greenberger, E., Chen, C., Beam, M. R., Whang, S. M., & Dong, Q. (2000). The perceived social contexts of adolescents' misconduct: A comparative study of youths in three cultures. *Journal of Research on Adolescence,* 10, 365-388. doi: 10.1207/SJRA1003_7

Goodman, R. (1999). The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden. *The Journal of Child Psychology and Psychiatry,* 40, 791-799. doi: 10.1111/1469-7610.00494

Haggerty, K. P., Kosterman, R. Catalano, R. F., & Hawkins, J. D. (1999). Preparing for the Drug Free Years. *OJJDP Juvenile Justice Bulletin,* 1-10.

Irvine, A. B., Biglan, A., Smolkowski, K., Metzler, C. W., & Ary, D. V. (1999). The effectiveness of a parenting skills programme for parents of middle school students in small communities. *Journal of Consulting and Clinical Psychology,* 67, 811-825. doi: 10.1037/0022-006X.67.6.811

Jacobsen, N. S., & Truax, P. (1991). Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, 59, 12–19. doi:10.1037/0022-006X.59.1.12.

Kaslow, N. J., Broth, M. R., Smith, C. O., & Collins, M. H. (2012). Family-based interventions for child and adolescent disorders. *Journal of Marital and Family Therapy,* 38, 82-100. doi: 10.1111/j.1752-0606.2011.00257.x

Lerner, R. M., Lerner, J. V., Almerigi, J. B., et al. (2005). Positive youth development, participation in community youth development programmes, and community contributions of fifth-grade adolescents: Findings from the first wave of the 4-H study of Positive Youth Development. *The Journal of Early Adolescence,* 25, 17-71. doi: 10.1177/0272431604272461

Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the Depression Anxiety Stress Scales* Sydney: Psychology Foundation.

Maximo, S., Tayaban, H. S., Cacdac, G. B., Cacanindin, M. J. A., Pugat, R. J. S., Rivera, M. F., & Lingbawan, M. C. (2011). Parents' communication styles and their influence on the adolescents' attachment, intimacy and achievement motivation. *International Journal of Behavioural Science,* 6, 59-72.

Moos, R. H., & Moos, B. S. (1994). *A social climate scale: Family environment scale manual* (3rd ed.), California: Consulting Psychologists Press, Inc.

National Research Council and Institute of Medicine. (2009). Preventing mental, emotional, and behavioural disorders among young people: Progress and possibilities. Washington, DC: National Academic Press.

Norton, R. (1983). Measuring marital quality: A critical look at the dependent variable. *Journal of Marriage and Family,* 45, 141-151.

Nowak, C., & Heinrichs, N. (2008). A comprehensive meta-analysis of Triple P - Positive Parenting Program using hierarchical linear modelling: Effectiveness and moderating variables. *Clinical Child and Family Psychology Review*, 11, 114-144.

Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-based prevention of child maltreatment: The U.S. Triple P System Population Trial. *Prevention Science*, 10, 1-13.

Ralph, A., & Sanders, M. R. (2001). *Every Parent's Guide to Teenagers.* Brisbane: Families International Pty Ltd.

Ralph, A., & Sanders, M. R. (2003). Preliminary evaluation of the Group Teen Triple P programme for parents of teenagers making the transition to high school. *AeJAMH (Australian e-Journal for the Advancement of Mental Health), 2*(3), No Pagination Specified.

Rosenberg, M. (1965) Society and the adolescent self-image. Princeton, NJ: Princeton University Press.

Sameroff, A., Gutman, L. M., & Peck, S. C. (2003). Adaptation among youth facing multiple risks. In S. S. Luthar (Ed.), *Resilience and Vulnerability: Adaptation in the Context of Childhood Adversities,* (pp. 364-391). Cambridge: Cambridge University Press.

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

Sanders, M. R., Markie-Dadds, C., Rinaldis, M., Firman, D., & Baig, N. (2007). Using household survey data to inform policy decisions regarding the delivery of evidence-based parenting interventions. *Child: Care, Health and Development*. doi: 10.1111/j.1365-2214.2006.00725.x

Spoth, R., Trudeau, L., Guyll, M., Chungyeol, S., & Redmond, C. (2009). Universal intervention effects on substance abuse use among young adults mediated by delayed adolescent substance initiation. *Journal of Consulting and Clinical Psychology, 77, 620-632.*

Stallman, H. M., & Ralph, A. (2007). Reducing risk factors for adolescent behavioural and emotional problems: A pilot randomised controlled trial of a self-administered parenting intervention. *AeJAMH (Australian e-Journal for the Advancement of Mental Health), 6,* 1-13.

Statistics New Zealand. (2013). *New Zealand in Profile 2013.*Retrieved from March 9, 2013
from, http://www.stats.govt.nz

Zubrick, S. R., Silburn, S. R., Garton, A. F., et al. (1995). *Western Australian Child Health
Survey. Developing health and well-being into the nineties.* Perth, WA: Australian
Bureau of Statistics.

Chapter 6 – Evaluating the Social Validity of Group Teen Triple P

The social validation of parenting programmes is becoming increasingly recognised as an essential component in parenting programme research (Kirby & Sanders, 2012). However, literature on parenting programmes for parents of adolescents frequently overlooks the perspective of parents and adolescents in the design, planning, delivery, and assessment of programme effectiveness. While demonstrating statistical changes on the effectiveness of a programme is important, it does not necessarily lead to programme uptake. A large number of families do not participate or engage in evidence-based parenting programmes (Metzler, Sanders, Rusby, & Crowley, 2012). A parenting programme needs to be meaningful and socially accepted by its consumers for it to be viable and sustainable when implemented at the population level. It is therefore necessary to understand the perspectives of parents and adolescents on parenting programmes, and qualitative methods can make a significant contribution in this area. Although the previous Chapter demonstrated that GTTP was efficacious, there is a need to understand how GTTP is received by its consumers, and whether the effects of the programme were meaningful and/or important to its consumers. The aim of the present study was therefore to evaluate the social validity of GTTP through parents' and adolescent's perspectives. This chapter consists entirely of a paper submitted to the *Journal of Child and Family Studies.*

6.1. Abstract

An increasing number of studies are appearing that support the use of parenting programmes for parents of adolescents. In addition to empirical evidence demonstrating the effectiveness of such programmes, the extent to which these programmes are socially valid for its consumers is essential to their long-term utility and widespread implementation. Parents and adolescents are consumers of parenting programmes, and their views of the programme are particularly important as such perceptions can impact programme uptake. The present paper explores parents' and adolescents' perceptions of the impact of an evidence-based parenting programme (Group Teen Triple P – GTTP), specifically designed for parents of adolescents aged between 12 to 15 years. Four discussion groups, two with parents ($n = 9$) and two with adolescents ($n = 7$) were conducted. Findings indicate that parents perceived GTTP to be acceptable and relevant (e.g., providing a range of tools and a supportive group environment). However, certain aspects of the programme were also identified to be less helpful (e.g., lack of discussion time). Parents and adolescents further perceived GTTP to be effective in producing meaningful changes (e.g., less use of coercive parenting practices and improved parent-adolescent relationship). Finally, recommendations for the programme were made by consumers. The implications of the findings on social validity in relation to a public health approach are discussed.

Keywords: parenting programme, adolescent, parenting, consumers, social validity

6.2. A Qualitative Evaluation of the Impact and Social Validity of a Universal Group Parenting Programme for Parents of Adolescents

Research consistently demonstrates that protective factors such as positive family relationships and effective parenting practices are critical to the reduction and prevention of adolescent problem behaviours (Kumpfer & Alvarado, 2003). By targeting changes in parenting practices such as parental monitoring, consistency, positive reinforcement, and establishment of clear boundaries, parenting programmes have been shown to result in positive outcomes (e.g., increase in parental confidence, reduction in adolescent problem behaviours; Lim, Tormshak, & Dishion, 2005; Stallman & Ralph, 2007). Given the increasing evidence, policy makers and scholars have taken a proactive stance to promote and adopt a public health approach to the delivery of parenting programmes at the population level (Mercy & Saul, 2009; National Research Council and Institute of Medicine, 2009). The aim of the approach is to enhance parenting practices, competent, and adjustment for all parents, and thus produce multiple beneficial health and developmental outcomes for children and young people at the population level (Sanders, 2012). However, poor participation by parents stands as the greatest barrier to widespread effective implementation of such programmes (Morawska et al., 2011). This implies that a large segment of the population is failing to receive the benefits of such programmes (Sanders, 2012). Even when a parenting programme has been shown to be effective, consumers are unlikely to participate if they perceive the programme to be irrelevant. Therefore, parenting programmes needs to be meaningful and of value to its targeted population if these programmes are to be viable and sustainable when implemented at the population level (Whittingham, Sofronoff, Sheffield, & Sanders, 2009). Presumably, a parenting programme that has demonstrated effectiveness and is socially valid is most likely to be utilised by consumers and result in more widespread dissemination (Kirby & Sanders, 2012). This paper provides a qualitative assessment of the social validity of an evidence-based parenting programme from the perspective of both parents and adolescents.

Social validity has been described by Wolf (1978) as the extent to which consumers perceive the goals of the intervention as important, the intervention procedures as acceptable,

and the intervention effects as meaningful. Social validity is important as it promotes programme fidelity and sustainability (Albin, Lucyshyn, Horner, & Flannery, 1996). In this light, Wolf (1978) considered consumers as the best judge of their needs related to an intervention. Schwartz and Baer (1991) further identified consumers as being 'direct consumers' (i.e., the person receiving the intervention) or 'indirect consumers' (i.e., person, such as family members who are considerably impacted by the direct consumers). Parents and their adolescent children are therefore, respectively, 'direct' and 'indirect' consumers of parenting programmes for parents of adolescents.

The extent to which the goals of the intervention are seen as relevant and socially important is an important aspect in predicting programme uptake (Albin et al., 1996). Goals can be assessed for both their importance (i.e., whether there is a need for working toward the particular treatment goal) and their acceptability (i.e., if the goal is relevant to or desired by consumers). To this end, information can be obtained from consumers that help programme developers to focus their interventions on relevant goals. For example, a survey conducted with parents of adolescents found that parents shared similar concerns (Ralph, Toumbourou, Grigg, Mulcahy, Carr-Gregg, & Sanders, 2003). These concerns were then incorporated into the programme content and materials. In this way, social importance and acceptability of the intervention goals were achieved by involving the opinions of the targeted consumers of the programme. Nonetheless, the study only obtained parents' perspectives, and no information was sought from adolescents. Given studies have identified discrepancies between parent and adolescent perceptions on parenting practices (e.g., Leung & Shek, 2014) there is a need to obtain information from the perspective of the adolescent.

In addition to the goals of the intervention, the acceptability of intervention procedures is also important to the engagement and long term utility of the programme (Kazdin & Wassell, 1999). Programme procedures that are deemed appropriate, relevant, and nonintrusive are important because these can lead to increased co-operation, engagement, and compliance to the programme (Kazdin & Wassell, 1999). Parents can make judgments of acceptability concerning the content, format, and modes of delivery used to implement a programme (Sanders & Kirby,

2011). For example, a study that evaluated the acceptability of a parenting programme for parents of children with Autism Spectrum Disorders by examining parents' experiences following programme participation demonstrated the relevance of the programme content and programme acceptability to the targeted population (Whittingham, et al., 2009). Parents reported high levels of satisfaction with the group format and found parenting strategies taught under the programme to be helpful and relevant to their families. By obtaining the views of parents about what works (or not) in a parenting programme can be used to tailor programmes to better meet the needs of families and enhance engagement in such programmes (Whittingham et al., 2009).

Finally, a successful parenting programme also depends on consumers' perception of its effects (Whittingham et al., 2009). While empirical findings may indicate an intervention was efficacious, such results do not always imply that a change is perceived to be meaningful by consumers. Consumers are unlikely to attend or engage in a programme if the effects of the programme are perceived to be non-meaningful or important (Kazdin & Wassell, 1999; Solish & Perry, 2008).

Along with parents, adolescents too have much to offer in the successful engagement and development of parenting programmes. Parenting is an interactive process in which parents not only influence their adolescent, but also are likewise, influenced by their adolescent (Smetana, 1995). Although there is increasing recognition for the need to include adolescents in parenting programme research, research in this area continues to be scarce (Sanders & Kirby, 2011). Where adolescents' experience has been examined directly, parents often identified more positive changes to family functioning than young people themselves (Ghate & Ramella, 2002). Given that adolescents are indirect consumers of parenting programmes, involving and consulting adolescents to obtain their input would seem to be an important research priority.

At present, studies rarely identify and report consumers' experiences and perceptions on parenting programmes for parents of adolescents. A noticeable gap exists in the literature as to what makes parenting programmes meaningful and helpful to parents and adolescents (McCurdy & Daro, 2001; Sanders & Kirby, 2011). Too often, parenting programmes are developed and implemented without sufficient understanding on how consumers will receive the intervention

(Sanders & Kirby, 2011). Of the few studies that do address social validity (e.g., acceptability of the programme), many only report on the overall satisfaction of the programme (e.g., Ralph & Sanders, 2003). Opportunities to understand how the intervention is experienced by consumers are often not fully utilised. Demonstrating social validity is an important step in ensuring that the programme meet the needs of the targeted population and can help establish the practical value and usefulness of the intervention when delivered at a population level.

The aim of the study was to examine the social validity and impact of Group Teen Triple P – GTTP, a parenting programme designed specifically for parents of adolescents. In order to do so, a descriptive qualitative method was used. Parents' and adolescents' perceptions of the acceptability of programme procedures (i.e., helpful and less helpful aspects of the programme, recommendation for the programme), and the social importance of the effects of GTTP (i.e., perceived changes on the family, parent, and adolescent following programme participation, and whether these changes (if any) were maintained) were examined. Views on adolescent involvement in parenting programmes were also sought from both parents and adolescents. By obtaining parents' and adolescents' perspectives, this qualitative study attempts to address a significant gap in the literature regarding the social validity of parenting programmes for parents of adolescents.

6.3. Group Teen Triple P (GTTP)

Teen Triple P is a variant of the Triple P - Positive Parenting Program that specifically targets parents of adolescents. Teen Triple P is broadly based on social learning principles and aims to target those modifiable risks and protective factors within the family context that are associated with negative adolescent outcomes (Ralph & Sanders, 2002). Like Triple P, Teen Triple P is available as a multi-level intervention and can be delivered in a range of formats, including large group seminars, small group or individual programmes, or as a self-directed programme. The group format of Teen Triple P, known as GTTP is designed to target both parents of adolescents considered to be at risk, and or the entire population of parents as a preventive approach to risk reduction.

GTTP consist of eight-sessions for parents and employs an active skills training process (i.e., observation, discussion, practice and feedback) to help parents acquire new knowledge and skills (Ralph & Sanders, 2002). The first four two-hour group sessions cover content including identification of parents' own goals for change, understanding common adolescent behaviour and emotional problems, developing good relationships with their teenagers, promoting positive behaviour in their teenager, managing difficult behaviours and planning ahead for high risk situations. Segments from a DVD *Every Parent's Guide to Teenagers* (Ralph & Sanders, 2001) are used to demonstrate positive parenting skills. Between sessions, parents complete tasks to consolidate their learning from the group sessions. Three 15-30 minute individual telephone sessions follow the group session to assist parents to fine-tune the implementation of the parenting strategies, and problem-solve any difficulties. One final group session is held following the telephone consultations to cover additional skills to facilitate generalisation and maintenance of positive changes (See Ralph & Sanders, 2002 for full review of the programme).

6.4. Method

6.4.1. Participants

Participants were recruited from among 69 families participating in a randomised controlled trial examining the efficacy of GTTP. Families in the original study were recruited through a variety of means including a community outreach approach involving newspaper stories, school newsletters, radio announcements, and distribution of flyers in a number of community events. Families were eligible if 1) the child was aged 12-15 years; 2) the child did not have a developmental or intellectual disability; 3) the child or parent was not currently seeing a professional for the target adolescent's behaviour or emotional problems; and 4) the parent was not currently receiving assistance for their own psychological or emotional problems.

In this study, all families randomly allocated to GTTP who had completed 6 month follow-up assessments were re-contacted via email and invited to participate in discussion groups. Of the 27 families contacted, 7 families (9 parents and 7 adolescents) agreed to participate. The discussion groups were held between 6-months to 1-year after parents had

completed GTTP. A total of four discussion groups were conducted (2 x parent groups and 2 x adolescent groups). Each discussion group involved between two to seven participants. The majority of parents were mothers (n = 6), with an average age of 47 years. All but one family were from a two-parent household family. Six adolescents were male with an average age of 14 years. All participants reported their ethnicity as New Zealand European.

6.4.2. Procedure

Ethical clearance for the study was obtained in accordance with the ethical review processes of the University of Auckland. Parents and adolescents who agreed to participate were contacted individually and advised of the time and venue for the discussion groups. Written consent was obtained from both parents and adolescents on the day of the discussion groups. Parent and adolescent discussion groups were held concurrently on the University campus, in separate rooms, in the evening. Each discussion group was facilitated by a member of the research team, and a note taker was present to observe and record nonverbal communication. Discussions lasted between 60 and 90 minutes, during which time refreshments were served. With permission of adolescents and their parents, discussions were audio-recorded.

For discussion groups, a number of predefined themes guided the discussion. For the parents, these included the general impression of the programme (i.e., helpful and less helpful aspects of the programme); perceived impact of the programme (i.e., changes to family, parent, and adolescent, the degree to which any changes had been maintained); and recommendation for the programme (i.e., views on adolescents' participation in parenting programmes).

For the adolescents, these included their general impression of the impact of their parents attending the programme (i.e., changes to the family, parent, and adolescent, the degree to which any changes had been maintained); and their views on adolescents' participation in parenting programmes.

As a token of appreciation at the completion of the discussion each participant received a $20 gift voucher. Recordings of the discussion groups were transcribed verbatim by the researcher and a member of the research team.

6.4.3. Data analysis

The data obtained from the discussion groups were analysed using a general inductive approach (Thomas, 2006). Although inductive data analysis is guided by the research questions, emergent findings came directly from the raw data. To this end, the transcripts were read a number of times so that the researcher became immersed in the data. Analysis involved the researcher searching the data for similar patterns, concepts, and themes (Thomas, 2006). Transcripts were broken down into smaller meaningful chunks of data by a process of open coding, and subthemes were identified and collated. Subthemes were then refined and checked for consistency.

The trustworthiness and credibility of the analysis was established by minimising researcher bias through having a second coder reading through the transcripts statements and coding them into the pre-determined themes. Both lists of codes were compared and contrasted, and adjustments were made as needed. In addition an audit trail (Lincoln & Guba, 1985) was established, which encompassed a detailed account of the raw data, data analysis, informed consent documents, and development of discussion group protocols.

6.5. Results

In this section, themes and corresponding sub-themes are presented. For each theme, parent data are presented first followed by adolescent data. Each participant's quote is identified by a series of letters and numbers indicating the focus group (i.e., F1, F2), the participant type (i.e., P = parents, A = adolescent), and participant number (i.e., 1-7).

6.5.1. Reasons for participating in GTTP

Two broad reasons for participating in GTTP were identified by parents. These included challenges associated with parenting adolescents and support for parents of adolescents.

6.5.1.1. Common challenges of parents of adolescents

Most parents commented on the impact of advanced technology on parents and adolescents, which raised new challenges for parents today compared with past generations.

> *It's just so much more, cell phones, Facebook, PlayStations, you name it. And it's a problem [monitoring and supervising], because they are always going to be way ahead of us, and for those [parent] that are not tech savvy, it's quite a big area (F1P6)*

> *[Facebook] is just clearly addictive, and the whole thing of being text bullied and stuff it's just ridiculous. (F2P2)*

> *That's a wave [generational changes] that us parents are getting into that [past] parents have not had before, in terms of how fast things happen, how socially fast kids get information, and how information can be shared. (F1P2)*

Another common challenge for parents was the difficulty in striking a balance between setting rules and limits with their adolescent, without being too controlling.

> *As parents how you put the rules in and use them for consequences or reward or however you do it. And I think it is quite a juggle you know, it's a juggling act really. (F1P2)*

> *It can be difficult to know how much [control] is enough. (F2P2)*

6.5.1.2. Support for parents of adolescents

In addition to the challenges raised above, parents were concerned that there is a lack of support available for parents of adolescents, including both extended family support and support from the wider community.

> *Back then you might have had people, you know aunties, uncle, whatever. A lot of people don't have any of those sorts of support now so it's a real problem. (F1P4)*

> *It's a real problem now-a-days with parenting, there aren't the same sort of extended family support groups that used to exist. (F1P3)*

> *When you have new babies, you go along to Plunket groups, but as your kids get older, there isn't really anything. (F1P3)*

This lack of support could also be related to several parents noting that it was far more difficult to be involved with the school and with other parents of adolescents, as their child transitions from primary into secondary schools.

> *It's difficult to know other parents of teenagers from your school and there just aren't those points of contact … the minute they start high school, you don't have anything to do with the school anymore. (F2P2)*

> *If they are at a big school when you go along, you meet different sets of parents every time, just whoever you happen to talk to and you might not see them again. (F1P5)*

6.5.2. Perceived impact of the programme

Parents were asked to comment on their overall experience of participating in GTTP. Responses were generally positive, with most parents replying with a variety of positive comments: "*definitely very worthwhile*", "*fantastic programme*", "*it's really specific to our everyday life*". All parents indicated that the programme was beneficial for themselves as well as

the family. For example, several parents commented that the programme heightened their awareness as a parent and the effects their behaviours have on their family.

> *It definitely highlights the awareness to us as a parent, where we were falling short, and you start realising that it doesn't matter how well you think you parent but there's always room for improvement. (F2P1)*

> *Just one or two things that you learn to do differently and basic attitude makes a huge difference, not just your life now but everyone's life in the long term. (F1P3)*

The majority of parents also indicated that they would encourage other parents to participate in GTTP. All parents agreed that other parents could "*learn a lot through the programme*".

> *I would encourage people to do the course, just to bring out those things that you always know but you get so busy with life that you just forget about and you don't see your teenager's need. (F2P1)*

> *People need to get into it before they start losing their kid. Once your child has become a problem it becomes so much harder to get them back. (F2P2)*

Adolescents overall impression of their parents' participation in GTTP was positive.

I am glad my parents did go. It makes my life easier for me and them. (F2A2)

I reckon it [GTTP] has helped her a lot. (F2A1)

I think it had worked slightly, I think it was good for mum to come. (F1A3)

6.5.2.1. Changes in parenting behaviour

Parents and adolescents were also asked to comment on any noticeable changes following parents' participation. The most common change reported by parents was being able to regulate

their emotion and stay calm when dealing with particular issues. Parents felt they had learned useful techniques for dealing with their adolescent; especially communication skills (e.g., tone of voice, eye contact, giving time for response) that often prevented an argument from escalating.

> *It was something to do with inflaming the situation, I think that did happen [prior to attending GTTP], with me and my daughter particularly, because there was quite a personality clash, and we can just wind each other up so much. So I guess there has been quite a bit of stepping back from that really and just being more aware of that. And I think too a bit more awareness of keeping it about the issue rather than allowing it to get personal. (F1P5)*

> *I think I have become a bit more focused and try to be calm and listen; it's a big one I think for me. And just step back from time to time as well (F1P6)*

A number of parents reported an improved capacity to empathise with their adolescents. Parents were more aware of their adolescent's needs and the struggles they are faced with.

> *You seem to forget what it was like being a kid, the things that you struggle with, and seeing things in their [adolescents] perspective. (F1P6)*

> *Makes me realise that he has grown up and he needs that quality time [to be on his own], so separating him from the other two [younger children] and have that special time. (F1P2)*

> *Because he is the oldest one, you tend to forget that they are a bit older, and we use to treat them [other children] all the same, whereas now, we are giving him a bit more space and a bit more leeway on things. (F2P2)*

Finally, several parents identified that they were more likely to involve their adolescent in decision making.

Even if it was a decision that we have already made, we would still make them believe that they had a part of that decision making power because it was our family and important that it worked for all of us. (F2P1)

A number of the parents' findings were mirrored by adolescents' reports. The majority of the adolescents commented that there was a reduction in coercive parenting practices (e.g., yelling) and therefore less parent-adolescent conflict occurred.

Well, mum doesn't get as angry, and I don't really shout at them anymore … like instead of shouting at me, she's just "could you please do this or you won't get pudding", in a calm simple way, yea so I think that was cool. (F2A2)

'If you're not saying something nice don't say it, or if you are getting angry walk away', its working for both of us [parents and adolescent]. Like you can just walk away and then come back new and calm. (F1A5)

Several adolescents felt that parents were more consistent with their parenting practices, particularly with following through with rewards and consequences. Adolescents also identified rewards that were perceived to be meaningful to them (e.g., family outing, computer time).

My mum put us on a point system like for getting points by doing chores, there's less argument because we just stick to the system and get rewards or get things taken away. (F1A3)

Similar to parents' findings, adolescents also reported an increased opportunity to be involved in making family decisions.

We will sit down and discuss it. I don't always get what I want but most of the time is better than what I used to get cause I have my own input and I can tell them why this and why that. (F2A2)

131

My family now is more family discussion rather than just parent discussion, it's much nicer than just having them making all the decisions themselves and making more decisions myself. (F1A1)

6.5.2.2. Changes in family relationships

Parents and adolescents further commented on a number of noticeable changes in family relationships, including parent-adolescent relationship, marital relationship, and sibling relationship. The changes in parenting practices appeared to have strongly influenced the quality of the parent-adolescent relationship. All parents reported a positive change and perceived improvements in communicating with their adolescents.

While doing the programme, I made an effort to talk with him every day, and now he's just gotten into a habit of telling me everything". (F2P2)

I think the course really reinforced how important it [communication] is. So yeah, I mean it has made a huge difference to our relationship. (F1P4)

Adolescents too, reported a more positive relationship with their parents, with many noting that there was more open communication with their parents. This open communication was perceived to be positive by many adolescents.

I use to not really talk to her about what I feel, but now, I can talk to her. They sort of welcomed up, you know like they are like "is there anything [you want to talk about]". It makes me feel better about coming home after school, had a hard day just talk to my mum about it. (F2A1)

We just talk more about things like what's happening, what's going on at school, how my homework is going, and who I am hanging out with. I can talk about things to them, it's a bit easier. (F1A5)

In addition to improvements in parent-adolescent relationships, adolescent also perceived changes in their parents' marital relationship. Adolescents commented that there were less marital conflicts.

They [parents] used to argue over the smallest, slightest little thing ... but now they don't yell in front of us and have the time to calm and work things out. I think they try not to ague as much. (F2A1)

As one adolescent further commented, this in turn impacted the overall family environment and resulted in a "*better mood in the family*" *(F1A2).*

Despite the positive changes, several adolescents noted that there was still considerable conflict between siblings. Adolescents further commented that the programme did not help parents to deal effectively with sibling conflict and often ended with parents getting distressed.

That's [sibling conflict] the only thing that stayed the same. That's the only time that my mum gets angry ... fighting over shared things in the family, like computers, play station, and TV. (F2A2)

I feel the same with siblings [conflict], when I want her [sister] to drive me somewhere, we always end up arguing. Then my mum gets super angry. (F2A1)

6.5.3. Maintenance of changes

Parents and adolescents were asked to comment on the degree to which they felt that changes attributed to participation in the programme had been maintained. To this end, all parents indicated that the benefits of the programme were still present 6-12 months following participation.

It's just an on-going thing [parenting strategy - behavioural contract], and yeah it works really well, well they respond really well. (F1P1)

He's still making his bed, and I think because he had done it so many times it's almost sort of like a habit. (F2P2)

It's the things that I have absorbed [following participation in GTTP]. Because we had to do things as part of the course so, once you do something, it becomes a part of something. If it works it becomes a part of what you do. (F1P5)

All adolescents indicated that the positive changes related to parenting behaviours and parent-adolescent relationships were still present 6-12 months following parents' completion of the programme.

Yea, well like everything is still going good. She is still doing the same things, and she is not like stopping. So, yea I am happy with that. (F2P2)

Yea, she is still calm, happy, and being kind to us all. (F2P1)

6.5.4. Helpful aspects of the programme

Parents were asked if they could identify aspects of the programme that were helpful. Three subthemes were identified through parents' responses. These included a supportive group environment, a range of parenting tools, and programme structure and material.

6.5.4.1. Group environment

Parents acknowledged that they felt a strong sense of support from other parents in the programme. Several parents noted that it was very reassuring knowing that they were not alone in experiencing difficulties as a parent and appreciated the opportunity to hear about other parents' experience on parenting. Parents considered this to be helpful in that it showed them that other parents were going through similar experiences.

I found with the course, we are not alone, as parents, which was quite nice that other people are in the same boat so to speak. (F1P6)

134

It's always good to talk to parents and also for yourself, knowing that you are not the
only one. (F2P1)

In addition to a sense of support, parents noted that working within a group helped them
to learn and improve their parenting skills.

Some people in our group had really good ideas about things, you think, oh that is a
great way of approaching it. (F1P5)

6.5.4.2. Range of positive parenting strategies

The fact that the programme offered a range of parenting strategies was appreciated. All
parents acknowledged that there were effective tools from GTTP that worked well in their
individual families and that it was *"handy"* to have a range of different strategies taught.

I liked that there were options for me in parenting, you know everyone just talks about
teenagers, like what you do, so being prepared and having different tools were good.
(F2P1)

Parents had different experiences with the parenting strategies taught in GTTP and
although some worked for one family, it was less effective for another. For example parents had
different opinions on holding family meetings. Some parents liked the fact that family meetings
allowed the whole family to be "involved in decisions". On the other hand, one parent
commented that family meetings were "too formal for them". For some parents, parenting
strategies such as monitoring adolescent behaviour, planning ahead for high risk situations and
acknowledging teenager's emotions were effective when implemented in their own family.

I find it really helpful … when [I am] feeling overwhelmed to monitor [the behaviour] for
a week and then realise it's actually not that bad. (F1P1)

My husband said we need to have conversation about what this [a high risk situation]
will look like. And I thought well, this is out of this [GTTP] really, and he said that he

found it really helpful and has made a big difference for how he is parenting, so that is great. (F1P5)

Mine is acknowledging teenage emotions, for me who tends to go on and on and on and want to make my point, to actually make me stop talking… if I can really see the structure [flow diagram for dealing with teen emotion] in my head and I am quite a visual person, so if I actually see all boxes of acknowledge and listen and summarise and then sort of offer to help or not, it actually gets us to a smoother path much faster, than if I talk and either try and solve or try and justify or explain stuff, I can actually see the structure in my head.(F1P2)

For some parents, the use of a behavioural contract was not suitable for their family, noting that it was "*too hard to manage*". One parent further commented that choosing a logical consequence for problem behaviours was difficult.

With the consequences, it didn't happen, at one stage we took his wind surfing off him but that was a double fail, because, one, that's the thing he loves, where it wears him out and giving him good head space and timeout. (F2P2)

6.5.4.3. Programme structure and material

Parents commented that the well-structured programme and the use of relevant programme materials were helpful for their learning.

The structure of the content, a lot of things we were already kind of doing, but it [the programme sessions] gave them context and structure. You know, some of the things that you do, you think that would be a good idea and you sort of do it half-heartedly and it doesn't work. But if you went through the activities properly, they really worked. So it's just sticking to things and doing it properly and using that structure. (F1P3)

The course workbook was highly recommended by parents as it provided structured content, as well as a good source of reference and reassurance. A number of parents noted that they had referred back to the workbook since completion of the programme.

If something particular comes up you can think okay well we will go and check this out and see what we can do. (F1P5)

Just a confidence thing to go back and have a bit of a check-up. For me, it's quite a nice way of, you know it's there. (F1P2)

Most parents shared similar perceptions of the course workbook and agreed that the between session tasks in the workbook were helpful and kept them '*on track*'.

We are all busy but you know I just sort of found that that was a big thing for me, keeping up the homework [between session tasks]. (F2P2)

Finally, the individual phone sessions were perceived by parents as being helpful in learning and implementing parenting strategies.

It's also the follow-up aspect … you know you are going to be held to an account and it's going to be someone on the phone and you are going to have to say well no I haven't done anything or yes I have done this. So yeah, that was helpful. (F1P5)

You sort of know that you would probably be asked how the week had gone, so it keeps you honest in terms of following your goals. (F1P2)

6.5.5. Less helpful aspects of the programme

Parents were also asked if they could identify aspects of the GTTP that they felt did not work so well for them or for the group as a whole. One of the issues that was identified related to the tight control on time. The programme is required to be delivered within a two-hour time-frame. Some parents noted that the highly structured and fast moving pace of the programme sometimes cut short time for discussion on key issues.

137

There was a lot to get through but there was a lot of value in the discussion. So sometimes the facilitator had to cut across people and move on. (F1P4)

One parent noted that the amount of information in the programme might seem overwhelming for some parents.

There is actually too much content, for that length of time. (F1P7)

It's also the danger that there is so much stuff that, well, it can become intimidating or overwhelming for people. You know, "oh there is just so much I should be doing so you need to get to the start right away". (F1P4)

6.5.5.1 Barriers to participation

Parents noted a number of barriers to participation. These included the lack of childcare facilities, location of the venue, and time commitment.

How many families can afford to have both parents get out of the house without getting a baby sitter and making the whole thing not expensive?(F2P2)

I think our group [of parents] was all from the Shore, except for us, so the venue itself was a mission to get to. It [venue] needs to be easy for parent and often parents are busy with work, so how do they get to the programme. (F2P1)

I mean it's an easy excuse, but we are all busy and having to commit to so many nights [group sessions], it's hard. (F1P6)

6.5.6. Recommendations

Parents were asked how GTTP could be improved. The most common recommendation was the inclusion of specific topics relevant to today's adolescents such as cyber safety and technology issues.

Put technology into the course and I would do it again. (F1P1)

My biggest fear is bullying, text bullying, cyber safety, tips to deal with that would be good. (F2P2)

Parents also offered innovative recommendations including parenting applications on smart phones, Facebook pages.

Maybe a website or even a Facebook page, even during the course so you can chat to other parents while you are doing it. Because something happens and it's the day after the course so you are like what am I supposed to do with this… if you can just put it out there [Facebook] and chat with the other parents and have the facilitator commenting on it if they want to. (F2P2)

6.5.7. Adolescents' involvement in parenting programmes

Regarding adolescent involvement, many parents believed that it would be a good idea to have a parallel programme, alongside the parents programme for adolescents. Parents felt that it might be beneficial for adolescents to receive advice from other trusted sources other than parents.

It might be quite good because I don't think kids get a lot of opportunity to talk about issues. (F1P7)

Yeah maybe if they were in a group that was not associated with the group that you were in, so there's no swapping of 'well your mother said'. (F1P4)

Parents also suggested a number of possible topics to be covered for adolescents including dealing with problem situations, peer pressure, and bullying.

Problem situations that they can get themselves into and maybe teaching them strategies like you did with us, like how we handle it if they did some of the things, mine hasn't gotten into that stage yet, but you know coming home drunk and that sort of thing. (F2P2)

Staying safe is the main thing. Sometimes it is really hard to say no [to peers] and I think that is something that when you are a teenager that you need to get through. (F1P4)

Maybe bullying, not even being bullied but even being the bully, I think sometimes kids don't even realise they are being the bully because they can be very nasty to each other. So I think definitely that kids can learn a lot out of it and if other kids come with their parents they can see that it's not that uncool, because obviously there is that fear of being so uncool. (F2P1)

Adolescents too, supported the idea of being given information on issues such as communication, and dealing with emotions. However, it was noted that if they were to be involved in parenting programmes, they should be taught separately from their parents.

Like if you learn about situations, even role playing, maybe not with your parent. (F1A1)

I think it would be a good idea, but maybe in a separate room and share [with parents] later what's going on. (F1A4)

One adolescent further commented that it may not be a good idea for adolescents to know the parenting strategies that parents are learning, as this may allow the adolescent to know the "trick" and counteract it.

If I knew what they were learning then maybe it won't work. (F1A3)

Parents noted that adolescents might be resistant to participate and gave reasons including busy life and stigma associated with participation.

It might be embarrassing being in front of people they know. (F1P4)

It wasn't even easy getting him to come here [discussion group]. (F1P1)

With respect to barriers to participation adolescents' comments mirrored those of the parents' with most expressing concerns about duration of programmes, time commitment, and stigma as barriers to engagement.

> *If I was to go [to a parenting programme] every week, I have got stuff on which really will be a bit of a drag. (F2A1)*

> *There were two other people that I actually knew that their mum and dad were actually going to these courses. And for me since then it's been really awkward between those two people ... one [of them] is just not talking to me, it's kind of weird. (F2A2)*

6.6. Discussion

While prior research has demonstrated the efficacy of parenting programmes for parents of adolescents, little is known about the social validity of such programmes. At present, very few qualitative studies have been conducted to examine parents' and adolescents' views on parenting programmes for parents of adolescents. This study is one of only a handful of qualitative studies in the international literature that examined the social validity of parenting programmes from the perspectives of parents and adolescents. The results are discussed in relation to the three key components of social validity, namely intervention goals, procedures, and effects.

6.6.1. Social importance of the goals of GTTP

One of the major goals of GTTP is to create a broader social environment that supports and acknowledges the importance of parenting and normalises the process of parenthood (Ralph & Sanders, 2002). All parents in the study shared similar common concerns, yet, parents noted that there were very few services available to support them as parents compared with parents of younger children. GTTP was therefore perceived by parents to be worthwhile and beneficial. Parents who received GTTP found the programme to be applicable to their daily concerns. All parents acknowledged that GTTP provided effective tools that worked well in their individual families and reported benefits from learning a range of parenting practices. Even within families

with few risk factors, the literature suggests that parents feel unable to establish limits and deal with their adolescent's behaviour (Ralph, et al., 2003). Such findings support the social validity of the goals of GTTP and speak to the need for evidence-based programmes to be made more widely available and accessible for parents of adolescents.

6.6.2. Acceptability of the procedures of GTTP

In terms of programme procedures, the content and delivery strategies of GTTP were seen as relevant and acceptable to parents. Parents felt that the group format of the programme had been helpful, in that it created a supportive environment. Meeting others, exchanging ideas, receiving support from peers, and normalising their own difficulties were viewed as valuable and beneficial by parents. This finding is consistent with a recent qualitative systematic review on parenting programmes for parents with young children in which group experience (e.g., sharing of personal stories, learning in a supportive environment, and normalising parenting difficulties) was highly valued for participants (Mytton, Ingram, Manns, & Thomas, 2013).

In addition, parents noted the content and course materials associated with GTTP was useful in helping them to learn and implement parenting strategies. Nonetheless, parents reported that the highly structured and fast paced sessions resulted in a lack of parent discussion time. Group discussions were sometimes cut short due to the need to adhere to delivery fidelity (i.e., covering key session content). This is not a complain particular to GTTP as evaluations of similar intervention studies often report challenges in relation to the need to adhere to delivery fidelity, whilst meeting the needs of families during group sessions (i.e., providing opportunities for discussion; Byrnes, Miller, Aaborg, Plasencia, & Keagy, 2010).

6.6.3. Meaningful effects of GTTP

All parents and adolescents reported that parents' participation in the programme had brought about positive changes within the family. Most notably, participants identified positive changes in parenting behaviour and improvements in family relationships (e.g., consistent parenting practices and improved parent-adolescent communication). Several positive changes

142

were reported by parents and adolescents to be present 6-12 months period following programme completion. Importantly, these outcomes include the perspectives of the adolescent which is missing from most similar studies which rely solely on parent reports (e.g., Doherty, Calam, & Sanders, 2013). Thus the findings suggest that GTTP was successful in bringing about changes that were meaningful to parents and adolescents. Furthermore, the findings are consistent with previous research examining the perceived effects of other variants of Teen Triple P (Chand, Farruggia, Dittman, Chu, & Sanders, 2013) and support the claim that GTTP holds promise in preventing future adolescent problem behaviours by strengthening protective factors within the family (Ralph & Sanders, 2003).

Interestingly, adolescents perceived no improvement in the level of sibling conflict as a consequence of their parents' participation in GTTP. However, sibling conflict was not raised as a concern by parents. This may have been because parents were directing their attention towards the targeted child and subsequently were less observant of other children. Alternatively, sibling conflict may have been of less concern or importance for parents than it was for adolescents. Given the adverse effect sibling conflict has on family relations (Cox, 2010), consideration should be given to incorporate content relevant to sibling conflict in future programmes.

6.6.4. Barriers to engagement

Several barriers to engagement in parenting programmes in general were suggested by parents (e.g., lack provision of child care facilities and transportation, work/family commitments). Similar barriers to participation have been reported in the general parenting literatures (Heinrichs, Bertram, Kuschel, & Hahlweg, 2005; Griffin, Samuolis, & Williams, 2011; Morawska et al., 2011). The findings highlight the need for continuous efforts to be made to address the potential barriers for family participation in parenting programmes. For example, offering flexible delivery options to meet the needs of parents, working with families ahead of time to provide transportation and organising childcare facilities, and ensuring that all parents can participate and easily access parenting programmes in a non-stigmatised way (e.g., marketing and media campaigns to support parenting programmes).

6.6.5. Adolescents' participation in parenting programmes

In general, both parents and adolescents saw potential benefits in adolescents' involvement in parenting programmes, however, rather than mixed sessions both parties agreed that sessions should be run in parallel. This finding warrants future investigation as currently, mixed findings have been reported for the benefits of adolescent participating in parenting programmes (e.g., Dishion & Tipsord, 2011; Cotter, Bacallao, Smokowski, & Robertson, 2013). Specifically, future studies may be designed to investigate the impact of directly involving adolescents in the Teen Triple P programme. This would include examining what skills or information taught within the youth stream would derive the most benefit for families (e.g., social skills training and/or family skill development), as well as investigating the best way to deliver the programme to young people. This information would help inform and better tailor parenting programmes to meet the needs of families.

6.7. Strengths and Limitations of the Study

The reported findings need to be interpreted in light of the studies strengths and limitations. Strengths included the use of a qualitative approach to gather rich data, multi-informant assessment, and credibility check by an independent researcher to minimise potential researcher bias. On the contrary, the relatively small sample size limits the representativeness of the sample. Despite attempts to engage families in the study, discussion groups suffered from low levels of participation. Thus, it cannot be assumed that the views of those who participated are typical of all the families that participated in GTTP. Moreover, the findings do not explore the perspective of families that did not engage and thus may miss an important contradictory perspective.

In conclusion, the study provided evidence for the social validity of GTTP. The findings suggest that parents perceive a need for parenting support, and an evidence-based parenting programme such as GTTP is likely to be well received by parents. Finally, arguable one of the strongest indicators of the social validity of GTTP is that all participating parents' reported that they would recommend the programme to other parents.

6.8. References

Albin, R. W., Lucyshyn, J. M., Horner, R. H., & Flannery, K. B. (1996). Contextual fit for behaviour support plans. In L. K. Koegel, R. L. Koegel, & G. Dunlap, (Eds.), *Positive behavioural support* (pp. 81-98). Baltimore: Paul H. Brookes.

Byrnes, H., Miller, B., Aalborg, A., Plasencia, A., & Keagy, C. (2010). Implementation fidelity in adolescent family-based prevention programmes: relationship to family engagement. *Health Education Research*, 25, 531-541.

Chand, N. L., Farruggia, S. P., Dittman, C. K., Chu, J. T. W., & Sanders, M. R. (2013). Positive youth development and Teen Triple P: Promoting positive youth development through a brief parenting intervention programme. *Youth Studies Australia,* 32, 29-36.

Chu, J., Farruggia, S., & Sanders, M.R., & Ralph, A. (2012). Towards a public health approach to parenting programmes for parents of adolescents. *Journal of Public Health*, 34, i41 – i47. doi:10.1093/pubmed/fdr123.

Cotter, K. L., Bacallao, M., Smokowski, P. R., & Robertson, C. I. B. (2013). Parenting interventions implementation science. How delivery format impacts the Parenting Wisely programme. *Research on Social Work Practice,* 23, 639-650. doi: 10.1177/10497351513490811

Cox, M. J. (2010). Family systems and sibling relationships. *Child Development Perspectives,* 4, 95–96.

Dishion, T. J., & Tipsord, J. M. (2011). Peer contagion in child and adolescent social and emotional development. *Annual Review of Psychology,* 62, 189–214.

Doherty, F. M., Calam, R., & Sanders, M. R. (2013). Positive Parenting Program (Triple P) for families of adoeslcents with Type 1 diabetes: a randomised controlled trial of self-

directed Teen Triple P. *Journal of Pediatric Psychology,* 38, 846-858. doi: 10.1093/jpepsy/jst046

Ghate, D., & Ramella, M. (2002). *Positive parenting: The national evaluation of the youth justice board's parenting programme.* London: Youth Justice Board.

Griffin, K. W., Samuolis, J., & Willaims, C. (2011). Efficacy of a self-administered home-based parent intervention on parenting behaviours for preventing adolescent substance use. *Journal of Child and Family Studies,* 20, 319-325. doi: 10.1007/s10826-010-9395-2.

Heinrichs, N., Bertram, H., Kuschel, A., & Hahlweg, K. (2005). Parent recruitment and retention in a universal prevention programme for child behaviour and emotional problems: Barriers to research and programme participation. *Prevention Science,* 6, 275-286.

Kazdin, A. E., & Wassell, G. (1999). Barriers to treatment participation and therapeutic change among children referred for conduct disorder. *Journal of Clinical Child Psychology,* 28, 160-172.

Kirby, J. N., & Sanders, M. R. (2012). Using consumer input to tailor evidence-based parenting interventions to the needs of grandparents. *Journal of Child and Family Studies,* 21, 626-636. doi: 10.1007/s10826-011-9514-8.

Kumpfer, K. L., & Alvarado, R. (2003). Family-strengthening approaches for the prevention of youth problem behaviours. *American Psychologist,* 58, 457-465. doi: 10.1037/0003-066x.58.6-7.457

Leung, J. T. Y., & Shek, D. T. L. (2014). Parent-adolescent discrepancies in perceived parenting characteristics and adolescent developmental outcomes in poor Chinese families. *Journal of Child and Family Studies,* 23, 200-213.

Lim, M., Tormshak, E. A. S., & Dishion, T. J. (2005). A one-session intervention for parents of young adolescents. *Journal of Emotional and Behavioural Disorders,* 13, 194-199.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage.

McCurdy, K., & Daro, D. (2001). Parent involvement in family support programmes: An integrated theory. *Family Relations,* 50, 113-121.

Mercy, J. A. & Saul, J. (2009). Creating a healthier furture through early interventions for children. *Journal of the Amereican Medical Association,* 47, 6-22.

Morawska, A., Sanders, M. R., Goadby, E., Headley, C., Hodge, L., McAuliffe, C., Pope, S., & Anderson, E. (2011). Is the Triple P-Positive Parenting Program acceptable to parents from culturally diverse backgrounds? *Journal of Child and Family Studies.* 20, 614-622. doi: 10.1007/s10826-010-9436-x.

Mytton, J., Ingram, J., Manns, S., & Thomas, J. (2013). Facilitators and barriers to engagement in parenting programmes: A qualitative systematic review. *Health Education and Behaviour*

National Research Council and Institute of Medicine. (2009). Preventing mental, emotional, and behavioural disorders among young people: Progress and possibilities. Washington, DC: National Academic Press.

Ralph, A., & Sanders, M. R. (2001). *Every Parent's Guide to Teenagers.* Brisbane: Families International Pty Ltd.

Ralph, A., & Sanders, M. R. (2002). The Positive Parenting Program: An early intervention to improve personal relationships between teenagers and their parents. In N. N. Singh, T. H. Ollendick, & A. N. Singh (Eds.), *International perspectives on child and adolescent mental health. Vol 2: Proceedings of the second international conference* (pp. 101-131). Oxford, UK: Elsevier Science.

Ralph, A., & Sanders, M. R. (2003). Preliminary evaluation of the Group Teen Triple P programme for parents of teenagers making the transition to high school. *AeJAMH*

(Australian e-Journal for the Advancement of Mental Health), 2(3), No Pagination Specified.

Ralph, A., Toumbourou, J. W., Grigg, M., Mulcahy, R., Carr-Gregg, M., & Sanders, M. R. (2003). Early intervention to help parents manage behavioural and emotional problems in early adolescent: what parents want. *Australian e-Journal for the Advancement of Medical Health (AeJAMH), 2.*

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

Sanders, M. R., & Kirby, J. N. (2011). Consumer engagement and the development, evaluation and dissemination of evidence-based parenting programmes. *Behaviour Therapy.* doi:10.1016/j.beth.2011.01.005.

Schwartz, I. S., & Baer, D. M. (1991). Social Validity Assessments: Is Current Practice State of the Art? *Journal of Applied Behaviour Analysis. Special Issue: Social Validity: Multiple Perspectives, 24*, 189-204.

Smetana, J. G. (1995). Parenting styles and conceptions of parental authority during adolescence. *Child Development, 66*, 299-316.

Stallman, H. M., & Ralph, A. (2007). Reducing risk factors for adolescent behavioural and emotional problems: A pilot randomised controlled trial of a self-administered parenting intervention. *AeJAMH (Australian e-Journal for the Advancement of Mental Health, 6*, 1-13.

Thomas, D.R. (2006). A general inductive approach for analysing qualitative evaluation data. *American Journal of Evaluation, 27*, 237-246.

Whittingham, K., Sofronoff, K., Sheffield, J., & Sanders, M. R. (2009). Behavioural family intervention with parents of children with ASD: What do they find useful in the parenting

programme Stepping Stones Triple P? *Research in Autism Spectrum Disorders*, 3, 702–713. doi:10.1016/j.rasd.2009.01.00

Wolf, M. M. (1978). Social validity: The case for subjective measurement or how applied behaviour analysis is finding its heart. *Journal of Applied Behaviour Analysis,* 11, 203-214.

Chapter 7 – Discussion

Parents play an important role in the lives of adolescents (Steinberg, 2001). Providing support for parents is therefore recognised as a key strategy to address and prevent many of the problem behaviours adolescents may engage in, and to enhance and sustain positive family functioning for healthy youth development (Steinberg, 2001; Sanders, 2012). There have been increasing calls from both researchers and policy makers to adopt a public health approach to parenting support (Sanders, 2012; Spoth et al., 2008; Prinz et al., 2009). The primary aim of this approach is to produce multiple beneficial health and developmental outcomes for young people at the population level (Shapiro et al., 2010).

However, despite strong advocacy for parenting support during the adolescence period, there is little controlled evidence attesting to the efficacy of these programmes (Chu et al., 2012; Tully, 2007). Significant gaps exist in the parenting literature on parenting programmes for parents of adolescents. These include a paucity of research that rigorously evaluates parenting programmes, the omission of adolescent's voice and input, and the lack of social validation of parenting programmes from the consumers' perspectives. Together, these limitations point to the need to conduct more methodologically rigorous evaluations on parenting programmes for parents of adolescents.

This research therefore attempted to address the gaps in the literature and justify the need for a public health approach to parenting programmes for parents of adolescents. In order to do so, this research examined the impact of a universal group programme designed specifically for parents of adolescents utilising a mixed-methods approach. This was accomplished through the conduct of both quantitative and qualitative studies. In the first study, a randomised controlled trial was conducted to examine the efficacy of Group Teen Triple P (GTTP). In the second study, the social validity of the programme was explored through qualitative data from programme participants and from adolescents' whose parents participated in GTTP. This chapter draws on the findings from the two studies and discusses the implications within the broader context of a

public health approach to supporting parents of adolescents. Strengths and limitations along with suggestions for future research are discussed.

7.1. Overall Findings

As discussed in previous chapters, a public health approach shifts away from the traditional clinical model that focus on treatment of individuals to a comprehensive model that focus on the well-being of the entire population. Parenting interventions that reach out to all parents and normalise seeking support in the parenting role can be highly beneficial for the well-being of the whole population (Sanders, 2012). GTTP, as part of a multilevel system of support, was therefore evaluated as a universal programme intended to serve a diverse population of parents in the community.

7.1.1. Efficacy of GTTP

Firstly, the study demonstrated the efficacy of GTTP. Both parents and adolescents reported positive changes in a number of parent- and adolescent-related outcome variables following parents' participation in GTTP. Effect sizes for these changes ranged from medium to large. Many of these positive changes (e.g., reduced adolescent problem behaviours) were attributed by parents to the development of positive parenting practices such as consistent enforced family rules and decreased use of coercive parenting practices (e.g., yelling). The findings were further confirmed by adolescents' qualitative comments, noting that their parents were dealing with issues more constructively. Improvements were also observed in parent-adolescent relationships with both parents and adolescents reporting less frequent occurrences of conflict. Again, these quantitative findings were corroborated by the qualitative comments made by both parents and adolescents (e.g., more open communication). The consistency between parents and adolescents quantitative and qualitative findings is important as it strengthens the validity of the results. Previous studies have often relied on single method (e.g., quantitative) and single-informant (e.g., parent) to obtain data and therefore may not provide the most comprehensive information about the efficacy of parenting programmes.

Interestingly, qualitative analyses suggested that adolescents perceived less marital conflict between parents following parents' participation in GTTP. However, this interpretation was not fully supported by parents themselves, in which neither the quantitative nor qualitative analyses suggested such changes. One possible explanation is that the present sample consisted mainly of well-functioning families and therefore, parents themselves may not have perceived marital conflict as a concern. This was reflected in the quantitative data in which parent-reported baseline data did not reach clinical level and therefore intervention effects were difficult to detect at post- and 6-month follow up. In addition, the non-significant changes on marital conflict as reported by parents are consistent with the results of other studies evaluating Triple P in general (e.g., Sanders et al., 2000; Matsumoto et al., 2007). Again, a majority of these studies are based on parents-self reports only. Thus, the current findings are important and demonstrated that GTTP was perceived to be effective in reducing marital conflict by adolescents. Additionally, this positive change was seen as beneficial and important to adolescents. This finding further suggested the importance of incorporating skills and strategies that reduce marital conflict in parenting programmes.

Furthermore, adolescents' qualitative comments revealed that sibling conflict was an area of concern that the programme did not appear to have impacted on. Although the comments were based on a small sample of adolescents, it suggested an important aspect that warrants future investigation. The majority of the studies conducted on parenting programmes (e.g., Strengthening Families Program 10-14, Molgaard & Spoth, 2001; Guiding Good Choices, Mason et al., 2003) do not include sibling relationships as an outcome measure. Similarly, in this study, sibling relationships were not examined in the RCT, therefore the effects of GTTP on sibling-related outcome remains inconclusive. Given the adverse effect of sibling conflict on adolescent development and family functioning (Cox, 2010), it might be important for future studies to include such measures and examine the effects of parenting programmes on sibling relationships.

The results of the RCT indicated that the majority of positive outcomes were maintained at 6-month follow up for both parent and adolescent reported outcomes. One exception was

parent-reported outcome on the level of family conflict where the results indicated a non-significant finding. A possible explanation for the non-significant finding was likely due to parents in the control condition reporting similar decreased levels of family conflict. Hence, maintenance effects across conditions were difficult to detect, given the small sample size. Nonetheless, maintenance of effects were supported by the qualitative findings, with both parents and adolescents reporting a number of improvements between the 6 to 12 months period following parents' completion of GTTP.

Together, the findings suggested that by teaching parents a repertoire of skills such as the use of positive reinforcement to support the development of appropriate behaviours, non-punitive consequences for negative behaviours, and enhancing the quality of parent-adolescent relationship, GTTP was effective in improving multiple outcomes for parents and adolescents. The study demonstrated the efficacy of GTTP as an effective intervention when offered universally to parents of adolescents and builds on the evidence base of Teen Triple P as a multilevel intervention to parenting support. The findings further reinforced the body of literature that supports parenting programmes to be effective in promoting positive parenting practices, improving parent-adolescent relationships, and reducing adolescent problem behaviours (e.g., Ralph & Sanders, 2003; Stallman & Ralph, 2007; Gates et al., 2006; Prado et al., 2012).

7.1.2. Social validity of GTTP

The study addressed an important gap in the current literature by demonstrating the social validity of GTTP. While demonstrating statistical changes on the effectiveness of a programme is important, it does not necessarily lead to programme uptake. Social validity can establish the practical value and the usefulness of the programme and are essential to its long-term utility and widespread implementation (Albin et al., 1996; Kazdin & Wassell, 1999). The findings demonstrated that GTTP was effective in producing a range of positive changes that were meaningful and important to parents and adolescents. Parents and adolescents commented on issues (e.g., improved parent-adolescent relationship) that were important to them based on their

153

own perspectives and provided examples (e.g., improved communication) from their own experience.

Furthermore, GTTP was perceived to be relevant and acceptable by parents. For example, qualitative findings indicated that parents identified the group environment as an important aspect for their learning of parenting skills and information taught in GTTP. This finding was consistent across international studies on group parenting programmes in general (e.g., Petra & Kohl, 2010). In addition to the positive aspects of the programme (e.g., range of parenting strategies, well-structured programme and relevant programme materials), the study also identified aspects of the programme that were perceived to be less helpful for parents (e.g., lack of childcare facilities, fast-paced sessions).

Together, these findings are important as consumers' perceptions of the significance and relevance of the programme is an important variable in predicting their potential utilisation of parenting programmes (Kazdin & Wassell, 1999; Solish & Perry, 2008; Whittingham, et al., 2009). These findings are useful for further adaptations of GTTP and other evidence-based parenting programmes and to help improve the services available to families and meet the diverse needs of parents of adolescents.

7.2. Bringing It All Together

Collectively, the two studies demonstrated the positive impact of GTTP which work exclusively with parents of adolescents. Most of the available programmes aimed at reducing and preventing adolescent problem behaviours have a primary focus on working with individual adolescents or at the school level with minimal parental involvement (Biehal, 2006; Kaslow eta l., 2012). There are very few parenting programmes that work with parents and even fewer efficacy trials of such programmes. Of those parenting programmes that have shown to be effective, some of these programmes (e.g., SFP 10-14) involve additional components (e.g., adolescent skills training) making it difficult to discern the degree to which the intervention effects can be attributed to the parent component. The present study therefore demonstrated the

potential benefits of working exclusively with parents as an effective approach in improving adolescent outcome and family functioning.

In addition to demonstrating the impact of GTTP, this research justified the need to support all parents of adolescents. Parenting adolescents is difficult even under the best circumstances and all parents are likely to benefit from support from time to time (Pugh et al., 1994). This is evident in the present findings where parents themselves identified common challenges with parenting adolescents and the lack of support available for parents of adolescents. Importantly, parents' were receptive to receiving information and support that were deemed to be relevant to their families. GTTP was effective in bringing about positive changes for both parents and adolescents. This suggested the likely benefits and the need for offering parenting programmes universally as an approach to reduce and prevent adolescent problem behaviours.

It is often the case that interventions aimed at reducing adolescent problem behaviours are targeted at the most vulnerable families (Ralph & Sanders, 2002). Although, such interventions are needed, selected interventions may miss out a substantial number of families, who, while not experiencing severe difficulties, maybe at risk of developing future problem behaviours (Marmot, 2010). Moreover, offering parenting programmes only to families where the problems are already severe may require considerable investment and resources to bring about positive changes. A minority of parents of adolescents require services that prevent problem behaviours from escalating, while a majority of parents require services that prevent problem behaviours from occurring in the first place (Kumpfer & Hansen, 2014; Tully, 2007).

A comprehensive approach, such as Teen Triple P, which includes multiple levels of interventions, may have the greatest impact on families as it has the potential to reach out to, and meet the needs of, more individuals than a single parenting intervention (Sanders, 2012; Tully, 2007). Advantages of such approach include decreased waste of limited resources, potential increase in engagement in programmes, and increased intervention potency (Collins et al., 2009). By increasing the accessibility and offering diverse, flexible delivery options, parents are more likely to participate in and benefit from parenting programmes (Sanders, 2012). Parenting

programmes such as Teen Triple P hold great promise for the prevention and reduction of adolescent problem behaviours and in improving adolescent outcome.

7.3. Strengths and Limitations

The strengths and limitations of the individual studies have been discussed in preceding chapters. The following section addresses the strengths and limitations of the studies as a whole.

7.3.1. Strengths of the study

Overall, this research was characterised by a number of strengths. The utilisation of a mixed-methods design was an important strength in the study. To the author's knowledge, this is the first mixed-methods study to evaluate the efficacy and social validity of GTTP, and one of only a handful of qualitative studies in the international literature that have examined parents' and adolescents' perceptions of parenting programmes. The study addressed a critical gap in the research on evidence-based parenting programmes by contributing a much-needed mixed-methods design to evaluating parenting programmes.

Mixed-methods enabled the maximisation of the strengths of quantitative and qualitative methods. It was possible to explore information from structured questionnaires in more detail through group discussions. For example, when the quantitative analysis demonstrated that there had been a significant change in parenting practices, the researcher was able to draw out detailed information from discussion groups and determine which specific parenting strategies (e.g., remaining calm) were meaningful for families. Furthermore, it provided confidence in the validity of some results. For example, quantitative data indicated that parents and adolescents reported a significant decrease in the levels of parent-adolescent conflict, which was then confirmed in what they reported in the group discussions. The concurrent findings strengthen the confidence in the reliability and trustworthiness of the study. Finally where quantitative and qualitative data were inconsistent, new insights were developed that lead to suggestions for future exploration (e.g., discrepancies between parent-reported marital conflict and adolescent perception of the level of marital conflict).

Another important strength of the study was involving adolescents in examining the impact of GTTP. While researchers have acknowledged the importance of obtaining adolescent input in the evaluation of parenting programmes, few studies have involved adolescents. By incorporating the views of adolescents, the validity of the findings was enhanced. This is one of only a few studies in the current literature that demonstrate the efficacy and social validity of parenting programmes through the perspectives of adolescents. The study findings represent an important addition to strengthening the evidence base for Teen Triple P. Importantly, this study highlights the fact that adolescents too can contribute significantly to parenting programme research. By valuing their voices, researchers can obtain important information that is unique to adolescents. The information can be used to better tailor programmes to meet the needs of parents and adolescents, with the aim to increase uptake and engagement in parenting programmes.

7.3.2. Limitations of the study

There are a number of limitations associated with the study. Despite efforts to engage a diverse mix of families, the sample included primarily middle class and well educated families. This homogeneity, coupled with the small sample size, limits the ability to generalise the findings. Additional research on GTTP may benefit from recruiting a larger sample of socioeconomically diverse families in order to address this issue.

In addition, the majority of participants in this study were mothers. Very few fathers participated in the study. The impact of GTTP therefore remains inconclusive for fathers of adolescents. This is consistent with the literature in which a significant gap exists regarding the impact of parenting programmes on fathers with children across all age group. Fathers' participation in parenting programmes has been and continues to be significantly understudied (Tiano & McNeil, 2005). This limitation points to the need for future studies in examining the impact of parenting programmes for fathers.

Another limitation was that the findings were based on self-reported data from parents and adolescents. Although a mixed-methods and multi-informant approach was utilised to

enhance the reliability and trustworthiness of the data, nonetheless, all the data obtained were self-reported. Data may be subjected to response bias, in which participants may have a tendency to give response that they believe to be socially desirable, or that will depict them in a favourable light in the eyes of others. Future studies may utilise observational methods to counteract response bias and strengthen the confidence in the results.

Finally, while the current study suggested positive changes on parent- and adolescent-related outcomes were maintained 6-months to 12-months after programme completion, families were not followed up beyond 12 months. This was due to time and resource constraints of the researcher. Long-term follow up studies are therefore needed to examine if GTTP ultimately results in enduring positive outcomes for families. Additionally, follow-up studies may reveal areas or patterns that support the need for booster sessions to maintain the intervention effects over time. Alternatively, GTTP might be of sufficient dosage for families to maintain intervention effects over time. For example, a recent meta-analysis on Triple P found no evidence of significant relapse and that intervention effects were maintained across studies with various follow up period (Sanders et al., 2013). Nonetheless, there is a need to conduct long-term follow up assessments to fully evaluate the long-term effects of parenting programmes for parents of adolescents.

7.4. Implications for Theory

The study reinforced the importance of developing parenting programmes that are based on strong theoretical and empirical foundations. More specifically, Teen Triple P was guided by social learning and behavioural theories, which emphasised the bidirectional nature of parent-adolescent interactions and stresses the importance of modelling, behaviour practices, and reinforcement. Adolescents are likely to model their parents' behaviour. As such, teaching positive child management skills to parents are likely to result in positive behaviour in adolescents. This was evident in the study in which by teaching parents positive parenting practices, it led to boarder change not only in parents, but also adolescents and the family environment. Similarly, drawing from a developmental psychopathology perspective, inter-

parent conflict, family conflict, parental distress, and poor parent-adolescent relationship have all been linked with problem behaviours in adolescents. Therefore, programmes that enhance parent communication and deal with conflict and stress are more likely to prevent and reduce problem behaviours in adolescents.

What is less clear however is whether existing family-based programmes that draw upon social learning and ecological theories can have an impact on preventing and reducing adolescent internalising problems. Poor parenting is one of many factors that place adolescent at risk of internalising problems (Rapee, 2009). Adolescence is also a time of increased risk of experiencing externalising problems (Steinberg, 2008). Importantly, internalising problems and externalising problems are closely related and often co-occur (Naghavi & Redzuan, 2012). Given that similar parenting factors (e.g., poor parent –adolescent relationship, high level of family conflict, and high level of inter-parent conflict) place adolescent at risk of internalising and externalising problems, prevention and intervention efforts to reduce these risk factors are important (Spoth et al., 2009; Odgers et al., 2012). Nonetheless, internalising problems have often been targeted through school-based or individual programmes that draw on cognitive behavioural theories. These include teaching the adolescent cognitive skills, emotion regulation, dealing with challenges, and social problem solving skills (Rapee, 2009). It remains to be determined if parental participation in parenting programme can protect against the manifestation of adolescent internalising problems (Havighurst, Wilson, Harley, Prior, & Kehoe, 2010). Including measures of adolescent's emotional competence in future efficacy studies on parenting interventions may be beneficial. This would allow a test of whether promoting positive parenting practices would enhance emotional development in adolescents that may reduce and prevent internalising problems.

7.5. Future Directions

On a broad level, the findings have several implications for future research and practice. These include examining the benefits of additional adolescent component to parenting programmes, increasing the voice of consumers in the development, implementation, and

evaluation of parenting programmes, identifying effective strategies to increase family engagement, moving beyond efficacy trials, and finally, building a collaborative effort to supporting parents.

7.5.1. Adolescent component in parenting programmes

As identified in the qualitative study, parents and adolescents themselves showed interest in an additional adolescent component to the programme. This is a noteworthy finding given that there are relatively few studies that examine the benefits of adolescents' participation in parenting programmes. Of the studies available, mixed findings have been reported. While some studies (e.g., Cotter et al., 2013) demonstrated the benefits of including an adolescent skill training component parallel to a parent training session for families with low level of concerns, others have reported negative effects in grouping high-risk adolescents together (Dishion & Tipsord, 2011).

Future studies may be beneficial to investigate the effects of including an adolescent component to the Teen Triple P programme. This will include identifying which format (i.e., parent-only, parent-adolescent together or parent-adolescent separate component) of the programme is most relevant and effective for families, and for which families. Moreover, studies will need to examine what information (e.g., social skills training, family skill development such as practicing communication skills and responding to praise) parent and adolescent desire in an adolescent component programme, and whether such programme derive benefits for families with adolescents. This has important implications for researchers and policy makers for adopting the most cost-effective and minimal sufficient solution to reducing and preventing adolescent problem behaviours at the population level.

7.5.2. The need for consumer voice

While this study attempted to address the lack of consumer input in addressing the social validity of GTTP, there remains much to be learnt from consumers of parenting programmes. There is a need for consumers to be involved in stages of programme development,

implementation, and outcome evaluation. Involving consumers is important as endeavouring to seek out their opinions sets the foundation for consumer trust and empowerment (Carnine, 1997). Voice implies participation and a sense that others value one's opinions and sentiments.

At present, there is an information gap in the literature regarding what parents, adolescents, and communities as consumers want or need in parenting programmes for parents of adolescents. The needs of parents of adolescents are often not differentiated from the needs of parents of young children (Ralph et al., 2003). Adolescence brings with it a range of new developmental challenges that are not present in young children (Steinberg & Morris, 2001). Moreover, although parents from past generations faced similar challenges in parenting adolescents (i.e., negotiation of parent-adolescent relationship), different challenges arise due to societal and environmental changes (Cavanagh et al., 2008; Livingstone & Helsper, 2010). Clearly, assessments of the needs of parents of adolescents are an important research priority and should be conducted routinely to keep up with the changing needs of parents.

Adolescents, too, are consumers of parenting programmes and consulting with them and identifying their needs is important. If the goal is to improve outcomes for adolescents, surely their involvement is of significance. Adolescents are an important source of information and can provide perspectives that may otherwise not be captured through their parents. This was evident in the present study, in which adolescents were in a unique position as observers of their parents and provided important information on the impact of GTTP (e.g., impact of the programme on marital conflict).

Finally, involving the community, such as service providers, and identifying what they need and want in parenting programmes may better meet the needs of communities. The resulting benefits of obtaining information from consumers would likely be development of more relevant programme content, more efficient use of family and community resources (e.g., time and money), and increase rates of parent engagement and retention in parenting programmes (Dumas et al., 2007). Such research would also help to highlight ways in which parents and communities might be encouraged to engage and utilise programmes such as Teen Triple P and how optimal outcomes might best be achieved for all families.

In addition to need assessments, consumers' opinions should also be sought during implementation and outcome evaluation of programmes. Successful parenting programmes depend not only on the extent to which they produce intended change, but also on consumers' perception of its acceptability and effectiveness (Whittingham et al., 2009). Given the importance of parent involvement in parenting programmes, it is necessary to consider how such programmes can increase acceptability and relevance to parents in order to encourage their participation (Sanders, 2012; Owens et al., 2007). For example, several recommendations were suggested by parents in the present study (e.g., adding in information on technology), this information can be used modify future programmes to meet the needs of parents of adolescents.

7.5.3. Engaging parents of adolescents

Although GTTP was intended to target a diverse population of parents, the majority of families who participated were generally well-functioning families. Consistent with international research on parenting programmes, recruiting families proves to be challenging (Kumpfer & Hansen, 2014). Parents with the greatest barriers to participation are often those with the greatest need. In the current study, recruiting families to commit to completing a series of questionnaires, participating in an 8-session programme, and for some (control condition) having to wait a long period before the programme was offered, was indeed challenging. Some families who may have initially met inclusion criteria and expressed interest in participation were not able to commit to the extensive time involvement, due to a number of different factors (e.g., work commitments, transportation).

Low level of parent participation poses a significant challenge to delivering evidence-based parenting programme at a population level. Several studies have identified a number of barriers that may hinder family participation (e.g., Spoth & Redmond, 2000; Prinz et al., 2001; Heinrichs et al., 2005). For example, the lack of childcare facilities, difficulty with transportation, work/family commitments, and location of the venue. The present study also revealed similar barriers to those in the international literature (Heinrichs et al., 2005; Koerting et al., 2013; Spoth & Redmond, 2000). Future research will be required to examine strategies for reducing barriers and increasing family participation. This may include providing childcare

facilities, offering transportation, or flexible delivery options of parenting programmes (e.g., web-based programmes) to increase the likelihood of parents' participation.

Another salient factor that may have underpinned the low level of parent participation is the stigma attached to parenting programmes. At present, parenting programmes are often seen as intervention for struggling or 'failed' families (Sanders, 2012; Heinrichs et al., 2005). One possible contributing factor to this perception is the negative image of adolescents held by the majority of society. Popular assumptions, rather than careful research, tend to dominate perceptions about adolescents and their behaviours (Faucher, 2009; Hines & Paulson, 2006). Adolescents are often portrayed in the media as hostile, violent, delinquent, alienated from parents and families, and resistant to any assistance (Clark & Churchill, 2012; Faucher, 2009). The focus is often on problematic behaviours rather than any adolescent accomplishments or good deeds, such assumptions have significant consequences for families and society as a whole. For example, parents may perceive their child's adolescent years with a sense of dread, society may place emphases on parenting deficits, and may therefore create a culture of blame in which parents are being judged as 'bad parents' (Clark & Churchill, 2012; Corrigan et al., 2006). This can create a significant barrier to parents seeking support and participating in evidence-based parenting programmes that are likely to be beneficial for families.

Given the likely benefits of evidence-based parenting programmes, there is a need to ensure that parents are able to access effective parenting services, without being stigmatised or labelled as failures for utilising such services. There needs to be a fundamental shift from seeing parenting programmes as an approach for 'failing parents' and 'problem families' to a more preventive and strengthening approach to supporting all parents of adolescents. Continuous efforts need to be made to normalise parents' participation in parenting interventions. For example, careful consideration should be given to marketing and media campaigns which normalise parenting programmes as a source of support for all parents. The message that it is not unusual to need support from time to time needs to be conveyed to help increase rates of parent engagement (Sanders, 2012).

7.5.4. From efficacy to effectiveness trials

Successful adoption of a public health approach to the delivery of parenting programmes, such as Teen Triple P will require continuous rigorous evaluation to assess the effects of parenting programmes for parents of adolescents. Replication research, by both developers and independent evaluators, are needed to investigate the impact of Teen Triple P as a public health intervention. While identifying parenting programmes that are efficacious under well controlled trial conditions is critical, demonstrating *effectiveness* when implemented on a large scale under real-world conditions is also essential (Sanders, 2012). The present study is an important step in moving towards a public health approach to supporting parents of adolescents. Demonstrating the efficacy of GTTP under well controlled conditions is essential before moving into trials to demonstrate its effectiveness. This next step of effectiveness trials is also important as many evidence-based parenting programmes for parents of adolescents have yet to demonstrate sustainability and effectiveness when implemented in the community. As such, these programmes often have minimal impact at the population level. Nonetheless, scaling up from an efficacy to an effectiveness trial raises new challenges (Spoth & Redmond, 2002; Biglan et al., 2003). For example, the manner in which a programme is implemented can have an enormous impact on its effectiveness; even evidence-based programmes are effective only when implemented with high quality and fidelity to the programme's design. Large scale population trials will provide important contributions in determining if a population-wide dissemination of parenting programmes can result in changes in population-level prevalence rates of adolescent problem behaviours and parenting variables (Clarke & Churchill, 2012).

In addition to increasing knowledge on the factors influencing programme dissemination and implementation, there is a need to conduct cost-benefit analysis that can assess long-term benefits. Evidence of a programme's future cost benefits can be a powerful tool in communicating the public value of such programmes to communities and policy makers (Small et al., 2009). The decision to adopt an evidence-based parenting programme can be greatly influenced by analyses that clearly indicate the potential cost-effectiveness and cost benefits of the programme.

7.5.5. A collaborative effort to parenting support

For evidence-based programmes to achieve population level impact, a collaborative effort between parents, researchers, communities, professionals, and policy makers is needed. This involves mobilising relevant national organisations to influence local action; forging a change in attitude to position the importance of parenting support in the minds of the entire population; using media to influence individual behaviour and organisational and policy change; diffusing practices at the local level to support change efficiently; and monitoring and tracking the targeted change at the population level (Maibach, Abroms, & Marosits, 2007). Strong collaborations between researchers, communities, and stakeholders are essential to build this capacity. Specific action may include policy makers supporting the development of a comprehensive approach to parenting support (i.e., funding to move from short-term discretionary grants to more stable funding streams). It also requires forming partnerships that include representatives of government, non-government organisations, service sectors, and key community leaders to address parenting needs. These include assessing the needs of parents, targeting these needs with tested and efficacious programmes, and ensuring that these programmes are well implemented and sustained at the population level.

7.6. Final Comment

Future research in the above identified areas is important if parenting programmes such as Teen Triple P are to be implemented and sustained at the population level. Given that most parents want to be good parents, and want to do the best for their adolescent, providing access to parenting support should be seen as a universal right. The success of parents in raising adolescents will shape the future not only of those individual adolescents, but of our whole future society. Strengthening family functioning and providing support for all parents should therefore be seen as the heart of policy initiatives and development. Parenting adolescents is difficult, but it is even more difficult when done alone.

References

Aber, J. L., Jones, S. M., Brown, J. L., Chaudry, N., & Samples, F. (1998). Resolving conflict creatively. Evaluating the developmental effects of a school-based violence prevention programme in neighbourhood and classroom context. *Development and Psychopathology,* 10, 187-213. doi:10.1017/s0954579498001576

Acocella, I. (2012). The focus groups in social research: advantages and disadvantages. *Quality & Quantity,* 46, 1125-1136.

Albert, D., Chein, J., & Steinberg, L. (2013). The teenager brain: peer influences on adolescent decision making. *Current Directions in Psychological Science,* 22, 114-120. doi:10.1177/0963721412471347

Albin, R. W., Lucyshyn, J. M., Horner, R. H., & Flannery, K. B. (1996). Contextual fit for behaviour support plans. In L. K. Koegel, R. L. Koegel, & G. Dunlap, (Eds.), *Positive behavioural support* (pp. 81-98). Baltimore: Paul H. Brookes.

Allison, B. N., & Schultz, J. B. (2004). Parent-adolescent conflict in early adolescence. *Adolescence,* 39, 101 – 119.

American Psychological Association. (2009). *Effective strategies to support positive parenting in community health centers: Report of the Working Group on Child Maltreatment Prevention in Community Health Centers:* Washington, DC: American Psychological Association.

Anderson, P., de Bruijm A., Angus, K., Gordon, R., & Hastings, G. (2009). Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies. *Alcohol and Alcoholism,* 44, 229-43.

Andrew, S., & Halcomb, E. J. (2006). Mixed methods research is an effective method of enquiry for community health research. *Advances in Contemporary Nurse*, 23, 145-153.

Andrews, J. A., Capaldi, D., Foster, S. L., & Hops, H. (2000). Adolescent and family predictors of physical aggression, communication, and satisfaction in young adult couples: A prospective analysis. *Journal of Consulting and Clinical Psychology, 68*, 195-208.

Aquilino, W. S., & Supple, A. J. (2001). Long-term effects of parenting practices during adolescence on well-being outcomes in young adulthood. *Journal of Family Issues, 22*, 289-308. doi: 10.1177/019251301022003002

Ardelt, M., & Eccles, J. S. (2001). Effects of mothers' parental efficacy beliefs and promotive parenting strategies on inner-city youth. *Journal of Family Issues, 22*, 944-972.

Bacchini, D., Miranda, M. C., & Affuso, G. (2011). Effects of parental monitoring and exposure to community violence on antisocial behaviour and anxiety/depression among adolescents. *Journal of Interpersonal Violence, 26*, 269-292. doi: 10.1177/0886260510362879

Baker, C. N., Arnold, D. H., & Meagher, S. (2011). Enrollment and attendance in a parent training prevention programme for conduct problems. *Prevention Science, 12*, 126-138.

Barlow, J., Smailagic, N., Huband, N., Roloff, V., & Bennett, C. (2012). Group-based parent training programmes for improving parental psychosocial health. *Cochrane Database of Systematic Reviews, 6*.

Barry, A. E. (2005). How attrition impacts the internal and external validity of longitudinal research. *Journal of School Health, 75*, 267-270.

Bandura, A. (2006). Guide for constructing self-efficacy scales. In F. Pajares & T. Urdan (Eds.), *Self-efficacy beliefs of adolescents*. Greenwich, CT: Information Age Publishing.

Bauman, K. E., Ennett, S. T., Foshee, V. A., Pemberton, M., King, T. S., & Koch, G. G. (2000). Influence of a family-directed programme on adolescent cigarette and alcohol cessation. *Prevention Science,* 1, 227-237.

Bauman, K. E., Foshee, V. A., Ennett, S. T., Hicks, K. A., & Pemberton, M. (2001). Family Matters: A family-directed programme designed to prevent adolescent tobacco and alcohol use. *Health Promotion Practice*, 2, 81-96.

Bayer, J. K., Hiscock, H., Morton-Allen, E., Ukomunne, O. C., & Wake, M. (2007). Prevention of mental health problems: rationale for a universal approach. *Archives of Disease in Childhood,* 92, 34-38.

Bayer, J. K., Hiscock, H., Ukoumunne, O. C., Scalzo, K., & Wake, M. (2010). 3-year-old outcomes of a brief universal parenting intervention to prevent behaviour problems: randomised controlled trial. *Archives of Disease in Childhood,* 95, 187-92.

Bayley, L. K., Wallace, L. M., & Choudhry, K. (2009). Fathers and parenting programmes: Barriers and best practice. *Journal of Community Practice,* 82, 28-31.

Beck, K. H. (1990). Monitoring parent concerns about teenage drinking and driving: A random digit dial telephone survey. *Amerecian Journal of Drug Alcohol Abuse,* 16, 109-124.

Beck, L. C., Trombetta, W. L., & Share, S. (1986). Using focus group sessions before decisions are made. *North Carolina Medical Journal,* 47, 73 – 74.

Bennett, D. L., Kang, M., Alperstein, G., & Kakakios, M. (2004). Collaborative strategies for improving the health of young people. *Hong Kong Journal of Pediatrics,* 9, 295-302.

Beyers, J.M., & Loeber, R. (2003). Untangling developmental relations between depressed mood and delinquency in male adolescents. *Journal of Abnormal Child Psychology*, 31, 247-266.

Biehal, N. (2008). Preventive services for adolescents: Exploring the process of change. *British Journal of Social Work,* 38, 444-461.

Biglan, A., Mrazek, P. J., Carnine, D., & Flay, B. R. (2003). The integration of research and practice in the prevention of youth problem behaviours. *American Psychologist,* 58, 433-440.

Biro, F. M., Galvez, M. P., Greenspan, L. C., et al. (2010). Pubertal assessment method and baseline characteristics in a mixed longitudinal study of girls. *Pediatrics,* 126, e582-e590.

Blakemore, S. J., & Choudhury, S. (2006). Development of the adolescent brain: implications for executive function and social cognition. *Journal of Child Psychology and Psychiatry,* 47, 296–312.

Boden, J. M., Fergusson, D. M., & Horwood, L. J. (2011). Alcohol and STI risk: Evidence from a longitudinal birth cohort. *Drug and Alcohol Dependence,* 113, 200-206.

Bogenschneider, K., Small, S. A., & Tsay, J. C. (1997). Child, parent, and contextual influences on perceived parenting competence among parents of adolescents. *Journal of Marriage and the Family,* 59, 345-362.

Bor, W., & Sanders, M. R. (2004). Correlates of self-reported coercive parenting of preschool-aged children at high risk for the development of conduct problems. *Australian and New Zealand Journal of Psychiatry,* 38, 738-745.

Boyd, R. C., Diamond, G. S., & Bourjolly, J. N. (2006). Developing a family-based depression prevention programme in urban community mental health clinics: A qualitative investigation. *Family Process*, 45, 187–203.

Bradley, R. H., McRitchie, S., Houts, R. M., Nader, P., & O'Brien, M. (2011). Parenting and the decline of physical activity from age 9-15. *International Journal of Behavioural Nutrition Physical Activity,* 8, 33-43. doi:10.1186/1479-5868-8-33

Brown, B. B., Bakken, J. P., Ameringer, S. W., & Mahon, S. D. (2008). A comprehensive conceptualisation of the peer influence process in adolescence. In M. J. Prinstein & K. Dodge (Eds.), *Peer influence processes among youth*. New York: Guildford Publications.

Bryman, A. (2006). Integrating quantitative and qualitative research: how is it done? *Qualitative Research,* 6, 97-113.

Buchanan, C. M., & Holmbeck, G. (1998). Measuring beliefs about adolescent personality and behaviour. J*ournal of Youth and Adolescence,* 27, 609-629.

Bullock, B. M., & Dishion, T. J., (2007). Family processes and adolescent problem behaviour: Integrating narratives into understanding development and change. *Journal of the American Academy of Child and Adolescent Psychiatry,* 46, 396–407.

Byrnes, H., Miller, B., Aalborg, A., Plasencia, A., & Keagy, C. (2010). Implementation fidelity in adolescent family-based prevention programmes: relationship to family engagement. *Health Education Research*, 25, 531-541.

Carnine, D. (1997). Bridging the research-to-practice gap. *Exceptional Children,* 63, 513-521.

Carr, A. (2009). The effectiveness of family therapy and systemic interventions for child-focused problems. *Journal of Family Therapy,* 31, 3-45.

Carter, M., McGee, R., Taylor, B., & Williams, S. (2007). Health outcomes in adolescence: Associations with family, friends and school engagement. *Journal of Adolescence,* 30, 51-62. doi: 10.1016/j.adolescence.2005.04.002

Cauffman, E., Shulman, E. P., Steinberg, L., et al. (2010). Age differences in affective decision making as indexed by performance on the Iowa Gambling Task. Developmental Psychology, 46, 193–207.

Cavanagh, S. E., Crissey, S. R., & Raley, R. K. (2008). Family structure history and adolescent romance, *Journal of Marriage and Family,* 70, 698-714.

Cavanagh, S. E., & Huston, A. (2008). The timing of family instability and children's social development. *Journal of Marriage and Family,* 70, 1258-1269.

Chand, N. L. (2012). *Promoting adolescent well-being and positive youth development through a brief parenting intervention programme.* Unpublished Masters dissertation, University of Auckland, Auckland, New Zealand.

Chand, N. L., Farruggia, S. P., Dittman, C. K., Chu, J. T. W., & Sanders, M. R. (2013). Positive youth development and Teen Triple P: Promoting positive youth development through a brief parenting intervention programme. *Youth Studies Australia,* 32, 29-36.

Chu, J. T. W., Farruggia, S., Sanders, M. R., & Ralph, A. (2012). Towards a public health approach to parenting programmes for parents of adolescents. *Journal of Public Health*, 34(s1), i41 − i47. doi:10.1093/pubmed/fdr123.

Clark, D. B., Kirisci, L., Mezzich, A., & Chung, T. (2008). Parental supervision and alcohol use in adolescence: Developmentally specific interactions. *Journal of Developmental and Behavioural Pediatrics*, 29, 285-292.

Clark, T. C., Fleming, T., Bullen, P., et al. (2013). Youth'12 Overview: The health and well-being of New Zealand secondary school students in 2012. Auckland, New Zealand: The University of Auckland.

Cohen, J. (1992). A power primer. *Psychological Bulletin,* 112, 155-159.

Collins, L. M., Chakraborty, B., Murphy, S. A., & Strecher, V. (2009). Comparison of a phased experimental approach and a single randomised clinical trial for developing multicomponent behavioural interventions. *Clinical Trials*, 6, 5-15.

Collins, W. A., & Laursen, B. (2004). Changing relationships, changing youth: Interpersonal contexts of adolescent development. *The Journal of Early Adolescence,* 24, 55–62. doi:10.1177/0272431603260882.

Comer, J. S., Chow, C., Chan, P., Cooper-Vince, C., & Wilson, L. A. S. (2013). Psychosocial treatment efficacy for disruptive behaviour problems in young children: A meta-analytic examination. *Journal of the American Academy of Child and Adolescent Psychiatry,* 52, 26-36.

Connell, A. M., & Goodman, S. H. (2002). The association between psychopathology in fathers versus mothers and children's internalising and externalising behaviour problems: A meta-analysis. *Psychological Bulletin,* 128, 746-773.

Corrigan, P. W., Watson, A., & Miller, F. E. (2006). Blame, shame, and contamination: the impact of mental illness and drug dependence stigma on family members. *Journal of Family Psychology,* 20, 239-246.

Cotter, K. L., Bacallao, M., Smokowski, P. R., & Robertson, C. I. B. (2013). Parenting interventions implementation science. How delivery format impacts the Parenting Wisely programme. *Research on Social Work Practice,* 23, 639-650. doi: 10.1177/1049731513490811

Cottrell, L., Li, X., Harris, C., D'Alessandri, D., et al. (2003). Parent and adolescent perceptions of parental monitoring and adolescent risk involvement. *Parenting: Science & Practice,* 3, 179-195.

Cox, M. J. (2010). Family systems and sibling relationships. *Child Development Perspectives,* 4, 95–96.

Creswell, J. W., Fetters, M. D., Plano Clark, V. L., & Morales, A. (2009). Mixed methods intervention trials. In S. Andrew & E. J. Halcomb (Eds.), *Mixed methods research for nursing and the health sciences* (pp. 161-180). Oxford: Blackwell Publishing.

Crocetti, E., Jahromi, P., & Meeus, W. (2012). Identity and civic engagement in adolescence. *Journal of Adolescence,* 35, 521-532.

Cui, M., Donnellan, M. B., & Conger, R. D. (2007). Reciprocal influences between parents' marital problems and adolescent internalising and externalising behaviour. *Developmental Psychology, 43,* 1455-1552.

Curtis, N. M., Ronan, K. R., & Borduin, C. M. (2004). Multisystemic treatment: A meta-analysis of outcome studies. *Journal of Family Psychology, 18,* 411–419.

Dadds, M. R., & Powell, M. B. (1991). The relationship of interparental conflict and global marital adjustment to aggression, anxiety, and immaturity in aggressive and nonclinic children. *Journal of Abnormal Child Psychology, 19,* 553-567. doi: 10.1007/BF00925820

Dane, A. V., & Schneider, B. H. (1998). Programme integrity in primary and early secondary prevention: Are implementation effects out of control? Clinical Psychology Review, 18, 23-45.

Daud, R. J. (2006). Examining the influence and developmental impact of after-school/out-of-school programmes on youth from high-risk environments. Unpublished Masters dissertation, University of Nevada, Las Vegas, United States.

De Graaf, I., Speetjens, P., Smit, F., de Wolff, M., & Tavecchio, L. (2008). Effectiveness of the Triple P Positive Parenting Program on behavioural problems in children. *Behaviour Modification, 32,* 714-735. doi: 10.1177/0145445508317134

Dekovic′, M. (1999). Risk and protective factors in the development of problem behaviour during adolescence. *Journal of Youth and Adolescence, 28,* 667-685.

Dekovic′, M., Janssens, J. M. A. M., & van As, N. M. C. (2003). Family predictors of antisocial behaviour in adolescence. *Family Process, 42,* 223-235.

Dempster, A. P., Laird, N. M., & Rubin, D. B. (1977). Maximum likelihood from incomplete data via the EM algorithm. *Journal of the Royal Statistical Society Series B, 39,* 1-38.

Diamond, G., & Josephson, A. (2005). Family-based treatment research: A 10-year update. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*, 872-887.

Dishion, T. J., & Andrews, D. W. (1995). Preventing escalation in problem behaviours with high-risk young adolescents: Immediate and 1-year outcomes. *Journal of Consulting and Clinical Psychology, 63*, 538-548.

Dishion, T. J., & Kavanagh, K. (2002). The Adolescent Transitions Program: A family-centered prevention strategy for schools. In J. B. Reid, J. J. Snyder, & G. R. Patterson (Eds.), *Antisocial behaviour in children and adolescents: A developmental analysis and the Oregon Model for Intervention,* (pp. 257-272). Washington, DC: American Psychological Association.

Dishion, T. J., McCord, J., & Poulin, F. (1999). When Interventions Harm: Peer Groups and Problem Behaviour. *American Psychologist, 54*, 755-764.

Dishion, T. J., & McMahon, R. J. (1998). Parental monitoring and the prevention of child and adolescent problem behaviour: a conceptual and empirical formulation. *Clinical Child and Family Psychology Review, 1*, 61-75.

Dishion, T. J., Nelson, S. E., & Kavanagh, K. (2003). The Family Check-Up with high-risk young adolescents: Preventing early-onset substance use by parent monitoring. *Behaviour Therapy, 34*, 553-571. doi:10.1016/s0005-7894(03)80035-7

Dishion, T. J., & Patterson, G. R. (2006). The development and ecology of antisocial behaviour. In D. Cicchetti, & D. J. Cohen (Eds.), *Developmental psychopathology. Vol. 3: Risk, disorder, and adaptation.* New York: Wiley.

Dishion, T. J., Patterson, G. R., Stoolmiller, M., & Skinner, M. L. (1991). Family, school, and behavioural antecedents to early adoelscent involvment with antisocial peers. *Developmental Psychology, 27*, 172-180.

174

Dishion, T. J., Spracklen, K. M., Andrews, D. W., & Patterson, G. R. (1996). Deviancy training in male adolescent friendships. *Behaviour Therapy, 27*, 373-390.

Dishion, T. J., & Stormshak, E. A. (2009). A family-centered interventionstrategy for public middle schools. In J. Bray & M. Stanton (Eds.), *Blackwell handbook of family psychology,* (pp. 499–514). Malden, MA:Blackwell Publishing.

Dishion, T. J., & Tipsord, J. M. (2011). Peer contagion in child and adolescent social and emotional development. *Annual Review of Psychology, 62*, 189–214.

Doherty, F. M., Calam, R., & Sanders, M. R. (2013). Positive Parenting Program (Triple P) for families of adoeslcents with Type 1 diabetes: a randomised controlled trial of self-directed Teen Triple P. *Journal of Pediatric Psychology, 38*, 846-858. doi: 10.1093/jpepsy/jst046

Dretzke, J., Davenport, C., Frew, E., et al. (2009). The clinical effectivness of different parenting programmes for children with conduct problems: a systematic review of randomised controlled trials. *Child and Adolescent Psychiatry and Mental Health, 3*. doi:10.1186/1753-000-3-7

Dryfoos, J. G. (1991). Adolescents at risk: A summation of work in the field: Programmes and policies. *Journal of Adolescent Health, 12*, 630-637.

Duffett, A., Johnson, J., & Farkas, S. (1999). Kids These Days' 99: What Americans ReallyThink about the Next Generation. New York:Public Agenda.

Dumas, J. E., Nissley-Tsiopinis, J., & Moreland, A. (2007). From intent to enrollment, attendance, and participation in preventive parenting groups. *Journal of Child and Family Studies, 16*, 1-26.

Dumka, L. E., Gonzales N. A., Bonds, D., & Millsap, R. (2009). Academic success in Mexican origin adolescent boys and girls: The role of mothers' and fathers' parenting and cultural orientation. *Sex Roles*, 60, 588-599.

Eamon, M. K. (2002). Poverty, parenting, peer, and neighbourhood influences on young adolescent antisocial behaviour. *Journal of Social Service Research,* 28, 1-23.

East, P. L., Matthews, K. L., & Felice, M. F. (1994). Qualities of adolescent mother's parenting. *Journal of Adolescent Health,* 15, 163-168.

Erikson, E. H. (1972). *Childhood and society.* Harmondsworth, Middlesex: Penguin Books.

Eisenberg, N., Cumberland, A., & Spinrad, T. L. (1998). Parental socialization of emotion. *Psychological Inquiry*, 9, 241–273.

Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Evidence-based psychosocial treatments for children and adolescents with disruptive behaviour. *Jounral of Clinical Adolescent Psychology,* 37, 215-237. doi: 10.1080/18374410701820117

Faucher, C. (2009). Fear and loathing in the news: A qualitative analysis of Canadian print news coverage of youthful offending in the twentieth century. *Journal of Youth Studies,* 12, 439-456. doi: 10.1080/13676260902897426

Field, A. (2009). *Discovering Statistics Using SPSS.* (3rd ed.). California: SAGE Publications Ltd.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation research: A synthesis of the literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Flannery, D., Hussey, D., & Jefferis, E. (2005). Adolescent delinquency and violent behaviour. In T. Gullotta & G. Adams, (Eds.), *Handbook of Adolescent Behavioural Problems:*

Evidence-based approaches to prevention and treatment (pp. 415-438). New York: Springer.

Flay, B. R., Biglan, A., Boruch, R. F., et al. (2005). Standards of evidence: criteria for efficacy, effectiveness and dissemination. *Prevention Science,* doi: 10.1007/s11121-005-5533-y

Fletcher, A., Bonell, C., Sorhaindo, A., & Strange, V. (2008). How might schools influence young people's drug use? Development of theory from qualitative case-study research. *Journal of Adolescent Health,* 45, 126-132.

Fletcher, A. C., Elder, G. H., & Mekos, D. (2000). Parental infleunces on adolescent involvement in community activities. *Journal of Research on Adolescence,* 10, 29-48.

Fletcher, A. C., Steinberg, L., & Williams-Wheeler, M. (2004). Parental influences on adolescent problem behaviour: Revisiting Stattin and Kerr. *Child Development,* 75, 781-796.

Fosco, G. M., Caruthers, A. S., & Dishion, T. J. (2012). A six-year predictive text of adolescent family relationship quality and effortful control pathways to emerging adult social and emotional health. *Journal of Family Psychology, 26,* 565-575.

Foster, E. M., Prinz, R. J., Sanders, M. R., & Shapiro, C. J. (2008). The costs of a public health infrasture for delievering parenting and family support. *Children and Youth Services Review,* 30, 493-501. doi:10.1016/j.childyouth.2007.11.002

Foster, S. L., & Mash, E. J. (1999). Assessing social validity in clinical treatment research issues and procedures. *Journal of Consulting and Clinical Psychology,* 67, 308-319.

Foxcroft, D. R., Ireland, D., Lister-Sharp, D. J., Lowe, G., & Breen, R. (2003). Longer-term primary prevention for alcohol misuse in young people: A systematic review. *Addiction,* 98, 397−411.

Frick, P. J., & Viding, E. (2009). Antisocial behaviour from a developmental psychopathology perspective. *Development and Psychopathology,* 21, 1111-1131. doi:10.1017/s0954579409990071

Gar, N. S., Hudson, J. L., & Rapee, R. M. (2005). Family factors and the development of anxiety disorders. In, J. L. Hudson & R. M. Rapee, (Eds). *Psychopathology and the family*. (pp. 125–145). Oxford, U. K.: Elsevier.

Gardner, F., Mayo-Wilson, E., Montgomery, P., Hopewell, S., Macdonald, G., Moher, D., & Grant, S. (2013). Editorial Perspective: The need for new guidelines to improve the reporting of trials in child and adolescent mental health. *Journal of Child Psychology and Psychiatry,* 54, 810–812. doi: 10.1111/jcpp.12106

Gates, S., McCambridge, J., Smith, L. A., & Foxcroft, D. R. (2006). Interventions for prevention of drug use by young people delivered in non-school settings. *The Cochrane Database of Systematic Reviews,*1. doi: 10.1002/14651858.CD005030.pub2/

Galambos, N. J., & Leadbeater, B. J., (2000). Trends in adolescent research for the new millennium. *International Journal of Behavioural Development,* 24, 289-294.

Ghate, D., & Ramella, M. (2002). *Positive parenting: The national evaluation of the youth justice board's parenting programme.* London: Youth Justice Board.

Gilliom, M., & Shaw, D.S. (2004). Co-development of externalizing and internalizing problems in early childhood. *Development and Psychopathology*, 16, 313-334.

Glazemakers, I., & Deboutte, D. (2012). Modifying the Positive Parenting Program for parents with intellectual disabilities. *Journal of Intellectual Disability Research,* 57, 616-626. doi: 10.1111/j.1365-2788.2012.01566.x

Gluckman, P. D., Low, F. M., & Franko, K. L. (2011). *Puberty and adolescence: transitions in the life course. Improving the Transition:* Reducing Social and Psychological Morbidity

During Adolescence. Auckland: Office of the Prime Minister's Science Advisory Committee, 19-34.

Gomby, D., Culross, P., & Behrman, R. (1999). Home visiting: recent programme analysis and evaluation. *The Future of Children,* 9, 4-26.

Goodman, E., Adler, N. E., Kawachi, I., Frazier, A. L., Huang, B. & Colditz, G. A. (2001). Adolescents' perceptions of social standing: Development and evaluation of a new indicator. *Pediatrics,* 108.

Graaf, I. de., Speetjens, P., Smit, F., Wolff, M, de., & Tavecchio, L. (2008). Effectiveness of the Triple P Positive Parenting Program on Parenting: A Meta-Analysis. *Family Relation,* 57, 553-566.

Gray, M. R., & Steinberg, L. (1999). Unpacking authoritative parenting: Reassessing a multidimensional construct. *Journal of Marriage and Family,* 61, 574-587.

Green, H., McGinnity, A., Metlzer, H., et al. (2005). *Mental health of children and young people in Britain, 2004.* Palgrave MacMilan.

Greenberg, M. T., & Lippold, M. A. (2013). Promoting health among multi-risk youth: Innovative approaches. *The Annual Review of Public Health,* 34, 253-270.

Greenberger, E., Chen, C., & Beam, M. R. (1998). The role of "very important" nonparental adults in adolescent development. *Journal of Youth and Adolescence,* 27, 321-343. doi: 10.1023/A:1022803120166

Greenberger, E., Chen, C., Beam, M. R., Whang, S. M., & Dong, Q. (2000). The perceived social contexts of adolescents' misconduct: A comparative study of youths in three cultures. *Journal of Research on Adolescence,* 10, 365-388. doi: 10.1207/SJRA1003_7

Griffin, K. W., Samuolis, J., & Willaims, C. (2011). Efficacy of a self-administered home-based parent intervention on parenting behaviours for preventing adolescent substance use. *Journal of Child and Family Studies,* 20, 319-325. doi: 10.1007/s10826-010-9395-2.

Goodman, R. (1999). The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden. *The Journal of Child Psychology and Psychiatry,* 40, 791-799. doi: 10.1111/1469-7610.00494

Gross, E. F., Juvonen, J., & Gable, S. L. (2002). Internet use and well-being in adolescence. *Journal of Social Issues,* 58, 75–90.

Grotevant, H. (1998). Adolescent development in family contexts. In W. Damon & N. Eisenberg (Eds.), *Handbook of child psychology: Vol. 3. Social, emotional, and personality development* (pp. 1097-1149). New York: John Wiley

Hair, E. C., Moore, K. A., Garrett, S. B., Ling, T., & Cleveland, K. (2008). The continued importance of quality parent-adolescent relationships during late adolescence. *Journal of Research on Adolescence,* 18, 187-200.

Haggerty, K. P., Kosterman, R. Catalano, R. F., & Hawkins, J. D. (1999). Preparing for the Drug Free Years. *OJJDP Juvenile Justice Bulletin,* 1-10.

Harachi, T.W., Catalano, R. F., & Hawkins, J. D. (1997). Effective recruitment for parenting programmes within ethnic minority communities. *Child and Adolescent Social Work Journal,* 14, 23-39.

Harvey-Arnold, E., & O'Leary, S. (1997). Mothers' and fathers' discipline of hard-to-manage toddlers. *Child and Family Behaviour Therapy,* 19, 1-11.

Havighurst, S. S., Wilson, K. R., Harley, A. E., Prior, M. R., & Kehoe, C. (2010). Tuning in to Kids: Improving emotion socialization practices in parents of preschool children –

findings from a community trial. *Journal of Child Psychology and Psychiatry*, 51, 1342-1350.

Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. *Psychological Bulletin,* 112, 64–105.

Hawthorn, J., Jessop, J., Pryor, J., & Richards, M. (2003). *Supporting family through change: a review of interventions and services for children of divorcing and separating parents.* Joseph Rowntree Foundation: New York.

Hayes, L., Matthews, J., Copley, A. & Welsh, D. (2008). A randomised controlled trial of a mother-infant or toddler parenting programme: Demonstrating effectiveness in practice. *Journal of Pediatric Psychology,* 33, 473–86.

Heinrichs, N., Bertram, H., Kuschel, A., & Hahlweg, K. (2005). Parent recruitment and retention in a universal prevention programme for child behaviour and emotional problems: Barriers to research and programme participation. *Prevention Science,* 6, 275-286.

Heneghan, A. M., Mercer, M., & DeLeone, N. L. (2004). Will mothers discuss parenting stress and depressive symptoms with their child's pediatrician? *Pediatrics,* 113, 460–467.

Henggeler, S. W., Clingempeel, W. G., Brondino, M. J., & Pickrel, S. G. (2002). Four-year follow-up of multisystemic therapy with substance abusing and dependent juvenile offenders. *Journal of the American Academy of Child and Adolescent Psychiatry,* 41, 695–711.

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). Multisystemic treatment of antisocial behaviour in children and adolescents. New York: Guilford Press.

Henricson, C., & Rooker, D. (2000). Support for the parents of adolescents: a review. *Journal of Adolescence,* 23, 763-783.

Herman-Giddens, M. E. (2006). Recent data on pubertal milestones in United States children: the secular trend toward earlier development. *International Journal of Andrology,* 29, 241-246.

Hines, A. R., & Paulson, S. E. (2006). Parents' and teachers' perceptions of adolescent storm and stress: relations with parenting and teaching styles. *Adolescence,* 41, 597-614.

Hoeve, M., Dubas, J. S., Eichelsheim, V. I., Van der Laan, P. H., Smeenk, W. H., & Gerris, J. R. M. (2009). The relationship between parenting and delinquency: a meta-analysis. *Journal of Abnormal Child Psychology,* 37, 749 -775.

Holton, E. F., & Burnett, M. F. (2005). The basics of quantitative research, In R. A. Swanson, & E. F. Holton (Eds.), *Research in organisations: foundation and methods of inquiry* (pp. 29-44). San Francisco: Berret-Koehler.

Hunter, E., Katz, L.F., Shortt, J.W., Davis, B., Leve, C. Allen, N.B., & Sheeber, L.B. (2011). How do I feel about feelings? Emotion socialization in families of depressed and healthy adolescents. *Journal of Youth and Adolescence*, 40, 428-441.

Irvine, A. B., Biglan, A., Smolkowski, K., Metzler, C. W., & Ary, D. V. (1999). The effectiveness of a parenting skills programme for parents of middle school students in small communities. *Journal of Consulting and Clinical Psychology,* 67, 811-825. doi: 10.1037/0022-006X.67.6.811

Ivankova, N. V., Creswell, J. W., & Stick, S. L. (2006). Using mixed-methods sequential explanatory design: From theory to practice. *Field Methods,* 18, 3-20.

Jackson, C., Geddes, R., Frank, J., et al. (2012). Interventions to prevent substance use and risky sexual behaviour in young people: a systematic review. *Addiction,* 107, 733-747.

Johnston, L. D., O'Malley, P. M. Bachman, J. P., & Schulenberg, J. E. (2009). Monitoring the future national results on adolescent drug use: overview of key findings 2008. (NIH Publication No. 09-7401).

Johnson, J. G., Smailes, E., Cohen, P., Kasen, S., & Brook, J. S. (2004). Anti-social parental behaviour, problematic parenting and aggressive offspring behaviour during adulthood: A 25-Year longitudinal investigation. *British Journal of Criminology,* 44, 915-930. doi: 10.1093/bjc/azh041

Johnson, K., Akister, J., McKeigue, B., & Wheater, J. (2005). What does 'supporting parents' mean? – Parents' views. *Practice,* 17, 3-14.

Jones, S., Calam, R., Sanders, M. R., Diggle, P., Dempsey, R., & Sadhnani, V. (2013). A pilot web based positive parenting intervention to help bipolar parents to improve perceived parenting skills and child outcomes. *Behavioural and Cognitive Psychotherapy*, 1-14.

Jones, T. L., & Prinz, R. J. (2005). Potential roles of parental self-efficacy in parent and child adjustment: a review. *Clinical Psychology Review,* 25, 341-363.

Kaslow, N. J., Broth, M. R., Smith, C. O., & Collins, M. H. (2012). Family-based interventions for child and adolescent disorders. *Journal of Maritatl and Family Therapy,* 38, 82-100. doi: 10.1111/j.1752-0606.2011.00257.x

Kazdin, A. E. (1977). Assessing the clinical or applied importance of behaviour change through social validation. *Behaviour Modification,* 1, 427-452.

Kazdin, A. E. (2005). Parent Mangagment Training: Treatment for opposition, aggressive, and antisocial behaviour in children and adolescents. New York: Oxford University Press.

Kazdin, A. E. (2008). Evidence-based treatment and practice. *American Psychologist,* 63, 146–159.doi:10.1037/0003-066X.63.3.146

Kazdin, A. E., & Wassell, G. (1999). Barriers to treatment participation and therapeutic change among children referred for conduct disorder. *Journal of Clinical Child Psychology,* 28, 160-172.

Keijsers, L., Frijns, T., Branje, S. J. T., & Meeus, W. (2009). Developmental links of adolescent disclosure parental solicitation and control with delinquency: Moderation by parental support. *Developmental Psychology,* 45, 1314–1327. doi:10.1037/a0016693

Keisner, J., Poulin, F., & Dishion, T. J. (2010). Adolescent substance use with friends: Moderating and mediating effects of parental monitoring and peer activity contexts. *Merrill-Palmer Quarterly,* 56, 529–556.

Kellough, R. D., & Kellough, N. G. (2008). *Teaching young adolescents: Methods and resources for middle grades teaching* (5th ed.), Upper Saddle River, NJ: Pearson Merrill Prentice Hall.

Kerr, M., Stattin, H., & Burk, W. J. (2010). A reinterpretation of parental monitoring in longitudinal perspective. *Journal of Research on Adolescence,* 20, 39-64. doi: 10.1111/j.1532-7795.2009.00623.x

Kidd-Hewitt, D. (2002). Crime and the media: a criminological perspective. In Y. Jewkes & G. Letherby (Eds.), *Criminology: A Reader* (pp. 116-129). London: SAGE.

Kirby, J. N., & Sanders, M. R. (2012). Using consumer input to tailor evidence-based parenting interventions to the needs of grandparents. *Journal of Child and Family Studies,* 21, 626-636. doi: 10.1007/s10826-011-9514-8.

Kitzinger J. (1994). The methodology of focus groups: the importance of interaction between research participants. *Sociology of Health*, 16, 103-21.

Koerting, J., Smith, E., Knowles, M. M., et al. (2013). Barriers to, and facilitators of, parenting programmes for childhood behaviour problems: A qualitative synthesis of parents' and

professionals' perception. *European Child Adolescent Psychiatry,* 22, 653-670. doi: 10.1007/s00787-013-0401-2.

Kotchick, B. A., Shaffer, A., Miller, K. S., & Forehand, R. (2001). Adolescent sexual risk behaviour: A multi-system perspective. *Clinical Psychology Review,* 21,493-519.

Kumpfer, K. L., & Alvarado, R. (2003). Family-strengthening approaches for the prevention of youth problem behaviours. *American Psychologist,* 58, 457-465. doi: 10.1037/0003-066x.58.6-7.457

Kumpfer, K. L., & Hansen, W. B. (2014). Family-based prevention programmes. In L. M. Scheier & W. B. Hansen (Eds.), Parenting and teen drug use. The most recent findings from research, prevention, and treatment. (pp. 166-193). USA: Oxford University Press.

Lachin, J. M. (2000). Statistical considerations in the Intent-to-Treat principle. *Controlled Clinical Trials,* 21, 167-189.

Lau, S., & Kwok, L. K. (2000). Relationship of family environment to adolescents' depression and self-concept. *Social Behaviour and Personality,* 28, 41–50.

Laursen, B., Hafen, C. A., Kerr, M., & Stattin, H. (2011). Friend influence over adolescent problem behaviours as a function of relative peer acceptance: to be liked is to be emulated. *Journal of Abnormal Psychology,* 121, 88-94.

Lei, L., & Wu, Y. (2007). Adolescents' paternal attachment and internet use. *CyberPsychology & Behaviour*, 10, 633-639. doi:10.1089/cpb.2007.9976

Leijten, P., Oveerbeek, G., & Janssens, J. M. A. M. (2012). Effectiveness of a parent training programme in (pre)adolesence: evidence from a randomised controlled trial. *Journal of Adolescence,* 35, 833-842. doi: 10.1016/j.adolescence.2011.11.009

Lerner, R. M., Lerner, J. V., Almerigi, J. B., et al. (2005). Positive youth development, participation in community youth development programmes, and community

contributions of fifth-grade adolescents: Findings from the first wave of the 4-H study of Positive Youth Development. *The Journal of Early Adolescence,* 25, 17-71. doi: 10.1177/0272431604272461

Leung, L. (2007). Stressful life events, motives for Internet use, and social support among digital kids. *Cyber Psychology & Behaviour*, 10, 204-214.

Leung, C., Fan, A., & Sanders, M. R. (2013). The effectiveness of a Group Triple P with Chinese parents who have a child with developmental disabilities: A randomised controlled trial. *Research in Developmental Disabilities,* 34, 976-984.

Leung, J. T. Y., & Shek, D. T. L. (2014). Parent-adolescent discrepancies in perceived parenting characteristics and adolescent developmental outcomes in poor Chinese families. *Journal of Child and Family Studies,* 23, 200-213.

Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science,* 2, 53–70.

Lim, M., Tormshak, E. A. S., & Dishion, T. J. (2005). A one-session intervention for parents of young adolescents. *Journal of Emotional and Behavioural Disorders,* 13, 194-199.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage.

Lindsey, E. W., Chamber, J. C., Frabutt, J. M., & MacKinnon-Lewis, C. (2009). Marital conflict and adolescents' peer aggression: the mediating and moderating role of mother-child emotional reciprocity. *Family Relations,* 58, 593-606.

Littell, J. (2006). Case for multisystemic therapy: Evidence or orthodoxy? *Children & Youth Services Review,* 28, 458-472.

Livingstone, S., & Helsper, E. (2010). Balancing opportunities and risks in teenagers' use of the internet: the role of online skills and internet self-efficacy. *New Media & Society,* 12, 309-329.

Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the Depression Anxiety Stress Scales* Sydney: Psychology Foundation.

Luthar, S. S. (2006). Resilience in development: A synthesis of research across five decades. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental Psychopathology: Risk, disorder, and adaptation* (pp. 740-795). New York:: Wiley.

Macmillan, R., McMorris, B. J., & Kruttschnitt, C. (2004). Linked lives: Stability and change in maternal circumstances and trajectories of antisocial behaviour in children. *Child Development, 75,* 205–220.

Maibach, E., Abroms, L., & Marosits, M. (2007). Communication and marketing as tools to cultivate the public's health: A proposed "people and places" framework. *BMC Public Health*, 7, 88.

Marmot, M. (2010). Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post.

Mann, S., Brima, N., & Stephenson, J. (2010). Early alcohol use and sexual activity in young people: a secondary analysis of the Ripple and Share school survey data. *HIV Medicine*, 11, 48.

Markie-Dadds, C., & Sanders, M. R. (2006). Self-directed Triple P (Positive Parenting Program) for mothers with children at-risk of developing conduct problems. *Behavioural and Cognitive Psychotherapy, 34,* 259-275.

Mason, W. A., Kosterman, R., Hawkins, J. D., Haggerty, K. P., & Spoth, R. L. (2003). Reducing adolescents' growth in substance use and delinquency: Randomised trial effects of a parent training prevention intervention. *Prevention Science, 4,* 203-212.

Matthews, J. N. S. (2000). *An Introduction to Randomised Controlled Clinical Trials,* Arnold: London.

Maximo, S., Tayaban, H. S., Cacdac, G. B., Cacanindin, M. J. A., Pugat, R. J. S., Rivera, M. F., & Lingbawan, M. C. (2011). Parents' communication styles and their influence on the adolescents' attachment, intimacy and achievement motivation. *International Journal of Behavioural Science,* 6, 59-72.

McCurdy, K., & Daro, D. (2001). Parent involvement in family support programmes: An integrated theory. *Family Relations,* 50, 113-121.

McKay, M. M., & Bannon, W. M. J. (2004). Engaging families in child mental health services. *Child and Adolescent Psychiatric Clinics of North America,* 13, 905–921.

McKnight, A. J. (1990). Intervention with alcohol-impaired drivers by peers, parents, and purveyors of alcohol. *Health Education Research,* 5, 225-236.

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

Mercy, J. A., & Saul, J. (2009). Creating a healthier furture through early interventions for children. *Journal of the Amereican Medical Association,* 47, 6-22.

Merriam, S. (2009). Qualitative research: A guide to design and implementation. San Francisco, CA: Jossey-Bass.

Metzler, C.W., Noell, J., Biglan, A., Ary, D., & Smolkowski, K. (1994). The social context for risky sexual behaviour among adolescents. *Journal of Behavioural Medicine,* 17, 419–438.

Milani, L., Osualdella, D., & Di Blasio, P. (2009). Quality of interpersonal relationships and problematicInternet use in adolescence. *Cyber Psychology & Behaviour,* 12, 681-684.

Miller, R. J., & Darlington, Y. (2002). Who supports? The providers of social support to dual-parent families caring for young children. *Journal of Community Psychology, 30*, 461-473.

Miller, T. R., Levy, D. T., Spicer, R. S., & Taylor, D. M. (2006). Societal costs of underage drinking. *Journal of Studies on Alcohol, 67*, 519-528.

Moffitt, T.E. (1993). Adolescence-limited and life-course persistent antisocial behaviour: a developmental taxonomy. *Psychological Review, 100*, 674–701.

Moffitt, T. E., Caspi, A., Harrington, H., & Milne, B. J. (2002). Males on the life-course-persistent and adolescence-limited antisocial pathways: Follow-up at age 26 years. *Development and Psychopathology, 14*, 179-207.

Molgaard, V., & Spoth, R. (2001) The Strengthening families programme for young adolescents: overview and outcomes in Pfeiffer, S.I. & Reddy, L. (Eds.), *Innovative Mental Health Programmes for Children: Programmes that Work Binghamton*, NY: Haworth Press.

Molgaard, V. M., Spoth, R., & Redmond, C. (2000). Competency training: The Strengthening Families Program for Parents and Youth 10-14. *OJJDP Juvenile Justice Bulletin (NCJ 182208).* Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

Moore, G. F., Rothwell, H., & Segrott, J. (2010). An exploratory study of the relationship between parental attitudes and behaviour and young people's consumption of alcohol. *Substance Abuse Treatment Prevention and Policy, 5.* doi: 10.1186/1747-597x-5-6

Moos, R. H., & Moos, B. S. (1994). *A social climate scale: Family environment scale manual* (3rd ed.). California: Consulting Psychologists Press, Inc.

Morawska, A., Haslam, D., Milne, D., & Sanders, M.R. (2011). Evaluation of a brief parenting discussion group for parents of young children. *Journal of Developmental and Behaviour Pediatrics,* 32, 136-145. doi:10.1097/DBP.0b013e3181f17a28

Morgan, D. L. (1988). *Focus groups as qualitative research*. Newbury Park, CA: Sage.

Morris, A., Cui, L., & Steinberg, L. (2012). Parenting research and themes: what we 've learned, and where to go next. In R. Larzelere, A. Morris, & A. Harrist (Eds.), *Authoritative Parenting: Synthesising nurturance and discipline for optimal child development.* (pp. 35-58). Washington, DC: American Psychological Association.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counselling psychology. *Journal of Counselling Psychology*, 52, 250-260.

Morsbach, S. K., & Prinz, R. J. (2006). Understanding and improving the validity of self-report of parenting. *Clinical Child and Family Psychology Review,* 9, 1-21.

Morse, J. M. (1991). Approaches to qualitative-quantitative methodological triangulation. *Nursing Research,* 40, 120-123.

Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals* (2nd ed.). Thousand Oaks, CA: Sage.

Mytton, J., Ingram, J., Manns, S., & Thomas, J. (2013). Facilitators and barriers to engagement in parenting programmes: A qualitative systematic review. *Health Education and Behaviour*

Naghavi. F., & Redzuan, M. (2012). Relationship between family functioning, alexithymia, and emotional intelligence among early adolescents in Tehran-Iran. *Life Science Journal,* 9, 396–401.

National Research Council and Institute of Medicine. (2009). *Preventing mental, emotional, and behavioural disorders among young people: Progress and possibilities.* Washington, DC: National Academic Press.

Norton, R. (1983). Measuring marital quality: A critical look at the dependent variable. *Journal of Marriage and Family,* 45, 141-151.

Nowak, C., & Heinrichs, N. (2008). A comprehensive meta-analysis of Triple P - Positive Parenting Program using hierarchical linear modelling: Effectiveness and moderating variables. *Clinical Child and Family Psychology Review*, 11, 114-144.

Nucci. L., Hasebe. Y., & Lins-Dyer, M. (2005). Adolescent psychological well-being and parental control of the personal. *New Directions for Child & Adolescent Development*, 108, 17-30.

Odgers, C. L., Caspi, A., Nagin, D., et al. (2008). Is it important to prevent early exposure to drugs and alcohol among teens? *Psychological Science*, 19, 1037-1044.

Odgers, C. L., Caspi, A., Russell, M. A., Sampson, R. J., Arseneault, L., & Moffitt, T. E. (2012). Supportive parenting mediates neighbourhood socioeconomic disparities in children's antisocial behaviour from ages 5 to 12. *Developmental Psychopathology,* 24, 705-721.

OECD (2011). Health at a Glance 2011: OECD Indicators, OECD Publishing.

Ohannessian, C. M., Hesslebrock, V. M., Kramer, J., Kuperman, S., Bucholz, K. K., Schuckit, M. A., & Numberger, J. I. (2004). The relationships between parental alcoholism and adolescent psychopathology: a systematic examination of parental co-morbid psychopathology. *Journal of Abnormal Child Psychology,* 32, 519-533.

O'Neill, H., & Woodward, R. (2002). Evaluation of the Parenting Wisely CD-ROM parent training programme: An Irish replication. *Irish Journal of Psychology,* 23, 62-72.

Owens, J. S., Richerson, L., Murphy, C. E., Jagelewski, A., & Rossi, L. (2007). The parenting
   perspective: informing the cultural sensitivity of programmes in rural communities. *Child
   Youth Care Forum.* 36, 179-194. doi: 10.1007/s10566-007-9041-3.

Palinkas, L. A., Horwitz, S. M., Chamberlain, P., Hurlburt, M. S., & Landsverk, J. (2011).
   Mixed-methods designs in mental health services research: A review. *Psychiatric
   Services*, 62, 255-263.

Patterson, G. R. (1982). *A social learning approach: 3. Coercive family process.* Eugene,
   OR:Castalia.

Patterson, G. R., & Stouthamer-Loeber, M. (1984). The correlation of family management
   practices and delinquency. *Child Development,* 55, 1299-1307.

Patterson, J., Mockford, C., & Stewart-Brown, S. (2005). Parents' perceptions of the value of the
   Webster-Stratton Parenting Program: a qualitative study of general practice based
   initiative. *Child Care Health Development.* 31, 53-64.

Paulson, S. E. (1994). Relations of parenting style and parental involvement with ninth-grade
   students' achievement, *Journal of Early Adolescence,* 14, 250-68.

Peterson, G. W., Madden-Derdich, D., & Leonard, S. A. (2002). Parent-child relations across the
   life-course: Autonomy within the context of connectedness. In S. J. Price, P. C. McKenry,
   & M. J. Murphy (Eds.), *Families Across Time: A Life Course Perspective.* (pp. 187-203).
   Los Angeles, CA: Roxbury Publishing Co.

Petrie, J., Bunn, F., & Byrne, G. (2007). Parenting programmes for preventing tobacco, alcohol
   or drugs misuse in children < 18: a systematic review. *Health Education Research,* 22,
   177-191. doi: 10.1093/her/cyl061

Pfeiffer, S. I., Soldivera, S., & Norton, J. (1992). Consumer's guide to mental health outcome measures. Villanova, PA: The Devereux Foundation. (Reprinted in ERIC Reports, TM019317).

Pittman, K. J., & Irby, M. (1996). *Preventing problems or promoting development: copeting priorities or inseparable goals.* Baltimore, MD: International Youth Foundation.

Porter, C. L., & Hsu, H-C. (2003). First-time mothers' perceptions of efficacy during the transition to motherhood: Links to infant temperament. *Journal of Family Psychology, 17,* 54-64.

Powell, D. R. (2005). Searches for what works in parenting interventions. In T. Luster & L. Okagaki (Eds.), *Parenting: An Ecological Perspective* (pp. 343-373). Mahwah, N. J: Lawrence Erlbaum Associates.

Powell, D. R. (2013). Parenting intervention outcome studies: Research design considerations. *Parenting: Science and Practice, 13,* 266-284.

Prinz, R. J. (2009). Dissemination of a multi-level evidence-based system of parenting interventions with broad application to child welfare populations. *Child Welfare, 88,* 127-132.

Prinz, R. J., Smith, E. P., Dumas, J. E., Laughlin, J., White, D. W., & Barron, R. (2001). Recruitment and retention of participants in prevention trials involving family-based interventions. *American Journal of Preventive Medicine, 20,* 31-37.

Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-based prevention of child maltreatment: The U.S. Triple P System Population Trial. *Prevention Science*, 10, 1-13.

Ralph, A., & Sanders, M. R. (2001). *Every Parent's Guide to Teenagers.* Brisbane: Families International Pty Ltd.

Ralph, A., & Sanders, M. R. (2002). *Teen Triple P group workbook.* Brisbane: Triple P International.

Ralph, A., & Sanders, M. R. (2002). The Positive Parenting Program: An early intervention to improve personal relationships between teenagers and their parents. In N. N. Singh, T.H. Ollendick, & A.N. Singh (Eds.), *International perspectives on child and adolescent mental health. Vol 2: Proceedings of the second international conference* (pp. 101-131). Oxford, UK: Elsevier Science.

Ralph, A., & Sanders, M. R. (2003). Preliminary evaluation of the Group Teen Triple P programme for parents of teenagers making the transition to high school. *AeJAMH (Australian e-Journal for the Advancement of Mental Health), 2*, No Pagination Specified.

Ralph, A., Toumbourou, J. W., Grigg, M., Mulcahy, R., Carr-Gregg, M., & Sanders, M. R. (2003). Early intervention to help parents manage behavioural and emotional problems in early adolescent: what parents want. *Australian e-Journal for the Advancement of Medical Health (AeJAMH), 2.*

Rapee, R. R. M. (2009). Anxiety disorders during childhood and adolescence: Origins and treatment. *Annual Review of Clinical Psychology*, 5, 311-341.

Rhee, K. (2008). Childhood overweight and the relationship between parent behaviours, parenting style, and family functioning. *American Academy of Political Social Science,* 615, 12-37. doi:10.1177/0002716207308400

Richards, R., McGee, R., Williams, S., Welch, D., & Hancox, R. J. (2010). Adolescent screen time and attachment to parents and peers. *Archives of Pediatric and Adolescent Medicine*, 164, 258-262.

Riggio, H. R. (2004). Parental marital conflict and divorce, parent-child relationships, social support, and relationship anxiety in young adulthood. *Personal Relationships,* 11, 99-114.

194

Rodgers-Farmer, A. Y. (2000). Parental monitoring and peer group association: Their influence on adolescent substance use. *Journal of Social Service Research,* 27, 1-18.

Romer, E., & Umbreit, J. (1998). The effects of family-centered service coordination: A social validity study. *Journal of Early Intervention,* 21, 95-110.

Rose, G. (1992). *The strategy of preventive medicine.* Oxford: Oxford University Press.

Rosenberg, M. (1965). *Society and the adolescent self-image.* Princeton, NJ: Princeton University Press.

Ross, L. T., & Hill, E. M. (2001). Drinking and parental unpredictability among adult children of alcoholics: a pilot study. *Substance Use and Misuse,* 36, 609-638.

Roth, J., & Brooks-Gunn, J. (2003). Youth development programmes: risk, prevention and policy. *Journal of Adolescent Health,* 32, 170-182.

Rust, G., & Cooper, L. A. (2007). How can practice-based research contribute to the elimination of health disparities? *Journal of the American Board of Family Medicine,* 20, 105-114.

Ryan, S. M., Jorm, A. F., & Lubman, D. I. (2010). Parenting factors associated with reduced adolescent alcohol use: A systematic review of longitudinal studies. *Australian and New Zealand Journal of Psychiatry,* 44, 774–783.

Sameroff, A., Gutman, L. M., & Peck, S. C. (2003). Adaptation among youth facing multiple risks. In S. S. Luthar (Ed.), *Resilience and Vulnerability: Adaptation in the Context of Childhood Adversities,* (pp. 364-391). Cambridge: Cambridge University Press.

Sanders, M. R. (1999). Triple P-Positive Parenting Program: towards an empirically validated multilevel parenting and family support strategy for the prevention of behaviour and emotional problems in children. *Clinical Child and Family Psychology Review,* 2, 71-90. doi: 10.1023/A:1021843613840

Sanders, M. R. (2008). Triple P-Positive Parenting Program as a public health approach to strengthening parenting. *Journal of Family Psychology*, 22, 506-517.

Sanders, M. R. (2010). Adopting a public health approach to the delivery of evidence-based parenting interventions. *Canadian Psychology/Psychologie canadienne,* 51, 17-23. doi: 10.1037/a0018295

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

Sanders, M. R., & Kirby, J. N. (2011). Consumer engagement and the development, evaluation and dissemination of evidence-based parenting programmes. *Behaviour Therapy.* doi:10.1016/j.beth.2011.01.005.

Sanders, M. R., Kirby, J., Tellegen, C., & Day, J. (2013). Towards a Public Health Approach to Parenting Support: A Systematic Review and Meta-Analysis of the Triple P-Positive Parenting Programme. Manuscript submitted for publication.

Sanders, M. R., Markie-Dadds, C., Rinaldis, M., Firman, D., & Baig, N. (2007). Using household survey data to inform policy decisions regarding the delivery of evidence-based parenting interventions. *Child: Care, Health and Development.* doi: 10.1111/j.1365-2214.2006.00725.x

Sanders, M. R., Markie-Dadds, C., & Turner, K. M. T. (2003). Theortical, scientific and cinical foundations of the Triple P - Positive Parenting Program: a population approach to the promotion of parenting competence. *Parenting Research and Practice Monogrph No,* 1.

Sanders, M. R., & Mazzucchelli, T. (2013). The promotion of self-regulation through parenting interventions. *Clinical Child and Family Psychology Review,* 16, 1-17.

Sanders, M. R., & Prinz, R. J. (2008). Using the mass media as a population level strategy to strengthen parenting skills. *Journal of Clinical Child and Adolescent Psychology,* 37, 609-621. doi: 10.1080/15374410802148103

Sayal, K., Tischler, V., Coope, C., et al. (2010). Parental help-seeking in primary care for child and adoelscent mental health concers: qualitative study. *The British Journal of Psychiarty,* 197, 476-481. doi:10.1192/bjp.bp.110.081448

Schlomer, G. L, Bauman, S., & Card, N. A. (2010). Best practices for missing data management in counseling psychology. *Journal of Counselling Psychology,* 57, 1-10.

Schwartz, I. S., & Baer, D. M. (1991). Social Validity Assessments: Is Current Practice State of the Art? *Journal of Applied Behaviour Analysis. Special Issue: Social Validity: Multiple Perspectives,* 24, 189-204.

Schwartz, O.S., Sheeber, L.B., Dudgeon, P. & Allen, N.B. (2012). Emotion socialization within the family environment and adolescent depression. *Clinical Psychology Review*, 32, 447-453.

Schulz, K. F., Altman, D. G., & Moher, D. (2010). CONSORT 2010 Statement: updated guidelines for reporting parallel group randomised trials. *Annals of Internal Medicine,* 152, 726-732.

Scott, S., Briskman, J., & Dadds, M. R. (2011). Measuring Parenting in Community and Public Health Research Using Brief Child and Parent Reports. *Journal of Child and Family Studies,* 20, 343-352. doi: 10.1007/s10826-010-9398-z

Seale, C. (1999). Quality in qualitative research. *Qualitative Inquiry,* 5, 465-478.

Shek, D. T. L., & Yu, L. (2011). A review of validated youth prevention and positive youth development programmes in Asia. *International Journal of Adolescent Medicine and Health,* 23, 317-324.

Shanahan, L., McHale, S. M., Osgood, D. W., & Crouter, A. C. (2007). Conflict with mothers and fathers from middle childhood through adolescence: Within and between family comparisons. *Developmental Psychology,* 43, 539-550.

Shapiro, C., Prinz, R., & Sanders, M. R. (2010). Population-based provider engagement in delivery of evidence-based parenting interventions: Challenges and solutions. *Journal of Primary Prevention,* 31, 223-234.

Shepperd, S., Lewin, S., Straus, S., et al. (2009). Can we systematically review studies that evaluate complex interventions? *PLoS.Med.,* 6, e1000086.

Sherriff, N., Cox, L., Coleman, L., & Roker, D. (2008). Communication and supervision of alcohol in the family: Parental perspectives. *Children & Society,* 22, 370-382. doi.org/10.1111/j.1099-0860.2007.00116.x

Shumow, L., & Lomax, R. (2002). Parental self-efficacy: predictor of parenting behaviour and adolescent outcomes. *Parenting, Science, and Practice,* 2, 127-150.

Silk, J. S., Morris, A. S., Kanaya, T., & Steinberg, L. (2003). Psychological control and autonomy granting: Opposite ends of a continuum or distinct constructs? *Journal of Research on Adolescence,* 13, 113-128. doi:10.1111/1532-7795.1301004

Silverberg, S. B., & Gondoli, D. M. (1996). Autonomy in adolescence: A contextualised perspective. In G. R. Adams, R. Montemayor, & T. P. Gullotta (Eds.), *Psychosocial development during adolescence: Progress in developmental contextualism* (pp. 12-61). Thousand Oaks, CA: Sage.

Simons, L. G., & Conger, R. D. (2007). Linking mother-father differences in parenting to a typology of family parenting styles and adolescent developmental outcomes. *Jounral of Family Issues,* 28, 212-241. doi:10.1177/0192513X06294593

Small, S. A., Cooney, S. & O'Connor, C. (2009). Evidence-based programme improvement: Using principles of effectiveness to enhance the quality and impact of family-based prevention programmes. *Family Relation,* 58, 1-13.

Smetana, J. G. (1995). Parenting styles and conceptions of parental authority during adolescence. *Child Development,* 66, 299-316.

Smith, A. R., Chein, J., & Steinberg, L. (2013). Impact of socio-emotional context, brain development, and pubertal maturation on adolescent risk-taking. *Hormones and Behaviour,* 64, 323-332.

Soenens, B., Vansteenkiste, M., & Sierens, E. (2009). How are parental psychological control and autonomy-support related? A cluster-analytic approach. *Journal of Marriage and Family,* 187-202.

Solish, A., & Perry, A. (2008). The role of parent involvement in child outcome in IBI. *Research in Autism Spectrum Disorders,* 2, 728-738.

Spoth, R., Clair, S., Greenberg, M., Redmond, C., & Shin, C. (2007). Toward dissemination of evidence-based family interventions: Maintenance of community-based partnership recruitment results and associated factors. *Journal of Family Psychology,* 21, 137-146. doi: 10.1037/0893-3200.21.2.137

Spoth, R., Greenberg, M., & Turrisi, R. (2008). Preventive interventions addressing underage drinking: State of the evidence and steps toward public health impact. *Pediatrics,* 121, 311-336.

Spoth, R. L., Kavangh, K. A., & Dishion, T. J. (2002). Family centred preventive intervention science: toward benefits to larger populations of children, youth, and families. *Prevention Science,* 3, 145–52.

Spoth, R., & Redmond, C. (2000). Research on family engagement in preventive interventions: Toward improved use of scientific findings in primary prevention practice. *The Journal of Primary Prevention,* 21, 267-284.

Spoth, R., Redmond, C., & Lepper, H. (1999). Alcohol initiation outcomes of universal family-focused preventive interventions: one- and two-year follow-ups of a controlled study. *Journal of Studies on Alcohol,* 13, 103-111.

Spoth, R., Redmond, C., & Shin, C. (2001). Randomised trial of brief family interventions for general populations: adolescent substance use outcomes 4 years following baseline. *Journal of Consulting & Clinical Psychology,* 69, 627-642. doi: 10.1037/0022-006X.69.4.627

Spoth, R., Redmond, C., & Shin, C. (2000a). Modeling factors influencing enrollment in family-focused preventive intervention research. *Prevention Science,* 1, 213-225. doi: 10.1023/A:1026551229118

Spoth, R., Redmond, C., & Shin, C. (2000b). Reducing adolescents' aggressive and hostile behaviours - Randomised trial effects of a brief family intervention 4 years past baseline. *Archives of Pediatrics & Adolescent Medicine,* 154, 1248-1257.

Spoth, R., Redmond, C., Shin, C., & Azevedo, K. (2004). Brief family intervention effects on adolescent substance initiation: School-level curvilinear growth curve analyses six years following baseline. *Journal of Consulting and Clinical Psychology,* 72, 535-542.

Spoth, R., Trudeau, L., Guyll, M., Chungyeol, S., & Redmond, C. (2009). Universal intervention effects on substance abuse use among young adults mediated by delayed adolescent substance initiation. *Journal of Consulting and Clinical Psychology,* 77, 620-632.

Spoth, R. L., Trudeau, L. S., Guyll, M., & Shin, C. (2012). Benefits of universal intervention effects on a youth protective shield 10 years after baseline. *Journal of Adolescent Health,* 50, 414-417.

Stallman, H. M., & Ralph, A. (2007). Reducing risk factors for adolescent behavioural and emotional problems: A pilot randomised controlled trial of a self-administered parenting intervention. *AeJAMH (Australian e-Journal for the Advancement of Mental Health),* 6, 1-13.

Stanton, B., Cole, M., Galbraith, J., et al. (2004). Randomised trial of a parent intervention: Parents can make a difference in long-term adolescent risk behaviours, perceptions, and knowledge. *Archives of Pediatrics & Adolescent Medicine,* 158, 947–955.

Statistics New Zealand. (2013). *New Zealand in Profile 2013.*Retrieved from March 9, 2013 from, http://www.stats.govt.nz

Steinberg, L. (2001). We know some things: parent and adolescent relationships in retrospect and prospect. *Journal of Research on Adolescence,* 11, 1. doi: 10.1111/1532-7795.00001

Steinberg, L. (2005). Cognitive and affective development in adolescence. *Trends in Cognitive Science,* 9, 69-74.

Steinberg, L. (2008). A social neuroscience perspective on adolescent risk-taking. *Developmental Review,* 28, 78-106. doi:10.1016/j.dr.2007.08.002

Steinberg, L., Fletcher, A., & Darling, N. (1994). Parental monitoring and peer influences on adolescent substance use. *Pediatrics,* 93, 1060-1064.

Steinberg, L., & Morris, A. S. (2001). Adolescent development. *Annual Review of Psychology,* 52, 83-110.

Stormshak, E. A., Fosco, G. M., & Dishion, T. J., (2010). Implementing interventions with families in schools to icnrease youth school engagement: the Family Check-Up model. *School Mental Health,* 2, 82-92.

Strasburger, V. C. (2010). Children, adolescents, and the media: seven key issues. *Pediatric Annals,* 39, 556-564.

Sundell, K., Hansson, K., Andrée Löfholm, C., Olsson, T., Gustle, L. H., & Kadesjö, C. (2008). The transportability of MST to Sweden: Short-term results from a randomised trial of conduct disordered youth. *Journal of Family Psychology,* 22, 550–560.

Tellegen, C. L., & Sanders, M. R. (2013). A randomised controlled trial evaluating a brief parenting programme with children with Autism Spectrum Disorders. Manuscript under review.

Thomas, D.R. (2006). A general inductive approach for analysing qualitative evaluation data. *American Journal of Evaluation,* 27, 237-246.

Thomas, R., & Zimmer-Gembeck, M. J. (2007). Behavioural outcomes of Parent-Child Interaction Therapy and Triple P - Positive Parenting Program: A review and meta-analysis. *Journal of Abnormal Child Psychology,* 35, 475-495.

Tiano, J. D., & McNeil, C. B. (2005). The inclusion of fathers in behavioural parent training: A critical evaluation. *Child & Family Behaviour Therapy, 27*, 1–28. doi:10.1300/J019v27n04_01

Tobler, N., & Kumpfer, K. L. (2000). *Meta-analysis of effectiveness of family-focused substance abuse prevention programmes*. (Report submitted to the Center for Substance Abuse Prevention, Rockville, MD.)

Torgerson, D. J., & Torgerson, C., J. (2008). Designing randomised trials in health, education and the social sciences: an introduction. Palgrave Macmillan.

Toumbourou, J. W., Blyth, A., Bamberg, J., & Forer, D. (2001). Early impact of the BEST intervention for parents stressed by adolescent substance abuse. *Journal of Community & Applied Social Psychology,* 11, 291-304. doi: 10.1002/casp.632

Tsitsika, A., Critselis, E., Louizou, A., et al. (2011). Determinants of Internet addiction among adolescents: A case-control study. *The Scientific World Journal,* 11, 866-874.

Tully, L. (2007). *Early intervention strategies for children and young people 8 to 14 years – A literature review*. New South Wales: Department of Community Services.

Turner, K. M. T., Richards, M., & Sanders, M. R. (2007). A randomised clinical trial of a group parent education programme for Australian Indigenous families. *Journal of Paediatrics and Child Health, 43,* 243-251.

Twisk, J., & Proper, K. (2004). Evaluation of the results of a randomised controlled trial: how to define changes between baseline and follow-up. *Journal of Clinical Epidemiology, 57,* 223–228. doi:10.1016/j.jclinepi.2003.07.009.

United Nations Office on Drugs and Crime. (2009). Guide to implementing family skills training programmes for drug abuse prevention. Vienna, Austria.

Valcke, M., Bonte, S., De Wever, B., & Rots, I. (2010). Internet parenting styles and the impact on internet use of primary school children. *Computer and Education, 55,* 454-464. doi:10.1016/j.compedu.2010.02.009

Van Breukelen, G. J. P. (2006). ANCOVA versus change from baseline: More power in randomised studies, more bias in nonrandomised studies. *Journal of Clinical Epidemiology, 59,* 920-925.

Waylen, A., & Stewart-Brown, S. (2010). Factors influencing parenting in early childhood: A prospective longitudinal study focusing on change. *Child: Care, Health and Development, 36,* 198-207.

Weinbergre, D. A., Tublin, S. K., Ford, M. E., & Feldman, S. S. (1990). Preadolescemts' social-emotional adjustment and selective attrition in family research. *Child Development, 61,* 1374-1386.

Wertheimer, R., Moore, K. A., & Burkhauser, M. (2008). The Well-Being of Children in Working Poor and Other Families: 1997 and 2004. Child Trends Research Brief 2008-33. *Child Trends*, Washington DC.

West, F., Sanders, M. R., Cleghorn, G. J., & Davies, P. S. W. (2010). Randomised clinical trial of a family-based lifestyle intervention for childhood obesity involving parents as the exclusive agents of change. *Behaviour Research and Therapy,* 48, 1170-79. doi:10.1016/j.brat.2010.08.008

Whittingham, K., Sofronoff, K., Sheffield, J., & Sanders, M. R. (2009). Behavioural family intervention with parents of children with ASD: What do they find useful in the parenting programme Stepping Stones Triple P? *Research in Autism Spectrum Disorders,* 3, 702–713. doi:10.1016/j.rasd.2009.01.00

Wierson, M., & Forehand, R. (1994). Parent behaviour training for child noncompliance: Rationale, concepts, and effectiveness. *Current Direction in Psychological Science*, 3, 146-150.

Williams, L., Degnan, K., Perez-Edgar, K., et al. (2009). Impact of behavioural inhibition and parenting style on internalising and externalising problems from early childhood through adolescence. *Journal of Abnormal Child Psychology,* 37, 1063-1075.

Wolf, M. M. (1978). Social validity: The case for subjective measurement or how applied behaviour analysis is finding its heart. *Journal of Applied Behaviour Analysis,* 11, 203-214.

World Health Organization. (2009). *Preventing violence through the development of safe, stable and nurturing relationships between children and their parents and caregivers. Series of briefings on violence prevention: The evidence.* Geneva, Switzerland: World Health Organization.

Wu, L. L., & Thomson, E. (2001). Race differences in family experience and early sexual initiation. Dynamic models of family structure and family change. *Journal of Marriage and Family,* 63, 682-696. doi:10.1111/j.1741-3737.2001.00682x

Yoshikawa, H., Aber, J. L., & Beardslee, W. R. (2012). The Effects of Poverty on Children's Mental, Emotional and Behavioural Health: Implications for Prevention. *American Psychologist,* 67, 272-284.

Zagar, A. K., Zagar, R. J., Bartikowski, B., & Busch, K. G. (2009). Cost comparisons of raising a child from birth to 17 years among samples of abused, delinquent, violent, and homicidal youth using victimisation and justice system estimates. *Psychological Reports,* 104, 309-338. doi: 10.2466/PR0.104.1.309-338

Zubrick, S. R., Silburn, S. R., Garton, A. F., et al. (1995). *Western Australian Child Health Survey. Developing health and well-being into the nineties.* Perth, WA: Australian Bureau of Statistics.

Appendix

Appendix A - Consolidated Standards of Reporting Trials (CONSORT) Statement

CONSORT 2010 checklist of information to include when reporting a randomised trial*

Section/Topic	Item No	Checklist item	Reported on page No
Title and abstract			
	1a	Identification as a randomised trial in the title	
	1b	Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts)	
Introduction			
Background and objectives	2a	Scientific background and explanation of rationale	
	2b	Specific objectives or hypotheses	
Methods			
Trial design	3a	Description of trial design (such as parallel, factorial) including allocation ratio	
	3b	Important changes to methods after trial commencement (such as eligibility criteria), with reasons	
Participants	4a	Eligibility criteria for participants	
	4b	Settings and locations where the data were collected	
Interventions	5	The interventions for each group with sufficient details to allow replication, including how and when they were actually administered	
Outcomes	6a	Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed	
	6b	Any changes to trial outcomes after the trial commenced, with reasons	
Sample size	7a	How sample size was determined	
	7b	When applicable, explanation of any interim analyses and stopping guidelines	
Randomisation:			

Sequence generation	8a	Method used to generate the random allocation sequence
	8b	Type of randomisation; details of any restriction (such as blocking and block size)
Allocation concealment mechanism	9	Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned
Implementation	10	Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions
Blinding	11a	If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how
	11b	If relevant, description of the similarity of interventions
Statistical methods	12a	Statistical methods used to compare groups for primary and secondary outcomes
	12b	Methods for additional analyses, such as subgroup analyses and adjusted analyses

Results

Participant flow (a diagram is strongly recommended)	13a	For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome
	13b	For each group, losses and exclusions after randomisation, together with reasons
Recruitment	14a	Dates defining the periods of recruitment and follow-up
	14b	Why the trial ended or was stopped
Baseline data	15	A table showing baseline demographic and clinical characteristics for each group
Numbers analysed	16	For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups
Outcomes and estimation	17a	For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval)
	17b	For binary outcomes, presentation of both absolute and relative effect sizes is recommended
Ancillary analyses	18	Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory
Harms	19	All important harms or unintended effects in each group (for specific guidance see CONSORT for harms)

Discussion

Limitations	20	Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses
Generalisability	21	Generalisability (external validity, applicability) of the trial findings
Interpretation	22	Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence

Other information

Registration	23	Registration number and name of trial registry
Protocol	24	Where the full trial protocol can be accessed, if available
Funding	25	Sources of funding and other support (such as supply of drugs), role of funders

Note. Adapted from "CONSORT 2010 Statement: Updated guidelines for reporting parallel group randomised trials" by Schulz, K. F., Altman, D. G., & Moher, D. 2010, *Annals of Internal Medicine,* 152, 726-732.

Appendix B - Advertising and Screening Materials

Free Parenting Programme
From the Triple P Research Group at the University of Auckland

We are looking for parents who:
- Have a teenager between 12-15
- Interested in attending an 8 session programme

Triple P
- Support wellbeing of parents and their family.
- Teenagers who grow up with positive parenting are more likely to feel good about themselves and develop to their full potential.

Please contact:

Joanna Chu on 09 623 8899 ext 83042 or jt.chu@auckland.ac.nz

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE on 20/10/2010 for 3 years. Reference 2010 / 208.

Screening Material

Triple P Research Group
Screening Interview: Group Teen Triple P

Introduce self and thank the person for calling.
Triple P Research Group, this is Joanna speaking. Thank you for calling.

If I call the parent:
This is Joanna speaking from the Triple P Research Group at the University of Auckland. Can I please speak with…? I'm just returning your call/responding to the email that you sent. You were hoping to find out some more information about our Group Teen Triple P and seminar series for parents of teenagers is that right?

If they have had **difficulty** getting through or have been waiting for our return call, explain that we have received many calls from interested families and it has taken us time to get back to everyone.

We have received many calls from interested families and it has taken us time to get back to everyone, so my apologies for that.

Tell them that today's call involves telling them more about the programme and answering any specific questions they may have. It also involves asking them a few questions to ensure the programme is going to be suitable for their needs.

What we're doing with parents is giving them more detailed information about the study. If they are then still interested in participating in the project, we take you through some questions to ensure that what we're offering is going to be helpful for your family.

Explain that the call may take around 5-10 minutes. Check that the parent has time to do this now. If not, organise a more appropriate time.

This call may take around 10 minutes. Do you have time to do this now, or shall I call you back at a better time?

No: Ok, that is no problem at all. When is the best time to call you back?

Yes: Ok, great. Let's start by giving you some more information about the project.

If you don't know the parent's name at this point, first ask their name & record it in the screening spreadsheet.

PART 1: INFORMATION ABOUT THE STUDY
Provide information about the study and Triple P. Check parent understanding throughout.

The aim of our study is to determine how helpful a parenting programme is for parents of a child who is becoming or already is a young teenager, both in the short-term and in the long-run. I'll start by telling

you a bit more the programme, and then I'll talk about what's involved in the research project. Please stop me at any point it you have questions.

The Group Teen Triple P programme is specifically design for parents with teenagers and is an 8-week programme which includes five 2-hour group sessions and three 15-minute individual telephone sessions. During the first four weeks, parents will meet together for 2 hours to go through their own goals for change, and will be given information on common parenting traps, strategies to develop good relationships with their own child and learning new parenting skills, managing difficult behaviours and planning ahead for high risk situations. Between sessions, parents complete tasks to strengthen what they have learned in the group sessions. The three follow up telephone sessions will provide additional support to parents as they put into practice what they have learnt in the group sessions. Parents then come back together for a final group session. .

Parents who want to participate will be asked to complete some questionnaires, as well as having their child complete their own set. The questionnaires help us to assess whether the programme is helpful for families. These questionnaires are completed either online or in hard copy and ask about a range of parenting and child behaviour issues, as well as about parents' own adjustment and relationships.

Once the first set is completed by both the parents and their child, the parents will be randomly assigned to one of two groups: Group Teen Triple P, or a start-later group. Parents in the Group Teen Triple P will attend their allocated programme soon after they have completed the first set of questionnaires. The start-later group will be asked to wait 6- 8 months after the initial assessment before they attend the Group Teen Triple P programme. Unfortunately due to research requirements, parents are not able to choose which group they would like to attend. I'll talk a little bit more in a moment about the start-later group.

As I mentioned, your teenager will also be asked to complete questionnaires that ask questions about their own behaviour and how they get along with their family. Each time you are asked to complete questionnaires, your child will have his/her own set. Your teenager does not have to share their responses with you if they do not want to. So that your teenager's responses remain confidential, they will be either given different log on details to complete their assessment online or a separate envelope if you elect to complete a hard copy version of the questionnaires.

So that we can assess how helpful the programme is in the immediate and the long-term, parents in the Group Teen Triple P will be asked to complete questionnaires before they attend the programme, after completing the programme, and again 6 months later.

Parents in the start-later group will also complete the questionnaires at three points in time. They'll complete them at the start of the study (before they know which group they are in), again 8-10 weeks later, and then for the final time 6 months after the second set of questionnaires. Parents in the start-later group will then be offered a place in the Group programme. It is also important to know that parents in this start-later group are free to access any other support or services while they are in the study.

The parent questionnaires take approximately 30 minutes to complete at each time point, and the teenager questionnaire takes about 15 minutes.

Once you've completed the first set of questionnaires, we will call you to notify tell you which group you have been allocated to; that is, whether you have been allocated to Group Teen Triple P, or the start-later group.

Do you have any questions so far?

There are just a few more things I need to tell you. The seminar sessions and the group sessions may be video-recorded. These recordings are only made for the purpose of ensuring that the psychologists have delivered the group according to the research protocol. Your responses will not be evaluated in any way.

There is no charge for parents who participate in the programme, and families receive all programme materials for free. All information provided is strictly confidential and accessed only by research staff. If you wish, you can withdraw from the project at anytime.

Based on that information, are you interested in participating in the project? YES NO

Reason if 'no'_____

Now, I need to ask you some questions to determine if the programme will meet your needs and that your family is eligible to participate. Is that ok? If you aren't eligible for the project, but feel you would like some assistance with your child or with parenting, I can give you some details for services that might be able to help.

PART 2: DETERMINE ELIGIBILITY
Complete screening spreadsheet.

Where did you hear about the project?
(Get the parent to be specific e.g., if they say 'the local paper', ask them if they can remember which one)

How old is your child?

→ *EXCLUDE IF NOT BETWEEN 12-14 YEARS*
(If the parent has 2 children in the target age range, ask them to choose the child they are most concerned about)

Does your child have a developmental or intellectual disability? YES NO

→ *EXCLUDE IF CHILD HAS DISABILITY*

Is your child receiving any treatment including medication, from a counsellor, psychologist or psychiatrist for behaviour or emotional problems? YES NO

Are you currently receiving any assistance for your child's behaviour or emotional adjustment?
YES NO

Are you currently receiving any assistance for your own psychological or emotional problems?
YES NO

→ *EXCLUDE IF CHILD or PARENT RECEIVING TREATMENT*

Are you able to attend the group or our seminar series in either X, X, or at the University of Auckland, Epsom campus?

EXCLUDE IF NO

If so, which is your preferred site? We will try our best to accommodate your preference but I'm afraid we won't be able to guarantee that you'll get a spot in that location.

RECORD PREFERENCE

IF PARENT WAS EXCLUDED AT ANY POINT SAY:
I'm afraid that our project isn't suitable for your family's needs right now. However, we really appreciate your interest and your time today. Would you like some contact details of alternative sources of support for you and your child?

IF YES, say: *the best person to contact if you are experiencing problems with the behaviour of your child is your family doctor. So, I would recommend talking to him or her in the first instance. There are also a couple of other options that I can give you numbers for, if you're interested.*

Auckland Council Contact

Provide phone number of the Barnardo's Parentline (0800 4727 368), and tell parents that some of their telephone counsellors are trained in Triple P. You can also tell them about the TPNZ centre in Ellerslie (579 1794) which sees families on a group and individual basis at the clinic and also holds a database of Triple P practitioners around NZ. Other options are Tough Love, which is a support programme for parents of challenging teenagers (09 624 4363), and the UOA Psychology Clinic at Tamaki (373 7559 ext. 86535).

PART 3: SUMMARY & NEXT STEPS

IF PARENT IS ELIGIBLE FOR THE STUDY SAY:
Okay, based on those questions, it does seem like our programme will be useful for your family's needs – so we'd love to get you involved, if you're happy to proceed.

What I'd like to do now is get some names and contact information from you to complete the registration for the project, and then I'll explain the next steps.

COMPLETE FAMILY CONTACT SHEET.

PARTNER SECTION
Does the father/mother of [child's name] live at home with you?

YES: *It would be wonderful if you both can come along to the seminars or the group sessions. If your partner is not available, it would be great if he/she can complete the assessment questionnaires.* (Record partner's contact details)

If partner will not participate in programme: *Even if your partner does not want to participate, we still need him (her) to also give permission for your son/daughter to complete the questionnaires. I will send you a consent form that needs to be signed by your partner and returned to me before I can assign you to one of the groups.*

NO: *Is there another adult at home that is involved in parenting your child?*
> *No: That is not a problem at all, then you just complete the assessments and participate in the project.*
> *Yes: It would be wonderful if you could both attend the seminars or the group. If your partner is not available to attend the programme, it would be great if he/she could at least complete the questionnaires.*

NO: Does your child have any contact with his/her father? In order for your child to participate in the study, we do need to have permission from his/her father too. (Record details; if no contact info is available, complete incident log). *Would you like to contact with his/her father first before we approach him?*
If parent refuses to provide details, then explain that, ethically, we have to exclude the family from the study.

ADOLESCENT SECTION
Record the teenager's name, date-of-birth and email address.

Once Family Contact Sheet is completed, say: *Thank you for all of that information. The last thing we need to do today is explain what happens next.*

Firstly, can I check if you have internet access at home or somewhere that is easy to get to so that you can complete the online questionnaires?

IF YES: *I'll send you an email today that will have the information and the links for the first set of assessments.*
[If applicable] *There will be two separate links – one for yourself and one for your partner/husband/wife. When you click on your link, it will take you to an information page that really just goes through the information I've gone through today on the phone.*
 [If applicable] *Obviously, this will be good for [partner's name] to read so that they are up to speed.*
 Clicking on the 'Next' button at the bottom of this page will take you to the consent page, which has a series of bullet points that you need to read through. Then, if you're happy to participate, then simply click on the 'I agree to participate' button. When you click on that button, it will take you to the first set of questionnaires.

In the email I send you, there will also be a participant access number. You'll be prompted to enter this number at the start of the first questionnaire. You and your partner use the same number.

I'll send a separate email to [child's name] with the link to their questionnaires and information sheet. It would be great if you could check with them that they have received the email and give them a reminder to complete the questionnaires.

One thing I need to warn you about is that there is no capacity to do half the questionnaires, save your responses and come back later and do the rest. So, you need to do the questionnaires in one sitting. They do take around 30 minutes, so you'll need to try your best to find a time that you will be free of interruptions for about that length of time.

Does that all make sense?

IF NO INTERNET ACCESS: *That's not a problem – we do have the option of completing a paper and pencil version. So, what we'll do is post you an information sheet about the study, (two) consent form(s) (if two parents in the home) and the first set of questionnaires.*

Once we've received the consent forms and questionnaires from you, [your partner], and your teenager, we will give you another call. The purpose of this call will be to tell you whether you have been allocated to the Group Teen Triple P, or the start-later group and to talk to you about the details of the time and date of the programmes.

Okay, that's everything! Do you have any questions before we finish?

Answer any questions that the participant has, and be willing to go over any aspect of the study again. Finally, thank the parent for their time and for their interest in the study.

Like I said, I'll send you [the link to access] the questionnaires today. I'll get in contact with you once we get the questionnaires back to let you know which group you have been allocated to, and to confirm the date and time of the groups.

Thank you again for your time and enjoy the rest of your day.

Appendix C - Participant Information Sheets and Consent/Assent Forms

JOANNA CHU
Doctoral Student
MATTHEW R. SANDERS PhD
Professor in Clinical Psychology
SUSAN FARRUGGIA PhD
Senior Lecturer
CASSANDRA DITTMAN PhD
Research Fellow

THE UNIVERSITY OF AUCKLAND
FACULTY OF EDUCATION

Te Kura Akoranga o Tāmaki Makaurau
Incorporating the Auckland College of Education
School of Professional Learning &
Practice
Te Kura Whakawhanake Akoranga
Ph: +64 (09) 623 8899
Fax: +64 (09) 623 8827
www.education.auckland.ac.nz
The University of Auckland
Private Bag 92601, Symonds St

Parenting Programme for Parents of Early Adolescents
PARTICIPANT INFORMATION SHEET (PARENT)

Dear Parents,

My name is Joanna Chu and I am a PhD student at the University of Auckland, supervised by Dr Susan Farruggia and Professor Matt Sanders. I am conducting a research project looking at the effectiveness of Triple P Positive Parenting Program. The project aims to evaluate the effectiveness of the Group Teen Triple P programme specifically designed for parents of youth. This study will recruit participants from Intermediate and High Schools in the Auckland region over a period of 6 months. About 200 parents and their child will be involved in this study. If you are a parent of a child between the ages of 12-15 years old, I would appreciate your assistance through participation in this research.

What is Triple P?
The Triple P - Positive Parenting Program is a unique system of parenting and family support, designed to be tailored to suit individual families' needs. Developed through over 30 years of research, Triple P offers practical resources for parents, and training and resources for practitioners and organisations in a variety of service settings. Your participation will help us to make Triple P more accessible and helpful to all families. You will also find out more about Triple P and positive parenting strategies.

What is involved in the Group Teen Triple P?
The programme is an 8-week programme consisting of five 2 hour group sessions and three 15 minute individual telephone sessions. Each group session is facilitated by trained practitioners. During the first four weeks, parents meet together for 2 hours to go through their own goals for change, understanding common parenting traps, developing good relationships with their own youth and learning new parenting skills, managing difficult behaviours and planning ahead for high risk situations. Between sessions, parents complete homework tasks to consolidate their learning from the group sessions. The three follow up telephone sessions provide additional support to parents as they put into practice what they have learnt in the group sessions. A final group session completes the programme. The programme is free-of-charge and parents will be allowed to keep any programme resources.

The group sessions may be video-recorded and reviewed by the research team. These recordings are only made for the purpose of ensuring that the therapists have delivered the seminar according to the research protocol. Parents' responses will not be evaluated in any way.

The Group Teen Triple P will be facilitated by accredited Triple P Providers which may include members of the research team. Group sessions will be conducted either at the Triple P Research Group clinic at Epsom or in intermediate schools in Auckland.

What does participation in the research study involve?
Participants in the project will be randomly allocated to one of two groups: Group Teen Triple P or the waitlist group. Parents in the Group Teen Triple P will start immediately after they have completed the first assessment. The waitlist group will be asked to wait 6-8 months after the initial assessment before they begin the seminar series. Please note that participants are not able to choose which group they would like to be allocated to.

Participation in this project involves completion of a number of questionnaires. These questionnaires contain a range of questions including parenting and youths' behaviour issues, parents' own adjustment and relationships. Parents in Group Teen Triple P group will be asked to complete the measures upon enrolment and at the end of the Group Teen Triple P programme and at 6 months following the end of the programme. Parents in the waitlist group will be asked to complete the questionnaires at the start of the study and again 8 weeks later. Each questionnaire takes approximately 45 minutes to 1 hour to complete at each time point and you will be given the option of completing them online or in hard copy.

Your child will also be asked to complete questionnaires at each time point that you complete a questionnaire. The questionnaires include questions about how they get along with each of their parents, their beliefs and behaviours (including positive behaviours (school success, competencies and extracurricular activities) as well as problematic behaviours (smoking, alcohol and drug use, sexual activity and illegal behaviour)). Your child does not have to share his/her responses with you if he/she does not want to. The responses are confidential. Your child will be given different log in details to complete his/her assent process and questionnaires.

Possible benefits and risk
You will have the opportunity to complete an empirically-based parenting intervention programme. The interventions are designed to have a positive impact on parenting skills, competency, and efficacy, along with positive influence on general well being and relationship functioning. The interventions also aim to improve parent-child relationships, family communication, and reducing behaviour problems in youth.

We do not anticipate any risks to you or your child if you participate in this project. However, if you and/or your child do become emotionally upset or distressed as a result of your participation in this project, please contact our research team who will arrange assistance for you.

Other important information about your participation
Confidentiality with respect to your identity cannot be guaranteed due to the group nature of the Group Teen Triple P, that is, other members of the discussion group may be able to identify you. Names and identifying details will not be used in any summary report of this data, and all data will be described only in general terms at the group level. Each family will be assigned a code number and your name will be erased from any forms or electronic files. Only the researchers will have access to information that matches names with code numbers. All information collected for this study will be stored in locked filing cabinets on University premises, and all electronic and web-based data will be secured by a password

system. All video-recordings and data, including questionnaires, forms, and electronic files, will be destroyed or erased 6 years after the end of data collection. If any internal use is to be made of the videotapes, e.g., for staff training, then specific consent for this purpose will be sought. The attached consent form will be kept separate from all other forms of data, including questionnaires. If the researchers are informed either during questionnaires or discussion groups that child abuse and/or neglect is occurring, confidentiality will be broken, and Child, Youth, and Family will be notified. A summary of the findings from the project will be made available on the Triple P Research Group website at the University of Auckland.

Your participation in this study is voluntary. You have the right to withdraw yourself and your child, and any information traceable to you and your child from the project at any time prior to the completion of data collection (01/07/2012) without penalty or giving a reason. Similarly, your child's assistance with this project is voluntary and they have the right to withdraw their participation at any time prior to the completion of data collection (01/07/2012) without penalty or giving a reason. Please note that, if at any time during the study period, the researchers have concerns about the welfare of participants, action will be taken that is deemed appropriate by the research team.

Thank you very much for taking the time to consider the invitation. If you are willing to participate, please complete and sign the enclosed consent form and return it with your questionnaire. If you have any questions or concerns about your participation in this study, please contact Joanna Chu on 09 623 8899 ext. 83042 or via email at tprg@auckland.ac.nz.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE on 20/10/2010 for 3 years. Reference 2010 / 208.

Yours sincerely,

Joanna Chu
Doctoral Student

Dr Susan Farruggia
Supervisor

Joanna Chu
The University of Auckland
School of Professional Learning and Practice
Private Bag 92601
Auckland 1150
Ph: 09 623 8899 ext. 83042
jt.chu@auckland.ac.nz

Dr Susan Farruggia
The University of Auckland
School of Professional Learning and Practice
Private Bag 92601
Auckland 1150
Ph: 09 623 8899 ext. 48326
s.farruggia@auckland.ac.nz

The Head of the School of Professional Learning and Practice
Dr Frances Langdon
The University of Auckland
Private Bag 92601
Auckland 1150
Ph: 09 623 8899 ext. 48769

For queries regarding ethical concerns, contact:
The Chair, the University of Auckland
Human Participants Ethics Committee
The University of Auckland
Office of the Vice Chancellor

Private Bag 92019   Ph: 09 373 7599 ext. 83711
Auckland 1142

JOANNA CHU
Doctoral Student
MATTHEW R. SANDERS PhD
Professor in Clinical Psychology
SUSAN FARRUGGIA PhD
Senior Lecturer
CASSANDRA DITTMAN PhD
Research Fellow

CONSENT FORM (PARENT)
THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF SIX YEARS.

Study title: Parenting programme for parents of early adolescents.

I have been given and have understood an explanation of this research project. I have had an opportunity to ask questions and have them answered. I have been informed that participation in this project is voluntary. I understand that a summary of the results of this study will be uploaded to the Triple P Research Group website at The University of Auckland.

- I agree to take part in this research.

- I understand that participation in this research involves the completion of a 5 week group session (2 hours each) followed by 3 telephone consultations (15 minutes each) (Group Teen Triple P), completion of questionnaires at the start of the study, upon completion of the Group Teen Triple P and 6 months following the end of the programme. I understand that, if allocated to the waitlist group, I will complete the questionnaires at the start of the study and again 8 weeks later.

- I give consent for my child and agree to invite him/her to participate in the project by completing questionnaires at the start and again 8 weeks later or at the end of Group Teen Triple P programme and six months following the group.

- I understand that group sessions may be video-recorded.

- I understand that confidentiality with regard to participant identity cannot be guaranteed.

- I understand that names and identifying details will not be used in any summary report of this data, and all data will be described only in general terms at the group level.

- I understand that all video-recordings and data, including questionnaires, and forms will be stored in a locked filing cabinet on University premises to maintain confidentiality. The attached consent form will be kept separate from all other forms of data, including questionnaires.

223

- I understand that all stored electronic data will be password protected.

- I understand that data and video-recordings from this study will be stored for the duration of the research and will be destroyed or erased six years after completion of data collection.

- I understand that if any internal use is to be made of the video-recordings, e.g., for staff training, then specific consent for this purpose will be sought.

- I understand that the research team will take action they deem appropriate if the researchers have concern about the welfare of participants at any time during the study period.

- I understand that I am free to withdraw myself and my child, and any information traceable to me and my child from the study at any time prior to completion of data collection (01/07/2012) without penalty or giving a reason.

Signed: _____   Date: _____/_____/_____

Name: _____

Child's Name: _____

Email: _____   Ph: _____

Preferred method of contact: EMAIL / PHONE

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 20/10/2010 for (3) years, Reference Number 2010 /208

JOANNA CHU
Doctoral Student
MATTHEW R. SANDERS PhD
Professor in Clinical Psychology
SUSAN FARRUGGIA PhD
Senior Lecturer
CASSANDRA DITTMAN PhD
Research Fellow

Parenting Programme for Parents of Early Adolescents
PARTICIPANT INFORMATION SHEET (YOUTH)

My name is Joanna Chu and I am a PhD student at the University of Auckland, supervised by Dr Susan Farruggia and Professor Matt Sanders. Your parents have decided to participate in a research project. This project looks at whether a programme with group sessions followed with telephone discussions is useful for parents of early adolescents. As part of the project, you are also invited to participate.

Triple P stands for 'Positive Parenting Program'. It is a group of different parenting programmes that help parents to learn useful skills and strategies for parenting children and early adolescents. Your parents will be going along to an 8-week programme consisting of five 2-hour group sessions and three 15 minute individual telephone sessions.

To help us figure out if the parenting group is useful, we will ask your parents to complete some questionnaires. We also need your help in seeing if the programme works. We would like to invite you to complete some questionnaires that ask you some questions about how you get along with each of your parents, as well as some activities that you engage in. You will be asked to complete the questionnaire up to 3 times over 8 months. Your parents will be given a reminder when the questionnaire needs to be done.

Some of the questions in the questionnaires ask about some sensitive things such as sneaking out of the house at night, and may make you feel uncomfortable or upset. You do not have to answer any questions you don't want to. If you do become upset or worried, you are free to discuss your concerns with your parents or any other trusted person. You may also contact us and we will arrange support for you.

The answers that you give on the questionnaires are private. We will not put your name in any report that we write about the parenting group. Each family will be given a code number and your name will be taken off any questionnaires that you fill out. All information, including questionnaires, forms, and electronic files, will be destroyed or deleted 6 years after we report our findings.

You also do not have to show your questionnaires to your parents if you do not want to. If you wish to complete the questionnaires online, you will be given a different link and log in details than the one that has been given to your parents. Or you will be given a hard copy of the questionnaires and a separate return envelope than the one that has been given to your parents. Your questionnaires and assent form will be stored separately from each other in our online system and all electronic information you provide will be secured with a password. We will not use your name or any personal details about your family in any report of the study and a family code number will be used instead of your name on all the information that

225

we collect. If the researchers are informed either during questionnaires or discussion groups that child abuse and/or neglect is occurring, confidentiality will be broken, and Child, Youth, and Family will be notified. A summary of the findings from the project will be made available on the Triple P Research Group website at the University of Auckland.

Your help with our project is voluntary, which means that you do not have to complete the questionnaire if you not want to. You and your parents also have the right to stop being a part of the project and have any information related to you and your parents deleted at any time before we finish collecting information for the study (01/07/2012). Your parents may also withdraw you from participating at anytime.

Thank you very much for taking the time to consider the invitation. If you are willing to participate, please complete and sign the enclosed assent form and return it with your questionnaire. If you have any questions or concerns about your participation in this study, please contact Joanna Chu on 09 623 8899 ext. 83042 or via email at tprg@auckland.ac.nz.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE on 20/10/2010 for 3 years. Reference 2010 / 208.

Yours sincerely,

Joanna Chu
Doctoral Student

Dr Susan Farruggia
Supervisor

Joanna Chu
The University of Auckland
School of Professional Learning and Practice
Private Bag 92601
Auckland 1150
Ph: 09 623 8899 ext. 83042
jt.chu@auckland.ac.nz

Dr Susan Farruggia
The University of Auckland
School of Professional Learning and Practice
Private Bag 92601
Auckland 1150
Ph: 09 623 8899 ext. 48326
s.farruggia@auckland.ac.nz

JOANNA CHU
Doctoral Student
MATTHEW R. SANDERS PhD
Professor in Clinical Psychology
SUSAN FARRUGGIA PhD
Senior Lecturer
CASSANDRA DITTMAN PhD
Research Fellow

ASSENT FORM (Youth)
THIS ASSENT FORM WILL BE HELD FOR A PERIOD OF SIX YEARS.

Study title: Parenting programme for parents of early adolescents

I have been told about and I understand what my participation in this research project involves. I have had the chance to ask questions and have them answered. I have been informed that my help with this project is voluntary. I understand that a summary of the results of this study will be uploaded to the Triple P Research Group website at The University of Auckland.

- I agree to take part in this research.

- I understand that participation in this research involves a group discussion (30minutes to an hour) about the acceptability and relevance of parenting programmes for parents with adolescents transitioning from primary to secondary school.

- I understand that I will be video recorded for the duration of the discussion group and that this video will be viewed only by the researcher and her supervisors.

- I understand that all data, including video recordings, transcriptions and forms will be stored in a locked filing cabinet on University premises under the control of the researcher's supervisor and all electronic data will be password protected to maintain confidentiality.

- I understand that confidentiality with regard to participant identity cannot be guaranteed.

- I understand that data from this study will be stored for the duration of the research and will be destroyed or erased six years after publication.

- I agree not to disclose anything talked about in this discussion group.

o I WOULD LIKE TO RECEIVE A SUMMARY OF THE RESEARCH STUDY.

Contact postal or email address for the summary to be sent to:

_____

Signed: _____ Date: _____/_____/_____

Name: _____

Email: _____ Ph: _____

Preferred method of contact: EMAIL / PHONE

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS
COMMITTEE on 20/10/2010 for 3 years. Reference 2010 / 208

JOANNA CHU
Doctoral Student
MATTHEW R. SANDERS PhD
Professor in Clinical Psychology
SUSAN FARRUGGIA PhD
Senior Lecturer
CASSANDRA DITTMAN PhD
Research Fellow

Parenting Programme for Parents of Early Adolescents – Discussion Group
PARTICIPANT INFORMATION SHEET (PARENT)

Dear Parents,

My name is Joanna Chu and I am a PhD student at the University of Auckland, supervised by Dr Susan Farruggia and Professor Matt Sanders. I am conducting a research project looking at the effectiveness of Triple P Positive Parenting Program. This project looks at whether a programme with group sessions followed with telephone discussions is useful for parents of early adolescents. Discussion groups will be used to gather information on investigating ways of engaging parents for Group Teen Triple P programme and what they would like to gain from attending. This information will add to the existing literature on adolescent parenting programme and help with recruitment and retention.

Your participation will involve taking part in a discussion group about the relevance of the Group Teen Triple P programme. You will be asked to give your opinion on what to include in these programmes and how to make the programmes interesting and relevant for parents who have a child transitioning from primary to secondary school. Your teenager will also be invited to take part in a separate discussion group to give opinion on the changes that they might have seen since you attended the programme. You and your teenager may chose not to answer a question and have the option of leaving the discussion group, but any information you provide cannot be withdrawn. There will be 6-10 participants in each discussion group, which is expected to take half an hour to an hour.

To ensure that every person's opinion is included and no valuable information is missed, the discussion will be video recorded. This video will only be viewed by the researcher, Joanna Chu, and her supervisors. The video will later be transcribed by the researcher, so that results of the discussion can be analysed.

The video and transcript will be stored at the University of Auckland in a locked cabinet. Participant consent forms will be kept in a separate secure location to ensure that participants cannot be identified. This information will be kept for a period of six years following completion of the research. After this time period any and all information including video recordings and consent forms will be destroyed.

Confidentiality with respect to your identity cannot be guaranteed due to the group nature of the research, that is, other members of the discussion group may be able to identify you. The information gathered from the group discussion will be reported as group trends and preferences. No names will be published in the report and if direct quotes are used they will be anonymous.

The information gathered will be used for future publication in psychology or education journals and conference presentations. If you wish to receive a summary of the report from the discussions, please fill in your contact information on the consent form and a summary will be sent to you.

The location of the discussion group and a map will be sent to you once the location and group participants are finalised.

Thank you very much for taking the time to consider the invitation. If you are willing to participate, please complete and sign the enclosed assent form and return it with the enclosed envelope. If you have any questions or concerns about your participation in this study, please contact Joanna Chu on 09 623 8899 ext. 83042 or via email at tprg@auckland.ac.nz.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE on 20/10/2010 for 3 years. Reference 2010 / 208.

Yours sincerely,

Joanna Chu
Doctoral Student

Dr Susan Farruggia
Supervisor

Joanna Chu
The University of Auckland
School of Professional Learning and Practice
Private Bag 92601
Auckland 1150
Ph: 09 623 8899 ext. 83042
jt.chu@auckland.ac.nz

Dr Susan Farruggia
The University of Auckland
School of Professional Learning and Practice
Private Bag 92601
Auckland 1150
Ph: 09 623 8899 ext. 48326
s.farruggia@auckland.ac.nz

JOANNA CHU
Doctoral Student
MATTHEW R. SANDERS PhD
Professor in Clinical Psychology
SUSAN FARRUGGIA PhD
Senior Lecturer
CASSANDRA DITTMAN PhD
Research Fellow

CONSENT FORM (PARENT)
THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF SIX YEARS.

Study title: Parenting programme for parents of early adolescents.

I have been given and have understood an explanation of this research project. I have had an opportunity to ask questions and have them answered. I have been informed that participation in this project is voluntary. I understand that a summary of the results of this study will be uploaded to the Triple P Research Group website at The University of Auckland.

- I agree to take part in this research.

- I understand that participation in this research involves a group discussion (1 to 1 and 1/2 hours) about the acceptability and relevance of parenting programmes for parents with adolescents transitioning from primary to secondary school.

- I understand that I will be video recorded for the duration of the discussion group and that this video will be viewed only by the researcher and her supervisors.

- I understand that all data, including video recordings, transcriptions and forms will be stored in a locked filing cabinet on University premises under the control of the researcher's supervisor and all electronic data will be password protected to maintain confidentiality.

- I understand that confidentiality with regard to participant identity cannot be guaranteed.

- I understand that data from this study will be stored for the duration of the research and will be destroyed or erased six years after publication.

- I agree not to disclose anything talked about in this discussion group.

○ I WOULD LIKE TO RECEIVE A SUMMARY OF THE RESEARCH STUDY.

Contact postal or email address for the summary to be sent to:

_____

_____

Signed: _____   Date: _____/_____/_____

Name: _____

Child's Name: _____

Email: _____   Ph: _____

Preferred method of contact: EMAIL / PHONE

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS
COMMITTEE ON 20/10/2010 for (3) years, Reference Number 2010 /208

JOANNA CHU
Doctoral Student
MATTHEW R. SANDERS PhD
Professor in Clinical Psychology
SUSAN FARRUGGIA PhD
Senior Lecturer
CASSANDRA DITTMAN PhD
Research Fellow

Parenting Programme for Parents of Early Adolescents – Discussion Group

PARTICIPANT INFORMATION SHEET (YOUTH)

My name is Joanna Chu and I am a PhD student at the University of Auckland, supervised by Dr Susan Farruggia and Professor Matt Sanders. Your parents have decided to participate in a research project. This project looks at whether a programme with group sessions followed with telephone discussions is useful for parents of early adolescents. I am using discussion groups to gather information on investigating ways of engaging parents for Group Teen Triple P programme and what they would like to gain from attending. This information will add to the existing literature on adolescent parenting programme and help with recruitment and retention.

Your participation will involve taking part in a discussion group about the relevance of the Group Teen Triple P programme. You will be asked to give your opinion on what to include in these programmes and how to make the programmes interesting and relevant for parents who have a child transitioning from primary to secondary school. You may chose not to answer a question and have the option of leaving the discussion group, but any information you provide cannot be withdrawn. There will be 6-10 participants in the discussion group, which is expected to take half an hour to an hour.

To ensure that every person's opinion is included and no valuable information is missed, the discussion will be video recorded. This video will only be viewed by the researcher, Joanna Chu, and her supervisors. The video will later be transcribed by the researcher, so that results of the discussion can be analysed.

The video and transcript will be stored at the University of Auckland in a locked cabinet. Participant consent forms will be kept in a separate secure location to ensure that participants cannot be identified. This information will be kept for a period of six years following completion of the research. After this time period any and all information including video recordings and consent forms will be destroyed.

Confidentiality with respect to your identity cannot be guaranteed due to the group nature of the research, that is, other members of the discussion group may be able to identify you. The information gathered from the group discussion will be reported as group trends and preferences. No names will be published in the report and if direct quotes are used they will be anonymous.

The information gathered will be used for future publication in psychology or education journals and conference presentations. If you wish to receive a summary of the report from the discussions, please fill

in your contact information on the consent form and a summary will be sent to you. The location of the discussion group and a map will be sent to you once the location and group participants are finalised.

Thank you very much for taking the time to consider the invitation. If you are willing to participate, please complete and sign the enclosed assent form and return it with the enclosed envelope. If you have any questions or concerns about your participation in this study, please contact Joanna Chu on 09 623 8899 ext. 83042 or via email at tprg@auckland.ac.nz.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE on 20/10/2010 for 3 years. Reference 2010 / 208.

Yours sincerely,

Joanna Chu
Doctoral Student

Dr Susan Farruggia
Supervisor

Joanna Chu
The University of Auckland
School of Professional Learning and Practice
Private Bag 92601
Auckland 1150
Ph: 09 623 8899 ext. 83042
jt.chu@auckland.ac.nz

Dr Susan Farruggia
The University of Auckland
School of Professional Learning and Practice
Private Bag 92601
Auckland 1150
Ph: 09 623 8899 ext. 48326
s.farruggia@auckland.ac.nz

JOANNA CHU
Doctoral Student
MATTHEW R. SANDERS PhD
Professor in Clinical Psychology
SUSAN FARRUGGIA PhD
Senior Lecturer
CASSANDRA DITTMAN PhD
Research Fellow

ASSENT FORM (Youth)
THIS ASSENT FORM WILL BE HELD FOR A PERIOD OF SIX YEARS.

Study title: Parenting programme for parents of early adolescents

I have been told about and I understand what my participation in this research project involves. I have had the chance to ask questions and have them answered. I have been informed that my help with this project is voluntary. I understand that a summary of the results of this study will be uploaded to the Triple P Research Group website at The University of Auckland.

- I agree to take part in this research.

- I understand that participation in this research involves a group discussion (30minutes to an hour) about the acceptability and relevance of parenting programmes for parents with adolescents transitioning from primary to secondary school.

- I understand that I will be video recorded for the duration of the discussion group and that this video will be viewed only by the researcher and her supervisors.

- I understand that all data, including video recordings, transcriptions and forms will be stored in a locked filing cabinet on University premises under the control of the researcher's supervisor and all electronic data will be password protected to maintain confidentiality.

- I understand that confidentiality with regard to participant identity cannot be guaranteed.

- I understand that data from this study will be stored for the duration of the research and will be destroyed or erased six years after publication.

- I agree not to disclose anything talked about in this discussion group.

o I WOULD LIKE TO RECEIVE A SUMMARY OF THE RESEARCH STUDY.

Contact postal or email address for the summary to be sent to:

Signed: _____   Date: _____/_____/_____

Name: _____

Email: _____   Ph: _____

Preferred method of contact: EMAIL / PHONE

Appendix D - Discussion Group Topic Guide

Parents' Topic

- Programme Procedures
    - Helpful aspects
    - Less helpful aspects
    - Recommendations
- Programme Effects
    - Overall impression
    - Changes to parent, adolescent, and family
    - Maintenance of change
- Adolescent Involvement in Parenting Programme

Adolescents' Topic

- Programme Effects
    - Overall impression
    - Changes to parent, adolescent, and family
    - Maintenance of change
- Adolescent Involvement in Parenting Programme