AN EVALUATION OF THE PARENT CENTRE'S POSITIVE PARENTING SKILLS TRAINING PROGRAMME: A RANDOMISED CONTROLLED TRIAL.

SORAYA LESTER

(LSTSOR001)

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Faculty of Commerce

University of Cape Town

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COMPULSORY DECLARATION:

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this research proposal from the work, or works of other people has been attributed, cited and referenced.

Signed by candidate

Signature:…… Date: 7 May 2015

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EXECUTIVE SUMMARY

This dissertation is both an assessment of the fidelity, and outcomes, of a parenting programme. The programme is implemented by The Parent Centre, a non-profit organisation (NPO) which provides a range of support services for caregivers of children. The primary audience for this dissertation includes programme stakeholders such as the organisation's director, programme manager and programme facilitators.

The programme theory underpinning this intervention was created in collaboration with programme stakeholders and expert opinion. Briefly, this theory assumes that by participating in the parenting programme, caregivers are likely to benefit from learning positive parenting techniques which, when used, will catalyse improvements in the relationship they have with their children, and their children's behaviour. A literature review of similar programmes' effectiveness was conducted to assess its plausibility. This review found evidence which largely supported the programme's theory.

This programme theory helped guide the focus of the evaluation. A total of nine evaluation questions were formulated. Two of these aimed to determine whether the programme was implemented with fidelity. The remaining seven aimed to determine the extent to which the programme was effective in improving its intended parent and child outcomes. A range of measures were employed to answer these questions. Implementation fidelity was assessed through asking programme facilitators to complete sessional checklists, collect programme attendance and participant homework checklists for each session. A randomised controlled trial design was used to assess programme outcomes; pre and post-test interviews were conducted in people's homes which utilised a range of measures.

The programme was found to be implemented with high levels of fidelity. Despite high levels of engagement also being demonstrated by those who attended, attendance rates were overall quite low. Limited evidence for programme effectiveness was found using both an intention to treat analysis, and after conducting a second analysis which took into consideration a moderator of programme effectiveness i.e., programme attendance. Poor levels of programme attendance, as well as ceiling effects on some measures at pre-test, changes in the control group over time due to control group participants accessing other

parenting assistance, reactivity to the questionnaire, and finally having the post-test conducted immediately after the programme was completed, are all factors which likely contributed to one finding limited evidence for programme effectiveness. Despite these factors hindering one's ability to determine programme effectiveness, further analyses are tentatively recommended based on the results that were found. Once participants have been allowed further time to practice programme skills, it is possible that programme effects may be found. Therefore, a long-term follow-up will likely allow one to come to a stronger conclusion regarding programme effectiveness.

Finally, a few recommendations are made with regards to programme design, content, delivery and monitoring of outcomes. Continued emphasis on praise, and some coverage of consistent discipline may increase the programme's effectiveness. Keeping group sizes smaller and including only parents of children of the specified ages will help ensure it is relevant to programme participants. Introducing a basic pre and post programme completion questionnaire will allow The Parent Centre to track outcome achievement over time and facilitate an understanding of participant demographics. More recommendations will be able to be made once the one year follow-up is completed. This dissertation addresses the gaps in the literature regarding parenting programme effectiveness in South Africa, and low and middle income countries in general.

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INTRODUCTION

Crucial to children's wellbeing is the quality of their family life (Sanders, Markie-Dadds & Turner, 2003). Family relationships, but more particularly the relationships children have with their parents, tend to have broad impacts on their wellbeing economically, socially, psychologically and physically.

Poor parenting practices are related to a number of negative child outcomes. A meta-analysis determined that some the strongest predictors of problem and delinquent behaviour in children is parental rejection, reduced parental supervision, and the type of involvement parents have with their children (Loeber & Stouthamer-Loeber, 1986). Harsh and inconsistent discipline has also been found to be correlated with aggressive child behaviour (Fite, Colder, & Pelham, 2006; Weiss, Dodge, Bates, & Pettit, 1992). Furthermore, child maltreatment, as the most severe type of poor parenting behaviour, is associated with detrimental long term outcomes affecting adolescent's educational achievement (Lansford et al., 2002); mental health (Lansford et al., 2002); as well as poor health outcomes (Johnson, Cohen, Kasen & Brooks, 2002).

In contrast, more positive parenting behaviours are related to more optimal child outcomes. Aggressive behaviour is generally quite stable across human development. If parents are able to exercise parenting practices which are more positive, then it is possible the progression of child externalising problem behaviour could be prevented or interrupted (Boeldt et al., 2012; Knerr, Gardner & Cluver, 2013). Furthermore, positive parenting styles like authoritative parenting – which is warm, democratic and firm – have also been linked to better performance and engagement in school (Steinberg, Lamborn, Dornsbusch & Darling, 1992). Therefore, positive parenting is facilitative of positive child outcomes which extend far beyond just preventing child problem behaviour.

Yet, despite the key role parenting plays in influencing children's developmental outcomes, parents largely obtain little preparation for this role beyond what they experienced when they themselves were parented (Risley, Clark & Cataldo, 1976). The intergenerational transmission of parenting behaviours, both positive and negative, has been observed across numerous economic and social contexts (Conger, Belsky, Capaldi,

2009). This can be extremely problematic if parents experienced poor parenting when growing up, as they are more likely to expose their children to the same behaviours.

A number of studies suggest that some South African parents rely on poor parenting strategies, and that the use of these strategies is widespread. There is evidence which suggests that parents who have children showing problematic behaviours tend to abandon their disciplinary responsibilities, are confused about what these are (Mandisa, 2007), and are only minimally involved in their children's lives (Leoschut & Bonora, 2007; Mandisa, 2007). Additionally, a national survey found that 57% of parents use corporal punishment, and of these parents 33% beat their children with an object (Dawes, De Sas Kropiwnicki, Kafaar, & Richter, 2005). These findings suggest that interventions directed at improving parenting behaviours may have utility for preventing poor child outcomes in South Africa.

Responding to the need for local parenting interventions is The Parent Centre - a registered NPO which has its office situated in a southern suburb of the Western Cape. It offers a broad range of parenting interventions to support different types of caregivers in various ways. The organisation "strives to contribute to a society in which every parent/caregiver is able to raise resilient and well-balanced children so that they are able to develop their full potential and be protected from victimisation and abuse in communities free from violence" (www.theparentcentre.org.za). This dissertation reports on an evaluation of one of the programmes the Centre offers as a means to achieve this goal, namely the Positive Parenting Skills Training Programme (PPST).

Programme Description

The information for this programme description was obtained from The Parent Centre's website (www.theparentcentre.org.za); numerous discussions with various programme staff in February and March of this year (C. De Vos, S. Paulous, F. Ryklief, J. Watlington, personal communication, 2014), and programme documents (e.g., Annual Reports, programme manual).

The Organisation

The Parent Centre has been operating for over 30 years and is thus a well-established organisation (The Parent Centre, 2014). Over this time the Centre has demonstrated a stable workforce, as well as good relationships with funders. The numerous funders of the organisation include: the Hosken Consolidated Investments Foundation, Western Cape Government Department of Social Development, World Childhood Foundation, the Stichting Trifid Trust, Glencore International, Community Chest of the Western Cape, Din Din Trust, Rolfe-Stephan Nussbaum Foundation, Glencore International, the National Lottery Distribution Trust Fund, and other anonymous donors (The Parent Centre, 2014). This funding allows the organisation to offer a range of programmes to people living in many different areas in the Western Cape e.g., Gugulethu, Mitchells Plain, Hout Bay et cetera. The programmes offered fall under four main categories: (1) Capacity Building and Support, (2) Parent Infant Home Visiting, (3) Teen Parenting and (4) Counselling (www.theparentcentre.org.za).

The PPST is classified under the Capacity Building and Support Programme (www.theparentcentre.org.za). This group-based parenting programme consists of seven weekly 3-hour sessions. The programme has been running since 1990 and has been implemented in various areas of the Western Cape over this time. The high level goals of the PPST include preventing child abuse, neglect, social problems like violence and delinquency, as well as encouraging the development of balanced and resilient children who are emotionally and physically healthy, so that they can reach their developmental potential.

Programme Targets and Beneficiaries

The target population of the PPST is caregivers of children between the ages of 6 and 12 years. This can include parents (biological, adoptive and foster), grandparents, aunts and uncles, et cetera. Caregivers of children falling outside this age range are also able to attend. The programme beneficiaries can be understood to be both the participating caregivers and their children. The Parent Centre has a policy of voluntary participation in the PPST. Nevertheless, it is possible for the Centre to sometimes to receive court-referred caregivers who have been mandated to attend the PPST.

When the programme is delivered the target population becomes narrowed to caregivers of a certain area or school e.g., caregivers of Hout Bay. Though no particular areas in the Western Cape are targeted, The Parent Centre does receive requests from funders or other organisations, for example, to implement the programme in particular areas. In such instances it has been recognised by these bodies that there is a 'need' for the programme in these areas. Thus, the programme is delivered on a universal basis by The Parent Centre. Universal interventions are offered to general populations, with the intention of preventing a problem from developing (Mrazek & Haggerty, 1994). In contrast, selective and indicated interventions attempt to reach individuals who are 'at risk' for developing problematic outcomes, or who are 'high-risk' and already have detectable signs for problems (in this context problematic parenting) respectively.

Programme Implementation

Programme facilitators.

The programme sessions are implemented by facilitators who are largely paraprofessionals (e.g., social workers, ex-teachers, lay counsellors, community workers, auxiliary social workers, from faith-based organisations, et cetera). The newest PPST facilitators have been working for a few months, while most have been implementing it for a number of years. This suggests that the programme facilitators are for the most part very familiar with the course and experienced in its implementation.

In order to qualify for this position, all facilitators had to show an interest in working with parents, be parents themselves, and demonstrate good levels of literacy. By ensuring facilitators are parents it is thought that they may more easily respond empathetically towards other parents (Ryklief, n.d.). Additionally, all facilitators had to pass through The Parent Centre's Parenting and Leadership Skills Training Course. This course is made up of 11 sessions (seven of which are the PPST sessions), and covers topics including: basic parenting skills, positive parenting skills, personal development, and group facilitation skills (www.theparentcentre.org.za). They are then gradually phased into facilitating sessions, until they are able to handle facilitating a full programme alone.

Facilitators receive supervision both during and after their training has been completed. Supervision is most intensive if the facilitator is new or if they are required to

co-facilitate for the first time. For more experienced facilitators, supervision functions as a way of providing feedback on programme delivery. Supervision is also used for conflict resolution between facilitators, provision of information, support and for facilitators to express other needs for further training. All supervision takes place outside of programme sessions.

Delivery.

The programme has been delivered in various types of settings; these include community centres, churches, mosques, and libraries. Programme delivery within these contexts is largely standardised. However, different facilitators may choose different methods to facilitate learning and engagement with the content e.g., facilitators may choose different ice-breakers or role-play exercises. The programme staff report that in their view there are many different ways of teaching the same lesson, and that having several options available is necessary to cater for different group's needs. Thus, there is an element of flexibility in the delivery approach.

Programme group size determines whether there is more than one facilitator implementing a session. Co-facilitation (implementation using two facilitators) takes place once group size reaches 20 or more people. Co-facilitation is implemented in varying ways depending on the facilitator's preferences. For example, some may divide the content equally in half; others may alternate sessions between facilitators.

Sessional content and activities.

In 1987 The Parent Centre created the first Positive Parenting Manual. This was an adaptation of the Systematic Training for Effective Parenting (STEP) programme manual, which was previously used by the Centre (The Parent Centre, 2014). The adaptations ensured the manuals included other content which was thought to be relevant e.g., Maslow's' (1943) hierarchy of needs, Erikson's (1963) stages of development, Thomas and Chess' (1977) work on child temperament, literature on poverty and parenting (which considers authors including Bettelheim (1987) and Biddulph (1997) among others) as well as violence prevention (Wessels, 2012). Additionally, these adaptions served to simplify the content for the South African context e.g., replacing the concept of democratic parenting

with assertive parenting (Wessels, 2012). The number of programme sessions has also varied between four, six, seven and nine sessions over time. Yet, the current seven session programme has been implemented for many years now.

There are two formal programme manual versions available at the moment; a longer and shorter version. The shorter version has taken preference in practice for over the past six years, and is currently used by both parents and the facilitators. The Centre has been able to translate manuals into Afrikaans as well as develop some hand-outs in isiXhosa. Currently, there is the intention to improve the PPST's manual, for example to make other activity options for formal and explicit. Additionally, there is the intention to provide facilitators with their own manuals which are different from the parents'.

The PPST is delivered in an interactive way; along with information, it includes a number of experiential activities to facilitate caregiver understanding, learning and skill building e.g., puzzles, small group discussion, role-plays. Some changes in these activities have been made over time. For example, instead of having each individual complete worksheets themselves, worksheets questions are now divided up and allocated to parents in small groups to be discussed. Table 1 (below) provides a description of the sessional content and activities covered, as found in the shortened programme manuals. It is clear from the programme manuals that each PPST session covers a specific area of content. Furthermore, the skills within each session build on the previous skills learnt which means that sessions are necessarily implemented in a particular sequence. The programme begins with an orientation session which provides an overview of the programme. It continues from session one through to session six (Orientation Session, n.d.). Session one aims to facilitate a more nuanced understanding of the factors which influence children's behaviour, also clarifying the underlying meaning of common problem behaviour and providing examples of appropriate positive disciplinary responses e.g., ignoring behaviour. Session two brings to light the connection between feelings and behaviour for both parent and child respectively, and focuses on improving parental communication with children through encouraging reliance on empathetic listening and responses. Session three introduces more positive disciplinary skills like positive reinforcement through praise, and focuses on ways to improve child self-esteem.

Table 1.

Positive Parenting Skills Training Programme Sessional Content and Activities

Programme session	Session content/topics	Session activities
Orientation session.	Enrolment, attendance, registration, group introductions, considering participants' expectations, overview of each session, handling administrative issues e.g., attendance; creating group rules, gaining consent on group contract.	Participant introductions (name-tag creation) and ice-breakers, eliciting participants' expectations, brainstorming of participant roles, responsibilities, and group rules, discussion of penalties for breaking rules, assigning of volunteer roles.
Session one Learning to understand children's behaviour.	Consideration of factors that affect children's behaviour: (1) stages of development, (2) basic human needs, (3) temperament, (4) child's position in the family, (5) gender, (6) child's life experiences, (7) context, (8) parent's expectations, (9) competition, (10) where parents stand with regards to their own needs. Encouraging quality time with children. Understanding unconscious goals of misbehaviour and parent's feelings e.g., attention seeking behaviour	Ice-breaker. Brainstorm factors affecting child behaviour. Small group discussion on stages of development. Small group activity on basic human needs. Role-plays to identify unconscious goals of misbehaviour. Homework: (1) read hand-outs on session one, (2) record observation of child's misbehaviour and parents understanding of factors which influenced it, (3) spend quality time with child.
Session two Listening to children's feelings.	Understanding children's and parents own feelings. Linking children's and parent's feelings to behaviour, how to understand and manage children's behaviour in relation to their feelings. Feeling and thinking disequilibrium/equilibrium. The right listening environment. The listening skill (empathetic response): (1) give full attention, (2) acknowledge problem with concern, (3) name the feeling (open responses), (4) give the child their wishes in fantasy, (5) accepting feelings but not certain behaviour. Contrasting of open and closed responses.	Ice-breaker. Large group exercise on linking feelings and behaviour. Brainstorm features of the right listening environment. Small group activity on practicing open responses. Role-plays to demonstrate how parents typically listen. Homework: (1) read notes, practice listening, (2) through listening identify child's feeling and reflect on it, (3) record child's response and parent's feeling in relation to response.
Session three Building children's self – esteem.	Self-esteem: (1) definition, (2) the importance of child self-esteem in relation to the role of the parent. Factors that build self-esteem. Re-labelling negative labels given to children make them positive. Focusing on positive behaviour, effort and improvement. How children become discouraged (e.g., use of put-downs). Definition of encouragement (examples of positive and improvement/effort-focused phrases). Lavish and descriptive praises. Components of descriptive praise.	Ice-breaker. Brainstorm on what self-esteem is, and ways parents can build it. Small group activity on negative labels for children, and re-labelling these to make positive labels. Brainstorming on features of encouragement. Role-plays and discussion on encouragement. Small group activity which focuses on the positive with child's work. Small group activity on descriptive praise. Complete mid-evaluation form. Homework: (1) read session's notes, (2) application of descriptive

		phrase, (3) focus on the positive of child and tell them, (3) and re-labelling of negative label given to child.
Session four Assertiveness and engaging co-operation.	Explanation of (1) Assertiveness, (2) Aggressiveness, (3) Non-Assertiveness/Passiveness. Parent-owned problems explanation. 'You-messages' (put-downs) - explanation and examples. Confronting assertively by using an 'I-message': (1) description, (2) function, (3) format of 'I-message' and 'I-feel' sentence. When 'I-messages' do not work - responding when angry. E.C.A. Assertiveness Model: (1) explanation, (2) format (a) express empathy, (b) deliver content, (c) express action. Problems that arise using this model.	Ice-breaker. Small group exercise on constructing 'I-messages' Small group practicing of the E.C.A. model. Homework: (1) read session notes, (2) practice confronting using 'I-feel sentences', (3) apply the E.C.A. model to a problem.
Session five Effective discipline.	Discipline: the uses and goals of discipline, effective discipline as respectful, i.e., not inclusive of hitting. The importance of a good parent-child relationship, and parental attitudes towards discipline problems: (1) maintaining self-control, (2) dealing with thoughts which are unhelpful/helpful when handling a discipline problem, (3) standing back and thinking instead of reacting immediately. Model for dealing with discipline problems (1) being clear and specific about house rules and expectations (2) describe problem (3) constructing 'I-messages' or 'I-feel sentences' and expressing feelings strongly but respectfully (4) tell the child specifically how you expect them to behave (5) give child a choice (6) allow natural consequences or take action (7) acknowledge child's feelings. Other factors relating to discipline: (1) showing children how to restore or make amends (2) instant obedience as unreasonable, (3) dealing with defiance (4) the importance of stopping and thinking.	Ice-breaker. Discussion on what discipline is. Discussion on model for dealing with discipline problems. Homework: (1) read session hand-out, (2) select discipline problem and apply discipline model.
Session six Problem-solving, values and family meetings.	The Problem-solving Model: (1) define the problem, (2) acknowledge child's feelings with problem (3) involve child in brainstorming solution, (4) evaluate ideas, (5) choose and implement mutually acceptable solution (6) agree to re-evaluate after short period. Values and discipline, their relationship, importance and how parents should handle issues relating to them. The family meeting: (1) uses, (2) how they should be conducted, (3) rules for the meeting.	Ice-breaker. Large group exercise: application of the discipline model to a discipline problem. Complete final evaluation forms. Certificate hand-out. Homework: (1) read hand-outs, (2) apply discipline model to a discipline problem with own child.

Session four also focuses on parent-child communication; encouraging parents to communicate in a firm and calm manner when wanting child co-operation. Session five encourages parents discipline instead of punish children; in a respectful and calm manner. Session six focuses on encouraging collaborative and respectful problem solving. Each session after the first begins with a review of the previous session, as well as on the tasks set for homework from this session. According to programme staff programme completion means that participants have missed no more than two sessions.

Service Utilisation Plan

A service utilisation plan explicitly reveals the assumptions about how and why the intended programme recipients will become engaged with the programme as intended, and continue participating in it for as long as is necessary to begin the change process found in the impact theory (Rossi et al., 2004). The PPST's service utilisation plan can be seen in Figure 1 (below).

Caregivers are able to participate in the PPST in two main ways. Staff at The Parent Centre may have been approached by another body such as a school, organisation or received direction from funders to implement the PPST. If their services have been requested, it is the responsibility of the requesting body to organise a venue, carry out recruitment and provide refreshments for the sessions. This is except for in the case where a funder has made a request, where such responsibilities are those at The Parent Centre's. In the second case, programme participation depends on whether it is staff at The Parent Centre's intention to deliver the course in a caregiver's area. The included service utilisation plan describes the latter way in which individuals can participate in the programme.

This plan makes the following assumptions. Parenting children is understood to be a challenge for most caregivers. It is thought that many caregivers struggle with parenting, a poor parent-child relationship and/or child behavioural problems. Caregivers are often aware that they lack parenting skills which would enable them to handle situations more effectively. Thus, they are aware they require support and information. Additionally, they have a desire to be better parents.

These caregivers learn about the PPST through the various advertisements e.g., radio adverts, newspaper adverts, flyers, community forums et cetera. Once they have signed up and attended the orientation session caregivers pass through sessions one to six. Caregivers remain engaged with programme because of its relevance to solving their problems, in other words, because they think it is helping them. A mid-term evaluation is completed after session three, and a final evaluation of the programme after session six – where they also receive certificates based on programme completion at this point. Once participants have finished the PPST they may receive referral to the additional services The Parent Centre provides (e.g., support groups, counselling). However, in the situation where programme facilitators become aware that a different programme may be more useful for a caregiver, they may divert them to this service immediately instead, thus ending their participation in the PPST. The Parent Centre staff report that after programme completion, parents feel better about their parenting and also parent better.

There is a single exception to this plan which was not made explicit in Figure 1 (below) simply because it rarely takes place. This is where a parent receives a mandated, court-referral to attend the PPST. In such a situation the caregiver is expected to follow the same path as a voluntarily attending caregiver would after being referred.

Programme Theory

Every social programme is supported by a programme theory; a set of assumptions about the way the programme is "supposed to work" (Rossi et al., 2004 p. 55). It is essential that a programme's conceptualisation and design is underpinned by valid assumptions about the nature of the targeted problem, and represent a feasible solution to the problem. A faulty programme theory which falls short in these aspects will result in an intervention failing to achieve its intended outcomes (Chen, 1990).

In light of the fundamental role of programme theory it is essential that consideration be given to the plausibility of the PPST's programme theory. Meetings with programme staff, forward and backward mapping sessions, and expert opinion on behalf of

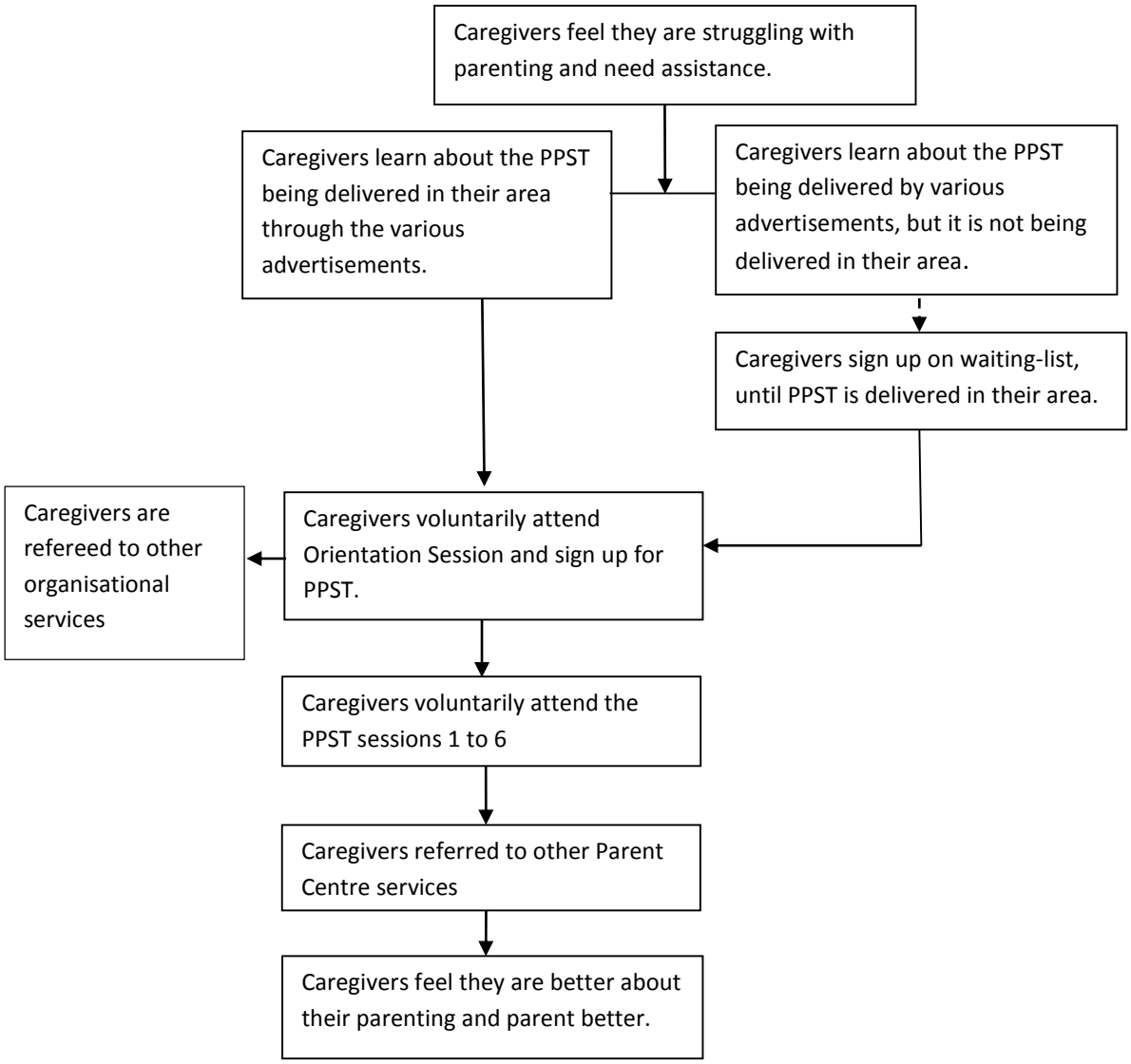

Figure 1. PPST's service utilisation plan.

my supervisor allowed for the explication of the PPST's programme theory. This theory can be found in diagrammatic form in Figure 2. According to this theory, by participating in the PPST parents may in the short term benefit from improved self-efficacy. Parental self-efficacy beliefs are the personal appraisals a parent makes about their competency in parenting (Coleman & Karraker, 2003). Parental self-efficacy may also be understood as the perceptions a parent holds about their ability to positively influence their child's development and behaviour. This rather immediate outcome will be as a result of support

from other parents and facilitators in the programme, gaining knowledge about positive parenting and factors that can influence child behaviour, as well as gaining positive parenting skills.

Intermediate changes may include improvements in parenting behaviour because parents will apply the skills they have learnt. It is further theorised that only once a parent has changed can a child be expected to change. Therefore, once parenting behaviour has improved their child's behaviour may improve. Additionally, a child's self-esteem may also be enhanced as a result of better parenting. The relationship between parent and child may also be improved due to enhanced parenting. It is also theorised that only in the context of a good parent-child relationship can parents apply effective discipline successfully. Therefore, once a healthy parent-child relationship is in place, parents may also begin to successfully apply more effective disciplinary strategies. Again, this change may feed back into additional enhancements in the parent-child relationship, children's self-esteem, child behaviour and parental self-efficacy.

All together the above mentioned changes may in the long-term reduce the likelihood that parents will abuse and neglect their children. Additionally, their children may be less likely to engage violent and delinquent behaviour. Instead, these children may be more likely to reach their developmental potential; be balanced, resilient and healthy individuals.

Assessment of the plausibility of the PPST's programme theory.

To determine the plausibility of the PPST's programme theory a review of the literature was necessary. This review will first determine whether parenting programmes are plausible solutions to social problems like child maltreatment, delinquency and aggression. Following from this, it considers the achievements of other similar universally implemented group-based parenting programmes. The outcomes considered in this second review are the same as those proposed by the PPST's programme theory. This information will be used to provide an estimation of the likelihood that the PPST will be able to achieve its specified outcomes. Exploration of the generalizability of these internationally implemented programmes' results to a context like South Africa will also be included.

The databases searched for this literature review included: Google Scholar, EbscoHost, Science Direct and Wiley Online. The first search completed on the risk and protective factors for the social problems of concern used search terms which included: “protective factors”; “risk factors”; “complex” and “causes”. These were searched in conjunction with the following terms: “child abuse”; “child neglect”; “child maltreatment”; “violence”, “deviancy” and “parenting”.

A second, larger search was conducted to determine the more specific effects of similar parenting programmes. The programmes considered in this review necessarily had to be group-based parenting programmes, and be evaluated using general population samples. Additionally, they had to consider programme outcomes which were similar to the intended outcomes of the PPST.

Search terms included: “universal parenting programme”; “review” and “universal parenting programme”; “child maltreatment” and “ parenting programme”; “community-based” and “parenting programme”; “population” and “parenting programme”; “parenting programme” and “child self-esteem”/ “parent-child relationship”; “Systematic Training for Effective Parenting”.

A significant bias in this literature became evident in initial searches. Interventions intended to support parenting have largely been directed at families who have clinical diagnoses and are ‘at risk’ (Sherr, Skar, Clucas, von Tetzchner & Hundeide, 2014). Very little is known about how effective preventative parenting programmes are when they are offered to parents who are not referred, and have children who have not received a diagnosis for behavioural or socio-emotional problems (Reedtz, Handegard & Morch, 2011).

In fact, trials of parenting programmes offered on a universal basis are quite rare (Simkiss et al., 2013). Because of this bias, other search strategies were employed too. These included considering relevant articles’ reference lists, placing no limit on publication date, searching for further information on the specific programmes, and including evaluations which relied on minimal eligibility criteria for sample selection, as well as those which considered entire populations belonging to a large geographical area to be at risk.

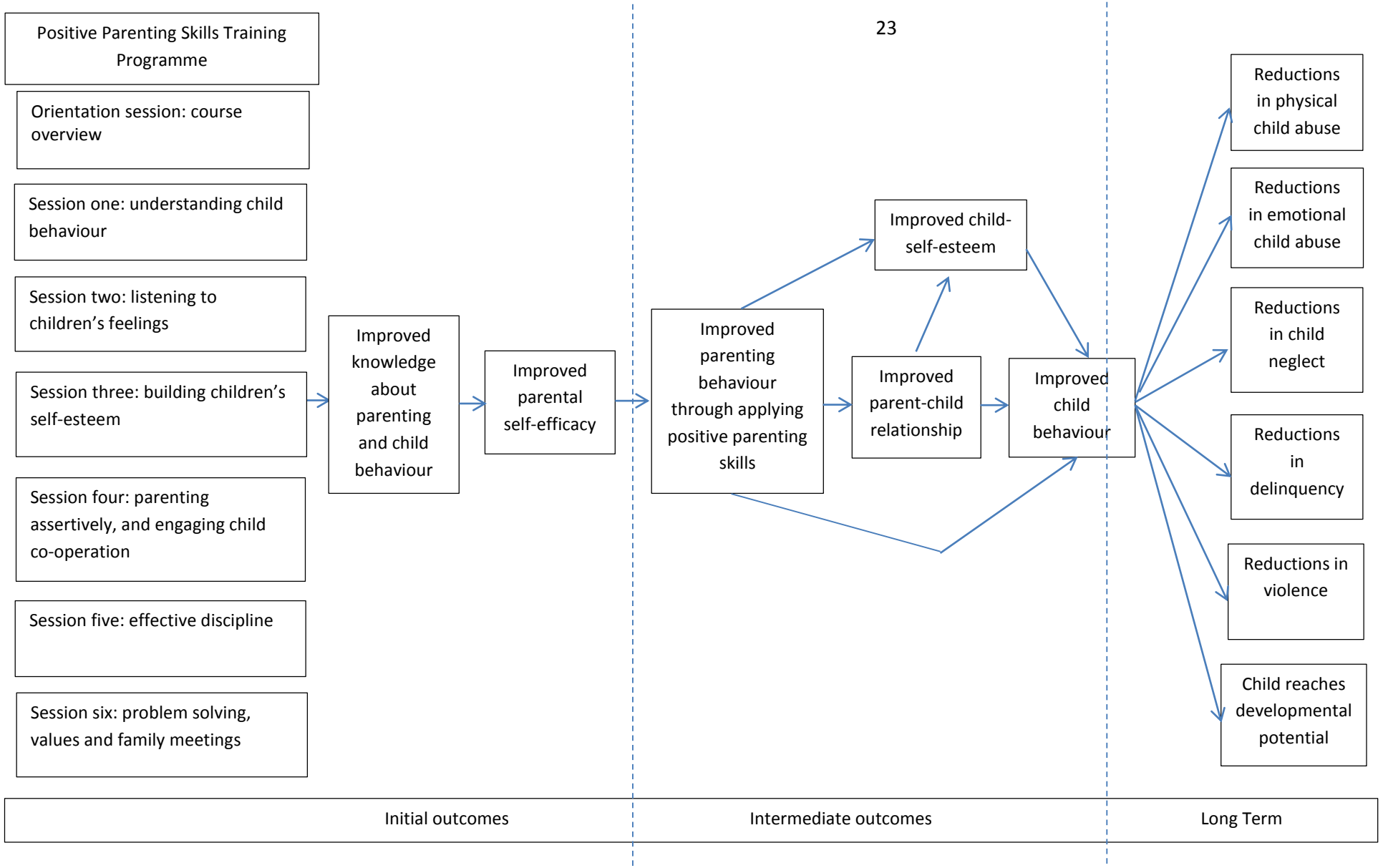

Figure 2. PPST's impact theory.

Literature review.

Programmes rarely have direct control over the social conditions they are expected to improve. Instead, they largely work indirectly by manipulating an important yet manageable feature of a situation which is anticipated to lead to further-reaching improvements (Rossi et al., 2004). Social problems like child abuse and neglect (child maltreatment), violence and delinquency are inherently complex. Like most social problems, none have a single cause (Black, Heyman, & Smith Slep, 2001; Dekovic, 1999; Krug, Mercy, Dahlberg & Zwi, 2002; Schumacher, Smith Slep & Heyman, 2001). Consequently, this complexity prevents any single intervention from having direct control over these social conditions.

However, a noteworthy number of risk and protective factors for these social problems are situated within the context of the family. More specifically, these social problems are associated with particular parenting behaviours (Black et al., 2001; Brown, Cohen, Johnson, & Salzinger, 1998; Crosnoe, Erickson, & Dornbusch, 2002; Dekovic, 1999; Krug et al., 2002). For example, established protective factors for youth engagement in problematic behaviour is parental monitoring, as well as youth attachment to parents (Dekovic, 1999). Additionally, youth who have experienced increased levels of harsh disciplinary practices show, on average, higher levels of behaviour that is violent (Antunes & Ahlin, 2014). In fact, youths' expected involvement in violence has been shown to increase by 33% for every additional confirmation of a harsh disciplinary method. Furthermore, some of the more proximal risk factors for child abuse include maternal parenting behaviours that are impulsive, rely on harsh disciplinary tactics, and negative attributions (Black, Heyman & Smith Slep, 2001). Parental impulsivity is also strongly related to risk for child neglect, along with low parental self-esteem (Schumacher et al., 2001). In recognition of these relationships, improving parenting is often proposed in the literature as a key solution to preventing child maltreatment, problem behaviour and violence (Hutchings et al., 2007; Knerr, Gardner, & Cluver, 2013; Krug et al., 2002; Wessels et al., 2013). This gives significant support to the connection between the PPST's intervention design and its long-term

objectives. It also begs the question, how effective are group-based parenting programmes at improving parenting as a mediating variable in this relationship?

A careful review of the literature returned only 23 individual evaluations of 13 different universally implemented group-based parenting programmes. Two of these programmes bear great similarity with the PPST, namely the Systematic Training for Effective Parenting (STEP) programme, and the Survival Training for Parent (STP) which is based on the prior (much like the PPST). The remainder vary in similarity with regards to the programme content of the PPST. Table 2 provides information on the content and skills, and well as programme activities included in the universally implemented group-based parenting programmes featured in this review.

This table highlights how the content and skills these programmes teach always focus on managing child problem behaviour. The strategies promoted to achieve this tended to include limit/rule setting, have consequences for misbehaviour, using planned ignoring, and praise and encouragement – instead of coercive discipline (e.g., hitting and shouting). Additionally, the programmes often included components which targeted the parent-child relationship, communication, problem-solving, promotion of positive child behaviour, and changing parent's beliefs about child behaviour and parenting, or the way they would approach parenting challenges. It is also evident that all the programmes encouraged experiential learning, with role-plays and discussion activities being included by most.

Though many of the programmes included a number of similar components to one another, as well as the PPST, differences can also be found between them. While the PPST does provide examples of various ways to promote positive parent-child interactions, it does not explicitly focus on child-centred play like the Parents Together Community Course. In fact, this latter programme and the shortened version of the Incredible Years intervention were the only two which seemed to include explicit focus on child play. The Parents Together Community Course also seemed to be the only programme which included an educational focus as well, albeit quite minor.

Table 2

Programme Content and Activities

Programme	Content and skills covered	Activities
123Magic	Rethinking parenting role, controlling behaviour which is obnoxious, dealing with manipulation and testing, encouraging positive behaviour, strengthening the parent-child relationship, enjoying family life. Strategies include: counting, time out, calm responses, praise, consequences.	Exploration, discussion and in-session practice.
Connect	Sessions based on attachment principles. Parental sensitivity, reflective and understanding function, mutuality and partnership, dyadic affect regulation. Collaborative instead of coercive parenting techniques for limit setting, monitoring, responding to problem behaviour with acknowledgement of emotion. Focuses on adolescent related issues specifically.	Role-plays, reflection exercises.
EFFEKT	Rules for positive parenting issues, demands and requests, coping with stress, limit setting, handling difficult parenting situations, improving the social relationships with friends and family.	Group discussion, presentations, role-plays, self-awareness exercises, workshops, structured teaching aids, homework.
Family Links Nurturing Programme	Manage and understand behaviour and feelings (e.g., consequences, time out, planned ignoring, listening), improve school and home relationships, enhance emotional health and wellbeing, improve self-esteem and self-confidence. Communication and relationship strategies, management of positive behaviour.	Discussion, role-plays, homework.
Harmony@Home	Relationship building, anger control, positive discipline, negotiating good behaviour.	Role-plays and alternative strategy suggestion, discussion, videos, homework.
Incredible Years – Shortened version	Based on a relational framework. Positive discipline (e.g., play, rewards, praise).	Discussion, vignettes, role-play, homework.
Survival Training for Parents	Mutual understanding and respect, accepting home atmosphere, democratic parenting, focus on positive behaviour, exploring alternatives, logical and natural consequences, reflective listening, open responses, good communication, focusing on adolescent problems and development.	Didactic material, discussion, skill practice, homework and review.
Systematic Training for Effective Parenting	Understanding misbehaviour, understanding one's self as a parent, understanding child and parent emotions, building child confidence, listening to one's child, talking and problem solving with child, natural and logical consequences for discipline, family meeting, developing self-confidence.	Cassette tapes, worksheets, discussion, posters.

Standard Triple P	Child management strategies e.g., quality time, praise, physical affection, good example setting, talking with children, rule setting, time out, logical sequences, planned ignoring, directed discussion, decide on rules, planning ahead and choosing activities which are engaging. Applying skills at home and in the community.	Videos, group discussion, role-play, homework and optional phone calls.
Group Teen Triple P	Behaviour management skills taught include: arranging engaging activities, providing brief contingent attention following desirable behaviour, monitoring problem behaviour, calm and clear requests, using directed discussion for minor problem behaviour, logical consequences to support instructions. Creation of behaviour contracts and use of family meetings are promoted. Specific strategies for preparing adolescents to handle risky behaviours are also taught.	Videos, discussion, homework, in session practice, feedback and phone calls.
Toddlers Without Tears	Normal child development (social, behavioural and motor), encouraging language development, plan and support desirable toddler behaviour, sensitive and warm relationships, managing unwanted behaviour, distraction, logical choices and planned ignoring, quiet time, planning ahead, alternatives to common "irrational beliefs".	Discussion, role-play, written information (e.g., hand-outs), video vignettes.
ICDP	Three dialogues of eight guidelines (1) emotional dialogue (e.g., child acknowledgement, showing loving feelings, praise) (2) comprehension dialogue (e.g., showing enthusiasm for child's experiences, supporting meaning-making of child) (3) regulative dialogue (e.g., setting limits). Also changing parental conceptions of children.	Discussion, role-play, homework.
Parents Together Community Course	Tuning into children, gathering one's self, child centred play and communication, teaching children how to behave well, encouraging and supporting children, attention, routines and rewards, gaining co-operation, helping children learn through play and reading books, consequences for misbehaviour, creative play activities, ensuring parents care for themselves.	Worksheets, homework

Few of the programmes also specified that they included content on the stages of child development. Only Toddlers Without Tears, Connect, Survival Training for Parents and Group Teen Triple P included content on particular developmental periods (infancy and adolescence) and the issues associated with them. This is different to the PPST which considers all stages of child development. Connect was also the only parenting programme to be guided by attachment theory principles. Lastly, both EFFEKT and Family Links Nurturing Programme were different from the other programmes in that they also provided some focus on improving relationships beyond the family. Overall, many of the identified differences between the reviewed programmes, and the PPST, relate only to certain (minor) aspects of programme content.

Based on consideration of these similarities and differences, the PPST's content, and programme activities do not seem to differ too extensively from other parenting programmes which have been implemented on a universal basis. This suggests one could expect fairly similar results for the programme.

A meta-analysis which considered the components of parenting programmes which are associated with programme effectiveness found greater effect sizes favouring the intervention group's parenting behaviours/skills, when parenting programmes taught parents how to establish positive parent-child interactions, and included components on emotional communication (e.g., active listening and reflection, reducing negative communication et cetera) (Kaminski, Valle, Filene & Boyle, 2008). Smaller programme effects for parenting behaviours were found when parenting programmes taught parents about problem solving, and promoted child academic skills or social skills. Effect sizes were large for child externalising behaviours when parenting programme components encouraged the use of time out instead of corporal punishment, consistent responses, and encouraging positive interactions with their child.

Most of the parenting programmes in this review, including the PPST, incorporated components targeting emotional communication, as well as positive interactions between parent and child. The PPST also considers problem solving - unlike a number of the other parenting programmes which are reviewed here. In contrast promoting child

social/academic skills and time out were key features of some programmes but not really featured within the content of the PPST manuals. Therefore, there is some preliminary support for the PPST to achieve its intended parent and child behavioural outcomes, although its content does not contain all the elements identified as effective in managing problem child behaviour.

Information about the delivery of the respective programmes is provided in Table 3 (below). This table highlights how most of the programmes were implemented by facilitators who had professional qualifications (e.g., social workers, psychologists). A number of programme facilitators acquired programme licences to implement the programme, while only a few facilitators were paraprofessionals. The training facilitators received to deliver the courses was, where specified, generally quite short. This could be because of their professional background. Most programme facilitators also received some supervision. The intended group sizes varied depending on the programme, but never exceeded 15. The target age of participants' children also varied quite significantly; ranging from birth to adolescence. Three programmes seemed to target an age range that spanned across the two, while others targeted more specific age-groups. It was also very evident that most programme sessions lasted for two hours, with only one programme really deviating from this. The number of programme sessions differed greatly; with a minimum of two and maximum of 10. However, nearly a third of the reviewed programmes lasted for six sessions.

In relation to this information the PPST seems to differ in three main ways: in terms of group size, session time-length and facilitator training length. The group size for the PPST can be far bigger in comparison to the programmes mentioned here. It is possible that this may impact on the quality of programme delivery. Additionally, session time-length though only an hour longer may increase the chances participants feel fatigued. Conversely, it could increase the chances participant grasp the material. Lastly, facilitator training seems to be far longer; most likely as a result of a reliance on paraprofessional staff.

Table 3

Features of Reviewed Programmes' Delivery

Author(s)	Programme	Delivery setting	Facilitator type	Facilitator training and supervision	Group size (no. of parents)	Target child ages	Session length and number
Bayer et al., 2010 & Hiscock et al., 2008	Toddlers Without Tears	Health centres	Nurse & child psychologist	5.5 hours training	2-12	8 months	2hrs, 2 sessions
Eisner et al., 2012; Malti et al., 2011	Standard Triple P	Not specified	Licensed provider	2 day training by programme representative, supervision	10-12	0-12 years	2-2.5hrs, 4 sessions
Fabrizio et al., 2013, 2014	Harmony@Home	Community agencies, schools	Social worker	2 day workshop, supervision	8-12	Pre-adolescents	2hrs, 4 sessions
Giannotta et al., 2013	Connect programme	Schools	Psychologist	Trained by programme creator, supervision	8-14	Pre-adolescents & adolescents	1 hr , 10 sessions (one double session)
Hahlweg et al., 2010	Standard Triple P	Not specified	Psychologist	Trained by programme representative, supervision	10-12	0-12 years	2hrs, 4 sessions
Huhn & Zimpfer, 1989	Survival Training for Parents	Schools	Male and female group leader	Not specified	10	Pre-adolescents	2.5hrs, 6 sessions
Bloomfield & Kendall, 2007	123Magic	Not specified	Specialist public health practitioners, family centre workers	Not specified	6-8	2-12 years	Not specified
Bloomfield & Kendall,	123Magic	Community Organisation	Health, social care and education	Formal training	Not specified	2-12 years	2hrs, 6 sessions

2010			backgrounds				
Bloomfield & Kendall, 2012	123Magic	Children's Centres	Two trained facilitators	Formal training in certified courses and in programme	Not specified	2-12 years	2hrs, 6 sessions
Kendall et al., 2013	123Magic	Community centres	Nurse	Not specified	Not specified	2-12 years	2hrs, 6 sessions
Kilroy et al., 2011	Parents Together Community Course	Schools, community family centre	Teacher and child care worker	2 day training	6-10 parents	Pre-school/ school-aged	2hrs, 6 sessions
Nystul, 1982	Systematic Training for Effective Parenting	Not specified	Psychology graduate and student assistant	1 day orientation	7	6-12 years	9 sessions
Ralph & Sanders, 2003	Group Teen Triple P	School library	Clinical psychologist and school guidance staff	1 training day	3-11	12-13years	2 hrs, 4 sessions (and four 15-30 minute phone calls)
Reedtz et al., 2011	Incredible Years – shortened version	Health centres	Nurse	Trained by programme representative, supervision.	10-12	3-8 years	2hrs, 6 sessions
Sherr et al., 2014	International Child Development Programme (ICDP)	Kindergartens, health centres	Licensed provider	Not specified	5-10	0-18 years	2hrs, 8 sessions
Simkiss et al., 2013	Family Links Nurturing Programme	Organisation facilities	Not specified	4 days training + 1 day yearly refresher, supervision	6-10	2-4 years	2hrs, 10 sessions
Stemmler et al., 2007 & LÖsel & Stemmler, 2012	EFFEKT	Not specified	Two psychology Master's graduates	Trainers developed curriculum	6-15	Kindergarten age	1.5 – 2 hrs, 5 sessions
Ting Wai Chu et al., 2015;	Group Teen Triple P	Community locations	Licensed provider	Not specified	3-12	12-15 years	2hrs, 5 sessions (and three 15-30 minute phone calls)

Zubrick et al., 2005	Standard Triple P	Health centres	Social worker, psychologist, health promotion officer, nurse	3 days training + co-facilitation with experienced facilitator	10-12	0-12 years	2hrs, 4 sessions

Short-term outcomes.

Parental self-efficacy.

Parenting programmes provide the opportunity for development of parental self-efficacy through experiencing the successes of other participating parents, learning and acquiring positive practices, as well as through emotional arousal and verbal persuasion (Kendall et al., 2013). A systematic review of qualitative research identified the constituents of parenting programmes that parents saw as necessary to aid them in changing their parenting style (Kane, Wood & Barlow, 2007). The finding's largely described these 'components' of programmes which purportedly improve parental self-efficacy. Parenting programmes assisted with parents obtaining knowledge, understanding, and skills, along with feeling support and acceptance from other parents - all of which allowed them to feel as if they could cope and regain control (Kane et al., 2007). This in turn led to parents feeling like they had the confidence to handle their behaviour. These findings support the contention that improvements in parental self-efficacy are likely to be one of the first outcomes able to be related to completing a parenting programme. Additionally, they suggest that improving parental self-efficacy is a necessary preliminary outcome to achieve.

If people do not feel efficacious they disregard the skills they were taught in a situation where they do not receive quick results, or applying these skills becomes a troublesome task (Bandura, 1989). This underscores the importance of targeting parental self-efficacy in a parenting programme, because failing to do so could halt other possible programme outcomes being realised. Also suggested by the PPST's programme theory, is that if parents do not feel efficacious about their parenting after completion of the programme, then one would expect none of the other intermediate programme outcomes to be achieved. The findings from those evaluations of group-based parenting programmes which have been implemented on a universal basis and which assessed parental self-efficacy as an outcome, provide substantial support for the contention that these programmes can improve parental self-efficacy.

The evaluation of Survival Training for Parents (STP) programme found that parents who received the STP programme showed significantly higher levels of confidence in their ability to handle parenting responsibilities and in themselves, than control group parents at post-assessment (Huhn & Zimpfer, 1989). The evaluation of a shortened version of the very popular Incredible Years programme found those who received the intervention showed significantly higher levels of satisfaction with parenting and parental efficacy, versus control parents on post-tests, in comparison to their baseline measures (Reedtz et al., 2011). Additionally, programme effects for satisfaction were sustained at the one-year follow-up. Parents participating in the more robust evaluation of the Group Teen Triple P also reported significant improvements in confidence immediately after programme completion (*d* = 1.05), in comparison to control group parents (Ting Wai Chu, Bullen, Farruggia, Dittman & Sanders, 2015). However, this effect disappeared six months later (Ting Wai Chu et al., 2015). All of these programme evaluations utilised the strongest evaluation design available to determine programme effectiveness i.e., a randomised controlled trial (RCT), which strongly supports the validity of their similar findings.

Evaluations of other group-based parenting programmes implemented on a universal basis have utilised weaker quasi-experimental designs, but largely found similar results. For example, the four evaluations of the 123Magic parenting programme demonstrated that the parenting intervention was consistently effective in improving parental self-efficacy at post-assessments, and longer follow-ups at three and four months post intervention completion (Bloomfield & Kendall, 2007; 2010; 2012; Kendall, Bloomfield, Appleton & Kitaoka, 2013). Similar results were found across time and place for this programme which strongly suggests the outcomes can be attributed to programme effects. Additionally, in the pilot trial of the Group Teen Triple P parents reported higher levels of self-efficacy after completion (Ralph & Sanders, 2003). In contrast to these positive findings the evaluation of the Connect programme found no significant programme effects in favour of the intervention group for parental efficacy or satisfaction (Giannotta, Ortega & Stattin, 2013). This evaluation utilised a stronger design that evaluations of 123Magic (due to the addition of a comparison group). However, the two groups of parents were different at the pre-test; the intervention group showed significantly lower levels of parental efficacy

(Giannotta et al., 2013). It is possible the programme resulted in an increase in parental self-efficacy for this group; however this was not enough to make up for the initial deficit found at baseline-assessment.

Together, these results suggest that group-based universal parenting programmes can be effective in improving parental self-efficacy. Furthermore, one can with some confidence expect such an outcome to persist for a fairly significant period of time after completing such a programme. Therefore, these findings provide substantial support for the PPST's programme theory, which suggest the programme will first be effective in improving parental self-efficacy.

Intermediate outcomes.

Parenting behaviour.

The majority of the evaluations considered programme effectiveness in terms of programme ability to improve parenting behaviours. This information along with evidence for effectiveness in improving child behaviour is provided in Table 4 (below). The evaluations of the STEP and STP parenting programmes did not assess changes in parenting behaviour directly. Instead, these evaluations only considered attitudinal change in programme participants. Attitude is a contributing factor to a person's behaviour (Ajzen & Fishbein, 1977). This relationship is partly moderated by the strength of one's attitude (Armitage & Christian, 2003). Therefore, if a parent holds a strong positive attitude about a particular behaviour, they are more likely to perform it, and vice versa.

The review of the STEP parenting programme found mixed evidence for the programme to be effective in influencing a positive change in parental attitudes (Robinson, Robinson & Dunn, 2003). The single evaluation of the STEP programme found that intervention group parents showed significantly higher levels of democratic child-rearing attitudes, were more likely to encourage their children's verbalisation, and showed lower levels of strictness (Nystul, 1982). No change in attitude was found in parental fostering of dependency, avoidance of communication and equalitarianism. Furthermore, the evaluation of the STP found comparable programme effects (Huhn & Zimpfer, 1989). Significant

differences favouring intervention group parents in terms of their confidence to parent, causation and the importance of being understanding were found. There were no significant differences between intervention and control group parents for child acceptance, trust, parental permissiveness, or autocratic versus democratic attitudes towards parenting.

These findings suggest that parenting programmes which are based on the STEP parenting programme will likely be able to strengthen parent's attitudes towards more positive parenting practices to some extent. Despite this potential, it remains important to remember that attitude changes do not necessarily translate into behaviour changes. Underscoring this disjuncture is that despite the STEP programme being found to be successful in changing parental attitude, there has been no additional evidence found for this to translate into changes in child behaviour (Robinson et al., 2003). Yet, determining the likelihood that the PPST will be able to effect change in parenting behaviours should also be based on the consideration of other similar parenting programmes which have assessed the programme ability to change this outcome directly.

Many of the evaluations of the parenting programmes utilised an RCT design to determine programme effectiveness. The effectiveness of these programmes will be considered first because of the strength of their method. Only three evaluations showed consistent programme effects. The evaluation of the shortened version of the Incredible Years parenting programme showed at both the post-test and one year follow-up, parents had higher levels of positive parenting, and lower levels of harsh discipline (Reedtz et al., 2011). Similar results were found by the more robust evaluation of the Group Teen Triple P (Ting Wai Chu et al., 2015). At immediate post-test and the six month follow-up lower levels of laxness and over-reactivity were reported by intervention group parents, in contrast to control group parents (Ting Wai Chu et al., 2015).

Table 4

Programmes Effects for Parenting and Child Behaviour Outcomes

Programme	Author	Sample (nationality, *n*, child ages)	Evaluation design	Parenting outcomes at pre to post intervention	Parenting outcomes at follow-up (follow-up points)	Child behaviour outcomes at pre to post intervention	Child behaviour outcomes at follow-up (follow-up points)
Systematic Training for Effective Parenting	Nystul, 1982	Australian, 28 mothers of children (age not specified)	RCT	NA	NA	NA	NA
Standard Triple P							
	Eisner et al., 2012	Swiss, adherent[1] parents of first graders in 56 schools	RCT	No significant effects for parental involvement, positive parenting, supervision, corporal punishment, erratic parenting.	No significant effects (17 and 30 months)	No effects for prosocial, attention deficit hyperactivity disorder, non-aggressive conduct disorder, aggression. Increase in internalizing behaviours was significant when assessed using teacher-reports (*d* = -0.24).	Increase in child internalising behaviour at 17 months (*d* = -0.29)[2] which disappeared by 30 months. No other significant effects.
	Hahlweg et al., 2010	German, 280 parents of children (3-6 years old) in 17 preschools	RCT	NA	Decrease in dysfunctional parenting (at 2 years) (*d* =0.49 and 0.41, for mothers and fathers respectively). Increase in positive parenting	NA	Reductions in internalizing (*d* = 0.32) and externalizing behaviour (*d* = 0.32) at 2 years (for mother only)[3]

					behaviour (for mothers only – excluding single mothers) at 2 years (*d* = 0.34).[3] No significant effects for mother-child interactions.		
	Malti et al., 2011	Swiss, parents of first graders in 56 schools	RCT	NA	NA	No significant effects for child externalising behaviour nor socially competent behaviour	No significant effects for child externalising behaviour nor socially competent behaviour
	Zubrick et al., 2005	Australian, 1610 parents of preschool children	Two-group pre and post-test quasi-experimental design	Decrease in dysfunctional parenting (ES = 1.08).	Decrease in dysfunctional parenting (at 1 and 2 years; ES = 0.59 and ES = 0.56 respectively)	Decrease in problem behaviour (ES = 0.83)	Decrease in problem behaviour (at 1 and 2 years; ES = 0.41 and ES = 0.47 respectively)
Group Teen Triple P							
	Ralph & Sanders, 2003	Australia, 27 parents of high school children	Single group, pre and post-test design	Decrease in dysfunctional parenting	NA	NA	NA
	Ting Wai Chu et al., 2015	New Zealand, 72 families with adolescents	RCT	Decrease in dysfunctional parenting (*d* = 0.82 and 0.90 for laxness and over-reactivity respectively). Increased monitoring (*d* = 0.74)	Decrease in dysfunctional parenting (*d* = 0.84 and 0.57 for laxness and over-reactivity respectively), and increased monitoring (*d* = 0.77) at six months	Decrease in problem behaviour (*d* = 0.90)	Decrease in problem behaviour at six months (*d* = 0.50 parent report; *d* = 0.92 child report)
Harmony@Home							
	Fabrizio et al., 2013,	Chinese, 150 and parents of	RCT	Higher frequency of good behaviour	No significant effects (3 months)	NA	NA

		children (10-13 years)		negotiation (*d* = 0.32) No significant effects for giving reasonable consequences, staying calm during arguments, making an effort to improve the relationship, stating clear expectations			
	Fabrizio et al., 2014	Chinese, 461 and parents of children (10-13 years)	RCT	No significant effects for giving reasonable consequences, staying calm before discipline, negotiating good behaviour, doing something nice for child.	No significant effects for not repeatedly telling a child to do something, doing something nice, giving suitable consequences, calmness during discipline, negotiating good behaviour. Less likely to repeatedly tell their child to do something (*d* = 0.22)[4]	NA	NA
Toddlers without Tears							
	Hiscock et al., 2008; Bayer et al., 2010	Australian, 733 parents of 6-7 month old toddlers	Cluster RCT	No significant effects for harsh discipline, unreasonable developmental expectations, and warm nurturing parenting.	Lower levels of unreasonable developmental expectations (ES = -0.22) and harsh discipline (ES = -0.22) at 2 years. No significant effects for warm nurturing parenting.	No significant effects for externalising or internalising problem behaviours at 18 months.	No significant effects for internalising or externalising problem behaviours at 2 or 3 years.

					At 3 years, lower levels of unreasonable expectations (ES = -0.29). No significant effects for warm nurturing parenting or harsh discipline.		
Connect							
	Giannotta et al., 2013	Italian, 147 parents of children aged 11-14 years	Two-group pre-post quasi-experimental design	No significant effects for attempting to understand, parental control, coldness-rejection or emotional outburst	NA	No significant effect for child problem behaviours.	NA
123Magic							
	Kendall et al., 2013	Japanese, 49 mothers of children in nursery schools	Single-group pre-post quasi-experimental	NA	NA	NA	NA
	Bloomfield & Kendall, 2012	English, 63 parents of children (6 months to 10 years)	Single-group pre-post quasi-experimental	NA	NA	Reduced level of conduct problems at 3 months. No other significant effects for hyperactivity-inattention, emotional symptoms, pro-social behaviour and peer problems.	NA
	Bloomfield & Kendall, 2010	English, 74 parents of children (age not specified)	Single-group pre-post quasi-experimenta	NA	NA	NA	NA

			l				
	Bloomfield & Kendall, 2007	English, 356 parents of children (6 months to 10 years)	Single-group pre-post quasi-experimental	NA	NA	NA	NA
Survival Training for Parents							
	Huhn & Zimpfer, 1989	American, 18 parents of children (10 - 12 years)	RCT	NA	NA	NA	NA
Incredible Years – shortened version							
	Reedtz et al., 2011	Norwegian, 186 parents of children (2-8 years)	RCT	Higher levels of positive parenting (η^2 = 0.20) Lower levels of harsh discipline (η^2 = 0.09)	Further increases in positive parenting at 1 year (η^2 =0.12). Lower levels of harsh discipline at 1 year (η^2 =0.05).	Lower levels of child problem behaviour (η^2 = 0.02)	No significant effects
International Child Development Programme (ICDP)							
	Sherr et al., 2014	Norwegian, 220 caregivers of children (1-6 years)	Two-group pre post quasi-experimental design	Higher levels of parent-child activities (η_p^2 = 0.08). Improved parenting strategies (η_p^2 = 0.03) Improved child management (η_p^2 = 0.05) No significant effects for positive discipline, engagement with child.	NA	Reduced distress and social impairment resulting from child difficulties (η_p^2 = 0.03)	NA
Family Links Nurturing Programme							
	Simkiss et al., 2013	Welsh, 286 families with	Multicentre RCT	NA	No significant differences for	NA	No significant differences for

		children (2-4 years)			negative or supportive parenting (at 9 months)		problematic child behaviour including internalising, conduct and hyperactivity (at 9 months)
EFFEKT							
	Stemmler et al., 2007	German, 144 parents[5] of kindergarten children	Matched control group (quasi-experimental)	Mothers showed improved positive parenting (*d* = 0.24) and less inconsistent parenting (*d* = 0.30)	Less inconsistent parenting at 1 year.	NA	NA
	LÖsel & Stemmler, 2012	31 parents		NA	NA	NA	Reduced child problem behaviour internalising and externalising (exclusive of delinquency) *d* = 0.49 – 0.63 at 4 and 5 years[6]
Parents Together Community Course							
	Kilroy et al., 2011	Irish, 31 parents of children (1-11 years)	Single-group pre-post quasi-experimental	NA	NA	Reduction in conduct problems (*d* = 0.44), hyperactivity (*d* = 0.67), and overall problem behaviour (*d* = 0.61). No significant effects for emotional symptoms, peer problems or prosocial behaviour. Reductions in the number of borderline	NA

							and clinical cases for overall problem behaviour (*d* = 1.65), conduct problems (*d* = 0.99), emotional symptoms (*d* = 0.75), hyperactivity (*d* = 0.76), peer problems (*d* = 0.61). Increase in the levels of prosocial behaviour from clinical/borderline cases (*d* = 0.47)

Note: NA = Not assessed.
1 = Parents included in the analysis had completed the entire programme.
2 = Finding based on teacher-reports. Parent and self-reports revealed no significant effects.
3 = Findings based on self-report. Teacher and observational reports revealed only non-significant results.
4 = Parents who received booster.
5 = Half of these mothers had children receive training only. Results reported for parent training only.
6 = Results found using child self-report. No significant effects were found using parent-reports.

These results contrast with the findings from the evaluation of the Family Links Nurturing Programme (FLNP) (Simkiss et al., 2013) which showed no significant programme effects for poor or positive parenting practices at nine months post programme completion. The programme shares similarities with the Incredible Years programme and others like the Triple P - which have proven more effective e.g., they all deal with positive behaviour management principles et cetera (Simkiss et al., 2013). The failure of the evaluation to find any significant effects was attributed to attrition in the intervention group, contamination in the control group and poor implementation of the programme.

The remaining evaluations which utilised an RCT design showed mixed results; finding both significant and non-significant programme effects for improving parenting behaviour. Globally, the Triple P is one of the most thoroughly evaluated parenting training programmes (Eisner, Nagin, Ribeaud & Malti, 2012). Four different evaluations were found considering level four of the programme, also known as *Standard Triple P* (Eisner et al., 2012; Hahlweg, Heinrichs, Kuschel, Bertram & Naumann, 2010; Malti, Ribeaud & Eisner, 2011; Zubrick et al., 2005). One evaluation made use of a strong quasi-experimental design and its findings are also included here. Overall, these evaluations provide evidence for the programme to be successful more so than not in improving parenting; through decreasing the levels of dysfunctional parenting primarily (Hahlweg et al., 2010; Zubrick et al., 2005). These effects were mostly found at the long-term follow-ups. Improvements in positive parenting were also found, but did not appear in data collected using multi-informants or observational data (Hahlweg et al., 2010). Only a few of the targeted behaviours changed significantly for parents receiving the intervention Harmony@Home, in comparison to parents who did not receive the intervention, from pre to post test and at the follow-up (Fabrizio, Lam, Hirschmann & Stewart, 2013; Fabrizio et al., 2014). This evaluation provides preliminary evidence for the usefulness of booster programmes post programme completion (Fabrizio et al., 2014).

Also showing limited programme effectiveness is the Toddlers Without Tears intervention (Bayer, Hiscock, Ukoumunne, Scalzo & Wake, 2010; Hiscock et al., 2008). There were no immediate programme effects. However, in the long-term the programme was successful in decreasing the levels of unreasonable developmental expectations parents

hold, as well as harsh discipline. These findings strongly suggests that parenting programmes need to only provide a brief educational component targeting developmental expectations in order to see long-lasting effects for which changes in them.

The remaining programmes utilised quasi-experimental designs to determine programme effectiveness for improving parenting. The most successful of these was the evaluation of another popular parenting programme; the evaluation of the Entwicklungsforderung in Familien: Eltern- und Kinder-training [Enhancing the development of families: Parent and child-training] (EFFEKT) programme. The programme was found to be effective in improving positive parenting and decreasing the levels of inconsistent parenting practices. Additionally, the latter effect persisted at the one year follow-up (Stemmler et al., 2007). Also successful was the International Child Development Programme (ICDP) (Sherr et al., 2014). Three out of the five measures of positive parenting practices were higher for parents after completion of the programme, in comparison to parents who did not participate in the programme. Finally, the pilot evaluation of Group Teen Triple P found that parents reported improvements in laxness and over-reactivity after completing the programme (Ralph & Sanders, 2003).

Unlike the above mentioned programmes the evaluation of the Connect parenting programme found no improvements in parenting behaviour post programme completion for participating parents (Giannotta et al., 2013). The programme was developed primarily for parents of teenagers who demonstrate particularly challenging behaviour, e.g., antisocial and violent behaviour (Moretti & Obsuth, 2009). The findings also revealed that intervention group parents felt less efficacious before completing the programme (Giannotta et al., 2013). As has been suggested above, it is possible there was no difference between the intervention and comparison group at post-assessment in parenting because the intervention group did not show sufficient improvement in self-efficacy in order to effect a change in parenting in turn.

The evaluations of the group-based positive parenting programmes which utilised community samples have shown fairly encouraging results. Only two of the reviewed programmes showed no programme effects for positive or poor parenting practices. The

possible reasons provided for the poor results of these two programmes do not suggest the parenting programmes themselves are necessarily ineffective. Further evaluations of these programmes are necessary to confirm this though. The remaining programmes were effective in improving parenting to varying extents, for which the strength of the presented evidence varied as well. There was evidence for improvements in parenting through programmes both decreasing levels of poor parenting behaviours, as well as increasing levels of positive parenting behaviours. Additionally, there is evidence for these programme effects to be fairly long lasting. These findings were found across programmes, different samples, times and places which increases confidence in the contention that such programmes can improve parenting. Based on these findings and the fact that the PPST shares similarities with these programmes, it is likely the PPST will be able to improve to some extent parental attitudes towards parenting, but also their parenting behaviours.

The causal pathway to child maltreatment is complex, with certain individuals being more at risk of exercising such harsh parenting practices than others. Consequently, intensive interventions which target this population through addressing the range of associated risk factors are likely to be the most successful in stemming levels of child maltreatment. Arguably, there may be a role for less intensive, universal parenting interventions to also play in preventing child maltreatment though. For example, there is evidence for very brief parenting interventions to be effective in promoting that parents understand that they avoid the use of ill treatment towards, or harsh punishment of, their children (Jordans, Tol, Ndayisaba & Komproe, 2013), and practice lower levels of dysfunctional parenting as well (Mejia, Calam & Sanders, 2015). Therefore, through changing the intermediate outcome of harsh parenting, it is possible that the PPST may also contribute to reducing the levels of child maltreatment in the long-term.

Child self-esteem.

In the context of the family, parents' appraisals of their children are generally expected to be important in terms of influencing their children's self-concepts (Gecas & Schwalbe, 1986). During socialisation, one internalises these significant individuals' ideas and attitudes which are expressed toward them. Consequently, one comes to develop

similar self-attitudes and responses towards oneself as those held by one's parents (Gecas, 1971). Importantly, these attitudes must be reflected in in parental behaviour towards their children if they are to influence their self-concept (Gecas & Schwalbe, 1986).

Numerous parenting practices are related to child self-esteem. For example, children who belong to families in which their parents provide support and affection are more likely to have high self-esteem (Gecas, 1971; Peterson, Southworth & Peters, 1983). Similarly, parents who show an interest in their children and their activities (Rosenberg, 1965 as cited in Gecas & Schwalbe, 1986), are involved in common activities, and ensure children are included in family decision making are also more likely to have children with high self-esteem (Bachman, 1970 as cited in Gecas & Schwalbe, 1986). Higher levels of child self-esteem are also related to parents who define and enforce limits on their child's behaviour, give their children respect and room for action so long as it remains within the specified limits, and are accepting of their children (Coopersmith, 1967 as cited in Gecas & Schwalbe, 1986). These parenting practices also suggest a positive parent-child relationship. Therefore, it remains unsurprising that children who have high quality relationships with their parents also tend to benefit from high levels of self-esteem (Amato, 1986). However, the relationship between numerous positive parenting practices and child self-esteem stands in contrast to parental use of punishment - which is negatively related to child self-esteem (Peterson et al., 1983).

Based on such findings, if one encouraged parents to practice such parenting behaviours one could expect that their children's self-esteem would improve. Very few of the reviewed evaluations seemed to consider this outcome despite promoting these parenting behaviours. The review of the effectiveness of the STEP parenting programme found evidence which suggests the programme is largely ineffective at improving child self-esteem (Robinson et al., 2003). However, children of parents who received the STP intervention showed significantly improved self-esteem at post-assessment, as opposed to children of parents who were assigned to the control group (Huhn & Zimpfer, 1989). Yet, these improvements applied to self-esteem at school only. A few plausible alternative hypotheses were provided to explain this finding e.g., the participating child's teacher may have expressed satisfaction with the fact that their family was involved in the research and

thus improved children's self-esteem. Additionally, it is possible that the result could be a product of small sample size which affected the power of the study to find effects. Child self-esteem was also assessed in the evaluation of the Group Teen Triple P (Ting Wai Chu et al., 2015). No significant programme effects for this outcome were present at immediate post-test, nor at the six month follow-up.

Overall, it would be impossible to say based on these three articles alone whether universal group-based parenting programmes, especially those which are based on the STEP parenting programme, are effective in improving child self-esteem. Further complicating matters is that the measures of self-esteem largely used in the evaluations of the STEP parenting programme were not substantiated as accurate measures of the concept (Robinson et al., 2003). This brings into question the reviewed findings. However, many parenting practices are linked to higher levels of child self-esteem. The PPST programme encourages parents to practice many of these parenting behaviours. Therefore, it is to some degree plausible that the PPST will be successful in improving child self-esteem through improving parenting.

Child behaviour.

Due to the fact that certain problem child behaviours can persist into adulthood (Broidy et al., 2003), it is a necessity that a primary goal of all parenting programmes should include a reduction in child problem behaviour. Many of the reviewed evaluations did consider programme effectiveness in terms of improving this outcome likely out of recognition for this relationship (see Table 4).

The single evaluations of the STEP programme and the STP intervention did not assess programme effects on child behaviour. However, the review of the STEP intervention implied the programme is largely ineffective in improving child behaviour (Robinson et al., 2003). From this, it seems programmes which are based on the STEP parenting programme are unlikely to improve child behaviour. This finding is somewhat surprising because the programme does include components which have been shown to be reliably linked to improvements in child behaviour (Kaminski et al., 2008). Consideration of other universally

implemented group-based parenting programmes may help to make sense of this contradiction.

There is mixed evidence which suggests that the Triple P parenting programme is effective in improving child behaviour when assessed utilising general population samples (Eisner et al., 2012; Hahlweg et al., 2010; Malti et al., 2011; Zubrick et al., 2005). However, evidence for improvements in child behaviour (where found) were shown to last for a significant period of length after programme completion. Group Teen Triple P was found be effective in improving child behaviour (Ting Wai Chu et al., 2015). These effects were sustained at the follow-up based on caregiver and child reports. The EFFEKT parenting programme also showed some evidence for long-term improvements in child behaviour (Lösel & Stemmler, 2012). Together these programmes suggest parenting programmes have the potential to be effective in halting the progression of externalising behaviours into adulthood.

However, the certainty that permanent behavioural changes will be guaranteed remains unclear because the majority of the programmes which were reviewed only showed evidence for short-term improvements in child behaviour (often only measuring this outcome at post-test). The Incredible Years - shortened version's single evaluation revealed the programme was effective in reducing the levels of problem behaviours (Reedtz et al., 2011). However, this programme effect disappeared by follow-up assessment. The ICDP also showed an improvement in parental distress as a result of child behaviour (likely improving) at the post-assessment (Sherr et al., 2014). The single evaluation of the 123Magic programme which assessed programme effectiveness for improving child behaviour also found short-term programme effects for this outcome; though this finding was limited to one type of problem behaviour (Bloomfield & Kendall, 2012). This limited finding contrasts with those from the evaluation of the Parents Together Community Course which showed the programme was successful in achieving a improvements in a broad range of child behaviour at post-test, including reducing the number of clinical and borderlines cases of problem behaviours (Kilroy et al., 2011).

Despite some reliable findings for short-term programme effectiveness, three evaluations of parenting programmes found non-significant programme effects for improving child behaviour i.e., the Family Links Nurturing Programme (Stemmler et al., 2007), Toddlers Without Tears (Bayer et al., 2010; Hiscock et al., 2008) and the Connect parenting programme (Giannotta et al., 2013). These findings may have resulted because parenting behaviour was not found to improve either, or at least to a sufficient enough extent. Support for this contention comes from the general trend which was evident in the evaluations included here; parenting programmes which were successful in improving parenting generally also showed effectiveness for improved child behaviour (see Table 4).

Overall, the majority of the parenting programme evaluations which assessed changes in child behaviour did find an improvement post completion of the intervention in this outcome. Improvements in child behaviour were predominantly seen through reductions in problem behaviour e.g., externalising and internalising behaviours. These evaluations also provide some evidence for this outcome being sustained over time. The amount of change in child behaviour was generally quite small. Yet, one should not expect long-term effect sizes to be any bigger than small or sometimes moderate, because most of the children of participating parents would generally not develop long-term behavioural problems even if they did not receive the programme (Lösel & Stemmler, 2012). Arguably, the same could likely be said for short-term effect sizes.

These evaluations also serve to further support the relationship between child behaviour and parenting behaviour which is already well-established in the literature. Therefore, despite the fact that there is largely negative evidence for the STEP parenting programme to improve child behaviour, the literature suggests that parenting behaviour as a result of participation in a parenting programme will likely improve. Based on this broader relationship one can with some confidence likely expect changes in child behaviour as well. This is further supported by the fact that the PPST incorporates components which have been associated with reductions in the levels of child externalising problem behaviour (Kaminski et al., 2008).

Parent-child relationship.

Children who have positive relationships with both their parents are less likely to develop problematic behaviour (Peterson & Zill, 1986). Therefore, parenting interventions should necessarily give attention to children's externalizing problem behaviours "in the context of the parent-child attachment relationship" as well (Brook, Yeon Lee, Finch & Brown, 2012, p. 418). This suggestion lends support to the plausibility of the PPST's programme theory which recognises that improved parenting will likely improve the parent-child relationship, both of which will in contribute separately to improving child behaviour.

Neither the review of the STEP parenting programme, the evaluation of the STEP parenting programme nor the evaluation of the STP parenting programme considered programme effectiveness in terms of improving parent-child relationship. The majority of the other group-based parenting programmes did not consider programme effects for this outcome either.

Parents who participated in the FLNP showed no more positive, and no fewer negative interactions with their children after participating in the parenting programme in comparison to control group parents (Simkiss et al., 2013). Additionally, there was no change in warmth of the parent-child relationship. These programme effects contrast to those found in the Harmony@Home evaluations. This is surprising considering the latter is less intense – offering fewer sessions. Both evaluations found parents completing the programme were more satisfied with the parent-child relationship than before they had participated, in comparison to control group parents (d = 0.25; 0.17) (Fabrizio et al., 2013; 2014). Unfortunately, this result did not last longer than six months after the programme finished (Fabrizio et al., 2014). However, based on "within group" analyses it was determined that at a year post intervention completion, intervention group parents retained a significant increase from pre-assessments in satisfaction with the parent-child relationship. Thus, the Harmony@Home intervention was largely successful in improving the parent-child relationship in both the trial and to scale programme.

The evidence presented by these evaluations does not allow one to conclusively say how likely it is that the PPST will be able to effect a parent-child relationship change. This is

largely due to the fact that so few evaluations of group-based parenting programmes which were utilised by general population samples and considered this outcome have been completed. Additionally, the evaluations reviewed here provide only mixed support for the contention that parenting programmes can improve the parent-child relationship. Yet, based on the limitations found in the evaluation of the FLNP, there is perhaps more support for the contention that a parenting programme which provides content focusing on improving the parent-child relationship could effect this outcome. Additionally, considering the broader relationship between child behaviour and the parent-child relationship established in the literature, parents participating in the PPST may also expect their children's behaviour to improve.

What does this research say overall, with regards to the plausibility of the PPST's programme theory in terms of its intermediate outcomes? The outcomes which received the most support from the literature are improved parenting and child behaviour. Yet, these outcomes were not consistently supported. However, bearing in mind that many parenting programmes (which were fairly similar) had programme effects for these outcomes on different samples, places, and times, these findings support the plausibility of these particular outcomes in the PPST's programme theory to a significant extent. However, these evaluations were all completed outside of the South Africa context. Additionally, they largely utilised mothers only. This brings into question the transferability of these programme results. It also begs the questions: Have any South African group-based universal parenting programmes been evaluated? What have those that have achieved? Furthermore, if none have been evaluated, then to what extent can we expect the findings based on this literature to generalise?

The literature on parenting programmes in South Africa is particularly scarce. The first review of group-based parenting programmes available in the country was only recently completed. This review looked at 21 parenting programmes and considered both their design and evaluation practices, in relation to principles or components of best practice (Wessels, 2012). This review 's ratings of the included programmes' fit with best practices found two programmes ratings were greater than 70%, 11 programmes had

between a 70% and 50% fit, while the remaining fell below this percentage range of fit. Despite these findings, it remains impossible to say which of the programmes are more or less effective than others because none had been through a summative evaluation. Yet, with regards to more formal evaluations it was discovered that only two of the considered programmes had been externally evaluated. Unfortunately, the findings of these evaluations were not made available to the researcher. Consequently, this leaves the question of locally implemented programme's effectiveness unanswered in any conclusive way.

It has been recognised that there is a significant need to build the evidence base for parenting programme's effectiveness in low- and middle-income countries in particular (Knerr et al., 2013; Mejia, Calam & Sanders, 2012). As the literature included here has also reflected, there is a large bias in where evaluations of parenting programmes are largely being completed. However, there is a growing evidence base for programmes created in developed contexts to be acceptable and effective in different contexts, so long as they are adapted appropriately to a different setting and culture (Knerr et al., 2013). Furthermore, there is some evidence which suggests the alterations to programme theories may not necessarily be major either. The PPST has been adapted to suit the South African context which suggests the chances of it being effective in achieving its intended outcomes are increased (Lau, 2006). Additionally, based on the similarities between the programmes reviewed here and the PPST, despite these other programmes being implemented in a developed context, these findings imply the results may also transfer.

Evaluation Questions

The PPST is a mature programme and has been relatively stable in implementation for a number of years. These features made it suitable for an outcome assessment (Rossi et al., 2004). However, implementation evaluations are highly recommended additions to outcome assessments (Rossi et al., 2004). Even if a programme is supported by a plausible theory, it is entirely necessary that the programme still be implemented as intended if it is to improve a situation. Therefore, the evaluation of the PPST assessed both aspects; the programme's implementation fidelity and its outcomes.

Implementation Fidelity

1) To what extent was the core programme components of each session delivered with fidelity?

Programme exposure, adherence and engagement.

2) To what extent did participants attend the PPST sessions, and engage in the course activities as intended?

Outcome Evaluation Questions

After participating in the PPST, and in comparison to parents who did not participate in the programme, did parents report:

3) A significantly higher use of positive parenting skills (e.g., praise, remaining calm during confrontation, parenting assertively)?

4) A significantly lower use of poor parenting skills (e.g., responding with high reactivity when child misbehaves, using harsh discipline)?

5) Significantly higher levels of parental sense of competence?

6) Significantly improved parent-child relationships?

7) That their children show significantly higher levels of self-esteem?

8) That their children show significantly improved behaviour (i.e. did the number of cases of child behaviour falling into the clinical range decrease? Parents who score 11 or more on the problem scale, or who have children scoring 127 or more on the intensity scale when using the Eyberg Child Behaviour Inventory).

9) Are all the above mentioned relationships confirmed by another adult in the home?

METHOD

Research Design

This evaluation was experimental; using a randomised controlled design. Participants were randomly allocated to either an intervention or waitlist control group. The intervention group received the seven-session PPST. There were two intervention groups which received this programme (n = maximum of 20 participants per group). These groups were delivered by different programme facilitators at different venues. Participants in the wait-list control group will receive the PPST programme in November 2015. It is common practice for The Parent Centre to use a waiting list, therefore this type of control group was appropriate for this evaluation. This evaluation was granted ethical approval by the Faculty of Commerce Ethics in Research Committee at the University of Cape Town (reference number: 1952) (See Appendix A).

Participants and eligibility criteria.

The participants in this evaluation were primary caregivers (the people most responsible for the wellbeing) of children between the ages of 5-12 years. Primary caregivers could include parents (biological, adoptive and foster) as well as other relatives e.g., grandparents. Primary caregivers are likely the most powerful figures in influencing their child's behaviour, because of their role in caring for their children. Therefore, including this type of participant would increase the chances of seeing parent and child behaviour changes. It was also necessary that this primary caregiver had to live with their child for a minimum of four nights a week in the same household. Ensuring that caregivers spent at least this amount of time with their children was thought to increase the likelihood of detecting successful behaviour change - due to the amount of interaction between caregiver and child. These caregivers had to reside in a large community of the Western Cape, known as Mitchells Plain for the purposes of this dissertation. This area was chosen by staff at The Parent Centre. Selecting participants from this area only was thought to encourage a fairly homogenous sample. One further exclusion criterion was that participants in this evaluation could not have attended the PPST programme, nor the Parenting and Leadership

programme previously. This step was taken to increase the chances of detecting a change in participants from pre to post - programme completion.

As a more objective measure, another adult in the household (if available) was also asked to participate in this study, and provide their perspective on the primary caregiver and their child. This adult could only be included if they lived with the index child (selected by the formerly mentioned caregiver) for at least four nights a week as well.

Recruitment

Participants were recruited through targeted sampling. The PPST and the evaluation of this programme were advertised by The Parent Centre representatives in primary schools, clinic talks, newspaper adverts, and in current Support Groups run by The Parent Centre (See Appendix B for supporting documents). Recruitment began in April 2014. Early recruitment was essential to reach the sample size required for this evaluation – which was much larger than the staff at The Parent Centre normally aim to gather. Recruitment for baseline assessment continued until July.

Sampling

Sample size for this evaluation was calculated using G*Power 3.1 (Faul, Erdfelder, Lang & Buchner, 2007). An *a priori* power analysis was calculated using analysis of variance (ANOVA) repeated measures, between factors. It was determined that a sample size of 60 participants was sufficient to meet the specified criteria (effect size = 0.3, power = 0.8; correlation between the repeated measures = 0.3). A moderate effect size was chosen based on what was found in the reviewed literature on the topic. However, attrition is common in parenting programmes and longer evaluations in general. It was thought that an additional 20 participants added to this sample size would likely reduce the effects of attrition. This addition is slightly larger than attrition rates found in other evaluations of parenting programmes (e.g., Hutchings et al., 2007). The desired sample size for this study was 80 participants. Ideally, this allowed for 40 participants to be allocated to the control and intervention groups respectively. The level of analysis was participant household.

Randomisation

The procedure for randomisation followed the CONSORT guidelines (Altman et al., 2001) (See Figure 3 for the CONSORT flowchart). Randomisation occurred on the level of the household, and after the completion of baseline assessment. There was an equal allocation of participants to both groups. The random allocation sequence was determined using free software, namely SealedEnvelope™. Group allocation was delivered by the main researcher. Blinding was not possible for the main researcher, participants or programme facilitators. Only the fieldworkers responsible for data collection were blinded so as to reduce bias in the data collection process.

Measures

Implementation fidelity.

All programme facilitators were requested to complete a self-report checklist after each session. These checklists required them to specify which core elements of the programme they implemented (See Appendix C). These were designed in collaboration with staff at The Parent Centre.

Participant exposure, adherence and engagement.

Facilitators were also requested to fill in attendance registers for each session - indicating participants' programme exposure and adherence (See Appendix D). Programme engagement was operationalised by using self-report checklists which participants completed. These were filled in at the beginning of programme sessions two to six. Checklists assessed the degree to which participants engaged with the homework practice activities set in the previous session. (See Appendix E).

Outcome assessment.

The strength of this evaluation was increased due to it utilising a multi-informant method (Lovejoy, Weis, O'Hare & Rubin, 1999). Another adult (multi-informant) who lived in the same home as the child's primary caregiver answered the same self-report questionnaires as this caregiver. They answered this questionnaire based on their

perspective on the primary caregiver's parenting and their child's behaviour. Primary caregivers were required to complete a questionnaire assessing all the outcomes (both primary and secondary) at every assessment point (See Appendix F), while the other adult in the home only completed questionnaires measuring the primary outcomes at every assessment point (See Appendix G). It was thought that the other adult's accounts were likely to be less accurate with regards to knowing about secondary outcomes, hence their exclusion from their questionnaire. All outcomes were measured at baseline and at post-assessment (immediately after the PPST has ended). All measures were in English – largely the participant's language of preference. 'The past month' was the time frame all measures referred to in order to account for potential changes able to be attributed to the intervention. However, none of the measures used in this study have been validated or standardised on any South African population, an unavoidable limitation of many studies in this context. See Table 5 for a summary of the measures used in this evaluation which were completed by both the primary caregiver and other adult.

Table 5

Measures Used in the Evaluation of the PPST

Area of assessment	Measure
Poor and positive parenting[1]	The Parenting Scale
	The Parent Behaviour Inventory
	Parenting Young Children Scale-Setting Limits Subscale
Parent-child relationship	Child-parent Relationship Scale
Child behaviour[1]	Eyberg Child Behaviour Inventory
Child self-esteem	Child Health Questionnaire – Self-Esteem Concept
Parent sense of competence	Parent Sense of Competence Scale
Programme fidelity	Facilitator checklist
Programme adherence and exposure	Attendance register
	Parent homework checklist

Note: [1] Primary outcomes in this evaluation.

Demographics.

The demographic information which was gathered about participants included: participant's gender, race, home language, highest educational qualification obtained, marital status, and employment status, number of children living in their home, child age and child gender.

Primary outcomes.

Positive and poor parenting behaviours.

The Parenting Scale (PS) – self report measures the dysfunctional discipline practices of parents of young children (Arnold, O'Leary, Wolff & Acker, 1993). This scale allows for the identification of parents who tend to mishandle disciplinary encounters even if these encounters do not happen frequently. The scale is comprised of three factors: verbosity, over-reactivity and laxness (Arnold et al., 1993). In total, the scale consists of 30 items. These are answered on a 7-point scale – some of which are reverse scored. Scale anchors vary per question but are essentially parenting mistakes paired with more effective parenting behaviours (e.g., "I often hold a grudge" vs. "things get back to normal quickly"). A total score for this scale was calculated and used in analyses. Higher scores on this scale indicate higher levels of dysfunctional parenting.

The scale has been validated on an American sample of parents of children between the ages of 5-12 years (Harvey, Danforth, Ulaszek & Eberhardt, 2001). There is evidence for the measure's ability to discriminate between parents of children with attention deficit hyperactivity disorder who showed high levels of delinquency and aggression, and parents of children who do not display clinical levels of problematic behaviours. Additionally, the measure has demonstrated high levels of internal consistency (Cronbach alpha's for mothers and fathers for the total scale, over-reactivity and laxness subscales were no lower than $\alpha = 0.82$). Moreover, the Parenting Scale has been used in numerous parenting programme evaluations (e.g., Hahlweg et al., 2010; Zubrick et al., 2005).

The Parent Behaviour Inventory (PBI) – a self-report measure - reflects two dimensions of parenting behaviour. One is hostile/coercive "behaviour which expresses negative affect or indifference toward the child" and could include using physical punishment, threat or coercion to influence child behaviour (e.g., "I grab or handle my child roughly") (Lovejoy et al., 1999, p.535). The second is supportive/engaged parenting which reflects parental acceptance of a child through signs of affection, instrumental and

emotional support and shared activities (e.g., “I have pleasant conversations with my child”) (Lovejoy et al., 1999, p.535). It is suitable for use with parents of children who are young school-age. The PBI consists of 20 items which can be answered on a 5-point Likert-type scale. Scale anchors range from “not at all true” to “very true”. Total scores for the respective subscales of this measure were also calculated. Higher scores indicate higher levels of the respective types of parenting behaviours.

The measure has demonstrated adequate test-rest reliability (r = 0.69 and r= 0.74 for the hostile/coercive scale and supportive/engaged scales, respectively). Additionally, inter-observer reliability (r = 0.90 and r = 0.87 for the supportive/engaged and hostile/coercive scales, respectively) and internal consistency (supportive/engaged scale α = 0.83, and hostile/coercive scale α= 0.81) is high. Furthermore, the scale’s validity and utility have also been partially supported in initial analyses (Lovejoy et al., 1999).

Parenting was also measured utilising the Parenting Young Children Scale (PARYC) Setting Limits subscale – self report (McEachern et al., 2012). This subscale assesses the frequency of engagement with setting limits (e.g., “Stick to your rules and not change your mind”) with children on a 7-point Likert scale from “never” to “always”. It also determines whether performing this behaviour is seen as a problem for the parent with response options including either “yes” or “no”. The Setting Limits subscale consists of 7 items. Only the primary caregivers in this evaluation were required to complete this latter section because the answers to these questions are very subjective. Items for this subscale were summed to result in a total frequency score and total problem score. Higher scores of on the frequency scale are indicative of more effective parenting in that the parent was able to set limits successfully. In contrast, higher scores on the problem scale are indicative that setting limits was a problem for the caregiver.

There is preliminary support for the scale’s construct validity which has been found through factor analysis (McEachern et al., 2012). The scale’s convergent validity is also suggested as it demonstrates significant positive relationships to other scales assessing dysfunctional and adaptive parenting behaviours e.g., the setting limits subscale shows significant correlations of r = -0.50 and r = -0.51 to the Parenting Scale laxness and overreactivity scores respectively. Significant positive correlations have been found

between this subscale and the Parenting Sense of Competence competency (r = 0.49), self-efficacy (r = 0.40) and satisfaction (r = 0.41) scores. Finally, the reliability of the scale overall is high; supporting positive behaviour (α = 0.78), setting limits (α = 0.79) and proactive parenting (α = 0.79) subscales all showing good Cronbach alpha's.

Child behaviour.

Child behaviour was assessed using the Eyberg Child behaviour Inventory (ECBI) - parent-report (Eyberg & Ross, 1978). The ECBI can be used to assess behaviour problems in children from 2 to 16 years old. It is comprised of 36 items. Each item is assessed on two dimensions; how often it occurs (i.e. frequency) and identification of the behaviour as a problem for the parent ("dawdles in getting dressed"). Frequency ratings are answered on a 7-point Likert-type scale ranging from "never occurs" to "always occurs". By summing these answers together one is provided with an overall problem behaviour Intensity Score. Higher scores are indicative of higher levels of problematic child behaviour. When identifying whether a behaviour is a problem for a parent, they answer with either "yes" or "no" to the question. These answers can also be summed to create a total Problem Score.

There is ample evidence that the ECBI is a psychometrically sound measure, demonstrating validity and reliability in measuring child problem behaviours (Boggs, Eyberg & Reynolds, 1990; Eyberg & Ross, 1978; Robinson, Eyberg & Ross, 1980). The Intensity score's mean split-half correlation was found to be r = 0.94, and the Problem Score's was r = 0.94. Test-retest correlations were also high for these respective subscales r = 0.86 and r = 0.88. Both scales also demonstrated very high internal consistency coefficients, r = 0.98 (Robinson, Eyberg & Ross, 1980).

Secondary outcomes.

Parent sense of competence.

Parents' sense of competence was measured using the parent self-report of the Parenting Sense of Competence Scale (PSOC; Johnston & Mash, 1989). The PSOC's factor structure is composed of two dimensions of parenting self-esteem namely, efficacy and satisfaction. The satisfaction factor reflects the extent to which parents feel poorly motivated, anxious and frustrated in their role. The efficacy factor reflects the extent to

which a parent feels familiar with the role, capable of solving problems and competent. The scale consists of 17 items which can be answered on a 6-point Likert-type scale ranging from "strongly disagree" to "strongly agree." Some of these items are reverse scored. A total score for this scale was also calculated by summing together the items' scores. Higher scores on this scale are indicative of lower levels of parental competence.

The scale and its respective subscales have demonstrated high levels of internal consistency (α = 0.75 and 0.76 were the lowest Cronbach alphas for the satisfaction and efficacy subscales found in two separate studies; Johnston & Mash, 1989; Ohan, Leung, & Johnston, 2000). There is support for the subscale's convergent and divergent validity as well (Ohan et al., 2000). The PSOC is another popular measure, and has been used in a number of evaluations of parenting programmes (Giannotta et al., 2013; Reedtz et al., 2011).

Parent-child relationship.

The Child Parent Relationship Scale (CPRS) self-report (Pianta, 1992) assesses parent's perceptions of the relationships they have with their children (between 3-12 years). It consists of 15 items, which are answered on a 5-point Likert-type scale (http://curry.virginia.edu/academics/directory/robert-c.-pianta/measures). The anchors for this scale range from "does not apply" to "definitely applies". The measure has two subscales; a conflict subscale assesses the extent to which a parent feels that the relationship with their child is characterised by negativity, and a closeness subscale which measures the degree to which a parent feels that the relationship with their child is characterised by open communication, warmth and affection (Driscoll & Pianta, 2011). A total score for each subscale was calculated. Higher scores for the closeness subscale indicate a positive parent-child relationship. Higher scores on the conflict subscale in contrast indicate a poorer parent-child relationship.

The scale has adequate evidence for reliability (Driscoll & Pianta, 2011). The lowest Cronbach alphas found across three measurements in time were α = 0.78 on the conflict subscale, α = 0.64 on the closeness scale, with the highest being α = 0.84 and α = 0.74 on the same subscales, respectively. Additionally, there is evidence for the scale to possess convergent and divergent validity. The measure's closeness subscale has shown negative

correlations with measures of child problem behaviour, while being positively correlated with a measure of child competence. In contrast, the measure's conflict subscale has been found to be negatively correlated with competence and positively correlated with child problem behaviour (Driscoll & Pianta, 2011). This scale was used in a national evaluation of the Sure Start early child development programme in England (National Evaluation of Sure Start, 2007 as cited in Simkiss et al., 2013).

Child self-esteem.

Child self-esteem was measured using the Child Health Questionnaire – self-esteem subscale (CHQ-ES) – parent-report. The CHQ measures 14 psychosocial and physical concepts, and is designed and normed for use with children between the ages of 5 and 18 years (www.healthactchq.com). Only the self-esteem concept was used in this evaluation. This concept is comprised of 6 items, which parents can answer on a 5-point Likert-type scale ranging from "very satisfied" to "very dissatisfied". The scale determines how satisfied the parent thinks their child is with aspects of themselves and their lives. A total score for this measure was created by summing the individual items' scores together. A higher total score shows that a child has a high self-esteem.

Internal consistency reliability in two samples (Australian and USA) was found to be above $\alpha = 0.8$ for this subscale (Waters, Salmon & Wake, 2000). This scale also shows high levels of item discriminant validity, suggesting it is psychometrically sound.

Procedure

Once participants were recruited the researcher contacted them and arranged to meet with them to conduct the initial assessment (See Appendix H for timeline). Participants were reminded of all appointments via a phone call or SMS a day in advance of this appointment. Post-assessment interviews were arranged with caregivers during the final week of the PPST delivery. Participants were interviewed in their homes and in some instances in the researcher's car with a fieldworker (in the case where the participants area of residence was seen to be dangerous, or privacy within the home was not possible).

Fieldworkers began each interview by explaining the study to the participants and gaining informed consent. Participants completed the questionnaires with a fieldworker who used an interview method to complete the questionnaires, i.e. fieldworkers asked participants questions from the questionnaire and filled in their answers for participants. This method catered for the likelihood of the low literacy levels of the participants. The second adult in the home passed through the same procedure. The majority of the interviews were conducted in English; fieldworkers were also fluent in Afrikaans so that if participants requested items to be explained in Afrikaans instead this was possible. Once the interview was finished the participant was thanked and given a small gift for their time (i.e., a packet of muffins). Primary caregiver interviews took approximately an hour to complete. Interviews with the other adult took approximately 1 hour to complete as well.

During programme implementation the researcher remained in contact with facilitators who provided her with the implementation fidelity data. After all the data was collected it was recorded and analysed.

Ethics

Prior to participating in the study, all participants were required to complete a consent form. This specified that participation was voluntary, their information was kept confidential, and provided information on the study (see Appendix I for a copy of the informed consent form). Collected data was stored on a password protected computer and in a locked filing cabinet to remain confidential – thus allowing access to only the researchers involved in this study. The only circumstance under which confidentiality could have been broken was in the case of suspected child maltreatment. See Appendix J for the protocol in such a situation.

All participants in this study received an incentive (a packet of muffins) for each interview. This incentive was thought to be too small to result in participants feeling coerced to participate, and functioned as a token of appreciation. Participants had to remain traceable in this evaluation so that the post-assessment and follow-up assessment could be completed. Therefore, we were required to request all participants for their own contact details, as well as those of three other individuals who would always know where they were.

Mitchells Plain can be considered to be a fairly dangerous area to conduct fieldwork within. A number of measures were taken to ensure fieldworkers would be safe throughout the duration of their fieldwork (See Appendix K for protocol).

Statistical Analysis

All quantitative data was recorded and analysed using IBM 'Statistical Package for the Social Sciences' (SPSS) version 21. The unit of analysis for this evaluation was the individual. Baseline equivalence on descriptive data, and primary and secondary outcomes was determined using an independent samples t-test (provided data were normally distributed). Two sets of analyses were run. First, an intention to treat (ITT) analysis assessed those randomised to the intervention group (including those who did not attend the programme) against those randomised to the control group. ITT analysis ensures that all the participants who were randomised are included, and according to their original assignment (Gupta, 2011). Anything which may have occurred after randomisation (e.g., withdrawal, non-compliance et cetera) is compensated for statistically. Therefore, the estimated treatment effect provided by this analysis is unbiased. Taking this approach also ensures factors which may help a programme seem effective (e.g., personal motivation to improve as a parent) are less likely to cloud an estimation of programme effectiveness. Second, to provide some estimate of whether the programme may work for those who attend, participants who attended at least one session were compared with those who attended none, regardless of group allocation.

A total of six primary caregivers and eight other adults were lost at post-test (see the CONSORT diagram and Appendix L respectively, for reasons for attrition). For both analyses, it was essential that all participants were retained in the analyses, and therefore statistical means were used to compensate for missing data. Where data were missing within a case, the missing data was imputed using multiple imputation (Sterne et al., 2009). Only eight items were missing across eight cases. Where whole cases were missing, two different datasets were created: one where the best possible outcomes were imputed for all missing cases, and one where the worst possible outcomes were imputed for these cases. Models were then run on both the "best possible" and "worst possible" datasets (see Appendix M

for further details). If the programme demonstrates an effect in both models, then one has confidence that the programme is effective.

Mixed models linear regression analyses were used to determine intervention effects. Covariates included in the models were: pre-test data, programme group, programme adherence and child age. Primary caregiver data and data collected from another adult in the home were analysed separately.

The programme fidelity data was analysed in a number of ways. Firstly, descriptive statistics (means and standard deviations) were calculated for the quantitative programme fidelity, attendance and exposure data (for each group). The level of programme fidelity was assessed by creating a ratio between the extent to which the programme was implemented according to its design.

RESULTS

Description of the Sample

The recruited sample consisted of 96 primary caregivers. Sixteen primary caregivers were lost (nine prior to randomisation) for various reasons (see CONSORT diagram below). This brought our final sample size to the target of 80 primary caregivers, and 60 other adults. At post-test, we were able to interview 72 (93%) primary caregivers and 52 (87%) other adults.

Description of primary caregivers.

Primary caregivers were predominantly female (91.30%, *n* = 73). Furthermore, the large majority of the primary caregivers were also biological parents (82.50%, *n* = 66). The remainder of this sample consisted of grandparents (11.30%, *n* = 9), adoptive parents, aunts, great grandmothers and co-habiting friends. The ages for this sample ranged from 24 years to 67 years. Nearly two thirds of the participating primary caregivers were married (63.70%, *n*=51), with the remaining being single, divorced, widowed, co-habiting or separated. Just over three quarters (77.50%, *n* = 62) of this sample was not working at the time of the first interview. With regards to education, the majority of the interviewed primary caregivers had not complete their formal school education; only 27.50% (*n* = 22) had finished Grade 12. A further 10% (*n* = 8) had achieved either a diploma or university degree.

At baseline just over two thirds (*n* = 54, *67*.5%) of the primary caregivers included in the evaluation gave reports that exceeded the clinical cut-off on the Parenting Scale. This suggests that most of the caregivers in the sample relied on a number of dysfunctional disciplinary tactics when handling their children's problem behaviour e.g., arguing about misbehaviour, holding grudges, disciplining in an inconsistent manner. Most parents also scored in the average range on the Parent Behaviour Inventory Hostility subscale. These findings lend support to the contention that poor parenting practices in this sample were exercised quite often, and when such tactics were exercised they were quite problematic in themselves. However, most of the primary caregivers also reported exercising positive parenting practices (i.e. setting limits and being supportive) very regularly as well. The

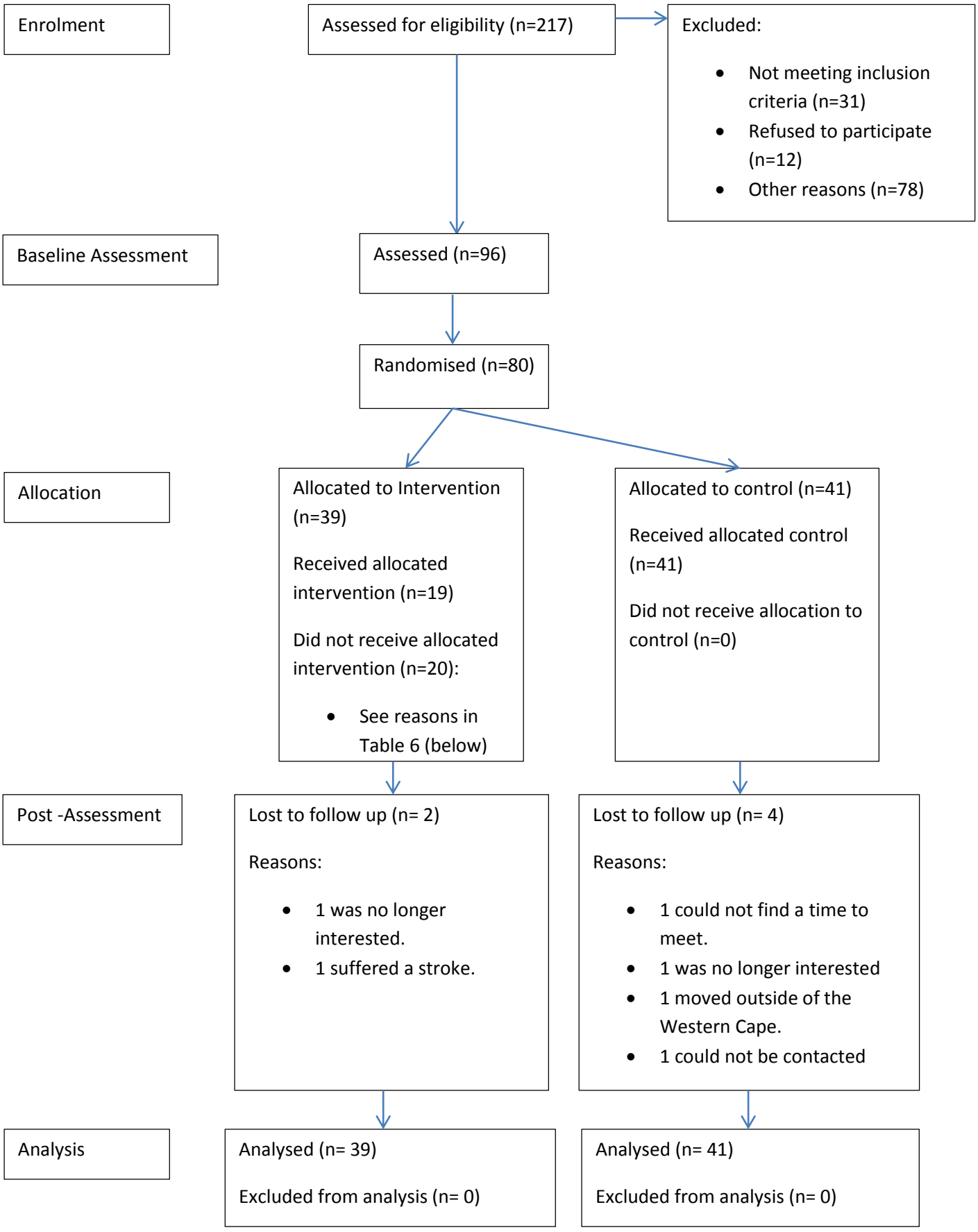

Figure 3. CONSORT flow diagram.

distribution of the various parenting scales (see Appendix M for details) suggested that for the most part caregivers practiced positive parenting styles more often than poorer ones, and when poor parenting tactics were used they were highly dysfunctional. Scores on the Parent Sense of Competency scale showed that few caregivers felt either extremely competent or incompetent with regards to their parenting; most scored in the average range on this scale. Additionally, the majority of caregivers reported high levels of closeness and average levels of conflict in their relationships with their children, implying that for the most part they had good relationships with their children.

Description of children who were the focus of the report.

Primary caregiver report.

The vast majority of primary caregivers had more than one child living in the home with them (88.70%, *n* = 71); most homes had between two and four children (76.25%, *n* = 61). There were slightly more male (56.30%, *n* = 45) than female children (43.8%, *n* = 35) who were selected by primary caregivers to be the focus of the evaluation. Nearly a third (32.50%, *n* = 26) of these selected children were aged between five and seven years, a quarter were eight years old (*n* = 20) at the time of the first interview, while the remaining nine to 12 year old children equally represented the last 40% of the sample.

The intensity score on the Eyberg Child behaviour Inventory revealed that 41.25% (*n* = 33) of caregivers perceived their children's problem behaviour as occurring so frequently, that it reached the clinical cut-off at baseline. Additionally, 76.25% (*n* = 61) of the parents perceived the extent to which they had problems with their children's behaviour as reaching the clinical cut-off on the frequency scale at baseline. A total of 19 children (23.75%) were perceived by their primary caregivers as behaving so well that neither their Eyberg Child Behaviour Inventory intensity nor problem scores were above the clinical cut-off.

Description of other adult.

Where another adult resided with the primary caregiver and child for at least four nights a week, most of the time this individual was also the biological parent to the selected

child (41.30%, *n* = 33), a quarter were grandparents (25.00%, *n* = 20), the remainder of the sample consisted of step-parents, adoptive parents, aunts, uncles or siblings. Based on their perspective, 58.33% (*n* = 35) of the primary caregiver's selected children were perceived as expressing problem behaviour so frequently that it reached the clinical-cut off at baseline on the ECBI frequency scale.

Implementation Fidelity

Programme facilitators implementing the PPST at both venues completed checklists each week the programme was delivered. These specified the components of the programme which were intended to be implemented. All the programme components which were intended to be implemented were delivered by the facilitators at both venues. Therefore, the programme was implemented with exceptionally high fidelity.

Programme exposure, adherence and engagement.

Attendance and exposure.

A total of 39 primary caregivers were allocated to the intervention group; 19 participants were assigned to the Bluebrook group, while the remaining 20 were assigned to the Southdale group. Of these participants only 19 attended a least one programme session. This signifies that programme attendance was very poor (See Table 20 in Appendix N for the number of attendants at each session). Therefore, complete exposure to the programme was found to be limited. As the majority of the participants who were allocated to the intervention did not attend even a single session, we also explored reasons for their non-attendance. Table 6 (below) provides such reasons. This table reveals that it was primarily caregiving responsibilities (e.g., looking after sick children, attending court for child's arrest et cetera) which were the main reason why participants could not attend the programme. The next most common reasons included being out of Mitchells Plain at the time, honouring work commitments, and experiencing difficulties in getting to the programme venue (e.g., lack of money for a taxi, getting lost etc.)

Table 6

Reasons Participants Did Not Attend the Programme

Reason	Percentage
Caregiving responsibilities relating to other family members	15.00
Out of Mitchells Plain at the time	5.00
Work commitments	5.00
Difficulty in getting to programme venue due to distance or costs related to travel.	5.00
Personal illness	4.00
Other commitments	2.00
Unknown	2.00
Death of a relative	1.00
Educational commitments	1.00

Participant engagement.

Participants were also required to complete checklists in programme sessions which asked about how many of the set homework activities participants managed to complete at home with their children. These checklists revealed a high level of engagement with programme material outside of programme sessions because in most instances programme attendants completed all the set homework (see Table 21 Appendix O). Additionally, there was never an instance where homework had not been attempted. These results suggest that when participants attended a programme session they did in fact apply at least some of the learnt skills at home. Therefore, for those who attended the programme sessions, one would expect that through applying the skills learnt in-session in their homes that they would change in ways specified by the programme's theory of change.

Outcome Evaluation

Reliability.

A Cronbach's alpha equal to or greater than 0.70 shows that a scale has an acceptable measure of reliability (Nunnally, 1978). According to this standard, the majority of the scales used in this evaluation were found to be reliable measures of the constructs of interest at baseline and post-test, for both primary caregivers and "other adults" (see Appendix M for reliability statistics). Therefore, these scales could be included in further analyses. Only two scales were found to have sub-standard reliability. Consequently, these were excluded from any further analysis. These scales included the Child Health Questionnaire, which showed Cronbach's alpha's below 0.70 at both assessment points based on primary caregiver accounts. Additionally, the Hostility subscale of Parent Behaviour Inventory which "other adults" completed also showed low levels of reliability. Possible reasons for these scale's low alphas are also provided in Appendix M.

Baseline equivalence.

Table 7 (below) shows there were no significant differences found for any of the demographic variables, or for the measures of parenting behaviour, child behaviour, the parent-child relationship, or parent sense of competency between the intervention and control group at baseline according to primary caregiver accounts. This equivalence between the intervention and control group at baseline is largely supported by "other adult" account's as well, where there was only a significant difference on the Supportive subscale of the Parent Behaviour Inventory. This difference favoured the control group, meaning that intervention group parents seemed to demonstrate lower levels of this parenting style. Given this, these groups can be regarded as equivalent at baseline. This equivalence essentially means that the characteristics of participants which can have some influence on the outcomes of interest are distributed equally between the groups (Roberts & Torgerson, 1999). Therefore, any difference which can be found at the post-test can only be attributed to the programme (Roberts & Torgerson, 1999).

Table 7

Characteristics of Participants at Baseline Based on Primary Caregiver's Accounts

Variable	Intervention group (*n* = 39)		Wait-list control group (*n* = 41)		*t* or (*U)* or [X^2]	*p*
Demographic variables						
	M	*SD*	*M*	*SD*		
Child age in years	8.56	2.39	8.29	1.89	0.57	0.57
	%		%			
Child gender (female)	22.50		21.25		[0.18]	0.67
Primary caregiver gender (female)	43.75		47.50		[0.22] Likelihood Ratio	0.64
Relationship to child (biological parent)	38.75		43.75		[0.64] Likelihood Ratio	0.89
Relationship status (married)	31.25		32.50		[2.81] Likelihood Ratio	0.73
Working status (working)	13.75		8.75		[1.43]	0.23
Scales						
	M	*SD*	*M*	*SD*		
PS	3.50	0.69	3.65	0.67	-0.99	0.32
PARYC	2.11	0.92	2.35	0.75	-1.32	0.19
PARYC PROB	36.60 (mean rank)		44.21(mean rank)		(647.50)	0.14
PBI Supportive	40.90 (mean rank)		40.12 (mean rank)		(784.00)	0.88
PBI Hostile	23.64	8.72	24.76	10.89	-0.50	0.61
PSOC	53.03	12.00	53.39	12.23	0.13	0.89
CPRS Conflict	21.92	8.40	22.90	8.46	-0.52	0.60
CPRS Closeness	40.28 (mean rank)		40.71 (mean rank)		(791.00)	0.94
ECBI Intensity	120.66	44.50	130.54	42.26	-1.02	0.31
ECBI PROB	15.33	9.11	17.17	8.16	-0.95	0.34

Note: PS - Parenting Scale, PARYC – Parenting Young Children Scale-Setting Limits Subscale, PARYC PROB – Parenting Young Children Scale-Setting Limits Subscale Problem Score, PBI Supportive - Parent Behaviour Inventory Supportive Parenting Subscale, PBI Hostile - Parent Behaviour Inventory Hostile Parenting Subscale, PSOC – Parent Sense of Competence Scale, CPRS Conflict – Child-parent Relationship Scale Conflict Subscale, CPRS Closeness – Child-parent Relationship Scale Closeness Subscale, ECBI Intensity – Eyberg Child Behaviour Inventory Intensity Subscale, ECBI PROB - Eyberg Child Behaviour Inventory Problem Subscale.

Intention to Treat Analysis

Primary caregiver.

Table 8 provides the pre and post-test means and standard deviations for both the intervention and control group. Under the best possible conditions it is evident that the scores on the Parenting Scale decreased over time for both groups, while scores on the Parenting Young Children Scale showed both groups set higher limits over time, and problems associated with limit setting decreased. Scores on the Supportive subscale of the Parent Behaviour Inventory showed only a slight increase over time, while scores on the Hostility subscale decreased over time. Both groups seemed to improve in parental self-efficacy, the intervention group more so than the control at post-test. Marginal decreases and increases in conflict and closeness in the parent-child relationship were respectively found. Large drops in the number of reported problematic child behaviours on the Eyberg Child Behaviour Inventory for both groups were found, and as one would expect parents in both groups also thought of their children's behaviour as less difficult for them to handle. Therefore, these findings were all in the expected direction, however under this condition we largely see both groups change in this direction in similar ways.

Table 8

Primary Caregiver Descriptive Statistics for Programme Effects – Best Possible Scenario

	Pre-test				Post-test			
Scale	Intervention group		Wait-list control group		Intervention group		Wait-list control group	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
PS	3.50	(0.69)	3.65	(0.67)	3.09	(0.85)	3.24	(1.07)
PARYC	38.62	(8.34)	37.02	(7.68)	41.92	(6.52)	40.66	(7.60)
PARYC PROB	2.15	(2.27)	2.76	(2.07)	1.64	(1.86)	1.95	(2.21)
PBI - Supportive	43.28	(10.00)	44.39	(7.56)	44.54	(8.96)	45.61	(6.17)
PBI - Hostile	23.64	(8.72)	24.76	(10.89)	17.72	(10.02)	19.44	(10.34)
PSOC	53.03	(12.00)	53.39	(12.23)	45.87	(13.69)	49.54	(14.45)
CPRS Conflict	21.92	(8.40)	22.90	(8.46)	20.10	(9.44)	20.98	(8.55)
CPRS Closeness	30.87	(5.19)	31.39	(4.24)	31.56	(5.17)	32.54	(3.68)
ECBI Intensity	120.66	(44.50)	130.54	(42.26)	102.90	(48.19)	109.37	(41.87)
ECBI PROB	15.33	(9.11)	17.17	(8.16)	11.23	(9.54)	13.05	(7.99)

Note: PS - Parenting Scale, PARYC – Parenting Young Children Scale-Setting Limits Subscale, PARYC PROB – Parenting Young Children Scale-Setting Limits Subscale Problem Score, PBI Supportive - Parent Behaviour Inventory Supportive Parenting Subscale, PBI Hostile - Parent Behaviour Inventory Hostile Parenting Subscale, PSOC – Parent Sense of Competence Scale, CPRS Conflict – Child-parent Relationship Scale Conflict Subscale, CPRS Closeness – Child-parent Relationship Scale Closeness Subscale, ECBI Intensity – Eyberg Child Behaviour Inventory Intensity Subscale, ECBI PROB - Eyberg Child Behaviour Inventory Problem Subscale.

Under the assumption of the worst possible condition the above findings are for the most part not replicated (see Table 9 below). Parenting Scale scores for the control group were found to increase at post-test, unlike the intervention group which were found to decrease. Additionally, the control group caregivers at post-test reported slightly lower levels of limit setting than at pre-test, while the intervention group caregivers reported an increase in this parenting behaviour. Both groups reported a slight reduction in having difficulties with implementing this parenting practice. Lower levels of supportive parenting were reported for both groups over time. Only the intervention group showed a reduction in hostile parenting practices, while the control group stayed the same over time. The table also suggest caregivers who received the programme showed improved self-efficacy after participation, as opposed to the control group caregivers who showed lower levels of parental efficacy at post-test. Control group caregivers reported more conflict in their relationship with their children at post-test, in comparison to intervention group mothers who reported similar levels at both pre and post-test. Similar levels of closeness in the parent-child relationship were reported at both time points for the intervention group, with

the control group caregivers showing a slight reduction. Child behaviour problems were only found to decrease for the intervention group caregivers over time. However, both groups reported having slightly lower levels of difficulty in handling this behaviour over time.

Table 9

Primary Caregiver Descriptive Statistics for Programme Effects – Worst Possible Scenario

	Pre-test				Post-test			
Scale	Intervention group		Wait-list control group		Intervention group		Wait-list control group	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
PS	3.50	(0.69)	3.65	(0.67)	3.39	(1.10)	3.82	(1.31)
PARYC	38.62	(8.34)	37.02	(7.68)	39.77	(9.97)	36.56	(12.12)
PARYC PROB	2.15	(2.27)	2.76	(2.07)	2.00	(2.16)	2.63	(2.57)
PBI Supportive	43.28	(10.00)	44.39	(7.56)	41.97	(13.28)	40.73	(14.83)
PBI Hostile	23.64	(8.72)	24.76	(10.89)	20.28	(11.49)	24.32	(11.75)
PSOC	53.03	(12.00)	53.39	(12.23)	50.23	(17.02)	57.83	(17.54)
CPRS Conflict	21.92	(8.40)	22.90	(8.46)	21.74	(9.98)	24.10	(9.08)
CPRS Closeness	30.87	(5.19)	31.39	(4.24)	30.13	(7.47)	29.81	(8.40)
ECBI Intensity	120.66	(44.50)	130.54	(42.26)	113.97	(55.95)	130.44	(52.86)
ECBI PROB	15.33	(9.11)	17.17	(8.16)	13.08	(10.64)	16.56	(9.32)

Note: PS - Parenting Scale, PARYC – Parenting Young Children Scale-Setting Limits Subscale, PARYC PROB – Parenting Young Children Scale-Setting Limits Subscale Problem Score, PBI Supportive - Parent Behaviour Inventory Supportive Parenting Subscale, PBI Hostile - Parent Behaviour Inventory Hostile Parenting Subscale, PSOC – Parent Sense of Competence Scale, CPRS Conflict – Child-parent Relationship Scale Conflict Subscale, CPRS Closeness – Child-parent Relationship Scale Closeness Subscale, ECBI Intensity – Eyberg Child Behaviour Inventory Intensity Subscale, ECBI PROB - Eyberg Child Behaviour Inventory Problem Subscale.

The first analysis conducted to determine the effectiveness of the intervention was an intention to treat (ITT) analysis. The results for the best and worst case intention-to-treat analysis can be found below in Table 10.

No group effects were found following an intent-to-treat analysis based on primary caregiver reports. This suggests that there were no differences between the intervention and control group across the various outcomes, and hence it appears that the programme was not effective. However, Table 10 does provide some support for the contention that there were changes in most outcomes over time. Based on analyses primarily under the best possible conditions, there were numerous significant findings for time across many of the scales. Yet, these can only be regarded as weakly suggestive of change because these findings were not upheld under the condition of worst possible scenario.

Table 10

Primary Caregiver Intention to Treat Analysis

	Best possible				Worst possible			
Scale	Coefficient[1]	*t*	*p*	95% CI	Coefficient[1]	*t*	*p*	95% CI
PS								
Model			0.00				0.25	
Group	-0.22	-0.91	0.36	[-0.48 – 0.18]	-0.29	-1.65	0.10	[-0.64 – 0.06]
Time	0.41	4.71	0.00	[0.24 – 0.59]	-0.04	-0.27	0.78	[-0.30 – 0.23]
PARYC								
Model			0.00				0.38	
Group	1.43	1.0	0.32	[-1.40 – 4.26]	2.40	1.36	0.18	[-1.08 – 5.90]
Time	-3.48	-3.90	0.00	[-5.24 – 1.71]	-0.33	-0.26	0.79	[-2.81 – 2.22]
PARYC PROB								
Model			0.01				0.22	
Group	-0.46	-1.13	0.26	[-1.26 – 0.34]	0.07	-1.47	0.15	[0.36 – 0.01]
Time	0.66	2.75	0.01	[0.19 – 1.14]	0.01	0.98	0.33	[0.01 – 0.10]
PBI Hostile								
Model			0.00				0.15	
Group	-1.42	-0.73	0.47	[-5.28 – 2.44]	-2.58	-1.24	0.22	[-6.67 – 1.52]
Time	5.61	5.10	0.00	[3.44 – 7.79]	1.86	1.50	0.14	[-0.58 – 4.31]
PBI Supportive								
Model			0.22				0.81	
Group	0.01	0.44	0.66	[0.17 – 0.41]	0.97	-0.15	0.88	[0.62 – 1.51]
Time	0.05	1.70	0.091	[0.00 – 0.22]	0.92	-0.64	0.52	[0.70 – 1.20]
PSOC								
Model			0.001				0.32	
Group	-2.02	-0.80	0.43	[-6.99 – 2.96]	-3.98	-1.44	0.15	[-9.44 - 1.48]
Time	5.46	3.61	0.00	[2.47 – 8.46]	-0.91	-0.48	0.63	[-4.68 - 2.85]
CPRS Conflict								
Model			0.10				0.55	
Group	-0.93	-0.54	0.59	[-4.35 – 2.49]	-1.67	-0.93	0.35	[-5.21 – 1.87]
Time	1.88	2.10	0.04	[0.11 – 3.64]	-0.53	-0.57	0.57	[-2.33 – 1.28]
CPRS Closeness								
Model			0.047				0.76	
Group	0.02	0.65	0.51	[0.07 – 0.26]	0.00	0.12	0.90	[0.16 – 0.20]
Time	0.05	2.41	0.02	[0.00 – 0.16]	0.01	-0.74	0.46	[0.16 – 0.03]
ECBI Intensity								
Model			0.00				0.33	

Group	-8.17	-0.89	0.37	[-26.25 – 9.90]	-13.17	-1.36	0.18	[-32.30 – [5.96]
Time	19.51	5.20	0.00	[12.13- -26.89]	3.31	0.64	0.53	[-6.96 – [13.58]
ECBI PROB								
Model			0.00				0.13	
Group	-1.83	-1.04	0.30	[-5.31 – 1.66]	-2.66	-1.44	0.15	[-6.31 – 0.99]
Time	4.11	5.01	0.00	[2.49 – 5.73]	1.41	1.46	0.15	[-0.51 – 3.33]

Note: [1] All co-efficients are presented for intervention and baseline assessment. PS - Parenting Scale, PARYC – Parenting Young Children Scale-Setting Limits Subscale, PARYC PROB – Parenting Young Children Scale-Setting Limits Subscale Problem Score, PBI Supportive - Parent Behaviour Inventory Supportive Parenting Subscale, PBI Hostile - Parent Behaviour Inventory Hostile Parenting Subscale, PSOC – Parent Sense of Competence Scale, CPRS Conflict – Child-parent Relationship Scale Conflict Subscale, CPRS Closeness – Child-parent Relationship Scale Closeness Subscale, ECBI Intensity – Eyberg Child Behaviour Inventory Intensity Subscale, ECBI PROB - Eyberg Child Behaviour Inventory Problem Subscale.

With regards to parenting there is some support for the contention that both the control group and intervention group showed marginally lower levels of dysfunctional parenting at post-test. Participants overall also seemed to practice a little more limit setting at the second assessment point than they did at pre-test. Caregivers also seemed to express slightly less trouble with practicing this parenting behaviour at post-test. A more substantial difference was found for hostile parenting; participants from both groups at post-test reported lower levels of this parenting style than they did at pre-test. This finding though smaller in size under the condition of worst possible scenario was not far off from being significant. This convergence in findings between the two conditions lends substantial support to the validity of this change. Based on the ITT analyses no difference could be detected over time for supportive parenting. This finding was somewhat expected considering that the majority of the sample scored very high at pre-test which would leave little room for improvement.

Mixed evidence was also found for caregiver's sense of competence to improve over time, due to the difference in significance of the findings between best and worst case scenario. Furthermore, only marginal changes in the parent-child relationship were noted for both groups over time; a slight decrease in conflict and an even smaller reduction in closeness were reported at post-test. The latter effect cannot be regarded as clinically significant due to its size. Additionally, finding an effect for this outcome would have been

challenging due to the fact that at pre-test parents reported very high levels of closeness as well.

Much greater improvements in child behaviour were found over time; participants reported on average 19.51 units less on the ECBI intensity scale at post-test as opposed to pre-test. Furthermore, they reported having fewer problems with their children's behaviour at post-test as opposed to pre-test. This latter finding was not significant (but only marginally so) under the condition of worst possible scenario. Additionally, though the size of the effect was smaller under this condition it was in the same direction. This lends additional support to this finding's validity.

The findings presented here only allow one to suggest very tentatively that both groups may have changed across the various measures over time. Though numerous effects for time were found, and these were often in the direction one would have hoped for, and were sometimes quite substantial in size as well, it is important to remember that they applied to the sample as a whole, and only under the condition of best case scenario. Under the condition of worst case scenario, all significant findings for time were lost. More support for this contention could be found from considering "other adults" results, as well as conducting further analyses which take into consideration moderators like programme attendance. The prior shall first be presented here.

Other adult.

Table 11 (below) provides the means and standard deviations for each of the scales completed by other adults, under the best possible situation. Both groups showed reductions in scores on the Parenting Scale over time suggesting both groups displayed less dysfunctional parenting (with the intervention group being favoured slightly more than the control group). Improvements were also noticed in limit setting across both groups due to increases in scores on the Parenting Young Children Scale at post-test (again slightly favouring the intervention group). Only the intervention group seemed to show increased levels of supportive parenting at post-test. Lastly, both groups showed reductions in the number of reported child problem behaviours over time.

Table 11

Other Adult Descriptive Statistics for Programme Effects – Best Possible Scenario

Scale	Pre-test				Post-test			
	Intervention group *M (SD)*		Wait-list control group *M (SD)*		Intervention group *M (SD)*		Wait-list control group *M (SD)*	
PS	3.65	(0.70)	3.63	(0.95)	2.90	(1.07)	3.09	(1.20)
PARYC	38.90	(9.64)	39.70	(9.45)	41.53	(8.96)	40.70	(8.43)
PBI Supportive	42.83	(9.43)	44.10	(11.37)	45.17	(9.46)	44.33	(9.88)
ECBI Intensity	116.43	(36.52)	123.79	(44.87)	95.60	(45.33)	103.57	(45.56)

Note: PS - Parenting Scale, PARYC – Parenting Young Children Scale-Setting Limits Subscale, PBI Supportive - Parent Behaviour Inventory Supportive Parenting Subscale, ECBI Intensity – Eyberg Child Behaviour Inventory Intensity Subscale.

Table 12 (below) provides the same statistics for other adults but assuming the worst possible scenario for parents and children who dropped out of the trial. Again, a number of differences can be found between the results under best and worst possible scenario. Both groups showed increases in the levels of dysfunctional parenting at post-test in comparison to pre-test (with control group parents showing slightly higher levels). Levels of setting limits seemed to decrease in both groups, but more so in the control group than intervention group over time. Both groups also showed reductions in levels of supportive parenting. Problematic child behaviour was found to increase for both groups over time.

Table 12

Other Adult Descriptive Statistics for Programme Effects – Worst Possible Scenario

Scale	Pre-test				Post-test			
	Intervention group *M (SD)*		Wait-list control group *M (SD)*		Intervention group *M (SD)*		Wait-list control group *M (SD)*	
PS	3.65	(0.70)	3.63	(0.95)	3.90	(1.55)	4.09	(1.51)
PARYC	38.90	(9.64)	39.70	(9.45)	34.53	(15.02)	33.70	(14.30)
PBI Supportive	42.83	(9.43)	44.10	(11.37)	36.83	(19.12)	36.00	(18.95)
ECBI Intensity	116.43	(36.52)	123.79	(44.87)	124.40	(63.88)	132.37	(60.22)

Note: PS - Parenting Scale, PARYC – Parenting Young Children Scale-Setting Limits Subscale, PBI Supportive - Parent Behaviour Inventory Supportive Parenting Subscale, ECBI Intensity – Eyberg Child Behaviour Inventory Intensity Subscale.

Table 13 (below) provides the results for the ITT analysis based on other adult reports. Evident from this table is that these reports suggest somewhat similar findings to those based on primary caregiver reports. No group effects were found within these analyses under either condition. Therefore, taking all the completed ITT analyses together, there is quite substantial support for assertion that control and intervention group participants did not differ from one another across the various outcomes which were assessed. Other adult reports also revealed various time effects (and again, these were largely significant under the condition of best possible scenario only). Where time effects for other adults were found to be in the same direction as those based on primary caregiver reports, additional support is leant to the contention that both the control and intervention did in fact change in similar ways over time.

Much like for the primary caregiver ITT analyses, the largest difference across time for the ITT analyses conducted using data provided by the other adults was found on the outcome of child problem behaviour. Significant under the condition of best possible scenario, the result suggests that there was quite a substantial drop in child problem behaviour across both groups from pre to post-test. Yet, because both primary caregiver and other adult reports show this finding to be significant only under the best possible condition, the validity of this finding remains overall quite questionable.

Other adult reports also suggested changes over time on the assessed outcomes which differed in direction to those implied by the reports given by primary caregivers. For example, only mixed evidence was provided by other adult reports for the contention that both the control and intervention group may have experienced a slight reduction in levels of dysfunctional parenting at post-test, in comparison to baseline scores. Furthermore, the results for both best and worst case scenario based on data provided by the other adults suggest that primary caregivers practiced slightly *lower* levels of limit setting at post-test in comparison to pre-test. This equates to a negative change on this outcome according to other adults, and contrasts with the positive change found in the primary caregiver analyses. Another negative change which was revealed in analyses based on other adult data was for the outcome of supportive parenting. Under the worst possible condition it

seems both the intervention and control group showed marginally lower levels of supportive parenting at post-test in comparison to pre-test.

The contradictions between the findings based on other adult and primary caregiver reports, along with the fact that only under one condition were time effects found to be significant, leaves one with mixed and essentially weak evidence for the assertion that parenting and child behavioural problems changed for both groups over time. What was noticeably similar across both sets of analyses was that changes across time for the outcome of parenting in particular were generally quite small. In fact, few of the findings suggested a difference across time on this outcome that was clinically meaningful in size. Based on both sets of ITT analyses it seems the strongest support for time effects relate to reduced levels of both hostile parenting and difficulty in handling problematic child behaviour for the intervention and control group over time.

Table 13
Other Adult Intention to Treat Analysis

	Best possible				Worst possible			
Scale	Coefficient[1]	*t*	*p*	95% CI	Coefficient[1]	*t*	*p*	95% CI
PS								
Model			0.00				0.18	
Group	-0.09	-0.42	0.68	[-0.49 – 0.32]	-0.09	-0.34	0.74	[-0.59 – 0.42]
Time	0.65	4.16	0.00	[0.34 – 0.96]	-0.35	-1.85	0.07	[-0.73 – 0.03]
PARYC								
Model			0.1				0.18	
Group	1.01	0.06	0.95	[0.64 – 1.60]	1.01	-0.06	1.00	[0.64 – 1.62]
Time	1.42	2.17	0.03	[1.03– 1.96]	0.76	-1.86	0.07	[0.57 – 1.02]
PBI Supportive								
Model			0.392				0.03	
Group	0.02	0.414	0.68	[0.27 – 0.64]	0.02	0.33	0.75	[0.50 – 0.96]
Time	0.07	1.309	0.193	[0.02 – 0.46]	0.57	-2.65	0.01	[1.74 – 0.04]
ECBI Intensity								
Model			0.002				0.43	
Group	-7.66	-0.81	0.42	[-26.50 – 11.18]	-7.66	-0.67	0.50	[-30.20 – 14.88]
Time	20.53	3.54	0.001	[9.06 – 32.00]	-8.27	-1.13	0.26	[-22.80 – 6.25]

Note:[1] All co-efficient are presented for intervention and baseline assessment. PS - Parenting Scale, PARYC – Parenting Young Children Scale-Setting Limits Subscale, PBI Supportive - Parent Behaviour Inventory Supportive Parenting Subscale, ECBI Intensity – Eyberg Child Behaviour Inventory Intensity Subscale.

Comparing Those who Attended the Programme with Those Who Did Not

The next set of analyses involved comparing those who attended at least one session of the programme against all the other participants. This meant that those who were allocated originally to the intervention group but never attended a programme session were now essentially allocated to the control group along with those originally allocated to it, for the purposes of this analysis. The benefit of taking this approach to analysis is that it allowed one to take into consideration a moderator of programme effectiveness i.e., dosage, but also allowed for a comparison group to be retained. Therefore, even though this set of analyses perhaps provides a biased estimate of programme effectiveness (because it is likely attenders were different from those who chose to not attend), it does allow one to determine whether those who received the programme did improve relative to everyone else.

Primary caregivers.

The findings for these analyses completed using primary caregiver data can be found in Table 14 (below). A few significant group effects were found across the best and worst case scenarios for various scales. The similarity of these findings in terms of their significance across both conditions provides significant support for their validity. With regards to parenting, a significant group effect across both conditions was found for the Hostility subscale of the Parent Behaviour Inventory. This effect suggests that those who did not attend the programme demonstrated substantially higher levels of this poor parenting behaviour in comparison to those who did attend. Groups effects which suggested that programme attenders performed more optimally than those who did not attend the programme were also found on measures assessing a parent's sense of competence, child problem behaviour and the extent to which caregivers had a problem with this. Additionally, the difference between attenders versus the rest of the sample on these measures was usually found to be quite large.

Other findings which were only slightly less weakly substantiated were found for the measures of dysfunctional parenting, setting limits, and conflict in the parent-child relationship. All these group effects again suggested that programme attenders performed

more optimally than non-attenders on these scales, i.e., attenders reported lower levels of conflict in their relationships with their children, showed lower levels of dysfunctional parenting and practiced higher levels of limit setting.

The only time effects worth discussing relate to changes over time on the Hostility subscale of the Parent Behaviour Inventory, and the Problem subscale of the Eyberg Child Behaviour Inventory. These findings suggest that lower levels of hostility and difficulty in handling problem behaviour were reported at post-test for both those who attended the programme and the rest of the sample. Only under the worst possible condition did these effects become marginally non-significant, consequently they retain a fair amount of strength.

Also rather unequivocal was that under the best or worst possible scenario, no group or time effect was found for supportive parenting, indicating that those who attended the programme and those who did not were similar on this outcome and did not change over time. All the other analyses conducted on the outcomes generally showed change over time, with no differences between the groups. This underscores the limited support for their validity.

Table 14
Primary Caregiver Attendance Analysis

	Best possible				Worst possible			
Scale	Coefficient[1]	*t*	*p*	95% CI	Coefficient[1]	*t*	*p*	95% CI
PS								
Model			0.00				0.01	
Group	0.35	1.80	0.07	[-0.03 – 0.72]	0.64	3.24	0.001	[0.25 – 1.03]
Time	0.41	4.71	0.00	[0.24 – 0.59]	-0.04	-0.27	0.78	[-0.30 – 0.23]
PARYC								
Model			0.00				0.10	
Group	-2.27	-1.35	0.18	[-5.57 – 1.04]	-4.33	-2.13	0.04	[-8.36 - -0.31]
Time	-3.48	-3.90	0.00	[-5.24 – 1.71]	-0.33	-0.26	0.79	[-2.81 – 2.15]
PARYC PROB								
Model			0.01				0.21	
Group	0.52	1.09	0.28	[-0.42 – 1.46]	0.86	1.71	0.09	[-0.13 – 1.86]
Time	0.63	2.75	0.01	[0.19 – 1.14]	0.14	0.51	0.61	[-0.39 – 0.67]
PBI Hostile								
Model			0.00				0.002	
Group	5.23	2.35	0.02	[0.83 – 9.62]	7.69	3.34	0.001	[3.14 – 12.23]
Time	5.61	5.10	0.00	[3.44 – 7.79]	1.86	1.50	0.14	[-0.58 – 4.31]
PBI Supportive								
Model			0.24				0.38	
Group	0.00	-0.05	0.96	[0.40 – 0.36]	1.39	1.25	0.21	[0.83 – 2.34]
Time	0.05	1.70	0.09	[0.00 – 0.22]	0.92	-0.64	0.52	[0.70 – 1.20]
PSOC								
Model			0.00				0.002	
Group	6.60	2.30	0.02	[0.92 – 12.49]	10.78	3.53	0.001	[4.75 – 16.82]
Time	5.46	3.61	0.00	[2.47 – 8.46]	-0.91	-0.48	0.63	[-4.68 - 2.85]
CPRS Conflict								
Model			0.047				0.101	
Group	2.71	1.35	0.18	[-1.27 – 6.69]	4.28	2.08	0.04	[0.22 – 8.35]
Time	1.88	2.10	0.04	[0.11 – 3.64]	-0.53	-0.57	0.57	[-2.33 – 1.28]
CPRS Closeness								
Model			0.05				0.30	
Group	0.01	0.46	0.64	[0.12 – 0.32]	1.44	1.55	0.12	[0.91 – 2.30]
Time	0.05	2.41	0.02	[0.00 – 0.16]	0.98	-0.14	0.89	[-0.77 – 1.25]
ECBI Intensity								
Model			0.00				0.01	
Group	21.70	2.06	0.04	[0.92 – 42.48]	32.32	2.96	0.00	[10.77 – 53.87]

Time	19.51	5.22	0.00	[12.13-26.89]	3.31	0.64	0.53	[-6.96 – 13.58]
ECBI PROB								
Model			0.00				0.001	
Group	5.43	2.72	0.01	[1.49 – 9.37]	7.20	3.53	0.001	[3.17 – 11.23]
Time	4.11	5.01	0.00	[2.49 – 5.73]	1.41	1.46	0.15	[-0.51 – 3.33]

Note: [1] All co-efficients are presented for intervention and baseline assessment. *Note:* PS - Parenting Scale, PARYC – Parenting Young Children Scale-Setting Limits Subscale, PARYCPROB – Parenting Young Children Scale-Setting Limits Subscale Problem Score, PBI Supportive - Parent Behaviour Inventory Supportive Parenting Subscale, PBI Hostile - Parent Behaviour Inventory Hostile Parenting Subscale, PSOC – Parent Sense of Competence Scale, CPRS Conflict – Child-parent Relationship Scale Conflict Subscale, CPRS Closeness – Child-parent Relationship Scale Closeness Subscale, ECBI Intensity – Eyberg Child Behaviour Inventory Intensity Subscale, ECBI PROB - Eyberg Child Behaviour Inventory Problem Subscale.

Other adults.

Table 15 provides the statistical output for the attendance analyses which were conducted using the data provided by other adults. This involved dividing the sample of other adults into groups that represented programme attenders, versus those that never attended a session – based on the group allocation given to the primary caregivers they were asked to provide input on.

Perhaps the clearest findings that resulted from this analysis related to the Supportive Parenting subscale. No group effect was found for this measure under the best or worst possible condition; suggesting that in the view of the "other adults", both programme attenders and non-attenders demonstrated similar levels of this parenting behaviour. All the remaining scales which assessed parenting showed significant group effects under one condition ("best" vs. "worst), but not the other. Significant group effects for the Parenting Scale suggested that programme attenders showed lower levels of dysfunctional parenting in comparison to non-attenders. The Parenting Young Children Scale also showed a group affect under one condition which suggests that attenders demonstrated higher levels of limit setting than those who did not attend the programme, holding constant the effect for time. However, because these latter two effects were only significant under one condition they are unlikely very valid findings. Additionally, both findings were quite small in size suggesting that overall they were not very meaningful.

All the included measures also showed a significant and marginally non-significant time effect, under either the worst or best possible scenario respectively. Time effects for the Eyberg Child Behaviour Inventory and Parenting Scale were found to be in different directions for each respective scale, depending on the condition in which the analyses were run. In other words, significant effects were found for both outcomes to increase and decrease at post-test under the best and worst possible scenario. This lack of congruency suggests that neither effect is particularly valid. Time effects for both supportive parenting and setting limits suggest that the sample demonstrated marginally higher levels of these parenting behaviours at pre-test than they did at post-test. These findings retain their strength because of the fact that in both cases programme effects were found to be in the same direction and show minimal change in significance under the various conditions. Once again though, the size of this difference between the two assessments points remains small.

These findings together with those provided by primary caregivers suggest a few clear findings. Firstly, there is a substantial amount of support for the contention that both attenders and non-attenders reported similar levels of supportive parenting. Despite other adults not reporting on the hostile parenting style of primary caregivers, or the extent to which they expressed problems with their children's poor behaviour, effects relating to these scales have been found across primary caregiver analyses and have tended to support a change in the desired direction.

Table 15

Other Adult Attendance Analysis

	Best possible				Worst possible			
Scale	Coefficient[1]	*t*	*p*	95% CI	Coefficient[1]	*t*	*p*	95% CI
PS								
Model			0.00				0.00	
Group	-0.28	-1.12	0.27	[-0.76 – 0.21]	-0.62	-2.07	0.04	[-1.21 – 0.03]
Time	0.65	4.16	0.00	[0.34 – 0.96]	-0.35	-1.85	0.07	[-0.73 – 0.03]
PARYC								
Model			0.03				0.02	
Group	0.66	-1.51	1.35	[0.38 - 1.14]	0.53	-2.30	0.02	[0.31 – 0.92]
Time	1.42	2.17	0.03	[1.03– 1.96]	0.76	-1.86	0.07	[0.57 – 1.02]
PBI Supportive								
Model			0.21				0.02	
Group	0.88	-0.40	0.69	[0.46 – 1.67]	0.18	-0.81	0.42	[2.06 – 0.36]
Time	1.33	1.75	0.08	[0.96 – 1.85]	0.57	-2.65	0.01	[1.74 – 0.04]
ECBI Intensity								
Model			0.001				0.15	
Group	-13.55	-1.81	0.24	[-36.27 – 9.17]	-21.33	-1.57	0.12	[-48.22 – 5.56]
Time	20.53	3.54	0.001	[9.06 – 32.00]	-8.27	-1.13	0.26	[-22.80 – 6.25]

Note: [1] All co-efficient are presented for intervention and baseline assessment. PS - Parenting Scale, PARYC – Parenting Young Children Scale-Setting Limits Subscale, PBI Supportive - Parent Behaviour Inventory Supportive Parenting Subscale, ECBI Intensity – Eyberg Child Behaviour Inventory Intensity Subscale.

DISCUSSION

The discussion of the findings presented here will be broadly divided between the two levels of evaluation which were specified in the evaluation questions presented earlier. First, the findings regarding programme fidelity will be discussed. This will be followed by a consideration of programme effectiveness. Possible reasons for the findings, limitations of this evaluation, and recommendations will also be included in this chapter.

Programme Fidelity

The PPST was implemented with exceptionally high levels of fidelity by the programme facilitators. All sessional content which was *intended* to be delivered by programme staff was shown to be delivered based on the checklists they completed during implementation. Despite, these encouraging findings programme attendance was shown to be very poor. Yet, for those who attended the programme good levels of engagement with the programme were found. Despite measuring content fidelity well, one of the limitations of this evaluation is that it was not able to consider leader delivery skills fidelity in depth.

Outcome Evaluation Findings

The results found after conducting an intention to treat analysis were not able to demonstrate any conclusive programme effects. A second analysis which took into consideration a moderator of programme effectiveness (i.e., attendance) revealed some changes across the groups and times of assessment. There are some findings which tentatively implied that programme participants reported more optimally on the various scales than control group participants. However, there is also evidence which suggests that the programme beneficiaries and control group caregivers changed in quite similar ways over time. In sum, there was no clear indication that programme participants necessarily improved above and beyond the control group at post-test, in comparison to their pre-test scores. However, the results do tentatively suggest that the programme is worth exploring in more detail.

The design used to evaluate the PPST allows one to rule out majority of the threats to internal validity that usually tend to prevent one from obtaining an accurate estimation

of programme effectiveness. These threats could include natural changes in participants over time (e.g., children's behaviour improving as they mature), some participants receiving access to other similar interventions for example. All participants at post-test were asked if they had received any additional support for their parenting or child behaviour (other than the parenting programme if they had received this). Quite a few of the participants did state they had accessed other material which they felt had either improved their parenting or their children's behaviour. This sort of material generally included reading educational material in magazines and books; only for a few did it involve actually engaging in a structured programme. This may explain why the control group sometimes showed a change in the assessed outcomes over time. A number of the participants also mentioned that the interviews they completed for the purposes of the evaluation, made them think quite critically about their parenting and their children's behaviour. This finding is suggestive of a testing effect i.e., that the measures used in the evaluation served as a catalyst for parents to change their behaviour.

Another plausible reason for the largely weak findings presented here is because of the fact that the intervention group participants showed such poor attendance. Sub-standard attendance to all programme sessions is likely to be a problem for all universal interventions because it is probable that a number of caregivers will not recognise a need to attend all programme session, especially so if they are not dealing with particularly problematic child behaviour or are busy (Bayer et al., 2010). Low attendance has been reported in other evaluations of universal parenting programmes. For example, of 169 families who received information about the Group Teen Triple P, 68 expressed interest in attending, 37 attended at least one session and only 26 completed the programme (Ralph & Sanders, 2003). In this evaluation, low attendance in the intervention group reduced statistical power in the analyses, as has been found in other evaluations (Simkiss et al., 2013). This means it was challenging to find a programme effect. Future research will be conducted with the sample used in this evaluation to explore the reasons for non-attendance.

Despite these factors, this evaluation benefitted from many other features which support the validity of these findings. For example, all the measures used in the evaluation were valid, and largely found to be reliable instruments because they demonstrated sufficient, if not high, Cronbach's alphas. Using an interview method also compensated for low literacy of several participants. All fieldworkers received training. However, none of the scales included had been validated on a South African sample. In addition, also evident were a number of ceiling effects present in measures which tended to asses positive parenting practices or positive aspects of the parent-child relationship. This may explain why throughout the analyses either negative or no programme effects for these measures were found. Ceiling effects present at pre-test mean participants are left with little room to show improvement at latter assessment points. Arguably, they also increase the likelihood of detecting a negative change over time because through additional practice on the scale over time, and familiarity with the research process, participants may be more critical of themselves at latter points in assessment than they were at earlier ones.

Despite the strength in evaluation design, a number of other factors may be able to explain why these effects were found. In discussion with staff at The Parent Centre it became clear that the levels of attendance in the programme conducted for the evaluation were far lower than The Parent Centre typically experiences, especially in Mitchells Plain. It is possible that incorporating a research component may have influenced parents' decisions to participate in the programme. However, over 90% of primary caregivers were able to participate in a post-test interview. Similarly high was the level of participation of other adults at this assessment point as well. Participant retention is a significant strength of this evaluation. These retention rates are very high, similar to what has been found in the evaluations of the Triple-P parenting programme (e.g., Eisner et al., 2012).

Universal programmes are generally less likely to show evidence for programme effectiveness than targeted interventions in evaluations, due to their increased likelihood of recruiting parents and children who show no significant problem behaviours. This is a further possible explanation for the results presented here. This is an issue associated with universal programmes that is also a concern for their cost-effectiveness. Choosing to

implement programmes that target populations who present with risk factors for problematic outcomes may in the long term save numerous costs. This is simply because of the certainty such interventions have with regards to identifying those who will most likely be the cause of such costs. However, a universal preventative intervention which shows a small effect size catalyses a larger impact on the public health of the population than that of a targeted intervention with a larger effect size (Fabrizio et al., 2014). In fact for populations as a whole, the main burden of risk of disease is carried by a relatively large number of individuals at lower risk - referred to as the "population paradox" (Stewart-Brown & Schrader-McMillan, 2011). Though individuals living in a certain area may be able to be classified as high-risk, as it turns out, most people at high risk are generally spread out over a range of areas (Stewart-Brown & Schrader-McMillan, 2011).

Furthermore, one must also consider whether it is in the reach of organisations implementing similar parenting programmes to be able to carry out screening activities in addition to their current responsibilities so as to implement selective or indicated interventions. Though screening can be quite a simple process depending on the chosen indicators of risk, there is also the potential for a screening process to trigger feelings of stigmatisation because parents may associate positive screening with failing (Stewart-Brown & Schrader-McMillan, 2011). This may in turn affect the extent to which the programme is actually accessed by the targeted population. Based on these considerations, a more conclusive answer regarding the PPST's effectiveness would be of much value in the South African context. Though there is a role for universal, selective and targeted interventions in the country, more research conducted on their respective benefits and costs would also be of significant importance.

Another possible reason for the lack of programme effectiveness found here is that the post-test assessment took place very soon after the programme had concluded. Post-test assessments began the week following the programme's conclusion. Behaviour change generally takes a substantial amount of time to effect. By having post-test assessments begin almost immediately after the programme it is very likely that not enough time had passed for participants to practice and learn to successfully use the skills learnt in the

programme. Under such conditions, only small if any programme effects would be expected. To cater for this weakness in the evaluation design a one year follow-up assessment will be conducted. This will allow for far more time for programme attender's behaviour to change, as well as their children's.

Of course, there is also the possibility that the programme is ineffective. The PPST is based on a programme which lacks strong evidence for effectiveness. If the programme is found to be ineffective after the one-year follow-up then this should have implications for the programme's subsequent delivery. These implications will comprise of either recommendations for adaptations to the programme's content and design, or the replacement of the programme with a different evidence-based programme which has been proven to be effective.

Due to the largely inconclusive results of programme effectiveness, at present only a few recommendations can be made to The Parent Centre which could serve to improve the PPST. Firstly, it is recommended that in the future delivery of the programme, caregivers of children only between the ages of six and 12 years be offered access. A programme that is developmentally appropriate is more relevant to participants and thereby, also more effective (Small, Cooney & O'Connor, 2009). There are developmental differences between children of even marginally different ages, effective family based preventative programmes respond to these differences instead of attempting to include all possible families (Durlak, 2003; Weissberg, Kumpfer & Seligman, 2003). Taking the latter approach would likely result in feelings of frustration and disappointment for a parent because of the possible failure of their new learnt skills to translate into the expected changes in their child. Therefore, when parents with children outside the specified range are interested in participating in the programme, they should be referred onto other resources offered by The Parent Centre, or other NPO's, instead of participate in the PPST.

On a related note, programme staff mentioned that despite the programme being designed to be preventative, in some cases people begin the programme with already established problems. If an intervention is delivered too late, or too early, it will experience significant obstacles to its effectiveness (Small et al., 2009). Preventative programmes need

be delivered so that they miss both points in a person's development (Nation et al., 2003). Therefore, if The Parent Centre aims to capitalise on the preventative capacity of the intervention, consideration could also be given towards narrowing even further the intended age range of programme participants, by including for example only parents of six to ten year olds. This would likely increase the chances of including parents who do not already struggle with significant difficulties because often these develop over time and will not have yet had the chance to. However, as no family is the same, and different struggles arise at different times for different families alternatively The Parent Centre could retain the recruitment of parents of children in the current age range, but conduct more intensive recruitment parents of children who are younger, rather than older.

Some recommendations can also be made regarding programme content and delivery. Parental praise is already a key focus of the parenting programme. The programme facilitators should continue to emphasise the practice of this behaviour by parents, and display it during programme delivery, as high levels of praise modelled by programme facilitators is predictive of higher levels of parent to child praise (Eames et al., 2010). Participants could also benefit from a more thorough exposure to the concept of consistent disciplinary practices. Discipline is another important area of focus the programme does include, however more detail regarding its execution could improve results. Disciplinary consistency has been associated with large programme effects on parenting behaviour outcomes and problematic child behaviour (Kaminski et al., 2008). Lastly, many of the universal parenting programmes which were reviewed ensured programme group sizes remained quite small (including at maximum 15 parents). Keeping group sizes smaller, no larger than 15 participants for a single facilitator, in the future delivery of the PPST is also recommended. This will enable facilitators to more easily manage participant queries and provide additional support if necessary.

A few recommendations can be made with regards to the future monitoring and evaluation of programme outcomes. The mid-evaluation is very similar to the final evaluation form, which assesses participant satisfaction with the programme and participants' perceptions of programme quality. Only minor consideration is given to

programme effectiveness. Therefore, instead of assessing this twice, it would be more beneficial to include a more thorough assessment of programme effectiveness. It is proposed that in place of the mid-evaluation, a pre and post-programme completion self-assessment should be incorporated. This would comprise of a basic and brief questionnaire to be completed by participants at the start (during the Orientation session), and end of the programme (in the last session). This should ask questions about participants' demographics (e.g., age, gender, whether there is anyone else responsible for providing caregiving, area of residence, child age and gender), as well as current (i.e. including only the past month) parenting practices and child behaviours (e.g., a simple tallying of how many times they have utilised some positive and poor parenting practices, and how many times their children have displayed problematic behaviour). This will allow the Centre to better monitor their outcomes over time, will help caregivers to clarify particularly challenging areas for themselves, and will also assist facilitators in giving specific attention to certain problem caregivers may be experiencing.

Further recommendations regarding programme content and design will be able to be made once analyses of the PPST's programme theory, and the one year follow-up have been completed. Causal pathways which are found to lack support in these analyses could be used to suggest either further intensification of the associated programme component, or its replacement with a different component. Alternatively, the results could also suggest the replacement of the PPST with a different programme which has better evidence for effectiveness.

Clear evidence of programme effectiveness is essential for the scaling-up of parenting programmes in South Africa. Minimal information regarding parenting programmes' effectiveness in the country is available at present. As has been shown, this problem is not particular to South Africa; less research is available on parenting programmes which have been implemented within low-and middle-income countries in general (Knerr et al., 2013; Mejia et al., 2012). Therefore, this dissertation contributes to addressing both gaps in the literature, and thereby also adds to the movement towards the scale-up of evidence-based parenting programmes in such contexts.

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APPENDICES

Appendix A – Ethical Approval

UNIVERSITY OF CAPE TOWN

FACULTY OF COMMERCE
ETHICS IN RESEARCH COMMITTEE

Courier: Room 2.21 Leslie Commerce Building Upper Campus University of Cape Town

Post: University of Cape Town • Private Bag • Rondebosch 7701

Email: Irwin.brown@uct.ac.za

Telephone: +27 21 650-2311

Fax No.: +27 21 689-7570

April 22, 2014

Soraya Lester

Management Studies

Project title:

Evaluation of The Parent Centre's Positive Parenting Skills Training Programme

Dear Researcher,

This letter serves to confirm that the amendments to this project as described in your revised submitted protocol has been approved.

Please note that if you make any substantial change in your research procedure that could affect the experiences of the participants, you must submit a revised protocol to the Committee for approval.

Regards,

Harold Kincaid

Professor Harold Kincaid

Commerce Faculty Ethics in Research Committee

Appendix B – Supporting Documents

the Parent Centre

Helping children through parents

- Why does my child behave in certain ways?
- How can I better understand my child's feelings?
- How do I build my child's self esteem?
- How can I be a more assertive parent?
- What are positive ways to discipline my child?
- How can I solve problems with my child?
- How do I bond with my baby?

The Parent Centre offers a range of parenting workshops and talks for parents and caregivers.

Some of the topics covered in our workshops and talks are:

- Raising boys
- Effective discipline
- Closing the gap
- Understanding your child's temperament
- How to talk so kids will listen and listen so kids will talk
- Helping your child cope with the effects of divorce

We have a Teen Parenting Programme and a Parent Infant Home Visiting Programme. Individual Parent Guidance Counselling is also offered.

Upper Level, Wynberg Centre, 123 Main Road, Wynberg,
7800 P O BOX 18889, Wynberg, 7824
021 762 0116 | Fax: 021 762 5160 | www.theparentcentre.org.za

CITY HEALTH — Specialised Health

2014-05-12

Research Request: Evaluation of the Parent Centre's Positive Parenting Training Skills Programme, ID: 10404

Dear Ms Lester:

Your request for access to City Health facilities has been approved for the following two clinics only:

Mitchells Plain Sub District: Contact People	**Rocklands and Westridge Clinics** Mrs S Eloker (Sub District Manager) Tel: (021) 391-5012/ 084 222 1478 Mrs N Njama (Head: PHC & Programmes) Tel: (021) 391-0175/ 084 2221489

Please note the following:

1. Access to these facilities must be arranged with the relevant Managers at mutually suitable dates and times.
2. A copy of the final report must be sent to the City Health Head Office, P O Box 2815 Cape Town 8001, within 6 months of its completion.
3. Your project has been given an ID Number (10404). Please use this in any future correspondence with us.

Kind Regards.

DR G H VISSER
MANAGER: SPECIALISED HEALTH

cc. Mrs Eloker & Ms Njama

Appendix C – Facilitator Implementation Checklists

Positive Parenting Skills Training Programme Facilitator Checklist

Facilitator name:

Venue:

Please tick **'Yes'** if you **did** manage to complete the training component. Please tick **'No'** if you **did not** manage to complete the training component.

You are reminded to answer honestly for the purpose of the research. There are no consequences for not completing homework activities. No one other than the researchers of this study will view this information.

Please return this form to Soraya.

Thank you.

Orientation Session:		
Date:	**Time:**	
	YES	**NO**
Parents completed enrolment forms?		
Parents completed attendance register?		
Parents welcomed to training?		
Parents made nametags?		
1) Introducing the training and explaining the research project		
2) Big group: Introductions and icebreakers		
3) Big Group: Group expectations		
Asked participants about their expectations for the course?		
Wrote down expectations?		
Explain which expectations will be met in this training?		

Explain which expectations will not be met in this training?		
4) Big group: How the training works		
5) Big Group: Course Outline		
6) Big Group: The nature of the group		
7) Big group: The role of the facilitator and the participant		
8) Big group: Group rules and the group contact		
9) Big Group: Common parenting challenges		
10) Starting "Understanding Children's Behaviour" Session – if time permits		
11) Closure		

Session one: Learning to understand children's behaviour		
Date:	**Time:**	
	YES	**NO**
1) Welcome (introductions, attendance register, name tags)		
2) Review and reflect on Orientation Session (especially for new participants)		
3) Complete any Orientation sections not completed last week		
4) Icebreaker: Perception exercise		
5) Brainstorm: What makes children behave the way they do?		
6) Small group discussions and input: Stage of development		
7) Large group activity and input: Basic human needs		
8) Input: Temperament		

9) Input and reflecting in the large group: Position in family		
10) Input: Gender		
11) Input: Life experiences		
12) Input: Context in which behaviour occurs		
13) Input: Parent's expectations		
14) Input: Competition		
15) Input: Where parents are at		
16) Input: Quality time		
17) Homework: Re-read handouts and Quality time handout		

Session two: Listening to children's feelings		
Date:	**Time:**	
	YES	**NO**
1) Welcome (attendance register and name tags)		
2) Icebreaker: S.T.O.P. (Statue game)		
3) Review and reflect on previous training session: • Homework checklist • What stood out for them, what they can recall • Homework feedback		
4) Complete sections not covered last week: • Basic human needs • Context in which behaviour occurs, parent's expectations, competition and where parents are at		
5) Input, role-plays, questions and input: Unconscious goals of misbehaviour		
6) Input: Important things to remember and traffic robot		
7) Homework: Re-read handouts and unconscious goals		

8) Introduce next session: listening to children's feelings		
9) Icebreaker: feeling faces		
10) Input: understanding children's feelings		
11) large group exercise and input: Identifying my own feelings		
12) Large group exercise: linking feelings to behaviour		
13) Input: Linking feelings to behaviour		
14) Input: The feeling egg		
15) Brainstorm: The right listening environment		
16) Input: The listening skill-an empathetic response		
17) Homework		

Session three: Listening to Children's Feelings and Building children's self- esteem		
Date:	**Time:**	
	YES	**NO**
1) Attendance register and name tags and colouring- in butterflies		
2) Welcome and explaining butterflies		
3) Review and reflect on previous training session and homework • Homework checklist • What stood out for them, what they can recall • Homework feedback		
4) Icebreaker: Feeling faces Talking with my body		
5) Input: The difference between open and closed responses		
6) Small group activity: Practicing open responses		
7) Role-plays, questions and discussion: How parents typically listen		

8) Butterfly story and discussion		
9)Homework: Open responses		
10)Introduce Building Self-Esteem session		
11) Icebreaker: Work tickle		
12) Brainstorm: What is self-esteem?		
13) Input: What is self-esteem?		
14) Brainstorm: Ways to build children's self-esteem		
15) Input: Ways to build children's self-esteem		
16) Small group activity and input: Labelling (part 1)		
17) Input: Turning negative labels into positive labels (part 2)		
18) Input: Examples of old and new labels (part 3)		
19) Input, small group activity and input: Re-labelling (part 4)		
20) Homework: Re-labelling		
21)Closure		
22) Parents completed mid-evaluation forms		

Session four: Building Children's Self-esteem and Assertiveness and engaging co-operation		
Date:	**Time:**	
	YES	**NO**
1) Welcome (attendance register and name tags)		
2) Icebreaker		
3) Review and reflect on previous training session and homework		
4)Recap on re-labelling and parts not covered completely in previous session. Give re-labelling homework if not done last week		
5) Large group activity- Shreds of self-esteem activity: The day in the life of Mary Brainstorm and input: types of put downs		

Brainstorm and input: when children become discouraged Weather massage		
6) Input: Focusing on the positive, effort and improvement Small group activity: responding to children's efforts		
7) large group exercise, input, small group activity: Descriptive praise		
8) Homework: descriptive praise and focusing on the positive		
9) Introduce the "Assertiveness and Engaging Co-operation" session		
10) Icebreaker: Bus trip to lost city		
11) Input: What is assertiveness, aggressiveness and non-assertiveness		
12) Input: You messages		
13) Input: Confronting assertively sending an I-message		
14) Small group activity: constructing I-message or I-feel sentences		
15) Input: When I-messages do not work		
16) Homework		
17) Closure		

Session five: Assertiveness and Engaging Co-operation and Effective discipline		
Date:	**Time:**	
	YES	**NO**
1) Welcome (attendance register and name tags)		
2) Review and reflect on previous training session and homework		
3) Constructing I-messages or I-feel sentences and homework		
4) Facilitator's input: E.C.A. Assertiveness model		
5) Small group activity: Practicing the E.C.A Model		
6) Input: Problems that arise		
7) Homework: E.C.A. Model		

8) Introduce the effective discipline session		
9) Icebreaker: Dancing with sticks		
10) Brainstorm and input: What is discipline?		
11) Individual activity and input: building a good relationship between you and your child checklist		
12) Input and brainstorms: the importance of the parent's attitude toward discipline problems and The Robot		
13) Input and discussion: A model for dealing with discipline problems		
14) Homework: The discipline model		
15) Closure		
16) Planning for the last session		

Session six: Effective Discipline, Problem solving, values and family meetings		
Date:	**Time:**	
	YES	**NO**
1) Welcome (attendance register and name tags)		
2) Review and reflect on previous training session and homework		
2) A model for discipline problems and effective discipline homework Other factors affecting discipline		
4) Introduce the problem-solving, values and family meetings session		
6) Icebreaker: Human spider web		
7) Input: possible causes of resistance to discipline		
8) Role-play, discussion and input: The problem-solving model		
9) Brainstorm and input: Values and discipline		
10) Input: the family meeting		
11) Homework: The Problem-Solving Model		
12) Closure: Ball of wool activity		

13) Parents completed final evaluation forms		
14) Handing out of certificates		
15) Recap and checked that expectations of the training were met		

Appendix D – Attendance Register

	Participant name	Orientation	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								

Appendix E – Participant Homework Checklists

Positive Parenting Skills Training

Participant Take-Home Checklist

Name:

Name of facilitator:

Please tick **'Yes'** if you **did** manage to complete the homework activity. Please tick **'No'** if you **did not** manage to complete the homework activity.

You are reminded to answer honestly for the purpose of the research. There are no consequences for not completing homework activities. No one other than the researchers of this study will see this information.

Session two: Learning to Understand Children's Behaviour	**Yes**	**No**
In the past week, did you manage to…		
A) Read the notes on Learning to Understand Children's Behaviour?		
B) Observe, record and try to understand the underlying factors of your child's behaviour?		

Thank you!

Session and homework		
Session one: Learning to understand children's behaviour	**Yes**	**No**
In the past week, did you manage to…		
A) Read hand-outs?		
B) Spend some quality time with your child/children?		

Session three: Listening to Children's Feelings and Building Children's Self-Esteem	**YES**	**NO**
In the past week, did you manage to…		
A) Read session 2's notes on Children's Feelings?		

B) On three occasions, practice listening with full attention and give an open response?		
C) Read session 3's notes on Re-labelling?		
D) Find a fault in your child, and re-label it?		

Session four: Assertiveness and engaging co-operation	**YES**	**NO**
In the past week, did you manage to…		
A) Read session 3's notes on Building your child's self-esteem?		
B) Apply descriptive praise to your child?		
C) Find a quality you like about your children, and tell them?		
D) Read session 4's notes on Assertiveness and Engaging Co-operation		
E) Practice confronting using an I-message?		

Session five: Assertiveness and Engaging Co-Operation & Effective discipline	**YES**	**NO**
In the past week, did you manage to…		
A) Read session notes on Assertiveness and Engaging Co-operation?		
B) Practice confronting using an I-message?		
C) Apply the E.C.A. Model in a problem situation?		
D) Read session notes on Effective Discipline?		
E) Apply the discipline model at home?		

Session six: Problem solving, values and family meetings	**Yes**	**No**

In the past week, did you manage to…		
A) Read the session notes on Effective Discipline?		
B) Apply the discipline model at home?		
C) Read the session notes on Problem-solving, Values and Family meetings?		
D) Apply the problem-solving model at home?		

Appendix F – Primary Caregiver Questionnaire

Baseline questionnaire.

Parent Questionnaire

DATE:

This questionnaire will help us understand how you parent, how you feel about parenting and the relationship you have with your child as well as your child's behaviour. First we will start with some demographic questions about yourself and your child.

Demographics

Have you ever been a participant of the Parent Centre's Positive Parenting Skills Training or Parenting and Leadership Training by The Parent Centre before?

(If yes, participant is not suitable for interview, please go no further).

Yes ☐ No ☐

Name of participant:

Do you look after a child between the ages of 5 – 12 years at least four nights a week? (Fieldworker: If no, participant is not suitable for interview, please go no further).

Yes ☐ No ☐

If you look after more than one child in between these ages please select the child with whom you have **the challenges with** to answer the following questions.

How old is this child? _____ DOB: _____/_____/_____

Is this child a girl ☐ boy ☐

What is this child's name: _____

What relation are you to this child? Biological Parent ☐ Step Parent ☐ Grandparent ☐

Adoptive Parent ☐ Foster Parent ☐ Other relation: _____

Please tell us how many children you have in your home: _____

What is your relationship status?

Married ☐ Single ☐

What is your employment status?

working ☐ or not working ☐

If working, is it?

full time ☐ part-time ☐

formal e.g. company ☐ informal e.g. flea- market stall ☐

What is the highest educational qualification you have obtained?

University degree ☐ Diploma ☐ Matric ☐ Highest grade passed:

What is your home-language?

English ☐ Afrikaans ☐ IsiXhosa ☐ Other ☐ _____

Participant Gender:

Female ☐ Male ☐

Participant Age: DOB: _____/_____/_____

<u>Sourcing information:</u>

We require that you provide us with the contact details of three individuals who will always know where you are so that we can find you for the later interviews. Please could you provide us with these details?

<u>Contact 1</u>

Name:

Cellphone:

Home phone:

<u>Contact 2</u>

Name:

Cellphone:

Home phone:

Contact 3

Name:

Cellphone:

Home phone:

Post-assessment

We will be conducting a second interview at the end of June through to the Middle of July. We will contact you to make this appointment closer to the time.

Is there any other adult present, who also lives with this child for at least four nights a week?
Yes ☐ No ☐

If yes, who is that?

Biological Parent ☐ Step Parent ☐ Grandparent ☐

Adoptive Parent ☐ Foster Parent ☐ Other relation: _____

Will they be taking part in this evaluation as well? Yes ☐ No ☐

If so, please provide their name: _____

Cellphone:

You will receive an SMS in the next few weeks which will state whether you will be able to participate in the Positive Parenting Skills Training now, or later. If you are a part of the group that can participate in it now, this SMS will provide you with the details about where and when the training will happen.

PARENTING SCALE

At one time or another, all children misbehave or do things that could be harmful, that are "wrong", or that parents don't like. Examples include: hitting someone, whining or complaining, damaging things, forgetting homework, leaving things lying around, lying, being over-emotional, refusing to follow requests, breaking family rules, swearing, taking other people's things, staying out late.
Parents have many different ways or styles of dealing with these types of problems.
Below are items that describe some styles of parenting. For each item, circle the number

that best describes your style of parenting during the **past 1 month** with your selected child.

Sample Item
At meal time...
I let my child decide what to eat. 1 2 3 4 (5) 6 7 I decide what my child eats.

1	When my child misbehaves…							
	I do something right away	1	2	3	4	5	6	7	I do something about it later
2	Before I do something about a problem…							
	I give my child several reminders and warnings	1	2	3	4	5	6	7	I use only one reminder or warning
3	When I'm upset or under stress…							
	I am picky and on my child's back	1	2	3	4	5	6	7	I am no more picky than usual
4	When I tell my child not to do something…							
	I say very little	1	2	3	4	5	6	7	I say a lot
5	When my child pesters me…							
	I can ignore the pestering	1	2	3	4	5	6	7	I can't ignore the pestering
6	When my child misbehaves…							
	I usually get into a long argument with my child	1	2	3	4	5	6	7	I don't get into an argument
7	I threaten to do things that…							

	I am sure I can carry out	1	2	3	4	5	6	7	I know I won't actually do
8	I am the kind of parent that…								
	Sets limits on what child is allowed to do	1	2	3	4	5	6	7	Lets my child do whatever he or she wants
9	When my child misbehaves…								
	I give my child a long lecture	1	2	3	4	5	6	7	I keep my talks short and to the point
10	When my child misbehaves…								
	I raise my voice or yell	1	2	3	4	5	6	7	I speak to my child calmly
11	If saying no doesn't work right away…								
	I take some other kind of action	1	2	3	4	5	6	7	I keep talking and trying to get through to my child
12	When I want my child to stop doing something…								
	I firmly tell my child to stop	1	2	3	4	5	6	7	I coax or beg my child to stop
13	When my child is out of my sight…								
	I often don't know what my child is doing.	1	2	3	4	5	6	7	I always have a good idea of what my child is

									doing
14	After there's been a problem with my child…								
	I often hold a grudge	1	2	3	4	5	6	7	Things get back to normal quickly
15	When we're not at home…								
	I handle my child the way I do at home	1	2	3	4	5	6	7	I let my child get away with a lot more
16	When my child does something I don't like…								
	I do something about it every time it happens	1	2	3	4	5	6	7	I often let it go
17	When there's a problem with my child…								
	things build up and I do things I don't mean to do	1	2	3	4	5	6	7	things don't get out of hand
18	When my child misbehaves, I spank, slap, grab, or hit my child …								
	never or rarely	1	2	3	4	5	6	7	most of the time
19	When my child doesn't do what I ask…								
	I often let it go or end up doing it myself	1	2	3	4	5	6	7	I take some other action
20	When I give a fair threat or warning…								

	I often don't carry it out	1	2	3	4	5	6	7	I always do what I said
21	If saying "No" doesn't work…								
	I take some other kind of action	1	2	3	4	5	6	7	I offer my child something nice so he/she will behave
22	When my child misbehaves…								
	I handle it without getting upset	1	2	3	4	5	6	7	I get so frustrated or angry that my child can see I'm upset
23	When my child misbehaves…								
	I make my child tell me why he/she did it	1	2	3	4	5	6	7	I say "No" or take some other action
24	When my child misbehaves and then acts sorry…								
	I handle the problem like I usually would	1	2	3	4	5	6	7	I let it go that time
25	When my child misbehaves…								
	I rarely use bad language or curse	1	2	3	4	5	6	7	I almost always use bad language
26	When I say my child can't do something…								
	I let my child	1	2	3	4	5	6	7	I stick to

	do it anyway								what I said
27	When I have to handle a problem…								
	I tell my child I am sorry about it	1	2	3	4	5	6	7	I don't say I am sorry
28	When my child does something I don't like, I insult my child, say mean things, or call my child names…								
	never or rarely	1	2	3	4	5	6	7	most of the time
29	If my child talks back or complains when I handle a problem…								
	I ignore the complaining and stick to what I said	1	2	3	4	5	6	7	I give my child a talk about not complaining
30	If my child gets upset when I say "No"…								
	I back down and give in to my child	1	2	3	4	5	6	7	I stick to what I said

Parenting Young Children Scale (Setting limits subscale)

For the next set of questions, please rate how often you engaged in each parenting strategy **during the last month.**
On a scale from 0 (never), 1 (very rarely), 2(rarely), 3(sometimes), 4(often), 5(very often) to 6 (always).

Please also specify whether or not you felt performing each of these parenting duties was problematic for you **in the past month?**

If it was a problem state "Yes". If it was not a problem state "no".

	How often does this occur with your child? **Never 0 Very rarely 1 Rarely 2 Sometimes 3 Often 4 Very Often 5 Always 6**								Is this a problem for you? Yes	No
1	Stick to your rules and not change your mind?	0	1	2	3	4	5	6	Yes	No
2	Speak calmly with your child when you were upset with him or her?	0	1	2	3	4	5	6	Yes	No
3	Explain what you wanted your child to do in clear and simple ways?	0	1	2	3	4	5	6	Yes	No
4	Tell your child what you wanted him/her to do rather than tell him/her to stop doing something?	0	1	2	3	4	5	6	Yes	No
5	Tell your child how you expected him or her to behave (such as in the grocery store)?	0	1	2	3	4	5	6	Yes	No
6	Set rules on your child's problem behavior that you were willing/able to enforce?	0	1	2	3	4	5	6	Yes	No
7	Make sure your child followed the rules you set all or most of the time?	0	1	2	3	4	5	6	Yes	No

Parent Behavior Inventory

Please think about each statement carefully. Think about how you and your child *generally* get along. Tell us how well the statement describes the way you have *usually* acted with your child within the **past 1 month.**

0 *not at all true (I do not do this)*
1 *a little true*
2 somewhat true
3 *moderately true*
4 *quite a bit true*
5 *very true (I often do this)*

Example: I quarrel with my child.
If you spend a great deal of time quarreling with your child, you would mark a 5 in the space.
If you never quarrel with your child, you would mark a 0 in the space.
If you quarrel sometimes, but not much, you would mark a 1 or 2.
If you quarrel often, but not all of the time, you would mark a 3 or 4.

		Not at all true (I do not do this) 0	**A little true 1**	**Somewhat true 2**	**Moderately true 3**	**Quite a bit true 4**	**Very true (I often do this) 5**
1	I lose my temper when my child doesn't do something I ask him/her to do.						
2	I have pleasant conversations with my child.						
3	I grab or handle my child roughly.						
4	I try to teach my child new things.						
5	I demand that my child does something (or stop doing something) right away.						
6	My child and I hug and/or kiss each other.						

7	I complain about my child's behavior or tell my child I don't like what s/he is doing.						
8	I laugh with my child about things we find funny.						
9	When my child misbehaves, I let him/her know what will happen if s/he doesn't behave.						
10	My child and I spend time playing games, doing crafts, or doing other activities						
11	I listen to my child's feelings and try to understand them.						
12	I thank or praise my child.						
13	I spank or use physical punishment with my child.						
14	I offer to help, or help my child with things s/he is doing.						
15	I threaten my child.						
16	I comfort my child when s/he seems scared, upset, or unsure.						
17	I say mean things to my child that can						

	make him/her feel bad.						
18	I hold or touch my child in an affectionate way.						
19	When I am disappointed in my child's behavior, I remind him/her about what I've done for him/her.						
20	When my child asks for help or attention, I ignore him/her or make him/her wait until later.						

Parent Sense of Competence (PSC)

Listed below are a number of statements about how you feel about parenting. Please respond to each item, indicating your agreement or disagreement. Please respond to them bearing in mind the time frame of the **past 1 month.** Please answer the questions using the following scale:

Strongly Agree **1**	**Agree** **2**	**Slightly Agree** **3**	**Slightly Disagree** **4**	**Disagree** **5**	**Strongly Disagree** **6**

1	The problems of taking care of a child are easy to solve once you know how your actions affect your child, an understanding I have acquired.	1	2	3	4	5	6
2	Even though being a parent could be rewarding, I am frustrated now while my child is at his/her present age.	1	2	3	4	5	6
3	I go to bed the same way I wake up in the morning, feeling I have not accomplished a whole lot.	1	2	3	4	5	6
4	I do not know why it is, but sometimes when I'm supposed to be in control, I feel more like the one being manipulated.	1	2	3	4	5	6
5	My mother/father was better prepared to be good a mother/father than I am.	1	2	3	4	5	6
6	I would make a fine model for a new mother/father to follow in order to learn what she/he would need to know in order to be a	1	2	3	4	5	6

	good parent.						
7	Being a parent is manageable, and any problems are easily solved.	1	2	3	4	5	6
8	A difficult problem in being a parent is not knowing whether you're doing a good job or bad one.	1	2	3	4	5	6
9	Sometimes I feel like I'm not getting anything done.	1	2	3	4	5	6
10	I meet my own personal expectations for expertise in caring for my child.	1	2	3	4	5	6
11	If anyone can find the answer to what is troubling my child, I am the one.	1	2	3	4	5	6
12	My talents and interests are in other areas, not in being a parent.	1	2	3	4	5	6
13	Considering how long I have been a parent, I feel thoroughly familiar with this role.	1	2	3	4	5	6
14	If being a parent of a child were only more interesting, I would be motivated to do a better job as a parent	1	2	3	4	5	6
15	I honestly believe I have all the skills necessary to be a good parent to my child.	1	2	3	4	5	6
16	Being a parent makes me tense and anxious.	1	2	3	4	5	6
17	Being a good mother is a reward in itself.	1	2	3	4	5	6

CHILD-PARENT RELATIONSHIP SCALE

Please reflect on the degree to which each of the following statements has applied to your relationship with your child in the **past 1 month**. Using the scale below, circle the appropriate number for each item.

		Definitely does not apply 1	Not really 2	Neutral, not sure 3	Applies somewhat 4	Definitely applies 5
1	I share an affectionate, warm relationship with my child.	1	2	3	4	5
2	My child and I always seem to	1	2	3	4	5

	be struggling with each other.					
3	If upset, my child will seek comfort from me.	1	2	3	4	5
4	My child is uncomfortable with physical affection or touch from me.	1	2	3	4	5
5	My child values his/her relationship with me.	1	2	3	4	5
6	When I praise my child, he/she beams with pride.	1	2	3	4	5
7	My child spontaneously shares information about himself/herself.	1	2	3	4	5
8	My child easily becomes angry at me.	1	2	3	4	5
9	It is easy to be in tune with what my child is feeling.	1	2	3	4	5
10	My child remains angry or is resistant after being disciplined.	1	2	3	4	5
11	Dealing with my child drains my energy.	1	2	3	4	5
12	When my child is in a bad mood, I	1	2	3	4	5

	know we're in for a long and difficult day.					
13	My child's feelings toward me can be unpredictable or can change suddenly.	1	2	3	4	5
14	My child is sneaky or manipulative with me.	1	2	3	4	5
15	My child openly shares his/her feelings and experiences with me.	1	2	3	4	5

CHILD HEALTH QUESTIONNAIRE (SELF-ESTEEM SUBSCALE)

The following ask about your child's satisfaction with self, school, and others. It may be helpful If you keep in mind how other children your child's age might feel about these areas.

During the past 4 weeks, how satisfied do you think your child has felt about:

		Very Dissatisfied	**Somewhat dissatisfied**	**Neither satisfied nor dissatisfied**	**Somewhat satisfied**	**Very Satisfied**
		1	**2**	**3**	**4**	**5**
1	his/her school ability?	1	2	3	4	5
2	his/her athletic ability	1	2	3	4	5
3	his/her friendships?	1	2	3	4	5
4	his/her looks/appearance?	1	2	3	4	5

5	his/her family relationships?	1	2	3	4	5
6	his/her life overall?	1	2	3	4	5

ECBI Eyberg Child Behaviour Inventory

Directions: Below are a series of phrases that describe children's behaviour. Please (1) circle the number describing **how often** the behaviour has occurred with your child in the past month, and (2) circle either "yes" **or** "no" to indicate whether the behaviour has been **a problem for you in the past month.**

For example, if seldom, you would circle the 2 in response to the following statement:

1 Refuses to eat vegetables 1 (2) 3 4 5 6 7 yes (no)

Circle the only one response for each statement and respond to all the statements. Do not erase. If you need to change an answer, make an "x" through the incorrect answer and circle the correct response. For example:

1. Refuses to each vegetables 1 (2) ~~3~~ 4 5 6 7 yes (no)

	How often does this occur with your child? **Never 1 Seldom 2 Sometimes 3 Often 4 Always 5 6 7**								Is this a problem for you? Yes	No
1	Dawdles in getting dressed	1	2	3	4	5	6	7	Yes	No
2	Dawdles or lingers at mealtime	1	2	3	4	5	6	7	Yes	No
3	Has poor table manners	1	2	3	4	5	6	7	Yes	No
4	Refuses to eat food presented	1	2	3	4	5	6	7	Yes	No
5	Refuses to do chores when asked	1	2	3	4	5	6	7	Yes	No
6	Slow in getting ready for bed	1	2	3	4	5	6	7	Yes	No
7	Refuses to go to bed on time	1	2	3	4	5	6	7	Yes	No
8	Does not obey house rules on own	1	2	3	4	5	6	7	Yes	No
9	Refuses to obey until threatened with punishment	1	2	3	4	5	6	7	Yes	No
10	Acts defiant when told to do something	1	2	3	4	5	6	7	Yes	No
11	Argues with parents about rules	1	2	3	4	5	6	7	Yes	No
12	Gets angry when doesn't get own way	1	2	3	4	5	6	7	Yes	No
13	Has temper tantrums	1	2	3	4	5	6	7	Yes	No
14	Sasses adults	1	2	3	4	5	6	7	Yes	No

15	Whines	1	2	3	4	5	6	7	Yes	No
16	Cries easily	1	2	3	4	5	6	7	Yes	No
17	Yells or screams	1	2	3	4	5	6	7	Yes	No
18	Hits parents	1	2	3	4	5	6	7	Yes	No
19	Destroys toys and other objects	1	2	3	4	5	6	7	Yes	No
20	Is careless with toys and other objects	1	2	3	4	5	6	7	Yes	No
21	Steals	1	2	3	4	5	6	7	Yes	No
22	Lies	1	2	3	4	5	6	7	Yes	No
23	Teases or provokes other children	1	2	3	4	5	6	7	Yes	No
24	Verbally fights with friends own age	1	2	3	4	5	6	7	Yes	No
25	Verbally fights with sisters and brothers	1	2	3	4	5	6	7	Yes	No
26	Physically fights with friends own age	1	2	3	4	5	6	7	Yes	No
27	Physically fights with sisters and brothers	1	2	3	4	5	6	7	Yes	No
28	Constantly seeks attention	1	2	3	4	5	6	7	Yes	No
29	Interrupts	1	2	3	4	5	6	7	Yes	No
30	Is easily distracted	1	2	3	4	5	6	7	Yes	No
31	Has short attention span	1	2	3	4	5	6	7	Yes	No
32	Fails to finish tasks or projects	1	2	3	4	5	6	7	Yes	No
33	Has difficulty entertaining self alone	1	2	3	4	5	6	7	Yes	No
34	Has difficulty concentrating on one thing	1	2	3	4	5	6	7	Yes	No
35	Is overactive or restless	1	2	3	4	5	6	7	Yes	No
36	Wets the bed	1	2	3	4	5	6	7	Yes	No

Scores	**Raw score**	**T score**	**Exceeds cut off**

Intensity			
Problem			

Primary caregiver post-test questionnaire (beginning).

Primary Caregiver Questionnaire

DATE:

FIELDWORKER:

This questionnaire will help us understand how you parent, how you feel about parenting and the relationship you have with your child as well as your child's behaviour, in the past month. Please bear in mind that all the questions are about only yourself and your selected child, and you are to consider this time period only.

Please keep information about which parenting programme group (i.e. this year's or next years) you were included in as CONFIDENTIAL, so please do not tell the fieldworker.

Introduction

Name of participant: _____

Name of participant's child: _____

Check contact details

Contact 1

Name:

Cellphone:

Home phone:

Contact 2

Name:

Cellphone:

Home phone:

Contact 3

Name:

Cellphone:

Home phone:

Follow-up-assessment

We will be conducting a THIRD interview in October next year. We will contact you to make this appointment closer to the time. After this third meeting, if you have not received the parenting programme yet, you will be contacted and informed about when and where the programme will be held for you.

PARENTING SCALE

At one time or another, all children misbehave or do things that could be harmful, that are "wrong", or that parents don't like. Examples include: hitting someone, whining or complaining, damaging things, forgetting homework, leaving things lying around, lying, being over-emotional, refusing to follow requests, breaking family rules, swearing, taking other people's things, staying out late.
Parents have many different ways or styles of dealing with these types of problems. Below are items that describe some styles of parenting. For each item, I will circle the number that best describes your style of parenting during the **past 1 month** with your selected child.

Sample Item
At meal time...
I let my child decide what to eat. 1 2 3 4 (5) 6 7 I decide what my child eats.

Interview Schedule – ALL (primary caregiver) participants

1) Since the first interview, have you received any form of help which you think may have assisted with improving your parenting or child's behaviour? This of course excludes the Positive Parenting Skills Training programme if you did receive this.

Yes ☐ No ☐

If yes, please provide us with information on the sort of assistance you received (e.g., type of service, how long for, when did you receive it, how do you think it helped).

Interview Schedule – programme participants who attended FOUR or more sessions

Participant name: **Date:**

1) Did you find anything difficult to understand or learn on the course? What was it? Why do you think you found it difficult to understand and learn?
2) Did you find anything easy to understand and learn on the course?

What was it? Why do you think you found it easy to understand and learn?

3) Has there been anything which has prevented you from applying the skills learnt in the course at home? What was this?
4) Has there been anything which has helped you apply the skills learnt in the course at home?
5) What do you think about the PPST overall?
6) What do you think about the PPST facilitator overall?
7) Do you know anyone else who is also a part of the research on the parenting programme?
   Yes ☐ No ☐
   If yes, since the first interview, have you shared any information with them about the parenting programme?

Yes ☐ No ☐

If yes, please specify what it is that you shared and who you shared this information with:

8) Some people had some difficult getting to the programme, what factors helped you attend the programme?

Interview Schedule – Programme participants who attended NO sessions

Name of participant:

1) What factors played a role in preventing you from attending the programme?

or

You were able to provide the following reasons for why you could not make the parenting programme when I phoned you. Is there anything you would like to add as to why you weren't able to make the programme other than these reasons?

Appendix G – Other Adult Questionnaire

Other adult baseline questionnaire.

Other Adult Questionnaire

DATE:

[Main caregiver name] is currently participating in a research study and possibly parenting programme. They have answered some questions in relation to their child [name of selected child].

We would like your input on [main caregiver name]'s parenting behaviour and [name of selected child]'s behaviour. When answering all the questions, please bear in mind only these two individuals.

First we will start with some demographic questions.

Demographics

Name of caregiver you will be answering questions about:_____

Name of child you will be answering questions about:_____

Name of participant:

What relation are you to this child? Biological Parent ☐ Step Parent ☐ Grandparent ☐ Adoptive Parent ☐ Foster Parent ☐ Other relation: _____

Participant Gender:

Female ☐ Male ☐

Participant Age: DOB: _____/_____/_____

<u>Sourcing information:</u>

We require that you provide us with the contact details of three individuals who will always

know where you are so that we can find you for the later interviews. Please could you provide us with these details?

Contact 1

Name:

Cellphone:

Home phone:

Contact 2

Name:

Cellphone:

Home phone:

Contact 3

Name:

Cellphone:

Home phone:

Post-assessment

We will be conducting a second interview at the end of June through to the Middle of July. We will contact you to make this appointment closer to the time.

PARENTING SCALE

At one time or another, all children misbehave or do things that could be harmful, that are "wrong", or that parents don't like. Examples include: hitting someone, whining or complaining, damaging things, forgetting homework, leaving things lying around, lying, being over-emotional, refusing to follow requests, breaking family rules, swearing, taking other people's things, staying out late.
Parents have many different ways or styles of dealing with these types of problems.
Below are items that describe some styles of parenting. For each item, circle the number that best describes [name of caregiver]'s style of parenting during the **past 1 month** with [name of selected child].

Sample Item

At meal time...
They let their child decide what to eat. 1 2 3 4 5 6 7 They decide what their child eats.

1	When [name of caregiver]'s child misbehaves…							
	[name of caregiver] does something right away	1	2	3	4	5	6	7	[name of caregiver] does something about it later
2	Before [name of caregiver] does something about a problem…							
	[name of caregiver] gives his/her child several reminders and warnings	1	2	3	4	5	6	7	[name of caregiver] uses only one reminder or warning
3	When [name of caregiver] is upset or under stress…							
	[name of caregiver] is picky and on his/her child's back	1	2	3	4	5	6	7	[name of caregiver] is no more picky than usual
4	When [name of caregiver] tells his/her child not to do something…							
	[name of caregiver] says very little	1	2	3	4	5	6	7	[name of caregiver] says a lot
5	When [name of caregiver]'s child pesters him/her…							

	[name of caregiver] can ignore the pestering	1	2	3	4	5	6	7	[name of caregiver] can't ignore the pestering
6	When [name of caregiver] child misbehaves…								
	[name of caregiver] usually gets into a long argument with his/her child	1	2	3	4	5	6	7	[name of caregiver] does not get into an argument
7	[name of caregiver] threatens to do things that…								
	[name of caregiver] is sure he/she can carry out	1	2	3	4	5	6	7	[name of caregiver] knows he/she won't actually do
8	[name of caregiver] is the kind of parent that…								
	sets limits on what his/her child is allowed to do	1	2	3	4	5	6	7	lets his/her child do whatever he or she wants
9	When [name of caregiver]'s child misbehaves…								
	[name of caregiver] gives his/her child a long lecture	1	2	3	4	5	6	7	[name of caregiver] keeps his/her talks short and to the point
10	When [name of caregiver]'s child misbehaves…								
	[name of caregiver] raises his/her voice or yells	1	2	3	4	5	6	7	[name of caregiver] speaks to his/her

									child calmly
11	If saying no doesn't work right away…								
	[name of caregiver] takes some other kind of action	1	2	3	4	5	6	7	[name of caregiver] keeps talking and trys to get through to his/her child
12	When [name of caregiver] wants his/her child to stop doing something…								
	[name of caregiver] firmly tells his/her child to stop	1	2	3	4	5	6	7	[name of caregiver] coaxes or begs his/her child to stop
13	When [name of caregiver]'s child is out of his/her sight…								
	[name of caregiver] often does not know what his/her child is doing.	1	2	3	4	5	6	7	[name of caregiver] always has a good idea of what his/her child is doing
14	After there's been a problem with his/her child…								
	[name of caregiver] often holds a grudge	1	2	3	4	5	6	7	things get back to normal quickly
15	When [name of caregiver] and [name of child] are not at home…								
	[name of caregiver] handles his/her child the way	1	2	3	4	5	6	7	[name of caregiver] lets his/her child get away

	he/she does at home								with a lot more
16	When [name of caregiver]'s child does something [name of caregiver] does not like…								
	[name of caregiver] does something about it every time it happens	1	2	3	4	5	6	7	[name of caregiver] often lets it go
17	When there's a problem with [name of caregiver]'s child…								
	things build up and [name of caregiver] does things he/she doesn't mean to do	1	2	3	4	5	6	7	things don't get out of hand
18	When [name of caregiver]'s child misbehaves, he/she spanks, slaps, grabs, or hit his/her child …								
	never or rarely	1	2	3	4	5	6	7	most of the time
19	When [name of caregiver]'s child doesn't do what he/she asks…								
	[name of caregiver] often lets it go or ends up doing it him/herself	1	2	3	4	5	6	7	[name of caregiver] takes some other action
20	When [name of caregiver] gives a fair threat or warning…								
	[name of caregiver] often does not carry it out	1	2	3	4	5	6	7	[name of caregiver] always does what he/she said

21	If saying “No” doesn’t work…								
	[name of caregiver] takes some other kind of action	1	2	3	4	5	6	7	[name of caregiver] offer his/her child something nice so he/she will behave
22	When [name of caregiver]’s child misbehaves…								
	[name of caregiver] handles it without getting upset	1	2	3	4	5	6	7	[name of caregiver] gets so frustrated or angry that his/her child can see he/she is upset
23	When [name of caregiver]’s child misbehaves…								
	[name of caregiver] makes his/her child [name of caregiver] why he/she did it	1	2	3	4	5	6	7	[name of caregiver] says “No” or takes some other action
24	When [name of caregiver]’s child misbehaves and then acts sorry…								
	[name of caregiver] handles the problem like he/she usually would	1	2	3	4	5	6	7	[name of caregiver] lets it go that time
25	When [name of caregiver]’s child misbehaves…								

	[name of caregiver] rarely uses bad language or curses	1	2	3	4	5	6	7	[name of caregiver] almost always uses bad language
26	When [name of caregiver]'s says his/her child can't do something…								
	[name of caregiver] lets his/her child do it anyway	1	2	3	4	5	6	7	[name of caregiver] sticks to what he/she said
27	When [name of caregiver] has to handle a problem…								
	[name of caregiver] tells his/her child he/she is sorry about it	1	2	3	4	5	6	7	[name of caregiver] does not say he/she is sorry
28	When [name of caregiver]'s child does something [name of caregiver] does not like, he/she insults his/her child, says mean things, or calls his/her child names…								
	never or rarely	1	2	3	4	5	6	7	most of the time
29	If [name of caregiver]'s child talks back or complains when he/she handles a problem…								
	[name of caregiver] ignores the complaining and sticks to what he/she said	1	2	3	4	5	6	7	[name of caregiver] gives his/her child a talk about not complaining
30	If [name of caregiver]'s child gets upset when he/she says "No"…								
	[name of caregiver] backs down and gives in to his/her child	1	2	3	4	5	6	7	[name of caregiver] sticks to what he/she said

Parenting Young Children Scale (Setting limits subscale)

For the next set of questions, please rate how often [name of caregiver] has engaged in each parenting strategy **during the last month.**
On a scale from 0 (never), 1 (very rarely), 2(rarely), 3(sometimes), 4(often), 5(very often) to 6 (always).

How often does this occur with [name of caregiver]'s child?

Never 0	Very rarely 1	Rarely 2	Sometimes 3	Often 4	Very Often 5	Always 6

1	[name of caregiver] sticks to his/her rules and not change his/her mind?	1	2	3	4	5	6	7
2	[name of caregiver] speaks calmly with his/her child when he/she is upset with him or her?	1	2	3	4	5	6	7
3	[name of caregiver] explains what he/she wanted his/her child to do in clear and simple ways?	1	2	3	4	5	6	7
4	[name of caregiver] tells his/her child what he/she wanted him/her to do rather than tell him/her to stop doing something?	1	2	3	4	5	6	7
5	[name of caregiver] tells his/her child how he/she expected him or her to behave (such as in the grocery store)?	1	2	3	4	5	6	7
6	[name of caregiver] sets rules on his/her child's problem behavior that he/she is willing/able to enforce?	1	2	3	4	5	6	7
7	[name of caregiver] makes sure his/her child followed the rules he/she set all or most of the time?	1	2	3	4	5	6	7

Parent Behavior Inventory

Please think about each statement carefully. Think about how [name of caregiver] and his/her child *generally* get along. Tell us how well the statement describes the way [name of caregiver] has *usually* acted with his/her child within the **past 1 month.**
0 *not at all true (he/she does not do this)*
1 *a little true*
2 somewhat true
3 *moderately true*
4 *quite a bit true*
5 *very true (he/she often does this)*

Example: [name of caregiver] quarrels with his/her child.
If they spend a great deal of time quarreling with they child, you would mark a 5 in the space.
If they never quarrel with their child, you would mark a 0 in the space.
If they quarrel sometimes, but not much, you would mark a 1 or 2.
If they quarrel often, but not all of the time, you would mark a 3 or 4.

		Not at all true (I do not do this) 0	**A little true 1**	**Somewhat true 2**	**Moderately true 3**	**Quite a bit true 4**	**Very true (I often do this) 5**
1	[name of caregiver] loses his/her temper when his/her child doesn't do something [name of caregiver] asked him/her to do.						
2	[name of caregiver] has pleasant conversations with his/her child.						
3	[name of caregiver] grabs or handles his/her child roughly.						
4	[name of caregiver] tries to teach his/her child new things.						

5	[name of caregiver] demands that his/her child does something (or stops doing something) right away.						
6	[name of caregiver] and [name of child] hug and/or kiss each other.						
7	[name of caregiver] complains about his/her child's behavior or tells his/her child he/she doesn't like what he/she is doing.						
8	[name of caregiver] laughs with his/her child about things they find funny.						
9	When [name of caregiver]'s child misbehaves, he/she lets him/her know what will happen if s/he doesn't behave.						
10	[name of caregiver] and [name of child] spend time playing games, doing crafts, or doing other activities						
11	[name of caregiver] listens to his/her child's feelings and tries to understand them.						
12	[name of caregiver] thanks or praises his/her child.						

13	[name of caregiver] spanks or uses physical punishment with his/her child.						
14	[name of caregiver] offers to help, or helps his/her child with things s/he is doing.						
15	[name of caregiver] threatens his/her child.						
16	[name of caregiver] comforts his/her child when s/he seems scared, upset, or unsure.						
17	[name of caregiver] says mean things to his/her child that can make [name of child] feel bad.						
18	[name of caregiver] holds or touches his/her child in an affectionate way.						
19	When [name of caregiver] is disappointed in his/her child's behavior, [name of caregiver] reminds him/her about what he/she has done for him/her.						
20	When [name of caregiver]'s child asks for help or attention, [name of caregiver] ignores him/her or makes him/her wait until						

	later.						

ECBI Eyberg Child Behaviour Inventory

Directions: Below are a series of phrases that describe children's behaviour. Please (1) circle the number describing **how often** the behaviour has occurred with [name of caregiver]'s child in the past month.

For example, if seldom, you would circle the 2 in response to the following statement:

1 Refuses to eat vegetables 1 (2) 3 4 5 6 7 yes (no)

Circle the only one response for each statement and respond to all the statements. Do not erase. If you need to change an answer, make an "x" through the incorrect answer and circle the correct response.

How often does this occur with [name of caregiver]'s child?

Never 1 Seldom 2 Sometimes 3 Often 4 Always 5 6 7

1	Dawdles in getting dressed	1	2	3	4	5	6	7
2	Dawdles or lingers at mealtime	1	2	3	4	5	6	7
3	Has poor table manners	1	2	3	4	5	6	7
4	Refuses to eat food presented	1	2	3	4	5	6	7
5	Refuses to do chores when asked	1	2	3	4	5	6	7
6	Slow in getting ready for bed	1	2	3	4	5	6	7
7	Refuses to go to bed on time	1	2	3	4	5	6	7
8	Does not obey house rules on own	1	2	3	4	5	6	7
9	Refuses to obey until threatened with punishment	1	2	3	4	5	6	7
10	Acts defiant when told to do something	1	2	3	4	5	6	7
11	Argues with parents about rules	1	2	3	4	5	6	7
12	Gets angry when doesn't get own way	1	2	3	4	5	6	7
13	Has temper tantrums	1	2	3	4	5	6	7
14	Sasses adults	1	2	3	4	5	6	7
15	Whines	1	2	3	4	5	6	7
16	Cries easily	1	2	3	4	5	6	7
17	Yells or screams	1	2	3	4	5	6	7

18	Hits parents	1	2	3	4	5	6	7
19	Destroys toys and other objects	1	2	3	4	5	6	7
20	Is careless with toys and other objects	1	2	3	4	5	6	7
21	Steals	1	2	3	4	5	6	7
22	Lies	1	2	3	4	5	6	7
23	Teases or provokes other children	1	2	3	4	5	6	7
24	Verbally fights with friends own age	1	2	3	4	5	6	7
25	Verbally fights with sisters and brothers	1	2	3	4	5	6	7
26	Physically fights with friends own age	1	2	3	4	5	6	7
27	Physically fights with sisters and brothers	1	2	3	4	5	6	7
28	Constantly seeks attention	1	2	3	4	5	6	7
29	Interrupts	1	2	3	4	5	6	7
30	Is easily distracted	1	2	3	4	5	6	7
31	Has short attention span	1	2	3	4	5	6	7
32	Fails to finish tasks or projects	1	2	3	4	5	6	7
33	Has difficulty entertaining self alone	1	2	3	4	5	6	7
34	Has difficulty concentrating on one thing	1	2	3	4	5	6	7
35	Is overactive or restless	1	2	3	4	5	6	7
36	Wets the bed	1	2	3	4	5	6	7

Scores	**Raw score**	**T score**	**Exceeds cut off**
Intensity			
Problem			

Other adult post-test questionnaire (beginning).

Other Adult Questionnaire

DATE:

FIELDWORKER:

These questions relate to [name of caregiver]'s parenting behaviours and [name of caregiver's child]'s behaviour within the past month. Please answer the questions bearing ONLY these two individuals in mind, as well as within this time frame. Additionally, please keep information about which parenting programme group (i.e. this year's or next years) which [name of caregiver] was included in as CONFIDENTIAL, please do not tell the fieldworker.

INTRODUCTION

Name of the caregiver you will be answering questions about:_____

Name of the child you will be answering questions about:_____

Name of participant: _____

Check contact details

Contact 1

Name:

Cellphone:

Home phone:

Contact 2

Name:

Cellphone:

Home phone:

Contact 3

Name:

Cellphone:

Home phone:

Post-assessment

We will be conducting a THIRD interview in October next year. We will contact you to make this appointment closer to the time.

PARENTING SCALE

At one time or another, all children misbehave or do things that could be harmful, that are "wrong", or that parents don't like. Examples include: hitting someone, whining or complaining, damaging things, forgetting homework, leaving things lying around, lying, being over-emotional, refusing to follow requests, breaking family rules, swearing, taking other people's things, staying out late.
Parents have many different ways or styles of dealing with these types of problems.
Below are items that describe some styles of parenting. For each item, I will circle the number that best describes [name of caregiver]'s style of parenting during the **past 1 month** with [name of selected child].

Sample Item
At meal time...
[name of caregiver] lets his/her child decide what to eat. 1 2 3 4 5 6 7 [name of caregiver] decides what his/her child eats.

Appendix H – Evaluation Timeline

Proposed Timeline	
Date	Activity
April 2014- 6th August 2014	Participants recruited. Baseline assessment. Participants randomly allocated to either control or evaluation group. Parents informed about which group they have been allocated to.
14th August 2014 – 25th September 2014	Positive Parenting Skills Training implemented.
29th September 2014 – October 2014	Post assessment.
September/October 2015	Follow-up assessment.
November 2015	Control group receives Positive Parenting Programme.

Appendix I – Participant Consent Forms

Informed Consent (Caregiver)

Consent to participate in a research study:

Parent Centre's Positive Parenting Skills Training Research

Dear Caregiver,

Study Purpose

You are being asked to participate in a research study being conducted by researchers from the School of Management Studies at the University of Cape Town in collaboration with the Parent Centre. The purpose of this study is to determine whether the Positive Parenting Skills Training helps improve parenting. This research has been approved by the Commerce Faculty Ethics in Research Committee.

Study Procedures

If you decide to participate in this study, it means you agree to take part in the Positive Parenting Skills Training AND the research. For the research, you will be interviewed for approximately an hour today. A second interview will happen in a few weeks' time, when the training is over; and a third interview again in a year's time. These interviews will take place if you are a part of the group which receives the Positive Parenting Skills Training now, or a part of the group which will only receive this training next year. The interviews will include questions about the way you parent, and other things such as how you feel about your parenting, the relationship you have with your child, and your child's behaviour. We will also ask you to suggest another adult who lives with you and who knows you and your child to participate; we will also ask them about your parenting and your child's behaviour.

Possible Risks

There are no real risks involved in this study. However, you may find some questions make you feel a bit upset or uncomfortable. Additionally, due to the nature of the study you will need to provide the researchers with some form of identifiable information however, the interview will be kept absolutely confidential by the research team. If there are any concerns about your parenting that cannot be addressed by the Positive Parenting Skills Training, we will refer you to a social worker for support – only in that case will we talk to anyone about you and your child.

Possible Benefits

We will give you a small gift (for instance, some muffins) to thank you for your time after each interview. You will also be able to participate in the Positive Parenting Training Skills course.

Alternatives

You may choose not to participate in this study. Your decision will not affect you in any way, and will not affect any services you receive.

Voluntary Participation

Participation in this study is completely voluntary. You are free to refuse to answer any question. You are free to change your mind and discontinue participation at any time.

Confidentiality

All the information you give will be kept confidential. Your consent form and other identifying information will be kept in locked filing cabinets or on password protected computers. The information obtained will not be disclosed to anybody else but the researchers involved. Any reports or publications about this study will not identify you or any other study participant; only grouped information will be given.

Questions

Any study-related questions or problems should be directed to the following researchers:
Ms Soraya Lester (083 774 0741)

Professor Catherine Ward (021 650 3422)

Questions about your rights as a study participant, comments or complaints about the study may also be presented to Mrs. Fazeela Felton (021 650 3778). If you are feeling distressed as a result of your participation you can get help from the Parent Centre (021 762 0116).

Please fill out the last page; you are welcome to keep the first two pages.

I have read the consent form and am satisfied with my understanding of the study, its possible risks, benefits and alternatives. I hereby voluntarily consent to the participating in the research study as described.

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Signature of participant (primary caregiver) Date

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Witness

Informed Consent (Other Adult)

Consent to participate in a research study:

Parent Centre's Positive Parenting Skills Training Research

To whom it may concern,

Study Purpose

You are being asked to participate in a research study being conducted by researchers from the Department of Management Studies at the University of Cape Town in collaboration with the Parent Centre. The purpose of this study is to determine whether the Parent Centre's Positive Parenting Skills Training helps improve parenting. A caregiver who has agreed to participate in this research already has stated that you might be willing to participate in this research as well. This research has been approved by the Commerce Faculty Ethics in Research Committee.

Study Procedures

If you decide to participate in this study, you will be interviewed for approximately 45 minutes today. A second interview will happen in a few weeks' time, and a third again in a year's time. The interviews will include questions about the caregiver's parenting, and how their child behaves. Therefore, it will not ask you questions about your own parenting.

Possible Risks

There are no real risks involved in this study. However, you may find some questions make you feel a bit upset or uncomfortable. Additionally, due to the nature of the study you will need to provide the researchers with some form of identifiable information however, the interview will be kept absolutely confidential by the research team.

Possible Benefits

You will be compensated with a packet of muffins to thank you for your time after each interview.

Alternatives

You may choose not to participate in this study. Your decision will not affect you or the caregiver who referred you in any way.

Voluntary Participation

Participation in this study is completely voluntary. You are free to refuse to answer any question. You are free to change your mind and discontinue participation at any time.

Confidentiality

All the information you give will be kept confidential. Your consent form and other identifying information will be kept in locked filing cabinets or on password protected computers. The information obtained will not be disclosed to anybody else but the researchers involved. Any reports or publications about this study will not identify you or any other study participant; only grouped information will be given.

Questions

Any study-related questions or problems should be directed to the following researchers:

Ms Soraya Lester (083 774 0741)

Professor Catherine Ward (021 650 3422)

Questions about your rights as a study participant, comments or complaints about the study may also be presented to Mrs. Fazeela Felton (021 650 3778). If you are feeling distressed as a result of your participation you can get help from the Parent Centre for help (021 762 0116).

Please fill out the last page; you are welcome to keep the first two pages.

I have read the consent form and am satisfied with my understanding of the study, its possible risks, benefits and alternatives. I hereby voluntarily consent to the participation of me in the research study as described.

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Signature of participant (other adult) Date

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Witness

Appendix J – Maltreatment Protocol

FIELDWORKER REPORTING PROTOCOL

WHAT TO DO IF A PARTICIPANT SAYS S/HE IS ABUSIVE

For reporting purposes, "abuse" means where a child is being hurt so that there are obvious marks or in obvious pain, or neglected so that they are not at school, or go hungry, or don't get medical treatment.

1. Complete the interview before doing anything about this. You will do any reporting at the end of the interview.

2. If the parent does disclose abuse that is currently going on, ask if it has been reported. If it has NOT been reported, at the end of the interview say to the parent: "Because you have told me you have been abusive, and because this was not reported, I have to report this to a social worker. Do you understand?"

3. Then say: "I need to fill in this form. I will give it to my supervisor, and s/he will fax it to the Department of Social Development."

4. Fill in the attached form.

5. Then say: "A social worker from the Department of Social Development may come to see you about this. It may take some time before they can come."

6. Give the form to your fieldwork supervisor (Soraya) as soon as possible. Soraya will the phone supervisor (Cathy Ward) and confirm that the case was maltreatment over the phone.

7. If the case is confirmed by supervisor as maltreatment Soraya will fax through the form to the Department of Social Development.

8. If emergency intervention is appropriate, the fieldwork supervisor must notify the police, who are authorized to deal with such situations.

FORM FOR REPORTING OF ABUSE OR DELIBERATE NEGLECT OF A CHILD REPORTING OF ABUSE TO PROVINCIAL DEPARTMENT OF SOCIAL DEVELOPMENT, DESIGNATED CHILD PROTECTION ORGANISATION OR POLICE OFFICIAL

TO: The Head of the Department

Pursuant to section 110 of the Children's Act, 2005, and for purposes of section 114(1)(a) of the Act, you are hereby advised that a child has been abused in a manner causing physical injury/ sexually abused/ deliberately neglected or is in need of care and protection. This abuse is ongoing.

Source of this report: I am supervising fieldwork during a study of parenting for the University of Cape Town and The Parent Centre. This parent has disclosed maltreatment in the course of this study.

Parent's surname: _____

Parents first name(s): _____

Sex: _____ Date of birth: _____

Name of child's school: _____

Grade: _____

Contact number for child / child's caregiver: _____

Type of abuse (i.e. deliberate neglect, physical or sexual abuse) _____

_____

Place and date of alleged incident (i.e. at the child's home, school etc.)_____

_____

_____

Description of alleged incident (i.e. nature and extent of the incident, is it ongoing, were injuries inflicted, perpetrator) _____

_____

_____

_____

_____

_____

Parent's address: _____

_____

I declare that the particulars set out in the above statement are true and correct to the best of my knowledge

Signature of person completing this form: _____

Date: _____

Appendix K – Fieldworker Safety Protocol

Prior to conducting an interview, Soraya will introduce both herself and the fieldworker to every participant before entering the household. This introduction will include a reference made to when the main researcher will pick them up (i.e. a short time). A quick check of the safety of the participant's home will also be made. This will consider for example the participant's sobriety. If the main researcher and/or fieldworker do not feel comfortable about conducting the researcher at that venue at that time, an excuse will be made for us to both leave. If both the fieldworker and main researcher feel comfortable conducting the research in the participant's home then interviews as per normal will proceed

In the case where a fieldworker in the process of an interview does not feel safe in a participant's home the following protocol will be adhered to:

1) The fieldworker will politely end the interview with the follow phrase: "At this stage in the interview I will have to get into contact with the main research of this study to confirm a question".

2) The fieldworker will then phone Soraya Lester and state: "Hi Soraya, everything is okay, but I am having trouble with one question, it seems to be worded incorrectly". This phrase will serve as code for: they do not feel safe conducting the interview any further and need to leave immediately.

3) Soraya will return immediately to pick up this fieldworker from the participants home.

4) Soraya will approach the home and make an excuse as to why the fieldworker is required to leave.

5) Returning to the home will be decided on a case by case basis.

Appendix L – Reasons for Other Adult Attrition at Post-test

Number lost to follow-up (n= 8)

Reasons:

- 1 could not find a time to meet.
- 2 not living with primary caregiver
- 5 were no longer interested or too busy

Appendix M – Statistical Appendix

The Parenting Scale, Hostility subscale of the Parent Behaviour Inventory, Parent Sense of Competency Scale, and Eyberg Child Behaviour Inventory all demonstrated adequate approximations of normality at baseline.

The Parenting Young Children's Scale along with the Supportive subscale of the Parent Behaviour Inventory, Closeness subscale of the Child-parent Relationship Scale, and Child Health Questionnaire demonstrated very negative skews at baseline. This distribution shape indicates that more of the sample scored higher on these measures than in the average or lower range. Consequently, it is very likely on these scales a ceiling effect was demonstrated. This indicates a lack of sensitivity of the scale to measure nuances on the upper end of a scale. It is quite possible that is was because of these skews that few effects for more positive outcomes were detected at post-test, because there was very little room for change.

Data Cleaning.

Participant's language.

Primary caregivers were asked to specify their home-language at baseline. On a number of occasions fieldworkers stated they were bilingual (speaking both English and Afrikaans). In this instance the first marker option was selected to be retained in the data sets created. This was usually English.

Participants living in the same household.

On seven occasions, more than one person in the household was interested in participating in the research e.g., both the mother and father, two sisters et cetera. In such cases, both of the interested participants were interviewed, and then randomly assigned to the intervention or control group as a single unit. Only one person was required to participate in a post-test interview and was to be considered in the analysis. The decision about who to exclude was based first and foremost on the highest amount of programme attendance (if assigned to the intervention group). If there was a tie for level of attendance,

or they were not assigned to the intervention, then who ever scored the highest on the ECBI's frequency scale was retained within the data set and invited to complete a post-test interview.

Missing data.

Single items.

Missing data for single items seemed to occur for three main reasons: (1) the fieldworker forgot to ask, or fill in the answer to a question (2) the question did not apply to a participant (3) the participant expressed that they didn't know the answer to the question. A complete data set was essential for conducting the intention to treat analysis. Therefore, all missing data had a respective solution to cater for this. Data that was missing due to the forgetfulness of a fieldworker was imputed using multiple imputation, or where the answer was obvious then it was filled in e.g., if their child never stole in the past month and the ECBI problem scale was blank, I filled in that this was *not* a problem for the parent. In total, 8 items were imputed using multiple imputation across both primary caregiver and other adult datasets. If the question did not apply to a participant or they did not know the answer, then their answer for their total scale score on the scale in question was prorated.

Participant drop-out.

Attrition is a common problem for studies that make use of multiple points of assessment. Participant drop-put in this evaluation was minimal, with only 6 primary caregivers and 8 other adults being lost at follow-up. To cater for participant drop-out for the intention to treat analysis, a naïve approach to best and worst-case imputation was conducted. "Best" and "worst" case scenario imputation typically involves replacing missing outcome data with "good" outcomes in one group and "bad" outcomes in the other treatment arm. It is a common sensitivity analysis to conduct in randomised controlled trials (Higgins, White & Wood, 2008; Sterne et al., 2009). This imputation technique provides the smallest and largest effect estimates which are compatible with the data (Higgins et al., 2008). The naïve approach I took was slightly different for this evaluation in that regardless of treatment arm, one data set contained "worst-case" imputed outcomes and another

contained “best-case” imputed outcomes. In other words, in one data set I assumed that at post-test those who dropped out achieved the worst possible scores they could have on the respective scales, while the latter assumed that participants scored the best possible scores on each of the scales. As the participant’s true answers would have been between such extreme cases (had they participated), one could compare the differences between the results obtained from the analyses conducted using the two respective data sets. Small qualitative differences between the respective results would increase confidence in the validity of the findings. In contrast, if large differences between test statistics are found then confidence in the validity of the discovered outcome is considerably weaker.

Variable Construction.

Programme engagement.

The attendance variable was constructed by counting the number of sessions of the programme which the participant attended. Also captured was the percentage of completed homework activities by attending parents. This is the same as other work on parenting programmes (e.g., Baydar, Reid, & Webster-Stratton, 2003).

Reliability Statistics.

Table 16 – 19 provide the reliability statistics for all the measures completed by both primary caregivers and “other adults” at pre and post-test. Evident from these tables is both a high level of reliability of the majority of the measures used in this evaluation, as well as consistency in results both across measurement points, and under best or worst case conditions. Only two scales showed problematic levels of reliability; the Child Health Questionnaire completed by primary caregivers, and the Hostility subscale of the Parent Behaviour Inventory which was completed by other adults.

Scale length is perhaps what may have affected their reliability; longer scales containing more items generally show higher levels of reliability. However, the Parenting Young Children Scale is of a similar length to the two, and demonstrated good reliability here. It is possible the primary caregivers could not give reliable accounts of their children’s

self-esteem because this was not something their children openly discussed with them. At baseline assessment 60% of the sample was younger than 9 years old. Therefore, the sample of children included in the evaluation was for the most part quite young. With this in mind, it is possible that most children had not yet been able to obtain a firm understanding of their self-concept, or a vocabulary to express their thoughts about it. Though the scale was age appropriate, there may be cultural differences in development relating to these two latter issues. The scale was developed in a developed context, and has not been standardised for South African use. Other adults may have not been able to provide a reliable account of the levels of hostility with which primary caregiver's parented because they may have not considered this aspect of their parenting very carefully before being interviewed.

Table 16

Reliability Statistics of Primary Caregiver Scales – Best Possible Scenario

Scales	Baseline		Post-test	
	Cronbach's alpha	No. of items	Cronbach's alpha	No. of items
PS[1]	0.70	29	0.82	29
PARYC	0.72	7	0.68	7
PARYC PROB	0.79	7	0.79	7
PBI Supportive	0.88	10	0.86	10
PBI Hostile	0.78	10	0.76	10
PSOC	0.76	17	0.76	17
CPRS Conflict	0.80	8	0.81	8
CPRS Closeness	0.79	7	0.80	7
CHQ Self-esteem	0.60	6	0.62	6
ECBI Intensity	0.92	36	0.92	36
ECBI PROB	0.91	36	0.92	36

Note: [1] Total scale is comprised of 30 items, however one was lost due to consistent misunderstanding of an item's (number 27) meaning on behalf of participants. PS - Parenting Scale, PARYC – Parenting Young Children Scale-Setting Limits Subscale, PARYC PROB – Parenting Young Children Scale-Setting Limits Subscale Problem Score, PBI Supportive - Parent Behaviour Inventory Supportive Parenting Subscale, PBI Hostile - Parent Behaviour Inventory Hostile Parenting Subscale, PSOC – Parent Sense of Competence Scale, CPRS Conflict – Child-parent Relationship Scale Conflict Subscale, CPRS Closeness – Child-parent Relationship Scale Closeness

Subscale, CHQ Self-esteem – Child Health Questionnaire- Self-esteem Subscale, ECBI Intensity – Eyberg Child Behaviour Inventory Intensity Subscale, ECBI PROB - Eyberg Child Behaviour Inventory Problem Subscale.

Table 17

Reliability Statistics of Primary Caregiver Scales – Worst Possible Scenario

Scales	Baseline		Post-test	
	Cronbach's alpha	No. of items	Cronbach's alpha	No. of items
PS[1]	0.70	29	0.82	29
PARYC	0.72	7	0.68	7
PARYC PROB	0.79	7	0.79	7
PBI Supportive	0.88	10	0.86	10
PBI Hostile	0.78	10	0.76	10
PSOC	0.76	17	0.76	17
CPRS Conflict	0.80	8	0.81	8
CPRS Closeness	0.79	7	0.80	7
CHQ Self-esteem	0.59	6	0.62	6
ECBI Intensity	0.92	36	0.92	36
ECBI PROB	0.91	36	0.92	36

Note: [1] Total scale is comprised of 30 items, however one was lost due to consistent misunderstanding of an item's (number 27) meaning on behalf of participants. PS - Parenting Scale, PARYC – Parenting Young Children Scale-Setting Limits Subscale, PARYC PROB – Parenting Young Children Scale-Setting Limits Subscale Problem Score, PBI Supportive - Parent Behaviour Inventory Supportive Parenting Subscale, PBI Hostile - Parent Behaviour Inventory Hostile Parenting Subscale, PSOC – Parent Sense of Competence Scale, CPRS Conflict – Child-parent Relationship Scale Conflict Subscale, CPRS Closeness – Child-parent Relationship Scale Closeness Subscale, CHQ Self-esteem – Child Health Questionnaire- Self-esteem Subscale, ECBI Intensity – Eyberg Child Behaviour Inventory Intensity Subscale, ECBI PROB - Eyberg Child Behaviour Inventory Problem Subscale.

Table 18

Reliability Statistics of Other Adult Scales – Best Possible Scenario

Scales	Baseline		Post-test	
	Cronbach's alpha	No. of items	Cronbach's alpha	No. of items
PS[1]	0.79	29	0.77	29
PARYC	0.85	7	0.83	7
PBI Supportive	0.92	10	0.92	10
PBI Hostile	0.64	10	0.70	10
ECBI Intensity	0.92	36	0.93	36

Note: [1] Total scale is comprised of 30 items, however one was lost due to consistent misunderstanding of an item's (number 27) meaning on behalf of participants. PS - Parenting Scale, PARYC – Parenting Young Children Scale-Setting Limits Subscale, PBI Supportive - Parent Behaviour Inventory Supportive Parenting Subscale, PBI Hostile - Parent Behaviour Inventory Hostile Parenting Subscale, ECBI Intensity – Eyberg Child Behaviour Inventory Intensity Subscale.

Table 19

Reliability Statistics of Other Adult Scales – Worst Possible Scenario

Scales	Baseline		Post-test	
	Cronbach's alpha	No. of items	Cronbach's alpha	No. of items
PS[1]	0.79	29	0.77	29
PARYC	0.85	7	0.83	7
PBI Supportive	0.92	10	0.92	10
PBI Hostile	0.64	10	0.70	10
ECBI Intensity	0.92	36	0.93	36

Note: [1] Total scale is comprised of 30 items, however one was lost due to consistent misunderstanding of an item's (number 27) meaning on behalf of participants. PS - Parenting Scale, PARYC – Parenting Young Children Scale-Setting Limits Subscale, PBI Supportive - Parent Behaviour Inventory Supportive Parenting Subscale, PBI Hostile - Parent Behaviour Inventory Hostile Parenting Subscale, ECBI Intensity – Eyberg Child Behaviour Inventory Intensity Subscale.

Appendix N – Number of Participants at Each Programme Session

Table 20

Number of Participants Attending Programme Sessions at Respective Venues

	Session number							
Number of attendants	Orientation	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	*M*
Bluebrook	7	7	5	6	7	6	7	6.43
Southdale	9	7	10	9	6	5	7	7.57

Appendix O – Participant Engagement with Homework

Table 21

Participant Engagement with Programme Session Homework

Session homework	Venue	
	Southdale (number of attendees)	Bluebrook (number of attendees)
Session 1		
Completed	66.66% (4)	60.00% (3)
Partially completed	33.33 % (2)	40.0% (2)
Incomplete	0	0
No. not attending session	2	2
Session 2		
Completed	75.00% (6)	60.00% (3)
Partially completed	25.00% (2)	40.00% (2)
Incomplete	0	0
No. not attending session	3	1
Session 3		
Completed	66.66% (4)	28.57% (2)
Partially completed	33.33% (2)	71.43% (5)
Incomplete	0	0
No. not attending session	6	0
Session 4		
Completed	100.00% (4)	100.00% (6)
Partially completed	0	0
Incomplete	0	0
No. not attending session	7	1
Session 5		
Completed	100.00% (4)	50.00% (3)
Partially completed	0	50.00% (3)
Incomplete	0	0

No. not attending session	5	0
Session 6		
Completed	66.66% (4)	85.71% (6)
Partially completed	33.33% (2)	14.29% (1)
Incomplete	0	0