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FEASIBILITY AND ACCEPTABILITY OF THE EBB AND FLOW PARENTING PROGRAM

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FEASIBILITY AND ACCEPTABILITY OF THE EBB AND FLOW PARENTING

PROGRAM

BY

MARIA CATHERINE DIFONTE

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE

REQUIREMENTS OF THE DEGREE OF

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OF

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Abstract

It is well-documented that parenting impacts childhood outcomes, and research has found specific positive parenting strategies that are associated with increased child resilience, well-being, and functioning (Williams et al., 2009). In-person and online programs aim to increase use of these strategies and have led to significant improvements in child outcomes and parental self-efficacy and adjustment (Webster-Stratton, 1981; Sanders, 1999; Morgan et al., 2018; Khanna et al., 2017). While findings are promising, work is needed to assess the preventative roles of single-session psychoeducational parent training programs in reducing the emergence of diagnosable concerns in children, yet research in this area is still in its early stages. The EBB and Flow Program was developed to provide caregivers with a brief, online psychoeducational program that teaches positive parenting strategies for families with a child between the ages of 3- and 7-years. The EBB and Flow Program offers information about minimizing accommodation, authoritative parenting, and process praise, along with why these approaches are effective and tips for implementing them. The current study aimed to assess the feasibility and acceptability of the EBB and Flow Program, and to conduct exploratory analyses of the effectiveness of the program improving parenting approaches and bolstering positive family outcomes, including increasing resilience and reducing child anxiety. In the study, 68 parents with a child between the ages of 3- and 7-years were randomized into either the EBB and Flow program (n =30) or a control group (n=38). Participants completed measures pre-intervention, post-intervention, and at a 3-month follow-up. At post-intervention, 96.6% of intervention group (n=30) felt that the program contained helpful strategies and that it was easy to understand. Similarly, 93.2%

of participants reported feeling confident that they could use the strategies and 96.7% reported that their child would benefit if they used these strategies. A majority (93.2%) also reported they were excited to try out the strategies presented in the EBB and Flow program and 86.2% reported that they enjoyed watching the videos. Similarly, a majority (93.3%) reported they would recommend the program to a friend and 96.7% of participants reported that they would apply what they learned in the future. Exploratory analyses were conducted to assess changes in parental self-efficacy, accommodation, and overprotection, parenting styles (i.e., authoritative, permissive, and authoritarian, child anxiety symptoms, and family resilience; however, these analyses did not find any statistical significance between the intervention and control groups over the three-month follow-up period. Given the challenges with retention, most of these analyses demonstrated low power, which may have not been able to identify possible small effects within the analyses. Overall, these findings suggest that the EBB and Flow Program is feasible and acceptable by parents and adaptations referencing some of the recommendations provided by the sample (i.e., shorter videos, reference materials, etc.) will likely only further enhance the program. Due to the brevity of the program and inability to refer back to the skills discussed, the dose of the intervention may have been too low to effect observable change in the variables of interest. Future research is necessary to continue exploring the most appropriate ways to provide families psychoeducational information regarding parenting approaches and to bolster the effectiveness of this program to enhance positive parenting strategies and family outcomes.

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push through by sending me memes, having late night phone calls with me, giving me words of encouragement, and sharing pictures of their cute pets. This meant more to me than you will ever know!

Dedication

This dissertation is dedicated to both my grandmother (Nonna) and great-grandmother (Joey's Nonna). Nonna, thank you for believing in me throughout this journey, even on the days when I did not believe in myself. Your encouragement and support have allowed me to be brave and follow my heart from Massachusetts to Rhode Island, then to New Mexico, and soon enough to Connecticut and has kept me strong throughout this difficult, exciting, and tireless journey. Thank you for counting down the years, months, and now mere days until I graduate. I am so excited for you to watch me become the first doctor in our family. I am forever grateful for how you selflessly devoted yourself to supporting me, Nicole and Anthony, and our entire family. Joey's Nonna, I hope that you are looking down on me and feeling proud that I am your namesake and was able to live out your lifelong dream of becoming a doctor. While Nonna says that I remind her of you, I can only aspire to be a quarter of the strong, brave, and confident woman that you were. Thank you both for sacrificing your education to take care of our family and for laying the foundation that has allowed me to pursue a graduate education. I hope that I have made you both proud and I love you so much! We did it!

Nonna, as you always tell me: Buon giorno si vede la mattina!

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Chapter 1

Introduction

Anecdotally, when parents are asked what they hope for their child, often the answer is that they want their child to “succeed” or “thrive.” While childhood outcomes are truly dependent on a mixture of genetics, environment, and cognitive thinking styles (McClure et al., 2001; Kercher & Rapee, 2009; Deater-Deckard & Petrill, 2004), parents and other caregivers play a vital role in setting their child up for “success” through their parenting approaches. Ainsworth’s (1979) seminal work on infant attachment demonstrates the importance of early parenting on child outcomes, particularly during the first few years of life. The way in which a caregiver responds to a child has been shown to have lifelong influences on child well-being and functioning (Giallo et al. 2014; Bornstein & Bornstein, 2007). Across cultural groups, research consistently highlights the effect of parenting styles on later child outcomes, such as internalizing or externalizing problems (Williams et al., 2009; Querio et al., 2002; Braza et al., 2015; Alizadeh et al., 2011).

Parenting programs implemented early in childhood have the potential to foster secure attachments and child well-being through early adulthood. Interventions addressing unhelpful child rearing approaches throughout early childhood can help the child develop secure attachments with their caregivers and effective coping strategies to manage the challenges they will experience throughout their lives. Parents should always continue to adapt and enhance their parenting approach to meet the needs of their child, particularly within the context of the child’s developmental age, and to further foster growth throughout childhood. Programs aimed at fostering positive parenting strategies

are not only effective, but are economically sound, as they minimize future health care costs (Duncan et al., 2017). Parenting interventions extend across disciplinary fields, including brain and physical development, nutrition and exercise, language development, mental health, and child temperament (Neville et al., 2013; O'Connor et al., 2009; Kitzmann & Beech, 2011; Tempel et al., 2009; Sheeber & Johnson, 1994). Despite the wide-ranging and long-lasting effects of parenting, no gold-standard parenting guide exists, and caregivers must rely on trial-and-error to determine the best ways to respond to their child.

While parenting interventions serve as an important avenue for bolstering child outcomes, there are often barriers to accessing these resources. These barriers include a lack of familiarity with available options, restricted physical or financial access, time constraints, long waitlists, and stigma associated with getting help (Tully et al., 2017). Additionally, parents often do not seek out services until their child's symptoms are severe (Tully et al., 2017). Some of these barriers have been addressed through the development of online interventions. However, McGoron and Ondersma (2015) note that while online parenting programs are being developed more frequently, research is needed to ensure adherence to and efficacy of these technology-based trainings prior to wide-spread dissemination.

Parenting Strategies

Parents often seek out information on how to promote emotional, academic, or social success for their child; however, accessible resources may not necessarily include evidence-based strategies for children or the entire family system. The following strategies have been demonstrated to have significant impacts on outcomes for children.

The first two parenting approaches below (i.e., accommodation and overprotection) have been associated with poorer outcomes and should be minimized, while the second two approaches (i.e., authoritative parenting and process praise) are ways to reduce accommodation and overprotection and therefore negative outcomes for children and families.

Accommodation. Accommodation occurs when caregivers engage in behaviors that reduce a child's experience of distress, by either having an active role in modifying their child's symptoms (e.g., allow avoidance, give reassurance) or rearranging their family's routine (Thompson-Hollands et al., 2014; Kagan et al., 2017; Lebowitz et al., 2014; Norman et al., 2015). Caregivers often accommodate with good intentions to help their child deal with unpleasant emotions, reduce their own distress when their child is upset, or both (Meyer et al., 2018). Despite these intentions, accommodation is linked with increased obsessive-compulsive and anxiety symptoms and poorer child treatment outcomes (Lebowitz et al., 2014; Lebowitz et al., 2016). As such, it is imperative for caregivers to learn about the long-term outcomes associated with accommodation.

Overprotective parenting. The term "overprotective parenting" is often referred to as helicopter parenting, intrusive parenting, lawnmower parenting, or overparenting (Garst & Gagnon, 2015). Segrin and colleagues (2013) define overprotective parenting as when parents become too involved in their child's life to the point that they are overly concerned with the child's behaviors and functioning. Similar to accommodation, it usually results from good intentions for protecting their child (Ungar, 2009). However, overprotective parenting has been associated with development of child anxiety and behavior disorders, including oppositionality and conduct problems (Gere et al., 2012),

along with reduced school engagement and parental promotion of child independence (Padilla-Walker & Nelson, 2012). Previous work suggests that engagement in overprotective parenting may vary across different identity groups due to differences in cultural values, experiences of stress, or socioeconomic status (Suarez-Morales & Torres, 2021; Ungar, 2009). Additionally, Garcia and Garcia (2009) found that children from various cultural backgrounds, such as families from Spain, may thrive when parents are providing high levels of warmth and less structure or rules, which is similar to overprotective parenting. The association between overprotective parenting and poor child emotional, behavioral, and academic outcomes emphasizes the critical need for caregivers to grant autonomy to promote child resilience and well-being. Additionally, it is also important to continue to explore how these associations vary across different cultural identities of the families.

Authoritative parenting. Baumrind (1991) outlined three parenting styles (i.e., authoritative, authoritarian, permissive) that impact child socialization and functioning. Authoritative parenting involves having clear rules, warmth and responsiveness, high expectations, and value for a child's independence. Compared to other parenting styles, authoritative parenting is more likely to increase social competency, academic achievement, independence, psychological well-being among children (Steinberg et al., 1989; Baumrind, 1991; Alizadeh et al., 2011; Strage & Swanson Brandt, 1999; Rudy & Grusec, 2001; Garcia & Garcia, 2009). It should be noted that while authoritative parenting was found to be associated with positive child outcomes in a number of different countries, some research has shown that children in some countries respond more favorably to authoritarian or permissive parenting, depending on that country's

cultural values surrounding parenting and family functioning, and as such it is important to promote strategies that are in line with the particular cultural values within the community receiving the intervention (Rudy & Grusec, 2001; Garcia & Garcia, 2009). Therefore, within the context of families in the United States, bolstering authoritative parenting is an important tool in promoting positive family outcomes. In contrast to accommodating and overprotective parenting, authoritative parents encourage their child to face challenges, while providing warmth and setting firm limits.

Process praise. Positive reinforcement increases the likelihood that a behavior will be repeated in the future (Walker & Buckley, 1968). In accordance, parents offer praise to increase a child's intrinsic motivation to repeatedly do certain behaviors (Henderlong & Lepper, 2002). However, recent work suggests that the wording of the praise may be more crucial than how frequently it is given (Gunderson et al., 2018). Specifically, process praise emphasizes the effort one puts in during a particular task, while person praise suggests that success is a trait and that will either occur or will not (Bayat, 2011; Kamins & Dweck, 1999). While preschoolers respond positively when receiving either process or person praise, by fourth grade, students respond more favorably to process praise compared to person praise (Henderlong & Lepper, 2007). During middle school, students who received process praise were more likely to approach challenges in school with the intention of increasing their understanding of a particular topic (Gunderson et al., 2018). While person and process praise may not have vastly different effects in early childhood, it may be important for parents to utilize process praise early on, as it will be more beneficial for their children later on compared to person praise.

Existing Parenting Interventions

In-Person Treatment Programs. Parenting interventions are most frequently administered through in-person trainings, such as parent workshops, consultations, or group counseling. Treatment programs are designed to address childhood concerns once they have already emerged. One example is the Incredible Years Program, a well-researched parenting intervention that teaches parents about positive attention, effective praise, prosocial behaviors and coping skills, setting limits, ignoring unwanted behaviors, and following through on consequences to reduce problematic child behaviors, particularly for children from infancy through early childhood (Webster-Stratton, 1981). Across 50 effectiveness studies and a meta-analysis of 15 randomized controlled trials (RCTs), families who participated in Incredible Years saw significant improvements in parent- and teacher-ratings of child disruptive behavior compared to either a control group or alternative treatment groups (Menting et al., 2013; Leijten et al., 2018).

Another approach is Parent-Child Interaction Therapy (PCIT), in which parents are coached by a clinician to engage in positive parenting strategies (i.e., consistent responding, such as providing praise for prosocial behaviors) through an earphone while they play with their child (Eyberg, 1988). PCIT and its adaptations have found positive long-term effects, including reduced inappropriate and maladaptive emotional and behavioral outcomes for their children and decreased parenting stress (Cooley et al., 2014; Kim et al., 2018; Ramos et al., 2018; Comer et al., 2012).

Individual and group-based parent-focused therapy have been shown to reduce ineffective parenting approaches and increase parental confidence (Simon et al., 2012; Waters et al., 2009; Cartwright-Hatton et al., 2011). For example, a brief, two-session,

parent-focused cognitive behavioral therapy (CBT) targeting parental accommodation was found to effectively reduce child anxiety (Thompson-Hollands et al., 2015). Similarly, Lebowitz and colleagues (2019) found that the 12-week, parent-only Supportive Parenting for Anxious Childhood Emotions (SPACE) program was effective in reducing child anxiety and was significantly better in reducing parental accommodation than child-focused CBT. Interventions as brief as a one-session parent workshop have been shown to effectively reduce the likelihood that a child will develop anxiety (Cartwright-Hatton et al., 2018). Including parents in child-focused sessions to learn about anxiety, overparenting, and accommodation, has been found to lead to improved treatment outcomes as well (Taboas et al., 2015; Esbjørn et al., 2014; Ginsburg et al., 2004).

In-Person Prevention Programs. The Triple P Positive Parenting Program (Triple P) and the Chicago Parenting Program are designed to prevent child behavioral problems. Triple P is a universal prevention effort that provides parents with tailored support to address child behavioral problems (Sanders, 1999). The level of support varies from tip sheets or individual sessions to an 8-week course or enhanced behavioral family interventions. Sander's (1999) Triple P program focuses on enhancing parental knowledge about effective parenting strategies, confidence, and resourcefulness, developing safe, nurturing family environments, and promote various outcomes in children, including social-emotional functioning, language and intelligence, and behaviors. In a systematic review and meta-analysis (Sanders et al., 2014), Triple P was found to effectively improve child outcomes, parenting practices, parental satisfaction and adjustment, and the overall parent-child relationship; these results were also

maintained over time. Parent reports and blind-observational reports were included in analyses, further supporting the effectiveness of Triple P (Sanders et al., 2014). Similarly, two randomized trials of the Chicago Parenting Program, a group educational program for African American and Latino families aimed at preventing child behavioral problems, demonstrated that parents used more consistent discipline and less corporal punishment, and had higher levels of self-efficacy and fewer child behavior concerns after the program (Breitenstein et al., 2012). See Table 1 for details of these and other existing in-person interventions.

Online Treatment Programs. Advancements in technology increased opportunities to disseminate parent trainings. Recent meta-analyses suggest that online and self-guided programs (e.g., workbooks, videos) may reduce child behavior and emotional concerns and increase use of positive parenting skills (Tarver et al., 2014). Cool Little Kids Online (Morgan et al., 2018) is an 8-module course in which parents learn about child anxiety and CBT strategies, such as fear hierarchies, rewards, and encouraging independence to reduce their child's anxiety symptoms. At the 6-month follow-up, significant decreases in child anxiety were associated with frequent use of the parenting strategies (Morgan et al., 2018). In a smaller study, Khanna and colleagues (2017) compared the Child Anxiety Tales program to a bibliotherapy training and a waitlist. This 10-week intervention provides caregivers strategies to help their child manage anxiety, including relaxation, challenging anxious thoughts, problem solving, rewards, and exposure tasks. Three-month follow-up data demonstrated reduction of anxiety symptoms by post-intervention; however, these changes were not significantly

different between the two intervention groups. This suggests that providing families with just psychoeducation may be an alternative option to intensive treatment programs.

Web-based interventions for disruptive behavior problems among children and teens are also promising. Programs, such as the Parent-Web, Internet-PMT, and Strongest Families Smart Website have been found to decrease child externalizing and emotional concerns and increase parental use of positive parenting strategies (e.g., effective communication, praise, ignoring unwanted behaviors, problem solving, and planning ahead for future challenges) at follow-up (Jones et al., 2017; Wetterborg et al., 2019; Enebrink et al., 2012; Sourander et al., 2016).

Online Prevention Programs. Triple P Online provides psychoeducation related to positive parenting behaviors, such as praise and planning ahead, managing oppositional behaviors, and emotion regulation strategies (Sanders et al., 2012). Findings from a 6-month follow-up indicated fewer reported child behavior problems and increased parental confidence and mental health outcomes (e.g., less stress and anger). Additional trials of the Triple P Online program have assessed outcomes in adaptations that offer telephone support (Day & Sanders, 2018), fewer modules (Baker et al., 2017), targeted intervention for families with children who have disabilities (Hinton et al., 2017), or with a parent who has bipolar disorder (Jones et al., 2017). These studies demonstrated increased positive parenting behaviors and parental self-efficacy and decreased child behavioral and emotional concerns at follow-up compared to control groups.

Partners in Prevention (Cardamone-Breen et al., 2018) was designed to prevent anxiety and depression among teens. Caregivers completed an evaluation about their

parenting strategies and were given information tailored to their needs on topics such as providing warmth, autonomy granting, discipline, coping strategies, managing family conflict, and seeking professional help. Pilot data suggested that, compared to a waitlist, the one-time online personalized feedback session significantly improved parenting risk and protective factors by the 3-month follow-up. More work is needed, however, to explore the actual effect of preventing adolescent anxiety and depression as no significant effects were found on the symptoms of these disorders (Cardamone-Breen et al., 2018). Other online prevention interventions, such as 5-a-Day Parenting Program (McGoron et al., 2018) and ezPARENT, an online version of the Chicago Parent Program (Breitenstein et al., 2017), focus on enhancing positive parenting behaviors to bolster school-readiness and prevent child behavioral problems, respectively. These programs have not yet published effectiveness outcomes, although demonstrate the feasibility of online programs for positive parenting strategies. See Table 2 for specific details of online parenting programs.

Current Research Gaps

While exploration of parenting programs has increased, continued work is needed to address remaining gaps in the literature. Pilot studies and RCTs of online programs demonstrate promising results; however, evaluation efforts often fail to assess long-term outcomes, complete replication trials, and/or compare results to in-person trainings (McGoron & Ondersma, 2015). Also, a majority of the samples used in the existing literature often are comprised of homogenous samples, including mostly White females from middle to upper socioeconomic groups that have a partner and secondary or tertiary degrees (Morgan et al., 2018; Baker et al., 2017). Given this, research is needed to ensure

that dissemination is appropriate for various populations (e.g., racial, ethnic, or cultural groups, socioeconomic status, and family systems, such as foster or single-parent families) (Mejia et al., 2017). In addition, studies that have explored adaptations for various ethnic minority groups rarely outline the adaptation process (Van Mourik, Crone, De Wolff, & Reis, 2017). Future work must also attempt to ameliorate barriers to such programs (Morawska et al., 2011).

Notably, many of the programs address child concerns that have already reached clinical thresholds and, therefore focus on strategies that address that concern. As such, many of these programs discuss tailored parenting approaches for specific child symptoms, such as managing behavioral dysregulation (i.e., setting clear, consistent limits, praise for positive behaviors) or anxiety symptoms (i.e., reducing accommodation), rather than strategies that may prevent the emergence of these concerns. It is imperative to consider the preventative opportunities of intervening earlier, and while measuring prevention requires long-term follow-ups, it is essential that the field shifts towards more of a preventative framework to bolster mental wellbeing across our population. Programs should incorporate parenting strategies that increase overall wellbeing, rather than address one specific concern and can do this by focusing on a wider scope of positive parenting behaviors (i.e., providing warmth, setting limits, reducing accommodation and overparenting, process praise, among others) may provide parents with a greater skill set to prevent both behavioral and anxiety concerns from emerging among their children. Recent protocols outlined interventions that aim to teach strategies to new or soon-to-be parents to bolster child outcomes; however, they focus on a singular index of outcome, such as children's readiness for school (Mihelic et al., 2018;

Fernando et al., 2018; Weisleder et al., 2016). Future endeavors should assess the efficacy of single-session online trainings, as preliminary findings in recent trials show positive changes in parenting protective and risk factors (Cardamone-Breen et al., 2018). Also, to date, few interventions have incorporated a universal dissemination approach to focus on prevention, and the lack of wide-spread and easily accessible parenting prevention programs for child mental and behavioral outcomes, particularly in the United States, is another area of growth for the field of parenting interventions.

Present Study

Brief, online interventions increase opportunities for individuals to participate in research by reducing barriers that may occur if it was conducted in person, such as time constraints or access to transportation (Wright, 2005). Despite potential disadvantages of online programs (e.g., limiting access to those without internet or an electronic device, lack of tailored information; Wright, 2005; Brown, 2018), conducting a feasibility and acceptability study of a brief, online intervention will provide critical information regarding whether participants are able to utilize a program that provides research-supported strategies and implement the strategies offered. As such, the single-session EBB and Flow Program was developed and was be examined in the current project.

The EBB and Flow Program is a brief, online psychoeducational prevention program of parenting strategies associated with positive child outcomes (e.g., reduced anxiety, increased resilience and well-being). Unlike most parenting interventions, the EBB and Flow Program offers the unique opportunity for parents to learn positive parenting strategies prior to their child developing clinical emotional or behavioral concerns.

The current study is a feasibility, acceptability, and pilot trial and is primarily exploratory in nature. Feasibility and acceptability studies provide critical information regarding the fit and sustainability of an intervention (Bowen et al., 2009). Results from such endeavors explore the effectiveness and appropriateness of further disseminating an intervention. In the present study, quantitative and qualitative data were collected related to participants' opinions about the EBB and Flow Program. The current design is a single-blind randomized trial where the intervention group received the EBB and Flow Program, read three parenting vignettes, and responded to items regarding the feasibility and acceptability of the program; the control condition watched a two minute "neutral" video on parenting that does not provide guidance or psychoeducational information regarding parenting strategies and then read the same three parenting vignettes. Participants were told that the current study is investigating various parenting approaches.

The EBB and Flow Program was designed as a single-session video series to teach positive parenting strategies, the importance of these strategies, and tips caregivers can use to actually incorporate these skills throughout a typical day. Specifically, the EBB and Flow Program teaches parents to minimize accommodation by promoting independence in their child, authoritative parenting by teaching how to balance warmth and firmness, and process praise to increase independent and brave behaviors. The current study explored the feasibility and acceptability of the EBB and Flow Parenting Program of teaching caregivers positive parenting strategies as a low-cost, single-session online preventative intervention to increase awareness of these evidence-based parenting approaches. Results from these types of endeavors help researchers decide whether an

intervention should be explored further among larger samples to determine if it is effective in addressing the concern of interest.

This study also served as a pilot randomized controlled trial to explore the effectiveness of this single-session online psychoeducational video series in increasing parental self-efficacy, positive parenting approaches (i.e., authoritative parenting, not accommodating or overparenting, process praise), and family outcomes (i.e., family resilience and child wellbeing). The goal of the EBB and Flow Program was to provide caregivers with the knowledge, perspective, and language and reasoning for these positive parenting strategies. To assess the effect of the EBB and Flow Program modules, participants read three vignettes about caregivers responding to a child in various situations and were asked to identify how the caregiver should respond utilizing each of the strategies presented in the modules. Given the primary goals of assessing the feasibility, acceptability and effectiveness of the EBB and Flow Program, the following hypotheses were tested:

1a) Participants who receive the brief, online psychoeducational intervention, EBB and Flow Program, will find that the intervention contains helpful strategies, that it is easy to understand, and that they feel confident in utilizing the strategies discussed. 1b) Participants will also feel that the strategies are applicable to their child(ren) and that their child(ren) will benefit from the strategies. 1c) Participants will report that they will apply the skills that they learned in the future.

2a) Participants who receive the intervention will feel excited to try out the strategies, report that they enjoyed watching the module videos, and want to learn more from the EBB and Flow Program. 2b) Participants will want to refer back to the program

to review strategies, if possible. 2c) Participants will report that they would recommend the program to a friend.

3a) Participants who receive the intervention will more accurately select the appropriate caregiver response in each of the vignettes compared to the participants in the control group at post-intervention. 3b) Participants who receive the intervention will experience a significant increase in self-efficacy across time-points compared to those who did not receive the intervention. 3c) Participants who receive the intervention will demonstrate a significant reduction in parental accommodation from pre-intervention to follow-up compared to those who do not receive the intervention. 3d) Participants who receive the intervention will demonstrate a significant reduction in parental overprotection from pre-intervention to follow-up compared to those who do not receive the intervention. 3e) Participants who receive the intervention will demonstrate significantly less anxiety symptoms in their child at follow-up than those who do not receive the intervention. 3f) Participants who receive the intervention will demonstrate a significant increase in family resilience from pre-intervention to follow-up compared to those who do not receive the intervention. 3g) Participants who receive the intervention will demonstrate a significant increase in their authoritative parenting from pre-intervention to follow-up compared to those who do not receive the intervention. 3h) Participants who receive the intervention will demonstrate a significant reduction in their level of permissive and authoritarian parenting from pre-intervention to follow-up compared to those who do not receive the intervention.

Chapter 2

Methods

Participants

Participants included caregivers and parents living in the United States who identified as the primary caregiver to a child between the ages of 3 and 7 years. The age range of 3- to 7-years-old was selected to cover the developmental period of early childhood. Participants were primarily recruited from virtual flyers on social media, along with email advertisements through listservs at preschools, daycares, community centers, and elementary schools. These direct emails and posts on social media sites contained a link to the online study. To preserve anonymity of participants, study participants were not required to identify their recruitment source, nor were they required to identify their names, dates of birth, or the state in which they currently reside.

A total of 68 participants completed the baseline survey and were entered into a drawing for one of four \$50 Amazon gift cards. An additional 38 participants completed at least part of the baseline survey; however, of this group, only 10 participants (5 in the intervention group, 5 in the control group) were randomly assigned to either the control group or intervention group, as the remaining 28 had stopped participating in the study during the baseline questionnaires. Given that the vast majority of these 38 participants discontinued participation after just a few questions they were not included in the analyses.

As the primary aim of the current study was to explore the feasibility and acceptability of the EBB and Flow program and not the comparison of treatment effects, recruitment ensured a minimum of 30 participants were enrolled in each group, in line

with recommendations for feasibility and pilot studies (Hertzog, 2008). This guidance provided by Hertzog (2008) was used to determine sample size, as a formal power analysis was not required for this project (Arian et al., 2010). The results of this study will inform additional design considerations for a larger scale trial that will explore the effectiveness of this brief parenting intervention compared to a waitlist control group. If the full impact of the EBB and Flow program were to be explored, power calculations recommend that a total sample of 352 participants be recruited, with 176 participants in each group. All 68 participants met the following eligibility criteria: 1) being over the age of 18; 2) having a child between the ages of 3- and 7-years, 3) being the primary caregiver to this child, 4) could provide consent, and 5) are able to read English without assistance. The final sample consisted of 68 participants, 30 (44%) in the intervention condition and 38 (56%) in the control condition (see Figure 1).

Measures

Demographic Information. Participants were asked to report their age, racial, ethnic and gender identity, sexual orientation, socioeconomic status, occupation, education level, household income, and mental health status. They also reported information about their child's age, racial identity, and gender identity. Participants were asked whether they were currently or previously engaged in family therapy or parent consultation and if they were their child's primary caregiver. A full list of demographic questions can be found in Appendix A.

Vignettes. Participants were presented with three vignettes, see Appendix B. Each vignette depicted a caregiving situation related to each of the EBB and Flow Program modules. For each vignette, a child between the ages of 3- and 7-years old was

described to be in a situation in which the caregiver would respond verbally with one of the three presented prompts. One of the three options demonstrated the caregiver responding to the child in a way that utilizes the parenting strategy discussed in the associated module. Both the intervention and control groups completed the vignettes to assess for group differences in identifying the evidence-based parenting responses.

Feasibility and Acceptability. The Feasibility of Intervention Measure (FIM) and the Acceptability of Implementation Measure (AIM; Weiner et al., 2017) are two 4-item measures that ask participants on a five-point scale how much they agree with each statement (1 = completely disagree, 5 = completely agree). Items on the FIM focus on whether participants believe the intervention is “implementable,” “possible,” “doable,” and “easy to use;” while items on the AIM focus on whether participants enjoyed the intervention. Both the FIM and AIM were found to have satisfactory internal consistency, test-retest reliability, and predictive validity (Weiner et al., 2017). See Appendix C to see the adapted feasibility and acceptability items specifically for the EBB and Flow Program.

Parental self-efficacy. The Parent Empowerment and Efficacy Measure (PEEM; Freiberg et al., 2014) is a 20-item measure that captures an individual’s efficacy to parent. Participants rate how well each statement describes their beliefs about their parenting on a ten-point scale (1 = definitely not, 10 = definitely). The PEEM has two subscales that measure an individual’s confidence in being a good parent and their capacity to access both informal and formal supports. The PEEM and its subfactors have been shown to have high test-retest reliability, internal consistency, and be a valid measure of parental efficacy (Freiberg et al., 2014).

Parental accommodation. The Family Accommodation Scale - Anxiety (FASA; Lebowitz et al., 2013) is a 13-item assessment of three areas of accommodation, which include parental participation in their child's experiences of anxiety (i.e., reassuring their child, helping their child avoid), modification of their family's routine or functioning, and the resulting distress and consequences from these behaviors. Participants rate the first nine items on a five-point scale (0 = Never, 4 = Daily) for how often they have engaged in the behavior during the past month. For the last four items, related to distress and consequences, participants rate the severity of each item on a five-point scale (0 = none, 5 = extreme) during the past month. The FASA has demonstrated high internal consistency and validity (Lebowitz et al., 2013).

Parental overprotection. The Parental Overprotection Measure (OP; Edwards et al., 2008) is a 19-item measure of parental behaviors related to providing autonomy and shielding children from potentially dangerous situations. Participants rate each item on a five-point scale (0 = not at all, 4 = very much) for how often they engage in that behavior. Sample items include, "I would not allow my child to go out with family or friends if I were not present," "I shelter my child from life's difficulties," and "I try to protect my child from making mistakes." Scores for all items are summed, with higher scores indicating greater parental protection. The OP has been shown to have high internal consistency, strong test-retest reliability, and good predictive and construct validity (Edwards et al., 2008).

Parenting style. The Parenting Styles and Dimensions Questionnaire – Short Version (PSDQ-Short Version; Robinson et al., 2001) is a 32-item measure of parenting approaches (i.e., authoritative, authoritarian, or permissive (Baumrind, 1971)). The PSDQ

– Short Version creates a score for each parenting approach, and items are rated on a five-point scale (1 = never, 5 = always). Scores on the items for each parenting style are averaged to get an overall score for each approach. There are subfactors for the authoritative (i.e., connection, regulation, and autonomy granting) and authoritarian (i.e., physical coercion, verbal hostility, and non-reasoning/punitive) scales. The authoritative and authoritarian scales were shown to have high internal consistency, while the permissive parenting scale was found to have adequate internal consistency and all scales were shown to be valid (Robinson et al., 2001).

Child anxiety. Participants will complete either the Revised Preschool Anxiety Scale (PAS-R; Edwards et al., 2010) or the Spence Childhood Anxiety Scale – Parent Report (SCAS-P; Spence, 1999), depending on the child’s age. These 28- and 38-item measures, respectively, ask participants to rate each item for how often it describes their child. The PAS-R has five possible responses (0 = not true at all, 4 = very often true) and the SCAS-P has four response options (0 = never, 3 = always), with higher scores indicating increased anxiety. There are four subscales on the PAS-R (i.e., generalized anxiety, social anxiety, specific fears, separation anxiety), and six subscales on the SCAS-P (i.e., panic and agoraphobia, separation anxiety, physical injury fears, social phobia, obsessive compulsive, generalized anxiety). The PAS-R has acceptable internal consistency and validity, while the SCAS-P has satisfactory to high internal consistency and validity (Edwards et al., 2010; Nauta et al., 2004; Whiteside & Brown, 2008). Scores will be converted to standardized scores to compare across age ranges.

Family resilience. The Family Resilience Assessment Scale (FRAS; Sixbey, 2005) is a 66-item measure of family resilience. Participants rate the how much they

agree with each item (1 = strongly disagree, 4 = strongly agree). Several of the items are reverse scored and then items scores are summed to produce a total score, which ranges from 66 to 264, with higher scores indicating higher family resilience. The FRAS consists of six subscales that include family communication and problem solving, utilizing social and economic resources, maintaining a positive outlook, family connectedness, family spirituality, and ability to make a meaning of adversity. The FRAS has high internal consistency and validity (Sixbey, 2005).

Procedure

Recruitment. All study procedures were reviewed and approved by the Institutional Review Board (IRB) at the University of Rhode Island. A demographically diverse sample was recruited to participate via flyers posted on social media platforms (e.g., Facebook, Instagram, Twitter) and in direct emails distributed through listservs at local community centers, day-cares, preschools and elementary schools. Flyers included a summary of eligibility and participation requirements, benefits of participating, contact information for the principal research investigator, and a Qualtrics link that directed individuals to the online survey. Participants first reviewed the consent form, which outlined confidentiality, inclusion and exclusion criteria, risks and benefits, and an outline of participation involvement. If an individual agreed to participate by selecting the “agree” button at the end of the consent form, they then proceeded to the survey.

Figure 1 provides a detailed summary of the recruitment process.

Randomization. After participants were determined to be eligible for the study, they were randomized to either the intervention arm or the control arm using the

Randomizer feature within the online survey platform, Qualtrics. Participants created a unique eight-digit code that was used to link baseline data to follow-up data.

The EBB and Flow Program: Intervention Arm. This newly developed evidence-based psychoeducational program was disseminated to participants randomized to the intervention condition. This program provided information regarding three parenting strategies that are associated with positive outcomes and increased mental wellbeing in children. The intervention was designed to be parent-focused and aimed to increase parental self-efficacy related to these parenting techniques and increase the likelihood that they will engage in these strategies. In accordance, with bolstering these outcomes, the intervention also aimed to increase family resilience and reduce child anxiety. The program presented psychoeducation regarding parenting more broadly, then presented three modules, each highlighting a different parenting approach, (i.e., Module 1: Encourage Independence, Module 2: Be Warm, But Firm, Module 3: Be Their Number One Fan).

Each module took roughly seven to eight minutes to complete, specifically the module videos were seven minutes and 40 seconds, eight minutes and 41 seconds, and seven minutes and 31 seconds, respectively. After each module, participants read a vignette of a caregiving situation and then selected the appropriate caregiver response to the child's behaviors. This served as a check that participants understood the content and could apply each strategy. Brief feedback was provided for both correct and incorrect responses. Finally, participants completed items regarding parental self-efficacy as well as feasibility and acceptability of the intervention. At the end of the baseline survey, participants were asked to enter their email in a separate survey to receive the link to the

follow-up survey. They were also able to endorse whether they wanted to be entered into a raffle for one of two \$50 gift cards.

Control Arm. Participants in this condition completed the study measures at the same timepoints as the intervention condition to parallel the frequency of data collection (i.e., baseline and follow-up) but were not presented with the psychoeducational information presented in the EBB and Flow Program. After completing measures, participants read the same three vignettes as the intervention group and selected the parenting approach they felt was most appropriate for each situation. They were not provided feedback on their responses. Participants in the control condition were then asked to complete the parenting self-efficacy measure. At the end of the baseline survey, participants (similar to those in the intervention condition) were asked to enter their email in a separate survey to receive the web link to the follow-up and had the option to opt into a raffle for one of two \$50 gift cards.

Follow-Up. All participants completed the series of measures and vignettes at a 3-month follow-up. See Table 3 for an outline of measures for each time point by condition. At completion of the follow-up, participants in both conditions were provided a list of parenting resources, including books, websites, and professional resources, as shown in Appendix D. Participants were also given the opportunity to provide their email in a separate survey to opt into a raffle for one of two \$50 gift cards.

Analytic Approach

All data were collected via the online survey platform, Qualtrics (Qualtrics, 2020). Deidentified data was stored in a SPSS file on a password-protected computer. Data were cleaned and checked for coding, scoring, and level of missing data. All

statistical analyses detailed below were conducted using IBM SPSS Statistics version 27 (IBM Corp., 2020).

Missing Data. SPSS Missing Values Analyses were conducted to explore patterns of missing data among the demographic characteristics and variables of interest. Across items, the level of missing data was found to be negligible (i.e., less than 5%; Jakobsen et al., 2017), and therefore, pairwise deletion was utilized to manage missing data. Despite debate in the literature regarding the utilization of pairwise deletion (Baraldi & Enders, 2010), a major benefit is that this method preserves statistical power and has been determined to be appropriate when missing data are found to be at random and negligible (Jakobson et al., 2017). Given that the sample evidence very low rates of missing data, utilizing pairwise deletion to manage missing data is unlikely to negatively impact the results of the following analyses.

Data analysis at Pre-Intervention (Time 1 [T1]). Descriptive statistics were conducted to summarize sample demographics and quantitative feedback regarding the feasibility and acceptability of the program. Additionally, descriptive statistics of other variables of interest (i.e., child anxiety, parental accommodation, etc.) were summarized at T1 and a series of independent-sample *t*-tests and chi-square tests of independence were conducted to assess pre-intervention group differences that may have occurred despite randomization. Any demographic variables that were found to be significantly different between the two groups at T1, were added as covariates into the following analyses (O'Connell et al., 2017).

Data Analyses at Post-Intervention (Time 2 [T2]) and Three-Month Follow-Up (Time 3 [T3]). An independent-sample *t*-test was conducted to explore group

differences in accurately identifying the appropriate caregiver response post-intervention. Additionally, a paired sample *t*-test was conducted to assess for changes in the intervention group's ratings of feasibility and acceptability at T2 and T3 (Hsu & Lachenbruch, 2007). To examine changes in parental self-efficacy, a 2 (condition) X 3 (time period: T1 v. T2 v. T3) ANCOVA was conducted. Also, a series of 2 (condition) X 2 (time period: T1 v. T3) ANCOVA analyses were conducted to assess group differences on all other variables of interest (e.g., child anxiety, family resilience, and parental accommodation).

Data Assumptions. To explore group differences, it is assumed that continuous data are linear, normal and homoscedastic. Analyses of means, standard deviations, skewness and kurtosis were conducted to explore whether the variables of interest were normally distributed. Based on guidelines provided by Kim (2013), findings suggest that the variables of interest are normally distributed (see Table 4).

Chapter 3

Results

Power Analyses

As discussed above, the primary aim of the current study is to explore descriptive statistics related to feasibility and acceptability. However, given that a secondary aim of this project is to determine possible effectiveness of the intervention, power analyses were required for this latter group of analyses. A priori analyses using G*Power 3.0.10 (Faul et al., 2007) were conducted for the planned ANCOVA analyses to evaluate group differences in the variables of interest across the time points. The power analysis was designed to assume two-tailed p values, a medium effect size of 0.25 (Cohen, 1988), and power of 0.80. The first analysis revealed that, for variables to be explored at two time points, at least 34 participants were required to detect medium effect sizes. The second analysis revealed that, for variables to be explored across three timepoints, at least 28 total participants were required in order to detect medium effect sizes.

Descriptive Statistics

Demographic Variables. Of the 68 participants included in analyses, 83.8% identified as female ($N = 58$), and the remaining 16.2% identified as male ($N = 10$). Participants ranged in age from 24 to 50 ($M=35.45$, $SD=6.29$). About 7.5% of participants identified as Hispanic or Latinx ($N = 5$), 88.2% identified as non-Hispanic or Latinx ($N = 60$), and the remaining 4.4% of participants ($N = 3$) did not report ethnicity. About 69% of participants identified as White or Caucasian ($N = 47$), 1.5% identified as Black or African American ($N = 1$), 4.4% identified as Asian ($N = 3$), 7.4% identified as

Native American or Alaska Native ($N = 5$), 1.5% identified as Native Hawaiian or Other Pacific Islander ($N = 1$) and 14.7% identified as multiracial ($N = 10$).

A majority of the sample identified as heterosexual (89.7%, $N = 61$) and married (83.8%, $N = 57$). Nearly 87% of participants reported currently being employed ($N = 59$). Of the sample, 38.2% of participants reported that their family income was \$100,000 or more ($N = 26$), 14.7% reported their family income to be between \$75,000 and \$99,999 ($N = 10$), 19.1% reported their family income to be between \$50,000 and \$74,999 ($N = 13$), 10.3% reported their family income to be between \$35,000 and \$49,999 ($N = 7$), 13.2% reported their family income to be between \$25,000 and \$34,999 ($N = 9$), and the remaining 4.4% reported their family income to be between \$15,000 and \$24,999 ($N = 3$). Additionally, 10.3% reported having a High School Diploma ($N = 7$), 50% of participants reported completing either a Bachelor's or Master's degree ($N = 34$), and an 14.7% reported having some other graduate degree ($N = 10$). A majority of participants reported that they were not or have not participated in therapy or other parenting workshops (73.5%, $N = 50$) nor were they currently on a waitlist for services for parenting support (72.1%, $N = 49$).

Participants reported having between one and four children ($M=1.9$, $SD=0.79$), with either one (83.8%, $N = 57$) or two (16.2%, $N = 11$) children between the age range of 3- to 7-years. Participants with multiple children in the eligible age range were asked to focus on one child for the purposes of the child focused measures. Of the identified children, the mean age was 4.63 years ($SD=1.28$), and 47.1% were reported to be female ($N = 32$), 50% were reported to be male ($N = 34$), one parent reported their child was "too young to know their gender", and one parent did not report their child's gender identity.

Just under 60% of the children were reported to be White ($N = 40$), 29.4% were reported to be multiracial ($N = 20$), 1.5% was reported to be Black or African American ($N = 1$), 1.5% was reported to be Asian ($N = 1$), 2.9% were identified as Native American or Alaska Native ($N = 2$), 2.9% were identified as Native Hawaiian or Other Pacific Islander ($N = 2$), and the remaining two children's racial identities were not specified.

Just over 55% of participants ($N = 38$) had some reported a personal history with mental health issues, either in the past, present, or both. About 27% of participants ($N = 19$) endorsed a history of depression, 10.3% reported a history of bipolar disorder ($N = 7$), and 33.2% reported a history of anxiety ($N = 23$). Additionally, 25% of participants reported a history of attention deficit hyperactivity disorder ($N = 17$), 15.7% reported a history of posttraumatic stress disorder ($N = 10$), and 5.9% reported a history of substance use disorder ($N = 4$). While follow-ups were scheduled to be completed three months, or 90 days, post-intervention, participants frequently needed reminder emails to complete their final surveys. It took participants an average of 120.05 days to complete the follow-up survey, with a range of 90 days to 206 days. See Table 5 for full report of demographic characteristics of the current sample with a breakdown of these variables for each treatment condition.

Pre-Intervention (T1) Group Differences

Independent-samples t-tests and chi square tests of independence were performed to compare demographic variables between the control and intervention conditions (see Table 5). There were two variables that were significantly different between the control group and the intervention group. First, participants in the intervention condition also had a significantly different ethnic identity than the control group, with more individuals

identifying as Hispanic or Latinx in the intervention group than in the control group $\chi^2(1,65) = 6.72, p = 0.01$. Finally, education level also varied between groups, with more individuals in the control group reporting higher levels of education than individuals in the intervention group, $\chi^2(6,68) = 15.19, p = 0.02$. As such, ethnic identity and education level were added as covariates to the exploratory analyses.

Hypothesis One: Feasibility of the EBB and Flow Program

Participants who received the EBB and Flow Program and completed all three modules ($N = 30$) were asked a series of questions regarding the feasibility of the parenting intervention. Descriptive statistics were employed to which participants either disagreed or agreed to several items related to feasibility of the EBB and Flow Program that were administered at both T2 and T3 Paired-sample t -tests were conducted to explore for differences between the item responses between T2 and T3. No significant differences were found between participant responses on any of the feasibility items between the two time points. See Table 6 for descriptive statistics for the feasibility items and results from paired t -tests. See Tables 7-10 for qualitative feedback from participants in the intervention condition at both T2 and T3.

Hypothesis 1a: Helpfulness, Ease, and Confidence to Apply Skills. At post-intervention, a majority of participants (96.6%, $N = 28$) reported that they either agreed or completely agreed with the statement “the EBB and Flow Program contains helpful strategies,” ($M=3.45, SD=0.57$). For the statement “The EBB and Flow Program seems easy to understand,” 96.6% of participants ($N = 28$) reported they either completely agreed or agreed ($M=3.55, SD=0.57$), with one participant reporting they disagreed with this statement, and one participant who did not endorse a response. The one participant

who disagreed, reported that the strategies “wasn’t anything new for me.” Similarly, 93.2% of participants ($N = 27$) reported feeling confident that they can use the strategies ($M=3.45$, $SD=0.74$), with one participant reporting they disagreed with this statement, and one participant who did not endorse a response. Participants also shared written feedback on what they perceived to be the most helpful part(s) of the EBB and Flow Program and what they liked most about it. Some responses included “I liked it all,” “it’s easy to follow,” “it’s easy to understand and apply the skills,” “love how it breaks down certain parts of parenting and really makes you focus on those parts,” “good examples were given to explain the concepts,” and “it has great information for how to communicate with kids.”

At the follow-up, participants in the intervention group ($N=15$) reported similar opinions as they did at post-intervention. In particular, 93.3% of participants ($N = 14$) reported that the EBB and Flow Program contains helpful strategies ($M=3.27$, $SD=0.59$), with one person reporting that they did not think the strategies were helpful. Qualitative feedback included that the program was “logical” and that “it reminded me that it’s ok to feel feelings and talk through them.” A majority of participants (93.3%, $N = 14$) reported that the EBB and Flow Program seems easy to understand ($M=3.33$, $SD=0.62$), with one participant reporting that they disagreed with this statement. One participant shared that the program was “really easy to follow and understand.” Also, 93.3% of participants ($N = 14$) reported feeling confident that they can use the strategies ($M=3.33$, $SD=0.62$), with one participant reporting they disagreed with this statement.

Hypothesis 1b: Applicability and Future Benefit. A majority of participants (93.3%, $N = 28$) reported that the skills discussed were applicable to their child ($M = 3.43$,

$SD=0.63$), and two participants reported that the strategies outlined were not applicable to their child. Some participants shared some challenges of applicability were related to not providing examples of “people with multiple kids,” ways to “adapt skills if a child is neurodivergent” for a “child with autism, who needs more supervision at times.” Of the participants in the intervention group, 96.7% ($N = 29$) reported that they believed that their child would benefit if they used the strategies suggested in the program ($M=3.60$, $SD=0.56$), and one participant reported they disagreed with this statement. Similarly, at the follow-up, 92.9% ($N = 13$) of participants endorsed that the strategies discussed in the EBB and Flow Program were applicable to their child ($M = 3.14$, $SD=0.77$) and 93.3% ($N = 14$) reported that their child would benefit if they used the skills suggested in the program ($M = 3.47$, $SD=0.64$).

Hypothesis 1c: Hope to Implement Skills in the Future. Finally, 96.7% ($N = 29$) endorsed that they would apply what they learned in the EBB and Flow Program in the future ($M=3.53$, $SD=0.57$), with one participant disagreeing with this statement. Participants similarly provided qualitative feedback suggesting they were planning to implement the skills, as some participants wrote, “I will try to be more specific in my encouragement and praise” and “I can be my child’s biggest fan by praising their effort.” Similarly, 93.3% ($N = 14$) reported at the 3-month follow-up that they would apply the skills they learned in the future ($M=3.13$, $SD=0.74$), again, with one participant disagreeing with this statement.

Hypothesis Two: Acceptability of the EBB and Flow Program

Participants who received the EBB and Flow Program and completed all three modules ($N = 30$) were also asked a series of questions regarding the acceptability of the

parenting intervention and descriptive statistics were conducted to determine whether participants agreed or disagreed with these items. Items regarding acceptability of the EBB and Flow Program were also completed at the 3-month follow-up. Paired-sample *t*-tests were conducted to explore within group changes from T2 to T3 regarding acceptability of the EBB and Flow Program. No significant differences were found in the participants' responses to the acceptability items across the two timepoints. See Table 11 for full descriptive statistics of acceptability variables from both the post-intervention and the 3-month follow-up, with results of the paired *t*-tests of the scores between the timepoints.

Hypothesis 2a: Excitement, Enjoyment, and Eagerness to Learn More. At post-intervention, most participants (93.2%, $N = 28$) reported that they were excited to try out the strategies presented in the EBB and Flow program ($M=3.38$, $SD=0.73$) and 86.2% ($N = 26$) reported that they enjoyed watching the videos ($M=3.24$, $SD=0.79$). Common feedback regarding what participants liked least about the program was that “the videos were long” and there was “some redundancy” and other participants recommended making “shorter videos.” Other feedback included “it was nice to get positive feedback on [what] parenting strategies to use,” “there was nothing that I did not like about this program!” and “It was so easy to follow. The scenarios provided an opportunity to reinforce what we learned.” Additionally, 90% of participants ($N = 27$) endorsed wanting to learn more from the EBB and Flow Program ($M=3.24$, $SD=0.79$). Qualitative feedback included “positive reinforcement and living by example are so important. My partner and I could use some improvement on living by example” and “would love to get even more parenting knowledge.”

At the three-month follow-up, 93.3% ($N = 14$) reported that they both were excited to try out the strategies presented in the EBB and Flow program ($M=3.27$, $SD=0.59$) and enjoyed watching the videos ($M=3.27$, $SD=0.59$). Qualitative feedback included, “it was so easy to follow” and “it made it easy for me to apply the skills.” Similarly, 93.3% of participants ($N = 14$) endorsed wanting to learn more from the EBB and Flow Program ($M=3.20$, $SD=0.56$).

Hypothesis 2b: Would Look Back at Reference Materials. Of the participants in the intervention condition, 83.3% ($N = 25$) reported at post-intervention that, if it were possible, they would refer back to the EBB and Flow Program to review the strategies presented ($M=3.30$, $SD=0.75$). While at the three-month follow-up, a slightly larger proportion of participants (93.3%, $N = 14$) reported interest in looking back at reference materials of the strategies presented ($M=3.13$, $SD=0.74$) with one participant reporting they wanted “strategy reminders” to reinforce the strategies discussed.

Hypothesis 2c: Recommend to a Friend. Similarly, a majority of participants (93.3%, $N = 28$) reported they would recommend the EBB and Flow program to a friend ($M=3.33$, $SD=0.61$), with only two of the thirty participants stating they would not recommend it. At the follow-up, 93.3% of participants ($N = 14$) again stated that they would recommend the EBB and Flow Program to a friend ($M=3.13$, $SD=0.74$).

Hypothesis Three: Intervention Effect on Variables of Interest

While the primary goals of the current study is to assess the feasibility and acceptability of the EBB and Flow Program, post-intervention and three-month follow-up data was collected on a number of variables of interest to explore possible effectiveness of the program on a number of family outcomes, including their ability to identify

effective parenting approaches in vignettes, parental self-efficacy, accommodation, and overprotection, along with family resilience, parenting style, and child anxiety. Parental ethnic identity and educational attainment were added as covariates in analyses looking at group differences among family outcomes. See Tables 12 and 13 for rate of correct identification of most appropriate caregiver responses in the vignettes.

Hypothesis 3a: Response to Caregiver Vignettes. To assess the effectiveness of the modules, participants in both groups were asked to read a series of three vignettes and select the most appropriate caregiver response. The first vignette described a situation in which the caregiver may respond in an overprotective way and participants were asked to identify the caregiver response that would “Encourage Independence” in the child. Results did not find a statistically significant group difference in accurately identifying the correct caregiver response for the first vignette, $t(66)=0.19, p=0.85$.

The second vignette described a situation in which a child was feeling anxious, and the parent may accommodate for their child. Participants were asked to identify the correct parenting response, which would describe the caregiver as “Being Warm, But Firm” or utilizing authoritative parenting. Results found no statistically significant group difference in accurately identifying the correct caregiver response for the second vignette, $t(66)=-0.79, p=0.43$.

Finally, the third vignette provided participants with a scenario in which a child was competing in a sporting event and the caregiver was responding to a situation in which the child did not succeed. Participants were asked to identify the correct response that would show the caregiver “Being their Number One Fan” by using process praise.

Results found no statistically significant difference in accurately identifying the correct caregiver response for the third vignette, $t(66)=1.41, p=0.16$.

Hypothesis 3b: Parental Self-Efficacy. Group differences for parental self-efficacy were explored by a 2 x 3 ANCOVA with between-subjects factor condition (intervention, control), within-subjects factor condition (T1, T2, T3) and covariates of ethnicity and education. Homogeneity of variances was upheld in this analysis. The effect of the intervention was not found to be significant, $F(1, 34)=1.02, p=0.32, \eta_p^2=0.028$. Both covariant variables were also not found to be statistically significant in predicting changes in parental self-efficacy between groups and across timepoints (Education: $F(1, 34)=1.63, p=0.21, \eta_p^2=0.046$; Ethnicity: $F(1, 34)=0.21, p=0.65, \eta_p^2=0.006$).

Hypothesis 3c: Parental Accommodation. A 2 x 2 ANCOVA with between-subjects factor condition (intervention, control), within-subjects factor condition (T1, T3), and covariates of ethnicity and education was conducted to explore group differences in parental accommodation. Homogeneity of variances was upheld in this analysis. The effect of the intervention was not found to be significant, $F(1, 31)=2.46, p=0.03, \eta_p^2=0.001$. Both covariant variables were also not found to be statistically significant in predicting changes in parental accommodation between groups and across timepoints (Ethnicity: $F(1, 31)=1.09, p=0.30, \eta_p^2=0.034$; Education: $F(1, 31)=1.63, p=0.21, \eta_p^2=0.046$).

Hypothesis 3d: Parental Overprotection. To explore changes in parental overprotection, a 2 x 2 ANCOVA was conducted with between-subjects factor condition (intervention, control), within-subjects factor condition (T1, T3), and covariates of ethnicity and education. Homogeneity of variances was upheld in this analysis. The effect

of the intervention was not found to be significant, however was trending, $F(1, 35)=2.76$, $p=0.11$, $\eta_p^2=0.073$. The effect of education was also not found to be significant, $F(1, 35)=1.11$, $p=0.30$, $\eta_p^2=0.031$. Ethnicity was significant in this model with a small to medium effect size, $F(1, 35)=18.15$, $p<0.001$, $\eta_p^2=0.34$. Those who identified as Hispanic or Latinx reported higher levels overprotection (T1: $M= 57.4$, $SD=8.02$; T3: $M=44.5$, $SD=2.12$) than those who identified as non-Hispanic or Latinx (T1: $M= 31.13$, $SD=11.89$; T3: $M=26.92$, $SD=2.12$).

Hypothesis 3e: Child Anxiety. To explore group differences in the level of child anxiety symptoms a 2 x 2 ANCOVA was conducted with between-subjects factor condition (intervention, control), within-subjects factor condition (T1, T3), and covariates of ethnicity and education. Homogeneity of variances was upheld in this analysis. The effect of the intervention was not found to be significant, $F(1, 30)=0.53$, $p=0.47$, $\eta_p^2=0.017$. The effect of ethnicity was also not found to be significant, $F(1, 30)=2.68$, $p=0.11$, $\eta_p^2=0.082$. Education was significant in this model with a small effect size, $F(1, 30)=4.79$, $p<0.05$, $\eta_p^2=0.138$. Those who reported the lowest (i.e., high school diploma) and highest (i.e., other graduate degree, e.g., M.D. or Ph.D.) levels of educational attainment endorsed lower levels of child anxiety at both timepoints compared to those who reported attaining a master's degree or some graduate school, whose reports of child anxiety had increased between the two timepoints. More specifically, participants who endorsed earning a graduate degree other than a master's degree reported a reduction in child anxiety symptoms (T1: $M= -0.59$, $SD= 0.43$; T3: $M= -0.83$, $SD= 0.65$) compared to those who reported having a master's degree, who reported a notable increase in child anxiety symptoms (T1: $M= -0.01$, $SD= 0.96$; T3: $M= 0.24$, $SD= 0.88$).

Hypothesis 3f: Family Resilience. A 2 x 2 ANCOVA was conducted to assess family resilience with between-subjects factor condition (intervention, control), within-subjects factor condition (T1, T3), and covariates of ethnicity and education. Homogeneity of variances was upheld in this analysis. The effect of the intervention was not found to be significant; however, it was trending, $F(1, 30)=1.24, p=0.27, \eta_p^2=0.04$. Both covariate variables were found to be significant in this model (Education: $F(1, 30)=10.60, p<0.01, \eta_p^2=0.261$; Ethnicity: $F(1, 30)=8.48, p<0.01, \eta_p^2=0.22$). Those who reported education levels of a high school diploma (T1: $M= 187.17, SD= 10.55$; T3: $M= 240, SD=0$) or some graduate school (T1: $M= 191.83, SD= 13.88$; T3: $M= 200.6, SD=10.43$), having larger increases in level of family resilience compared to those who reported earning a bachelor's degree (T1: $M= 187.71, SD= 12.89$; T3: $M= 190.6, SD=14.19$), master's degree (T1: $M= 195.59, SD= 17.38$; T3: $M= 200.69, SD=19.09$), or some other graduate degree (T1: $M= 202.75, SD= 14.94$, T3: $M= 203.89, SD=20.18$). Those who identified as Hispanic or Latinx experienced greater increases in family resilience between the two timepoints (T1: $M= 179, SD= 11.19$; T3: $M= 202, SD=53.74$) than those who identified as non-Hispanic or Latinx (T1: $M= 193.47, SD= 15.02$; T3: $M=199.14, SD=16.47$).

Hypothesis 3g: Parenting Styles. Three 2 x 2 ANCOVA analyses were conducted to explore group differences across three parenting styles (i.e., authoritative, permissive, and authoritarian) with between-subjects factor condition (intervention, control), within-subjects factor condition (T1, T3), and covariates of ethnicity and education. The first analysis compared authoritative parenting between the two groups, and results did not find a significant group difference, $F(1, 34)=0.82, p=0.37, \eta_p^2=0.023$.

Both covariant variables were also not found to be statistically significant in predicting changes in authoritative parenting between groups and across timepoints (Ethnicity: $F(1, 34)=0.03, p=0.85, \eta_p^2=0.001$; Education: $F(1, 34)=0.32, p=0.58, \eta_p^2=0.009$).

Homogeneity of variances was upheld in this analysis.

The second analysis that focused on permissive parenting also did not find a significant group difference, $F(1, 34)=0.19, p=0.66, \eta_p^2=0.006$. Neither covariant variable was found to be statistically significant in predicting changes in permissive parenting between groups and across timepoints (Ethnicity: $F(1, 34)=0.11, p=0.75, \eta_p^2=0.003$; Education: $F(1, 34)=1.84, p=0.18, \eta_p^2=0.051$). Homogeneity of variances was upheld in this analysis.

Finally, results of the analysis exploring authoritarian parenting also did not find a significant group difference, $F(1, 34)=1.78, p=0.19, \eta_p^2=0.05$. Both covariant variables were also not found to be statistically significant in predicting changes in permissive parenting between groups (Education: $F(1, 34)=0.08, p=0.77, \eta_p^2=0.003$; Ethnicity, $F(1, 34)=1.29, p=0.26, \eta_p^2=0.037$). Homogeneity of variances was upheld in this analysis.

Chapter 4

Discussion

The EBB and Flow Program is a single-session online psychoeducational parenting program that was designed to teach caregivers evidence-based parenting approaches that have been associated with positive outcomes for children and families, including increased wellbeing, resilience, and reduced family stress and mental health concerns among children. The three modules discussed in the EBB and Flow Program outline minimizing accommodation along with use of authoritative parenting and process praise. Most previously developed parenting-focused interventions tend to target problematic parenting approaches once behavioral and emotional concerns have already emerged among their children or these programs tend to not be easily accessible to the families who may be in most need due to lack of resources (Webster-Stratton, 1981; Cooley et al. 2014; Sanders et al., 2014). The EBB and Flow Program was specifically designed to provide evidence-based psychoeducation to caregivers in a brief online format, as few psychoeducational programs on parenting utilize a preventative framework. Additionally, the format of the EBB and Flow Program aims to minimize barriers that are common among existing parenting interventions, including reduced time availability, transportation, waitlists to mental health providers, and financial concerns (Tully et al., 2017).

As such, there were three core goals of the current study. The first goal was to explore whether the EBB and Flow Program would be feasible to implement among caregivers with children between the ages of 3- and 7-years. The second goal was to examine whether the program would be acceptable by this group. Finally, the third goal,

which was more exploratory in nature due to limited sample size, would assess whether the EBB and Flow Program would demonstrate preliminary effectiveness in increasing participant recognition of evidence-based parenting approaches, along with positive outcomes (i.e., parental self-efficacy, family resilience, and authoritative parenting), and reductions in problematic outcomes (i.e., parental accommodation, overprotection, and child anxiety). The sections below will review the findings of the current study and will outline findings from the current project, address limitations, discuss clinical implications, and provide suggestions for future research related to the refinement and dissemination of the EBB and Flow Program.

Feasibility and Acceptability of the EBB and Flow Program

The primary goals of the study were to assess the feasibility and acceptability of the newly developed single-session psychoeducational EBB and Flow Program. In line with the deployment-focused model of mental health interventions for youth (Weisz et al., 2005), the current study aimed to collect feasibility and acceptability data of the EBB and Flow Program in the early stages of program development to ensure that challenges to implementation are addressed before the program is disseminated to larger groups or communities. Overall, the study participants in the intervention group endorsed that the EBB and Flow Program was feasible and acceptable. Related to its feasibility, a vast majority of participants found the strategies presented in the program to be helpful and easy to understand. Similarly, participants in the intervention group reported being eager to apply the knowledge they gained through the program in their future interactions with their own children. Many of the participants felt the program was applicable to their child, and the two participants who reported they felt that the program was not applicable

to their child cited that the EBB and Flow Program did not provide guidance for families who have children with behavioral dysregulation or that have a diagnosis of autism spectrum disorder. While these concerns are valid, it should be noted that providing this level of specialized information was outside of the scope of the EBB and Flow Program, given that it was designed to be a preventative program tailored for families whose children have not already experienced the emergence of emotional, behavioral, or other mental health concerns. Finally, a majority of participants reported that they felt confident to use the strategies and believed their child would benefit if they implemented the presented strategies at home in the future. As such, overall, participants indicated that they believed the EBB and Flow Program contained strategies that were helpful and easy to implement.

Regarding acceptability of the EBB and Flow Program, participants in the intervention group shared that they were excited to try out the parenting strategies presented in the program. Most participants also shared that they enjoyed watching the program videos, found the videos easy to follow, and enjoyed the way the material was presented. Qualitative responses suggest that participants felt that the ways in which the information was presented in the videos helped increase their knowledge of evidence-based parenting approaches. These findings coincide with previous research that suggests providing psychoeducational information to families (regardless of the topic) is often viewed by participants as beneficial to increasing their knowledge of the content and something that they enjoyed receiving (Magaña et al., 2017; Montoya et al., 2011; Sousa et al., 2021). Participants also reported continued interest in learning more from the EBB and Flow Program. At follow-up, several participants indicated that they would find it

helpful to review the material again or be provided with reference materials in order to further develop their knowledge and skills in implementing evidence-informed parenting approaches into their daily routine. Finally, at both post-intervention and the 3-month follow-up, participants reported that they would recommend the EBB and Flow Program to a friend, indicating further that they felt that the prevention program was acceptable. Participants also highlighted a number of recommendations that would further enhance their acceptability of the program, including having shorter videos, reference materials, and more specific examples for younger children.

Effectiveness of the EBB and Flow Program

Caregiving Response Recognition. Across the intervention and control groups, there was a high accuracy rate of caregiving response recognition for each of the three vignettes. The goal of the intervention was to enhance parent awareness, understanding, and ability to recognize parenting approaches that are associated with positive outcomes for children and their families. Yet, participants in the intervention group did not outperform those randomized into the control group in accurately identifying the evidence-informed caregiver response in any of the three vignettes. This may be explained by three potential reasons, including difficulty level of the vignettes, characteristics of the intervention and control groups, and dosage of the program.

First, the accurate response options to the vignettes may have been too easy to identify compared to the incorrect ones. The vignettes were initially presented to a small focus group ($N=10$) including both parents who were non-mental health professionals and child mental health clinicians for the purpose of seeking feedback about the clarity of the vignettes. Of the focus group members, just over half of participants had accurately

responded to the items. Based on the focus group, it appeared that the items had a mid-level of difficulty however, it may have been beneficial to test the vignettes in larger focus groups in order to determine the level of difficulty of the questions. Previous research has demonstrated that the use of vignettes is efficient to assess for participant knowledge, beliefs, and values, yet also poses a number of limitations, including respondent fatigue, carryover effect, along with challenges associated with the creation of vignettes that accurately depict the targeted content (Erfanian et al., 2020). In line with this, additional considerations when creating the original focus group could have enhanced the accuracy in vignette development, as the focus group should have more closely resembled the target audience for the EBB and Flow Program. While it was not possible to host in-person groups during the pandemic, having a collaborative group conversation about them may have also refined the vignettes. Ryan and colleagues (2013) provide a detailed framework for how to design a focus group along with guidance on types of questions to ask to further enhance the information gathered from the focus group. The focus group assembled for the current study was potentially skewed given it was a sample of convenience and included several individuals who were child and family-focused mental health professionals.

Second, the non-significant difference between the control and intervention conditions could possibly be due to some of the characteristics of the samples. It should be noted that there were significant differences between the control and intervention conditions on demographic variables including education level and ethnicity. More specifically, participants randomized into the control condition had significantly higher levels of educational attainment compared to the intervention condition. Previous

research has demonstrated that families with higher educational attainment may have more access to or increased awareness of evidence-informed parenting approaches (Davis-Kean et al., 2021). Given the group differences in educational attainment, it could be hypothesized that those in the control condition may have had a higher level of knowledge of positive parenting approaches prior to their participation; therefore, leading to a high rate of accurate recognition in the vignettes. Related to ethnicity, significantly more participants identified as Hispanic or Latinx within the intervention condition ($N = 5$), as compared to the control condition, which included no individuals who identified as Hispanic or Latinx. Previous literature suggests that different parenting styles may be more beneficial for positive child outcomes for different ethnic groups; for example, authoritative parenting has been associated with academic achievement only for individuals identifying as European American, as opposed to Hispanic American, Asian American, or African American (Park & Bauer, 2002). With this in mind, knowledge of the evidence-based strategies discuss may not fit within the cultural values or lens of individuals from various ethnic groups and may not in fact be necessarily associated with positive outcomes for individuals within these groups. Of importance, these variables remained a significant predictor in several of the analyses on group differences. Further discussion about the significant findings associated with parental ethnic identity and educational attainment will be provided below.

The third potential cause for the non-significant difference in caregiver response recognition may be that the dosage of the EBB and Flow Program may be too low for notable changes in a three-month time period. While in both the current study and previous work the single-session approach was found to be effective in increasing

knowledge of the target content (Hymmen et al., 2013;), findings from the current study suggest that it may not be enough time to allow families to fully absorb and implement the content. The current literature on single-session intervention approach is somewhat mixed, with some studies finding a significant effect for up to 18 months, however, many of these endeavors have notable limitations, such as a lack of control group, non-randomization of participants, or lack of clear or standardized measures to assess effectiveness of the intervention (Hymmen et al., 2013). While the current endeavor had addressed a number of these issues, including a control group, randomization, and standardized measures, findings did not demonstrate significant differences between the control and intervention conditions in recognition of evidence-based parenting approaches within the vignettes. As noted by many of the participants who received the EBB and Flow Program, having access to the content to review post-intervention may help support and enhance their abilities to recall and implement the skills more effectively and consistently, rather than learning the material one time and then not being able to refer back to the material for review.

Parenting and Child Variables of Interest. Despite participants' high ratings of feasibility and acceptability of the EBB and Flow Program, it should be noted that none of the outcome variables were found to have changed significantly between groups over the course of the study. Specifically, findings suggest that participants in the intervention condition did not experience significant reductions in parental accommodation, parental overprotection, child anxiety, or authoritative and permissive parenting styles compared to those in the control condition. Additionally, the intervention condition did not see

significant increases in parental self-efficacy, family resilience, or authoritative parenting compared to participants in the control condition.

Possible explanations for nonsignificant findings on group differences across the variables of interest are similar to those identified as potential causes for the null results of participant caregiver response recognition in the vignettes. First, it should be noted that at pre-intervention, participants in both conditions endorsed high scores on measures assessing positive outcome variables, such as parental self-efficacy, family resilience, and authoritative parenting, and endorsed low scores on measures assessing less ideal outcome variables, including parental accommodation or overprotection, child anxiety, and authoritarian or permissive parenting. As such, providing knowledge of the parenting skills that were aimed at either increasing or reducing these variables, respectively, may have not added much benefit, as knowledge of these evidence-based parenting approaches may have been high prior to the intervention. Unfortunately, the vignettes were not provided to participants at the beginning of the survey to assess for baseline knowledge of these approaches. Additionally, if participants had minimal family, parenting, or child concerns at baseline, there are likely to be no observable changes over the course of the study, regardless of group condition.

A second explanation, similar to above, is that nonsignificant findings are the result of small sample size and moderate attrition rate, as about 40 percent of the sample did not complete the follow-up. Due to this, analyses exploring changes in outcome variables across timepoints obtained very low observed power, and therefore, it was likely not strong enough to detect any group differences. This is particularly important as the low power suggests that despite the current nonsignificant findings, it may be that

with larger samples the EBB and Flow Program could in fact provide some changes in these outcome variables. A third possible explanation could lie within the concern about the dose or brevity of the EBB and Flow Program. Providing families with non-tailored information about these evidence-based strategies in just one sitting likely is useful in increasing awareness of these skills but may fall short of supporting families in being knowledgeable and confident enough to utilize these skills themselves in real-time. Previous work on single-session treatments have demonstrated that one-time approaches may be more beneficial when the information is tailored to the individual family by providing specific tips for implementing the strategies (Cardamone-Breen et al., 2018; Hymmen et al., 2013). These tailored single-session approaches also offer additional resources, such as a list of strategies to try, that the family can then refer to post-intervention. Given that participants of the EBB and Flow Program did not receive these reference materials, it may have limited the potential impact of the program on the identified parenting and child outcomes in the follow-up. In line with this, the control condition video may have provided a placebo or unintended effect on some of these variables, particularly parental self-esteem and family resilience. Recent work on single-session intervention approaches for child and youth mental health outcomes recommends providing control conditions that mimic the intervention condition, yet they also caution that the control condition should not provide therapeutic content (Schleider et al., 2020). Although the control condition video did not provide specific details of the evidence-based parenting strategies presented in the EBB and Flow Program, it may have unintentionally influenced parental confidence in their parenting abilities in suggesting that there is no “perfect way” to parent and that “parenting involves trial and error.”

While these suggestions are not evidence-based, they may increase parental self-efficacy and parental perceptions of their family's current levels of functioning.

Additional Findings

When conducting the planned analyses, it was found that two demographic characteristics were significant in predicting outcomes over the course of three months from baseline to the follow-up, regardless of condition. Of note, participant's ethnic identity and educational attainment were found to not only be significantly different between group characteristics, with more individuals identifying as Hispanic or Latinx in the intervention condition and individuals with higher educational attainment to be in the control condition, but also, these demographic characteristics were significantly predictive of changes of several of the outcome variables. The findings associated with these demographic characteristics are described in the sections below.

Ethnicity. Participants' ethnic identity was found to play a role in several of the above findings. In particular, participants' ethnic identity significantly influenced both changes in parental overprotection and family resilience between the two timepoints. Related to parental overprotection, participants in the current study who identified as Hispanic or Latinx demonstrated higher rates of parental overprotection than those who identified as non-Hispanic or Latinx at baseline. Recent literature suggests that parental overprotection may be higher among Hispanic and Latinx families who are experiencing higher levels of psychosocial stress (Suarez-Morales & Torres, 2021). While parental level of stress was not collected in the current analysis, future work should explore how parental stress may influence their engagement in overprotective approaches and whether this varies between ethnic identities. Similarly, culturally-informed research suggests that

parental overprotection among families with strong familism values may, in fact, bolster child outcomes as it is suggested that overprotective parenting or controlling behaviors may provide children with clear expectations and guidelines for success in social, emotional, and other outcome domains (Holly, 2016). Participants who identified as Hispanic or Latinx reported a significant reduction in overprotective behaviors compared to those who identified as non-Hispanic or Latinx as well.

In regard to the significant influence ethnic identity had on family resilience, it was found that participants who identified as Hispanic or Latinx endorsed lower rates of family resilience at baseline and endorsed equal rates of family resilience as participants who identified as non-Hispanic or Latinx at follow-up. As noted early, all of the participants who identified as Hispanic or Latinx were randomized into the intervention group. Previous work has suggested that conceptualization of resilience within Hispanic or Latinx families may include additional factors that are not typically accounted for on general assessment measures of resilience, including connection to ethnic identity, culturally specific family values, and considerations for family transitions, unique adversities or vulnerabilities depending on one's identities (Bermudez & Mancini, 2013). Therefore, rates of resilience at baseline in the current study may not accurately reflect some of these additional considerations that should be incorporated into assessments of one's perceived resilience and may have influenced the baseline reports of family resilience.

Additionally, previous research has demonstrated that strategies which have been deemed "positive parenting approaches" tend to be more common among families that identify as non-Hispanic or Latinx and White, and therefore may be more in line with

cultural values of the dominant ethnic group in the United States. Of importance, the extant literature also suggests that these positive parenting approaches highlight which strategies have been useful in bolstering child outcomes specifically among those who identify among non-Hispanic or Latinx communities, as these individuals tend to make up a majority of the samples in these studies (Park & Bauer, 2002). However, the assumption that these strategies are equally effective across cultural groups may be misleading when interpreting findings. As such, learning about these practices may be new information or may be strategies that are less in-line with cultural practices or family values for individuals from various ethnic backgrounds.

Education. Throughout the analyses, it was found that parent-reported educational attainment was found to play a significant role in changes in child anxiety symptoms and family resilience over the follow-up period. As previously discussed, participants in the control condition endorsed significantly higher rates of educational attainment compared to those in the intervention condition. In the current study, parental educational attainments demonstrated a nonlinear or inverted “u shaped” relationship with levels of child anxiety, in that, participants with the lowest level of educational attainment within the sample (i.e., a high school diploma) and those with the highest level of educational attainment (i.e., a graduate degree other than a master's degree) reported the lowest levels of child anxiety. Previous work has suggested that higher levels of educational attainment is associated with increased awareness of evidence-informed parenting approaches and, oftentimes, more access to resources that can bolster child outcomes (Davis-Kean et al., 2021). The current findings both coincide with this

perspective and challenge it, as participants in the current study who had lower levels of educational attainment also endorsed fewer child anxiety symptoms.

Related to family resilience, participants who reported higher levels of educational attainment also reported increased levels of resilience at baseline. This is similar to previous work that suggests higher levels of parental educational attainment has been shown to be related to two factors of family resilience, which include one's ability to respond and cope effectively to stressors (i.e., emotional reactivity) and one's sense of relatedness to others (Prince-Embury, 2009). Other work suggests that increased parental educational attainment is a protective factor for a number of child outcomes, primarily because it has been associated with family adaptability (Benzies & Mychasiuk, 2009; Henry et al., 2015). Current findings suggest there was significant increases in family resilience over the course of the study, particularly for participants who reported having a high school diploma. While the change was significant for this subgroup, it should be noted that those in this subgroup were randomized into the intervention condition, suggesting that providing individuals with lower educational attainment psychoeducation on parenting approaches may significantly increase their perception of their level of family's resilience, possibly by increasing their confidence in managing challenging situations through the way in which they utilize the presented parenting skills. Finally, as previously stated, parental educational attainment was significantly related to both child anxiety and family resilience, and interestingly, recent research suggests that parental educational attainment may not directly impact child anxiety experiences; however, increased family resilience is associated with decreased child anxiety symptoms (Morgan, 2019). Future work should further explore the significant

association between parental educational attainment, family resilience, and child anxiety to disentangle how these variables interact with each other.

Limitations

While this study utilized a randomized controlled trial design to assess the feasibility, acceptability, and effectiveness of the EBB and Flow Program, there are several important limitations to note. First, the study sample was found to be quite homogenous regarding demographic characteristics. Specifically, a majority of participants identified as White (69.1%), non-Hispanic or Latinx (88%), heterosexual (89.7%), married (83.8%), having at least a Bachelor's degree (64.7%) and being currently employed (87%). Given the homogeneity of the sample, it may be challenging to generalize the current findings to larger populations with varying identities and family structures. In line with this, the evidence-based strategies presented in the EBB and Flow Program have been found to be primarily useful parenting skills among homogenous populations that have identifies listed above (i.e., White, non-Hispanic, educated, married, etc.; Park & Braun, 2002; Morgan et al., 2018; Baker et al., 2017). Given the limitation of the cultural identities incorporated in the sample, it should be cautioned against generalizing the feasibility and acceptability of the program to more diverse communities, as cultural considerations must be considered when promoting specific parenting styles or approaches, and when identifying what types of examples are offered in a psychoeducational program.

Secondly, the recruitment strategy may be limited due to the recruitment strategies that were utilized and due to the impact of restrictions associated with the COVID-19 pandemic. The original recruitment procedure involved utilizing email

listservs, social media, and paper-copy flyers at schools, community centers and pediatric offices. Given the restriction of social distancing, virtual learning and closing of public buildings, the recruitment strategy was altered to be completely virtual. Unfortunately, of the more than 150 schools, pediatrician offices, and community and daycare centers that were contacted to request assistance for recruitment, only seven responses were received, of which only two daycare centers had agreed disseminate the research flyer. One of the most frequent explanations for not disseminating the flyer was that contacts reported that families may feel overwhelmed with the number of emails they have received during the transition to virtual contact due to the pandemic. Also, related to recruitment, participants self-selected themselves into the study, and a majority of participants were recruited through social media platforms which may also have influenced the sample population. Follow-up reminders were sent via email, and a third of the sample never completed the follow-up ($N = 28$), despite receiving over 30 weekly reminder emails. Of those that did complete the follow-up, there was a range of time to survey completion. Some of the sample completed their follow-up within a few days of their first reminder emails (at three months post baseline) and some took almost six months to complete their follow-up ($M = 120.05$ says, range = 90-206 days). The wide range of follow-up response time should be noted as some participants who waited longer periods between the baseline and the follow-up survey may have remembered less of the program or gained access to additional parenting knowledge during the gap, both of which may influence the current findings.

Another key limitation of the current project is the nature of the study, as a small sample was recruited to explore feasibility and acceptability of the EBB and Flow

Program. While the original sample was intended to be small (i.e., 30 participants per group), the challenges related to recruitment and retention of participants noted above further created a small sample per condition. Importantly, the original sample size was within the range calculated through the a priori power analyses; however, due to retention issues, the sample ultimately was too small to observe possible small group differences (Algina & Olejnik, 2003). As such, observed power was found to be very low in many of the analyses that explored the effectiveness of the EBB and Flow Program on the variables of interest. Therefore, it should be noted that the current analyses may not have had enough power to detect small or medium effect sizes, which may have led to the null results related to group differences in the variables of interest. Related to the nature and the design of the study, the study would have benefitted from a specific measure of parental engagement in process praise. There is not currently a valid, accessible measure that examines parental use of process praise, and, therefore, the present study was not able to explore whether process praise utilization changed over the course of the study.

Fourthly, while the virtual format of the EBB and Flow Program may increase access to individuals from a broader geographical range, it may have simultaneously limited participation to individuals with access to the Internet. Previous research has demonstrated that access to the Internet varies across a number of demographic characteristics including parental education level, family income, geographic location, levels of English proficiency, parental ability status, and racial or ethnic identities (Martin, 2021). Therefore, utilizing online surveys and videos may have influenced the demographic characteristics of the sample. While the videos offered both audio and written text to increase accessibility, the format of the surveys and vignettes limited

participation to individuals who were literate and English-speaking. In addition, research suggests that individuals without Internet or who have significant internet connectivity issues are less likely to seek out evidence-informed health information (McCloud et al., 2016), which may suggest individuals who were unable to participate in the current study may have had an increased need for access to evidence-informed information, such as that provided by the EBB and Flow Program.

Clinical Implications and Future Directions

The EBB and Flow Program has been shown to be feasible and acceptable among parents with children between the ages of 3- and 7-years of age. Additionally, the current findings suggest that while the program was positively received by participants, the program did not create a clinically significant change in the family outcomes over a three-month period, compared to the control condition. As such, there are several clinical implications for the program going forward. One key implication suggests that the EBB and Flow Program may be a viable format to provide families with information regarding evidence-based parenting approaches, as participants found it to be easy to understand, be applicable to their children, and contain informative content. As such, the program may serve as a useful tool for communities to offer families. A second clinical implication of these findings is that a single-session psychoeducational program potentially may not be of sufficient dosage to demonstrate significant change in parental knowledge of the material or ability to implement these skills in the future, and therefore providing families with reference material of the content from the EBB and Flow Program may increase its effectiveness. Finally, given that the EBB and Flow Program is specifically designed to prevent emotional and behavioral concerns among children and bolster parental self-

efficacy and the use of positive parenting approaches, additional consideration is needed to determine which groups may benefit most from gaining access to this evidence-informed information, for example, families with younger children, lower educational attainment, or reduced access to resources.

While the current study found the EBB and Flow program to be feasible and acceptable by participants, future work is needed prior to wide-spread dissemination. First, it would be essential to address the concerns identified by the research participants. Specifically, shortening the length of the videos, providing examples for younger children, and including more information on how parents can regulate their own emotions when children are displaying challenging or defiant behaviors. Secondly, given the goal of preventing emotional and behavioral concerns among young children throughout the community, it would be critical for future iterations of the EBB and Flow Program to utilize the community-based participatory research conceptual model (Belone et al., 2016) to ensure that the strategies presented in the prevention program fit within the community's context, needs, and system. One participant expressed this concern in their feedback by sharing the recommendation for program developers to "ask for advice from parents about what real life situations could be addressed." Utilizing the community-based participatory research conceptual framework would address this crucial concern and further refine the utility of the EBB and Flow program in preventing mental and behavioral health concerns for children in the identified communities along with directly targeting parenting concerns within these communities.

Another key area of future work involves tailoring interventions, such as the EBB and Flow Program, to different populations, including, but not limited to, various cultural

groups, family systems (i.e., blended families, foster families, single-parent families, or different family constellations), racial or ethnic groups, and socioeconomic groups. Specifically, in line with the first goal, the program developers aim to adapt the EBB and Flow Parenting Program for different ethnic and linguistic communities as a next step to ensure that it is culturally relevant for a wider target audience to truly enhance the preventative nature of the program within diverse communities. It is of primary importance that these adaptations are conducted in a culturally sensitive way and will ensure to include members of the community throughout the content development process, identifying or creating appropriate assessment measures to track intervention effectiveness, and ensuring the program is appropriate for each community for which it is being provided (Mejia et al., 2017). This goal also involves continued work addressing potential barriers that prevent families from accessing preventative programs or treatment interventions; such barriers include location, cost, or having transportation or the time to commit to a program (Morawska et al., 2011). Another future endeavor for the development team is to design different psychoeducational materials for families with children across various age-ranges, such as one course for new parents or those that have infants and toddlers, for caregivers with children in the early childhood age-range (that was studied in this project), and one for families with children in late childhood. Given the vast developmental changes that occur during the first decade of life (Denham et al., 2002), it would be critical to ensure that the information and examples provided are tailored for each different age groups to support parents in adapting these evidence-informed parenting strategies for their child's developmental level.

Additionally, when exploring the effectiveness of the EBB and Flow Program, future work should explore the potential role of parental wellbeing and mental health on outcomes associated with parent training. To date, this impact has not been assessed consistently across other parenting interventions (Piehler, Lee, Bloomquist, & August, 2014). Recent endeavors have started to suggest that parental mental health concerns, such as depression or anxiety, significantly impede treatment outcomes for families (Ludmer, Salsbury, Suarez, & Andrade, 2017; Dempsey, McQuillin, Butler, & Axelrad, 2016). Therefore, future research on the effectiveness or appropriateness of the EBB and Flow Program should continue to explore how parental adjustment and functioning may influence outcomes and what strategies can be incorporated into the intervention to ameliorate outcomes.

Once these recommendations and adaptations have been developed, future endeavors should re-examine the possible benefits of this parenting psychoeducational prevention program. Should these findings demonstrate preliminary effectiveness of the revised EBB and Flow Program, continued work should be done to disseminate the program to larger communities and explore the long-term preventative impact of the EBB and Flow Program on mental health and behavioral concerns among young children and their families. If found to be an effective prevention intervention, the EBB and Flow Program should be disseminated through school systems, community centers, and pediatrician offices as a universal preventative program to ensure families are provided access to information on evidence-informed parenting approaches with the goal of bolstering family and child wellbeing and functioning on a larger scale.

Table 1. *Summary of in-person parent training interventions.*

<i>Intervention</i>	<i>Age of Target Child</i>	<i>Participants</i>	<i>Program Content</i>	<i>Results</i>
Brief Family Intervention (Thompson-Hollands et al., 2015)	Over 18	18 family members (56% male; 94% White)	One session of psychoeducation about OCD, accommodation, problem solving. Second session about trouble shooting obstacles	Found to significantly reduce family accommodation. Family members had reduced OCD symptoms at 8 and 16 weeks compared to control group.
SPACE program (Lebowitz et al., 2019)	7-14 years	124 parents (83% white; 92% married, 40% with tertiary degree)	Psychoeducation on anxiety, supportive strategies to manage anxiety and reduce accommodation and increase confidence in child's coping	SPACE was as efficacious as child-focused CBT in reducing child anxiety symptoms by the end of treatment.
Parent focused intervention (Simon et al., 2012)	8-12 years	49 parents (no specified demographic information)	Psychoeducation about CBT, exposures, cognitive restructuring, modeling, relaxation, and reinforcement	At 2-year follow-up, parent intervention was shown to be more cost effective than child-focused interventions at reducing child anxiety symptoms.
Take ACTION Program (Waters et al., 2009)	4-18 years	80 parents (53% female, 93% married)	10 group sessions regarding psychoeducation about anxiety, relaxation strategies, coping thoughts, exposures, problem solving, and social skills training (assertiveness)	At 6- and 12-month follow-ups, child's anxiety levels significantly decreased, however there were small reductions of parent satisfaction and competence
Timid to Tiger (Cartwright-Hatton et al., 2011)	Under 9 years	74 parents (74% White)	10 group sessions with feedback on progress and homework, and psychoeducation on CBT, child anxiety, praise, exposures, rewards, limit	At the end of treatment and at 12-month follow-up, 57% of children in intervention group were free of their primary anxiety diagnosis, and 32%

Parent Workshop (Cartwright-Hatton 2018)	3-9 years	100 parents (85% female; 85% White; 38% secondary degree)	setting, ignoring, managing worry, and consequences 1 day, group workshop providing psychoeducation on anxiety symptoms, avoidance, coping thoughts, positive parenting strategies (praise, reward, attention/ignoring, consequences, overprotection), exposures, and accessing support	were free of all anxiety diagnoses Intervention was found to be feasible and acceptable. Children whose parents were in intervention group were more likely to not have a diagnosis at follow-up compared to control group.
Parent-involved CBT (Esbjørn et al., 2014)	7-12 years	54 parents (100% ethnic Danes, 34% tertiary degrees)	Co-client condition where parent and child both had 6 parallel but individual sessions, providing psychoeducation on anxiety, family risk factors, over-involved parenting.	At post-treatment, no significant changes in parental cognitions; increased autonomy granting behaviors; reduced parental overinvolvement
PCIT (Cooley et al. 2014)	See original article for specifics from each study	See original article for specifics from each study	Various designs included, but PCIT involves parents receiving in-the-moment feedback and suggestions for positive parenting strategies (praise, consequences, ignoring, attention) while doing tasks with their children	This meta-analysis included 11 studies on PCIT and found that parents reported reductions in child behavior problems, increases in their temperament and self-regulatory abilities, and positive caregiver/parent-child interactions.
Infant Behavior Program (Ramos et al., 2018)	12-15 months	60 parents (93% Latino; 73% Spanish-speaking households)	Home-based version of PCIT, where a therapist guides and models positive parenting behaviors in participant's home (praise, reflection,	Increases were found in positive parenting behaviors in both groups, however both groups continued to use other parenting approaches, which authors contribute to

			descriptions, and ignoring unwanted behaviors), parents were observed and provided feedback	cultural values of <i>respeto</i> .
CALM (Comer et al. 2012)	3-7 years	17 parents (53% female, 44% families were White)	Family focused sessions on psychoeducation about child anxiety incorporating PCIT coaching model that addresses positive parenting approaches (praise, reinforcement, attention)	At post-treatment, most of the children in the intervention group no longer met criteria for their primary anxiety diagnosis at baseline and increases in positive parenting behaviors were found.
Review of Incredible Years Parent Program (IYPT; Leijten et al., 2018)	See original article for specifics from each study	See original article for specifics from each study	Group psychoeducation and practice regarding positive parenting strategies (praise, empathy, rewards, clear limits, ignoring, communication, problem solving, and attention)	Research review of 14 RCT trials of IYPT demonstrated that parental use of praise increased, while use of punishment, threats and shouting decreased. Also, child conduct and attention problems significantly decreased across studies.
Triple P Positive Parenting Program (Sanders et al., 2014)	0-12 years	16,099 families (See original article for specifics from each study)	Universal, targeted, or treatment approaches involving coaching and psychoeducation on positive parenting strategies, such as praise, reinforcement, rule setting, consequences, consistency, and managing unwanted behavior	This systematic review and meta-analysis found that across the 101 studies conducted, significant improvements were found for use of positive parenting strategies and child social-emotional behaviors regardless of intervention format.
Chicago Parent Program	2-5 years	504 parents (58% African American;	12 session community-based group sessions providing	At the 12-month follow-up, both groups had significant reductions in child

(Breitenstein et al., 2012)	42% Latino families)	psychoeducation on positive parenting strategies (behavior management, praise, consistency, problem solving, and stress management)	behavior problems and increases in parental self-efficacy
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Table 2. *Summary of online parent training interventions.*

<i>Intervention</i>	<i>Age of Target Child</i>	<i>Participants</i>	<i>Program Content</i>	<i>Results</i>
Cool Little Kids Online (Morgan et al., 2018)	3-6 years	433 parents (96% female, 92% married, 63% had tertiary degree, 48% had income >\$116,000)	Psychoeducation about anxiety, strategies for creating and using fear hierarchies and rewards, and reducing overparenting and parental anxiety	Reductions in child anxiety symptoms when parents reported increased used of practicing strategies at 6 months after baseline.
Child Anxiety Tales (Khanna et al., 2017)	7-14 years	73 parents (81% female; 52% White; 42% African American 59% married; 65% secondary degree)	Psychoeducation on anxiety and CBT, the F.E.A.R. steps and how to implement exposure tasks	At 3-month follow-up, both intervention and bibliotherapy groups were found to reduce child behavior and anxiety outcomes, and parents had increased knowledge. No group differences were found.
Partners in Prevention (Cardamone-Breen et al., 2018)	12-15 years	349 parents (92% female; 77% married 33% tertiary degree)	Psychoeducation about symptoms of adolescent depression and anxiety, positive parenting strategies and early intervention steps. Information is tailored for each family based on initial assessment.	At 3-month follow-up parents reported increased use of positive parenting strategies, no significant effect for adolescent symptoms.
Triple P Online (Sanders et al., 2012)	2-9 years	106 parents (90% female, 88% married, 33% had tertiary degree)	Psychoeducation about positive parenting, reinforcement, dealing with misbehavior, planning ahead and parental self-regulation	At 6-month follow-up parents reported fewer child conduct problems, less utilization of ineffective parenting behaviors, increased parental confidence and fewer parental

Triple P Online Enhanced (Day & Sanders, 2018)	1-8 years	183 parents (95% female, 90% married, 91% white, 34% had tertiary degree)	Same as Triple P Online	stress and anger symptoms. At 5-month follow-up participants who received practitioner support reported significantly fewer dysfunctional parenting behaviors and child behavior problems compared to self-directed and control groups. Self-directed group was significantly better than control.
Triple P Online Brief (Baker et al., 2017)	2-9 years	200 parents (92% female, 82% married, 56% secondary degree)	Shortened version of Triple P Online. Psychoeducation about positive parenting, disobedience, fighting and aggression, and parental self-esteem	At 9-month follow-up, parents in intervention group reported significant reductions in dysfunctional parenting and child behavior problems, and an increase in parental confidence. No change in parent-child conflict or parent anger.
Triple P Online – Disability (Hinton et al., 2017)	2-12 years	98 parents (86% female, 69% married)	Same as Triple P Online	At 3-month follow-up, those in intervention group showed increased in positive parenting strategies and parental self-efficacy, and reduced child behavioral and emotional concerns.
Web-based intervention for parents with bipolar disorder (Jones et al., 2017)	4-10 years	39 parents (97% female; 54% secondary degree)	Psychoeducation on increasing desirable behavior (reinforcement, modeling, consistency) coping with difficult	At post-intervention, parents reported significant reductions in child behavior problems and increases in positive parental behaviors.

			behavior (clear rules, consequences, ignoring), and managing sleep routines (clear bedtime, consistent reinforcing)	
Parent-Web (Wetterborg et al., 2019)	12-18 years	75 parents (88% females, 73% had tertiary degree, 65% married)	Psychoeducation about strategies to improve parent-child relationship (i.e., supportive communication, positive reinforcement), and how to handle conflicts and rule-breaking	Short-term effects including reduced family conflict and child externalizing behaviors, however no significant differences in parenting strategies were found.
Internet-PMT (Enebrink et al., 2012)	3-12 years	103 parents (70% female with university degree)	Psychoeducation on positive parenting strategies (increased communication and positive reinforcement)	At 6-month follow-up, parents reported using less inconsistent discipline and more positive praise, and children had greater decreases in conduct problems than waitlist control group.
Strongest Families Smart Website (Sourander et al., 2016)	4 years	464 parents (83% biological parents, 58% of mothers and 45% of fathers had tertiary degree)	Psychoeducation on praise, ignoring unwanted behavior, identifying triggers, planning ahead, being consistent with other providers, time-outs, and problem solving	At 12-month follow-up, children had fewer externalizing and internalizing behaviors, and aggression; parents had increases in positive parenting strategies.
5-a-Day Parenting program (McGoron et al., 2018)	Under the age of 5 years	160 parents (90% female, 83% African American/Black, 34% did not graduate high	Psychoeducation about five positive interactions between parents and children (reading, playing a	Parents rated the intervention positively, but experienced barriers to utilizing the intervention. Some

		school, 73% had income <\$20,000)	game, sharing a meal, showing affection, and having a bedtime routine)	indication for increases in positive parenting behaviors,.
ezPARENT (Breitenstein et al., 2017)	2-5 years	83 parents (95% female, 57% African American, 33% Hispanic; 81% unmarried; 64% some college; 69% never married; 71% had income <\$20,000)	Psychoeducation of harsh parenting and positive parenting strategies (praising, establishing routines, problem solving, stress management, ignoring)	Parents appeared to be actively engaged on the website and demonstrated high adherence metrics. No analyses were done to look at changes in parent or child outcomes.

Table 3. *Data collection plan of variables of interest by time point.*

<i>Measure</i>	<i>Intervention Group</i>			<i>Control Group</i>		
	<i>T1: Pre-Condition</i>	<i>T2: Post-Condition</i>	<i>T3: 3-Month Follow-Up</i>	<i>T1: Pre-Condition</i>	<i>T2: Post-Condition</i>	<i>T3: 3-Month Follow-Up</i>
Demographic Information	X			X		
FASA	X		X	X		X
OP	X		X	X		X
PSDQ-Short Version	X		X	X		X
FRAS	X		X	X		X
PAS-R or SCAS-P	X		X	X		X
PEEM	X	X	X	X	X	X
AIM & FIM		X	X			

Table 4. *Descriptive statistics for variables of interest.*

<i>Variable</i>	<i>M</i>	<i>SD</i>	<i>Skewness</i>	<i>Kurtosis</i>
T1 Parental Self-Efficacy	152.32	26.57	-0.09	-0.84
T1 Accommodation	10.86	6.78	0.98	1.18
T1 Overprotection	33.16	13.44	0.35	-.048
T1 Authoritative Parenting	3.95	0.58	-0.28	-0.97
T1 Authoritarian Parenting	2.07	0.74	0.42	-0.86
T1 Permissive Parenting	2.54	0.75	0.01	-0.79
T1 Z Score for Child Anxiety	0.02	0.98	0.33	-0.92
T1 Family Resilience	192.59	15.42	0.64	0.12
T2 Parental Self-Efficacy	158.86	29.58	-.42	-0.70
T3 Parental Self-Efficacy	157.98	29.13	-1.19	2.52
T3 Accommodation	8.90	6.45	1.94	4.69
T3 Overprotection	27.72	12.14	0.44	-0.49
T3 Authoritative Parenting	4.14	0.52	-0.55	0.02
T3 Authoritarian Parenting	1.77	0.51	0.56	-0.59
T3 Permissive Parenting	2.22	0.63	0.29	-0.04
T3 Z Score for Child Anxiety	0.0001	0.99	0.24	-0.93
T3 Family Resilience	199.82	18.39	0.23	-0.15

Note. T1 & T2 *N* = 68. T3 *N* = 38. *M* = Mean. *SD* = Standard Deviation.

Table 5. Demographic characteristics of participants.

<i>Variable</i>	<u>Condition</u>		<i>Difference</i>	<i>p</i>
	<i>Intervention</i> (<i>N</i> =30)	<i>Control</i> (<i>N</i> =38)		
Gender Identity				
Female	24 (80%)	34 (89.47%)		
Male	6 (20%)	4 (10.53%)	$\chi^2 (1)=1.2$	n.s.
Mean Age (<i>SD</i>)	34.86 (6.44)	35.89 (6.23)	$t(65)=-.66$	n.s.
Ethnic Identity				
Hispanic or Latinx	5 (16.67%)	0 (0%)		
Non-Hispanic or Latinx	24 (80%)	36 (100%)	$\chi^2 (1)=6.72$	0.01
Racial Identity				
Asian	0 (0%)	3 (7.89%)		
Black/African American	0 (0%)	1 (2.64%)		
Native American/Alaska Native	1 (3.33%)	4 (10.53%)		
Native Hawaiian/Pacific Islander	1 (3.33%)	0 (0%)		
White/Caucasian	20 (66.67%)	27 (71.05%)		
Multiracial	7 (23.34%)	3 (7.89%)		
Not listed	1 (3.33%)	0 (0%)	$\chi^2 (6)=9.64$	n.s.
Sexual Orientation				
Lesbian	0 (0%)	2 (5.26%)		
Gay	1 (3.33%)	0 (0%)		
Bisexual	1 (3.33%)	1 (2.64%)		
Heterosexual	27 (90%)	34 (89.47%)		
Not listed	1 (3.33%)	0 (0%)	$\chi^2 (4)=4.12$	n.s.
Marital Status				
Never Married	2 (6.67%)	2 (5.26%)		
Married	25 (83.33%)	32 (84.22%)		
Separated	1 (3.33%)	1 (2.63%)		
Divorced	2 (6.67%)	1 (2.63%)		
Widowed	0 (0%)	2 (5.26%)	$\chi^2 (1)=2.28$	n.s.
Education Level				
High school diploma	7 (23.34%)	0 (0%)		
Some college	3 (10%)	6 (15.79%)		
Associate's degree	1 (3.33%)	1 (2.63%)		
Bachelor's degree	9 (30%)	8 (21.05%)		
Some graduate school	3 (10%)	3 (7.89%)		
Master's degree	6 (20%)	11 (28.95%)		
Other graduate degree	1 (3.33%)	9 (23.69%)	$\chi^2 (6)=15.19$	0.02
Employment Status				
Currently Employed	27 (90%)	32 (84.21%)		
Not Currently Employed	3 (10%)	6 (15.79%)	$\chi^2 (1)=0.49$	n.s.
Household Annual Income				
>\$15,000	0 (0%)	0 (0%)		

\$15,000-\$24,999	1 (3.34%)	2 (5.26%)		
\$25,000-\$34,999	4 (13.33%)	5 (13.16%)		
\$35,000-\$49,999	4 (13.33%)	3 (7.89%)		
\$50,000-\$74,999	9 (30%)	4 (10.53%)		
\$75,000-\$99,999	4 (13.33%)	6 (15.79%)		
≥\$100,000	8 (26.67%)	18 (47.37%)	$\chi^2 (5)=5.89$	n.s.
Parental Mental Health				
Current depression	2 (6.66%)	4 (10.53%)		
Past depression	4 (13.33%)	8 (21.05%)		
Current and past depression	1 (3.33%)	0 (0%)		
No history of depression	23 (70.08%)	26 (68.42%)	$\chi^2 (3)=2.27$	n.s.
Current bipolar disorder	0 (0%)	2 (5.26%)		
Past bipolar disorder	2 (6.67%)	3 (7.89%)		
Current and past bipolar disorder	0 (0%)	0 (0%)		
No history of bipolar disorder	28 (93.33%)	33 (86.84%)	$\chi^2 (2)=1.69$	n.s.
Current anxiety	9 (30%)	7 (18.42%)		
Past anxiety	3 (10%)	3 (7.89%)		
Current and past anxiety	0 (0%)	1 (2.63%)		
No history of anxiety	18 (60%)	27 (71.05%)	$\chi^2 (3)=2.14$	n.s.
Current psychosis	0 (0%)	1 (2.63%)		
Past psychosis	1 (3.33%)	2 (5.26%)		
Current and Past psychosis	0 (0%)	0 (0%)		
No history of psychosis	39 (96.67%)	35 (92.11%)	$\chi^2 (2)=0.97$	n.s.
Current ADHD	6 (20%)	5 (13.16%)		
Past bipolar ADHD	1 (3.33%)	3 (7.89%)		
Current and past ADHD	1 (3.33%)	1 (2.63%)		
No history of ADHD	22 (73.34%)	29 (76.32%)	$\chi^2 (3)=1.13$	n.s.
Current PTSD	0 (0%)	2 (5.26%)		
Past PTSD	3 (10%)	3 (7.89%)		
Current and past PTSD	0 (0%)	2 (5.26%)		
No history of PTSD	27 (90%)	31 (81.59%)	$\chi^2 (3)=3.38$	n.s.
Current SUD	1 (3.33%)	0 (0%)		
Past SUD	1 (3.33%)	2 (5.26%)		
Current and past SUD	0 (0%)	0 (0%)		
No history of SUD	28 (93.34%)	36 (94.74%)	$\chi^2 (2)=1.41$	n.s.
Current or Previous Treatment				
Yes	7 (23.33%)	10 (23.32%)		
No	22 (73.33%)	28 (73.68%)	$\chi^2 (1)=0.04$	n.s.
Current Waitlist for Treatment				
Yes	11 (36.67%)	8 (21.05%)		
No	19 (63.33%)	30 (78.95%)	$\chi^2 (1)=2.03$	n.s.
Mean Number of Children (SD)	2.1 (0.89)	1.74 (1.24)	$t(66)=0.01$	n.s.
Mean Number of Children Between 3- and 7-Years (SD)	1.17 (0.38)	1.16 (0.37)	$t(66)=1.91$	n.s.
Mean Child Age (SD)	4.63 (1.35)	4.63 (1.24)	$t(66)=0.09$	n.s.
Child Gender Identity				

Female	14 (46.67%)	18 (47.37%)		
Male	16 (15.33%)	18 (47.37%)		
Not listed	0 (0%)	1 (2.63%)	χ^2	
Child Racial Identity			(2)=0.896	n.s.
Asian	0 (0%)	1 (2.63%)		
Black/African American	0 (0%)	1 (2.63%)		
Native American/Alaska Native	1 (3.33%)	1 (2.63%)		
Native Hawaiian/Pacific Islander	1 (3.33%)	1 (2.63%)		
White/Caucasian	17 (56.67%)	23 (60.53%)		
Multiracial	10 (33.34%)	10 (26.32%)		
Not listed	1 (3.33%)	1 (2.63%)	χ^2 (6)=1.99	n.s.

Note. ADHD = Attention Deficit Hyperactivity Disorder; PTSD = Posttraumatic Stress Disorder; SUD = Substance Use Disorder; n.s. = not significant, $p > 0.05$

Table 6. Responses to feasibility items.

<i>Variable</i>	<u>Timepoint</u>		<i>Difference</i>	<i>p</i>
	<i>T2 (N=30)</i>	<i>T3 (N=15)</i>		
The EBB and Flow Program contains helpful strategies.				
Disagree	1 (3.33%)	1 (6.67%)		
Agree	14 (46.67%)	9 (60%)		
Completely Agree	14 (46.67%)	5 (33.33%)	<i>t</i> (14)=0.81	n.s.
The EBB and Flow Program seems easy to understand.				
Disagree	1 (3.33%)	1 (6.67%)		
Agree	11 (36.67%)	8 (53.33%)		
Completely Agree	17 (56.67%)	6 (40%)	<i>t</i> (14)=1.47	n.s.
I feel confident I can use the strategies discussed.				
Completely Disagree	1 (3.33%)	0 (0%)		
Disagree	1 (3.33%)	1 (6.67%)		
Agree	11 (36.67%)	8 (53.53%)		
Completely Agree	16 (53.33%)	6 (40%)	<i>t</i> (14)=-0.32	n.s.
The strategies are applicable to my children.				
Disagree	2 (6.67%)	1 (6.67%)		
Agree	13 (43.33%)	9 (60%)		
Completely Agree	15 (50%)	4 (26.67%)	<i>t</i> (13)=0.62	n.s.
My children would benefit from these strategies.				
Disagree	1 (3.33%)	1 (6.67%)		
Agree	10 (33.33%)	6 (40%)		
Completely Agree	16 (53.55%)	8 (53.53%)	<i>t</i> (14)=0.44	n.s.
I will apply the skills learned in the future.				
Completely Disagree	0 (0%)	1 (6.67%)		
Disagree	1 (3.33%)	0 (0%)		
		10		
Agree	12 (40%)	(66.67%)		
Completely Agree	17 (56.67%)	4 (26.67%)	<i>t</i> (14)=1.38	n.s.

Note. n.s. = not significant, $p > 0.05$

Table 7. *Qualitative feedback of the most helpful parts of the EBB and Flow Program.*

T2 Responses

“Help me to educate my children better”
“The warm but firm part”
“Advise how to help your child understand things”
“Be their biggest fan by praising the effort”
“Children can be independent”
“Teach your children to grow”
“Similar to conscious discipline which I already use”
“Tips”
“It was easy to follow. The scenarios provided an opportunity to reinforce what we learned.”
“A reminder of how to praise the parts of a situation in detail”
“Presented clear”
“Videos”
“Real life scenario applications”
“Positive Reinforcement”
“It was nice to have positive feedback on parenting strategies that I already use. I’ve never had a name for the things I’m doing.”
“We actually use these strategies. Positive reinforcement and living by example is so important. We personally could use improvement on living by example.”
“I will try to be more specific in my encouragement and praise.”
“The better ways to respond to your child when they need”

T3 Responses

“Positive parenting tips”
“Not that helpful”
“Renaming common things I can do/say to my children”
“New strategies for parenting”
“logical”
“Strategy reminders”
“The reminder about how to speak better with my child to guide her through frustrations”

Table 8. *Qualitative feedback of the favorite parts of the EBB and Flow Program.*

T2 Responses

“More parenting knowledge”
“I like it all”
“It gave examples”
“Positive parenting approach”
“The positive parenting techniques”
“Children can be independent”
“Education mode”
“Similar to conscious discipline which I already use”
“These ideas seem like common modern parenting strategies.”
“Videos”
“The practicality of the strategies”
“It is straightforward.”
“Good examples were given to explain”
“Presentation”
“Easy to follow steps”
“Easy to understand and apply”
“Easy to follow”
“I already use these strategies for my child. My child has autism which necessitates more supervision at times.”
“I liked how the speaker spoke slow and clearly. And used examples of each strategy.”
“It has great information for people who have no idea how to communicate w/their kids.”
“Love it how it breaks down certain parts of parenting and really makes you focus on those parts”

T3 Responses

“Easy to follow”
“Don’t remember the program”
“It is easy to understand”
“Easy to understand and apply”
“Easy to follow”
“The approach”
“It reminded me that it's ok to feel feelings and talk through them.”

Table 9. *Qualitative feedback of the least favorite parts of the EBB and Flow Program.*

T2 Responses

“There really isn’t anything I didn’t like”
“Long videos”
“The video redundancy”
“None”
“No”
“N/a”
“Wasn’t anything new”
“Some strategies are too simple-children can be more unpredictable in their responses”
“I was not clear on how the Flow came into it - but I may have missed it.”
“This is all pretty common sense”
“My personal opinion is that parenting programs/classes ignore the parent. They teach great skills for interacting with the child but don’t address how the caregiver may be feeling (e.g., frustrated, overwhelmed, stressed, etc.) by the 10th tantrum of the day. It’s hard to apply skills learned as a parent when you yourself are feeling overwhelmed.”
“Nothing in particular”
“I feel like most parenting strategies are aimed at neurotypical kids. There is often little information of how to adapt them if a child is neurodivergent.”
“There was not anything that I disliked I felt it was very easy to understand clear and to the point with helpful suggestions.”
“So far it hasn’t presented practical ways to deal with a child screaming in your face. My kid does not have anxiety.”
“There’s nothing I did not like about this program”
“There really isn’t anything I didn’t like”

T3 Responses

“Nothing”
“Don’t remember the program”
“None”
“Sometimes situations are more complicated as a parent than what the program addresses”
“It made me question my parenting and ability to follow through, which was uncomfortable”
“N/A”

Table 10. *Qualitative feedback of recommendations for the EBB and Flow Program.*

<i>T2 Responses</i>
“More detailed plans”
“I can’t think of anything!”
“Shorter videos”
“Shorter videos”
“No”
“Temporarily no”
“N/a”
“The videos are very long.....”
“Strategies for children who have emotional regulation trouble”
“I cannot think of anything”
“A program for people with multiple kids”
“More examples of how to apply to the younger end of the age range”
“Easy to read right to the point sheet to follow”
“It’s a good baseline program. We struggle with physical aggression with my child. It would be nice to hear the suggestions of how to deal with a 6-year-old punching you using the strategies.”
“Considering we already use the examples and strategies that were covered I would love to hear more in depth about ebb and flow programs.”
“Describe better coping skills for kids who are defiant, not just anxious.”
“Nothing”
<i>T3 Responses</i>
“None”
“Needs practical everyday life ideas. when this, do these ideas”
“None”
“Ask for advice from parents about what real life situations could be addressed and how they could be handled”
“N/A”
“NA”

Table 11. Responses to acceptability items.

Variable	Timepoint		Difference	p
	T2 (N =30)	T3 (N =30)		
I am excited to try out the strategies.				
Completely Disagree	1 (3.33%)	0 (0%)		
Disagree	1 (3.33%)	1 (6.67%)		
Agree	13 (43.33%)	9 (60%)		
Completely Agree	14 (46.67%)	5 (33.3%)	$t(14)=-0.37$	n.s.
I enjoyed watching the module videos.				
Completely Disagree	1 (3.33%)	0 (0%)		
Disagree	3 (10%)	1 (6.67%)		
Agree	13 (43.33%)	9 (60%)		
Completely Agree	12 (40%)	5 (33.3%)	$t(14)=-1.15$	n.s.
I want to learn more from the EBB and Flow Program.				
Completely Disagree	1 (3.33%)			
Disagree	2 (6.67%)	1 (6.66%)		
Agree	12 (40%)	10 (66.67%)		
Completely Agree	15 (50%)	4 (26.67%)	$t(14)=-0.69$	n.s.
I would refer back to the program to review strategies, if possible.				
Disagree	5 (16.66%)	1 (6.66%)		
Agree	11 (36.67%)	10 (66.67%)		
Completely Agree	14 (46.67%)	4 (26.67%)	$t(14)=-1.00$	n.s.
I would recommend the EBB and Flow Program to a friend.				
Disagree	2 (6.67%)	1 (6.66%)		
Agree	16 (53.33%)	10 (66.67%)		
Completely Agree	12 (40%)	4 (26.67%)	$t(14)=0.37$	n.s.

Note. n.s. = not significant, $p > 0.05$

Table 12. Rate of caregiver response recognition in T2 vignettes.

<i>Variable</i>	<u>Group</u>		<i>Difference</i>	<i>p</i>
	<i>Intervention (N =30)</i>	<i>Control (N =38)</i>		
Vignette #1				
Correct	25(83.33%)	31 (81.58%)		
Incorrect	5 (16.67%)	7 (18.42%)	$t(66)=0.19$	n.s.
Vignette #2				
Correct	28 (93.33%)	37 (97.37%)		
Incorrect	2 (6.67%)	1 (2.63%)	$t(66)=-0.79$	n.s.
Vignette #3				
Correct	25 (83.33%)	26 (68.42%)		
Incorrect	5 (16.67%)	12 (31.58%)	$t(66)=1.41$	n.s.

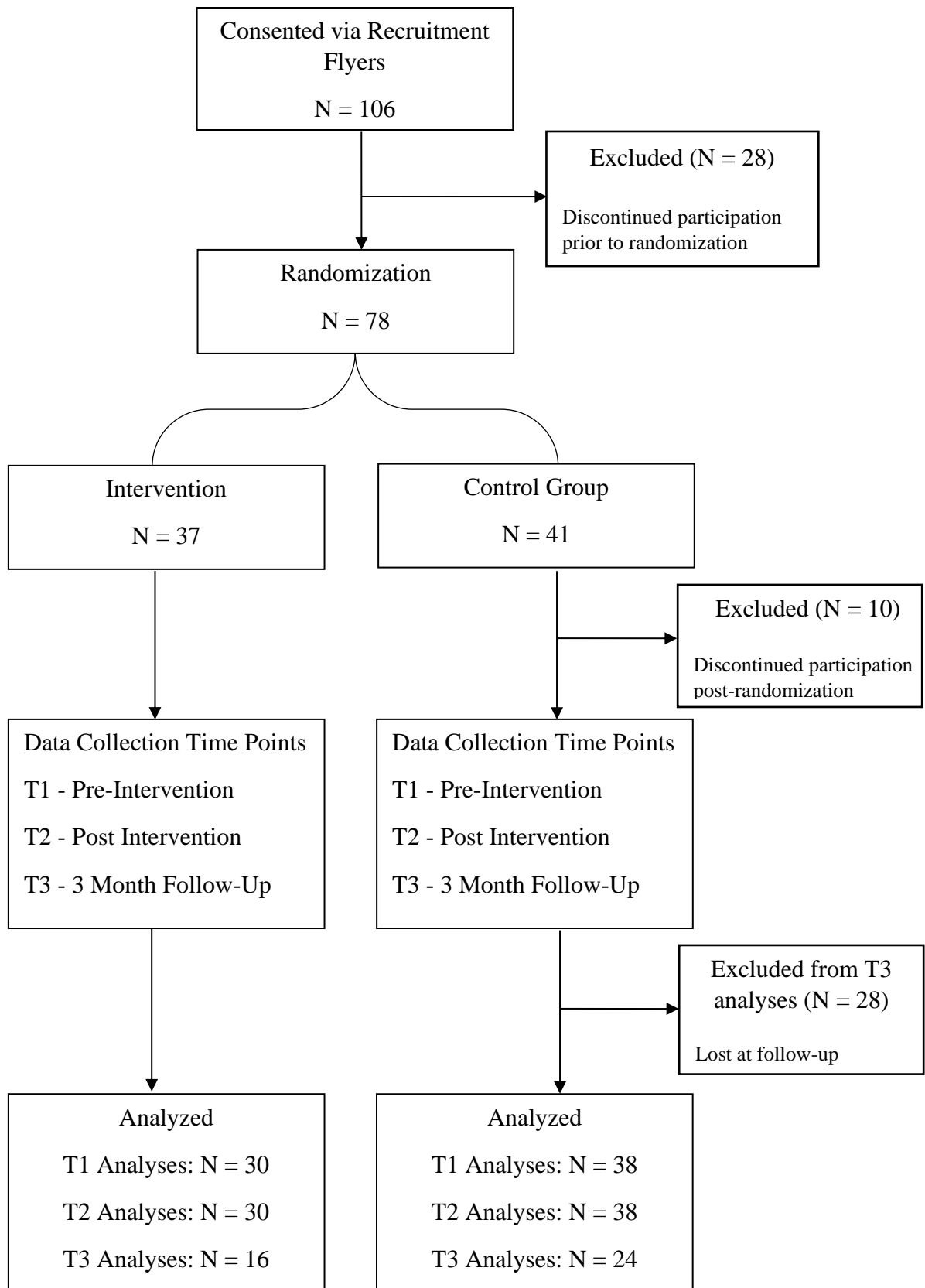
Note. n.s. = not significant, $p > 0.05$

Table 13. *Rate of caregiver response recognition in T3 vignettes.*

<i>Variable</i>	<u>Group</u>		<i>Difference</i>	<i>p</i>
	<i>Intervention (N =15)</i>	<i>Control (N =23)</i>		
Vignette #1				
Correct	15 (100%)	18 (78.26%)		
Incorrect	0 (0%)	5 (21.74%)	<i>t</i> (36)=1.99	n.s.
Vignette #2				
Correct	15 (100%)	22 (80%)		
Incorrect	0 (0%)	1 (20%)	<i>t</i> (36)=0.80	n.s.
Vignette #3				
Correct	14 (93.33%)	19 (82.61%)		
Incorrect	1 (6.67%)	4 (17.39%)	<i>t</i> (36)=0.94	n.s.

Note. n.s. = not significant, $p > 0.05$

Figure 1. Flow diagram of participants.



Appendices

Appendix A. *Demographics Questionnaire.*

Please tell us the following information about yourself:

1. Age: _____
 2. Gender Identity: Female Male Trans Male Trans Female
 Gender Fluid Non-Binary Not listed, please specify:
 3. Ethnicity: Hispanic or Latinx Not Hispanic or Latinx
 4. Racial Identity (select all that apply):
 Asian Black or African American Native American/Alaska Native
 Native Hawaiian or Pacific Islander White Multiracial
 Not listed, please specify:
 5. Sexual Orientation:
 Lesbian Gay Bisexual Pansexual
 Heterosexual Multiracial Asexual Not listed, please
specify:
 6. Marital status: Never married Married Separated Divorced Widowed
 7. How many children do you have? 1 2 3 4 5 or more
 8. How many children do you have between the ages of 3- and 7-years old?
 0 1 2 3 or more
 9. Are you currently or have you previously participated in either therapy or any
groups/workshops related to parenting? Yes No
 10. Are you currently on the waitlist for, or do you anticipate that you will participate in
either therapy or any groups/workshops related to parenting in the next three months?
Yes No
- Complete the next series of items for your child who is between the age of 3 and 7
years old. If you have more than one child, please complete the items for the child
whose birthdate is closest to January 1.**
11. Child's Age (in years): _____

12. Child's Gender Identity: Female Male Trans Male Trans Female
 Gender Fluid Non-Binary Not listed, please specify:

13. Child's Racial Identity (select all that apply):
 Asian Black or African American Native American/Alaska Native
 Native Hawaiian or Pacific Islander White Multiracial
 Not listed, please specify:

14. What if your family's approximate average annual household income?
 Under \$15,000 \$15,000-\$24,999 \$25,000-\$34,999
 \$35,000-\$49,999 \$50,000-\$74,999 \$75,000 - \$99,999
 \$100,000 and over

15. Are you currently employed? Yes No

16. If so, please specify what field you work in: _____

17. What is your highest level of education?

18. Please check off any difficulties you may have experienced in the areas noted below.
If you have not experienced that condition, please leave it unchecked.

Depressive Disorder	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Bipolar Disorder	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Anxiety Disorder	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Psychosis	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Attention Deficit/Hyperactivity Disorder	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Posttraumatic Stress Disorder	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Substance Use Disorder	<input type="checkbox"/> Current	<input type="checkbox"/> Past

Appendix B. *Parenting Vignettes and Caregiver Response Options*

Vignette #1:

A child is getting ready to go on stage for their first spring concert. Their grandparent helped them prepare for their singing debut, but now the child wants their grandparent to go on stage with them because they feel scared. How should their grandparent respond?

- “Sure, I’ll stand near the stage just in case you forget your lines”
- “Don’t worry, you’ll be fine. It’s not that big of a deal, you’re going to do great”
- **“You are really brave and should go up there. Let’s quickly think about what you can do if you do make a mistake”**

Vignette #2:

A parent was invited to a work picnic and is planning to bring their child. The child is very anxious about meeting new people and becomes so worked up that they refuse to get out of the car. How should the parent respond?

- **“I’m sorry you’re nervous, let’s take a couple deep breaths. How about we go for 5 minutes to see if it really is as scary as it might seem”**
- “I see that you’re overwhelmed. Let’s head back home instead and you and I can play a game, just the two of us”
- “Honey, please stop crying. This is really nothing to be scared of. Everyone’s so nice”

Vignette #3:

A child had a tough soccer game and their team lost. The child is disappointed that they missed the game-winning shot. How should their parent respond?

- “Better luck next time kiddo! Maybe we should practice taking more shots before next game”
- “Wow...it’s too bad you missed that shot”
- **“You did such a nice job focusing on the shot. It must have been really hard not letting the other team distract you”**

Note. Bold items are the correct response.

Appendix C. *Adapted Feasibility and Acceptability Items.*

For each of the following statements, select how much you agree with each statement.

1. The EBB and Flow Program contains helpful strategies.
 Completely Disagree Agree Disagree Completely Agree
2. The EBB and Flow Program seems easy to understand.
 Completely Disagree Agree Disagree Completely Agree
3. After watching the EBB and Flow Program, I feel confident that I can use the strategies discussed.
 Completely Disagree Agree Disagree Completely Agree
4. I believe my child would benefit if I used the strategies suggested in the EBB and Flow Program.
 Completely Disagree Agree Disagree Completely Agree
5. I am excited to try out the strategies of the EBB and Flow Program.
 Completely Disagree Agree Disagree Completely Agree
6. I enjoyed watching the EBB and Flow Program videos.
 Completely Disagree Agree Disagree Completely Agree
7. I want to learn more from the EBB and Flow Program.
 Completely Disagree Agree Disagree Completely Agree
8. If it were possible, I would refer back to the EBB and Flow Program to review the strategies.
 Completely Disagree Agree Disagree Completely Agree
9. I would recommend the EBB and Flow Program to a friend.
 Completely Disagree Agree Disagree Completely Agree
10. I think the strategies discussed by the EBB and Flow Program were applicable to my child.
 Completely Disagree Agree Disagree Completely Agree
11. I will apply what I learned in the EBB and Flow Program in the future.
 Completely Disagree Agree Disagree Completely Agree

Appendix D. *Parenting Resource Guide.*

THE EBB AND FLOW PROGRAM PRESENTS

A Resource Guide for Parents

~ **INFORMATIONAL WEBSITES** ~

Child Mind Institute
<https://childmind.org>
A national nonprofit dedicated to transforming the lives of children and families struggling with mental health and learning disorders. This organization delivers the highest standards of care, advances the science of the developing brain and empowers parents, professionals and policymakers to support children when and where they need it most.

The Greatest 8
<https://thegreatest8.org>
An initiative designed to help parents give their children a great emotional start in life. The initiative focuses on eight key skills, which if developed at an early age, can set a child up for a life of mental wellness. The Greatest 8 is about helping parents help their kids with healthy emotions and behavior.

Essentials for Parenting Toddlers and Preschoolers
<https://www.cdc.gov/parents/essentials/index.html>
The Center for Disease Control's Essentials for Parenting website provides families with informational guides, videos, practice skills, and additional resources to help manage common parenting challenges and increase parental confidence.

Healthy Children
<https://www.healthychildren.org/>
The American Academy of Pediatrics's parenting website is designed to provide families with information from physicians to help them attain optimal physical, mental, and social health and well-being for infants through young adulthood.

The Australian Parenting Website
<https://raisingchildren.net.au/>
The Australian government's website for parenting, that provides up-to-date and evidence-based information about raising children and ways parents can care for themselves as well. The website includes articles, videos, and interactive resources throughout the life stages, from pregnancy to adulthood.

~ **BOOKS** ~

Helping Your Anxious Child: A Step-By-Step Guide for Parents (Second Edition)
Rapee, Wignall, Spence, Cobham, and Luncheon (2008)

Building Resilience in Children and Teens: Giving Kids Roots and Wings
Ginsburg (2014)

Freeing Your Child From Anxiety (Revised and Updated Edition)
Chansky (2014)

~ **ADDITIONAL RESOURCES** ~

Therapy Provider Registries
<https://www.psychologytoday.com/us/therapists>
<https://www.findcbt.org/FAT/>

Parenting Support Group
<http://circleofparents.org>

Available Interventions and Treatment Registries
<https://effectivechildtherapy.org/>
<https://www.blueprintsprograms.org/>
<http://www.incredibleyears.com/>

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