

Parent- and Community-focused Approaches to Supporting Parents of Young Children: The Family Networks Project

Cheri J. Shapiro

Parents and primary caregivers are the most important individuals influencing the development of young children. Growing recognition of the importance of nurturing environments to the health and well-being of children and families (Biglan et al. 2012) underscores the need to promote and support parents, who create the most proximal environment for nurturing children's growth and development. Enhanced caring and protection within families, and reduction in adverse events such as child maltreatment, have the potential to have long-term impact on child development, health, and functioning, extending into adulthood (Shonkoff et al. 2012). Parenting supports and interventions that assist parents in engaging responsively and warmly with their children, encouraging positive daily interactions, establishing and maintaining safety, and providing structure and limits in a non-coercive manner are particularly important. Such warm, nurturing home environments foster healthy child development. Nurturing environments also offer protection to young children from the negative biological, developmental, psychosocial, and health impacts of prolonged (toxic) stress caused by adverse circumstances and can promote healthier brain development and enhanced physical and mental well-being (Shonkoff et al. 2012).

Importantly, no one type of parenting support can meet the needs of all parents. The type of support needed varies based on the specific needs and desires of parents and primary caregivers, as well as the developmental level and needs of the child. Extant parenting interventions and supports vary widely and can target a range of outcomes including the quality of the parent-child relationship, parenting skills, parenting self-efficacy, child behavior, literacy, or school readiness (among others).

C.J. Shapiro (✉)
Institute for Families in Society, College of Social Work,
University of South Carolina, Columbia, SC, USA
e-mail: cshapiro@mailbox.sc.edu

Given the wide range of purposes that parenting supports and interventions can serve, it should not be surprising that parenting services are provided by a host of individuals embedded in a variety of organizations from many different professional and paraprofessional backgrounds. While this array of providers and settings sets the stage for parents to potentially obtain support in a number of settings that they encounter in daily life, such as childcare centers or health clinics, it also means that parent support and intervention services can be fragmented and difficult to implement in a systematic way. The fact that no single program can meet the needs of all parents and young children also creates significant challenges for implementation and evaluation of large-scale parent supports.

While all parents can benefit from some type of support, either formal or informal, parents of young children, here defined as children below age 5, warrant particular attention. The prenatal period through the first five years of life sets the stage for development over a lifetime. The critical nature of this early period to healthy child development has been clearly established (e.g., Shonkoff 2003). Effective care in the early years provides the foundation for a child's future social, emotional, and behavioral functioning, as well as health outcomes in adulthood (Shonkoff 2010; Shonkoff et al. 2012). Because of the importance of the 0–5 age range, extant models of pediatric practice recommend frequent contact with caretakers and children during the age range of 0–5 years in order to provide necessary anticipatory guidance and support (see Chapter “[Promoting Early Child Development in the Pediatric Medical Home](#)”, this volume). The need for supporting parents of young children is made even more clear when one considers that rates of child maltreatment are highest in the 0–5 age range (“Child Maltreatment: Facts at a Glance—childmaltreatment-facts-at-a-glance.pdf,” n.d.).

Support for parents of young children takes many forms, ranging from anticipatory guidance to help parents understand children's growth and development to more intensive interventions for children who may be experiencing social, emotional, or behavioral challenges. Under certain circumstances, however, specialized supports are likely to be needed. Parents of young children with disabilities may require support beyond that needed for typically developing children. Additional or specialized supports may be needed because children with disabilities are at higher risk for developing behavior problems than are typically developing children (Handen and Gilchrist 2006; Ozonoff et al. (2007), especially those with fair or poor health or communication difficulties (Emerson and Einfeld 2010). Youth with autism spectrum disorder (ASD) as well as intellectual disabilities are at higher risk for hyperactivity, conduct, and emotional problems (Totsika et al. 2011). The connection between disabilities and behavior problems has been noted for children as young as age two and can be stable across time (Baker et al. 2002; Herring et al. 2006). Problem behaviors that are present in typically developing children can occur with greater severity, frequency, or duration among children with developmental disabilities (Sanders et al. 2003a). Such problem behaviors can negatively impact the child, their family, and the community by increasing parent stress, disrupting parent–child relationships, contributing to family isolation, and to possibly place children at higher risk for maltreatment (Sanders et al. 2003a). Indeed,

studies have documented links between child maltreatment and disabilities (Sullivan 2009; Sullivan and Knutson 2000). Young children with disabilities may be at greater risk for maltreatment than typically developing young children because of the increased rates of child behavior problems, parental stress, and social isolation that may be found in this population. While early intervention efforts have demonstrated positive impact on a range of developmental outcomes for youth with developmental delays (Love et al. 2005; Mercy and Saul 2009), the extent and degree to which these efforts can improve parenting and family functioning, thereby decreasing the risk for later maltreatment, is not known.

Given the importance of supporting parents of both typically developing young children as well as parents of young children with disabilities, this chapter begins with a brief overview of several examples of current evidence-based approaches for supporting parents and primary caregivers of children below age 5 that focus on parents as the agents of change. The approaches included here have been selected as illustrative examples of the power and potential of interventions designed specifically to support parents and caregivers of young children. These interventions have all clearly demonstrated empirical evidence of impact on important outcome domains for children and parents and are included on at least one nationally recognized list of evidence-based programs and practices (e.g., National Registry of Evidence-based Programs and Practices, California Evidence-Based Clearinghouse for Child Welfare). However, because parenting interventions alone may not be sufficient to address the many needs of parents of young children with disabilities, the remainder of the chapter describes the Family Networks Project, a collaborative intervention designed to support and strengthen protective factors in parents of very young children with disabilities. Results of two randomized trials examining the impact of the project will be presented. The concluding portion of the chapter identifies potential future directions for helping support families with young children through parenting supports and interventions.

Current Evidence-Based Approaches for Supporting Parents of Young Children

Nurse Family Partnership

Perhaps the most optimal time to provide support for parents is during the prenatal and early childhood period, given the importance of early development and supportive environments to later functioning. Supporting positive development of both mothers and children also can prevent a wide variety of maladaptive outcomes, including child maltreatment and involvement in the criminal justice system. Designed specifically for low-income first-time mothers, the Nurse Family Partnership (NFP) program provides mothers' support from pregnancy until the children turn two years of age (see www.nursefamilypartnership.org/). Mothers are

enrolled through the end of the second trimester of pregnancy and receive services until the child's second birthday. The intervention focuses on improving prenatal health, preventing child maltreatment and behavioral dysregulation, as well as improving family functioning and economic self-sufficiency in the first two years of life (Olds 2008, pp. 2–3). The initial intervention targets are improving maternal prenatal health. Post-delivery intervention targets include increasing maternal caregiving skills to promote child health and development as well as promoting future family stability through educational and work goal setting.

NFP services are delivered in client homes by nurses using a reflective model of practice (Beam et al. 2010). The NFP National Service Office works with organizations and communities interested in implementing NFP. Interested agencies/communities must be able to serve 100 families. Standard delivery is 8 nurse home visitors serving 25 families each (see <http://www.nursefamilypartnership.org/communities/local-implementing-agencies>). Research has supported significant short-term benefits, including improved maternal health, increases in responsive parent–child interactions, reduced injuries and emergency room visits, and reductions in child maltreatment (Olds 2006, 2007, 2008). Long-term impacts include reductions in maltreatment as well as youth involvement in the juvenile justice system (Olds 2007). Program impact appears to be greatest for those families at greatest risk (Olds 2007).

Parent–Child Interaction Therapy

Encouraging children's social, emotional, and behavioral skills, especially when child behavioral challenges are present, can involve a specific focus on the parent–child relationship. This approach is the core of parent–child interaction therapy (PCIT). PCIT is designed for parents of children ages 2–7 with externalizing behavior challenges (e.g., aggression, defiance; see <http://www.cebc4cw.org/program/parent-child-interaction-therapy/detailed> for a complete overview).

PCIT is grounded in attachment, social learning, and parenting approaches, and, in contrast to standard behavioral parent training models, focuses on modifying the interaction between parents and children (Foote et al. 1998). Thus, both parents and their children participate in the intervention, an approach designed and particularly well suited for parents of young children. An additional distinguishing feature is the use of live, in-session coaching by the therapist to support parent mastery of skills. Parents receive direct coaching from the therapist to acquire the skills being taught, and each phase ends when parents demonstrate mastery of the requisite skills. The intervention consists of two major phases: child-directed intervention (CDI) and parent-directed intervention (PDI). CDI uses a client-centered model of play; within this context, parents are taught skills to attend to their children and encourage appropriate talk and play. The primary goal of this phase is to strengthen the relationship between parents and children. During the PDI phase, parents are taught non-coercive strategies for increasing compliance and managing misbehavior.

PCIT is typically delivered in clinic settings; however, recent research has examined delivery in other settings (e.g., primary care, Berkovits et al. 2010) or via Internet videoconferencing methods (Comer et al. 2015). The length of the intervention is determined by parent attainment of specific competencies and not on a fixed number of sessions. Thus, delivery for a specific family can vary but averages at approximately 14 weeks. Recent research has examined two brief versions of PCIT using a randomized design; while between-group differences were not found, this type of adaptation has the potential to broaden reach of the intervention (Berkovits et al. 2010). PCIT has also been examined with parents of young children with disabilities or developmental delays. Improvements have been noted for parents and young children (ages 3–6) with intellectual disabilities and oppositional defiant disorder (Bagner and Eyberg 2007). PCIT has also demonstrated positive impact for mothers of young children born prematurely; significant decreases in child behavior problems were noted and the mothers were observed to be more positive in child-led play compared with mothers of similar children in a waitlist control group (Bagner et al. 2010). PCIT outcomes include improvements in parent–child interactions and reductions in child behavior problems and parenting stress (Eyberg et al. 2001); intervention gains can be maintained over time, especially among families who complete the intervention (Boggs et al. 2004; Hood and Eyberg 2003).

Incredible Years

Incredible Years (IY) is a multifaceted approach designed to increase children's social competence and prevent and treat conduct problems in children that includes parent-, child-, and teacher-directed interventions (Webster-Stratton 2001). The rationale for this integrated approach is that IY targets a range of risk factors for the development of conduct problems and aims to strengthen protective factors that operate at multiple levels of the social ecology: parents, children, and the school environment (Webster-Stratton and Herman 2010).

IY interventions target parents and teachers working with children in the age range of 3–8 years, as well as children directly. IY interventions are delivered in a group format and can occur at a variety of community settings including clinics and schools. Of note, in addition to being evaluated with parents of typically developing children with disruptive behavior, IY has also been examined with parents of young children (ages 3–6) with developmental disabilities. The IY parent training group intervention was found to improve the behavior of preschool children with developmental disabilities (McIntyre 2008). IY has also been examined in a small study with two parents of young children with disabilities; an individual coaching model was used in addition to parent participation in an IY group (Barton and Lissman 2015).

Two primary parent training programs are available, the BASIC and ADVANCE programs; a SCHOOL AGE prevention parenting program is also available. The

majority of research has focused on the BASIC and ADVANCE programs. The BASIC program lasts 12 weeks and teaches parents a variety of strategies to promote prosocial behaviors and to effectively manage misbehavior (Webster-Stratton 2001). The ADVANCE program supplements the BASIC program by addressing a range of additional parent and family risk factors for conduct problems such as depression, lack of support, and marital discord and also lasts 12 weeks (Webster-Stratton 2001). Outcomes for the parenting intervention include improved child behavior and child social and emotional competence or prosocial behavior, as well as improved parent–child interactions (Menting et al. 2013; Webster-Stratton 2001; Webster-Stratton et al. 2008). IY programs have also been demonstrated to be effective with low-income minority families (Reid et al. 2001). Initial feasibility of IY has been established for parents of children with developmental delays (McIntyre 2008), and application to parents of children with ADHD has been explored (Trillingsgaard et al. 2014).

The teacher training program also occurs in groups, delivered in group workshop format. The child program has two versions; one is a selective intervention delivered by classroom teachers and consisting of curriculum for children to enhance social, emotional, and behavioral functioning and is delivered in schools over a 18- to 22-week period (Webster-Stratton 2001). A second version of the child program is a 22-week small group therapeutic program that can be delivered in tandem with the parent program that targets skills including empathy, communication, and problem-solving skills, as well as anger management strategies (Webster-Stratton and Herman 2010). The teacher and child training programs have been demonstrated to positively impact teacher classroom management strategies and improved social and emotional functioning among young children when used as a universal prevention approach (Webster-Stratton et al. 2008).

Triple P-Positive Parenting Program

Triple P-Positive Parenting Program (Triple P) is a suite of parent-only interventions designed to improve parenting confidence and competence on a broad scale; this is the only parenting intervention intentionally designed from the outset as a public health approach to parenting (Sanders and Kirby 2014). Derived from behavioral family interventions, the intervention explicitly promotes parental self-sufficiency and independent problem-solving, which represents a unique approach to parenting interventions. Within Triple P, parents acquire effective parenting strategies within a self-regulatory framework designed to improve parental knowledge, skills, and confidence (Sanders 2012). Core Triple P interventions consist of five levels of increasing intensity and reach. When these core levels of the intervention are utilized as a system, it can be conceptualized as an approach to prevent or reduce child maltreatment through positive impact on family-based risk factors for maltreatment (Sanders et al. 2012).

Derived from behavioral family interventions, Triple P interventions focus on parents of typically developing children as well as children with disabilities ages 0-17. Core Triple P interventions consist of five levels of increasing intensity and reach. These include a universal media-based parenting information strategy (Level 1), Selected Triple P to provide advice about a specific parenting concern (Level 2), narrow-focus parent skills training (Level 3 Primary Care Triple P), broad-focus parent skills training (Level 4 Standard or Group Triple P), and more intensive behavioral family intervention (Level 5 Enhanced Triple P) (Sanders et al. 2002). Interventions occur in individual family, small group, and large group formats, depending on the level and type of Triple P used. Online delivery has been recently evaluated (Sanders et al. 2014).

Common outcomes from Triple P interventions include reductions in parent-reported child behavior problems, reductions in aversive parenting practices, and improvements in parental self-efficacy (Bor et al. 2002; Hoath and Sanders 2002; Sanders et al. 2000, 2003a). Several meta-analyses have documented the positive effects of *Triple P* (de Graaf et al. 2008a, b; Nowak and Heinrichs 2008; Sanders et al. 2014). Triple P interventions have been evaluated in multiple service delivery contexts (e.g., home, primary care, and online (Sanders et al. 2003b, 2012; Turner and Sanders 2006) with a wide variety of populations including toddlers/preschoolers, as well as children with conduct problems, attention deficit hyperactivity disorder, and developmental disabilities (Hoath and Sanders 2002; Roberts et al. 2006; Sanders et al. 2000). The strong evidence base, coupled with the availability of standardized program materials, manualized training procedures, and an infrastructure to support implementation, has resulted in widespread dissemination (Sanders 2012) and population-level trials (Prinz et al. 2009; Sanders et al. 2008; Zubrick et al. 2005).

Stepping Stones Triple P

One program variant of Triple P, known as Stepping Stones Triple P (SSTP), has been specifically designed and evaluated for parents of preadolescent children with disabilities (Roberts et al. 2006; Sanders et al. 2004). SSTP was developed to address the unique challenges experienced by parents of preadolescent children with developmental disabilities. Problem behaviors often noted in this population include poor social skills, aggression, or non-compliance.

SSTP has been evaluated in randomized controlled trials of young children with comorbid developmental disabilities and behavior problems, with parents of children with developmental disabilities only (Sofronoff et al. 2011), as well as with parents of young children of mixed disability types (Roux et al. 2013). SSTP can be delivered in a range of community settings including health or mental health care service settings, community settings, as well as in family homes. A recent meta-analysis of 12 SSTP studies found significant positive impact on child behavior and parenting outcomes; effect sizes for child behavior were medium;

effect sizes for parenting style were large but small for parent personal adjustment (Tellegen and Sanders 2013).

Need for Collaborative Interventions

As is evident from the empirical literature, evidence-based parenting interventions have demonstrated improvements in parenting behaviors, child behaviors, parent self-efficacy, and parent personal functioning in populations of both typically developing children and their parents as well as for parents of children with disabilities. Yet, it is important to acknowledge that parenting interventions alone may not be sufficient to optimize the long-term functioning of caregivers and children. This may be particularly true for young children with disabilities, who may require a range of services and supports to reach their full potential.

The Family Networks Project

The need to develop collaborative approaches that include evidence-based parenting interventions as part of a larger system of support lead to the development of the Family Networks Project (FNP). The FNP was designed to create and test the initial impact of a collaborative intervention designed to support and strengthen families with young children (below age 2) with developmental and other disabilities and to prevent negative outcomes including child maltreatment. Funded by the National Quality Improvement Center for Early Childhood (QIC-EC; Web site), the FNP was one of four research and demonstration projects each designed to develop innovative approaches for using a Strengthening Families framework (developed by the Center for the Study of Social Policy) to enhance protective factors and thereby prevent child maltreatment in children below age 2 (for information on the QIC-EC and each of the four projects, see the special issue published by the Journal of Zero to Three, Exploring New Paradigms for Evaluation and Service Delivery: The National Quality Improvement Center on Early Childhood, 2014, as well as Chapter “[From Thought to Action: Bridging the Gap in Early Childhood for Our Most Vulnerable Children and Families](#)”, this volume).

The FNP project was made possible by the confluence of a number of factors, including interagency collaborations begun during the conduct of the U.S. Triple P System Population Trial, a population-level approach to child maltreatment prevention (Prinz et al. 2009; Shapiro et al. 2010). Representatives from state-level agencies and organizations responsible for school readiness, IDEA Part C services, child maltreatment prevention, early childhood systems, and a university conceptualized FNP as an avenue to extend the research and application of interventions to improve services and outcomes for families with young children with disabilities, specifically those children eligible for early intervention services through the

federally mandated Individuals with Disabilities Education Act, Part C (IDEA Part C) program.

The FNP had two primary goals. The first goal was to examine the potential role of Stepping Stones Triple P (SSTP; Sanders et al. 2003b, 2004) as an evidence-based parenting intervention in improving key protective factors for families of very young children (below age 2) with developmental and/or other disabilities who were eligible for IDEA Part C (early intervention) services. SSTP was conceptualized as a selective prevention approach, as children were not required to have behavior problems as a condition of project involvement; furthermore, no prior SSTP research had been conducted with parents of children this young. The version of SSTP selected for use was a 10-session individual family-based intervention implemented using a home-based model of service delivery given the goal of provision of supports in the natural environment. Level 4 Standard SSTP includes 10 sessions covering a wide range of strategies to promote positive relationships between parents and children, encourage positive behaviors, teach new skills, manage misbehavior, and ways to promote generalization of parenting skills (planned activity routines).

The FNP team acknowledged that a parenting intervention alone would likely be insufficient to increase protective factors and reduce the potential for child maltreatment. Thus, the second goal of the FNP was to consider the synergistic impact of SSTP along with an intervention designed to impact the community level of the social ecology. Specifically, the FNP aimed to support families further by enhancing the capability of individuals who interact regularly with families in the early intervention system, early intervention service coordinators, to build strong, supportive relationships with parents and thereby reduce risk for maltreatment.

Like early care and education professionals, early intervention service coordinators are in a strong position to develop trusting and supportive relationships with the families that they serve. However, many early interventionists may not have had specific training in family engagement or have a high degree of self-efficacy to engage with and support parents. Fortunately, self-efficacy is an important predictor of ability to engage and support parents, and exposure to in-service training can have a positive impact on practitioner self-efficacy (Dunst et al. 2014). However, no curriculum existed for professional in-service training of service coordinators in the area of supporting parent-child relationships and preventing maltreatment. To address this gap, an existing skills training approach, *Preventing Child Abuse and Neglect: Parent-Provider Partnerships in Child Care* (PCAN) was selected for use in the FNP. Created by Zero to Three, the PCAN curriculum was originally developed for early care and education professionals to enhance family-level protective factors and prevent child maltreatment (Seibel et al. 2006). In collaboration with key stakeholders from Zero to Three and members of the FNP team, informed by input from IDEA Part C service coordinators, the PCAN curriculum content was adapted for an early intervention workforce (see Kilburn and Shapiro 2015, for a complete description of the PCAN adaptation process and outcomes).

For the FNP, two separate randomized studies were conducted in two different regions of one southern state (see Shapiro et al. 2014). For both studies, families

were recruited through a range of referral sources including early intervention providers as well as via self-referral. To be eligible for either study, families had to have an infant between the ages of 11 and 23 months who was receiving early intervention services from an early intervention service coordinator who had agreed to be a part of the study (given the need to coordinate with and obtain information from the service coordinator). Families had to have no history of prior referrals for child abuse or neglect, be willing and able to participate in the study, have a telephone, and be open to receiving parenting intervention services in the home. Children whose severity of disability suggested a high likelihood of out-of-home placement during the time frame of the study (i.e., determined to be medically fragile per state guidelines) were not eligible for either study.

All families underwent assessments prior to study entry (baseline), five months after randomization, and at a 12-month follow-up point. Assessment instruments were selected to cover key domains of functioning including child behavioral functioning (Child Behavior Checklist 1.5–5; <http://www.aseba.org>), parenting style (Parenting Scale, Rhoades and O’Leary 2007), parenting confidence (Toddler Care Questionnaire, Gross and Rocissano 1988), parent personal functioning (Depression, Anxiety, Stress Scales, short form), parent–child relationship quality (Keys to Interactive Parenting Scale or KIPS, an observational measure; Comfort et al. 2011), relationship with service providers and, for families receiving the SSTP intervention, a client satisfaction measure.

For both studies, SSTP was delivered in family homes; no prior SSTP studies had examined the intervention using a home-based service delivery model. SSTP was delivered by community providers trained and accredited to deliver this intervention; all sessions were audiotaped to support assessment of fidelity and all providers had regular supervision by experts in Triple P interventions (see Shapiro et al. 2014 for additional details).

FNP Study One

The specific research question addressed in the first study was as follows: Will SSTP combined with IDEA Part C services as usual increase family strengths by improving parent and child functioning and parent–child relationships as compared to early intervention (IDEA Part C services) as usual? Thus, eligible families ($n = 49$) were randomly assigned to receive SSTP in addition to early intervention services as usual ($n = 25$), or early intervention services as usual ($n = 24$). The vast majority of the participants (96 %) were women, average age 30.94 years ($SD = 8.2$). A majority of the caregivers (63 %) were Caucasian, with 27 % African American, and 10 % “other.” Forty-three percent described themselves as single. The majority (82 %) had an education of high school or beyond. Slightly less than half were in paid employment (45 %) and reported annual household incomes over \$30,000 (49 %); 31 % reporting earning less than \$20,000/year.

Assessments took place at baseline, post-treatment (5 months after baseline), and at 12-month follow-up.

A majority of the children (63 %) were boys with an average age of 19 months ($SD = 3.37$). Almost half (49 %) were Caucasian, with 25 % African American, and 25 % “other.” Most (65 %) were eligible for IDEA Part C services because of developmental delay(s), and the other children were eligible due to a diagnosis increasing risk for current or future disability.

With regard to study outcomes, among the most important process results from this study were the level of attrition from the SSTP plus early intervention services as usual condition; 14 families received 5 or more SSTP sessions while only 12 families (48 %) completed all 10 sessions. This level of attrition was surprising given delivery of services in family homes. The majority of families that did not complete the intervention cited lack of time as the main reason for discontinuation.

Despite the low completion rate for the intervention, some trends were found in favor of the treatment group, especially in the areas of increased family strengths (in the form of fewer caregiver symptoms of depression), a more marked decrease in child behavior problems between post-treatment and 12-month follow-up for the treatment group only, and possibly decreased likelihood of child maltreatment (one family in the comparison group had a founded case of maltreatment during the course of the study but caution is warranted due to low base rate of maltreatment and small sample size in this study).

FNP Study Two

For the second FNP study, the impact of SSTP was assessed against a backdrop of the PCAN skills training approach implemented with IDEA Part C service coordinators. The specific research question addressed in Study Two was as follows: Will SSTP combined with IDEA Part C services enhanced by PCAN training increase family strengths by improving parent and child functioning and parent-child relationships as compared to IDEA Part C enhanced by PCAN training alone? In Study Two, a total of 40 families were eligible for the study; 20 were randomly assigned to the SSTP/PCAN enhanced services as usual condition and 20 were assigned to the PCAN enhanced services as usual condition. The sample consisted of 40 caregivers of a child with a disability. All of the participants were women, with an average age of 30.63 years ($SD = 6.73$); 37.5 % were single parents. The majority (90 %) had an education of high school or beyond. Slightly more than half (58 %) of the caregivers were Caucasian, with 35 % African American and 8 % “other.” Forty-five percent were in paid employment, and half had annual household incomes over \$30,000; 30 % reported earning \$20,000/year or less.

Slightly more than half (58 %) of the children were boys. The mean age of the children was 19.9 months ($SD = 3.34$). Over half (55 %) were Caucasian, with 28 % African American and 18 % “other.” Most (68 %) were eligible for IDEA

Part C services because of developmental delay(s), and the other children were eligible due to a diagnosis.

In contrast to the first study, far less attrition was found from the SSTP/PCAN condition in Study Two, with 16 of 20 families (80 %) completing the SSTP intervention. At the individual family level, findings from Study Two (in which there was little attrition from the intervention group) showed significant differences and trends in favor of the treatment group in the area of increased family strengths (reductions in permissive parenting practices and post-treatment impact on caregiver symptoms of depression), but other areas showed no significant results. Child functioning as assessed using the CBCL showed no significant treatment-comparison group differences at post-treatment or follow-up. However, in terms of parenting style, results indicated a trend toward significant treatment-comparison group difference favoring the treatment group at five months in terms of reduction in parental laxness (i.e., permissiveness); by the twelve-month follow-up time point, significant differences favoring the treatment group were evident in terms of parental laxness. Parents in the treatment group evidenced significant reductions in permissive parenting practices over time. In the area of parental personal functioning, a trend toward a significant difference was found between the treatment and comparison groups for depression symptoms at five months ($p = 0.078$) again favoring the treatment group. Other findings in the areas of parent personal functioning were not significant. Lastly, on an observational measure designed to assess the overall quality of the parent-child relationship, there was a trend toward relative improvement in this area for the intervention group as compared to the comparison group post-treatment ($t = 1.77$, $p = 0.082$) that was significant at the 12-month follow-up ($t = 2.33$, $p = 0.022$).

At the community level of the social ecology, the PCAN training as modified for an early intervention workforce was both feasible to deliver and positively received. Significant pre/post-changes in content knowledge were reported by the early intervention service providers who were trained. It is possible that PCAN training impacted retention in the SSTP intervention in this study as evidenced by the marked differences in attrition in this study as compared to Study One. One hypothesis is that PCAN training strengthened the parent-early intervention service provider relationship and that these early intervention providers supported parent continued participation in SSTP. However, any comparisons made between the two studies in this regard are tentative.

The findings of impact on laxness, a measure of permissive parenting practices, indicate that caregivers who learned and then implemented the SSTP strategies were able to implement appropriate and effective parenting strategies, avoiding lax and permissive practices. In terms of the significant difference in caregiver depression, the findings could be an indication that caregivers who learned and then implemented the SSTP strategies experienced less depression because of enhanced self-efficacy in managing their child's behavior; however, these differences were not maintained at follow-up. An important finding is the improvement in the quality of the parent-child relationship for the SSTP intervention group evident at the trend level at post-treatment but significant by follow-up. Changes in parenting practices

appear to have positively influenced the quality of the parent–child relationship that appeared to strengthen with the passage of time.

Summary of FNP

The FNP was designed to examine the potential impact of an evidence-based parenting intervention for parents of very young children with disabilities and to examine this impact as part of a collaborative intervention that included a workforce enhancement curriculum. The potential impact of SSTP on parent and child functioning in Study One was diminished by significant attrition from the intervention group; however, trends in outcomes for parent depression and possibly child behavior in the treatment group are suggestive that this is worth further exploration. The findings of Study Two are important and indicate the potential for SSTP to have an impact on parenting practices, parent functioning, and on the parent–child relationship when used as a selective preventive intervention.

Important lessons and considerations for future intervention research can be derived from the FNP. First, families cited lack of time was a significant factor contributing to the attrition noted from SSTP in Study One. This suggests that a brief intervention format may be more appealing to families with a child in the early intervention system, but this remains to be empirically examined. A second issue relates to how families perceive the need for interventions that focus on parenting skills and support. The FNP used a selective prevention model, providing intervention for parents of children who were at increased risk for the development of behavioral challenges, but who did not need to be demonstrating problems in this area in order to receive SSTP. Children in the FNP were under two years of age at project enrollment, further limiting the likelihood that they were exhibiting behavioral problems. Thus, the perceived need for receiving information on parenting strategies may have been low. A third issue relates to service delivery. Parents of young children with disabilities who are receiving early intervention services may have to contend with a number of specialized providers all working to support their children in different ways. Ideally, upskilling the existing workforce of early intervention providers to effectively deliver evidence-based parenting interventions may be the most efficient model. The feasibility, practicality, and impact of this approach await empirical examination.

Conclusions and Future Directions

Interventions that focus on parents as the agents of change offer tremendous promise to improve the lives of families with young children. The greatest benefit is likely to be achieved by providing support and, if necessary, intervention for families of very young children, and families of children who are at higher risk to

develop social, emotional, or behavioral problems. A number of evidence-based parenting interventions exist that have demonstrated both the power and promise of improving the lives of families with young children by helping caregivers promote child competencies, strengthen their parenting practices, improve their relationships with their children, and decrease the likelihood of maladaptive outcomes including child maltreatment. However, more work is needed, especially in the area of prevention and interventions for supporting parents of very young children with disabilities.

Important future directions include additional efficacy and effectiveness studies of current evidence-based parenting interventions with a wider range of children and families, including families of young children with disabilities, as well as examining multiple service delivery models. Consumer preferences need to be taken into account; research suggests that parents may prefer self-directed formats such as online intervention deliver over more traditional group or home-based models (Metzler et al. 2012). Modular approaches such as those created Chorpita and colleagues (Chorpita et al. 2013) as well as collaborative interventions that involve several types of interventions to support parents and improve family outcomes also need to be examined, especially with parents of children below age 5. Examination of interventions at multiple levels of the social ecology, that include pre-service and in-service training for professionals serving families with young children, is also needed. The continued high rates of social, emotional, and behavioral problems in youth and the significant impact these have on families, neighborhoods, and society demand ongoing efforts to support parents and caregivers in raising competent, happy, confident adults.

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