A Tele-Coaching Intervention to Support Families in the NPP+: An Experimental Mixed Method Design

Wendella Wray

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LOMA LINDA UNIVERSITY
School of Behavioral Health
In conjunction with the
Faculty of Graduate Studies

A Tele-Coaching Intervention to Support Families in the NPP+:
An Experimental Mixed Method Design

by

Wendella Wray

A Dissertation submitted in partial satisfaction of
the requirements for the degree
Doctor of Philosophy in Marital and Family Therapy

September 2016
Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality as a dissertation for the degree of Doctor of Philosophy.

Susanne Montgomery, Professor of Research

Winetta Oloo, Associate Professor of Counseling and Family Sciences

Jacqueline Williams-Reade, Associate Professor of Counseling and Family Sciences

Colwick Wilson, Professor of Counseling and Family Sciences
DEDICATION

I would like to dedicate my dissertation to my loving, supportive family. I am the person that I am today because of my family. First and foremost, I want to thank my dear, loving mother. Mom, you are truly one of my best friends. Thank you for your courage to migrate to America to better yourself and open doors for your children to afford us more opportunities. You have indeed exemplified the essence of a woman. You have instilled in me the concept that I can achieve anything that I put my mind to. Thank you for being my number one cheerleader and for believing in me. I also want to thank my dear father for his wisdom as he rests in peace. Dad, you have passed on to me the desire to empower myself through knowledge in various ways.

I sincerely want to thank my siblings, Lavern, Anton, Charmain, Dionne and my in-laws Colin, Joan, and Roman. I want to thank each of you for accepting me for who I am. You have all supported me throughout my lifelong educational endeavors. Thank you for investing in me in so many ways. I am forever grateful for your pep talks, financial, spiritual, and social support, in addition to your infinite wisdom. I will always remember the miraculous power of prayer that we experienced as a family. Also, I want to thank my extended family for being a regular part of our family bi-weekly prayer line for almost 4 years. Our prayer group has provided me with the necessary support to overcome any obstacle through faith, prayer and God’s wisdom. My family has also inspired me to serve others who are not as fortunate as I am to have a supportive team on their side. Lastly, I want to thank my best friends across the U.S. from my early years to my college years and recognize dear friends along the way. Thank you all for being a part of my community. I love, respect and admire each of you.
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First and foremost, I want to acknowledge God for being my rock and fortress. He has provided me with his wisdom and guidance every step of the way. I also want to thank my dissertation committee chair and the members of my committee. You have all complimented me in ways that I could not fathom. To my chair, Dr. Susanne Montgomery, you have been a tremendous blessing to me. You have been an exceptional mentor, teacher, confidant and leader. Your experience, wealth of knowledge and instruction has enriched my life in ways that words could never explain. You have inspired me, challenged me, helped me to become more realistic and provided me with opportunities to engage in some of the best professional experiences that I have had during my tenure at Loma Linda University (LLU). You have been my accountability partner and yet allowed space for me to grow into my full potential. Today, I say THANK YOU, my lady, for all of your support.

Dr. Winetta Oloo, you may not be a woman of many words, but the words that you share have always proven to be timely messages for me to reflect on. You have encouraged me to plan ahead and stay focused while keeping the end goal in mind, and I appreciate you. Dr. Jackie Williams-Reade, I am so grateful for your direct caring approach and for being so meticulous. You have often reminded me that “quality comes before quantity” so I need to slow down or my quality will be affected. I also appreciate your check-ins from time to time to let me know you were thinking of me. Thank you for understanding me. Dr. Colwick Wilson, you are truly one of a kind. You are the peace that calms any storm. You are truly a man of excellence and you always make others feel special in your presence. You have focused on the students’ success no matter the
sacrifice and you will always be remembered for your dedication and commitment. Thank you for your mentorship, compassion, and for always being there for me. I am forever grateful that you were all a part of my “Dream Team.”

I want to thank the team at Care Counselors. Dr. Ian Chand, you have been a father figure to me throughout my time at LLU. You have mentored me during my academic career and provided me with supervision in my clinical career. You have provided me with invaluable counsel to guide me in my personal life, and the wisdom that you have shared with me has helped the families in my dissertation study. Your non-judgmental approach to life has encouraged me to confidently work with families and embrace a positive outlook no matter the situation. I have also learned to become more flexible. I am so grateful to all of you for investing in my life as spiritual, academic, research and professional mentors. THANK YOU.

I want to take a moment to thank my statistics mentor and consultant Dr. Durtuschi from the AAMFT Minority Fellowship program. Thank you for encouraging me to do a randomized controlled trial. I am truly grateful for the support you provided me every step of the way. Your passion for statistics has empowered me. Your teaching style, fun approach and patience have changed my perspective on statistics and I just want to say Thank You. Lastly, I want to say a special thanks to First 5 and Reach Out for providing the population to complete my research study. Reach Out, your drive to strive for excellence as a team is admirable. It was a pleasure working with your entire organization. Lastly, I want to thank the grant contributors of this study, California American Professional Society on the Abuse of Children (CAPSAC) and California Association of Marriage and Family Therapists (CAMFT) for your contributions.
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACE</td>
<td>Adverse Childhood Experiences</td>
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<tr>
<td>ANCOVA</td>
<td>Analysis of Covariance</td>
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<tr>
<td>ANOVA</td>
<td>Analysis of Variance</td>
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<tr>
<td>AAPI-2A</td>
<td>Adult Adolescent Parenting Inventory 2A</td>
</tr>
<tr>
<td>AAPI-2B</td>
<td>Adult Adolescent Parenting Inventory 2B</td>
</tr>
<tr>
<td>BPSS</td>
<td>Biological-Psychological-Social-Spiritual</td>
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<tr>
<td>CM</td>
<td>Child Maltreatment</td>
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<td>CDC</td>
<td>Center of Disease Control</td>
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<tr>
<td>CERQ</td>
<td>Cognitive Emotion-Regulation</td>
</tr>
<tr>
<td>CFA</td>
<td>Confirmatory Factor Analysis</td>
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<td>CPS</td>
<td>Child Protective Services</td>
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<td>EB</td>
<td>Evidence-Based</td>
</tr>
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<td>EBPP</td>
<td>Evidence-Based Parenting Program</td>
</tr>
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<td>EFA</td>
<td>Exploratory Factor Analysis</td>
</tr>
<tr>
<td>FA</td>
<td>Factor Analysis</td>
</tr>
<tr>
<td>FPL</td>
<td>Federal Poverty Level</td>
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<tr>
<td>H.O.P.E.</td>
<td>Helping Our Parents Excel</td>
</tr>
<tr>
<td>IRB</td>
<td>Institutional Review Board</td>
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<tr>
<td>MFTs</td>
<td>Marriage and Family Therapists</td>
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<td>MBSR</td>
<td>Mindfulness Based Stress Reduction</td>
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<td>MST</td>
<td>Multi-Systemic Therapy</td>
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<td>NFP</td>
<td>Nurse Family Partnership</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>NPP</td>
<td>Nurturing Parenting Program</td>
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<td>NPP+</td>
<td>Nurturing Parenting Program Plus Case Management</td>
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<tr>
<td>PCIT</td>
<td>Parent-Child Interaction Therapy</td>
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<tr>
<td>SE</td>
<td>Self-Efficacy</td>
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<tr>
<td>SES</td>
<td>Socio-economic Status</td>
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<tr>
<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
</tr>
<tr>
<td>T-CBT</td>
<td>Telephone-Cognitive Behavioral Therapy</td>
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<tr>
<td>Triple P</td>
<td>Positive Parenting Program</td>
</tr>
<tr>
<td>USDHHS</td>
<td>United States Department of Health and Human Services</td>
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ABSTRACT

A Tele-Coaching Intervention to Support Families in the NPP+:
An Experimental Mixed Method Design

by

Wendella V. Wray

Doctor of Philosophy, Graduate Program in Marital and Family Therapy
Loma Linda University, September 2016
Dr. Susanne Montgomery, Chairperson

Poverty is the single greatest threat to a child’s well-being. Poverty has been shown to exacerbate child maltreatment (CM) and minimize nurturing parenting. CM is a leading cause of death among children under the age of five in the United States. Both poverty and CM are major public health concerns worldwide with important implications for the family. For over three decades great focus has been placed on developing evidence-based (EB) parenting and family interventions to promote the well-being of high-risk families. Using a conceptual framework guided by elements of the social cognitive theory, attachment theory and family systems theory, this pilot study examined if adding personalized tele-coaching to the delivery of the 16-week, evidence-based parenting program (EBPP) Nurturing Parenting Program (NPP) plus case management (NPP+) would offer better results for high-risk, low SES parents. Parents attending the NPP+ in community sites were randomly selected to receive 30-60 minutes of tele-coaching. Key treatment variables (i.e., stress-management, parental self-efficacy, child attachment and self-regulation of emotions) were examined for increases in self-reported parenting competencies scores in the intervention versus the control groups. Pre and post test survey results suggest that while the overall NPP+ is highly effective, adding a
telecoaching intervention to individually review key topics to support parenting and related variables seems to not significantly add to the NPP+’s effectiveness. Nevertheless, in our process evaluation most parents stated that they really appreciated the flexibility and additional support that the individualized tel-coaching sessions offered. Thus, tele-coaching was well received. Tele-coaching as a content solidifying intervention should be explored adding it alone to NPP vs. NPP with case management as this may benefit some high need parents if resources are limited and a decision has to be made to offer case management or tele-coaching.

*Keywords:* Parents, child maltreatment, poverty, tele-coaching, attachment, stress self-efficacy, evidence-based, Nurturing Parenting Program (NPP).
CHAPTER ONE

INTRODUCTION


According to the National Children Center (2012) poverty is the single greatest threat to a child’s well-being. Poverty is linked to a higher risk of child maltreatment (CM) and is also negatively associated with mental and physical health (Rutter & Sroufe, 2000; Sameroff, 2000). Nearly one million children are victims of child maltreatment annually. Child maltreatment for the purposes of this study will be defined as children who are neglected, and experience emotional and/or physical abuse that contribute to early childhood trauma (USDHHS, 2014) every year. CM is one of the leading causes of death among children under the age of five in America (USDHHS, 2014) and it is estimated that associated costs will exceed $124 billion dollars annually (Fang, Brown, Florence & Mercy, 2012). In addition to the financial costs, the human toll of abuse and neglect is immeasurable (Hodnett, Faulk, Dellinger & Maher, 2009), often lasting through adulthood and then affecting a new generation of children, if affected individuals decide to become parent themselves creating a vicious cycle. CM most often occurs in families where there is chronic stress such as a family history of abuse, poverty, and/or chronic health problems (Fujiwara et al., 2012b; Shonkoff et al., 2012). Indeed, children who live in poverty are at higher risks of suffering from traumatic experiences such as CM in childhood (Moore & Ramirez, 2016). These traumatic experiences can negatively impact behavior, learning, physical and mental well-being and may also have lifelong effects (Shonkoff et al., 2012). Solutions are complicated especially as poverty is a
complex issue that is slow to change. For example, removing children from challenging homes should not be the first option as family life is an essential part of well-being of children (Sanders, Cann & Markie-Dadds, 2003) and family relationships influence the psychological, socio-emotional and economic security of children (Bolger, Patterson, & Conger, 2011; Conger & Dogan, 2007; Martin et al., 2010; Walsh; 2012). Therefore, parents can benefit from programs that help them to be more successful in their parenting role as a potential way of decreasing the occurrence of CM.

Research findings conveyed that maternal stress and parenting styles have significant influences and result in detrimental effects in their children (e.g., Niever & Luster, 2006). According to findings reported by Hao & Matsueda (2006), a mother’s use of corporal punishment and early childhood poverty shapes a child’s behaviors. In addition, child maltreatment causes toxic stress that can disrupt early brain development and harm the development of the nervous and immune systems (Luby-Dobson & Perry, 2010). The lack of parental care and nurturance are characteristics of neglect, which poses one of the greatest threats to children’s healthy development and well-being (Rutter & Sroufe, 2000; Sameroff, 2000). When parents live in poverty with high levels of chronic stress and report low parental self-efficacy (Kendall, Bloomfield, Appleton & Kitaoka, 2013) they tend to lack the understanding of child development, have poor self-regulation of emotions, and experience more difficulty parenting their children. They are also more likely to practice harsh, abusive forms of punishment and often develop insecure attachments with their children (Conger & Donnellan, 2007).

Early trauma has both immediate and long-term effects including implications for later emotional development (Creeden, 2009). However, a positive parental response can
alter a child’s attachment response pattern, which can change the composition of the brain (Begley, 2006). Longitudinal studies have revealed that the long-term emotional and psychological health of the child is affected by maternal health and well-being (Caplan, Coghill & Alexandra, 1986; Rutter, 1996). A follow-up study by Caplan and Coghill (1989) and another study by two researchers England and Sim (2009) concluded that a number of factors relating to the mother’s psychosocial and mental health could significantly affect the mother-infant relationship, increasing maladaptive infant health and attachment problems in childhood. Hence, the well-being of the parent is a critical factor in promoting healthy parenting.

Parenting stress has been linked to both negative parenting behavior and child functioning (Ostberg & Hagekull, 2000). It is well-known that parenting stress is a risk factor for child maltreatment (Fujiwara et al., 2012b). Increasing parenting self-efficacy (SE) is an important safeguard against parenting stress (Kendall, Bloomfield, Appleton & Kitaoka, 2013). Parental SE has been identified as a major determinant of parenting competence and psychological functioning (Coleman & Karraker, 2003). A relationship between parenting SE and parenting stress has also been identified in other studies (Sevigny & Loutzenhiser, 2009; Bloomfield & Kendall, 2012).

There is a serious need to implement interventions aimed at promoting well-being of the mother, to decrease both the disruption to the child’s emotional, educational, and social adjustment (Murray, 1995; England & Sim, 2009). Longitudinal research results has shown us that when a child has a secure attachment to a caregiver it increases the child’s ability to be more resilient against stress (Ford & Collins, 2010; Masten & Coatworth, 1998, Pasco-Fearon & Belsky, 2004), personal self-efficacy (Kendall,
Parent education is one of the most commonly used interventions for prevention of abusive or high-risk parents in child welfare agencies across the country (Barth, Landsverk, Chamberlain, Reid, Rolls et al., 2005; Huebner, 2002; Hurlburt, Barth, Leslie, & Landsverk, 2007). As part of this movement a great deal of attention has been given to the development of evidence-based (EB) parenting and family interventions (Barth, Landsverk, Chamberlain, Reid, Rolls et al., 2005; Bavolek; 2002; Turner & Sanders, 2005). The development of interventions that promote positive, caring, and consistent parenting practices has been repeatedly highlighted as being essential to reduce the incidence of CM and promote nurturing parenting practices (Azar, 1997; Sanders & Cann, 2002; Hodnett, Faulk, Dellinger & Maher, 2009). However, due to minimal implementation and evaluation of outcomes, there is still much to be learned about the effectiveness of parent education in prevention of child abuse or neglect (Hodnett, Faulk, Dellinger & Maher, 2009) and reoccurrences of child maltreatment.

The parenting programs with the strongest evidence of effectiveness have most commonly been studied in clinical settings primarily focused on behavior-disordered children (Barth et al., 2005). Parenting models such as Multi-Systemic Therapy (MST) (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998), Parent-Child Interaction Therapy (PCIT) (Eyberg & Robinson, 1982), The Incredible Years (Webster-Stratton, 2000), and Parent Management Training (PMT) (Patterson, Reid, & Eddy, 2002) are primarily focused on preventing, reducing, and treating serious behavior
problems in children. Although prevention in behavioral disorders are necessary, there is a strong need to emphasize parenting issues in addition to, and other than, those relating to serious behavior problems in children (Hodnett, Faulk, Dellinger & Maher, 2009).

The parent-child relationship, specifically as it relates to nurturing, attachment, empathy, and parental insight into the needs of the child, should play a key role in improving parenting practices (Hodnett, Faulk, Dellinger & Maher, 2009).

Experts argue that even more is needed given the complex needs of low-income parents and that most interventions lack one-on-one coaching in addition to group parenting sessions. While such personalized sessions are ideal, they would increase the length of already lengthy programs, likely resulting in higher cost and attrition rates. Nevertheless, current literature demonstrates that community programs, which offer a multidisciplinary approach, offer an array of resources that are often necessary to affect relational change in families (Patterson & Vakili, 2014). Low SES parents, who have a higher risk of engaging in child maltreatment, can benefit from the information taught in parenting classes in a significant way. While several EB parenting interventions have proven successful, the needs of families in poverty and with multiple additional stressors may exceed what these programs can offer and may benefit from an augmented, more personalized approach that helps them to review one-on-one what they have learned in the parenting program and brainstorm how to best apply it to their often chaotic lives. Moreover, requiring additional group intervention time, even one-on-one in the form of case management sessions, may simply be too much of a time commitment. Thus we considered tele-coaching using planned weekly phone calls aligned with the parent programs to individually serve these families. Personalized tele-coaching can offer
copious benefits. Tele-coaching can provide further exploration of the material taught in parenting classes each week and review the information in a meaningful way. It can also help to improve the parent’s understanding of child development, increase parental self-efficacy, provide stress management tools, as well as increase parent child/attachment and self-regulation of emotions.

Community programs have been created as an early intervention approach to prevent the onset of mental illness for mothers with at-risk children (Patterson & Vakili, 2014). Hence, providing partnerships with at-risk mothers of infants to promote secure attachment relationships (Patterson & Vakili, 2014) is a collaborative approach to intervene at an early stage. Family therapists need to be the leaders in the field of mental health and utilize their systemic training of families and larger systems to partner with community programs, incorporate progressive neuroscience and early intervention research, and create awareness through a systemic lens to promote effectiveness and sustainability of mental health outcomes for clients (Patterson & Vakili, 2014).

Consequently, partnering with evidence-based parenting programs (EBPPs) in providing communication services is an expedient way to provide effective results and improve positive mental health and quality of life for the parent and child.

**Telemedicine**

After analyzing the definitions of a compilation of 104 peer-reviewed perspectives and conceptual underpinnings, the authors determined that there is no single or uniform telemedicine application (Sood, et al., 2007). The literature suggest that telemedicine is a branch of e-health or tele-health that uses communications networks for
delivery of healthcare services and medical education from one geographical location to another. It is organized to surmount challenges like uneven dissemination and scarcity of infrastructural and human capital (Sood, et al., 2007). While the health field has incorporated tele-coaching as a form of tele-health, the mental health field has been slow to mainstream it.

**Tele-Coaching**

According to International Coach Federation (ICF) (2015), coaching has been defined as “an ongoing professional relationship that helps people to gain amazing results in their lives, careers, businesses, or organizations.” Research surrounding the area of coaching is still extremely limited. While there is no particular approach to coaching, the International Coach Federation (ICF) (2015) provides the following outline of the coaching process: the coach typically does a personal interview (either face-to-face or by teleconference call) to assess the individual’s current opportunities and challenges, define the scope of the relationship, identify action items, and establish goals and outcomes the client is seeking. Consequent coaching sessions may be held in person or over the telephone, with each session lasting an agreed upon amount of time. To complete the coaching sessions, the individual may be asked to achieve particular actions that support the accomplishment of one’s customized goals. Throughout the duration of the coaching, the coach may provide additional resources in the form of relevant articles, checklists, assessments, or models, to support the individual’s thinking and actions. The duration of the coaching may vary depending on the personal needs of the individual (ICF, 2015). While coaching may differ from therapy in many ways, therapists that are systemically
trained should invest in being coaches since this is the wave of the future.

**Family Therapists as Tele-Coaches**

High attrition rates in psychotherapy pose a major problem for mental health care professionals (Hamilton, Moore, Crane & Payne, 2011). Early termination can result in poorer outcomes and diminished cost-effectiveness and efficiency of treatment (Pekarik, 1985). Common factors associated with premature therapy termination results indicate that variables such as ethnic minority status (Kazdin, Holland, & Crowley, 1997), race (Huey, 1999), socioeconomic status (Kazdin et al., 1997), and severity of symptoms (Kazdin, 1990) are associated with higher dropout rates (Hamilton, Moore, Crane & Payne, 2011). The high dropout rate in psychotherapy is a critical factor that needs to be addressed to help high-risk families to thrive.

Marital and family therapists working with distressed families need to find better approaches to increase retention for high-risk families and develop interventions that reduce stress and target intermediates to be more effective with high-risk families (Hackman et al., 2010). Partnering with community organizations and providing personalized coaching may prove to increase retention outside of traditional family or individual therapy for high-risk parents and help parents faced with multi-stressors to overcome adversity and be more successful.

To add to the complexity of the practice, coaches with graduate training in mental health services often bring with them a range of theoretical orientations and models to coaching. A few examples of different coaching approaches are psychodynamic (Kilburg, 1996), narrative therapy (White, 2007), solution-focused (Grant, 2001), and
cognitive–behavioral therapy (Ducharme, 2004). While coaching may differ from traditional therapy, therapists are trained with a systemic lens. The skill set that therapists have developed over time to assess the situation from a systemic lens can help them to become some of the best coaches. Good therapists have to be flexible and cannot rely solely on “traditional therapy” as usual with high-risk populations.

Tele-coaching is a promising lower cost approach that might be utilized (Lingley & McGrath, 2007; 2008; Hodnett, Faulk, Delinger & Maher, 2009) to effectively help high-risk parents to gain further support in a convenient way. However, there is a scarcity in the literature examining the effectiveness of tele-coaching interventions (Collet, 2008; Lingley & McGrath 2007; 2008; McGloin, Timmins, Coates & Boore, 2014) associated with other EBPPs for low SES parents.

**Summary and Rationale**

Child maltreatment (CM) is a serious and widespread public health problem in the United States, responsible for substantial morbidity and mortality (Fang, Brown, Florence & Mercy, 2012). Research has been proven that protective factors reduce the likelihood of poor outcomes for children in high-risk situations. One study concluded that protective factors were (1) characteristics of the individual/parent (e.g. self-regulation), (2) quality of the child’s relationship (e.g. attachment) and (3) ecological factors (e.g. external factors such as support from policies and laws that protect children and families and quality of the environment) (Luthar & Zigler, 1992).

Child development, especially in the first years of life, is a succession of biological development for which there is seldom a second chance. Studies have
discovered that before the age of three, up to 90% of the adult brain has been formed (Schore, 2001; Perry, 2002; McGregor et al., 2007). Despite the vulnerability of the brain to early insults, remarkable recovery is often possible with interventions and most often the earlier the intervention the better the outcome (McGregor et al., 2007). When parents live in poverty, a lack of understanding of child development leads to decreased levels of parental self-efficacy, and poor management of stress and ability to regulate emotions as well as insecure parent child/attachment. They tend to have more difficulty implementing effective parenting competencies to support their children in a nurturing way (Conger and Donnellan, 2007). The challenges mentioned earlier in this section are all systemic in nature; therefore the family system can be impacted in an insurmountable way.

Marriage and family therapists receive ample training to help understand family and ecological systems. Understanding micro and macro systems are a critical component to the success of families. When parents are able to create self-awareness, change negative habits, break generational patterns and embrace change, it would not only be beneficial for the parent, but also for the child.

**Purpose of the Study**

The purpose of this study was to conduct a pilot study that explored if adding an innovative personalized tele-coaching intervention concurrently to an evidence-based parenting program (NPP) that offered a 16-week parenting program plus a weekly seven session case management lasting 45 minute to an one hour (NPP+) would result in better program outcomes for high-risk parents.
The aim of the study was:

1. To examine through an experimental design if adding a 30-60 minutes personalized tele-coaching component to the 16-week “NPP+” will offer better results for low SES families in comparison to NPP+ without telecoaching (control).
CHAPTER TWO

CONCEPTUAL FRAMEWORK

“Where there is love there is life.” - Mahatma Gandhi

Theory is a “set of interrelated concepts based on assumption, woven together through a set of propositional statements (Fitzpatrick, 1997, p.37). On the other hand, science is a “systemized body of knowledge that has a main purpose to discover the truths about the world” confirmed through empirical investigation (Jacox, 1974 p4). As the field of social science advances we have recognized the importance of the reciprocal interaction between theory and science and how they both contribute to the development of a systemic explanation of experiences (Lavee & Dollahite, 1991).

Due to the complexity of poverty and CM and the adverse affects that they both have on the family unit and society (Fang, Brown, Florence & Mercy, 2012), this study intertwined three theories that served as conceptual frameworks to analyze the contributing factors and better comprehend the association amongst those factors. Social cognitive theory is a theory that focuses on individual development. This theory underlies the concept that the reciprocal nature of influences is what produces behavior (Bandura, 1986:1991). The personal factors, existing behaviors, and the social and physical environment all interact and as a result of their reciprocal influences new behaviors are formed (Bandura 1991; Riekert, Ockene, Pbert, 2014). Attachment theory states that every individual is “born” to connect and maintain a strong affectionate bond with another human being (Bowlby 1973; 1980). Attachment theory informed us that the attachment figure serves as a “secure base” from which the child can confidently explore the world (Bowlby, 1988). Attachment bonds are critical in childhood and throughout
adulthood. In this study, parents were taught how to become more nurturing and empathetic towards their children to create secure attachment bonds between parent and child.

Lastly, *family systems theory* views the interactional patterns of the family and believes that the family is a system and entity in itself with “the whole being greater than the sum of its parts” (von Bertalanffy, 1967). Family systems therapists recognize the importance of taking a broader look inclusive of bio-psycho-social-spiritual (BPSS) issues to gain a better understanding of how the larger context contributes to the individual and family system. The researcher utilized the theories in this study to provide a detailed explanation of the ways in which factors at the various levels significantly contributed to the development of healthy parent child interactions and internal and external factors that affect thoughts, attitudes and behaviors in low SES parents.

**Theoretical Framework**

As the field of social science advances, we have recognized the importance of the reciprocal interaction between theory and science, and how they both contribute to the development of a systemic explanation of experiences (Lavee & Dollahite, 1991). The theoretical framework of this paper hypothesizes that there is a bilateral relationship between social cognitive theory, attachment theory and family systems theory.
Social Cognitive Theory

Social cognitive theory originated out of the social learning theories (Miller & Dollard, 1941; Rotter, 1954; Patterson, 1982; Bandura; 1961; 1963). Miller and Dollard (1941) suggested that four factors are essential to learning: drives, cues, responses, and rewards. Social motivations, which are secondary drives, consist of mimicking, a method by which equal actions are recommended in two people and connected to appropriate cues. The proposition of social learning was expanded upon and advanced by Canadian psychologist Albert Bandura (Bandura, Ross & Ross, 1961; 1963). Bandura, along with his apprentices and colleagues conducted a series of studies known as the Bobo doll experiment in 1961 and 1963 to determine why and when children display aggressive behaviors. The findings in these studies demonstrated the value of modeling for attaining novel behaviors. Bandura began developing theoretical foundations of his social learning theory to incorporate the conspicuous role of observational learning and social modeling.

The primary concept in social cognitive theory explains psychosocial functioning in terms of triadic reciprocal causation (Bandura, 1988). In this causal model, behavior, cognitive and other personal factors and environmental events all function as interacting determinants that influence each other bi-directionally (Bandura, 1988). Individuals learn attempts to explain and predict development of behavior using several key concepts: incentives, outcomes expectations, and efficacy expectations. Bandura (1977) outlined the roles of these concepts in a paradigm that assumes that a person with given information, beliefs, attitudes, and needs functioning in given social and physical environments will engage in acts that will have a subsequent outcome (Riekert, Ockene & Pbert, 2014). “Outcome expectations” involve beliefs in the capability of a person to perform a particular behavior that leads to those outcomes. Both outcome and efficacy expectations reflect a person’s beliefs about capabilities and the connections between behavior and outcome (Reikert, Ockene, Pbert, 2014).

If there is any characteristic that is distinctively human, it is the capability for reflective self-awareness (Bandura, 1991). This allows people to analyze their experiences and to think about their own thought processes. By reflecting on their varied experiences and on what they know, they can derive basic information about themselves and the world around them (Bandura, 2001). People not only attain understanding through reflection, they assess and alter their own thinking (Bandura 1986, pg 21).

In social cognitive theory human behavior is significantly motivated and
regulated by the ongoing exercise of self-influence (Bandura, 1991; 2001). Self-regulation also encompasses the self-efficacy mechanism, which plays a central role in the exercise of personal agency by its strong impact on thought, affect, motivation and action (Bandura, 1991; 2001). The same self-regulation system is involved in moral conduct. Although as far as an individual's development is concerned, moral competence is the growth of cognitive-sensory processes; simply put, it is being aware of what is considered right and wrong (Santrock, 2008). Modeling is an effective way to show parents alternative ways to parenting while expanding their perspectives on right and wrong to help them to improve their parenting.

**Modeling**

Modeling is the first step in developing competencies (Bandura, 1988). Difficult skills are broken down into simple skills and then modeled for mastery (Bandura, 1988). Providing many brief examples demonstrates how the rules can be broadly applied and adjusted to fit changing circumstances. Human competency requires not only skills, but also self-belief in one’s capability to use those skills well (Bandura, 1988). Modeling is being extensively used with good outcomes to improve intellectual, social and behavioral competencies (Bandura, 1986). The method that produces the best results includes three major elements. First, the appropriate skills are modeled to convey the basic competencies. Second, the people receive guided practice under simulated conditions so they can perfect the skills. Third, they are helped to apply their newly learned skills in work situations in ways that will bring them success (Bandura, 1988).
Another distinctive feature of social cognitive theory is the central role it assigns to self-regulatory functions. It is a dimension related to how individuals develop understanding of their own behavior and evolve their outcome and efficacy expectations (Reikert, Ockene, Pbert, 2014). A human’s behavior is vastly motivated and regulated by internal standards and self-evaluative responses to their own actions (Bandura, 1986).

**Self-Regulatory Systems**

Self-regulatory systems lie at the very heart of causal processes. They not only mediate the effects of most external influences, but also provide the very basis for purposeful action. Most human behavior, being purposive, is regulated by forethought. The future time perspective manifests itself in many different ways. People form beliefs about what they can do, they anticipate the likely consequences of probable actions, they set goals for themselves, and they otherwise plan courses of action that are likely to produce desired outcomes. Through exercise of forethought, people motivate themselves and guide their actions in an anticipatory proactive way (Bandura, 1991).

Consciousness is the very substance of mental life that not only makes life personally manageable but worth living. Conscious awareness involves purposefully accessing and deliberative processing of information for selecting, constructing, regulating, and evaluating courses of action (Bandura, 1986; 2001; 2004). Agency gives shape to appropriate courses of action and helps to motivate and regulate its execution. Actions give rise to self-response influence through performance comparison with personal goals and standards. Goals, embedded in a value system and a sense of personal identity, promotes actions with meaning and purpose (Bandura, 2001).
Self-Efficacy

No other thought that affects action is more central or pervasive than a person’s judgments of their capabilities to deal effectively with different realities (Bandura, 1986). Perceived self-efficacy occupies a pivotal role in the causal structure of social cognitive theory because efficacy beliefs affect adaptation and change not only in their own right, but also through their impact on other determinants (Bandura, 1997; Maddux, 1995; Schwarzer, 1992).

Efficacy beliefs play a central role in the self-regulation of motivation through goal challenges and outcome expectations (Bandura, 2001). It is partly on the basis of efficacy beliefs that people choose what challenges to undertake, how much effort to expend in the endeavor, how long to persevere in the face of obstacles and failures, and whether failures are motivating or demoralizing (Bandura, 2001). A strong sense of coping efficacy reduces vulnerability to stress and depression in taxing situations and strengthens resiliency to adversity. Parenting stress is a risk factor for child maltreatment (Fujiwara et al., 2012b). Increased parenting self-efficacy is known as a protective factor against parenting stress (Kendall, Bloomfield, Appleton & Kitaoka, 2013) in low SES parents.

Self-efficacy beliefs regulate human functioning through cognitive, motivational, affective, and decisional processes (Bandura, 2002). They affect whether individuals think in self-enhancing or self-debilitating ways; how well they motivate themselves and persevere in the face of difficulties; the quality of their emotional life, and the choices they make at important decisional points which set the course of life paths (Bandura, 2002). Numerous large-scale meta-analyses have been conducted on findings from
studies with diverse experimental and analytic methodologies applied across diverse spheres of functioning (Boyer, Zollo, Thompson, Vancouver, Shewring, & Sims, 2000; Moritz, Feltz, Fahrbach, & Mack, 2000; Stajkovic & Lee, 2001). The converging evidence from these diverse lines of research verifies that efficacy beliefs contribute significantly to the quality of human functioning (Bandura, 2002).

Perceived self-efficacy is concerned with people’s beliefs in their capabilities to produce given attainments (Bandura, 1997). Therefore, a person cannot require mastery in every realm of human life (1997). People differ in the areas in which they cultivate their efficacy and in the levels to which they develop it even within their given pursuits.

Social cognitive theory has become extensively recognized and has played a significant role in contributing to a number of salient concepts and models of behavior change (Reikert, Okene & Pbert, 2014). In spite of that, some criticism of social cognitive theory has been raised concerning its focus on individual behavior and its basis and emphasis on cognition and perception as opposed to greater acknowledgment of “ecological” determinants (Bronfenbrenner, 1979). Nonetheless, it is still viewed as a highly regarded theory in health behavior change (Tierney et al; Shrot, James & Plotnkoff, 2013). While focusing on ecological determinants may appear to be essential to Bronfenbrenner’s ecological systems theory of human development (1979), it is not always clear which system (e.g., micro, meso, exo and macro system) best accounts for the behavior we attempt to explain (Strong, DeVault & Cohen, 2011). Hence, there is some ambiguity as to whether particular systems provide the best explanation for successful related behaviors and beliefs (Strong et al., 2011). As a family therapist, my goal is to provide a more holistic understanding of how to operationalize the factors that
interfere with the wellbeing of families based on the parents’ attitudes, beliefs and behaviors.

Social cognitive theory is relevant to this study as the Nurturing Parenting program (NPP) being used in this study is primarily based on social learning theory, which supports the widely accepted belief that most parenting patterns are learned during childhood and are replicated later in life as the child becomes a parent (Bavolek, 2002). This study also focuses on the ability to form secure parent/child attachments. Research findings suggest that secure attachments are considered to be a protective factor for negative parenting responses and child functioning (Conger & Conger, 2002; Simmons, Paternate, & Shore, 2001).

Attachment Theory

Attachment theory is the primary theory utilized in the area of infant mental health (Becker-Weidman, Ehrmann & Lebow 2012). British psychiatrist John Bowlby is the founder and also known as the “Father of Attachment Theory” (1969; 1973). Attachment theory compliments social cognitive theory as it focuses on the caregiver-child dyad relationship not solely on the individual traits of any one person (Ainsworth & Bowlby, 1991; Becker-Weidman, Ehrmann & Lebow 2012). Bowlby’s (1969; 1973) attachment theory states that every individual has a natural inclination to affectionately bond with another human being. The eminence of these bonds plays an essential role in the overall well-being of the individual. Infant-caregiver relationships provide the basis, by which the child forms healthy, loveable, trustworthy, or unhealthy avoidant and anxious interpersonal relationships later on in life (Bowlby, 1979).
Bowlby believed that disturbed relationships with parents or caregivers and their young children could impair a child’s psychological well-being, physical health and social growth (Johnson, 2013). Bowlby’s (1944) empirical evidence of troubled adolescents revealed that behind the “affectionless character” of emotionless children nurture rather than nature was the pathogenic agent that led to cold-heartedness and despair. He conducted a groundbreaking study of orphaned children that were removed from their home after World War II. Bowlby’s findings led to a report published for the World Health Organization (1951; 1952) concluding that depriving children of emotional nourishment was “as damaging to the psyche as is the lack of food is to the body” (Johnson, 2013).

Mary Ainsworth was a well-known researcher who worked alongside Bowlby to further develop attachment theory. Attachment theory advanced significantly after empirical evidence was provided by the prominent study known as “Strange Situation” conducted by Ainsworth and her colleagues, Blehar, Waters and Wall (1978). The researchers observed interactional patterns between mother-infant dyads and believed that attachment figures played a critical role in managing anxiety during the infant’s period of complete dependency. By engaging in sensitive receptiveness or the ability to be attuned to the infant and respond appropriately, the mother helps the infant to develop a secure attachment (Atwool, 2006). Ainsworth et al. (1978) identified three patterns of attachment: secure, ambivalent and avoidant. In later years, an additional category known as disorganized attachment was added by Main, Kaplan, & Cassidy (1985). This “coined” term described children in high-risk populations that most likely experienced abuse or more volatile behaviors (Atwool, 2006).
Certain contextual factors predict the advancement of secure patterns. Parents that have better psychological health and well-being normally provide their children with increased quality care (Belksy, 1984; Gelfand & Teti, 1990) and their offspring typically tend to be more securely attached. A child’s secure attachment to caregiver also increases parental and child self-efficacy (Simmons, Paternate, & Shore, 2001) and healthy emotion regulation (Hill-Soderlund, & Karrass, 2010; Maughan & Cicchetti, 2002; NICHD Early Child Care Research Network, 2004).

Attachment theory is an evolutionary theory of human social behavior from the “cradle to the grave” (Bowlby, 1979, p.129). Primarily, the theory focuses on normative and individual diverse mechanisms of attachment that should promote infant survival. Bowlby proposed that attachment behaviors are organized into an attachment behavioral system that involves inherent motivation (Shaver & Mikulincer, 2012). Children can become attached whether a parent is meeting his/her needs or not. As a result, children become attached even to abusive mothers (Bowlby, 1956). The organization of the attachment behavioral system involves cognition components specifically mental representations of the attachment figure, the self, and the environment all of which are largely based on experiences. Bowlby referred to these representations as “internal working models.” Attachment behavioral system is an important contributor to behavior across the life span and becomes a foundational aspect of how we view others and ourselves (Pittman, 2012).

Distressed patterns of attachment behavior can exist at any age due to development having followed an unexpected pathway (Bowlby, 1980). Recent research has shed light on how attachment patterns can evolve across the lifespan (Simpson &
Belsky, 2008) and have intergenerational affects. Therefore, parents’ attachment history is important to their parenting behavior (Shaver & Mikulincer, 2012). Some studies have shown that the parent’s state of mind with respect to attachment is the most robust predictor of a child’s attachment (Main, 1995; Shaver & Mikulincer, 2012). Hence, both parent attachment history and parent-child attachment bond is critical in helping low SES parents in this study to understand child development. It is essential for parents to learn how to regulate their own emotions before helping their own children to regulate their emotions (Hughes, 2009). Regulation of the infant’s emotional state develops through the repeated appropriate responses of an attentive, attuned caregiver to the child’s altering emotional states, e.g., fear, anger, and distress (Luby-Dobson & Perry, 2010). Through this consistent, predictable, and recurring nurturing, the child develops the capacity to self-regulate these emotional states as well as to communicate his or her emotions (Emde, 1998).

Attachment theory has become the principal theory in understanding the influence of chronic early maltreatment on a child’s development, mental health, and capacity to form emotionally meaningful relationships (Becker-Weidman, Ehrmann & Lebow 2012). Even though attachment theory is the primary theory utilized in parent/child relationships and it has increased our understanding of infants and toddlers’ development and attachment patterns, there is still work to be done within the framework of attachment theory and the ecological approach to human development. Harwood, Miller, and Irizarry (1995) have raised some ethical concerns about the theory in regards to suggesting that a “one size approach” will fit for all cultures. Other researchers question
that attachment theory does not focus on the whole family and tends to focus more on the mother-child dyad without including the father (Crespo, 2012).

Recently attachment research has begun to examine these attachment relationships in relation to their contextual background and family (Mikulincer & Shaver, 2007). New approaches are being developed (Diamond, Levy, Israel, & Diamond, 2009) to try to address these concerns. Hence, there is still a scarcity of studies of the potential advantage of integrating attachment theory and family systems theory (Shaver & Mikulincer, 2012). It is also known that external factors are not greatly explored when focusing on the mother/child dyad in attachment theory. Family systems theory provides us with a systemic approach to examine the dynamics between different subsystems within the family, cultural factors and external systems that can impact the family and provide further clarity and explanations for the way the family is functioning.

**Family Systems Theory**

“The most basic unit of society is the family” (James, Moore & Assay, 2008 pg 26). As such, the family system is an integral part of the larger social system impacted by all social, economic, political, and environmental changes (James, Moore & Assay, 2008 pg. 24). Family systems theory is beneficial in understanding how the relational dynamics of the family of origin and external factors can provide a more comprehensive understanding of parent/child interactions in low SES families which impacts child development and parenting. The researcher will review the past and present literature to examine the history and evolvement of family systems theory and discuss why it is an appropriate element of the conceptual framework for this study.
In the 1940s Australian biologist, Ludwig von Bertalanffy made an attempt to combine concepts from systems thinking and biology into a universal theory of living systems from the human mind to the global ecosphere (Nichols, 2006; 2009; 2013). He eventually began to extrapolate to more complex social systems and developed a model called general systems theory (Nichols, 2006; 2009; 2013). The major concept of this theory is that every system is a subsystem of larger systems hence the “whole is greater than the sum of its parts” (von Bertalanffy, 1969). Family Systems theory was born out of general systems theory. Several aspects of general systems theory were distinctly applicable to the family as a system (James, Moore & Assay, 2008).

**Cybernetics**

Cybernetics was the first model of family dynamics. As applied to families cybernetics focused on (1) family rules, which controls a range of behaviors that a family system can endure (the family’s homeostatic range); (2) negative feedback instruments that families use to enforce those rules (guilt, punishment, symptoms); (3) sequences of family interaction around a problematic interaction that depicts a system’s response to it (feedback loops); and (4) what happens when a system’s habituated negative feedback is in ineffective, activating positive feedback loops (Nichols, 2006; 2009; 2013). Cybernetics focuses on the feedback loops within families otherwise known as patterns of communications as the fundamental source of family dysfunction (Nichols, 2006; 2009; 2013). System’s theory educated us on the importance of understanding how people’s lives are shaped by their interchanges with those around them (Minuchin, Colapinto & Minuchin, 2007).
The foundation of family systems therapy has been challenged and expanded by the postmodern ideas (Nadine, Johns, Osman & Mahan, 2004). The modernist approach presupposes the possibility of objectivity and a knowable reality (Kerr & Bowen, 1988), while the assumptions of postmodern therapies presupposes multiple realities and multiple selves that are socially constructed through interaction and language— independent of the observer (Berger & Luckman, 1966; Gergen, 1991; Hoffman, 1990).

In 1960, Nathan Ackerman developed the Ackerman Institute for the Family, one of the founding centers for family therapy. The Ackerman Institute recognizes the importance of using a systemic approach integrating techniques from both modern and postmodern theories that focuses on the development, clarification and nurturance of interpersonal bonds (Brewster & Sheinberg, 2012). For the purposes of this study the author utilizes a systemic approach that is inclusive of techniques from both modern and postmodern theories.

**Families as Systems**

Families are a special kind of system, with structures, patterns, and properties that organize stability and change (Minuchin, Colapinto, Minuchin, 2007 pg 18). Families have a structure that entails patterns of interactions that are recurrent and predictable. These patterns reflect the relationships, tensions and hierarchies important in human societies and convey meaning for behaviors and relationships (Minuchin, Colapinto & Minuchin, 2007 pg. 18). Family system theorists recognize that family problems are determined by multigenerational, unconscious shaping of both neural structure and behavior. The functioning of brains and family dynamics reflect how they have been
organized (Cozolino, 2010). The dysfunctional brain, like the dysfunctional family, is shaped by the avoidance of thoughts and feelings, resulting in the detachment of neural systems of affect, cognition, sensation, and behavior, as well as a lack of human autonomy (Cozolino, 2010). Increased autonomy of individuals within a family decreases the overall rigidity of the system and helps families to become more responsive to the needs of others and less reactive to their own inner conflict (Cozolino, 2010).

Educating the family about these concepts and exploring the family history through several generations (i.e., by way of family genograms, family trees, and reflective questioning) helps the family to gain awareness about their problems and improve their understanding. Ultimately psychologically, interpersonal, and neural integration are various levels and representations of the same process (Cozolino, 2010). In this study we expand the conceptual framework of systems therapy to a collaborative and integrative multi-systemic approach that offers holistic care (Delbridge, Taylor & Hanson, 2014).

**Family Systems Takes a Broader Look**

For treatment to be effective it is essential for it to be systemic in nature (Prest & Robinson, 2006). The complexity of treatment is demonstrated on multiple system levels, reciprocally linked to the overall health and well-being of the individual, family, and community (Hickey et al., 2005; Yapko, 1997). Relational and systemic therapists such as medical family therapists and marriage and family therapists (i.e., MedFts and MFTs) can utilize systemic training to endure critical challenges. As a result, it is believed that an integrated and collaborative assessment and treatment approach, such as
one based on general systems theory (von Bertalanffy, 1969) and the bio-psycho-social-spiritual (BPSS) model is essential when helping people with such potentially incapacitating difficulties (Hickey et al., 2005).

Viewing the family as a system and also assessing the multi-systemic (i.e., biological, psychological, social and spiritual (BPSS)) context of the individual that may be suffering from health challenges is critical (Wright, Watson & Bell, 1996) to a person’s well-being. Though the limitations of this study may cause the bio-psycho-social-spiritual BPSS to be outside of the scope of this study, the BPSS model (Wright, Watson, & Bell, 1996) has proven to be useful in understanding the interaction among the key components of various system levels. Due to emerging evidence in current literature, family systems therapists recognize the importance of taking a broader look inclusive of BPSS issues to gain a better understanding of how the larger context contributes to the individual and family system. For the purposes of this study, I believe that incorporating aspects of the BPSS approach is beneficial because it has an impact on the brain development of children, and can contribute to the parents’ ability to regulate their stress by effectively tapping into spirituality and social support as coping mechanisms.

Therefore, the philosophy of the BPSS model is utilized as a guide to family systems theory throughout this study when working with low SES parents and their young children.

Although family systems theory is not specifically being measured in this study, the all-encompassing framework is essential for this study. Observing and understanding the internal and external systems within and outside of the individual and family unit is critical in helping us to gain awareness about the role that family plays in regards to the
parents’ ability to form secure attachment bonds with their children and to help parents better understand their perceived self-efficacy as well as their ability to regulate emotions in the parent/child relationship.

**Conclusion**

It is important to build upon what we have come to understand about individuals, parent/child relationships, families and external systems through the advancement of theory. The theories that contribute to the conceptual framework of this pilot study helped the author to formulate and examine what skills contributed to the potential outcomes of the intervention that was designed to assist families in understanding unhealthy patterns and emotional responses that impact their behaviors. This includes working with parents to better understand their own thoughts, attitudes and behaviors about parenting by exploring their own attachment history. The author hopes that utilizing the conceptual frameworks in this study will allow us to better understand the “black box” approach of most EB parenting interventions and determine if augmenting one such intervention, NPP+ with a phone coaching series of personalized skill building discussions designed to address parents’ lack of understanding of child development, decreased levels of parental self-efficacy, poor stress management, as well as insecure parent child/attachment and poor self regulation will result in better outcomes.
CHAPTER THREE

BACKGROUND

There can be no keener revelation of a society’s soul than the way in which it treats its children.” –Nelson Mandela

Poverty and child maltreatment (CM) are complex, multi-faceted problems that significantly impact families globally (Hodnett, Faulk, Dellinger & Maher, 2009). Mental health challenges in children have been directly attributed to risk factors associated with poverty (Teicher, Andersen, Polcari, Anderson, & Navalta, 2002). Other risk factors are associated with adults experiencing adverse childhood experiences (i.e., child abuse, neglect) (Center for Disease Control, 2011) or being raised in environments with toxic stress (Patterson & Vakili, 2014). With that being said, poverty and child maltreatment has a long lasting deleterious effect on infant brain development.

The Neuroscience of Poverty, Child Maltreatment and Chronic Stress

The child’s brain is influenced by his/her environment, and continues to evolve throughout adolescence and young adulthood (Lenroot & Giedd, 2006). Chronic exposure to stress in early childhood, including neglect, primes a child’s brain to be more responsive to subsequent stress throughout life (Favez et al., 2012; Shonkoff et al., 2012; Yoshikawa et al., 2012). Attunement, affect coordination, and synchronization of mother and infant’s physiological and behavioral systems during early delicate phases of infant development shape the physiology of the infant’s nervous system, affecting an infant’s ability to regulate stress and develop healthy attachments later in life (Feldman, 2012; Feldman, Magori-Cohen, Galili, Singer, & Louzoun, 2011). While maternal nurturing
can affect brain and psychosocial development, factors such as social interactions, family dynamics, nutrition, and physical environment can alter gene expression (Patterson & Vakili, 2014).

In children, significant occurrences of childhood stress and poverty are risk factors for chronic diseases during adulthood, and childhood abuse and trauma can alter the brain in ways that render individuals more prone to mental health issues (Teicher, Andersen, Polcari, Anderson, & Navalta, 2002). When individuals have experienced past trauma (i.e., child maltreatment), there is increased levels of activation in the amygdala (Teiter et al., 2002). The amygdala, (i.e. emotional part of the brain) is responsible for initiating autonomic responses (i.e., increased blood pressure and heart rate) that activate primary defensive reactions (i.e., freeze, fight and flight) to any threat response when danger is detected. This leads to problems with affect regulation, speech and relational challenges (Teiter et al., 2002). In terms of cognitive skills and affective functioning, prenatal and postnatal exposure to stress and growing up without adequate resources may cause issues with memory, executive functioning, linguistic skills, cognitive skills, and social-emotional skills (Hackman, Farah, & Meany, 2010; Shonkoff et al., 2012).

Adults who endure chronic levels of childhood stress exhibit poor mental and physical health. Chronic stress causes physiological changes that alter immune system functioning and increase the occurrence of diseases involving the heart, liver, and pulmonary system (Shonkoff et al., 2012). An intergenerational cycle is often established when these adults are unable to provide relationships for their children that mitigate the affects of stress, resulting in children growing up in homes exposed to toxic stress (Shonkoff et al., 2012).
Adverse Childhood Experiences on Physical and Mental Health

The Center for Disease Control and Prevention (CDC, 2011) and Kasier Permanente’s Health Appraisal Center (HAC) in San Diego, California has an ongoing collaboration on one of the largest studies ever done on trauma known as the Adverse Childhood Experiences (ACE). More than 17,000 Health Maintenance Organization (HMO) members completed a comprehensive physical exam and provided details about their childhood experience, of abuse, neglect and household dysfunction. The objective was to assess the impact of numerous, interconnected, ACEs on health behaviors and outcomes and on health care utilization (CDC 2011).

The Adverse Childhood Experiences (ACE) study findings specified that adverse childhood experiences are main risk factors for the leading causes of ailment and mortality as well as poor quality of life in the United States (CDC, 2012). Development in prevention programs is necessary to help decrease ACE’s that contribute to the nation’s worst health and social problems (CDC, 2012). In completing this longitudinal study they were able to determine that early childhood trauma had a direct impact on physical health (Glaser 2000). Extreme, traumatic or repetitive childhood stressors such as abuse, witnessing abuse, and related types of ACE were frequent (Hagar, Runtz, & Hager, 2012). Collectively chronic stress, low SES, and a poor attachment relationship with an adult can severely impair a child’s mental health (Patterson & Vakili, 2014).

Poverty and Chronic Stress on Parent/Child Relationships

Parenting stress has been linked to both negative parenting behavior and child functioning (Ostberg & Hagekull, 2000) and is also a main risk factor for child
maltreatment (Fujiwara et al., 2012b). Conger and Conger’s (2002) research findings from a longitudinal study completed with 558 children and mid-western families inform us that when parents are faced with chronic stress and poverty it significantly affects the parent/child relationship. Conger & Conger (2002) analyzed the impact of different levels of economic hardship on the family. The results indicated that resilience to economic adversity for the family of the youth was fostered by relational support through partners and family and external relationships being strengthened (i.e. secure attachments). Resilience to stress and challenging transitions periods in childhood was mainly promoted by a nurturing, caring relationship. Parent/child relationships that utilized a less hostile parenting approach are also considered to be strong protective factors for children. The absence of nurturing parenting relationships decreased the attachment bond and increased harsher forms of parenting (Conger et al., 2003) that may be equivalent to child maltreatment.

**Secure Versus Insecure Attachment History**

Over the past three decades research has determined that the presence of a secure-attachment is a protective factor that increases the individual’s capability for adversity, which in turn promotes cognitive, emotional and social well-being (Shaver & Mikulincer, 2007). According to Fonagy (2003) children thrive when they have a secure attachment with the primary caregiver. Empathetic expression helps to promote the child’s development and well-being (Fonagy, 2003). Schore (2001) emphasizes that during the first three years of life brain development occurs at a rapid pace creating neural pathways that allows more complicated structures of the brain to exist. Early
attachment experiences are critical for the human and infant brain development and for forming resilience throughout life (Corbin, 2007). Schore (2001) and Luby-Dobson and Perry (2010) suggests that there is a link between attachment and the development of self-regulation. According to Lyons-Ruth and Spielman (2004), a mother’s capacity to regulate her own emotions and her infant’s distress and fear, is vital to the child’s ultimate sense of security.

If parents grew up with an insecure attachment history due to child maltreatment and struggles with unresolved issues, developing intimate emotional relationships in adulthood (i.e., partners, close friends and therapists) can help to resolve past events from his/her attachment history (Hughes, 2009). An autonomous (adult) attachment developed by means of reflective functioning can help to improve self-acceptance, awareness, empathy and self-attunement (Siegel, 2007) to facilitate growth. Self-reflection on attachment history can facilitate the ability to learn how to regulate one’s emotions when a child’s behavior activates specific memories from childhood (Siegel & Hartzell, 2003).

Several longitudinal studies have examined the effects of secure versus insecure attachment and have concluded that a child’s secure attachment to a caregiver increases that child’s personal self-efficacy, (Simmons, Paternate, & Shore, 2001) resilience against stress, (Ainsworth et al., 1978; Ford & Collins, 2010) healthy cognitive development, (van Bakel & Rikson-Walraven, 2002), empathy and sensitivity, (Lindsey, Caldera & Tankersley, 2009; Mikulineer & Shaver, 2005) healthy emotion regulation, (Barry & Kochanska, 2010; Maughan & Cicchetti, 2002; NICHD Early Child Care Research Network, 2004; Pauli-Pott, Mertesacker, & Beckmann, 2004) and positive affect (Borelli et al, 2010; Milan, Snow, & Belay, 2009; Paulussen-Hoogeboom, Stams,
Secure attachments developed between a parent and a child act as a protective factor to help decrease a child’s risk of developing psychopathology while, insecure attachment increases a child’s risk of developing psychopathology (Becker-Weidman, Ehrmann & Lebow 2012).

**Parenting Self-Efficacy**

Research has been able to make a link between parenting stress and parenting self-efficacy revealing that lower self-efficacy is related to higher levels of stress (Kendall, Bloomfield, Appleton & Kazuyo, 2013). The results of one study conducted by Kazui (1997) suggested that parents improved in both parenting self-efficacy and parenting stress after attending a parenting program. The change in parenting stress was accounted for through the variation in scores on the difficult child scale, which might suggest that the social expectation to raise good children has an impact on mother’s well-being (Kendall, Bloomfield, Appleton & Kazuyo, 2013). Consequently, perceived cognitive and emotional coping strategies may be a valuable context of prevention and intervention that play an important role in the relationship between the experience of negative life events and the reporting of symptoms of depression and anxiety (Garnefski, Kraaij, & Spinhoven, 2001). The ability to regulate our emotions is a key factor in well-being or successful functioning (Cichetti, Ackerman & Izard, 1995 & Thompson, 1991). It can also help parents to build healthy attachment bonds with their children.

**Cognitive Emotion Regulation**

There is a great deal placed on our ability to successfully regulate our emotions
Emotion regulation can be connected to a wide array of biological, social, behavioral as well as conscious and unconscious cognitive processes (Gross, 2007). Maturational changes in behavioral and physiological response systems involved in emotion play a fundamental role in the development of emotion particularly in infancy and early childhood (Gross, 2007 pg. 5). Therefore, when parents are unable to regulate their emotions this may contribute to poor regulation of emotions in their children (Gross, 2007; Schore, 2001; & Hughes, 2009). These negative patterns interfere with building secure parent/child attachments in low SES parents and increases instability and poor decision making in parents. It also leads to higher attrition rates in psychotherapy (Hamilton, Moore, Crane & Payne, 2011). Marriage and family therapists may be able to provide additional support to parents by partnering with community organizations. Utilizing EB parenting practices and offering a more personalized coaching approach may also contribute to the improvement of retention rates and better promote protective factors (i.e., secure parent/child attachments) for high-risk families being examined in this study.

**Interventions and Community Partnerships to Help High-Risk Families**

High attrition rates in psychotherapy pose a major problem for mental health care professionals (Hamilton, Moore, Crane & Payne, 2011). Early termination can result in poorer outcomes, diminished cost-effectiveness and efficiency of treatment (Pekarik, 1985). Common factors associated with premature therapy termination results indicate that variables such as ethnic minority status (Kazdin, Holland, & Crowley, 1997), race (Huey, 1999), socioeconomic status (Kazdin et al., 1997), and severity of symptoms
(Kazdin, 1990) are associated with higher dropout rates (Hamilton, Moore, Crane & Payne, 2011). The high dropout rate in psychotherapy is a critical factor that needs to be addressed to help high-risk families to thrive.

Marital and family therapists working with distressed families need to find better approaches to increase retention for high risk families and develop interventions that reduces stress and target intermediates to be effective with high-risk families (Hackman et al., 2010) as mentioned earlier in chapter one (e.g., MST, PCIT, Incredible Years and PMT). Partnering with community organizations and providing personalized coaching may prove to increase retention outside of traditional family or individual therapy for high risk parents and help parents faced with multi-stressors to overcome adversity and be more successful.

Marital and family therapists can also apply techniques to improve parental mental health during pregnancy and early childhood, provide psycho-education regarding healthy parenting techniques and help to reduce stress, refer community resources, increase parent coping tools, and use therapy to facilitate the building of stronger attachment relationships between children and parents so the effects of chronic stress are minimized (Patterson & Vakili, 2014). Current literature demonstrates multiple resources are sometimes necessary to affect relational change in families (Patterson & Vakili, 2014). Parenting programs can be considered to be a supportive, valuable resource to parents. Parent training programs are also identified as the most effective intervention strategy for promoting changes in parents, including enhancing their knowledge, confidence and skills (Sanders, 2012).
Although the use of parenting interventions is documented as far back as the early 1800s (Sherrets, Authier, & Tramontana, 1980), parenting programs began in the 1960s and parent-training groups began in the 1970s (Barlow, Coren & Brown, 2002). Research published on the effectiveness of programs targeting abusive and neglectful families was not found prior to 1981 (Wolfe, Sandler, & Kaufman, 1981). Almost two decades later, Morrison Dore and Lee (1999) reported “a scarcity of well-designed outcome studies” in the child welfare literature (p. 314). Since that time, the research around parenting interventions has begun to increase, albeit gradually, and without adequate methodological rigor (Hodnett, Faulk, Dellinger & Maher, 2009). Nevertheless, there is a growing body of evidence that early start parenting programs that are EB can offer long-term changes that will positively impact the parent and the parent/child relationship biologically, cognitively and socio-emotionally (Adams, 2001; Campbell et al. 2002; Crane & Barg, 2003; Perez-Blasco, Viguer & Rodrigo, 2013; Webster-Stratton and Reid, 2005).

**Evidence-Based Parenting Programs (EBPPs)**

Early childhood policy and program development indicates that EB interventions can significantly improve life outcomes (Shonkoff, 2010; Allen, 2011). It is recognized that parenting programs enhance parents’ relationships with their children and their understanding of child development (The Centre for Social Justice, 2010). Although there is a variety of parent educational and family support programs, only a selected amount of these programs have been formally evaluated. Those that are based on in-depth research are not generally available (Taylor & Biglan, 1998). Many services
continue to use non-evaluated parenting and family support programs (Webster-Stratton & Taylor, 1998). If parents access programs that are not tested that provide ineffective services or strategies without adequate support, they may conclude that interventions “do not work” (Patterson & Chamberlain, 1994) and may be less likely to seek further help or become more resistant to therapeutic suggestions (Turner & Sanders, 2005).

For that reason, the author evaluated evidence based programs or practices that are comparable to the “Nurturing Parenting Program” being examined in this study. The terms empirically based or evidence-based refer to interventions that have undergone rigorous efficacy research (Turner & Sanders, 2005). Concerns have been expressed about the generalizability of efficacy research findings to community settings (Weisz et al., 1995 & Weisz et al., 1992). This form of efficacy study should not be the sole basis for conclusions about empirical validity (Turner & Sanders, 2005). Hence, other select community parenting programs are mentioned that may not be classified as “authentic” evidence based programs. Due to the scarcity of literature on EB practices for implementing parenting tele-coaching interventions, if the parenting program or intervention entailed a coaching component the author may have included it as a part of the literature. A coaching component is salient to this study because tele-coaching will be examined in addition to the NPP being evaluated. Most parenting programs discussed in the current study met vigorous standards classified by the SAMHSA’s National Registry of Evidence Based Programs (NREBPP) and practices to be termed an “evidence-based program.”
Emotion-Coaching Parenting Programs

The aim of the emotion coaching prevention program is to improve emotion socialization practices in parents of young children (Wilson & Havighurst, 2012). The research findings of one study examined the effectiveness of Tuning into Kids (TIK) parenting program. The study had N=128 parents of children ages 4.0 –5.11 years that were recruited from preschools and randomized into intervention and waitlist conditions (Wilson & Havighurst, 2012). Parents in the intervention condition (n= 62) attended a six-session group-parenting program. They completed pre and post surveys before and 7 months after treatment. Parents reported on their emotion socialization beliefs and practices, other parenting practices, and on child behavior. In comparison to the control group intervention parents were significantly less emotionally dismissive in their beliefs, less dismissive and more coaching in their practices in response to children’s negative emotions, and more positively involved. Significant improvements were noticed in both conditions over time for parent-reported child behavior and teacher-reported social competence, compared to the waitlist group. New parenting program targeting emotional regulation and communication in parent-child relationships needs to be considered (Wilson & Havighurst, 2012).

Improving emotion socialization practices in parents by teaching parents the skills of emotion coaching and also targeting parents’ own emotion awareness and regulation has been proven to be a successful parenting technique (Kaminski, Valle, Filene, & Boyle, 2008). In a recently published meta-analytic review of interventions associated with parent training program effectiveness, the authors found strong evidence that included training in positive parent-child interactions while offering an opportunity for
parents to practice skills with their own child resulted in better parenting behavior outcomes and fewer child externalizing behavior outcomes (Kaminski, Valle, Filene, & Boyle, 2008).

**Mindfulness Based Stress Reduction Parenting Program**

Mindfulness Based Stress Reduction (MBSR) program is an EB training program that has become quite popular in current research. In recent years, this program constructed on mindfulness practices, has begun to yield positive results promoting well-being and reducing psychological distress, particularly, in the area of parenting and child education (Perez-Blasco, Viguer & Rodrigo, 2013). Mindful parenting entails living the experience of maternity–paternity with an attitude of unconditional acceptance toward one’s children, oneself as a mother/father, and towards other factors related to parenting (Perez-Blasco, Viguer & Rodrigo, 2013). Kabat-Zinn and Kabat-Zinn (1997) defined it as attending to and parenting children on purpose, in the present moment, and non-judgmentally.

Mindful parenting is thought of as a tool to encourage the formation of bonds of secure attachment (Siegel & Hartzell, 2003). In a randomized controlled trial, Vieten and Astin (2008) found that pregnant women that attended the mindfulness intervention group exhibited significantly less negative affect and anxiety than women in the control group. Research is recognizing the need for parenting programs to focus on parents being more aware of their own emotions (Perez-Blasco, Viguer & Rodrigo, 2013), thoughts, behaviors as well as regulating their emotions in a positive way to create secure parent/child attachments and promote well-being. The author’s goal of this study is to
implement a personalized tele-coaching intervention to help parents to self-reflect and create awareness about their own emotional and thought processes associated with (e.g., understanding child development, perceived parental self-efficacy, stress management, as well as parent child attachment and self-regulation) that negatively impacts the parent/child relationship.

**Comparative Analysis of Evidence-Based Parenting Programs**

In their seminal analysis of parent-training programs in child welfare Barth and colleagues (2005) made a compelling argument for the need to build the EB parent-training programs specifically utilized in child welfare agency settings. While behaviorally disordered children represent a portion of the child welfare population and these programs are a valuable resource to meet their specific needs, 60% of families involved in the child welfare system are facing allegations of parental neglect (i.e., including medical neglect), and 32% of all victims are age 4 years and under (Administration for Children and Families, 2007).

Four evidence based parent training programs, Parenting Wisely (Gordon, 2003), Project 12 Ways (Lutzker & Rice, 1984), STEP (Adams, 2001), and Nurturing Parenting (Bavolek, 2002), are identified as being commonly used in child welfare and possibly efficacious but lacking rigorous evaluation or implementation on a large enough scale within a child welfare system (Hodnett, Faulk, Dellinger & Maher, 2009). Lundahl, Nimer, and Parsons (2006) conducted a meta-analysis of parent education programs on the prevention of child abuse. An equivalent but expanded version was completed by Johnson, Stone, Lou, Ling, Claassen et al. (2006). Only three of the programs examined
in these reviews have been widely discussed in the literature regarding parenting programs designed for parents of young children involved in the child welfare system: The Nurturing Parenting Program (Bavolek, 2002), Project 12 Ways/SafeCare (Lutzker & Bigelow, 2002), and Triple P (Sanders, Cann, & Markie-Dadds, 2003). In another systematic review of parent training programs discussed for use with the populations in a child welfare system, Barth et al. (2005) developed a four-level rating system based on an integration of criteria established by Chambless and Hollon (1998) and the Cochran Collaborative (Clark & Oxman, 2003). The NPP and Project 12 Ways were each rated as having a Level 2 rating of demonstrated program effectiveness because studies were limited to quasi-experimental or single-subject designs with the target population (Hodnett, Faulk, Dellinger & Maher, 2009).

Although evaluations of these programs use standardized measures, such as the AAPI-2 (Bavolek, 2002) for the NPP and the Eyberg Child Behavior Inventory (Eyberg & Pincus, 1999) for Project 12 Ways, the methodology of the studies did not warrant a Level 1 rating due to a lack of clinical trials that included maltreated children with evidence of effectiveness. Similarly, of the 10 parenting programs rated by the California Evidence-Based Clearinghouse for Child Welfare, only two were rated at the highest level for relevance to child welfare, NPP and Safe Care. However, both were rated at a Level 3 (“Promising”) on evidence of effectiveness. The author of this study will take a moment to review these effective EB programs that current literature compares to the Nurturing Parenting Program being examined in this study.
SafeCare (SC) Program

The SafeCare (SC) model, originally known as Project 12-Ways, was developed as a home-based treatment of parents with children 0-5 years of age in child protective services (CPS) for child neglect (Lutzker, 1984). Research and intervention program provides parent training to families of children at-risk for maltreatment, and families of children who were victims of maltreatment (Hodnett, Faulk, Dellinger & Maher, 2009). Parents were trained in treating children illnesses and maximizing their own healthcare skills (health), positive and effective parent–child interaction skills (parenting), and maintaining low hazard homes (safety) (Gershater-Molko, Lutzker, Wesch, 2003). Statistically significant improvements were seen in child health care, home safety, and parent–child interactions (Gershater-Molko, Lutzker, Wesch, 2003). It uses a multi-faceted approach involving parental, social, and environmental factors (Gershater-Molko, Lutzker, Wesch, 2003). SC research (i.e., over 60 studies to date) suggests that the model is promising, however, the model has not been tested to date in a scaled-up field implementation (Hodnett, Faulk, Dellinger & Maher, 2009).

Nurse Family Partnership (NFP)

Another well-known program is known as the Nurse Family Partnership (NFP). This program offers prenatal and infancy visitation for low-income pregnant women and parents of young children (Old, 1998:2007). NFP provides prenatal and postnatal home visits to expectant mothers for two years. The three primary goals are (1) to improve pregnancy outcomes, (2) to improve children’s subsequent health and development, and (3) to increase mother’s personal development especially economic self-sufficiency. The
NFP conducted three randomized control trials (i.e., Elmira, NY; Memphis, TN; and Denver, CO). The results of the studies proved that nurses enhanced parents’ economic self-sufficiency, improved prenatal behaviors, pregnancy outcomes, maternal employment, relationship with partner and reduced child abuse, neglect, welfare and food stamp use (Old, 1998; 2007). While NFP research results prove to have great success, it is often not available to the public whereas, personalized tele-coaching may be a more convenient readily available option.

**The Triple P-Positive Parenting Program**

The Triple P—Positive Parenting Program is a multi-level, EB parenting and family support system that help parents with their children’s social and emotional development and decreasing behavioral challenges (Sanders, Turner, & Markie-Dadds, 2002). The parenting program utilizes concepts from social learning models that highlight the reciprocal and bi-directional nature of parent–child interactions (e.g., Patterson, 1982). It also incorporates many successful behavior change techniques identified through research in child and family behavior therapy (Sanders, 1996).

A meta-analysis encompassing all studies evaluating the impact of the Triple P-Positive Parenting Program on parent and child outcome measures was conducted in an effort to identify variables that moderate the program’s effectiveness. The results ($N = 55$ studies) indicate that Triple P causes positive changes in parenting skills, child problem behavior and parental well-being in the small to moderate range, varying as a function of the intensity of the intervention. The most salient findings of variables moderating the interventions’ impact were larger effects found on parent report as compared to
observational measures and more improvement associated with more intensive formats and initially more distressed families. The analysis clearly identified several strengths of the Triple P system, most importantly its ability to effect meaningful improvement in parents and children (Nowalk & Henrichs, 2008).

**Parent-Child Interaction Therapy (PCIT)**

Also worth mentioning is a parenting program known as Parent-Child Interaction Therapy (PCIT). PCIT is a 14- to 20-week, manualized intervention grounded in social learning and attachment theories designed for children between 2 and 7 years of age with externalized behavior problems (Eyberg & Robinson, 1983). PCIT is unique to other parenting programs because PCIT therapists coach parents to adjust their speech and behavior toward their children, and provide them with insight into their children’s behavior (Timmer, Urquiza, McGrath, & Zebell, 2005). A study by Chaffin, Silovsky, Funderburk, Valle, Brestan, et al. (2004) evaluated Parent-Child Interaction Therapy (PCIT) (Eyberg & Robinson, 1982). This is the only available study evaluating parent training using a randomized control design with a pure child welfare population to study the efficacy of the program in preventing re-abuse. The study involved 110 families randomly assigned to one of three treatment groups: The results indicated that PCIT reduced rates of future maltreatment among physically abusive parents. At follow-up (median time 850 days), 19 percent of the PCIT group had a re-report for physical abuse compared to 36 percent who participated in EPCIT and 49 percent who participated in the standard parenting group. Outcomes for child neglect did not show improvement by PCIT (Hodnett, Faulk, Dellinger & Maher, 2009). Adding a personalized tele-coaching
component may have proven to be beneficial in offering better overall results for this parenting program.

What is Tele-Coaching?

According to International Coach Federation (ICF) (2015) coaching has been defined as “an ongoing professional relationship that helps people to gain amazing results in their lives, careers, businesses, or organizations.” However, research surrounding the area of coaching is still extremely limited. While there is no specified approach to coaching, the International Coach Federation (ICF) (2015) explains that the coach typically does a personal interview (either face-to-face or by teleconference call) to assess the individual’s current opportunities and challenges, define the scope of the relationship, identify action items, and establish goals and outcomes the client is seeking. Consequent coaching sessions may be held in person or over the telephone, with each session lasting an agreed upon amount of time. To complete the coaching sessions the individual may be asked to achieve particular actions that support the accomplishment of one’s customized goals. Throughout the duration of the coaching the coach may provide additional resources to support the individual’s thinking and actions.

Tele-coaching is a form of coaching that was developed to provide customized support over the phone that results in positive outcomes in the privacy of one’s own home (Van Mierlo, Meiland & Droes, 2012). Tele-coaching includes the following components: goal setting, probing questions, a self-reflective process, affirmations, accountability, exploration of opportunities and challenges and relevant parent resources. Tele-coaching is a promising approach (Lingley & McGrath 2007; 2008) to add to
parenting programs as it may help promote behavioral health changes and also provide additional assistance to parents who may not benefit as much from traditional parenting programs.

**Research on Tele-Coaching Interventions**

Health professionals are realizing the advantages of tele-coaching in comparison to mental health professionals. A small amount of researchers have studied the effectiveness of tele-coaching (Lingley-Pottie, 2006; Lingley-Pottie & McGrath 2007; 2008; McGloin, Timmins, Coates & Boore, 2014; Collet, 2008). Outcome studies on tele-coaching has demonstrated that tele-coaching can be an effective alternative to service delivery.

**Health Coaching**

Health coaching has been explored across a number of health outcomes. For instance, health coaching facilitated an increase in personal control of health and built confidence in patients’ self-management of their diabetes. Patients felt really motivated and supported towards self-care. It embraces the principles of empowerment and warrants further evaluation in supporting long-term behavioral changes (McGloin, Timmins, Coates & Boore, 2014).

**Home-Based Phone Coaching Parenting Program**

University of Kansas and Notre Dame Researchers were the first to do a randomized controlled trial utilizing texting and phone calls to mothers who participated
in a home-based parenting program. The aim of this study was to prevent child maltreatment by showing parents a different more positive way to interact with their children. Parent coaches known as home visitors texted mothers twice a day, five days a week as well as calling them at least once a week with reminders and words of encouragement and suggestions of free community resources. The cell phone addition, had relatively large effects on parenting and improved the retention rate by 50% in comparison to the parenting group without the cell phone component (Carta, Lefever, Bigelow, Borkowski, & Warren, 2013). Mothers who received text messages were much more likely than the other mothers that participated in a traditional program to learn and use positive parenting strategies both immediately and six months after the end of the program. They were less depressed and less stressed in comparison to mothers in the control group or the mothers who received the traditional parenting training without the cell phone component. This study was the first to test the effectiveness of cell phones of increasing engagement in parenting programs and retention.

**Telephone – Administered Psychotherapy for Depression**

The authors of this randomized control trial conducted a 16-week telephone – administered cognitive-behavioral therapy (T-CBT) against a 16-week comparison group. They both administered therapy through the telephone. The comparison group administered supportive emotion focused therapy and conducted a 12-month follow up (Mohr, et al. 2005). Effectiveness of telephone-administered vs. face-to-face cognitive behavioral therapy for depression compared 127 participants to complete a 16-week telephone administered supportive emotion-focused therapy. Patients showed significant
improvement in depression and positive affect during the 16 weeks of telephone – administered treatment. The specific components of T-CBT produced improvements above and beyond the nonspecific effects of telephone-administered supportive emotion focused therapy on evaluator-rated measures of depression and self-reported positive affect. Attrition was also low (Mohr, et al 2005).

**Family Help Program**

A study known as the Family Help program also utilized a manualized, distance treatment by telephone. Participants in the Family Help program (both parent and child) have reported a strong therapeutic alliance with their telephone coach. Participants also described how during treatment sessions they felt comfortable and safe in their own home; they did not feel stigmatized or judged; they had little apprehension about self-disclosure and they felt that treatment was delivered at their convenience. Attrition rates were found to be very low and children actively engaged in the structured, distance treatment. Acceptance and integration of EB distance delivery is a promising approach to the delivery of mental health care (Lingley-Pottie & McGrath, 2007; 2008).

**Dementelcoach**

Dementelcoach is a new telephone intervention to support informal caregivers of community-dwelling people with dementia. The effectiveness of this intervention was evaluated on burden and mental health problems of informal caregivers (Van Mierlo, Meiland & Droes, 2012). A pre-test/post-test comparison group design was used with three groups of informal caregivers. Two of the groups were experimental and received
either (1) telephone coaching or (2) telephone coaching in combination with respite care (psychogeriatric day care); the third was a comparison group that received day care only. Trained coaches offered telephone coaching once every two to three weeks over a period of 20 weeks (Van Mierlo, Meiland & Droes, 2012). Informal caregivers who received telephone coaching in combination with respite care reported significantly less burden compared to caregivers who received tele-coaching only, and they experienced significantly fewer mental health problems than those who received day care only. Tele-coaching according to the principles of Dementelcoach combined with respite care (psychogeriatric day care) is more effective in reducing burden and health complaints in informal caregivers of community-dwelling people with dementia than tele-coaching or day care only (Van Mierlo, Meiland & Droes, 2012).

**Tele-coaching and Therapeutic Alliance**

In one study two researchers investigated whether a distance therapeutic alliance was studied to determine the effectiveness of children receiving manualized, cognitive-behavioral treatment via telephone, in the absence of face-to-face contact. The therapeutic alliance scores were measured in 55 child-parent pairs. Parent scores were significantly higher than child scores, though the dissimilarity may not be clinically meaningful. This study provides evidence that a strong therapeutic alliance does occur between child-coach and parent-coach pairs when treatment is delivered from a distance (Lingley-Pottie & McGrath, 2008).

The results of another case study revealed that telephone coaching could be as least as effective as face-to-face coaching. The results indicated that coaches may be able
to ensure that tele-coaching is effective by way of listening, using silence, using an ontological approach and paying attention to building relationships with their clients. Seventy nine percent of clients in the study were likely to accept phone coaching while 21% were likely to reject it or prefer face to face sessions when clients utilized the telephone coach (Collett, 2008).

New methods to service delivery are essential to decrease attrition rates. Distance delivery systems that do not include face-to-face communication are still questioned by some researchers due to uncertainty about a therapeutic alliance (Sanders & Rosenfield, 1998). Nonetheless, the overall evidence points to tele-coaching as a promising approach. Therapists, and the mental health field need to strongly consider tele-coaching as an alternative way to deliver services to enhance parenting programs as well as other therapeutic services for families. After ample research, and recognizing an obvious need for personalized interventions, the authors of this study chose to do an experimental design adding tele-coaching to an EBPP to determine the effectiveness of blending programs.

**Defining Tele-Coaching in this Study**

Tele-coaching in this study is an innovative approach that parents are able to experience in the privacy of their own home. The coaching session is 30-60 minutes weekly for the length of 16 weeks. The sessions are done entirely over the phone, following the introduction of the coach and coaching program in the parenting class. To engage in the program parents must be registered to attend the Nurturing Parenting Evidence-Based Parenting program, have at least one child from 0-5 years old, and
voluntarily agree to participate in the coaching program. The program has four phases that will encourage parents to create a paradigm shift (please see table 1 below) to embrace a new way of thinking, by helping parents to create understanding of their own attachment style and promoting secure attachments, foster positive emotions, and help parents interact with their child and/or partner, (if present) in a healthy way. The telecoach visited most classes in the beginning, middle and end to maintain a strong bond with parents and to remind parents of the value in coaching and the necessity of participating in the coaching sessions weekly to gain the best results.

The tele-coaching approach in this study utilizes a strength-based approach to help parents explore their own perceptions and cognitive distortions from their past, to make meaning while creating healthy patterns to foster safe, and secure attachment bonds with their children in the present. When parents create self awareness about the stories that they believe about themselves, through the use of reflective questioning, probing questioning and examining their own attachment patterns, parents will be able to increase self-efficacy and create balance by tapping into their biological, psychological, social and spiritual (BPSS) side to create meaning and awaken their purpose. They can be more empathetic towards themselves, more accepting of their pasts, and be present to address the needs of their children. By understanding their own family system they can move from the subconscious to the conscious mind and eventually experience a paradigm shift.

The tele-coach also serves as a form of accountability. She/he brings new information into the system by utilizing psycho-education, sharing current research on attachment patterns, family systems, creating awareness about the dangers of chronic stress and poor self-regulation and helping parents to achieve targeted goals weekly.
According to Bandura (1986:1989) creating self-awareness is also a key element to breaking the negative interactional cycle and creating a new healthy pattern with their children. However, it is not enough to just focus on areas that parents identify as their problem area because often times some of the behaviors that high-risk families engage in are considered “normal.” Often times severe consequences (i.e., such as losing their children or being ordered to parenting classes) may open up their eyes to the necessity of change. Tele-coaching is similar to post modern therapeutic approaches. It helps parents to co-create meaning and uses brainstorming through a collaborative approach to come up with solutions instead of focusing on problems. The intent is that the tele-coaching process is transformational for parents and that it will help them to write their new life story with new insight and live a healthier happier life. Tele-coaching is a convenient alternative approach added to an EBPP known as the Nurturing Parenting Program (NPP) to provide the necessary support that parents need to thrive.

**Nurturing Parenting Program (NPP)**

After appraising several EBPP, the author decided to evaluate the “Nurturing Parenting Program for this study.” This parenting program appeared to be the most feasible parenting program to supplement a wellness tele-coaching component. The Nurturing Program was developed from extensive clinical and empirical research by the author Stephen (Bavelok et al., 1979) in identifying and validating the parenting and nurturing needs of families exhibiting physical and emotional abuse. Activities, goals, and objectives focus on remediating distinct patterns of inappropriate parenting that lead to parent-child interaction difficulties. Attitudes were measured along five dimensions:
(A) inappropriate parental expectations, (B) lack of parental empathy, (C) strong belief in the use and value of corporal punishment, (D) reversing parent-child family roles, and (E) oppressing children’s power and independence. The NPP (Bavolek, 2002) is primarily based on social learning theory, with characteristics of attachment theory and family systems theory. The NPP program supports the widely accepted belief that most parenting patterns are systemic and learned during childhood and replicated later in life as the child becomes a parent (Hodnett, Faulk, Dellinger & Maher, 2009).

In developing a program to assess, treat, and prevent abusive parenting practices the Bavolek and colleagues (1999) completed a literature review to determine distinctive patterns or concepts of abusive and neglectful parenting. The core concepts that were identified around parental expectations of the child were: empathy regarding children’s needs, use of corporal punishment as a means of discipline, parent-child role responsibilities, and children’s power and independence.

In addition, the NPP included several characteristics associated with positive program outcomes, including teaching emotional communication and behavioral skills training and engaging both parents and children so parents can model learned skills with their own child. The programs are personalized in multiple ways, including matching the recommended intensity and duration based on family risk factors and the age of the child. The specific program for parents of infants, toddlers, and pre-school children focuses on parental self-awareness and empowerment, the development of empathy, understanding child development and the role of discipline, emotional communication, behavior skills training, the importance of nurturing routines, and making good decisions for child safety (Bavolek, 1985).
The author believes that the Nurturing Parenting program is the most appropriate selection for this study. It utilizes theories that the author will use for this study (i.e., social cognitive theory, attachment theory and family systems). Lastly, it offers a program that is geared towards parent populations with multi-stressors (i.e., high risk for child maltreatment or prior allegation of child maltreatment, low socio-economic status, and children in the age range of 0-5 years old) (Hodnett, Faulk, Dellinger & Maher, 2009) which, is the targeted population for this current study. While, many EBPPs tend to be somewhat effective, none of the prominent EBPPs to date has tested the effectiveness of their program with the addition of a tele-coaching component. The aim of this study is to incorporate a personalized tele-coaching component to an EBPP (i.e. Nurturing Parenting program), to explore if there are significant increases in effectiveness when a tele-coaching component is added to a parenting program.
CHAPTER FOUR

METHODS

“Every child you encounter is a divine appointment.” - Wess Stafford

The purpose of this study was to conduct a pilot study using an experimental design (randomized control trial) designed to explore if a 16-week “Nurturing Parenting Program (NPP)” with a seven 45 minutes-1 hour case management sessions component (NPP+) would improve its effectiveness for low income, high need parents by adding a 30-60 minutes innovative personalized tele-coaching intervention. The randomized controlled trial design will allow us to test the comparative effectiveness of NPP+ vs. NPP+ case management. Of note, NPP+ (control group) was already being offered to parents in community settings and only the addition of the tele-coaching intervention was delivered as an augmentation by the researcher. However, data collection for both groups was designed by and overseen by the researcher.

Participants

A total of 57 parents with children between the ages of 0-5 years of age participated in either one of the 9 intervention or control groups that consisted on average of 5-8 parents per group. For the purposes of this study a participant consisted of at least one caretaker (i.e., parent, step-parent or primary caregiver with at least one child between the ages of 0-5 years of age). Random assignment occurred by community program delivery site. The majority of the parents derived from low SES backgrounds and was considered to be at risk for child maltreatment. The household income for participating parents was less than 125% ($29,813) of the federal poverty guideline for a
family of four (USDHHS, 2015). Approximately 50%-60% of the families attending parenting sessions were court ordered due to prior alleged child maltreatment or were recommended by the court to gain parenting skills for custody or prior allegation. Most parents that participated in the study were Hispanics though we also had Blacks, Whites, Asians or Multiracial parents.

A power analysis was conducted to determine the sample size needed to find significant differences between the groups. It was discovered that with an effect size of .02 and a power of .80 an acceptable sample size is n=108. Since we however decided to conduct a feasibility pilot study power was not a major concern. However, in the end we had strong enough effects that a lower sample size was able to answer our research question.

While the criterion for the study was at least one parent/caretaker had to attend the parenting classes to be included in the study, we did not exclude couples from the study. The intent of this study was to promote positive change in the parent/child relationship that includes the family system. However, to decrease attrition rates the agreed upon parent(s) needs to be consistently present to partake in the tele-coaching intervention.

**Procedure**

Participants for each of the sites were recruited by the collaborating agency “REACH OUT.” REACH OUT is a community service organization that partners with many organizations throughout Southern California to offer services to parents with children between the ages of 0-5 to deliver the NPP. The agency agreed to a randomized design by site-in other words, some sites randomly received NPP+ alone, and others
NPP+ augmented by tele-coaching (see letter in Appendix). As part of the agreement the author attended a 3-day facilitator-training workshop conducted by the originator of Nurturing Parenting Program (Bavelok, 1979) to gain knowledge and understanding about the program being tested and also became a certified facilitator. The training provided me with:

- A strong understanding of the Nurturing Parenting Program (NPP)
- Overall goals and objectives of NPP
- Understanding of NPP Competencies and Curriculum
- Systemic Approaches Utilized (evaluation, tools, recruitment procedures)

**Study Design**

A total of nine groups (sites) were randomly assigned to either the 16 session NPP+ or the NPP+ augmented by tele-coaching (30-60 minutes over the phone coaching for each of the 16 weeks of NPP). If the participant was absent for a tele-coaching session the session was either made up on another day of the week, or two sessions were combined in the upcoming week. To be considered “completers” parents had to attend at least 12 out of the 16 sessions to graduate from the tele-coaching program. While the parent may have missed a session due to unexpected life circumstances, the missed session required a make-up session to ensure that each parent received the required doses of tele-coaching. All parents enrolled in the study (intervention and control) were also asked to complete a series of self-reported measures that provided information on the parent and the parent-child interactions.
The study utilized a longitudinal design with two time points (i.e., pre-test and post-test) to determine program outcomes over time. The study was completed at the various “REACH OUT” locations throughout Southern California. The researcher gained approval from the Loma Linda University Institutional Review Board (IRB) prior to the start of the study. As part of the enrollment active consent was obtained from parents after study, purpose, procedures, risks and confidentiality were explained. Whether participants received the personalized tele-coaching component or not, every participant included in the study had to complete pre and post surveys. In intervention and control group participants received gift cards as a small token of appreciation to encourage them to complete all coaching sessions and/or all surveys. Also, all participants that competed the study qualified to have their name drawn in a raffle to receive and I-pad at the completion of the study. All participants were assigned an ID number to link the data and all analyses were conducted on the de-identified data set that was linked only by an ID number.

Program Descriptions

Table 1 on the next page provides a brief description of what occurs in both NPP and the personalized tele-coaching each week. It also provides what theories the lesson is being influenced by. First parents would attend parenting class on the assigned day and sometime during the week parents would also receive a call from the tele-coach prior to the next parenting class.
### Table 1. Description of NPP and Tele-coaching Intervention.

<table>
<thead>
<tr>
<th>WEEK</th>
<th>Nurturing Parenting Program</th>
<th>Personalized Tele-Coaching</th>
<th>Theory Being Influenced By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>Introductions, Hopes and Fears, Program Description, Nurturing as a Lifestyle</td>
<td>Introduction, Evaluation, Program Description, and Hopes and Fears: Desired Goals</td>
<td>Social Cognitive Theory</td>
</tr>
<tr>
<td>Week 2</td>
<td>Nurturing Parenting: Children Brain Development</td>
<td>Brain/Child Development, Parenting Style &amp; Parent-Child Bonding and Attachment</td>
<td>Attachment Theory</td>
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<td></td>
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<td></td>
<td>Family Systems/BPSS</td>
</tr>
<tr>
<td>Week 3</td>
<td>Building Parent-Child Bonding and Attachment: Developing Empathy in Children</td>
<td>Adverse Childhood Experiences</td>
<td>Attachment Theory</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Family Systems/BPSS</td>
</tr>
<tr>
<td>Week 4</td>
<td>Expectations and Development of Children: Infants, Toddlers and Preschoolers</td>
<td>Understanding and Breaking Generational Patterns</td>
<td>Attachment Theory, Family Systems/BPSS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social Cognitive Theory</td>
</tr>
<tr>
<td>Week 6</td>
<td>Improving Children’s Self-Worth; Praising Children and Their Behavior</td>
<td>A Holistic Approach to Wellness</td>
<td>Social Cognitive Theory</td>
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<tr>
<td>Week 8</td>
<td>Developing Family Morals and Values; Developing Family Rules</td>
<td>Stress Management</td>
<td>Family Systems</td>
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<td></td>
<td></td>
<td></td>
<td>Social Cognitive Theory</td>
</tr>
<tr>
<td>Week 9</td>
<td>Rewarding Children and Their Behavior; Punishing Children’s Behavior</td>
<td>Relaxation Techniques</td>
<td>Family Systems</td>
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<td></td>
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<td></td>
<td>Social Cognitive Theory</td>
</tr>
<tr>
<td>Week 10</td>
<td>Recognizing and Handling Feelings; Helping Your Children Handle Their Feelings</td>
<td>Self Awareness and Regulating Emotions</td>
<td>Social Cognitive Theory</td>
</tr>
<tr>
<td>Week 11</td>
<td>Establishing a Nurturing Bath Time Routine; Establishing a Nurturing Bedtime Routine</td>
<td>Conditioning Your Brain to Create New Healthy Responses</td>
<td>Attachment Theory</td>
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<td></td>
<td></td>
<td></td>
<td>Social Cognitive Theory</td>
</tr>
<tr>
<td>Week 12</td>
<td>Possessive and Violent Relationships; Keeping Our Children Safe</td>
<td>Creating Customized Systems and Routines</td>
<td>Family Systems</td>
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<td></td>
<td></td>
<td></td>
<td>Social Cognitive Theory</td>
</tr>
<tr>
<td>Week 13</td>
<td>Understanding and Handling Stress; Helping Children Manage their Behaviors</td>
<td>Goal Setting Part I</td>
<td>Social Cognitive Theory</td>
</tr>
<tr>
<td>Week 14</td>
<td>Managing Anger; Alternatives to Spanking</td>
<td>Goal Setting Part II</td>
<td>Social Cognitive Theory</td>
</tr>
<tr>
<td>Week 15</td>
<td>Families and Alcohol; Keeping Kids Drug Free; Smoking and My Child’s Health</td>
<td>My New Life Story</td>
<td>Family Systems Theory, Social Cognitive Theory</td>
</tr>
<tr>
<td>Week 16</td>
<td>Hopes and Fears, Review Closing Activity</td>
<td>Reflection: Graduation and Certificate of Completion</td>
<td>Social Cognitive Theory</td>
</tr>
</tbody>
</table>

**Primary Research Question**

Can adding a 30-60 minute personalized tele-coaching to the 16-week “Nurturing
Parenting Program+ ” offer better results for low SES families of same backgrounds?

**Hypothesis**

Adding a 30-60 minute personalized tele-coaching to the 16 week Nurturing Parenting Program+ results in better outcomes for low SES families of same backgrounds in comparison to attending a 16 week parenting group without such a personalized coaching?

**Data Collection**

The researcher collected data at two time points for each of the participating groups at the various NPP locations. The data was collected at the beginning and at the end of the program. After the data was collected, it was analyzed to determine if there was a significant difference.

**Data Entry and Management**

All analyses were conducted utilizing the statistical program known as SPSS 23.0. Once data was collected, it was entered into a data entry shell. Descriptive data analysis screening occurred prior to data analysis to determine whether the data was appropriate for further statistical analyses. The researcher identified missing data, linearity, homogeneity, homoscedasticity and outliers (Tabachnick & Fidell, 2013). Kurtosis and skew figures within a range of -2 and +2 were acceptable values (Fields, 2009). To limit missing data the researcher checked the accuracy of the data and made sure all surveys were completed in totality. When missing data occurred it was determined whether it was
missing systematically, missing completely at random or missing at random (Mertler & Vanatta, 2010). If the missing data was less than 5% the appropriate method to address this issue of missing data was decided upon by the researcher (Fields, 2009; Mertler & Vanatta, 2010), but usually included missing data imputation.

**Data Analysis**

Once data was entered and cleaned, scales were constructed as published. Generally speaking we explored scale fit (compared to published data) by obtaining Cronbach alpha statistics for each published scale. Multicollinearity between scales was explored before univariate analyses proceeded. Based on the research questions we assessed changes between each time point of the study using t-tests for within and ANOVAS for across groups (intervention vs. control) to explore if results were maintained over time. To determine if observed were contributable to baseline demographic differences, we explored differences between the intervention and control group. For variables that were statistically different, we then controlled for these by using ANCOVA to explore study results. It is often possible that one or more variables may impact the dependent variable. ANCOVA provides researchers with an approach that allows us to more appropriately analyze data collection especially in social science environments (Merther & Vanatta, 2010).

**Exploratory Factor Analysis (EFA)**

This statistical method is used to uncover the underlying structure of a relatively large set of variables. EFA is a technique within factor analysis whose overarching goal
is to identify the underlying relationships between measured variables and determine if the variables measured share commonality (Mertler & Vanatta, 2010).

**Confirmatory Factor Analysis (CFA)**

This test is a statistical technique that explores the underlying structures that a researcher is attempting to understand. This test was applied in this pilot study to help the researcher determine the extent to which measurement overlap also known as shared variance exists among a set of variables. The ultimate goal was to determine whether measures for different variables were in fact, measuring the same construct. The advantage of confirmatory factor analysis is that researchers can attempt to measure variables that are unobservable (Mertler & Vannatta, 2010; Tabachnick & Fidell, 2013).

**T-Tests**

Our variables were collected over two time points (Babbie, 2013). A paired t test or repeated measures t-test was therefore used to examine the difference within groups over time on the variable of interest. Before paired t-tests were completed it was important to ensure that the data met the assumptions of this test: Normal distribution and independence of observation (Field, 2009) before building the model to ensure that the data was ready for analysis. The assumptions included: Multicollinearity, homoscedasticity, independent errors, the independence of values, and normal distribution errors and linearity (Field, 2009). We ran descriptive statistics on all variables and checked the assumptions.
ANOVA

This tests if the two groups differed for our outcome variables over time we conducted ANOVA analyses. Before an ANOVA is conducted, the data needs to meet certain assumptions required by this test: Normal distribution and variances of populations is equal and independence of observation (Field, 2009). This longitudinal design involves the collection of data at different time points (i.e., repeated measures) (Babbie, 2013). Two time points were measured (i.e., pretest and posttest). Using the test and retest approach in a longitudinal study helps to add validity and reliability to the study (Greenstein, 2006: Babbie, 2013).

Program Evaluations

This study included two evaluations. An outcome evaluation was conducted at the beginning of the study to determine the relative program effectiveness of adding a personalized tele-coaching intervention and a process evaluation to attempt how the additional intervention (tele-coaching) was experienced/received by participants (Rossi et al., 2004; Patton, 2012). The outcome evaluations reflected the impact or sought after changes of the program (Williams-Reade, Gordon, Wray, 2014). For the purposes of this study the outcome evaluation was utilized based on the pre and post results in the Nurturing Parenting Plus Program versus the personalized tele-coaching intervention. However, since this was real life implementation it was critical to observe the program as it was being implemented, for that purpose a process evaluation was included.

Process evaluations were conducted to describe the program and capture data necessary to evaluate the intensity and reliability of service delivery and seek to
understand what occurred in the program with the target population (Williams-Reade, Gordon, Wray, 2014 pg 294). For the purposes of this study the process evaluation measured dose, gained program feedback at the end and kept record notes to determine if any external influences impacted the outcomes.

**Measures**

There were several surveys included in the study. Since the NPP is already an EB intervention we mostly utilized the scales usually used to determine program outcomes for NPP. Thus, the surveys mostly consisted of normed scales and their psychometrics are described later in this section. Additional scales and questions were identified based on the tele-coaching aims of the study. For example, Bandura (2006) suggested that efficacy scales should not be generalized because there is no all-purpose measure of perceived self-efficacy. We therefore tailored our self-efficacy questions to the parenting outcomes targeted (Bandura, 2006). On the Cognitive-Emotion Regulation questionnaire (CERQ) scale (Garnefski, Kraaij & Spinhoven, 2001) the survey was also adapted because several of the sub-constructs did not fit the objective of this study (see Appendix for detailed documentation of all measures).

**Independent Variables - Parent/Child Characteristics**

The independent variables are divided into parent/child characteristics including demographics, parent participation, and child participation. These variables were selected for inclusion into the model because they are hypothesized to be associated with the outcome and/or were variables of interest to see how outcomes stemming from the
intervention may or may not be different for different types of participants.

**Gender**

Gender is defined as the participant’s sex. The dichotomous variable is coded as 1 for female and 0 for male. The TIPS data were the most complete source of information. The AAPI-2 data contains client self-report of gender.

**Education**

Education was derived from participant self-report on the pre-intervention AAPI-2. We created a dichotomous variable with ‘1’ indicating high school graduate or higher and ‘0’ for less than high school graduation. The variable was constructed from participant self-report on the highest grade completed from the following list of responses: grade school, 7th grade to 11th grade, high school graduate, some college, college graduate, and post-graduate or above.

**Income**

Income was derived from participant self-report on the pre-intervention AAPI-2. Participants were asked to indicate their current household income by selecting from the following list of responses: under $15,000, $15,001 - $25,000, $25,001 - $40,000, $40,001 - $60,000, and over $60,000.

**Marital Status**

Marital status is defined as whether the participant reported having a partner or not. This dichotomous variable was coded ‘1’ for participants with a partner (married,
unmarried partner, or common law partner) and ‘0’ for participants who reported no
partner (e.g., divorced, single, separated, widowed, and other).

**Parent History of Child Maltreatment as a Child**

This dichotomous variable abuse by family member was coded ‘1’ for yes and ‘0’
for no. The AAPI-2 was the source of this item. Participants completing the AAPI-2
instrument were asked to respond to the following question: As a child, did you
experience any type of abuse by a person within your family? This dichotomous variable
abuse outside the home was coded ‘1’ for yes and ‘0’ for no. Participants completing the
AAPI-2 instrument were asked to respond to the following question: As a child, did you
experience any type of abuse by a person living outside your family?

**Dependent Variables**

A dependent variable is the outcome variable. Parenting scores will be the
outcome variable in this study. The definitions are provided below of all dependent
variable scales.

**Adult Adolescent Parenting Inventory (AAPI -2A and 2B)**

The NPP uses the AAPI-2 to evaluate changes in parental attitude from the
beginning of the group to the end of the group and after a 3-month follow-up. The AAPI-
2 is an assessment of parenting and child-rearing attitudes based on research of abusive
and neglectful parenting behaviors. The AAPI-2 attempts to measure parenting attitudes
across five parenting constructs derived from theory, research, and practice (Bavelok,
The AAPI-2 A and B inventories are each comprised of 40 5-point Likert scale items of Strong Agreement to Strong Disagreement. Content validity was evaluated by submitting the items to professionals in different fields to review the items and rate them for clarity, construct fit, and respond to the items. The resulting inventories were administered by 53 different agencies in 23 states. Factor analysis (FA) confirmed five subscales with internal consistency estimates (Cronbach’s alpha) for the A and B variants ranging from .83 to .98 and ranging from 1 to 7. There are two versions of the AAPI-2. Each version contains 40 items. Each of the 40 items is associated with one of five parenting constructs. Each item on the instrument is scored from 1 to 5 to indicate degree of agreement with the item. Specific item responses are reverse-coded therefore, all items within a construct are consistently scored to represent more or less positive parenting attitudes. These responses are then summed to generate the raw score. A higher raw score is interpreted to represent a more positive parenting attitude, which is also associated with a lower risk of engaging in abusive behavior. The description of each construct and corresponding raw score range are as follows: Subscale A Inappropriate Parental Expectations 7 to 35; Subscale B Parental Lack of Empathic Awareness of Children’s Needs 10 to 50; Subscale C Strong Belief in Use and Value of Corporal Punishment 11 to 55; Subscale D Parent-Child Role Reversal 7 to 35; Subscale E Oppressing Children’s Power and Independence 5 to 25 (Bavolek et al., 1979; Bavelok, 2002) (see Appendix).

**Cognitive Emotion-Regulation (CERQ)**

The CERQ was developed in 1999 both on theoretical and empirical bases and
was the first questionnaire explicitly measuring the specific cognitive emotion regulation strategies participants use in response to the experience of threatening or stressful life events (Garnefski, Kraaij, & Spinhoven, 2002b). The CERQ is a 36-item questionnaire, consisting of 9 conceptually distinct subscales, each consisting of four items and each referring to what someone thinks after the experience of threatening or stressful events: e.g., Self-blame, Other-blame, Rumination, Catastrophizing, Putting into Perspective, Positive Refocusing, Positive Reappraisal, Acceptance and Planning.

The CERQ can be used to measure cognitive strategies that characterize the individual’s style of responding to stressful events as well as cognitive strategies that are used in a particular stressful event or situation, depending on the nature of the questions under study (Garnefski, Kraaij, & Spinhoven, 2002b). The CERQ is designed to be a self-report questionnaire that can be administered to anyone above the age of 12. Items are measured on a 5-point Likert scale ranging from 1 ((almost) never) to 5 (almost) always).

The psychometric properties of the CERQ have decent (Garnefski, Baan, & Kraaij, 2005; Garnefski et al., 2002b; Kraaij et al., 2003), Cronbach’s alpha coefficients in the range of .70 to slightly over .80. Additionally, the CERQ has been shown to have good factorial validity, good discriminative properties and good construct validity (Garnefski et al., 2002b). A short scale version of the CERQ was constructed to provide an option to researchers that wanted a brief standardized measurement tool. Nine two-item subscales remained, leaving the original distinction into nine conceptually different scales intact. Reliabilities, means and standard deviations of the short scales Cronbach’s alpha reliability coefficients were calculated for the two-item subscales of the CERQ
(CERQ-short). Alpha reliabilities for the CERQ-short subscales were acceptably high. The lowest alpha was found for Self-blame (.67). All other alphas ranged from .73 to .81 (Garneski, Kraaij, & Spinhoven, 2001).

For the purposes of this study the author modified the short scale version and maintained five out of nine subscales. In addition, the author reduced the nine four-item subscales to four subscales sustaining four items on each scale and one subscale sustaining two items to prevent additional strain on the participants due to multiple measurements. According to current research the author utilizes a strength-based approach to focus on protective factors for this study instead of risk factors resiliency (Walsh, 2006; 2012). Therefore, the author selected positive subscales in comparison to negative subscales (e.g., focus on thoughts of rumination, positive refocusing, refocusing on planning and putting into perspective). A factor analysis will be conducted to verify that the items on the subscales correlate well after modifications have been made in this study (see Appendix).

**Self-Efficacy Questionnaire**

According to Bandura’s (2006) self-efficacy guide the self-efficacy belief system is not a global trait but a discriminated set of self-beliefs connected to dissimilar realms of functioning (Bandura, 2006). There is no all-purpose measure of perceived self-efficacy. The “one measure fits all” approach usually has limited descriptive and predictive value since many of the items in an all-purpose test may have minimal or no relevance to the domain of functioning (Bandura, 2006). Scales of perceived self-efficacy must be tailored to the particular domain of functioning that is the object of
interest (Bandura, 2006).

The efficacy scale is measured with a response format from 0-100 to make it stronger in predictor of performance than one with a 5-interval scale (Pajares, Hartley, & Valiante, 2001). Preliminary instructions should establish the appropriate mindset that participants should have when rating the strength of belief in their personal capability. People are asked to judge their operative capabilities as of now, not their potential capabilities or their expected future capabilities with increments of 10 from 0 to 100 with 0 being low (not confident at all) to 100 being high (very confident). There are 3 subscales (personal/stress management, parenting, goal setting/future planning) (see Appendix).
CHAPTER FIVE
A TELE-COACHING INTERVENTION TO IMPROVE
PARENTING OUTCOMES: EXPERIMENTAL MIXED-METHOD DESIGN

Approximately 700,000 children are victims of child maltreatment (CM) annually (USDHHS, 2014). There is a great need for alternative community mental health support programs to help high needs low-income parents to thrive. Several evidence-based parenting programs (EBPP) help parents to gain new knowledge and techniques to improve parenting skills, however new research suggests that for high-risk parents augmented higher dose programs that provide additional support and resources may be needed to help parents to succeed. One alternative support program that may be combined with an EB is tele-coaching. Tele-coaching is an innovative approach that may help with parent program retention rates while providing the necessary support that parents need to thrive. Using a randomized control pre, post-test design with 57 participants, we explored if an EB program, the Nurturing Parenting Program (NPP) plus case management (+) would be more effective if we added tele-coaching after each of the 16 NPP+ group sessions. Using standardized measures we found that NPP+ was equally as effective as NPP+ plus tele-coaching. Using our process evaluation, we however found that most participants appreciated the additional learning and reiteration of content from the individual coaching session and the flexibility of the approach. Moreover, tele-coaching was well received and the researcher recommends this type of program to others. Future studies should explore if NPP with case management is as effective as NPP plus tele-coaching given the reduced burden and increased flexibility of the approach.
**Keywords:** parent-child attachment, high-risk parents, parenting programs, self-efficacy, chronic stress, tele-coaching, child-maltreatment, poverty
Background

Over 3 million child abuse referrals are reported annually with approximately 700,000 children being substantiated as victims of child maltreatment (USDHHS, 2014). Child maltreatment (CM) is one of the leading causes of death among children under the age of five in America (USDHHS, 2014). Maternal neglect is a universal public health challenge with serious long-term effects on child health and development (USDHSS, 2010). When parents live in poverty with high levels of chronic stress and report low parental self-efficacy (Kendall, Bloomfield, Appleton & Kitaoka, 2013) they tend to lack the necessary understanding of child and brain development, have poor self-regulation of emotions, and experience more difficulty parenting their children (Shonkoff et al., 2012). They are also more likely to have chronic stress and practice abusive forms of punishment that leads to insecure parent-child attachment patterns and an increase in child maltreatment (Conger & Donnellan, 2007; Shonkoff et al., 2012).

However, a positive parental response can alter a child’s attachment response pattern, which can positively change the composition of the brain (Begley, 2006). Low SES parents, who have a higher risk of engaging in child maltreatment, can benefit from the information taught in parenting classes in significant ways.

Conceptual Framework

Our study utilized strength-based conceptual approaches including Attachment focused family therapy (Hughes, 2007), Social cognitive theory (Bandura 2001; 2011) and Family systems theory (Minunchin, Colapinto & Minunchin, 2007) to help parents explore their own perceptions and cognitive distortions from their past, while creating
healthy patterns to foster safe, and secure attachment bonds with their children in the present. Through the tele-coaching process the hope is that parents will engage in a transformational experience and be empowered to write their new life story to live a healthier life and promote parent and child well-being.

The theoretical framework in this paper hypothesizes that there is a bilateral relationship between social cognitive theory, attachment theory and family systems theory. The theories in this study were selected to provide a holistic view of the individual development, parent-child and family relationship.

**Figure 1.** Conceptual Framework.

*Tele-coaching and Nurturing Parenting Program (NPP)*

While there are a number of EB parenting approaches, many are individual based and even those who are offered in groups that suffer from poor long-term attendance. Indeed, regular attendance in the parent program is often a challenge for high-need
parents. Alternative methods of service delivery are essential for the success of parents at risk for child maltreatment. Tele-coaching is an alternative form of coaching delivery that has been effectively used in a number of contexts including parenting with promising success (Carter et al., 2013; Lingley-Pottie & McGrath, 2007; 2008; Mohr, et al 2005; Van Mierlo, Meiland & Droes, 2012).

According to International Coach Federation (ICF) (2015) coaching has been defined as “an ongoing professional relationship that helps people to gain amazing results in their lives, careers, businesses, or organizations.” However, research surrounding the area of coaching is still extremely limited. Tele-coaching is a form of coaching that was developed to provide tailored support over the phone that results in positive outcomes in the privacy of one’s own home (Van Mierlo, Meiland & Droes, 2012). Tele-coaching includes the following components: goal setting, probing questions, a self-reflective process, accountability, exploration of opportunities and challenges and free parent resources.

Clearly more research is needed on how to best use tele-coaching to support promising programs that may suffer from poor retention or dealt with parents with complex needs. Thus adding personalized tele-coaching to EB parenting intervention can offer copious benefits. As it is delivered at the leisure of parents and thus more flexible than planned session, tele-coaching likely results in improving attendance and at the same time allows for further exploration of the material taught in parenting classes. It can be used to further address parents’ understanding of child development, increase parental self-efficacy, provide stress management tools, as well as increase parent/child attachment and self-regulation of emotions. Tele-coaching is a
promising approach (Lingley & McGrath 2007; 2008) to add to parenting programs as it may help promote behavioral health changes and also provide additional assistance to parents who may not benefit as much from traditional parenting programs. Overall, tele-coaching may provide parents the additional support needed to help increase current parenting program outcomes.

The Nurturing Parenting Program (NPP) was selected as a candidate to be augmented with tele-coaching. NPP was developed from extensive clinical and empirical research by the author Stephen (Bavelok et al., 1979) for parenting and families exhibiting physical and emotional abuse. The NPP (Bavolek, 2002) is primarily based on social learning theory, with characteristics of attachment theory and family systems theory. It is a program for parents of infants, toddlers, and pre-school children and focuses on parental self-awareness and empowerment, the development of empathy, understanding child development and the role of discipline, emotional communication, behavior skills training, the importance of nurturing routines, and making good decisions for child safety (Bavolek, 1985).

**H.O.P.E Wellness Tele-Coaching Program Added to NPP**

Helping Our Parents Excel (HOPE) was the wellness tele-coaching intervention added to the NPP+ program. The tele-coaching intervention consists of four phases. Each phase below consists of three to four sessions. The tele-coach is flexible and works with the client to gain the most out of the tele-coaching program. While all sessions are completed in the 16-week timeframe, accommodations are made for the parents to succeed. Incomplete sessions are either made up during the same week that the session
was missed, or in the following week. Providing parents with flexibility allows the parent to gain better outcomes and thrive in a supportive environment. A demonstration of the four-phase model is listed below.

*Overview of H.O.P.E Wellness Tele-Coaching Intervention*

**Phase I - Program Initiation: A Systemic Approach to Create Awareness**

In the first phase the tele-coach engages in a verbal evaluation to assess the parents’ expectation of the tele-coaching program and determine if there are any concerns about engaging in this experience. The tele-coach orients the parent to the program and explains what they can expect from the process, the tele-coach and what is expected of them. The tele-coach discusses any hopes and fears of the parents. The first phase introduces the program and utilizes psycho-education to help parents understand brain and child development through attachment patterns. Parents create self-awareness about their own family system by examining their own attachment style and in return makes a direct correlation to how it impacts their parenting. The tele-coach uses reflective questions to create awareness, and self-reflective activities to shift thoughts, emotions and behaviors.

**Phase II - Creating a Paradigm Shift**

Parents engage in a meaningful process to develop tools and techniques to promote change and begin the process of breaking generational patterns. The tele-coach help parents to understand their personal power to overcome any adversity. The tele-coach also helps parents to create awareness and increase self-efficacy by helping them to realize the impact of their thoughts and words. In Phase II parents also evaluate
themselves by learning how to assess their spirituality, physical and mental health, ability to nurture self and others and support systems. When working with the parents the telecoach specifically utilizes a biological, psychological, social and spiritual (BPSS) approach to create meaning (Hickey et al., 2005) and explore how effective the parents’ self-care systems are.

**Phase III - Self-Management and Development**

In Phase III the tele-coach help parents to reflect on the impact they are having on their children in comparison to the desired effect. The tele-coach reiterates the importance of consistency and making positive changes. When parents gain a better understanding of their emotions and engage in self-reflection through the use of reflective questions, they can create meaning and become more attuned to their triggers and emotional process to better regulate their own emotions and behaviors. As parents further explore the root cause of their stress and understand the perils of chronic stress they will recognize the importance of doing their best to live a healthier life. Parents also learn stress management and simple relaxation techniques that they can do almost anywhere. As parents become more attuned to the relationship between their brain and bodily reactions, and observe their triggers they can learn healthy ways to respond. We explore triggers that occur right before emotional reactivity and engage in a self-reflective process to create awareness and responsiveness. The goal is to promote a paradigm shift and encourage responsive behaviors by helping parents to slow themselves down before impulsively reacting in a negative way.

**Phase IV - Goal Setting and Creating a New Story**
The final phase of the H.O.P.E. tele-coaching program helps parents to reflect on their program experience. Parents evaluate their current systems and routines or absence thereof. The tele-coach collaboratively works with parents to give parents insight into what needs to happen differently and incorporate parenting tips and strategies learned throughout the program to create customized systems and gain favorable outcomes. Parents learn how to set S.M.A.R.T. goals. The acronym for a S.M.A.R.T. goal is specific, measurable, action oriented, realistic and time-bound (Issel, 2014). The tele-coach empowers the parent to tap into his/her personal power, be the parent he/she wants to be, embrace positive thoughts, words and action to gain better control of their lives and make better life choices and create a paradigm shift. Lastly, parents will write their new life story.

**Procedure**

Whether participants received the personalized tele-coaching component or not, every participant included in the study was asked to complete a pretest and a posttest. All parents in the study were also asked to complete a series of self-reported measures that provided information on the parent and the parent-child interactions. The study utilized a longitudinal design with two time points to determine program outcomes over time. The study was completed at the various “REACH OUT” locations throughout Southern California.

**Data Analyses and Ethics**

The researcher of this study utilized version 23.0 of SPSS to conduct the data
cleaning and data analysis including all descriptive as well as scoring and generating reliability coefficients for all measures. Approval from the Loma Linda University Institutional Review Board (IRB) was obtained prior to any data collection to ensure that research would be conducted in an appropriate manner. As part of the enrollment written consent was obtained from parents before the study started and the purpose, procedures, risks and confidentiality were explained.

Sample

The sample population included parents with children between the ages of 0-5 that are from high needs low income families. The participants were randomly assigned by site to one of nine groups (5 intervention groups and 4 control groups). All 57 participants in the study were between 21-45 years of age. The majority of the participants in both groups were 35 years of age or less with 86% (49) of the participants in the study being between 21-35 years of age. There were also more women in comparison to men in the study. Approximately 60% (34) of the participants were women and 40% (23) of the participants in the study were men. While the study consisted of various races (e.g., Hispanics, Blacks, Whites, Asians, Pacific Islanders, and Mixed) the majority of the participants were Hispanic. There was a total of 56.1% (32) Hispanics in the study with an equal number 10% (6) of Blacks, Whites, and Mixed participants in the study totaling 32% (18) participants. Participants had no more than five children. However, 74% (42) of the participants had two or less children. The educational level of the participants varied from 9th grade education to a post-graduate degree. Fifty-two percent (26) of the participants had no more than a high school degree.
and 47% (29) of the participants had at least started college. Remarkably, 34% (19) of the participants started college but did not finish. The participants were employed either (full or part time) or unemployed. Fifty-one percent (29) of the study population was employed and 45% (26) of the population was unemployed.

Interestingly, several parents felt uncomfortable answering questions about their total household income. At least 21% (12) checked unknown, while 46% (26) participants stated that their combined household income was $25,000 or less in line with the guidelines issued in 2016 by the Department of Health and Human Services (HHS) on the federal poverty level (FPL) for a household family of 4 earning less than $24,250. Thirty three percent (19) of the participants made more than $25,000 in combined household income. When questioned about being abused growing up 26% (15) of the participants reported that they were abused outside of their family and 73% (40) reported that they were not abused outside of their family in the past. On the other hand 33% (18) participants reported experiencing abuse inside of their family and 67% (37) reported that they did not experience abuse in their family (see Table 1 for all demographic information).

To ensure that both control and intervention groups had similar demographics we conducted demographic comparisons between the intervention and the control group. A chi-square test was completed for 8 categorical variables (i.e., gender, race, marital status, education etc.) (see Table 2 below) an independent t-test was also completed for 2 scale variables (i.e., number of children and age) and no significance noted. There were two significant differences noted between the control and the intervention group when conducting the chi-square test. Participants were statistically different for marital status
(married in comparison to single) $X^2(1) = 12.682, \ p < .001$ and with respect to a participant or spouse having military $X^2(1) = 7.104, \ p < .012$. In the control group 81% (21) participants stated that they were either married or unmarried partners while 19% (5) participants stated that they were single (never married, separated or divorced). In the intervention group 32% (10) of the participants were either married or unmarried partners while 65% (20) participants were single. In the control group 73% (19) participants did not serve in the military but 19% (5) participants said that either self or spouse served in the military, while in the intervention group neither participant or spouse ever served in the military thus, 100% (31) of the participants in the intervention group never served in the military (see Table 1).
Table 1. Sample Descriptive Characteristics.

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**Employment Status**

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<td>19.2 (5)</td>
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**Annual Household Income**

| Known                   | 19.2 (5) | 22.6 (7) | 23.1 (6) | 21.1 (12) |
| Under                   | 26.9 (7) | 25.8 (8) | 16.1 (5) | 26.3 (15) |
| $15,000                 | 7.7 (2)  | 29.0 (9) | 19.3 (11)| 19.3 (11) |
| $15,001-$25,000        |         | 7.7 (2)  | 29.0 (9) | 19.3 (11) |
| $25,001-$40,000        |         | 23.1 (6) | 16.1 (5) | 19.3 (11) |
| $40,000-$60,000        |         | 11.5 (3) | 3.2 (1)  | 7.0 (4)   |
| Over $60,000           |         | 11.5 (3) | 3.2 (1)  | 7.0 (4)   |

**Military**

| Known                   | 7.7 (2)  | 3.5 (2)  |
| No                     | 73.1 (19)| 100.0 (31)| 87.7 (50) |
| Yes, partner           | 7.7 (2)  | 3.5 (2)  |
| Yes, only me           | 11.5 (3) | 5.3 (3)  |

**Abused outside your family**

| Known                   | 15.4 (4) | 37.9 (11) | 26.3 (15) |
| No                     | 84.6 (22)| 62.1 (18) | 72.7 (40) |

**Abused in family**

| Known                   | 23.1 (6) | 41.4 (12) | 32.7 (18) |
| No                     | 76.9 (22)| 58.6 (17) | 67.3 (37) |
Table 2. Chi-Square Descriptive Table.

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<td>17</td>
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</table>

Note. Variables with significant values are shown as: \(p<.05\) \(p<.01\) \(p<.001\)***
The Nurturing Parent Program+ (NPP+):

Participants in the NPP+ had to complete all 16 sessions before the end of the program to receive a certificate of completion. The sessions were held once a week from one and a half to two and a half hours depending on location and class size. When children attended the NPP+ with their parent(s) weekly they were able to engage in a lesson conducted by another parenting facilitator in another room who helped the children to learn through play for the same duration of time as the parents’ lesson. The last 15 minutes of the program is a joint activity between the parent and the child to promote healthy bonding time. The program focus was to teach positive parenting techniques to improve parenting behavior and to help parents to develop nurturing parenting skills as an alternative to abusive and neglectful parenting and child-rearing practices.

Tele-Coaching Intervention

Participants in the tele-coaching intervention group had to complete at least 12 out of 16 phone coaching sessions. Participants with 4 or less sessions were discontinued from the tele-coaching program but still included in the analyses as we conducted intent to be treated analyses. Seventy-five percent (43) participants completed the requirements for the tele-coaching program. Twenty-five percent (14) participants discontinued the program. While both the control and intervention group were encouraged to complete the tele-coaching program, 29% (9) of the participants discontinued the tele-coaching and 71% (22) of the participants met the minimum requirement of twelve sessions, to complete the intervention group in the tele-coaching program. In addition, 16% (5) of the
participants discontinued the control group and 21 (84%) of participants in the control group completed the program (see Table 3 below).
Table 3. Number of Tele-coaching Sessions Completed.

<table>
<thead>
<tr>
<th>Control/Intervention Group</th>
<th>Number of Sessions</th>
<th>Frequency</th>
<th>%</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Control Group</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>(NPP+)</td>
<td>.00</td>
<td>5</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>Did not complete</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed 16 sessions</td>
<td>.00</td>
<td>21</td>
<td>84%</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>26</td>
<td>100.0</td>
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</tr>
<tr>
<td>Intervention Group</td>
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<tr>
<td>(NPP + Plus tele-coaching)</td>
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<td></td>
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<tr>
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<td>19.4</td>
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<td>4.00</td>
<td>3</td>
<td>9.7</td>
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<td>3</td>
<td>9.7</td>
<td>38.7</td>
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<tr>
<td></td>
<td>13.00</td>
<td>2</td>
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<td>25.8</td>
<td>71.0</td>
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<td>15.00</td>
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<td>9.7</td>
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<td></td>
<td>16.00</td>
<td>6</td>
<td>19.4</td>
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<tr>
<td>Total</td>
<td></td>
<td>31</td>
<td>100.0</td>
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</table>

Note: The table above demonstrates the amount of sessions completed and the frequency of session amounts in the 16-week tele-coaching program. Parents that participated in a minimum of 12 sessions completed the tele-coaching program. A total of 43 parents (75.4%) completed the overall program. Five (16%) out of 26 parents did not complete the control group and 21 (84%) out of 26 parents completed the control group. Nine (29%) out of 31 parents did not complete the intervention group and twenty-two (71%) out of 31 parents completed the intervention group.

Measures and Scale Cronbach’s Alpha Reliability Analyses

All Cronbach’s alpha reliability analyses were conducted on baseline data. Below is a brief description of measures (see Table 4 for more detailed statistics). As part of the outcome evaluation a battery of surveys were administered to participants in the study.
Measures included demographic measures (e.g., age, ethnicity, marital status etc. see Table 1) as well the Adult Adolescent Parenting Inventory 2 (AAPI 2A and AAPI 2B), Cognitive Emotion Regulation (CERQ) and Self-Efficacy (SE) scales and subscales to test the variables being observed in this study (e.g., understanding of child and brain development parent-child attachment, stress management, increased parental self-efficacy and self-regulation).

**Adult Adolescent Parenting Inventory (AAPI 2A-2B)**

The AAPI-2A is a 40 question Adult Adolescent Parenting Inventory on a 5-point Likert scale questionnaire including 5 subscales. Due to the fact that Subscale E had an unacceptable reliability score (α=.41), 5 questions on Subscale E were removed from the questionnaire. The total AAPI-2A questionnaire minus subscale E had 35 items with a Cronbach’s alpha reliability of (α=.86), and Subscale A, (α=.60) Subscale B (α=.69). Subscale C (α=.74) Subscale D= (α=.72). Overall the Cronbach’s alpha ranged from (α=.60-.86) all within an acceptable range. It was noted that the reliability scores in this study was apparently lower for the population being studied in comparison to the populations that the questionnaires were previously normed on in other states (Bavelok & Keene, 2010) that ranged from (α=.83-.98).

AAPI-2B is also a 40-question 5-point Likert scale questionnaire with 5 subscales. The 5 questions from Subscale E were also removed from the analysis due to an unacceptable Cronbach’s alpha score of (α=.33). The total AAPI-2B questionnaire minus subscale E had 35 items with a reliability of (α=.87). Subscale A, (α=.63) subscale B, (α=.75) subscale C (α=.72) subscale D (α=.67). All reliability scores ranged from
(α=.63-.87) for the population being studied in comparison to the populations that the scales were previously normed on in other states (Bavelok & Keene, 2010) that ranged from (α=.83-.98).

**Cognitive Emotion Regulation (CERQ)**

The CERQ was used to measure cognitive strategies that characterize the individual’s style of responding to stressful events as well as cognitive strategies that are used in a particular stressful event or situation, depending on the nature of the questions under study (Garnefski, Kraaij, & Spinhoven, 2002b). Items are measured on a 5-point Likert scale. The 36-item questionnaire with 9 subscales was modified and four were removed (i.e., self-blame, other blame, catastrophizing, acceptance). Since the author of this study was focusing on positive thinking in comparison to negative thinking the subscales that were primarily questioning participants about negative thoughts were removed and only those focusing on positive thoughts (e.g., positive reappraisal, ruminating and focusing on thoughts, refocusing on planning, positive refocus and putting it into perspective) remained. The five subscales were examined to determine the reliability of the remaining factors. The putting it into perspective subscale had an unacceptable reliability score of (α=.41) and the 2 items were removed from the questionnaire. The total CERQ questionnaire minus the subscale for putting it into perspective had a Cronbach’s alpha reliability of (α=.87). While the subscale for positive reappraisal had a Cronbach’s alpha reliability score of (α=.57), subscale 2 rumination focus on thoughts (α=.70), subscale 3 refocus on planning (α=.61) and subscale 4 positive refocus (α=.78). All CERQ reliability scores ranged from (α=.57-.78) in
comparison to the reliability scores for the population that the scales were previously normed on (Garneski, Kraaij, & Spinhoven, 2001) that ranged from (α=.67-.81).

**Self-Efficacy Scale (SE)**

There is no all-purpose measure of perceived self-efficacy. Scales of perceived self-efficacy must be tailored to the particular domain of functioning that is the object of interest (Bandura, 2006). The self-efficacy scale in this study was a 4-point Likert scale. After the questions were developed a factor analysis was completed to determine how well the questions factored together. A principle factor axis was completed with a varimax rotation through SPSS on 18 items (Fields, 2009). A principle component extraction was used prior to principal factors extraction to estimate the number of factors, absence of Multicollinearity, and factorability of the correlation matrices. Due to less than acceptable factorability (< .5) a total of 4 items (q3, q4, q13, q18) were deleted after 3 rotations. Three factors were extracted and all factors were internally consistent and well defined by the variables (Tabachnick & Fidell, 2012). The significance test Kaiser Meyer-Olkin Measure of Sampling Adequacy (KMO) was a moderate level at .858, which is above the required .6 value (Fields, 2009). There was a significant value (p< .001) that determined if the items were factorable. Seventy four percent of the variance was explained by the three factors with eigenvalues approaching one. After completing the Cronbach’s alpha reliability test the reliability score for Subscale 1 stress management (q1, q2, q5, q6, q7) was (α=.89), subscale 2 parenting attachment bonding was (q8, q9, q10 , q11, q12) (α=.90) and subscale 3 future planning (q14, q15, q16, q17) was (α=.91) (Please see Table 4 below for all Cronbach’s alpha reliability scores).
Table 4. Descriptive Statistics for Scales.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Cronbach’s Alpha</th>
<th>Items</th>
<th>*M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Adult Adolescent Parenting Inventory (AAPI A) Total Mean</td>
<td>α=(.86)</td>
<td>35</td>
<td>127.13(16.69)</td>
</tr>
<tr>
<td>*Subscales/ 4 Parenting Constructs (AAPI A)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a Subscale A Inappropriate Parent Expectations</td>
<td>α=(.60)</td>
<td>7</td>
<td>22.45(3.79)</td>
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<tr>
<td>a Subscale B Parental Lack of Awareness of Child Needs</td>
<td>α=(.69)</td>
<td>10</td>
<td>38.38(5.25)</td>
</tr>
<tr>
<td>a Subscale C Strong Beliefs in Use of Corporal Punishment</td>
<td>α=(.74)</td>
<td>11</td>
<td>41.28(6.84)</td>
</tr>
<tr>
<td>a Subscale D Parent-Child Reversal</td>
<td>α=(.72)</td>
<td>7</td>
<td>24.50(5.29)</td>
</tr>
<tr>
<td>*Adult Adolescent Parenting Inventory (AAPI B) Total Mean</td>
<td>α=(.87)</td>
<td>35</td>
<td>13138.60(15.81)</td>
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<tr>
<td>*Subscales/ 4 Parenting Constructs (AAPI B)</td>
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</tr>
<tr>
<td>a Subscale A Inappropriate Parent Expectations</td>
<td>α=(.63)</td>
<td>7</td>
<td>25.40(3.76)</td>
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<tr>
<td>a Subscale B Parental Lack of Awareness of Child’s Needs</td>
<td>α=(.75)</td>
<td>10</td>
<td>42.27(4.90)</td>
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<tr>
<td>a Subscale C Strong Beliefs in Use of Corporal Punishment</td>
<td>α=(.72)</td>
<td>11</td>
<td>42.75(6.40)</td>
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<tr>
<td>a Subscale D Parent-Child Reversal</td>
<td>α=(.67)</td>
<td>7</td>
<td>25.00(4.66)</td>
</tr>
<tr>
<td>*Cognitive Emotion Regulation (CERQ) Total Mean</td>
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<td>16</td>
<td>64.73(9.17)</td>
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<tr>
<td>*Subscales/ 5 Cognitive Constructs (CERQ)</td>
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<td></td>
<td></td>
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<tr>
<td>b Positive Appraisal</td>
<td>α=(.57)</td>
<td>4</td>
<td>16.54(7.90)</td>
</tr>
<tr>
<td>b Ruminate/Focus on thoughts</td>
<td>α=(.70)</td>
<td>4</td>
<td>12.67(3.55)</td>
</tr>
<tr>
<td>b Refocus on Planning</td>
<td>α=(.61)</td>
<td>4</td>
<td>15.52(3.13)</td>
</tr>
<tr>
<td>b Positive Refocus</td>
<td>α=(.78)</td>
<td>4</td>
<td>11.74(3.73)</td>
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<tr>
<td>*Self-Efficacy (SE) Total Mean</td>
<td>α=(.93)</td>
<td>17</td>
<td>44.42(9.99)</td>
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<tr>
<td>*Subscales/ 3 Self-Efficacy (SE) Constructs</td>
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<tr>
<td>c Stress Management</td>
<td>α=(.89)</td>
<td>5</td>
<td>13.80(4.50)</td>
</tr>
<tr>
<td>c Parenting/Attachment Bond</td>
<td>α=(.90)</td>
<td>5</td>
<td>17.47(3.64)</td>
</tr>
<tr>
<td>c Future Planning</td>
<td>α=(.91)</td>
<td>4</td>
<td>13.14(3.33)</td>
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</table>

**Note:** *M=Mean SD=Standard Deviation. *Adult Adolescent Parenting Inventory (AAPI A) Total Mean score and all 4 AAPI A and B Parenting subscales were measured on a 5-point Likert scale with 1=Strongly Agree 2=Agree 3=Uncertain 4=Disagree 5=Strongly Disagree. *Cognitive Emotion Regulation (CERQ) Total Mean and all 5 CERQ subscales were measured on a 5-point Likert scale with 1=Almost Never 2=Sometimes 3=Regularly 4=Often 5= Almost Always. ‘Self-Efficacy (SE) Total Mean and all 3 SE subscales were measured on a 4-point Likert scale with 1=Not confident at all 2=Somewhat confident 3=Confident 4=Very Confident.
Measures

As a part of the outcome evaluation a battery of surveys were administered to participants in the study. Measures included a demographic survey (e.g., age, ethnicity, marital status etc.). In addition, participants had to complete the Adult Adolescent Parenting Inventory 2 (AAPI 2A and AAPI 2B), Cognitive Emotion Regulation (CERQ) and Self-Efficacy (SE) scales and subscales to test the variables being observed in this study (e.g., understanding of child and brain development, parent-child attachment, stress management, increased parental self-efficacy and self regulation).

A repeated measures t-test was conducted to compare within the same group by utilizing pretests and posttests of the control and intervention groups. An ANOVA was completed to compare outcomes between groups and an ANCOVA was completed to add any covariates that needed to be adjusted for due to variables with unequal variances between the control and the intervention group.

Results

Prior to conducting a paired t-test to compare the means of pretest and posttest scores for both the control NPP Plus (case management) and intervention group NPP Plus + (tele-coaching). The assumption of normally distributed scores was examined. The assumptions were considered satisfied, as the skew and kurtosis levels were less than the allowable values for a t-test (i.e., skew ≤ 2.0 and kurtosis ≤ 2.0 (Fields, 2009). Frequencies were run to verify that all other assumptions were met. We then ran simple pre/post-test analyses within group, exploring if the construct improved significantly once the intervention was delivered. Table 4 below summarizes these analyses. Overall,
all control group pre and post-test changes indicate significantly improvement, while one subscale (Focus on Thoughts; p=.916) was not and only one approached significance (Attachment Bonding; p=.064). The following are our results for each scale.

**Adolescent Adult Parenting Inventory (AAPI 2A) Results**

In conducting a paired t-test to compare the means of the pretests and posttests for both groups on the AAPI 2A, on the parenting survey it was noted that the intervention group experienced significant results on all scales and on 4 subscales at post intervention (p<.001). In the control group there was also significant improvement (p<.01). Both the control and intervention groups displayed significant improved scores in every area on the AAPI 2A from the pretest to the posttest (p<.01).

**Adolescent Adult Parenting Inventory (AAPI 2B) Results**

In conducting a paired t-test to compare the means of the pre and post-test for both groups on the AAPI 2B, on the parenting survey it was noted that the intervention group experienced significant results in all scales and subscales at post intervention (p<.01). In the control group there was also significant improvements (p<.05) on the AAPI 2B total scale and all 4 subscales. Both control and intervention group displayed significant improvement in scores in all areas on the AAPI 2B.

**Cognitive Emotion Regulation (CERQ) Results**

The CERQ scale (focus on thoughts) t(23)=.106, p=.92 declined for the intervention group at post-test while the control group was still able to show significant
gains at posttest $t(20)=-2.42$, $p=.025$.

**Self-Efficacy (SE) Results**

In conducting a paired t-test to compare the mean scores on the SE scale for both groups, it was noted that the intervention group experienced significant positive changes for the total SE scale and on a SE subscales in self-efficacy $p<.05$; though parenting and attachment bonding was marginal at 90% CI (Confidence Interval) at $t(22)=-1.95$, $p<.06$. The SE total scale and all SE subscales were also showed significant improvements at ($p<.05$) for the control group but not for the intervention group.

Overall the mean scores for total scale and subscales varied between intervention and control groups although most all results were significant for the control and most for the intervention group. At certain points there were increased mean scores for the intervention group in comparison to the control group and at other points the mean scores were increased for the intervention group in comparison to the control group (see Table 5 and Table 6 for details).
Table 5. Pre and Post Paired T-Test Results of Outcomes Scales and Subscales by Group (Control and Intervention).

<table>
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<tr>
<th>Parameters</th>
<th>Control Group</th>
<th></th>
<th>Intervention Group</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Pre-test M(SD)</td>
<td>Post-test M(SD)</td>
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<td>3.62(.557)</td>
<td>4.64(.437)</td>
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<tr>
<td>Construct A-Inappropriate Expectations</td>
<td>21</td>
<td>3.18(.595)</td>
<td>4.23(1.23)</td>
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</tr>
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<td>Construct B-Parental Lack of Empathy</td>
<td>21</td>
<td>3.86(.555)</td>
<td>4.67(.306)</td>
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<td>Towards Children</td>
<td>21</td>
<td>3.73(.710)</td>
<td>4.82(.234)</td>
<td>20</td>
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<tr>
<td>Construct C-Strong Parental Beliefs</td>
<td>21</td>
<td>3.50(.853)</td>
<td>4.74(1.80)</td>
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<td>in Corporal Punishment</td>
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<tr>
<td>Construct D-Reversing Parent-Child</td>
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<td>3.88(.516)</td>
<td>4.62(.247)</td>
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<tr>
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<td></td>
<td>24</td>
<td>3.80(.620)</td>
<td>4.78(.274)</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>24</td>
<td>3.67(.688)</td>
<td>4.64(.524)</td>
<td>23</td>
</tr>
<tr>
<td>CERQ Total Mean</td>
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<td>3.37(.680)</td>
<td>3.96(.582)</td>
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<td>Positive Reappraisal</td>
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<td>3.88(.678)</td>
<td>4.40(.723)</td>
<td>20</td>
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<td>Focus on Thoughts</td>
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<td>2.80(.849)</td>
<td>3.32(.783)</td>
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<td>Refocus on Planning</td>
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<td>3.80(.820)</td>
<td>4.36(.669)</td>
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<td>3.01(.947)</td>
<td>3.75(.891)</td>
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<td>Self-Efficacy Total Mean</td>
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<td>3.33(.682)</td>
<td>3.86(.251)</td>
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<td>3.75(.400)</td>
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<td>3.57(.716)</td>
<td>3.93(.159)</td>
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<td>Future Planning</td>
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<td>3.55(.736)</td>
<td>3.90(.301)</td>
<td>20</td>
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Table 6. Change in Pre and Post-test Means for Study Outcome Scales and Subscale. Scores Between Intervention and Control Groups.

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Control Group Mean Change Score Between Pre and Post Test (SD)</th>
<th>p-value</th>
<th>Intervention Group Mean Change Score Between Pre and Post Test (SD)</th>
<th>p-value</th>
</tr>
</thead>
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<tr>
<td>AAPI 2A Total Mean</td>
<td>N 21 -1.03(.526)</td>
<td>.000</td>
<td>N 25 -.704(.450)</td>
<td>.000</td>
</tr>
<tr>
<td><strong>Construct A-Inappropriate Expectations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Towards Children</td>
<td>N 21 -1.04(1.44)</td>
<td>.003</td>
<td>N 25 -.624(.500)</td>
<td>.000</td>
</tr>
<tr>
<td><strong>Construct B-Parental Lack of Empathy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Towards Children</td>
<td>N 21 -.814(.478)</td>
<td>.000</td>
<td>N 25 -.635(.499)</td>
<td>.000</td>
</tr>
<tr>
<td><strong>Construct C-Strong Parental Beliefs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in Corporal Punishment</td>
<td>N 21 -1.09(.666)</td>
<td>.000</td>
<td>N 25 -.794(.739)</td>
<td>.000</td>
</tr>
<tr>
<td><strong>Construct D-Reversing Parent-Child Family Roles</strong></td>
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<td>.002</td>
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<td>.002</td>
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<tr>
<td>AAPI 2B Total Mean</td>
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<td>.000</td>
<td>N 26 -.796(.435)</td>
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<td><strong>Construct A-Inappropriate Expectations</strong></td>
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</tr>
<tr>
<td>Towards Children</td>
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<td>.007</td>
<td>N 26 -.470(.666)</td>
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<tr>
<td>Towards Children</td>
<td>N 24 -.575(.441)</td>
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<td><strong>Construct D-Reversing Parent/Child Family Roles</strong></td>
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</tr>
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<td>CERQ Total Mean</td>
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<td>.000</td>
<td>N 23 -.454(.526)</td>
<td>.000</td>
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<tr>
<td>Positive Reappraisal</td>
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<td>N 23 -.609(.825)</td>
<td>.002</td>
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<td>Focus on Thoughts</td>
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<td>N 23 .022(.983)</td>
<td>.916</td>
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<td>Refocus on Planning</td>
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<td>N 23 -.490(.789)</td>
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<td>Positive Refocus</td>
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<td>N 23 -.732(.685)</td>
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</tr>
<tr>
<td>Self-Efficacy Total Mean</td>
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<td>N 23 -.390(.516)</td>
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<td>N 23 -.635(.785)</td>
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<td>Attachment Bonding</td>
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<td>N 23 -.226(.557)</td>
<td>.064</td>
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<tr>
<td>Future Planning</td>
<td>N 21 -.357(.669)</td>
<td>.024</td>
<td>N 23 -.293(.611)</td>
<td>.031</td>
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</table>
**ANCOVA Results**

A one-way between groups analysis of covariance (ANCOVA) was conducted to do a comparison between the NPP Plus (case management) control group and the NPP Plus + tale-coaching intervention group. The independent variables were the two groups and the dependent variables consisted of the posttest scores on the total scales and subscales of the AAPI-2A, AAPI-2B, CERQ and Self-Efficacy test. Marital and military status was the two covariates in this analysis. Analyses were preformed using SPSS to adjust for unequal n. An ANCOVA was completed to test the alternative hypothesis to determine if there was a significant difference between the intervention and the control group when personalized tele-coaching was added. Preliminary checks were conducted to determine if there were any violation of the assumptions of normality, linearity, homogeneity of variances, and reliable measures of the covariate.

After adjusting for marital status independent of military there was marginal significance F(1,40) = 3.73, p=.061 between the intervention and the control group on time point 2 (T2) of the AAPI-2A subscale A Inappropriate Expectations. The strength of the relationship was moderate with $\eta^2 = (.47)$ 90% confidence level. However, when adjusting for military independent of marital status there was no significant difference noted. No other statistical results or interactions were found at posttest between the scales and subscales on the AAPI 2A, AAPI 2B, CERQ and Self-Efficacy between the intervention and control group before or after adjusting for the covariates marital status and military status. Therefore there was no significant different between the control and the intervention group after adding the tele-coaching program (see Table 7).
Table 7. Comparing Intervention and Control Group Outcomes. Controlling for Baseline Differences in ANCOVA.  
*Pretest Means, Adjusted Posttest Means, Standard Deviations, and Analysis of Covariance Results.*

<table>
<thead>
<tr>
<th></th>
<th>Control Group Pretest</th>
<th>Control Group Posttest</th>
<th>Intervention Group Pretest</th>
<th>Intervention Group Posttest</th>
<th>F(1,40)</th>
<th>p</th>
<th>η²</th>
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<td>AAPI 2A Total Mean</td>
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<td>4.39 .383</td>
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<td>Construct A - Inappropriate Expectations</td>
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<td>4.29 1.30</td>
<td>3.17 .500</td>
<td>3.79 .586</td>
<td>1.95</td>
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<td>Construct B - Parent Lack of Empathy</td>
<td>3.89 .578</td>
<td>4.66 .319</td>
<td>3.89 .486</td>
<td>4.60 .390</td>
<td>.800</td>
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<td>.060</td>
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<td>3.80 .714</td>
<td>4.82 .218</td>
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<td>4.61 .470</td>
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<td>.113</td>
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<td>Construct D - Reversing Parent-Child Family Roles</td>
<td>3.57 .860</td>
<td>4.80 .189</td>
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<td>4.34 .840</td>
<td>.370</td>
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<tr>
<td>AAPI 2B Total Mean</td>
<td>4.01 .463</td>
<td>4.68 .197</td>
<td>3.86 .430</td>
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<td>4.36 .559</td>
<td>4.86 .225</td>
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<td>4.94 .206</td>
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<td>4.88 .177</td>
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<td>4.84 .337</td>
<td>.253</td>
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<td>.020</td>
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<td>Construct D - Reversing Parent-Child Roles</td>
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<td>4.69 .524</td>
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<td>4.73 .492</td>
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<td>CERQ Total Mean</td>
<td>3.42 .674</td>
<td>3.93 .585</td>
<td>3.67 .595</td>
<td>4.13 .565</td>
<td>.824</td>
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<td>.061</td>
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<td>Positive Appraisal</td>
<td>3.95 .632</td>
<td>4.36 .742</td>
<td>4.00 .723</td>
<td>4.63 .482</td>
<td>.635</td>
<td>.597</td>
<td>.048</td>
</tr>
<tr>
<td>Focus on Thoughts</td>
<td>2.81 .866</td>
<td>3.31 .801</td>
<td>3.63 .875</td>
<td>3.57 .845</td>
<td>1.94</td>
<td>.140</td>
<td>.133</td>
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<tr>
<td>Refocus on Planning</td>
<td>3.86 .826</td>
<td>4.36 .683</td>
<td>3.97 .788</td>
<td>4.44 .620</td>
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<td>Self-Efficacy Total Mean</td>
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<td>3.83 .262</td>
<td>3.20 .683</td>
<td>3.60 .548</td>
<td>1.43</td>
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<td>Stress Management</td>
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<td>3.73 .409</td>
<td>2.74 .917</td>
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<td>1.59</td>
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<td>Attachment Bonding</td>
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<td>3.91 .166</td>
<td>3.57 .646</td>
<td>3.80 .492</td>
<td>.586</td>
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<td>Future Planning</td>
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<td>3.88 .315</td>
<td>3.30 .772</td>
<td>3.61 .573</td>
<td>1.41</td>
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Program Evaluation

To document how participants experienced the intervention the authors completed a qualitative process and outcome evaluation through two pre and post interviews and a quantitative outcome evaluation reported elsewhere. As a new program the researchers inquired about the effectiveness of the program and what was perceived as most beneficial to the participants. On the first session participants were asked, “What do you hope to gain out of tele-coaching?” Similarly at the end of the program we inquired, “What did you gain from the tele-coaching?” We asked them in what ways was tele-coaching most helpful and least helpful? Did they have concerns or even fears about engaging in this process? If so, what are they? How did you experience the quality of the tele-coaching over the phone? Do you think the quality of the tele-coaching would have been different if the program was conducted face-to-face?

Most parents stated they didn’t have any concerns and if there were some initial fears these centered around them not being sure how this approach would work for them and will we bond over the phone. Indeed, 75-80% of the parents stated that they appreciated the knowledge, and sincerity of the tele-coach. They felt appreciative of the personalized nature including the coach spending so much time with them and investing in them to become a better parent, person and/or partner.

At least 75%-80-% of the parents stated that they appreciated the knowledge, and sincerity of the tele-coach. By spending so much time with them and investing in them to become a better parent, person and/or partner. At least 90% of the parents appreciated the fact that it was flexible and convenient.
Of note none of the parents experienced parenting or wellness coaching before while about 30% had gone to a therapist at one time or another. About 15% could identify with a mentor in AA and 10% had a sports coach of some sort when they were younger. Initially most (55-60%) parents did not know what to expect with it being over the phone with a total stranger and would have preferred it was face-to-face meetings. However, at the end of the program nearly 90% of the parents preferred the session over the phone and noted it as “safe”, sincere, flexible especially as they saw the therapist as knowledgeable. All parents appreciated how convenient it was and how flexible it was. Almost 10% of the parents still felt that face-to-face may have been better and approximately 5% would have preferred a landline or computer because the reception was not always 100% clear. To share an example of one parent’s experience with tele-coaching a case study example is provided below.

**Case Study**

A 35 year-old Caucasian male named Tim (pseudo name) had a hard time letting go of his past. Tim knew that he didn’t want to repeat the patterns of his dad who he hated and had no respect for. His dad was an alcoholic and drug addict and abused him terribly as a child and even as a teenager. Tim had a lot to be angry about and he was often explosive. In Phase I of the tele-coaching program it became evident that Tim had a turbulent upbringing that led him to prison and he too became an alcoholic. As we explored Tim’s insecure attachment, fear of trusting and his generational family patterns we discussed that it was “normal” for Tim to be so angry and feel rejected. Tim felt like he was robbed of his childhood because of unstable teenage parents who suffered from
addiction and needed help but never sought help out. In Phase II Tim learned how his misplaced anger, un-forgiveness and the stories that he chose to believe about himself impact his day-to-day life as a person, parent and partner. Tim wanted to be a different person and break his negative patterns to be a good example to his two beautiful children. Tim started learning affirmations each week and he was excited about me texting them to him weekly. Tim started to set short-term goals to do better because he no longer wanted to repeat history. Tim reflected on the reality that his grandparents stepped up and he was forever grateful that they were a part of his life. In Phase III Tim and I started working on managing his stress and regulating his emotions. He felt his anger no longer controlling him as he recognized his personal power and he was now a believer that he didn’t have to stay angry for the rest of his life. He didn’t have to minimize the truth but he had the ability to create a new future and a new story for he and his children. In Phase IV Tim set long-term goals and finally wrote his new life story.

“I was born to two teenage kids, both of them were on their own journey in life. Lucky for me I was blessed to have been taken in by my grandparents who loved me as their own. They raised me and loved me no matter what. I always have clean clothes and always had food on the table. I never went without. At a young age I chose my journey in life. The fast life intrigued me so I did what I thought was cool and I did it to the best of my ability. My goals were different than others. But by the grace of God I overcame addiction and poverty. By the grace of the State of California I was put into a state prison where I got my high school diploma and learned how beautiful life really was and was given two years as an opportunity to think about what I wanted to do with my life. Since then I have learned how to love not only others but myself. I have 8 years sober today, and two beautiful children. I have two parents that I love and adore and take care of and I have a beautiful girl who I don’t understand how I got and today I will do my best to live right and to continue on the right path and give to my children everything I got from my grandparents, time love and support.”

Tim was finally able to reach his goal and be truly happy without feeling resentment or being angry all the time. Tim created his new life story.
Outcomes

When parents were asked what did you like most about coaching and what was most helpful they shared a variety of thoughts. One couple said at the end of the program, “We don’t know where our family would be without you.” Another mother said, “Coaching was a life changing experience, I don’t know if I could have made the changes I made with out you.” A young couple shared, “This was more than just parenting information coaching helped us as parents, partners and in every area of our lives and we are forever grateful.” One partner shared, “This was such a positive experience, it was so great we wish everyone had a coach to talk to.” Another couple said, “Thank you for your knowledge and sincerity. Our family has really benefited from the coaching sessions.” A single parent stated, “You definitely enlightened me! I will forever be grateful. You make me see things differently and understand how I could change situations.” Qualitative outcome evaluations were able to tell the parents’ stories about how they experienced the tele-coaching program. Most importantly, most participants felt that these outcomes were achieved regardless of the delivery modality. Indeed, they felt that tele-coaching afforded them flexibility and made it more likely for them to stick to the process.

Discussion/Conclusion

While process evaluation results concluded that among our tele-coaching participants our tele-coaching program worked, our randomized control trial results did not support parents’ valuing the program with better or more improved outcomes. Indeed, while both control and intervention groups showed significant changes from pre
to post test scores only two scales for the intervention group did not show significance. These were the CERQ subscale (focus on thoughts) and the SE subscale (parenting and attachment bonding), which however was approaching significance. The findings of the study determined that overall parents benefitted significantly for both control and intervention groups. However, the addition of tele-coaching did not provide better results to the NPP Plus in comparison to the NPP plus case management alone. Future studies should be conducted to more clearly allow isolating the unique effect of the tele-coaching program without cross condition contamination. In addition, more outcome studies need to be completed that compare tele-coaching with face-to face one to one services in comparison to EBPPs without other additional support services to determine if tele-coaching is just as effective as face-to face one-to-one services.

**Limitations**

One limitation of the study is that the original study design that was evaluated for almost a year with REACH Out did not include carrying out a competing 7-session face-to-face case management component in addition to the NPP parenting program. The unwarranted change detrimentally impacted the study and the researchers were not able to quantitatively determine the effectiveness of tele-coaching on the parenting population being served. Another limitation is related to power. As this is a pilot study we only had n=57 participants, a much smaller sample size than the projected fully powered study that called for (n=108).

Another limitation of the study could be inflation of parent scores at baseline. It is not uncommon for parents to inflate or overestimate their parenting abilities due to
overconfidence and lack of education. This makes parenting studies a challenge (Pauliz & Vazire, 2007). The issue is that over the course of the parenting program parents tend to become more realistic, about their ability to parent, which they tend to judge much better initially in comparison to what they then later learn to understand.

**Strengths**

While we were not able to conclusively evaluate the additional comparative effectiveness of tele-coaching in addition to the NPP, we were able to successfully offer a structured curriculum with a 16-week tele-coaching wellness program to parents and have the program received very positively. This demonstrates that a therapeutic relationship can be formed over the telephone with approximately 90% of the parents at post evaluation stating that they actually preferred the flexibility, convenience, safety, and ease of the phone sessions to those conducted in person.

We are excited that similar to a one-to-one coaching in person counseling session, tele-coaching was able to lead to the therapist recognizing some of the systemic patterns that occur in the home environment that impacted the parent child and partner relationship and then work with parents on techniques and accountability to help parents to grow and break unhealthy generational patterns. We also were able to help parents to realize how stress impacts their performance as a parent or partner and help manage their anxiety and stress-in emotionally charged situations through redirecting and breathing skills. Learning these skills and holding parents accountable by setting short term weekly goals and checking in the following week to reflect on what worked and what didn’t work helped parents to believe in their ability to successfully change their past behaviors.
Future Research

Future research needs to test tele-coaching programs in a true comparison to established delivery methods of evidence-based programs such as the NPP. Future research should also ensure fidelity throughout the study. Lastly, studies should explore the therapeutic alliance between parents and tele-coach as fears about a lack of connection may keep participants from enrolling in this promising modality.
References


Delbridge, E., & Taylor, J., & Hanson, C. (2014). Honoring the “spiritual” in biopsychosocial-spiritual health care: Medical family therapists on the front lines


CHAPTER SIX:

TELE-COACHING: A COLLABORATIVE APPROACH TO PROMOTE SUCCESS IN PARENTING PROGRAMS

Research suggests that tele-coaching is an alternative method to provide support to individuals in need, however there is limited research on the effects of tele-coaching in high risk parenting populations. In this paper we use a review of the literature to propose that tele-coaching is an innovative strategy that should be added to community mental health interventions, specifically parenting programs for high-risk populations. Even though there is a critical need for complex high-risk populations to receive additional parenting support services, they often face attendance challenges, which results in high attrition rates and lower outcomes. We believe that enhancing current parenting programs with a tele-coaching component will provide high-risk parents with the additional support they need in order to succeed. The authors present a review of evidence-based parenting programs, tele-coaching and programs currently using tele-coaching methods in order to make the case for a new, innovative tele-coaching component that utilizes MFTs. The tele-coaching component is based on social cognitive, attachment and family systems theories designed to increase parental outcomes for an existing EBPP. A review of a proposed tele-coaching component as well as implications and direction for future research are discussed.

**Keywords:** attachment and family patterns, high-risk parents, parenting programs, self-efficacy, tele-coaching, child-maltreatment
Background

Child maltreatment (CM) is one of the leading causes of death among children under the age of five in the United States (U.S.) (USDHHS, 2014), with an estimate of $124 billion representing the cost of new CM cases that occur in the U.S. in a single year (Fang, Brown, Florence & Mercy, 2012). In addition to the financial costs, the human toll of abuse and neglect on families is inestimable as traumatic experiences such as CM in childhood may have lifelong effects (Moore & Ramirez, 2016). CM most often occurs in families where there is chronic stress such as a family history of abuse, poverty and or chronic health problems (Fujiwara et al., 2012b; Shonkoff et al., 2012).

Parenting stress is a risk factor for CM (Fujiwara et al., 2012b) and has been linked to both negative parenting behavior and child functioning and parental self-efficacy (SE) or the lack thereof has been linked to poor parenting outcomes (Kendall, Bloomfield, Appleton & Kitaoka, 2013). According to Bandura (2002) parental SE is the ability for parents to think in self-enhancing or self-debilitating ways. It determines how well one can motivate self and persevere in the face of difficulties; the quality of their emotional life, and the choices one makes at important decisional points which set the course of life paths. SE beliefs regulate human functioning through cognitive, motivational, affective, and decisional processes (Bandura, 2002) and have been identified as a major determinant of parenting competence and psychological functioning (Coleman & Karraker, 2003; Kendall, Bloomfield, Appleton & Kitaoka, 2013). SE beliefs also play a significant role in how well parents will be able to regulate their emotions. The capability to perform emotional “regulation” is the quintessence of emotional intelligence. Emotional intelligence increases by improving one’s self-control.
and engaging in self-reflection (Hughes, Baylin, 2012). Therefore, the higher the SE of the parent, the better he/she will be able to engage in self-reflection and regulate his/her emotions. Increasing parenting SE is an important safeguard against parenting stress (Kendall, Bloomfield, Appleton & Kitaoka, 2013). Therefore interventions that emphasize healthy parenting strategies that incorporate parental SE should be implemented.

Research suggests that high stress and poor parenting can also result in serious behavioral and emotional problems in children (Hodnett, Faulk, Dellinger & Maher, 2009; Maughan & Cichetti, 2002; Shaffer, 2012). For example, when a parent has chronic stress she/he tends to practice harsher forms of parenting and often develop insecure parent-child attachments (Conger & Donnellan, 2007). Findings reported by Matsueda (2006) suggest that corporal punishment can impact child functioning and behavior in a negative way. Early childhood trauma has both and immediate and long-term effect including implications for later emotional development (Creeden, 2009). For instance, child maltreatment causes toxic stress that can disrupt early brain development and harms the development of the nervous and immune systems of the child (Luby-Dobson & Perry, 2010). As lack of parental care and nurturance poses one of the greatest threats to a child’s well-being (Conger & Donnellan, 2007; Shaffer, 2012), there is a great need to implement more multi-disciplinary community mental health programs to better serve high-risk parents and their children.

Community mental health programs have been created as an early intervention approach to prevent the onset of mental illness for mothers with at-risk children (Patterson & Vakili, 2014). Particularly, a partnership developed with at-risk parents of
infants that incorporate progressive neuroscience and early intervention can promote secure attachment relationships (Patterson & Vakili, 2014). Promoting interventions that utilize these components alongside a collaborative approach between parents, marriage and family therapists (MFTs) and mental health care providers can help community mental health programs intervene at an early stage and improve mental health outcomes for clients (Patterson & Vakili, 2014). While the need for such interventions has been clearly demonstrated, getting parents to attend to such program has proven to be a challenge. While most programs utilize traditional group sessions with some case management these programs often experience high attrition due to the time demand of scheduled interventions. In this context, a promising approach being discussed is tele-coaching which allows for more flexible program delivery although concerns about the effectiveness of this approach has been noted.

**What is Tele-coaching?**

According to International Coach Federation (ICF) (2015) coaching has been defined as “an ongoing professional relationship that helps people to gain amazing results in their lives, careers, businesses, or organizations.” Research surrounding the area of coaching is still extremely limited. While there is no specified approach to coaching, the International Coach Federation (ICF) (2015) explains that the coach typically does a personal interview (either face-to-face or by teleconference call) to assess the individual’s current opportunities and challenges, define the scope of the relationship, identify action items, and establish goals and outcomes the client is seeking. Consequent coaching sessions may be held in person or over the telephone, with each session lasting an agreed
upon amount of time. To complete the coaching sessions the individual may be asked to achieve particular actions that support the accomplishment of one’s customized goals. Throughout the duration of the coaching the coach may provide additional resources to support the individual’s thinking and actions.

Tele-coaching is a form of coaching that was developed to provide customized support over the phone that results in positive outcomes in the privacy of one’s own home (Van Mierlo, Meiland & Droes, 2012). Tele-coaching includes the following components: goal setting, probing questions, a self-reflective process, affirmations, accountability, exploration of opportunities and challenges and relevant parent resources. Tele-coaching is a promising approach (Lingley & McGrath 2007; 2008) to add to parenting programs as it may help promote behavioral health changes and also provide additional assistance to parents who may not benefit as much from traditional parenting programs. For example, participants in one study (both adults and children) reported a strong therapeutic alliance with their telephone coach. Participants described how safe they felt partaking in sessions in the comfort of their own home. Participants did not feel judged or stigmatized in anyway, they also had little apprehension about self-disclosure and were actively engaged in the sessions. The convenience of treatment led to significantly lower attrition rates for both parents and children who participated in the telephone coaching in comparison to face-to-face treatment (Linglye-Pottie & McGrath, 2008). Overall, tele-coaching may provide parents the additional support needed to help increase current parenting program outcomes.
**Family Therapists as Tele-Coaches**

While there are several parenting programs listed in this article (on pg 10 and 11) that discuss EBPPs with positive results, the authors argue that it may prove to be more beneficial to parents if MFTs officially partner with parenting programs using tele-coaching techniques to improve parental mental health during pregnancy and the child’s early years to minimize the effects of chronic stress on the parent and child system (Patterson & Vakili, 2014). Family therapists can also provide psycho-education regarding healthy parenting, increase parent coping tools, and use therapeutic interventions to help parents build stronger parent-child and adult attachment relationships. Approaches that include MFTs partnering with parenting programs can be a supportive, valuable resource to parents.

Thus the authors hypothesize that the HOPE wellness tele-coaching approach utilizing family therapists is an expedient way to promote mental health, gain effective outcomes, and increase the quality of life for the parent and child. The tele-coaching approach will (1) help parents to create a paradigm shift by alleviating chronic stress and curtailing recurring generational behavioral risk outcomes in children, which can improve nurturing parenting practices, (2) help increase quality of life for parent and child by providing parents with psycho-education on child and brain development, improving self-regulation of emotions and increasing parent-child attachment bonds and parental self-efficacy, (3) make an effort to improve high attrition rates common in therapeutic and parenting programs, through personalized coaching. The implications of adding to traditional parenting programs are significant in the context of epidemic levels of CM and its association with later poor health and mental health outcomes in children (Hodnett,
Faulk, Dellinger & Maher, 2009). Adding a tele-coaching component can help increase the effectiveness as it not only focuses on the parental techniques learned in the program but on a more personal and holistic level unique to each parent. In this innovative tele-coaching addition to the parenting program, parents will learn techniques to nurture both self and child, better manage stress, form strong attachment bonds, gain a new understanding and awareness about child and brain development, and engage in self-reflective processes that will help them to better regulate their emotions and increase self-efficacy which will promote increased parenting outcomes.

**Parenting Interventions for Prevention and Intervention**

Parent education is one of the most commonly used interventions for prevention of abusive or high-risk parents in child welfare agencies across the country (Barth, Landsverk, Chamberlain, Reid, Rolls et al., 2005; Huebner, 2002; Hurlburt, Barth, Leslie, & Landsverk, 2007). As part of this movement a great deal of attention has been given to the development of EB parenting and family interventions (Barth, Landsverk, Chamberlain, Reid, Rolls et al., 2005; Bavolek; 2002; Turner & Sanders, 2005). The development of interventions that promote positive, caring, and consistent parenting practices has been repeatedly highlighted as being essential to reduce the incidence of CM and promote nurturing parenting practices (Azar, 1997; Sanders & Cann, 2002; Hodnett, Faulk, Dellinger & Maher, 2009). However, due to minimal implementation and evaluation of outcomes, there is still much to be learned about the effectiveness of parent education in prevention of child abuse or neglect (Hodnett, Faulk, Dellinger & Maher, 2009) and reoccurrences of CM.
The parenting programs with the strongest evidence of effectiveness have most commonly been studied in clinical settings primarily focused on behavior-disordered children (Barth et al., 2005). Parenting models such as Multi-Systemic Therapy (MST) (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998), Parent-Child Interaction Therapy (PCIT) (Eyberg & Robinson, 1982), The Incredible Years (Webster-Stratton, 2000), and Parent Management Training (PMT) (Patterson, Reid, & Eddy, 2002) are primarily focused on preventing, reducing, and treating serious behavior problems in children. Although, prevention in behavioral disorders are necessary, there is a strong need to emphasize parenting issues in addition to, and other than, those relating to serious behavior problems in children (Hodnett, Faulk, Dellinger & Maher, 2009). The parent-child relationship, specifically as it relates to nurturing, attachment, empathy, and parental insight into the needs of the child, should play a key role in improving parenting practices (Hodnett, Faulk, Dellinger & Maher, 2009).

There is a serious need to implement interventions aimed at promoting wellbeing of the parent, to decrease both the disruption to the child’s emotional, educational, and social adjustment (England & Sim, 2009). Longitudinal research results has shown us that when a child has a secure attachment to a caregiver it increases the child’s ability to be more resilient against stress (Ford & Collins, 2010; Masten & Coatworth, 1998; Pasco-Fearon & Belsky, 2004), personal self-efficacy, (Kendall, Bloomfield, Appleton & Kitaoka, 2013; Simmons, Paternate, & Shore, 2001) empathy (Mikulineer & Shaver, 2005) and healthy emotion-regulation (Maughan & Cicchetti, 2002; NICHD Early Child Care Research Network, 2004).
Finally critics argue that even more is needed given the complex needs of low-income parents and that most interventions lack one on one coaching in addition to group parenting sessions. While such personalized sessions are ideal, they would increase the length of already lengthy programs likely resulting in higher cost and attrition rates. Nevertheless, current literature demonstrates that community programs that offer a multidisciplinary approach that offers an array of resources are often necessary to affect relational change in families (Patterson & Vakili, 2014).

MFTs and community mental health programs who work with distressed families need to find better approaches to increase retention for high-risk families and develop interventions that reduce stress and target intermediates to be effective with high-risk families (Hackman et al., 2010). One reason that tele-coaching may be helpful and cost effective is because of the high dropout rates psychotherapy and other community mental health programs experience when working with high-risk families. In addition to other factors, high attrition rates pose a major challenge for mental health care professionals (Hamilton, Moore, Crane & Payne, 2011). Utilizing tele-coaching may be a great alternative route to help high-risk families to increase retention and help families to thrive. Partnering with community organizations and providing personalized coaching may prove to increase retention outside of traditional family or individual therapy for high risk parents and help parents faced with multi-stressors to overcome adversity and gain greater success.

Tele-coaching is a promising lower cost approach that might be utilized (Lingley & McGrath, 2007; 2008; Hodnett, Faulk, Delinger & Maher, 2009) to effectively help high-risk parents to gain further support in a convenient way. The tele-health services are
implemented entirely over the phone at the parent’s convenience. However, there is still a scarcity in the literature examining the effectiveness of tele-coaching interventions (Collet, 2008; Lingley & McGrath 2007; 2008; McGloin, Timmins, Coates & Boore, 2014) associated with other evidence based parenting programs for low SES parents.

**Tele-Coaching Research**

Health professionals are realizing the advantages of tele-coaching and define it as tele-health. Tele-health uses communications networks for delivery of healthcare services and medical education from one geographical location to another. It is organized to surmount challenges like uneven dissemination and scarcity of infrastructural and human capital (Sood, et al., 2007). The main tele-health service that is discussed in this paper is tele-coaching. A small amount of researchers have studied the effectiveness of tele-coaching (Collet, 2008; Lingley-Pottie, 2006; Lingley-Pottie & McGrath 2007; 2008; McGloin, Timmins, Coates & Boore, 2014). While the health field has incorporated tele-coaching as a form of tele-health (McGloin, Timmins, Coates & Boore, 2014), the mental health field has been slow to mainstream it. However, some mental health professionals are able to see the benefits of utilizing this framework for special populations in need.

**Family Help Program**

A study known as the Family Help program utilized a manualized, distance treatment by telephone. Participants in the Family Help program (both parent and child) have reported a strong therapeutic alliance with their telephone coach. Participants also described how during treatment sessions they felt comfortable and safe in their own
home; they did not feel stigmatized or judged; they had little apprehension about self-disclosure and they felt that treatment was delivered at their convenience. Attrition rates were found to be very low and children actively engaged in the structured, distance treatment. Acceptance and integration of EB distance delivery is a promising approach to the delivery of mental health care (Lingley-Pottie & McGrath, 2007; 2008).

**Home-Based Coaching**

University of Kansas and Notre Dame Researchers were the first to do a randomized controlled trial utilizing texting and phone calls to mothers who participated in a home-based parenting program (Carta, Lefever, Bigelow, Borkowski, & Warren, 2013). The aim of this study was to prevent CM by showing parents a different more positive way to interact with their children. Parent coaches known as home visitors texted mothers twice a day, five days a week as well as calling them at least once a week with reminders and words of encouragement and suggestions of free community resources.

The cell phone addition, had relatively large effects on parenting and improved the retention rate by 50% in comparison to the parenting group without the cell phone component (Carta, et al., 2013). Mothers who received text messages were much more likely than the other mothers that participated in a traditional program to learn and use positive parenting strategies both immediately and six months after the end of the program. They were less depressed and less stressed in comparison to mothers in the control group or the mothers who received the traditional parenting training without the cell phone component. This study was the first to test the effectiveness of cell phones of increasing engagement in parenting programs and retention (Carta, et al., 2013).
Telephone –Administered Psychotherapy

The authors of this randomized control trial conducted a 16-week telephone cognitive behavioral therapy (T-CBT) against a 16-week comparison group. They both administered therapy through the telephone. The comparison group administered supportive emotion focused therapy and conducted a 12-month follow up (Mohr, et al. 2005). Effectiveness of telephone-administered vs. face-to-face cognitive behavioral therapy for depression compared 127 participants to complete a 16-week telephone administered supportive emotion-focused therapy. Patients showed significant improvement in depression and positive affect during the 16 weeks of telephone–administered treatment. The specific cognitive behavioral components of T-CBT produced improvements above and beyond the nonspecific effects of telephone-administered supportive emotion focused therapy on evaluator-rated measures of depression and self-reported positive affect. Attrition was also low (Mohr, et al 2005).

Dementelcoach

Dementelcoach is a new telephone intervention to support informal caregivers of community-dwelling people with dementia. The effectiveness of this intervention was evaluated on burden and mental health problems of informal caregivers (Van Mierlo, Meiland & Droes, 2012). A pre-test/post-test comparison group design was used with three groups of informal caregivers. Trained coaches offered telephone coaching once every two to three weeks over a period of 20 weeks (Van Mierlo, Meiland & Droes, 2012). Informal caregivers who received telephone coaching in combination with respite care reported significantly less burden compared to caregivers who received tele-
coaching only, and they experienced significantly fewer mental health problems than those who received day care only. Tele-coaching according to the principles of Dementelcoach combined with respite care (psychogeriatric day care) is more effective in reducing burden and health complaints in informal caregivers of community-dwelling people with dementia than tele-coaching or day care only (Van Mierlo, Meiland & Droes, 2012). This study demonstrated the effectiveness of blending services to gain better outcomes for families. A wellness tele-coaching program was also developed to provide additional support for high-risk low-income families parents using a blended approach. The next section will expound on a wellness tele-coaching approach that was added to an evidence-based parenting program (EBPP).
Table 1. Brief Description of Evidence-based (EBPP) Tele-coaching Programs.

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Methods</th>
<th>Description of Study</th>
<th>Key Findings</th>
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<tbody>
<tr>
<td>Lingley-Pottie &amp; McGrath (2008)</td>
<td>pre-test/post-comparison group design</td>
<td>A distant therapeutic alliance was studied with 55 child parent pairs to determine the effectiveness of children receiving a manualized cognitive-behavioral treatment via phone in the absence of face-face contact</td>
<td>Parent scores were significantly higher than children scores though the difference may not be clinically meaningful. The study provides evidence that a strong therapeutic alliance does occur between child-coach and parent-coach when treatment is delivered from a distance.</td>
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<tr>
<td>Carter et al. (2013)</td>
<td>randomized control trial</td>
<td>A home based phone-coaching program that prevents child maltreatment by showing parents various positive ways to interact with their children. Parents received texts twice a day and a phone call once a week to share words of hope, give reminders and free resources information comparison to the other mothers just received home visits.</td>
<td>The cell phone addition had relatively large effects on parenting and improved the retention rate by 50% in comparison to the parents without the cell phone component. Mothers who received the phone coaching were more likely to participate in a traditional program to learn and use positive strategies both at post-test and six months after the end of the program. This study was the 1st to test the effectiveness of cell phones of increasing engagement in parenting programs and retention.</td>
</tr>
<tr>
<td>Moher et al. (2005)</td>
<td>randomized control trial</td>
<td>Effectiveness of telephone-administered versus face-to-face cognitive behavioral therapy for depression with a sample size of 127 participants. Participants completed a 16-week telephone CBT psychotherapy group against a 16-week comparison group administering emotion-focused therapy and conducting a 12-month follow up.</td>
<td>The specific cognitive behavioral components of telephone CBT produced improvements above and beyond the nonspecific effects of telephone-administered supportive emotion focused therapy on evaluator-rated measures of depression and self-reported positive affect. Attrition was also low.</td>
</tr>
<tr>
<td>Van Mierlo, Meiland &amp; Droes (2012)</td>
<td>pre-test post-test comparison group design</td>
<td>A new telephone intervention to support caregivers of community dwelling people with dementia. Two out of the 3 groups were experimental and received either telephone coaching or telephone coaching with respite care. The 3rd group received day care only. Services were rendered once every 2 to 3 weeks over a 20-week period.</td>
<td>Blended services reported significantly less burden in comparison to caregivers who received tele-coaching only and they experienced significantly fewer mental health problems than those who received day care only. Dementelcoach combined with respite care is more effective in reducing burden and complaints in informal caregivers than tele-coaching or day care only.</td>
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</table>

*Note: All studies included in this table are mentioned in the article in either a citation or narrative form.

**Introduction to H.O.P.E. Wellness Tele-Coaching Program**

This paper introduces a new innovative wellness tele-coaching program known as “Helping Our Families Excel” (HOPE) wellness tele-coaching program. The authors of
this paper believe it is important to utilize an integrative multi-systemic approach that offers holistic care to be effective (Delbridge, Taylor & Hanson, 2014; Prest & Robinson, 2006). Utilizing HOPE a systemic wellness tele-coaching approach, in addition to an EBPP is an appropriate alternative way to provide parents with additional support to help them to succeed. HOPE is currently being utilized in a high-risk parenting population to provide parents with the necessary support that they need to thrive (Wray, Montgomery, Wilson, Williams-Reade, & Oloo, 2016 in process). The program encourages parents to create a paradigm shift (please see Table 2 below) to embrace a new way of thinking, by helping parents to create understanding of their own attachment style and promote secure attachments, foster positive emotions, and help parents interact with their child and/or partner, (if present) in a healthy way. The proposed tele-coaching technique is based on three separate theories that make up its conceptual framework.

Theoretical Framework

As the field of social science advances, we have recognized the importance of the reciprocal interaction between theory and science, and how they both contribute to the development of a systemic explanation of experiences (Lavee & Dollahite, 1991). The theoretical framework of this paper hypothesizes that there is a bilateral relationship between social cognitive theory, attachment theory and family systems theory (see conceptual framework 1 below).
Social Cognitive Theory

Social Cognitive theory recognizes that it is the reciprocal nature of influences that produces behavior (Bandura, 2002; 2011). In other words, cognition, personal, and environmental factors are primary components. The primary concept in social cognitive theory explains psychosocial functioning in terms of triadic reciprocal causation (Bandura, 1988). In this causal model, cognitive, personal factors and environmental events all function as interacting determinants that influence each other bi-directionally and impact behavior (Bandura, 1988). Self-regulation also encompasses the self-efficacy mechanism, which plays a central role in the exercise of personal agency (Bandura, 1991; 2001).

Social Cognitive theory allows people to analyze their experiences and to think about their own thought processes. If there is any characteristic that is distinctively human, it is the capability for reflective self-awareness (Bandura, 1991). By reflecting on
their varied experiences and on what they know, they can derive basic information about themselves and the world around them (Bandura, 2001). People not only attain understanding through reflection, they assess and alter their own thinking (Bandura 1986). In this tele-coaching program social cognitive theory is used to help parents to gain better outcomes by attempting to increase parental SE by utilizing strength based approaches to challenge their negative beliefs about their capabilities, and helping parents to engage in reflective self-awareness that directly impacts their behavior and outcomes. Creating self-awareness also helps parents to self-evaluate their own parenting behaviors and alter when necessary to develop strong, healthy attachment bonds with their children.

**Attachment Theory**

Over the past decade scientific evidence has shown that both nature and nurture are needed to function successfully and develop secure attachments (Ludy-Dobson & Perry, 2010; Perry, 2012). Nurture plays a significant part in how a child’s brain and attachment is shaped and how the child experiences the world. Attachment theory focuses on the parent-child dyad. According to Bowlby 1979; 1988) every human being is born to connect. Attachment patterns stem from the early years and has a significant impact throughout an individual’s lifetime (Bowlby, 1979; 1988; Mikulineer & Shaver, 2005; Perry, 2012). As Bandura suggested, behavior is produced by the reciprocal nature of influences. We also know that the parent/child attachment relationship is one of the first relationships that help to shape who we become as adults (Ainsworth, Blehar, Waters & Wall, 1978; Bowlby 1979; 1988, Cozolino, 2006; 2002/2010, Johnson, 2004;
Mikulineer & Shaver, 2005). Therefore family systems, structures and patterns vastly impact the parent-child subsystem.

**Family Systems Theory**

Family Systems theory plays a significant role in the perceptions that we hold whether positive or negative. Family systems are structures, patterns and properties that organize stability and change (Minuchin, Colapinto & Minunchin, 2007), in other words, the “the whole is greater than the sum of its parts (von Bertanlaffy, 1967). If a child was never affirmed, valued or felt unlovable in their family system, that child will grow into an adult that may have very little empathy, and nurturing may be very difficult. When experiences stored in the subconscious are not brought to the conscious mind, the child will be more likely to repeat the systemic family pattern from childhood and engage in those harsh behaviors with their own children.

The authors theorize that the ability to experience a paradigm shift all stems from a transformation that is brought about by the way we view the world and our circumstances. The experiences we currently engage in, and those in the past, shape the narrative that we live by. Unresolved issues should be addressed for an individual to experience a paradigm shift and overcome the old negative story from the past. When their past remains present in their thoughts, words, and actions due to unresolved issues, a paradigm shift may never occur.

Hence, the authors believe that there is a reciprocal relationship between social cognitive theory, attachment theory, and family systems theory, as they work collectively in this theoretical framework to help parents to create a paradigm shift by focusing on the
present, and the new future ahead, while letting go of the aspects of the past that are destructive to their well-being and their parenting. Tele-coaching can be an innovative way to help parents to experience a paradigm shift. It can also be a great opportunity for family therapists to partner with community mental health programs.

The tele-coaching approach in this study utilizes strength-based approaches to promote and Attachment focused family therapy (Hughes, 2007), Social cognitive theory (Bandura, 2002; 2011) and Family systems theory (Minunchin, Colapinto, & Minunchin, 2007) lens, to help parents explore their own perceptions and cognitive distortions from their past, while creating healthy patterns to foster safe, and secure attachment bonds with their children in the present. It helps parents to co-create meaning through the use of a collaborative approach that utilizes brainstorming and reflective questions to offer effective solutions instead of focusing on problems. The intent is that through the tele-coaching process parents will have a transformational experience and write their new life story with new insight to live a healthier, happier life. Tele-coaching conducted by family therapists and based on these theories can be an innovative way to help parents to experience a paradigm shift.

**Helping Our Parents Excel (H.O.P.E.) Wellness Tele-coaching Program**

The main author of this study developed a wellness tele-coaching program that offers a holistic approach to help high-risk low SES parents to thrive in adversity. The wellness tele-coaching program offers a supportive, encouraging, psycho-educational, trusting environment for parents to feel safe, share their difficulties and brainstorm solutions, while setting goals to gain better outcomes in their future as individuals,
parents and partners. The overall goal of this program is to provide a convenient, flexible alternative method for parents to receive the help that they need to be successful.

**Session Routine**

Each 30-60 minute individual session follows a similar routine over the course of the 16 weeks program. First the tele-coach begins the session in a very optimistic way by checking in on the well-being of parents and simply asking “How are you doing today?” The coach makes a deliberate effort to ask “Are there any highlights or wins over the past week that you want to discuss today?” The tele-coach will then ask are their any challenges that you were faced with this week or anything else that you want to discuss or brainstorm?” The tele-coach then checks in with parent by creating accountability by asking the parents’ about the progress of their short-term goals set in the previous week. The tele-coach will either congratulate small wins or discuss shortcomings. The tele-coach will ask questions like, “What did you do differently to achieve your goal or what do you think prevented you from achieving your goal?” Using reflective questioning may help parents to identify what they felt contributed to or hindered their success.

After discussion the tele-coach and parent make a collaborative decision whether or not the parent feels he/she just needs more time and will continue to work on the same goal or whether the goal should be modified to increase chances of being successful in the upcoming week. Either way the tele-coach celebrates their attempt and willingness to do something different. The ultimate purpose is to help parents to have small wins to increase SE by building self-confidence. Afterwards there is a quick review of the information taught in the parenting class that occurred in the previous week. After a brief recap, a self-reflective process occurs. The tele-coach asks the parent to reflect on what
was most helpful in the parenting class last week? The tele-coach then asks how he/she plans to incorporate this new technique or way of thinking? Both check in and review of last parenting class normally lasts about 10-12 minutes. The tele-coach then shares the objective for the week and provides a short introduction about the lesson for the day.

Research and psycho-education are used in addition to reflective questions and activities to keep the parents engaged. Parents engage in the sessions by answering questions, repeating phrases, taking verbal quizzes, sharing examples and doing relevant activities to help parents to process the new subject area and master techniques. As the session concludes the parents are asked “What do you want to leave with or take away from today’s session? “What short-term goal do you want to challenge yourself with in this upcoming week after engaging in today’s lesson?” Before the session concludes the tele-coach speaks words of encouragement through weekly affirmations and remind the parents that they are their child’s first teacher. The tele-coach emphasizes how their words, actions and behaviors are essential to their child’s well-being since children will mimic the behaviors they observe. The tele-coach repeats inspirational quotes based on the lesson covered to inspire and give parents hope with something positive to reflect on during the upcoming week. Throughout the 16-week tele-coaching program the tele-coach visits the class three times, in the beginning, middle and end to maintain a strong bond with parents and to remind parents of the value in coaching and the necessity of participating in the coaching sessions weekly to gain the best results.

**Four Phases of H.O.P.E Wellness Tele-Coaching Program**

The program consists of four phases. Each phase below consists of three to four
sessions. The tele-coach is flexible and works with the client to gain the most out of the tele-coaching program. Parents have to complete at least 12 separate sessions to fulfill the requirement for the program. While all sessions are completed in the 16-week timeframe, accommodations are made for the parents to succeed. Incomplete sessions are either made up during the same week that the session was missed, or in the following week. If the parent is incapable of completing a session due to unexpected life circumstances, two sessions will be combined in the upcoming week. Providing parents with flexibility allows the parent to gain better outcomes to thrive in a supportive environment. A demonstration of the four-phase model is listed below.
<table>
<thead>
<tr>
<th>Phases</th>
<th>Steps</th>
<th>Interventions</th>
<th>Goals</th>
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<tr>
<td><strong>Phase I</strong>&lt;br&gt;Introduction, evaluation, exploring attachment and family patterns</td>
<td>1. Conduct an outcome evaluation to find out about expectations of the program, introduce coaching program and begin exploration of hopes fears and relational patterns.</td>
<td>Create a trusting attachment bond by using a non-judgmental stance between coach and parent. Utilize psycho-education, research, pictures, reflective questions, genogram activities and a quiz.</td>
<td>Provide an overview of the program, evaluate parent’s expectations of program and help parents to gain perspective and create meaning of their past as they learn about nurturing, and both child and brain development.</td>
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<td><strong>Phase II</strong>&lt;br&gt;Empowering parents to break generational patterns by incorporating a new thought process, positive self-talk and holistic care</td>
<td>Use psycho-education, research and activities to help parents to engage in different thoughts and positive self-talk. Ask clients about conscious awareness of self and behaviors.</td>
<td>Use a systemic approach to ask reflective questions to create self-awareness and to determine what needs to happen differently for change to occur. Help parents to embrace positive self-talk, believe in self, and use visualization to view life differently through the use of engaging activities.</td>
<td>Help parents learn how to change their perceptions and embrace a new way of positive thinking and being to promote mental health and well-being for parent and child.</td>
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<td><strong>Phase III</strong>&lt;br&gt;Helping parents to better understand self and their own desires and utilize healthy strategies for success</td>
<td>Provide psycho-education, engage in and brainstorm, relaxation and stress management techniques that work. Discuss and learn about nurturing practices and challenge parents to incorporate techniques daily.</td>
<td>Use reflective questioning to help parents understand their value and gain motivation to prioritize self and work together on stress management and relaxation techniques.</td>
<td>Encourage parents to invest in themselves by learning and implementing coping strategies for them to live successfully.</td>
</tr>
<tr>
<td><strong>Phase IV</strong>&lt;br&gt;Put things into perspective, goal setting and writing new life story</td>
<td>Help parents to create and write specific, measurable action oriented, realistic and time conscious goals while creating customized systems that they can use.</td>
<td>Parents will learn how to and be prompted to write their own goals. They will also develop their new life story through this process.</td>
<td>Empower parents to create specific goals and reflect on past 16 weeks to write their new life story.</td>
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Phase I- Program Initiation: A Systemic Approach to Create Awareness

In the first phase the tele-coach engages in a verbal evaluation to assess the parents’ expectation of the tele-coaching program and determine if there are any concerns about engaging in this experience. The tele-coach orients the parent to the program and explains what they can expect from the process, the tele-coach and what is expected of them. The tele-coach determines if the parent has any hopes and fears. The first phase introduces the program and utilizes psycho-education to help parents understand brain and child development through attachment patterns. Assessing attachment and family patterns helps the tele-coach to determine the systemic relationship between parent behaviors in relation to family of origin.

Parents create self-awareness about their own family system by examining their own attachment style growing up with caretakers and in return make a direct correlation to how it impacts their parenting. Did the parent experience insecure attachments and negative family patterns growing up? Are they motivated to parent differently? Understanding the adverse childhood experiences that parents have faced helps the tele-coach to tap into the parents’ old narrative to promote resilience and foster change. The tele-coach uses reflective questions to create awareness, and self-reflective activities including a family tree with visual images to shift thoughts, emotions and behaviors from the subconscious mind to the conscious mind to create change.

Phase II- Creating a Paradigm Shift

Parents engage in a meaningful process to develop tools and techniques to promote change and begin the process of breaking generational patterns. The tele-coach help parents to understand their personal power to overcome any adversity. The tele-
coach also creates awareness and increases SE by helping parents to realize the physical and emotional impact of their thoughts and words. The tele-coach facilitates simple exercises that allow parents to repeat positive versus negative phrases to determine how it makes them feel (i.e., “I am a great parent” and “I am a special” versus “I am a terrible parent” and “I am a failure”). Helping parents to recognize the power of their thoughts and words and how it physically and emotionally affects them either in a positive or negative way is the beginning of creating a paradigm shift. When parents learn how to incorporate daily mantras (positive phrases) similar to “I feel great today,” “I can do anything that I put my mind to,” “I love myself,” and “I am a great parent,” it can prove to be very beneficial. Furthermore, engaging in visualization to imagine positive things occurring in parent lives can also help them to tap into their personal power to actively begin pursuit of this new outlook on life to gain better results.

In Phase II parents also evaluate themselves by learning how to assess their spirituality, physical and mental health, ability to nurture self and others and support systems. When working with the parents the tele-coach specifically utilizes a biological, psychological, social and spiritual (BPSS) approach to create meaning (Hickey et al., 2005) and explore how effective the parents’ self-care systems are. Increasing parental self-efficacy and self-awareness helps to promote well-being (Bandura, 2002; Kendall, Bloomfield, Appleton & Kitaoka, 2013) for both parent and child and promotes positive self-talk and cognition.

**Phase III- Self-Management and Development**

In Phase III the tele-coach help parents to reflect on the impact they are having on their children in comparison to the desired effect. The tele-coach reiterates the
importance of consistency and making positive changes. When parents gain a better understanding of their emotions and engage in self-reflection through the use of reflective questions, they can create meaning and become more attuned to their triggers and emotional process to better regulate their own emotions and behaviors. As parents further explore the root cause of their stress and understand the perils of chronic stress they will recognize the importance of doing their best to live a healthier life. As parents honestly reflect on their reactivity and ability to manage themselves when faced with chronic stress, anger or feel a loss of control, they can learn techniques to engage in healthy self-care practices and explore tools to be more successful in their lives and incorporate new stress management techniques to better manage stress.

Parents also learn simple relaxation techniques that they can do almost anywhere. As parents become more attuned to the relationship between their brain and bodily reactions, and observe their triggers they can learn healthy ways to respond. We explore triggers that occur right before emotional reactivity and engage in a self-reflective process to create awareness and responsiveness. The goal is to promote a paradigm shift and encourage responsive behaviors by helping parents to slow themselves down before impulsively reacting in a negative way.

**Phase IV - Goal Setting and Creating a New Story**

The final phase of the H.O.P.E. tele-coaching program help parents to reflect on the entire program. Parents reflect on the systems and routines that they have in place or need to develop and evaluate how their systems are working. This gives parents a keen insight into what needs to happen differently. The tele-coach will collaboratively work with parents to incorporate parenting tips and strategies learned throughout the program
to create customized systems and gain favorable outcomes. The tele-coach helps parents to create realistic ways to utilize their time more efficiently. One successful approach is assisting parents in making a daily schedule. Whether the daily schedule is written down or spoken into a device, the idea is to take control by setting realistic daily goals that are achievable. The tele-coach engages in this activity weekly with parents to facilitate this process.

Parents go one step further by learning how to set S.M.A.R.T. goals. The acronym for a S.M.A.R.T goal is specific, measurable, action oriented, realistic and time-bound (Issel, 2014). Parent goals are specific to personal, relational and family growth. Using a Solutions-focused (Grant, 2001) approach helps parents to think futuristically. Goal setting helps to encourage parents to believe in their capabilities by working towards a brighter future. To conclude parents utilize a Narrative approach (White, 2007) to reflect on their growth over the past 16 weeks and write their new life story. The wellness coach empowers the parent to tap into his/her personal power, be the parent he/she wants to be by embracing positive thoughts, words and action. Embracing a new thought process and writing a new life story can help parents to gain better control of their lives, make better life choices and create a paradigm shift.

**Graduation**

Graduation occurs in person during the final parenting class. Each parent receives a certificate for the completion of the tele-coaching sessions and a certificate for the completion of the parenting classes. This is a moment to celebrate parents for their hard work and help them to feel proud about their accomplishment.
Conclusion

Mental health professionals and health care providers have realized that providing information is not enough to create change. Unless a parent obtains the necessary support, is consciously aware of how to create change and motivate themselves to engage in the process of change, quite often, change does not occur especially when there is a consistent challenge with low attendance and high attrition rates. High attrition rates in psychotherapy and other community mental health programs pose a major problem for mental health care professionals. Marriage and family therapists may be able to provide various benefits to parents by partnering with community organizations. Utilizing evidence based parenting practices (Bavelok, 2002; Carta, et al, 2013) and offering a more personalized coaching approach may also contribute to the improvement of retention rates and promote protective factors (i.e., secure parent/child attachments, stress management, self-regulation, parental self-efficacy) for high-risk families being targeted. The telecoaching intervention introduced in this paper is an alternative method that can work alongside EBPPs to help high risk families to gain the necessary support, promote well-being and create a paradigm shift to help families to thrive.
References


CHAPTER SEVEN
DISCUSSION/IMPLICATIONS

“Love begins at home, and it is not how much we do but how much love we put in that action.” - Mother Teresa

Engaging with community service providers in real life settings offers critical contributions to the literature and the social science field at large. It is at this junction where evidence based programs begin to matter not just from an academic standpoint but more importantly to the community, assuming they translate into success in these settings as well. In this study, the researcher had the opportunity to partner with two community organizations, Reach Out and First 5 of San Bernardino, to help high-risk families involved in the court system to improve their parenting skills—many as an only option to regain custody of their children. It is exciting to note that both NPP programs the one with the addition of case management, and the one with the additional tele-coaching on top of case management worked. Indeed, our preliminary data suggest that there was no significant benefit of adding tele-coaching to the case management.

Nevertheless, many participants responded very positively to the personalized “easy” access approach of tele-coaching. Families shared how tele-coaching was not just about parenting, one partner stated, “it was more than just parenting it was about me as a person, a parent and a partner, I gained so much from it.” Another parent stated, “It was life changing and I don’t know where my relationship would be without it.” Some participants shared that they understood the importance of embracing positive thoughts and creating daily mantras to promote the power of positive self-talk starting from within. Others really appreciated the psycho-education, research, and activities, while some really felt valued and supported through the weekly phone calls and knowing that
someone would call to check in with them weekly. Watching parents grow over the 16-week process was an unexplainable experience, and gaining the experience first hand, on how to implement randomized control trials is a major asset to any researcher. While every program has highlights, there are also challenges. The next section will discuss the strengths and limitations of this study.

**Strengths**

There were several strengths and advantages to this study. The initial design was set out to explore if tele-coaching was a convenient but effective approach for parents to engage with additional one-on-one parenting skills development in the privacy of their own homes. While our ability to partner with community-based organizations is extremely laudable and should be replicated by others, some precautions should be noted when entering in a close research partnership with research in-experienced partners. Since the organization was truly invested and cared about the well-being of families in the community that they serve, they did all they could to share what they learned from the researcher with their clients—indeed so much so, that the added intervention content was shared with all. Clearly much more education of our community partners of what is involved in a comparative study would need to happen.

While the lapses in the execution of the design did not allow us to effectively compare the two conditions, the study was nevertheless beneficial in showing that the families that received the 16-week intervention in either condition had consistently significant outcomes, an important finding as the population we served were high-risk families who usually struggle to gain positive outcomes. Using a mixed method
approach we furthermore learned much about how these families engaged with the new modality suggested the promise of tele-coaching in future intervention studies with parents.

Partnering with high-risk families that often times have severe trust issues with community organizations due to prior or current court involvement or pending child abuse cases, makes it important to utilize multiple techniques to gather the true narrative of the family. Incorporating both pre and post outcome and process evaluations helped to enrich the overall value of the study and gain a meaningful perspective directly from the families involved to determine how they experienced the tele-coaching process and whether or not they felt supported. They also provided valuable feedback on the elements of tele-coaching that was most helpful. Lastly, doing a randomized control study in the field of marriage and family therapy adds to the body of research for social scientists but even more specifically for marriage and family therapists.

**Limitations**

While we learned a lot we also have several noted limitations. What we learned from this study is that in a live clinical intervention trial there are numerous ever-changing parts that need to be monitored and managed such as survey collection, the intervention, implementation and fidelity, and finally data entry and analysis. It is important to have a strong checks and balances system every step of the way to ensure high quality of your intervention and data distribution and collection. Clearly, according to our original design we did not envision that the community partner would add a seven sessions a week case management to the base NPP. This indeed highly contaminated a
well-defined comparison between NPP and tele-coaching. Without this additional component (case management) we likely would have had a stronger affect on the Nurturing Parenting Program. The researcher should have insisted that the case management sessions act as a comparison group (delivered only to the control group) instead of adding it simultaneously to both the intervention of the tele-coaching personalized support services. This would have allowed us to compare NPP + case management to NPP+ tele-coaching- a compelling exploration as clearly the high need clients served by this agency needed more than just NPP alone.

Another limitation was that one could argue that having one person to facilitate the intervention is good for fidelity purposes, nevertheless, but this does not allow an investigation if the success observed was due to the person who delivered it or truly due to the modality. In the future, it would be helpful to repeat the intervention with a small team of tele-coaches. Additionally, while the data collection was managed fairly well by an office staff person from Reach Out who voluntarily assisted, there were still some data collection errors. We were unable to utilize surveys in one class because one group did not sign the consent forms prior to beginning the study so those participants had to be excluded. Thus including a research assistant to manage the day-to-day operations of multiple sites for a study this involved would have helped to minimize errors and increase results. Finally, as a pilot study, the sample size N=57 was relatively small and likely was not able to achieve power allowing us to further probe mechanisms behind the changes we observed.
Theory

As the field of social science advances we have recognized the importance of the reciprocal interaction between theory and science and how they both contribute to the development of a systemic explanation of experiences (Lavee & Dollahite, 1991). Due to the complexity of poverty, child maltreatment and the adverse effect that they both have on the family unit and society (Fang, Brown, Florence & Mercy, 2012), the author provided a comprehensive overview of the literature and selected the theories that would be the most suitable for this study.

This current study used a conceptual framework that was informed by three theories (i.e., social cognitive theory, attachment theory and family systems theory) to analyze the contributing factors and better comprehend the association amongst those factors. Social cognitive theory is a theory that focuses on individual development. This theory underlies the concept that the reciprocal nature of influences is what produces behavior (Bandura, 1986:1991). Attachment theory focuses on the parent/child dyad and states that every individual is “born” to connect and maintain a strong affectionate bond with another human being (Bowlby, 1973:1980). These attachment bonds are critical in childhood and throughout adulthood. Lastly, this study utilized a bio-psycho social spiritual (BPSS) systemic lens to gain a more comprehensive understanding of family systems to view the interactional patterns of the family.

The current study examined the major concepts of each theory as operationalized by key variables associated with each theory and provided a detailed explanation of the relationships amongst these factors. While, it was difficult to gain a holistic picture from each theory individually the author utilized this study to add to the existing literature and
provided a comprehensive overview of parent(s) and parent/child relationships by combining three theories. Understanding the intrinsic and extrinsic factors that contribute to healthier parents’ attitudes, thoughts and behaviors in low SES families is essential for family growth. Applying Bandura’s perspective (1986), parents had to gain self-awareness and reflect self-thoughts and behaviors and learn new healthy ways of being through modeling, information and experience. They also had to learn how to regulate their emotions to better manage stress and to be able to model that healthy trait to their children. Helping parents to create a healthy attachment bond, become nurturing and increase parental self-efficacy through providing practical tools and helping parents to better manage stressful situations, empowered parents to break negative family patterns from their childhood system and it helped them to become consciously aware of the negative behaviors and perceptions they embraced that promoted new opportunities and pathways to engage in new patterns. Combining these three theories proved to be very meaningful in this study. NPP+ tele-coaching is clearly an innovative approach to help families to experience significant growth and future studies should in a cleaner design evaluate one additional modality to another weighing factors such as resources, cost and reception by clients.

**Clinical Implications**

Due to the high dropout rates in psychotherapy mental health care professionals need to consider more desirable ways to increase retention (Hamilton, Moore, Crane & Payne, 2011). This is especially true for ethnic minority families from a low socioeconomic background with young children who face multiple challenges to
parenting success. This study utilized new methods to service delivery to decrease attrition rates (Lingle-Pottie & McGrath, 2007; 2008) for both groups-clearly adding to the NPP worked well in both cases as we experienced low drop-out rates. Current literature has demonstrated that multiple resources are often necessary to affect relational change in families (Patterson & Vakili, 2014).

Findings from this research can now help to inform a more detailed plan for the design and implementation of evidence-based parenting programs inclusive of a tele-coaching vs. another alternative to parenting services one for which parents have to come to a site yet gain (case management, vs. one where they can get personalized attention in the privacy of their home by phone. Though psychotherapists were the primary coaches involved in this study, collaboration with other professionals and community organizations will play a significant role in the development of this evidence based family program inclusive of tele-coaching.

Policy

Early childhood policy and program development indicates that EB interventions can significantly improve life outcomes (Shonkoff, 2010; Allen, 2011). The author hopes that this study is the first of many that continues to highlight the economic and mental health advantages to families of this type of evidence-based + approach that critically need the program due to a recommendation, a mandate, or having limited tools and strategies on parenting. Attending parenting programs with additional resources and support programs added similar to tele-coaching that are convenient and cost efficient is beneficial. The next steps to consider on a policy level would be for policymakers to
consider funders to support the needed additional dose that tele-coaching interventions provide and allow clinicians to bill for such services if their needs are assessed to be high enough. This kind of expansion existing programs would likely increase the well-being of these high need families and positively impact society on a whole.

**Future Research**

This current study proposed that when low SES families who have a higher risk of child maltreatment attends a 16 week “Nurturing Parenting Program” with the addition of aligned weekly 30-60 minute tele-coaching sessions would result in significant improvement in parenting related outcomes. Since the study was not able to make a clear distinction of the significant impact of tele-coaching vs. case management alone, the researcher recommends that the study is repeated in a similar population that separates the 2 conditions more clearly with one group receiving NPP + case management and one group receiving NPP + telecoaching. Future research could also explore a program alternative of online or web based communication in comparison to face-to-face coaching and phone coaching to determine who has the greatest effect.

This study is important because we live in a changing society with increasing dependency on ever improving communication technologies (Sood, et al., 2007). Technology communication is the foreseeable way of the future, therefore we need to consider various forms of communication beyond traditional therapy or face-to-face services to reach families in the 21st century. Tele-health has increasingly been used in other fields, especially in the health field, suggesting that professionals in the mental health field should also consider embracing alternative ways of service delivery. It is
important for mental health to stay competitive and remain on the cutting edge of services that are effective, cost efficient and may offer an increase in retention rates. Indeed we found that clients liked and preferred the tele-coaching modality suggesting that it will likely work as an alternative to support services for high-risk families, and a more efficient way to deliver services to families. Lastly, our study contributes to the argument one can and should develop community partnerships and conduct rigorous real life research (Patterson & Vakili, 2014), but also that one should be cautious and provide sufficient training and oversight to not experience the type of challenges we encountered.
References


Shonkoff, J. P., Garner, A. S., The Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care,


APPENDIX A

SURVEY QUESTIONNAIRES

INSTRUCTIONS:

There are 40 statements in this booklet. They are statements about parenting and raising children. You decide the degree to which you agree or disagree with each statement by circling one of the responses.

**STRONGLY AGREE** – Circle SA if you strongly support the statement, or feel the statement is true most of the time.

**AGREE** – Circle A if you support the statement, or feel this statement is true some of the time.

**STRONGLY DISAGREE** – Circle SD if you feel strongly against the statement, or feel the statement is not true.

**DISAGREE** – Circle D if you feel you cannot support the statement or that the statement is not true some of the time.

**UNCERTAIN** – Circle U only when it is impossible to decide on one of the other choices.

When you are told to turn the page, begin with Number 1 and go on until you finish all the statements. In answering them, please keep these four points in mind:

1. Respond to the statements truthfully. There is no advantage in giving an untrue response because you think it is the right thing to say. There really is no right or wrong answer – only your opinion.

2. Respond to the statements as quickly as you can. Give the first natural response that comes to mind.

3. Circle only one response for each statement.

4. Although some statements may seem much like others, no two statements are exactly alike. Make sure you respond to every statement.

If there is anything you don’t understand, please ask your questions now. If you come across a word you don’t know while responding to a statement, ask the examiner for help.

**PLEASE TURN THE PAGE AND BEGIN...**
Adult-Adolescent Parenting Inventory (AAPI-2)
Stephen J. Bavelier, Ph.D. and Richard G. Keene, Ph.D.

Test Form A
This test can only be scored online at assessingparenting.com

Before you take the Inventory, we need some important information from you.

1. Administered on: ________________ ________________ ________________
   Month Year Date

2. First Name: ________________________________

3. Middle Initial (optional): ________________

4. Last Name: ________________________________ Last 4 digits of SSN# (optional): ________________

5. Birthday: ________________ ________________ ________________
   Month Year Date

6. Gender: ○ Male ○ Female

7. Race: ○ Unknown ○ White ○ Black ○ Asian ○ Hispanic ○ Native American ○ Pacific Islander
   Nationality: ________________________________

8. Marital Status: ○ Unknown ○ Single ○ Married ○ Divorced ○ Unmarried Partners
   ○ Separated ○ Widowed

9. How many children do you have: ________________

10. What is the highest grade you completed in school: ○ Unknown ○ Grade School ○ 7th Grade ○ 8th Grade
    ○ 9th Grade ○ 10th Grade ○ 11th Grade ○ High School Grad ○ Some College ○ College Graduate
    ○ Post-Graduate or above

11. What is your employment status: ○ Unknown ○ Employed Full Time
    ○ Unemployed ○ Not Employed because of Disability
    ○ Employed Part Time ○ Retired

12. What is your annual household income: ○ Unknown ○ $25,001 - $40,000
    ○ Under $15,000 ○ $40,001 - $50,000
    ○ $15,001 - $25,000 ○ Over $60,000

13. Were you and/or your partner in the military: ○ Unknown
    ○ No ○ Yes, both of us
    ○ Yes, only my partner ○ Yes, only me

14. As a child, did you experience any type of abuse by a person:
    a. Outside your family? ○ Don't Know ○ Yes ○ No
    b. Within your family? ○ Don't Know ○ Yes ○ No

(800) 668-5822 • (435) 649-5822 (outside the United States) • fdr@nurturingparenting.com
www.assessingparenting.com

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<table>
<thead>
<tr>
<th>AAPI Online - Form A</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Uncertain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Children need to be allowed freedom to explore their world in safety.</td>
<td>SA</td>
<td>A</td>
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<td>2. Time-out is an effective way to discipline children.</td>
<td>SA</td>
<td>A</td>
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<tr>
<td>3. Children who are one-year-old should be able to stay away from things that could harm them.</td>
<td>SA</td>
<td>A</td>
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<td>4. Strong-willed children must be taught to mind their parents.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>5. The sooner children learn to feed and dress themselves and use the toilet, the better off they will be as adults.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
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<td>6. Spanking teaches children right from wrong.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
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<tr>
<td>7. Babies need to learn how to be considerate of the needs of their mother.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
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<td>8. Strict discipline is the best way to raise children.</td>
<td>SA</td>
<td>A</td>
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<td>9. Parents who nurture themselves make better parents.</td>
<td>SA</td>
<td>A</td>
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<tr>
<td>10. Children can learn good discipline without being spanked.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
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<td>11. Children have a responsibility to please their parents.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
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<tr>
<td>12. Good children always obey their parents.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
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<tr>
<td>13. In father's absence, the son needs to become the man of the house.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
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<tr>
<td>14. A good spanking never hurt anyone.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
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<tr>
<td>15. Parents need to push their children to do better.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
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<tr>
<td>16. Children should keep their feelings to themselves.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
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<tr>
<td>17. Children should be aware of ways to comfort their parents after a hard day's work.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
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<td>18. Children learn respect through strict discipline.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
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<tr>
<td>19. Hitting a child out of love is different than hitting a child out of anger.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
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<td>20. A good child sleeps through the night.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
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<tr>
<td>21. Children should be potty trained when they are ready and not before.</td>
<td>SA</td>
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<td>AAPI Online - Form A</td>
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<td>22. A certain amount of fear is necessary for children to respect their parents.</td>
<td>SA</td>
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<td>23. Spanking teaches children it's alright to hit others.</td>
<td>SA</td>
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<td>24. Children who feel secure often grow up expecting too much.</td>
<td>SA</td>
<td>A</td>
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<tr>
<td>25. There is nothing worse than a strong-willed two-year-old.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
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<tr>
<td>26. Sometimes spanking is the only thing that will work.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
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<tr>
<td>27. Children who receive praise will think too much of themselves.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
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</tr>
<tr>
<td>28. Children should do what they're told to do, when they're told to do it. It's that simple.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
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<tr>
<td>29. Children should be taught to obey their parents at all times.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
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<td>30. Children should know what their parents need without being told.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
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<td>31. Children should be responsible for the well-being of their parents.</td>
<td>SA</td>
<td>A</td>
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<td>32. It's OK to spank as a last resort.</td>
<td>SA</td>
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<tr>
<td>33. Parents should be able to confide in their children.</td>
<td>SA</td>
<td>A</td>
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<tr>
<td>34. Parents who encourage their children to talk to them only end up listening to complaints.</td>
<td>SA</td>
<td>A</td>
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<td>35. Children need discipline, not spanking.</td>
<td>SA</td>
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<tr>
<td>36. Letting a child sleep in the parents' bed every now and then is a bad idea.</td>
<td>SA</td>
<td>A</td>
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<td>37. A good spanking lets children know parents mean business.</td>
<td>SA</td>
<td>A</td>
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<td>38. A good child will comfort both parents after they have argued.</td>
<td>SA</td>
<td>A</td>
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<tr>
<td>39. &quot;Because I said so&quot; is the only reason parents need to give.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
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<tr>
<td>40. Children should be their parents' best friend.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
</tbody>
</table>
INSTRUCTIONS:

There are 40 statements in this booklet. They are statements about parenting and raising children. You decide the degree to which you agree or disagree with each statement by circling one of the responses.

**STRONGLY AGREE** – Circle SA if you strongly support the statement, or feel the statement is true most of all the time.

**AGREE** – Circle A if you support the statement, or feel this statement is true some of the time.

**STRONGLY DISAGREE** – Circle SD if you feel strongly against the statement, or feel the statement is not true.

**DISAGREE** – Circle D if you feel you cannot support the statement or that the statement is not true some of the time.

**UNCERTAIN** – Circle U only when it is impossible to decide on one of the other choices.

When you are told to turn the page, begin with Number 1 and go on until you finish all the statements. In answering them, please keep these four points in mind:

1. Respond to the statements truthfully. There is no advantage in giving an untrue response because you think it is the right thing to say. There really is no right or wrong answer – only your opinion.

2. Respond to the statements as quickly as you can. Give the first natural response that comes to mind.

3. Circle only one response for each statement.

4. Although some statements may seem much like others, no two statements are exactly alike. Make sure you respond to every statement.

If there is anything you don’t understand, please ask your questions now. If you come across a word you don’t know while responding to a statement, ask the examiner for help.

PLEASE TURN THE PAGE AND BEGIN...
Adult-Adolescent Parenting Inventory (AAPI-2)
Stephen J. Bavolek, Ph.D. and Richard G. Keene, Ph.D.

Test Form B
This test can only be scored online at assessingparenting.com

Before you take the inventory, we need some important information from you.

1. Administered on: ____________________________
   Month     Year     Date

2. First Name: _________________________________

3. Middle Initial (optional): __________________

4. Last Name: ____________________________ Last 4 digits of SSN# (optional): ____________

5. Birthday: ________________________________
   Month     Year     Date

6. Gender: ○ Male ○ Female

7. Race: ○ Unknown ○ White ○ Black ○ Asian ○ Hispanic ○ Native American ○ Pacific Islander
   Nationality: _________________________________

8. Marital Status: ○ Unknown ○ Single ○ Married ○ Divorced ○ Unmarried Partners
   ○ Separated ○ Widowed

9. How many children do you have: __________

10. What is the highest grade you completed in school: ○ Unknown ○ Grade School ○ 7th Grade ○ 8th Grade
    ○ 9th Grade ○ 10th Grade ○ 11th Grade ○ High School Grad ○ Some College ○ College Graduate
    ○ Post-Graduate or above

11. What is your employment status: ○ Unknown ○ Employed Full Time
    ○ Unemployed ○ Not Employed because of Disability
    ○ Employed Part Time ○ Retired

12. What is your annual household income: ○ Unknown ○ $25,001 - $40,000
    ○ Under $15,000 ○ $40,001 - $60,000
    ○ $15,001 - $25,000 ○ Over $60,000

13. Were you and/or your partner in the military: ○ Unknown
    ○ No
    ○ Yes, both of us
    ○ Yes, only my partner
    ○ Yes, only me

14. As a child, did you experience any type of abuse by a person:
    a. Outside your family? ○ Don't Know ○ Yes ○ No
    b. Within your family? ○ Don't Know ○ Yes ○ No

(800) 686-5822 • (435) 649-5822 (outside the United States) • fdr@nurturingparenting.com
www.assessingparenting.com

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<table>
<thead>
<tr>
<th>AAPI Online - Form B</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Uncertain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Children who learn to recognize feelings in others are more successful in life.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>2. Children who bite others need to be bitten to teach them what it feels like.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>3. Children should be the main source of comfort for their parents.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>4. You cannot teach children respect by spanking them.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>5. Children should be taught to obey their parents at all times.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>6. Parents should expect more from boys than girls.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>7. Children who express their opinions usually make things worse.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>8. If a child is old enough to defy a parent, then he or she is old enough to be spanked.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>9. Older children should be responsible for the care of their younger brothers and sisters.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>10. Crying is a sign of weakness in boys.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>11. Parents spoil babies by picking them up when they cry.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>12. If you love your children, you will spank them when they misbehave.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>13. Praising children is a good way to build their self-esteem.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>14. Children cry just to get attention.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>15. Parents who are sensitive to their children's feelings and moods often spank them.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>16. In father's absence, the son needs to become the man of the house.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>17. Mild spankings can begin between 15 to 18 months.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>18. Give children an inch and they'll take a mile.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>19. The less children know, the better off they are.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>20. Rewarding children's appropriate behavior is a good form of discipline.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>AAPI Online - Form B</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
<td>Uncertain</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------</td>
<td>-------</td>
<td>----------</td>
<td>-------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>21. Children should be considerate of their parents' needs.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>22. Never hit a child.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>23. Children should be seen and not heard.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>24. Good children always obey their parents.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>25. Children learn violence from their parents.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>26. Two-year-old children make a terrible mess of everything.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>27. Parents' expectations of their children should be high but appropriate.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>28. The problem with kids today is that parents give them too much freedom.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>29. Children who are spanked behave better than children who are not spanked.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>30. Children should offer comfort when their parents are sad.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>31. Children should be obedient to authority figures.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>32. Children need to be potty trained as soon as they are two years old.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>33. Strong-willed toddlers need to be spanked to get them to behave.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>34. Children today have it too easy.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>35. Children should know when their parents are tired.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>36. Children who are spanked usually feel resentful towards their parents.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>37. Parents' needs are more important than their children's.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>38. Spanking children when they misbehave teaches them how to behave.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>39. Parents who encourage their children to talk to them only end up listening to complaints.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
<tr>
<td>40. Consequences are necessary for family rules to have meaning.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
<td>U</td>
</tr>
</tbody>
</table>
CERQ(C)

How do you cope with events?
Everyone gets confronted with negative or unpleasant events now and then and everyone responds to them in his or her own way. By the following questions you are asked to indicate what you generally think, when you experience negative or unpleasant events.

<table>
<thead>
<tr>
<th>(almost) never</th>
<th>sometimes</th>
<th>regularly</th>
<th>often</th>
<th>(almost) always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I often think about how I feel about what I have experienced</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I think of nicer things than what I have experienced</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I think of what I can do best</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I think I can learn something from the situation</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I am preoccupied with what I think and feel about what I have experienced</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I think of pleasant things that have nothing to do with it</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I think about how I can best cope with the situation</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I think that I can become a stronger person as a result of what has happened</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I want to understand why I feel the way I do about what I have experienced</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. I think of something nice instead of what has happened</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. I think about how to change the situation</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. I think that the situation also has it’s positive sides</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. I think that it hasn’t been too bad compared to other things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. I dwell upon the feelings the situation has evoked in me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. I think about pleasant experiences</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. I think about a plan of what I can do best</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. I look for the positive sides to the matter</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. I tell myself that there are worse things in life</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Thank you for filling out the questionnaire!
Self-Evaluation (SE) Questionnaire

Directions: Everyone has beliefs about their ability to perform in various situations. On the statements below, please rate your confidence level about performing in your personal life, as well as your parenting abilities and your perspective on setting future goals on a regular basis. Please rate your confidence level by circling a number from 0 to 100 using the scale with zero being low confidence and 100 being high confidence.

1. I feel confident managing stress using relaxation techniques.
   0 10 20 30 40 50 60 70 80 90 100

2. I feel confident thinking of positive images and saying positive words to myself to manage stress.
   0 10 20 30 40 50 60 70 80 90 100

3. I feel confident asking for the social support I need when I feel a loss of control.
   0 10 20 30 40 50 60 70 80 90 100

4. I feel confident tapping into my spirituality to manage stress (prayer, faith and/or religion).
   0 10 20 30 40 50 60 70 80 90 100

5. I feel confident managing my stress through physical activity/exercise.
   0 10 20 30 40 50 60 70 80 90 100

6. I feel confident managing my depression.
   0 10 20 30 40 50 60 70 80 90 100

7. I feel confident managing my anxiety.
   0 10 20 30 40 50 60 70 80 90 100

8. I can understand child development and be responsive to my child’s needs.
   0 10 20 30 40 50 60 70 80 90 100

9. I am confident in my ability to manage the daily tasks of parenting.
   0 10 20 30 40 50 60 70 80 90 100

10. I am confident that I can securely attach/bond with my child even in difficult situations/life’s phases.
    0 10 20 30 40 50 60 70 80 90 100

11. I am confident that my childhood attachment helps me to attach/bond with my child in difficult times.
    0 10 20 30 40 50 60 70 80 90 100

12. I can understand the importance of creating a safe/maturing environment for my child to explore the world.
    0 10 20 30 40 50 60 70 80 90 100

13. I can manage my emotions as a parent and help my child to manage his/her emotions on a daily basis.
    0 10 20 30 40 50 60 70 80 90 100

14. I can set realistic short-term goals and achieve them.
    0 10 20 30 40 50 60 70 80 90 100

15. I can set realistic long-term goals and achieve them.
    0 10 20 30 40 50 60 70 80 90 100

16. I feel confident about planning for a better future for my family and myself.
    0 10 20 30 40 50 60 70 80 90 100

17. I can still plan and be hopeful about the future when setbacks happen.
    0 10 20 30 40 50 60 70 80 90 100
APPENDIX B

IRB APPLICATION AND APPENDICES

INSTITUTIONAL REVIEW BOARD
RESEARCH PROTECTION PROGRAMS
24887 Taylor Street • Suite 202 • Loma Linda, CA 92350
(909) 558-4531 (voice) • (909) 558-0131 (fax)

---

Extension Requested - Approval Notice Expedited

To: Montgomery, Susanne B
Department: Social Work and Social Ecology
Protocol: A tele-coaching intervention to support low SES families in the "nurturing parenting program": A randomized controlled trial

Your request to extend the protocol indicated above has been reviewed administratively. This review resulted in the following determinations:

- Extension Request: Approved
- Risk to research subjects: Minimal
- Approval period begins: 23-Mar-2016 and ends 22-Mar-2017
- Stipulations of approval:

Consent Form
If this study was approved on the condition that a consent form is required AND subjects are still being enrolled, only the consent form bearing the IRB authorization stamp can be used. This will become your OFFICIAL consent form for the dates specified and should be used as the new master for making copies to give prospective subjects.

☑ Master consent form with up-dated authorized stamp enclosed.

☐ Updated consent form not required. Approval limited to data analysis or follow-up of currently enrolled subjects only.

☐ Not applicable; IRB approved a waiver of informed consent, as noted above.

IRB Communications
Please continue to notify the IRB in writing of any modifications or adverse events relating to the approved research protocol. Your assistance in providing the PI's name and the protocol's IRB # on all communications with the IRB about this project will expedite necessary communications.

Thank you for your cooperation in LLU's shared responsibility for the ethical use of human subjects in research.

IRB Chair/Designee 3/23/14

Date
INSTITUTIONAL REVIEW BOARD
RESEARCH PROTECTION PROGRAMS
24887 Taylor Street • Suite 202 • Loma Linda, CA 92350
(909) 558-4531 (voice) • (909) 558-0131 (fax)

Initial Approval Notice - Expedited

To: Montgomery, Susanne B
Department: Social Work and Social Ecology
Protocol: A tele-coaching intervention to support low SES families in the "nurturing parenting program." A randomized controlled trial

This study was reviewed and approved administratively on behalf of the IRB. This decision includes the following determinations:
- Risk to research subjects: Minimal
- Stipulations of approval:
  See attached list of items (if applicable).
  See Appendix A for Conditions of Approval.

Adverse events and unanticipated problems must be reported in accord with the attached Adverse Event Reporting Matrix A.

All investigators are responsible for assuring that studies are conducted according to the approved protocol. Principal investigators are responsible for the actions of sub-investigators and staff with regard to this approval.

Please note the PI's name and the assigned IRB number, as indicated above, on any future communications with the IRB.

Direct all communications to the IRB c/o Research Protection Programs.

Thank you for your cooperation in LLU's shared responsibility for the ethical use of human subject in research.

Signature of IRB Chair/Designee: [Signature]
Date: 3/25/15

Loma Linda University Adventist Health Sciences Center holds Federally-Required Assurance (FRA) No. 00000447 with the U.S. Office for Human Research Protections and the IRB registration no. is #OR025000329. This Assurance applies to the following: Loma Linda University, Loma Linda University Medical Center (including Loma Linda University Children's Hospital, LLU Community Medical Center), Loma Linda University Behavioral Medicine, and affiliated medical practices groups.

IRB Chair:
Rhodas L. Rigby, MD, MBA
Department of Medicine
(909) 558-2341, rigby@llu.edu

IRB Administrator:
Linda G. Halstead, MA, Director
Research Protection Programs
Ext 43570, Fax 80131, halstead@llu.edu

IRB Analyst:
Anuradha Diedmann, MPH, CCRP
Research Protection Programs
Ext 86215, Fax 80131, adiedmann@llu.edu

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A tele-coaching intervention in the Nurturing Parenting Program: A randomized controlled trial

WHAT ARE THE REASONABLY FORESEEABLE RISKS OR DISCOMFORTS I MIGHT HAVE?
There are minimal risks to participating in this study. The most specific type of risk is a breach of confidentiality. The Nurturing Parenting Program/REACH Out also has mandatory reporting protocols, which requires reporting of suspected child abuse. All participants will be advised of the protocols. If a parent experiences emotional distress or become upset and it requires attention outside of the expertise of the parenting coach then referrals will be provided for affordable counseling services to the participant at Catholic Charities or Care Counselors.

WILL THERE BE ANY BENEFIT TO ME OR OTHERS?
Direct benefits will include gaining an increased understanding of self, parenting style and parenting.

WHAT ARE MY RIGHTS AS A PARTICIPANT?
If you have any concerns, please call the lead investigator, Dr. Susanne Montgomery at (909) 558-9586 for more information and assistance. If you wish to contact an impartial third party not associated with this study regarding any questions about your rights or to report a complaint you may have about the study, you may contact the Office of Patient Relations, Loma Linda University Medical Center, Loma Linda, CA 92353 (909) 558-4647, patientrelations@llu.edu for further assistance.

HOW WILL INFORMATION ABOUT ME BE KEPT CONFIDENTIAL?
Confidentiality risks will be handled by removing identification from surveys and audio files and entering information into an electronic data file that is password protected. ID numbers will be assigned and the consent form will be stored in separate filing cabinets. Numbers will be assigned and identifying information will be removed at the end of the study. Also, if a participant does not wish to continue at any time, he/she can stop without any negative effect on their participation in the program.

WILL I BE PAID TO PARTICIPATE IN THIS STUDY?
You will receive a $25 thank you gift card for volunteering your time to complete the three surveys. Participants that are selected to receive coaching in the study will also need to complete at least 12 out of 16 coaching sessions. You will also be entered into a raffle and one person will win an I-pad.

PARTICIPANT'S STATEMENT OF CONSENT
- I have read the contents of the consent form and have listened to the verbal explanation given.
- My questions concerning this study have been answered to my satisfaction.
- Signing this consent document does not waive my rights
- I hereby give voluntary consent to participate in this study. I understand I will be given a copy of this consent form after signing it.

______________________________  ______________________________
Signature of Participant                  Printed Name of Participant

__________________
Date

INVESTIGATOR'S STATEMENT
I have reviewed the contents of this consent form with the person signing above. I have explained potential risks and benefits of the study.

______________________________  ______________________________
Signature of Investigator                  Printed Name of Investigator

__________________
Date

Loma Linda University
Adventist Health Sciences Center
Institutional Review Board
Approved 3/25/15 Void after 3/15/2016
Chair R.T. Regier, M.D.

180
A tele-coaching intervention in the Nurturing Parenting Program: A randomized controlled trial

LOMA LINDA UNIVERSITY
INFORMED CONSENT

TITLE: A TELE-COACHING INTERVENTION TO SUPPORT LOW SES FAMILIES IN THE "NURTURING PARENTING PROGRAM:" A RANDOMIZED CONTROLLED TRIAL

SPONSOR/COLLABORATORS: First 5 in San Bernardino and REACH Out Organization
PRINCIPAL INVESTIGATOR: Susanne Montgomery, MS, MPH, PhD, Loma Linda University
STUDENT INVESTIGATOR: Wendella Wray, MS, M.Ed., PhD (c) Loma Linda University

WHY IS THIS STUDY BEING DONE?
The purpose of this study is to help support parents with children between the ages of 0-5 who attend the 16-week parenting program by adding a phone coaching intervention. The goal of the phone coaching is to provide additional support for parents attending the 16-week 1½ - 2 hour a week Nurturing Parenting Program by reviewing the objectives learned in the program and also to incorporate techniques that promote well-being for parents. The study will determine whether adding a phone coaching intervention improves the overall results of the parenting program in comparison to a parenting program alone.

HOW MANY PEOPLE WILL TAKE PART IN THIS STUDY?
The study will have 140 parents in 10-12 groups. Since the study is randomized by location half of the sites will receive a phone coaching intervention in addition to the parenting program and the other half of the sites will receive the parenting program interventions alone. The surveys and evaluations will be administered to all 140 subjects attending the parenting program groups. The study will be offered to both parents or to the sole parent attending the parenting program.

HOW LONG WILL THE STUDY GO ON?
The study will be a 16-week coaching program and a follow-up will be done 3 months post the study.

HOW WILL I BE INVOLVED?
Some of you will receive a 30-45 minutes coaching session over the phone once a week in addition to the parenting program that you will attend weekly. Parents will also be asked to complete a pre and post survey when the program ends. A follow-up survey will be offered 3 months after the program ends to determine whether the phone coaching intervention improves the overall results of the parenting program. You will also complete a questionnaire over the phone verbally prior to the start of the program and at the end of the program to better understand the participant’s experience with phone coaching. The surveys will be administered in the class and the follow-up survey will be given at the Reach Out office site. The surveys will be administered by the parenting coach/researcher and it will take no longer than 30 minutes. Sessions will be audiotaped to verify consistency of the coaching intervention in different group settings. The sessions will be erased when the study is completed.
Dear Nurturing Parenting Families,

My name is Wendy Wray and I am a 4th year doctoral student at Loma Linda University. The intent of this letter is to inform you of my new partnership with REACH OUT that will benefit all of the participants of the Nurturing Parenting Program. As a certified coach with a degree in both marital and family therapy and early childhood education, I will be offering volunteer coaching services free of charge as a part of my dissertation research study. I am excited about this opportunity to spend time with you and your family to offer you services that I believe will be valuable to you as well as life changing.

The coaching services will be offered for 30-45 minutes once a week during the 16-weeks that you will attend the Nurturing Parenting Program classes. The coaching will be offered over the phone at your leisure. We will work out a time schedule that you feel will work best for you. In the event that we are not able to speak over the phone one week, we may be able to meet before or after the parenting group as an alternative.

The goal is to provide you with additional support outside of the parenting group to help you to succeed even further and reach your goals in the parenting group and in other areas of your life. Working together as a team will afford us the opportunity to further develop the skills and techniques you are learning in the class. I am confident that this opportunity to partner with you will be beneficial and helpful in many ways. I look forward to working with you and hearing about your overall experience with our new coaching relationship.

If you have any questions feel free to contact Angie or Karini at REACH OUT at 909-982-8641 or contact me personally at 301-675-9294.

Sincerely yours,

Wendy Wray.

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INFORMED CONSENT SCRIPT

The purpose of this study is to introduce a personalized phone-coaching intervention by adding it to the “Nurturing Parenting Program.” The goal is to determine if adding a phone coaching intervention would improve the overall results of the Nurturing Parenting Program. The study will have 140 parents in 10-12 groups. Since the study is randomized by location half of the sites will receive a phone coaching intervention in addition to the parenting program and the other half of the sites will receive the parenting program interventions alone. All participants will complete pre and post surveys in addition to the follow up survey. The parenting coach/researcher will also do a verbal evaluation over the phone in the form of a questionnaire to determine the parent’s experience with phone-coaching. The surveys and evaluations will be administered to all 140 subjects attending the parenting program groups and only half of the parents will receive coaching. The study will be offered to both parents or to the sole parent attending the parenting program.

You will receive phone-coaching for approximately 30-45 minutes a week for 16 weeks. All coaching interventions will be done over the phone unless other arrangements have been made to meet before or after the parenting class. Coaching calls will be audiotaped to help the parenting coach monitor the consistency of her techniques being used across the different groups.

There are minimal risks to participating in this study. The most specific type of risk is a breach of confidentiality. The Nurturing Parenting Program also has mandatory reporting protocols. All participants in the study will be advised of the protocols. If a parent experiences emotional distress or become upset and it requires attention outside of the expertise of the parenting coach/researcher, then referrals will be provided for affordable counseling services to the participant at Catholic Charities or Care Counselors.

The benefits of this study are each participant that completes at least 12 sessions of coaching and completes all pre and post surveys will receive a $25 thank you gift card for his/her participation. He/she will also be entered into a raffle to receive a free 1-pad. Other benefits include gaining an increased understanding of self, parenting style and parenting. This study is completely voluntary and you may at any time decide to not participate without any penalty or effect on the parenting program.

If you have any further questions or concerns please contact the Principal Investigator of this study Susanne Montgomery at Loma Linda University or a neutral third party not involved with the study at Patient Relations (both numbers are located on second page of your informed consent form). Do you have any questions at this time?
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Post-Process Evaluation

1. Now that you have experienced phone coaching what are you thoughts and/or feelings about phone-coaching during your parenting program?

2. After receiving phone coaching do you still have the same fears and concerns? Why or Why not?

3. What was different for you before you started phone coaching and after you completed phone coaching?

4. In what ways do you think phone coaching helped you to feel supported? If not what do you think would have been more helpful?

5. In what ways did you find phone coaching to be most helpful? Least helpful?

6. Did the phone coaching meet your expectations?

7. What do you think could happen differently to make this a better experience for you in the future?

8. How did you experience the quality of the coaching relationship over the telephone?

9. Do you think the quality of the coaching relationship would have been different if it had been in person versus over the phone? Tell us why?
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Pre-Process Evaluation

Introduction: Hello my name is Wendy Wray and I am a doctoral student at Loma Linda University. I also work collaboratively with REACH Out organization. I will be asking you questions to better understand your prior experience if any with coaching and your feeling and/or concerns about coaching. We would also like to find out if adding a phone-coaching component to the Nurturing Parenting Program will offer better results than just the parenting program alone. Therefore, at the end of the program we will be asking you many similar questions to determine your overall experience with phone-coaching.

1. Have you ever had coaching in any form (face to face or phone coaching)? If yes, what do you expect? If no, what you think might happen?
2. What are you thoughts and/or feelings about experiencing phone coaching during your parenting program?
3. Do you have any fears or concerns about receiving coaching over the phone?
4. What do you hope to gain out of phone coaching?
5. What do you think the coach can do to make this experience most helpful for you?
6. What do you think you can do to make phone coaching a meaningful/beneficial experience for you?
7. Do you feel like it makes a difference to do coaching in person versus over the phone? Tell us why.
8. How do you expect the quality of the coaching relationship to be impacted by it being offered via telephone versus in-person?