*Research Article*

# A Randomized Controlled Pilot Study of the Project Support Positive Parenting Module

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## Abstract

**Purpose:** Parental support is theorized to promote healthy child development and is a frequent target of brief parenting programs. However, evaluations of these brief programs often rely on parents' self-reports. This randomized controlled trial uses mothers' self-reports and observational methods to evaluate the Project Support Positive Parenting module—a brief parenting program designed to enhance parental support. **Method:** After completing a pretreatment assessment, 73 mothers and their children (40 girls; aged 6–12 years) were randomized to the Project Support module or to a wait-list control group. Families also completed posttreatment and follow-up assessments. **Results:** Results of multilevel modeling analyses showed that mothers randomized to the Project Support module demonstrated greater improvements over time in mothers' self-reports of parent–child communication and observed respect for their child's views, compared to mothers in the control condition. **Discussion:** Results suggest that the Project Support Positive Parenting module can result in changes in parental support.

## Keywords

parental support, brief intervention, parenting, parent–child interaction, evaluation

Parental support, typically defined to include parental attentiveness and warmth toward children, is theorized to promote healthy child development and positive adaptation to stressful circumstances (Grych et al., 2015; Zheng & McMahon, 2022). Attentive, warm parenting is beneficial for children of all ages, but it may be particularly so for young, school-aged children (6–12 years). Children in their early school years typically spend less time with their parents than they did when they were preschoolers, and they are presented with many new demands and challenging experiences (Neubauer et al., 2021). According to reflective functioning theory, parents who are attentive and warm toward their children are able to validate their children's experiences and help their children deal with new challenges (Borelli et al., 2016). Consistent with theory, substantial empirical evidence indicates that greater parental support is associated with lower levels of child adjustment difficulties (see Barlow & Coren, 2017; Clayborne et al., 2021; Yap & Jorm, 2015, for reviews). Similarly, parental support is known to contribute to positive child functioning following stressful circumstances and protects children from developing mental health difficulties when confronted with adversity (see Eltanamly et al., 2021; Fogarty et al., 2019; Yule et al., 2019, for reviews).

Enhancing parental support among families with young school-aged children is a frequent target of brief parenting programs (e.g., Kjøbli & Bjørnebekk, 2013; Kjøbli & Odgen, 2012; Porzig-Drummond et al., 2016; Sumargi et al., 2015). From a prevention perspective, brief parenting programs that target supportive parental behaviors directed at young, school-aged children can help prepare parents to address child problems before they become entrenched and difficult to treat (Zheng & McMahon, 2022). Brief programs can also circumvent some of the obstacles that prevent parents from receiving services. Specifically, time is often an obstacle for parents to participate in comprehensive and longer parenting programs (Gopalan et al., 2010), and brief parenting programs require less time commitment from parents to participate. Additionally, comprehensive parenting programs require more time for agencies to deliver, which frequently results in families spending extended periods of time waiting for services (Brown et al., 2002); time spent

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waiting for services has been associated with decreased motivation for treatment and greater psychological distress (Brown et al., 2002; Schraeder & Reid, 2015). Brief parenting programs can also instill hope that parents can improve their parenting skills in a short period of time (Ofonedu et al., 2017).

The current pilot study is designed to provide an initial evaluation of a brief, three-to-four session parenting program designed to enhance parental support of young, school-aged children: the Project Support Positive Parenting module. It is a subset of sessions taken from a longer, efficacious parenting intervention, Project Support (Jouriles et al., 2009; Jouriles et al., 2001; Jouriles et al., 2010; McDonald et al., 2006). Consistent with principles of learning theory as applied to family interaction (Patterson, 1982) and reflective functioning theory (Borelli et al., 2016), it focuses on teaching mothers to listen effectively and to respond to their child's distress supportively. The Project Support Positive Parenting module is similar to many other brief parenting programs that focus on enhancing supportive parenting (see Tully & Hunt, 2016, for a review), but it differs from most in at least two important ways. First, it is administered in individual sessions, as opposed to a group format. This is done because parents often prefer individual sessions over group sessions (Fehr et al., 2020; Wymbs et al., 2016), and individual sessions can be scheduled at the parents' convenience, circumventing potential scheduling obstacles. Individual sessions can also potentiate the learning process: the sessions can easily be tailored to the parents' skill level and the child's needs. Second, almost all of the session time is devoted to the mothers learning and practicing the skills, through practice sessions that involve direct and personalized feedback and coaching on their use of the skills. The practice is conducted via role plays first with the service provider, and then, when some degree of success is ensured, via interactions with the child.

## Evaluations of Brief Parenting Programs: State of the Science

For brief parenting programs to fully realize their potential, they must demonstrate effectiveness in enhancing supportive parenting. Although there is some empirical evidence that brief parenting programs designed to enhance parental support of young school-aged children in the general population may be effective (see Tully & Hunt, 2016, for a review), this evidence is based almost exclusively on parents' self-reports of their own parenting. In our review of the literature, we identified only four published studies evaluating brief parenting programs that included both parent self-report and observational methods. Turner and Sanders (2006) found that Primary Care Triple P decreased parent self-report of dysfunctional discipline, but found no effects on observed aversive parenting. Morawska and colleagues (2017) reported that Healthy Living Triple P similarly decreased parent self-report of dysfunctional discipline, but had no effect on observed aversive or inappropriate parenting behavior. Baker and colleagues (2017) reported the Triple P Online Brief program decreased parent self-report of dysfunctional discipline, but had no effect on observed ineffective parenting. Finally, Timmer and colleagues (2019) found that Parent–Child CARE improved parent self-report of the parent–child relationship and also increased observed effective parenting skills. Notably, the observational assessments in these prior evaluations were largely focused on aversive parenting behavior (e.g., criticizing the child), the only exception was the study conducted by Timmer et al., which found promising effects on observed effective parenting skills. Altogether, as noted by others (e.g., Graziano et al., 2020), few evaluations of brief parenting programs include a multi-method assessment of supportive parenting, and even fewer have observed significant improvements in observational measures of parenting. This represents a significant gap in the literature.

## Parent Self-Reports on Their Parenting

There is no question that parents can provide valuable information on their own parenting. Parents' knowledge of their own parenting spans multiple time periods and contexts, some of which only the parents themselves can report (Zaslow et al., 2006). Parents also are uniquely situated to interpret their own parenting behavior in reference to the needs of their children, the particular contexts in which they parent their children, and their children's responses to them as a parent (Azar et al., 2005; Rodríguez et al., 2011). As a result, parent-report measures can provide valuable information that is not directly observable, such as parents' perceptions of how willing their children are to talk with them about feelings or problems. However, sole reliance on parent reports makes evaluations of parenting programs vulnerable to several biases. For example, demand characteristics may influence parent reports, prompting them to respond to questions in the way they think service providers or researchers want (Duncan et al., 2015; Hendriks et al., 2018; Herbers et al., 2017). Parents' expectations of and standards for themselves and their children, unique interpretations of specific words and phrases on questionnaires, memory biases, and even parents' moods at the time of the report also may affect responses to parenting questionnaires (Gardner, 2000; Morsbach & Prinz, 2006; Sessa et al., 2001). As a result, conclusions about changes in parenting after an intervention, when based solely on parent self-reports, are prone to error.

## Observational Methods

Observational methods provide researchers with the opportunity to directly view behavior to determine whether parents are being supportive toward their children. In studies that use observational methods to help evaluate parenting

interventions, typically the parent–child dyad is observed by trained researchers (who ideally are unaware of the experimental condition to which the family was assigned) in an interaction or a series of interactions at a pretreatment and posttreatment assessment. Observers code the extent to which the parents acted in a supportive manner toward their child, and their codes are checked for accuracy (i.e., interrater reliability). Observational methods allow researchers to obtain nuanced information on parenting behavior that is indicative of support, such as how attentive mothers appear to be during conversations with their child (e.g., are they looking at the child, being patient, and letting the child talk without interrupting; are they asking appropriately timed clarification and follow-up questions). An advantage of observational methods is that a number of the potential biases associated with self-reports are eliminated (Sessa et al., 2001). There are, however, limitations to the use of observational methods for assessing parenting. Observational methods are more time-consuming, labor-intensive, and expensive for researchers to use than self-report methods (Duncan et al., 2015; Smith, 2011; Zaslow et al., 2006). In addition, the parent–child dyad typically is observed for only a short period of time, and often in a context that may feel contrived to the parents, children, or both (Gardner, 2000). Observational assessments of parenting also are potentially vulnerable to demand characteristics (Hendriks et al., 2018).

## Self-Report Measures Versus Observational Methods

Self-report and observational measures of parenting are typically only weakly associated with one another (see Hendriks et al., 2018, for a meta-analysis). This is unsurprising, given that these two methods capture different types of information and are affected by different limitations and biases (Gardner, 2000; Hendriks et al., 2018; Zaslow et al., 2006). As a result, including both methods when conducting initial evaluations of parenting programs is valuable in order to obtain a more complete picture of intervention effects on parenting. In other words, an evaluation of a brief parenting program that yields converging results across parent-report and observational methods can bolster confidence in the potential value of the program.

## Current Study

The primary objective of the current study is to provide a multimethod evaluation of a brief parenting program designed to enhance parental support of young, school-aged children: the Project Support Positive Parenting module. This is a pilot study, in which the Project Support module was made universally available to mothers who wanted help communicating with their young, school-aged child. Observations of mother–child interactions, as well as mother self-reports of her communications with her child, were collected to examine changes in supportive parenting. The use of a multimethod assessment addresses an important gap in the literature on the evaluation of brief parenting programs, particularly those designed for parents of school-aged children. Thus, the study was designed to add to the empirical literature in two ways: (1) it tests a new, brief parenting program designed specifically to enhance parental support of young, school-aged children, and (2) it uses a rigorous assessment of parenting outcomes that extends beyond parent self-report. We hypothesized that mothers randomly assigned to the Project Support condition, compared to those assigned to a wait-list control condition, would demonstrate improvements over time in parental support on both mother-report and observational assessments of parenting. Because past findings indicate that the number of children in the home (Nomaguchi, 2012), child age (Nomaguchi, 2012), child gender (Sturge-Apple et al., 2004), household income (Uzun et al., 2021), and parental psychological distress (Letourneau et al., 2010; Vreeland et al., 2019) can impact parental warmth and parent–child relationship quality, these were controlled in analyses (Holmberg & Andersen, 2022).

## Method

### Participants

Participants were 73 mothers (24–65 years old; $M = 38.28$, $SD = 8.68$) and their children (33 boys and 40 girls) between 6 and 12 years of age ($M = 8.19$, $SD = 2.07$). The sample composition was 59% White, 30% Black/African American, 6% Asian, 3% American Indian/Alaskan Native, and 4% more than one race. Almost half of the mothers (44%) reported themselves to be Hispanic. The number of children living in the home ranged from 1 to 9 ($M = 2.81$, $SD = 1.60$), and 64% of mothers reported they were currently living with a romantic partner.

Advertisements and announcements about the program were disseminated in a variety of sources including local mental health agencies, elementary schools, and social media (e.g., Facebook). The materials described a brief program offering to teach mothers new skills to improve parent–child communication. Most of the final sample, 77% (56/73), was recruited through social media ads. Families were eligible if mothers indicated during the phone screening that they had at least one child in the target age range with no history of traumatic brain injury, developmental disability, or autism spectrum diagnosis. Inclusion criteria for mothers included no current symptoms of severe mental illness (e.g., psychosis), history of traumatic brain injury, or substance dependence. Of the 146 families who were screened, 103 were eligible and scheduled for a pretreatment assessment. Of these, 73 attended the pretreatment assessment. Figure 1 summarizes the flow of participants through the project.

### Procedures

The study is a randomized, controlled, assessor-masked, single-center trial with two parallel groups: the Project

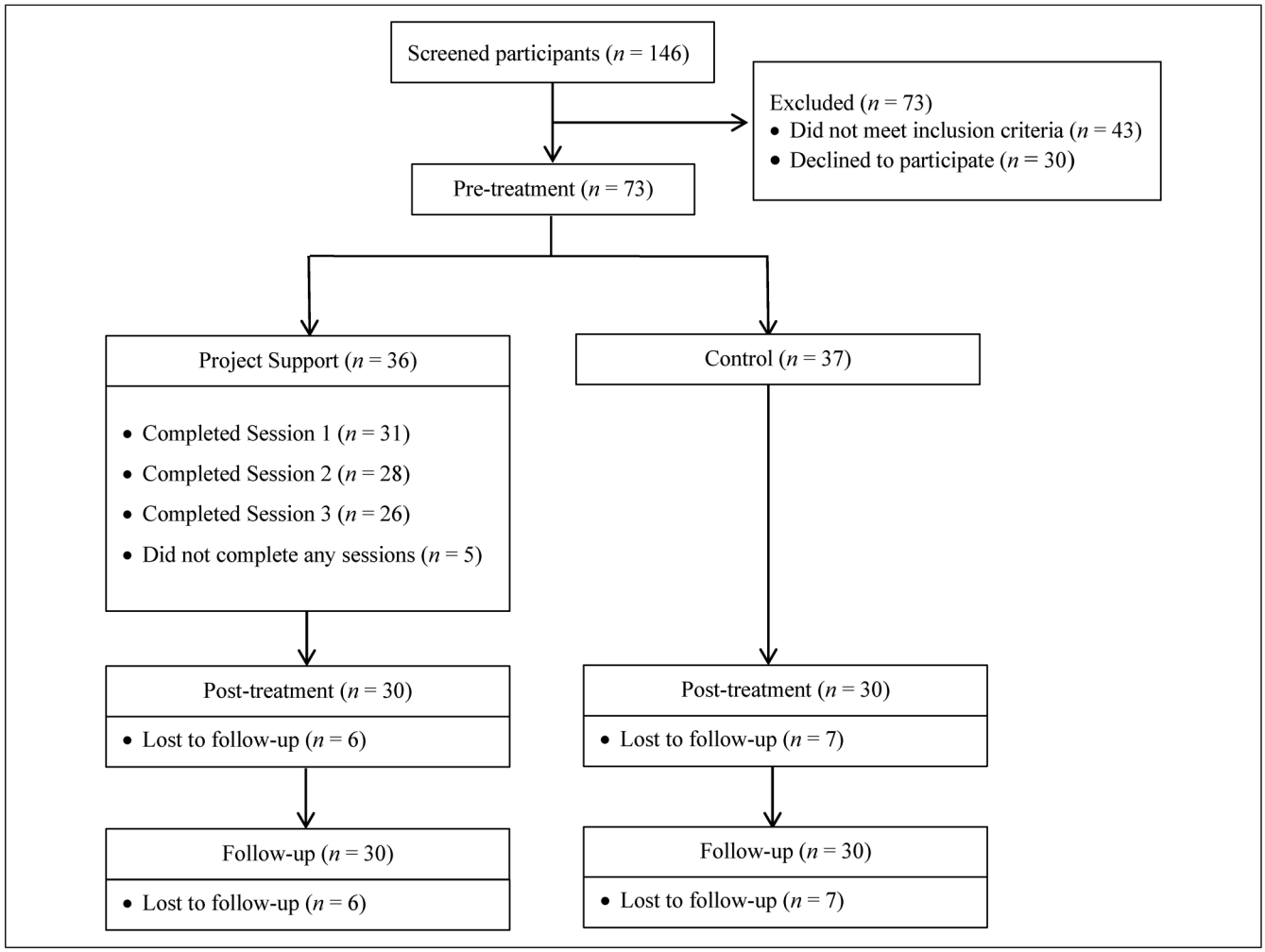


**Figure 1.** Project CONSORT diagram.

Support Positive Parenting module and a wait-list control group. The last author's Institutional Review Board approved all study procedures. Families were randomized to condition using computer-generated variable-sized permuted block randomization (Erfird, 2010) with a 1:1 allocation. Of the 73 families who completed the pretreatment assessment, 36 were randomized to the Project Support module and 37 to the control group. All families completed assessments at pretreatment, posttreatment (4–6 weeks after pretreatment for the control group), and 1-month follow-up. Observations of mother–child communication were recorded for coding. All assessments and program sessions were conducted in-person at an outpatient clinical psychology training clinic in the Southern United States. Families completed the pretreatment assessment between May 2016 and August 2017. Mothers provided consent and children provided assent to participate. Families were informed that they could withdraw from the study at any time, without penalty.

Research staff collecting pretreatment data were masked to group assignment by using sequentially numbered sealed containers. The container was opened at the end of each pretreatment assessment to determine the condition to which each family was assigned. A separate group of research staff also masked to group assignment, collected the posttreatment, and follow-up assessment data. Mothers were compensated $70 at the end of each assessment, and control group families were offered the Project Support Positive Parenting module after their participation was completed.

## Experimental Conditions

*Project Support Positive Parenting Module.* This module is derived from a longer, efficacious parenting intervention, Project Support (Jouriles et al., 2009; Jouriles et al., 2001; Jouriles et al., 2010; McDonald et al., 2006). The module consisted of up to four, 60- to 90-min individual sessions focused on specific positive parenting skills (attentive listening and comforting). Attentive listening involves simple verbal and nonverbal responses to show interest and keep the child engaged until he or she is ready to end the conversation.

These responses include reflecting on what the child is saying, requests for clarification, nodding, and other nonverbal expressions designed to keep the conversation going and express understanding of the child's communications, and the provision of unconditional positive regard. Comforting involves using the same attentive listening skills when a child is upset or distressed, and additional responses to show acceptance of the child's feelings and to help soothe their distress.

Although the Project Support Positive Parenting module is a manualized program, it is designed to be individually tailored to mothers and their children, with instruction paced to match the mother's capabilities and enhance her likelihood of success and mastery of each skill. Mothers were provided with direct instruction and demonstrations of the skills; practiced the skills in role-plays with the service provider, receiving tailored feedback and additional practice until skill mastery; and then used the skills in interactions with their child. The learning process was iterative, with multiple opportunities for practice, coaching, and feedback, and implementation with the child in a stepwise fashion as the various components of the skills were learned. Most of the session time consisted of the mothers learning and mastering the skills in practice role plays. These included conversation topics that the mother has had and would like to have, with her child. Mothers received the module over the course of 4–6 weeks. Again, the pacing of the Project Support Positive Parenting module is determined by the mother's capabilities. Therefore, mothers who master the skills more quickly may receive a full "dosage" of the module in fewer sessions compared to mothers who need more time and practice to master the skills. On average, mothers assigned to the Project Support Positive Parenting module condition attended 2.42 ($SD = 1.18$) sessions.

Service providers included one licensed clinical psychologist and four clinical psychology doctoral students. Each received extensive training in the content and delivery of the Project Support Positive Parenting module. Specifically, providers read and discussed the treatment manual, discussed background theory on behavioral parent training, attended weekly group supervision meetings to learn from discussion and supervision of other cases, and were required to demonstrate proficiency in delivering the module through in vivo practice. To facilitate ongoing training and help ensure treatment fidelity, all sessions were video-recorded, and service providers engaged in weekly group supervision in which parts of recorded sessions were reviewed and discussed. Treatment fidelity was assessed directly on the basis of the successful delivery of positive parenting skills (attentive listening and comforting). Successful delivery required five steps: (1) instruction about the skill, (2) service provider demonstration of the specific positive parenting skill, (3) the provision of an opportunity for the mother to practice the skills in role-plays, (4) service provider providing the mother tailored feedback and additional practice in role-plays; and (5) service provider providing the mother with opportunities to use the skills in interactions with the child. The first skill (attentive listening) was successfully delivered to 86% (31/36) of the mothers, and both skills (attentive listening and comforting) were successfully delivered to 72% (26/36) of the mothers. A few families (14%; 5/36) did not attend any sessions. Consistent with an intent-to-treat approach, all families were invited to complete the posttreatment and follow-up assessments and were included in the analyses, regardless of the number of attended sessions. Additional informational materials about delivering the Project Support Positive Parenting module are available upon request to the last author.

*Wait-List Control Condition.* Families in the control group were offered the Project Support Positive Parenting module after completing all assessments.

## Measures

*Maternal Support (Pretreatment, Posttreatment, Follow-Up).* Mothers completed the 20-item Parent–Child Communication Scale (PCCS; McMahon et al., 1997) reporting their communication and support of their child (e.g., "Does your child let you know what is bothering him/her?") on a 5-point scale (0 = Almost never, 1 = Once in a while, 2 = Sometimes, 3 = Often, 4 = Almost always) in the past month. Items were summed to create a total score with higher scores indicating better communication. The PCCS has been found to differentiate between families at high- and low-risk for child problems (McCarty & Doyle, 2001). In the current sample, the internal consistency for the PCCS was: $\alpha = .67$ at pretreatment, $\alpha = .72$ at posttreatment, and $\alpha = .75$ at follow-up.

At each assessment, mothers and their children participated in an observation task in which they were instructed, "*For this task we would like to get a better idea of how your family talks to each other. You will be given three different topics to discuss."* They were given up to 8 min to discuss each topic. The presentation of the three different conversation topics was counterbalanced across participants to mitigate order or sequence effects. Topics included (1) what is strong about our family, (2) what are the main problems in our family, and (3) what would you like to change about our family. All interactions were video recorded.

Research staff who were masked to the study hypotheses, group allocation, and assessment time point coded the interactions using the Timberlawn Couple and Family Evaluation Scales (TCFES; Lewis et al., 1999). We used two subscales from the TCFES that conceptually align with parental support: respect for subjective reality and positive regard. Respect for subjective reality reflects the extent to which mothers respond to their child with clear regard for their child's views. It is indicated by such things as careful listening, accurate and timely requests for clarifications and acknowledgments, and expressing patience. Positive regard reflects both mother and child expressions of warmth

toward, pleasure with, acceptance of, and affection for one another. Positive regard could be demonstrated verbally, such as through tone of voice, or nonverbally, such as by smiling or nodding affirmatively. Respect for subjective reality and positive regard were both coded on a 4-point scale (0 = little to no evidence of respect/positive regard to 3 = high levels of respect/positive regard).

Codes on the TCFES were assigned during the first 4 min of each of the 3 conversation topics and then summed (possible range 0–9), with higher scores indicating greater parental support. Only the first 4 min were used because most of the participating families stopped their conversations during the latter half of the 8-min observation period. The TCFES coding system is a validated measure of observed interactions within families (Lewis et al., 1999). It has been found to discriminate between clinic and nonclinic samples (Lewis et al., 1999), and it has been correlated with caregiver self-report of family functioning (Hetrick, 2006). We computed the internal consistency of the codes in each domain across conversation topic. With respect to subjective reality, $\alpha = .72$ at pretreatment, $\alpha = .80$ at posttreatment, and $\alpha = .76$ at follow-up. For positive regard, $\alpha = .84$ at pretreatment, $\alpha = .88$ at posttreatment, and $\alpha = .86$ at follow-up. A secondary coder reviewed 30% of the video-recorded data and inter-rater intraclass correlations were .73 for respect for subjective reality and .82 for positive regard. Disagreements were reviewed by both coders to come to a consensus on the final code.

*Maternal Psychological Distress (Pretreatment).* Mothers reported on their psychological distress during the past week on the 53-item global psychological distress scale of the Brief Symptom Inventory (BSI; Derogatis, 1992). Responses to items (e.g., "Suddenly feeling scared for no reason") were made on a 5-point scale (0 = Not at all, 1 = A little bit, 2 = Moderately, 3 = Quite a bit, and 4 = Extremely). Responses were summed to create a total score, with higher scores indicating greater distress. Higher scores on this scale have previously been correlated with lower parent–child relationship quality (Stein et al., 2009). In the current sample, the internal consistency for the BSI was .97 at pretreatment.

### Hypotheses

Mothers randomly assigned to the Project Support condition, compared to those assigned to a wait-list control condition, would demonstrate improvements over time in:

1. mother-report of maternal support on the Parent–Child Communication scale (PCCS);
2. observed respect for subjective reality as coded on the Timberlawn Couple and Family Evaluation Scales (TCFES); and
3. observed positive regard as coded on the TCFES.

### Data Analysis and Sample Size Justification

To evaluate the randomization procedures, *t*-tests, and chi-square analyses were conducted to assess for differences at pretreatment between families randomized to the Project Support module and the control condition. To evaluate the study hypotheses, multilevel modeling (MLM) was used, in which every participant who was randomized to a condition was included in the final analyses, regardless of missing data, consistent with an intent-to-treat approach. The AIC and BIC fit indices were examined across the various ways of modeling time (linear, quadratic, hyperbolic, and logarithmic); the hyperbolic model resulted in the optimal fit with the lowest AIC and BIC scores. Full information maximum likelihood estimates were used.

Separate MLM analyses were conducted for each of the three dependent variables. The number of children in the home, child age, child gender, household income, and maternal psychological distress was included as control variables. Treatment group was coded dichotomously (0 = Project Support module, 1 = control group). Each model included time, treatment group, and the Time × Treatment Group interaction, representing the change over time between the Project Support module and the control group. For each interaction effect, the difference between groups was examined with time centered on the posttreatment and follow-up assessments in two separate models. Cohen's *d* is reported as a measure of effect size (Feingold, 2015). The MLM power analysis program RMASS2 (Hedeker et al., 1999) indicated that with alpha set at .05, power at .80, attrition of 18%, and a sample of 73 participants, power was sufficient to detect a medium-sized effect ($d = .55$) for the test of the time-by-treatment interaction.

## Results

### Sample Characteristics

Sample characteristics are summarized in Table 1. There were no statistically significant differences between families assigned to the Project Support module and those assigned to the control group on demographic characteristics (child age and gender, mother age and ethnicity, and household income) or any of the dependent or control variables at pretreatment ($ps > .08$). Means and standard deviations at each assessment are summarized in Table 2.

### Program Effects on Mother-Report of Maternal Support (Hypothesis 1)

Results indicated a Time × Treatment Group interaction, with mothers in the Project Support condition showing greater improvement from pretreatment to follow-up on self-reported mother–child communication, $b = 5.78$, $t(100.01) = 2.34$, $p = .021$, 95% CI [0.88, 10.67], $d = .68$ (see Figure 2). At posttreatment, there were no group differences in self-reports of mother–child communication, $b = 3.16$, $t(67.19) = 1.55$, $p = .126$, 95%

CI [−0.91, 7.24], $d = .37$; however, at follow-up, self-reports of mother–child communication were higher for mothers in the Project Support condition than for mothers in the control condition, $b = 4.30$, $t(108.01) = 2.19$, $p = .031$, 95% CI [0.41, 8.19], $d = .51$. Therefore, our first hypothesis was supported.

### *Program Effects on Observed Respect for Subjective Reality (Hypothesis 2)*

Results indicated a Time × Treatment Group interaction, with mothers in the Project Support condition showing greater improvement from pretreatment to follow-up on observed respect for subjective reality, $b = 1.25$, $t(90.20) = 2.08$, $p = .040$, 95% CI [0.06, 2.44], $d = .70$ (see Figure 3). At both posttreatment, $b = 0.65$, $t(57.19) = 2.40$, $p = .020$, 95% CI [0.11, 1.19], $d = .37$, and follow-up, $b = 0.86$, $t(56.78) = 2.72$, $p = .009$, 95% CI [0.23, 1.50], $d = .48$, mothers in the Project Support condition demonstrated greater observed respect for subjective reality than mothers in the control condition. Therefore, our second hypothesis was supported.

**Table 1.** Sample Characteristics by Experimental Condition at Pretreatment.

| Variable | Project Support (%) | Wait-List Control (%) |
|---|---|---|
| Child sex (female) | 49.32 | 50.68 |
| Mother employment (employed) | 30.14 | 35.62 |
| Mother ethnicity | | |
| White, non-Hispanic | 9.86 | 14.08 |
| Black, non-Hispanic | 15.49 | 12.68 |
| Hispanic | 19.72 | 22.54 |
| Asian or Pacific Islander | 2.82 | 2.82 |
| American Indian/Alaska Native | 0 | 2.82 |
| | *M (SD)* | *M (SD)* |
| Number of children in the home | 2.84 (1.83) | 2.78 (1.36) |
| Child age | 8.28 (1.97) | 8.11 (2.18) |
| Mother age | 38.31 (8.41) | 38.24 (9.05) |
| Mother annual income ($) | 91,676.00 (94,869.00) | 60,108.00 (74,685.00) |
| Maternal psychological distress | 28.14 (32.03) | 20.22 (20.16) |

*Note.* Maternal psychological distress was assessed using mother self-report on the 53-item global psychological distress scale of the Brief Symptom Inventory (BSI; Derogatis, 1992); higher scores indicate higher levels of psychological distress. There were no between-group differences in demographic variables or maternal psychological distress ($ps > .08$).

### *Program Effects on Observed Positive Regard (Hypothesis 3)*

There were no differences between conditions in the rate of change for observed positive regard, $b = 0.99$, $t(86.99) = 1.30$, $p = .197$, 95% CI [−0.52, 2.51], $d = .21$. Therefore, our third hypothesis was refuted.

## Discussion and Applications to Practice

This study provides a multimethod evaluation of the Project Support Positive Parenting module, a brief parenting program focused on teaching mothers to listen and respond to their young, school-aged child in a supportive manner. Most previous evaluations of brief parenting programs have relied on parents self-reports of their own parenting (Graziano et al., 2020; Tully & Hunt, 2016); thus, we were especially interested in program effects on observational measures of supportive parenting. In this study, medium-sized between-group differences emerged with the observational variable "respect for subjective reality" ($d = .70$) and for self-reports of mother–child communication ($d = .68$), but between-group differences did not emerge for observed positive regard. In short, we found evidence suggesting the Project Support Positive Parenting module enhanced supportive parenting across both parent self-report and observational methods.

The present findings address an important gap in the literature evaluating brief parenting programs using observational

**Table 2.** Means and Standard Deviations of Study Variables Across Assessments.

| | Assessment | | | | | |
|---|---|---|---|---|---|---|
| | Project Support | | | Wait-List Control | | |
| Variable | Pretreatment | Posttreatment | Follow-up | Pretreatment | Posttreatment | Follow-up |
| Mother–child communication[M] | 47.41 (8.46) | 51.10 (7.58) | 51.48 (8.57) | 48.57 (7.85) | 48.83 (8.18) | 49.07 (8.38) |
| Respect for subjective reality[O] | 5.42 (1.23) | 5.42 (1.65) | 5.01 (1.41) | 5.36 (1.37) | 4.52 (1.53) | 4.37 (1.25) |
| Positive regard[O] | 2.67 (2.07) | 3.20 (2.19) | 2.55 (2.24) | 3.36 (3.02) | 2.88 (1.94) | 2.42 (1.95) |

*Note.* Means were computed from participants with data available at the specified assessment.
[M]Mother-report
[O]Observer rating.
Mother–child communication scores could range from 0 to 80. Respect for subjective reality and positive regard could range from 0 to 9. There were no between-group differences on any of the dependent variables at pretreatment ($ps > .08$).

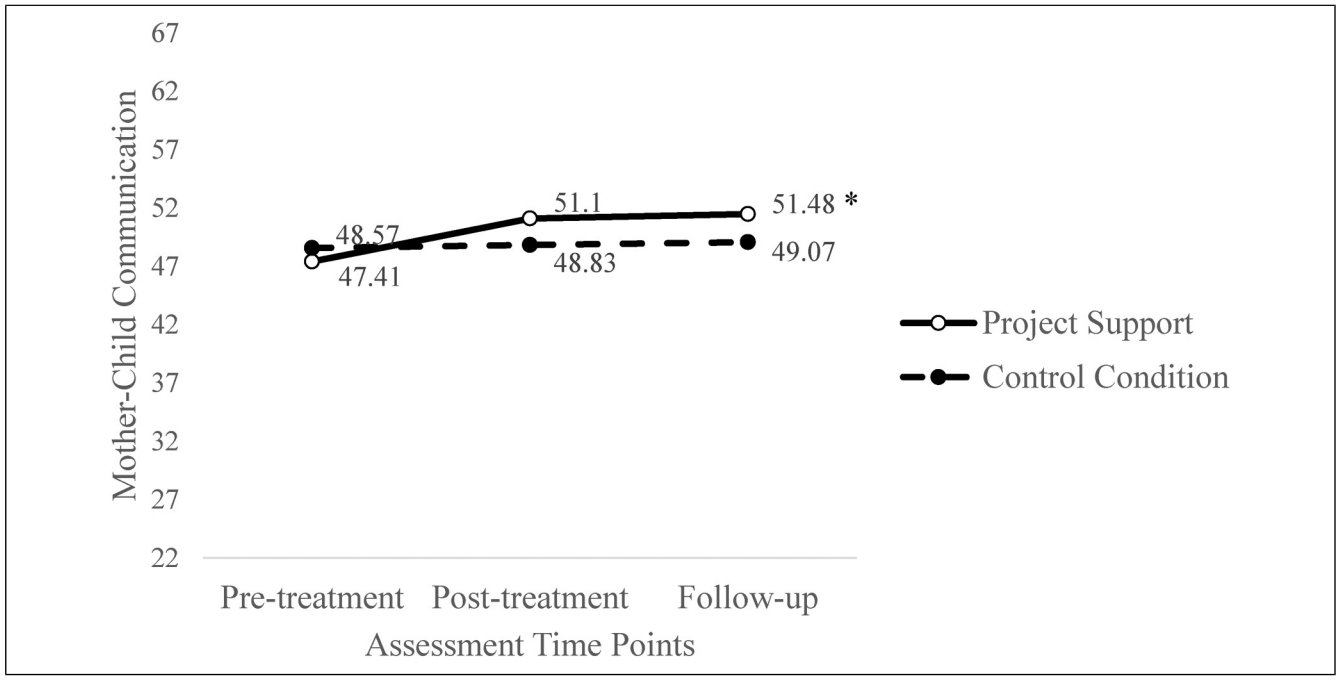


**Figure 2.** *Between-Group change in mother–child communication (mother-reports) across assessments. Note.* The vertical axis represents the range of mother–child communication scores across all time points, 22–67. Mothers randomized to the Project Support module self-reported greater improvement in mother–child communication over time compared to mothers in the control condition, $b = 5.78$, $t(100.01) = 2.34$, $p = .021$, 95% CI [0.88, 10.67], $d = .68$. *$p < .05$, for between-group differences at the designated assessment point.

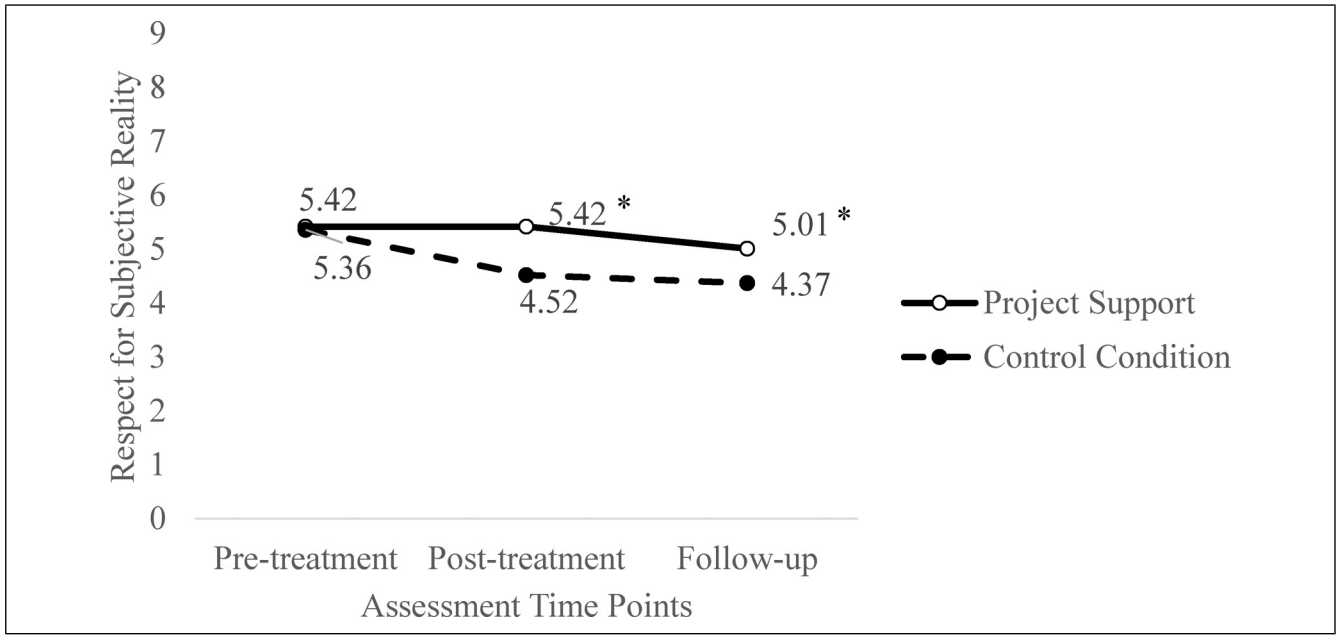


**Figure 3.** *Changes in observer ratings of respect for subjective reality over time. Note.* The vertical axis represents the range of scores for respect for subjective reality across all assessments, 0–9. Mothers randomized to the Project Support module showed greater improvement in respect for subjective reality over time compared to mothers in the control condition, $b = 1.25$, $t(90.20) = 2.08$, $p = .040$, 95% CI [0.06, 2.44], $d = .70$. *$p < .05$, for between-group differences at the designated assessment point.

methods of supportive parenting. In the handful of studies that have used observational methods, most are focused on observations of aversive or ineffective parenting behaviors (Baker et al., 2017; Morawska et al., 2017; Turner & Sanders, 2006). As many have argued (see Huang, 2021, for review), aversive parenting and supportive parenting are not opposite ends of a parenting behavior continuum. Null effects on observed aversive parenting could lead to false conclusions about the ineffectiveness of brief parenting programs and their possible impact on enhancing supportive parenting. Additionally, aversive parenting behaviors may also be more sensitive to biases such as demand characteristics as parents seek to avoid appearing harsh or critical of their child (Herbers et al., 2017). Indeed, the previous mixed-method evaluations noted they observed low pretreatment levels of aversive parenting, which may have prohibited their ability to detect change (Baker et al., 2017; Morawska et al., 2017; Turner & Sanders, 2006). Our findings are consistent with the work by Timmer and colleagues (2019) suggesting that brief parenting programs may have promising effects for enhancing supportive parenting. In practice, providers and researchers may consider observing supportive parenting behaviors to comprehensively assess the effects of brief parenting programs.

The pattern of results was different across the parent self-report and observational methods. The findings for parent self-report are consistent with prior evaluations of brief parenting programs (Tully & Hunt, 2016); mothers who received the intervention reported improvements, while those in the control condition reported no change. The observational findings are more nuanced. It may be that the nature of the task contributed to the decrease in respect for subjective regard observed among mothers in the control condition. Engaging a young, school-aged child in a lengthy conversation can be challenging even for very skilled, supportive parents. The respect for the subjective reality code required parents to demonstrate some level of advanced skill (e.g., careful listening, accurate and timely requests for clarifications and acknowledgments) during a potentially difficult task. As families repeated this task at subsequent assessments, mothers who received Project Support may have relied on skills they learned in the intervention to maintain a pretreatment level of observed behavior, while mothers in the control condition deteriorated in their supportive parenting skills. Regardless, an important takeaway from using this multimethod approach is that the data would have led to different conclusions had only one of these two measures been used.

A lack of convergence across self-report and observational measures of parenting is not unusual (Baker et al., 2017; Hendriks et al., 2018; Morawska et al., 2017), and there are a number of possible explanations for the lack of convergence. First, self-report and observational methods may not be assessing the exact same parenting behaviors. Although we selected subscales on the TCFES that conceptually aligned with parental support, respect for a child's subjective reality is not identical to comfort in parent–child communication. Second, the self-report and observational measures in this study used different reference periods; the self-report asked about behaviors that occurred over the past month versus the observation task assessed behaviors within the first minutes of a conversation task. The self-report also asked parents to subjectively interpret vague quantifiers (i.e., "Sometimes" vs. "Often"), which represents another source of variance when compared to parenting behaviors coded by trained observers (Morsbach & Prinz, 2006). The discrepancies between self-reports and observational measures have led some researchers to suggest these methods are not interchangeable and both should be routinely included when assessing parenting behaviors in treatment populations (Zahidi et al., 2019). Our findings suggest that focusing on a single method of evaluation would overlook important information that can only be captured using a multimethod approach.

Study strengths include randomization to condition, a multimethod assessment of parenting, and a larger sample compared to many other evaluations of brief parenting programs. One limitation is that the follow-up period was brief, in part because it was deemed sufficient for the objective of examining whether brief parenting programs have effects on measures of parenting beyond parent self-reports. Furthermore, we did not want to delay offering the program to families assigned to the wait-list control condition for a long period of time. Consequently, it is not clear if the Project Support Positive Parenting module can affect sustained change in parental support. A second limitation is that the use of a wait-list control group, which is common in treatment outcome research, may have contributed to the inflation of between-group differences. It has been hypothesized that wait-listing creates an expectancy among individuals assigned to such groups that they have to wait until they begin treatment before reporting improvements (Cunningham et al., 2013; Miller & Rollnick, 2002). A third limitation is that the caregivers who participated in this research were all mothers, which raises questions about the generalizability of finding to fathers and other caregivers. As some have found that fathers may differentially respond to parenting interventions (Lechowicz et al., 2019) and engagement of both parents can enhance intervention outcomes (Lundahl et al., 2008), future research is needed to understand how different types of caregivers would benefit from the Project Support module.

In conclusion, the current study extends the literature evaluating brief parenting programs (Tully & Hunt, 2016) in at least two key ways. First, it introduces another brief program, the Project Support Positive Parenting module, which appears promising for enhancing supportive parenting among a community sample of mothers and their children. Second, it provides much-needed empirical evidence of the effectiveness of a brief parenting program using both self-report and observational measures of supportive parenting.

Program effects emerged for both parent self-report measures and direct observations of mother–child interactions, although the pattern of results differed across methods. The findings for the three-to-four session Project Support Positive Parenting module can be interpreted as promising, but replication is needed to bolster confidence in them. Future research should also begin to examine the efficacy of brief parenting programs in comparison to one another as well as to more comprehensive parenting programs.

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