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Pepperdine University  
Graduate School of Education and Psychology

THE IMPACT OF A MANUALIZED PARENT PSYCHOEDUCATIONAL PROGRAM AND  
PARENTS' KNOWLEDGE OF SOCIAL SKILLS IN YOUTH: A PILOT STUDY

A clinical dissertation submitted in partial satisfaction  
of the requirements for the degree of  
Doctor of Psychology

by

Leanne Mendoza

July, 2018

Judy Ho Gavazza, Ph.D., ABPP, CFMHE – Dissertation Chairperson

This clinical dissertation, written by

Leanne Mendoza

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

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## ABSTRACT

Over 50% of mental disorders have an onset in childhood, and mental health issues during adolescence impact adult psychological, social, and occupational functioning. Parents serve as the primary gatekeepers to child mental health resources, and as such factors that influence parental help-seeking were discussed, and a manualized psychoeducational program for parents was developed with the aim of addressing these barriers. The program was developed based on the need for evidenced-supported school-based programs that target parental knowledge, competence, and access to community resources while simultaneously decreasing stigma toward children with mental health difficulties. A quantitative pilot study was conducted as a means to examine change in parent perception of knowledge of social skills in youth before and after receiving the preventative program. It was hypothesized that parent perception of their knowledge post-presentation would be negatively correlated with parental age, and positively correlated with education and household income. Bivariate correlations indicated that parent age, ethnicity and sex, as well as highest level of education were not significantly associated with perceived knowledge of social skills post-presentation. The implications for program development, including the possibility of adding manual versions based on parental education level were considered, and study limitations were discussed.

Keywords: barriers to treatment, youth, psychoeducation, parents/caregivers, parent

## Introduction

Mental health disorders are defined in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) as “syndromes characterized by a clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning” (American Psychiatric Association, 2013). Research has indicated that over 50% of mental disorders have an onset in childhood (prior to age 18), and mental health issues during youth have been found to have a profound impact on psychological, social, and occupational functioning into adulthood (Carta, Fiandra, Rampazzo, Contu, & Preti, 2015; Polanczyk, Salum, Sugaya, Caye, & Rohde, 2015). For example, childhood depression is associated with adult substance use disorders and anxiety disorders (Benjamin, Harrison, Settiapni, Brodman, & Kendall, 2013; Dawson et al., 2005), as well as impaired functioning in health, education, social relationships, and criminality (Costello & Maughan, 2015). Children with behavioral disorders such as attention-deficit/hyperactivity disorder (ADHD) have also been found to have a higher likelihood of substance use disorders and conduct disorders in adulthood (Hinshaw et al., 2012). Further, research indicates that children with anxiety disorders (e.g., separation anxiety, generalized anxiety, social phobia, specific phobia, agoraphobia, panic disorder, obsessive-compulsive disorder, and posttraumatic stress disorder), mood disorders (major depression, dysthymia, mania, and hypomania), conduct disorder, oppositional defiant disorder, attention-deficit/hyperactivity disorder, and substance disorders are more than six times more likely to suffer from adverse outcomes in health, legal, financial and social realms in adulthood (Copeland, Wolke, Shanahan, & Costello, 2015).

## **The Importance of Early Intervention**

Without early identification and treatment, mental health disorders can cause social and academic impairments, including difficulties forming friendships, lower academic achievement, and truancy (Fox, Halpern, & Forsyth, 2008). Despite these findings, up to 80% of children with these disorders do not get the mental health help that they need (Stagman & Cooper, 2010). This constitutes a global problem, as the World Health Organization (2005) indicates there is no place in the world where child mental health needs are met. Additionally, in approximately 33% of the countries in the world, there is no identifiable governmental entity designated to ensure children get the mental health care they require (World Health Organization, 2005).

The significance of early treatment for mental health difficulties is emphasized by findings that early intervention can counteract or reduce the possibility of long-term impairments in multiple domains of life (Conroy & Brown, 2004; Hester & Kaiser, 1998; Maag & Katsiyannis, 2010; McConachie & Diggle, 2007). For example, interventions that focus specifically on providing parenting skills training to target early signs of aggressive social behavior in early childhood subsequently aid in preventing the development of more externalizing and internalizing disorders in adulthood (O'Connell, Boat, & Warner, 2009). Additionally, early interventions that are targeted to increase positive engagement in parent-child interactions have been associated with protecting against the growth of existing problem behaviors (Sitnick et al., 2015). Further, providing services to children who are at risk for developing problems related to mental health prior to adolescence has been found to have an impact at the community level, by preventing lost economic productivity and community destabilization (Morris et al., 2011).

## **The PEP4SAFE Program**

The Psychoeducation Program for School-Aged Families and Educators (PEP4SAFE) considers the prevalence of childhood emotional/behavioral problems and their impact on youth functioning in multiple domains and subsequent negative adult outcomes in adulthood. The program focuses on evidence-supported early intervention strategies aimed to provide important parenting skills for managing common childhood emotional/behavioral issues and educates parents on identification of more serious problems that require professional intervention. Psychoeducation, which is a professionally delivered treatment modality that utilizes both psychotherapeutic techniques and educational interventions in order to increase knowledge and competence related to managing specific mental health issues and may include referrals to key resources for mental health help in the community, is found to bolster the provision of community resources (Lukens & McFarlane, 2004). Subsequently the PEP4SAFE program is marketed as a universal primary and secondary prevention and psychoeducational program that encourages participation from all parents to learn about common (and not necessarily clinically pathological) childhood emotional/behavioral problems, how to deal with them using scientific strategies, and how to refer if problems become clinically significant.

The PEP4SAFE program was also developed to address barriers to parental help-seeking for their children. The literature indicates that parental help-seeking behaviors are the primary deciding factor in whether a child with mental health difficulties receives treatment (Briggs-Gowan, Horwitz, Schwab-Stone, Leventhal, & Leaf, 2000; Dempster, Davis, Faye Jones, Keating, & Wildman, 2015). Parents and caregivers serve as the primary gatekeepers to their children's mental health care, and within that role they are tasked with both referring their child and providing access to necessary care (Becker et al., 2015; Morrissey-Kane & Prinz, 1999).

Parents are also a key factor in whether their child completes the required course of treatment (Becker et al., 2015; Morrissey-Kane & Prinz, 1999). The World Health Organization (2005) cites multiple logistical barriers to parents seeking care for their children, including lack of time, lack of transportation, limited financial means, or inadequate health insurance coverage. Given that the existing literature asserts that using a group format with briefer interventions also strengthens parental networks (Becker et al., 2015), PEP4SAFE was developed as time-limited, easily accessible and no-cost, and provides a forum for building connectedness amongst parents. Another significant barrier to treatment is the lack of resources available for youth mental health care in the community. According to the United States Department of Health and Human Services (2011), 71% of states were assessed as lacking adequate community-based mental health services for children. Moreover, access to community resources is scarcely provided through school-based services (Evans & Weist, 2004), despite the fact that schools may help treatment engagement due to easy accessibility in a community setting. The current literature asserts that providing low-cost services and providing services in settings that both parents and children regularly attend is highly effective for treatment of children's mental health (Becker et al., 2015). The PEP4SAFE program is conveniently provided in local school settings, which aims to help decrease logistical barriers and lack of resources by not requiring travel to a specialty mental health clinic.

Additionally, attitudes about treatment, beliefs about causes of mental illness, and stigma regarding mental health issues highly influence parents' approach to obtaining care (Salloum, Johnco, Lewin, McBride, & Storch, 2016). Extant literature demonstrates that parental involvement, particularly in early intervention approaches with established efficacy (Becker et al., 2015; de Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013; Dempster et al., 2015), can be

paramount in achieving positive outcomes from therapeutic approaches in youth. However, parents who view treatment for their child as demanding or not highly relevant to the child's problem, or who have had a poor relationship with their child's clinician in the past, are less likely to seek treatment and tend to prematurely pull their child out of therapy prior before the prescribed course has been completed (Kazdin, 2000; Smith, Linnemeyer, Scalise, & Hamilton, 2013). This further underscores the influence of parental attitudes about all aspects of their child's treatment. Further, the experience or threat of stigma, which refers to the perception that something is unacceptable or wrong with the person experiencing mental health difficulties (Dempster, Wildman, & Keating, 2013), may prevent parents from considering professional treatment for their child despite their belief that it is warranted and even when services are available and accessible (Mukolo, Heflinger, & Wallston, 2010).

Subsequently, the PEP4SAFE program is a departure from previous research and offers some additional helpful elements that have not been well represented in the extant literature in order to target parental attitudes and stigma. It focuses on several elements of a child's behavior, addressing commonly occurring issues that might be helped by the implementation of self-administered strategies. Some of these difficulties addressed are considered normative and developmental instead of pathological which also serves to destigmatize these issues when observed in children. The issues addressed include possible internalizing and externalizing symptoms, rather than specific diagnoses, which allows the strategies learned to be more broadly applied. Finally, many programs cited do not provide a step-by-step manual to parents. This manual is written in lay language and provides parents with guidelines for effective parenting through various situations as they arise. As such, the program is less stigmatizing and more hands-on and interactive than some existing psychoeducation programs. It is also a step-by-step

reference that parents can keep and utilize later, should the information not be fully retained in the initial psychoeducation presentation.

### **The Pilot Study Phase**

The pilot phase is a crucial step in the research process that occurs prior to a larger scale efficacy study. A pilot study has been defined as a “small-scale test of the methods and procedures to be used on a larger scale” (Porta, 2008, p. 215). This phase serves as a preliminary application of an intervention in order to inform feasibility of its implementation and to identify modifications needed for the design of a future hypothesis testing study (Leon, Davis, & Kraemer, 2011). Leon et al. (2011) assert that factors such as recruitment, retention, implementation, and other issues related to the methods of a study are examined during the early pilot phase, which serves to enhance the probability of success in the subsequent efficacy study. According to Moore, Carter, Nietert, & Stewart (2011):

In general, pilot studies contribute to the development and design of future, more costly, primary studies by clarifying and sharpening the research hypotheses to be studied, identifying relevant factors that could create barriers to subsequent study completion, evaluating the acceptability of methods and instruments to participants, measuring the time required for study participation, and providing concrete estimates of the expected rates of missing data and participant attrition. (p.333)

The pilot study phase also allows for an estimation of treatment response and efficacy as well as variance of outcomes among participants (van Teijlingen & Hundley, 2002). The current pilot study conducts an evaluation of content (in terms of helpfulness and likelihood parents would use the strategies learned in the future), parental knowledge outcomes, and elicits responses regarding the program’s coverage of specific needs of the parents participating in the PEP4SAFE

program. Specifically, parents' perceived knowledge of specific topics related to youth mental health after an implementation of the program is assessed quantitatively; a strength of this study that helps build on prior research initiatives.

### **A Review of Psychoeducational Programs**

Psychoeducation is an intervention that utilizes didactic communication of psychotherapeutic and educational information (Bai, Wang, Yang, & Niu, 2015; Montoya, Colom, & Ferrin, 2011). Findings from literature regarding adult psychological health indicate that psychoeducation about mental health disorders leads to more positive outcomes when given to both patients and their families rather than just one or the other. (Glick, Burti, Suzuki, & Sacks, 1994; Rea et al., 2003). However, Ong and Caron (2008) note that research is lacking regarding family-based interventions for children with mental health disorders, despite the fact that school-based parent psychoeducation has been cited as a promising yet underdeveloped modality for service delivery to youth (Pollio, McClendon, North, Reid, & Jonson-Reid, 2005). Subsequently, the aforementioned researchers developed the PsychoEducation Responsive to Families Coping with a Child with Emotional Disorders (C-PERF), a group program that spanned 12 weeks and introduced specific mental health diagnoses. This program utilized a discussion based format to develop possible interventions, and enacted role-plays to allow parents to practice techniques. This intervention had high retention rates (13 out of 15 families completed the program); however due to the lack of quantitative follow up it is challenging to determine the program's impact on increasing parental knowledge of youth emotional disorders or their opinion of the group program in general (Pollio et al., 2005).

Fristad, Goldberg-Arnold, and Gavazzi (2002) developed a similar but non-preventative psychoeducation program for families of children with bipolar disorder that focused on



describing diagnosis, types of treatment, and common issues and barriers to treatment to parents, followed by an open discussion about parents' experiences managing their child's behaviors. Overall, the families who participated in this psychoeducation group noted they felt they had gained knowledge, skills, support and positive attitudes as a result of treatment as measured by coding qualitative data from parent interviews. However, this qualitative study also did not provide any quantitative data on parental knowledge increases or perceived confidence in their ability to continue using techniques they learned (Fristad et al, 2002).

Anderson and Guthery (2015) pilot tested a psychoeducation program for parents of children with ADHD. The outcomes of this study indicated that treatment decreased parental stress and decreased parent-child dysfunctional interactions, as measured by the *Parenting Stress Index* (PSI-4-SF) self-report questionnaire that assesses stress in the parent/child system. While the authors note that there was no significant change in the rating of children's behaviors, it indicated that parental perspective of the relationship with their child and parental knowledge about how to respond effectively to their children's behavior was changed, which is associated with improvements in children's behavioral and emotional functioning (Smith et al., 2013).

The Incredible Years is another program that was developed by Carolyn Webster-Stratton to treat behavioral issues when they first begin, prior to school age (Weisz & Kazdin, 2012). The parent psychoeducational component targets promotion of parents' competency in managing their children's emotional and behavioral functioning. The program involves demonstrations of social learning, which refers to the tendency for children to learn and exhibit behaviors modeled by parents, as well as education of child development principles. The combination of group discussion, psychoeducation via a trained therapist, and modeling interventions for managing child behavior was associated with improvement in parental attitudes toward mental health issues

in childhood as measured by the *Parent Curriculum Involvement and Satisfaction Questionnaire*, and this finding was consistent among multiethnic, socioeconomically disadvantaged families in the study (Webster-Stratton, 1998; Webster-Stratton, Reid, & Hammond, 2001; Weisz & Kazdin, 2012).

In summary, existing psychoeducation programs that are targeted at parents have been found to provide support in addressing various barriers to childhood mental health treatment including attitudes toward mental health treatment and the clinician/parent relationship, as well as in increasing parent knowledge of youth mental health issues, parents' competence in managing their children's behavior, parent relationships with mental health providers, and attitudes toward children's psychological difficulties. Further, they are effective in maintaining parental involvement in improving their child's functioning as evidenced by high retention rates (Pollio et al., 2005). Notably, these improved effects extend across various ethnic groups and levels of socioeconomic status suggesting the potential for generalizability to diverse families (Bai et al., 2015; Fristad et al., 2002; Webster-Stratton, 1998; Webster-Stratton, et al., 2001; Weisz & Kazdin, 2012). However, there are significant gaps in the literature that have not yet been fully addressed. Specifically, current research is lacking regarding benefits of evidence-supported, school-based psychoeducation programs that especially strengthen and measure increases in parental knowledge, improve parental perceptions of their competence in managing their children's behaviors, and increasing access to community resources while simultaneously decreasing negative stereotypes and stigma toward children with mental health difficulties.

### **Parental Knowledge**

Mental health knowledge, also termed "mental health literacy," refers to the awareness of how to prevent mental health disorders, the ability to recognize developing disorders and access

treatment, knowledge of strategies to implement for less severe problems, and having skills to assist and support others with mental health difficulties (Frauenholtz, Conrad-Hiebner, Mendenhall, 2015). This mental health knowledge is essential for parents to develop in order for their children to be appropriately identified as needing professional care and treatment (Morrissey-Kane & Prinz, 1999; Oh & Bayer, 2015; Salloum et al., 2016). Particularly, a higher understanding of children's mental health difficulties influences parent beliefs regarding the need for services as well as whether they feel resources are accessible (Kerkorian, McKay, & Bannon, 2006; Yeh, Hough, McCabe, Lau, & Garland, 2004). Some studies on mental health literacy have also found that higher levels of parent knowledge help to reduce mental health stigma toward children (Frauenholtz et al., 2015; Pinfold et al., 2003).

Research suggests that the majority of parents surveyed via online questionnaire perceived that they did not have the specialized knowledge or understanding of childhood mental health issues (Frauenholtz et al., 2015). Interestingly, Frauenholtz and colleagues (2015) note that parents are often aware of their lack of knowledge and express significant uncertainty at their ability to understand and identify childhood mental health issues. This finding is mediated by parent's previous experience with mental health, and severity of their child's symptoms; such that parents are less likely to identify mental health issues in their child when they have less prior experience with professional mental health treatment and when symptoms are perceived less severe (Susan, Aislinn, & Amy, 2015). Perceived knowledge is important to investigate, as it impacts actual knowledge attainment as well as confidence in actively addressing specific issues. Parental uncertainty about their knowledge base and low capability to identify mental health problems in their children can decrease their likelihood of seeking treatment in the first place, and, once treatment has begun, can be associated with less parental buy-in and decreased

willingness to become involved in the process. This may hinder the formation of a positive alliance with their child's clinician, which is a salient aspect in positive treatment outcomes (Israel, Thomsen, Langeveld, & Stormark, 2004). Additionally, it has been established that when parents are able to play an active role in maintaining and improving their children's mental health, the children are more likely to improve, further highlighting the importance of parental buy-in and involvement (Dowell & Ogles, 2010). Indeed, parent participatory engagement in treatment is considered a part of evidence-based practice for improving disruptive behaviors in children (David-Ferdon & Kaslow, 2008; Eyberg, Nelson, & Boggs, 2008; Kazdin, 2000; Silverman, Pina, & Viswesvaran, 2008).

**Knowledge of social skills.** It is essential for parents to understand youth social development in children in particular. Social development is crucial for children to develop positive peer relationships and form meaningful friendships, which is associated with greater self-esteem, positive attitudes, and good behavior (Berndt, 2002). Social skills deficits have been associated with negative long-term outcomes, such as a greater risk of depression and less resilience when faced with difficult life situation (Segrin, 2000). An increased level of understanding of this domain leads to greater parent engagement in interventions used to improve social skills in children (Martinez, Lau, Chorpita, & Weisz, 2015). Increased parent involvement with regards to children's social development is subsequently associated with better social skills and decreased problem behaviors in their children (Nokali, Bachman, & Vortrubal-Drzal, 2010).

Parents who demonstrate high knowledge of child development and believe in their own ability to be successful in the parenting role tend to exhibit greater competence in interactions with their children (as measured by self-report questionnaires regarding level of self-efficacy that

parents felt in caring for their children after being videotaped playing with them; Hess, Teti, & Hussey-Gardner, 2004). Specifically, this knowledge leads to parents' accurate expectations of their children's behavior with respect to their developmental stage and their subsequent tendencies to respond more sensitively to their child's behaviors during play interactions (Azar, Robinson, Hekimian, & Twentyman, 1984; Damast, Tamis-LeMonda, & Bornstein, 1996). Furthermore, psychoeducational approaches geared towards parents of children with social skills difficulties have been found to increase parents' knowledge (as determined by a meta-analytic review of psychoeducational approaches used with parents) about the difficulties and positive attitudes towards these children (Nussey, Pistrang, & Murphy, 2013). Consequently, the social skills module of the PEP4SAFE manualized psychoeducation program was developed, in order to address this fundamental need for parent knowledge regarding this developmental domain.

Interventions that are aimed to increase parental knowledge of social skills are most effective when they target the specific needs of each participant (Mendenhall & Frauenholtz, 2015). Thus, it is important to investigate parental factors that impact their ability to retain information from educational interventions. Current research is scant regarding how age, level of education, and income of parents influence their capacity to gain knowledge from psychoeducation programs. Of the little data available, one study found that younger adults are better able to retain new learned health information (Merriam, 2001). This study aims to expand upon the little research available in this area by examining how parental age, income, and education facilitate parents' perception of knowledge learned regarding children's social skills and helpful strategies to improve upon these skills from the PEP4SAFE program.

## Hypotheses

We propose three hypotheses related to clinical correlates of parental knowledge of social skills. First, based on previous empirical findings we predict that parents' self-perception of post-presentation knowledge of normative social skills development and prosocial behaviors will be negatively correlated with parental age. Second, we hypothesize that clinical correlates of post-presentation parental knowledge of normative social skills development and prosocial behaviors will be positively correlated with level of parental education achieved in the formal school system. Third, we predict that parents' self-perception of post-presentation knowledge of normative social skills development and prosocial behaviors will be positively correlated with level of family income.

## Method

### Participants

**Parent participants.** Parents from two elementary schools in the Los Angeles area were recruited for the PEP4SAFE parent psychoeducational program via flyers and posters posted and handed out at their children's schools. School B was of a higher socioeconomic status than school A. Further, there were qualitative differences between School A and School B's perception of the research study. For example, following the first three modules of the PEP4SAFE program, School B expressed a desire for a less manualized program and instead requested the opportunity to engage in question and answer session with a licensed professional. As such, there is significantly less data from School B. A total of 39 parents participated (95% female, 5% male). Their average age was 42.79 (SD = 4.39). One participant elected not to state her age. Two percent of participants reported having a high school/general educational development (GED) education, 2% attended some college, 2% have received a two-year college degree, 38% have received a four-year college degree, 31% have received a master's degree, 10% have a doctoral degree (e.g., Ph.D.), and 15% have a professional degree (e.g., M.D., J.D.). A majority of participants were married (85%), and the others were living together (3%), separated (5%), or divorced (7%). Mean household income was \$100,000-199,999 (28%); 7% of participants had an income below \$99,999, 21% had an annual household income between \$200,00-499,999, and 17% had an income higher than \$500,000. There were 10 participants who elected not to provide their income (27%). Additionally, 67% percent of participants identified as non-Hispanic white, 15% were Latino, 15% were Asian/Pacific Islander, and 3% identified as "other." Each participant reported their preferred language as English (100%). See Tables 1, 2, and 3 for sample characteristics.

**Table 1***Full Sample, Schools A and B*

	<i>n</i> or (M)	% or (SD)
Female parent participants	37	95%
Male parent participants	2	5%
Age of parent	(42.8)	(4.39)
Parent education level		
High school/GED	1	2%
Some college	1	2%
Two-year college	1	2%
Four-year college	14	38%
Master's degree	12	31%
Doctoral degree	4	10%
Professional degree	6	15%
Marital Status		
Married	33	85%
Living together	1	3%
Separated	2	5%
Divorced	3	7%
Annual household income		
< \$99,000	3	7%
\$100,000 - \$199,999	11	28%
\$200,000 - \$499,999	8	21%
> \$500,000	7	17%
No answer	10	27%
Ethnicity		
Non-Hispanic White	26	67%
Latino	6	15%
Asian/Pacific Islander	6	15%
Other	1	3%
Preferred language		
English	39	100%

*Note.* Sample characteristics ( $N = 39$ ).**Table 2***School A*

	<i>n</i> or (M)	% or (SD)
Female parent participants	5	80%
Male parent participants	1	20%

(continued)



	<i>n</i> or (M)	% or (SD)
Age of parent	(38.17)	(1.72)
High school/GED	0	0%
Some college	1	16.7%
Four-year college	3	50%
Master's degree	1	16.7%
Professional degree	1	16.7%
Marital Status		
Married	6	100%
Annual household income		
< \$99,000	2	33.3%
\$100,000 - \$199,999	2	33.3%
No answer	2	33.3%
Ethnicity		
Non-Hispanic White	3	50%
Latino	3	50%
Preferred language		
English	6	100%

*Note.* Sample characteristics ( $n = 6$ ).

**Table 3**

*School B*

	<i>n</i> or (M)	% or (SD)
Female parent participants	32	97%
Male parent participants	1	3%
Age of parent	(43.7)	(4.2)
Parent education level		
High school/GED	1	3%
Two-year college	1	3%
Four-year college	11	33.3%
Master's degree	11	33.3%
Doctoral degree	4	12%
Professional degree	5	15%
Marital Status		
Married	27	82%
Living together	1	3%
Separated	2	6%
Divorced	3	9%
Annual household income		
< \$99,000	1	3%
\$100,000 - \$199,999	9	27.2%

(continued)

	<i>n</i> or (M)	% or (SD)
\$200,000 - \$499,999	8	24.2%
> \$500,000	7	21.2%
No answer	8	24.2%
Ethnicity		
Non-Hispanic White	23	69.7%
Latino	3	9%
Asian/Pacific Islander	6	18.2%
Other	1	3%
Preferred language		
English	33	100%

*Note.* Sample characteristics ( $n = 33$ ).

**Recruitment.** The overall project and associated research study protocol received approval from the Pepperdine Graduate and Professional Schools Institutional Review Board (GPS IRB) in March 2016 (Principal Investigator [PI]: Judy Ho; see Appendix A, IRB approval letter). Following distribution of recruitment letters and flyers to principals of 38 public elementary schools (selected for their proximity to the Pepperdine West Los Angeles [WLA] campus) advertising the availability of psychoeducational program for parents of school-age children and interest in collaborating with staff to hold sessions on school property, two principals responded in the South Bay area of Los Angeles, California (CA). It is of note one of the two schools that responded had a pre-existing relationship with one of the researchers, which likely influenced their decision to participate in the study. Following approval of school staff, distribution of informational flyers advertising the session dates/times of the psychoeducational program were made through school staff, and interested parent participants made reservations via an online registry (maintained by school staff at one site, and by the present research lab at the school's request for the second site) and attended sessions (see Appendix B for sample recruitment letter and Appendix C for sample recruitment flyer). Important to note, initially this intervention was intended to be a full day workshop, but school administrators at School B

preferred to break up the program into multiple meetings over several weeks to make it more feasible for parents to attend. To be consistent and flexible, the same was done for School A. Those parents that could attend sessions on days that they were available for topics they were interested in. The flyers indicated that the program developers were asking them to answer some brief questions before/after the session about the quality and content of the program, as well as about any suggestions they might have for the program. Additionally, the flyers explained that participation in these questionnaires is not required in order for them to attend and receive the psychoeducational program. Potential parent participants were also made aware that advanced notification of their attendance is not required but appreciated.

**Research team.** The research team consists of masters and doctoral level graduate students in Pepperdine University's Graduate School of Education and Psychology, led by Judy Ho, Ph.D. Each student underwent training with the principal investigator and the manual developers in order to learn how to optimally present the material with fidelity to the manual components. The research team subsequently presented the psychoeducational program to parents in evening workshops and collected pre-program and post-program data.

**Human subjects/ethical considerations.** Confidentiality and ethical considerations regarding research participants was incorporated throughout the study. For example, the limits of confidentiality for research database inclusion were reviewed at the outset of psychoeducational sessions with the parent participants. Researchers provided all participants with informed written consent to participate in the study (see Appendix H for informed consent form). To de-identify each participant, each subject was assigned a Research Identification Number (RIN) upon enrollment in the study. Further, all research team members who handled data in the research database have completed an IRB certification course. All researchers also completed a Health

Insurance Portability & Accountability Act of 1996 (HIPAA) to ensure adequate adherence to ethical standards of participant research and handling of confidential health information prior to accessing content of the research database.

Data have been de-identified and will only be reported in the aggregate. Only the researchers and principal investigator will have access to the data, which is not linked to any identifying information about the participants as each individual was assigned a research identification number immediately upon enrollment. All hard copies of data are stored in locked file cabinets at Pepperdine University GSEP, WLA campus in the office of Judy Ho, Ph.D., and all electronic data is stored in Microsoft Excel and Statistical Package for the Social Sciences (SPSS) with password protection on lab laptops of Judy Ho, Ph.D., which are kept locked and secured at the Pepperdine University GSEP WLA Office.

### **Psychoeducational Manual Overview**

The PEP4SAFE manual is a treatment intervention for parents that provides them with psychoeducation on common mental health issues among school-age children and adolescents, when/how to seek mental health services for their child, and essential elements of the treatment process; intervention also facilitates a collaborative discussion with parents about potential barriers to treatment and how to overcome these barriers. It was adapted, edited, and compiled by Judy Ho, Ph.D., and a team of clinical psychology doctoral and psychology master students at Pepperdine University (i.e., Genevieve Lam, Erika Rajo, Joseph Farewell, Jennifer Duarte, Emily Blum, Leanne Mendoza, and Jillian Yeargin). The manual also has a teacher component, which was not used for the purposes of this pilot study. The manual contains both a provider and participant edition, the former which was disseminated to parents in a presentation format, with elements of didactic instruction, group discussion and question/answer. The participant version

contains the information presented in the specific module and was distributed to the parents to be used as a reference throughout the presentation and for future use.

**Social skills module.** The Social Skills module begins by providing an agenda of the session, outlining the topics of discussion. It then introduces the concept of social skills difficulties and encourages discussion of parents' personal experiences with children who have difficulties with social functioning. It assists parents in identifying when children have social skills difficulties by introducing four components of social competence, which include self-related, task-related, interpersonal, and environmental behaviors. It targets increasing parents' understanding of where problems in those domains emerge from, whether it be situational factors or deficits in fluency, performance, or knowledge. A case vignette with an example of a child experiencing social skills difficulties is presented during implementation of the program, and parents are invited to discuss their perceptions of what skill deficit the child is experiencing. Factors that put children at a higher risk for social skills difficulties are also discussed in the context of emotional, cognitive, and behavioral issues. The module also presents the negative consequences of social skills issues at both an individual and larger-scale, community level. Several strategies for promoting children's prosocial behavior are taught to parents, and parents are able to implement such strategies via a role-play with another parent. Specific skills to promote are listed as well. Parents are then taught to identify when it may be necessary to seek treatment for their child and are provided with online resources to supplement topics learned as well as local resources for additional help.

### **Description of the Pilot Study**

For the purposes of this study and its companion study, two modules of the psychoeducational manual were examined, Social Skills and Internalizing Behaviors, as they

were the most requested topics at both of the school districts by school staff and also the most requested topics at an earlier parent focus group conducted in spring 2016, and therefore implemented prior to other four modules in the program (Disruptive Behaviors, Attention and Concentration, Staying Connected with Your Child, Bullying). Parents attended one psychoeducational session on one weeknight at Juan Cabrillo Elementary School or one morning at Manhattan Beach School District. Each session was led by Judy Ho, Ph.D., and several masters and doctoral students from Pepperdine University's Graduate School of Education and Psychology. Each module was approximately 75-90 minutes in administration time, including time to complete pre- and post-questionnaires. Participants were given a workbook at the initiation of each session which consists of the participant version of these modules, which they are allowed to keep.

Prior to the psychoeducational session, participants were asked whether they'd like to participate in the optional research study, which consisted of filling out brief questionnaires before and after the session. Participants were informed that their participation was voluntary and they could withdraw from the study at any time, and that their participation decision would not affect their receipt of the psychoeducational program. Research associates guided participants through a review of the consent form using a standardized script (see Appendix D). Those who chose to participate signed a consent form and one copy was filed by the research lab, while a second duplicate copy was offered to participants for their records.

## **Measures**

**Demographics questionnaire.** The Parent Demographic Questionnaire (Appendix E) was developed by Judy Ho., Ph.D., and her research assistants in order to obtain data regarding individual parent characteristics. Specific questions were selected for the purpose of examining

variability among parents and how it relates to child behavioral characteristics, knowledge, confidence, and retention of information. Demographic variables utilized in this study include parent's age, education, income, sex, ethnicity, marital status, and preferred language.

The second portion of the demographic questionnaire was developed based on the content of the well-known Child Behavior Checklist (CBCL; Achenbach, 1992). The CBCL is one of the most widely-used standardized measures for the report of childhood internalizing and externalizing behaviors. The CBCL uses a Likert scale and asks caregivers to report whether their children experience or demonstrate specific symptoms. As such, the present investigators developed a similar scale that aimed to focus on the symptoms we addressed in each module of the psychoeducational manual. This served as a baseline to understand what topics were important to parents, and what symptoms they were observing more often. Parents were also asked to rate their knowledge and confidence in managing their children's difficulties regarding specific topics within each module. These questions were selected in order to gather data regarding parent attitudes about their perceived level of mental health literacy and capabilities of identifying how their child is functioning within those specific domains of each module. As previously noted, greater mental health literacy and higher perceived capability contribute to better child outcomes (Mendenhall & Frauenholtz, 2015; Susan et al., 2015). The psychometric properties of the scale are unknown as this version was especially developed and adapted for the purposes of the present pilot study.

**Pre- and post-questionnaires.** The module-specific pre- and post-questionnaires (Appendix F and G) were also developed by Judy Ho., Ph.D., and her research team with the aim to determine how much information regarding the module topic parents already knew, and how much information they retained directly following the administration of the

psychoeducational program. Forced-choice questions were created based on specific content addressed in the module handouts and psychoeducational presentations. Questions assessing parent's perceived level of knowledge regarding specific topics after the presentation and level of confidence in managing children's difficulties were also created and included in both pre- and post-questionnaires. Parents were also asked to rate the helpfulness of the psychoeducation session in the post-questionnaire. These questions serve to examine whether or not parents' knowledge increased regarding the topics covered in the session, which helps to understand whether the certain sub-topics were addressed adequately in the presentation so that the majority of parents learned or retained the information. It also provides information on what topics parents already had adequate knowledge of prior to the presentation or what topics may be more difficult for parents to retain. This pilot data can be used to inform the need for modifications to the questionnaire or to the points covered in the modules in the larger scale study (Leon et al., 2011). For this study, parent's post-presentation perceived level of knowledge regarding normative social skills development and prosocial behaviors in children were used. The psychometric properties of the scale are unknown as this version was especially developed and adapted for the purposes of the present pilot study.

### **Procedures for Entering and Analyzing Data**

**Quantitative analysis.** Quantitative data was inputted and initially managed using Microsoft Excel and planned for export and transfer to SPSS software for data analyses. Before data was entered into Excel and SPSS, the researchers were properly trained by Judy Ho., Ph.D., in use of the software to ensure accurate data entry. Researchers each had individual roles in data entry, review, spot-check, and correction of any errors. Ongoing data management included direct computer data entry of questionnaire data, data quality control and tracking, checking of



adherence to confidentiality protocols, and development of data files for statistical analysis. Additional data quality checks were conducted via SPSS once data was transferred. Analyses will regression models in order to test the study hypotheses.

### **Research Bias and Quality of Study**

The researchers and principal investigator addressed potential biases by proactively exploring their own biases and expectations of the study. This involved discussing preconceived notions about participants' potential responses and acknowledging factors for their own personal and clinical experiences that may influence certain expectations regarding outcomes. This a-priori discussion served to minimize the effect of researcher bias on subsequent data analysis.

## Results

### Preliminary Analyses

Bivariate correlations between study variables are displayed in Table 4. Using a bivariate correlation, we explored a number of demographic variables as possible correlates of perceived knowledge of normative social skills development and prosocial behaviors (on a scale of 1 = Not at all knowledgeable to 5 = Very knowledgeable).

The average and standard deviation of perceived knowledge scores reported for the two areas of social skills knowledge are as follows: normative social skills development average score = 3.86;  $SD = 0.71$ ; prosocial behaviors average score = 3.76,  $SD = 0.71$ .

These results suggest parental income is positively correlated with age ( $r = .28, p < .05$ ) and highest level of education ( $r = .46, p < .01$ ) and parental knowledge regarding prosocial behaviors in children is positively correlated with level of knowledge regarding normative social skills development ( $r = .70, p < .01$ ).

**Table 4**

*Intercorrelations Between Study Variables*

Item/Scale	1	2	3	4	5	6	7
1. Sex of Parent	1						
2. Ethnicity	-.04	1					
3. Age	.11	-.06	1				
4. Annual household income	.14	-.1	.28*	1			
5. Highest level of education	.09	.03	-.06	.46**	1		

(continued)

Item/Scale	1	2	3	4	5	6	7
6. Level of knowledge regarding normative social skills development	-.17	-.12	.04	.28	.07	1	
7. Level of knowledge regarding prosocial behaviors in children	-.07	-.18	.03	.21	.19	.70**	1

*Note.* \* Correlation is significant at the 0.05 level (2-tailed)

\*\* Correlation is significant at the 0.01 level (2-tailed)

### Factors Associated with Knowledge

As displayed in Tables 5 and 6, two hierarchical multiple regression models examined two predictors; specifically: (a) post-presentation parent perceived knowledge of normative social skills development, (b) post-presentation parent perceived knowledge of prosocial behaviors. In the first step of each of the two models, ethnicity of parent and sex of parent were entered as control variables as a result of our literature review, and no significant effects were found between the control variables and parent report of post-presentation perceived knowledge of normative social skills development, nor were any significant effects found between the control variables and parent report of post-presentation perceived knowledge of prosocial behaviors.

The three target independent variables were entered in the second step of the two models, and included (a) age of parent, (b) highest level of education completed by parent, (c) total annual household income. These independent variables were selected based on previous literature. First, based on previous empirical findings we predicted that parents' self-perception of post-presentation knowledge of normative social skills development and prosocial behaviors would be negatively correlated with parental age. Second, we hypothesized that clinical

correlates of post-presentation parental knowledge of normative social skills development and prosocial behaviors would be positively correlated with level of parental education achieved in the formal school system. Third, we predicted that parents' self-perception of post-presentation knowledge of normative social skills development and prosocial behaviors would be positively correlated with level of family income. No significant associations were found between any of the three independent variables and post-presentation perceived parental knowledge of normative social skills development or post-presentation perceived parental knowledge of prosocial behaviors after taking into account the unique contributions of the control variables.

**Table 5**

*Summary of Multiple Regression Analysis for Variables Predicting Knowledge Regarding Normative Social Skills Development*

	Variable	<i>B</i>	<i>SE B</i>	Beta
Step 1	<i>Control</i>			
	Ethnicity of Parent	-.07	.08	-.15
	Sex of Parent	-.43	.51	-.15
Step 2	<i>Level of Knowledge Regarding Normative Social Skills Development</i>			
	Age of Parent	-.01	.03	.07
	Highest Level of Education Completed	.04	.08	.09
	Annual Household Income			
	Step 1 for Level of Knowledge regarding prosocial behaviors	.16	.10	.29

*Note.*  $R^2 = .05$  ( $p < .43$ ) for Step 1;  $R^2 = .05$  ( $p < .62$ ) for Step 2

**Table 6**

*Summary of Multiple Regression Analysis for Variables Predicting Knowledge Regarding Prosocial Behaviors*

	Variable	<i>B</i>	<i>SE B</i>	Beta
Step 1	<i>Control</i>			
	Ethnicity of Parent	-.07	.08	-.15
	Sex of Parent	-.43	.51	-.15

(continued)

	Variable	<i>B</i>	<i>SE B</i>	Beta
Step 2	<i>Level of Knowledge Regarding Prosocial Behaviors</i>			
	Age of Parent	.01	.03	.05
	Highest Level of Education Completed	.11	.10	.19
	Annual Household Income	.12	.11	.22

*Note.*  $R^2 = .05$  ( $p < .43$ ) for Step 1;  $R^2 = .05$  ( $p < .62$ ) for Step 2

## Discussion

This study examined the feasibility and effectiveness of implementing the Social Skills module of a manualized psychoeducation program for parents of school-aged children. Specifically, a hierarchical regression was used to examine clinical correlates of parental knowledge of normative social skills development and prosocial behaviors. We hypothesized that parents' self-perception of post-presentation knowledge of normative social skills development and prosocial behaviors would be negatively correlated with parental age. Second, we hypothesized that clinical correlates of post-presentation parental knowledge of normative social skills development and prosocial behaviors would be positively correlated with level of parental education achieved in the formal school system. Third, we predicted that parents' self-perception of post-presentation knowledge of normative social skills development and prosocial behaviors would be positively correlated with level of family income.

Contrary to what we predicted, there was no relationship between self-perception of post-presentation knowledge of normative social skills development and parental age, or self-perception of post-presentation knowledge of prosocial behaviors and parental age. Previous research indicated that older adults tend to learn less than younger adults regarding health-related information when objectively assessed on their ability to recall the information (Brown & Park, 2002). As was noted previously, Israel et al. (2004) found that parents are less likely to seek mental health treatment for their children and can be less willing to be involved in their treatment if they have uncertainty about their knowledge base and low capability to identify mental health problems in their children. However, current research is lacking regarding the relationship between age and self-perception of ability to retain mental health information.

Further, parents' self-perception of post-presentation knowledge of normative social skills development and prosocial behaviors were not significantly related to parental level of education. This hypothesis was based on a proposed extension of current literature findings, which suggests that parents with higher education have children who are more likely to retain newly acquired information of various types (Brown & Park, 2002). Current research is scant regarding parents' own retention of mental health-related information regarding their children as it relates to the amount of education they completed. This study's findings suggest that there may not be a relationship between level of formal parental education and their self-perception of knowledge attainment regarding social skills development in children, at least in our sample.

Additionally, the findings of this study did not support our hypothesis regarding an anticipated positive correlation between parents' self-perception of post-presentation knowledge of normative social skills development with level of family income or parents' self-perception of post-presentation knowledge of prosocial behaviors with level of family income. In previous research, parents with higher socioeconomic status were found more likely to retain newly acquired information (Brown & Park, 2002). Again, in this study, family income did not significantly inform parental perception of their retained knowledge.

Our findings may suggest that age, parental level of education, and family income may not be the most critical factors when assessing parents' perception of information retention about their child's mental health. Thus, future implementations of the PEP4SAFE program can include diverse groups of parents within the same sessions, and the content does not necessarily need to be tailored to target specific age groups, parents with certain levels of education, or areas of differing socioeconomic status. The program can be implemented in various community settings

and achieve similar engagement without the need for added support to promote self-perception of knowledge in specific groups based on those three demographic variables.

Aside from the possibility of no effect regarding parental age, level of education, and level of family income on parents' self-perception of post-presentation knowledge of both normative social skills development and prosocial behaviors, it is also possible that parents' self-perception of knowledge was not reflective of the actual amount of information learned. Specifically, parents may self-perceive that they have not acquired much new information, when actually on a content-based exam or when observed in a naturalistic environment for their application of these skills, they would fare quite well. Future studies that incorporate a paper and pencil exam that might comprehensively assess their actual knowledge through regurgitation of the material, or a structured observation of a naturalistic play or social setting, may help elucidate this hypothesis further. In fact, most previous research attends to actual ability to retain information measured by more objective measurements of attained knowledge (e.g., a written test asking questions about material to check for comprehension of content) rather than their own perception of retention (which is more subjective; Brown & Park, 2002). While this might help explain the lack of significant relationship in our study, extant literature has suggested that parents' own perception may link to parents' willingness to engage in services and confidently apply the information learned. The current study focused on parent self-perception of knowledge to further explore what factors facilitate their engagement and increase in self-efficacy as a result of newly learned material regarding their children's social skills development, rather than measuring the actual amount of content learned.

While our hypotheses were not supported, we did find some bivariate correlations that are consistent with what would be expected given extant literature findings. Parental perception of



post-presentation level of knowledge regarding normative social skills development was significantly correlated with level of knowledge regarding prosocial behaviors in children. It appears that knowledge in the general domain of social skills is generalizable to sub-domains, such as development and prosocial behavior. These two constructs are very similar and may have contained overlapping content, both contributing to the general construct of perceived social skills knowledge. As such, in future iterations of the manual, it may be helpful to measure the general construct rather than specific sub-constructs to achieve parsimony, as when parents perceive themselves as being knowledgeable in one sub-skill set, it appears to increase their perception of knowledge of the other. To take this a step further, future studies may evaluate the factor loadings of these sub-domains to assess whether there is significant overlap, which would provide additional evidence to combine these two separate factors into one parent construct.

Our small sample size may have been a significant limitation to our study. Though a low  $n$  sample is consistent with the pilot study phase, the smaller sample size in combination with the self-selective process of the study (based on parents who demonstrated interest in the program) may have limited the generalizability of our findings as well as low statistical power to detect a significant effect if one truly exists. Further, we used two significantly different samples to make conclusions about the efficacy of the program, but due to the disparities between samples (e.g., income level, education level, number of attendees, level of engagement in the program itself), it may be difficult to generalize our findings to community samples. To partially address this issue, we ran a multiple regression analysis following our preliminary bivariate correlations that specifically address the two hypotheses, which is considered a more sensitive statistical analysis to further verify our findings. Additionally, it is possible that the intervention format impacted parental perceptions of knowledge. The manual was originally intended to be a full day

workshop, but due to administrator request, it was divided into modules. There is a possibility that a full day workshop would have had more impact on increasing parental perceptions of knowledge more quickly or heavily than a module based format. Also, it is important to note that everyone from one of the school districts who attended the program did complete the study questionnaires, resulting in a 100% participation rate. Because the second school district preferred to keep their records private, we do not have information as to how many participants in the program elected not to complete the questionnaires. There may have been some common factors that separated individuals who elected to complete questionnaires versus those who did not (e.g., engagement in the psychoeducational program). Use of a convenience sample may also be a study limitation. We recruited two small and homogeneous samples from nearby and convenient school districts in southern California that does not adequately represent the general population and thus is not fully generalizable to parents of school-aged children as whole in the United States, or arguably, even to Los Angeles County which is quite diverse across several sociodemographic domains. Further, the sample self-selected not only based on parental interest in the program, but also that only parents with assistance in child care and more free time to attend the sessions on school nights were able to participate and therefore directly surveyed. In fact, several participants approached the researchers before or after sessions to discuss the difficulty they experienced arranging their schedules in order to participate, and also reported to the researchers that there were other parents they knew who wanted to participate but could not due to the above logistical difficulties. Therefore, future implementations may consider ways to decrease these barriers to participation, including scheduling multiple sessions; integrating sessions with an existing program with high parental participation (such as Parent Teacher Association meetings or Back to School nights), or offering an alternative, online-based

implementation so parents can attend from the comfort of their home, office, or other convenient location.

Our study design could be another limitation in our decision to measure self-perception rather than actual retention of knowledge. We examined parents' self-rated perception of knowledge after attending a presentation of the social skills module, and believed it would yield useful results as parents' perception of knowledge was found to be related to their engagement in taking an active role in promoting their child's development and participating in necessary treatment if necessary. We have discussed the limitations to using this operational definition, as it is qualitatively and conceptually different from measuring objective knowledge attained. Due to anticipated perceived burden to parents (e.g., such as requesting their participation by sitting for a more traditional paper-and-pencil exam regarding their skills retention), the potential for further invasiveness on parents that might be incurred by setting up an observational protocol in which student researchers appear to be "judging" and rating parents' capabilities in encouraging prosocial skills in their children, and our primary goal of providing services to the community and ensuring their receipt of these services first and foremost (as opposed to placing the goal of obtaining high quality of data of the utmost rigor), our study design inherently favored parsimony over comprehensiveness. Obtaining and comparing both types of information, parents' self-perception of knowledge as well as parents' actual, objective knowledge regarding social skills development, may have provided for a richer dataset, allowed us to test the interaction between perceived and actual parental knowledge, and provide at least one other way of measuring knowledge increase post-presentation. Future studies will take this into account in the study design and explore time-efficient methods to collect both types of information.

Despite the limitations discussed, the researchers believe that this study, and the Psychoeducational Program itself, holds significant potential to help parents, educators, and children of our community. This study adds to the literature on parental mental health literacy, specifically regarding their understanding of their children's mental health. The study and especially the psychoeducational program help to address the significant need for increased parental involvement in their child's psychosocial functioning as gatekeepers of access to mental health resources. It targeted and emphasized the need for early intervention in formative years and addresses barriers to help-seeking by providing free services conveniently located in community settings. Because the manual was constructed to apply to all children, regardless of mental health need, it provides psychoeducation to parents who may not be concerned about their child's mental health or carry stigmatized attitudes toward such topics.

It is our hope that this study, despite its limitations, has helped to provide further insight into parental ability to retain and evaluate psychoeducational information. Due to the scarcity of research regarding self-perception of knowledge retention in general, future research is warranted to inform how much perception of capability informs motivation to apply learned material. Additionally, it may be helpful to have different manual versions based on beginning, intermediate and advanced levels of understanding of manual topics. Future research could investigate whether parent's self-perceptions of understanding change based on the amount of detail provided in the manual, and how challenging the topic is. This idea is particularly salient given that Brown and Parks (2002) findings suggest that prior knowledge of health topics tends to increase ability to retain knowledge about that topic. Finally, this study justifies the need for continuing research and a large scale efficacy study utilizing PEP4SAFE Manual to provide more information regarding objective measures of parental mental health literacy.

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Appendix A  
IRB Approval Letter



Pepperdine University  
24255 Pacific Coast Highway  
Malibu, CA 90263  
TEL: 310-506-4000

## NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: March 31, 2016

Protocol Investigator Name: Judy Ho

Protocol #: 15-12-146

Project Title: PsychoEducational Program 4 School-Aged Family and Educators Focus Group and Pilot Study

School: Graduate School of Education and Psychology

Dear Judy Ho:

Thank you for submitting your application for expedited review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

Based upon review, your IRB application has been approved. The IRB approval begins today March 31, 2016, and expires on March 30, 2017.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. You can only use copies of the consent that have been stamped with the IRB expiration date to obtain consent from your participants.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and will require a submission of a new IRB application or other materials to the IRB. If contact with subjects will extend beyond March 30, 2017, a continuing review must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at [community.pepperdine.edu/irb](http://community.pepperdine.edu/irb).

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Page: 1





Pepperdine University  
24255 Pacific Coast Highway  
Malibu, CA 90263  
TEL: 310-506-4000

Judy Ho, Ph.D., IRB Chairperson

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

Mr. Brett Leach, Regulatory Affairs Specialist

Appendix B  
Sample Recruitment Letter

**Judy Ho, Ph. D., ABPP, CMHFE**  
 Assistant Professor, Licensed Clinical Psychologist  
 Board Diplomate, American Board of Professional Psychology  
 Board Diplomate, National Board of Forensic Evaluators

**DATE**

**(NAME)**  
**(TITLE)**  
**(DISTRICT)**

Dear (NAME):

We are writing to let you know about an extraordinary, no-cost opportunity for the parents and teachers of (Fill in name of school) to attend a psychoeducational program about common childhood emotional and behavioral problems. This program was developed by Dr. Judy Ho and the doctoral and master students in her clinical research lab at Pepperdine University's Graduate School of Education and Psychology. Dr. Judy Ho is a two-time recipient of the National Institute of Mental Health National Services Research Award, and she has a long track record of doing community mental health research with children, teachers, and families. She is a frequent correspondent on CNN and a variety of other news channels where she speaks about important mental health issues for children and families. Her program is devoted to ensuring those who are at-risk have access to resources and early intervention to ensure a positive developmental trajectory. The program aims to provide parents and teachers with concise and targeted information regarding common childhood issues they may encounter, such as social skills difficulties, attention and concentration problems, acting out behaviors, and sadness and anxiety. We strongly believe that educating parents and teachers about how to identify these common problems in children they work with can help to foster positive development in youth.

We would like to meet with you briefly (20-30 minutes) to discuss the possibility of introducing this training program to help serve the needs and interests of your school.

There has been much research that demonstrates the significance of early intervention to enhance students' learning and positive behavior. Some of the positive outcomes associated with prevention and early intervention include improved standardized test scores, GPA, citizenship ratings, and reduced disciplinary actions (e.g., truancy, suspension). We are interested in partnering and collaborating with your school to introduce the program to teachers and parents, and to gain valuable input from you as to how to better present the material so that it can achieve maximum benefits for the children you serve.

The program is structured and designed to provide parents and teachers with psychoeducation on common emotional and behavioral issues among school-age children, how to help modify these

behaviors with scientifically proven behavioral strategies at home and at school, when/how to seek mental health services for a child, and the essential elements of the treatment process. They also aim to provide teachers and parents with information about services and resources available within their community.

We would appreciate a short meeting with you to discuss this training program in more depth. We know you are busy and can come to your school at a time convenient to you. Please let us know if you have any questions or need more information and we will be happy to provide more details. You can call Brian Goldstein at (INSERT PHONE NUMBER) or email him at [brian.goldstein@pepperdine.edu](mailto:brian.goldstein@pepperdine.edu).

Looking forward to meeting you to discuss this exciting project!

Sincerely,

Judy Ho, Ph.D., ABPP, CMHFE  
Assistant Professor of Psychology, Clinical Psychologist, Pepperdine University

Emily Blum, M.A.  
Genevieve Lam, M. A.  
Leanne Mendoza, M. A.  
Erika Rajo, M. S.  
Clinical Psychology Doctoral Students, Pepperdine University

Joey Farewell  
Brian Goldstein  
Clinical Psychology Master Students, Pepperdine University

Appendix C  
Sample Recruitment Flyer

## PARENTS WANTED!

**Who:** Parents of school-aged children

**What:** Learn more about how to work with your child to bring out their best!

- Learn techniques to help students effectively complete homework
- Connect with your child
- Help your child identify thoughts and feelings and discuss them with you
- Help your child develop friendships and prosocial skills

Dr. Judy Ho and her research team have developed a training program that covers these topics and more! We are looking for parents to complete the training and provide feedback, all while learning more about how to effectively help children reach their full potential.

**When:** (Time & date here)

**Where:** (Location here)

Questions? Call **Dr. Judy Ho**, professor at Pepperdine University and licensed clinical psychologist at **310-568-5604** or **judy.ho@pepperdine.edu**

Appendix D  
Informed Consent Script



## PEP4SAFE

### CONSENT FORM SCRIPT FOR RESEARCHERS

*Please use this script to overview consent forms with potential participants  
(What you will say is in **bold**)*

**Hi! My name is \_\_\_\_\_.** I would like to take about five minutes to go over the research aspect of our presentation- would that be okay with you?

**The research aspect of the presentation takes about 20 minutes total- including the time we will spend talking right now. Essentially, we are trying to determine how helpful our program is, and what could be improved.** (Start on page 1 of consent form and point to "Purpose" paragraph)  
**Would you be willing to help us out with it?**

Yes- Continue on: **Great- I will tell you more about the study- please feel free to stop me at any time if you have questions.**

No- **Okay, thank you so much for your time!**

(Point to Study Procedures Paragraph)

**In order to determine what works and what does not work in our presentation, we will ask you to complete some questionnaires both before and after our presentation. These questionnaires ask you basic demographic information, questions about your familiarity with the topics we are covering in our presentation, and how useful you think the strategies are. In total, they take about 10 minutes before and 5 minutes after our presentation to complete. Does that sound okay so far?**

Yes-Continue On

No- **Okay, thank you so much for your time!**

(Point to Risks and Discomforts Paragraph)

**Should you choose to participate, there are a few risks and benefits. First, you may become tired or bored, or may feel uncomfortable answering some questions. If you need to take a break while completing the questionnaires or skip certain questions, you are welcome to. You can also discontinue the study at anytime. If you are willing to complete the study, the benefit is that we will gain valuable information about how to present this information, and ways to possibly improve the presentation, which will benefit future parents and teachers of children with common behavioral issues. Does that sound okay?**





Yes- Continue on

No- **Okay, thank you so much for your time!**

(Turn to page 2 and Point to Confidentiality Paragraph)

**It is important that you know this study is confidential. Even the demographic information that we collect is de-identified, so none of your personal information will be connected to your name. However, I do need to inform you that if you report child or elder abuse, as a mandated reporter I do need to make a report. This section outline exactly how your information is de-identified. Does that sound okay?**

Yes-continue on

No- **Okay, thank you so much for your time!**

(Point to Participation and Withdrawal Paragraph)

**This paragraph simply outlines that your participation is voluntary and you can choose not to participate at any time.**

(Point to Alternatives to Full Participation Paragraph)

**If you do not want to participate you do not have to. Or you can just answer the questions you feel comfortable with.**

**Do you have any questions?**

Yes- answer questions

No- **Great- should any questions come up, the contact information of Dr. Ho, the principal investigator on this study, is listed here.**

**If all of that sounds okay-** (turn to page 3 and point to Signature of Research Participant section) **I'll have you sign, print your name and date here, and I will sign below your signature. I will give you a copy of what you signed to take with you.**

(Hand an unsigned consent form to parent, and keep the version with parent signature and your signature for our files). **Thanks so much!**

Appendix E  
Parent Demographic Questionnaire

RIN: \_\_\_\_\_ DATE: \_\_\_\_\_



PEP4SAFE

## PARENT DEMOGRAPHIC QUESTIONNAIRE

Your answers will be kept confidential. Please circle the best option OR write in your response.

1. Age: \_\_\_\_\_ 2. Sex: M F Other

3. What is your marital status?

- |                                       |              |
|---------------------------------------|--------------|
| a. Single, never married              | e. Separated |
| b. Married                            | f. Divorced  |
| c. Living together                    | g. Widowed   |
| d. In a relationship but living apart |              |

4. Who else lives in your household? What is their relationship to you?

- |                                |           |
|--------------------------------|-----------|
| a. Child 1: RELATIONSHIP _____ | AGE _____ |
| b. Child 2: RELATIONSHIP _____ | AGE _____ |
| c. Child 3: RELATIONSHIP _____ | AGE _____ |
| d. Child 4: RELATIONSHIP _____ | AGE _____ |
| e. Adult 1: RELATIONSHIP _____ | AGE _____ |
| f. Adult 2: RELATIONSHIP _____ | AGE _____ |
| g. Adult 3: RELATIONSHIP _____ | AGE _____ |

5. Which category best describes your total household yearly income?

- |                      |                         |
|----------------------|-------------------------|
| a. Under \$14,999    | f. \$60,000-\$74,999    |
| b. \$15,000-\$24,999 | g. \$75,000-\$99,999    |
| c. \$25,000-\$34,999 | h. \$100,000-\$199,999  |
| d. \$35,000-\$49,999 | i. \$200,000-\$499,999  |
| e. \$50,000-\$59,999 | j. \$500,000 or more    |
|                      | h. Prefer not to answer |

6. Ethnicity

- |                        |                                 |
|------------------------|---------------------------------|
| a. White, non-Hispanic | d. African-American             |
| b. Latino/Hispanic     | e. Asian-Pacific Islander       |
| c. Native American     | f. Other (please specify) _____ |

7a. Language Preference: \_\_\_\_\_ 7b. Language Spoken at Home: \_\_\_\_\_

8. Years in the United States: \_\_\_\_\_

9. Highest level of education completed

- a. Less than High School
- b. High School/GED
- c. Some College
- d. 2 - Year College Degree (Associates Degree)
- e. 4 - Year College Degree (BA,BS)
- f. Master's Degree (MA, MS, MFT)
- g. Doctoral Degree (PhD, PsyD)
- h. Professional Degree (MD,JD)

1

RIN: \_\_\_\_\_ DATE: \_\_\_\_\_

**10. Please endorse how much your child displays the following behaviors (check one):**

Question	Rarely/Never		Sometimes		Always
	1	2	3	4	5
a. Restless, overactive, cannot stay still for long					
b. Often loses temper					
c. Generally well behaved, usually does what adults request					
d. Often fights with other children, bullies them, or is bullied					
e. Often unhappy, depressed or tearful					
f. Easily distracted, concentration wanders					
g. Picked on or bullied by other children					
h. Gets along better with adults than with other children					
i. Good attention span, sees work through to the end					

**11. Please rate your level of knowledge regarding these topics (check one):**

Question	Not at all Knowledgeable		Somewhat Knowledgeable		Very Knowledgeable
	1	2	3	4	5
a. Normative social skills development					
b. Prosocial behaviors in children					
c. Bullying prevention strategies					
d. Cyberbullying					
e. Disruptive Behaviors					
f. Self-care					
g. Internalizing Behaviors					
h. Coping with feelings					
i. Attention and Concentration					
j. Structuring the Home Environment					
k. Connecting with your child					
l. Connecting with teachers					

**12. Rate your level of confidence in managing children's difficulties regarding (check one):**

Question	Not at all Confident		Somewhat Confident		Very Confident
	1	2	3	4	5
a. Normative social skills development					
b. Prosocial behaviors in children					
c. Bullying prevention strategies					
d. Cyberbullying					
e. Disruptive Behaviors					
f. Self-care					
g. Internalizing Behaviors					
h. Coping with feelings					
i. Attention and Concentration					
j. Structuring the Home Environment					
k. Connecting with your child					
l. Connecting with teachers					

Appendix F

Social Skills Module Pre-Questionnaire

RIN: \_\_\_\_\_ Date: \_\_\_\_\_



**PEP4SAFE**  
**SOCIAL SKILLS MODULE**  
 Pre-Program Questions

**Please answer the following questions regarding topics we will be discussing today. If you are unsure of the answer, please give your best guess.**

1. What are some negative consequences that children with poor social skills might experience (circle all that apply)?
  - a. Social rejection
  - b. Symptoms of depression and anxiety
  - c. Struggle with academic performance
  - d. Higher incidence of involvement in the criminal justice system as adults
  
2. Which of the following is NOT a prosocial skill to promote (circle one)?
  - a. Waiting patiently
  - b. Complimenting others
  - c. Following directions
  - d. Accepting criticism

**PLEASE DO NOT TURN OVER THE PAGE UNTIL THE SESSION IS OVER TODAY TO ANSWER THE POST-SESSION QUESTIONS. THANK YOU!**

Appendix G

Social Skills Module Post-Questionnaire

RIN: \_\_\_\_\_ Date: \_\_\_\_\_



**PEP4SAFE**  
**SOCIAL SKILLS MODULE**  
 Post-Program Questions

1. What are some negative consequences that children with poor social skills might experience (circle all that apply)?

- Social rejection
- Symptoms of depression and anxiety
- Struggle with academic performance
- Higher incidence of involvement in the criminal justice system as adults

2. Which of the following is NOT a prosocial skill to promote (circle one)?

- Waiting patiently
- Complimenting others
- Following directions
- Accepting criticism

3. Please rate your level of knowledge regarding the following topics after the presentation (check one):

Question	Not at all Knowledgeable		Somewhat Knowledgeable		Very Knowledgeable	
	1	2	3	4	5	
a. Normative social skills development						
b. Prosocial behaviors in children						

4. Please rate your level of confidence in managing children's difficulties regarding (check one):

Question	Not at all Confident		Somewhat Confident		Very Confident	
	1	2	3	4	5	
a. Normative social skills development						
b. Prosocial behaviors in children						

5. How helpful did you find today's session (circle one)?

Not at all Helpful		Somewhat Helpful		Very Helpful
1	2	3	4	5

6. How likely are you to use the strategies you learned at home (circle one)?

Not Likely		Somewhat Likely		Very Likely
1	2	3	4	5



Appendix H  
Informed Consent Form

RIN: \_\_\_\_\_ Date: \_\_\_\_\_



**PSYCHOEDUCATIONAL PROGRAM 4 SCHOOL-AGED FAMILIES AND EDUCATORS  
INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES**

You are invited to participate in a study conducted by Dr. Judy Ho, Tenured Assistant Professor of Psychology at Pepperdine University and Licensed Clinical Psychologist. Your participation is voluntary. You should read the information below, and ask questions about anything that you do not understand, before deciding whether to participate. Please take as much time as you need to read the consent form. You may also decide to discuss participation with your family or friends. If you decide to participate, you will be asked to sign this form. You will also be given a copy of this form for you records.

**PURPOSE OF THE STUDY**

The purpose of the study is to evaluate the implementation a manualized psychoeducational program for parents to help increase their knowledge of common childhood emotional/behavioral issues, strategies for managing these issues at home, and when/how to seek professional services for their child. The study aims to assess the usefulness and helpfulness of this program. You will be asked to questions about your current knowledge about common childhood issues, which aspects of the program you found helpful, and whether you would use any of the suggested strategies in your home.

**STUDY PROCEDURES**

If you volunteer to participate in this study, you will be asked to provide some basic background information about yourself and some questions about the program by filling out short questionnaires.

**POTENTIAL RISKS AND DISCOMFORTS**

The potential and foreseeable risks associated with participation include boredom and fatigue while completing the questionnaires. If you become bored or fatigued, you can take breaks at any time. Also possible are some uneasy feelings that may arise when asked to answer questions about your personal background. If this occurs, you may decide to skip questions or discontinue filling out the questionnaires.

If you experience any significant discomfort or stress as you are filling out the questionnaires, you can discuss the discomfort with a research associate or the Principal Investigator. You will also be provided with referrals for centers where appropriate support or mental health services are available.

**POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY**

Direct benefits to you include gaining knowledge about common childhood issues and learning strategies to manage these issues at home. In addition, the research team will use your feedback to improve the program, and a revised version of the manual can be emailed or mailed to you upon request. Other indirect, anticipated benefits to society and the field of psychological research include increasing understanding and knowledge of common childhood issues for other parents who might participate in future implementations of our programs. The data collected may be used to help attain funding to continue this type of research at no cost to schools and community mental health clinics, and/or used in research manuscripts or textbooks to help increase public awareness of common childhood issues and how to manage them effectively.

Pepperdine University Graduate & Professional Schools Institutional Review Board (GPS IRB) Informed Consent

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RIN: \_\_\_\_\_ Date: \_\_\_\_\_

**CONFIDENTIALITY**

No identifying information will be collected from the questionnaires. You will be assigned a research identification number (RIN) upon enrollment in the study to further de-identify your responses on questionnaires. Hard copies of questionnaires and an additional electronic copy created from the hard copy questionnaire will be stored in a locked file cabinet and on a password protected computer, respectively, in the principal investigators office at Pepperdine University's West Los Angeles campus. Signed copies of this consent form will be kept in a separate locked file cabinet. The data, which is not linked to any identifying information, will be stored for a minimum of three years and only the principal investigator and research associates will have access to the data.

The principal investigator and her research associates will take all reasonable measures to protect the confidentiality of your records as permitted by law. However, if required to do so by law, I may have to disclose information collected about you. Examples of the types of issues that would require me to break confidentiality are if you tell me about instances of child abuse and elder abuse. Pepperdine's University's Human Subjects Protection Program (HSPP) may also access the data collected. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research subjects.

The findings of this study may be published in journals, textbooks, or presented at conferences. However, data from this study will only be reported in the aggregate, which ensures confidentiality.

**SUSPECTED NEGLECT OR ABUSE OF CHILDREN**

Under California law, researchers will not maintain as confidential, information about known or reasonably suspected incidents of abuse or neglect of a child, dependent adult or elder, including but not limited to physical, sexual, emotional, and financial abuse or neglect. If any researcher has or is given such information, he or she may be required to report this abuse to the proper authorities.

**PARTICIPATION AND WITHDRAWAL**

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this study.

**ALTERNATIVES TO FULL PARTICIPATION**

The alternative to participation in the study is not participating or completing only the items on the questionnaires for which you feel comfortable.

**EMERGENCY CARE AND COMPENSATION FOR INJURY**

If you are injured as a direct result of research procedures you will receive medical treatment; however, you or your insurance will be responsible for the cost. Pepperdine University does not provide any monetary compensation for injury.

**INVESTIGATOR'S CONTACT INFORMATION**

The principal investigator is willing to answer any inquiries you may have concerning this study. You may contact Judy Ho, Ph.D., ABPP, CMHFE, Tenured Assistant Professor of Psychology at Pepperdine University and Licensed Clinical Psychologist at 310-568-5604 or via email at: [judy.ho@pepperdine.edu](mailto:judy.ho@pepperdine.edu).

**RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION**

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Kevin Collins, Manager of the Graduate & Professional Schools Institutional Review Board at Pepperdine University 6100 Center Drive Suite 500, Los Angeles, CA 90045, 310-568-5753 or [gpsirb@pepperdine.edu](mailto:gpsirb@pepperdine.edu).

Pepperdine University Graduate & Professional Schools Institutional Review Board (GPS IRB) Informed Consent

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RIN: \_\_\_\_\_ Date: \_\_\_\_\_

**SIGNATURE OF RESEARCH PARTICIPANT**

I have read the information provided above. I have been given a chance to ask questions. My questions have been answered to my satisfaction and I agree to participate in this study. I have been given a copy of this form.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

**SIGNATURE OF INVESTIGATOR**

I have explained the research to the participants and answered all of his/her questions. In my judgment the participants are knowingly, willingly and intelligently agreeing to participate in this study. They have the legal capacity to give informed consent to participate in this research study and all of the various components. They also have been informed participation is voluntarily and that they may discontinue their participation in the study at any time, for any reason.

\_\_\_\_\_  
Name of Person Obtaining Consent

\_\_\_\_\_  
Signature of Person Obtaining Consent

\_\_\_\_\_  
Date