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Pepperdine University
Graduate School of Education and Psychology

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

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

by

Emily Morse, M.A., Psy.D.

February, 2018

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

This clinical dissertation, written by

Emily Morse

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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DEDICATION

To my family. Your love and support has been unwavering, and I am so appreciative.

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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 this research discussed factors that influence parental help seeking, and developed a manualized psychoeducational program for parents with the aim of addressing barriers. The program was developed based on the need for evidence-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 internalizing behaviors in youth before and after receiving the preventative program. The researchers hypothesized that parent perception of their knowledge post-presentation would be negative correlated with parental age, and positively correlated with education and household income. Bivariate correlations indicated that parent age, ethnicity, sex, and highest level of education were not significantly associated with perceived knowledge of internalizing behaviors post-presentation. Parental income was inversely correlated with parental perception of knowledge of internalizing behaviors as well as coping with feelings. 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 illness and psychiatric disorders refer to all mental health disorders, 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, p. 20). Research indicates that over 50% of mental disorders have an onset in childhood, prior to age 18 (Carta, Fiandra, Rampazzo, Contu, & Preti, 2015). Mental health issues occurring in childhood can have significant impact on psychological, social, and occupational functioning into adulthood. For example, childhood depression is associated with adult substance use disorders and anxiety disorders (Benjamin, Harrison, Settapani, Brodman, & Kendall, 2013; Dawson et al., 2005), as well as impaired functioning in health, education, and social relationships, and increased criminality (Costello & Maughan, 2015). Children with behavioral disorders such as ADHD have also been found to have a higher likelihood of substance use and conduct disorders in adulthood (Hinshaw et al., 2012). Further, research indicates that children with anxiety disorders (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).

Importance of Early Intervention

Seventy-five percent of anxiety disorders and 14-24% of depressive disorders begin prior to adulthood. Without early identification and treatment, these disorders can cause school and social impairments, including difficulties making friends, truancy, and lower academic

achievement (Fox, Halpern, & Forsyth, 2008). Despite these findings, up to 80% of children with these disorders did not receive needed mental health assistance (Stagman & Cooper, 2010). This constitutes a global problem, as the World Health Organization (2005) indicated that there was no place in the world where child mental health needs were met. In one-third of the countries in the world, there was no identifiable governmental entity designated to ensure children received mental health care (World Health Organization, 2005). Additionally, children who did obtain mental health treatment were often referred to primary care physicians, and were less likely to be offered a follow up visit to receive specialized assistance (Fox et al., 2008).

The importance of receiving an adequate course of mental health treatment as early as possible has been underscored by studies that found 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). Interventions that focused on providing parenting skills training to target early signs of aggressive social behavior in early childhood subsequently aided in preventing the development of more significant externalizing and internalizing disorders in adulthood (O'Connell, Boat, Warner, United States Institute of Medicine, & National Research Council, 2009). Additionally, early interventions 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 mental health services to children who were at risk for developing problems related to mental health prior to adolescence was found to reduce the strain on the community system and health care system in adulthood by preventing lost economic productivity and community destabilization (Morris et al., 2011).

The PEP4SAFE Program

The PEP4SAFE program focuses on evidence-supported early intervention strategies aimed to provide important parenting skills for managing common childhood emotional and behavioral issues as well as educating parents on identification of more serious problems that

require professional intervention. Psychoeducation 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. Psychoeducation may include referrals to key resources for mental health help in the community (Lukens & McFarlane, 2004), and it has been found to bolster the provision of community resources. As a result, 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 diagnostically significant) childhood emotional and behavioral problems, how to deal with them using therapeutic strategies, and how to refer to mental health resources if problems become clinically significant.

The PEP4SAFE program was also developed to address barriers to parental help seeking for their children. The literature shows that parental help seeking was the primary deciding factor in whether a child with mental health difficulties received treatment (Briggs-Gowan, Horwitz, Schwab-Stone, Leventhal, & Leaf, 2000; Dempster, Davis, Faye Jones, Keating, & Wildman, 2015). As primary gatekeepers to their children's mental health care, parents are tasked with identifying mental health concerns as well as providing referrals and access to treatment (Morrissey-Kane & Prinz, 1999). The World Health Organization (2005) cited multiple logistical barriers to parents seeking care, including lack of time, lack of transportation, limited financial means, or inadequate insurance. Given that the current literature has asserted that using a group format with briefer interventions also strengthened parental networks (Becker et al., 2015), PEP4SAFE was developed to be time-limited, easily accessible, no-cost, and provides a forum for building connectedness amongst parents.

Another significant barrier to treatment is the lack of community resources available for youth mental health care. According to the U.S. Department of Health and Human Services, Children's Bureau (2005), only one state in the country provided all five factors necessary (low-cost services, use of group format to strengthen parental networks, briefer interventions, use of

settings that parents attend, use of settings that children attend) for effective treatment, whereas 71% of states were assessed as lacking adequate community-based mental health services for children. Further, often no access to community resources has been provided through school-based services (Evans & Weist, 2004), despite the fact that schools are a setting that may help treatment engagement due to easy accessibility in a community setting. The current literature has asserted that providing low-cost services and providing services in settings that both parents and children regularly attend has been 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.

Moreover, 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 has demonstrated that parental involvement, particularly in early intervention approaches, which have established efficacy (Becker et al., 2015; de Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013; Dempster et al., 2015), can be paramount to achieve positive youth outcomes from therapeutic approaches. Parents who felt that treatment for their child is demanding, not highly relevant to the child's problem, or who have had a poor alliance with their child's clinician in the past, were less likely to seek treatment and tended to pull their child out of therapy prior to completing the prescribed course (Kazdin, 2000). Cultural factors also play a role, as ethnic groups tend to vary in beliefs regarding causes of symptoms, leading to differences in perceptions of when children's behaviors warrant the need for help-seeking (Weisz & Weiss, 1991). In sum, the inability to recognize and identify children's difficulties is a significant barrier to accessing necessary care (Oh & Bayer, 2015). Additionally, the experience or threat of stigma, which refers to the perceptions 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. As was noted, many psychoeducation programs have focused on one specific diagnosis (ADHD, bipolar disorder, etc.) rather than covering all aspects of a child's functioning in order to target parental attitudes and stigma. The PEP4SAFE program focuses on several elements of a child's behavior, addressing commonly occurring issues, some of which are considered normative and developmental instead of diagnostically significant. The issues addressed include possible internalizing and externalizing symptoms, rather than specific diagnoses, and as such can be more broadly applied. Finally, many programs cited did not provide a step-by-step manual to parents. Such a manual could be written in lay language and provide parents with guidelines for effective parenting through various situations that may arise. As such, the PEP4SAFE program is less stigmatizing and more hands-on and interactive than some existing psychoeducation programs. The PEP4SAFE program also includes a step-by-step reference that parents can keep and utilize later, should the information not be effectively retained in the 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, & Kramer, 2011). Leon et al. (2011) asserted that factors such as recruitment, randomization, 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. Successful pilot studies provide information for the optimal

completion of future studies and focus on refining the research hypotheses, “identifying barriers to participant completion, evaluating the acceptability of methods and instruments to participants, measuring the time required for study participation, and providing estimates of the expected rates of missing data and attrition” (Moore, Carter, Nietert, & Stewart, 2011, p. 333). The pilot study phase also provides an estimation of treatment response and efficacy as well as variance of outcomes among participants (van Teijlingen & Hundley, 2002). The current pilot study evaluated content, knowledge outcomes, and specific psychoeducational needs of parents who participated in the PEP4SAFE program. Specifically, parental perceptions of knowledge before and after an implementation session of the program were assessed.

A Review of Psychoeducational Programs

Psychoeducation is an intervention involving didactic communication of psychotherapeutic and educational information (Bai, Wang, Yang, & Niu, 2015; Montoya, Colom, & Ferrin, 2011). Findings from literature regarding adult psychological health have indicated that psychoeducation about mental health disorders led to better outcomes when given to both patients and their families, rather than separately (Glick, Burti, Suzuki, & Sacks, 1994; Rea et al., 2003). However, Ong and Caron (2008) noted that there was scant research on family-based interventions for children with mental health disorders despite the fact that school-based psychoeducation had been cited as a promising yet underdeveloped modality for service delivery to youth (Pollio, McClendon, North, Reid, & Jonson-Reid, 2005). Pollio et al. (2005) also noted that while school-based psychoeducational interventions were used, often there was no description of the group process, which is an important factor to use to understand possible reasons for a treatment’s efficacy. Therefore, Pollio et al. developed their own intervention, called 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. C-PERF used a discussion-based format to discover possible interventions, and implemented role-plays to allow parents to practice techniques. This

intervention had high retention rates (13 out of 15 families completed the program), but due to the lack of quantitative follow up it was challenging to determine the program's impact on parental knowledge of the emotional disorders, or their opinion of the group program in general (Pollio et al., 2005).

Fristad, Goldberg-Arnold, and Gavazzi (2002) developed a similar non-preventative program for families of children with bipolar disorder that focused on describing diagnosis, types of treatment, and common issues and barriers to treatment, followed by an open discussion about the diagnosis and parents' experiences with their child. 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. However, this qualitative study did not provide any quantitative data on knowledge increases, such as through the use of a post-program test (Fristad et al., 2002).

Anderson and Guthrey (2015) further pilot tested a psychoeducation program for parents of children with ADHD. The outcomes of this study indicated that treatment decreased parental stress and parent-child dysfunctional interactions. While the authors noted that there was no significant change in the rating of children's behaviors, they indicated that parental perspective of the relationship and parental knowledge about how to respond effectively to their children's behavior changed, which should lead to improved child outcomes (Smith, Linnemeyer, Scalise, & Hamilton, 2013).

The Incredible Years is another program, developed by Carolyn Webster Stratton, to treat behavioral issues when they first begin, prior to school age (Weisz & Kazdin, 2012). The program contains an essential parent psychoeducational component, which targets promotion of parents' competency in managing their children's emotional and behavioral functioning. The program utilizes didactic intervention over 12-20 sessions and involves demonstrations of social learning and child development principles. The combination of group discussion, education via a trained therapist, and modeling interventions for managing child behavior was associated with

improvement in parental attitudes toward mental health issues in childhood, and this finding was consistent among multiethnic, socioeconomically disadvantaged families (Webster-Stratton, 1998; Webster-Stratton, Reid, & Hammond, 2001; Weisz & Kazdin, 2012).

In summary, existing psychoeducation programs targeted at parents have been found to provide support in addressing various barriers to childhood mental health treatment, such as 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 were found to be effective in maintaining parental involvement as evidenced by high retention rates (Pollio et al., 2005). Notably, these improved effects extended across various ethnic groups and levels of socioeconomic status (Bai et al., 2015; Fristad et al., 2002; Webster-Stratton, 1998; Webster-Stratton et al., 2001; Weisz & Kazdin, 2012).

However, there are important gaps in the literature that have not yet been fully addressed. Current research is lacking regarding benefits of evidence-supported, school-based psychoeducation programs that target parental knowledge, competence, and access to community resources while simultaneously decreasing negative stereotypes and stigma toward children with difficulties related to mental health (Schachter et al., 2008).

Parental Knowledge

Parents' lack of knowledge regarding when, where, or from whom to seek help is a significant barrier to treatment and is primarily evaluated via questionnaires and online self-report measures (Salloum et al., 2016). Interestingly, parents have tended to rely on pediatricians for referrals and recommendations regarding mental health services for their children, but pediatricians often under-identify mental health problems due to lack of specialized training in emotional and behavioral issues in children (Briggs-Gowan et al., 2000). This results in lack of effective care for children.

Parents surveyed via online questionnaire perceived that they did not have the specialized knowledge or understanding of childhood mental health issues (Frauenholtz, Conrad-Hiebner, & Mendenhall, 2015). Frauenholtz et al. (2015) noted that parents were often aware of their lack of knowledge and expressed significant uncertainty at their ability to understand and identify childhood mental health issues. This finding was mediated by type of mental health issue, parent's previous experience with mental health, and severity of their child's symptoms. Parents were less likely to identify mental health issues in their child when symptoms were primarily internal in nature, when the parents had less experience with mental health treatment, and when symptoms were less severe. While it does not suggest actual knowledge, parental perceived knowledge is important to study, because it indicates confidence in addressing specific mental health issues. Parental uncertainty about their knowledge base and capability to identify mental health problems in their children can directly impact treatment initiation decisions and how much buy-in parents have to the treatment process once treatment is initiated.

Despite significant parental barriers, it is notable that when parents play an active role in their children's mental health, consistent improvements in child outcomes have been established (Dowell & Ogles, 2010). Further, parent participatory engagement in treatment is considered evidence-based practice for children with both disruptive and internalizing behaviors (David-Ferdon & Kaslow 2008; Eyberg, Nelson, & Boggs, 2008; Kazdin, 2000; Silverman, Pina, & Viswesvaran, 2008). Additionally, it has been found that parents' relationship with their child's psychotherapist (rather than the child's relationship with the psychotherapist) had the largest impact on whether the child dropped out of treatment early (Smith et al., 2013). This makes sense, as parents are the gatekeepers to their children's mental health care (Morrissey-Kane & Prinz, 1999), both in terms of initiation and treatment termination. In sum, parental commitment to and participation in youth treatment is vital to children's mental health.

Parental Knowledge of Internalizing Behaviors

Parents who demonstrated high knowledge of child development and believed in their abilities to be successful in the parenting role tended to exhibit greater competence in interactions with their children (Hess, Teti, & Hussey-Gardner, 2004). Hess et al. (2004) videotaped parents playing with their children and asked those parents to complete questionnaires reporting the level of self-efficacy they felt when caring for their children. Specifically, this competence brings around better understanding of children's behavior with respect to developmental stage, making it more likely for parents to respond appropriately in future interactions (Azar, Robinson, Hekiman, & Twentyman, 1984; Damast, Tamis-LeMonda, & Bornstein, 1996). Furthermore, psychoeducational approaches geared toward parents of children with early mental health difficulties increased parents' knowledge (as determined by a meta-analytic review of psychoeducational approaches used with parents; Nussey, Pistrang, & Murphy, 2013). As such, the PEP4SAFE manualized psychoeducation program was developed to address this fundamental need for parent knowledge regarding early mental health difficulties.

Interventions that aim to increase parental knowledge are most effective when they are targeted to the needs of the participants (Frauenholtz et al., 2015). As such, it is important to determine which parental factors impact retention of information from educational interventions. Current research is scant regarding how age, level of education, and income of parents inform their ability to gain knowledge from psychoeducation programs. One study found that younger adults were more able to retain new information (Merriam, 2001). This study aimed to expand upon the little research available by examining how parental age, income, and education facilitated parents' perception of knowledge learned regarding child internalizing behaviors and helpful strategies to address these behaviors from the PEP4SAFE program.

Hypotheses

The hypotheses for the current study were as follows. First, based on previous empirical findings we predicted that parents' self-perception of post-presentation knowledge of internalizing behaviors and coping with feelings would be negatively correlated with parental age. Second, we hypothesized that clinical correlates of post-presentation parental knowledge of internalizing behaviors and coping with feelings 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 internalizing behaviors and coping with feelings would be positively correlated with level of family income.

Method

Participants

Parent participants. Recruitment was conducted via flyers and posters handed out at children's schools to parents of Los Angeles students that announced the PEP4SAFE parent psychoeducational program (Appendix A). Of note, two schools were included in this dataset, 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 desire for a less manualized program and instead requested the opportunity to engage in a question and answer session with a licensed professional. As such, there was significantly less data from School A.

A total of 37 parents participated in the study (81% female, 16% male, 3% no answer). The participants' average age was 42.51 ($SD = 4.24$), though one participant elected not to state their age. Eleven percent of participants reported having some college education, while the majority (38%) reported having a college degree. Twenty-seven percent of participants had a Masters degree, while 3% reported having a Doctoral degree and 19% reported having a Professional degree, which is a degree that prepares someone for work in a particular role, such as that of a lawyer or a doctor. One participant elected not to answer the question about their education level (2%). A majority of participants were married (84%). The remainder of participants were divorced (8%), separated (5%), or elected not to answer (3%). The Mean household income of participants was \$100,000-199,999; 11% of participants had an income below \$99,999, 19% of participants had an annual household income between \$100,000-199,999, 24% had an annual household income between \$200,000-499,999, and 16% had an income higher than \$500,000. Eleven (30%) parents elected not to provide their income. Sixty-two percent of participants identified as non-Hispanic white, 14% were Latino, 3% were Native American, 14% were Asian/pacific islander, 5% identified as other, and one participant elected

not to answer. Each participant reported their preferred language as English (95%) and two participants elected not to answer. See Tables 1, 2, and 3 for sample characteristics.

Participating schools. The overall project and associated research study protocol received approval from the Pepperdine GPS IRB in March 2016 (PI: Judy Ho; Appendix B). Recruitment letters (Appendix C) and flyers (Appendix A) were distributed to principals of 38 public elementary schools, selected for their proximity to the Pepperdine West Los Angeles campus, advertising the availability of a 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, CA. One of the two schools that responded did so due to a pre-existing relationship with one of the study researchers, which likely influenced their decision to participate in the study. Following approval, distribution of informational flyers advertising the session dates and times of the psychoeducational program were made through school staff, and interested parent participants RSVP'd 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).

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. The same format change was made to School A to be consistent and flexible. Parents could attend sessions on days they were available for topics in which they were interested. The flyers indicated that the program developers would ask parents to answer some brief questions before and after each session about the quality and content of the program, and would elicit any suggestions they might have for the program. Additionally, the flyers explained that completion of these questionnaires was not required in order for parents to attend and receive the psychoeducational program. Potential parent participants were also made aware that advanced notification of their attendance was not required but was appreciated.

Research team. The research team consisted of masters and doctoral level graduate students in Pepperdine University's Graduate School of Education and Psychology, led by Dr. Ho. 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 both pre and post program data.

Human subjects and ethical considerations. Due to the importance of confidentiality regarding research participants, techniques were incorporated throughout the study to maintain the highest levels of ethical consideration. 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 D for informed consent form). In order to de-identify each participant, each participant was assigned a Research Identification Number (RIN) upon enrollment in the study. Further, all research team members who handled data in the research database 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.

Only aggregate data will be reported, and all data was de-identified. Only the researchers and principal investigator have access to the data, which is not linked to any identifying information about the participants, due to the use of RINs. All hard copies of data are stored in locked file cabinets at Pepperdine University Graduate School of Education and Psychology (GSEP), West Los Angeles campus in the office of Dr. Judy Ho. All electronic data is stored in Microsoft Excel and Statistical Package for the Social Sciences (SPSS) with password protection on Dr. Judy Ho's lab laptops, which are locked and secured at Pepperdine University GSEP West Los Angeles Office.

Psychoeducational Manual Overview

The PEP4SAFE manual is a psychoeducational treatment program for parents that provides them with knowledge on common mental health issues among school-age children and adolescents, when and how to seek mental health services for their child, and essential elements of the treatment process. This intervention style also facilitates a collaborative discussion with parents about potential barriers to treatment and how to overcome these barriers. PEP4SAFE was adapted, edited, and compiled by Dr. Judy Ho and a team of clinical psychology doctoral and psychology master students at Pepperdine University (Genevieve Lam, Erika Rajo, Joseph Farewell, Jennifer Duarte, Emily Morse, 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 consists of both provider and participant editions. The provider edition was circulated to parents in a presentation format, with elements of didactic instruction, group discussion and question and answer. The participant version was distributed to the parents to be used as a reference throughout the presentation and for future use, as it contains module-specific information.

The companion study evaluated the Social Skills Module, which introduced the concept of social skills difficulties and encouraged discussion of parents' personal experiences with children who had difficulties social functioning. The Social Skills Module assists parents to identify when children have social skills difficulties by introducing four components of social competence, which include self-related, task-related, interpersonal, and environmental behaviors. The module targets increasing parents' understanding of where problems in those domains emerge from, whether it is 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 further presents the negative consequences of social skills 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.

This study addressed the efficacy of the Internalizing Behaviors Module, which begins by providing an agenda of the session outline, including topics for discussion. The Internalizing Behaviors Module then provides a definition of internalizing behaviors, as well as a description of the factors that may influence the development of internalizing behaviors and how those factors may impact a child's functioning. Further, the module provides parents with ideas as to how to help when a child suffers from internalizing behaviors and aids parents in guiding their children to develop positive coping and stress management techniques. Finally, the module provides parents with a better understanding of when they should seek professional assistance for their child's internalizing behaviors, as well as resources for how they can do so.

Description of the Pilot Study

For the purposes of this study and its companion study, two modules of the psychoeducational manual were examined: internalizing behaviors and social skills. These modules were the two 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. Therefore, these two modules were implemented first, before the other four modules in the program (Disruptive Behaviors, Attention and Concentration, Staying Connected with Your Child, Bullying). Parents attended these two psychoeducational sessions on two weeknights at Juan Cabrillo Elementary School or two mornings at Manhattan Beach School District, approximately twice a month. Dr. Ho, and several masters and doctoral students from

Pepperdine University's Graduate School of Education and Psychology led each session. Each module was approximately 75-90 minutes in administration time, including time to sign the consent form and complete pre- and post-questionnaires. Participants were given a workbook at the initiation of each session, which consisted of the participant version of the modules, and the participants were allowed to keep the workbooks.

Prior to the psychoeducational session, participants were asked whether they would like to participate in the optional research study, which consisted of filling out brief questionnaires before and after the session. Participants were informed that the questionnaires would take approximately ten minutes, 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 E). Parents who chose to participate signed the consent form and the research lab filed one copy, while a duplicate copy was provided to participants for their records.

Data Collection

Demographic questionnaire. The Participant Demographic Questionnaire (Appendix F) was developed by Dr. Ho and her research assistants in order to obtain data regarding individual parent characteristics. Specific questions were selected to examine variability among parents and how it relates to child behavioral characteristics, knowledge, confidence, and retention of information. 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. There are both parent and teacher-report versions, and it is used to evaluate children between the ages of two and 18. The CBCL uses a Likert scale and asks caregivers to report whether their children experience or demonstrate specific symptoms. We 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 in identifying how their child is functioning within the specific domains of each module. As previously noted, greater mental health literacy and higher perceived capability contributed to better child outcomes (Frauenholtz et al., 2015). The psychometric properties of this scale are unknown as it was developed and adapted for the specific purposes of the present pilot study. The administration of pre- and post-program measures allow for direct assessment of potential change in parental knowledge (both regarding their own perception of knowledge improvement and their performance on forced-choice learning questions taken from the content of the program) on specific childhood issues before and after receiving the program. The assessment process also includes questions regarding the feasibility of implementing the child management strategies presented and their perception on its helpfulness to the parent, a proxy question to better understand parental motivation and buy-in. Hopefully, the program will help parents to address problems as they arise to prevent or reduce negative child outcomes, and facilitate parental help seeking in the youth mental health services pathway.

Pre- and post-questionnaires. The module-specific pre- and post-questionnaires (Appendices G and H) were also developed by Dr. Ho and the 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. These 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 when managing children's difficulties were also developed and were 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 served to examine whether or not parents' knowledge increased regarding the topics covered in the session, which helped to understand whether the certain sub-topics were addressed adequately in the presentation so that the majority of parents learned or retained the information. The questions also provided 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, parents' post-presentation perceived level of knowledge regarding internalizing behaviors and coping with feelings in children were used. Questionnaires were administered both before and after the presentation, with each one designed to be completed in approximately 5-7 minutes. Each participant was given an RIN to avoid recording participant names.

Procedures for Entering and Analyzing Data

Quantitative data was entered and initially organized 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 trained to use the software by Dr. Ho to ensure accurate data entry. Researchers were assigned individual roles in the data entry process to ensure that data was reviewed, spot checked, and corrected for 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 included 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 our own biases and expectations of the study by considering preconceived notions about participants' potential responses and acknowledging factors for our 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 internalizing behaviors and coping with feelings (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 internalizing behaviors were as follows: internalizing behaviors average score = 3.91; $SD = 0.75$; coping skills average score = 3.91; $SD = 0.75$. These results suggested that, on average, parents reported that post-presentation they considered themselves to be somewhat knowledgeable regarding internalizing behaviors. Parent age, ethnicity and sex, as well as highest level of education were not significantly associated with perceived knowledge of internalizing behaviors post-presentation. Parental income was inversely correlated with parental perception of knowledge of internalizing behaviors as well as coping with feelings ($r = -.52, p < .05$ for both). Further, parental age and income were positively correlated ($r = .28, p < .05$), parental education and income were positively correlated ($r = .46, p < .01$), and parental perception of knowledge of internalizing behaviors was positively correlated with parental perception of knowledge of coping with feelings ($r = .90, p < .01$).

Factors Associated with Knowledge

As displayed in Tables 5 and 6, two hierarchical multiple regression models examined two predictors (a) post-presentation parent perceived knowledge of internalizing behaviors, and (b) post-presentation parent perceived knowledge of coping with feelings. 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 internalizing behaviors,

nor were any significant effects found between the control variables and parent report of post-presentation perceived knowledge of coping with feelings.

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, and (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 internalizing behaviors and coping with feelings would be negatively correlated with parental age. Second, we hypothesized that clinical correlates of post-presentation parental knowledge of internalizing behaviors and coping with feelings 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 internalizing behaviors and coping with feelings would be positively correlated with level of family income. No significant associations were found between any of the three independent variables and (a) post-presentation perceived parental knowledge of internalizing behaviors, and (b) post-presentation perceived knowledge of coping with feelings after taking into account the unique contributions of the control variables.

Discussion

This study examined the feasibility and effectiveness of implementing the internalizing behaviors module of a manualized psychoeducational program for parents of school aged children. Hierarchical regression was used to examine clinical correlates of parental knowledge of internalizing behaviors and coping with feelings. First, we hypothesized that parents' self-perception of post-presentation knowledge of internalizing behaviors and coping with feelings would be negatively correlated with parental age. Second, we hypothesized that clinical correlates of post-presentation parental knowledge of internalizing behaviors and coping with feelings would be positively correlated with level of parental education achieved in the formal school system. Third, we hypothesized that parents' self-perception of post-presentation knowledge of internalizing behaviors and coping with feelings 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 internalizing behaviors and parental age, or perception of post-presentation knowledge of coping skills and parental age. Previous research indicated that older adults tend to learn less than younger adults when asked to read an article regarding health-related information and then tested on their ability to recall that information (Brown & Park, 2002). As was noted previously, Israel et al. (2005) found that parents are less likely to seek mental health treatment for their children and can be less willing to be involved in their child's mental health treatment if they have uncertainty about their own knowledge base and low capability to identify mental health problems in their children. However, current research is scarce when considering whether demographic variables such as parental age might impact parental self-perception of their ability to retain mental health information. We believed age might be an important factor to self-perception of knowledge because, according to Brown and Park (2002), older adults experience declines in working memory that may impede their ability to retain mental health related information. If we did find this correlation, we thought it might be

helpful to target younger parents so they could retain information prior to the decline of working memory abilities.

Our findings suggest that age may not be a significant factor when assessing parents' perception of information retention about their child's mental health. However, it is possible a relationship exists but we were unable to detect a significant relationship with our pilot sample. For example, we may not have found the expected relationship due to a small sample size, or due to having a homozygous sample that differs significantly from the general population in terms of demographics such as annual household income, ethnicity, gender, and education level. Therefore, it remains a possibility that a relationship exists but due to limited power to detect effects it was not shown through our results.

Further, parents' self-perception of post-presentation knowledge of internalizing behaviors was not significantly related to parental level of education. We thought parents with a higher level of education might be able to understand and retain mental health related information more readily due to experiences doing so in school. If this correlation did exist, we may change the content and presentation style of the manual based on education level. Additionally, parents' self-perception of post-presentation knowledge of coping skills was not significantly related to parental level of education. Again, if this correlation was significant, it may have impacted the way module information was presented.

Our findings are not consistent with the findings from current literature, which indicate that parents with higher education have children who are more likely to retain new learned information of various types (Brown & Park, 2002). Aside from the possibility of no effect between the aforementioned study variables, it is also possible that parents' self-perception of knowledge was less than the actual amount of information learned if knowledge retention was measured objectively. 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 such a future study, we will be able to examine both parental self-perception of knowledge as well as parental objective knowledge, and examine whether any interesting patterns emerge; particularly whether a discrepancy between self-perception of knowledge attainment and objective knowledge attainment might have an impact on youth initiation into, engagement during, and outcomes from treatment.

Additionally, our findings did not support our hypothesis regarding an anticipated positive correlation between parents' self-perception of post-presentation knowledge of normative internalizing behaviors development and coping with feelings with level of family income. In previous research, parents with higher socioeconomic status were found more likely to retain new learned information (Brown & Park, 2002), possibly due to more life experience related to the medical field, either through schooling or access to healthcare. Again, our findings indicate family income did not significantly inform parental perception of their retained knowledge. This may be due to our homogenous sample or small sample size, and may not suggest that such a relationship does not exist in the population. As an alternate explanation and similar to the hypothesis posited above regarding parental education level and self-perception of post-presentation knowledge, it is possible that there is a relationship between parental education level and objective post-presentation knowledge. In fact, most previous research attends to parental ability to retain information (thought to provide a more objective measurement of attained knowledge), which is more objective, rather than their perception of retention, which is more subjective (Brown & Park, 2002). This might help explain the lack of significant relationship in this study.

While our hypotheses were not supported, we did find some significant bivariate correlations that are consistent with expectations given extant literature findings. Namely, parental income was positively correlated with age and highest level of education. According to

a report by the Center on Education and the Workforce at Georgetown University, higher lifetime earnings are positively correlated with both age and educational attainment independently (Carnevale, Rose, & Cheah, 2011). Moreover, for those with a higher education level, the degree to which a person's earnings increases later in their career (i.e., at a later age) is higher (Carnevale et al., 2011).

Interestingly, parental self-perception of internalizing behaviors and coping with feelings was negatively correlated with parental education. It appears that higher educated parents were less confident in their ability to understand the concepts of internalizing behaviors and coping with feelings. Perhaps, due to higher levels of education, they worried about being overconfident, or they simply learned through higher education that there is a significant amount of information that they do not know, and thus have the general self-perception that they are not experts in any field besides their own. Finally, higher educated parents may not have perceived the module to be helpful because they already knew the information presented. This correlation supports the idea that creating modules specific to parents with higher education level may be helpful, as they may want more complex explanations beyond what they have already learned in their high education.

There are a few important ways to modify the modules so that the content is more suited for varying education levels. Firstly, the module could be separated into beginner, intermediate and expert levels with more detailed information being provided with each iteration of the manual. This idea is particularly salient due to Brown and Park's (2002) finding that prior knowledge about health topics may increase ability to retain future knowledge about that topic. Then, there are two options as to how to place parents into sections. Either participants could self-select and place themselves into the level of knowledge they believe they have, or parents could be provided into a pre-intervention questionnaire and then placed into groups according to questionnaire results. Given the finding that parents with higher level of education may have a self-perception that they are not experts, the pre-questionnaire option may more appropriately

place people into sections at a more objectively measured ability level (rather than at their perceived ability level). There are many exciting considerations in modifying the manual in this way, and doing so is a potentially helpful idea that might especially benefit our higher educated parental participants.

Finally, it appears that two of our manual topics, namely, internalizing behaviors and coping with feelings, are positively correlated. This makes sense as these two constructs are very similar and may have contained overlapping content, and contributed to the general construct of perceived knowledge. As such, in future iterations of the manual, it may be helpful to measure the general construct rather than specific ones, as when parents are provided information regarding one skill, it increases their knowledge of the other.

Study Limitations

The small sample size may have been an important limitation to the 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 generalizability 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 differences between samples it may be difficult to generalize our findings to any one sample. 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 or increased parental perceptions of knowledge more quickly or heavily than a module based format. Because of this, we ran a multiple regression analysis, which is considered a more sensitive statistical analysis following our preliminary bivariate correlations to further verify this finding. Also, it is important to note that everyone from one of the school districts who attended the program did complete the study questionnaires. 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. Despite this fact, this limitation was expected; as the current investigation was designed a priori to be an initial pilot study intended to guide decisions regarding further manual edits, to gauge parental response, and to guide plans regarding future implementation of an efficacy study. Therefore, by design, this project was developed to be a “small scale test of methods and procedures to be used on a larger scale” (Porta, 2008, p. 215), and is the first step of many toward testing the efficaciousness of the program.

Use of a convenience sample may also be a study limitation. We recruited a small and homogeneous sample from nearby and convenient school districts in southern California that does not adequately represent the general population and thus is not 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 socio-demographic domains. Further, the sample self-selected not only based on parental interest in the program, but also in 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 parent’s self-rated perception of

knowledge after attending a presentation of the internalizing behaviors module. We have discussed the limitations to using this operational measure, 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 identifying internalizing behaviors 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 was flawed in that we did not obtain both perception of knowledge and a more objective measure of knowledge. Obtaining both types of information will have definitely provided for a richer dataset, allowed us to test the interaction between perceived and actual parental knowledge, and provided 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, we believe that this study, and the psychoeducational program itself, hold 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. It helps to address the significant need for increased parental involvement in their child's psychosocial functioning as gatekeepers of access to mental health resources. Further, it targeted and emphasized the need for early intervention in formative years and addressed 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 may carry stigmatized attitudes toward such topics.

We hope that this study, despite its limitations, has provided further insight into parental ability to retain and evaluate psychoeducational information. Due to the scarcity of research about self-perception of knowledge retention in general, future research is recommended to inform how much perception of capability informs motivation to apply learned material. Additionally, as was discussed earlier, 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. Further, it justified the need for continuing research and a large-scale efficacy study utilizing the PEP4SAFE Manual to provide more information regarding objective measures of parental mental health literacy.

REFERENCES

- Achenbach, T. (1992). *Manual for the child behavior checklist/2-3 and 1992 profile*. Burlington, VT: University of Vermont Department of Psychiatry.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed.). Washington, DC: American Psychiatric Association.
- Anderson, S. B., & Guthery, A. M. (2015). Mindfulness-based psychoeducation for parents of children with attention-deficit/hyperactivity disorder: An applied clinical project. *Journal of Child and Adolescent Psychiatric Nursing*, 28(1), 43-49. doi:10.1111/jcap.12103
- Azar, S. T., Robinson, D. R., Hekimian, E., & Twentyman, C. T. (1984). Unrealistic expectations and problem-solving ability in maltreating and comparison mothers. *Journal of Consulting and Clinical Psychology*, 52(4), 687-691. doi:10.1037/0022-006X.52.4.687
- Bai, G., Wang, Y., Yang, L., & Niu, W. (2015). Effectiveness of a focused, brief psychoeducation program for parents of ADHD children: Improvement of medication adherence and symptoms. *Neuropsychiatric Disease and Treatment*, 11, doi:10.2147/NDT.S88625
- Becker, K. D., Lee, B. R., Daleiden, E. L., Lindsey, M., Brandt, N. E., & Chorpita, B. F. (2015). The common elements of engagement in children's mental health services: Which elements for which outcomes?. *Journal of Clinical Child and Adolescent Psychology*, 44(1), 30-43. doi:10.1080/15374416.2013.814543
- Benjamin, C.L., Harrison, J.P., Settapani, C.A., Brodman, D.M., & Kendall, P.C. (2013). Anxiety and related outcomes in young adults 7 to 19 years after receiving treatment for child anxiety. *Journal of Consulting and Clinical Psychology*, 81, 865–876. doi:10.1037/a0033048
- Briggs-Gowan, M. J., Horwitz, S. M., Schwab-Stone, M. E., Leventhal, J. M., & Leaf, P. J. (2000). Mental health in pediatric settings: Distribution of disorders and factors related to service use. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39, 841–849. doi:10.1097/00004583-200007000-00012
- Brown, S. C., & Park, D. C. (2002). Roles of age and familiarity in learning health information. *Educational Gerontology*, 28(8), 695-710. doi:10.1080/03601270290099723
- Carnevale, A. P., Rose, S. J., & Cheah, B. (2011). *The college payoff*. Retrieved from Georgetown University, Center on Education and the Workforce website: <https://cew.georgetown.edu/cew-reports/the-college-payoff/>
- Carta, M. G., Fiandra, T. D., Rampazzo, L., Contu, P., & Preti, A. (2015). An overview of international literature on school interventions to promote mental health and well-being in children and adolescents. *Clinical Practice & Epidemiology in Mental Health*, 11(1), 16-20. doi:10.2174/1745017901511010016
- Conroy, M. A., & Brown, W. H. (2004). Early identification, prevention, and early intervention with young children at risk for emotional or behavioral disorders: Issues, trends, and a call for action. *Behavioral Disorders*, 29(3), 224-236.

- Copeland, W. E., Wolke, D., Shanahan, L., & Costello, E. J. (2015). Adult functional outcomes of common childhood psychiatric problems. *JAMA Psychiatry*, 72(9), 892. doi:10.1001/jamapsychiatry.2015.0730
- Costello, E. J., & Maughan, B. (2015). Annual research review: Optimal outcomes of child and adolescent mental illness. *Journal of Child Psychology and Psychiatry*, 56(3), 324-341. doi:10.1111/jcpp.12371
- Damast, A. M., Tamis-LeMonda, C. S., & Bornstein, M. H. (1996). Mother-child play: Sequential interactions and the relation between maternal beliefs and behaviors. *Child Development*, 67(4), 1752-1766. doi:10.2307/1131729
- David-Ferdon, C., & Kaslow, N. J. (2008). Evidence-based psychosocial treatments for child and adolescent depression. *Journal of Clinical Child & Adolescent Psychology*, 37(1), 62-104. doi:10.1080/15374410701817865
- Dawson, D.A., Grant, B.F., Stinson, F.S., Chou, P.S., Huang, B., & Ruan, W.J. (2005). Recovery from DSM-IV alcohol dependence: United States, 2001-2002. *Addiction*, 100, 281-292. doi:10.1111/j.1360-0443.2004.00964.x
- de Haan, A. M., Boon, A. E., de Jong, J. T., Hoeve, M., & Vermeiren, R. R. (2013). A meta-analytic review on treatment dropout in child and adolescent outpatient mental health care. *Clinical Psychology Review*, 33(5), 698-711. doi:10.1016/j.cpr.2013.04.005
- Dempster, R., Davis, D. W., Faye Jones, V., Keating, A., & Wildman, B. (2015). The role of stigma in parental help-seeking for perceived child behavior problems in urban, low-income African American parents. *Journal of Clinical Psychology in Medical Settings*, 22(4), 265-278. doi:10.1007/s10880-015-9433
- Dempster, R., Wildman, B., & Keating, A. (2013). The role of stigma in parental help-seeking for child behavior problems. *Journal of Clinical Child and Adolescent Psychology*, 42(1), 56-67. doi:10.1080/15374416.2012.700504
- Dowell, K. A., & Ogles, B. M. (2010). The effects of parent participation on child psychotherapy outcome: A meta-analytic review. *Journal of Clinical Child and Adolescent Psychology*, 39(2), 151-162. doi:10.1080/15374410903532585
- Evans, S. W., & Weist, M. D. (2004). Implementing empirically supported treatments in the schools: What are we asking? *Clinical Child and Family Psychology Review*, 7, 263-267. doi:10.1007/s10567-004-6090-0
- Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. *Journal of Clinical Child & Adolescent Psychology*, 37(1), 215-237. doi:10.1080/15374410701820117
- Frauenholtz, S., Conrad-Hiebner, A., & Mendenhall, A. N. (2015). Children's mental health providers' perceptions of mental health literacy among parents and caregivers. *Journal of Family Social Work*, 18(1), 40-56. doi:10.1080/10522158.2014.974116

- Fristad, M. A., Goldberg-Arnold, J. S., & Gavazzi, S. M. (2002). Multifamily psychoeducation groups (MFPG) for families of children with bipolar disorder. *Bipolar Disorders*, 4(4), 254-262. doi:10.1034/j.1399-5618.2002.09073.x
- Fox, J. K., Halpern, L. F., & Forsyth, J. P. (2008). Mental health checkups for children and adolescents: A means to identify, prevent, and minimize suffering associated with anxiety and mood disorders. *Clinical Psychology: Science and Practice*, 15(3), 182-211. doi:10.1111/j.1468-2850.2008.00129.x
- Glick, I. D., Burti, L., Suzuki, K., & Sacks, M. (1994). Effectiveness of psychiatric care III: Psychoeducation and outcome for patients with major affective disorder and their families. *British Journal of Psychiatry*, 164, 104–106. doi:10.1192/bjp.164.1.104
- Hess, C. R., Teti, D. M., & Hussey-Gardner, B. (2004). Self-efficacy and parenting of high-risk infants: The moderating role of parent knowledge of infant development. *Journal of Applied Developmental Psychology*, 25(4), 423-437. doi:10.1016/j.appdev.2004.06.002
- Hester, P. P., & Kaiser, A. P. (1998). Early intervention for the prevention of conduct disorder: Research issues in early identification, implementation, and interpretation of treatment outcome. *Behavioral Disorders*, 24(1), 57-65. Retrieved from <http://journals.sagepub.com/home/bhd>
- Hinshaw, S.P., Owens, E.B., Zalecki, C., Huggins, S.P., Montenegro-Nevado, A.J., Schrodek, E., & Swanson, E.N. (2012). Prospective follow-up of girls with attention-deficit/hyperactivity disorder into early adulthood: Continuing impairment includes elevated risk for suicide attempts and self-injury. *Journal of Consulting and Clinical Psychology*, 80, 1041–1051. doi:10.1037/a0029451
- Israel, B. A., Parker, E. A., Rowe, Z., Salvatore, A., Minkler, M., López, J., Butz, A., ... Halstead, S. (2005). Community-based participatory research: Lessons learned from the Centers for Children's Environmental Health and Disease Prevention research. *Environmental Health Perspectives*, 113(10), 1463-1471. doi:10.1289/ehp.7675
- Kazdin, A. E. (2000). Perceived barriers to treatment participation and treatment acceptability among antisocial children and their families. *Journal of Child and Family Studies*, 9(2), 157-174. doi:10.1023/A:1009414904228
- Leon, A. C., Davis, L. L., & Kraemer, H. C. (2011). The role and interpretation of pilot studies in clinical research. *Journal of Psychiatric Research*, 45(5), 626–629. doi:10.1016/j.jpsychires.2010.10.008
- Lukens, E. P., & McFarlane, W. R. (2004). Psychoeducation as evidence-based practice: Considerations for practice, research, and policy. *Brief Treatment and Crisis Intervention*, 4(3), 205-225. doi:10.1093/brief-treatment/mhh019
- Maag, J., & Katsiyannis, A. (2010). Early intervention programs for children with behavior problems and at risk for developing antisocial behaviors: Evidence- and research-based practices. *Remedial and Special Education*, 31(6), 464-475. doi:10.1177/0741932509355992

- McConachie, H., & Diggle, T. (2007). Parent implemented early intervention for young children with autism spectrum disorder: A systematic review. *Journal of Evaluation in Clinical Practice*, 13(1), 120-129. doi:10.1111/j.1365-2753.2006.00674.x
- Merriam, S. B. (2001). *The new update on adult learning theory*. San Francisco, CA: Jossey-Bass.
- Montoya, A., Colom, F., & Ferrin, M. (2011). Is psychoeducation for parents and teachers of children and adolescents with ADHD efficacious? A systematic literature review. *European Psychiatry*, 26(3), 166-175. doi:10.1016/j.eurpsy.2010.10.005
- Moore, C.G., Carter, R.E., Nietert, P.J., & Stewart, P.W., (2011). Recommendations for planning pilot studies in clinical and translational research. *Clinical and Translational Science*, 4(5), 332–337. doi:10.1111/j.1752-8062.2011.00347.x
- Morris, J., Belfer, M., Daniels, A., Flisher, A., Villé, L., Lora, A., & Saxena, S. (2011). Treated prevalence of and mental health services received by children and adolescents in 42 low-and-middle-income countries. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, 52(12), 1239-1246. Retrieved from <https://www.cambridge.org/core/journals/journal-of-child-psychology-and-psychiatry-and-allied-disciplines>
- Morrissey-Kane, E., & Prinz, R.J. (1999). Engagement in child and adolescent treatment: The role of parental cognitions and attributions. *Clinical Child & Family Psychology Review*, 1999(2),183. doi:10.1023/A:1021807106455
- Mukolo, A., Heflinger, C. A., & Wallston, K. A. (2010). The stigma of childhood mental disorders: A conceptual framework. *Journal of the American Academy of Child & Adolescent Psychiatry*, 49(2), 92-103. doi:10.1097/00004583-201002000-00003
- Nussey, C., Pistrang, N., & Murphy, T. (2013). How does psychoeducation help? A review of the effects of providing information about Tourette syndrome and attention-deficit/hyperactivity disorder. *Child: Care, Health and Development*, 39(5), 617-627. doi:10.1111/cch.12039
- O'Connell, M. E., Boat, T. F., Warner, K. E., United States Institute of Medicine, Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults, & National Research Council. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities on the prevention of mental disorders and substance abuse among children, youth and young adults*. Retrieved from: <https://www.ncbi.nlm.nih.gov/books/NBK32775/>
- Oh, E., & Bayer, J. K. (2015). Parents' help-seeking processes for early childhood mental health problems. *Child and Adolescent Mental Health*, 20(3), 149-154. doi:10.1111/camh.12081
- Ong, S. H., & Caron, A. (2008). Family-based psychoeducation for children and adolescents with mood disorders. *Journal of Child and Family Studies*, 17(6), 809-822. doi:10.1007/s10826-008-9191-4
- Pollio, D. E., McClendon, J. B., North, C. S., Reid, D., & Jonson-Reid, M. (2005). The promise of school-based psychoeducation for parents of children with emotional disorders. *Children & Schools*, 27(2). doi:10.1093/cs/27.2.111

- Porta, M. (2008). *A dictionary of epidemiology* (Vol. 5). New York, NY: Oxford University Press.
- Rea, M., Tompson, M., Miklowitz, D., Goldstein, M. J., Hwang, S., & Mintz, J. (2003). Family-focused treatment versus individual treatment for bipolar disorder: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 71*, 482–492. doi:10.1037/0022-006X.71.3.482
- Salloum, A., Johnco, C., Lewin, A. B., McBride, N. M., & Storch, E. A. (2016). Barriers to access and participation in community mental health treatment for anxious children. *Journal of Affective Disorders, 196*, 54-61. doi:10.1016/j.jad.2016.02.026
- Schachter, H. M., Girardi, A., Ly, M., Lacroix, D., Lumb, A. B., van Berkomp, J., & Gill, R. (2008). Effects of school-based interventions on mental health stigmatization: A systematic review. *Child and Adolescent Psychiatry and Mental Health, 2*(18). Retrieved from U.S. National Library of Medicine, National Institutes of Health website: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2515285/>
- Silverman, W.K., Pina, A.A., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobia and anxiety disorders in children and adolescents. *Journal of Clinical Child & Adolescent Psychology, 37*(1), 105–130. doi:10.1080/15374410701817907
- Sitnick, S. L., Shaw, D. S., Gill, A., Dishion, T., Winter, C., Waller, R., ... Wilson, M. (2015). Parenting and the family check-up: Changes in observed parent-child interaction following early childhood intervention. *Journal of Clinical Child and Adolescent Psychology, 44*(6), 970-984. doi:10.1080/15374416.2014.940623
- Smith, T., Linnemeyer, R., Scalise, D., & Hamilton, J. (2013). Barriers to outpatient mental health treatment for children and adolescents: Parental perspectives. *Journal of Family Psychotherapy, 24*(2), 73-92. doi:10.1080/08975353.2013.792203
- Stagman, S., & Cooper, J. L. (2010). *Children's mental health: What every policymaker should know*. Columbia University, NY: National Center for Children in Poverty.
- United States Department of Health & Human Services, Children's Bureau. (2005). *Alternative responses to child maltreatment: Findings from NCANDS*. Retrieved from <https://aspe.hhs.gov/pdf-report/alternative-responses-child-maltreatment-findings-ncands>
- van Teijlingen, E., & Hundley, V. (2002). The importance of pilot studies. *Nursing Standard, 16*(40), 33-36. doi:10.7748/ns.16.40.33.s1
- Webster-Stratton, C. (1998). Preventing conduct problems in Head Start children: Strengthening parent competencies. *Journal of Consulting and Clinical Psychology, 66*(5), 715-730. doi:10.1037/0022-006X.66.5.715
- Webster-Stratton, C., Reid, M.J., & Hammond, M. (2001). Preventing conduct problems, promoting social competence: A parent and teacher training partnership in Head Start. *Journal of Clinical Child Psychology, 30*(3), 283-302. doi:10.1207/S15374424JCCP3003_2

- Weisz, J. R., & Kazdin, A. E. (2012). *Evidence-based psychotherapies for children and adolescents* (2nd ed.). New York, NY: Guilford.
- Weisz, J.R., & Weiss, B. (1991). Studying the referability of child clinical problems. *Journal of Consulting and Clinical Psychology*, 59, 266–273. doi:10.1037/0022-006X.59.2.266
- World Health Organization. (2005). *Atlas: Child and adolescent mental health resources: Global concerns, implications for the future*. Geneva, Switzerland: World Health Organization.

TABLES

Table 1

Full Sample, Schools A & B, Sample Characteristics (n = 37)

Characteristics	<i>n</i> or (<i>M</i>)	% or (<i>SD</i>)
Female parent participants	30	81%
Male parent participants	7	19%
Age of parent	(42.5)	(4.24)
Parent Education Level		
Some College	4	11%
Four Year College	14	38%
Masters Degree	10	27%
Doctoral Degree	1	3%
Professional Degree	7	19%
Marital Status		
Married	31	84%
Separated	2	5%
Divorced	3	8%
Annual Household Income		
<\$99,999	4	11%
\$100,000-199,999	7	19%
\$200,000-499,999	9	24%
>\$500,000	6	16%
No Answer	11	30%
Ethnicity		
Non-Hispanic White	23	62%
Latino	5	14%
Asian/Pacific	5	14%
Islander		
Native American	1	3%
Other (East Indian)	2	5%
Preferred Language		
English	35	95%
No Answer	2	5%

Table 2

School A, Sample Characteristics (n = 8)

Characteristics	<i>n</i> or (<i>M</i>)	% or (<i>SD</i>)
Female parent participants	5	62.5%
Male parent participants	2	25.0%
Age of parent	(38.5)	(1.87)
Parent Education Level		
Some College	3	37.5%
Four Year College	4	50.0%
Masters Degree	0	0.0%
Doctoral Degree	0	0.0%
Professional Degree	1	12.5%
Marital Status		
Married	5	62.5%
Separated	0	0.0%
Divorced	1	12.5%
Annual Household Income		
<\$99,999	4	62.5%
\$100,000-199,999	1	12.5%
\$200,000-499,999	0	0.0%
>\$500,000	0	0.0%
No Answer	2	25.0%
Ethnicity		
Non-Hispanic White	2	25.0%
Latino	5	62.5%
Asian/Pacific Islander	1	12.5%
Native American	0	3.0%
Other (East Indian)	0	5.0%
Preferred Language		
English	8	100.0%
No Answer	0	0.0%

Table 3

School B, Sample Characteristics (n = 29)

Characteristics	<i>n</i> or (<i>M</i>)	% or (<i>SD</i>)
Female parent participants	25	86%
Male parent participants	5	17%
Age of parent	(43.2)	(4.04)
Parent Education Level		
Some College	1	3%
Four Year College	10	34%
Masters Degree	10	34%
Doctoral Degree	1	3%
Professional Degree	6	21%
Marital Status		
Married	25	86%
Separated	2	7%
Divorced	2	7%
Annual Household Income		
<\$99,999	0	0%
\$100,000-199,999	6	20%
\$200,000-499,999	9	30%
>\$500,000	6	20%
No Answer	9	30%
Ethnicity		
Non-Hispanic White	21	72%
Latino	0	0%
Asian/Pacific	4	14%
Islander		
Native American	1	3%
Other (East Indian)	2	7%
Preferred Language		
English	27	93%
No Answer	2	7%

Table 4

Intercorrelations between Study Variables

Item/Scale	1	2	3	4	5	6	7
1. Sex of Parent	1						
2. Ethnicity of Parent	-.04	1					
3. Age of Parent	.11	-.06	1				
4. Annual Household Income	.14	-.10	.28*	1			
5. Highest Level of Education	.09	.03	-.06	.46**	1		
6. Level of Knowledge regarding Internalizing Behaviors	-.05	.23	-.17	-.52*	-.36	1	
7. Level of Knowledge regarding coping with feelings	-.05	.29	-.28	-.52*	-.30	.90**	1

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

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

Table 5

Summary of Multiple Regression Analysis for Variables Predicting Knowledge Regarding Coping with Feelings

	Variable	<i>B</i>	<i>SE B</i>	Beta
Step 1	Control			
	Ethnicity of Parent	.11	.11	.20
	Sex of Parent	-.08	.48	-.17
Step 2	Level of Knowledge regarding coping with feelings			
	Age of Parent	-.05	.04	-.26
	Highest Level Education Completed	-.13	.09	-.26
	Annual Household Income	-.17	.08	-.50

Note. $R^2 = .04$ ($p < .59$) for Step 1; $R^2 = .10$ ($p < .44$) for Step 2

Table 6

Summary of Multiple Regression Analysis for Variables Predicting Knowledge Regarding Internalizing Behaviors

Step	Variable	B	SE B	Beta
Step 1	Control			
	Ethnicity of Parent	.11	.11	.20
	Sex of Parent	-.08	.48	-.17
Step 2	Level of Knowledge regarding internalizing behaviors			
	Age of Parent	-.03	.04	-.16
	Highest Level Education Completed	-.16	.09	-.34
	Annual Household Income	-.18	.08	-.52

Note. $R^2 = .04$ ($p < .59$) for Step 1; $R^2 = .05$ ($p < .77$) for Step 2

APPENDIX A
Recruitment Flyer

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

APPENDIX B
IRB Approval Letter

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.

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 C
Recruitment Letter

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 (PHONE NUMBER) or email him at (EMAIL ADDRESS).

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 D

Informed Consent Form

Informed Consent Form

RIN: _____ Date: _____



PEP4SAFE

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 1

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 [REDACTED]

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.

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

2

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

APPENDIX E

Informed Consent Script

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 F

Participant Demographic Questionnaire

Participant 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

- Less than High School
- High School/GED
- Some College
- 2 - Year College Degree (Associates Degree)
- 4 - Year College Degree (BA,BS)
- Master's Degree (MA, MS, MFT)
- Doctoral Degree (PhD, PsyD)
- 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 G

Internalizing Behaviors Module Pre-Program Questions

Internalizing Behaviors Module Pre-Program Questions

RIN: _____ Date: _____

**PEP4SAFE****INTERNALIZING BEHAVIORS 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 examples of internalizing behaviors (circle all that apply)?
- Excessive worry
 - Feeling unloved
 - Pushing others in line
 - Experiencing frequent stomachaches and headaches
 - Teasing younger kids

What is a psychosomatic reaction to internalizing behaviors?

- Sadness or irritability caused by difficulty managing anxiety
- Fear based worries or rumination
- Physical complaints in response to anxiety-provoking stimuli
- Social withdrawal

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

APPENDIX H

Internalizing Behaviors Module Post-Program Questions

Internalizing Behaviors Module Post-Program Questions

RIN: _____ Date: _____

**PEP4SAFE****INTERNALIZING BEHAVIORS MODULE**

Post-Program Questions

1. What are examples of internalizing behaviors (circle all that apply)?

- Excessive worry
- Feeling unloved
- Pushing others in line
- Experiencing frequent stomachaches and headaches
- Teasing younger kids

What is a psychosomatic reaction to internalizing behaviors?

- Sadness or irritability caused by difficulty managing anxiety
- Fear based worries or rumination
- Physical complaints in response to anxiety-provoking stimuli
- Social withdrawal

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. Internalizing behaviors						
b. Coping with feelings						

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

Question	Not at all Confident		Somewhat Confident		Very Confident	
	1	2	3	4	5	
a. Internalizing behaviors						
b. Coping with feelings						

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