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Effective Parenting to Prevent Adverse Outcomes and Promote Child Well-Being at a Population Level

Ronald J. Prinz

Parenting variables are implicated either directly or as exacerbating factors in a large variety of child and adolescent outcomes and societal problems, including but not limited to attention deficit hyperactivity disorder, childhood aggression and oppositional defiant disorder, conduct disorder and delinquency, low school readiness, school dropout, substance abuse, teen pregnancy, youth depression, and child maltreatment (Biglan, Brennan, Foster, & Holder, 2004; Collins, Maccoby, Steinberg, Hetherington, & Bornstein, 2000; Hawkins, Catalano, & Miller, 1992; Jones & Prinz, 2005; Patterson, 1982; Patterson, Reid, & Dishion, 1992). Several decades of research have produced an impressive collection of parenting and family-based interventions that can be readily applied to the promotion of positive child development and the prevention of adverse outcomes, such as mental health problems, substance abuse, academic failure, and delinquency. Much of the effort in evidence-supported parenting and family interventions has been grounded in a comprehensive array of parenting strategies and practices associated with beneficial child outcomes.

Efficacious parenting and family interventions have emerged for the prevention of a variety of target outcomes. Many of these interventions have several elements in common, although specific implementation varies with age group, application, and contextual factors. Despite the documented advantages and benefits of parenting and family interventions, however, the field is struggling with insufficient impact. In answer to this challenge, a newer paradigm is emerging in the parenting intervention field that emphasizes wide-scale dissemination and population impact.

The purpose of this chapter is to articulate a conceptual foundation for a population-based approach to parenting intervention aimed at preventing adverse outcomes in children and adolescents and broadly promoting children's health and well-being. In doing so, the hope is to provide new insights and guidance to scholars in Transformative Consumer Research who are interested in joining in and contributing to this vitally important area of social life. As a backdrop, the first part of the chapter describes basic assumptions about what constitutes many of the beneficial parenting strategies and practices that are central to most of the evidence-based parenting and family interventions in the field. This section is meant to be a distillation of key principles and not a substantive and methodological review of the many studies that have contributed to the body of knowledge. For the latter, the reader is referred to Benjet and Kazdin (2003); Bornstein (2008); Cowan and Hetherington (1991); Holden and Edwards (1989); Polster, Dangel, and Rasp (1987); and Taylor and Biglan (1998) as starting points.

The second part of the chapter identifies some of the more prominent parenting and family interventions in prevention. This discussion is meant to provide examples rather than be exhaustive. The last section of the chapter discusses several critical issues related to population-based prevention and parenting and family interventions, including common elements shared by most interventions, questions about whether long-term studies are always necessary, movement toward wide-scale prevention, whether interventions are designed for broad dissemination, goals to reduce population-level prevalence rates, and improvement in parent accessibility to evidence-based parenting information and support.

BENEFICIAL PARENTING STRATEGIES AND PRACTICES

Undoubtedly, there are many ways to parent successfully, and the identification of effective parenting methods is not meant to imply otherwise. That said, elements of parenting strategies and practices associated with positive child adjustment and healthy parent–child relationships are known and form the basis for viable preventive interventions (Hart & Risley, 1995; Taylor & Biglan, 1998). A number of tenets underlie beneficial parenting. One such tenet is grounded in how the parental role is characterized and is useful to construe parenting as more like that of a teacher than an enforcer. Learning to speak, tie one's shoes, cross the street safely, use the bathroom, share with other children, and show good manners all require patient and continual teaching (cf. Becker, 1971). Beneficial parenting is also developmentally appropriate. Expectations, rules, requests, and interactions should match a child's developmental level, not too high or too low. For example, the frequent holding of infants, coddling them, and goggling over them are not only developmentally appropriate but also highly desirable. Doing the same thing with 10- or 12-year-olds, however, would be quite inappropriate and would infantilize and embarrass children at this age. Parents can and should find ways to express affection to older children, but the mode of affection should be developmentally matched.

Related to developmental appropriateness is the notion of starting with what a child can already do and building on that, something that effective classroom teachers routinely do (Alberto & Troutman, 1999). Before young children can form words, they need to make sounds that imitate what they hear. Before a child can use the toilet on his or her own, the child needs to acquire requisite skills (e.g., recognition of the urge, pulling down his or her pants). Before a teenager can learn to drive, he or she needs to be aware of traffic patterns, how drivers navigate, and rules of the road. When parents are trying to help a child learn a new skill or way of behaving, it is important to break down that goal into its parts and make sure the prerequisite elements are mastered first.

Harsh and coercive parenting tactics, particularly in the absence of frequent positive interactions, are counterproductive (Hutchinson, 1977). Frequent reliance on threats, slapping and hitting, angry criticism, and other coercive parental tactics can sometimes produce the illusion of immediate gains (e.g., momentary obedience) but runs the pronounced risk of long-term side effects. Chronic use of harsh and coercive parenting is associated with several problematic outcomes, such as resentment and retaliatory behavior, anxiety and lack of confidence, running away from home, delinquency, and aggressive or violent behavior with others (Patterson, 1982; Patterson et al., 1992; Prinz & Connell, 1997).

Beneficial parenting encompasses many strategies and practices. Some of the more prominent ones found in evidence-supported parenting interventions include:

- Give rules and instructions before situations begin. Children do better when they know what the rules and expectations are ahead of time. Clear and simple instructions about what to do and not do in a pending situation (e.g., before taking a child into a store), and

what the consequences will be for cooperation or problematic behavior, increase the likelihood of success (Webster-Stratton, 2006).

- Give frequent attention to positive behaviors. Most interchanges by parents with children should be about things the children are doing well or correctly. Every positive child behavior does not have to produce parental praise, but parental attention for positive child behavior should greatly overshadow parental attention for negative child behavior for optimal impact (Dangel & Polster, 1984; Hutchinson, 1977).
- Give prompts, coaching, and correction. Frequent and/or acerbic criticism is not optimal parenting. However, children do need corrective feedback for healthy and prosocial growth. Parents can use minimal prompts, positive coaching, and nonnegative corrections in modest proportion in child socialization (Sanders, 2004).
- Set clear limits and boundaries. Children benefit from knowing what is and is not acceptable in terms of conduct. Humane and effective parenting does not mean discarding limits for child behavior. However, there are ways to communicate and back up such limits that do not demean or overcontrol children. If parents teach a self-regulatory approach, children can learn to be partners in acquiring self-control and adhering to limits and boundaries (Sanders, 2004).
- Ignore harmless but annoying behavior. When a parent frequently engages a child about minor behaviors that the parent finds annoying, the result is often the opposite of what the parent intended; that is, the annoying behaviors occur more often over time. This is particularly true if the child behavior is an attempt to gain an audience among those watching (Dangel & Polster, 1984; Sanders, 2004).
- Recognize and reward the opposite of the problem. Successful parents and teachers will tell you that they cannot simply punish their way to good child outcomes. A more promising and useful general strategy is to strengthen positive behaviors that can replace the problematic behaviors through recognition and reward. The key is to pick a positive behavior that is truly incompatible with the problematic behavior, such as chewing food with mouth closed rather than open, putting clothes and toys in the hamper rather than leaving a mess, playing gently and talking in a nice way with other children rather than hitting and yelling, and staying in school the whole day rather than being truant. Technically, this process is called direct reinforcement of other behavior (Dangel & Polster, 1984; Sanders, 2004; Webster-Stratton, 2006).
- Use naturally occurring rewards. When the lay public hears the word *reward*, the impression is that this entails payment or prize, but there is a more palatable way of thinking about rewards, which are called reinforcers in the technical literature. Positive attention, fun activities, access to special places (e.g., playroom), public recognition, and other naturally occurring events in the environment are actually better and more durable rewards than money or prizes. Parents can arrange the environment to take advantage of such opportunities. For example, a parent can say to a child, "Finish your homework, and then I will play catch with you," or "When you are ready for bed, we will read a story."

These are just examples of some of the many parenting practices that contribute to positive child adjustment and good long-term outcomes.

PARENTING AND FAMILY-BASED INTERVENTIONS FOR PREVENTION

Parenting and family-based interventions represent a critical domain in the prevention of child and adolescent mental health problems, substance abuse, and other adverse outcomes, as well as

for the promotion of child well-being. Family-related risk factors such as coercive discipline practices, an inconsistent or disorganized parenting style, strained parent–child relations, incomplete or ineffective socialization by parents, and marked family conflict have been implicated as proximal and distal influences for child and adolescent mental health problems and substance abuse. Parenting and family interventions have been deployed to pursue a number of prevention goals, including (a) risk reduction for a specific outcome, such as oppositional defiant disorder or conduct disorder in children or substance abuse in adolescence; (b) risk reduction for multiproblem outcomes in adolescence (Biglan et al., 2004); and (c) reduction of parenting and family risk factors as a general strategy without linking the intervention to specific adverse outcomes. Some of the parenting and family interventions serve more than one of these prevention goals, which is particularly true for interventions applied to parents of younger children (i.e., toddler, preschool, early elementary school).

There are universal preventive interventions that focus on all families, selected interventions that address families at collective risk (e.g., families living in poverty, premature infants, divorcing families), and indicated interventions that assist families in which children have begun to show early signs of emerging problems. Extensive reviews of parenting and family interventions can be found in Barrett and Turner (2004); Biglan et al. (2004); Dadds and Fraser (2003); Donovan and Spence (2000); Lochman and van den Steenhoven (2002); Petrie, Bunn, and Byrne (2007); Prinz and Dumas (2004); Prinz and Jones (2003); and Sutton (2007). Additionally, there are other prevention initiatives that have a parenting and family intervention embedded with several other intervention components (e.g., Fast Track). Other components besides a parenting and family intervention might include classroom and school programs, social skills training, child intervention, and academic tutoring. Multicomponent prevention programs are not considered here, primarily because it is generally not possible to determine what contribution the parenting and family intervention component made to any observed outcomes. Multicomponent approaches are useful to the field and should be considered in their own right. However, a big advantage of stand-alone parenting and family interventions is that the cooperation of multiple settings is not a necessary condition for successful dissemination; also, stand-alone programs can be evaluated more effectively.

Developmental considerations play out explicitly and implicitly in the body of literature on evidence-based parenting and family interventions. The greatest distinction is between parenting and family interventions for preadolescents versus adolescents. For parenting and family interventions aimed at families with preadolescents, especially toddlers and young children, the emphasis is on the parent or caregiver role as a socialization agent. Parenting and family interventions for this age group concentrate on positive and effective strategies for handling misbehavior, teaching new behaviors, promoting positive behaviors, enhancing the affective quality of parent–child interactions and family relations in general, and anticipating future challenges. The specific parenting strategies vary across developmental periods (e.g., toddler, preschool, elementary school), but the principles of effective parenting across those ages are generally robust.

Parenting and family interventions for families with adolescents concentrate more on family communication issues, risky behavior and its prevention, parental monitoring and supervision of adolescents when they are out of the home, and parenting strategies aimed at strengthening adolescent self-regulation and responsible independence. Programs for the adolescent age group are also more likely to involve the youth directly in the intervention, in either family sessions or concurrent youth sessions. Parenting and family interventions draw from a number of theoretical and conceptual frameworks, including but not limited to social learning and social-interactional theories, cognitive-behavioral principles, developmental psychopathology, attribution theory, attachment theory, public health, and an array of child and family development models.

Prevention of Preadolescent Problems

Family-based prevention of oppositional defiant disorder and related behavior problems in children is one of the more successful parenting and family intervention application areas. There are numerous interventions that have demonstrated varying degrees of impact in reducing or preventing child aggressive behavior, defiant uncooperative behavior, and associated difficulties. The interventions described below, although not exhaustive, are intended to represent the strength of the evidence-based parenting and family interventions and illustrate some unique and innovative features.

The Incredible Years program developed by Webster-Stratton and colleagues focuses primarily on parents of 3–8-year-old children with oppositional defiant disorder or conduct problems (Webster-Stratton & Reid, 2003). This program, which is typically administered to groups of parents over the course of 12–14 weekly sessions, mainly functions as either an indicated preventive intervention or a clinical treatment. However, the Incredible Years has also been implemented as a selected preventive intervention with parents of children in Head Start programs. In an impressive series of controlled outcome studies spanning over 20 years, the core parenting program produced reductions in child aggressive and destructive behavior and improved parent–child interactions and parenting competence. The Incredible Years is flexible in that it can be implemented in a variety of settings, including preschools, elementary schools, and clinics. There are also companion programs in the form of child group training and teacher classroom management. The program has produced favorable cost–benefit data.

The Incredible Years has been successfully disseminated in the United States and elsewhere. With respect to the parenting and family intervention prevention goals mentioned at the beginning, the Incredible Years mainly serves the first goal: risk reductions for a specific outcome, which in this case is oppositional defiant disorder and associated conduct problems. However, the program also addresses concomitant internalizing problems, such as anxiety and fears, that are seen in the indicated populations. Additionally, the selected intervention application of the Incredible Years (e.g., with Head Start parents) fits the third goal to some degree, namely, the general reduction of parenting and family risk factors (The Incredible Years, 2009).

Another well-supported parenting and family intervention, but one that takes a somewhat different structural approach than The Incredible Years and other similar programs, is the Triple P—Positive Parenting Program (Sanders, 2008; Sanders, Turner, & Markie-Dadds, 2002). Triple P, which is actually a system of parenting interventions rather than a single one, is intended in its fullest implementation to be a population-wide strategy for prevention of childhood social, emotional, and behavioral problems. Although the system runs from infancy through age 16, this discussion focuses only on the 1–12-year-old age range for comparison purposes. Triple P incorporates five levels of intervention on a tiered continuum of increasing strength but with narrowing utilization by parents. The five levels are summarized in Table 28.1.

Triple P was designed from the outset for population dissemination in terms of the materials, portability of the interventions, utilization of multiple disciplines and settings in the existing workforce, and a standardized professional training process. The ultimate goals of the system are to strengthen parenting across the population and reduce the prevalence of common child social, behavioral, and emotional problems. To this end, the multilevel interventions of increasing intensity subscribe to the public principle of taking the minimally sufficient action to solve the problem at hand. The assumption is that much can be accomplished across the population with a universal media-based program, which is relatively cost-efficient compared to professionally delivered programming, plus the other lower levels of intervention, and if a family needs or wants more assistance, the higher intensity interventions are still available. Over 25 years of empirical work went into the development and refinement of Triple P.

A sizable number of effectiveness trials and a few dissemination studies have been conducted with various components of the Triple P system, including over 40 randomized trials and several field evaluation studies. These have yielded consistently positive results in terms of reduced child externalizing problems, and internalizing problems where appropriate, reduced use of coercive parenting methods, improved parent–child interactions and relations, and benefits for other aspects of parent and family functioning. Favorable cost–benefit data have been reported for Triple P, and it is currently being disseminated in 16 countries including the United States. The system is sufficiently flexible that organizations and communities can adopt some or one of the interventions and still accrue benefits. However, the elegance of this approach is in the synergy of the various levels and program formats (see Table 28.1). The universal media piece is intended to not only convey positive parenting information but also normalize and destigmatize the accessing of parenting and family support (http://www.pfsc.uq.edu.au/research/publications).

Prevention of Adolescent Problems

In the area of adolescent substance abuse, there is some evidence that parenting and family interventions can delay onset and reduce the extent of substance abuse. One of the best examples is found in the Strengthening Families Program (Molgaard & Spoth, 2001; Spoth, Randall, Shin, & Redmond, 2005). This universal preventive intervention, typically but not exclusively conducted in school settings, consists of seven group sessions with parents while concurrent group sessions are conducted with the youth. It has shown impressive preventive effects in randomized trials in terms of lower levels of drug, tobacco, and alcohol use; lower rates of aggressive and destructive behaviors; and better parent–youth interactions. Strengthening Families has yielded positive cost–benefit data, too. The intervention model is relatively efficient but can be expanded with booster sessions. It is primarily a school-based parenting and family intervention but presumably can be implemented

Table 28.1 Five Intervention Levels for the Triple P—Positive Parenting Program System

Level	Focus	Variants
Level 1—Universal	• Coordinated media and communication strategies • Access by all interested parents to useful information about parenting	Not applicable
Level 2—Selected	• Brief intervention • Early anticipatory developmental guidance • Addressing normative concerns and mild behavior problems	• *Individual*—Brief and flexible consultation • *Parenting seminars*—Large group
Level 3—Primary care	• Narrowly focused parent training in a brief (up to four contacts) and flexible consultation mode	Brief and flexible consultation
Level 4—Standard	• Intensive parenting intervention to address moderate to severe social, behavioral, and emotional difficulties • Indicated prevention	• *Standard format*—Individual families • *Group format*—Multiple families • *Stepping Stones*—Families of children with developmental disabilities • *Self-directed format* • *Lifestyles*—Parents of obese children
Level 5—Enhanced	• Add-on to level 4 • For families also experiencing family difficulties (e.g., parental depression or stress, conflict between partners)	• *Enhanced*—For family difficulties • *Pathways*—For child abuse risk

in a community center or house of faith. The intervention lends itself well for dissemination in terms of materials, family recruitment, and technical support.

An approach that is built on a blended prevention model is the Adolescent Transitions Program developed by Dishion and Kavanagh (2003), which is consistent with the aforementioned goal number 2, risk reduction for multiple outcomes. This program targets reduction of risk for adolescent substance abuse, behavior problems, and school failure and combines universal, selected, and indicated interventions into a blended prevention strategy. Delivered in middle or high schools, the Adolescent Transitions Program includes the following:

- A universal access family resource center that includes brief consultation with parents either face-to-face or by telephone, feedback when solicited to parents about their teenager's behavior at school, and resource videos and books
- A selected intervention called the Family Check Up, which is offered to families of youth who are identified as high risk for behavior problems based on teacher ratings, consisting of three family sessions emphasizing motivational interviewing and culminating in feedback about family strengths, needs, and possible intervention linkages
- An indicated intervention that relevant families choose from a menu of family-centered interventions that provide support for family management practices conducive to positive adolescent development

In a randomized study, the Adolescent Transitions Program resulted in slower growth of externalizing behavior problems and alcohol, tobacco, and marijuana use from age 11 through 17 and decreased risk for substance abuse and police arrests by age 18. More work needs to be done on the portability and dissemination of the program; nonetheless, it is a unique and promising multilevel preventive intervention.

Evidence-supported parenting and family interventions that specifically target the prevention of anxiety disorders in adolescence have not emerged. Most of the work on family-based intervention related to adolescent anxiety disorders has been in the context of treatment for youth already experiencing diagnosable problems. A potentially fruitful area in need of research and development is family-based prevention of anxiety problems in the offspring of adults who have an anxiety disorder. The testing of selected prevention of anxiety disorder would be well justified, given the likely genetic, modeling, and socialization contributions parents might make to their children.

With respect to the prevention of conduct disorder, parenting and family interventions geared toward parents of adolescents (e.g., Adolescent Transitions Program, Strengthening Families Program) have shown reduction of risk for externalizing problems. However, it is not clear yet how well parenting and family interventions that are initiated during adolescence can prevent the emergence of actual cases of conduct disorder. Part of the problem is that by adolescence, youth who are going to qualify for a conduct disorder diagnosis may already have done so when an intervention is being offered. In this regard, there might be some blurring of definitions regarding treatment versus prevention, compounded by timing issues.

Family-based prevention of depression in adolescence, like the anxiety area, is not well developed. Most of the family-based intervention work in this area centers around treatment of depressed youth, with one notable exception. A selected preventive intervention, the Clinician-Based Cognitive Psychoeducational Intervention (Beardslee, Gladstone, Wright, & Cooper, 2003) is a family-based approach for the offspring of parents who have significant mood disorders. This intervention shows promise in terms of improving youth and family functioning, increasing knowledge about affective disorders and the resilience of children, and reducing risk for internalizing disorders. The extent to which it can reduce the prevalence of adolescent depression is not yet known; however, the strategy

seems well justified. Also, the intervention has the potential to link youth to treatment earlier than usual and thereby possibly prevent the long-term debilitating sequelae associated with untreated depression. Offspring of depressed parents have at least a fourfold greater likelihood of developing depression during adolescence and early adulthood. In terms of potential dissemination impact, what is not as well known is the extent to which depressed parents are able to be involved in the treatment with their offspring. Nonetheless, this intervention deserves more research, given the dearth of family-based strategies for prevention of depression.

Additionally, a few of the universal interventions (e.g., those based on the work of Hawkins and colleagues), geared primarily for parents of adolescent youth and the prevention of substance abuse, have begun to show promise in terms of reducing depressive symptoms. There is some lack of clarity in the field as to whether changes in depressive-type symptoms correspond to prevention of clinical depression. Added research including independent replication should help bolster this promising work.

Another parenting and family intervention focuses on children of divorce and fits the third prevention goal noted at the outset in terms of reducing parenting and family risk factors as a general strategy not tied to a specific disorder or outcome. The New Beginnings Program helps divorced mothers promote resilience in their children (Wolchik, Sandler, Weiss, & Winslow, 2007). It is sort of a hybrid of the standard kinds of parenting and family interventions for all families plus normative and useful information about divorce-specific issues, such as parental guilt reactions and multiple household issues. Although not yet ready for broad dissemination, the New Beginnings Program in controlled research has shown promise in reducing risk for internalizing and externalizing problems.

SAMPLING OF CRITICAL ISSUES

Distillation of Common Elements

Across the various preventive interventions and domains, the evidence-supported parenting and family interventions have a number of common elements or features:

- *Action focused*—Parents actually do things during the intervention rather than simply engage in conversation with the interventionist.
- *Problem-solving oriented*—Parenting and family interventions generally work toward addressing specific challenges and solving problems. A problem-solving orientation does not preclude building on child, parent, and family strengths. What it means, though, is that parental goals are pursued. Parents want to solve the challenges they are facing in child rearing. For example, if a child is frequently exhibiting violent tantrums in public places, such as restaurants and shopping malls, and seems to have difficulty with emotional regulation, then the parent is looking for effective ways of solving this stressful problem. Parenting and family interventions offer strategies that have a reasonable probability of solving the problems at hand rather than just talking about the child's problems without generating action plans.
- *Specific, concrete, and practical parenting strategies*—Although it is important for parents to induce general principles that they can apply in future situations, parenting and family interventions still try to focus on practical parenting strategies that parents can readily implement. Parents need and want suggestions for action. Parenting and family interventions typically offer a menu of specific parenting strategies, so parents can find the best fit for their personal style and still address the issue at hand. Instead of vague generalities, such as "Show your child a lot of love," the interventions focus, for example, on specific

ways to build closer, more affectionate parent–child relationships. For more complex situations, interventionists walk parents through specific but straightforward steps to implement a strategy.

- *Collaborative goal setting*—Parenting and family interventions seem to work better if parents set the specific goals for themselves and their children, in consultation with the interventionist. The professional asks facilitative questions and helps parents articulate useful and specific goals. The parents' role in this process is paramount. They are not passive participants but rather a consumers who have a major stake in what happens with their children and families. The interventions typically involve identification and sharpening of parents' goals for their children. Parents often begin with distress and concern as they discuss their children's adjustment. It is the interventionist's job to join with the parents and help them figure out what the needs are in terms of the specific challenges relevant to their children's development and functioning.
- *Consultative rather than prescriptive*—Although not all parenting and family interventions subscribe to this principle equally, there is a general trend toward making the intervention consultative, in line with collaborative goal setting noted above, rather than prescribing to the parent what they must do. Providing menu options and answering parents' questions are important facets of the consultative approach.
- *Adopting a positive frame*—Parents do not need to feel blamed or inept for an intervention to be successful. Successful parenting and family interventions adopt a positive frame about the child, the parent, the program tasks, and the intervention itself.

Engagement of Parents

One of the biggest challenges in the successful implementation of parenting and family interventions is the engagement of parents initially (i.e., recruitment) and then throughout the program. Compared with 15 years ago, program implementers have become savvier in addressing potential barriers to participation by being more sensitive to program time and location, availability of transportation and child care, and other logistical considerations. From a dissemination perspective, however, delivery systems and staff may or may not share the same flexibility. We know more about parental engagement now than we used to, but it is still a major challenge. Who delivers a parenting and family intervention, how they deliver it, in what context it is offered, and how the community perceives it are just some of the critical variables that can impact engagement.

Are Long-Term Studies of Every Intervention Needed?

There is no doubt that long-term longitudinal and preventive intervention studies have contributed to progress in parenting and family-based prevention. Nonetheless, it is a debatable issue whether every parenting and family intervention needs to be subjected to a long-term study that is both costly and potentially delaying. For example, suppose that a parenting and family intervention shows strong positive impact on parenting competence and child behavior when a child is 5, and the effects sustain over a 2-year period. If in other research those constructs (i.e., same facets of parenting competence and child behavior) have been shown to be pertinent to prevention of substance abuse, is it necessary or advisable to test the parenting and family intervention over a 10-year follow-up period? Or, is it sufficient to draw inferences across studies to arrive at a conclusion about the parenting and family intervention's impact on precursor risk factors in childhood? Individual studies or sources of evidence should not be considered in isolation or out of context. Parenting and family interventions that can reduce the prevalence of known parenting and family-related risk factors at the time of implementation are useful whether 10-year forecast data are available or not.

MOVING TOWARD WIDE-SCALE PREVENTION

The field has produced efficacious interventions for improving parenting and parent–child relations and preventing or ameliorating children's social, emotional, behavioral, and health problems (Miller & Prinz, 2003; Olds, Sadler, & Kitzman, 2007; Prinz & Dumas, 2004; Zubrick et al., 2005). Also emerging is evidence that parenting interventions can reduce child maltreatment and children's injuries (Prinz, 2007; Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009). Despite strong evidence for positive impact, most of the parenting and family interventions have not met with wide adoption. The limitations of these interventions collectively are apparent with respect to not achieving, or even attempting to achieve, broad or population-level effects. In part as a response to this state of affairs, a paradigm shift is beginning to take place that emphasizes a public health and population approach over one that is strictly clinical and focused on high-risk children (Biglan & Metzler, 1998; Prinz & Sanders, 2007).

Interventions Designed for Broad Dissemination

Many of the existing parenting and family interventions were designed for potentially cumbersome, or at least not very practical, efficacy trials. This issue cuts two ways. First, a parenting and family intervention that shows efficacy but cannot be readily disseminated is not a good candidate for widespread adoption. Second, if the efficacious intervention has to be modified before dissemination, the disseminated version may not retain the same level of efficacy as the original version. As new interventions are readied for efficacy testing, it makes sense that the end state goal of dissemination be taken into account up front when the intervention is being designed. This recommendation pertains to intervention materials, length and efficiency, provider training methods, promotion and verification of intervention fidelity, and ease of administration.

Targeting Reduction of Population Prevalence

As attempts are being made to more widely disseminate parenting and family interventions, greater attention is being paid to the challenges and requirements of going to full scale. Generally speaking, however, the field does not appear to be making the reduction of population prevalence (e.g., child mental health problems, child maltreatment) the overarching goal. From a public health perspective, if society spends billions of dollars on prevention, but the problem remains at the same prevalence level, the approach has not succeeded. Reframing the prevention challenge in terms of prevalence reduction at a population level is a major undertaking that will require a concerted paradigm shift. Additionally, our community surveillance systems need to be overhauled and improved, so population effects can be more readily detected.

Improving Accessibility to Parenting Interventions and Information

One of the keys to moving toward a population-wide approach to family-based prevention is improving the accessibility of parenting interventions and information. This means utilizing many settings including nontraditional ones, so parents can "bump into" programming wherever it is convenient and most advantageous to them, and also requires a shift in the paradigm. Typically, mental health–type interventions have been guarded by mental health providers, at least in certain disciplines. Although parenting is obviously a major influence on children's mental health and well-being, it is also something that belongs to a broader domain. Parenting interventions for the most part need to be demedicalized and destigmatized. Drawing on many settings and types of providers is one way to start that process.

Research on media-based approaches to improving parenting has begun to emerge but is still in its infancy. The greatest advances in this work in relation to evidence-based parenting and family

interventions and media utilization have been made by Sanders and colleagues (Calam, Sanders, Miller, Sadhnani, & Carmont, 2008; Sanders, Calam, Durand, Liversidge, & Carmont, 2008; Sanders & Prinz, 2008). Three studies have demonstrated the potential benefits of using media delivery for an evidence-based parenting and family intervention such as Triple P, as described earlier. In the first media study, Sanders, Montgomery, and Brechman-Toussaint (2000) established the feasibility of using an infotainment-style television series with embedded segments on parenting to promote positive family outcomes. Using a controlled design, the investigators found that 12 half-hour episodes led to fewer child behavior problems and better child adjustment, as well as greater parental confidence, in comparison to the wait list control. The second study examined the effects of Triple P as a reality series on British television (Sanders et al., 2008). The six-episode documentary television series *Driving Mum and Dad Mad* (Campbell, 2005–2006) depicted the experiences and emotional journey of five families with young children who had severe conduct problems, as the parents participated in Group Triple P (an eight-session intensive group program).

A randomized trial involving approximately 500 families examined the impact of viewing the television series. The intricacies of the study are beyond the scope of the discussion here, but a primary finding is that substantial benefits could be accrued from parental viewing of the series with respect to child behavior, dysfunctional parenting, parental anger about child behavior, and parental disagreements about the use of discipline. The third study (Calam et al., 2008) also investigated the effectiveness of *Driving Mum and Dad Mad* and involved 723 families who were randomly assigned to either a standard viewing condition or a technology-enhanced one, which provided additional online support. Parents in both conditions reported significant improvements from preintervention to postintervention in child behavior, dysfunctional parenting, parental anger, depression, and self-efficacy, and these improvements were maintained at the 6-month follow-up. Of particular importance is that Calam et al. demonstrated that the television series approach had positive benefits for a diverse range of families with respect to socioeconomic level. In contrast to the aforementioned work supporting media strategies grounded in evidence-based parenting and family interventions, there are non-evidence-based television programs related to parenting, such as *Nanny 911* and *Supernanny*, that have not been scientifically tested. Society does not know not only the potential benefits of such programs but also whether there are potentially iatrogenic or harmful effects from these particular television approaches.

Pertinent to the media discussion and furthering the paradigm of taking a population approach to parenting and family support, a few recent studies have integrated media strategies with parenting and family interventions delivered face-to-face. One of the larger of such studies is the U.S. Triple P System Population Trial funded by the Centers for Disease Control and Prevention (Prinz et al., 2009). Aimed at the prevention of child maltreatment among parents of children ages 0–8, 18 counties were randomized to either the Triple P system, including a media component, or community services as usual. Hundreds of service workers in many settings (e.g., clinics, schools, daycare centers, health centers, community nongovernmental centers, churches) were trained in the delivery of Triple P.

All levels of the Triple P system were implemented (see Table 28.1). There were also concurrent media and communication strategies involving local newspaper stories and articles with parenting tips, newsletter mass mailing, radio public service announcements, website information, and information distributed at community events. After controlling for baseline levels, counties in the Triple P system condition yielded significantly lower rates of substantiated maltreatment, child out-of-home placements (i.e., foster care), and child injuries resulting in hospital treatment, compared with the counties randomized to services as usual. Although it was not possible to tease out the separate effects of the media strategies from those of direct services, prior media-only studies coupled with studies on individual-level Triple P suggested that there was possibly a synergistic

effect. Media strategies for improving parenting and child adjustment are promising, but there is much to study before the field knows their full potential as well as their limitations.

CONCLUSION

Children and families can benefit from well-tested parenting and family support interventions that are practical, action oriented, problem solving, and efficient and delivered collaboratively in partnership with parents regarding goals and parenting options. Although not yet fully adopted, the field has begun to move toward a newer paradigm that emphasizes broad dissemination, impact on prevalence rates at a population level, and integration of media strategies with more traditional modes of service delivery. Consumer researchers who specialize in social marketing, vulnerable populations, and quality of life have much to contribute to this area (see Andreasen, Goldberg, & Sirgy, Chapter 2 of this volume; Grier & Moore, Chapter 15 of this volume; Pechmann, Biglan, Grube, & Cody, Chapter 17 of this volume), in addition to those whose expertise includes families (Epp & Price, Chapter 29 of this volume), online communities (Hoffman, Chapter 9 of this volume; Kozinets, Belz, & McDonagh, Chapter 10 of this volume), materialism (Burroughs & Rindfleisch, Chapter 12 of this volume), and practical wisdom (Mick & Schwartz, Chapter 32 of this volume). Overall, there are many opportunities for Transformative Consumer Research to contribute to understanding and positively influencing effective parenting of young and maturing consumers.

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