**Supporting parents to support children with vision impairments:**

**How flexible delivery of evidence based training can make a difference**

Author: Courtney McKee, Vision Australia, Courtney.mckee@visionaustralia.org, 373 Old Cleveland Road, Coorparoo, 07 3727 2275

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# Abstract

This paper explores the implementation and outcomes of an evidence-based training program for parents of vision impaired children aged 2 to 12. Group Stepping Stones Triple P (Sanders, Mazzucchelli, & Studman, 2009) provides principles and practical strategies designed to enhance family relationships and assist parents to promote positive behaviour, teach new skills and manage misbehaviour. The author outlines the method by which this program was delivered to varying group sizes via different modes and how content was contextualized. The author also discusses practical implications for families, strategies for maximizing engagement, aspects of group facilitation and the benefits of peer interaction. Program evaluation and participant outcomes are described in both quantitative and qualitative terms through the presentation of results from pre- and post-participation psychometrics as well as micro case studies.

# Keywords

Parent training, vision impairment, blind, challenging behaviour, video conference, Triple P.

# Parenting a child with a Vision Impairment

Parenting is a wonderful and demanding endeavour and parenting a child with vision impairment (VI) is no exception. Regular parenting difficulties tend, however, to be compounded in the presence of disability with particular complexities specific to vision impairment. Children with disabilities including vision impairment are thought to be more likely than their normally developing peers to demonstrate challenging behaviour (Dekker, Koot, van der Ende, & Verhulst, 2002; Roberts, Mazzucchelli, Taylor, & Reid, 2003). Challenging behaviour is defined as actions which cause damage to property, others or self, or reduce opportunities for successful inclusion. This challenging behaviour is now believed to have substantial long-term negative implications for the child, their family and the community.

Parents of a child with vision impairment report that a sometimes draining amount of time and effort is required to teach their child new behaviours and to support them to maintain existing positive behaviours (Leyser & Heinze, 2001). Furthermore many children with vision impairment have been found to be less responsive than sighted peers to parent directives such as instructions to do or to stop doing something (Kekelis & Prinz, 1996). When parents are in the process of assisting their child to achieve social norms, challenging behaviours can place restrictions on family activities including time spent in public spaces and types of public spaces accessed. Family members of children with vision impairment who demonstrate challenging behaviour tend to experience increased stress (Erin, Rudin, & Njoroge, 1991; Ferrell, 1986; Hancock, Wilgosh, & McDonald, 1990; Moore, Van Hasselt, Ammerman, & Hersen, 1994; Nixon, 1991; Tuttle, 1986), and this may have a negative impact on the quality of the care given to the child (Bradley, Rock, Whiteside, Caldwell, & Brisby, 1991; Bugental, Blue, & Cruzcosa,1989).

At school, challenging behaviour can be a source of stress for teachers (Hudson, Jauernig, Wilken, & Radler, 1995) and strain teacher-parent relationships (Ferrell, 1986; Hancock et al., 1990; Moore et al., 1994). Adding to this, children with vision impairment with challenging behaviour may be even more likely than children with other disabilities to be rejected by their peers because they lack basic social skills and miss important visual cues (Jones & Chiba, 1985). Classmates may be intimidated by aggressive behaviours or alienated by unusual behaviour such as stereotyped mannerisms, often called blindisms. Children with vision impairment may also have a tendency toward egocentrism, being unreceptive to peer interests (Kekelis, 1992; Kekelis & Sacks, 1992; MacCuspie, 1992), as demonstrated by interrupting or otherwise redirecting interactions to focus exclusively on them or their interests. These types of behaviours routinely result in the child’s social isolation (Corsaro, 1985; Putallaz & Gottman, 1982).

Early challenging behaviour is indicative of more severe behaviours emerging in adolescence and adulthood and early intervention is often a simpler prospect than tackling the challenging behaviour in later life when it is well-entrenched. Challenging behaviours which persist into later life also predict lower levels of self-esteem and quality of life for the child in question (Hemphill, 1996; Sanders, 1995).

Among the additional pitfalls faced by parents raising a child with a disability is that parents may attribute challenging behaviour to the disability and assume it cannot be addressed. While providing additional nurturance is a natural response to parenting a child with additional needs, low expectations of behaviour can be a self-fulfilling prophecy, maintaining a child’s dependence and maladaptive interpersonal strategies, and leading to missed opportunities for assisting the child to reach his or her full potential (Stokes, Mowery, Dean, & Hoffman, 1997).

Parents faced with these types of issues have expressed a need for information about raising a child with vision impairment and for assistance in connecting with other parents doing the same (Leyser & Heinze, 2001) and the literature indicates that these pathways can be fruitful. Providing parents with information about evidence-based strategies for promoting their child’s development has been shown to be effective in reducing the severity and prevalence of challenging behaviour (Turner & Sanders, 2006). Parents can also find both giving and receiving social support in contexts such as parent groups to be particularly useful in assisting them to adjust to raising a child with vision impairment (Leyser & Heinze, 2001; Moore et al., 1994; Nixon, 1991).

# What is Group Stepping Stones Triple P?

The Triple P (Positive Parenting Program) system includes multiple levels of intervention and various incarnations all of which aim to support parents’ management of their children’s behaviour by training them in effective parenting strategies. Triple P has a strong evidence-base (Sanders, 1996, 1999; Sanders, Markie-Dadds, Tully & Bor, 2000) and is universally applicable but is particularly useful as an early intervention to address challenging child behaviour. It has also been shown to reduce parent stress and discord between parents (Zubrick, et al, 2005).

Group Stepping Stones Triple P is the Triple P foundation with additional strategies arising from disability research built in (Sanders, Mazzucchelli & Studman, 2004). It is a 9-session program tailored to meet the needs of parents of children with disabilities aged 12 years or under, in a group training context. The structure is flexible but typically, five weekly group sessions provide opportunities for parents to learn through discussion and practise. Three individual sessions follow and a final group session is held in week nine. Between sessions, parents pursue individually-tailored homework assignments to consolidate learning and put it into practise.

Facilitator tools include: the Facilitators Manual for Group Stepping Stones Triple P, containing session guidelines; a disk of PowerPoint slides for each group session; Stepping Stones Triple P Parent Workbook for reference; and a Stepping Stones Triple P: A survival guide for families with a child who has a disability DVD. Training activities include didactic presentations, group discussion, DVD clips to show strategies in action, and skill rehearsal.

The parenting strategies covered include those for enhancing relationships (e.g., quality time, communication, affection), those for promoting positive behaviour (e.g., praise, attention, rewards, engaging activities, activity schedules, behaviour charts), those for teaching new behaviours (e.g., incidental teaching, physical guidance, modelling, ask-say-do, teaching backwards, instructions) and those for managing misbehaviour (e.g., planned ignoring, quiet time, time out, diversion, logical consequences) as well as routines that combine multiple strategies (Sanders, Mazzucchelli & Studman, 2009). The research indicates that Stepping Stones Triple P is an effective intervention for challenging behaviours demonstrated by children with a range of disabilities including sensory impairment (Harrold, Lutzker, Campbell & Touchette, 1992; Roberts, Mazzucchelli, Studman & Sanders, 2006).

# The Stepping Stones Triple P Project

The Stepping Stones Triple P (SSTP) Project is led by chief Investigators: Prof Stewart Einfeld, the University of Sydney; Prof Matthew Sanders, The University of Queensland; and Emeritus Prof Bruce Tonge, Monash University. The project is funded by the National Health and Medical Research Council and involves the roll out of SSTP free of charge across New South Wales, Queensland and Victoria over a five year period.

The project’s objective is to assess whether SSTP is helpful for a broad range of families and to identify whether increased access to evidence-based programs can reduce the impact of challenging behaviours at a population level. Teachers and allied health professionals who work with children have been able to nominate to receive training toward becoming accredited SSTP practitioners and committed to deliver the program to families in their community. Parents are eligible to participate in the various SSTP programs being delivered by these practitioners if they have a child with a disability aged two to twelve and are able to communicate in English. Interested parents are able to register to participate on the SSTP website.

# Stepping Stones Triple P with Vision Australia and VidKids™

Under the auspices’ of the Stepping Stones Triple P (SSTP) Project, SSTP programs were delivered at Vision Australia free of charge by an accredited SSTP provider. These programs were open to parents within the Vision Australia community. This included sighted parents of a child with VI, sighted parents of a child with multiple impairments including VI and parents who have VI and have a child with a disability of any kind.

Three programs were offered in 2014 on different days of the week and via different modes (i.e., teleconference, face to face and video conference). The video conference program was run in conjunction with VidKids™.

VidKids™ was funded by the Australian Government’s Department of Social Services (DSS) and was a partnership between Vision Australia, VisAbility, Deaf Children Australia and members of the First Voice national service network. This pilot project provided specialised services via videoconference to children aged 0 to 18 with vision and/or hearing impairments who live in outer regional and remote areas. The aim of the project which commenced in October 2012 and concluded in July 2015 was to address the lack of access to specialised services in remote locations.

# Facilitation Style

The same accredited SSTP practitioner delivered the three programs and some aspects of group facilitation remained constant across the different delivery modes. The parent was acknowledged as the expert in their child’s life. As such a strengths-based approach was taken and involved affirming existing effective parenting strategies and celebrating achievements to date. Participating in the program was presented as a way of adding to the parenting toolkit and parents were encouraged to see the program as a safe space to share and be creative. Parents were regularly thanked for their contributions to the collective wisdom of the group. Group facilitation skills used included paraphrasing, posing questions and invitations, balancing the contributions of all group members, reframing, redirecting and developing participant competence in a self-regulatory framework.

# Participants

Of the 25 families who enrolled in Group Stepping Stones Triple P (SSTP) across the three program offerings (i.e., teleconference, face to face, videoconference), 16 families progressed to completion. These 16 families represented 18 participants, as in the case of two families, both parents were able to attend. The 18 participants consisted of four fathers, eleven mothers, one step-mother and two grandmothers. Families were based in regional and metropolitan Queensland, regional New South Wales and the Northern Territory.

One member of each family responded to a pre-participation questionnaire which requested a range of demographic data. Thirteen respondents had English as their first language and three came from a non-English speaking background. One respondent was blind. In terms of the highest level of educational attainment, one participant attained Grade 8, four attained Grade 10 and eleven attained Grade 12. Three respondents attained a trade, four attained a bachelor’s degree and three attained a post graduate degree.

Ninety-three percent of respondents identified as their child’s primary care-giver. Three were sole parents, eleven cohabited with another biological parent and two identified as grandparents or blended families. Three respondents were employed full-time, seven worked on a part-time or casual basis and one was engaged in study. Of those respondents who identified as being unemployed, one was looking for work and three were not looking for work because family responsibilities were prohibitive.

Each family included at least one child who was blind or who had low vision. These children were aged between two and twelve years with an even distribution across ages except in the case of 4 year olds who represented 20% and seven year olds who represented 27% of the cohort. Sixty percent of the children were male and 40% were female. Many children had other disabilities including brain injury, Pervasive Developmental Disorder, Cerebral Palsy, global developmental delay and Sensory Processing Disorder.

The majority of children were in main stream schooling with teacher aid support, although a small number attended preschool and some attended a special school or were engaged in a special program. One child was in main stream schooling with no aid. Sighted sibling and step-sibling numbers ranged from none to three and some sighted siblings had received diagnoses such as Reactive Attachment Disorder and Attention Deficit Hyperactive Disorder.

# Method: Teleconference Group

***Equipment and Materials.*** Equipment used by the facilitator included an office phone and headset to access the teleconferencing system. An audio recorder/player was used to play audio files from the DVD. Facilitator notes were accessed on a laptop with an earpiece. Participants used their home or mobile phones and had access to their hard copy SSTP Parent Workbook which was funded and mailed out to them by the SSTP Project team. One parent was provided with the parent workbook in accessible electronic format as per reasonable adjustment guidelines.

***Procedure.*** This program was offered via teleconference for the convenience of regional, rural, remote and interstate clients. The program ran in Term 1 2014 from 10:00 to 12:30 Queensland time and from 11:00 to 1:30 Daylight Savings Time each Wednesday for six weeks with a half-hour break. Individual phone calls were scheduled in weeks seven through nine.

The variation to usual program structure was made in consultation with the three participants as five group sessions was found to be insufficient to cover all core content in this mode. As such, the week nine group session was shifted to week six, allowing parents to be fully briefed together before moving into individual sessions.

For each group session, the Vision Australia facilitator dialled parents into the teleconference, delivered training content interspersed with audio clips from the DVD, and facilitated group discussion and practise. In instances where a parent was unable to attend a session, the facilitator contacted that parent by phone during the week to work through content individually. Queensland-based Vision Australia staff who work routinely with children were invited to observe one or more sessions for professional development and one to seven staff members attended each session.

There were some facilitation considerations specific to this mode of delivery. Dial in of participants took around five to ten minutes. As the Conferlink system is set to a compulsory one-hour automatic cut-off, dial in time subtracted from group time. To make dial in as effective as possible, participants were asked to notify the facilitator in advance if they could not attend and wait by the phone when due to be dialled in. To avoid instances of participants disconnecting from the session, they were asked to ensure their phone was charged. Where disconnections did occur, the facilitator encouraged discussion to continue in her absence and left the call to redial the missing participant. To maximise audio quality for all participants, they were asked to minimise distractions, interruptions and background noise. Roll calls were conducted at the beginning of each session so everyone knew who was in attendance and participants were asked to give their name each time they spoke until familiarity enabled speakers to be identified by voice.

# Results: Teleconference Group

In week five, participants provided verbal feedback about the program. Participants appreciated a number of features: the smaller group size which enabled them to get to know one another and contribute to every strategy discussion; being expected to do homework which enabled them to trial strategies and apply theories to see how they worked for them; how the information about each strategy was delivered a few different ways allowing the time, repetition and perspectives needed to develop solid understanding; and the flexible delivery which allowed material to be rolled over if extra time was needed on particular strategies.

One parent’s major goal for the program was that her son would learn to do what mum asked when she asked and, at completion of the program, she reported that this goal had been achieved. She reported that she was no longer experiencing a rising sense of panic when her son misbehaved, because both he and she now knew that “mum is the boss.”

# Method: Face to Face Group

***Equipment and Materials.*** Equipment used to deliver the program included a laptop with earpiece and two large-screen televisions to display slides and DVD segments. Parents each had access to their hard copy SSTP Parent Workbook which was funded by the SSTP Project team.

***Procedure.*** This program was offered face to face at Vision Australia, 373 Old Cleveland Road, Coorparoo for the convenience of clients residing in the Brisbane area. The program ran in Term 2 2014 from 4:00pm to 6:30pm each Thursday for five weeks with individual phone calls scheduled in weeks six through eight and then a final group session in week nine. In instances where a parent was unable to attend a session, the facilitator contacted that parent by phone during the week to work through content individually.

A therapy session for children who were Vision Australia clients ran parallel to SSTP for the eleven attending parents. Children were dropped off at the therapy session between 3:30 and 3:45 and collected between 6:30 and 6:45. Parents were asked to bring something for their child to eat for dinner during the therapy session as well as a plate to share with parents at training.

The therapy team included Occupational Therapists, Physiotherapists, Orientation and Mobility Instructors, a Speech Pathologist, an Adaptive Technology Trainer and volunteer psychology students. Goals developed by parents during the first week of SSTP were conveyed to the therapy team who supported goal attainment by promoting goal oriented behaviour during fine motor, gross motor, orientation and mobility, social skills and homework sessions.

# Results: Face to Face Group

In week eight, during individual sessions, parents and the facilitator reviewed the level of attainment reached for each parent goal (i.e., achieved, partially achieved or not yet achieved) and parents identified which strategies they felt had been most effective toward this end. Parents also provided an outcome statement which encapsulated what they had gained from participating.

One parent expressed her outcomes in the following manner: (1) my child will Use a knife and fork correctly to eat his dinner - partially achieved via physical guidance; (2) my child will spend 75% of his home time in independent play - partially achieved (90%) via activity schedule, clear calm instructions, rules and descriptive praise; (3) when anxious, my child will use a suitable relaxation strategy to calm down - achieved via rules and clear calm instructions; (4) when unsure of what to do, my child will apply the problem solving model to take suitable action - partially achieved via descriptive praise and clear calm instructions. This parent provided her outcome statement as follows: “The program has been of huge benefit to me. It's not only clarified that I'm on the right track with how I go about things but it's also given me great ideas about how to handle his behaviour and make my life easier. It's been great to bounce ideas off people and have them suggest things. It's also been good to know I'm not the only one dealing with these types of issues.”

# Method: Video Conference Group

***Equipment and Materials.*** Where necessary, VidKids™ provided internet connections and video conferencing hardware and software including a computer, web cam and speakers for eligible participants. VidKids™ also supplied technology support and the Microsoft Lync video conferencing software. An audio recorder/player was used by the facilitator to record sessions to provide an audio file to parents where they could not attend. Parents each had access to their hard copy SSTP Parent Workbook which was funded by the SSTP Project team and mailed to them along with print copies of slides and a copy of the DVD which was funded by VidKids™.

***Procedure.*** This program was offered via video conference for the convenience of regional, rural, remote and interstate clients. The program ran in Term 3 2014 from 10:00 to 12:30 each Tuesday for five weeks with individual video conferences scheduled in weeks six through eight and then a final video conference group session in week nine. Where one of the four participants was unable to attend sessions, the facilitator emailed her a Drop Box link to an audio recording which was made during the session with the permission of all attendees.

Some aspects of facilitation were specific to this mode of delivery. Prior to program commencement, all participants were contacted individually by a member of the VidKids™ team to ensure that internet connections, hardware and software were functional. The facilitator conducted two technical trials with the assistance of the VidKids™ Project team to test delivery style in this mode as well as considerations such as server performance and bandwidth demands. As with teleconferencing, technical issues (e.g., connection latency) which effect one participant, effect all. As such, it was important to have technical support and contingency plans on hand should issues arise.

During the first session, the facilitator provided participants with an orientation to their Lync screen including the functions of various buttons. The mute button was used by participants to minimise the impact of environmental noise, at their location, on discussion. Participants opted to view the group in gallery view which enabled them to see all participants at once. This was possible due to the small group size but speaker view, where only one participant is visible on screen at a time, requiring less band width, may have protected connection quality should the group have been larger. As DVD footage was not shown during the sessions due to bandwidth restrictions, participants were encouraged to view relevant segments at their leisure and this meant that participants were often at different points in the process of viewing and recalling strategies depicted on the DVD.

# Results: Video Conference Group

In week four of the program, parents were asked to complete an online survey identifying the value of Group Stepping Stones Triple P (SSTP) as delivered via video conference within the greater VidKids™ context. Three participants responded to the survey. They each reported that participating in SSTP enhanced their experience of video conferencing services, that they would like to continue with SSTP and that they would recommend SSTP to others. They also advised that the most beneficial features of the program were the information provided, the reassurance they felt and the ability to experience fellowship with other parents of children with vision impairment despite geographic and social isolation. Constructive feedback centred on difficulties with operating the technology as well as variable connection strength which resulted in variable video conference quality.

Parents in this program set various goals for their child’s behaviour: my child will do as mum/dad says; my child will manage his/her feelings using exercise, relaxation and other self-soothing strategies; my child will use a calm voice at all times; my child will take turns both in conversation and when using equipment; my child will comply with ground rules and accept pre-agreed consequences if she/he does not. Parents also set goals for their own behaviour including that they would engage in self-care activities every week and keep expectations realistic.

In week eight, during individual sessions, parents and the facilitator reviewed the level of attainment reached for each parent goal (i.e., achieved, partially achieved or not yet achieved) and parents identified which strategies they felt had been most effective toward this end. Parents also provided an outcome statement which encapsulated what they had gained from participating.

One parent expressed her outcomes in the following manner: (1) my child will calmly do what mum asks when she asks - achieved via clear calm instructions, rules, logical consequences, quiet time; (2) my child will express her feelings and needs using her indoor voice - partially achieved via directed discussion, clear calm instructions; (3) my child will use one of the agreed soothing strategies when she feels angry or upset – relevant behavioural Issues did not arise during the program.

This parent provided her outcome statement as follows: “Being able to connect with other parents with children with vision impairments was the best part for me. Other parents I usually spend time with don’t get it. They say they do but they don’t. There are other stresses associated with raising a child with a vision impairment that they don’t have. Talking with parents who are on the same playing field has been a huge benefit. The strategies were also of benefit. I’ve been reminding myself to stay calm and every week I’m holding her accountable. She’s gained clarity on what’s expected of her through me using stop and start instructions and consequences. Routines have also helped her to know what’s expected around the house. I’m much calmer. I step back and speak calmly instead of yelling. I also used to bite my nails and I’ve stopped because I’m not so anxious.”

# Results: Psychometrics for All Three Groups

The Stepping Stones Triple P (SSTP) Project team contacted parents to conduct assessments at two points – prior to and following their participation in the program. Additional assessment time points not included in this paper were 3 and 12 months post-participation. Pre- and post-participation assessment batteries were comprised of the Developmental Behaviour Checklist - Primary Carer - Short Form (DBC-P24), the Child Adjustment and Parent Efficacy Scale - Developmental Disability (CAPES-DD) and the Parent and Family Adjustment Scale (PAFAS). Paired-sample t-tests were used to ascertain the statistical significance of differences between pre and post participation scores for the entire cohort.

Analysis of Parent and Family Adjustment Scale (PAFAS) scores showed that parental consistency improved significantly from pre-participation (*M*=5.36, *SD*=1.86) to post-participation (*M*=3.64, *SD*=1.81, *t*(10)=3.85, *p*<.005). Coercive parenting strategies such as shouting, hitting and nagging reduced significantly from pre-participation (*M*=5.73, *SD*=3.00) to post-participation (*M*=3.18, *SD*=1.60, *t*(10)=3.99, *p*<.005) and were replaced by a non-significant upward trend in encouraging parenting strategies from pre-participation (*M*=2.45, *SD*=1.51) to post-participation (*M*=1.55, *SD*=2.02, *t*(10)=1.61, *p=ns*). Parents’ perceptions of their relationship with their children showed a non-significant trend toward improvement from pre-participation (*M*=1.80, *SD*=2.57) to post-participation (*M*=1.00, *SD*=1.89, *t*(9)=1.81, *p=ns*). Parent adjustment, which may also be characterised as enjoyment of life generally, improved, nearing significance from pre-participation (*M*=5.30, *SD*=2.31) to post-participation (*M*=3.90, *SD*=3.07, *t*(9)=1.87, *p=ns*). Non-significant trends were observed whereby participants were experiencing a greater degree of parental teamwork at pre-participation (*M*=6.78, *SD*=1.39) compared with post-participation (*M*=7.56, *SD*=1.01, *t*(8)=-1.11, *p=ns*) and more family cohesion at pre-participation (*M*=8.09, *SD*=2.07) compared with post-participation (*M*=9.91, *SD*=1.70, *t*(10)=-2.29, *p=ns*).

Analysis of scores on the Developmental Behaviour Checklist - Primary Carer - Short Form (DBC-P24) showed a non-significant decline in challenging child behaviours like lying and disobedience, kicking and hitting, disproportionate distress and over-excitement from pre-participation (*M*=13.60, *SD*=5.76) to post-participation (*M*=10.20, *SD*=8.60, *t*(9)=1.85, *p=ns*). Child Adjustment and Parent Efficacy Scale - Developmental Disability (CAPES-DD) results also showed a non-significant decline in challenging child behaviours like screaming and whining, rude noises and words, flapping and rocking, self-injury and separation anxiety from pre-participation (*M*=26.36, *SD*=8.10) to post-participation (*M*=22.09, *SD*=10.77, *t*(10)=1.80, *p=ns*). Finally, parent confidence increased significantly from pre-participation (*M*=124.45, *SD*=41.85) to post-participation (*M*=172.09, *SD*=21.97, *t*(10)=-3.07, *p*<.05).

Satisfaction ratings collected at post-participation showed that overall parents were highly satisfied with their Group Stepping Stones Triple P experience at Vision Australia. Parents were asked questions such as, ‘How would you rate the quality of the service you and your child received?’ (Mean score = 6.27, where a score of 5 = Good and a score of 7 = Excellent), ‘How satisfied were you with the amount of help you and your child received?’ (Mean score = 6.55, where a score of 5 = Satisfied and a score of 7 = Very Satisfied), ‘Has the program helped you to deal more effectively with your child's behaviour?’ (Mean score = 6.45, where a score of 5 = Somewhat and a score of 7 = A great deal), ‘In an overall sense, how satisfied are you with the program you and your child received?’ (Mean score = 6.36, where a score of 5 = Satisfied and a score of 7 = Very Satisfied).

# Discussion

Together with the anecdotal data and satisfaction ratings collected, the statistically significant results obtained on psychometrics clearly indicate that participating in Group Stepping Stones Triple P (SSTP) had appreciable benefits for families of children with vision impairments. Parents felt more confident, were better adjusted and enjoyed a stronger sense of connection with their children. Children were encouraged more and coerced less and were therefore able to sustain more constructive behaviours.

The sample size was small and this may have been why a number of observed trends failed to reach statistical significance. Of particular interest were the non-significant trends observed on the parental teamwork and family cohesion subscales of the Parent and Family Adjustment Scale (PAFAS). These results may have been due to a divergence in parenting styles brought about when one parent attended SSTP, subsequently modifying their parenting approach, while the other parent maintained the previous parenting approach which may not have been evidence-based. This divergence may have led to a breakdown in teamwork and family tension where the parent who was not involved in SSTP declined to adopt or support new parenting strategies.

It is therefore recommended that, wherever possible, both parents seek out SSTP training. Where this is not an option, prior to one parent commencing training, a plan could be established between parents whereby the participating parent shares his or her knowledge with the other parent, as training progresses. This may be facilitated by undertaking homework together (e.g., working through workbook exercises, reviewing DVD footage, rehearsing/role playing strategies prior to trialling them with children). It is possible that even though non-significant reductions in parenting teamwork and family cohesion were evident at conclusion of the program, 3 and 12 month follow-up testing may see this gap close. The non-attending parent may observe tangible gains in child behaviour as a result of the participating parent’s new strategies and this may influence the non-attending parent to follow suit.

Of the 25 families who enrolled in Group Stepping Stones Triple P across the three offerings, 16 families (i.e., 18 parents) completed the program. Drop out prior to commencement was associated with both unexpected (e.g., child illness) and expected (e.g., birth of a child) life events as well as direct barriers to participation (e.g., computer problems excluding participation in a video conference group). Once the program started, unexpected (e.g., changes to work commitments) and expected (e.g., scheduled medical treatments, travel) continued to be factors in drop out. One parent felt comfortable to decline on the basis that the program was not a good fit for him. Efforts were made during recruitment to inform parents about the commitment required for participation in the program however many of the expected life events and direct barriers which led to drop out were either not disclosed or not thoroughly addressed during the recruitment discussion. Amending recruitment to explicitly identify and problem solve around barriers to participation may reduce drop out for future programs.

Participant engagement in the three program offerings was maintained through a number of strategies. An emphasis in delivery of Group Stepping Stones Triple P is that all parenting strategies must be presented to participants in the order given. This was of particular concern with regard to absenteeism. Parents were asked to advise the facilitator if they were unable to attend a session. A distinguishing characteristic of the 18 completing parents was that they complied with this request which enabled an alternative learning strategy to be arranged. While few participants took the lead in arranging the alternative, they were for the most part receptive to either attending an individual catch up session or reviewing a recording of the missed group session.

Of these two strategies, which were trialled during different offerings, the recording was the most manageable in terms of efficient use of the facilitator’s time and flexible access for the participant. With recordings, consent and privacy for the recorded participants was addressed by ensuring that all participants were validated to either give or withhold permission for the recording to take place. Recording only went ahead with unanimous consent. The recording was only provided to participants who had already engaged to a significant level in the program. This meant that the recorded participants and the absent listeners knew each other reasonably well prior to information being shared in this fashion.

As confirmed by participants in verbal feedback summarised in the results section of this paper, engagement was also maintained by aspects of facilitation style, program structure and content and group dynamics.

With regard to delivery mode, there were benefits associated with teleconference and video conference that bare mention. Parents were able to participate from the comfort of their own home. This proved less disruption to family routines, negating the need for travel or child care. These modes were also more cost effective in terms of staffing as only one staff member, the accredited Stepping Stones Triple P practitioner, was required. In the case of the face to face offering, approximately five staff members and several volunteers needed to be rostered on to support each therapy session which ran parallel to parent training. Face to face training could have been offered without the attendant therapy session however it was judged an important factor in participant engagement, providing a therapeutically valuable alternative to individually arranged child care and an additional incentive to travel and rearrange other commitments around attendance.

The standard Group Stepping Stones Triple P was contextualised, to support families around vision impairment, in a number of ways. Training adhered to SSTP facilitator manual specifications in the presentation of strategies, adding tactile and audio cues where they were not already included and emphasising them where they were. For example, children with vision impairments do not have to see their parent looking at them to know he or she is giving attention to their positive behaviour. They might come to this conclusion just as easily when they hear him or her halt her progress through the house and pull up a chair to sit nearby for a moment. Activity schedules can be constructed using tactile pictures or objects to represent activities that might usually be represented by photographs or drawings, and if a child with vision impairment is not yet able to vocalise his or her needs, to replace ineffective ways of communicating them, he/she might be taught adapted signing (Chen, Downing, & Rodriguez-Gil, N.D.).

Outside of the facilitator’s preparation and delivery, participants governed the degree to which their program focused on vision impairment through their initial goal setting and their contributions to group discussions. The self-regulatory framework promoted during the program enabled participants to draw upon their pre-existing knowledge of visual alternatives that work for their children to tailor the strategies they elected to trial. Participants were also able to ask the group to brainstorm vision impairment friendly solutions and modifications and this was particularly effective and affirming given that raising a child with vision impairment was their common bond.

# Further Information

For information about Triple P professional training programs visit the Triple P website www.triplep.net.

For information about the Stepping Stones Triple P project visit http://www.triplep-steppingstones.net/au-en/home/

For information about VidKids™ visit: http://www.vidkids.org/

For enquiries regarding this paper and future Group Stepping Stones Triple P programs being run by Vision Australia contact Courtney McKee on 07 3727 2275 or at courtney.mckee@visionaustralia.org or for general information about Vision Australia services visit: <http://www.visionaustralia.org/>

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