Promoting Optimal Parenting and Children's Mental Health: A Preliminary Evaluation of the How-to Parenting Program

Mireille Joussemet, Geneviève A. Mageau & Richard Koestner

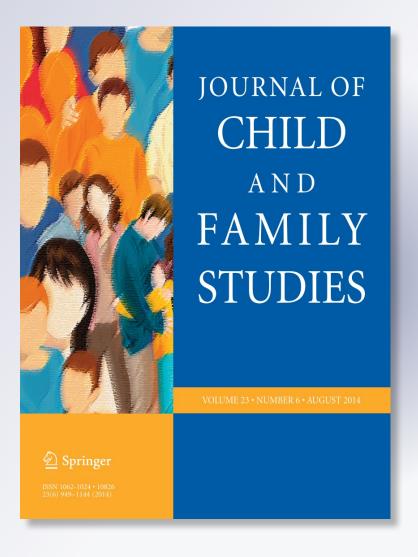Springer

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Promoting Optimal Parenting and Children's Mental Health: A Preliminary Evaluation of the How-to Parenting Program

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Abstract Parenting quality is widely accepted as a primary predictor of children's mental health. The present study examined the effectiveness of a parenting program in fostering optimal parenting and child mental health. The selected program was *How to talk so kids will listen & listen so kids will talk* (How-to Parenting Program). This program was selected because its content corresponds closely to what the parenting style literature suggests is optimal parenting (i.e., includes structure, affiliation and autonomy support). Eleven groups of six to twelve parents were conducted in 7 local grade schools. The program, offered by two trained leaders, consisted of eight weekly sessions and taught a total of 30 skills. A total of 82 parents completed questionnaires both prior to and after the program. Participants' children between eight and 12 years old ($N = 44$) completed questionnaires at school, at both assessment points. Repeated measures ANOVAs using parent reports indicated that structure, affiliation and autonomy support were increased after the program, compared to baseline. The level of child internalizing and externalizing problems also decreased significantly. Importantly, children reports confirmed that parental autonomy support increased from pre to post-test and child-reported well-being improved as well. The preliminary evidence from this pre-test versus post-test repeated measures design suggests that the How-to Parenting Program is effective in improving parenting style and in promoting children's mental health and that future evaluation research examining the potential of this program is warranted.

Introduction

Children's optimal adjustment and well-being are a primary aspiration for parents, who are also uniquely positioned to foster their children's mental health. Indeed, among environmental factors, parenting quality is considered a critical force in child development (Masten and Shaffer 2006). Sadly, prevalence reports of mental disorders suggest that 10 % of youth suffer from a serious mental health problem and another 10 % have a mild to moderate problem (APA 2007; Breton et al. 1999; Egger and Angold 2006). Recent longitudinal studies further show that adult mental disorders, rather than "appearing" in adulthood, often begin early in life (e.g., Costello et al. 2003; Maughan and Rutter 2008; Tremblay et al. 2005).

In childhood, psychological problems are categorized in two broad categories: internalizing and externalizing problems (Achenbach 1998; Eisenberg et al. 2000). Children with externalizing problems (e.g., opposition, aggression, delinquency) display *under*controlled behaviors (Cole et al. 1996; Eisenberg et al. 2000; Hinshaw 1997), lack self-regulation, and direct their negative emotions against others (Eisenberg et al. 2000). In contrast, children with internalizing problems (e.g., anxiety, depression) display *over*controlled behaviors (Cole et al. 1996; Eisenberg et al. 2001; Ialongo et al. 1996), have overly rigid self-regulation, and direct their negative emotions toward themselves (Roeser et al. 1998). In addition to psychopathology, it is

M. Joussemet (✉) · G. A. Mageau
Department of Psychology, Université de Montréal, C.P. 6128,
Succursale Centre-Ville, Montreal, QC H3C 3J7, Canada
e-mail: m.joussemet@umontreal.ca

R. Koestner
Department of Psychology, McGill University, Montreal,
QC, Canada

important to consider children's well-being to gain a complete account of children's mental health (Cowen 1994; Cowen et al. 1996; Seligman and Csikszentmihalyi 2000). Examples of positive indicators of mental health include children's subjective experience of positive affect, life satisfaction, and self-esteem.

Among the contextual determinants of child mental health, parenting quality is identified as a primary predictor (Masten and Shaffer 2006). For example, a recent study revealed that the magnitude of the impact of daycare quality on child adjustment was much smaller than the impact of responsive, sensitive parenting (NICHD Early Child Care Research Network 2006). Despite the vast influence of parenting on children's optimal development and mental health, evidence-based parenting education is not commonly offered to the general population. Most evaluated parenting programs typically target children who are already showing psychological problems (mostly externalizing; Thomas and Zimmer-Gembeck 2007). In addition, available parenting resources (e.g., diverse parenting books, magazines and television programs) are often contradictory, abstract, and rarely tap all three important dimensions of optimal parenting (i.e., structure, affiliation and autonomy support).

Given the robust linkage between parenting quality and children's mental health, offering and evaluating parenting education that fosters optimal parenting in the general population is essential. Such primary or universal prevention involves promoting skills and well-being (Albee 1986; Cowen 1994; Weisz et al. 2005) rather than targeting problematic behaviors. We evaluate the parenting program called "*How to talk so kids will listen & listen so kids will ta*lk" (Faber and Mazlish 1980, 2000, 2002, 2010; referred to as the How-to Parenting Program herein), dedicated to improving parenting style by modifying the way parents communicate with their children. This program was developed by Faber and Mazlish (1974, 1980, 2000, 2010) and is based on Ginott's work (1959, 1961, 1965), a founder of the communicative approach to parenting programs (Krebs 1986). Though this material is widespread, it has received little empirical attention thus far. Only one study evaluated this parenting program and revealed that it was associated with better parental self-esteem and coping (Fetsch and Gebeke 1995) but this study had important methodological limitations and did not assess child adjustment. Our goal was to evaluate the potential of this parenting program in fostering optimal parenting and promoting children's mental health.

We selected the How-to Parenting Program because it advocates authoritative parenting, which has been shown to be positively associated with child mental health (Aunola and Nurmi 2005; Steinberg 2001; Wood et al. 2003). Indeed, adopting a typological approach, early socialization research

showed that *authoritative* parenting was associated with better child outcomes, compared to authoritarian or permissive parenting (Baumrind 1966, 1971; Maccoby 1992; Maccoby and Martin 1983), and this finding has been replicated across various samples (Dwairy et al. 2010; Lohaus et al. 2009; Pong et al. 2010). Recently, research untangled the different parenting dimensions underlying the optimal authoritative style and consistently points to the same three key positive dimensions: affiliation, structure, and autonomy support (Aunola and Nurmi 2005; Barber and Olsen 1997; Gray and Steinberg 1999; Grolnick and Ryan 1989; Schaefer 1965). *Affiliation* (also called acceptance, warmth, or nurturance) refers to a caring interpersonal involvement (Ainsworth et al. 1978; Schaefer 1959). The opposite of this dimension is rejection, coldness, or even harshness. *Structure* (also called behavioral control, regulation, or limit-setting) refers to the provision of clear and consistent rules, expectations and consequences (Barber and Olsen 1997; Grolnick and Pomerantz 2009; Patterson and Stouthamer-Loeber 1984). Its opposite is permissiveness or laisser-faire. *Autonomy support* (also called autonomy granting, psychological autonomy, or democratic parenting) refers to empathy and respect for children's own ideas, feelings, and initiatives (Grolnick et al. 1997; Ryan et al. 2006). The opposite of autonomy support is psychological control (Barber 1996), or controlling parenting, characterized by pressure, intrusion, and power assertion, which can be either overt (e.g., coercive threats) or covert (e.g., conditional love, invalidation, shaming; Soenens and Vansteenkiste 2010).

To support a child's autonomy, one needs to consider him/her as a distinct individual, with his/her unique needs and feelings (Deci, and Ryan 1985, 2000; Grolnick and Ryan 1989). In the socialization context, the goal for parents is to help children feel a sense of agency and ownership of their behaviors, even though some of the socially sanctioned behaviors may not be enjoyable. In empirical, motivation research, autonomy support has been operationalized as (1) acknowledging the child's feelings and perspective, (2) offering meaningful rationales for rules and requests, and (3) providing choice and opportunities for initiative taking (Koestner et al. 1984). This definition, used in the host of studies demonstrating the benefits of parental autonomy support on children (Joussemet et al. 2008), was based on Ginott's writings (1959, 1961, 1965).

Given that Ginott's work (1959, 1961, 1965) informed both the operational definition of autonomy support (Koestner et al. 1984) and the specific parenting skills included in the How-to Parenting Program, it is not surprising that the How-to Parenting Program perfectly captures what it means to *provide autonomy support*, an important criterion in selecting the program. Session 1 covers empathy, a key component of autonomy support. Parents are also taught how to encourage their children's initiatives (session 4) and how to help them

achieve their full potential by avoiding confining them in certain roles (session 6). *Structure* is also an integral part of the How-to Parenting Program, which teaches parents how to provide structure effectively and consistently. Parents learn how to communicate expectations (session 2), give feedback (session 4), follow through with logical consequences (session 3) and use problem solving for recurrent problems (session 3). *Affiliation* is all-pervading (sessions 1–6), as promoting a positive parent–child relationship is at the heart of this program. The curriculum does not pertain to the expression of love, or how to express affection. Rather, parents learn how to communicate with their children in a way that helps children feel loved and accepted for who they are. By fostering all key elements of optimal parenting, the How-to program constitutes a promising intervention to improve parenting and child mental health in the general population (universal, primary level of mental health prevention).

The affiliation and structure dimensions are well-established determinants of children's mental health. First, a warm parent–child bond is generally found to facilitate adjustment (Barber and Olsen 1997; Hart et al. 2003) and has been associated with diverse socio-emotional strengths (e.g., prosocial behaviors). Hostile and rejecting parenting, by contrast, has been linked to externalizing behaviors (Baumrind 1966; MacKinnon-Lewis et al. 1994; Scaramella et al. 2008). Second, while the provision of structure has consistently been linked to lower levels of externalizing problems (Barber 1996; Eccles et al. 1997; Pettit et al. 2001), permissiveness is positively related to impulsive, rebellious and dependent behaviors (Baumrind 1971; Gray and Steinberg 1999; Veronneau and Dishion 2010).

In the child development literature, autonomy support has received relatively less attention compared to structure and affiliation. Though developmental researchers have pointed to the detrimental effects of controlling parenting (Becker 1964; Schaefer 1965), they have paid relatively little attention to autonomy support, the opposite (and positive) pole of this dimension. One reason may be the common misconception of autonomy, where autonomy is often confused with independence (Ryan et al. 2006; Silk et al. 2003). Motivation research anchored in self-determination theory (SDT; Deci and Ryan 1985, 2000; Ryan and Deci 2000), a prominent theory of human motivation, helped filled this gap by providing empirical evidence on the benefits of parental autonomy support.

In a nutshell, Deci and Ryan stipulate that human beings have three basic psychological needs, relatedness, competence and autonomy, whose fulfillment promotes optimal functioning and well-being. Autonomy refers to the experience of initiating and/or regulating behaviors from one's sense of self. This conceptualization draws from the construct of internal perceived locus of causality (Heider 1958). When regulating autonomously, individuals feel volitional and

authentic (Ryan and Deci 2004). Thus, autonomy does not refer to independence: whereas children become increasingly independent or self-reliant with age, they need autonomy (or self-determination) at all ages (Ryan et al. 2006; Soenens and Vansteenkiste 2010). Over more than three decades, research conducted within the SDT framework across various settings has demonstrated that when authority figures support subordinates' (e.g., students, employees, patients) basic psychological needs, positive consequences ensue. As regards to the family context, these three needs map onto the three key parenting dimensions (Grolnick and Ryan 1989). Together, parental affiliation, structure and autonomy support foster children's sense of relatedness, competence and autonomy, paving the way for optimal mental health (Grolnick et al. 1997; Grolnick and Ryan 1989; Ryan et al. 2006).

In line with the empirical classification of child psychopathology, SDT posits that when children's basic need for autonomy is thwarted, it leads children either to (1) internalize requests and self-regulate, but in a rigid and pressured way (internalizing problems; Deci and Flaste 1995; Ryan et al. 2006) or (2) reject parental requests and fail to self-regulate (externalizing problems). Numerous studies have shown that controlling parenting is a significant predictor of internalizing problems (Barber et al. 1994; Fauber et al. 1990). Specifically, psychological control has long been recognized as a significant determinant of childhood anxiety (Ballash et al. 2006; Rapee 1997; Wood et al. 2003) and linkages have also been found with depression (Barber 1996; McCranie and Bass 1984; Miller et al. 1990; Soenens et al. 2008a, b), eating disorders (Soenens et al. 2008c), and lower self-esteem (Conger et al. 1997; Garber et al. 1997; Silk et al. 2003). In addition, an emerging literature suggests that autonomy thwarting is also a risk factor for externalizing problems (Galambos et al. 2003; Schaefer 1965). Controlling parenting is linked to children's opposition (Bronstein 1994), emotional self-regulation problems (Fabes et al. 2001) and antisocial behaviors (Barber 1996; Conger et al. 1997; Herman et al. 1997; Joussemet et al. 2008; Prinzie et al. 2010).

In addition to decreasing psychopathology, abundant research has also shown that autonomy support within the parent–child relationship fosters positive indicators of mental health (Joussemet et al. 2008). In particular, it is associated with socio-emotional strengths such as optimal self-regulation (Grolnick 2003; Guay et al. 2008; Ryan and Connell 1989), positive classroom adjustment (Grolnick et al. 1991; Joussemet et al. 2005; Soenens and Vansteenkiste 2005), social adjustment (Bronstein et al. 1996; Gagne 2003; Joussemet et al. 2005; Soenens and Vansteenkiste 2005) and higher well-being (Downie et al. 2007). Experimental studies also provide evidence for the causal role of autonomy support in fostering positive indicators of mental health. For example, autonomy-supportive (vs.

controlling) limit setting led to better internalization of limits, motivation and well-being among young children (Koestner et al. 1984). Similarly, when introducing a tedious task to children, autonomy support improved well-being and motivation compared to standard contexts (Joussemet et al. 2004), even in a clinical population (Savard et al. 2013). Benefits have also been found in applied studies in school and medical settings (e.g., Reeve 1998; Williams 2002).
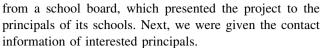
In sum, whereas controlling parenting acts as a generalized risk factor related to externalizing and internalizing psychological problems, autonomy support promotes children's socio-emotional strengths and well-being. Importantly, these effects can also be observed when the effects of affiliation and structure are controlled (Gray and Steinberg 1999; Mageau et al. 2012; Soenens et al. 2008a). It thus seems important not only to warn parents against the detrimental effects of controlling parenting, but also to provide education about *how* they can support their children's autonomy, in addition to providing the needed structure and affiliation (Grolnick et al. 1997; Jang et al. 2010; Ryan et al. 2006).

While research has identified three key dimensions of optimal parenting, providing them is not necessarily natural or easy for parents. On the contrary, it is challenging to (1) require children to adopt socially desirable behaviors (2) without thwarting their need for self-determination, (3) while preserving a positive parent–child relationship. Results from a recent meta-analysis provide support for the adoption of a program that encompasses all of the three essential dimensions of optimal parenting (Kaminski et al. 2008). Indeed, Kaminski and colleagues found that the components of parenting programs that were predictive of larger effect sizes pertained to autonomy support, affiliation and structure (i.e., emotional/empathic communication, positive interactions, and consistent responding). We hypothesized that the How-to Parenting Program fosters all three key elements of optimal parenting and that offering this program to the general population would promote children's mental health. Specifically, we predicted that compared to baseline, parental affiliation, structure and autonomy support would be increased after parents participated in the How-to Parenting Program. We also expected that following parental participation to the program, children's mental health problems (internalizing and externalizing difficulties) would decrease while their well-being would increase.

Method

Recruitment and Informed Consent

The study was conducted in the Montreal area (Quebec, Canada). After gaining permission from the authors of the program and ethical approval, permission was obtained from a school board, which presented the project to the principals of its schools. Next, we were given the contact information of interested principals.

Participants were recruited in a total of seven grade schools, over 3 years. After gaining principals' permission, recruitment began by sending out an information sheet and brochure to each family, via children's school bags. The recruitment material explained that the parenting program aimed to foster positive parent–child communication and focused on the program's themes (see chapter titles, Table 1). There was no mention of the study's potential effects on parenting dimensions or on child mental health to keep parents (and their children) as blind as possible to the research hypotheses. Interested parents returned a coupon with their contact information, allowing the research coordinator to give them more information about the program's format by phone and send them consent forms by mail. Consent forms described parents and children's participation (for children of age 8 or more). Parents were asked to fill-out separate sections, making their children's potential participation independent from their own (i.e., parents could participate without consenting to their child's participation)

Participants

A total of 100 parents from 93 different families participated in the study. Parenting groups comprised six to twelve parents. Usually only one parent per family attended the program, except for five couples who participated together. In two other families, both parents participated but not in the same group (e.g., a mother enrolled in the spring, after her spouse had participated during the previous fall). The data from only one parent per family was included in the statistical analyses ($N = 93$ at T1). When both parents attended but one after the other, the data of the first participant was included in the analyses. When couples attended the program together, data from mothers were included in the analyses. A total of 82 parents completed questionnaires at both assessment points (attrition of 12 %). When parents had more than one child attending grade school, they were asked to "target" one of their children for the study. Parents were asked: "If you have more than one child at school, please write down the name of the child you were thinking of when signing up for this program." This allowed parents to refer to the same targeted child whenever they had to answer questions about their child.

A total of 56 children of participating parents were old enough to fill-out questionnaires. When there was more than one participating child per family, data from the non-targeted child was removed. From the resulting sample

($N = 47$), 44 children completed the questionnaires at both assessment points (attrition of 6 %).

Socio-Demographic Information

Parental age ranged from 26 to 56 years old (mean age = 39.3 years old) while the mean age of children was 9.3 years old. Mothers composed most of the parent sample (80.6 %). The number of children in families ranged between one and four. Approximately half of the children were boys (53.2 %), and most (61.8 %) were first-borns. Only 17.2 % of parents reported being single parents.

While most parents reported being of French-Canadian origin, 15.3 % reported originating from another ethnical background (i.e., Hispanic, 7.5 %; Haitian, 2.4 %; French, 2.4 %; English, 1.2 %; and Arabic, 1,2 %). Most of the sample (75.3 %) reported that French (the language used in the study) was their mother tongue. The educational level attained by participants was high, as all reported having completed High School and only 27 % did not complete a university level. Finally, approximately half of the sample of parents reported having a familial income above 75 000$, with 16.5 % earning less than 30 000$ per year.

Parenting Program Overview

The How-to Parenting Program covers all three essential dimensions of an optimal parenting style. It is a manual-based program that offers concrete, specific, and readily applicable skills.

Skills

A total of 30 skills are taught in a user-friendly way, with "comic strips" accompanying each skill. Through these skills, the three key dimensions of optimal parenting are addressed across common situations in familial daily living. Table 1 presents an overview of the program's content and exercises.

The How-to Parenting Program content centers on empathy, which is the cornerstone of autonomy support. The first session teaches how to help children with their difficult/painful feelings. Parents learn how to listen with full attention (e.g., looking at the child) and reflect the child's emotion (e.g., name the feeling). A key distinction is made between children's emotions versus behaviors, as while all feelings can be accepted, not all behaviors should be. The next five sessions build on the empathic communication and target various domains, such as facilitating children's cooperation, reacting to their misdeeds, how to praise children in a non-controlling way and promoting their autonomy. The sixth session addresses how to free children from certain roles they may have (e.g., "the

complainer", the "irresponsible"). A common feature throughout the various communication skills is the impersonal style. Indeed, whether praise is given or a problem is described, parents are asked to focus on what they see, refraining from making allusions to the child's worth (e.g., "I see books back on their shelves and toys in their box" versus "*You* are such a good girl"; "There are shoes in the entrance, there is no place to walk" versus "*You* are so careless; I want *you* to pick up your shoes"; It's time for tooth brushing" versus "*You* have to brush *your* teeth now").

Format

Sessions were led by teams of 2 trained group leaders. While the first and last session lasted 1.5 h (after data collection), sessions 2–7 lasted 2.5 h. The meetings took place one evening per week, from 7 p.m. to 9:30 p.m., at children's grade schools.

Session 1 The first session's goal is to establish rapport between participants and group leaders, present the program's format (outline of a typical session) and give an overview of the essential elements of the program. Parents' needs and expectations are addressed and efforts are made to link them with key elements of the program, as addressing parents' motivation is a key determinant of successful behavioral change (Olds et al. 2007).

Sessions 2–7 Every session begins with a discussion pertaining to the previous week's homework (starting on session 3). Time is devoted to describing what new skills parents tried at home. Parents describe a situation, what they said/did, their subjective experience and what happened next (e.g., child's reaction). Next, the topic of the day is introduced. Every new topic begins with a perspective taking exercise. Indeed, participating parents are placed in "a child's shoes" by hearing examples of what children typically hear. Parents are encouraged to describe how it feels, and reactions are listed on a blackboard or a flip chart. Alternative parenting and communication skills are then introduced. Skills are presented, read out loud by volunteering participants and leaders. Comic strips illustrate each skill. A total of four to six new skills are taught per session (total of 30 skills; see Table 1). Finally, parents get to practice each skill by taking part in various exercises. Most are role playing activities, conducted in pairs. Parents are often asked to describe how they feel in a scenario, while playing the role of a child and/or a parent. The teams then share their reactions and a structured discussion addresses participants' reactions and questions. Before leaving, the homework for the week is presented. After

Table 1 Skills taught in the How-to Parenting Program

Session/chapter	Title	List of skills	Example
Session 1	Introduction		
Session 2/chapter 1	When child feels distressed	Listen with full attention	Look at the child
		Acknowledge (word, sound)	"Hm"; "Oh…"
		Name the feeling	"That can feel frustrating"
		Give wish in fantasy	"I wish a snack could appear *right now*!"
Session 3/chapter 2	When child doesn't cooperate	Describe the problem	"There are toys all over the couch"
		Give information	"We can't sit when toys are on the couch"
		Remind it with one word;	"The books"
		Express own feelings *without attacking character*	"I feel irritated when I can't sit on the couch"
		Write a note	"Please bring us back in our box!" Your toys
Session 4/chapter 3	When child misbehaves	Express own feelings *without attacking character*	"I don't like to see markers on the couch!"
		State expectation	"I expect that drawing takes place at the table"
		Show how to make amends	"This couch needs to be cleaned. Here's a sponge"
		Give a choice	"You can either play with the ball outside or play inside but with something else"
		Take action	After giving the choice (see above), take away ball
		Problem-solve	Feelings: acknowledge child's; express own
			Ideas: brainstorm (write own and child's)
			Choose idea, plan, and implement it
Session 5/chapter 4	When child could decide by himself/herself	Give choices	"Do you want the blue or the red one?"
		Respect struggle	"Tying shoelaces can be tricky, sometimes it helps to begin with a big loop"
		Limit questions	Child can talk about his/her day when wants
		Don't rush to answer questions	"Why do *you* think the sky is blue?"
		Promote outside resources	"I wonder what the dentist would tell us"
		Don't take away hope	"Astronaut! what an interesting career"
Session 6/chapter 5	When child does well	Describe child's behavior or accomplishment	"I see books on the shelf!"
		Describe own feelings	"It feels good to sit on the couch that easily!"
		Summarize behavior with a word	"That's what I call *organization*"
Session 7/chapter 6	When child is stuck in a role	Notice counter role behavior	"You thought of looking in the lost/found box"
		Facilitate new situations	"Here is 2$ to go buy milk"
		Let overhear positive comments	"Sam reminded me to …"
		Model appropriate behavior	Adopt the appropriate behavior
		Recall past counter role behavior	"I remember the time you…"
		If child returns to old role, state feelings/expectations	"I expect that my books be returned when they are no longer needed"
Session 8	Conclusion		

having practiced skills in the group, parents are asked to try their new skills at home, with their own children. Leaders stress the importance of trying the skills and explain that time will be devoted at the beginning of the next session for sharing their experiences (whether it was positive or not). By sharing their stories, parents become models for each other, showing how the parenting skills can be implemented.

Session 8 During the last session, a structured discussion is conducted in order to review and integrate the parenting skills. Participants are offered a colored poster summarizing the 30 parenting skills learned (created for the present research project). Next, group leaders ask parents to provide an example of challenging situations with children, so that all participants can generate ideas, based on the program's skills.

Group Leaders

A total of fifteen group leaders received a 3-days training, provided by 2 mental health professionals who have had a long experience offering the How-to Parenting Program. Most (8) leaders were graduate students in psychology. Other leaders included the main investigators, a licensed psychologist, two experienced leaders, and two mothers. Each led between one and four groups.

During the training, future leaders were exposed to all of the programs' content. Exercises were presented, practiced and discussed. The approach favored by the program's authors (Faber and Mazlish 2010) was also discussed: not presenting leaders as experts but suggesting parents to try the skills themselves to test if they are helpful or not. Empathy is emphasized, as well as impersonal feedback and structure. During training, leaders experienced all exercises as if they were participating parents. Tips about handling more delicate situations were also taught (e.g., skepticism, misunderstanding). The main investigators also developed a guide for trained leaders to prepare each session. This guide lists tips for potential problems and was updated frequently, as new questions arose during supervision meetings. Supervision meetings took place before and after each parenting group, to promote intervention integrity. Each team was composed of a more experienced leader with a less experienced one. After each session, both leaders of each team had a debriefing meeting, to ensure that less experienced leaders received some supervision after each session and that any problem/question could be addressed as needed.

Content Coverage and Exposure

After each session, leaders rated the extent to which the material was covered, in percentage. They also took attendance, to document participating parents' exposure to the program. An intent-to-treat approach was used, as all participants were included in analyses, regardless of the amount of sessions attended. On average, 93 % of the program's content and activities was covered. Attendance was good, as 41 % of parents were present at all sessions and 44 % missed only 1 or 2 sessions (15 % missed 3–5 sessions).

Data Collection

Parents

The first questionnaire parents filled-out assessed their familial and socio-demographic situation as well as all the other parenting and mental health information that was re-assessed after the parenting group. The pre-test questionnaire was filled-out in group, during the first part of the first meeting. Research assistants were in charge of administering the questionnaires, answering questions and collecting envelopes. The group leaders were not present during data collection; they arrived and introduced themselves once research assistants had left.

Children

Before the parenting group began, research assistants went in schools to administer child reports. Inclusion criteria were: having a participating parent, being 8 years old or older and parental consent. After finding an appropriate time with the child's teacher, the research assistant introduced herself to the child, told him/her that their parent participated in a study, and asked him/her whether s/he agreed to participate (verbal consent). There was no mention of the parenting program. Next, she accompanied each child to an available room (e.g., library, empty classroom) and administered the pre-test questionnaire. The research assistant explained to the child that she could help him/her to read questions and/or explain some words. Children answered questions about their parents' parenting style and their own well-being.

Measures

Parent Reports

Socio-Demographic Information Basic demographic questions were included to determine participating parents' age, gender, first language, ethnic group, education, familial income, familial status, and number of children. Parents also indicated their children's age, gender and birth order. Socio-demographic variables were assessed in the pre-test questionnaire only. All other constructs were assessed both in the pre-test (T1) and post-test (T2).

Structure Nine items of the Laxness subscale of the Parenting Scale (Arnold et al. 1993) were translated in French and used to assess the extent to which parents are permissive, give in, and allow rules to go unenforced, as contrasted with being in control, setting limits, and enforcing rules. Parents were asked to rate how they generally behave toward their children, using 9-point bipolar items, where one pole is anchored with a structured stance and the other with a permissive, laxness stance (e.g., I'm the kind of parent that … "set limits on what my child is allowed to do" versus "let my child do whatever he/she wants"). This subscale has been positively associated with observational measures of laxness ($r = .61$) and shown to differentiate mothers who visited a clinic because of difficulties in handling their children from mothers who did
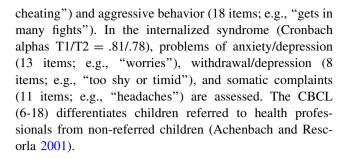
not (Arnold et al. 1993). The internal consistency of this French version was good (Cronbach alphas T1/T2 = .75/.72).

Affiliation Ten items of the Care subscale of the Parental Bonding Instrument (Parker et al. 1979) were translated in French and used to measure parents' care and involvement, contrasted with indifference and rejection. Parents were asked to rate their behaviors toward their child (e.g., "I often smile at my child") on a 7-point scale ranging from 1 (*almost never*) to 7 (*almost always*). This subscale has been positively related to an observational measure of parental care (Parker et al. 1979). The internal consistency of our French version was good (Cronbach alphas T1/T2 = .79/.77).

Autonomy Support (Attitude) On the Parental Attitude Scale (Gurland and Grolnick 2005), parents rate their attitude (10 items) toward autonomy support (e.g., "I encourage my child to make his/her own decisions") and psychological control (e.g., "Children should always do what their parents say, no matter what") on a 7-point scale, ranging from 1 (*do not agree at all*) to 7 (*very strongly agree*). This scale has predictive validity and has been associated with a behavioral measure of autonomy-supportive versus controlling behaviors (Gurland and Grolnick 2005). In the present study, the French version, obtained from a back to back translation, showed good internal consistency (Cronbach alphas T1/T2 = .76/.73).

Autonomy-Supportive Parenting Skills The Autonomy-supportive Parenting Skill Scale was designed for the purpose of this study. Some autonomy-supportive skills taught in the How-to Parenting Program are contrasted with various controlling strategies parents typically use. Parents rate how they generally communicate with their child (12 items) using 9-point bipolar items, where one pole is anchored with an autonomy-supportive comment and the other with a controlling reaction (e.g., "Milk turns bad when left on the table" versus "You left the milk on the table again; Put it in the refrigerator right now"). The internal consistency was acceptable at T1 and good at T2 (Cronbach alphas T1/T2 = .64/.81).

Child Mental Health Problems Internalized and externalized mental health problems were measured by the Child Behavior Checklist (CBCL, 6-18; Achenbach and Rescorla 2001), one of the most widely used validated instruments to assess children's mental health. Parents rate their children's behaviors, using a 3-point scale ranging from 0 (*do not apply*) to 2 (*always or often true*). The externalized syndrome (Cronbach alphas T1/T2 = .88/.85) reflects rule-breaking behavior (17 items; e.g., "lying or

cheating") and aggressive behavior (18 items; e.g., "gets in many fights"). In the internalized syndrome (Cronbach alphas T1/T2 = .81/.78), problems of anxiety/depression (13 items; e.g., "worries"), withdrawal/depression (8 items; e.g., "too shy or timid"), and somatic complaints (11 items; e.g., "headaches") are assessed. The CBCL (6-18) differentiates children referred to health professionals from non-referred children (Achenbach and Rescorla 2001).

Child Reports

The following constructs in the child reports were assessed both in the pre-test (T1) and the post-test (T2). Their assessment targeted how children felt during the past 2 weeks at T1, and during the past few days at T2. All response scales presented to children were 4-point scales.

Perceived Parental Structure Six items of the Laxness subscale of the Parenting Scale (see above; Arnold et al. 1993) were adapted to measure children's perception of the extent to which their participating parent is permissive or setting limits (e.g., "My mother set limits on what I am allowed to do"; "My mother lets me do whatever I want"). Children were asked to rate how their parent behave in general, on a scale ranging from 1 (*almost never true for my mother*) to 4 (*almost always true for my mother*). The internal consistency was low for this scale (Cronbach alphas T1/T2 = .57/.56).

Perceived Parental Affiliation The Care subscale of the Parental Bonding Instrument (see above; Parker et al. 1979) was adapted to measure children's perception of their participating parent's care and involvement, contrasted with indifference and rejection. Children were asked to rate the behaviors of their parent toward them (e.g., "My mother often smiles at me") on a 4-point scale ranging from 1 (*almost never true for my mother*) to 4 (*almost always true for my mother*). The internal consistency was good (Cronbach alphas T1/T2 = .76/.70).

Perceived Parental Autonomy Support An adapted version of the Perceived Parental Autonomy Support Scale (French version; Mageau et al. 2012) was used to assess children's perception of the frequency (*almost never* to *almost always*) with which their parent supports their autonomy (9 items; e.g., "My mother can put herself in my shoes and understand how I feel") and uses controlling strategies (9 reversed items; e.g., "My mother makes me feel guilty to make me do what she wants"). This scale has a sound factor structure, demonstrates convergent validity, and predicts psychological adjustment. In the present study

the internal consistency was good (Cronbach alphas T1/T2 = .70/.78).

Positive Indicators of Mental Health Well-being was assessed by using measures of positive affect, life satisfaction and self-esteem. In order to assess positive affect among French-speaking children, a simple subscale (Savard et al. 2013) was used, based on the PANAS (Watson et al. 1988) and the PANAS for Children (Laurent et al. 1999). This Positive Affect subscale includes 10 positive emotion items, chosen for their simplicity (e.g., "happy"). The instructions targeted how children felt, on a scale ranging from 1 (*almost never*) to 4 (*almost always*). This French subscale showed good internal consistency in the present study (Cronbach alphas T1/T2 = .86/.88). Children also completed four items adapted from the French version of the Satisfaction with Life Scale (Blais et al. 1989; Diener et al. 1985; e.g., "I'm satisfied with my life"). In the present study, the adapted scale had a good internal consistency (Cronbach alphas T1/T2 = .89/.93). Finally, children filled-out five adapted items from the French version of Rosenberg's Self-Esteem Scale (Rosenberg 1989; Vallières and Vallerand 1990), one of the most widely-used measure to assess global self-esteem with children. It assesses the extent to which children have a positive attitude toward themselves (e.g., "I think that I have many nice qualities"), has a unidimensional factor structure and shows good construct validity, temporal stability and convergent validity (Vallières and Vallerand 1990). The scale had a good internal consistency (Cronbach alphas T1/T2 = .71/.83).

A global index of child well-being was calculated by taking the mean of positive affect, life satisfaction and self-esteem. The creation of a global index was used because of the high positive correlation between these three measures (r = .41 to .70 at T1; r = .38 to .68 at T2), and because our predictions were framed in terms of general well-being. The alpha of the global well-being index was high (Cronbach alphas T1/T2 = .90/.91).

Results

Preliminary Analyses

First, correlational analyses were conducted to explore whether parental attendance was related to socio-demographic variables. These analyses revealed that attendance (number of sessions) was positively correlated with parental age (r = .44, p < .001) and familial income (r = .36, p = .005).

Descriptives statistics for the study's main variables can be found in Table 2 while Table 3 presents the correlations

between them. Regarding the three parenting dimensions, assessments of autonomy support were positively related to affiliation at both time points, within child reports and parent reports. Parent reports of structure were positively related to autonomy support at both time points and to affiliation at T2. Interestingly, the link between perceived structure and affiliation changed between T1 and T2 for children. Prior to the program, child reports of structure tended to relate negatively to affiliation (p = .053). In contrast, the correlation between perceived structure and affiliation was positive after the program. Finally, two unexpected correlations emerged, as parents' self-reports of an autonomy-supportive attitude was negatively related to children reports of well-being (at T1) and to children's perception of structure (at T2).

Regarding child mental health, many significant correlations were found. Within child reports, well-being at post-test was positively related to their perception of structure, affiliation, and autonomy support. Within parent reports, child externalizing problems were negatively related to affiliation (T1 and T2) and to autonomy support (T2). Internalizing problems were also negatively related to affiliation at post-test and this finding was also found when using child-reported affiliation. Finally, child reports of well-being were significantly negatively related to parent reports of externalizing and internalizing problems at post-test, indicating better agreement between parents and children.

Table 2 Variables' descriptive statistics

Variable	Theoretical range	Mean		Standard Deviation	
		T1	T2	T1	T2
Parent reports					
Parenting					
Structure	1–9	6.79	7.03	1.01	0.86
Affiliation	1–7	5.92	6.06	0.60	0.56
AS (skills)	1–9	5.02	6.79	1.02	1.04
AS (attitude)	1–7	5.42	5.82	0.84	0.72
Child mental health problems					
Externalizing	0–2	0.30	0.19	0.22	0.16
Internalizing	0–2	0.27	0.14	0.19	0.13
Child reports					
Perceived parenting					
Structure	1–4	2.06	2.10	0.54	0.50
Affiliation	1–4	3.38	3.51	0.53	0.38
AS	1–4	3.08	3.26	0.40	0.41
Child well-being	1–4	3.47	3.59	0.46	0.44

AS autonomy support; n = 78–93 for parent reports; 38–47 for child reports

Table 3 Intercorrelations between variables

	1	2	3	4	5	6	7	8	9	10
1. Structure (PR)		.08	.24*	.17	−.03	−.03	.13	−.23	−.26	.01
2. Affiliation (PR)	.30**		.36**	.27*	−.18	−.33**	.08	.02	.05	.12
3. AS attitude (PR)	.53**	.52**		.52**	−.08	−.15	−.16	.26	.13	−.34*
4. AS skills (PR)	.49**	.39**	.36**		−.18	−.12	−.07	−.17	.08	−.21
5. Child I problems (PR)	−.02	−.26*	−.10	−.02		.51**	−.21	−.05	−.04	−.18
6. Child E problems (PR)	−.19	−.46*	−.23*	−.19	.48**		−.20	−.11	.11	−.23
7. Structure (CR)	−.19	.01	−.43*	.04	−.22	−.28		−.29	−.22	.21
8. Affiliation (CR)	−.03	−.20	−.17	−.12	−.42*	−.28	.35*		.53**	.16
9. AS (CR)	.01	−.24	−.06	.02	−.33	−.02	.15	.62**		.14
10. Child well-being (CR)	−.28	−.02	−.21	−.12	−.69**	−.45*	.40**	.54**	.46**	

T1 correlations are above the diagonal and T2 correlations are below the diagonal. $N = 30–93$. For correlations between child and parent reports, only the data from targeted children was used
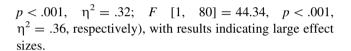
AS autonomy support, *I* internalizing, *E* externalizing, *PR* parent report, *CR* child report

* $p < .05$; ** $p < .01$

Principal Analyses

Repeated measures MANOVAs were first performed for (1) parent reports and (2) child reports. Significant effects were followed by series of univariate repeated measures ANOVAs. For parent reports, there were a significant change at the multivariate level (Wilks' $\lambda = 0.29$, $F (6, 73) = 29.39$, $p < .001$) over time. Child reported dependent variables were also found to change significantly (Wilks' $\lambda = 0.72$, $F (4, 37) = 3.55$, $p = .015$).

Parent Reports

Series of univariate repeated measures ANOVAs were conducted to examine how parent reports of parenting and child mental health changed over time. All means and standard deviations can be found in Table 2. Examining parent reports, there was an increase in all of the parenting indicators after parental participation in the How-to Parenting Program. Compared to baseline, parental structure and affiliation increased ($F [1, 81] = 6.53$, $p = .012$, $\eta^2 = .08$; $F [1, 81] = 7.11$, $p = .009$, $\eta^2 = .08$, respectively). Unsurprisingly, parents reported using autonomy-supportive strategies from the program to a greater extent ($F [1, 79] = 154.99$, $p < .001$, $\eta^2 = .66$). Parental positive attitude toward autonomy support also increased after participation in the program ($F [1, 81] = 41.90$, $p < .001$, $\eta^2 = .34$). The effect sizes were moderate for structure and affiliation and large for autonomy support (Cohen 1988). Importantly, children's mental health improved significantly compared to baseline. At post-test, parent reports of externalizing and internalizing psychological problems had decreased compared to baseline ($F [1, 81] = 38.40$,

$p < .001$, $\eta^2 = .32$; $F [1, 80] = 44.34$, $p < .001$, $\eta^2 = .36$, respectively), with results indicating large effect sizes.

Child Reports

Results of ANOVAs conducted with child reports indicate that children perceived greater parental autonomy support compared to baseline ($F [1, 43] = 10.44$, $p = .002$, $\eta^2 = .20$) and the size of this effect was large. However, no significant improvement in parental structure or affiliation was perceived by children ($F [1, 41] = 0.35$, $p = .556$, $\eta^2 = .01$; $F [1, 40] = 2.56$, $p = .117$, $\eta^2 = .06$, respectively), though mean differences were in the expected direction. Finally, in terms of child reported well-being, a significant improvement was also revealed, as the positive index increased at post-test compared to baseline ($F [1, 42] = 5.45$, $p = .024$, $\eta^2 = .12$). The size of this effect on child well-being was moderate (Cohen 1988).

Discussion

The goal of our study was to assess whether the How-to Parenting Program is effective in improving parenting style and in fostering children's mental health. We used a pre-test versus post-test repeated measures design to test the hypothesis that positive changes in parenting and child mental health would be observed among participating parents and their children. In general, the study's findings supported our hypotheses. There were significant improvements in five of the seven parenting measures and in all of the three indicators of child mental health.

The present research contributes to research on parental education in several ways. First, it suggests that key parenting dimensions can be taught. There was a strong increase in parental reports of autonomy-supportive skills taught in the program, as 66 % of the variance in these skills was explained by the time factor. Parental autonomy-supportive attitude also increased to a large extent after parents' participation, with 34 % of the variance on parent reports and 20 % of the variance on child reports explained by time. This finding is in line with previous parenting education studies that have shown the effectiveness of teaching autonomy-supportive behaviors such as empathy. For example, an early prevention parenting program taught empathy and emotional coaching to parents of preschoolers. Among positive outcomes found, parents showed decreases in emotionally dismissive behaviors and child behavior problems decreased (Havighurst et al. 2010).

Second, the present research shows that, in addition to these large effects, there were improvements in parental affiliation and structure, but these were detected solely in parent reports. Parents reported demonstrating a higher level of affiliation and structure at post-test, compared to pre-test, with a difference over time explaining 8 % of the variance in both measures. When children reports of these constructs were examined, change over time was in the expected direction (6 and 1 % of the variance explained in structure and affiliation, respectively) but it was not statistically significant. Perhaps these improvements would have been detected with a larger sample size. The fact that affiliation levels was found to increase solely by parents may indicate that more time is required for children to feel a stronger connection to their parent. The How-to program does not pertain to the expression of affection or amount of "quality time" parents and children spend time together. Rather, it teaches how to communicate empathy, unconditional regard (misdeeds and successes described in an impersonal manner), and mutual respect. Though this change in parental communication should contribute to improve the parent–child relationship over time, children may not necessarily feel closer to their parent immediately after the program. Similarly, children may not have noticed an immediate improvement in their parents' provision of structure because the implementation of new strategies was accompanied by a reduction in punitive discipline. Child reports of parenting thus show a weaker effect than self-reported parenting. This is not surprising because while parents are made very conscious of their parenting and invested time and energy in trying to apply new skills, children were more or less aware that their parents were trying to interact with them differently. The fact that children perceived some positive changes corroborates and strengthens the present findings.

The present study also adds to the empirical evidence showing that parenting education is effective in reducing problem behaviors. On parent reports of behavioral problems, both indices of externalizing and internalizing were found to decrease significantly. Compared to baseline, parents reported that children displayed less aggressive and rule-breaking problems. The decrease in externalizing problems was large, with 32 % of the variance explained by time. Children were also rated as less sad or anxious and as directing less negative emotions toward themselves (e.g., withdrawal, somatisation). The diminution in internalizing difficulties was also large, with 36 % of the variance in these problems explained by the time factor. The latter effect is notable and a strength of the present study, as internalizing problems are less frequently assessed in prevention programs, which tend to target externalizing problems and measure only this type of psychological difficulties (Kaminski et al. 2008).

As a fourth contribution to the parental education literature, this study shows that parenting programs can increase positive indicators of child mental health in addition to reducing problem behaviors. When we investigated whether change in children's mental health would take place, we sought to assess indicators of well-being (child reports) in addition to psychological problems (parent reports). The results revealed that child mental health improved significantly over time, on all of the indicators used. Not only did parents reported fewer problematic child behaviors, but children also reported a higher subjective well-being (positive affect, self-esteem and life satisfaction) after their parents participated in the program. The size of this effect was large, with 20 % of the variance in well-being explained by time. This finding is particularly important given that it was reported by informants (i.e., children) less likely to be biased by parents' prior investment in the program.

Our goal to assess the How-to material (Faber and Mazlish 1980, 2001, 2002, 2010) was also motivated by a social/ethical incentive, as this parenting book and program is widespread but had been studied only minimally (Fetsch and Gebeke 1995). As a preliminary evaluation, the present study has shown that it is feasible to implement the How-to Parenting Program uniformly and to assess its impact. Local grade schools were a practical implementation setting because they are easily accessible for parents and allowed us to collect child reports. Importantly, the study reveals that all parenting and mental health variables changed in the predicted direction over time, providing preliminary evidence of the program's effectiveness. Though the magnitude of the improvements is probably overestimated due to shared variance, and though the present design did not allow us to control for time and parental investment, the present results are encouraging and provide a strong basis to undertake further research on the How-to Parenting Program.

In addition to contributing to the parental education literature, the present research provides important insights

on the parenting dimensions and how they may relate to each other. First, the correlations between affiliation and autonomy support were always positive, indicating that autonomy support is seen as positively related to involvement and caring. Structure was also positively related to affiliation by parents and children, but only at post-test. Instead of seeing rules and consequences as harsh, structure may have been seen as related to parental involvement and care at post-test, perhaps because of the new way structure is provided and of the increase in autonomy support. The positive correlation between structure and autonomy support in parent reports corroborate the important distinction that must be made between autonomy support and permissiveness (Grolnick 2003; Joussemet et al. 2008). Indeed, autonomy support is often mistakenly confused with permissiveness, which refers to a lack of structure.

At post-test, the correlations between the parenting dimensions and mental health indicators were in the expected direction. Child well-being was positively related to child reports of the three key dimensions of parenting. Moreover, while parent reports of child externalizing problems were associated with lower levels of autonomy support and affiliation, higher internalizing problems were correlated with lower parental affiliation, as perceived by children.

There were two unexpected correlations with the parent report of autonomy-supportive attitude (Gurland and Grolnick 2005). First, it is unclear why at pre-test, children of parents who endorsed a highly autonomy-supportive attitude reported lower well-being. However, the fact that this relation was not found at post-test suggests that it may not be a very robust finding. Second, children of parents who, at post-test, endorsed a highly autonomy-supportive attitude reported a lower level of structure. Yet, these parents seemed to believe that they provided high structure as indicated by a positive correlation between autonomy-supportive attitude and structure in parent reports. Perhaps children confounded the perspective taking involved in the new structuring strategies with a lower degree of strictness from their parent. Longitudinal work is necessary to investigate long-term effects of the program.

The present study also contributes to the SDT literature. An important reason why we selected the How-to Parenting Program was because we judged that its skills truly translated the meaning of autonomy support. The results confirmed that autonomy support was enhanced after the program, as reported by both members of the parent–child dyads. This finding expends past research anchored in SDT (Deci and Ryan 1985, 2000), which has found similar effects in other life domains (e.g., school, work, sports, health). For example, studies have shown that an autonomy-supportive approach is teachable to doctors and teachers, and that it is beneficial in fostering treatment

adherence, promoting health habits (e.g., Williams 2002; Williams et al. 1999, 2000) and fostering motivation and well-being at school (Jang et al. 2010; Reeve 1998; Reeve et al. 2004). The present study thus contributes to providing initial evidence that autonomy support can also be learned by parents, who can "bring it home" to benefit their children.

The most important limitation of the present study is the absence of control group. In future work, it will be important to compare participating parents and children to participants on a waiting-list, to control for the passage of time. The comparison group could also be an active control group, such as a support or discussion group for parents, to also control for the effect of parental investment. We cannot make any firm conclusion about the positive impact of the How-to Parenting Program before positive results emerge from a randomized controlled trial.

Next, because some participating parents had more than one child going to grade school, we asked them to assess the child "they were thinking of when they registered for the program." This procedure may have increased the risk of implicit selection of children with more mental health problems. In future research, it would be wiser to randomly select the participating child for the participating parents. In addition, the fact that lower parental age and income was related to lower attendance points to another potential limitation of generalizability. It is possible that a program requiring time (eight weekly meetings) might be less feasible for parents with fewer resources. Alternatively, perhaps something about the How-to Parenting Program's content diminished younger and/or less advantaged parents' desire to attend. A closer look at the potentially moderating impact of socio-demographic variables on the program's attendance impact would be possible with a larger sample size.

Future studies could also explore whether parenting and child mental health improvements can be sustained over time. Follow-up assessments are required to assess whether participants put their newly acquired skills into practice beyond the duration of the program and whether mental health benefits are present in the long run. Another important research question that should be explored in future work is whether improvements in structure, affiliation and autonomy support mediate the program's impact on child mental health. Such information would be helpful in better understanding how each parenting dimension contribute to various aspects of optimal and non-optimal child development.

The multi-informant assessment approach is a strength of the present study. It is essential to assess children's view of their own well-being instead of relying solely on parental perception. Since the program was offered to families from the general population, we invited children to

report on their well-being rather than on feelings of depression or aggression for example. However, it would have been valuable to have another informant than the parent to report on psychological difficulties. Future studies could use teacher reports or observational measures. We also believe it is important to assess parenting as it is perceived from children's point of view. Ideally, observational measures of parenting would provide a more objective parenting assessment, but children's perspective and their interpretation of parental behaviors is often seen as especially important for child development (Lamborn et al. 1991; Schaefer 1965; Steinberg et al. 1992).

The fact that this evaluation study was theory-driven also represents a strength. We used theory and previous empirical research to identify the relevant aspects of parenting that should be assessed, as recommended by the Institute of Medicine for developing preventive interventions (Olds et al. 2007). Evaluating change in structure, affiliation and autonomy support, the three key components of the authoritative parenting, allows monitoring which aspect is improved by the program. Such precision is valuable, as the "positive parenting" construct found in the literature sometimes reduces optimal parenting to one of its dimension.

Though the present findings should be interpreted with caution, some practical and clinical implications can be derived from this research. First, it seems that the material developed by Faber and Mazlish (1980, 2000, 2010), based on Ginott's writing (1959, 1961, 1965), does correspond to optimal parenting and is useful in its promotion in the general population. It also seems that the optimal, authoritative parenting style (Baumrind 1966; Gray and Steinberg 1999) is teachable to parents of grade school children. Finally, the How-to Parenting Program can be seen as a promising primary prevention intervention. Promoting children's mental health is a crucial endeavor and using this program to do so, by helping parents in their socialization role, seems to be a reasonable approach. Promoting children's mental health may be best achieved by helping parents provide them structure and express their affiliation while supporting their autonomy.

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