RESEARCH ARTICLE

Effects of an Online Emotion Socialization Intervention for Parents of At-Risk Preschoolers Enrolled in Head Start During a Global Pandemic

Briana J. Williams

John S. Carlson

Michigan State University

This study explored the engagement, effectiveness, and acceptability of an unstudied online version of an evidence-based emotion-focused intervention – Tuning in to Kids Online (TIKOL) – within a sample of parents of at-risk preschoolers. Risk was measured using the Devereux Early Childhood Assessment for Preschoolers, Second Edition (LeBuffe & Naglieri, 2012). This pilot study within a small Head Start sample demonstrated that parents watched, on average, 97% of the ten modules across the program duration, and all reported using "quite a few" of the parenting skills taught. Outcome data revealed significant improvements in employing an emotion coaching parenting style. Distressing reactions and parent-reported child conduct problems both decreased. There were no significant reductions in emotion dismissing beliefs. High levels of treatment acceptability were reported. Treatment engagement, effectiveness, and acceptability findings from this pilot TIKOL intervention study support the need to study this accessible, online version of a well-supported parenting program approach.

Keywords: parent training, preschoolers, social-emotional development

INTRODUCTION

Children can name and decode emotional processes as young as preschool and appropriately regulate and manage emotions (Kaur & Sharma, 2021). Emotion regulation (ER) skills help to facilitate positive interactions and support young children's school readiness (Raver, 2002). Approximately 25% of preschool-aged children experience social-emotional difficulties putting them at risk for adverse developmental outcomes (Brown et al., 2012). Children displaying prosocial behaviors (e.g., sharing, empathy, turn-taking) experience affirmative acceptance from peers and are likely to have higher-quality relationships. However, children from low-income families experience more risk factors (e.g., familial stress, economic disadvantage) than their middle- and upper-class peers, contributing to increased problem behaviors across their lifespan (Ramanathan et al., 2017).

Head Start programs have long recognized the importance of building positive adult-child relationships to promote young children's social-emotional development (Morris et al., 2020). According to the United States Department of Health and Human Services ([USDHHS]; 2019), 45.7% of families enrolled in Head Start programs received parenting education services during the 2018-2019 program year. By focusing on parent education, Head Start programs ensure parents are well-prepared to support their children's early learning and development (USDHHS, 2019), specifically addressing the importance of shared responsibility in a child's development between Head Start programs and families (USDHHS, 2016). To that end, it is crucial for parents and educators to actively promote positive social-emotional development, as it impacts children's preparedness for school and general well-being (Raver, 2002).

Parental Meta-Emotion Philosophy

Gottman and colleagues' (1996) parental meta-emotion philosophy is the belief that parents are aware of their and their children's emotions, recognizing opportunities to validate and connect children's emotions with a label (Gottman et al., 1996). Emotion dismissing (ED) refers to a parent's belief that a child's response to anger, fear, or sadness is viewed as harmful to the child and should be managed by the parent as quickly as possible so as not to cause further harm (Gottman et al., 1996). Dismissive parenting is not inherently problematic, as parents are often sensitive to their children's feelings, but they ignore the emotion with the hope that it will go away quickly (Gottman et al., 1997). Emotion coaching (EC) is a parenting philosophy that emphasizes attention to their child's emotions to help them better self-regulate (Gottman et al., 1997).

Research has focused on EC's unique contributions to promoting young children's social-emotional development (Dunsmore et al., 2013; Herman et al., 2011; Leijten et al., 2017; Stewart & Carlson, 2010). When children can fully experience their emotions with supportive reactions from parents, there are positive implications for better emotional competence, behavior, and social functioning (Eisenberg et al., 1998; Gus et al., 2015; Havighurst & Kehoe, 2017; Katz et al., 2012; Loop & Roskam, 2016; Morris et al., 2020). Parental support that increases EC and decreases ED has been linked to improved children's ER and social-emotional difficulties (Dunsmore et al., 2013; Havighurst & Harley, 2007). Researchers demonstrated that children with oppositional behavior problems were more likely to report reduced conduct problems and improved ER when mothers reported higher EC strategies in response to aggression (Dunsmore et al., 2013).

Emotion Coaching Parent Programs

Intervention studies have examined the impact of adding skills-based EC components to improve outcomes for parents and their children. One example is the Incredible Years (IY) Parent Training Program (Webster-Stratton, 2006). IY provides weekly training sessions for parents to learn how to utilize and incorporate strategies to improve their and their children's communication skills, ER, and self-control. As an early intervention, research for IY has focused on promoting social competence, reducing conduct behavior problems, and decreasing internalizing symptoms in young children (Webster-Stratton & Bywater, 2019). IY employs an EC component to help parents model and scaffold regulating emotions with their children. The IY Parent Training Program has

also been examined as a preventative program for children in underrepresented groups and those enrolled in Head Start programs (Leijten et al., 2017). The IY Program not only has strong evidence for its impact on children's skill development but is also easy to implement as intended with high rates of parent acceptability (Stewart & Carlson, 2010).

Porzig and colleagues (2014) integrated EC into the cognitive-behavioral 1-2-3 Magic parenting program. They found reductions in parents' dysfunctional parenting practices (e.g., viewing the child as being difficult) and child behavior problems than those receiving the base program after three months and a two-year follow-up (Porzig-Drummond et al., 2014). Similarly, Chronis-Tuscano and colleagues (2016) examined Parent-Child Interaction Therapy with added EC (PCIT-ECo) to improve children's emotion recognition and ER. Parents exposed to PCIT-ECo displayed more positive parenting practices, and changes in parental practices were associated with improvements in ER for children with ADHD. Researchers also found high satisfaction regarding treatment acceptability but did not examine treatment engagement (Chronis-Tuscano et al., 2016).

Tuning In To Kids (TIK)

Tuning in to Kids (TIK; Havighurst & Harley, 2007) is an emotion-focused program developed to support parents' emotional responsiveness to their children's emotions. TIK emphasizes Gottman and colleagues' (1996) five critical components of EC: (a) being aware of children's emotions, (b) viewing children's emotions as a time for bonding, (c) helping children label emotions, (d) validating children's emotions, and (e) helping solve problems (Havighurst & Harley, 2007). During the intervention, parents engage with other parents and a certified facilitator using various activities (e.g., psychoeducation, handouts, home-based activities) to differentiate learning and accommodate different parenting styles. Activities allow parents to share their experiences employing EC scaffolding between sessions and to practice using skills with each other (i.e., role-playing) before using them with their children.

Several studies have been conducted with parents of preschool-aged children in Australia (Havighurst et al., 2013, 2019; Wilson et al., 2012) and Iran (Aghaie Meybodi et al., 2019; Edrissi et al., 2019). Participating parents reported increased EC beliefs and reduced child behavior problems (Havighurst et al., 2019) and anxiety symptoms (Edrissi et al., 2019). TIK sessions have high fidelity with trained facilitators and high attendance and parental acceptability (Duncombe et al., 2016; Havighurst et al., 2010, 2013). One qualitative study examined parents' perceptions of the program within a rural community in the United States (U.S.; Hernandez et al., 2020). Parents expressed the need for the program to incorporate EC skills within a family's established values; however, no quantitative outcome data were reported. Presently, no research has investigated TIK's effectiveness, integrity, and acceptability within a low-income preschool population in the U.S.

While the literature surrounding TIK has produced promising results for group-based sessions, the impact of the online adaptation – TIK Online (TIKOL; Havighurst & Harley, 2020) – has not yet been investigated. TIKOL provides parallel content to TIK, condensed into 10 video modules. The accessibility of the Internet during the COVID-19 pandemic, paired with accessibility challenges (e.g., time, transportation), emphasizes the need for self-guided, digital interventions to improve access to interventions for families (Breitenstein et al., 2014). Digital interventions are also more

cost-effective, creating a more feasible treatment option for low-income families (Hollis et al., 2017). Several meta-analyses of parenting interventions have demonstrated no significant differences in parent or child outcomes regardless of the intervention delivery format (de Graaf et al., 2008; DuPaul et al., 2018; Lundahl et al., 2006). Spencer and colleagues (2020) found online programs exhibited large effects in increasing parent encouragement ($d = 1.13$) and positive parenting behaviors ($d = 1.00$), and decreasing negative parent-child interactions ($d = -0.97$). Additionally, online programs incur significantly lower costs for families and costs to train facilitators (Ingels et al., 2022), situating online interventions as a means to reduce barriers for low-income and under-resourced communities (e.g., Head Start families). Given this knowledge, there is an opportunity to investigate whether the self-guided TIKOL program is effective in improving parents' EC beliefs, reducing child internalizing, and externalizing symptoms.

CURRENT STUDY

This pilot study explored parent-rated engagement, effectiveness, and acceptability of TIKOL with parents of children enrolled in Head Start. The hypotheses were that TIKOL would yield increased EC beliefs in parents, decreased ED beliefs, and improvements in parents' emotion socialization (ES) practices. We also expected to see reductions in children's externalizing behaviors (i.e., conduct behavior problems) and internalizing symptoms (i.e., anxiety). Given the at-risk nature of the young children and the accessibility of digital interventions during a global pandemic, treatment engagement and acceptability were expected to be high.

METHOD

Participants

Eleven of 15 eligible parents elected to enroll in the study. Eight of the 11 families completed the intervention, and the remaining three discontinued participation due to unforeseen personal difficulties in completing the intervention (72% completion rate). Of participating parents (seven biological mothers and one adoptive mother), the average parent age was 35.5 years ($SD = 7.7$), and all parents identified as female. The majority ($n = 7$) of participating parents were White/Caucasian, and one parent was Black/African American. All parents reported receiving postsecondary education, with most ($n = 5$) earning a postsecondary degree and three completing some college, reflecting a more highly educated group than the national Head Start parent population (USDHHS, 2019). Five parents were working full-time, one reported working part-time, and two were not working, indicating a higher representation of parents with limited daily availability than the national Head Start population (20%; USDHHS, 2019). Family incomes demonstrated varied diversity, with five parents (62.5%) reported low family income (less than $40,000), one (12.5%) reported middle income, and two (25%) reported income higher than $60,000.
English was the primary language spoken at home for all participants. The average child age was just over four years ($M = 53.8$ months; $SD = 4.1$), and half of the children in the sample were female ($n = 4$). Children were White/Caucasian ($n = 6$), Black/African American ($n = 1$), and multiracial ($n = 1$). All eight parents had children who demonstrated a significant need for social-

emotional skill development as measured by the Devereux Early Childhood Assessment for Preschoolers, Second Edition (DECA-P2; LeBuffe & Naglieri, 2012).

MEASURES

Engagement

Engagement data was collected via a brief survey to parallel attendance rate reports from prior TIK studies for each module. Parents were asked to reflect on the content from previous videos, indicating how many skills they practiced. Parents rated responses on a 5-point Likert scale from 0 (*none*) to 4 (*a lot*). After each module, parents estimated the percentage they believed they watched. They rated their engagement with TIKOL on a scale from 1 (*not very much at all*) to 5 (*very much engaged*).

Parent Measures

The 21-item Parental Emotional Style Questionnaire (PESQ; Havighurst et al., 2010) was adapted from the Maternal Emotional Style Questionnaire (Lagacé-Séguin & Coplan, 2005), which assesses parental beliefs about their children's ability to cope with sadness, fear, and anger. Parents rated items based on their beliefs on a 5-point scale from 1 (*strongly disagree*) to 5 (*strongly agree*). The questionnaire includes EC and ED subscales. The EC scale endorses items such as: *"When my child is scared, I take some time to try and experience this feeling with him/her"*; an example of an ED item is: *"Sadness is something that one has to get over."* Cronbach's alphas for the PESQ were reported for EC (11 items; α = .82 to .87) and ED (10 items; α = .78 to .84) over time, indicating good internal consistency (Havighurst et al., 2013).

The Coping with Children's Negative Emotions Scale (CCNES; Fabes et al., 1990) measures parents' ES practices. Ratings on a 7-point scale from 1 (*very unlikely*) to 7 (*very likely*) indicate how likely the parent is to respond to 12 scenarios within six subscales: distressed reactions (DR), punitive reactions (PR), expressive encouragement (EE), emotion-focused reactions (EFR), problem-focused reactions (PFR), and minimization reactions (MR). For example, *"If my child is panicky and cannot go to sleep after watching a scary TV show,"* presents responses representing each subscale. The EFR and PFR scales were not included in the analysis because they do not emphasize initially tuning into their child's emotions. The removal of these scales is consistent with previous research in measuring ES (Havighurst et al., 2019; Wilson et al., 2012). Each subscale has been reported to have good reliability (α = .69 to .85), validity, and stability over four months (Fabes et al., 2002).

Child Measures

The DECA-P2 (LeBuffe & Naglieri, 2012) is a 38-item, strengths-based assessment measuring risk and protective factors in preschool-aged children. The Total Protective Factors (TPF) scale

screened for study eligibility and inclusion. Twenty-seven items comprise the TPF scale, divided into three subscales: Initiative, Self-regulation, and Attachment. T-scores on the TPF scale indicate 60 or above as a strength, and below 40 indicates areas of need. An 11-item scale identifies areas of Behavior Concern (BC). A score above 60 indicates areas of need, and scores 59 and below are typical. Psychometric properties of the TPF (α = .92) and the BC (α = .80) scales meet recommended standards for internal consistency (LeBuffe & Naglieri, 2012).

The Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999) is a 36-item parent-report scale of conduct problem behaviors. Items are rated on a 7-point scale from 1 (*never)* to 7 (*always*). Summed scores create an Intensity Scale score, with 131 or above indicating significant behavior problems (Eyberg & Pincus, 1999). Parents also indicated *yes* or *no* to identify if individual items are a problem. Summed *"yes"* responses correspond to the Problem Scale. Scores of 15 or higher indicate significant distress concerning their child's behavior. Psychometric properties for both the Intensity scale (α = .92 to .95) and Problem scale (α = .86 to .94) show strong internal consistency (Gross et al., 2007).

The Revised Preschool Anxiety Scale (PASR; Edwards et al., 2010) is a 28-item scale assessing parents' perception of their child's anxiety symptoms. The total PASR score was used in this study. Parents rated their child on a 5-point Likert scale from 0 (*not at all true*) to 4 (*very often true*). The maximum possible score of 112 indicates more severe symptoms of anxiety. Psychometric properties for the total scale (α = .92) display good internal consistency (Edwards et al., 2010).

Acceptability

Acceptability data (i.e., parents' perceived usefulness and appropriateness of the intervention) was measured with the brief 8-item Abbreviated Acceptability Rating Profile (AARP; Tarnowski & Simonian, 1992). Parents rated items on a 6-point Likert-type scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). Acceptability is considered moderate to high when total scores are 28 or higher (Kazdin et al., 1981). The scale (α = .89 to .98) has been reported to have good internal consistency (Tarnowski & Simonian, 1992).

PROCEDURES

Referred parents completed a screening questionnaire to determine eligibility for the study. Parents were eligible to participate if TPF T-scores on the DECA-P2 were at least one standard deviation below the mean (scores $\leq$ 40; LeBuffe & Naglieri, 2012). T-scores 40 or below indicate risk factors for children and their families on the DECA-P2. Exclusionary criteria included families where English was not the primary language spoken at home or parents who reported their child having intellectual disabilities or developmental disorders. Researchers obtained informed consent from eligible families based on these criteria. Participating families completed all surveys before the intervention and parent measures after completing the fifth module. All parent and child measures and the AARP were collected after completing TIKOL. Weekly links were sent to parents who consented to complete the program, using anonymized identification numbers throughout the program. Engagement data was collected through the same link throughout each week of the study.

Tuning In To Kids Online (TIKOL)

TIKOL (Havighurst & Harley, 2020) is an online parenting program developed to equip parents with EC strategies to support their parenting practices and learn to address their children's emotions in the moment. TIKOL was adapted from the original emotion-focused TIK program. TIKOL comprises ten video modules (see Table 1) covering topics such as managing various emotions and situations (i.e., fears, sibling conflict). At the beginning of the modules, the developer discusses and defines EC, and subsequent modules provide role-played scenarios with examples of EC between a parent and child. Each video module includes mini-lectures, testimonials from parents, and role-played scenarios with step-by-step instructions. Guidelines for completing the intervention are flexible; however, we recommended that parents watch one video each week to complete the program in 10 weeks. Each module provided downloadable fact sheets with additional resources.

Table 1

Tuning in to Kids Online Modules and Levels of Engagement

Module	Description	M % watched (Range)	M time spent on module (in hours)[b]	M engagement rating
Getting Started	Introduction to TIKOL and its purpose	89% (15 – 100%)	1.3	4.5
Raising Emotionally Intelligent Children	Understanding emotional intelligence	96% (68 – 100%)	1.0	3.5
Emotion Coaching	Understanding how and when to coach a child	100%[a]	1.3	4.8
Tuning In	Parents must acknowledge and reflect the child's emotions	100%[a]	1.7	4.6
Empathy	Empathy as the core of emotion coaching	97% (75 – 100%)	1.0	4.5
Automatic Reactions	The importance of building in a pause	98% (87 – 100%)	2.0	4.8
Fears	A child's fear comes from a lack of understanding	100%[a]	1.1	4.5
Anger	Build in a pause and detect low vs. high-intensity anger	98% (85 – 100%)	1.0	4.5
Sibling Rivalry	Giving children the tools and confidence to resolve their problems	98% (48 – 100%)	1.3	4.0
Final Thoughts	Parents need to "recharge" and understand realistic times to emotion coach	98% (86 – 100%)	1.1	4.4

[a] All participants reported watching 100% of the module.

[b] Data were collected using Qualtrics' internal timer, which continued running when participants paused and returned to the module later. Outliers above 5 hours were excluded from this analysis.

Analysis

Descriptive statistics were conducted for demographic variables, engagement, and acceptability data using SPSS 25. Group-level parent outcomes were tested using one-way ANOVAs, and child outcomes were examined using paired-samples t-tests. Given this pilot study's small sample size, Reliability Change Index (RCI) values were calculated individually for both parent and child outcomes and serve as a supplement to group analyses. The RCI determines a meaningful clinical change in intervention research for values of 1.96 or higher (Jacobson & Truax, 1991).

RESULTS

Engagement

Across all ten modules, parents reported watching on average 97% of the weekly videos (see Table 1) and were "quite engaged," with an average rating of 4.4 (SD = .2) on a 5-point scale. Parents reported using "quite a few" skills and strategies with an average of 3.0 (SD = .5) on the 4-point scale. The average length of time to complete TIKOL was 11 weeks. According to Qualtrics' internal system, parents spent, on average, 1.3 hours watching each module.

Effectiveness

Parent Outcomes.   Table 2 presents outcomes for parent-reported ES changes. Parent EC scores increased significantly, $F(1.555,10.884) = 152.312$, $p < .001$, indicating an improvement in parent EC scores. RCI scores were calculated for each parent. RCI values ranged from 2.43 to 4.38, indicating clinically meaningful improvements (i.e., RCI scores greater than 1.96 indicate the difference is reliable and not likely due to the unreliability of the measure; Jacobson & Truax, 1991) for all parents. Parent ED scores varied from pre- to post-test. Contrary to expectations, there was a 4.1-point increase, instead of a decrease, from mid- to post-test, $F (1.073,7.513) = 3.338$, $p = .106$. RCI scores ranged from 0.22 to 4.89, with only one parent meeting the RCI threshold for clinically meaningful improvement. Four of the eight parents demonstrated meaningful changes in ED scores opposite expectations.

Parent-reported parenting practices are displayed in Table 2. Parent-reported DR scores decreased significantly, $F(1.354,9.481) = 12.566$, $p = .004$, indicating a high level of improvement in parent DR scores. RCI values ranged from 0.17 to 4.04, with three RCI values meeting the threshold for clinically meaningful changes. Parent-reported PR scores on the CCNES did not significantly decrease from pre- to post-test, $F(1.289,9.024) = 3.474$, $p = .089$. Individual RCI values ranged from 0 to 4.69, with only two parents meeting the RCI threshold for making clinically significant changes. EE scores from the CCNES significantly increased from pre- to post-test, $F(1.196, 8.371) = 4.979$, $p = .05$. RCI values ranged from 0 to 4.02, with two parents meeting the threshold for clinically meaningful change. Parent-reported MR scores from the CCNES produced a marginal decrease, $F(1.473,10.311) = 3.618$, $p = .074$; however, these findings were not statistically significant. RCI values across all parents ranged from 0.15 to 4.15, with only one parent meeting the RCI threshold for clinically meaningful change

Table 2

Mean Change Differences for Measures of Parent Emotion Socialization Outcomes

Measure/Parent	Pre-Test M (SD)	Mid-Test M (SD)	Post-Test M (SD)	M change	p	RCI
EC						
Parent 1	32	34	42	10		**2.43**
Parent 2	53	52	64	11		**2.68**
Parent 3	39	44	57	18		**4.38**
Parent 4	49	53	64	15	-	**3.65**
Parent 5	49	54	67	18		**4.38**
Parent 6	39	47	56	17		**4.14**
Parent 7	48	52	64	16		**3.89**
Parent 8	39	43	54	15		**3.65**
Mean	**43.5 (7.2)**	**47.4 (6.8)**	**58.5 (8.1)**	**+15**	**< .001**	**3.65**
ED						
Parent 1	24	16	25	1		0.22
Parent 2	44	44	54	10		**2.22**[†]
Parent 3	45	28	23	-22		**4.89**
Parent 4	33	34	43	10	-	**2.22**[†]
Parent 5	37	33	43	6		1.33
Parent 6	32	32	41	9		**2.00**[†]
Parent 7	34	34	44	11		**2.22**[†]
Parent 8	36	38	44	8		1.78
Mean	**35.4 (7.3)**	**31.6 (8.4)**	**39.0 (11.0)**	**+3.57**	**.015***	**2.11**
DR						
Parent 1	2.83	3	2.75	-0.1		0.17
Parent 2	2.67	2.25	1.58	-1.1		**2.30**
Parent 3	2.92	1.91	1	-1.9		**4.04**
Parent 4	2.17	1.58	1	-1.2	-	**2.46**
Parent 5	1.75	1.75	1.5	-0.3		0.53
Parent 6	3.58	2.75	2.92	-0.7		1.39
Parent 7	2.67	2.42	1.92	-0.8		1.58
Parent 8	3	3.17	3.17	0.2		0.42
Mean	**3.3 (.7)**	**3.1 (.4)**	**2.0 (.9)**	**-1.3**	**.004**	**1.61**
PR						

Parent 1	1.08	1.5	1.25	0.17		0.50
Parent 2	1.5	1.58	1	-0.50		1.47
Parent 3	2.67	1.42	1.08	-1.59		**4.69**
Parent 4	1.75	1.33	1.25	-0.50		1.47
Parent 5	1.25	1.25	1	-0.25	-	0.74
Parent 6	2.17	1.67	1.42	-0.75		**2.21**
Parent 7	1.75	1.5	1.75	0.00		0.00
Parent 8	1.92	2	1.92	0.00		0.00
Mean	**1.8 (.5)**	**1.5 (.2)**	**1.3 (.3)**	**-.5**	**.089**	1.39
EE						
Parent 1	7	6.73	7	0.00		0.00
Parent 2	6.25	6.25	6.7	0.45		0.60
Parent 3	3.83	5.08	6.83	3.00		**4.02**
Parent 4	6	6.33	6.75	0.75	-	1.01
Parent 5	6.5	6.42	6.75	0.25		0.34
Parent 6	4.33	5.42	6	1.67		**2.24**
Parent 7	6.27	6.08	6.75	0.48		0.64
Parent 8	4.92	5.33	5	0.08		0.11
Mean	**5.7 (1.2)**	**6.0 (.6)**	**6.7 (.3)**	**+1**	**.05**	1.12
MR						
Parent 1	1	1.08	1.5	0.50		0.92
Parent 2	2.83	2	2.33	-0.50		0.92
Parent 3	3.5	1.33	1.25	-2.25		**4.15**
Parent 4	1.58	1.5	1.5	-0.08	-	0.15
Parent 5	2	1.25	1.25	-0.75		1.38
Parent 6	2	1.92	1.5	-0.50		0.92
Parent 7	2.08	1.17	1.25	-0.83		1.53
Parent 8	2.36	2.83	1.83	-0.53		0.98
Mean	**2.1 (.8)**	**1.5 (.4)**	**1.5 (.4)**	**-0.6**	**.074**	1.37

Note. RCI = reliable change index. Reliable changes (> 1.96) are bolded.
*Statistically significant change between mid-test and post-test
†Reflects a reliable change in the opposite intended direction.

Child Outcomes.   Parent-reported BC from the DECA-P2 are displayed in Table 3. BC T-scores produced a statistically significant decrease, $t(7) = 3.499$, $p = .01$. RCI values ranged from 1.11 to 4.90, with three parents meeting the threshold for clinically meaningful improvements following exposure to TIKOL.

ECBI Intensity and Problem Scale scores are also displayed in Table 3. Parent-reported Intensity scale scores significantly decreased, $t(7) = 2.991$, $p = .02$. RCI values range from 0.85 to 4.83, with seven parents meeting the threshold for clinically meaningful improvements. Parent 1 reported clinically meaningful improvement in the opposite direction. Problem scale scores decreased from pre- to post-test. A 5.1-point decrease indicated a statistically significant change, $t(7) = 3.488$, $p = .01$. RCI values ranged from 0.88 to 5.26, with five parents meeting the threshold for clinically meaningful improvement.

As highlighted in Table 3, parent-reported anxiety symptoms did not produce statistically significant change, $t(7) = .249$, $p = .810$. RCI values for individual parents range from 0.88 to 5.75, with three meeting the threshold for clinically meaningful change. Two parents reported meaningful change in the opposite direction.

Table 3
Mean Change Differences for Measures of Child Behavior and Anxiety Outcomes

Measure/Parent	Pre-Test M (SD)	Post-Test M (SD)	M change	p	RCI
Intensity Scale					
Parent 1	116	135	19		**2.70[†]**
Parent 2	96	79	-17		**2.42**
Parent 3	139	106	-33		**4.69**
Parent 4	147	113	-34	-	**4.83**
Parent 5	98	65	-33		**4.69**
Parent 6	106	85	-21		**2.99**
Parent 7	113	107	-6		0.85
Parent 8	142	111	-31		**4.41**
Mean	**116.4 (19.7)**	**98.6 (23.7)**	**-17.8**	**.05**	3.45
Problem Scale					
Parent 1	0	2	2		0.88
Parent 2	7	0	-7		**3.07**
Parent 3	16	11	-5		**2.19**
Parent 4	14	6	-8		**3.51**
Parent 5	12	0	-12	-	**5.26**
Parent 6	6	2	-4		1.75
Parent 7	9	4	-5		**2.19**
Parent 8	6	4	-2		0.88
Mean	**8.8 (5.1)**	**3.6 (3.6)**	**-5.1**	**.01**	2.47
Behavior Concerns					
Parent 1	58	65	7.0		1.11
Parent 2	69	38	-31.0		**4.90**

Parent 3	66	50	-16.0		**2.53**
Parent 4	64	52	-12.0	-	1.90
Parent 5	50	38	-12.0		1.90
Parent 6	63	52	-11.0		1.74
Parent 7	48	33	-15.0		**2.37**
Parent 8	66	54	-12		1.90
Mean	**60.5 (7.8)**	**47.8 (10.6)**	**-12.8**	**0.01**	**2.29**
Total Anxiety					
Parent 1	43	56	13		**2.88**[†]
Parent 2	35	9	-26		**5.75**
Parent 3	23	11	-12		**2.65**
Parent 4	37	41	4	-	0.88
Parent 5	10	15	5		1.11
Parent 6	32	19	-13		**2.88**
Parent 7	15	20	5		1.11
Parent 8	28	42	14		**3.10**
Mean	**27.9 (11.3)**	**26.6 (17.3)**	**-1.3**	**.810**	**2.54**

Note. RCI = reliable change index. Reliable changes (> 1.96) are bolded.
[†]Reflects a reliable change in the opposite intended direction.

Acceptability

AARP scores (see Table 4) ranged from 1 (*strongly disagree*) to 6 (*strongly agree*). Average AARP scores across eight items were 4.8 to 5.9. The average AARP score for the question *"Overall, the treatment would help the child"* was 5.6 (*SD* = .5). The average overall total was 43.8 (*SD* = 3.5), indicating high acceptability of the program. Total AARP scores ranged from 38 to 48, indicating moderate to high acceptability ratings from all eight parents (Kazdin et al., 1981).

Table 4
Parent-reported Acceptability of TIKOL Treatment

Item	M	SD
This is an acceptable treatment for the child's behavior.	5.8	0.5
The treatment should be effective in changing the child's behavior.	4.9	1.4
The child's behavior is severe enough to justify the use of this treatment.	4.8	1.8
I would be willing to use this treatment with my child.	5.9	0.4
This treatment would not have bad side effects for the child.	5.6	0.5
I liked this treatment.	5.6	0.5
The treatment was a good way to handle the child's problem.	5.6	0.5
Overall, the treatment would help the child.	5.6	0.5

Note. Ratings on a scale of 1 (strongly disagree) to 6 (strongly agree)

DISCUSSION

This pilot intervention study aimed to examine (1) parented-reported engagement, (2) the effectiveness of parenting beliefs and practices, (3) the impact of child internalizing and

externalizing outcomes, and (4) the acceptability of a self-guided emotion-focused parenting intervention. The results highlight the potential for TIKOL to positively impact parenting practices and outcomes for children. The findings of this study support existing data suggesting that online parenting programs can effectively improve parenting practices and outcomes for children (DuPaul et al., 2018; Ingels et al., 2022). Within the current COVID-19 pandemic, this is an essential finding for parents seeking support but who lack access to services. The online nature of the intervention can be helpful for childcare centers to integrate into their existing parent education programs.

Given the self-guided nature of the intervention, it was crucial to gauge the engagement of parents in completing the modules over time. The data suggests that parents find the material and delivery format highly engaging. This finding parallels past research on self-guided parenting programs (Day & Sanders, 2018); however, research indicates that minimal support may provide additional engagement and benefit from these interventions. These data are essential for a self-guided program with limited peer interaction or engagement with a trained facilitator. These programs can benefit early childhood centers seeking to provide information to parents without exhausting resources (e.g., teachers' time; Ingels et al., 2022). High reports of watching the weekly videos on average in this TIKOL study parallel TIK literature (Havighurst et al., 2019; Wilson et al., 2014, 2016). Most parenting program research examines the impact of group-based service delivery (Barlow et al., 2016; Barlow & Parsons, 2003; Olofsson et al., 2016; Ruma et al., 1996; Wymbs et al., 2016). However, recent research suggests that adapting parenting programs to an online, self-guided format can be just as effective and engaging for parents who do not have access to in-person resources (Spencer et al., 2020). This is particularly important during the COVID-19 pandemic, which limits parents' access to in-person services (Bhat, 2021). Parents also found TIKOL to be highly acceptable. These data support further research on TIKOL as an alternative to TIK in addressing parental ES beliefs and child BC (Havighurst et al., 2004).

The increase in EC beliefs in this pilot study suggests TIKOL's ability to provide psychoeducation on the importance of employing an EC framework for parenting. While modules three through five focus on specific domains of emotionally supporting children (see Table 1), each subsequent module puts the skill into practice with specific situations parents may encounter with their children (i.e., problem-solving fear or sibling conflict). While the findings are consistent with expectations regarding EC beliefs (Aghaie Meybodi et al., 2019; Havighurst et al., 2009, 2010; Wilson et al., 2012, 2014), parents in the present study unexpectedly reported increased ED beliefs over time. These findings differ from previous TIK research showing reduced parent-reported emotion dismissing beliefs (Havighurst et al., 2013, 2015). These findings raise questions about the need for an additional module dedicated to ED beliefs and practices to see the same impacts found in the TIK literature. Alternatively, future TIKOL investigations may uncover the necessity of additional sessions to allow parents to better understand ED practices and the negative impact these practices can have on young children's ER development.

One plausible explanation for the unexpected increase in ED beliefs is the lack of direct support for parents to ask questions or practice skills in a group or with a trained facilitator. Results from group-based TIK have successfully demonstrated reductions in parents' ED beliefs (Havighurst et al., 2009, 2010). However, the broader literature suggests that parents may view dismissing children's emotions as protective in removing negative experiences from their child (Gottman et

al., 1997; Lunkenheimer et al., 2007). Without the opportunity to speak directly with other parents and a trained facilitator through role-play, the importance of challenging ED practices may be lost in the online modules. This presents a potential opportunity to integrate weekly support for parents to discuss the material covered in each module (Day & Sanders, 2018).

Consistent with other TIK literature, the current study measured changes in parental ES with the same tool (CCNES; Fabes et al., 1990; Havighurst et al., 2004; Havighurst et al., 2019). Parents' self-reported DR significantly decreased, indicating exposure to TIKOL may benefit parents who experience high-stress levels when addressing their children's negative emotions. These findings also align with outcomes in PCIT-Eco interventions (Eyberg et al., 2008) in improving parenting practices. Havighurst and colleagues (2019) found significant changes in EE, MR, and PR between baseline measures and a 6-month follow-up using the CCNES; however, these differ from the outcomes of the current pilot study. These conflicting findings across individual and group analytic approaches support the need to further examine the effectiveness of TIKOL within a larger sample of parents.

Changes in parent-reported child behavior are analogous to reductions in child conduct problems reported in previous TIK studies (Aghaie Meybodi et al., 2019; Duncombe et al., 2016; Havighurst et al., 2004). These findings suggest that TIKOL strategies can create positive shifts in how parents perceive their child's behavioral challenges. Findings were consistent with previous research demonstrating that children with high problem intensity demonstrated the most significant improvements following TIK (Havighurst et al., 2004). Changes in anxiety symptoms were minimal for all parents. The average total score decreased slightly; however, only three parents reported perceived decreases in their child's anxiety. Prior studies on the impact of TIK found that 69% of children demonstrated reduced anxiety symptoms at treatment completion (Edrissi et al., 2019). A prior examination of changes in anxiety was conducted in a sample of children with clinical anxiety levels. These preliminary findings suggest that online parenting programs are uniquely positioned to impact child outcomes as well indirectly. Children with conduct behavior problems and anxiety are at risk for adverse outcomes later in life (Brown et al., 2012; Comer et al., 2010; Spencer et al., 2020). These indirect changes from parenting programs support the literature that changes in parental practices and beliefs directly benefit children's developmental outcomes (Chan et al., 2009).

LIMITATIONS AND FUTURE DIRECTIONS

While the results of this pilot study provide insights into the impact of TIKOL within a previously unstudied population, clear limitations must be considered in interpreting the results. First, participants in the small sample were self-selected for the study during a global pandemic, representing a highly motivated, homogenous group hoping to see improvements in their children's behaviors. This small sample limited the ability to test for statistical changes that could be generalized to a larger population. Additionally, these eight parents represented a more educated group than national Head Start families, with 100% of parents receiving some college education or more compared to 31% of Head Start parents pursuing some college or above (USDHHS, 2020). Future investigations of TIKOL should attempt to replicate the findings in a larger sample to better account for statistical significance.

Another limitation was the COVID-19-related challenges limiting efforts to recruit a more heterogeneous sample. Many parents indicated that participating in a 10-week program was not feasible at the beginning of the COVID-19 pandemic. Future research should seek a larger and more diverse sample, providing the opportunity to examine potential differences in child or parent characteristics, such as age, gender, race, and relationship to the child. Second, the study employed a pre-post design and, as a result, did not control for other threats to the internal validity, such as time. It is also important to note the effect of testing, where completing multiple questionnaires about social-emotional competence and ES practices can increase perceived sensitivity to the intended effects of the intervention. Future studies would benefit from a more robust methodology, such as a waitlist control trial or a randomized control trial comparing TIKOL to a non-treatment group. A randomized control trial comparing TIKOL to TIK would also provide vital information to investigate if the online program is as effective as its facilitated counterpart.

Third, outcomes from this pilot study were gathered from parents' self-report. This source of data is susceptible to social desirability and expectancy bias. Reports collected from more than one caregiver or a classroom/daycare teacher would be optimal to examine if child outcomes differ across settings. Future research may consider direct observations of parents practicing skills. Direct observations with blind coders can provide a more reliable measure of parents' use of the skills (Havighurst et al., 2010). Additionally, it is crucial to recognize that the self-guided nature of the program may present challenges when considering passive viewing of each module. To this end, it may be beneficial to examine how providing supplemental clinical support from a certified facilitator can enhance parents' experiences with the program.

CONCLUSION

Results of this study contribute to the growing literature on parenting programs highlighting ES strategies as a pathway to improve parent-child bonds and children's emotional competence. Parents facing considerable barriers in accessing services (e.g., global pandemic) may benefit from a self-guided, digital intervention like TIKOL. While TIKOL aims to support parents, the content can apply to early childhood educators seeking support for their students' development and building protective factors (Dunsmore et al., 2013). Using this feasible and accessible approach to parenting interventions within a tiered model of service delivery warrants further study within services like Head Start, where risk factors related to children's development are significant.

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