Parent Coaching Within a Pediatric Primary Care Practice

An Innovation Station Promising Practice

Purpose: This document is intended to support MCH professionals to implement a practice found in Innovation Station. This resource provides the information needed to replicate the practice and is divided into two sections: the first section provides a high-level overview of the practice while the second section describes how to implement the practice. For additional information on any of the content provided below, please reach out to the practice contact located at the bottom of this document.

Section I: Practice Overview

Location:	Ohio	**Title V/MCH Block Grant Measures Addressed**
Category:	Promising	
Date Submitted:	5/2019	

Practice Description

There is an increasing awareness of the need for pediatric practices to provide holistic care to their patients, inclusive of parents, since up to 50% of health outcomes are attributable to social and economic factors.[1] This program addresses that need by embedding parent coaches within pediatric practices to intervene swiftly and mitigate the potential for negative long-term health and social concerns.

Purpose

Healthcare systems are becoming increasingly aware of the high cost of non-physical factors that impact health, with up to 50% of health outcomes attributable to social and economic factors.[1] Data indicates that the lifetime cost for a child who has been maltreated ($210,012) is comparable to other costly healthcare conditions such as stroke ($159,846) or type 2 diabetes ($181,000-253,000).[2] However 4 in 5 physicians report lacking confidence in their ability to meet patients' social needs, and that this deficit impedes their ability to provide high quality care.[3]

Parent coaching is a collaborative process that helps parents and other caregivers navigate everyday parenting challenges. The coaching process supports parents in reducing and/or preventing toxic stress within their family, as well as helping their children develop critical life skills and coping skills needed for them to thrive. Families are identified for parent coaching through positive screens at pre-selected well-child visits or through direct pediatrician referrals

as parenting issues arise during medical appointments. Co-location of the parent coach within the pediatric practice removes barriers to service activation and enables enhanced communication among pediatricians, medical office staff, and parent coaches.

Coaching engagements with parents typically range between two and six sessions; current program average is 2.86 sessions. The initial session is approximately 90 minutes, while follow-up sessions typically last 45 minutes to one hour. The primary reasons parents seek and/or are referred to coaching are for child behavioral issues, child emotion regulation, anxiety, school concerns, sleep issues, sibling rivalry and parental stress.

Practice Foundation

Conceptually, coaching is rooted in the belief that all individuals have the capacity for change and that each individual is the expert on his or her life. As such, the parent coach serves as partner and guide to parents rather than provider of expert opinion and advice. The coach collaborates with parents to co-create solutions rather than simply provide parent education. In the course of their work, coaches display unconditional positive regard for their clients and ensure that all interactions are not only respectful but accepting and non-judgmental. More specifically, the parent coaching model is rooted in the Natural Strength Parenting™ framework and positive psychology coaching.

Natural Strength Parenting™ is a theoretical framework within which parent-child interventions are developed at Beech Acres Parenting Center. It is grounded in Social Cognitive Theory and Positive Psychology and developed through the lens of trauma informed care. Social Cognitive Theory constructs (e.g., reciprocal determinism, goal-setting and monitoring, self-efficacy), are used to initiate and maintain goal-directed behavior and form the basis for Natural Strength Parenting™ interventions. Techniques and strategies from Positive Psychology research (e.g., intentionality, mindfulness, strengths) address inherent limitations in purely social-cognitive interventions, incorporating techniques that enhance intrinsic motivation and facilitate positive emotional response and resonance. Trauma-informed care is applied with appropriate populations and individuals to ensure physical, psychological, and emotional safety, helping survivors rebuild a sense of control and empowerment.

Within the context of the Natural Strength Parenting™ framework, parent coaches use a structured protocol developed using evidence-based practices. Change is facilitated through a process of 1) envisioning the desired end result, 2) building on successes and strengths as the foundation for change, 3) providing parent education as appropriate, 4) collaboratively identifying daily actions that support progress, 5) ongoing monitoring and benchmarking progress, and 6) overcoming any barriers to change. When identified family concerns are beyond the bounds of coaching, parent coaches ensure appropriate referrals are made to address the social determinants of health, mental health issues, adverse childhood experiences (ACEs), trauma, toxic stress, and learning/educational concerns.

Screenings of adverse childhood experiences, the social determinants of health, and other risk factors are necessary to promoting the health of the population being served. Equally critical is the shared vision among pediatric practice staff of the importance of regular screenings, as well as comfort addressing identified concerns. Pediatricians are consequently trained in Motivational Interviewing as a modality for engaging parents in a dialogue around

social/emotional concerns and obtaining treatment for them. The key drivers necessary for successful integration into the pediatric practice are outlined here.

Positive Psychology Coaching: Coaching psychology has been defined as the enhancement of well-being and performance in personal life and work domains, underpinned by models of coaching grounded in the application of psychological and behavioral science into practice, and using the best up-to-date knowledge based on current research, theory and practice.[6] Meta-analytic studies[7,8] and systematic reviews[9] demonstrate that coaching is an effective intervention. The most common theoretical models reinforcing coaching psychology are cognitive behavioral coaching and positive psychology coaching.[10] Family coaching has recently emerged within the field of coaching psychology as a new and distinct intervention as it seeks to foster the achievement of family-identified goals through a process-driven relationship between a family and professional coach.

Positive Psychology coaching specifically marries the science of coaching psychology with the extensive research base of that exists on positive wellbeing and optimal human functioning in the positive psychology.[6] Positive Psychology research on childhood has focused on both school-based and family-based interventions. Evidence shows that school-based positive psychology programs are significantly related to improvements in child wellbeing, relationships and academic performance,[11] while school-based intervention for adolescents' also show significant decreases in general distress, anxiety and depression symptoms.[11,12] Positive parenting educational and group sessions have been shown to significantly improve parent-reported and observed child behaviors, and parenting skills,[13] and strength-based parenting is positively associated with life satisfaction among family members.[14] Converging evidence indicates that interventions which successfully promote factors such as positive emotions, character strengths, and hope advance subjective well-being as well as decrease psychiatric symptoms in the general population of children and teens.[11,12]

Core Components

Population-wide **screenings at identified well-child visits** (1 month, 15 months, 3 years, etc.) assess risk factors such as adverse childhood events (ACEs), food/financial insecurity, harsh discipline and parental stress. Families screening as "at risk" are identified for parent coaching, as are families who report parenting concerns at other pediatric appointments. Coaches repeatedly outreach to parents to **engage** them in coaching. The goal of coaching is to educate, empower and guide parents in creating their own solutions to parenting concerns, addressing risk factors and improving family functioning in order to support their children's development

The coaching process is focused on collaborative identification and attainment of the goals identified by parents at intake. Specific steps in the process include: **1) identify desired outcomes, 2) establish specific parenting vision/goals, 3) provide information/education key to obtaining desired change, 4) co-create an action plan for achieving parenting goals, 5) monitor and evaluate progress, and 6) modify action plans as needed**. The monitor-evaluate-modification steps of this process constitute a simple cycle of self-regulated behavior that is key in creating intentional behavior change[4] and resulting in sustained improvements in parent-child interactions.

Practice Activities

Core Component	Activities	Operational Details
Screening	Assess risk factors such as Adverse Childhood Experiences (ACEs), food/financial insecurity, harsh discipline and parental stress	Screenings conducted by medical staff at specific well child visits (e.g., 1 month, 15 months, 3 years)
Referral	Refer to Parent Coaching	Patients and families referred to parent coaching based on routine screenings that are deemed positive or when an identified need arises during a patient visit at any age.
Coaching process: Outcomes	Outcome identification	Coaches receive referral information from medical staff and general information from parents regarding the identified need
Coaching process: Engagement	Connection with Parent Coach	Coaches reach out to parents to coordinate convenient meeting times and locations. Virtual sessions are available.
Coaching process: Vision/goals	Establish parent vision/goals	Coaches elicit parents' specific goals or vision of what they would like to achieve via coaching.
Coaching process: Education	Provide education	Throughout the coaching process, coaches provide the foundational education needed for the family to achieve their goals.
Coaching process: Action Plan	Co-create action plan	Coaches partner with parents to identify the concrete steps they will take to achieve their goals.
Coaching process: Monitor and Evaluate	Monitor and evaluate progress	Coaches partner with parents to benchmark progress and overcome identified barriers to achieving their goals.
Coaching process: Modify Plan	Modify plan as needed	Based on outputs of evaluation process, coaches partner with parents to identify alternate next steps to achieve goals. Process repeated until goals are achieved.

Evidence of Effectiveness (e.g. Evaluation Data)

Evaluation Plan:

Response: The evaluation plan for the parent coaching program includes processes for measuring programmatic outcomes, the quality of coach-parent interactions, and operational quality metrics (e.g., timeliness of scheduling, outreach).

Identification:

At identified well-child visits, parents complete a parent questionnaire assessing the presence of parenting challenges, harsh discipline, parental depression, parental substance abuse, food/financial insecurity, and domestic violence. Parents reporting scores categorized as "at-risk" (score of one or greater) are referred by providers to parent coaching, as well as any other parents of patients who report parenting concerns during an office visit; those accepting the referral are contacted by a member of the coaching team and scheduled with a parent coach. See the Safe Environment for Every Kid (SEEK) Model for such an assessment tool: https://www.seekwellbeing.org/

Data Collection:

- **At intake**: parents complete basic demographic information, consent and client's rights documentation and four subscales of the Healthy Family Parenting Inventory (HFPI): Parenting Efficacy, Parent-Child Behavior, Role Satisfaction, and Personal Care. (Healthy Families Parenting Inventory: http://lecroymilligan.com/pages/resources-hfpi.php)
- **At session three:** parents again complete the four subscales of the HPFI.
- **At case closure**: parents are asked to complete an online satisfaction survey, sent via email. Those who did not complete three sessions (so did not complete the session three HFPI), are also asked to complete the four subscales of the HFPI.
- **Three months post case closure:** parents are requested to complete the four HFPI subscales via online survey.

Outcomes:

Primary outcomes for parent coaching are improvements in parental/family functioning as assessed by the HFPI, as well as reduction in risk factors as assessed by the Parenting Questionnaire.

Data analysis:

Evaluation of operational outputs, programmatic outcomes, and satisfaction data comprise the data analytic plan.

- **Monthly operational metrics**: total screens completed, total number/percent positive screens, top risk factors noted, number of referrals to parent coaches (including referral type and screening/non-screening referrals), number of referrals to external agencies, number/percent of those referred who engaged in parent coaching, average number of coaching sessions, and primary parent and/or child needs at time of referral.
- **Quarterly programmatic outcome metrics**: change in HFPI total and subscale scores, changes in Parent Questionnaire (% reduction in risk factors for total risk factors, parenting challenges, harsh punishment, parental depression, parental substance abuse, financial/food insecurity, and domestic violence.
- **Monthly customer satisfaction metrics**: net promoter score for parent coaching; net promoter score for physician/physician office; satisfaction with access to services (scheduling, timeliness, location), service needs met, quality of service, and competence of staff.

Results:

All families referred to parent coaching are documented in our data system. We outreach to each family referred at least three times using multiple channels (phone, email, text), checking to ensure we have the correct contact information for parents to promote engagement. Approximately 50% of families referred to parent coaching engage in the program (i.e., meet for one or more coaching sessions).

Parent report via the Healthy Families Parenting Inventory (HFPI) and the Parent Questionnaire (PQ) indicate improvements in family functioning between intake and session three (or case closure if prior to session three), and between intake and three months following case closure. See documentation linked here, and described below, for detailed statistical information.

Healthy Families Parenting Inventory:

Between intake and session three/case closure:

- Scores on the HFPI (n= 246), which measures a variety of protective factors, indicate significant improvements in Role Satisfaction (-5.68, p=0.001), Parent-Child Behavior (-6.86, p<0.001), Parenting Efficacy (-7.67, p<.001), and Overall Score (7.53, p<0.001). See Table 1 in attached document.
- Among parents who reported elevated or "concerning" HFPI subscale scores at intake, the following reported scores within normal range by session three/case closure: Personal Care (33%), Role Satisfaction (43%), Parent-Child Behavior (36%), and Parenting Efficacy (40%). See Table 3 in attached document.

Between intake and session three months post case closure:

- Scores on the HFPI (n= 81) indicate significant improvements in Role Satisfaction (-3.70, p=0.001), Parent-Child Behavior (-4.90, p<0.001), Parenting Efficacy (-2.57, p=.012), and Overall Score (4.06, p<0.001). See Table 1 in attached document.
- Data on reduction in HFPI scores from "concerning" to within normal range is not reported for three months post case closure due to small sample size.

Parent Questionnaire:

- The average number of risks endorsed by parents on the PQ (n=233) fell from 1.5 at intake to 0.9 by session three/case closure (8.18, p<0.001). For those completing the survey at three months post case closure (n=55), average number of risks fell from 1.2 at intake to 0.8 at three months post case closure (2.50, p=0.015). See Table 2 in attached document.
- Among parents who reported specific risk factors at intake, the following reported no risk by session three/case closure: Parenting Challenges (45%), Harsh Discipline (71%), Food/Financial Insecurity (50%), Parental Depression (54%). See Table 3 in attached document. No such data is reported three months post case closure due to small sample size.

Evaluation outcomes and results are impacted in a number of ways.

- Because physicians and their staff are the primary referral vehicle to parent coaching, parent coaches and other program staff do not control how families are referred to us. Initial

and ongoing training and education for medical staff is conducted regarding the scope of appropriate referrals, how to describe parent coaching to parents, and Motivational Interviewing to overcome ambivalence to the intervention. Program staff are unable to guarantee physicians are referring the entire population who would benefit from parent coaching or that the program is offered to parents in an engaging or motivating manner.

- As part of continuous improvement efforts, program staff have elevated the presence of signage and informational materials in pediatric practices to increase self-referral rates. With these efforts, self-referrals have increased from between 5-7% in prior years to approximately 10% over the past 3-6 months. Another continuous improvement project that is underway involves testing outreach methods to families with positive screens at well-child visits who were not referred by medical staff.
- Multiple unknown factors that influence parental motivation and readiness to engage in parent coaching certainly influence and bias program outcomes. Program staff work to address any barriers to coaching as they arise. Parents are also made aware they may participate in the program at any time, as the time is right for them, and our coaches are trained in techniques that support parent engagement (e.g., active listening, acceptance without judgment).

Replication

To date, there have not been any replications of this practice in other areas. If you are interested in replicating the practice, please reach out to the project contact listed at the end of this document.

Section II: Practice Implementation

Internal Capacity

Staffing required for this program included:

- Program Director**:** provides strategic direction for program and staff; oversees relationships with health networks and medical staff leadership; provides oversight overall aspects of program including budgeting, staffing, staff service delivery, test-and-learn agenda, etc. (1 FTE)
- Program Supervisor: meets with parent coaches to provide supervision; assists parent coaches with crisis management and case support; ensures high quality service delivery and documentation; manages daily operations; maintains relationships with pediatric practices (1 FTE)
- Program Coordinator: manages parent referrals, data collection, management, and operational reporting (.75 FTE)
- Parent coaches: Parent coaches are embedded at 1-2 practices, depending on size and need of the practice. In 2019, 5 parent coaches provided service at 10 pediatric practices. Parent Coach qualifications include a minimum of 5 years of experience working with children and families, as well as a bachelor's degree in a related field (psychology, social work, human development).

A structured yet flexible coaching model with accompanying manual was developed, grounded in Natural Strength Parenting™ and best practices as identified by the International Coaching Federation. New coaches are trained on the model and supported by other program staff with regard to its adherence. In addition to supervision, coaches engage in ongoing peer case consultation and regular practice of coaching concepts and best practices.

Collaboration/Partners

There are a variety of ways in which the program engages with stakeholders to obtain feedback and share in decision-making.

For staff:

- **Staff meetings/trainings prior to program launch**: Implementation processes begin at least 3 months prior to launch. Meetings and trainings with all staff are held to obtain input, create buy-in, and prepare the entire practice staff for program launch.
- **Ongoing staff meetings**: Monthly meetings are held with staff in first-year pediatric practices to build trusting relationships, obtain feedback, continue training, and encourage continued growth and development of the program model within the practice. Starting in the second year, meetings continue at least quarterly with all practice staff inclusive of doctors, nurse practitioners, nurses, medical assistants and practice administrators. Data outputs are reviewed along with discussion focused on identifying and implementing process improvements and enhancements to best serve parents.
- **Information Sharing:** Parent Coaches add notes in the medical practice's shared Electronic Health Record. This allows for intentional case consultation information sharing and ongoing communication/feedback practices to serve parents and families holistically.
- **Pediatrician Advisory Council (PAC)**: This group of pediatricians meets quarterly; meetings are facilitated by the Program Director and a physician consultant from the Mayerson Center for Safe and Healthy Children at Cincinnati Children's Hospital Medical Center. Information and feedback from these quarterly meetings inform all aspects of the program. Pediatricians on the PAC are also available via conference call or email for feedback/consultation between meetings
- **Satisfaction Survey**: Pediatrician feedback regarding the program is received annually via an online satisfaction survey sent via email. Feedback is incorporated into the ongoing program improvement process.

For parents:

- **Parent Advisory Council**: The Parent Advisory Council meets quarterly to obtain input from previous parent participants in coaching about their experience of the program, as well potential enhancements. The Council meetings are facilitated by a parent coach and the Beech Acres Parenting Center Director of Marketing. Parents' feedback is incorporated into the ongoing program improvement process, including refinement of

how the program connects with parents, components of the coaching model, and all other innovative ideas or program enhancement options.

- **Data review**: Case-related information (e.g., parenting concerns) is reviewed quarterly internally and with medical practice staff to understand the types of concerns parents bring to parent coaching in order to refine and improve program processes and curriculum.
- **Net Promoter/Satisfaction Survey**: At case closure, parents are sent an online satisfaction survey via email. Feedback is incorporated into the ongoing program improvement process.

Practice Cost

Budget		
Activity/Item	**Brief Description**	**Total**
Annual Licensing	Practice Licensing cost determined per pediatrician based on a standard 6-pediatrician practice. This total includes the training and equipping of the pediatricians, nurses, medical assistants and other staff. The price includes the training team, inclusive of a pediatrician, master trainer and a Parenting Specialist trainer. The goal is to train the practice staff and parenting specialist to implement the standardized model so they can get the coaching results. The licensing model also includes ongoing coaching and support during implementation phase and potentially beyond. **Preliminary pricing outlined includes the salary for the parenting specialist.**	$90,000 (for 6 pediatrician practice)

Practice Timeline

Practice Timeline				
Phase	**Description of Activity**	**Date/Timeframe**	**# of hours needed to complete/ oversee activity**	**Person(s) Responsible**
Planning/ Pre-implementation	Model Framework Created	March 2016- September 2018	720	Parenting Specialist, Consultant
	Training Schedule Developed	September 2018- October 2018	40	Agency Staff
	Plan for Quality and Monitoring created	October 2018	20	Director of CQI, Agency Staff, VP
Implementation	Training Delivered	November 2018- March 2019	20	Trainer
	Service Manual created and implemented	February 2019	20	Parenting Specialist, Consultant
	Fidelity Monitoring during sessions followed by coaching	December 2018- March 2019	25	Consultant
Sustainability	Ongoing Training Sessions (formal and informal)	March 2019 - ongoing	2 hours per month	Parenting Specialists
	Team Case Consultation	March 2019 – twice per month ongoing	4 hours per month	Parenting Specialists
	Routine Supervision Meetings	July 2018 - Ongoing	2 hours per month	VP
	Session Monitoring and Coaching/Feedback	March 2019 - Ongoing	10 hours per month	Program Evaluation, VP

Resources Provided

Bethell, Christina D., et al. "Adverse childhood experiences: assessing the impact on health and school engagement and the mitigating role of resilience." *Health Affairs* 33.12 (2014): 2106-2115. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0914

Lessons Learned

At program launch, the coaching delivery model lacked a consistent foundational framework and was therefore individually interpreted and implemented by parent coaches, making it difficult to drive for routine outcomes and results. Through the continuous improvement process, a standardized coaching protocol has been developed and includes expectations and best practices for engaging parents and staff, research-informed behavior change techniques to be incorporated into the coaching process, ethical and compliance standards, and consistent documentation of cases.

Coaches receive ongoing training and supervision regarding best practices in engagement and high-quality delivery of the coaching model. Quality indicators have been developed that assess coach adherence to engagement practices, delivery of coaching protocols, ethical and compliance standards and guidelines, and documentation audits. Feedback to coaches encourages ongoing growth and skill development. Additional quality checks, supervision and mentoring are provided when gaps in quality are identified.

The coaching team also uses a continuous rapid cycle learning process to boost innovation and enhance service delivery for the program. Since inception of the program, rapid-cycle learning practices have been used continuously to ensure consistent methods for planning and tracking lessons learned. Monthly team meetings with parent coaches are dedicated to innovation and learning. Using a team approach, “leap of faith assumptions” are tested, focused on key value propositions regarding what is important to pediatricians and to parents. Parent Coaches are encouraged to consider what enhancements would drive the most value and benefit to our customers (parents and medical staff). Examples of hypotheses tested include: Do we save medical staff time? What if doctors could always access us in the moment when they needs us? Would parents prefer phone coaching versus in-office visits?

Each coach on the team is charged with conducting six learning experiments each year. Coaches develop a concept, identify anticipated outcomes, write up an experiment design sheet, and test their hypothesis within a 30-60 day time window. When positive impact is identified, the learnings are shared with the team, the test concept is integrated across the team and, dependent on the outcome of further team monitoring and input, modifications are made to existing processes and practices. All test information is entered into the program’s data system and the library of tests are easily accessible. The team uses this library to identify what tests have been conducted previously (and their results), and to generate additional innovation and process improvement ideas.

The team uses feedback received from stakeholders to inform and identify experimentation opportunities and incorporates process improvements accordingly. As an example, one parent shared that it would be helpful to know the kind of issues that parent coaches could address to

help inform their decision to whether engage in services. As a follow up, the coaching team worked with members of the Parent Advisory Council to create a parent friendly list of common parenting challenges addressed in coaching services and added this information to a program handout. After this was implemented, parents engaging in services were asked if they had seen this listing prior to connecting for services for a pre-determined ~~set~~ period of time and found that more than 50% of the respondents said "yes." As a result, this information is available in all practice exam rooms for parents to easily access.

Next Steps

The parent coaching model is intended to be replicable and scalable. The program strategy includes replication in a variety of types of pediatric practices (e.g., different socio-demographics), as well as potential virtual delivery of aspects of the program going forward.

Practice Contact Information
For more information about this practice, please contact: • *Beech Acres Parenting Center in Cincinnati, OH* • *Jill Huynh, VP Parent Connext™* • *513.233.4801* • *jhuynh@beechacres.org*

References

[1]Robert Wood Johnson County Health Rankings Program 2014. http://www.countyhealthrankings.org/what-is-health)

[2] The economic burden of child maltreatment in the United States and implications for prevention" http://www.sciencedirect.com/science/journal/aip/01452134

[3]Fenton. Health care's blind side: the overlooked connection between social needs and good health. Available from: http://www.rwjf.org/vulnerablepopulations/product.jsp? id=73646). Accessed December, 2018.

[4]Grant, A. M., & Cavanagh, M. J. (2007). Evidence-based coaching: Flourishing or languishing? *Australian Psychologist*, *42*(4), 239-254.

[5]Mitchell P, Wynia R, Golden B, et al. Core principles and values of effective team-based health care. Discussion Paper. Washington, DC: Institute of Medicine; 2012. https://www.nationalahec.org/pdfs/VSRT-Team-Based-Care-Principles-Values.pdf. Accessed December 2018.

[6]Green, S., & Palmer, S. (Eds.). Positive psychology coaching in practice. Routledge, 2019.

[7]Theeboom, T., Beersma, B., & van Vianen, A. E. (2014). Does coaching work? A meta-analysis on the effects of coaching on individual level outcomes in an organizational context. *The Journal of Positive Psychology*, *9*(1), 1-18.

[8]Jones, R. J., Woods, S. A., & Guillaume, Y. R. F. (2015). Measuring the Immeasurable: the Perceived Coaching Effectiveness Scale.

[9]Lai, Y. L., & McDowall, A. (2014). A systematic review (SR) of coaching psychology: Focusing on the attributes of effective coaching psychologists. *International Coaching Psychology Review*, *9*(2), 120-136.

[10]Palmer, S., & Whybrow, A. (2017). What do Coaching Psychologists and Coaches really do? Results from two International surveys. In *Invited paper at the 7th International Congress of Coaching Psychology*.

[11]Waters, L. (2011). A review of school-based positive psychology interventions. *The Educational and Developmental Psychologist*, *28*(2), 75-90.

[12]Shoshani, A., & Steinmetz, S. (2014). Positive psychology at school: A school-based intervention to promote adolescents' mental health and well-being. *Journal of Happiness Studies*, *15*(6), 1289-1311.

[13]Cummings, E.M. and Cummings, J.S. (2001). Parenting and attachment. Handbook of parenting: Practical issues in parenting. Bornstein, M.H., ed. Lawrence Erlbaum Associates.

[14]Waters, L. E. (2015). Strength-based parenting and life satisfaction in teenagers. *Advances in Social Sciences Research Journal*, *2*(11).