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The Acceptability of Parenting Strategies for Grandparents Providing Care to Their Grandchildren

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Abstract Despite the evidence supporting parenting programmes as a pathway to reduce and prevent childhood emotional and behavioural problems, these programmes still have low rates of uptake by families in the community. One way of increasing the participation rates of families in parenting programmes is to adopt a consumer's perspective to programme design and development. This study sought to examine whether grandparents providing regular care to their grandchildren viewed the strategies advocated in a parenting programme developed specifically for them as being acceptable and useful, and whether there were barriers to programme use. Forty-five grandparents, with an average age of 61.4 years (SD=5.0), participated in the study. Grandparents provided between 11 and 20 h of care per week to their grandchildren, who were on average 4.5 years old (SD=2.4), with the majority being boys (60 %). Results revealed that grandparents found the strategies promoted in the parenting programme highly acceptable and useful and were likely to use the strategies. Barriers to using specific strategies included time demands and belief that a specific strategy would not work. The implications of these findings are discussed within the context of consumer involvement in programme design and development.

Keywords Consumer · Programme design · Evidence-based parenting programme · Triple P · Grandparents

Increasing the availability and uptake of evidence-based psychological interventions by consumers is one of the primary challenges within the field of psychological services and mental health care delivery (Santucci et al. 2012). It is well documented that despite evidence demonstrating the efficacy and effectiveness of psychological interventions, there are still low rates of uptake by consumer groups in need of care (Kazdin and Blase 2011). There are many potential ways of resolving this disparity. For example, developing innovative ways of delivering psychological care such as web-based delivery or the development of specific smartphone applications can improve reach of interventions (e.g. Kazdin and Blase 2011; Santucci et al. 2012). Programme developers can adopt a public health approach towards prevention and treatments of commonly occurring psychological disorders in order to achieve change at a population level (Sanders 2012). A final approach to increasing the reach of interventions is to include the consumer within all stages of programme design and development (Rogers 1995; Kirby and Sanders 2012). By including consumers within the programme design and development stages, the 'pull demand' for evidence-based psychological interventions can be increased. Pull demand, as defined by Santucci and colleagues (2012, p. 2), 'refers to a demand for a product or service from one consumer group (e.g., retailers) that subsequently increases the demand from another group (e.g., wholesalers)'. This approach has been well adopted by the pharmaceutical industry (Santucci et al. 2012); however, the field of psychology has not been as successful at applying this principle towards consumer engagement and programme uptake nearly as successfully.

We have previously argued that the inclusion of consumers in programme design and development can help strengthen the pull demand of the programme, as well as increase the perceived 'ecological fit' of the programme for the consumer group (Kirby and Sanders 2012). If the consumer group is involved in the programme design stage, it could lead to a process where they begin to advocate for the programme by demanding it from government agencies and mental health delivery services. One way of including consumers in the programme design stages is to determine if the consumer group deems the ensuing developed or adapted programme

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acceptable. We argue that if the programme is viewed as acceptable by the specific target group, it will increase the pull demand of the service, which will have the rippling effect of increasing the uptake of psychological interventions.

Establishing acceptability is an important and necessary step in adapting existing programmes for new target populations. In the context of parenting interventions, acceptability refers to the extent to which a specific parenting group (e.g. grandparents) considers that a parenting programme or specific parenting advice is useful (e.g. sleep management routine, routine for managing temper tantrums), relevant, and culturally appropriate (Kirby and Sanders 2012). Parents can make judgments of acceptability concerning the content, format, and modes of delivery used to implement a programme (Morawska et al. 2011). Several studies have successfully tailored existing evidence-based parenting programmes to specific parenting groups following qualitative methods (e.g. focus groups) and quantitative methods (e.g. questionnaires) and/or through applying relevant theory (Kirby and Sanders 2012; Morawska et al. 2011; Whittingham et al. 2010). A key reason to assess for consumer acceptability of a programme is that individuals are more likely to access treatments that they view as acceptable (Borrego and Pemberton 2007), while treatments that are perceived as unacceptable may not be accessed regardless of their effectiveness (Eckert and Hintze 2000). This paper will examine the consumer acceptability of a modified parenting programme for grandparents.

Grandparents as a New Consumer Group for Parenting Programmes

Grandparents are increasingly recognised as playing a vital role in the upbringing of children by providing either custodial grandparenting (Backhouse and Graham 2010; Hayslip and Kaminski 2005) or regular child care to their grandchildren (Rosenthal and Moore 2012). In the USA between 2.3 and 2.4 million grandparents have primary responsibility for the care and upbringing of 4.5 million children (Hayslip and Patrick 2003). Grandparents also provide significant amounts of informal child care to grandchildren. Informal child care refers to non-regulated care that takes place in the child's home or elsewhere (Australian Bureau of Statistics [ABS] 2012). In Australia, 26 % of all children aged between 0 and 12 years receive informal child care from their grandparents (ABS 2012). Importantly, grandparents who provide informal child care provide on average 12 h of care to their grandchildren per week, a similar amount to that of parents who access formal child care services (14 h; ABS 2012). The trend of grandparents providing informal child care in Australia is also echoed in other Western cultures such as the UK, the USA, and New Zealand (Francese 2009; Hendricks 2010; Ochiltree 2006).

The increasing involvement of grandparents in helping raise grandchildren is evidence for the importance of creating nurturing environments in order to prevent and treat early onset conduct problems in children (Biglan et al. 2012). The distinguishing features of nurturing environments include (a) minimizing biologically and psychologically toxic environments, (b) promoting and reinforcing prosocial behaviours such as self-regulatory skills, (c) reducing the opportunities for problem behaviour, and (d) encouraging psychological flexibility of individuals. In accordance with this framework, it has been argued that the field of parenting takes a greater social ecological perspective and considers the impact that outside influences such as grandparents have on the emotional and behavioural development of children (Barnett et al. 2010). One way of contributing to positive outcomes in children and creating nurturing environments is for grandparents to adopt positive parenting strategies (Kirby and Sanders 2012). With research evaluating parenting practices over the last 30–40 years, we now have a better understanding of what strategies are effective and ineffective in helping prevent and reduce childhood emotional and behavioural problems (Sanders 2012; Webster-Stratton 2008). Many researchers have suggested that grandparents may not be cognisant of current parenting practices due to the time delay between being a parent for the first time and becoming a grandparent (Dolbin-MacNab 2006; Rosenthal and Moore 2012). As such, information on current parenting strategies may be useful in helping grandparents in their caregiving role and subsequently helping create nurturing environments to promote positive outcomes for children.

The Challenges of Grandparenting

There are many factors that influence whether grandparents can provide nurturing environments for children. Whether grandparents utilise positive parenting strategies, communicate and problem solve functionally with the parents, and manage their own stress levels are all positive examples that can impact on the nurturing environment in which children grow. There is a significant amount of research investigating the parenting behaviours of custodial grandparents. Research suggests that there are many inherent difficulties for grandparents when parenting for a second time (Smith et al. 2008); many of the grandchildren they care for have higher levels of emotional and behavioural problems (Fergusson et al. 2008; Pittman 2007; Smith and Palmieri 2007), the full parenting role itself is often unexpected (Dolbin-MacNab 2006), they have an insufficient knowledge about child development and current parenting strategies (Jendrek 1994), and there are many opportunities for potential conflict with other family members, particularly with their adult children (Dolbin-MacNab 2006; Heywood 1999; Minkler and Fuller-

Thomson 1999). Subsequently, researchers have suggested that custodial grandparents need information about new and effective parenting strategies that are more relevant and currently acceptable (Hayslip and Kaminski 2005; Jendrek 1994; Minkler and Fuller-Thomson 1999).

In contrast to custodial grandparents, there is a paucity of research investigating the parenting behaviour of grandparents providing informal child care. One study conducted by Rosenthal and Moore (2012) provided some insights into this grandparent population by conducting a survey examining the everyday experiences of 1,205 Australian grandmothers. Grandmothers in the survey reported providing on average 12 h of care per week to their grandchildren, the average age of the grandmothers was 63 years, and the majority of grandmothers provided care for between two and three grandchildren. Based on the results from their survey, Rosenthal and Moore (2012) reported that grandmothers found that there was a clear distinction between being a grandmother and a mother, with the main aim of the grandmother being to reinforce the parents' rules and discipline strategies. Furthermore, grandmothers reported that it was important to be firm, set limits with the grandchildren, and discuss parenting strategies with the parents. Grandmothers also reported that parenting practices that they had used when they were parents were not considered acceptable in today's era (e.g. an authoritarian approach to parenting that included strategies such as spanking and strict rules), suggesting that grandparents may appreciate having access to a refresher course on alternative parenting methods. One fifth of grandmothers surveyed reported experiencing conflict over discipline or child upbringing with the parents.

The notion that grandparents and parents experience conflict over parenting strategies is not new. For example, Thomas (1990) asked 69 mothers (52 married and 17 divorced) to describe the advantages and disadvantages of having grandparents in the family. Both married and divorced mothers agreed that grandparents' childrearing advice and their interference in childrearing were the worst aspects of having grandparents in the family. As a result, researchers have acknowledged that when designing programmes to help assist grandparents, the inclusion of components to help the grandparent–parent team could help overcome difficulties (Rosenthal and Moore 2012; Thomas 1990). Communication-based and problem-solving strategies may help minimize the psychological toxicity of the environment in these families by reducing disagreement and conflict between grandparents and parents.

Given the significant involvement of grandparents in providing care to their grandchildren, it is not surprising that many grandparents find the role challenging (Coall and Hertwig 2010). Grandparents have reported experiencing emotional tiredness, isolation from friends, finding it difficult to manage more than one grandchild at a time, and feeling as though they were being taken for granted (Goodfellow and Laverty 2003). In addition, focus group research by Kirby and Sanders (2012) found that grandparents struggled with feelings of stress, guilt, frustration, and tiredness. These feelings tended to be exacerbated in situations where grandparents felt as if they were being taken for granted by the grandchild's parents, felt obligated to provide the child care, or felt that they were unable to take a break from the child care role. This research suggests that coping strategies to assist grandparents with managing these unhelpful feelings could be beneficial for grandparents. However, no research has yet examined whether grandparents would find parenting strategies, communication-based strategies, and coping strategies designed to address these difficulties acceptable if delivered in a programme designed for grandparents.

Grandparent Triple P

Grandparent Triple P (GTP) is a variant of the Level 4 Group Triple P-Positive Parenting Program (Triple P; Turner et al. 2002), which has been tailored to the concerns and needs of grandparents who provide care to their typically developing grandchildren (Kirby and Sanders 2012). Triple P is a multilevel system of parenting aimed at preventing behavioural, emotional, and developmental problems in children and adolescents by enhancing the knowledge, skills, and confidence of parents (Sanders 2012). Triple P has been extensively evaluated with 68 randomized controlled trials evaluating its efficacy on parent and child outcomes, with 66 of these being peer-reviewed publications (Sanders, Kirby, Tellegen, & Day, Systematic Review and Meta-Analysis of the Triple-P System, unpublished; see Triple P evidence-based website www.pfsc.uq.edu.au/research/evidence). Furthermore, Triple P has been assessed by independent evaluators through four different meta-analyses, all of which reported positive intervention effects for both parent and child outcomes (de Graaf et al. 2008a, b; Nowak and Heinrichs 2008; Thomas and Zimmer-Gembeck 2007).

GTP is an adaptation of Triple P for grandparents, which consists of a 9-week intervention comprising six group sessions lasting 120 min and three telephone consultations lasting between 20 and 30 min (see Table 1 for an overview of session content). There are three key aims of GTP. The first is to provide a refresher course in parenting strategies for grandparents (parenting strategies), the second is to help improve the relationship between grandparents and parents (team strategies), and the third is to provide coping strategies to help grandparents manage stress and other unhelpful emotions that can arise from the grandparenting role (coping strategies). In the first session of GTP, the programme introduces the parenting strategies. At this point, resistance can occur, as it implies that grandparents may not have adequately parented their own adult children (Dolbin-MacNab 2006; Hayslip and Kaminski 2005). One way to circumvent this resistance is to emphasize in the initial session that grandparents already have a wealth of

Table 1 Description of GTP session content

Session	GTP session content
Session 1: Parenting strategies	Positive grandparenting • The principles of positive grandparenting are introduced; grandparents are asked to set goals for change and taught how to keep track of grandparent/grandchild behaviour.
Session 2: Parenting strategies	Helping grandchildren develop • A refresher in positive parenting strategies is reviewed with the grandparents. The strategies are aimed to build positive relationships, encourage desirable behaviour, and teach new skills and behaviours to grandchildren. Grandparents are taught how to apply the strategies of descriptive praise, talk, affection, and setting a good example to the parents.
Session 3: Parenting strategies	Managing misbehaviour • A refresher in managing misbehaviour strategies is reviewed with the grandparents.
Session 4: Team strategies	Building a positive parenting team • Grandparents are introduced to possible grandparenting traps that can negatively influence the grandparent–parent relationship. • Grandparents are introduced to positive/negative communication skills and problem-solving strategies and taught how to manage the emotional distress of parents.
Session 5: Coping strategies	Grandparent survival skills • Grandparents are introduced to the unhelpful emotions of stress, anxiety, depression, and anger and taught how these emotions can affect the relationship with the parents, their partners, and grandchildren. • Grandparents are taught coping strategies to manage unhelpful emotions (e.g. controlled breathing, pleasant activity scheduling).
Session 6	Planning ahead • Grandparents are taught how to assess for high-risk situations and develop routines on how to manage them (e.g. situations with the parents, going shopping)
Sessions 7–8	Telephone consultation • Grandparents are given the opportunity to set an agenda and discuss positive and challenging situations they are having. The practitioner provides support utilising a self-regulatory framework.
Session 9	Programme close • Grandparents are introduced to how to maintain change and identify future obstacles, and finally family survival tips are discussed.

parenting experience. Consistent with adult learning theories (Barer-Stein and Kompf 2001; Smith 1983), the GTP programme encourages grandparents to reflect on their past parenting experiences, consider the strategies advocated in the programme, and self-evaluate whether the suggested parenting strategies would be helpful for them in managing grandchild behaviour. In this way, GTP is acknowledging the grandparents' past parenting experience and at the same time is encouraging continual parenting self-regulation.

Another unique component of GTP is the inclusion of a session centred on how to build a positive parenting team with parents (e.g. team strategies). This session includes strategies derived from evidence-based behavioural couple therapy programmes such as communication skills and problem-solving strategies (Halford et al. 2008; Petch and Halford 2008). Partner communication and problem-solving strategies have not been previously applied to intergenerational relationships such as between grandparents and parents; rather they are typically used when the couple relationship does not improve through responding to parenting strategies alone (Ireland et al. 2003). Researchers have argued (Kirby and Sanders 2012; Thomas 1990) that strategies to enhance grandparent–parent communication need to be a core element in a grandparenting programme. Although the relationship between grandparents and parents differs from that of romantic couples, these strategies could potentially enhance the grandparent–parent relationship.

Collectively, providing programmes like GTP to grandparents has the potential to create nurturing environments for children to prevent and treat early onset conduct problems (Biglan et al. 2012). However, before the efficacy of GTP is assessed in a randomized controlled trial, it is important to assess the acceptability of the programme from the perspective of the consumer. If the programme is not deemed acceptable by the consumer group, it may not be accessed by the very community it was intended to be disseminated to regardless of its effectiveness (Eckert and Hintze 2000).

Study Aims

The main aim of this study was to evaluate the acceptability of the GTP strategies in a sample of grandparents who provide regular care to their grandchildren. Furthermore, we sought to identify any specific barriers that grandparents may face in using the strategies promoted in Grandparent Triple P. Addressing each of these areas is important, as it will determine the likely uptake and engagement of GTP in the community. This study aims to provide researchers with information regarding what grandparents want from a parenting programme and to help determine whether GTP needs to be further modified to better suit the needs of grandparents.

Methods

Participants

This study was embedded in the context of a randomized controlled trial of Grandparent Triple P, which is being conducted in Brisbane, Australia (Sanders and Kirby 2011).

Participants were recruited from October 2010 to February 2012 through child care centres, kindergartens, and schools in metropolitan Brisbane, Queensland. Participants were eligible for the study if the grandparents were providing 12 h of care or more per week to their grandchild aged between 2 and 9 years (at point of first contact) and expressed concerns regarding their grandchild's current functioning ('Are you concerned about social, emotional, or behavioural problems in your grandchild?') *or* were in the clinical range for depression, anxiety, or stress according to the Depression Anxiety and Stress Scale (Lovibond and Lovibond 1995). Grandparents were excluded if their grandchild had a disability and/or chronic illness, including language and speech impairment; if the grandparents or parents were currently seeing a professional for the child's behaviour difficulties; if the grandparents were currently receiving psychological help or counselling; or if the grandparents were intellectually disabled and/or hearing impaired. For grandparents who provided care to more than one grandchild, grandparents were asked to complete the measures and programme in reference to the grandchild they were most concerned with social, emotional, or behavioural problems.

In total, 105 grandparents were assessed for eligibility by the first author. Based on a standardized telephone screen, 54 (51.4 %) grandparents (51 female, 3 male) met eligibility criteria. Grandparents were not included in the study if they did not meet eligibility criteria (n=35), were too busy to attend the programme (n=7), or lived outside of Brisbane (n=9). Of the 54 grandparents involved in the GTP programme, 45 (83 %) participants completed a questionnaire on the acceptability of the strategies advocated in the programme. Grandparents were asked to complete the questionnaire in the final session of the GTP programme. Reasons for participants not completing the questionnaire were due to the grandparents being too busy to attend the final session (n=4) or not being able to be contacted (n=5). Grandparents attended on average eight sessions (M=8.65) of the nine-session programme, yielding a 96 % attendance rate across all sessions of the programme. Grandparent participants were not compensated for their time, and this research was conducted under ethical approval from the University of Queensland Behavioural and Social Sciences Ethical Review Committee.

Table 2 Specific strategies used in GTP that were assessed for acceptability

Category of strategy	GTP specific strategy
Parenting strategies	Strategy 1: Quality time • Spending small amounts of special time—as little as 1 or 2 min—often throughout the day. Strategy 2: Descriptive praise • Describe the behaviour that you like; be clear and specific, and genuine. Strategy 3: Ask, say, do • For teaching a new skill or behaviour. Break into three steps—ask your grandchild what you do→if they cannot tell you, say what you do→if they cannot do the skill for themselves, help or do it for them. Strategy 4: Logical consequences • If your grandchild does not follow a rule or clear instruction, then choose a consequence that fits the situation.
Team strategies	Strategy 5: Positive speaking/listening skills • Listen attentively to the parent, keep to the point, and speak in simple and clear language. Strategy 6: Casual conversations • Ask parents about their day; ask about the grandchildren, so you are both kept up to date. Brief conversations, keep to one or two stories, ask parents whether they would like you to listen or help problem solve. Strategy 7: Problem solving • Simple problems—ask parents what they could do or have done previously. Complex problems—ask what is the goal, what options do they have, the consequences, trial it, and review. Strategy 8: Acknowledge the parents' emotions • Stop and listen to the parent, try and name the emotion, validate the emotion; if the parent calms down, ask if you can help or if they would prefer you to listen.
Coping strategies	Strategy 9: Acceptance • Being prepared to accept that you are unable to change situations that are outside of your control. Strategy 10: Coping statements • To help challenge and change thoughts—e.g. 'I have done it before', 'I have a plan'. Strategy 11: Pleasant activities • Doing activities that you like and scheduling them into your diary—e.g. go for a walk. Strategy 12: Controlled breathing • Slow controlled breathing.

Materials

Each grandparent completed the group GTP programme that was conducted by the first author. Each grandparent received a workbook summarizing the session content also including suggested between-session homework. A summary of the key content areas covered in each session of the GTP programme is displayed in Table 1, and each specific strategy assessed for acceptability is described in Table 2. The facilitator discussed each strategy in the GTP programme with the grandparents in the session providing active demonstrations on how to use each strategy.

With respect to the specific parenting strategies discussed in the programme, the *Every Parent's Survival Guide* (Sanders et al. 2005), which is a DVD that provides an explanation of the parenting strategies utilised by Triple P, was used and shown over the course of the programme. Each of the parenting strategies is presented individually, and the DVD provides a description of how to implement the strategy. The DVD uses parent and child actors who reflect a number of different

cultural backgrounds to act out the appropriate way to use each strategy. When the DVD was shown during GTP sessions, the facilitator instructed grandparents to 'pretend' that the parent actors used in the video were actually grandparents and emphasized that the video was being used only to demonstrate the parenting strategies. The research team is aiming to develop a grandparenting-specific video that features grandparent actors and includes not only the parenting strategies, but also the positive parenting team strategies and coping strategies that form part of the GTP programme.

Measures

The sociodemographic characteristics of the sample were collected using the Family Background Questionnaire (FBQ; Zubrick et al. 2005). The FBQ collected data on the age, gender, marital status, and ethnicity of the participant. It also collected information on level of education, employment status, and socio-economic background. Participants were also asked how many hours per week they cared for their grandchildren, for which family they provided care (i.e. daughter/son-in-law family or son/daughter-in-law family), and whether they lived with the grandchildren and parents.

Child Behaviour The Eyberg Child Behavior Inventory (ECBI; Eyberg and Pincus 1999) is a 36-item measure of parental perceptions of disruptive behaviour in children between the ages of 2 and 16 years. It consists of two subscales, one for the frequency of disruptive behaviours (Intensity) and one for the number of behaviours that are a problem for parents (Problem). The two subscales have high internal consistency (α=.95 and .94, respectively), and the questionnaire has good test–retest reliability (r=.86) (Eyberg and Pincus 1999).

Parenting Style The Parenting Scale (PS; Arnold et al. 1993) is a 30-item questionnaire measuring three dysfunctional discipline styles. Its yields three factors: laxness (permissive discipline), overreactivity (authoritarian discipline, displays of anger, meanness, and irritability), and verbosity (overly long reprimands or reliance on talking). Each scale and the total score have good internal consistency (α=.83, .82, .63, and .84, respectively), and the scale has good test–retest reliability (r=.83, .82, .79, and .84, respectively; Arnold et al. 1993).

Grandparent Adjustment The Depression Anxiety Stress Scale-21 (DASS; Lovibond and Lovibond 1995) is a 21-item questionnaire assessing symptoms of depression, anxiety, and stress in adults. The DASS has good convergent and discriminant validity (Lovibond and Lovibond 1995) and test–retest reliability (r=.71–.81 for each scale). In this sample, the three subscales demonstrated good internal consistency (α=.84, .85, and .87, respectively).

Grandparent Acceptability The acceptability questionnaire was modified based on Morawska et al.'s (2011) acceptability survey that examined the acceptability, usefulness, likelihood of use, and current use of the Triple P strategies. The survey was modified so that it covered four strategies from each key area of the Grandparent Triple P programme. Grandparent Triple P covers three key areas: parenting strategies, team strategies, and coping strategies. As a result, 12 strategies were assessed for their acceptability. Grandparents rated the acceptability, usefulness, likelihood of usage, and current use for each strategy by circling a number on a 10-point scale with higher scores indicating that a strategy is more acceptable, useful, likely to be used, and currently used. Following this, parents indicated whether or not there were barriers to using each strategy, and if yes, they were asked to indicate what these potential barriers were by ticking the appropriate box or writing on the line provided. The following barriers were included: the strategy takes too much time, the strategy will not work for my grandchild, other family members object to the strategy, lack of confidence in using the strategy, other family members would not support me when using the strategy, and the strategy is against my cultural beliefs. There was also a free text category for grandparents to include other barriers that were not listed. Grandparents were also asked how helpful they found the *Every Parents' Survival Guide* DVD on a 10-point scale, with 10 indicating it was 'extremely helpful' and one indicating that is was 'not at all helpful'.

Results

Sociodemographic Characteristics of the Sample

There were 45 grandparents who participated in the study, of which 42 (93 %) were women. The average age of grandparents was 61.40 years (SD=5.0), and most participants were married or in a de facto relationship (62.2 %). The average age of the grandchildren was 4.46 years (SD=2.4), with the majority being boys (60 %). Grandparents provided between 11 and 20 h of care to the target grandchild per week (66.7 %), with the majority of care provided to their biological daughter/son-in-law family (75.6 %) compared to their biological son/daughter-in-law family (24.4 %). The grandparents were predominantly of Australian/Caucasian background (97.8 %). Most grandparents indicated that they had enough money left over after their expenses to purchase some (28.9 %) or most of the things (57.8 %) they wanted; however, four grandparents (8.9 %) had not been able to meet their household expenses at some stage in the previous 12 months. The majority of grandparents lived with their grandchildren in some form of household arrangement (51.1 %), with 20 % living in their own home with the parents and grandchildren, 17.8 % living in

their daughter/son-in-law's home with grandchildren, and 13.3 % living in their son/daughter-in-law's home with grandchildren. The remaining 48.9 % of grandparents lived in their own home without their grandchildren. The majority of grandparents had completed a vocational education course, trade, or university degree (73.3 %), with 26.7 % of grandparents having completed only high school education or less. Most of the grandparents were in paid work (73.3 %).

Child Behaviour, Parenting Style, and Grandparental Adjustment

Grandparents reported generally moderate levels of grandchild behaviour difficulties, with a mean ECBI Intensity score of 115.1 (SD=27.1) and a mean Problem score of 11.9 (SD=8.4). Grandparents reported 26.7 % of children as being in the clinical range for the intensity scale (clinical cut-off 131) and 31.1 % in the clinical range on the problem scale (clinical cut-off 15). Compared to the norms provided by the ECBI (Colvin et al. 1999), the results from this sample suggest that the children were elevated in terms of childhood problems compared to the general population (2–6 years old mean ECBI Intensity=99.2, ECBI Problem=6.3; 7–11 years old mean ECBI Intensity=99.7, ECBI Problem=7.2).

In terms of parenting style, grandparents tended to be in the normal range on the PS with 13.3 % of grandparents scoring in the clinical range for laxness (M=2.4, SD=.7), 8.9 % in the clinical for overreactivity (M=2.0, SD=.7), and 20 % in the clinical range for verbosity (M=3.0, SD=1.3). According to the norms provided for the PS for a non-clinical sample (Arnold et al. 1993), it suggests that the grandparents are in the normal range for parenting practices (mean score for laxness=2.4, overreactivity=2.4, and verbosity=3.1).

Finally, in terms of grandparental adjustment, 20 % of grandparents were in the clinical range on the depression subscale (M=4.8, SD=6.0), 6.6 % in the clinical range on the anxiety subscale (M=2.8, SD=5.1), and 15.5 % in the clinical range for stress (M=8.2, SD=7.4) as measured by the DASS. According to the norms provided for the DASS (Crawford et al. 2011), adults in the 25–90-year range have a mean score for depression of 2.2, anxiety 1.5, and stress 3.8. These norms suggest that the grandparents recruited in this sample were elevated on adjustment issues compared to the general population.

Acceptability of Parenting Strategies and Video Material

As reported in Table 3, grandparents found the strategies advocated in GTP highly acceptable and useful, and most grandparents reported either currently using the strategy or being likely to use the strategy in the future. A one-way analysis of variance (ANOVA) was conducted to check for differences between grandparents providing between 12 and 20 h of care per week compared to grandparents providing more than 20 h of care per week. Across the 12 strategies assessed, there were no differences in acceptability, how often, or how likely grandparents were to use the 12 strategies. However, grandparents providing more than 20 h of care per week (M=9.6, SD=.5) reported using descriptive praise more often than grandparents providing less than 20 h of care (M=8.8, SD=1.0; $F(1, 32)$=9.6, p=.003).

Table 3 Mean and standard deviation for acceptability, usefulness, likelihood of use, and current use for 12 strategies used in Grandparent Triple P (N=45)

Strategy	Acceptability *M* (SD)	Usefulness *M* (SD)	Likelihood of use *M* (SD)	Current use *M* (SD)
Quality time	9.3 (1.1)	9.2 (1.0)	8.9 (1.3)	8.4 (1.5)
Descriptive praise	9.6 (.8)	9.5 (.7)	9.5 (.7)	9.0 (.9)
Ask, say, do	8.7 (.9)	8.6 (1.2)	8.3 (1.2)	7.4 (1.5)
Logical consequences	8.8 (1.3)	8.6 (1.1)	8.5 (1.4)	7.9 (1.6)
Speaking/listening skills	9.3 (1.0)	9.3 (.9)	9.1 (1.1)	8.6 (1.4)
Casual conversations	8.9 (1.2)	8.9 (1.2)	8.6 (1.3)	8.0 (1.5)
Coach problem solving	8.5 (1.3)	8.4 (1.3)	7.8 (1.3)	7.2 (1.6)
Acknowledging parents' emotions	9.1 (1.1)	9.1 (1.1)	8.6 (1.4)	7.8 (1.9)
Acceptance	9.0 (1.2)	9.0 (1.1)	8.4 (1.3)	8.0 (1.5)
Coping statements	9.1 (1.2)	9.0 (1.1)	8.8 (1.3)	8.2 (1.6)
Pleasant activities	9.4 (1.1)	9.3 (1.0)	9.3 (1.1)	8.7 (1.6)
Controlled breathing	9.3 (1.3)	9.4 (1.3)	9.0 (1.5)	8.3 (2.0)

A one-way ANOVA was also conducted to check for differences between grandparents who provide child care to their daughter/son-in-law family compared to their son/daughter-in-law family. Across the 12 strategies assessed, there were no differences in acceptability, usefulness, likelihood, or how often the strategies were used.

Analyses were conducted to determine whether grandparents found the different categories of strategies (e.g. parenting, team, and coping) suggested in GTP as being more acceptable than others. The mean acceptability score for parenting strategies was 9.1 (SD=.8), team strategies was 9.0 (SD=.9), and coping strategies was 9.2 (SD=.9). T tests revealed that the acceptability ratings were higher for coping strategies than for team strategies (M=9.0, SD=.9), t=2.2, p=.034. However, there were no other significant differences found, with mean ratings across all of the three types of strategies being very high.

In addition, a series of one-way ANOVAs were conducted to determine whether grandparents in the clinical range on the ECBI, PS, or DASS subscales found the strategies less acceptable than the grandparents not in the clinical range. All results were non-significant except for grandparents in the clinical range on the laxness subscale of the PS who reported

finding the parenting strategies less acceptable (M=8.5, SD=.9) than grandparents not in the clinical range (M=9.2, SD=.7; $F(1, 43)=6.1$, $p=.018$). Finally, grandparents reported that they found the video helpful (M=8.7, SD=1.5).

Barriers to Strategy Use

Grandparents were asked what strategy they would encounter the most barriers with when attempting to use them. Forty-eight percent of grandparents reported coach problem solving as the strategy with the most barriers, then Ask Say Do (42.2 %) and quality time (40 %). This was followed by logical consequences (40 %) and casual conversations (33.3 %). The strategies with the least barriers were coping statements (11.1 %), descriptive praise (6.7 %), and controlled breathing (6.7 %). Finally, grandparents reported the most commonly experienced barriers to using GTP strategies were the time required to use the strategy (15.2 %) and the belief that the strategy would not work (8.2 %), while the least likely barriers were opposition from other family members for using the strategy (1.3 %) and cultural barriers (0 %).

Discussion

The results indicated that overall, grandparents found the parenting, team, and coping skills strategies promoted in GTP highly acceptable and useful and reported that they were very likely to use the strategies. Furthermore, there was a very high attendance rate for grandparents participating in GTP (96 % attendance rate), suggesting grandparents found the programme acceptable and engaged in the 9-week programme. Given that grandparents reported high acceptability of the strategies advocated in GTP, this is promising for the potential pull demand and uptake of the programme if disseminated to the community. Although grandparents rated all strategy types very highly, grandparents reported that the coping strategies were significantly higher in acceptability compared to the team strategies. Despite this difference, grandparents still rated the team strategies highly. The finding of high acceptability of the parenting strategies advocated in GTP supports the approach recommended by Hayslip and Kaminski (2005) and Dolbin-MacNab (2006) of acknowledging the past parenting experiences of grandparents to minimize resistance to suggested parenting advice.

This study also found that grandparents who were in the clinical range for laxness reported finding the parenting strategies less acceptable than grandparents who were not. However, these grandparents still reported high acceptability of parenting strategies (M=8.5). This finding has implications for practitioners delivering GTP, as they can be more attuned to assisting grandparents who scored in the clinical range on laxness when delivering the parenting strategies to those grandparents.

There were no differences found between grandparents who were involved in the care of their daughter/son-in-law families compared to their son/daughter-in-law families on the acceptability of strategies in GTP. It has been previously noted that grandparents feel a distinct difference between communicating with their daughter-in-law compared to communicating with their son-in-law (Kirby and Sanders 2012). Given this finding, the team strategies adopted by GTP seem to be acceptable for grandparents providing care to both their daughter/son-in-law family and son/daughter-in-law family.

In regard to the barriers identified by grandparents, the main barriers were related to issues surrounding time and the belief that the strategy would not work for their grandchild. These barriers were also the main ones identified in the Morawska et al. (2011) study, indicating that these barriers may be common across parenting populations. These results have implications for practitioners potentially delivering GTP. For example, practitioners may be able to anticipate such barriers and assist grandparents in overcoming them. In particular, practitioners can adopt a motivational interviewing approach, by asking grandparents during sessions which barriers they believe they will face and how they can successfully manage and overcome these barriers.

The least likely barrier reported by grandparents was opposition from other family members. This finding was important, as it indicated that grandparents did not perceive objection from the parents regarding parenting strategies or team strategies advocated in GTP. This result has implications for dissemination of GTP, as it suggests that parents will not act as a barrier to grandparents participating in the programme. In addition, given that the team strategies were rated highly acceptable by grandparents, it supports romantic partner support strategies as an acceptable pathway to enhance the grandparent–parent relationship.

Interestingly, 51.1 % of grandparents in the sample were living in some form of household arrangement with their grandchildren. This large proportion of co-residential living between grandparents, parents, and children provides further weight behind the importance of creating nurturing environments for children (Biglan et al. 2012). Further, this trend of co-residential living has implications for parenting programmes that aim to prevent and treat childhood social, emotional, and behavioural problems. Currently, parenting programmes typically focus on the immediate parent–child relationship; however, this study indicates that this view should be broadened, and parenting programmes should look to extend their reach to include other family members such as grandparents in order to help children (Barnett et al. 2010).

These findings provide a valuable insight into how grandparents view the acceptability of parenting programmes to assist them in their role of providing care to their grandchildren. The high acceptability of the types of strategies adopted in the GTP programme indicates that the programme has good

perceived ecological fit with the target population of grandparents. When a programme has increased ecological fit with a parenting population, there is likely to be better engagement, uptake, and fidelity with the programme by the consumer group (Kirby and Sanders 2012). The major implication of the high acceptability found of GTP by grandparents is it could lead to better uptake of the programme in the community if disseminated, and this is an important empirical question that needs to be tested. Increasing uptake in parenting programmes is important, as a recent population survey of parents showed that 75 % of parents who had a child with an emotional or behavioural problem had not participated in a parenting programme (Sanders et al. 2007). This result is concerning, as it has been suggested that the quality of parenting children receive impacts on every aspect of children's development and adult outcomes (Collins et al. 2000).

Although GTP, a Level 4 group-based programme, was deemed acceptable by grandparents, it does not mean that other levels of Triple P should not be developed in the future for grandparents. Triple P adopts a public health approach to parenting (Sanders 2012), as traditional methods of delivering parenting programmes (such as individual or group therapy) have limited impact on prevalence rates of social, emotional, and behavioural problems in children, as well as rates of child maltreatment, at a population level (Prinz and Sanders 2007). The Triple P system incorporates five levels of intervention on a tiered continuum of increasing strength and narrowing population reach for parents of children from birth to age 16. The population of grandparents providing care to grandchildren is heterogeneous, with some grandparents providing full-time care and others providing informal child care to their grandchildren. Accordingly, it might be necessary to develop a system of grandparenting interventions that adopts differing levels of intervention in order to best meet the needs of the different populations of grandparents. For example, Level 5 of the Triple P system might be best suited to custodial grandparents experiencing clinical levels of psychological distress, whereas Level 2 of the programme (i.e. large group seminars) might be more appropriate for informal grandparent caregivers providing only 2–5 h of child care per week to their grandchild. Therefore, both universal and targeted interventions might need to be developed and included in a system of interventions in order to meet the differing needs of grandparents and provide a comprehensive system of grandparenting support.

Limitations and Future Research Directions

The present study had a number of limitations that need to be considered when interpreting the results. Only a representative sample of the strategies included in GTP were assessed for acceptability. If all 34 strategies were evaluated, it would have added considerably to participant burden. As such, the key strategies from each section (i.e. parenting, team, and coping strategies) were evaluated. The sample size recruited for this study was relatively small (N=45), which may have been a possible reason for the lack of significant findings reported when comparing differences in acceptability for the different strategies. The sample itself was also somewhat restricted, as to be eligible for inclusion grandparents needed to report difficulties with child behaviour and possible adjustment problems. These restrictions may impact on the generalizability of the obtained findings to the population of grandparents at large. However, we would argue that the grandparents who are most likely to access a programme like GTP are the ones who are experiencing difficulty with grandchild behaviour and adjustment difficulties. In addition, given grandparents could only report on one target grandchild, it is unknown whether the programme had generalized effects on siblings or other grandchildren. Moreover, the study sample was predominantly women (93 %) and did not have much diversity in ethnicity, with over 90 % of the participants identifying as having a Caucasian/Australian background. As such, the results cannot be generalized to other diverse cultural backgrounds. In addition, there was a lack of custodial grandparents involved in the study; further research needs to assess the strategies with this population. It would have been advantageous to ask grandparents why they were providing regular care to their grandchildren in order to understand the recruited sample and the grandparent population more fully. Finally, grandparents provided high ratings of all of the strategies, implying a possible impact of social desirability on ratings. However, there were significant differences in ratings between different types of strategies, indicating that grandparents did discriminate between strategies and were not simply rating all strategies equally.

In terms of future research directions, the strategies included in GTP need to be assessed for acceptability with custodial grandparents. Moreover, to further explore the acceptability of GTP with the grandparent population as a whole, the penetration of the programme needs to be assessed. As such, effectiveness and dissemination trial evaluations should be conducted in order to further explore the acceptability of GTP. In addition, GTP could be assessed for acceptability with grandparents who have impairments themselves (e.g. disability) or who have grandchildren who have a disability, and the perspectives of grandfathers need to be better captured in future research. Finally, the acceptability of lighter touch versions of GTP, such as a seminar programme or a brief discussion group, should be examined, with different grandparenting groups (e.g. custodial grandparents and grandparents providing informal child care), as not all grandparents would be in need of a nine-session group programme.

Conclusions

The chief aim of the current study was to determine whether grandparents found the strategies advocated in GTP as being acceptable and usable. Overall, the results from the study

indicated that grandparents do find the strategies acceptable. A randomized clinical trial of GTP is clearly warranted and is currently being conducted. However, further research should continue to assess the acceptability of GTP with other populations, such as custodial grandparents and grandparents from other ethnic backgrounds. Assessing for acceptability of a programme and its strategies is a necessary step in helping improve the reach of psychological interventions, as effectiveness alone does not equate to successful programme dissemination.

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