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# EFFECTIVENESS OF THE GROUP TRIPLE P (POSITIVE PARENTING PROGRAM) IN AN ORPHANAGE CONTEXT IN LAHORE, PAKISTAN

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**Abstract:** An inadequate caregiving environment in an orphanage can negatively impact children's well-being, while a lack of specialized training can induce work-related stress and lower self-efficacy among caregivers. This study examined the effectiveness of the Group Triple P (positive parenting program) with caregivers of children in Pakistani orphanages. Fourteen caregivers across three orphanages completed self-report questionnaires and took part in Group Triple P. A repeated measures ANOVA indicated that the personal well-being of the caregivers improved following intervention. There was also a significant increase in caregivers' parenting efficacy and a decrease in the use of dysfunctional parenting practices. The frequency and number of children's challenging behaviors was reported to decrease significantly, along with a significant increase in warmth and reduction in negativity in caregiver–child relationships. This study was the first to implement Group Triple P in an orphanage context. The outcomes support the use of an evidence-based parenting intervention with orphanage caregivers who are in a proxy parenting role.

**Keywords:** behavioral problems, parenting practices, orphanages, Triple P, orphanage context, orphanage caregivers

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**Data availability statement:** The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Pakistan is home to 4.6 million child orphans who rely solely on state or private charity organizations (Mahmood et al., 2020). Orphans are vulnerable in the sense that they are exposed to conditions or circumstances that are not within their control (Isnaeni et al., 2021). Losing parents and being placed in an orphanage can significantly impact the psychological well-being of a child (Yendork & Somhlaba, 2014). Orphaned children, in addition to facing many hardships early in life, often experience additional trauma once placed in orphanages. This is especially true if the institution's caregiving environment is inadequate, as this can negatively affect children's development (Hermenau et al., 2015, 2017; Vik et al., 2018). There is consistent evidence that institutionalized children exhibit more behavioral and emotional problems, along with developmental and intellectual delays, compared to those raised in a family environment (Bromfield et al., 2010). Proposed mechanisms for these poorer outcomes include emotional distress caused by the absence of a consistent positive caregiver (Palusci, 2011), and a lack of emotional and social sustenance (Lakhdir et al., 2021).

People who work as caregivers for orphans are a significant part of their lives (Alvi et al., 2017), and caregivers' capacity to provide responsive caregiving plays a vital role in children's psychological and physiological development (Slack et al., 2011). Orphanage caregivers often experience significant caregiving stress that can decrease their work capacity and self-confidence (Akram et al., 2015). Caregiving work is challenging and emotionally demanding, making caregivers susceptible to mental health issues and exhaustion (Kaufman et al., 2019). Work-related stress and lower self-efficacy can directly impact not only the well-being of caregivers but also the development of the children under their care (Akram et al., 2015), shaping and affecting caregivers' attitudes, behaviors, and caregiving practices (Kaufman et al., 2019). Raskin et al. (2015) found high-stress symptoms among orphanage caregivers in Ukraine and proposed that caregiving stress leads to hostile parenting of institutionalized children and is a major predictor of children's adverse developmental outcomes. Caregivers in Ghanaian orphanages reported that a lack of caregiving training and support was related to their high stress levels and low skill set (Bettmann et al., 2015).

When primary caregivers view a child's behavior to be problematic, the chances of neglect increase (Deb, 2015). Other risk factors for maltreatment include caregivers' lack of parenting knowledge and skills, low self-confidence, poor emotion regulation, lack of social support, negative interactions with the child, and a poor caregiver–child relationship (Akram et al., 2015; Bromfield et al., 2010). Certain protective factors such as a positive and healthy attachment with caregivers, and caregivers' knowledge of parenting and child development, resilience, social connections and support, and self-efficacy can provide a buffer against maltreatment (Austin et al., 2020).

For positive psychological outcomes, young children need stable and consistent relationships with their primary caregiving figures, as well as responsive, trustworthy, and developmentally

appropriate care (Clément et al., 2016). Research involving child–caregiver attachment in orphanages shows that there is often a lack of caregiver stability, consistency, responsiveness, and emotional availability, which can hinder the child–caregiver bond and cause difficulties with the development of healthy, stable, relationships in a child's future life (Slack et al., 2011). Although there is some evidence of a positive impact on the mental well-being of children after being placed in an orphanage (Dahlan, 2016; Whetten et al., 2014, 2009), these results were connected to constructive and healthy orphanage management, children's basic needs being met, and emotional support being provided to the children by a consistent and responsive attachment figure. This suggests that promoting a warm, consistent, and positive upbringing in orphanages can enhance developmental outcomes (Isnaeni et al., 2021).

Caregiving practices in orphanages can be enhanced by staff training and expansion of their skill sets; even a little training accompanied by ongoing monitoring can prevent poor developmental outcomes for children and improve caregivers' psychological well-being (Bani Ismail et al., 2018). Positive changes in caregiving practices can also decrease the risk of child maltreatment. Indonesian caregivers have expressed a strong need for context-specific training (Dahlan, 2016), which has also been seen in Pakistan (Alvi et al., 2017; Shafiq et al., 2020; Yousuf & Khan, 2017).

There are many similarities in the roles of parents and orphanage caregivers, such as providing emotional support to children, taking care of their daily needs, and helping with household chores and schoolwork, along with disciplining them (Vashchenko et al., 2010). Caregivers share the same challenges as parents when it comes to dealing with matters both small and large: from picking the right color of socks to responding to serious temper tantrums (Vik et al., 2018), which makes their roles and responsibilities very similar. In orphanages in Ghana, Darkwah et al. (2017) found that caregivers considered themselves to be "parents" of the children under their care, rather than just minders. Since parents and orphanage caregivers share similar roles and responsibilities, many studies have concluded that parenting programs could be effective for caregivers as well (Vik et al., 2018; Vlahovicova et al., 2017).

Parenting programs that focus on social learning and behavior change have demonstrated efficacy in the prevention and management of children's emotional and behavioral issues (de Graaf et al., 2008; Sanders et al., 2014). Parent training results in improved knowledge, more confidence, and effective caregiving (Hermenau et al., 2015, 2017; Holzer et al., 2006). Some meta-analyses have confirmed the benefits of evidence-based parenting interventions with regard to child-rearing practices, parent–child relationships, parenting stress, and emotional and behavioral problems of children in foster care and adoption (Schoemaker et al., 2020). Comparable results, at least in the short term, have been found for families of disadvantaged socioeconomic status (Leijten et al., 2013).

One parenting intervention, the Triple P – Positive Parenting Program (Sanders, 2023), which was built on the premises of social learning theory (Hart & Risley, 1995), principles of applied

behavior analysis (Baer et al., 1968) and self-regulation theory (Bandura, 1986; Karoly, 1993), aims to improve parenting knowledge and skills and reduce negative behavioral, emotional, social, and developmental outcomes in children. Rigorous and extensive evidence for its effectiveness has been reported in many meta-analyses (de Graaf et al., 2008; Nowak & Heinrichs, 2008; Sanders et al., 2014). Triple P has been shown to reduce rates of child maltreatment (Prinz et al., 2022) and has been applied and proven effective in diverse countries and cultures, including Iran (Tehranidoost et al., 2008), China (Guo et al., 2016), Japan (Matsumoto et al., 2007), Switzerland (Bodenmann et al., 2008), Singapore (Zhou et al., 2017), and Australia (Turner et al., 2007).

Multiple formats have been proven to be effective, including individual face-to-face delivery (Turner & Sanders, 2006), small and large group-based programs (Morawska, Haslam et al., 2011; Sanders et al., 2000), telephone-based and self-directed modules (Morawska & Sanders, 2007; Sanders & Mazzucchelli, 2018), and interactive online delivery (Baker et al., 2017; Prinz et al., 2022). Triple P has been deployed in 39 countries and has been translated into 22 languages (Turner et al., 2020).

Extant literature has emphasized the impact of dysfunctional parenting practices on the lives of children in multiple contexts, and how learning responsive, positive, child-rearing practices can protect children against further mistreatment; learning such practices also enhances the skill sets and well-being of primary caregivers. Many studies in Pakistan (Akram et al., 2015; Alvi et al., 2017; Shafiq et al., 2020; Yousuf & Khan, 2017) have strongly emphasized the importance of training caregivers in orphanages with evidence-based caregiving knowledge for skill enhancement, stress management, and healthy developmental outcomes among children under their care. Although Triple P has proven efficacy and effectiveness in many contexts and populations, it has not been evaluated in an orphanage context. Furthermore, Triple P has never been implemented in Pakistan. This provided the impetus for an evaluation of evidence-based parenting support for caregivers in the context of Pakistani orphanages.

This study focused on examining the effectiveness of Group Triple P (Turner et al., 2015) with the caregivers of children residing in orphanages in Lahore, Pakistan. It was hypothesized that, after participating in Group Triple P, caregivers would report (a) improved personal well-being and self-efficacy (H1); (b) a reduction in dysfunctional parenting practices (H2); (c) a reduction in emotional and behavioral problems among children in their care (H3); (d) improved caregiver–child relationships (H4); and (e) satisfaction with the program and its outcomes (H5).

## Method

This study was a feasibility trial using a quasi-experimental, within-group design to assess the effectiveness of Group Triple P among caregivers working in orphanages in Lahore, Pakistan. Assessment occurred at three points in time: pre-intervention, post-intervention, and at a 6-month follow-up.

### *Participants*

Purposive sampling was used to recruit caregivers of 4- to 12-year-old children from three orphanages in Lahore, Pakistan. This age group was the focus because orphanages do not admit children younger than four years and the needs of teenagers are different. Caregivers had to be providing care to children in the focus age group, and able to read and write in English so they could complete the assessment measures. We also required that they not be suffering from any terminal illness, in order to control for the confounding effect that it could have on caregivers' perceived well-being and level of stress. The total number of children across the three orphanages was 687, with 20 caregivers (32 children/3 caregivers from orphanage 1, 184/5 from orphanage 2, and 471/12 from orphanage 3). No further information was collected on the children due to the orphanages' privacy policies. Fourteen caregivers met the study criteria (the remaining six were not caring for 4- to12-year-old children) and agreed to participate. Participants' ages ranged from 27 to 51 years ($M$ = 40.6, $SD$ = 7.5). Six were female and eight were male. All of the male caregivers had Master's level qualifications, while four female caregivers had high school education and two had Master's qualifications. Caregivers usually worked in pairs, doing either day or night shifts of 10 to 12 hours. Accommodation was provided to all caregivers and their families by the orphanages. They were also provided with free meals, utilities, and education for their own children. Caregivers' roles in the orphanages included daily care, mentoring, and supporting schoolwork.

### *Procedure*

Permission to conduct the research was obtained from the heads of the three orphanages and confidentiality agreements were signed. The project was approved by the University of Queensland's Human Research Ethics Committee (approval number 2020001253). The head of each orphanage referred participants based on our inclusion and exclusion criteria. The participating caregivers provided informed, written consent. Due to COVID-19 pandemic travel restrictions, negotiations with the heads of the orphanages and study participants led to the online delivery of the program. Group sessions were facilitated via video conferencing to groups of caregivers in their workplaces. A locally based facilitator was available to help with logistical matters such as computer, internet, and screen set-up, and distributing assessment measures and program notes.

A 2-hour introductory session was conducted in which the aim and purpose of the study were discussed, participant information sheets and consent forms were provided, and any questions about the research were answered. Participants signed consent forms and completed pre-assessment measures. Participants were advised that they could refuse to answer any questions they were not comfortable with, and they could opt out of the research at any time without having to provide an explanation. They also gave written consent for recording the video program sessions, for fidelity checks to ensure that the parenting program was being delivered consistently and reliably, for the creation of transcriptions, and for the involvement of the researcher's academic supervisors.

### *Measures*

Because caregivers acted as proxy parents to the children in their care, the assessment included measures that have been validated with parents. English versions of these measures were used, as all the caregivers in our study could read and understand the English language.

The short version of the General Health Questionnaire (GHQ-12; Goldberg & Hillier, 1979) was used to measure the personal well-being of the caregivers (H1). The GHQ measures a person's current condition and compares it to their routine state. The original version, the GHQ-28, has been used with a student population in Pakistan (Riaz & Reza, 1998). A score of 19 or greater on the 12-item GHQ-12 indicates the presence of a psychological problem (Goldberg & Hillier, 1979). The GHQ-12 is a reliable tool with Cronbach's alpha .93 (Hankins, 2008). Reliability for the current sample was $\alpha = .74$.

The Parenting Sense of Competence Scale (PSOC; Gibaud-Wallston & Wandersman, 1978) was used to measure parental self-efficacy in caregivers (H1). It was designed for use with parents with children up to age 17. It includes items assessing parenting satisfaction (anxiety, motivation, frustration) and efficacy (competence, capability, problem-solving). Higher parental competence is indicated by higher scores. There are no recommended clinical cutoff scores. The total score has good internal consistency ($\alpha = .80$; Gibaud-Wallston & Wandersman, 1978). This scale has been used with Pakistani mothers to assess their parental competence (Shakil et al., 2021). Reliability for the current sample was $\alpha = .76$.

The Parenting Scale (PS; Arnold et al., 1993; Rhoades & O'Leary, 2007) was used to assess the parenting practices of caregivers (H2). It consists of 30 items that measure three dysfunctional parenting styles: Laxness (permissiveness, inconsistency), Overreactivity (authoritarian discipline, anger, meanness, irritability), and Hostility (using verbal or physical force). Higher scores indicate more dysfunctional parenting. It has the following cutoff scores: Laxness > 3.6, Overreactivity > 4.0, Hostility > 2.4, and total score > 3.2 (Rhoades & O'Leary, 2007). The PS has been recommended as a valid measure of parenting practices ($\alpha = .88$; Locke & Prinz, 2002) and has previously been used in Pakistan with mothers of preschool children (Khowaja et al., 2016). Cronbach's alpha coefficients for the current sample were: Laxness $\alpha = .91$, Overreactivity $\alpha = .76$, Hostility $\alpha = .73$, and total $\alpha = .82$.

The Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999) was used to measure children's behavioral and emotional issues as reported by caregivers. Each caregiver was asked to complete the measure for the two children whose behavior they found the most challenging (H3). We asked caregivers to provide information on those two children in order to gain a better understanding of perceived child problems and the caregiver–child relationships. Later, the score of just one child was randomly selected per caregiver for analysis. This child's score was used for all the assessment measures to maintain uniformity. Selecting two children per caregiver for the assessment measure and then later randomly selecting one child per caregiver controlled for bias and added an element of randomization to this feasibility trial.

The ECBI is designed for parents of 2- to16-year-old children. Its 36 items yield two subscales. The Intensity score, which measures how often challenging behaviors occur, ranges from 1 (*never*) to 7 (*always*), with the clinical cutoff being 131 or more. For the Problem score, which measures the number of behaviors that are considered to be a problem by parents, the clinical cutoff is ≥ 15. The scale has high internal reliability for both the Intensity (α = .95) and Problem (α = .94) scales (Robinson et al., 1980) and was adequate in the current sample, with α = .70 and .62 respectively.

The Child-Parent Relationship Scale (CPRS; Pianta, 1992), which measures how parents perceive their relationship with their child, was used to assess caregivers' perceived relationship with the same two children for whom they completed the ECBI (H4). The child who was randomly selected for ECBI was used for the assessment analysis of this scale as well. The 30-item CPRS comprises two subscales, Closeness and Conflict. The Closeness subscale measures parents' feelings of warmth and affection in their relationship with their child, with a cutoff score of 37 (Driscoll & Pianta, 2011). A higher score indicates more warmth in the relationship. The Conflict subscale assesses the extent to which a parent perceives their relationship with their child as negative, with a cutoff score of 16 (Driscoll & Pianta, 2011). A higher score indicates more perceived negativity in the relationship. The CPRS has demonstrated good reliability for both Closeness (α = .72) and Conflict (α = .83) subscales (Pianta, 1992), and has been used with foster carers in the United States (Farris, 2017). In the current sample, the scales showed reliability for Closeness (α = .90) and for Conflict (α = .72).

The Client Satisfaction Questionnaire (CSQ; Turner et al., 2015) was used to assess caregivers' general satisfaction with Group Triple P (H5). It is a 13-item questionnaire (7-point Likert scale) that measures participants' satisfaction with the quality of the program, how well it met their needs, and whether they would recommend the program to others. The range of possible scores is 13 to 91, with higher scores indicating greater satisfaction with the program.

### *Intervention*

Group Triple P (Turner et al., 2015) was delivered to caregivers in a group workshop format over Zoom. Two 5-hour sessions were conducted in each orphanage. The program's content related to positive parenting principles, common issues reported by caregivers (Khalid et al., 2022), and tailoring the use of relevant parenting skills and techniques for an orphanage context. Audiovisual aids included slides (Turner et al., 2010) and the *Every Parent's Survival Guide* video (Sanders et al., 2018) to illustrate skills for positive parenting. Sessions also involved group discussion, role play, and active skill rehearsal. Handout notes of the digital material and *Every Parent's Group Workbook* (Markie-Dadds et al., 2009) were also provided to participants. These handouts allowed caregivers to refer to the program content during and after the group sessions. In the first session, practice tasks were given as homework. These were intended to help caregivers set personal goals regarding which strategies to implement in their daily caregiving roles. Any challenges they faced were discussed at the second session or at a follow-up session.

There were two key adaptations in our delivery of Group Triple P. First, groups were conducted in Urdu, the national language of Pakistan, for ease of communication and to facilitate richer discussion by boosting the caregivers' confidence. However, intervention materials such as presentation slides and workbooks were presented in English, as all caregivers were able to read and comprehend English. Second, the content on positive parenting principles and skills was discussed as it applied in an orphanage context, addressing common issues reported by caregivers (Khalid et al., 2022b). Culturally relevant and context-specific examples and terminology were used. There is considerable evidence that an intervention developed and delivered in one culture can be just as impactful when delivered with minor, surface-level, adaptations in another culture (Al-Amer et al., 2015, 2016; Gardner et al., 2016; Mamauag et al., 2021; Turner et al., 2020).

Once the Group Triple P sessions were complete, three follow-up Zoom sessions of 20 to 30 minutes each were conducted, again in a group format, to check in with the caregivers, get their feedback regarding their use of the positive parenting strategies, and provide additional support as required. To maintain the fidelity of the intervention, manualized intervention content was delivered by the researcher to all participants as per the Group Triple P session checklists and workbooks. The researcher (Khalid) was an accredited Triple P practitioner, who was supervised by two senior accredited Triple P practitioners who were also registered clinical psychologists.

## Results

### *Data Analysis*

Using SPSS V.27, repeated-measures (within-subjects) ANOVAs were conducted to evaluate the effectiveness of Group Triple P on the dependent variables (general well-being, parental self-efficacy, parenting practices, children's challenging behaviors, and caregiver–child relationships). The means and standard deviations for each measure at three assessment points (pre-test, post-test, and 6-month follow-up) are provided in Table 1, along with mean differences and Cohen's *d* effect sizes from pre-test to post-test, and pre-test to follow-up.

### *Caregiver Well-Being*

The repeated measures ANOVA indicated a significant time effect for the GHQ-12 mean scores from pre-test to follow-up. Bonferroni pairwise comparison revealed a significant decrease in GHQ-12 scores from pre-test to post-test and this was sustained at follow-up with large effect sizes, indicating that the personal well-being of study participants improved after participation in Group Triple P. However, scores did not fall in the elevated range at any time point.

### *Caregiver Parental Efficacy*

A significant time effect was also found for the PSOC mean scores from pre-test to follow-up, with Bonferroni pairwise comparisons revealing a significant change in PSOC total score from pre-test to post-test. This was sustained at follow-up as well, with a reduced but still large effect size. These results suggest that there was a significant increase in caregivers' sense of parental efficacy following participation in Group Triple P.

Table 1. *Effects of Group Triple P on Caregiver and Child Outcomes*

| Measure | Pre *M* (*SD*) | Post *M* (*SD*) | Follow-up *M* (*SD*) | *F (df)* | *p* | Mean difference (95% CI) Pre to post | *p* | *d* | Mean difference (95% CI) Pre to follow-up | *p* | *d* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| GHQ-12 | 11.21 (2.36) | 4.64 (2.06) | 6.93 (1.52) | 59.64 (2,12) | <.001 | 6.57 [4.90, 8.24] | <.001 | 2.96 | 4.25 [2.65, 5.93] | <.001 | 2.16 |
| PSOC | 52.71 (6.28) | 83.71 (5.14) | 63.86 (5.98) | 215.72 (2,12) | <.001 | 31.00 [26.40, 35.59] | <.001 | 5.40 | 11.14 [4.54, 17.75] | .001 | 1.81 |
| PS | | | | | | | | | | | |
| Laxness | 3.78 (1.53) | 1.21 (0.32) | 3.16 (0.79) | 42.72 (2,12) | <.001 | 2.56 [1.43, 3.69] | <.001 | 2.32 | .6 [-.55, 1.78] | .52 | 0.51 |
| Overreactivity | 4.73 (1.21) | 1.38 (0.44) | 2.96 (0.36) | 77.20 (2,12) | <.001 | 3.34 [2.42, 4.26] | <.001 | 3.67 | 1.78 [.83, 2.71] | .001 | 1.98 |
| Hostility | 4.05 (0.84) | 1.40 (0.47) | 1.57 (0.53) | 43.69 (2,12) | <.001 | 2.64 [1.89, 3.39] | <.001 | 3.89 | 2.48 [1.64, 3.32] | <.001 | 3.53 |
| Total | 4.18 (0.58) | 1.33 (0.31) | 2.56 (0.47) | 239.32 (2,12) | <.001 | 2.85 [2.45, 3.24] | <.001 | 6.13 | 1.62 [1.06, 2.18] | <.001 | 3.06 |
| ECBI | | | | | | | | | | | |
| Intensity | 151.07 (15.71) | 94.07 (11.05) | 123.86 (14.44) | 178.24 (2,12) | <.001 | 57 [48.57,65.43] | <.001 | 4.19 | 27.21 [18.75, 35.68] | <.001 | 1.80 |
| Problem | 17.36 (2.40) | 8.21 (1.63) | 14.07 (2.64) | 165.24 (2,12) | <.001 | 9.14 [7.57, 10.72] | <.001 | 4.46 | 3.29 [1.78, 4.79] | <.001 | 1.30 |
| CPRS | | | | | | | | | | | |
| Closeness | 27.57 (6.96) | 40.21 (3.91) | 39.86 (3.74) | 20.1 (2,12) | <.001 | 12.64 [6.99, 18.29] | <.001 | 2.23 | 12.28 [6.79, 17.78] | <.001 | 2.19 |
| Conflict | 50.93 (3.97) | 19.21 (4.98) | 35.64 (9.35) | 186.70 (2,12) | <.001 | 31.71 [27.19, 36.24] | <.001 | 7.04 | 15.29 [7.73, 22.84] | <.001 | 2.12 |

*Note.* GHQ = General Health Questionnaire, PSOC = Parenting Sense of Competence Scale, PS = Parenting Scale, ECBI = Eyberg Child Behavior Inventory, CPRS = Child-Parent Relationship Scale.

### *Caregiver Parenting Practices*

The results of repeated measures ANOVA indicated that there was a significant time effect on the PS total mean scores from pre-test to follow-up. Bonferroni pairwise comparison revealed a significant change in PS total mean from pre-test to post-test and this was sustained at follow-up with a large effect size. These results indicate a significant decrease in the use of dysfunctional parenting practices among caregivers following participation in Group Triple P.

While looking at subscales of the PS individually, the repeated measures ANOVA for the Laxness subscale indicated a significant time effect from pre-test to follow-up. A Bonferroni pairwise comparison revealed a significant decrease in Laxness from pre-test to post-test with a large effect size, but this was not sustained at follow-up. These results suggest that there was a significant decrease in the permissive parenting practices of caregivers following participation in Group Triple P; however, this was not sustained in the long term.

Repeated measures ANOVA for the Overreactivity subscale indicated a significant time effect from pre-test to follow-up. A Bonferroni pairwise comparison revealed a significant decrease in Overreactivity from pre-test to post-test, which was sustained at follow-up, with large effect size. These results suggest that the authoritarian parenting practices of caregivers significantly decreased following participation in Group Triple P.

For the Hostility subscale, repeated measures ANOVA indicated a significant time effect from pre-test to follow-up. Bonferroni pairwise comparison revealed a significant decrease in Hostility from pre-test to post-test, which was sustained at follow-up, with a large effect size. The results suggest that caregivers significantly reduced the use of verbal or physical force in their parenting practices following participation in Group Triple P.

### *Challenging Child Behavior*

The results of repeated measures ANOVA for both the Intensity and Problem subscales of the ECBI indicated significant time effects on the mean scores from pre-test to follow-up. In both cases, Bonferroni pairwise comparison revealed a significant change in Intensity and Problem scores from pre-test to post-test, and this was sustained at follow-up with a large effect size. Taken together, these results suggest that there was a significant decrease in the frequency of challenging behaviors of children reported by caregivers after participation in Group Triple P.

### *Caregiver–Child Relationship*

Repeated measures ANOVA for the Closeness subscale of the CPRS indicated a significant time effect from pre-test to follow-up. A Bonferroni pairwise comparison revealed a significant increase in Closeness means from pre-test to post-test, which was sustained at follow-up, with a large effect size. These results suggest that there was a significant increase in warmth and affection in the caregiver–child relationship following Group Triple P.

Repeated measures ANOVA for the CPRS Conflict subscale indicated a significant time effect from pre-test to follow-up. A Bonferroni pairwise comparison revealed a significant change in Conflict scores from pre-test to post-test, and this was sustained at follow-up with a large effect size. These results suggest that the perceived negativity in the caregiver–child relationship decreased significantly following participation in Group Triple P.

### *Consumer Satisfaction*

The mean program satisfaction rating on the CSQ was high ($M = 86.79$; $SD = 1.53$; maximum possible score 91). Most caregivers rated the quality of the service provided as "good" or higher (95%); indicated that the program had helped them manage children's challenging behavior (92%); and reported that they were "satisfied/very satisfied" overall with the program (96%). This indicates a high level of satisfaction with the quality and acceptability of Triple P and how well the program strategies met the caregivers' and children's needs.

## Discussion

This study examined the effectiveness of Group Triple P with caregivers of children residing in orphanages in Lahore, Pakistan. Overall, the findings supported the hypotheses that Group Triple P is effective in improving the personal well-being and parental efficacy of caregivers, along with reducing both the use of ineffective parenting practices and children's challenging behaviors, while also improving the relationship between caregivers and the children in their care. The program was well received by participants.

Caregivers reported a significant improvement in their general well-being and parental efficacy after completing Group Triple P and at the 6-months follow-up. These findings are in line with research that shows parenting interventions that focus on positive parenting skills training are effective in improving mental well-being and a sense of self-efficacy among parents (Gray et al., 2018; Morawska, Sanders et al., 2011), foster parents (Van Holen et al., 2018), and orphanage caregivers (Whetten et al., 2014). Other randomized controlled trials also suggest that the skills training provided in Group Triple P improves parental efficacy, satisfaction, and mental well-being (Bodenmann et al., 2008; Sanders et al., 2014).

Punitive or harsh parenting methods like corporal and emotional punishment are prevalent in many low-income countries (Devlin et al., 2018; Knerr et al., 2013). In Pakistan, harsh parenting practices are considered normal and used by most parents to discipline their children (Lakhdir et al., 2021). Prior to intervention in the current study, caregivers reported elevated use of many ineffective and harsh parenting practices such as humiliation, insults, and physical punishment, which was evident from high scores (above the clinical cutoff) on the Overreactivity and Hostility subscales of the PS. After completing Group Triple P, caregivers reported significantly less reliance on dysfunctional parenting practices, and fell within the normal community range at post-test and follow-up. These findings parallel the outcomes of Group Triple P with parents (Au et al., 2014; Bodenmann et al., 2008).

Along with a significant reduction in parental stress and unhelpful parenting practices, parents attending Group Triple P have reported a reduction in children's behavioral issues (Gallart & Matthey, 2005; Nogueira et al., 2022). Similarly, orphanage caregivers in this study reported significant reductions in challenging child behavior, with the group mean moving from the clinical to the non-clinical range at post-test and follow-up.

We found sustained improvements in caregiver–child relationships, with increased warmth, affection, and open communication, and decreased discord and negativity. Parent training programs that encourage parental behavior change can result in caregiving that is warmer and more responsive (Clément et al., 2016), improved parental attitudes towards their children, and enhanced trust and comfort (Fujiwara et al., 2011; Lundahl et al., 2006). There is some evidence of enhanced parent–child relationship quality, at least in the short term, following other Triple P interventions (Li et al., 2021; Prinz et al., 2022).

Group Triple P was positively received by all caregivers; they believed the principles of positive parenting to be closely aligned with their cultural and religious beliefs regarding kindness and compassion to others. Caregivers found that, with practice and with contextual adaptations, the positive parenting strategies were convenient to use. They reported that most of the strategies were successful in responding practically to the behavioral and emotional issues of the children, an indication of how well the program strategies met the caregivers' and children's needs. As has been suggested, evidence-based parenting programs can be delivered in a culturally informed way, and adapted to the local context in terms of policies, cultural practices, worker readiness, funding and other resources, and workforce availability and competency (Sanders, 2023).

Although all hypotheses were supported in this evaluation, with all outcomes (bar Laxness) being sustained at follow-up, there was a trend for outcomes to drop off between post-test and follow-up (i.e., effect sizes at follow-up were somewhat reduced). The most well-sustained outcomes at follow-up were enhanced caregiver–child closeness and reduced caregiver hostility. These were the most commonly reported issues for caregivers (i.e., lack of positive relationships and use of coercive caregiving practices to deal with commonly reported issues of children under their care). The only outcome that was not maintained at follow-up was Laxness, showing that caregivers reverted to permissive or inconsistent caregiving, which could be related to reduced concerns about children's behavior and caregivers feeling more confident and in control.

It is also worthwhile noting that the significant outcomes of this Group Triple P trial were achieved via remote program delivery using videoconferencing. This provides support for flexible program delivery in the future. Programs need to be gender-sensitive, culturally informed, and attuned to the local context.

Although the quantitative aspects of the intervention's impact are the focus here, this study is only one part of a broader program of research. One study in this program (Khalid et al., 2022) explored the same caregivers' perceptions regarding their roles, challenges, and the children under

their care before implementation of the intervention. Another (Khalid et al., 2023) reported descriptive narratives of the perceived impact of Group Triple P on caregiver well-being, caregiving practices, parental efficacy, and perceived children's problems, along with exploring the pre- and post-intervention caregiver–child relationship.

### *Limitations*

The main limitation of this study is the small number of participants, which limits the generalizability of the findings. There are many circumstances in which conducting a randomized control trial is not possible, such as in novel situations, or when working with an unfamiliar population or settings. In this study both of these apply, since the Triple P intervention had not previously been used in either an orphanage context or in Pakistan. In these circumstances, using a carefully designed quasi-experimental study can be effective and logical (Maciejewski, 2020). It is also important to note that as a quasi-experimental design precludes conclusions about causality, the results of this study should be seen as a feasibility trial for future research in a similar context but with a larger number of participants using a randomized controlled trial design (Kim & Steiner, 2016). Another methodological limitation is that some of the measures used had not previously been used or validated in orphanage settings. Although they appear to have been change-sensitive (i.e., able to detect changes in outcomes over time), clinical cutoffs are extrapolated from parenting research in other countries and should be interpreted with caution. It should also be kept in mind when interpreting this study that small sample sizes can lead to larger reported effect sizes. We also noticed that, although frequent short breaks were provided during the training sessions, watching a screen for four to five hours caused participant fatigue, requiring the researcher to provide more prompts and motivation to encourage group participation than would typically be needed in face-to-face program delivery.

### *Recommendations*

Further research is recommended in the orphanage context, with larger sample sizes and controlled designs, to strengthen the evidence base and support generalizability. However, the results of the current trial provide support for the idea that evidence-based parenting interventions can be tailored to meet the needs of caregivers working in orphanages. The results also show promise for the implementation of evidence-based parenting intervention programs, such as Triple P, that may be a good cultural and contextual fit for Pakistani families. There is also the potential to use such programs with different populations (e.g., parents, foster carers, healthcare workers, social workers, and staff of shelter homes). For optimal dissemination of positive parenting practices in the orphanage system, organizational supports such as ongoing professional learning and skills development, and organizational processes such as monitoring of caregiver and child outcomes could be employed. Since the orphaned children visit relatives occasionally, a brief parent training program could be conducted with family members. Providing knowledge to orphaned children's relatives regarding positive parenting and child development could positively influence the upbringing of the children, and increase consistency and predictability for them. Finally, as administration staff and other support staff also interact with children on a daily basis,

and ineffective or harsh interactions can impact children's development, providing some form of parallel training to staff other than caregivers may be of benefit to the orphanage culture and create a safer, more consistent environment for the children.

### *Conclusion*

This study was the first to implement Group Triple P in an orphanage context and explore its effectiveness for caregivers and the children in their care. The positive outcomes evidenced — increased caregiver well-being, parenting confidence and skills, and improved child behavior and caregiver–child relationships — support the use of an evidence-based parenting intervention with orphanage caregivers in a proxy parenting role.

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