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# Caregivers and Facilitators' Experience of an Online Implementation of GenerationPMTO in a Pandemic Context

# Experiencia de Cuidadores y Facilitadores sobre la Implementación Online de GenerationPMTO en Contexto de Pandemia

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This research seeks to know the experience of participants -15 caregivers of children between 4 and 12 years old from two schools with a high vulnerability index in Santiago de Chile and 4 facilitators - in the GenerationPMTO program adapted to a remote modality, in the context of the COVID-19 health crisis. A descriptive, exploratory, qualitative study was carried out. Semi-structured interviews with 15 caregivers from both schools participating in the program; one focus group with 4 facilitators who implemented the online program; and a documentary review of the journals registered by the facilitators after each session were conducted. The information collected was analyzed qualitatively through the open coding procedures of Grounded Theory. After that, the perspectives of both groups were gathered through an integrated analysis. From the experience of participants, the online adaptation of the program was successful since the facilitators were able to develop the contents and strategies of the intervention in virtual mode, and the families were able to participate and learn them from their homes. This was compatible with physical distancing (given the COVID-19 pandemic) and allowed caregivers' participation in the program to be compatible with other life activities. Among challenges, strengthening group participation and cohesion were highlighted, as well as overcoming barriers related to unstable internet connection and/or inappropriate home conditions to participate. These results show a successful adaptation of the program from the perspective of its participants, providing insights that contribute to improve the adaptation of this and other programs to virtual modality.

*Keywords*: online implementation, e-mental health, prevention, parent training, GenerationPMTO

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Esta investigación buscó conocer la experiencia de los participantes —15 cuidadores de niños entre 4 y 12 años de dos escuelas con alto índice de vulnerabilidad en Santiago de Chile y 4 facilitadores — del programa GenerationPMTO en su adaptación a modalidad remota, en contexto de crisis sanitaria causada por COVID-19. Se realizó un estudio cualitativo exploratorio descriptivo, en el cual se realizaron entrevistas semiestructuradas a 15 cuidadores de ambas escuelas participantes del programa, un grupo focal con 4 facilitadoras que implementaron el programa de forma *online* y una revisión documental de las bitácoras completadas por las facilitadoras luego de cada sesión. La información recolectada fue analizada cualitativamente a través de los procedimientos de codificación abierta de la teoría fundamentada, para luego reunir las perspectivas de ambos grupos en un análisis integrado. Desde la experiencia de los participantes, la adaptación del programa a formato *online* resultó exitosa, ya que las facilitadoras lograron desarrollar los contenidos y estrategias de la intervención en modalidad virtual y los cuidadores pudieron participar y aprender desde sus casas, siendo esto compatible con el distanciamiento físico (por COVID-19) y con otras actividades de la vida de los cuidadores. Se destacan como desafíos potenciar la participación y cohesión grupal y superar barreras relacionadas con la conexión a Internet inestable y/o lugar físico poco adecuado en algunos hogares para participar. Estos resultados muestran una exitosa adaptación del programa desde la perspectiva de sus participantes, aportando aprendizajes que permitirán mejorar la adaptación de este y otros programas a modalidad virtual.

*Palabras clave*: implementación *online*, e-salud mental, prevención, entrenamiento parental, GenerationPMTO

The Parent Management Training - Oregon Model (GenerationPMTO) is an evidence-based parent training intervention developed by Gerald R. Patterson et al. at the Oregon Social Learning Center (OSLC) in Oregon, USA. OSLC has been working since 1970 on the development and evaluation of evidence-based interventions that address and/or prevent behavioural problems in children and adolescents. In 2001, Implementation Sciences International, Inc. (ISII), a subsidiary of OSLC, was created to research the programmes developed and ensure the fidelity of implementation of GenerationPMTO in different contexts and countries.

GenerationPMTO is based on the social interaction learning model and coercion theory. The former posits that behaviour is shaped by reinforcing contingencies provided during interactions with key people in the social environment (Forgatch & Patterson 2010; Patterson, 2005); it explains how parents inadvertently model the externalisation of negative behaviours on their children (Patterson et al., 1992, cited in Forehand et al., 2014; Patterson & Fisher, 2002). As for coercion theory, it understands the family as a source of learning for the child, both prosocial skills and coercive skills to resolve conflicts. Thus, in families with difficulties, children learn that coercive methods are functional, while prosocial skills are not (Patterson, 2005). Thus, coercive parenting and ineffective monitoring are highly conducive to the development of overt forms of antisocial behaviours, such as arguing, teasing, hitting and tantrums (Patterson et al., 2010). GenerationPMTO seeks to position parents as agents of change by teaching parenting skills that prevent and reduce negative and coercive family interactions, replacing them with positive parenting practices, to address and/or prevent the development of problem behaviours in children (Forgatch & Kjøbli, 2016). The programme only works with the child's primary caregiver(s), so the child's primary caregiver(s) do not participate in the sessions. Although the intervention has a defined structure, it incorporates a component of flexibility that allows the work to be adapted to the needs of each family.

Another point to highlight are the core components of GenerationPMTO, which seek to positively impact families with long-lasting outcomes (Forgatch & Domenech Rodríguez, 2015), by reducing coercive parenting practices and increasing positive practices. These core components are: (a) motivating positive behaviours in children, (b) setting limits and agreements, (c) parental monitoring/supervision, (d) problem solving and (e) positive parental involvement (The California Evidence-Based Clearinghouse for Child Welfare [CEBC], 2022).

Accordingly, GenerationPMTO seeks to: (a) help children develop pro-social skills, (b) reduce children's disruptive behaviour through effective rules, (c) strengthen parental supervision, (d) help family members negotiate and reach agreements, and (e) promote positive engagement between caregivers and children (Parra-Cardona et al., 2017). For this, the programme uses intervention strategies that promote meaningful learning and practice of parenting skills by caregivers, seeking to train families through active teaching methodologies, such as role-plays, problem-solving exercises, brainstorming, home practice, among others.

## Evidence of the Effectiveness of GenerationPMTO

There is consensus in the literature on the evidence that parental training interventions have a high standard of effectiveness in addressing externalising problems in children (Kaminski et al., 2008; Michelson et al., 2013), as well as in contributing to the reduction of internalising symptomatology in children (Forgatch et al., 2009; Parra-Cardona et al., 2017).

The GenerationPMTO programme has over 50 years of history and has been adapted for a wide variety of settings and populations in different countries (United States, Canada, Norway, Iceland, Denmark, Mexico and Uganda, among others), ranging from universal preventive interventions to selective and indicated prevention.

Its effectiveness has been demonstrated through several randomised studies (e.g., Askeland et al., 2019; Bjørknes & Manger, 2013; Patterson et al., 2010; Sigmarsdóttir et al., 2015), including a nine-year longitudinal study (Forgatch & Kjøbli, 2016). The main results show improvements in internalising and externalising symptomatology in children, decreased likelihood of substance use, prevention of socialisation with at-risk peer groups and decreased arrest rates (Forgatch & Kjøbli, 2016). In caregivers, it has shown positive effects on parenting practices, marital satisfaction, co-parenting and improvements in depressive symptoms in mothers (Bullard et. al, 2010; Forgatch & Kjøbli, 2016), among others.

It is estimated that GenerationPMTO has benefited more than 50,000 families worldwide, from different socio-economic and cultural backgrounds and diverse family composition structures. This has led to the conclusion that the consistency between the systematised implementation and the theoretical model allows the programme to be replicated in a wide range of contexts and cultures, maintaining fidelity to the model and positive outcomes in terms of its effectiveness (Askeland et al., 2019; Forgatch & Kjøbli, 2016).

## Experience of Remote Adaptation of GenerationPMTO and other Similar Programmes

Mothers, fathers and caregivers are often unable to participate in face-to-face parenting programmes due to various barriers (e.g. lack of time, geographical distance, work and home responsibilities). One way to bridge this gap is to deliver programmes remotely, combining the comfort of home with the facilities provided by technology.

In the evidence available at the international level, several positive experiences of remote programme implementation can be found, which were increased between 2020 and 2021, due to the pandemic health context. This is the case of a programme implemented in India to improve adolescent mental health and well-being, which reports a successful experience of adapting to a virtual modality, in order to overcome access barriers for beneficiaries (Wasil et al., 2020). In Peru, as part of COVID-19, an *online* nutritional intervention was carried out with the aim of increasing the consumption of foods that strengthen the immune system. The results were positive, increasing the consumption of such foods (Padilla Ruiz & Wong Carrera, 2020).

It is also possible to find evidence of positive results from the remote implementation of programmes aimed at mothers, fathers and caregivers. For example, the PET Social Stories programme for families with children diagnosed with autistic disorder was implemented remotely in China during the health crisis. Caregivers and facilitators highlighted as positive aspects the mutual support in recognising their own parenting skills and that remote implementation made it possible to reach families who, due to their geographic location, could not otherwise be reached (McDevitt, 2021). In Iran, Samadi et al. (2020) conducted a study in the context of the closure of day care centres due to the pandemic, in which caregivers of children with autism spectrum disorders received synchronous video sessions and information (visual and written) to guide learning objectives. The results of the study show a high degree of acceptability of this modality, called telepractice, with caregivers perceiving it as very useful and reporting a high degree of satisfaction.

Pre-pandemic studies of parent training programmes have also found positive experiences with remote implementation, associated with: appreciation of virtual sessions, comfort and willingness to use technological tools (Baharav & Reiser, 2010); improved parenting skills, compatibility with home tasks, reduced travel time and costs, and better coordination of time between team members. Some disadvantages were also found, such as difficulties related to connectivity and the need for face-to-face contact to support initial communication (Ashburner et al., 2016).

On the other hand, in the context of the COVID-19 pandemic, in Chile there have been experiences of adapting interventions to the remote modality. A qualitative research on an intervention specialised in child

abuse (Pinto-Cortez et al., 2021) showed certain risks associated with this modality, such as, for example, the precariousness of the socio-material conditions of the families, related to the lack of privacy spaces for the interventionists to work with the children, added to the low Internet connectivity of the most vulnerable families. Despite this, this study proved that interventions can be adapted to this format, with teamwork being a fundamental pillar for the success of these adaptations.

In the case of GenerationPMTO, it has been shown that it can also be implemented in remote mode, delivering all the core components of the model through the same active teaching methodology as in face-to-face mode, through remote means of communication. This modality has already been tested in Vancouver (Canada), Michigan and New York (United States), with positive preliminary results reported by participating families (ISII, 2016).

## GenerationPMTO in Chile

The San Carlos de Maipo Foundation (FSCM) is a non-profit organisation whose objective is the prevention of problematic behaviours in children and adolescents. To this end, it seeks evidence-based programmes that address the risk and protective factors that are at the root of these behaviours, and thus make them available for public and private intervention in the country. In 2019 FSCM takes the decision to implement GenerationPMTO in Chile, in its group intervention modality, called Parenting Through Change (PTC), in the format of 10 sessions, for which FSCM has the required certification processes and ISII license. Rigorous linguistic and cultural adaptations were made, validated by ISII, to favour the application in the Chilean context, while maintaining fidelity to the model. In addition, a face-to-face pilot of the individual modality of the programme was carried out between October 2019 and January 2020. Based on this implementation, a study of cultural adaptations of the programme in Chile was carried out, which showed that, from the facilitators' perspective, the core components of GenerationPMTO are relevant to Chilean caregivers (Parra-Cardona et al., 2022).

The sessions are held weekly, last 90 minutes and all families receive material with relevant information for the work in session and practice at home. A maximum of 15 caregivers participate and are guided by a pair of facilitators trained in the model (psychologists and/or social workers). Each family is assigned a facilitator from the pair, who is in charge of calling the caregivers every week to follow up, resolve doubts and adjust the work done in the session to the needs of each family.

The intervention was initially planned as a face-to-face intervention; however, the intervention had to be adapted to a remote mode, given the health measures resulting from the COVID-19 pandemic.

This research contemplated families intervened between May and July 2020. Families with a history of psychiatric hospitalisation in the last three years and families in which the responsible adult and/or child were involved in an active judicial process or participating in other psychological or psychosocial intervention programmes on a weekly basis were excluded from the programme, in order to avoid over-intervention of the family group.

This research sought to understand the experience of caregivers and facilitators regarding the pilot implementation of the GenerationPMTO programme, for the first time in Chile in remote mode.

From the results of the study, we seek to contribute to the identification of adaptations needed for the remote dissemination of the GenerationPMTO programme or other evidence-based parenting programmes. This may be highly relevant when contextual conditions require it (new pandemics, health crises or states of catastrophe) and to facilitate access for those users who would not be able to participate face-to-face in this type of programme.

## Method

A qualitative, descriptive, cross-sectional and exploratory study was conducted. The consideration of a qualitative design responded to the nature of the problem: to investigate the subjective experience and perceptions of the participants -caregivers and facilitators- (Flick, 2007; Strauss & Corbin, 2002) in relation to the implementation of the GenerationPMTO programme adapted to remote modality. Considering that the implementation to be evaluated corresponded to a pilot application of the programme in its remote modality and that there was no evidence in Chile or Latin America regarding its adaptation to this modality, the study was exploratory in nature (Hernández Sampieri et al., 1991).

It should be noted that this research is part of a larger investigation entitled "Implementation and cultural adaptation of the GenerationPMTO programme in its remote mode implementation in the context of the COVID-19 pandemic health crisis".

**Participants**

The PMTO programme involved 93 Spanish-speaking caregivers of children aged 4-12 years from two private subsidised schools in the city of Santiago, Chile, with a vulnerability index between 87.28% and 90.62% (Junta Nacional de Auxilio Escolar y Becas, 2019).

Fifteen of the 93 caregivers who participated in the programme were selected for the study. This selection was done through purposive sampling (Krause, 1995), adhering to the rule that data should be collected under the paradigm of maximum structural variation of perspectives (Kleining & Witt, 2000). The following heterogeneity criteria were considered: representativeness of both schools, age of primary caregivers and children, relationship of primary caregiver to children, and the relationship of primary caregiver to children (Kleining & Witt, 2000). and educational level of the primary caregiver. In addition, caregivers were chosen who had at least 80% attendance of the programme, in order to maintain a greater knowledge of the contents addressed in the sessions and the core components of the programme. Their ages ranged from 25 to 47 years (mean age = 34.93 years, SD: 8.06), 12 participants were mothers and 3 were fathers. In terms of educational level, two of them had completed basic education, eight had completed secondary education and five had completed higher education. They were recruited by telephone, briefly explaining the study, its voluntary nature and inviting them to participate in the research. Table 1 presents the characteristics of the 15 caregivers selected.

**Table 1**

*Responsible Adults Interviewed*

| Interviewee | School | Intervention group | Age of the child | Relationship | Educational level of the caregiver |
|---|---|---|---|---|---|
| 1 | School 1 | 3 | 10 | Father | Higher education |
| 2 | School 1 | 3 | 4 | Mother | Full basic |
| 3 | School 1 | 2 | 9 | Mother | Full basic |
| 4 | School 2 | 6 | 11 | Mother | Higher education |
| 5 | School 1 | 2 | 11 | Mother | Full media |
| 6 | School 2 | 8 | 6 | Mother | Full media |
| 7 | School 1 | 4 | 6 | Mother | Full media |
| 8 | School 1 | 4 | 4 | Mother | Full media |
| 9 | School 2 | 7 | 6 | Mother | Full media |
| 10 | School 2 | 7 | 11 | Father | Full media |
| 11 | School 1 | 1 | 8 | Mother | Higher education |
| 12 | School 2 | 6 | 7 | Mother | Higher education |
| 13 | School 2 | 8 | 6 | Mother | Higher education |
| 14 | School 2 | 5 | 10 | Mother | Full media |
| 15 | School 2 | 5 | 8 | Father | Full media |

In relation to the facilitators, four of the five professionals who implemented the programme participated in the study. They are all Chilean women, psychologists, between 25 and 35 years old. They have 2 to 11 years of experience in the mental health field and two of them have a master's degree in clinical intervention. All facilitators completed the GenerationPMTO trainings provided by ISII to implement PTC groups in Chile.

Their contact details were requested from FSCM, the institution that implemented the programme. An informative and consultative invitation was extended regarding their wish to participate in the study, to attend a virtual focus group.

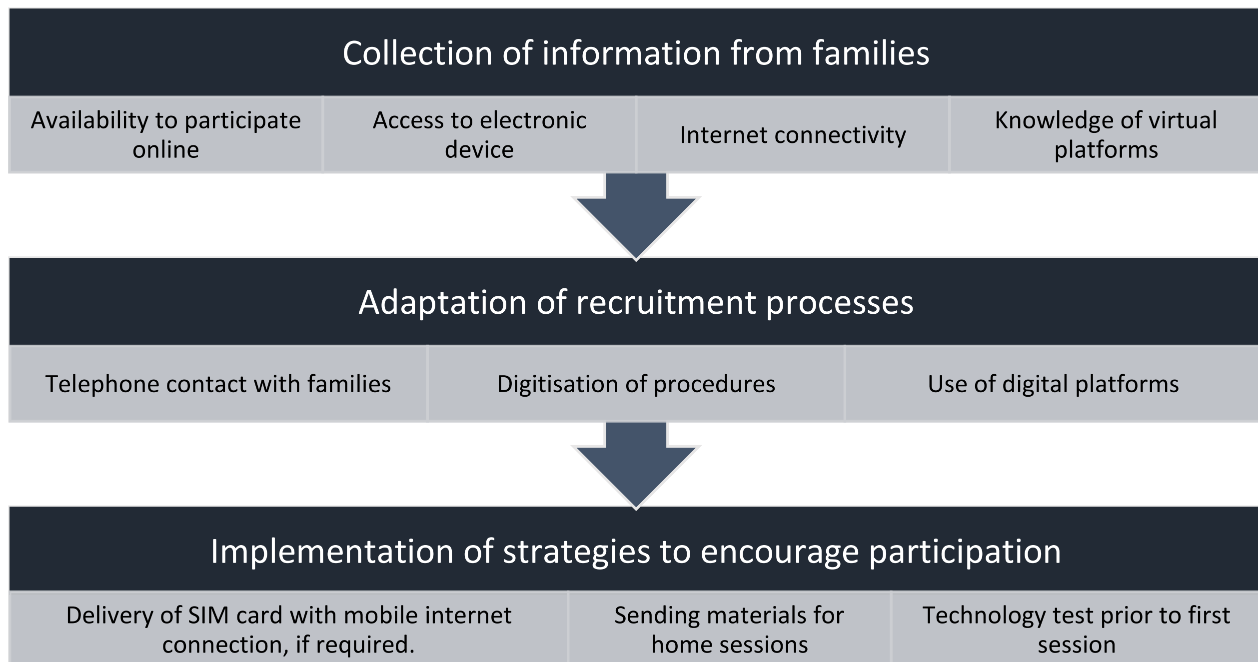
## Procedures

### *Process of Adapting the GenerationPMTO Programme to Remote Modality in Chile*

To implement the programme remotely, due to the pandemic context, FSCM hired an external consultant who trained the implementation team in virtual platforms, which was fundamental for the correct execution of the programme. In addition to the above, FSCM carried out a needs assessment from the families, with the objective of visualising availability and identifying elements that could favour the enrolment and participation of families. Subsequently, adaptations were made to recruitment processes and strategies to facilitate the enrolment of families. Figure 1 describes this procedure.

**Figure 1**

*Procedures for the Adaptation of the Intervention (from Face-to-Face to Remote Mode)*




### *Procedure for Collecting Information*

Once caregivers agreed to participate, a virtual interview was scheduled and a digital informed consent form was sent to them so that they could review it before signing, through an audio recording where the interviewee confirmed their participation.

With respect to the facilitators, once they accepted the invitation, they were sent an informed consent form via email, so that they could read it prior to the signing process, which was carried out at the beginning of the focus group.

The research was approved by the Scientific Ethics Committee of the Pontificia Universidad Católica de Chile, the institution that carried out the research.

After registering the families, the team began to implement the 10 sessions in virtual mode through the Zoom videoconferencing platform, with the 8 intervention groups in parallel *(see Table 1)*, seeking to maintain the characteristics and structure of the intervention described above (PTC), with the aim of ensuring the fidelity of implementation, regardless of the means of delivery (face-to-face or remote).

As in the face-to-face modality, implementation fidelity is evaluated through the *Fidelity of Implementation Rating System* methodology of the programme's creators. As indicated by the model, the sessions were led by a pair of facilitators trained in the model (psychologists and/or social workers).

The interviews with the caregivers and the focus group with the facilitators were conducted remotely, audio-recorded and transcribed for later analysis. The interviews lasted around 40 minutes and the focus group lasted one hour. They were conducted by social science professionals with experience in qualitative research. In order to protect confidentiality, all the information provided was stored in a digital platform, protected by a password. Each family and facilitator was assigned an ID code.

## Instruments

### *Facilitators' logs*

The logs that the facilitators kept after each session of the GenerationPMTO programme - which in qualitative methodology is called document collection (Krause, 1995) - were reviewed in order to identify and analyse the cultural adaptations introduced in the course of its implementation. In these logs, a self-evaluation of the session is recorded, including the level of fulfilment of objectives, activities and methodology with the main elements of the session, observations regarding the group, challenges and aspects to be improved. The objective of this review was to make recommendations and adaptations that were identified as necessary.

### *Semi-structured interviews*

For the collection of information from caregivers, semi-structured qualitative interviews were conducted (Flick, 2007, Taylor & Bodgan, 1987). A thematic script was developed, the main themes of which were: (a) experience of participation in the GenerationPMTO programme, (b) methodological adaptations introduced by the facilitators in the context of the health crisis, (c) remote implementation of GenerationPMTO and (d) implementation of core programme components and support components.

The relevance of conducting semi-structured interviews lies in the fact that they are encounters between the researcher and the informants, aimed at understanding the latter's perspectives on certain experiences, expressed in their own words (Taylor & Bodgan, 1987). What we are interested in rescuing are opinions, perceptions, representations and attributions, among other subjective processes. The aim is to understand and apprehend the meaning of these processes, adopting the stimulus/narrative format, without expecting objectively true answers, and often succeeding in obtaining responses that include emotional aspects.

### *Focus Group*

A focus group was conducted with the team of facilitators (Folch-Lyon & Trost, 1981). Focus groups are useful for checking information with specific groups, but they are not useful for finding out very private information about people (Jaramillo, 2013). For this reason, the focus groups were used only with the facilitators and not with the beneficiaries of the programme. The main themes of the focus group were the description of the experience of participation in the Generation PMTO programme; cultural adaptations; and the implementation of core components of the programme.

## Data Analysis

The information from the interviews, focus group and logbook review was analysed descriptively, following the principles proposed by grounded theory for open coding (Glaser & Strauss, 1967; Strauss & Corbin, 2002). Following this procedure, emergent concepts and categories were developed, relating to the experience and perceptions of caregivers and facilitators in relation to the remote implementation of the programme and the cultural adaptations made.

The concepts and categories were organised into hierarchical classification schemes for the development of core descriptive categories. The results were first analysed separately (caregivers and facilitators), and then an integrated analysis of the cases as a whole was carried out in terms of similarities and differences. Two separate coding trees were thus created for each group first, and then the integrated analysis was carried out, as a number of common categories emerged from both the caregiver and facilitator groups.

Some specific categories also emerged in each group, but most were common, hence the way the results are presented below.

To ensure the quality of the results, the strategy of researcher triangulation was employed, which allowed neutralising or minimising deviations and potential biases derived from the researcher as a person, increasing the reliability of the analysis (Denzin, 2009). This involved each interview, focus group and logbook being coded by a member of the research team, and then triangulating this coding (the complete coding) in reconciliation meetings with the whole team, so that all categories were established through inter-subjective agreement.

The results for each core category are shown below, articulated according to the similarities found between the perspectives of caregivers and facilitators, and then some of the differences between the two groups are noted.

## Results

In general terms, the families indicated having a positive experience in the programme. As favourable aspects, they mentioned feeling motivated to participate, relief from daily stress and highlighted the group work that generated a safe, respectful and non-judgmental environment. The facilitators also describe a positive experience, linked to the beneficial bond and connection they achieved with the families and the effect this had on them.

Families and facilitators refer positively to the experience of conducting remote sessions. Most of the participants say that it was a process of adaptation. Being a new and different digital modality, they thought it would be somewhat complex, as this participant indicates:

> Yes, it was good, what I was saying was that it was different, because I, at least, had never done anything like having Zoom meeting or anything, so I didn't know how anything worked. (Interviewee 12).

It is possible that, at the beginning, some participants started the programme with a reticent attitude towards the remote modality, but later they adapted to this way of working. Some families also indicate that the virtual modality was an obstacle, as the fear of the screen inhibits active participation in the sessions, opting to participate in a more passive way.

For their part, the facilitators state that the adaptation to the remote modality had positive results: they were surprised with the new virtual modality, they felt that they were able to bond with the caregivers and that they were able to meet the objectives of the programme. As relevant to the positive outcome, the facilitators mention that, due to the context of pandemic and isolation, the need arose to share with a group of people who were living a similar situation, and the programme managed to fulfil this function, as mentioned by one professional:

> I want to emphasise [how important it is for the programme] this bond. It was a time when we were all alone, (...), there was a lack of contact with adults, with humans, who were also there for you and sharing the concern of how to be with the children 24/7? Being there, being a teacher, being a father, doing everything, working (...). (Focus group).

## Main Differences with the Face-to-Face Mode

### *Differences Perceived by Participants*

Although the participants report a positive experience and learning in the remote mode, most of the participants mention that they prefer the face-to-face mode, because in the remote mode the physical contact is lost, as this participant mentions:

> On one occasion a mother shared something kind of sad and I would also have liked to maybe, I don't know, give her some physical touch, that can't be done, but at least tell her at that moment, looking in her eyes, that we were there even though we didn't know each other, at leats, a touch on the back. (Interviewee 6).

### *Differences Perceived by the Facilitators*

On the other hand, the facilitators highlight the difference in participation in the different modalities. In the face-to-face modality, caregivers were more involved, as they know the group directly and, by physically attending the sessions, attendance or absences are more noticeable.

On the other hand, in the virtual modality, the level of commitment of the participants with the programme is difficult to know, as it is possible to enter the virtual rooms in a partial way, with the camera and/or microphone turned off. Facilitators report that this opens the possibility that families may be doing other activity/s, for example, work and household chores, among others, taking attention away from the sessions, as indicated by this facilitator:

> Also the remote can, to some degree, diminish the sense of commitment. [In face-to-face] I go to a place, I'm there, I know the psychologists, I know the other participants, it's noticeable when I'm not there, for example. On the other hand, remote is more permeable, it gives a flexibility like "well, I can be there, but maybe I can be there with the camera off, perhaps, because things are happening at home". This "I'm here and I'm not here" is more permeable in the virtual mode (Focus group).

Likewise, the facilitators highlight the differences about the execution of some activities in remote mode. Regarding the activities in separate small groups, it was initially difficult to monitor, as the division in the virtual format does not allow to see all the groups at the same time, generating doubts among the facilitators as to whether everyone was able to practice. In relation to the body activities, such as the breathing and relaxation exercises, the facilitators mention that in some cases they worked in virtual format, while in other cases the participants had interference from home, which can be avoided in a face-to-face format, as the activities are carried out in a physical space without distractions.

## Benefits and Contributions of the Remote Mode

### *Main Benefit Perceived by Participants: Staying at Home*

Some of the participants mentioned that staying at home facilitated participation in the programme, and described it as a comfortable way to participate, allowing them to combine it with taking care of the children, saving time and travel expenses, avoiding exposure to low temperatures and possible diseases (including COVID-19).

Other participants mentioned that having the sessions at home was a facilitator for bonding with other caregivers, indicating that verbal communication between participants and facilitators is favoured, because of the feelings of trust and intimacy of being at home, as this participant indicates:

> I think that, if it had been in person, it would have been a little difficult to let go, to talk about these issues (...) But by doing it virtually, by doing it from home, each one of us was more "tight-knit" [as a group], more... it gave us the confidence and intimacy to be able to talk more freely (Interviewee 1).

### *Main Benefit Perceived by Facilitators: Flexibility of Assistance*

Facilitators comment that the remote implementation allowed for flexibility in the way caregivers attended the session. In some cases. caregivers warned the facilitators about their inconveniences to have 100% attendance due to work or domestic reasons. These caregivers were given the option to participate with camera off when necessary. In this way, the virtual modality promoted that people could participate from a "split presence" between two simultaneous activities. This ensured that people arrived at the session and received the contents of the programme, despite their difficulties. However, the facilitators consider it essential to ensure that this alternative was an exception, as the use of the camera favours active participation.

## Factors Mentioned by Participants and Facilitators that Favoured the Remote Implementation of the Programme

### *Zoom*

The Zoom videoconferencing platform is considered by both facilitators and participants as essential for the development of the sessions.

Some participants indicated as positive the Zoom function of forming small groups, which favoured the organisation of the sessions and a greater depth in certain discussions. They also expressed the function of requesting and giving the floor to speak, allowing conversations to be orderly and regulating the development of a balanced group dynamic.

Zoom is also one of the video conferencing platforms with the lowest mobile data consumption. This advantage is essential to reach families with a stable connection and controlled internet costs.

Finally, according to the facilitators, the Zoom chat became an appropriate space for participants to post questions and to address them in order. The use of the chat also allowed people to continue to participate even when they could not use the camera or microphone.

### *Physical Materials and Connection Assistance*

From the perspective of the participants, almost all of them referred to the support material provided by FSCM as essential for the smooth running of the remote sessions (caregivers' manual, wristbands and SIM card, if required). Most families refer to the SIM card with mobile internet connection as fundamental, since it provided them with the means by which they could connect to the sessions.

### *Help from Others*

The facilitators named as fundamental support the technology manager during the sessions, who took care of helping the families, offering support in case of Internet connection problems, difficulties in logging in, on the use of the platform or others. This support figure is considered important because it allowed the facilitators to pay attention to the session, transmit contents and facilitate the group dynamics, avoiding technical distractions.

Likewise, some participants highlight that the technological test prior to the first session provided by the facilitators and the support given by the technology manager during the sessions favoured the development of the programme. The caregivers point out that the facilitators helped them to install the application, access the Zoom virtual platform from mobile phones and/or computers, as indicated by this mother:

> [The facilitator] took the time to teach me, to teach us all in general, how to sing in, how to click on the link, that you have to download the application to be able to participate. (Interviewee 4).

Other participants underline the help of their family members in order to participate better. One of them indicates how her husband's help was essential to participate in the sessions calmly, as he took care of the children during that time and when he was not there, she could not participate fully:

> On Tuesday [the day of the sessions] it was already a schedule that everyone knew, I said "please, nobody do anything... everybody be quiet". And with my husband we would organise ourselves (...) one day when he [husband] didn't come, it was a riot in the house. (Interviewee 2).

### *Implementation of a Pre-Session Space*

The facilitators allude to the importance of starting the Zoom meeting 10 minutes before the start of the session, as a space to meet earlier with the families who wished to connect beforehand, favouring punctuality, having time to correct audio or video difficulties with the families, as well as promoting a space for health and exchange of personal situations that were being experienced in relation to the pandemic:

> It was a bit difficult for me to assimilate all this change and everything, because I was unemployed, without a job. It changed everything, so having this support from women was quite good (Interviewee 12).

### *Midweek Calls*

Among the methodologies highlighted positively, both the facilitators and some of the participants interviewed emphasised the incorporation of the facilitators' weekly calls, which made it possible to make up for the lake of a face-to-face meeting, adapting the contents of these calls to the characteristics of each family. In the case of the participants interviewed, they significantly appreciated the possibility of talking individually with the facilitator, indicating that in this instance it was possible to go deeper into personal aspects or into things that were not comfortable to share in a group:

> Yes, because sometimes you don't want to talk about things in the group, so if there wasn't that call, you keep your opinion to yourself, like what you really wanted to say. You just stay silent, because you don't want to share it in a group setting. It's not that you have an issue with or that you are against of others listening to you, but you want the psychologist to listen to you, the person who is guiding you in the session (...) and maybe you don't want others to criticise you, judge you or anything. That call is very relevant, I think (Interviewee 5).

> [The calls allowed us] to observe how what we had discussed [in session] was unfolding within each family one by one, how it could also be done as a group, especially thinking about the particular needs of each family, the challenges, the same limitations and obstacles that they identified, how to take what we saw in the group and work on it in the calls, work on it with each of the families, while we were in... virtual mode and in a pandemic. (Focus group).

## Obstacles and Difficulties of the Remote Mode

### *Obstacles Perceived by Participants: Organising and Creating Space for Remote Modality Sessions*

The main obstacles reported by the participants were the difficulty of making the schedules of the virtual sessions compatible with family duties and work, and the need of an exclusive place for the virtual sessions. Similarly, the facilitators mention the difficulty for participants to reconcile the various responsibilities in the context of confinement - childcare, mealtimes, work - and participation in the sessions.

Some participants also note the importance of an appropriate, quiet and peaceful place to participate in the sessions. Caregivers indicate that it is difficult to participate without interruptions at home, as their children are noisy, time-consuming and constantly interrupting, as this mother indicates:

> The difficulties of the programme were, of course, them [the children], the noise issue (...) It was difficult to have two children in silence for almost two hours. Well, for me, mainly, the space was not a difficulty, because we have the bedrooms and the living-dining room, but I think maybe for other mothers, it was difficult to find a space where they could close the door, in silence. (Interviewee 6).

### *Difficulties Perceived by Facilitators: Obstacles to the Flow of Sessions and Group Cohesion*

A relevant element pointed out by the facilitators was the unpunctuality and early withdrawal of some caregivers; the remote modality allows a "dropper" entry, which could delay the start of the session and become a problem for those people who do arrive on time. On the other hand, there were situations in which people left early, which generated doubts in the facilitators about how to handle the situation, highlighting as an additional challenge the domino effect that this generates in the group.

On the other hand, the facilitators report that group cohesion becomes more complex in remote mode, explaining that they must mute the microphones in order to maintain order, listen to each other and prevent ambient noise from the caregivers' homes. This practice, while favouring order, inhibits their spontaneous interactions, unlike what happens in person.

The facilitators also mention the difficulty of group work when they keep their cameras off, which creates challenges for the group and the facilitators in terms of group cohesion and practical activities in the session. In turn, this promotes a state of alertness in the facilitators, who must achieve a balance to promote participation even with cameras off, be aware of the chat, make proper use of Power Point, among other aspects, which could affect the concentration of the facilitator duo.

### *Commonly Perceived Difficulties: Internet Connection*

Facilitators report moments of sessions with connectivity problems, such as audio freezing, which prevented them from hearing the caregivers and vice versa. On some occasions caregivers were unable to participate or did not stay for the entire session due to connection failures, which sometimes even hindered the group's constant attention and continuous communication. The timing and flow of some sessions were affected by connection instability, forcing participants to try to connect from different devices and to look for places in their houses where the signal was perceived to be more stable.

Similarly, half of the GenerationPMTO caregivers report having some kind of internet connection problem - influenced by contextual factors such as rain or power cuts - or inability to use the device from which they connected, which made it difficult for them to attend calmly or participate in all the sessions in full, as one facilitator indicates:

> But there are also things that are involuntary, which are the Internet "crashes", we have sectors that we know that we have a very bad signal (...) or that have difficulties accessing the device that they can generally use [for the sessions], because, I don't know, the children had an exam [at school] that day. (Focus group).

## Challenges Perceived by Facilitators in Achieving Fidelity to the PMTO Methodology

Regarding adaptations specifically associated with PMTO's particular methodology, facilitators report that in remote and face-to-face modalities there are different experiences. For example, in session, positive reinforcement is modelled by giving bracelets to participating caregivers, so that they can live the experience of being rewarded and then implement that strategy with their children. In remote mode, the facilitators "send" a bracelet through the screen and the families make the gesture of receiving it. The facilitators explain that in these actions, physical proximity and visual contact give an added value to the face-to-face modality, as indicated by a professional:

> And with the virtual modality it is different, as if it needs to be explicitly stated "put on the bracelet", "here is a bracelet for you". You lose this feeling of experiencing it without saying it, without words (...) On the other hand, in the face-to-face version, you just experience it. (Focus group).

Along with the above, facilitators point out that role-plays in remote settings are more challenging, since the use of the body is crucial for effectively conveying tools through this methodology. Therefore, in virtual mode, facilitators must verbalise the body to compensate for the lack of non-verbal language, as this facilitator points out:

> When we are face-to-face, one could see what it meant to move away, what it meant to maintain eye contact, for example, to bend down to talk to the children at eye level and look them in the face, we kind of showed that. (Focus group).

According to the facilitators, the small group practice moments also lose power in virtual mode, as this learning tool would give better results if they could monitor what each small group is practising: however, the facilitators mention that they do not manage to go through all the virtual rooms.

A cross-cutting element of the programme's methodology is to promote the active participation of the group to facilitate meaningful learning. In this sense, another challenge was to encourage the participation of those who participate less, have technological difficulties, are perceived to be more shy or uncomfortable with the remote modality, so the facilitators emphasise the importance of being attentive to each participant and respecting their pace.

### Recommendations and Changes Suggested by Caregivers

Some caregivers recommend the use of a computer -rather than mobile devices- for a better session experience. On the other hand, some caregivers recommend setting up in a comfortable and quiet place in the home to avoid interruptions:

> Obviously if they have access to more equipment, like a computer, having a bigger screen would be ideal for staying well connected, a good signal, because there were many mothers who had problems with signals. (Interviewee 13).

Some mothers recommend reducing the number of participants per virtual session, arguing that this allows for a more comfortable and intimate atmosphere between participants and facilitators. They indicate that some caregivers were not able or did not want to talk, because they did not feel confident enough to do so, as this participant points out:

> If we were 6 instead of 12, I think that every issue they have to deal with will be better addressed (...). So if there are fewer of us, you feel more comfortable. I feel like you have more chances of speaking, more chances of listening. I think so. And by the third or fourth session, you'll get to know the group you've had to listen to a bit better (Interviewee 5).

Finally, some caregivers recommend decreasing the length of sessions, but increasing the number of sessions, arguing that being in sessions for so long becomes complicated, as one participant describes below:

> I told them about the time, perhaps they could be shorter, but they could have more sessions, but shorter. Because of the children, because of course, there were several who had only one child, but there were several who had four children, so it is much more complicated (Interviewee 6).

## Discussion

### The Impact of the Pandemic on the Adaptation of the GenerationPMTO Programme to Remote Modality

The GenerationPMTO programme had to be adapted to a remote mode due to the context of the health crisis at the beginning of the pandemic. This aspect is relevant, as the context was complex, not only for the participants, but also for the general population. The United Nations (United Nations, 2020) reports a significant increase in psychological distress as an impact of the pandemic, generating important consequences in people's lives. This global scenario prompted the adaptation of GenerationPMTO to a remote modality in Chile, which beyond its complexities, opened up new possibilities for intervention.

According to the results, from the perspective of the caregivers and facilitators, positive aspects, lessons learned, opportunities and challenges can be highlighted. The results show that the remote implementation was positively received by the caregivers and, at the same time, fidelity to the model was maintained. In view of this, the learnings validate the implementation of GenerationPMTO in remote mode in Chile and, at the same time, could be useful for the implementation of other evidence-based parenting programmes.

Firstly, it can be highlighted that this modality facilitated access to the programme for caregivers who have to combine work and family responsibilities, reducing geographical barriers of time and travel. Connecting from home, despite the fact that concentration could be interfered with during the sessions, favoured that some caregivers could participate and remain in the programme, an aspect that coincides with other similar programmes that show that this modality allows overcoming access barriers for beneficiaries (McDevitt, 2021; Wasil et al., 2020).

Most of the caregivers point out that, although face-to-face activities are favourable for working on parenting issues, if the programme had been face-to-face they would probably have attended the same or fewer sessions; they never say that their attendance would have been higher. They explain that contingencies always occur and that being at home, not paying for transportation and not depending on weather conditions, allowed them to connect and be part of the programme.

As with experiences in similar modalities (McDevitt, 2021; Samadi et al. 2020), the facilitators share this positive view of the advantages of remote implementation, emphasising that they were surprised at how much was achieved through virtual working. While this was driven by the health context and prior to the pandemic they would not have imagined this remote scenario as a possibility, they now note that it will be important to consider these advantages when planning future implementations, in a COVID-19 free context.

Another positive aspect of the programme was the possibility for carers to meet with other carers who were experiencing similar situations. This allowed them to feel accompanied in an unprecedented confinement. At the same time, families value even more the sharing of parenting strategies in a group space that is enhanced by the personalised moments of the GenerationPMTO mid-week calls.

On the other hand, the facilitators highlighted that, faced with the challenges of achieving fidelity to the GenerationPMTO methodology in remote modality, they managed to find the necessary adjustments so that the strategies would work effectively, which is reflected, for example, in the role-plays, the various ways of promoting active participation, modelling and positive reinforcement, moments of practice in session, among others. This methodology of the model allows to generate a meaningful learning space, promote the practice of skills and maintain the link with each family. Both caregivers and facilitators emphasised an element that combines the group logic with the personalised weekly call to each caregiver, to support them with the practices for the home and to resolve doubts about the sessions. This call, typical of the GenerationPMTO model, made it possible to learn about and attend to emergencies or family contingencies in which caregivers needed support in the daily exercise of parenting. The generation of a positive bond between the caregivers and the facilitators, which was successfully implemented remotely, was a very transversal aspect in sustaining the participation of caregivers in the programme.

Another positive aspect highlighted by caregivers and facilitators is related to the potential of technological tools when used appropriately: the Zoom chat, the screen sharing option, the possibility of small working groups, among others. According to the interviewees, the use of all these tools facilitated the implementation and development of the sessions, an aspect that is also repeated in other similar experiences (Baharav & Reiser, 2010). The most challenging item that could be strengthened is the constant monitoring of the practical activities in small groups from the platform, where, unlike in the face-to-face modality, there is a loss of fluency in the guidance of the activities.

In addition, the possibility of having flexibility in the way of attending the programme, for example, participating with the camera turned off or commenting only via chat, was mentioned as a positive aspect of the remote aspect. It is important to point out that this flexibility in the conditions of participation should be exceptional, since, if it becomes a habitual practice, it could affect group cohesion, which is an essential aspect of the GenerationPMTO methodology for achieving significant learning. In this sense, another aspect to consider for the continuity of the programme in remote mode has to do with exploring the option of implementation in hybrid mode, in which remote sessions are combined with other face-to-face sessions. In this way, the advantages of each modality could be enhanced, while the disadvantages could be mitigated, such as, for example, the difficulties related to connectivity and the need for face-to-face contact to favour initial communication (Ashburner et al., 2016).

This opens up new possibilities, as the decision to implement a programme in virtual or face-to-face mode should take into consideration both research data and the particular context of the target population. In this sense, both this research and that of Pinto-Cortez et al. (2021) demonstrate the relevance of having adequate technological devices and good Internet connectivity. Access to these elements, therefore, would be fundamental assumptions for an intervention in a remote context to be implemented effectively.

It is likely that it is not possible to determine whether one alternative is better than the other, but rather that it depends on the advantages and disadvantages that are identified in the implementation in each context, with a view to choosing the best alternative for potential participating families. The conclusions of this research are preliminary, so it will be important to contrast the results with other studies and to continue investigating the advantages and disadvantages of both modalities in different implementation contexts.

Finally, it is very important to highlight the importance of making adaptations to interventions when contexts and implementation environments change. As mentioned above, GenerationPMTO in Chile previously went through a rigorous process of cultural adaptation, in which language and material adaptations were made (Parra-Cardona et al., 2022). That study, like the present one, highlighted the important role of the different actors involved in the process of adapting the programme, including the participating families, the facilitators and the organisational role of the San Carlos de Maipo Foundation. In particular, having the voice of the families and facilitators always present when implementing this new modality was fundamental to ensure the relevance of the intervention in a remote context. This is in line with other research (Pinto-Cortez et al., 2021), which highlights the preponderant role of the implementing teams to ensure the success of interventions in remote formats, emphasising flexibility and teamwork as key qualities in these scenarios.

The implementation of GenerationPMTO with fidelity to the model in remote modality is a great achievement, which facilitates reaching families at times of high complexity and demand, which would not have been possible in person. In this way, the remote intervention becomes an instance of protection and promotion of the mental health of both caregivers and their children, covering a greater diversity of families.

## Limitations of the Study

This study has limitations mainly related to methodology. As it is an exploratory study on the implementation of a pilot programme in the context of a pandemic, there are no other studies or evidence of this type in Chile that would allow comparisons of the results.

In terms of future lines of research, it will be relevant to generate new research questions that delve deeper into relational aspects between facilitators and caregivers, as well as into cultural adaptations.

Although this study provides knowledge and information regarding the advantages and disadvantages of remote implementation of GenerationPMTO from the perspective of families and facilitators, given the exploratory nature of the study, the results are preliminary and therefore it is not possible to draw generalisable conclusions. It will be important for future research to consider a methodology to confirm or contrast the results presented.

On the other hand, it would be interesting in the future to carry out a study on the advantages and disadvantages that may arise from the experience of implementing GenerationPMTO, both in virtual and face-to-face modalities, with the aim of comparing both intervention modalities in similar contexts. Likewise, it would be optimal to experimentally compare the effectiveness of remote implementation in relation to face-to-face implementation and to a control group, in order to measure the impact of the intervention in the different modalities.

In the future, it would also be relevant to contrast these results with research on other programmes implemented remotely in Chile.

This study was conducted at the beginning of the pandemic, so there was great uncertainty about the future, and the remote intervention modality was unusual, being used in very specific contexts. After the end of the pandemic, families and professionals are aware of virtual platforms and see them as a real intervention alternative, and caregivers are more familiar with their use. This could also be a limitation of the study, as some perceptions could change after the technological transformation that has taken place worldwide as a result of the COVID-19 pandemic.

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