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The effect of family-focused psychoeducational therapy for autism spectrum disorder children's parents on parenting self-efficacy and emotion

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ABSTRACT

The purpose of this pilot study was to design, implement, and evaluate the family-focused psychoeducational therapy (FFPT) for autism spectrum disorder (ASD) family. In Phase I, 64 parents of ASD children (ASD-group) and 63 parents of typically development children (TD-group) were invited to investigate parenting self-efficacy and emotion at baseline. In Phase II, the 4-week of FFPT was offered for the ASD-group. Date was collected at baseline, post-intervention and one-month follow-up, using the parental self-efficacy, Self-Rating Anxiety Scale and Self-Rating Depression Scale. The results showed that ASD-group significantly lower levels of parenting self-efficacy and worse emotion than TD-group ($p < 0.05$); And after attending the program, ASD-group had significant improvements for all outcome measures and these changes maintained over a period of time ($p < 0.05$). This preliminary study suggests that the FFPT may effectively improve parenting self-efficacy, reduce anxiety and depression for parents of children with ASD.

Autism spectrum disorders (ASD) represent a spectrum of complex, neurological, and developmental disorders. According to the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), there are two main classes of symptoms: (a) difficulties/deficits in social communication; and (b) restricted/repetitive behavior, interest, or activity patterns (American Psychiatric Association, 2013). The current prevalence rates of ASD was estimated at approximately one in 88 children in the United States (Centers for Disease Control and Prevention, 2012), and In China, the pooled prevalence of ASD was about 28.8 per 10,000 individuals (Hao, 2015). The identified rate of ASD has increased significantly around the world over the last few decades (Centers for Disease Control and Prevention, 2012; Kim et al., 2011).

There is no cure for ASD children, ASD deficits manifest in early development and are pervasive in nature, not only affecting children throughout their lifespan, but also on the lives of parents (Karst & Van Hecke, 2012). To fulfill caregiving responsibilities, parents often need to tolerate significant changes and losses in their lives, including undertaking multiple roles (e.g. coaches, problem solvers, tutors), quitting their jobs and reducing social activities (Hoogsteen & Woodgate, 2013). Since caregiving responsibilities are often imposed on parents, they might have a worse psychological state for their situation, studies have shown that parents, especially mothers, who parenting a ASD children often reported elevated psychological-distress profiles, i.e. higher depression, anxiety (Gau et al., 2012; Jones, Hastings, Totsika, Keane, & Rhule, 2014; Zhang, Zhang, & Yang, 2010), increased obsession-compulsion, interpersonal sensitivity, and hostility (Gau et al., 2012; Rivard, Terroux, Parent-Boursier, & Mercier, 2014), more uncertainty, weariness (Huang & Zhou, 2016), less marital satisfaction and reduced family cohesion (Gau et al., 2012). In addition, successful adaptation to parenthood may require that parents believe they have the ability to succeed at this challenging task (Reece & Harkless, 1998), but the effect on parents mental health and the lifelong care burden in ASD family may alter parents' perception of parenting, lack of parenting confidence, display low level of parenting self-efficacy (Author Blinded, 2016; Weiss, Tint, Paquette-Smith, & Lunsky, 2016). Parenting self-efficacy (PSE) is a cognitive construct that can be defined as an individual's appraisal of his or her competence in the parenting role (Sevigny & Loutzenhiser, 2010), higher PSE tend subsequently to demonstrate more effective parenting even in the face of challenging child behavior (Jones & Prinz, 2005), and buffering against parenting stress, reducing the feeling of guilt (Batool & Khurshid, 2015; Kuhn & Carter, 2006). ASD affects the parents' mental health due to the severity of the disease, the burden of long-term rehabilitation and care, reciprocally, the parents' mental health and well-being, communication, and beliefs influence illness management and health outcomes. Hence, with

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attainment of improve parents' parenting self-efficacy and emotion, a comprehensive interventions that incorporate these components are recommended.

However, the previous studies about the ASD family in China shown that the mental health of parents and parental involvement in rehabilitation training had little concern (Zu, Xu, & Du, 2016). Notably, incorporating parent and parenting support within treatment plans may improve not only child and family well-being, but also treatment outcomes (Mitchell, Fraser, Morawska, Ramsbotham, & Yates, 2016). An appropriate alternative to intervention program is “Family-Focused” rehabilitation model by intervenors (Rea et al., 2003). Family-Focused Psychoeducational Therapy (FFPT) is such an intervention. FFPT is a group intervention, it provides psychological support for patients and their families. The aims are to decrease family stress and negative emotional reaction and improve psychosocial functioning, ensuring children will obtain better social and family support in rehabilitation process (George, Taylor, Goldstein, & Miklowitz, 2011; Levy-Frank, Hasson-Ohayon, Kravetz, & Roe, 2011; Rea et al., 2003). Though the model of Family-Focued has been proposed recently, the FFPT intervention has not been applied to ASD family yet. Given these premises, we implemented the FFPT program in a sample of parents with children diagnosed with ASD.

The current study focused on FFPT for mental health of ASD children's parents including four subjects: psychiatry, psychology, community nursing, and special education. We hypothesized that the FFPT program would induce clinically significant improvements in parents' parenting self-efficacy, anxiety and depression, and that these effects would be maintained over time.

Purpose of the pilot study

Some studies emphasize that it is important to involve the family as a unit of care and offering relational family-level interventions to empower families who are lacking ability to adequately care for their ill child and themselves. The purpose of this study was to assess the effectiveness of a Family-Focused Psychoeducational Therapy (FFPT) model designed to improve parenting self-efficacy and emotion for China family parents of children with ASD.

Method

Study design

Phase I used a cross-sectional questionnaire design to investigate parenting self-efficacy and anxiety/depression of ASD children's parents at baseline; Phase II conducted a before and after quasi-experimental study to measure changes in parenting self-efficacy and anxiety/depression after attending a FFPT program and to determine if these changes were maintain over time.

Setting and participants

A convenience method was used to recruit participants from an autism rehabilitation clinic between October 2015 and March 2016. The inclusion criteria were: (a) having a child with a diagnosis of ASD which was made after a series of structured interviews were conducted by a psychologist and a developmental pediatrician at the Children's Hospital of Chongqing Medical University based on the DSM-V criteria (First, 2013); (b) being 20 to 45 years old and whose child is 0 to 72 months; and (c) participating in ASD rehabilitation training for the first time. Parents and children were excluded if they were cognitively impaired, physical dysfunction, brain disorder; or if they had received any interventions focused on improving psychological health in the 6 months before the study.

The typically-developing (TD) group sampled from the same Hospital. This class was matched to the ASD families according to age, gender, the family structure, parents' education levels and so on (at the lower intermediate socioeconomic level). The TD children have no language, social developmental disorders, or physical dysfunction, as determined according to the reports of the parents, physical examination and neuropsychological assessment.

Informed consent

The research was conducted according to the guidelines stated in the Declaration of Helsinki, and ethical approval was obtained from an Institutional Review Board (No.110). Prior to data collection, all participants were given information about the study objectives and procedures. Participants were also informed of their right to withdraw from the study at any time or choose not to answer questions about their experience without any consequence to clinical services they were receiving. Informed consent was obtained from each family member for the FFPT intervention and related data collection. Anonymous and confidential procedures were performed to record participants' information, and access given only to the research team.

Phase I: investigation of parenting self-efficacy and emotion at baseline

The questionnaire comprised instructions, a demographic questionnaire, The Tool to measure parenting self-efficacy (TOPSE), Zung Self-Rating Anxiety Scale (SAS) and Zung Self-Rating Depression Scale (SDS). We obtained permission from the authors of all the published scales via email to use the scales for this study.

Socio-demographic variables

Parents were asked to provide information about their age, gender, educational level, marital status, place of residence, employment status, and family incomes. In addition, parents also provided some information about their children, including children's age, gender, and whether the one-child.

Parenting self-efficacy

The tool to measure parenting self-efficacy (TOPSE) was used to assess parents' parenting self-efficacy. The TOPSE is a parenting program evaluation tool that took into account the views and experiences of parents from a range of cultural and social backgrounds (Kendall & Bloomfield, 2005). It was a multidimensional, validated instrument of 48 statements within eight scales, each scale representing a distinct dimension of parenting: Emotion and affection, Play and enjoyment, Empathy and understanding, Control, Discipline and setting boundaries, Pressure, Self-acceptance, Learning and knowledge. The items were rated on an 11-point Likert scale, where 0 represented completely disagree and 10 represented completely agree, the lower the score, the lower the level of parenting self-efficacy. Subscale alphas ranged from 0.80 to 0.89, and total scale alpha was 0.94 (Kendall & Bloomfield, 2005). However, we used the Chinese version of this scale, which translated by our team and had been shown to have good available use in the study. The subscales alpha coefficients range from 0.59 to 0.87, the total scale was 0.91, test-retest reliabilities ranged from 0.51 to 0.71.

Anxiety and Depression Scale

The level of anxiety and depression were assessed by Zung Self-Rating Anxiety Scale (SAS) and Zung Self-Rating Depression Scale (SDS) (Zung, 1971; Zung, Richards, & Short, 1965). Each scale contained 20 items based on a 4-point scale (1, Never or rarely; 2, some time; 3, frequently; and 4, Always). The possible range of raw scores were 20 to 80 for each scale, the raw score was standardized according to the formula: standard score = int(1.25*raw score), a higher score indicating a higher level of anxiety or depression. According to the Chinese norm, the SAS cutoff point was 50 and the SDS was 53 (Huo, 2015), when standard score higher than the cutoff point indicated that

Table 1
Content of the FFPT program.

Week	Intervention contents			
	Session 1: Parents psychoeducational class		Session 2: rehabilitation training	
	Topic	Teaching strategies	Topic	Teaching strategies
Week one	ASD related knowledge i.e. Clinical manifestation, causes, diagnosis, treatment, prognosis	Group (PPT, case report)	1.Jointly formulated Individualized Education Plans (IEPs) 2.the basis rehabilitation training related practice operation, i.e. the Applied Behavior Analysis (ABA), Treatment and Education of Autism and Related communication Handicapped children (TEACCH), Picture Exchange Communication system (PECS), sensory integration therapy and Floor time	1.Trainers guided, parents participate in 2.QQ online platform
Week two	1. Rehabilitation training related theories, i.e. ABA, Discrete Trial Teaching, Social Games, making teaching aids 2. management of behavior problem 3.Family communication skills	Group (PPT, demonstration)	Rehabilitation training related practice operation as same with the first week	Trainers guided, parents participate in
Week three	1. Family Problems we are facing 2. Diet care	Group (PPT. Video)	IEPs and Rehabilitation training from easy to hard	Parents guided, trainers assisted
Week four	Management of Emotion. i.e. positive copy style, model learning.	Group (PPT, discussion)	Rehabilitation training as same with the third week	Parents guided, trainer assisted

the person suffered from anxiety or depression symptoms. The Cronbach's alpha values for both scales ranged from 0.83 to 0.84 in the present sample (Zhong et al., 2016).

Phase II: Implement the FFPT program

The second phase of the study was the implementation of the FFPT. Participants in Phase II included all of the ASD children's parents from the first phase. The 4-week Family-Focus Psychoeducational Therapy involved once-weekly parent's psychoeducational class and a semi-daily rehabilitation training. All parts of parent's psychoeducational class were approximately 90–120 min and were taught by a FFPT team. The FFPT team conducted by 11–12 professionals, they were psychological doctors, nurses, special education teachers, PT, OT and SLP. All professionals had extensive experience working with ASD families. And we also asked parents to attend the whole process of children's rehabilitation training, 20 min/class, 3 h/day. On the basis of training needs survey and our previous study, the knowledge and skills related to ASD and how to manage children's behavior problems were also included, the detailed content of the FFPT was shown in Table 1.

Data collection

Data were collected over a six-month period and in this study occurred in three parts. Baseline questionnaires were included socio-demographic information, TOPSE, SAS and SDS for ASD and TD groups, which were surveyed prior to the intervention. At the end of intervention, ASD-group repeated these outcome measures by data collector guiding in the parents training classes. And at 1 month follow-up, these questionnaires were completed again by e-mail or telephone contact. All of the test questionnaires were coded with unique participant identify numbers to ensure that all sets of questionnaires were matched to the participants, and every evaluation results were record and strict confidentiality.

Statistical analyses

All statistical analyses were performed using SPSS statistical software version 20.0. The findings from Phase I were used to develop the FFPT implemented in Phase II. Descriptive statistics were generated from the demographic data. The baseline characteristics of the participants in ASD and TD groups were compared using analysis of independent-samples t-test for the continuous variables, a chi-square test for the categorical. Differences of TOPSE scores in changes over time among pre-, post-intervention, and follow-up were compared using Two-way repeated-measures ANOVA, differences detection rates of anxiety and depression were using Paired McNemar test. For all analyses, a P-value of < 0.05 was considered statistically significant.

Results

Socio-demographic characteristics of parents and children

There were 64 eligible fathers or mothers in ASD-group and 63 in TD-group. Parents' age ranged from 21 to 45, mean age 31.98 (SD = 4.86) years, 72.4% female, 97.6% married, 76.4% employed, and 83.5% living in an urban area. The proportion of parents who reported that they had received Junior college or above was 60.6% and 63.8% of families had income of more than RMB¥ 3000 per month.

Most of ASD children were boys (83.1%), and 68.9% children were from one-child families. The age ranged from 24 to 68, mean age 41.84 (SD = 10.82) months. The two groups did not differ on socio-demographic characteristics of the children and their parents (all $P > 0.05$; Table 2).

Comparison of outcome measures at baseline

Table 3 showed that the TOPSE subscales and mean total scores were significantly lower in the ASD-group compared with TD-group ($p \leqq 0.001$). Table 4 displayed the SAS and SDS scores for ASD-group were 45.49 (SD = 11.26) and 45.49 (SD = 11.26), significant higher than Chinese norm (Zhang, 1998) (t = 11.16,p = 0.000; t = 12.94, p = 0.000, respectively).

The effect of FFPT programs on parenting self-efficacy

The analysis revealed significant improvements in all the TOPSE scales from pre- to post-intervention and follow-up for ASD children's parents. (all $p < 0.05$; Table 5).

The effect of FFPT programs on anxiety and depression

The detection rates of anxiety and depression were significantly decreased from pre- to post-intervention and pre-intervention to follow-up for ASD children's parents. (all $p < 0.05$; Table 6).

Table 2
Demographic characteristics between ASD and TD groups at baseline.

	Mean (SD)/frequency(%)		X^2/t	P-values
Characteristic of parents	ASD-group (N = 64)	TD-group (N = 63)		
Age (years)	32.81(5.37)	31.14(4.15)	−1.962	0.052[a]
Gender				
Male	17(26.6)	18(28.6)		
Female	47(73.4)	45(71.4)	0.064	0.800[b]
Educational level				
High school or less	26(40.6)	24(38.1)		
Junior college	17(26.6)	14(22.2)		
Bachelor degree or above	21(32.8)	25(39.7)	0.710	0.701[b]
Marital status				
Married	61(95.3)	63(100)		
Others	3(4.7)	0(0)	3.025	0.082[b]
Place of residence				
Rural area	11(17.2)	10(15.9)		
Urban area	53(82.8)	53(84.1)	0.040	0.842[b]
Family income (RMB/month)				
< 1000	3(4.7)	3(4.8)		
1000–3000	22(34.4)	18(28.6)		
3000 above	39(60.9)	42(66.7)	0.503	0.778[b]
Employed				
Yes	48(75.0)	49(77.8)		
No	16(25.0)	14(22.2)	0.136	0.713[b]
Characteristic of children	ASD-group(N = 61)	TD group (N = 63)		
Age (months)	43.48(11.05)	40.25(10.44)	−1.669	0.098[a]
Gender				
Boy	54(88.5)	49(77.8)		
Girl	7(11.5)	14(22.2)	2.544	0.111[b]
Whether one-child family	42(68.9)	45(71.4)	0.098	0.754[b]

[a] Independent-samples t-test.
[b] Chi-squared test.

Table 3
TOPSE scores between ASD and TD groups at baseline.

	ASD-group(N = 64) Mean(SD)	TD-group(N = 63) Mean(SD)	*t*	P-values
Emotion & affection	7.01 (1.01)	7.77 (0.84)	4.622	0.000
Play & enjoyment	6.89 (1.69)	8.66 (0.96)	7.280	0.000
Empathy& understanding	6.94 (1.52)	8.56 (1.01)	7.092	0.000
Control	5.64 (1.46)	6.90 (1.37)	4.993	0.000
Discipline& setting boundary	5.62 (1.67)	7.26 (1.47)	5.864	0.000
Pressure	6.03 (1.05)	7.13 (1.13)	5.721	0.000
Self-acceptance	6.81 (0.98)	7.58 (0.95)	4.498	0.000
Learning & knowledge	7.46 (1.26)	8.14 (1.03)	3.314	0.001
Mean total TOPSE scores	6.55 (0.95)	7.75 (0.76)	7.851	0.000

Note. TOPSE = the Tool to measure Parenting Self-Efficacy.

Table 4
SAS and SDS scores between ASD-group and Chinese norm at baseline.

	ASD-group(N = 64) Mean(SD)	Chinese norm(N = 1158) Mean(SD)	*t*	P-values
SAS	45.49 (11.26)	29.79 (10.01)	11.16	0.000
SDS	50.74 (10.68)	33.46 (8.55)	12.94	0.000

Note. SAS = self-rating anxiety scale; SDS = self-rating depression scale.

Discussion

ASD is a complex group of neuro-developmental disorders, the treatment and prognosis are closely related to the psychological state of parents. Parents often act as the gateway to service use, and it is important that we support their sense of mastery and efficacy in this role. The findings of Phase I showed that at the start of the program, many parents of children with ASD reported significantly lower levers of parenting self-efficacy and worse emotion than parents of TD-group. This clearly suggested that parents who were feeling less confident within parenting a ASD child, they need a comprehensive program to be developed for improving this situation.

The present study of Phase II showed that TOPSE scores improved in all domains of parenting after parents attending the FFPT program, and these changes could be maintain over time. The observed treatment effects consisted with some previous studies (Batool & Khurshid, 2015; Bloomfield & Kendall, 2010; Liu, Sui, & Sun, 2014) and several aspects might explain these changes. First of all, our multidisciplinary program was a well-established category of psychotherapy and family skill-building plus psychoeducation (Fristad, 2016), as well as being theory-driven: it was based on a precise model of change, including both psychological and physical components, linking child-focused rehabilitation caring and family-focused facing problems according to our previous interview. These specially contents and positive examples we were giving may have changed the parents' cognition, raised the awareness of cooperate with family members and encouraged them to adapt to primary caregivers, problem solvers or other multiple roles (Hoogsteen & Woodgate, 2013). At the family level, psychological acceptance (Weiss, Cappadopcia, MacMullin, Viecili, & Lunsky, 2012) and supportive partner relationship (Bandura, 1995) appear to bolster parental efficacy and mental health. Furthermore, our program provided an opportunity for parents to freely learn from experienced families and communicate with professionals related to child care practices and their impact. It was an available way to help confused parents observing, modeling, and applying class strategies in the home environment, then become sources of empowerment, which may have contributed to enhancing parenting self-efficacy. In addition, established a QQ online platform, in the form of participant-to-participant and participant-to-professors communication channel could be helpful for parents to consult and obtain information outside of class and/or once the study was completed. Overall, this improvement of parenting self-efficacy indicated that parents of ASD children had more confident in their parenting role after intervention.

We also found that the detection rates of anxiety and depression were significantly decreased by the end of intervention and these were sustained a period of time. The reasons given for attending FFPT programs was around the course about how to manage the emotion and these were reflect in the SAS and SDS scores. On the one hand, though feelings of loss and grief play an important role in the complex emotions experienced by parents of children with ASD (Fernańdez-Alcántara et al., 2016), our program was designed to provide psychosocial support and encourage parents to form a positive solution way to face the problems, which can be a lasting protective effect on parents' mental health (He, Zhou, & Li, 2015). On the other hand, the Family-Focused therapy is an outgrowth of skills-oriented family intervention approach for families (George et al., 2011; Miklowitz, George, Richards, Simoneau, & Suddath, 2003), it combined theoretical study with practical rehabilitation training, which may encouraged parents and family members to participate in children's disease management and let them increasing the control of difficult events (Polkki, Pietila, Vehvilainen-Julkunen, Laukkala, & Ryhänen, 2002). Some parents reported that due to the sheer amount of time that they spend with their child on a daily caring basis, they have become unofficial experts of their children's rehabilitation training, and they obtained the joy and self-efficacy from the improvement of their child when it involved daily adaptive living routines. Therefore, The FFPT program not only focused

Table 5
Compare TOPSE scores at pre-, post-intervention, follow-up for ASD children's parents (N = 64).

	Pre-intervention mean(SD)	Post-intervention mean(SD)	Follow-up mean(SD)	*F*	P-values
Emotion & affection	7.01 (1.01)	7.22 (0.76)	7.42 (0.82)	5.435	0.007[b]
Play & enjoyment	6.89 (1.69)	7.44 (1.26)	7.56 (1.29)	7.577	0.001[a,b]
Empathy& understanding	6.94 (1.52)	7.33 (1.24)	7.48 (1.24)	5.300	0.007[a,b]
Control	5.64 (1.46)	6.23 (1.19)	6.32 (1.34)	8.863	0.000[a,b]
Discipline & setting boundary	5.62 (1.67)	6.45 (1.46)	6.71 (1.34)	15.393	0.000[a,b]
Pressure	6.03 (1.05)	6.38 (1.15)	6.55 (0.98)	5.500	0.005[a,b]
Self-acceptance	6.81 (0.98)	7.12 (0.86)	7.17 (1.07)	4.106	0.019[a,b]
Learning & knowledge	7.46 (1.26)	7.75 (1.00)	7.96 (0.86)	5.014	0.010[b]
Average total TOPSE scores	6.55 (0.95)	6.99 (0.76)	7.15 (0.81)	17.574	0.000[a,b]

Note. TOPSE = the Tool to measure Parenting Self-Efficacy.
[a] LSD back testing: Pre-intervention < Post-intervention.
[b] LSD back testing: Pre-intervention < Follow-up.

Table 6
Influence of FFPT on detection rates of anxiety and depression for ASD children's parents (N = 64).

	Pre-intervention (n(%))	Post-intervention (n(%))	Follow-up (n(%))	P-values[a]	P-values[b]
SAS	18(28.1)	10(15.6)	9(14.1)	0.039	0.049
SDS	30(46.9)	19(29.7)	18(28.1)	0.035	0.012

Note. SAS = self-rating anxiety scale; SDS = self-rating depression scale.
[a] Compared with pre- and post-intervention.
[b] Compared with pre-intervention and follow-up.

on enhancing the abilities to manage child care and strengthen parenting confidence but also increased communication skills, decreased adverse emotion for ASD children's parents.

Our findings suggested that FFPT strategies including modification of maladaptive cognition induced positive attitudes, professionals-peer support, rehabilitation and problem-solving skills, as well management of emotion regulation. The FFPT appeared to empower parents. With the telephone follow up, most parents were highly satisfied with this intervention and they had established the confidence to do a good parent role for further parenting. It was worth noting that the FFPT program has to be considered at low-cost, as about its unique family-centered caring had put training place from the agencies to their home and family-problems solving methods into practice, a certain extent, reducing the training cost and time.

Our study had several limitations. First, the study due to the practical feasibility, our intervention time was four weeks, which may provide more psychoeducation knowledge and practical skills for parents of children with ASD. Future research could involve a longer period of the intervention time. Second, the sample size was relatively small. Furthermore, Compared with the small numbers of children with ASD in autism rehabilitation centers, most children with ASD are living at home. It is recommended that further studies on FFPT is need to corporate outside rehabilitation centers like community, and examine the FFPT program under controlled conditions with measures that include family functioning and child health outcomes.

It would be worth for this FFPT to be extended and tested in China by other health providers who care for ASD families and other childhood chronic illnesses. Specific implications for clinical practice include developing programs to provide parents with the care skills to work along with health care providers to transform positive parenting motivation to do better in children's rehabilitation training. Also successful family empowerment requires that health care providers be able to conceptualize the family as the unit of care, build a trusting relationship with the family members, recognize the reciprocal impact of illness and family needs, provide a compassionate and caring atmosphere, encourage families to exchange experiences, explore beliefs about illness, identify family strengths and offer commendations, and encourage reflections. This FFPT could be involved more ASD family members than only the primary family caregiver and promoted in the future works.

Conclusions

The impairments germane to ASD not only affect the diagnosed individual but also his or her parents and family, the effective methods need to be found to assist them. Although the relevant research about FFPT has just been started in China, we are trying to set up and deliver this within an autism rehabilitation clinic and encourage parents to join the program. Parents who took part in this study reported that the FFPT helped them share beliefs and experience related to caring for their ASD child, provide social support, and develop increased ability to manage care for their ill child, the results of this study are timely and provide preliminary evidence that FFPT intervention for parents of children with ASD may be efficacious in enhancing parenting self-efficacy, reducing adverse emotion, and these changes can be maintain a period of time after the intervention ended.

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