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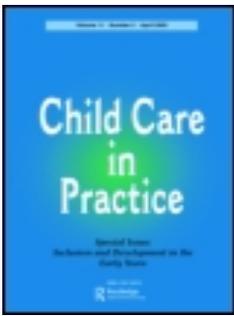
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Helena Draxler, Fredrik Hjärthag & Kjerstin Almqvist

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## Replicability of Effect when Transferring a Supportive Programme for Parents Exposed to Intimate Partner Violence and Their Children from the US to Sweden

Helena Draxler, Fredrik Hjärthag  and Kjerstin Almqvist 

Department of Social and Psychological Studies, Karlstad University, Karlstad, Sweden

### ABSTRACT

Transferring an evidence-based parenting programme for parents exposed to intimate partner violence (IPV) and their children with emotional and behavioural problems reveals the extent to which cultural and social aspects can interfere with the programme's effectiveness. Feasibility studies are of value in such circumstances, and the aim of the present feasibility study was to explore, on a small scale and in its natural context, whether the effects of the parenting programme, Project Support, were replicable when transferred to another country. In this study, the programme, which was originally designed for parents exposed to IPV and their children who had developed psychological symptoms in the United States, was evaluated in an equivalent population receiving Swedish social services. Parents ( $n = 35$ ) self-assessed their parenting capacity and their children's ( $n = 35$ ) psychological symptoms. The results indicate that the parents improved their parenting capacity, and feelings of helplessness and fear regarding parenting their children decreased. Those feelings were also associated with the children's psychological symptoms. The promising results are similar to the findings of previous research from the US, and further implementation and evaluation of Project Support in Sweden are indicated.

### KEYWORDS

Feasibility study; parenting; domestic violence; social work; children's psychological symptoms

### Introduction

Intimate partner violence (IPV) can appear in many guises—including physical, psychological and sexual abuse and economic deprivation—and its prevalence varies among societies and in different societal contexts (Abramsky et al., 2011; Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). At some point in their lives, one in four Swedish women have been victimised in a close relationship (Brå, 2014; World Health Organization, 2013). In 65% to 86% of families where IPV has occurred, children have witnessed the violence (Hamby, Finckelhor, Turner, & Ormrod, 2011). Exposure to IPV is devastating for the whole family, and the ways in which the violence may affect the mother and her parenting capacity as well as the

**CONTACT** Helena Draxler  Helena.draxler@kau.se  Department of Social and Psychological Studies, Karlstad University, SE-651 88 Karlstad, Sweden

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children are complex. Children lose a secure haven when one parent activates their fear and the other parent is too frightened to give protection and comfort (Hesse & Main, 2006).

Depending on the form of violence and the phase in the children's developmental process, the exposure to IPV can generate different consequences (Cicchetti & Toth, 2005). Younger children, infants and toddlers are developmentally limited and, therefore, aggression, sleeping problems, difficulties at separation and regressed behaviour can be ways of showing their emotions (Lundy & Grossman, 2005). Older children aged 6–12 years have better developed cognitive capacity and therefore attempt to find out how to predict and prevent violence (Holt, Buckley, & Whelan, 2008). IPV not only affects children's social and psychological development, but may also impact the children biologically, since chronic levels of stress and anxiety are associated with deviant development of the brain's functions, plus vulnerability for mental illness tends to continue during childhood and into adulthood (Cater, Miller, Howell, & Graham-Bermann, 2015; Davis, 2013).

Women who experience and survive IPV are often burdened with anxiety, depression, post-traumatic stress disorder and physical problems or injuries in the aftermath of the abuse. Therefore, their parenting capacity may also be affected by their psychological reactions and emotions, which could be manifested as feelings of isolation, lack of energy, inability to engage with the child and worry about the child's future, and also as a reduced level of nurturing and warmth (Levendosky & Graham-Bermann, 2000; Levendosky, Lynch, & Graham-Bermann, 2000). This situation is problematic since the child cannot rely on the abusive father when the child is afraid of him. The situation also constitutes a high risk for negative child development (Featherstone & Peckover, 2007).

Since violence in the family is complex, interventions and parenting programmes need to be individualised in order to target problems in both children and parents, and to ensure a strong alliance with the counsellor as their base. Individual safety, parenting capacity, the symptoms of trauma, the effects of the abuse on mother and child, parenting capacity and everyday life structures are important to address when individualised support is planned (Levendosky & Graham-Bermann, 2000; Levendosky et al., 2000).

In 2013, the Australian Centre for Posttraumatic Mental Health and the Parenting Research Centre charted interventions and empirical support for children exposed to violence. Project Support (PS) was one programme developed for children exposed to parental IPV, with the positive effects of PS being shown in randomised control trials and systematic evaluations (Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2013; Jouriles et al., 2001, 2009, 2010; McDonald, Dodson, Rosenfield, & Jouriles, 2011; McDonald, Jouriles, & Skopp, 2006).

### Project Support

The PS programme was originally designed for mothers who had been exposed to severe IPV and their children (age three–nine years) who had developed externalising problems. The programme has two components: social and emotional support (e.g. with finance, health issues and legal proceedings) and parenting skills training. Eleven parenting skills, which are trained cumulatively, address rewarding children's prosocial behaviour and promoting parental sensitivity and warmth, and include conflict resolution skills. The programme is delivered by a PS trained social worker in the mother's home for a minimum of once a week. The mother trains in each skill as long as she needs to, so

the number of sessions varies, but the average length of treatment is about 20 sessions over eight months (Jouriles et al., 2009).

The PS programme has been shown to reduce harsh parenting and children's externalising problems. Mothers who have taken part in PS have been shown to be less likely to return to their violent partner (Jouriles et al., 2001; McDonald et al., 2006). Similar results were found in a randomised controlled study in which PS was compared with service as usual (Jouriles et al., 2009). In previous research on PS, only mothers participated in the programme. However, the programme is not gender specific and can be helpful for all parents who have been exposed to IPV.

### The need for a new support programme for families exposed to IPV in Sweden

A Swedish national evaluation of existing support programmes for families exposed to IPV revealed a need for interventions that could substantially reduce children's psychological symptoms (Broberg et al., 2011). These findings highlighted the need to conduct feasibility studies before implementing any new intervention. The aim of a feasibility study is to test an intervention on a small scale in its natural context, to find out if the effects of the intervention are replicable, as well as to determine the most suitable level of the organisation for its implementation. There is also need to consider the degree of acceptance and receptivity, the demands and conditions for continued research, practicalities such as adaptation needs, the degree of integration into existing systems, as well as the expansion options and the limitations of testing (Bowen et al., 2009).

### Transferability and adaptations of PS to a Swedish context

The Swedish National Board of Health and Welfare (2012) has highlighted that cultural and social aspects may interact with previously shown effects when transferring interventions from one country to another. Hasson, Sundell, Beelmann, and von Thiele Schwarz (2014) found that parenting programmes that were modified for a Swedish context concerning cultural norms or practicalities (adapted) were more effective than adopted ones. Cultural differences between countries and their effects on interventions by adaptations are difficult to evaluate, but it seems that countries where citizens value gender equality and tolerance benefit from adaptations of parenting programmes transferred from countries with a predominance of more traditional values (Gardner, Montgomery, & Knerr, 2016). Sweden and Texas, US, where PS was evaluated originally, differ legally in terms of whether corporal punishment of children is allowed (prohibited in Sweden), whether same sex marriage is allowed (legal in Sweden), the right to parental leave (18 months in Sweden) and state-funded day care (a right for every child in Sweden). Swedish culture and attitudes about parenting and legislation are well in line with the commitment Sweden bears to the UN Convention on the Rights of the Child (SFS 2001: 453; United Nations, 1989). Consequently, interviews with mothers and counsellors about their experiences of taking part in PS clarified that the PS programme needed to be adapted to better fit the Swedish context.

Adaptations of programmes for children exposed to IPV need to identify and consider which specific components in treatment are crucial for the outcome to better understand which components are changeable (Overbeek, De Schipper, Willems, Lamers-

Winkelman, & Schuengel, 2017). Initially the PS manual was translated to Swedish, and from discussions with the originators, modifications of the manual were made concerning language and clarifications about the content and delivery of restricting parenting skills such as time out or withdrawal of rewards and privileges. However, the programme's core components, based on learning theory, were never modified.

Considering aspects of feasibility, the aim of the present study was to explore whether the effects of the PS programme, concerning a decrease in children's psychological symptoms and an improvement in parenting capacity among children and parents exposed to IPV, could be replicated in Sweden.

## Method

### Recruitment and screening procedure

Social service agencies in Swedish communities and domestic violence shelters that had previously expressed interest in interventions for children exposed to IPV were invited to participate in the study. Eight small or mid-sized municipalities and two large domestic violence shelters took part in the study. The units financed their own participation and were responsible for legislative, regulatory and insurance coverage of participating caregivers and their children.

Caregivers who were invited to participate had been exposed to IPV and voluntarily sought help for their children's psychological symptoms within the social service. The need for an intervention had been assessed by the social services, which declared that the caregivers were entitled to fully financed treatment according to the Swedish Social Services Act. Swedish legislation obligates social services to give treatment to all caregivers who have been exposed to IPV regardless of gender, and PS was thus offered to caregivers of both sexes who fulfilled the criteria. All caregivers in this study were biological parents and are in this article referred to as parents. The families were recruited and participated in the intervention from August 2013 to December 2016. A majority of the parents had previously participated in other interventions that they had not perceived as sufficiently helpful for their children. Measurements of parenting capacity and child psychological symptoms were filled out by parents before (T1) and after (T2) the PS intervention. In addition, they also filled out a short form before each session rating their parenting capacity and their children's psychological symptoms during the preceding week. Parents exposed to IPV can be vulnerable to further stress, thus to participate in this study and answer questions about their situation might be an effort. To prevent increased levels of stress, parents had regular contact with their counsellors, and as a part of the intervention, parents received social and emotional support at every session. Before parents were accepted for participation in the study, their needs and situation were routinely assessed within the social service, which might reduce risk for further stress due to participation.

### Participants

Thirty-five parents (34 mothers and one father) were targeted for the programme and included in the study. One child from each family (19 boys and 16 girls), whom the parent felt most worried about and had most difficulties with, was in the parent's focus when questions were answered about the child's behaviour. The mean age of the child

in the family was six years. Ten parents were living in a domestic shelter together with their children when they were included in the study and started the programme. Seven children alternated living with parents who were separated, and the remaining 18 children lived with their mothers. For 12 of the target children, the mother had sole custody; the remainder had joint custody. Eleven parents were employed, 14 parents relied on various forms of public financial assistance, and for ten parents, their situation was unknown.

Before the intervention (T1), self-assessments of violence exposure (psychological, physical and sexual) with the revised Conflict Tactic Scales, CTS2 (Straus, Hamby, Boney-McCoy, & Sugarman, 1996), were collected. All parents (100%) had experienced psychological violence, over half of them (54%) more than 20 times during the previous year. Physical violence was the second most common type of exposure (88%). All 35 children (100%) had witnessed psychological abuse of the parent, 84% had witnessed physical violence and over half of them (55%) had seen or in other ways been aware of the parent being injured as a result of IPV.

The least frequent exposure to IPV in this study was sexual coercion (66%), which was witnessed by 17% of the children.

Predominantly, the exposure of all types of violence towards the intimate partner had been some years ago, and not during the preceding year (79%).

### Treatment fidelity

Of the 34 counsellors who offered the PS programme, 94% had a university degree and more than 80% had been in their profession for more than five years. Everyone had experience of working with families and IPV, and were trained and supervised in PS by the originator of the method in the same way as counsellors in the US, with the exception that the sessions were never recorded in Sweden (Jouriles et al., 2009). The study started with a thorough training of the counsellors for three days followed by regular supervision by the originator.

For each session with the parents, the counsellors filled out a fidelity form measuring to what extent they had offered social and emotional support, and how they had worked with the different parenting skills according to the manual. The mean time for the parents taking part in PS was 8.6 months (range 1.5–13.0 months), and the number of sessions varied from six to 40 ( $M = 16.7$  sessions). During the study, 11% of the parents were trained in all 11 parenting skills, 35% were trained in the skills that were based on positive reinforcement, 12% were trained in some of the skills that addressed children's misbehaviour and 42% were trained in only the first two parenting skills.

The PS programme has no fixed number of sessions and the parents are trained according to their individual capacity. Participants' data were included in the study (T1 and T2) if the parent had received at least six sessions ( $n = 28$ ). To be able to include parents who lived for short periods in shelters, the lower limit for inclusion based on number of sessions was set to six. This also took into account the fact that some effects from treatment could be expected to be proven after about six sessions (Nielsen, Bailey, Nielsen, & Pedersen, 2016).

### Attrition

Of the initial 35 parents, seven parents chose to withdraw their participation shortly after the initial self-assessment (T1). They received fewer than six sessions and did not

participate in the post-self-assessment (T2). Of these seven families, two parents needed another form of intervention owing to mental illness, two parents moved and three parents gave no reasons for ending the programme early. The completed sample comprised 28 parents. There were no significant differences between the seven dropouts and the remaining sample with regard to parenting capacity or child psychological symptoms. However, the non-completing parents appeared to have a higher frequency of exposure to IPV according to the CTS2: they accounted for about half of all the parents who had been most frequently (>20 times) exposed to physical assault and sexual coercion in the previous year.

## Instruments

The parents filled out two questionnaires about their child's adjustment problems (one behavioural questionnaire and one psychological questionnaire) and three self-assessment questionnaires about their parenting capacity before treatment (T1) and after the final session (T2).

### Measuring child psychological symptoms

The Eyberg Child Behavior Inventory (ECBI) is a parental questionnaire to measure the extent of externalising symptoms for children between two and 16 years old. The questionnaire comprises two scales: the intensity scale and the problem scale. The intensity subscale consists of 39 items in which different problem behaviours are stated and the parent reports how often the behaviour occurs, from "Never" (0) to "Always" (7). In the problem scale, the parent marks whether the problem behaviour is a problem for the family or not (1 = "Yes", 0 = "No"). The two scales are summarised separately, with the range for the intensity scale being 0–36 and that for the problem scale being 36–252, where a high score indicates difficulties (Eyberg & Pincus, 1999). In a subsequent Swedish validation study of ECBI, clinical cut-off levels for children aged three–ten years were calculated: 136.9 on the intensity scale and 14.0 on the problem scale (Axberg, Hanse, & Broberg, 2008).

The Strength and Difficulties Questionnaire–Parent (SDQ-P) measures children's level of general functioning as well as any psychological illness and any impact of psychological symptoms. The sum of all the item scores yields the total difficulties score. The SDQ-P contains five scales: prosocial behaviour, hyperactivity/inattention, emotional symptoms, conduct problems and peer relationship problems. A high score indicates difficulties, except for the prosocial behaviour scale, in which a high score indicates strength. The 25 items are scored from 0 ("Totally disagree") to 2 ("I agree"). A supplementary scale that contains seven items measures the impact of the symptoms in different areas (with friends, at home, etc.). Statements are rated on a four-grade scale, from "Not at all" to "A great deal". The recommended Swedish clinical cut-off value for the total difficulties score for children age six to ten years is 14 ( $M = 6.5$ ). For the five scales, the cut-off limits are prosocial behaviour  $\leq 5$ ; hyperactivity/inattention  $\geq 7$ ; emotional symptoms  $\geq 5$ ; conduct problems  $\geq 4$ ; and peer relationship problems  $\geq 4$  (Smedje, Broman, Hetta, & von Knorring, 1999). As the recommended Swedish clinical cut-off value for the impact of the symptoms is lacking, the UK value of  $\geq 2$  was used in the present study, in accordance with Goodman

(1997). The Child Behavior Checklist (CBCL), which contains 90 items, was used in previous studies of PS (Jouriles et al., 2001, 2009; McDonald et al., 2006). The scale was also used in the present study as a comparison and to measure children's level of conduct problems. Counsellors distributed the scales and sometimes they had to clarify and support the parents as they answered the questions. It was necessary to balance what was manageable for both parents and counsellors and the SDQ-P was a shorter scale and an alternative, as it has been compared with the CBCL with good results (Goodman & Scott, 1999).

### Measuring parenting capacity

The parental control sub-scale of the Parental Locus of Control (PLOC) Scale is a ten-item sub-scale measuring levels of experienced parental control. Questions are scored from 1 to 5, where 1 represents "I totally disagree" and 5 "I totally agree" (scores are based on the mean and the total range is 1–5); a high value is interpreted as high control (Campis, Lyman, & Prentice-Dunn, 1986). In a Swedish longitudinal study, children were followed from 33 weeks to nine years of age, with  $M = 3.22$ ,  $SD = 0.67$  being reported at 33 weeks old and  $M = 3.49$ ,  $SD = 0.65$  at nine years of age (Hagekull, Bohlin, & Hammarberg, 2001).

The Caregiving Helplessness Questionnaire (CHQ) measures a caregiver's feelings of helplessness with regard to parenting a child in the age range of three–11 years. The questionnaire consists of three sub-scales: Mother Helpless, Mother–Child Frightened and Child Caregiving. The Mother Helpless sub-scale reflects whether the caregiver experiences a lack of control over the child and feelings of failure as a parent. The Mother–Child Frightened sub-scale reflects to what extent there are feelings of fear in the relationship between a parent and a child and therefore a risk of mutual violence. The third sub-scale, Child Caregiving, addresses whether the child has taken on the responsibility of the parent, a situation of reversed care. The questionnaire includes 18 statements and can be scored from 1 ("I disagree") to 5 ("I agree"), generating a total score from 18 to 90. High scores indicate a high level of disorganised caregiving. At the 95th percentile, the range for the Mother Helpless sub-scale is 9.14–10.24, that for the Mother–Child Frightened sub-scale is 8.30–9.12, and that for the Child Caregiving sub-scale is 18.03–19.21 (Solomon & George, 2011). When clinical cut-off limits were used in the present study, a mean for the range was calculated.

The Alabama Parenting Questionnaire–Preschool Revision (APQ-PR) was used to better fit the sample of the study according to the children's age. The APQ-PR comprises three sub-scales: positive parenting (12 items), negative/inconsistent parenting (seven items) and punitive parenting (five items). For all three sub-scales, the items are scored from 1 ("Never") to 5 ("Always"); for children in the age range of 3.06–7.58 years, the mean for the positive parenting sub-scale is 52.22, that for the negative/inconsistent parenting sub-scale is 15.88, and that for the punitive parenting sub-scale is 9.49. A high score indicates difficulties, except for the positive parenting scale, in which a high score indicates strength (Clerkin, Marks, Policaro, & Halperin, 2007).

### Statistical analyses

The Wilcoxon two-tailed signed-rank test was used to measure the changes for completers before treatment (T1) and after treatment (T2) on the outcome variables.

The Wilcoxon signed-rank test was also used to measure clinically significant changes where the medians were compared with cut-off levels before and after treatment. The effect sizes were calculated with Cohen's *d*, with 0.2 indicating a small effect, 0.5 a medium effect, and 0.8 a large effect (Cohen, 1988). The Pearson product-moment correlation was computed to assess the association between child adjustment problems and parenting capacity.

## Results

### Children's psychological symptoms

According to parents' reports, children's psychological symptoms decreased after intervention with the PS programme as measured by the SDQ-P total score and more specifically by three of the scales: emotional symptoms, conduct problems and hyperactivity/inattention. The effect sizes were small or medium, ranging from 0.356 to 0.761. The ECBI showed no significant change (see Table 1).

Pursuant to parents' scoring, most of the children (82%) suffered from clinically significant levels of symptoms before the intervention (SDQ-P), and post-treatment showed a change of 36 percentage points from above to below clinical cut-off levels. The median for the SDQ-P total score was compared with the cut-off level and changed from being significantly above the cut-off level pre-treatment to showing no significance post-treatment. This indicates that the median level had changed and was after treatment closer to the cut-off level and that the parents experienced that the children's problems had decreased. For the SDQ-P scales, the largest difference was shown in emotional symptoms, conduct problems and hyperactivity/inattention. Pre-treatment, there were no differences in these scales between the median levels and the cut-off levels. After the intervention, the median levels changed significantly to below the cut-off levels (see Table 2).

**Table 1.** Children's psychological and behavioural problems.

Instrument	Pre-treatment			Post-treatment			z	d
	M	Mdn	SD	M	Mdn	SD		
<b>SDQ-P (n = 28)</b>								
Emotional symptoms	5.04	5.00	2.28	3.54	4.00	2.66	-2.759**	.735
Conduct problems	4.29	4.00	1.88	2.89	3.00	1.81	2.864**	.761
Hyperactivity	6.00	6.50	2.84	5.02	5.00	2.56	2.150*	.356
Peer problems	2.46	2.00	1.88	2.32	2.00	1.76	n.s.	
Prosocial	7.04	7.50	2.13	6.92	6.50	1.90	n.s.	
<b>Total difficulties</b>	17.79	18.00	5.85	13.79	12.50	6.14	-2.925**	.667
<b>Impact</b>	2.38	2.00	2.31	1.34	.00	1.82	-2.835**	.507
<b>ECBI</b>								
Intensity (n = 16)	122.19	121.00	42.02	113.19	110.00	33.50	n.s.	
Problem (n = 12)	15.58	15.50	9.46	14.42	16.50	9.18	n.s.	

Note: SDQ-P = Strength and Difficulties Questionnaire (Goodman, 1997); ECBI = Eyberg Child Behavior Inventory (Eyberg & Pincus, 1999).

Means, standard deviations and numbers of participants of outcome variables at pre- and post-treatment, and level of significance and effect sizes for post-treatment.

\*Significant at 0.05 level (2-tailed).

\*\*Significant at 0.01 level (2-tailed).

**Table 2.** Changes in children's conduct problems and significant clinical change compared to cut-off values pre- and post-treatment.

	Cut-off value	Children with clinical symptoms pre-treatment	Mdn	p	Children with clinical symptoms post-treatment	Mdn	p	Percentage change
<b>SDQ-P (n = 28)</b>								
Emotional symptoms	5 <sup>a</sup>	64%	5.0	n.s.	36%	4.0	.008	28%
Conduct problems	4 <sup>a</sup>	75%	4.0	n.s.	43%	3.0	.007	32%
Hyperactivity	7 <sup>a</sup>	50%	6.5	n.s.	29%	5.0	.001	21%
Peer problems	4 <sup>a</sup>	25%	2.0	<.001	25%	2.0	.001	0%
Prosocial	5 <sup>b</sup>	29%	7.5	<.001	25%	6.5	<.001	4%
Total difficulties	14 <sup>a</sup>	82%	18.0	.006	46%	12.5	n.s.	36%
<b>ECBI</b>								
Intensity (n = 16)	136.9 <sup>a</sup>	63%	121.00	n.s.	69%	110.0	.017	6%
Problem (n = 12)	14 <sup>a</sup>	42%	15.5	n.s.	50%	16.5	n.s.	10%

Note: SDQ-P = Strength and Difficulties Questionnaire (Goodman, 1997); ECBI = Eyberg Child Behavior Inventory (Axberg et al., 2008; Eyberg & Pincus, 1999).

<sup>a</sup>Clinical level is at cut-off value or above.

<sup>b</sup>Clinical level is at cut-off value or under.

### Parenting capacity

Parents reported that they had made improvements after the PS intervention according to the measures on the APQ-PR sub-scales for positive parenting and negative parenting. The results for the CHQ, total score, indicated that parents generally felt more in control of how they handled situations with their children. The scoring reflected that parents were being less helpless after the intervention and were no longer afraid to the same extent. The results for the PLOC (sub-scale parental control) showed that parental control had improved. The effect sizes were both small and large (see Table 3).

For the CHQ sub-scale Mother-Child Frightened, most of the parents (82%) initially reported that they had feelings of fear in the relationship with their child. Post-treatment, these negative feelings decreased from above to below the cut-off level for

**Table 3.** Parenting capacity measured with PLOC, CHQ and APQ-PR pre- and post-treatment.

Instrument	Pre-treatment			Post-treatment			n	z	d
	M	Mdn	SD	M	Mdn	SD			
<b>FLOC</b>									
Sub-scale Parental control	3.10	31.00	7.00	3.39	34.50	7.23	20	2.139*	.408
<b>CHQ</b>									
Mother helpless	16.63	16.00	5.12	12.70	12.00	5.48	27	-2.745**	.742
Mother-child frightened	13.43	14.00	3.99	10.18	8.00	4.13	28	-2.710**	.802
Child caregiving	20.59	20.00	4.26	19.92	19.00	4.57	27	n.s.	
Total sum	50.74	51.00	10.59	42.93	43.00	8.95	27	-3.254**	.797
<b>APQ-PR</b>									
Positive parenting	48.21	49.00	5.19	50.74	51.00	5.15	19	2.446**	.482
Negative parenting	17.84	17.00	4.25	15.26	16.00	3.75	19	-2.540**	.645
Punitive parenting	8.22	8.00	1.93	7.61	7.00	1.78	19	n.s.	

Note: PLOC = Parental Locus of Control (Campis et al., 1986); CHQ = Caregiver Helplessness Questionnaire (Solomon & George, 2011); APQ-PR = Alabama Parenting Questionnaire-Preschool Revision (Clerkin et al., 2007).

Means, medians, standard deviations, numbers of participants of outcome variables, level of significance and effect sizes for post-treatment.

\*Significant at 0.05 level (2-tailed).

\*\*Significant at 0.01 level (2-tailed).

**Table 4.** Changes in parenting capacity and significant clinical change compared to cut-off values pre- and post-treatment.

	Cut-off value	Parents with parenting problems pre-treatment	Mdn	p	Parents with parenting problems post-treatment	Mdn	p	n	Percentage change
<b>FLOC</b>									
Sub-scale Parental control	3.49 <sup>b</sup>	80%	3.10	.040	60%	3.45	n.s.	20	20%
<b>CHQ</b>									
Mother helpless	9.69 <sup>a</sup>	93%	16.00	<.001	67%	12.00	.014	27	26%
Mother-child frightened	8.71 <sup>a</sup>	82%	14.00	<.001	46%	8.00	n.s.	28	36%
Child caregiving	18.62 <sup>a</sup>	74%	20.00	.029	59%	19.00	n.s.	27	15%
<b>APQ-PR</b>									
Positive parenting	53.01 <sup>b</sup>	89%	49.00	.001	58%	51.00	n.s.	19	31%
Negative parenting	15.96 <sup>a</sup>	68%	17.00	n.s.	53%	16.00	n.s.	19	15%
Punitive parenting	9.62 <sup>a</sup>	30%	8.00	.003	17%	7.00	<.001	23	13%

Note: PLOC = Parental Locus of Control (Campis et al., 1986); CHQ = Caregiver Helplessness Questionnaire (Solomon & George, 2011); APQ-PR = Alabama Parenting Questionnaire-Preschool Revision (Clerkin et al., 2007).

<sup>a</sup>Clinical level is at cut-off value or above.

<sup>b</sup>Clinical level is at cut-off value or under.

this sub-scale, a change of 36 percentage points. Parents also experienced less helplessness (CHQ), and there was an improvement of 26 percentage points when their results were compared with the clinical cut-off level. Parenting factors such as positive parenting also increased (APQ-PR), and clinically significant change was also shown in the locus of control (PLOC), where the median levels improved and reached cut-off levels (see Table 4).

There were no significant differences between parents who stayed at shelters ( $n = 10$ ) and parents who lived at their homes ( $n = 25$ ) regarding parenting capacity or children's psychological symptoms before (T1) and after treatment (T2).

#### Association of change in parents' scoring of parenting capacity and their children's psychological symptoms

A significant association was shown between improvement (T1–T2) in parenting capacity measured by the CHQ and decreases in child psychological symptoms (SDQ and ECBI). Parents' reports of reduced experiences of fear correlated to their reports of children's psychological symptoms such as emotional symptoms, conduct problems and hyperactivity (SDQ-P) [Emotional:  $p = 0.0304$ ,  $n = 28$ , Conduct:  $p = 0.026$ ,  $n = 28$ , Hyperactivity:  $p = 0.024$ ,  $n = 28$ ] as well as reduced conduct disorders (ECBI intensity and problem scales) [ $p = 0.018$ ,  $n = 16$  and  $p = 0.004$ ,  $n = 12$ , respectively]. Parents' capability of positive parenting (APQ Positive) was also associated with children's difficulties (SDQ Total) [ $p = 0.038$ ,  $n = 12$ ] (see Table 5).

**Table 5.** Pearson correlation (2-tailed) between changes in parents' scoring concerning parenting capacity and child psychological symptoms before and after intervention (T1–T2).

	CHQ Mother helpless	CHQ Mother– child frightened	CHQ Child caregiving	CHQ Total	Plock Parental control	APQ Positive	APQ Negative	APQ Punitive
SDQ Emotional symptoms	.457*	.410*	n.s.	.417*	n.s.	n.s.	n.s.	n.s.
SDQ Conduct problem	n.s.	.419*	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.
SDQ Hyperactivity/ inattention	.459*	.425*	n.s.	.494**	n.s.	n.s.	n.s.	n.s.
SDQ Peer problem	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.
SDQ Prosocial	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.
SDQ Total	n.s.	.549**	n.s.	.559**	n.s.	–.492*	n.s.	n.s.
ECBI Intensity	n.s.	.580*	n.s.	.646**	n.s.	n.s.	n.s.	n.s.
ECBI Problem	n.s.	.764**	n.s.	.762**	n.s.	n.s.	n.s.	n.s.

\*Correlation is significant at 0.05 level (2-tailed).

\*\*Correlation is significant at 0.01 level (2-tailed).

## Discussion

The results from this feasibility study indicate that it might be possible to transfer the Project Support programme to Swedish social service, a new context, with positive results. A similar effect size compared to previous studies in both parenting capacity and child psychological problems could be noted, where parenting capacity improved and children's psychological symptoms decreased (Jouriles et al., 2009). The reductions were seen in such categories as emotional symptoms, conduct problems and hyperactivity/inattention (SDQ-P). Levels of parental feelings of fear and helplessness (CHQ) were associated with these decreased emotional symptoms, hyperactivity and conduct problems (SDQ-P) in the children. Parents' assessment showed that a substantial number of the children clinically significantly decreased in symptomatology. However, in almost half of the children, the symptom levels were still above the clinical cut-off levels after the intervention. It may be that the parents' improvements in parenting capacity will lead to further improvements in their children, but this was not possible to show in this study without long-term follow-up.

In the present study, the difference in parental control (PLOC) between the mean pre- and post-treatment was  $M = 0.35$ . In another study in which PS was used with parents who had been referred for child maltreatment (Jouriles et al., 2010), parental control (PLOC) changed more than in the present study. In the Jouriles et al. study (2010), the mean difference between pre-treatment and 16 month's post-treatment was  $M = 0.46$ . Conduct problems among children exposed to IPV whose parents had received PS in Sweden and in the US were measured with ECBI in both instances. In the present study, only ten parents and their children were recruited from domestic violence shelters compared with all the families in the US study (Jouriles et al., 2009). In a comparison, the children in this study had a lower level of conduct problems ( $M = 122.19$ ) pre-treatment, according to the parents' assessment, than the children in the US study ( $M = 142.1$ ). Post-treatment, there was still a difference between the present sample and the US sample, with the participants in the present study scoring higher ( $M = 113.19$ ) than the participants in the US study

( $M = 102.5$  (Jouriles et al., 2009)). One explanation for this difference might be that children with the largest difficulties tend to change the most (Beauchaine, Webster-Stratton, & Reid, 2005). Another reason might be the length of treatment. In the present study, the length of treatment was slightly more, but the parents received fewer sessions than in some studies in the United States (Jouriles et al., 2001). One possible explanation to why the treatment was longer in Sweden is that counsellors there have longer holidays (five weeks in summer and two–three weeks in winter) as compared to US counsellors. In addition, many parents were employed and worked daytime, which led to difficulties finding appointment times that were suitable. Although parents were interested in the restricting parenting skills, a majority of counsellors chose to only train skills that were based on positive reinforcement. This could be due to Swedish culture, which is much influenced by the UN Convention on the Rights of the Child (United Nations, 1989), and also indicates some difficulties in transferring the more restrictive parenting skills in a Swedish context, as well as the need to provide the intervention on a frequent and regular basis. Further knowledge and aspects of transferring PS to Sweden according to feasibility (acceptance, receptivity, practicalities, adaptation needs, etc.) will be published elsewhere (Draxler et al, unpublished manuscript).

In the present study, when parents scored their children's psychological symptoms measured with the SDQ-P, more than 82% of the children initially exhibited clinical levels of psychological symptoms measured by the SDQ-P total score pre-treatment, and post-treatment, 46% of the sample still reached clinical levels. In another comparison study using the CBCL, 72% of the children initially exhibited clinical levels of problems (McDonald et al., 2006). In a follow-up study 24 months later, two of 13 children (15%) reached the clinical cut-off levels after receiving PS, and in the comparison group, nine of 17 children (53%) were above the clinical cut-off levels. A similar result was seen in one of the first evaluations of PS, where 72% of the children initially exhibited clinical levels of problems, and after receiving PS, 17% were above clinical cut-off levels, and in the comparison group, who received treatment as usual, 44% of the sample reached the clinical cut-off level after treatment (Jouriles et al., 2001). The present study indicates that parents experienced that their children's psychological symptoms decreased less as a result of the PS programme in Sweden compared to what has been shown in the US. However, research has also shown that parents experienced that their children continued to improve after ending the programme (Jouriles et al., 2001; McDonald et al., 2006), which might have also been seen in the present study if there had been an opportunity to measure follow-up treatment. On the other hand, the decrease is still substantial and is higher than previously shown in an evaluation of local methods used for children in this target group in Sweden (Broberg et al., 2011).

An interesting result in the present study is the association between the parents' feelings of helplessness and fear (CHQ) and their children's emotional symptoms, hyperactivity and conduct problems. This finding suggests that in a parenting programme for parents with children with psychological symptoms, a changing factor might be to address and focus on how parents view themselves as a parent and how they frame and label their children's negative behaviour. The results from this study indicate that PS is not only targeting both aspects of cognition and emotion, but also showing effects to be replicated in a new context. The encouraging results of this feasibility study will hopefully prompt further research to demonstrate the generalisability of these findings and to determine whether PS could be further implemented and disseminated.

## Limitations and further research

This is a feasibility study and a first attempt to confirm if it is possible to use PS as an option for treatment for children who have developed psychological symptoms after parental exposure to IPV, in Swedish social services. The sample was small, especially for the assessment with the ECBI, so the findings may not be generalisable to a larger sample. Reasons for the small sample size in ECBI could be that ECBI was the final scale for the parents to fill out and parents found it difficult and energy-consuming. This also reinforces our decision to use the shorter SDQ instead of CBCL for the assessment of parents' views of their children's psychological symptoms. Another reason for missed items could be that parents found it difficult to answer questions regarding the age of the child or that the child did not have siblings, which some items assumed. Due to a large internal drop-out rate on several ECBI items, it was not possible to replace missing values using imputation.

The drop-outs ( $n = 7$ ) were parents who had had higher exposure to IPV than the complete sample (T1 and T2). Parents also self-evaluated their parenting capacity and their children's adjustment problems, and the study might have benefited from including child interviews and a more objective measure such as observation of parent-child interactions. The results from this feasibility study are, however, promising and support the further implementation and evaluation of PS in Sweden. If PS is to be implemented in Sweden, a randomised controlled trial is necessary to ensure the impact of the intervention and to analyse how mediators and treatment factors influence the outcome since adaptations have been made. This study has laid the foundation for forthcoming work by its findings and by establishing a group of trained counsellors who can contribute in future studies of PS.

## Conclusions

The results of this study show that employing the PS programme improved parents' parenting capacity and reduced their feelings of helplessness and fear regarding parenting their children. These changes were also associated with an experience of reduction in emotional symptoms and conduct problems among their children. The largest clinical change was seen in how parents experienced less helplessness and felt less afraid, and also reported more positive parenting. The largest changes that the parents experienced concerning their children, with focus on clinical levels, were seen in the areas of emotional symptoms, conduct problems and hyperactivity/inattention.

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## Notes on Contributors

Helena Draxler, Lic Phil, is a Doctoral student at the Department of Social and Psychological Studies at Karlstad University, Sweden. She is also a licenced psychotherapist and works in her private clinic with children and adults.

Fredrik Hjärthag, PhD, is a senior lecturer in psychology at the Department of Social and Psychological Studies at Karlstad University, Sweden. His research has primarily been focused on different aspects of severe mental illness, especially relatives' situation.

Kjerstin Almqvist, licenced psychologist and psychotherapist, PhD, is a professor in medical psychology at the Department of Social and Psychological Studies at Karlstad University, Sweden. Her research has primarily been focused on children exposed to violence and different interventions aimed for them.

## ORCID

Fredrik Hjärthag  <http://orcid.org/0000-0002-1088-9793>

Kjerstin Almqvist  <http://orcid.org/0000-0002-3560-0394>

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