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# Social support dimensions predict parental outcomes in a Spanish early intervention program for positive parenting

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ABSTRACT

Research has shown that social support influences parenting, and yet few studies have reported how different dimensions of social support influence outcomes in a group-based parenting intervention for parents with young children. We examined the influence of social support source, type, satisfaction, and access barriers on parental outcomes in the "Growing Up Happily in the Family" program targeting parents with children aged 0–5. The sample was 256 mainly at-risk (87.2%) and non-at-risk parents participating in 49 program groups in local social services in three Autonomous Communities of Spain. Social support variables were examined as predictors of pre-post change scores in parents' child-rearing attitudes, sense of parental competence, and parenting stress using hierarchical linear regression analyses. Results showed significant contributions of social dimensions to lack of empathy, belief in corporal punishment, parental satisfaction, dysfunctional interaction, and perception of the child as difficult. The direction of the effects varied depending on the social support dimension considered. While formal support use was associated with positive changes in parenting stress, informal support predicted positive changes in child-rearing attitudes. Support involving tangible and positive social interaction and the cumulation of perceived barriers to service access were related to negative changes in child-rearing attitudes and satisfaction with the role. In conclusion, efforts should be made to promote the dimensions of support that are most useful in increasing the effectiveness of evidence-based parenting programs.

## 1. Introduction

Under the concept of positive parenting, there is an increasing use of evidence-based parenting programs in Europe aimed at empowering parents and preventing child maltreatment (Morrison et al., 2014; Rodrigo et al., 2016). The notion of positive parenting is defined by the Council of Europe Recommendation (Rec2006/19) as: "parental behavior based on the best interest of the child that is nurturing, empowering, non-violent and provides recognition and guidance which involves setting of boundaries to enable the full development of the child" (p. 6). The recommendation also emphasizes the responsibility of the state to create the best conditions for providing sufficient and adequate support for parents from a variety of family situations, but especially for parents and children of vulnerable families. Parental education programs are especially relevant for families raising young children, given the critical importance of this period of development and the severe impact of neglect and abuse on their physical, social, and emotional wellbeing.

Research into the effectiveness of parenting programs has shown positive changes in parental dimensions, such as parents' knowledge and understanding of child development, parents' confidence in their capacities as parents, a reduction of parenting stress, and adequate parenting practices (Barlow & Coren, 2017; Barlow et al., 2012; Barth, 2009; Johnson et al., 2010; Prinz et al., 2009). Also, some studies have investigated whether sociodemographic factors are differentially associated with program effectiveness (Lundahl et al., 2006; Reyno & McGrath, 2006; Shelleby & Shaw, 2014). Less emphasis has been placed, however, on enlisting social support as a protective external factor in these programs. And yet, under the ecological model of parenting (Belsky et al.,1986), social support may not only have some influence on parenting, but can also moderate outcomes in parenting interventions.

Social support is a multidimensional or multifaceted construct, which mainly includes such diverse aspects as the structural characteristics of the social networks, the type or functions of support provided

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and the perceptions of support adequacy (Gottlieb & Bergen 2010; Sarason & Sarason, 2009). Social networks should be differentiated from the notion of social support. Social networks can be generally defined as the set of structural components of social relationships that surround individuals comprising kinship, friendship, employment or other community ties, while social support is a function of those social relationships (Cochran & Walker, 2005; Geens & Vandenbroek, 2014). In this line, Thompson (1995) defined social support as "social relationships that provide (or can potentially provide) material and interpersonal resources that are of value to the recipient such as counseling, access to information and services, sharing of tasks and responsibilities, and skill acquisition." (p. 43). However, for the purpose of the present study, we favored a less reductionist notion of social support involving three components: the structure of the social network, the functions of the support and the perceptions of their adequacy, more in line with the Gottlieb & Bergen's (2010) definition. Our position takes into account the complexity of this topic and the need of performing a multidimensional assessment of social support to examine their respective contribution to program outcomes.

Regarding the structure of the social network, we were interested in assessing formal and informal sources of help (Thompson, 2015). Formal support can be obtained from institutions and professionals such as social workers, teachers, or police, and is embedded in a framework of unidirectional professional-client exchanges. Informal support is provided by personal networks made up of family members, friends, or neighbors, and is embedded in a natural framework of bidirectional, reciprocal relationships. Both sources of support are necessary for adequate parenting, although their composition may vary from one family to another.

Regarding the functions of social support, we were interested in the following four types that have received more attention (Cohen & Wills, 1985; Langford et al., 1997; Thompson, 1995): a) emotional support, involves the provision of love, affection, care, empathy and trust; b) instrumental or tangible support, as the provision of practical assistance (e.g. financial assistance); c) informational support is providing advice or information with regard problem-solving; d) cognitive or appraisal support, in terms of cognitive assistance related to decision-making and self-evaluation. Some models empathizes the perspective of the giver or provider, whereas others focus on the perspective of the recipient (King et al., 2006). From the recipient's perspective, we were also interested in measuring those subjective aspects, such as the perception of adequacy or satisfaction with the support (Gottlieb & Bergen 2010), and barriers to access (Katz et al., 2007; Pote et al., 2019).

Social support may be especially important as a protective factor for families with young children. For many parents, raising toddlers and young children can be difficult and entail plenty of challenges (Corkin et al., 2018; Mulsow et al., 2002). The fast developmental changes occurring in the child's physical, cognitive, emotional, and social abilities demand a continuous adjustment of parental competences and strategies to deal with them. Also, new concerns in time management issues appear in terms of how to reconcile family and work or ensure access to affordable, quality child care (Glynn et al., 2009; Repetti & Wang, 2014). Satisfaction with the couple usually decreases due to limitations to spending time together (Kluwer, 2010). The situation can be aggravated for vulnerable families with complex needs that may need to be met through the provision of social support. The goal of the current study was to analyze the influence of relevant dimensions of social support on the parental outcomes of an education program for parents of young children at psychosocial risk.

### 1.1. Social support and parenting in at-risk families

A large body of research on social support highlights its benefits in the context of parenting, especially in circumstances of high adversity (Turner & Brown 2010; Kang 2012). Social support is a buffer that helps prevent or reduce the risk of depression, stress, anxiety, and other mental illnesses in the parenting process (Osborne & Rhodes, 2001) and mitigate their negative impact on child well-being (Nunes et al., 2020). And yet, the protective effect of a supportive social network may be more difficult to attain for vulnerable families. Social isolation and insufficient social contact with relatives, families, and friends are common among families at psychosocial risk who are more likely to maltreat their children (Arruabarrena & De Paúl, 2002; Coohey, 2007; Coulton et al., 2007). In turn, at-risk families are more dependent on formal support (Menéndez et al., 2010; Rodrigo & Byrne, 2011; Rodrigo et al., 2007). The lack of social support is especially worrisome in early childhood. Mothers with a poor social network, compared to others with more supportive networks, are nearly twice as at risk to maltreat their child during the first six years of age (Sidebotham & Heron, 2006). For families in the Child Protection System, social support is also crucial in promoting the successful reception and reunification (Vaquero et al., 2020; Pérez-Hernando, 2020).

Relying on existing sources of informal support or even increasing the amount of social support provided to the family does not necessarily restore its beneficial effects in at-risk families. When people draw on specific members of their social network for help during stressful times, support seeking often serves as an additional cause of distress (Bolger et al., 2000), which can affect the nature and quality of social support available (Heaney & Israel, 2008). Role modeling could also be negative, since those informal sources can share similar inadequate beliefs and reinforce punitive or neglectful parenting practices (Spilsbury & Korbin, 2013; Thompson, 2015). In turn, just increasing the presence of multiple sources of formal support may interfere in families' daily life, reducing their sensation of privacy and promoting the loss of responsibility for their own life (Evans & Harris, 2004; Rodrigo et al., 2007). However, despite the difficulties the use of a Spanish parenting program "Parenting Skills Program for families" was able to increase social support among vulnerable parents who were younger, unemployed, or non-cohabiting partners (Vázquez et al., 2020).

### 1.2. Social support and parenting outcomes

Based on the above studies, it seems reasonable to expect that social support may partially account for the impact of group-based interventions on parental outcomes. Those parents with higher levels of social support versus those with lower support at initial may have received more help to motivate and regularly attend the program (e.g. help with with childcare) enabling them to devote more attention to the program goals and the appropriate learning of competences (Guttentag et al., 2006). More specifically, it is important to know which dimensions of parental support are associated with better program results. Previous findings are not conclusive in this respect, given the paucity of studies evaluating programs for parents with young children that have included social support as predictors. In an adaptation of the "Incredible Years Series" program, responsive parenting and stimulation were negatively moderated by social support from friends, since the positive effects were concentrated on parents with weak support from friends (Theise et al., 2014). Opposite results were found in another evaluation study, showing that within the group of mothers who received the "Play and Learning Strategies" program, those with higher levels of social support were more likely to maintain pre-existing optimal parenting behaviors and to show positive change following the program than mothers with lower levels of social support (Guttentag et al., 2006). Similarly, Fuentes-Peláez, Balsells, Fernández, Vaquero, and Amorós (2016) found that social support enhances family resilience in participants after the group Spanish program "Learning Program for Kinship Foster Families". A mixed impact of social support on parental outcomes was found in an evaluation study of the Spanish "Personal and Family Support" program with at-risk families. The frequency of use of and satisfaction with informal support has a positive impact on reducing simpler views about child development and increasing couple agreement, irrespective of when the help is provided (at the start or end of the

program). By contrast, formal support only has a positive impact when applied at the start of the program, predicting the reduction in permissive–neglectful practices, while high final satisfaction with formal support predicts the increase in coercive practices (Byrne et al., 2012). In sum, previous studies have just used one or two dimensions of social support (e.g., usage and satisfaction), with controversial results with respect to their influence on the process of change in parenting interventions.

### 1.3. The intervention program

The "Growing Up Happily in the Family" program (Crecer felices en familia; Rodrigo et al., 2008) targets parents at psychosocial risk with children under five years old. The program is regularly included as part of the Family Preservation Services of the Spanish Autonomous Communities of Castile and Leon, Catalonia and the Canary Islands. Implementation and evaluation across sites were made possible thanks to a University–Agency partnership for evidence-based programs in social services (University of La Laguna and University of Las Palmas de Gran Canaria, and the municipal social services of these communities). Social services personnel in each municipality (e.g., psychologists, social workers) are responsible for selecting families with a minor declared to be at risk. The declaration of risk is made when a minor is in a situation that could be potentially harmful to his or her healthy development, according to psychosocial family and personal factors (e.g., marital violence, parent's low educational background, poverty, parental substance abuse, children out of school or at risk of dropping out). The program is also open to parents from the community to avoid stigmatizing the at-risk families and to promote social cohesion in the neighborhoods.

The program includes five modules: (1) Sensitive and Responsive Parenting, (2) Coming to Know Our Children, (3) Regulating Child Behavior, (4) First Family-School Relationships, and (5) Parenting: A Solitary Task? It is delivered through 1½-hour weekly group meetings. Because participants often have limited education along with low levels of literacy and verbal comprehension (a sizable proportion are migrant families), materials include vignettes, videos, case studies, guided fantasies, puzzles, games, and group discussions to facilitate the learning process. The experiential methodology helps parents to verbalize their interpretations of a variety of family situations, enrich their interpretations with other parents' views, reflect on the consequences of their actions on family life, and reach commitments to change in a non-directive and participative atmosphere (Byrne, Rodrigo, & Máiquez, 2014; Rodrigo, Byrne, & Álvarez, 2012). This methodology has two phases that help to organize the activities within the sessions: 1) an impersonal phase that comprises an introduction to the topic and the observation of what other parents do in concrete situations of daily life, to encourage perspectivism and alternative thinking in parents; 2) and a personal phase that comprises the parents' explanation of their thinking, acting and feeling in those situations, to make an analysis of consequences and to verbalize personal objectives of change.

Previous evaluations of the program showed that participants in clusters with better results on parental child-rearing attitudes, parental perceived competence, and parenting stress were more satisfied with the program than those with worse results (Álvarez et al., 2020). Quality of implementation factors such as greater program adherence, fewer crucial content adaptations, participant responsiveness, and better didactic functioning of the sessions predicted positive changes in parental child-rearing attitudes and parenting stress (Álvarez et al., 2016; Álvarez, et al., 2018).

### 1.4. The present study

The present study focused on how the parents' involvement with social support influences parental outcomes in parents with young children participating in the "Growing Up Happily in the Family" program. The first goal was to describe the participants' social support system according to frequency of use of informal or formal sources of social network, type of support received, perceived satisfaction with informal and formal sources of support, and barriers to accessing support. The second goal was to examine the contribution of different dimensions of social support to the parental outcomes of the program. The evaluation focused on the parents' child-rearing attitudes and behavior, parental sense of confidence in their capacities, and parenting stress. We hypothesized that the changes in these dimensions would be partially predicted by different dimensions of social support, such as source, type, satisfaction, and access barriers, though the direction of the effects would vary depending on the social support dimension explored. We expected that use of and satisfaction with informal support would have a more positive influence on parental outcomes than the use of and satisfaction with formal support (Byrne et al., 2012). We also expected that emotional support may have a positive influence, since it allows at-risk parents to share frustrations over minor daily hassles, thus preventing further escalation of difficulties (Ayala-Nunes et al., 2016; Lakey & Orehek, 2011). Finally, the cumulation of perceived barriers to accessing social support, such as lack of knowledge of the resource (Henricson, 2002), non-accessibility (Frost, 2001) or the risk of stigmatization as a recipient of help that can occur at the social level (Kissane, 2003), would have a negative influence on parental outcomes.

## 2. Method

### 2.1. Participants and procedure

The participants in the intervention group were 256 parents who attended the group-based "Growing Up Happily in the Family" program. Another group was made up of 164 parents on a waiting list to start the program on the next trial. The program was conducted in local social services in the Autonomous Communities of Castile and Leon, Canary Islands, and Catalonia (Spain).

Participants were mainly at-risk families (87.2%) referred by the municipal social services invited or mandated to participate as part of the family's casework plan. The declaration of risk occurs when a minor is in a situation that could be potentially harmful to his or her healthy development, according to psychosocial family and personal factors (e.g., marital violence, parent's low educational background, poverty, parental substance abuse, children out of school or at risk of dropping out). Professionals of social services selected families according to their needs and the priority of intervention. Non-referred parents (12.8%) were from the same communities and attended the program on a voluntary basis. Social services professionals interviewed the non-referred parents to assess their motivations for participation and to ensure that they did not have any problematic situation that put their children at risk. General inclusion criteria for the participants were having children aged between 0 and 5 years old, and exclusion criteria were parents having mental health or substance abuse problem that prevented them from attending the intervention.

Participants were randomly assigned to intervention or control group (waiting list). However, since the purpose of the study mainly focused on the implementation factors of the intervention group, only data from this group ($n = 256$) was included for the following analyses. The sociodemographic characteristics of the parents who participated in the Intervention group are presented in Table 1. All parents had children aged between 0 and 5 years old. The majority of participants were young mothers; half lived in single-parent families and had two children; most lived in urban areas, had no or primary-level studies only, tended to be on welfare, and were unemployed.

An intensive training program of 25 h was given to the group facilitators and to the coordinators responsible for each of the local social services. The training program covered the core principles, methodology, and evaluation of the program and provided guidance on how to implement it successfully and integrate it into the social workers'

**Table 1**
Sociodemographic profile in the Intervention group (n = 256).

| | *Intervention group M (SD) %* |
|---|---|
| Psychosocial risk status: At-risk | 87.2 |
| Sex (%): Mother | 90.6 |
| Maternal age | 31.33 (7.45) |
| Partner age | 34.31(9.20) |
| Family structure (%): One-parent | 44.5 |
| Number of children | 2.19 (1.17) |
| Child's sex (%): | |
| Male | 34.8 |
| Female | 21.5 |
| Male and female (siblings) | 43.6 |
| Residential area (%): Urban | 72.2 |
| Educational level (%): | |
| No studies or primary level | 79.2 |
| Secondary high school / university level | 20.8 |
| Financial situation (%): On welfare | 68.6 |
| Employment situation (%): Unemployed | 84.7 |

existing casework plan. There was also online follow up throughout the program, to ensure the supervision of the facilitators and the quality of data collection. Once the program had started, two warm-up sessions were necessary to create a group feeling and to establish the group roles. Part of the first session was also used to complete the questionnaires. The post-test questionnaires were completed within a week of the program completion in the last session.

### 2.2. Instruments

*Sociodemographic profile.* This instrument was developed specifically for the current study to gather parents' sociodemographic and family information. This information included continuous variables: age, age of partner, and number of children; and categorical variables: parental sex, sex of children, immigrant status, family structure, residential area, education level, financial situation, employment situation, and psychosocial risk status.

*Adult-Adolescent Parenting Inventory* (AAPI-2; Bavolek & Keene, 2001; *ad hoc* Spanish version, using a back translation procedure). This measures parental attitudes and behavior using two forms (Form A at initial session and Form B at completion), each including 40 items presented on a 5-point Likert scale (1 = *agree*; 5 = *strongly disagree*). The AAPI-2 provides five subscales: inappropriate expectations (Form A α = 0.80; Form B α = 0.77), parental lack of empathy towards the child's needs (Form A α = 0.69; Form B α = 0.72), support of the use of corporal punishment (Form A α = 0.70 ; Form B α = 0.63), parent–child role reversal (Form A α = 0.65 ; Form B α = 0.77), and oppressing the child's independence (Form A α = 0.74; Form B α = 0.76). As the scale was reversed, higher mean scores for the AAPI-2 subscales indicate more positive outcomes (i.e., less role reversal).

*Parental Sense of Competence* (PSOC; Johnston & Mash, 1989; Spanish version by Menéndez et al., 2011). This is a self-report scale of perceived self-efficacy and satisfaction in the parental role. It is a 16-item self-report questionnaire rated on a 6-point Likert scale (1 = *strongly disagree*; 6 = *strongly agree*). The PSOC provides two subscales: parents' self-efficacy (α = 0.77) and satisfaction with the parenting role (α = 0.78). Higher mean scores for the subscales indicate more self-efficacy and satisfaction with the parental role.

*Parenting Stress Index-Short Form (PSI-SF*; Abidin, 1995; Spanish version by Díaz-Herrero et al., 2010). This is a measure of parenting stress using a 36-item self-report questionnaire with a 5-point Likert scale (1 = *strongly disagree*; 5 = *strongly agree*). The PSI-SF provides three subscale scores: parental distress (α = 0.81), dysfunctional parent–child interaction (α = 0.83), and difficult child (α = 0.80). Higher mean scores for the subscales indicate more parenting stress.

*Scale of personal and social support.* This instrument consists of two parts. The first part was adapted from the Scale of Social Support in Informal and Formal systems (Escala de Apoyo social en los sistemas informales y formales) by Gracia et al. (2002) and the Social Support Questionnaire (SSQ; Sarason et al., 1983). This part presented a list of possible sources of informal support (partner, grandfather, grandmother, older sibling, aunt/uncle, friend, neighbor, and others) and another list of sources of formal support (school, social services, church, the Catholic NGO Caritas, police, neighborhood association, child protection agency, and others). The parents have to mark the ones they use with no limitation. Ratings of support satisfaction (0–4 scale) are obtained for each of the informal and formal sources of support. The second part records barriers or concerns related to asking for support using 14 items with a dichotomous Yes/No response (e.g. "I am afraid that they will take away my children"; "Because I don't trust them"). A cumulative barrier score was calculated for each participant.

The *Medical Outcomes Study Social Support Survey* (*MOS-SS*; Sherbourne & Stewart, 1991; Spanish version by Revilla et al., 2005) to explore types of support provided. This is an instrument with 20 items and a 5-point Likert scale (1 = *never*; 5 = *always*), to indicate how often participants can count on people to support them in different situations. The MOS-SS provides four subscales: tangible support (α = 0.86), defined as the availability of the other person to provide material aid or behavioral assistance; emotional/informational support (α = 0.90), which refers to the expression of positive affect and empathic understanding, and the offering of advice, information, or feedback; positive social interaction (α = 0.82), which is the availability of other persons to do fun things with you; and affection (α = 0.85), defined as offering company, enjoying time together, and providing expressions of love. Mean scores were calculated in each factor.

### 2.3. Ethical consideration

This study was approved by the Ethics Committee of the University of La Laguna. Each participant received written and oral information regarding the study. Written consent was obtained from all the participants before the intervention according to the protocol approved. In accordance with data protection laws, to guarantee confidentiality, we create a dataset with identifying information and a code assigned to each participant, and another one without identifying information and with the code and data of the different variables of interest.

### 2.4. Plan of data analysis

First, descriptive analyses were conducted to describe the composition of informal and formal sources of support in the intervention group. These analyses were conducted on the overall use and satisfaction measures for informal and formal sources of support. Satisfaction ratings for each source of support were only averaged when the source was actually used. The four factor scores of the type of support variables and the cumulative scores for the barriers were also included.

Second, pre-post comparisons for the outcome variables (parental attitudes and behavior, parental sense of competence, and parenting stress) in the intervention group were performed using repeated measures analysis of variance (ANOVAs). The effect size was explored using the *R* statistic; the clinical relevance of this statistic is classified as negligible when $R^2 < 0.01$, small when $R^2 > 0.01$ and $R^2 < 0.09$, medium when $R^2 > 0.09$ and $R^2 < 0.25$ and large when $R^2 > 0.25$ (Cohen, 1988).

Third, hierarchical linear regression analyses in the intervention group were run separately for each of the change scores in parental attitudes and behavior (5), parental sense of competence (2), and parenting stress (3), as predicted by the social support measures. Change scores for each factor were calculated by subtracting the pre-test score from the post-test score. For the AAPI and PSOC, higher post-test scores indicate more favorable responses, therefore a positive change score indicated a positive change on those assessments. For the PSI, lower post-test scores indicate more positive responses, thus a negative change

score indicates a positive change on those assessments. For the social support variables, the analyses were conducted on the overall use and satisfaction measures with both informal and formal sources of support. The four factor scores of the type of support variables as well as the cumulative scores for the barriers were also included. All the variables in the regression models were standardized (Tabachnick & Fidell, 2007).

To examine the respective influence of the social support components on the program outcomes, a three-step procedure was used in the regression models: in Step 1, we introduced risk status and family sociodemographic variables. After testing all the sociodemographic variables, we selected those that were most related with the parental outcomes. In Step 2, we included the variables related with the structural dimensions of social support (informal support, formal support, and types of support). In Step 3, we included subjective variables related to participants' satisfaction with the informal and formal sources of support and perceived barriers to access. We checked for collinearity, normality of residuals, linear relationship between variables, and homoscedasticity of variances. To interpret the global significance of the model, at each step we examined the statistic $F$, the values for the Adjusted $R^2$ (Adj$R^2$), and the change in $R$ ($\Delta R^2$), as well as the specific contribution of each variable to the total variance explained by the model through the significance and the value of the squared semi-partial correlation ($rs^2$). All analyses were conducted using the SPSS 18.0 statistical software assuming a confidence level of 95% for Type I error.

## 3. Results

For the first goal we examined the parents' social support according to relevant dimensions (Table 2). In general, parents sought support more in their personal, informal networks than in formal networks. Most parents turned to their partners, ($M = 0.55$; $SD = 0.43$), or to their own mothers ($M = 0.40$; $SD = 0.41$), siblings ($M = 0.30$; $SD = 0.38$), and friends ($M = 0.24$; $SD = 0.36$) for support. They also mostly relied upon the support of social services ($M = 0.52$; $SD = 0.44$) and schools ($M = 0.22$; $SD = 0.32$). With regard to type of support, parents mostly received affection and positive interaction types of support, followed by emotional support and tangible support. Parents reported more satisfaction with informal than with formal support. Parents listed around two or three barriers related to not asking for help, because "they have been there before and have not been helped" ($M = 0.26$; $SD = 0.44$), because "they are embarrassed" ($M = 0.21$; $SD = 0.41$), and because "they have to fill in a lot of paperwork" ($M = 0.21$; $SD = 0.4$).

### 3.1. Use of the change scores in parental outcomes

As a previous step for the second goal, we examine changes in the intervention group using change scores corresponding to the differential post-test < pre-test scores in all parental dimensions. With respect to the pre-post comparisons (Table 3), results showed that parents were significantly less likely to have inappropriate expectations toward the child, to respond less empathetically to their children, to support the use of corporal punishment, and to show parent–child role reversal following the program than at the program start, with medium to large effect sizes in role reversal (0.09) and lack of empathy (0.56). In relation to parental sense of competence, results showed a significant increase in parental satisfaction and a decrease in parental efficacy, with small effect sizes (0.04 and 0.02). Finally, with regard to parenting stress, parents who completed the intervention reported significantly less distress, fewer dysfunctional parent–child interactions, and lower perception of their child as difficult, with medium to large effect sizes (0.05, 0.07 and 0.08). To further overcome the limitation that a change score may minimize the favorable scores on the pre-tests yielding a zero or close to zero scores (pre-test = post-test), we showed that the 95% confidence intervals in the intervention group did not include zero. This indicates that there was no risk that these cases would be minimized, since change score means differed significantly from zero in all the factors.

**Table 2**
Social support dimensions for the Intervention group at initial (n = 256).

| | *Intervention group M (SD)* |
|---|---|
| Source of support | |
| Informal support | 0.23 (0.16) |
| Formal support | 0.14 (0.13) |
| Type of support | |
| Emotional support | 3.53 (1.0) |
| Tangible support | 3.24 (1.25) |
| Positive interaction | 3.64 (0.95) |
| Affection | 4.09 (1.0) |
| Satisfaction | |
| Informal support | 0.88 (0.63) |
| Formal support | 0.49 (0.51) |
| Support barriers | 2.27 (2.32) |

### 3.2. Regression models of social support on parental changes

For the second goal, regarding parents' child-rearing factors, the regression model for the change scores in lack of empathy was significant in Step 1 ($F = 2.65$, $p = .05$), Step 2 ($F = 2.16$, $p = .026$), and Step 3 ($F = 2.18$, $p = .014$), explaining 13% of the variance. Psychosocial risk status and higher use of formal support predicted increases in lack of empathy, whereas high use of informal support and high satisfaction with formal support predicted reductions in lack of empathy. The variables that contributed most to the model were psychosocial risk status and satisfaction with formal support ($rs^2 = 0.03$)

The model for belief in corporal punishment was not significant in Step 1 ($F = 0.31$, $p = .82$) or Step 2 ($F = 1.56$, $p = .13$), but was significant in Step 3 ($F = 1.65$, $p = .05$), explaining 11% of the variance. Higher use of informal support predicted less belief in corporal punishment, whereas higher use of formal support, receiving more tangible support, and higher levels of barriers to access contributed to greater endorsement of belief in corporal punishment. The variable that contributed most to the model was tangible support ($rs^2 = 0.03$).

Concerning parental sense of competence, the regression model for change scores in parental satisfaction was not significant in Step 1 ($F = 2.06$, $p = .11$), but was significant in Step 2 ($F = 2.47$, $p = .011$) and Step 3 ($F = 2.04$, $p = .022$), explaining 15% of the variance. Higher educational levels and higher levels of affection support contributed to an increase in parental satisfaction, whereas higher levels of positive interaction support contributed to a reduction in parental satisfaction. The variables that contributed most to the model were positive interaction support and affection support ($rs^2 = 0.05$; $rs^2 = 0.04$).

Concerning parenting stress, the regression model of dysfunctional interaction was not significant in Step 1 ($F = 2.44$, $p = .06$), but was significant in Step 2 ($F = 2.35$, $p = .015$) and Step 3 ($F = 2.32$, $p = .008$), explaining 13% of the variance. Older parental age and high formal support satisfaction predicted the increase in dysfunctional interaction, whereas high use of formal support predicted the decrease in dysfunctional interaction. The variable that contributed most to the model was use of formal support ($rs^2 = 0.04$).

The model on change scores in the difficult child factor was not significant in Step 1 ($F = 1.86$, $p = .13$), but was significant in Step 2 ($F = 2.04$, $p = .036$) and Step 3 ($F = 2.12$, $p = .017$), explaining 12% of the variance. High use of formal support predicted the decrease in the perception of the child as difficult, whereas high levels of affection support predicted the increase in this factor. The variable that contributed most to the model was affection support ($rs^2 = 0.03$) (see Table 4).

## 4. Discussion

This study examined how initial social support source, type, satisfaction, and access barriers modulated pre-post changes in parental outcomes after completing the "Growing Up Happily in the Family"

**Table 3**
Mean differences in outcome measures in the Intervention group (n = 256) as well as the 95% Confidence Intervals (CI) of the change score (Post-test – Pre-test). Higher mean scores in parental attitudes indicate fewer negative outcomes (i.e., less role reversal).

| Dimensions | Intervention Pre-test *M* (*SD*) | Intervention Post-test *M* (*SD*) | Intervention Pre-test / Post-test *F* *(1,256)* | Effect size (partial $R^2$) | Change scores 95% CI Lower | Upper |
|---|---|---|---|---|---|---|
| **Parental attitudes** | | | | | | |
| Inappropriate expectations | 2.58(0.72) | 2.68 (0.67) | 4.80* | 0.02 | 0.01 | 0.2 |
| Lack of empathy | 3.07(0.65) | 3.89 (0.66) | 323.20*** | 0.56 | 0.73 | 0.92 |
| Belief in corporal punishment | 3.67(0.66) | 3.83 (0.62) | 12.04* | 0.05 | 0.06 | 0.25 |
| Parent–child role reversal | 2.91(0.73) | 3.16(0.82) | 26.36*** | 0.09 | 0.18 | 0.38 |
| Oppressing child's independence | 3.73(0.68) | 3.65(0.65) | 2.12 | 0.01 | -0.22 | -0.01 |
| **Parental competence** | | | | | | |
| Satisfaction | 3.85(0.75) | 4.01(0.81) | 10.22** | 0.04 | 0.04 | 0.24 |
| Efficacy | 4.16(0.86) | 4.01(0.83) | 6.53* | 0.02 | -0.26 | -0.03 |
| **Parenting stress** | | | | | | |
| Parental distress | 2.86(0.75) | 2.64(0.73) | 23.07*** | 0.08 | -0.29 | -0.11 |
| Dysfunctional interaction | 2.14(0.87) | 1.91(0.68) | 14.45*** | 0.05 | -0.34 | -0.12 |
| Difficult child | 2.63(0.81) | 2.40(0.73) | 19.36*** | 0.07 | -0.34 | -0.13 |

* $p < .05$.
** $p < .01$.
*** $p < .001$.

**Table 4**
Regression models involving social support dimensions as predictors of pre-post changes in parental outcomes.

| | Lack of empathy[a] | | | Belief in corporal Punishment[a] | | | Satisfaction | | | Dysfunctional interaction[b] | | | Difficult child[b] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *β* | *AdjR²* | *ΔR²* | *β* | *AdjR²* | *ΔR²* | *β* | *AdjR²* | *ΔR²* | *β* | *AdjR²* | *ΔR²* | *β* | *AdjR²* | *ΔR²* |
| **Step 1** | | **0.04*** | | | **0.00** | **0.00** | | **0.03** | **0.03** | | **0.03** | | | **0.03** | **0.03** |
| Psychosocial risk | **-0.21**** | | | -0.07 | | | 0.03 | | | -0.02 | | | -0.01 | | |
| Educational level | -0.11 | | | -0.50 | | | **0.15*** | | | -0.12 | | | **-0.14*** | | |
| Maternal age | -0.08 | | | -0.00 | | | 0.07 | | | **0.15*** | | | 0.10 | | |
| **Step 2** | | **0.09*** | **0.05*** | | **0.06** | **0.06** | | **0.11*** | **0.08*** | | **0.09*** | **0.06*** | | **0.08*** | **0.05*** |
| Psychosocial risk | **-0.16*** | | | -0.04 | | | 0.02 | | | 0.02 | | | 0.03 | | |
| Educational level | -0.10 | | | -0.03 | | | **0.15*** | | | -0.11 | | | **-0.14*** | | |
| Maternal age | -0.07 | | | 0.03 | | | 0.05 | | | **0.15*** | | | 0.11 | | |
| Informal support | 0.00 | | | 0.12 | | | -0.02 | | | 0.10 | | | 0.11 | | |
| Formal support | -0.11 | | | **-0.14*** | | | -0.03 | | | **-0.21**** | | | **-0.20**** | | |
| Emotional support | -0.00 | | | **0.21*** | | | 0.11 | | | 0.06 | | | -0.11 | | |
| Tangible support | 0.06 | | | **-0.24*** | | | 0.03 | | | 0.04 | | | 0.02 | | |
| Positive interaction | 0.18 | | | 0.08 | | | **-0.39***** | | | 0.05 | | | -0.05 | | |
| Affection | -0.06 | | | -0.06 | | | **0.29**** | | | -0.16 | | | **0.20*** | | |
| **Step 3** | | **0.13*** | **0.04*** | | **0.11*** | **0.05*** | | **0.15*** | **0.04*** | | **0.13**** | **0.04**** | | **0.12*** | **0.04*** |
| Psychosocial risk | **-0.16*** | | | -0.04 | | | 0.04 | | | 0.03 | | | 0.06 | | |
| Educational level | -0.10 | | | -0.04 | | | **0.16*** | | | -0.09 | | | -0.11 | | |
| Maternal age | -0.08 | | | 0.02 | | | 0.04 | | | **0.15*** | | | 0.11 | | |
| Informal support | **0.43*** | | | **0.44*** | | | -0.32 | | | 0.13 | | | -0.21 | | |
| Formal support | **-0.55*** | | | **-0.37*** | | | 0.02 | | | **-0.75**** | | | **-0.45*** | | |
| Emotional support | -0.03 | | | 0.17 | | | 0.09 | | | 0.09 | | | -0.12 | | |
| Tangible support | 0.07 | | | **-0.22*** | | | 0.02 | | | 0.02 | | | 0.01 | | |
| Positive interaction | 0.18 | | | 0.10 | | | **-0.40***** | | | -0.01 | | | -0.08 | | |
| Affection | -0.05 | | | -0.06 | | | **0.28**** | | | -0.15 | | | **0.19*** | | |
| Informal support satisfaction | -0.44 | | | -0.34 | | | 0.32 | | | -0.01 | | | 0.34 | | |
| Formal support satisfaction | **0.47*** | | | 0.27 | | | -0.05 | | | **0.54*** | | | 0.26 | | |
| Support barriers | -0.10 | | | **-0.14*** | | | -0.04 | | | 0.05 | | | -0.04 | | |

* $p \leq 0.05$.
** $p \leq 0.01$.
*** $p \leq 0.001$.
[a] A positive change score indicated a positive change on those assessments.
[b] A negative change score indicates a positive change on those assessments.

program. For the first goal, we analysed the composition of the participants' social networks support. Parents sought support more in their informal networks and were more satisfied with informal support, turning to partners, their own mothers, siblings, and friends, confirming the tendency of going to proximal sources for help and looking for natural, reciprocal, and more satisfactory support (Byrne et al., 2012; Gottlieb, 2000; Rodrigo et al., 2007). Considering the types of support, parents reported that they mostly had access to affection support, with the lowest level of access reported for tangible support, which is typical of families who are at risk (Albarracin et al., 1997; Belsky, 1993; Connell-Carrick, 2003). Parents face practical barriers to seeking support, such as perceived unhelpfulness or excessive bureaucracy, as well as barriers related to psychological factors, such as stigma-related feelings of embarrassment, one of the most common barriers (Roller-Dillon, 1995). The effect of multiple barriers to accessing support for at-risk families has been documented in other studies (Katz et al., 2007; Pote et al., 2019).

For the second goal, our results showed that different dimensions of social support predict changes in child-rearing attitudes, parental sense of competence, and parenting stress in at-risk families, as expected. Social support systems in place in the early childhood years contribute to shaping parents' capacity to parent after the program. This is consistent with the scarce evidence showing that social support influences parental changes in education programs (Byrne et al., 2012; Guttentag et al., 2006; Theise et al., 2014).

With regard to the overall magnitude and direction of program effects, after the intervention parents reported having fewer inappropriate parental expectations and more empathetic responses to their children, as well as less support of the use of corporal punishment and parent–child role reversal. Parents reported a significant increase in parental satisfaction, were less likely to report distress and dysfunctional parent–child interactions, and perceived their child as being less difficult. These changes are crucial for positive parenting in at-risk psychosocial contexts (Barlow et al., 2012; Barth, 2009; Johnson et al., 2010; Prinz et al., 2009). And yet, parents reported a significant decrease in parental efficacy, suggesting that they learnt from the program that the parenting task is more difficult and demanding than they expected and that they are still far from reaching adequate standards (Byrne et al., 2010; Jones & Prinz, 2005).

The crucial part of this study was to examine how different dimensions of social support would predict program changes in the parenting dimensions evaluated. The proposed regression models, which included both objective components (such as structure and types of support) and subjective components (satisfaction and barriers), predicted changes in the three parental dimensions. Although the explanatory power of the regression models is modest, the results were significant after accounting for the effect of the at-risk status and sociodemographic variables. The models showed differences with respect to each of the components, which suggests that the direction of the effects varies depending on the social support dimension explored.

As expected, the use of *informal support* promotes reductions in negative child-rearing attitudes such as lack of empathy and positive beliefs towards corporal punishment, both characteristics of at-risk parenting. Informal support is traditionally characterized as having a buffer effect on at-risk families (Byrne et al., 2012; Ceballos & McLoyd, 2002, Rodrigo & Byrne, 2011; Rodrigo et al., 2007) and is shown to be a protective factor in the refusal of abusive forms of discipline and physical punishment (Bonds et al., 2002; McCurdy, 2005). Having a personal network illustrates the benefits of supportive relationships with family and friends in terms of providing a variety of role models, opportunities for receiving and giving advice to others, and multiple occasions to reflect upon ideas and practices. However, contrary to our expectations, informal support was not associated with the perception of parental competence or parenting stress, showing that its benefits were not generalized to other parenting dimensions, as was also the case in a previous study (Byrne et al., 2012).

The use of formal support has differential effects depending on the parental dimension examined. The provision of formal support was associated with an increase in lack of empathy toward the child's needs and in positive attitudes towards corporal punishment. High use of formal support may lead to a loss in personal and family control, showing low levels of responsibility for the parenting task (Evans & Harris, 2004; Ghate & Hazel, 2002; Matos & Sousa, 2004; Rodrigo et al., 2007). In these circumstances, parents need to recover their autonomy and internal locus of control so that they can understand and become more aware of their roles in meeting their child's needs. By contrast, the use of formal support is the main contributor to the reduction in parenting stress in terms of less dysfunctional interaction and less perception of the child as difficult. It seems that when circumstances and problems of family life become worse, the use of formal support appears to play a typical buffer function (Kotch et al., 1995, Kotch et al., 1997).

With regard to *satisfaction with formal support*, results showed mixed effects depending on the parental dimension examined. Families who were satisfied with formal support may have been more motivated to make positive changes to parental attitudes, decreasing their lack of empathy, in line with other studies (Byrne et al., 2012). However, higher satisfaction with formal support was related with poorer outcomes on parenting stress, increasing the dysfunctional interaction with the child. Prior studies have found that satisfaction with formal support may undermine parents' feelings of adequacy and confidence in their role (Doherty & Beaton, 2000). Rodrigo and Byrne (2011) also showed that parents who are satisfied with formal support could be excessively relying on professionals' work and do not tend to complement their parental task with informal sources of support.

Regarding the *type of support*, it can be said that *affection support*, namely offering company, enjoying time together, and providing expressions of love, had a positive influence on parents' satisfaction with their role, but having this intimate and affective support does not help to decrease the perception of the child as complicated and difficult. *Positive interaction support*, which refers to having someone to go out with, to do things with, to forget about problems and to have fun with, was associated with a decrease in parental satisfaction. It seems that both types of support could be helpful at a personal level but may not necessarily be a protective factor for parenting issues (Belsky, 1984; Bonds et al., 2002). In turn, the use of *tangible support* was associated with high endorsement of parental attitudes towards corporal punishment, which is more typical of at-risk families who are in conditions of need and with lower parenting skills. Finally, a higher *number of barriers to accessing support* also predicted increases in the belief in corporal punishment, typical of at-risk families. The number of barriers indicate a low use of support (Henricson, 2002; Kissane, 2003), and this low support would therefore be associated with negative child-rearing practices (Green et al., 2007).

### 4.1. Limitations

Some limitations of our study must be acknowledged. First, as cross-sectional data were used causality in the relationship between social support and parental outcomes cannot be claimed. Second, self-reported data were used to measure all constructs; however, the complex pattern showing the variability of outcomes depending on the social support dimensions reduced the likelihood of an interpretation in terms of spurious effects. Third, the lack of pre-post-test measures in the waiting list group limits the possibility of firmly concluding the effectiveness of the intervention. Four, given the lack of a post-test measure of social support we do not know to what extent the program is also a source of support in itself, contributing to the positive results. Finally, further research is needed to examine the impact of social support on long-term effects of the prevention program.

### 4.2. Conclusions and practical implications

The broader conceptualization and measurement of different forms

of social support provides a greater understanding of their effects on parenting outcomes. Some dimensions of parental support were associated with better program results indicating that the adequate provision of social support may be an effective way to promote positive parenting and prevent child maltreatment. However, not all forms of support are beneficial in achieving prevention goals. Our findings suggest that the use of informal support involving personal exchanges with partners, family members, and friends is more effective at changing child-rearing attitudes than seeking professional support. Informal exchanges are more horizontal and less guided by external prescriptions of what should be believed and thought about child-rearing issues. By contrast, formal support has a great influence in times of crisis and stressful parenting, helping to reduce dysfunctional interactions and the perception of the child as difficult. Relying on affectionate exchanges with parents increases their satisfaction as parents but is not helpful for reducing stress. Finally, the provision of tangible support, the cumulation of perceived barriers, and professional embarking with positive interaction on the basis of leisure activities for the parent were related to poorer outcomes on parental child-rearing attitudes and parental sense of competence.

To conclude, our findings have implications for prevention parenting programs targeting at-risk families. First, a relevant community issue is to examine the extent to which physical, psychological, or social barriers exist that limit the ability of all parents, and especially at-risk parents, to access social support. The fact that a well-resourced environment exists does not mean that at-risk parents are benefiting from these resources. Second, evidence-based parenting programs should recognize the importance of social support, and one target of the intervention should be to train parents to seek support. This is especially important when designing and planning the delivery of a parental education program for at-risk parents with young children who are overwhelmed by multiple demands. Finally, efforts should be made to promote the dimensions of support that are more useful to increase the effectiveness of the intervention program. A clear recommendation is to keep a balance between informal and formal sources of support, avoiding multiple forms of assistance from professional sources. It is also important to create opportunities for affectionate exchanges with parents, not necessarily in the form of leisure activities, to keep their satisfaction with their role high.

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## Declaration of Competing Interest

The authors declared that there is no conflict of interest.

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