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THE IMPACT OF A PARENTING GUIDANCE PROGRAMME FOR MOTHERS WITH AN ETHNIC MINORITY BACKGROUND

Abstract

The current mixed-method study investigates the effects of a culturally adapted version of the International Child Development Programme (ICDP) with 135 mothers – 29 ethnic Pakistani mothers residing in Norway attending Urdu-language groups and a comparison group of 105 Norwegian mothers attending Norwegian-language groups. All mothers completed questionnaires on parenting and psychosocial health before and after participating in the ICDP programme. In-depth interviews with a subgroup of 12 ethnic Pakistani mothers and 8 ethnic Norwegian mothers were analysed using thematic analysis. Before the ICDP programme, the Urdu-speaking mothers spent more time with the child, scored higher on distant child management and reported poorer mental health. Most changes over time were similar but significant for the Norwegian-speaking group only, which might imply that the minority mothers were in the process of change. In the interviews, the Urdu-speaking mothers' emphasized enhanced communication and regulation as well as enhanced family relationships and life quality, whereas the Norwegian-speaking group told about increased consciousness and empowerment, and a more positive focus.

Keywords

Parenting programme • ICDP • ethnic minorities • mothers • evaluation

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1 Introduction

Parenting may be challenging and stressful (Evenson & Simon 2005: 341). Research indicates that migration and acculturation (Berry 2003) may create mental health challenges (Carballo & Nerukar 2001: 556) and influence parental behaviours (e.g. Chiu, Feldman & Rosenthal 1992: 205) as well as parenting sensitivity due to socioeconomic disadvantage (Mesman, van IJzendoorn & Bakermans-Kranenburg 2011: 239). Migration may include struggles to preserve the cultural values of the country of origin (Renzaho, McCabe & Sainsbury 2011: 416) with children endorsing family obligations less than their parents (Phinney, Ong & Madden 2000: 528), possibly threatening the harmony of family relations through different cultural practices and expectations (Kwak, 2003: 131–133).

In Norway, Pakistanis account for the largest group of children born to immigrant parents (Henriksen 2010: 179). Compared with ethnic Norwegian mothers, first-generation Pakistani immigrant mothers, defined as women who live in Norway but were born in Pakistan, have lower education and employment rate, more children (3.11 vs. 1.95), spend considerably more time on household chores, have more economical and psychosomatic difficulties (22% vs. 10% express distress), poor Norwegian language proficiency and few ethnic Norwegian friends (Henriksen 2010: 179–210; Schmidt 2011). Furthermore, Pakistanis report less social support and feel more powerlessness (Syed *et al*. 2006: 551–558). In a US population study (382 families) having more than three children, multiple moves, poor majority language proficiency and parental depression were related to fewer positive parenting behaviours and negative perceptions of the child (Glascoe & Leew 2010: 316–317). A report from Statistics Norway shows that there are positive correlations between employment, economic stability, majority language proficiency, having ethnic Norwegian friends, low levels of loneliness and psychological health (Henriksen 2010: 6). High bicultural identity among parents is related to better psychological and behavioural adjustment among the children (Calzada *et al*. 2009).

Early child development programmes have been developed to support optimal child development (WHO, 2012) by improving parents' skills and confidence. Reviews suggest that parenting programmes may contribute to improved maternal psychosocial health (Barlow & Coren 2004: 3–5), reduced parental stress and improved parenting capacity (Barlow *et al*. 2010: 1). Although parenting programmes seem to be effective in diverse cultural settings (Jones *et al*. 2010: 592), culturally adapted programmes seem more effective (Smith, Rodríguez & Bernal 2011: 126–136). Provision for ethnic minority

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populations is, however, wanting (Bernal & Rodríguez 2009: 169–178) and parenting programmes need adaptation (Jones *et al*. 2010: 592). Evaluations of parenting programmes concentrate on children at risk for mental health or behavioural problems, but community-wide programmes may reach a larger group of parents supporting positive parenting practices (Sanders & Morawska 2010: 435; Sherr *et al*. 2013: 13). Research on parenting strategies for ethnic minority parents in the general population are lacking (Lyon & Budd 2010) and most studies are conducted in the USA (Abdou *et al*. 2010). There is hence a need to evaluate interventions tailored to ethnic minority parents in general populations within a European context.

The International Child Development Programme (ICDP) (Hundeide 2001; Rye 2011) is offered on a national level in Norway by the Ministry of Children, Equality and Social Inclusion. The present study compares the impact of ICDP courses on mothers with a Pakistani or Norwegian background. It was hypothesized that programme attendance would influence parenting, confidence and relationship with the child in both groups.

2 Methodology

To provide nuances to the understanding of the impact of ICDP attendance, the study uses a mixed-method design with a pre-post design with a group of mothers with an ethnic Pakistani background who participated in Urdu-speaking ICDP groups (N=29) compared with a group of mothers attending Norwegian-speaking groups (N=105). Both completed questionnaires before and after attending the ICDP programme, and an Urdu-speaking (N=12) and a Norwegian-speaking group (N=8) participated in a structured debrief interview.

2.1 Participants

From October 2008 to March 2010, there were 15 ICDP groups in Urdu and 132 in Norwegian at kindergartens/family centres with ICDP trained staff. Caregivers were recruited through billboards and all attenders were invited to participate in the programme evaluation. Sixty-nine mothers in the Urdu-speaking group and 201 mothers from the Norwegian-speaking group (90.5% ethnic Norwegians, see Table 1) completed questionnaires before ICDP and 29 from the Urdu group and 105 from the Norwegian group completed questionnaires after ICDP. Qualitative interviews were conducted with a convenient sample of 12 mothers attending Urdu-speaking groups and 8 mothers attending Norwegian-speaking groups.

2.2 The ICDP programme: Content and implementation

ICDP is a theoretically based preventive psychosocial parenting programme (Hundeide 2001; 2010; Rye 2011) designed to build parent confidence and promote child understanding, empathy, positive perception of the child and a positive parent–child relationship. The programme is formulated around three caregiver–child dialogues with eight guidelines for good interaction (Hundeide 2010) based on developmental theory. They include the emotional dialogue, for showing loving feelings, praise and acknowledgement; the comprehension dialogue, for supporting meaning-making and showing enthusiasm for the child's experiences; and the regulative dialogue, to regulate actions step by step (Hundeide 2010).

The programme has been adapted for parents from ethnic minority backgrounds with translated and culturally adapted trainer manuals (Hannestad & Hundeide 2006) to provide culturally appropriate courses (Bernal, Jimenez-Chafey & Rodríguez 2009: 262) to support parenting and promote healthy child development. During group meetings, parents share experiences and discuss child-related issues related to the dialogues guided by two certified, trained and supervised facilitators, and have home assignments related to parent–child interaction. In ethnic minority groups, one of the facilitators has the same lingual background as the group in order to allow discussions both in the mother tongue and Norwegian. The general programme usually consists of eight 2-hour group meetings while ethnic minority groups have four additional meetings – devoted to cultural bridge building (Hundeide 2001; ICDP 2014). Child-care facilities are sometimes available to enable parental attendance.

2.3 Materials

Participants completed a questionnaire constructed to log demographic details, parenting, ICDP content and other standardized and previously validated measures describing social relationships and emotional issues. Child-related measures were gathered for a target child who was nearest in age to 4 years (focus child). The material was translated into Urdu by certified translators, and back translated for accuracy. Semi-structured debrief interviews were conducted with a sub-sample (Goodwin & Goodwin 1984) to explore personal relevance and importance of the topics, usefulness of the programme and suggestions for improvements.

2.4 Procedure

The Regional Committee for Medical and Health Research and the Norwegian Social Science Data Services approved the study. All participants were informed about the study procedures, confidentiality and the right to withdraw consent at any time. Consent was gathered in oral and written form. A referral protocol for distress was in place but was never required.

The questionnaires were completed before the first and after the last meeting with a mailed reminder within 2 weeks. The first author conducted the interviews within a week after the final meeting. All Norwegian language group interviews and seven Urdu language group interviews were conducted in Norwegian, whereas five interviews required an authorized interpreter. All interviews were recorded.

2.5 Analysis

Chi-squared tests were used to compare mothers in the Urdu and Norwegian language group on demographic information and questionnaire scores before the programme. Independent samples *t*-tests were used to compare the scores in the two groups before and after the programme, and paired samples *t*-test were used to investigate group changes from before to after the ICDP programme. An interaction analysis, 2 (group: Urdu group/Norwegian group) × 2 (time of measurement: before/after ICDP) mixed ANOVA with repeated measures on time of measurement, was used to investigate differences in score patterns in the two groups (p = significance level, * ≤0.05).

Table 1. Demographic information about the mothers in the Urdu (N = 29) and Norwegian (N = 105) group

	Urdu group		Norwegian group		Chi-square	*p*
	N	%	N	%		
Education					14.9	<0.001
High school or less	24	82.8	47	44.8		
Higher education	4	13.8	58	55.2		
Born in Norway					76.06	<0.001
Yes	2	6.9	95	90.5		
No	25	86.2	10	9.5		
Civil status					3.54	0.352
Married/partner	25	86.2	97	92.4		
Separated/divorced/	0	0	8	7.6		
widow/single						
Employment					71.423+	<0.001
Full time	0	0	47	44.8		
Part time	1	3.4	20	19		
At home	20	69	5	4.8		
Other	6	20.7	31	28.6		

+Fisher's exact test.

All interviews were transcribed verbatim using HyperTranscribe (2014) and then subjected to thematic analysis using NVivo (2014) to identify, analyse and report thematic patterns (Braun & Clarke 2006: 77–101). The text was read and reread to examine commonalities and unique cases (Pratt 2009: 856–862). The transcripts were read by a second analyst to check themes (Elliott, Fischer & Rennie 1999: 222).

3 Questionnaire Results

Table 1 shows maternal background information. The average age was 35.0 years (range 24–56) in the Urdu-speaking group and 34.3 years (range 24–52) in the Norwegian-speaking group. The average age of the focus child was 4.0 years (range 1.5–6 years) and 3.6 years (range 0.5–10), respectively. Higher education was significantly more prevalent in the Norwegian-speaking group (55.2% vs. 13.8%), as was employment (63.8% vs. 3.4%) and birth in Norway (90.5% vs. 6.9%). Caregivers in the Norwegian-speaking group also had a higher number of children (*MS* = 1.95, 0.78 vs. 2.86, 0.99, $t = -4.75$, $p < 0.001$) and number of people in the home (*MS* = 3.67, 1.08 vs. 5.43, 1.63, $t = -4.72$, $p < 0.001$). The groups did not differ on civil status, age (parent or child) or gender of the focus child.

There were no significant differences on demographic or other measures between the Urdu group who completed the first questionnaire only and those who completed both questionnaires. The Norwegian language group who completed both questionnaires were more likely to be *married or with a partner* (92.4% vs. 77.9%, X^2 [1, 200] = 8.44, $p = 0.004$), and less *depressed* (*M* = 2.96 vs. 3.90; t [1, 192] = -2.47, $p = 0.015$) than mothers in the Norwegian language group who only completed the first questionnaire.

3.1 Differences between the groups before the ICDP programme

Table 2 shows the results for parenting measures. Before attending the ICDP programme, Urdu-speaking mothers relied significantly more on *distant child management*[1] (*M* = 2.59 vs. 1.84) and reported a significantly larger number of hours spent with the child on weekdays (*M* = 10.24 vs. 4.86 hours), and there was a trend for them to also report more frequent engagement in *activities*[2] (*M* = 109.69 vs. 105.08), less *emotional engagement*[3] (*M* = 2.88 vs. 2.28) and more frequent use of *parenting strategies*[4] (*M* = 35.17 vs. 33.46). There were no significant group differences for *facilitating child management*[5], *strategic engagement*[6] or *positive discipline*[7].

Table 2. Parenting measures with group differences before and after the ICDP, and changes in groups scores from before to after the ICDP

	Group	Before ICDP					After ICDP					Group changes from before to after ICDP						
Measure		**N**	**Mean**	**SD**	***t***	***p***	**N**	**Mean**	**SD**	***t***	***p***	**N**	**M**	**SD**	**M**	**SD**	***t***	***p***
Distant child management	Urdu	15	2.59	0.66	-6.07	<0.001*	17	2.69	0.66	-5.50	<0.001*	11	2.41	0.37	2.51	0.72	-0.42	0.682
	Norwegian	72	1.84	0.37			81	1.77	0.35			62	1.82	0.37	1.76	0.33	1.65	0.105
Facilitating child management	Urdu	22	1.83	0.57	-0.03	0.978	22	1.77	0.39	-0.57	0.570	17	1.93	0.46	1.75	0.41	1.57	0.135
	Norwegian	73	1.83	0.36			84	1.72	0.33			68	1.83	0.35	1.72	.30	3.18	0.002*
Total hours mother child weekday	Urdu	12	10.24	7.42	-2.45	0.030*	14	11.54	5.21	-4.58	<0.001*	10	11.43	7.58	9.75	4.10	0.89	0.392
	Norwegian	76	4.86	4.07			76	5.22	4.65			56	4.87	3.69	5.08	4.64	-0.42	0.679
Activities	Urdu	16	109.69	9.94	-1.84	0.070	20	107.60	10.29	-1.56	0.122	13	111.54	9.26	108.85	8.53	1.25	0.235
	Norwegian	50	105.08	8.29			58	102.90	12.02			37	105.14	8.70	105.41	8.24	-0.27	0.786
Emotional engagement	Urdu	23	2.88	1.38	-1.99	0.057	23	2.70	1.49	0.93	0.363	20	2.55	1.49	2.51	1.43	0.11	0.916
	Norwegian	87	2.28	0.85			101	3.00	0.88			90	3.08	0.96	2.99	0.87	1.00	0.320
Strategic engagement	Urdu	23	2.64	1.46	1.40	0.173	22	2.52	1.13	-2.29	0.024*	21	2.80	1.36	2.67	1.21	0.40	0.696
	Norwegian	94	3.09	0.94			102	2.06	0.77			86	2.28	0.86	2.08	0.79	2.12	0.037*
Parenting strategies	Urdu	23	35.17	4.46	-1.86	0.065	26	35.58	4.85	-0.49	0.626	22	35.00	4.48	36.68	4.64	-0.78	0.445
	Norwegian	89	33.46	3.79			98	35.08	3.23			85	33.42	3.71	34.89	3.31	-5.15	<0.001*
Positive discipline	Urdu	21	2.83	0.66	-0.82	0.416	25	2.98	0.68	0.07	0.948	19	2.83	0.66	3.04	0.66	-1.81	0.087
	Norwegian	86	2.71	0.58			97	2.99	0.80			81	2.73	0.57	3.04	0.84	-3.11	0.003*

Table 3 shows the results and scores for psychosocial measures. The Urdu group scored significantly higher on *happiness with partner*[8] (*M* = 4.80 vs. 3.52), *self-esteem*[9] (*M* = 22.33 vs. 20.05), *positive emotions*[10] (*M* = 5.67 vs. 5.12), *explore* (*M* = 5.76 vs. 5.29), *anxiety*[11] (*M* = 8.48 vs. 5.51) and *depression* (*M* = 6.04 vs. 2.96), and lower on *anger* (*M* = 2.63 vs. 3.30) and number of *social supports*[12] (*M* = 1.82 vs. 3.62).

3.2 Group differences after the ICDP programme and interaction effects

Tables 2 and 3 show group differences after the programme for parenting and psychosocial measures. The difference between the two groups' scores on *distant child management* was maintained after the programme, with the Urdu-speaking mothers reporting a more distant form of child rearing than the Norwegian speaking mothers (*M* = 2.69 vs. 1.77). The two groups showed similar change on *facilitating child management* with both reflecting better child management after the programme with a significant within-subject effect across groups (*F (1, 85)* = 10.67, *p* = 0.002, $\eta\rho^2$ = 0.11) and no interaction between group and time of measurement. Change reached significance in the Norwegian language group only (*M* = 1.83 and 1.72), and the two groups did not differ significantly after the programme.

The groups did not change significantly on total *hours with child on weekdays* and the Urdu-speaking mothers still reported significantly more hours than the Norwegian language group (*M* = 11.54 vs. 5.22). There were no significant changes on activities with the child or difference between the groups.

The Norwegian language group showed increased *strategic engagement* after the programme (*M* = 2.28 and 2.08), with a significant group difference on strategic engagement after the programme, indicating less engagement in the Urdu language group (*M* = 2.52 vs. 2.06). None changed significantly on emotional engagement nor differed significantly after the programme.

Both groups showed significant increases in *positive discipline* after the programme (*F (1, 100)* = 5.84, *p* = 0.018, $\eta\rho^2$ = 0.06). The change in the Norwegian language group on positive discipline (*M* = 2.73 and 3.04) was significant, with a trend for the Urdu language group (*M* = 2.83 and 3.04).

Parenting strategy scores increased for all (*F (1, 107)* = 9.06, *p* = 0.003, $\eta\rho^2$ = 0.08), although only the Norwegian language group had significantly higher scores after compared with before the programme (*M* = 33.42 and 34.89), and the groups did not differ significantly on parenting strategies after the programme. There were no significant interaction effects for the parenting measures.

There was a significant interaction effect of time and group on *happiness with partner* (*F* = 4.67, *p* = 0.033, $\eta\rho^2$ = 0.04), reflecting a

Table 3. Child and parental psychosocial measures before and after the ICDP, and group changes from before to after the ICDP

	Group	Before ICDP					After ICDP					Group changes from before to after ICDP						
Measure		**N**	**Mean**	**SD**	***t***	***p***	**N**	**Mean**	**SD**	***t***	***p***	**N**	**M**	**SD**	**M**	**SD**	***t***	***p***
SDQ prosocial behaviour	Urdu	26	7.85	1.87	-0.86	0.394	26	7.50	1.77	-0.86	0.394	24	8.00	1.84	7.46	1.84	2.50	0.020
	Norwegian	91	7.46	2.06			98	7.61	2.16			91	7.46	2.06	7.68	2.13	-1.44	0.152
SDQ child difficulties	Urdu	20	9.85	5.30	-0.86	0.392	21	12.14	6.16	-3.73	0.001*	16	9.88	5.88	11.19	6.25	-0.91	0.378
	Norwegian	92	8.82	4.79			94	6.89	4.07			89	8.84	4.68	6.97	4.10	4.92	<0.001*
SDQ impact score	Urdu	21	.38	0.97	0.47	0.643	22	.18	0.59	0.074	0.941	17	0.41	1.06	0.12	0.49	1.23	0.236
	Norwegian	101	0.53	1.45			88	0.19	0.59			86	0.43	1.05	0.20	0.67	2.08	0.041*
Happiness with partner	Urdu	25	4.80	1.26	-4.76	<0.001*	27	4.41	1.08	-3.54	0.001*	24	4.83	1.27	4.50	1.10	1.45	0.162
	Norwegian	89	3.52	0.92			89	3.61	.82			80	3.54	0.80	3.61	0.82	-0.97	0.334
Loneliness	Urdu	25	13.32	4.73	-1.20	0.233	27	13.44	3.83	-1.97	0.051	23	13.52	4.85	13.30	4.07	0.29	0.771
	Norwegian	101	12.18	4.15			105	11.76	3.99			101	12.18	4.15	11.72	3.88	1.86	0.065
Self esteem	Urdu	18	22.33	4.19	-2.14	0.035*	23	21.09	5.62	-0.29	0.777	16	22.69	4.22	22.75	5.31	-0.07	0.943
	Norwegian	88	20.05	4.13			92	20.73	4.29			82	19.99	4.17	20.55	4.30	-1.81	0.074
Positive emotions subscale	Urdu	26	5.67	1.07	-2.44	0.020*	24	5.54	1.02	-1.96	0.060	22	5.73	0.98	5.63	1.02	0.69	0.500
	Norwegian	101	5.12	0.82			104	5.11	0.80			100	5.12	0.83	5.09	0.81	0.36	0.720
Explore subscale	Urdu	27	5.76	1.05	-2.36	0.020*	26	5.60	1.10	-1.55	0.124	25	5.78	1.00	5.74	0.23	0.23	0.817
	Norwegian	102	5.29	0.89			105	5.26	0.98			102	5.29	0.89	2.25	0.98	0.48	0.629
Anger subscale	Urdu	26	2.63	1.50	2.38	0.019*	26	2.19	1.17	4.09	<0.001*	23	2.59	1.51	2.17	1.20	1.48	0.154
	Norwegian	102	3.30	1.23			105	3.12	1.00			102	3.30	1.23	3.12	1.01	1.61	0.111
HADS anxiety	Urdu	27	8.48	3.25	-3.85	<0.001*	25	7.84	3.72	-3.78	<0.001*	23	8.70	3.43	8.00	3.84	1.18	0.249
	Norwegian	99	5.51	3.63			104	5.03	3.24			98	5.50	3.65	5.02	3.32	2.02	0.046*
HADS depression	Urdu	26	6.04	3.40	-4.37	<0.001*	24	6.13	3.39	-4.47	<0.001*	22	6.00	3.39	6.14	3.48	-0.36	0.723
	Norwegian	100	2.96	2.27			102	2.83	2.54			97	2.95	2.30	2.87	2.59	0.47	0.637
Number of social supports	Urdu	14	1.82	1.77	3.27	0.001*	12	1.63	0.86	6.03	<0.001*	9	1.48	0.57	1.83	0.91	-1.15	0.285
	Norwegian	95	3.62	1.94			97	3.48	1.77			89	3.57	1.96	3.43	1.76	0.97	0.337

decrease in happiness in the Urdu language group and little change in the Norwegian language group. The two groups did not change significantly on happiness with partner, and the Urdu language group still scored significantly higher on this measure (*M* = 4.41 vs. 3.61). The Norwegian language group tended to score lower on *loneliness*[13] after compared with before the programme (*M* = 12.18 and 11.72), whereas the Urdu-speaking mothers showed little change. The Norwegian language group tended to have higher scores on *self-esteem* after than before the programme (*M* = 19.99 and 20.55). The Urdu language group did not change on this measure, and after the programme there was no longer a significant group difference.

The scores of the total group decreased pre and post on *anxiety* (*F (1, 121)* = 4.30, *p* = 0.040, ηp^2 = 0.04) and *anger* (*F (1, 125)* = 4.90, *p* = 0.029, ηp^2 = 0.04). The Norwegian language group reported significantly lower post scores on anxiety (*M* = 5.50 and 5.02), but neither changed significantly on anger. The absence of interaction effects indicates a similar influence on the two groups. Several group differences before the programme were maintained after the programme, with the Urdu-speaking mothers scoring higher than the Norwegian language group on *anxiety* (*M* = 7.84 vs. 5.03) and *depression* (*M* = 6.13 vs. 2.83), and lower on *anger* (*M* = 2.19 vs. 3.12) and *number of social supports* (*M* = 1.63 vs. 3.48). There was a significant interaction effect of time and group on *life satisfaction*[14] (*F* (1, 126) = 8.80, *p* = 0.004, ηp^2 = 0.07), reflecting a decrease in life satisfaction in the Urdu language group and a slight increase in the Norwegian language group. The groups did not differ significantly on this measure pre or post.

There was a significant interaction between group and time of measurement for the *SDQ child difficulties score*[15] (*F (1, 105)* = 8.66, *p* = 0.004, ηp^2 = 0.08) and the *SDQ prosocial behaviour score*[16] (*F*

*(*1, 115*)* = 5.77, p = 0.018, $\eta\rho^2$ = 0.05), indicating that the mothers in the Norwegian language group perceived less difficulties and more prosocial behaviour in their children after the programme, while the Urdu-speaking mothers perceived an increase in difficulties and a decrease in the prosocial behaviour. This decrease (M = 8.00 and 7.46) and the decrease in perceived child difficulties in the Norwegian language group (M = 8.84 and 6.97) were significant. A new group difference in perceived child difficulties (SDQ) appeared after the programme, with higher scores in the Urdu language group and lower scores in the Norwegian language group (M = 12.14 vs. 6.8). The *SDQ impact score*[17] decreased from before to after the programme for the total group (F *(*1, 103*)* = 3.72, p = 0.057, $\eta\rho^2$ = 0.04). The decrease in scores was significant for the Norwegian language group (M = 0.43 and 0.20) and there was no significant group difference in SDQ impact scores after the programme. There were no other interaction effects for psychosocial measures and child outcomes.

4 Interviews with mothers in the Urdu language group: Results and analyses

Four themes were identified in the interviews with the Urdu-speaking mothers: (1) cultural factors, (2) increases in communication and positive regulation, (3) improvements in relationships and changes in the children and within the family and (4) a decrease in loneliness and an improved life quality.

4.1 Cultural factors

The discussions of cultural aspects of parenting raised awareness of acculturation as well as cultural similarities and differences and confusion on which culture to emphasize. The tension of dual cultures represented stress for both mothers and children who had to manage multiple identities and roles.

> *I was a bit distraught at the beginning about whether I should teach them our culture and parenting, Pakistani culture, or whether I should teach them the Norwegian culture.* (mother 6)

4.2 Increased communication and positive regulation

Following the increased consciousness on cultural customs, some mothers became critical to practices that they had not thought about earlier. For example, several of the mothers talked about what they called a cultural practice of not talking so much with the child. Many of the mothers reported substituting authoritarian control for a more positive calmer approach with enhanced communication.

> *I have improved in setting limits, as I did not do this earlier. Everything gets easier when you regulate the child with explanations, explain to them and show them.* (mother 5)
> *Before I was very aggressive. If I became angry and things, then it affected the kids, but now I have more control of myself. I control my anger and listen to the children and explain things.* (mother 7)
> *In our culture we easily deny, if we say no it is no, in a way. Nothing to discuss. But we have seen here* (in the ICDP group) *that we need to talk, we need to discuss with them, negative and positive sides. Explain to them, so that they understand why we say no.* (mother 5)

4.3 Improved relationships and changes in the children and within the family

The mothers reported improvements in family relationships, positive communications and joint quality time, which affected parent–child relationships and the marital relationship.

> *Before it was only screaming: "Don't do this and don't do that and this is not allowed." But now the kids know what they must and must not do. Whining does not help!* (mother 3)
> *There has been an improvement with everything. Home related work,* (the child's) *homework, cooperation. I use the method* (ICDP) *for everything, so they* (the children) *are happy. I use this method on my husband as well (laughs). Before I complained about him, really, and screamed at him. Now I use the method and try to talk to him calmly as I have learned at this course. That's very good. It becomes calmer and less screaming between the two of us.* (mother 1)

4.4 Decreased loneliness and improved life quality

For many, the group experience and support was transformative, providing both support and social networks which affected mood, energy and parenting.

> *It was like, "wow, you have problems, and you have problems, and I have problems", and "I am not alone, there are others who are struggling, there are others as well", in a way (…). And then I started to get more self-esteem, and that is important.* (mother 12)
> *I think that all humans should have this course. You see, I have no family here.* (mother 2)

Taken together, the interviews reflect a change in the mother's understanding of the importance of their role as parents in the lives of their children, which in turn seemed related to increased parental investment. More shared time with the child, more communication and a calmer and more positive style thus seemed to have strengthened the family ties. These factors seemed intertwined, leading to improved familial relationships.

5 Interviews with mothers in the Norwegian language group: Results and analyses

Three themes were identified in the Norwegian language group: (1) increased consciousness, (2) parental role empowerment and (3) positive mindedness.

5.1 Increased consciousness

All the interviewees reported that the programme first and foremost had made them more conscious of their own parenting and parent–child interactions, and served as a prompt or reminder to lapsed knowledge. This increased awareness enhanced the repertoire of solutions.

It's like, I know what is working and I know what is right and I know what I need to do more of. Like, I didn't get any deep new insight, (…) but I feel that I have been reminded on this, without being able to count more good moments because of it, at least now it is more clear .., so I have more hope for the future. (mother 1)
It's like I have an extra voice when I have a conflict with my daughter, small things we have talked about here (ICDP), *remember, "this is probably smart", trying small adjustments all the time.* (mother 5)
I think that you become a better caregiver after this course. .. I think that most of us are not as conscious before such a course as we are after. (mother 7)

5.2 Empowerment

Support and confirmation of their parenting practices were empowering resulting in more parenting confidence. Rather than learning new things, the mothers point to the importance of receiving confirmation on existing skills and knowledge.

So I feel that it is a confirmation that I'm doing quite a lot of things right. (mother 3)
When you don't feel good enough you get to hear from the others that you are. And that has been really great. (mother 4)
I feel safer in what I am doing. The challenges are still there, but you learn to take a big breath and evaluate things from a distance. (mother 6)

5.3 Enhanced positive attitude

The mothers also reported on an increased positive life attitude, which in turn improved the family atmosphere and reduced conflicts. This was linked to the increased levels of awareness, as they now felt more able to appreciate positive things.

I think that I appreciate things more, especially in relation to those at home. (mother 3)
It has become a bit nicer at home. (mother 5)
More focus on being positive, so we have fewer confrontations. And we have a nicer tone at home. (mother 7)

6 Discussion

This field evaluation provides a detailed insight into how the ICDP programme influenced diverse parent groups. There were group differences in parenting and psychosocial measures before the programme, and although the changes in scores generally were in the same direction, the Norwegian language group showed more significant changes than the Urdu language group over time. The qualitative interviews revealed different pathways to change, but consistent endorsement and learning in both groups.

The Urdu language group had more children than the Norwegian language group and were less likely to have higher education and work outside the home. This resulted in more time spent with the child, more frequent use of parenting strategies and higher scores on activity-related items. More frequent use of distant child management in the Urdu-language group may reflect different attitudes to parenting (Maynard & Harding 2010: 632–636).

An important finding is the change in the Urdu-speaking mothers' attitudes towards communicating with the child. In the interviews, several mothers said that their earlier communication and regulation had been characterized by denying, scolding and a lack of openness. They reported better communications with the child, and that they had gained better control over their negative emotions, corrected the child in a more positive manner, gave more explanations to the child, and that their children had become calmer, happier and more cooperative. The changes may have a broader positive influence on the children's development as studies have found that communication between caregiver and child is related to the child's intelligence and language development (Klein 1990: 1–131). The interview accounts also suggest that the Urdu-speaking mothers gave more attention and time playing or reading with the child after the programme. They reported spending more time with their child than the Norwegian language group before the programme, but after the programme the activities with the child were more interactive. A study of low-educated Mexican immigrant mothers in the USA found that participation in programmes showing the mothers how to take part in children's learning through positive attitudes, conversation, reading and playing, contributed positively to the child's development (Schaller, Rocha & Barshinger 2007: 351). In the current study, increased communication and involvement might have been a contributing factor to the improved parent–child relationship reported by the Urdu-speaking mothers. The mothers from the Norwegian language group said that they had become more conscious of their parental role and behaviour and that support from the group had empowered them as caregivers.

The Urdu-speaking mothers scored higher on anxiety, depression and loneliness, and lower on social supports than Norwegian-speaking mothers. Several mothers from the Urdu language group described psychological stress prior to ICDP attendance, consistent with Norwegian data showing poorer mental health in ethnic minority groups than the general population (e.g. Syed *et al.* 2006: 551–558). Social support groups may prevent depression and anxiety by empowering the group members (Dalgard & Bøen 2008: 15). Immigrant families might have reduced extended network in the country of residence (Leidy, Guerra, & Toro 2010). Community-implemented programmes like the ICDP may to some extent compensate these factors. The ICDP programme might have contributed to the acculturation of the mothers by helping them incorporating and adopting new values and reduce the possible conflicting identifications caused by the bi-cultural situation of the Pakistani group (Weinreich 2009: 128–135). In the present study, both groups had lower scores on anger and anxiety after the programme – however, the decrease was significant for the Norwegian-speaking group only. The Urdu language group were significantly happier with their partner than the Norwegian language group and scored higher on life satisfaction. However, the scores of the minority group decreased after the programme on both of these measures (although not significantly). It is possible that participation in the ICDP programme made them more aware of child rearing practices and more realistic or self-critical about their own and the child's situation. This explanation is in line with the fact that the interview accounts described less loneliness, higher life quality and increased parenting confidence and social support from the group, similar to UK debrief data, where the qualitative interview data yielded more positive results than the questionnaire data (Patterson, Mockford & Stewart-Brown 2005: 53–64).

The Urdu-speaking mothers tended to perceive more difficulties in their child than the Norwegian-speaking mothers, which is in line with previous Norwegian data (Oppedal *et al.* 2008). This may reflect

different expectations, but also socio-economic, familial and parenting factors. A Dutch study reported similar findings in first-generation immigrants, showing that socio-economic disadvantage, poor family functioning and parenting factors such as harsh discipline explained the relationship between ethnic minority status and increased risk of problem behaviour (Flink *et al*. 2012: 1092–1102). In our study, the mother-reported child difficulties increased in the Urdu language group after programme attendance, possibly reflecting changes in concepts of difficult child behaviour. The mothers in the Norwegian language group scored significantly lower on impact of the child's difficulties after the programme. The scores of the Urdu language group also decreased, although not significantly. In a study by Vitaro et al. (2001: 201–213), higher effect sizes were detected in the months following a parental intervention, which might indicate a need for longer term follow up to capture evolving change.

There are a number of limitations to consider, including no matched non-attender control group with similar ethnic or socioeconomic background and possibly a selection bias where mothers with more life stress participated in the programme, hindering generalization, as well as low response rate and power. The measures were not culturally standardized with Western skew (Stewart & Bond 2002: 379–392) and lengthy with possible fatigue. Multiple statistical tests increase the probability of finding effects that are not really true.

Further research should explore cultural background and socioeconomic status confounders (McLoyd 1998: 12) and control for social class with a more robust sample size. Causal relationships could be better inferred with a randomized controlled trial and longer term follow-up design. Furthermore, the effects on fathers need to be understood. Although the ICDP is designed to be culturally sensitive and non-imposing, the programme is implemented by the state or municipality and cultural bias may need to be examined. Research should investigate whether cultural issues should be included in Norwegian language groups, and whether the programme support bicultural identities, which is related to lower levels of child internalizing problems and higher levels of adaptive behaviour (Calzada *et al*. 2009: 515–524). Despite the limitations, the study has added information about parenting practices and the effectiveness of ICDP for parents with an ethnic Pakistani minority background residing in Norway. The results suggest that participation in the ICDP programme may have positive effects for non-clinical groups of mothers with an ethnic minority background, through empowering and supporting their positive capacities and reduce psychological distress through not only by addressing unmet mental health and social needs but also by increasing self-awareness and stimulating self-criticism, pointing to the possible need of follow-up meetings.

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Notes

1 Nine items created to measure the emotional dialogue in the ICDP (e.g. "I do not talk much to my child and only say what is necessary" and "I think it is difficult to have emotional conversations with my child") with an average score from 1 to 5 (α = 0.74), with a higher average score indicating greater distant management.

2 Measured using the Parent–Child Activity Scale (Bigner 1977), with a summed score from 25 to 125 (α = 0.86).

3 Six bipolar items: loving–unloving, engaged–unengaged, good–bad, talkative–non-talkative, sensitive–insensitive and adjusting to child-directing, scored from 1 to 7 with a lower average score indicating greater emotional engagement (α = 0.82).

4 Eight items created to measure caregivers' parenting strategy based on the components of the ICDP, especially the comprehension dialogue (e.g. "I expand my child's experiences by giving explanations and telling stories") and regulative dialogue (e.g. "I set limits without explaining why"), with a summed score from 8 to 48 (α = 0.66), with a higher average score indicating greater parenting strategies.

5 Thirteen items were created to measure the regulative dialogue in the ICDP (e.g. "Even when angry I listen to my child" and "I help my child to make plans and carry them out") with an average score from 1 to 5 (α = 0.74), with a lower average score indicating greater facilitative child management.

6 Four bipolar items: negotiating–commanding, kind–aggressive, rewarding–punitive and lenient–strict, scored from 1 to 7 with a lower average score indicating greater interactive engagement (α = 0.74).

7 Six items were created (e.g. "Praised them for achieving something on their own" and "Rewarding them for behaving well"), whose format was based on the Parent–Child Conflict Tactics Scales (Straus *et al*. 1998) (α = 0.74). A higher score represented more frequent positive discipline.

8 A visual analogue scale scored from 0 (extremely unhappy) to 6 (perfectly happy) from the Dyadic Adjustment Scale, item 31 (Spanier 1976).

9 Measured using the Rosenberg (1965) 10 item Self-Esteem Scale (RSE), with a summed score from 0 to 30 (α = 0.79).
10 Assesses emotions of pleasure (e.g. "happy") and exploration, (e.g. "interested") (α = 0.85), each reported on a scale from 1 (never) to 7 (all the time), derived from the Basic Emotions Trait Test (BETT) (Vittersø 2009). BETT also assesses emotions of anger (e.g. "angry") and fear (e.g. "nervous").
11 Seven anxiety (α = 0.80) and seven depression (α = 0.74) items taken from the Hospitalized Anxiety and Depression Scale (HADS) (Zigmond & Snaith 1983), scored from 0 to 21.
12 Measured with the Social Support Questionnaire (SSQ6) – short form (Sarason, Sarason, Shearin & Pierce 1987). Participants indicated up to nine persons on whom they could rely in six different situations (mean score could range from 0 to 9, α = 0.93).
13 Measured with The UCLA Loneliness Scale (Russell 1996): seven items scored from 1 (hardly ever/ever) to 3 (often) with a summed score from 7 to 21.
14 Five statements from the The Satisfaction with Life Scale (Diener, Emmons, Larsen & Griffin 1985) (e.g. "So far I have got the important things I want in life"), with a summed score from 5 to 35 (α = 0.87).
15 Measured using four subscales from the Strengths' and Difficulties Questionnaire (SDQ) (Goodman 1999) measuring Emotional Symptoms (e.g. "Many fears, easily scared"), Conduct Problems (e.g. Often lies or cheats"), Hyperactivity (e.g. "Restless, overactive, cannot stay still for long"), Peer Problems (e.g. "Picked on or bullied by other children") (α = 0.78).
16 Measured using the Prosocial behaviour subscale from the SDQ (Goodman 1999) (α = 0.73) (e.g. "Kind to other children").
17 Measured using the impact supplement from the SDQ (Goodman 1999), assessing whether the respondent thinks the child has a problem, and if so, assesses chronicity, distress, social impairment and burden to others.

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