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Evaluation report of Early Intervention Program in Situation of Child-to-Parent Abuse: Parents and children as participants

The current definition of child-to-parent abuse (CPA) includes different forms of abuse (physical, emotional, psychological and financial) toward one parent, the perpetrator's awareness of such violent behavior and repeated perpetration, excluding isolated acts of violence (Pereira et al., 2017). CPA has received growing social, clinical and scientific interest during the last decade due to the increase of complaints filed by parents, according to the General Prosecutor's Office of Spain (Fiscalía General del Estado, 2019). However, the number of cases in which parents do not report their children's behavior to the Juvenile Court remains unknown. In their review of community sample prevalence data, Simmons, McEwan, Purcell and Ogloff (2018) estimated the 12-month incidence of adolescent-perpetrated physical CPA to be between 5% and 21%. These data reflect the magnitude of this social problem.

Clinical practice experiences of practitioners in child and adolescent mental health suggest that CPA is increasing (Coogan, 2014; Hong, Kral, Espelage, & Allen-Meares, 2012). Currently, practitioners from different fields are constantly seeking help regarding adolescents or young people who have been expelled from school, who have problems with the law and act violently toward their parents. Research suggests that CPA tends to begin with verbal aggression before escalating to other forms (Cottrell, 2001) and can increase in both frequency and intensity without intervention (Bachli, 2008). Thus, families that experience this type of situation require immediate intervention to reduce family conflict and discomfort. Moreover, parents talk with embarrassment and fear about their experiences of victimization by their children (Coogan, 2014). Taking the judicial path is a resource more of support for dealing with serious cases of CPA. The appearance of behavior problems in childhood and

adolescence are considered a risk factor for violence and criminal behavior in adulthood; thus strategies to prevent violence directed toward children and adolescents (Farrington, 2003), as well as family programs, are considered priority interventions. According to Fitz-Gibbon, Elliott and Maher (2018), typical patterns of behavior described by parents experiencing CPA situations are feelings of insecurity at home, fear of the young person, children not listening to them and having little or no control over them. In this situation, many parents change their own behaviors in order to avoid conflict and minimize violence.

Family correlates

There are different family variables that correlate with CPA. A change of family composition could be a risk factor. For example, Pagani, Larocque, Vitaro and Tremblay (2003) found that divorce or separation of parents represented a major risk factor for physical CPA directed toward mothers, due to difficulties associated with single parenting.

Some evidence to support a hypothesis of intergenerational transmission of family violence has been found. For example, inter-parental violence and/or parent-to-child violence have been observed as significant predictors of child-to-parent abuse in many studies (Cottrell & Monk, 2004; see Hong et al., 2012, for a review of such studies; Lyons, Bell, Fréchette, & Romano, 2015). However, some authors indicate that there is no evidence in the scientific literature to support claims of a direct causation between childhood experiences of abuse and CPA (Coogan, 2014; Woods & Sommers, 2011). In families where CPA takes place, parents feel disempowered and unable to assert their authority as parents (Calvete, Orue, & Gamez-Guadix, 2013; Omer, 2011), but child and family services tend to consider that children are victims and need support (Tew & Nixon, 2010).

Primary prevention is needed to show parents non-violent strategies by not using physical punishment (Beckmann, 2019). Past research has also studied negative parental disciplinary strategies such as corporal punishment as a risk factor for CPA (Brezina, 1999; Ibabe & Bentler, 2015). In his longitudinal national U.S. sample of 1886 15-year-old boys, Brezina (1999) found that corporal punishment (defined as parental use of spanking) was associated with an increased likelihood of CPA one year later. Conversely, Ibabe and Bentler (2015) did not find any relationship between positive family discipline and supervision and lower levels of violence against parents, while positive family relationships predicted a lower level of CPA. They concluded that affectivity and quality of family relationships are more important than parental disciplinary strategies for preventing violent behaviors in adolescents. In fact, Beckmann (2019) indicated that cohesive family relationships turned out to be an important protective factor against violent behaviors in adolescence. In addition, family members with CPA show higher level of difficulties with drugs and alcohol, and higher rates of trauma and mental health problems (Moulds & Day, 2017).

CPA treatment programs

The development and persistence of CPA depends on family characteristics and personal variables of children (Calvete, Orue, & Gámez-Guadix, 2013; Ibabe, Arnoso, & Elgorriaga, 2014), and as with other types of family violence, it requires rigorous professional intervention. The search for effective treatment programs for adolescents or young people who exercise incipient, mild or severe CPA is a very relevant issue.

In the literature review by Ibabe, Arnoso, & Elgorriaga (2018) on intervention programs for CPA treatment, three aspects were taken into account (child protection, clinical and judicial). Ten databases of evidence-based programs were consulted, but the search failed to find any positive results regarding specific treatment for CPA.

Nevertheless, it is worth mentioning that the King County Superior Court, Step-Up program*, Building Respectful Family Relationships,* of Routt and Anderson (2004) showed some results of an evaluation program, but this program did not have enough evaluation reports to be considered an evidence-based program. Furthermore, the preliminary outcomes of *Breaking the Cycle* (Freiverts, & Bautista, 2017), a manualized therapeutic group work program for parents of adolescents who engage in adolescent family violence, indicate that intervention contributes to the reduction of adolescent-perpetrated violence and parents reported improved relationships with their adolescents (Freiverts et al., 2019). However, intervention programs on CPA with a detailed protocol are scarce, and among them there is none that has sufficient scientific support to corroborate its effectiveness in clinical practice.

An innovative program of early intervention on CPA (EP-CPA) has been elaborated in Spain (Ibabe et al., 2019). This program has integrated relevant aspects of *Step up* (Routt & Anderson, 2004) and *Educational and Therapeutic Treatment for Child-to-Parent Abuse* (González-Álvarez et al., 2013). It has a detailed protocol for each session so that it can be implemented by any professional with training in clinical psychology. Similarly, it also has parents' and adolescents' workbooks in order to create activities during sessions and as reference material on aspects developed in the program sessions.

Evaluation program

Many parents feel the need to receive parenting support regarding socio-emotional child development, inappropriate children's behavior, or general parenting skills. Parenting interventions have been developed with varying content, but it is difficult for professionals to select the most appropriate and effective interventions. Interventions generally consist of many elements, and it is important to identify which elements of the

interventions contribute to the effects (Chorpita & Daleiden, 2009; Michie et al., 2013). Evaluations of parenting programs have focused on the treatment of behavioral problems and disorders, and these programs have been shown to be effective tools for these purposes (Merry & Moor, 2015). However, the development and persistence of the aggressive behavior of adolescents is a complex phenomenon, and multidimensional treatments have demonstrated their efficacy with this population (Caldwell & Van Rybroek, 2013). Moreover, research on early intervention is also relevant because it supports families during critical years.

Research has focused on efficacy (studies delivered under optimal conditions with strong control by researchers) more than on effectiveness (studies conducted in real-word conditions, such as schools and primary care health centers (Streiner, 2002). Group-based interventions are widely used to promote health-related behavior change, but it remains unclear how behavior change is generated (Borek et al., 2019). However, understanding the main mechanisms by which such interventions work is important to guide intervention design and process evaluations.

Objectives of the study

The main objective of this study was to evaluate short-term effects of the early intervention program EP-CPA (Ibabe et al., 2019) on individual behavior (children and parents), clinical symptomatology and family relationships (family conflict, among others).

Other objectives were to analyze the evolution of family relationships quality of parents and children during the development of the Families subprogram of EP-CPA, and to examine the general acceptability and satisfaction of participants with the Families Subprogram of EP-CPA and their evolution during program development. Other interesting objective was to identify the main mechanisms by which EP-CPA

works as well as elements related to the design, context and change processes in parents and children, which may help explain how positive changes in individual behavior, clinical symptomatology and family relationships are generated by the intervention program.

Method

Participants

At the start of the program, there were thirty families with children between 12 and 17 years who took part in the Early Intervention Program in Situation of Child-to-Parent Abuse ($N = 76$). These families were composed of 30 adolescents (21 sons and 9 daughters), 30 mothers and 16 fathers. Some participants dropped out of the program voluntarily or attended fewer than 65% of sessions ($n = 11$), and 4 participants did not do the post-test despite finishing the program. This means that the dropout rate was 14%. Thus, data analysis was performed with 61 participants (21 adolescents and 40 parents from 23 families).

Research Site

This program was promoted by the Children and Family Services (CFS) of the City Council of Vitoria-Gasteiz, who hired the research team of Izaskun Ibabe from the University of the Basque Country for its elaboration. Vitoria-Gasteiz is a multicultural city in the Basque Country with a population of 242,082 inhabitants. The program was designed by Ibabe et al. (2019) and was also adapted and extended taking into account the needs of the population under the auspices of the city's Council, based on a participative work process led and coordinated from CFS by Loli García García and Belén Ceberio Cuñado.

The authors of EP-CPA program conducted the evaluation of the effects of this intervention, while after verifying that families fulfilled the inclusion criteria of the program, CFS offered them the opportunity to participate in it. There were two

inclusion criteria: (1) behaviors of mild or moderate aggression of children toward the father or mother, (2) parental inability to control aggressive behavior in any context. Exclusion criteria were not being able to speak Spanish fluently, cases of gender violence (the perpetrator was excluded from the program), or severe cases of parent abuse. The intervention was executed by five therapists and a coordinator of the IPACE Applied Psychology unit, contracted by City Hall for the program's implementation. Those who agreed to participate were called to do a pre-intervention evaluation. This study was approved by the Ethical Board of the University of the Basque Country. Both parents and children provided informed consent before participation in this program.

Early Intervention Program in Child-to-Parent Abuse (EP-CPA) description

The general objectives of the program are the reduction of CPA behavior and clinical symptoms, as well as the improvement of parent-child relationships by establishing adequate alternative strategies for the resolution of conflictive family interactions.

This is a psycho-educational program with a cognitive-behavioral type of group approach (5-10 participants) that takes into account systemic family therapy for family intervention, including relational system diagnosis. The target population is families (parents and adolescents) whose children, ranging in age from 12 and 17 years, present CPA as a main problem. This program includes three subprograms (Adolescents, Parents and Families) with 35 sessions in total. Adolescents (Adolescents Subprogram, 16 sessions) and parents (Parents Subprogram, 11 sessions) have a separate space for learning competences and strategies, sharing experiences with persons in similar situations. Subsequently, all members of each family put the skills learnt into practice in the family context under the practitioner's supervision (Family Subprogram, 8 sessions). The intervention program has a 508-page manual, in which each of 35

sessions (90 minutes) are clearly explained, with timing for every activity, and recommendations for special situations. It also includes a workbook for participants.

Characteristics of Families Subprogram of EP-CPA

In the Family Subprogram sessions, single families participate, except in the first one, which is a multifamily session. The main objective is to encourage positive interrelations between parents and children in order to create a family environment based on respectful behavior and affect that implies greater family cohesion. Table 1 briefly describes the corresponding sessions.

Insert Table 1

Design and evaluation

A single-case experimental design was used, which allows the monitoring of change within participants through comparison between phases. The study had an AB-design, with the A-phase being the baseline period between the first contact and the start of the intervention (T0-T1) during which the assessment is conducted. In this period, families do not receive any EI-CPA intervention. The B-phase is the period in which families receive treatment over a period of 6 months (T1-T2). Participants receive pre- and post-intervention assessment (T1 and T2, respectively), and a follow-up assessment 6 months post-intervention (T3). During the assessment sessions, parents and children complete the questionnaires under the supervision of an independent psychologist. This paper reports results of pre-intervention and post-intervention evaluation.

Aside from process evaluation, each session involved feedback on family relationship quality as well as general acceptability and satisfaction of participants in the three subprograms. The qualitative evaluation was a semi-structured interview for children, and focus groups for parents were administered in post-intervention (T2) by an independent person from the intervention program.

Variables and instruments

In order to standardize the answer format in all instruments, a five-point Likert scale was used. The frequency of violent behavior in the last year was measured on the following scale: 1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Very often. Some instruments were administrated to children (CH), others one to parents (PA), and one to both children and parents (ALL).

Irrational beliefs of children (CH) (Irrational Beliefs Inventory for adolescents, Cardeñoso & Calvete, 2004). This inventory included one scale of Irrationality and six subscales of irrational beliefs: Need for Approval/Success, Helplessness, Blame Proneness, Avoiding Problems, Intolerance to Frustration, and Justification of the Use of Violence. This inventory has 37 items (e.g., Sometimes you have to hit someone because they deserve it), which are answered in degrees of agreement from 1 (Completely false) to 5 (Completely true). The global internal consistency was excellent (pre-intervention $\alpha = .87$; post-intervention $\alpha = .92$). However, avoiding problems (pre-intervention $\alpha = .49$; post-intervention $\alpha = .50$) and intolerance to frustration (pre-intervention $\alpha = .61$; post-intervention $\alpha = .50$) did not reach the desirable level ($\alpha \geq .70$).

Depressive symptomatology (CH) **(**Children's Depression Scale, CDS, Lang & Tisher, 2014). CDS was applied to measure adolescents' depression symptoms, for which three subscales were selected (affective response, social problems and self-esteem) with 24 items (e.g., I often feel lonely). In the current study, internal consistency was excellent for both overall (pre-intervention $\alpha = .93$; post-intervention $\alpha = .96$) and self-esteem (pre-intervention $\alpha = .85$; post-intervention $\alpha = .89$).

Depressive symptomatology (PA) (Brief Symptom Inventory, BSI-18, Derogatis, 2001). This instrument was elaborated to measure the most prevalent psychopathology

symptoms in clinical, medical and community populations. As originally constructed, BSI-18 consists of three factors that include somatization (e.g., Faintness or dizziness), depression (e.g., Feeling no interest in things), and anxiety (e.g., Feeling tense or keyed up). A global severity index can be calculated, which is the full-scale score across the three factors. Items are summed, with higher scores indicating more distress during the previous week. This scale showed excellent internal consistency in pre-intervention condition (α = .93) and post-intervention condition (α = .87).

Psychological inflexibility (PA) (Acceptance and Action Questionnaire-II, AAQ-II; Bond et al., 2011). Psychological flexibility and acceptance are key concepts of Acceptance and Commitment Therapy (Spanish adaptation of Ruiz, Langer, Luciano, Cangas, & Beltrán, 2013). It is composed of 7 items (e.g., "Emotions cause problems in my life") on a 5-point Likert scale. In this study, the internal consistency for this instrument was excellent (pre-intervention α = .92; post-intervention α = .93).

Child-to-parent abuse (PA) (Adolescent Child-to-Parent Aggression Questionnaire, Calvete et al., 2013). The scale assessed two types of violence against parents (physical and psychological) with 10 parallel items (e.g., You have been insulted or sworn at by your son/daughter), consisting of 3 items on physical violence and 7 items on psychological violence based on the last year of living together. This questionnaire, answered by parents, showed an acceptable internal consistency for physical violence (pre-intervention α = .75; post-intervention α = .60) and for psychological aggression (pre-intervention α = .83; post-intervention α = .87).

Corporal punishment (PA) (Dimensions of Discipline Inventory DDI-C, Straus & Fauchier, 2007; Spanish adaptation, Calvete, Gámez-Guadix, & Orue, 2010). Although this inventory measures four general dimensions, the present study only measured corporal punishment by the parent in their relationship with their son or daughter. The

subscale for corporal punishment (e.g., "How often did your father/mother shake or grab you to get your attention?") had four questions. In this study, the internal consistency for the subscale was excellent (pre-intervention α = .88; post-intervention α = .94).

Family conflict and involvement of CPA out family (ALL) **(**Family Environment Scale, FES; Moos & Moos, 1981; Spanish version adapted by TEA Ediciones, 1984). Items of the subscale on family conflict (the amount of openly expressed anger and conflict among family members) were selected (e.g., In our family we fight a lot). This subscale contains 9 items with a true/false response format. In this study, the alpha reliability coefficient was acceptable (pre-intervention α = .67; post-intervention α = .61), taking into account that this scale has reverse score items. Additionally, involvement of CPA out family (Is your family problem affecting other areas of your life, such as work/studies, friends, or other social relationships?) were measured.

Empathy (ALL) (Interpersonal Reactivity Index IRI, Davies, 1980; Spanish adaptation of Pérez-Albéniz, de Paúl, Etxeberria, Montes, & Torres, 2003). The IRI measures four different dimensions of dispositional empathy. However, in this study only two subscales were administered (empathic concern and perspective taking, with 7 and 9 items respectively). The Empathic Concern subscale assesses emotional empathy, or feelings of compassion for others in distress (e.g., "I often have tender, concerned feelings for people less fortunate than me"), while the Perspective Taking subscale assesses cognitive empathy, or the tendency to see the world from others' viewpoints (e.g., "I sometimes try to understand my friends better by imagining how things look from their perspective"). The internal consistency of this instrument overall was acceptable (pre-intervention α = .69; post-intervention α = .83) as was empathic concern

(pre-intervention α = .72; post-intervention α = .65) and perspective taking (pre-intervention α = .85; post-intervention α = .67) individually.

Socio-demographic data and mental health problems (ALL). A questionnaire was applied to assess socio-demographic variables (sex, age and country of origin) of the children and parents. Moreover, parent reports included other characteristics such as family structure, parental education level (none, compulsory education, further education/job training or university), and family income. Information about mental health and family problems was provided by CFS.

Process evaluation and other variables

The assessment of family members' progress was done through inter-treatment evaluations that could explain the success or failure of the intervention. In the scheduled sessions, parents and children were questioned about their family relationship quality, and the acceptability of and satisfaction with different aspects (motivation, satisfaction, learning, and relevance for their life) were assessed in each session (e.g., To what extent were you motivated in today session?) on a Likert scale from 0 (Not at all …) to 10 (Very …). In order to identify the main mechanisms by which EP-CPA works, participants were asked about the useful aspects of each session, and the perceived effectiveness of the intervention once finished (To what extent do you think the program has helped in your family relationship problem?). Moreover, three focus groups with parents and two interviews with adolescents were conducted to analyze the changes in potential behavior and beliefs identified by participants, family environment perception or support net.

Data Analysis

Data regarding the profile of family participants was recorded using the initial sample (N = 76). Data analysis was made with the 61 participants (21 adolescents and 40 parents) who finished the program satisfactorily and completed pre and post-tests.

The study collected information from three sources: parents and adolescents participating in the program and the professionals responsible for implementing the intervention. SPSS (version 24) was used for all statistical analyses. The intervention effects of the EI-CPA program were analyzed using *t* test, in which pre-intervention scores serve for comparison with post-intervention scores. All significance tests were set at .05 alpha level. The effect size measure for means comparison results were reported with Cohen's *d*. In line with recommendations, the values were interpreted as small: $\eta^2 = .20$, medium: $\eta^2 = .50$, or large: $\eta^2 = .80$ when interpreting the effect of an intervention (Cohen, 1977). The evaluation of program acceptability by participants was made according the opinion of all participants, but the analysis unit is the family. The median was used to calculate the average of each variable (motivation, satisfaction, learning, and relevance to their life) because there were differences between parents and children. This paper presents the evaluation process of the Families Subprogram. The presentation of interviews and focus group answers in this report has been integrated with the quantitative findings. For the qualitative analysis, a thematic analysis of interview and focus group transcripts was undertaken and cross-validated.

Results

Profile of family participants

The family structure was: 11 two-parent families and 12 one-parent families or blended families). These families had more children ($M = 2.24$) than the mean children per woman ($M = 1.33$) in the Spanish population. Domestic violence was found in three families, in another family the parents were in the process of separating, and three more families had conflictive intimate partner relationships. Three families had had parent-to-child abuse or some type of negligence. Parents did not attend any other city program, but one child was attending an emotions workshop. Three adolescents were attending

Child and Adolescent Psychiatry Services. There were three parents with serious mental disorders, such as bipolar disorder, but these parents did not participate in the program.

Eighty-five percent of adolescents were in compulsory secondary education, 34% considered they were not doing well in school. Fifty percent of monthly family incomes ranged from €650 to €2,500, 33% from €2,500 to €4,000, and 17% had more than €4,000. Moreover, 31% had had problems with the police, and 22% had had problems with police for assaulting parents.

Short-term effects of intervention program

Child-to-parent abuse

Taking into account the results of Table 2, in post-intervention condition parents perceived less psychological CPA (M = 2.40) than in pre-intervention condition (M = 3.15), $t(37) = 4.55$, $p < .001$, $d = .70$, 95% CI [.41, 1.07], as well as less physical CPA in post-intervention and pre-intervention, respectively (M = 1.36 and M = 1.77), $t(36) = 3.80$, $p = .001$, $d = .62$, 95% CI [.19, .63]. All means comparisons regarding CPA were significantly lower in post-intervention than pre-intervention condition, except physical CPA toward fathers, in which there were no significant differences, $t(12) = 1.53$, $p = .152$, $d = .42$, 95% CI [-.12, .68]. The highest effect sizes appertained to psychological aggression toward the father (d = .99).

Insert Table 2

Clinical symptoms and family environment

After intervention, children showed fewer irrational beliefs (M = 2.60) than before intervention (M = 2.33), $t(20) = 2.33$, $p = .03$, $d = .51$, 95% CI [.03, .49], less frustration tolerance (M = 3.38 vs. M = 2.84), $t(20) = 2.92$, $p = .008$, $d = .64$, 95% CI [.15, .92] and fewer avoidance problems (M = 2.69 vs. M = 2.19), $t(20) = 2.46$, $p = .02$, $d = .54$, 95% CI [.08, .92]. Moreover, children showed better self-esteem in the post-

intervention (M = 3.21) than in the pre-intervention (M = 2.88), $t(20) = 2.38$, $p = .03$, $d = .52$, 95% CI [.04, .63].

Parents presented less depressive symptomatology after intervention (M = 1.70) than before intervention (M = 2.23), $t(37) = 5.04$, $p < .001$, $d = .82$, 95% CI [.31, .74], lower levels of psychological inflexibility (M = 2.47 vs. M = 2.77), $t(36) = 2.41$, $p = .02$, $d = .39$, 95% CI [.05, .58], as well as more empathy (perspective taking) (M = 3.34 vs. M = 3.60), $t(37) = -2.21$, $p = .04$, $d = .47$, 95% CI [.05, .58]. It is noticeable that parents applied less corporal punishment after the intervention (M = 1.20 *vs*. M = 1.70), $t(37) = 5.22$, $p < .001$, $d = .82$, 95% CI [-.50, -.02].

Taking into account children and parents, family relationships improved after intervention (M = 7.24 *vs.* M = 4.22), $t(44) = -6.80$, $p < .001$, $d = -1.03$, 95% CI [-3.91, -2.12], the perception of family conflict was lower in post-intervention condition (M = 3.92 *vs*. M = 4.96), $t(56) = 3.13$, $p = .003$, $d = .41$, 95% CI [.37, 1.69], and involvement of CPA in areas out of family context after intervention was lower (M = 2.86 *vs*. M = 3.81), $t(56) = 4.33$, $p < .001$, $d = .57$, 95% CI [.51, 1.39]. The highest effect sizes appertained to family relationships, corporal punishment and depressive symptomatology of parents.

According to ANOVA analyses, there were no differences between family figures (children, fathers and mothers) for family relationship quality, family conflict or involvement of CPA out family.

Insert Table 3

Process evaluation of Families Subprogram

At the end of each session, all family members were asked to what extent family relationships had been satisfactory during the previous week on a 0-10 scale. Averages of all family members in each family session are shown in Figure 1. The perception of

family members participating in family sessions on the quality of family relationships evolves positively throughout the development of the subprogram since the trend line is clearly rising.

Insert Figure 1

Figure 2 shows the perception of participants (average of all family members) regarding the level of motivation, satisfaction, learning, and relevance to their life depending on the family session. Relevance to their life (M = 7.87) is the indicator which showed the highest averages among of four variables measured during the intervention program (motivation M = 6.99; satisfaction M = 6.94; learning M = 6.66). These results indicate that the family intervention program is well accepted by participants and the program is adapted to their reality, although it is necessary to indicate that parents rated higher than adolescents in motivation, satisfaction and learning. With respect to program efficacy perception, taking into account all participants, 63% perceived that the program had helped them in their family relationship problem while 22% were not sure.

Insert Figure 1

Participants indicated family communication, awareness of the perspective of the other person, sharing problems with other parents, and control strategies at crisis moments (setting the weekly goal or time out strategies) as among the most useful in the Family Subprogram topics. Moreover, the analysis of three focus groups conducted with 15 parents (11 mothers and 4 fathers) who completed the program confirms that the program helped them to generate a support network to break the isolation in which they previously found themselves: “We have got support. Often you have no one to talk to

about this. People do not understand what is happening and judge you without understanding you or the family unit" (Mother 1), "In the group we have learned many things and we have also learned from each other" (Mother 2). In addition, participants stated that the program had offered them strategies to know how to act in family conflictive situations: "It has helped me to know how far to go, how to act when children act badly..." (Mother 2). Finally, parents internalized the importance of responding respectfully in a difficult situation: "It has helped me to understand why adolescents behave in this way, and the consequences that certain behaviors of ours can have" (Mother 1).

After intervention, three adolescents were interviewed who stated that they had initially been reluctant to participate and thought they were not going to make changes. However, on participating in program sessions, especially at the end, they thought that it did serve to change the family situation: "Firstly, I thought the program was not going to work at all, but it is good for a lot" (Adolescent 1). Adolescents changed the way they understand family situations, considered that they have acquired strategies to control themselves and confirmed that the family environment has improved. They thought that their parents understood them, and they felt more relaxed.

Discussion

This report contributes to a small but growing body of literature assessing the efficacy of family intervention programs. Although frequently used in clinical practice, studies on their effectiveness have rarely been conducted (Sepers, Werff, de Roos, Mooren, & Maric, 2019). To our knowledge, this study will be the first rigorously reported study investigating the effectiveness of an intervention in CPA, with a good level of protocolization to ensure it can be replicated using quantitative and qualitative methods. Moreover, this program is very complete because it includes three

subprograms (parents, adolescents and families). The objective of the evaluated program, Early Intervention Program in Child-to-Parent Abuse (Ibabe et al., 2019), is to stop CPA, improve child-parent relationships and clinical symptoms of parents and adolescents.

Firstly, the objective of this study was to analyze the short-term treatment effect of the EI-CPA program in Spanish families on the outcome variables of children and parents. The study reports that children have fewer behavioral and emotional problems after treatment. Specifically, the research demonstrates that the EI-CPA program is an effective intervention for reducing physical and psychological CPA between T1 and T2. Moreover, children showed lower levels of frustration tolerance, avoidance problems and higher self-esteem in T2 compared with T1. Positive changes on CPA and depressive symptomatology outcomes had been found in a preliminary study on EI-CPA (Ibabe et al., 2018). With respect to parent behaviors, the use of corporal punishment was lower after intervention, as was their depressive symptomatology and psychological inflexibility, while their empathy improved. In the previous preliminary study (Ibabe et al., 2018), there had been no evidence regarding corporal punishment and psychological inflexibility. The pattern of reduced behavior and emotional problems of children and parents reflects the EI-CPA program's efficacy. Adolescent violence is a complex issue, and a high proportion of affected families have other problems and needs that are associated with adolescent behavior, including parents' and adolescents' own experience of trauma and violence (Wilks & Wise, 2012).

Secondly, it is worth noting that the evolution of family relationships quality is positive during the EP-CPA program development. Changes in the closeness of the child-parent relationship during treatment were observed as the program progressed, and the level of family conflict was significantly lower after intervention. This suggests

a significant improvement in the quality of the parent-adolescent relationship because participants start to understand their own circumstances and the cycle of violence, and implement changes in the way they interact with and respond to their adolescent or father/mother. This means that family communication has improved and that parents and children have acquired control strategies at crisis moments. The reduction in violence is clearly evident in the short-term, as are improvements in parent-children relationships and communication. An important step in program evaluation would be to compare the effectiveness of EI-CPA interventions with other established evidence based, family-focused interventions, such as Multisystemic Therapy or Life-Skills Training.

The third objective was to analyze the general acceptability of the Families Subprogram of EP-CPA program and the satisfaction of participants with it, and their evolution during the program's development. These results indicate that this subprogram was well accepted by participants (scoring 6-7 out of 10). All measures of program acceptability (motivation, satisfaction, learning and relevance to their life) can be considered quite satisfactory, with relevance to their life showing higher scores than the other measures. This subprogram presented more difficulties than other subprograms because family members had to work together when the family climate was not good.

Potential mechanisms were evaluated in qualitative data collected through inter-treatment assessments and three focus groups at the end of the treatment. Participants were taught to detect signals associated with violence. Two components of the program, "time out" and "my weekly goal", seem useful for participants. Adolescents reported that their relationship with their parents had improved, and the family environment was better than before. Parents were more motived to participate than adolescents and gave

more information about useful aspects of the program or about the changes observed in their family.

The results of this study must be viewed in consideration of methodological limitations. The absence of a control group and the small sample size reduce the ability to attribute changes solely to the intervention as there may be alternative explanations contributing to the changes. CPA was measured exclusively based on parent-report. A further limitation is the potential bias in children and parent reports. Participants are aware that only the researchers see the primary measures scores and that the data are stored anonymously. The children are informed that their parents will not have knowledge of their answers. As Martínez-Muñoz, Arnau and Sabaté (2019) indicated, it is possible that families were more critical of their behavioral and emotional problems as well as family relationships after participation in the program. Despite these limitations, the EI-CPA program is a promising intervention model for families in which there is CPA, working with adolescents and parents using a therapeutic and educational approach which is manualized and carefully sequenced (Ibabe et al., 2019). EI-CPA is able to overcome the barriers of engagement of adolescents and effectively assist families to achieve meaningful outcomes. These outcomes include an improvement in parent-adolescent relationship, and a reduction in adolescent-perpetrated violence toward parents and corporal punishment.

In conclusion, the Early Intervention Program in Child-to-Parent Abuse is intensive (minimum six months), and strong positive evidence of its efficacy is shown within a clinical setting. The program could be promising if these results are confirmed in the follow-up evaluation, and it could be applied to cases of incipient CPA or also for more serious cases. This study provides evidence of the first rigorous evaluation of the EP-CPA within a Social Services framework, where few evaluation results of this type

have been published. EP-CPA is potentially an evidence-based program in child and family services because the program has achieved its proposed goals at least in the short term and has included children and parents in the assessment process.

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Table 1

Description of each Family Subprogram session

S1. Presentation of program   The program is presented to all families together, explaining objectives and function rules in two separate groups (children and parents)
S2. Diagnostic of relational system   It instills the idea that, to solve a family problem, the participation of all members is essential. In this session the therapist makes an initial family relational system diagnosis.
S3. Take a time-out   Participants learn to use the time-out strategy in order to defuse difficult situations, and how to break the power struggles. A family time-out plan is drawn up with the agreement of all members.
S4. Problem solution in family   Solving intra-family conflicts, using extra-family support, and taking into account other family members. For this purpose, a problem-solving technique is put into practice jointly and solutions are suggested for talking about an issue when difficulties arise.
S5. Assertive communication and limits in family environment   Family members reflect on different ways of communicating in the family environment and the positive and negative consequences for each other. The basis for assertive communication in the family and home rules are established.
S6. Changes and repair in family environment   Each person reflects on learning and the changes made during the program's development, on damage caused and the way to repair it, as well as those aspects that the participant thinks need changing but where change has still not been initiated.
S7. Positive and negative emotions in families   The adaptive functioning of the family is characterized by the open interchange of information on feelings and emotions. Activities are used to help family members to identify and express different emotions they feel toward other members and to analyze the reasons for those feelings.
S8. What have we changed?   First, participants reflect on changes that the family has made jointly and what remains to be done. After this, the therapist gives feedback on the family's progress, encouraging them to continue with the changes and not to be discouraged in the case of failure or relapse.

Table 2

Means comparison between pre-intervention and post-intervention for CPA based on parent reports, with standard deviations in parenthesis

Variables	**Pre-intervention**	**Post-intervention**	***t***	**Cohen's *d***
Father reports (*n* = 13)				
Physical CPA toward father	1.59 (.73)	1.31(.55)	1.53	.42
Psychological CPA toward father	2.76 (.79)	1.97 (.68)	3.56**	.99
CPA toward father	2.17 (.65)	1.64 (.47)	2.91*	.81
Mother reports (*n* = 25)				
Physical CPA toward mother	1.87 (.67)	1.39 (.46)	3.36**	.71
Psychological CPA toward mother	3.35 (.58)	2.63 (.85)	3.22**	.64
CPA toward mother	2.61 (.54)	2.01 (.59)	3.72**	.74
Parents reports (*n* = 38)				
Physical CPA	1.77 (.70)	1.36 (.49)	3.80**	.62
Psychological CPA	3.15 (.70)	2.40 (.85)	4.55 ***	.70
CPA	2.46 (.60)	1.88 (.57)	4.73 ***	.77

Note: All variables have scores between 1 and 5. ***: $p < .001$; **: $p < .01$; *: $p < .05$.

Table 3

Means comparison between pre-intervention and post-intervention for clinical symptoms and family environment as well as standard deviation

Variables	**Pre-intervention**	**Post-intervention**	***t***	**Cohen's *d***
Children (*n* = 21)				
Irrational beliefs	2.60 (.51)	2.33 (.59)	2.33*	.51
Frustration tolerance	3.38 (.85)	2.84 (.95)	2.92**	.64
Avoidance problems	2.69 (.68)	2.19 (.83)	2.46*	.54
Self-esteem	2.88 (.82)	3.21 (.80)	2.38*	.52
Parents (*n* = 37)				
Corporal punishment	1.70 (.46)	1.20 (.37)	5.22***	.85
Depressive symptomatology	2.23 (.81)	1.70 (.51)	5.04***	.82
Psychological inflexibility	2.77 (1.01)	2.47 (1.02)	2.41*	.39
Empathy	3.34 (.54)	3.60 (.31)	-2.21*	.47
Children and parent reports (*n* = 58)				
Family relationship quality[a]	4.22 (2.58)	7.24 (1.78)	-6.80***	-1.03
Family conflict	4.96 (2.14)	3.92 (2.24)	3.12**	.41
Involvement of CPA out family	3.86 (1.26)	2.71 (1.36)	4.15***	.57

[a]: Family relationship quality was measured in the process evaluation context after the first and eighth sessions; ***: $p < .001$; **: $p < .01$; *: $p < .05$.

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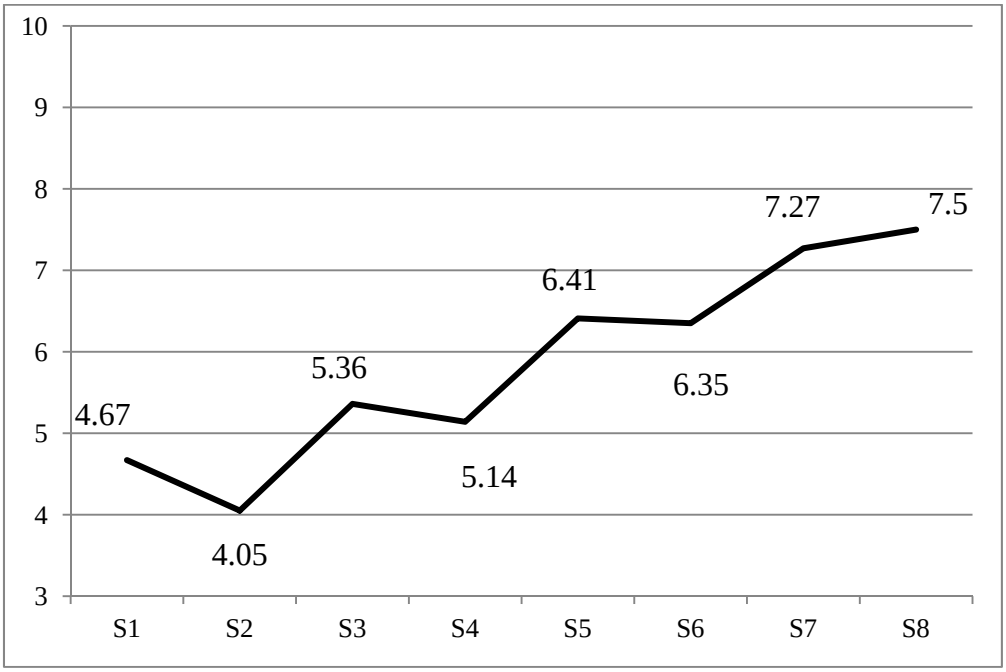

Figure 1. Evolution of family relationship quality from session 1 to session 8 (n = 38)

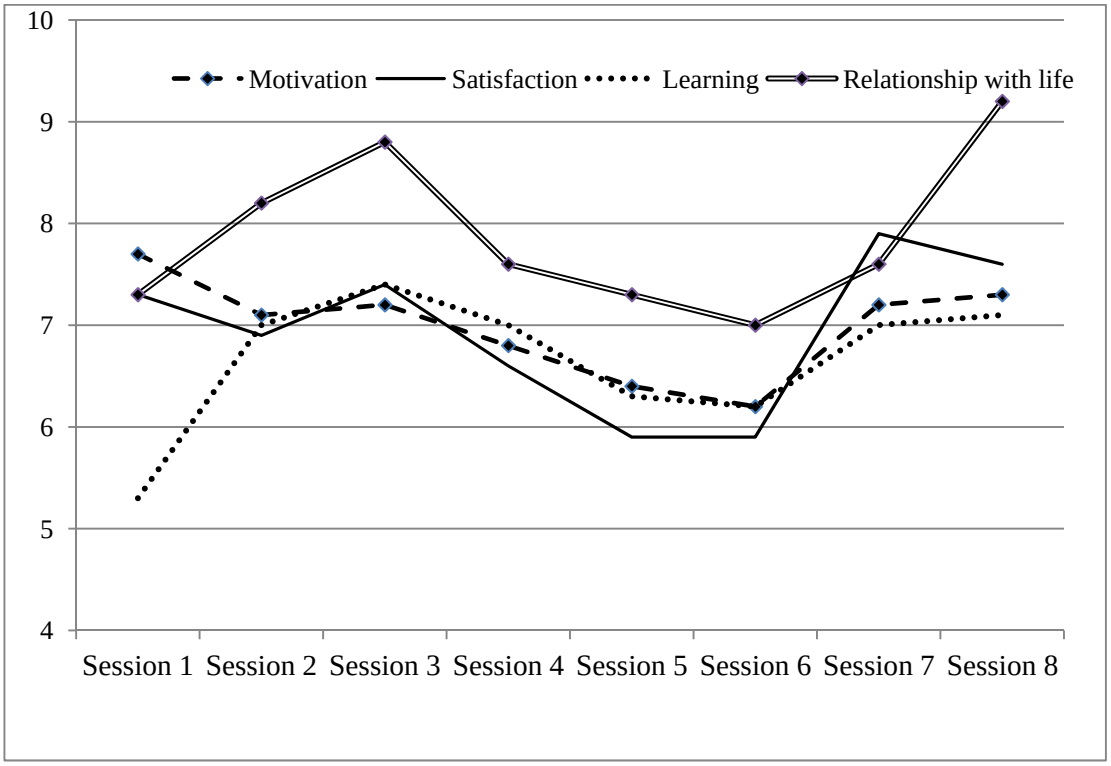

Figure 2. Motivation, satisfaction, learning, and relevance to their life as a function of family sessions