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Implementation and evaluation of a parenting program to prevent child maltreatment in Suriname

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ABSTRACT

The prevention of child maltreatment has become a global health concern because child maltreatment is a violation of children's rights. Across the world a variety of parenting programs have been developed to address this problem. However, no such parenting programs currently exists in Suriname. This pilot study aimed to implement a parenting program ('Lobi Mi Pikin'; LMP) in Suriname and to evaluate its effects on corporal punishment (CP) and child behavioral problems. Parents/caregivers (N = 70) of children (aged 3–12 years) with externalizing behavioral problems participated in a protocolled parenting program. The child's behavioral problems and parenting style of the parent/caregiver were assessed using the Strengths and Difficulties Questionnaire and Parental Behavior Scale, pre-treatment and post-treatment. Five-week follow-up measures revealed significant positive effects of LMP on all outcome measures. Follow-up comparisons demonstrated (a) a large reduction of total child difficulties and conduct problems, (b) a moderate reduction of hyperactivity and emotional problems, (c) a moderate to large increase in the self-reported positive behavior of the parent, and (d) a small decrease in the use of CP. This study provides preliminary evidence that LMP may be an effective model of parent training in Suriname. Moreover, it can help guide efforts to reduce the use of CP and encourage positive parenting, thereby preventing child maltreatment.

INTRODUCTION

The prevention of child maltreatment has become a global health concern because child maltreatment is a violation of children's rights (Finkelhor & Tucker, 2015). Its impact is profound, long lasting (often lifelong), and has enormous social and economic costs (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Fang et al., 2015; Gilbert, 2009; Mueller et al., 2010). Poor parenting is a critical risk factor for child maltreatment (Munro, Taylor, & Bradbury-Jones, 2014). That is, children are more likely to be maltreated if parents perceive them as 'difficult', have insufficient knowledge of child development, have poor parent-child relationships, have high levels of stress and depression or believe that corporal punishment (CP) is useful (Crosson-Tower, 2004; Hansen, Sedlar, & Warner-Rogers, 1999; Murphy et al., 2014; Poole, Seal, & Taylor, 2014; Stith et al., 2009).

According to Belsky, parenting is a multi-determined set of behaviors that are influenced by a broad range of factors, including the parent's developmental history and personality, characteristics of the child, and contextual sources of stress and support (Belsky, 1984). Parenting should thus be considered a complex and dynamic repertoire of behaviors, which are embedded in an ecological network consisting of the family context (e.g., the marital relationship, family financial stress), characteristics of the parent (e.g., personality), characteristics of the child (e.g., temperament) and the social context (e.g., ethnicity/culture, community characteristics; Kotchick & Forehand, 2002; Okagaki & Luster, 2005). These factors, along with educational and socialization goals, may result in particular parenting styles, some of which are well described by Baumrind (e.g., 1971).

The use of CP to correct misbehavior is a widespread practice, yet its effectiveness and even its appropriateness are shrouded in debate (Gershoff & Grogan-Kaylor, 2016). CP is sometimes considered an attractive option for parents to discipline the child, not least because of its prompt (although perhaps not enduring) result of immediate compliance (Gershoff, 2002; Larzelere & Kuhn, 2005). In particular in situations of great psychosocial stress (e.g., households in poverty, or with a drug/alcohol abusing parent) frustration and agitation may result in violence towards the child (see also Roopnarine et al., 1995). Arguably, non-violent forms of conflict-resolution and discipline take more effort without the guarantee of 'immediate success'. However, meta-analyses provide evidence that CP is largely ineffective and harmful. It is associated with a lower quality of the parent-child relationship, lower levels of moral internalization and mental health in childhood and adulthood, as well as higher levels of cognitive impairment (academic impairment, suicidality, and attitudes about spanking), aggression in childhood and adulthood, antisocial behavior in childhood and adulthood, risk of being a victim of

physical abuse, and risk of abusing one's own child or spouse as an adult. Furthermore, harsher methods of CP are more strongly associated with negative child outcomes than ordinary spanking (Ferguson, 2013; Gershoff, 2002; Gershoff et al., 2016; Larzelere & Kuhn, 2005; Paolucci & Violato, 2004).

Societies, communities, and families differ in their views on the acceptability of the use of violence in conflict resolution and in helping children conform to the wishes of parents. Sometimes religious motives ('save the rod and spoil the child') are used in rationalizing these practices. In many communities it was, and often still is, accepted that husbands use physical and psychological violence towards their spouses, as well as towards their children. In Suriname, more than 80% of parents report using corporal punishment (CP; UNICEF, 2006; UNICEF, 2010). Suriname is no exception in the Caribbean region: a cross-national regional study involving 34 countries found that a majority of mothers in Jamaica, Belize, Trinidad and Tobago and Guyana uses CP on children between 2 and 12 years of age (Cappa & Kahn, 2011). In our previous national prevalence study on child abuse and neglect (van der Kooij et al., 2015), we reported that 35% of all adolescents and young adults in Suriname had been subjected to CP in the year prior to the interview (CP, including excessive CP, was measured as physical assault within the family).

Since the ratification of the Convention on the Rights of the Child (CRC) in 1999 (Convention on the Rights of the Child, 2000) many Surinamese parents have been in conflict. The principle of the CRC states that a child should be protected from 'all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child' (article 19(1)). What used to be considered necessary (i.e., corporal punishment) and therefore common practice is now morally abnormal and abusive (for an overview on international reactions to the introduction of the CRC, see Doek, 2009).

Influenced by growing scientific knowledge about the importance of the parent-child relationship and knowledge about the detrimental effects of child maltreatment on the development of the child, a variety of parenting programs have been developed that focus on helping parents develop non-violent ways of parenting. A parenting program is a structured process of education and training intended to enhance the parenting skills of participants (Bunting, 2004). Parenting programs designed to prevent child maltreatment typically aim to do so by trying to improve parents' child rearing skills, encouraging positive child management strategies and increasing parents' knowledge of child development (Mikton & Butchart, 2009). In general, child maltreatment prevention

studies concluded that parent education programs show promise in reducing the risk factors for child maltreatment and for actually preventing child maltreatment (Barlow, 2014; Chen & Chan, 2016). However, research on their effectiveness in low-income countries is limited (Knerr, Gardner, & Cluver, 2013). Most programs stem from a foundation rooted in Western developmental psychology and Western educational values and aspirations. These do not necessarily correspond to rearing goals and values in developing and non-western cultures, or with longstanding local styles of parenting (Baumrind, 1971; Berry, 2016; Roe, 2012).

Therefore, one of the key issues to consider when implementing a parenting program in non-western or developing countries is the modification of the program to fit the local cultural situation (Baumann et al., 2015; Mejia, Calam, & Sanders, 2012). Not adapting a program to the local context, education goals and language is likely to compromise both engagement and outcomes (Lau, 2006). Socialization practices may be different from those in Western and – in terms of the Human Development Index (United Nations Development Programme, 2011) – more developed countries. This certainly poses a challenge to the development of parenting programs in the Caribbean: the vast region consists of many cultural groups and ethnicities that speak many different languages. Suriname's population (570,000 inhabitants) is composed of three relatively large ethnic groups: the Creoles (persons of mixed African and European heritage), the descendants of escaped African slaves known as Maroons, and the descendants of Indian and Javanese contract workers (World Factbook, 2016). In Suriname, the official language (and thus the language of the former oppressor) is Dutch, but the widely and informal spoken language in the country is Sranan Tongo, a mix of Dutch, English and several other languages.

Parenting programs are available in the country, but conducted on a small scale. Thus far no other evidence-based programs have been implemented, adapted, and evaluated. A recent study on CP among Creoles and Maroons conducted in Suriname showed that both adults and adolescents believed that using some form of CP is at times a necessary and a respected form of child discipline. Those who received of CP agreed on the necessity or acceptability of CP when this was 'in the best interest of the child' and did not consider CP as a form of violence or maltreatment in that case. Parents expressed the wish to be able to discipline their children in non-violent ways, but also reported that they lacked the skills to do so (Van der Kooij et al., 2017). In recent years, governmental and non-governmental organizations have implemented many different activities to meet the expressed needs of parents for support in the upbringing of their children.

This study aimed to implement a tailored parenting program (Lobi Mi Pikin [LMP], meaning "I love my child" in the Sranan Tongo language) in Suriname. It evaluates Lobi Mi Pikin's effects on positive parenting and the use of CP and child behavioral problems. To the best of our knowledge, this is the first study to address the scientific evaluation of a parenting program in Suriname.

METHOD

Participants

In total, 72 parents/caregivers of children with (mild) externalizing behavioral problems signed up for the parenting program 'Lobi Mi Pikin' (LMP). All parents lived in and around Paramaribo, the capital of Suriname. Two parents/caregivers discontinued the program due to time constraints. Of 70 parents/caregivers that followed LMP, 59 (27–56 years old, M = 39.81, SD = 7.00) completed at least two measures (one before and one after intervention) about themselves and their children (3 till 14 years old, boys: 67.8%, M = 7.12 years, SD = 2.89). In total, 11 parents were excluded from analyses because they did not complete a measurement after intervention (Time 2 and Time 3). Ten LMP courses have been conducted, with an average of five participants per group (M = 5.4, SD = 2.90). Data collection took place from November 2012 till November 2014. Demographic variables are shown in Table 6.1.

Instruments

Child behavior problems

The Strengths and Difficulties Questionnaire (SDQ) is a screening inventory comprising 25 items, which ask parents about pro-social and difficult behavior in children aged 3 to 16 years (Goodman, 1997; Dutch translation by Van Widenfelt, Goedhart, Treffers, & Goodman, 2003). The questionnaire consists of five subscales (Emotional Problems; Conduct Problems; Hyperactivity; Peer Problems; and Pro-social behavior), each including five items that are rated on a three-point Likert scale (0 = not true; 1 = a little bit true; 2 = very true). A Total Difficulties Score (maximum total score = 40) is derived from the combined scores of the first four scales, with higher scores indicating more difficulties. A score of 14 or above is considered in the 'abnormal' range. The subscales have a mean internal consistency reliability coefficient of 0.71, mean test–retest reliability co-efficient over six months of 0.62, and strong criterion validity for predicting psychological disorders (Goodman, Meltzer, & Bailey, 1998; Goodman, 2001; Muris & Van den Berg, 2003).

Table 6.1 Demographics of the participants

	N = 59	
	n	%
Parent/caregiver		
Mother	47	79.7
Father	5	8.5
Other family member (female)	5	8.5
Other	2	3.4
Ethnicity		
Indo Caribbean	4	6.8
Javanese	8	13.6
Afro Surinamese	20	33.9
Mix	25	42.4
Missing	2	3.4
Education		
Lower vocational and extensive education	8	13.6
Secondary	23	39.0
Senior general secondary and pre-university	8	13.6
Higher vocational and university	20	33.9
Children		
Boys	40	67.8
Girls	19	32.2

Parenting behavior

The Parental Behavior Scale-short version (PBS, Van Leeuwen & Vermulst, 2004; Van Leeuwen & Vermulst, 2010) was used to measure parenting behavior. The PBS comprises five subscales: Positive Parenting (8 items), Discipline (4 items), Corporal Punishment (5 items), Material Rewarding (3 items), and Rules (5 items; maximum total score: 75). All items are formulated as statements about concrete parenting behavior in everyday life towards one specific child; for example, "I give my child a slap when he/she has done something that was not allowed". The frequencies of these behaviors are rated on a five-point Likert scale (1 = (almost) never, 2 = little, 3 = sometimes, 4 = often, and 5 = (almost) always). Internal reliability was acceptable to good for all subscales. Confirmative factor analyses supported structural validity (Lambrechts, Van Leeuwen, Boonen, Maes, & Noens, 2011).

Socio demographics

Questions regarding socio-demographic characteristics of the children and their parents/caregivers were embedded in the abovementioned questionnaires (i.e. date of birth, parents'/caregivers' relation to child, ethnicity and highest level of education of parent/caregiver).

Procedure

The study received ethical approval from the Ministry of Education in Suriname and was conducted from November 2012 to November 2014. Recruitment was facilitated through advertisement in local newspapers, newsletters, a local television network, radio and the Internet. One of the employees of the Medical Parenting Bureau in Paramaribo (MOB; a governmental center offering psychosocial and educational help) and one of the facilitators conducted the consent/sign-up procedure by telephone. All parents with children between 3 to 12 years of age having externalizing behavioral problems were accepted for LMP, providing that these externalizing behavioral problems were not too complex. The complexity was assessed by telephone by one of the facilitators. All parents were included in the study, irrespectively of the pre-treatment SDQ scores of their children. There were no exclusion criteria. Those who agreed completed a consent form and the set of standardized assessment measures. All sessions took place at the MOB or at the University of Suriname's Institute for Graduate Studies and Research (IGSR), both in Paramaribo. All participants were compensated for their participation (LMP, measurements, follow-up).

Study design

Assessments were conducted prior to the start of the parenting program (Time 1), immediately after program delivery (Time 2), and at five-weeks' follow-up (Time 3). Only one parent per family participated in the study. Participants who completed Time 1 (pre-intervention), the intervention (LMP) and Time 2 (post-intervention) and/or Time 3 (post-intervention) were included in the study (see Figure 6.1).

Training

Lobi Mi Pikin (LMP; De Gijsel & Spanjaard, 2012) is a groupbased training intervention for parents of children from 3 to 12 years of age with (mild) externalizing behavioral problems. It is the revised and culturally adapted version of 'Parenting Course of Medical Parenting Bureau', a course given in the past at the Medical Parenting Bureau that was

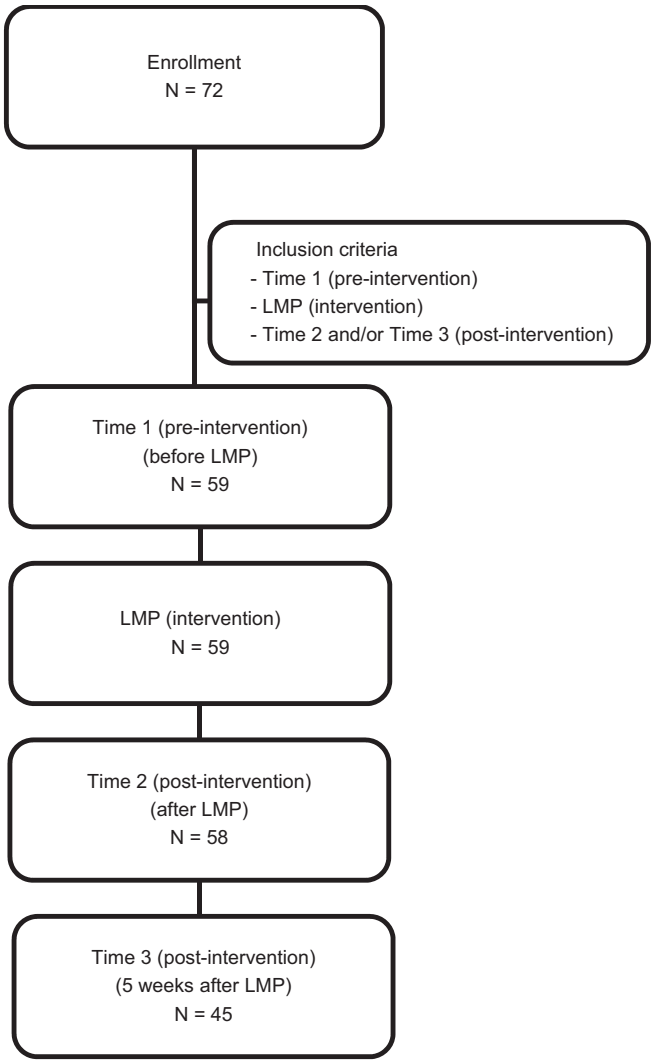

Figure 6.1 Study design.

developed out of the two Dutch parenting courses '3x Growth' (Dangel & Polster, 1984; Theunissen & Haspels, 2007) and 'Parenting & So' (Janssen, Blokland, & Ligtermoet, 2006). LMP uses a combination of principles from these two parenting programs, i.e. the competence model and the social learning theory. Core features of the competence model include a focus on parenting qualities and the parent–child relationship and a functional approach emphasizing behaviors and skills in everyday performance. The

social learning theory assumes that learning is a cognitive process that takes place in a social context and that it can occur through observation or direct instruction. In addition, learning also takes place through the experience of reward and punishment. Combining positive attention with good 'example' behavior of the parent/caregiver is considered essential for good parenting. Parents/caregivers are also taught to set limits on their child's undesirable behavior without using corporal punishment.

Parents practice each intervention extensively with each other during the course before they carry out the intervention at home. The group sessions provide abundant opportunities for practice (e.g., modeling, role plays, followed up with direct feedback and experiential exercises). Self-initiated change involves a complex but difficult to define interplay of cognitive, behavioral and affective processes; these changes include the capacity to plan and anticipate, regulate one's own emotions, solve problems and collaborate when necessary with others (e.g., partners, teachers, and grandparents) involved in the care or education of children. It also involves a set of planned actions; the execution of the plan; a review of whether the plan worked; and if necessary, further tailoring of the plan until the goal is attained (Moffitt et al., 2011; Sanders & Mazzucchelli, 2013).

LMP therefore involves teaching techniques of positive and negative reinforcement to parents, helping them to focus on their child's positive behavior (by praising and rewarding the desired behavior), and helping them to introduce limit-setting and 'timeout' consequences for the child's negative behavior. Parents are also taught how to model appropriate behavior. Group facilitators and leaders have the opportunity to model key parenting skills in each session, whilst parents imitate and practice the new skills through role play and homework assignments. The cognitive component of LMP focuses on problematic thinking patterns in parents that have been associated with conduct problems in their children. For instance, typical cognitive distortions include globalized 'all or nothing' thinking in which one minor setback may trigger a negative automatic thought (e.g., 'I am a bad parent') thereby leading to feelings of stress, hopelessness, low self-esteem, a perceived inability to cope with the situation and learned helplessness (Seligman, 1990). Thus, LMP aims at helping parents to learn how to reframe distorted cognitions or misattributions and to coach them in the use of problem-solving and anger management techniques. An outline of the topics LMP covered over the five weeks is shown in Table 6.2.

Table 6.2 Outline of 'Lobi Mi Pikin'

Session	Content
Session 1	Introduction to course Developmental stages of children Important parenting skills
Session 2	Attention Praise Reward
Session 3	Prohibit Instruct
Session 4	Time out
Session 5	Appropriate punishments Evaluation
Session 6 (Follow-up)	Sharing experiences

Program facilitators

All facilitators had a professional background in health or education and were experienced in delivering parenting programs (e.g., Parenting Course of Medical Parenting Bureau) in The Netherlands and Suriname. Each program was delivered by two facilitators. Prior to program implementation all facilitators followed an intensive training course for LMP that was delivered by one of the program authors. The training also included a topic regarding potential biases during evaluation, as the facilitators were also the assessors. Facilitators completed adherence checklists at the end of each group session and also attended small group supervision sessions with other facilitators after each session.

Cultural adaptation

All facilitators were already experienced in delivering the original 'Parenting Course of Medical Parenting Bureau', a program that was used to gather pilot/feasibility data for LMP. Observations of the facilitators and evaluations of the parents were both used in the adaptation process. First, some language issues were addressed. LMP uses a mixture of the original language of the Dutch program and Sranan Tongo. Some important changes were made. Surinamese parents who participated in the original course thought that the word 'ignore' meant ignoring the child completely. For this reason, the name of the sub-intervention 'ignore' was changed to 'unresponsiveness to undesirable conduct'.

Furthermore, some Dutch words were translated into Sranan Tongo. Names of persons in example scenarios were changed to recognizable Surinamese names, and information in the manual was made detailed and sufficiently colloquial to be understood by largely illiterate parents/caregivers. Second, all exemplary situations were adapted to the Surinamese culture. Furthermore, one of the main strategies was modified after LMP had already been started. After two full LMP programs (consisting of four sessions) it became clear that in the fourth – and last – meeting too much information was conveyed at one time. The 'time out' intervention in this specific session raised many questions, because most were not familiar with this strategy. Instructions regarding this intervention were extended and refined according to the guidelines of Parent Child Interaction Therapy (PCIT; Eyberg, Nelson, & Boggs, 2008). Based on observations of the facilitators it was decided by the facilitators and research team to add a fifth meeting for parents to receive feedback on practicing the 'time out' intervention and to leave room for other questions. We had to keep in mind that time management is not as strict as in more developed countries, many participants do have more than one job, and that transportation facilities are limited and irregular. This means that participation in the study may have taken a lot of effort. All participants received a fee (25USD) after completing the tasks in the study. In addition, handout materials were provided.

Consent procedure

Participants were informed about the study's aims and procedures by letter and in vivo. Consent forms for the participants were completed prior to the first session. To ensure that participants understood the information in the consent form, these topics were communicated verbally, i.e. (1) participation ("You have the right to withdraw at any time"); (2) the purpose of the study ("We would like to see if LMP can help making parenting more easy and fun"; "We would like to see if LMP effects the behavior of the children"; "We would like to write and publish an article about this"); (3) procedures; (4) risks/discomfort for participant; (5) time schedule; (6) personal contact in case of questions/remarks; and (7) confidentiality ("We will not associate your name with anything you say in the sessions"; "We will ask participants to respect each other's confidentiality, here and outside the sessions").

Analysis

Data were analyzed with SPSS Statistics 19 (Chicago, IL, USA). Prior to analyses all variables were examined for accuracy of data entry, missing values and presence of outliers. Descriptive statistics (percentages, means, frequencies and standard deviations)

were computed for demographic variables. Inspection of the distribution of scores on the continuous dependent variables showed that the scores were reasonably normally distributed. One-way repeated measures analyses of variance (ANOVA) were used to examine change over time (Time 1 pre-intervention to Time 2 post-intervention and Time 3 at five weeks' follow-up) on (parent and child) standardized measures (PBS and SDQ). A p value of less than .05 was considered significant. Partial eta-squared (tekentje toevoegen), a measure of effect size for use in ANOVAs, was used. Effect sizes of .02, .13 and .26 were considered small, medium, and large, respectively (Pierce, Block, & Aguinis, 2004).

RESULTS

Within group outcomes

Means, standard deviations, and main effects for time are displayed in Table 6.3. For a graph of change scores over time on both measures, see Figure 6.2 and Figure 6.3.

SDQ

Post-intervention scores on the SDQ indicated that, compared to the start of the program, parents reported that their child displayed significantly less hyperactivity, $F(1.91, 80.17) = 7.47$, $p = 0.001$, and fewer conduct problems, $F(1.87, 78.69) = 22.19$, $p = 0.000$, and emotional problems, $F(1.91, 80.17) = 7.47$, $p = 0.001$, after the program. Furthermore, the Total Difficulties scale score reduced significantly, $F(1.90, 79.93) = 30.39$, $p = 0.000$.

Children were classified as clinically improved if they moved from the clinical ranges to the non-clinical range on the SDQ Total Difficulties scale. Of the 31 (52.5%) children who scored in the clinical range at Time 1, this number decreased to 20 children (34.5%) at Time 2 and further decreased to 13 children (28.9%) remaining in the clinical range at Time 3.

PBS

Post-intervention scores on the PBS indicate that, compared to the start of the program, parents tended to show more positive parenting toward their children, $F(1.78, 76.52) = 14.15$, $p = 0.000$. Furthermore, their use of (noncorporal) discipline was higher, $F(1.89, 81.46) = 5.10$, $p = 0.009$, and their use of violent parenting practices (corporal punishment) was significantly reduced, $F(1.71, 73.40) = 5.25$, $p = 0.010$, after the program.

Table 6.3 Repeated measures ANOVA time effect LMP

	Time 1 N = 59		Time 2 N = 58		Time 3 N = 45				
Scale	M	SD	M	SD	M	SD	ANOVA		Partial η^2
SDQ									
TD	15.00	6.18	11.97	6.14	10.71	5.61	F (1.90, 79.77) = 31.73	p = 0.000	0.43
EMOT	2.50	2.27	1.91	1.84	1.51	1.60	F (1.91, 80.17) = 7.73	p = 0.001	0.16
HYPER	5.24	2.90	4.67	2.61	4.20	2.49	F (1.93, 81.18) = 10.72	p = 0.000	0.20
CON	4.07	2.28	2.66	2.09	2.49	2.14	F (1.87, 78.69) = 22.19	p = 0.000	0.35
PEER	3.33	1.96	2.90	2.05	2.51	1.80	F (1.94, 81.36) = 4.43	p = 0.016	0.10
PRO	7.38	2.04	7.86	1.70	7.91	2.00	F (1.76, 74.00) = 2.04	p = 0.143	0.05
PBS									
PP	38.39	11.20	43.17	10.27	44.20	10.99	F (1.78, 76.52) = 14.15	p = 0.000	0.25
D	56.19	8.95	59.76	8.67	59.91	8.90	F (1.89, 81.46) = 5.10	p = 0.009	0.11
CP	65.85	10.00	63.50	9.61	62.36	9.83	F (1.71, 73.40) = 5.25	p = 0.010	0.11
MR	52.71	11.19	56.64	10.01	58.93	8.74	F (1.83, 78.76) = 4.88	p = 0.012	0.10
R	51.78	10.75	53.95	11.18	55.31	10.66	F (1.88, 80.88) = 4.33	p = 0.018	0.09

Note. Data in Times 1–3 are means, with standard deviations in parentheses. *ANOVA* analysis of variance; *SDQ* Strengths and Difficulties Questionnaire, *TD* Total Difficulties, *EMOT* Emotional Symptoms, *HYPER* Hyperactivity, *CON* Conduct Problems, *PEER* Peer Problems and *PRO* Prosocial Behavior; *PBS* Parent Behavior Scale-short version, *PP* Positive Parenting, *D* Discipline, *CP* Corporal Punishment, *MR* Material Rewarding and *R* Rules. Time 2 = 1 missing.

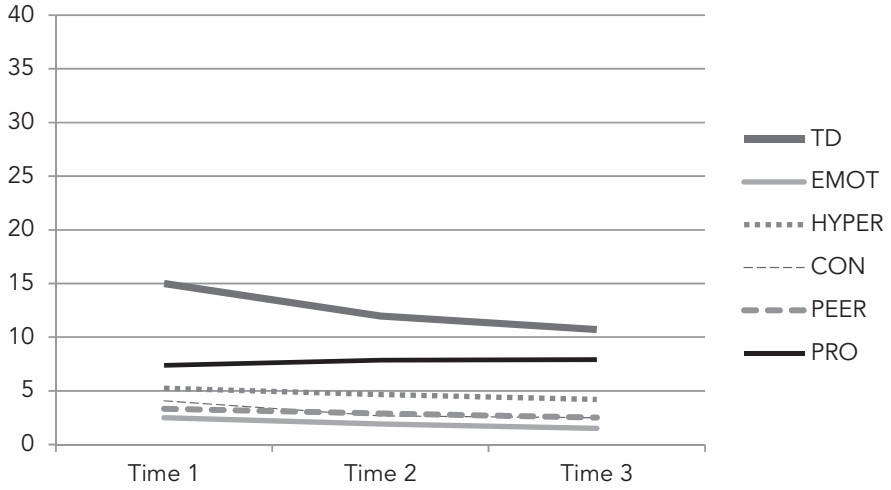

Figure 6.2 Strengths and Difficulties Questionnaire: pre- and post-intervention scores.
TD, Total Difficulties; EMOT, Emotional Problems; HYPER, Hyperactivity; CON, Conduct Problems; PEER, Peer Problems; PRO, Pro-Social Behavior.

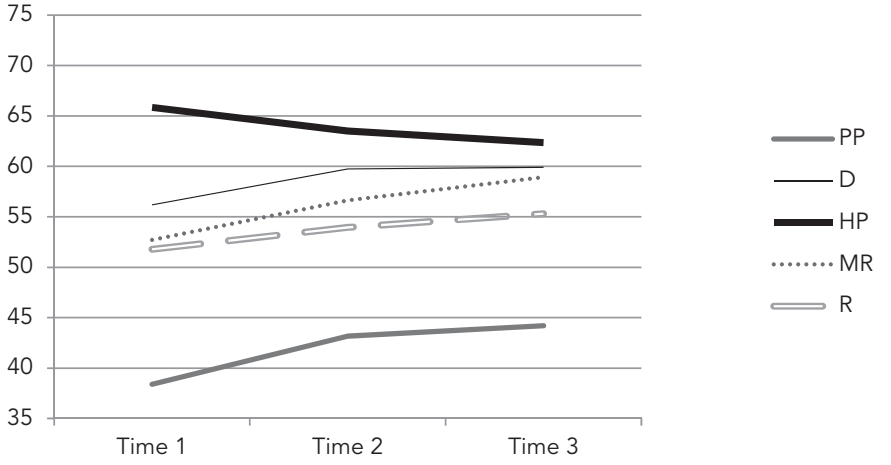

Figure 6.3 Parenting Behavior Scale - short version: pre- and post-intervention scores.
PP, Positive Parenting; D, Discipline; CP, Corporal Punishment; MR, Material Rewarding; R, Rules.

Parents/caregivers were classified as clinically improved if they moved from the clinical ranges to the non-clinical range on the PBS scale Corporal Punishment. Of the 30 parents/caregivers (50.8%) who scored in the clinical range at Time 1, this number decreased to 23 parents/caregivers (39.7%) at Time 2 and further decreased to 18 parents/caregivers (40.0%) remaining in the clinical range at Time 3.

DISCUSSION

The aim of this study was to implement and evaluate the parenting program 'Lobi Mi Pikin' (LMP), a program aimed at supporting parents in the use of non-violent forms of parenting, thereby reducing the risk of child maltreatment, in Suriname. The findings of the study provide encouraging results for parents who attended the program and their children. After completing the program, parents showed more positive behavior towards their child(ren). They displayed a greater ability to discipline their children by using rules instead of corporal punishment (CP). Parents also reported fewer conduct and emotional problems and hyperactivity in their children. The results of our study are broadly consistent with comparable international parenting programs. Systematic reviews, meta-analyses, and benchmarking studies provide evidence that parenting programs derived from social learning theory produce changes in parent behavior, child behavior, and parent adjustment (Lee, Horvath, & Hunsley, 2013; Michelson, Davenport, Dretzke, Barlow, & Day, 2013; Proctor & Brestan-Knight, 2016; Sanders, Kirby, Tellegen, & Day, 2014a; Sanders, Kirby, Tellegen, & Day, 2014b). Still, some parents found it difficult to let go old habits and ideas regarding the use of CP. This in line with earlier research, which revealed that adults who were physically punished as children are more likely to accept and enforce CP on their own children, indicating the cyclical nature of CP in families (Bell & Romano, 2012).

There are several hypotheses about why the positive changes in the parents and their children occurred. First, when considering intervention and behavior change that occur in the family context, it is necessary to keep in mind the 'non-independence' of the data. Parents and children are mutually influential in their emotions and behaviors. This is implied in a parent-directed treatment such as LMP, where the parent is necessarily the mediator of change in the behavior of the child. Intervening to change the way of parenting changes the patterns of responsivity and sensitivity in the parent-child relationship, leading to improvements in child behavior (Forgatch & DeGarmo, 1999; Gardner, Hutchings, Bywater, & Whitaker, 2010; Masten & Schaffer, 2006; Shaffer, Lindhiem, Kolko, & Trentacosta, 2013). The increased self-regulation of the parents could also have caused a change in child behavior (Bridgett, Burt, Edwards, & Deater-Deckard, 2015). Family environments both contribute to and are affected by children's problems (Grusec, 2011). Children flourish when their parents and other caregivers provide a safe, stimulating environment that encourages exploration and mastery (Lee, 2010). Second, increased parental social support and confidence may have resulted from sharing problems within a group context (Barlow & Stewart-Brown, 2001; Patterson, Mockford, & Stewart-Brown, 2005). Third, and most likely, the positive changes that

occurred may have resulted from a combination of all abovementioned factors. It is likely that increased knowledge of child development, improved parenting skills, a change in attitude towards behavioral problems, but also the expertise and professionalism of the program facilitators may all have led to more positive parenting and decreased behavioral problems of the child (Wyatt Kaminski, Valle, Filene, & Boyle, 2008).

Limitations

Although first results show that LMP resulted in positive effects in terms of changed behaviors on both parenting and child behavior, some limitations regarding the study should be mentioned. First, although a randomized controlled trial (RCT) is the most rigorous scientific method and 'gold standard' for evaluating the effectiveness of health care interventions, our study used a non-experimental design (pre- and posttest comparison of the intervention group). This choice was made because of logistic restrictions (Hanley, Chambers, & Haslam, 2016). A second limitation of this study is the reliance on parents' self-reports as the only source of data. There is the possibility of overestimation of the desired behavior of their children at Time 2 and 3, because they wished to see it. It is possible that parents judged their own behavior as being more positive and less violent (for example based on a social desirability tendency or the wish to do 'better'). Earlier research showed that parents might be biased toward reporting benefits of the program (Shaw, 2006). Future research could evaluate the validity and reliability of the self-report measure by comparing the parents' responses to ratings provided by independent observers, and to self-reports on other well-established measures (Al-Hassan & Lansford, 2011). Third, while highly unlikely, it may be that this study – conducted by not fully independent researchers – may have led to more positive results. There might be a chance of 'allegiance bias', that is, the possibility that improvement is effected by a placebo effect, based on a therapeutic optimism of the program facilitators (Cuypers & Cristea, 2016). There could also be a 'high fidelity view', that is, facilitators trained by intervention developers know the characteristics and theoretical background of the intervention very well - they know better than anyone how to implement them as precisely as possible. However, interventions are carried out less precisely in daily practice, resulting in less favorable results. This could have affected generalization (Beelmann & Lösel, 2006; Gorman & Conde, 2007). To minimize these tendencies, all facilitators were informed and trained from the start regarding this topic.

Strengths

Some clear strengths of the study should also be acknowledged. The current feasibility study was the first to address an evaluation of a protocolled parenting program in Suriname. We evaluated what ingredients worked for the parents (study design, amount of sessions, formation of groups, etc.) and what caused parents to be willing to participate in the program. The parenting program was initiated and implemented by senior local practitioners and researchers with understanding of cultural traditions and background of the participants. At the last session and at five-weeks' follow-up, all participants evaluated LMP positively and could identify ways that LMP had changed them and their practices. Although parents initially tended to blame their children for their parenting problems and although they were not used to sharing such problems 'in public', they soon candidly shared their 'shortcomings' and questions in parenting a particular child. Research showed that when parenting programs are restricted to a small minority of vulnerable parents with established serious problems (a common approach used in targeting parenting interventions), such programs can be viewed as something for struggling or 'failed' parents with difficult children (Sanders, 2012). To normalize parental engagement, and to increase openness toward participating in the program, we normalized the process of seeking help for children with behavioral and emotional problems by focusing on the positive outcomes and other evidence-based interventions throughout the world. A recent meta-analysis (Gardner, Montgomery, & Knerr, 2015) suggested that parenting programs appear to be at least as effective when they are applied in cultures other than the country where they were first developed. The basic psychological principles (e.g., parent-child relationship building through play and positive attention, child behavior change through social learning) of a parenting course such as LMP are universal across cultures (O'Connor, Matias, Futh, Tantam, & Scott, 2013). Furthermore, the principles of LMP do not only 'fit' the principles of the CRC (respectful treatment of children, parenting goals, supporting parents in raising questions and learning to renounce violence), they also 'fit' local customs and wishes in Suriname, such as requirements for non-violent strategies and understanding and respect for longstanding habits (Van der Kooij et al., 2017). Our program adherenced to the imported manual and training methods with some adaptations for Suriname. Many adults in Suriname have great difficulty discussing parenting problems, especially in the presence of other parents (and families) because such might be a sign of failure as a parent. The facilitators were all well aware that their attitude regarding this matter might be an important determinant of the atmosphere in the group. Abovementioned qualities probably contributed to the continued success of LMP.

Implications and recommendations for policy and future research

Although this study showed that LMP has a positive impact on a range of outcomes, the availability is limited and many parents do not receive the support they need. Given the high emotional, relational, social and economic costs associated with ineffective parenting, the implementation of policies supporting LMP, aimed at the development of positive parenting, should be prioritized. Furthermore, programs for Surinamese parents of adolescents (12 years and older) – for whom different types of Social Media play a substantial role – should be developed and evaluated as well. Further research should also aim to explore the factors that affect parenting program attendance, as well as responsiveness to the intervention. Conducting a follow-up is important for establishing the validity of the program. Prolonging the period before the follow-up assessment to six months would help to further test the sustainability of treatment effects observed following LMP. Furthermore, a 'refresher' after a few months would be useful for parents. Although fathers and surrogate fathers have been identified as important figures in combating poverty – addressing the lost developmental potential of young children, improving the nutritional status and safety of children, and reducing experiences with violence during the early childhood years (Cabrera & Tamis-LeMonda, 2013; Lamb, 2010; Shwalb, Shwalb, & Lamb, 2013) – the limited number of studies within the Caribbean region has largely focused on mothers and children's behavioral difficulties. Further research should focus on how fathers contribute to developmental outcomes in difficult circumstances and harsh, conflict-ridden family environments (Roopnarine, 2013; Roopnarine & Hossain, 2013; Samms-Vaughan, 2005). It could also be valuable to consider gathering data from children/adolescents whose parents have attended parent training in evaluating such programs. Evaluations of second (objective) informants should be included. The possibility of using an RCT can be considered when it would be logistically possible in Suriname. To make the social-emotional outcomes more visible, future research would be strengthened through the inclusion of qualitative data (Tinajero, Cohen, & Ametorwo, 2016).

At this moment, the government in Suriname is involved in developing strategies addressing child maltreatment, within the framework of a multidisciplinary child mental health approach, targeting all violence against children (UNICEF 2006; 2010). Every approach to change degrading and humiliating practices like CP needs requires efforts from several fronts, for example international and national policy; legislation; public health; psycho-education; evidence based parenting programs; and awareness of the costs in terms of loss of health, schooling and productivity. The Convention on the Rights of the Child produces sound General Comments, offering a range of valuable suggestions and strategies helping to address CP.

Conclusion

This study provides preliminary evidence that the parenting program LMP in Suriname may be an effective form of parent training. Parenting is a challenging and complex life task and LMP may be seen as a useful resource for supporting parents in their vital parental tasks. Investment in reducing violence towards children in Suriname – in particular very small children, who are most vulnerable and most at risk for child maltreatment – needs much more attention. Cultural traditions do not change overnight, however; years of inspired effort of many kinds are necessary to make the world safer for children.

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