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Universal parent support groups for parents of adolescents: Which parents participate and why?

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Leader-led parent support groups, offered universally to parents of adolescents, are increasingly common, yet little is known of the parents who use this support. The study presented here explored the characteristics of parents of 10- to 17-year-olds (N = 192) who had enlisted in universal support groups and their reasons for enrollment. Sociodemographic factors (parents' country of origin, educational level, long-term sick-leave or unemployment, and marital status) were compared to the general population (Statistics Sweden, 2012) and parents' psychological health and children's psychiatric symptoms were compared to a control group (the BITA study). Results showed that support group parents reported more psychosocial difficulties, such as higher frequency of long-term sick-leave or unemployment, more symptoms of anxiety and depression and more psychiatric symptoms in their children than parents in general. While about a fifth of the parents had problem-oriented (targeted) reasons for enrollment, most parents had general (universal) reasons. Thus, the universal approach does seem to reach its intended recipients.

Key words: Universal prevention, adolescence, parental support, parenting programs.

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INTRODUCTION

Adolescence is a period of rapid emotional and social development, and the transition from childhood can be challenging for both adolescents and their parents (Steinberg & Silk, 2012; Steinberg & Steinberg, 1994). Not surprisingly, therefore, most parents find it important with parental support during these years (Alfredsson, Broberg & Axberg, 2015; Thorslund, Johansson-Hanse & Axberg, 2014). Many mental health problems emerge in adolescence (WHO, 2015) and the quality of the relationship between young people and their parents is the single most consistent predictor of adolescent mental health and well-being (Resnick, Bearman, Blum *et al*., 1997). Despite this, large-scale interventions that support parents of adolescents are scarce (Henrichson & Roker, 2008; SOU 2008; Chu, Farruggia, Sanders & Ralph, 2012).

The trend is changing, however; in Sweden, more and more municipalities provide universal support to parents of older children and teenagers, often in the form of structured, leader-led parent groups, focusing on the interaction between parent and adolescent (Folkhälsomyndigheten, 2014). As yet, little is known about the parents who participate in these groups. While many parents of adolescents have a positive attitude towards structured parental support groups (Olsson, Hagekull & Bremberg, 2004), only 4% to 10% make use of them (Bremberg, 2006; Alfredsson *et al*., 2015). What characterizes these parents? Are they representative of parents in general, and why do they participate?

BACKGROUND

In 2009, the Swedish government formulated a national strategy to support parents, requiring municipalities to offer equal support to all parents of children aged 0 to 17, with the main purposes of strengthening the parents in their parental role, promoting a healthy relationship between parent and child, and preventing mental health problems and distress in children (Socialdepartementet, 2009; SOU 2008). Structured, leader-led parent support group programs were presented as a promising model of support. Most of these programs were originally developed in North America for parents of younger children and for clinical groups. Over time, however, the interventions have been adapted and recommended for mental health promotion and prevention more generally, including for parents of adolescents (Bremberg, 2004).

As a result of the Swedish national strategy on parental support, research teams were commissioned by the Swedish National Institute of Public Health to evaluate existing support group programs when offered universally to parents of children aged 10 to 17 years.

Prevention on different levels

A continuing question is whether public health measures such as preventive parental support programs to prevent the development of mental health problems should be offered universally (directed at the whole population) or targeted to groups with known risk factors (Offord, Chmura Kraemer, Kazdin *et al*., 1999; Smith, Perou & Lesesne, 2012). Supporters of the targeted approach argue that it is wiser and more economically justifiable to direct interventions to those already at risk because the effects on these groups are larger. They also question whether the universal approach really reaches those in need of support or if they only benefit those not in real need of an intervention (Biglan & Metzler, 1998; Howe & Longman, 1992; Jones, 1996; Offord

et al, 1999). Others argue that it is difficult to predict which individuals in at-risk groups will actually develop future problems (Offord *et al*., 1999; Stattin & Trost, 2000), and that the stigmatizing effects of targeted interventions can be avoided by the use of a universal approach, with inclusion not based on problems or deficits (Ulfsdotter, Enebrink & Lindberg, 2014).

Previous research on parents' characteristics and reasons for enrollment

Factors that have been shown to influence participation in parent support programs fall into three categories: socio-demographic, psychological and behavioral, and practical and program-related (Pettersson, Lindén-Boström & Eriksson, 2009), where the latter have already been identified as barriers to participation (Pettersson *et al*., 2009), and will not be discussed in this article.

Many studies (e.g., Bauman, Ennett, Foshee, Pemberton & Hicks, 2001; Haggerty, Flemming, Lonczak, Oxford, Harachi & Catalano, 2002; Spoth, Redmond, Kahn & Shin, 1997; Spoth, Redmond & Shin, 2000) have found better educated parents to participate more often than parents with a lower education, but some have failed to find this relationship (Heinrichs, Bertram, Kuschel & Hahlweg, 2005). Fathers seem to have a lower interest in parental programs than mothers (Roker & Coleman, 1998). Some studies (Bauman et al, 2001; Komro, Perry, Veblen-Mortenson *et al*., 2006), but not others (Heinrichs *et al*., 2005), have found that families with girls seem more likely to participate than families with boys. Parents living together are more likely to participate according to some (Bauman *et al*., 2001; Henrichs *et al*., 2005), while others found single mothers more likely to attend (Dumas, Nissley-Tsiopinis & Moreland, 2007). Parents who perceive their children having behavioral problems have been shown to be more likely to enroll (Haggerty *et al*., 2002, Heinrichs *et al*., 2005), as are mothers who experience higher degrees of personal and family-related stress (Dumas *et al*., 2007).

The research findings reported above emanate either from studies of programs offered universally to parents with younger children (3–7 years) or of programs targeted to parents of adolescents at risk of externalizing (e.g., criminal) behavior or drug/alcohol abuse. The studies were mostly experimental rather than naturalistic. Recruitment to parent programs was part of the research, and comparisons were made between participating parents and those who were offered, but declined, participation; it is unclear whether parents who declined participation were representative of "parents in general."

Results from Swedish studies are consistent with international findings in that mothers seem to have a greater interest and more frequent participation in support programs than fathers do (Bremberg & Eriksson, 2008; Olsson *et al*., 2004; Thorslund *et al*., 2014; Wells, Sarkadi & Salari, 2015). Interest and participation has been greater among more educated parents (Fängström & Sarkadi, 2012; Olsson *et al*., 2004; Pettersson *et al*., 2009), and not influenced by whether parents were born within or outside the Nordic countries (Olsson *et al*., 2004). However, one study (Wells *et al*., 2015) found that non-native parents were less likely to participate than parents born in Sweden.

Those who enroll in parent groups have reported their children to have more behavioral and emotional problems (Fängström & Sarkadi, 2012; Wells, Sarkadi & Salari, 2015) and themselves to feel less satisfaction with their parental role (Fängström & Sarkadi, 2012) than those who do not enroll. Mothers who enroll have been shown to feel less secure and more lenient, and to perceive higher degrees of parental stress than other mothers, while fathers who enroll have been shown to experience more personal symptoms of depression and anxiety than those who do not (Fängström & Sarkadi, 2012).

Reasons for support group participation offered by parents in one study (Rahmqvist, Wells & Sarkadi, 2013) included a general interest in parenting issues and a desire to learn techniques and strategies for working through problems.

To summarize, international results on the effect of parents' educational level on group participation are inconsistent, while findings in Swedish samples indicate that parents with higher education are more inclined to enroll. Mothers are more frequent participants than fathers, but results regarding marital status and gender of the child vary. Parents reporting personal emotional problems and emotional and behavioral problems in their children seem more likely to enroll. Finally, enrolling mothers and fathers seem, at least in Sweden, to have partly different characteristics.

As in the international studies, Swedish studies of parents enrolling in support groups are experimental, and comparisons have been made with parents who declined participation. The studies have included only parents of younger children (up to 10 years old) or parents participating in programs targeting specific adolescent problem behaviors (e.g., underage drinking). To date, the characteristics and enrollment reasons of parents who participate in universal programs for preventing mental health problems in adolescents have not been studied, nor have support group parents been compared with parents in the general population.

AIMS

The first aim of the present study was to explore whether and how parents of 10- to 17-year-olds enrolling in universally offered parent support group programs differed from parents in general in terms of socio-demographic factors (country of origin, educational level, long-term sick-leave or unemployment, and marital status), psychological health, and children's psychiatric symptoms. The second aim was to analyze what reasons parents gave for choosing to participate.

METHOD

The present study is part of a research project supported by the Swedish National Institute of Public Health and run by a research team at the Department of Psychology, University of Gothenburg. It was approved by the Regional Ethics Committee of Gothenburg (Reg. nr: 976-12).

In total, 28 parent groups in eight municipalities were held during the research period (September 2011 to February 2014). The groups were gathered from three different parenting programs: COPE (N = 65; Cunningham, Bremner & Secord, 2010), Active Parenting (N = 46; Stagling Birgersson & Hansson, 2012) and Connect (N = 62; Moretti, Braber & Osbuth, 2009), which were all offered universally through advertisements in schools, local newspapers, websites, etc. The design of

the study was naturalistic; the research team followed already existing parental support activities in the participating municipalities. We did not engage in the recruitment of participants to the parent groups.

Procedure

During the first group meeting, parents who enrolled in a parenting program were informed about the study by a member of the research team. Those who consented to participate were given a questionnaire booklet to fill in at home. The booklets were then collected at the second group meeting. As a reward, parents could choose a scratch card worth 3 euros or a gift card for groceries for the same amount.

Parents' socio-demographic information was compared with population data for 2012 from Statistics Sweden. Further, unpublished Swedish norms from the BITA study (Barn I TAndvården/Children in dental care; Lundgren, Robertson, Nilsson, Broberg & Arnrup, 2015) were used for comparisons of parents' symptoms of anxiety and depression and children's psychiatric symptoms. The BITA study is based on a general sample of children participating in universally offered regular oral health check-ups. Data derived from the project contain dimensions of biological and physical, as well as psychological and social, factors. The mean age of the children in the BITA study was 13.44 (sd. 2.04) and did not differ from the support group sample.

Participants

One hundred and ninety-two parents (151 mothers and 41 fathers) from 173 families, of which 38 were parents to the same child, chose to participate in the study. This was approximately 90% of all parents in the universal groups invited to the study. In order to simplify data analyses and avoid potential dependency in the data, we excluded every other parent at random (as many mothers as fathers) in families were both parents participated, thus leaving only one parent left from every family. This resulted in 141 mothers and 32 fathers.

Measures

Socio-demographic questions about the parent. These included gender, country of origin, educational level, long-term sick leave or unemployment (≥ 6 months), and marital status (married/co-habitating or other).

Socio-demographic questions about the child. These included age, gender, and earlier contact with school health care or child psychiatry.

Parental anxiety and depression. The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) was used. The measure consists of two subscales, one measuring depressive symptoms, with seven items such as "I feel as if I am slowed down," and the other measuring anxiety symptoms, with seven items such as "Worrying thoughts go through my mind." A total score was calculated by adding together all the items. Answers ranged from 0 (never) to 3 (almost always). Cronbach's alpha was 0.90.

Parents' negative attitudes. Factor analysis of items from the Parental Sense of Competence Scale (Gibaud-Wallston & Wandersman, 1978) and the Parental Locus of Control Scale (Campis, Lyman & Prentice-Dunn, 1986) resulted in three sub-scales measuring parental attitudes. In the present study, the subscale *negative and uncomfortable in the parental role was* used, with eight items: "My child often behaves in a manner very different from the way I would want him/her to behave," "Sometimes I feel that my child's behavior is hopeless' "Sometimes I feel that I do not have enough control over the direction my child's life is taking," "Even though being a parent could be rewarding, I am frustrated now while my child is at his/her present age," "Being a parent is quite simple and problems that occur is easily solved (reversed)," My child's behavior is sometimes more than I can handle," "Given the time I have been a parent, I feel completely comfortable in my parental role (reversed)," and "Being a parent makes me tense and anxious." Parents answered on scales ranging from 1 ("Not true at all" or "Strongly disagree") to 6 ("Totally true" or "Strongly agree"). Cronbach's alpha was 0.86.

Parental reactions to child behavior. The scale *Emotional outbursts* from Tilton-Weaver, Kerr, Pakalniskeine, Tokic, Salihovic & Stattin (2010) was used, and was based on the question "What do you do when your child does something you really do not like?" We used four out of five items: "My first reaction is anger and I yell at the child," "I have problems controlling my irritation in such situations," "I get into arguments where we yell at each other," "I get angry and have an emotional outburst." Parents responded on a scale ranging from 1 (never) to 3 (most often). Cronbach's alpha was 0.74.

Children's psychiatric symptoms. The *Total Difficulties* scale from the parental version of the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1999; Smedje, Broman, Hetta & von Knorring, 1999) was used. Parents were instructed to choose the most fitting answer option on a three-point-scale ("0, Not true," "1, Partly true," or "2, Totally true") on 20 statements about the child, such as "Often complains of headaches, stomachaches, or sickness," "Has many worries or often seems worried," "Constantly fidgets or squirms," "Often is unhappy, depressed, or tearful," and "Often lies or cheats." Cronbach's alpha was 0.84.

The SDQ has supplemental impact questions about the severity of the child's functional impairment, and the first of these questions was included in the present study: "Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get along with other people?" Parents could choose from the alternatives of 0 ("No"), 1 ("Yes, minor difficulties"), 2 ("Yes, definite difficulties"), or 3 (Yes, severe difficulties"). In the analysis we merged the Yes alternatives (1, 2 and 3) and used the dichotomous choice of No versus Yes.

To elicit parents' reasons for participating in the group, an open-ended question at the beginning of the questionnaire asked "What was your most important reason for joining the parent support group?" Parents answered the question in writing.

Data analysis

Comparisons between different groups of parents were made using χ^2 for proportions and independent *t*-tests for means. Cohen's *d* was used for estimating effect sizes (Cohen, 1988). The open-ended question about reason for support group participation was analyzed with content analysis according to Graneheim and Lundman (2004). An interrater reliability analysis using the Kappa statistic was performed to determine consistency between two raters for categories and themes. χ^2 was then used for between group comparisons regarding different themes. Analyses were made in Excel 2010 and SPSS Statistics version 22 (IBM, Armonk, NY). The internal non-response rate in the data was low (0.2–1.7% for single items) and missing data was handled by replacing missing items with the mean of the existing items of the current scale (as long as no more than 20% of items were missing in that scale).

RESULTS

More mothers ($N = 141$) than fathers ($N = 32$) chose to participate in the parent support groups ($\chi^2 = 68.68$, $p < 0.001$). There was no significant difference between the gender of the children (boys $N = 92$; girls $N = 81$, $\chi^2 = 0.70$, *ns*), and the mean age of the children was 13.13 (sd = 1.59).

Comparisons between support group sample and the population

Compared to parents in the general population (Statistics Sweden, 2012), parents in the support group sample were more often on long-term sick-leave or unemployed. Support group mothers were

more likely to report living apart from the child's father, and were more highly educated than mothers in general. There was no difference regarding whether parents were born in Sweden or not. Both mothers and fathers in the support group sample reported more symptoms of anxiety and depression and greater psychiatric symptoms in their child compared to the control group (BITA study). The effect sizes of these differences were moderate. See Table 1 for statistics.

Reasons for support group participation

Parents' response rate on the open-ended question ("What was the most important reason for signing up to the parent group?") was 81%, and did not differ between mothers and fathers. In total, 163 answers were given by 140 parents; 16% gave two reasons for their participation in a support group. The answers were condensed into nine categories clustered into two main themes. The first theme reflected parents' more *General* reasons for attending the support group, whereas the second theme captured their *Problem-oriented* reasons (Table 2). Two categories did not fit in any of the two main themes and were placed in an *Other* theme. The majority of answers (72%) fitted into the categories belonging to the General theme and about 22% were more Problem-oriented. For proportions and distribution over themes, see Table 2. The categories are presented below, with citations from parents presented in Table 3.

Table 1. *Differences in background information between the population (Statistics Sweden) and the support group, and differences in parents' psychological health and children's psychiatric symptoms between control (BITA study) and the support group*

	Population (Statistics Sweden)		Support group		Differences χ^2	
	Mothers	Fathers	Mothers	Fathers	Mothers	Fathers
Long-term sick-leave or unemployment	5.3%	4%	11.4%	16.7%	10.41**	10.01**
Parents living together	76.4%	78%	61.2%	67.7%	17.85***	1.90
Higher education (college/university)	46.5%	40.9%	57.5%	39.3%	6.45*	0.03
Born in Sweden	84%	85.5%	85%	96.9%	0.10	3.34
	Control (BITA) M(sd)		Support group M(sd)		Differences t, d	
	Mothers	Fathers	Mothers	Fathers	Mothers	Fathers
Parental anxiety and depression	6.94 (5.56)	7.32 (4.79)	9.97 (6.23)	10.22 (6.11)	5.58**, .50 (m)	2.97**, .58 (m)
	Control (BITA) M(sd)		Support group M(sd)		Differences t, d	
	10–13 years	14–17 years	10–13 years	14–17 years	10–13 years	14–17 years
Children's psychiatric symptoms	5.67 (5.0)	5.43 (4.0)	8.80 (6.49)	8.28 (4.80)	5.74**, .60 (m)	5.47**, .70 (m)

Notes: *$p < 0.05$, **$p < 0.01$, ***$p < 0.001$. Effect size (*d*): (s) = small, (m) = medium, (l) = large.

Table 2. *Parents' reasons for support group participation*

		Category	All n = 163	Mothers n = 133	Fathers n = 30	Boys n = 89	Girls n = 74	10–13 n = 103	14–17 n = 60	Living together n = 99	Separated n = 61
Theme	General	Knowledge, understanding, and skills Promotion and prevention Curiosity Meeting and exchanging experiences with other parents Belonging to the targeted age group	72.4%	72.9%	70.0%	68.5%	77.0%	72.8%	71.7%	71.7%	73.8%
	Problem-oriented	Identified problems Support	20.9%	20.3%	23.3%	23.6%	17.6%	19.4%	23.3%	21.2%	19.7%
	Other	External influences Earlier positive experiences	6.7%	6.8%	6.7%	7.9%	5.4%	7.8%	5.0%	7.1%	6.6%

Notes: The interrater reliability was found to be Kappa = 0.83 ($p < 0.001$) for the categories and kappa = 0.90 ($p < 0.001$) for the themes.

Table 3. *Examples of answers from parents concerning reasons for support group participation*

Theme	Category
General	Knowledge, understanding, and skills
	'To learn what it means to be a teenager's parent, and to get some tips.'
	'I want to understand and be able to help my child the best way I can.'
	'Get tools to help my children through puberty, and get answers to a few questions I have.'
	'Learn to communicate better in various discussions.'
	'I want to develop my approach and be a listening and involved parent.'
	'I want to be more secure in my parental role to a (soon to be) teenager'
	'That I and my husband would get tools (and) a consensus, a common language to meet our daughter with.'
	Promotion and prevention
	'(I) want to do what I can to get the best relationship possible with my children who soon turn into teenagers one by one.'
	'To maintain a good communication with the children during adolescence.'
	'My daughter is thirteen and peaceful now, but it feels good to be prepared.'
	'(I) believe in the idea. Want to be prepared when the storm comes.'
	'I don't want to make the same mistakes as with my older children.'
	Curiosity
	'Curious (about) what the course implicates.'
	'The content seemed exciting, especially mindfulness.'
	Meeting and exchanging experiences with other parents
	'Fun to meet other parents (in a group) with children in the same age.'
	'To get tips and exchange ideas with other parents.'
	'Benefit from the experiences of others.'
	Belonging to the targeted age group
	'(I) have a teenager.'
	'I have two sons aged 10 and 12 years. This course is for me.'
	'Our oldest son is between 10 and 15 years old.'
Problem-oriented	Identified problems
	'Difficult teenager.'
	'(I have a) daughter who doesn't feel well and (I) don't know how to, or if (I should), set boundaries // not only for the child but also for myself . . .'
	'(I) often end up in power struggles; (I) want a nicer everyday life with my kids.'
	'I feel powerless and inadequate in my parenting.'
	Support
	'I have wished to participate and get support (. . .) for years.'
	'I want support in my parental role.'
	'(. . .) support and guidance during adolescence with three teenage daughters.'
Other	External influences
	'My wife wanted me to attend.'
	'They (the other parents) wanted company.'
	'Recommendation from the school counselor.'
	Earlier positive experiences
	'Good experience from previous parenting course.'
	'(I) attended KOMET earlier and want an update now when my daughter is approaching adolescence.'
	'I took a course in Active Parenting when the children were young (one to three years) and thought that now could be the time for a new parenting course.'

General reasons

Knowledge, understanding, and skills. Parents searched for general knowledge, understanding, and perspectives on adolescence and parenting. They also asked for concrete tools and suggestions or wanted to strengthen or develop their parental role.

Promotion and prevention. Parents wanted to support their children's development or protect an already positive relationship. Some wanted to prepare themselves for what "was to come" during adolescence, or wanted to prevent a negative development or relationship with the child.

Curiosity. Parents expressed general or more specific curiosity as reason to participate in a support group.

Meeting and exchanging experiences with other parents. Parents wanted to use the support group as a forum to meet and exchange experiences and ideas with others in the same situation.

Belonging to the targeted age group. A few parents felt they should participate simply because they had children in the targeted age.

Problem-oriented reasons

Identified problems. Parents described different problems, of different severity, as reasons for enrollment. Some parents said that their child had various problems, or mentioned difficulties in their relationship with the child. Others experienced problems in parenting, such as low self-esteem, aggression, or insecurity.

Support. Parents expressed a direct wish and need for support as a reason for participating in a support group.

Other reasons

External influences. Parents referred to other parents' or professionals' advice or suggestions as reasons for enrollment.

Earlier positive experiences. A few parents stated having earlier good experiences with support groups and expressed a wish for an age-specific update.

No differences were found in proportions between mothers and fathers, parents with younger (10–13) or older (14–17) children, married/co-habitating and separated parents, parents of boys versus girls, or parents of younger versus older children in the themes (i.e., general, problem-oriented or other). Neither were any of the themes overrepresented in any of the three support group programs.

Compared with parents with general reasons, parents with problem-oriented reasons for enrollment reported more negative attitudes ($t = 3.43$, $p < 0.01$, $d = 0.75$) and more emotional outbursts ($t = 4.29$, $p < 0.001$, $d = 0.94$) in their parenting. They also tended to experience their children to have more emotional or behavioral difficulties (SDQ Impact scale; $\chi^2 = 2.94$, $p < 0.10$), and their children tended more often to have had contact with mental health care within the last year ($\chi^2 = 3.74$, $p = 0.05$).

DISCUSSION

Compared with parents in the general population, support group parents as a group reported having a more difficult psychosocial situation, such as higher frequency of long-term sick-leave or unemployment, more symptoms of anxiety and depression and more psychiatric symptoms in their children. The vast majority of parents gave general reasons for enrolling, such as a desire for knowledge, understanding, and skills, for promotion (of a positive development for the child and the relationship) and prevention (of a negative development for the child or the relationship). About a fifth of the parents gave problem-oriented reasons, and those reported more negative circumstances for both themselves and their children than parents who gave more general enrollment reasons.

Participant characteristics

Our results showed that more mothers than fathers of adolescents enrolled in universally offered parent support groups, a finding also present in studies of parents with younger children (Wells, Sarkadi & Salari, 2015). It also supports the results from Roker & Coleman (1998) who showed that different organizations in the UK offering various parenting programs for parents of adolescents all had large difficulties in attracting fathers to their groups. Thorslund and colleagues (2014) found that Swedish municipalities are generally better at evoking the interest of mothers than fathers in all forms of parental support other than webpages, where interest is relatively equal. This corresponds to another study (Enebrink, Högström, Forster & Ghaderi, 2012), which found that when a parenting program was offered online, 69% of parents participated together, compared with only 8% when the same program was offered in the usual group setting. These findings support the suggestion that a well-functioning and user-friendly local web page could be one way of reaching more fathers with parental support programs.

We also found that mothers living separated or divorced from the father of the child were overrepresented among participants. While Bauman and colleagues' (2001) study on parents of adolescents showed that participation were more likely when both parents lived in the same household, findings from studies of support group participation among parents of younger children are inconsistent in this matter (see Dumas *et al*., 2007; Heinrichs *et al*., 2005). However, our results are in line with Dumas and colleagues (2007) who found that mothers who were single tended to attend sessions in preventing parenting groups more frequently than mothers who were not single. Being a separated or a single parent has been shown to increase parental stress (Weinraub, Horvath & Gringlas, 2012) and hence might lead to a bigger perceived need for support from outside the family. In general, there does not seem to be much emphasis on parents' personal situation in parent program curriculums (Andersson & Arnell Vu Minh, 2014). Professionals who work with parents of adolescents need to take into account that, due to the high frequency of separation, enrolling parents (usually mothers) might have limited support from the other parent in their everyday parenting, and thus, the program content might need to be adapted to these circumstances.

Further, enrolling mothers in our study were more highly educated than mothers in general, a finding previously seen in some enrollment studies of parents with younger children (Haggerty *et al*., 2002; Fängström & Sarkadi, 2012) and in several studies of parents with adolescents attending targeted parenting groups (i.e., Bauman *et al*., 2001; Spoth *et al*., 1997; 2000; Pettersson *et al*., 2009). This finding might be a result of recruiters' difficulties in reaching all parents, or of various barriers for participation (Pettersson *et al*., 2009). The Swedish national strategy for parental support (Socialdepartementet, 2009) states that all parents are entitled access to the support that municipalities offer. We agree with Pettersson and colleagues (2009) that an important challenge for the future is to design and market parental support programs that attract parents independent of their educational level.

Just like Henrichs and colleagues (2005) who studied program participation among parents of younger children, we found that parents of girls were just as inclined to enroll as parents of boys. This is however in contrast to Bauman and colleagues (2001) who found that parents of girls were more inclined to enroll in a family-directed tobacco and alcohol prevention program for adolescents.

Finally, support group parents in our study reported more symptoms of anxiety and depression compared to other parents, a finding corresponding to results from Fängström & Sarkadi (2012) who found that fathers of preschoolers enrolling in a universal parent training intervention experienced more personal symptoms of depression and anxiety than non-enrolling fathers, while enrolling mothers perceived higher degrees of parental stress than other mothers. We also found that support group parents experienced more psychiatric symptoms in their adolescents than parents in general, a finding similar to several other studies of parents with younger children (i.e., Fängström & Sarkadi, 2012; Haggerty *et al*., 2002; Heinrichs *et al*., 2005). Thus, our findings contradict the claims and concerns that universally offered interventions fail to reach individuals in real need of support (e.g., Offord *et al*., 1999). In sum, the results from the present study of participant characteristics are mostly consistent with earlier studies of parents with younger children but somewhat inconsistent with at least one other study (i.e., Bauman *et al*., 2001) of parents with adolescents.

Reasons for participation

A large majority of parents gave general reasons for participation, while about a fifth gave problem-oriented reasons. This replicates

findings among parents of younger children (Rahmqvist *et al*., 2013) and points to a difference between "universal" and "targeted" needs among parents, further supported by the findings showing that parents with problem-oriented motives reported greater child-related difficulties than those with general reasons. There might be a risk that parents with defined problems feel marginalized in a group in which the majority of parents have more general motives and interests and fewer personal and familial difficulties. The opposite is also possible: parents with more general or universal reasons for participation might feel that their needs and everyday worries are insignificant compared with those of parents with greater problems. This underlines the importance of individual contact with parents prior to group start in order for group leaders to become familiar with every parent's needs. Sometimes group leaders may also want to be explicit about that the variation among parents' enrollment reasons might initially cause tension in the group. In order to be able to adjust the composition of the groups according to the different needs of parents, municipalities are also advised to offer both universal and targeted interventions.

Limitations

The present study has its limitations. First and most importantly, results are based on parental self-reports, and information about parental or child variables from external or independent sources were not used. Second, questionnaires were completed after the first group session, hence, it is possible that insights parents might have gained from the first session influenced their answers.

CONCLUSIONS

Our findings suggest that on a group level, parents of older children and teenagers who enroll in universally offered parent support groups tend to have a more difficult psychosocial situation than parents in general. This contradicts claims that universal efforts risk missing their target. We conclude that when leader-led parent support groups are offered in a universal setting, they are successful in reaching their intended recipients – parents with good reasons for participation and an actual need of support.

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