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Prevention and Treatment of Behavioural Problems Among Small Children in Norway.

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Introduction: Behavioural problems among small children - ideology and approaches

In Norwegian child protection, there is a clear professional and political ideology that problems shall be discovered and solved as early as possible. This has led to increased emphasis on social work strategies aimed at family preservation, support for families, early intervention, measures to strengthen parental competence, and preventive help to avoid the need for placing children in foster homes or residential care (NOU 2000).

Behavioural problems among Norwegian children have increased in the last few decades. It is estimated that between 3 - 5 % of Norwegian children sometimes during infancy will require treatment for behavioural problems (NFR report 1998). Such figures have led to a political and professional concern, and have resulted in extensive governmental funding to try programs which aim at preventing and treating behavioural problems among children as early as possible. Broadly the programs can be divided into two categories: 1) programs aimed at all Norwegian parents, and 2) programs aimed at parents to children already showing behaviour problems or are considered being at risk.

Programs aimed at all Norwegian parents

An example of such a program is the national parental guidance program from 1995 – 1998. The aim of the program was to support and strengthen parents' rearing and care skills. The target was parents - the goal was prevention of behavioural and psychosocial difficulties in their children. The means to achieve the goal was stimulation of local initiatives to make conditions favourable for family guidance. The local communities received some financial and professional support from the initiating ministries which also had training programs for local supervisors. The local family guidance initiatives established themselves as, 1)forums where parents could meet and learn from each other (mutual guidance), 2) strengthening of knowledge and competence of professionals working with families (professional guidance), and 3) trials of parent focused methods.

The program was evaluated (Tjelflaat & Midjo 2000), and one important finding showed that most parents enjoyed group activities; they appreciated being included in a social fellowship which involved practical and relational benefits. The transmission of knowledge seemed to be of less importance; it was social relationships with peers that counted. The professionals, however, questioned that such forums had less potential as to include parents with substantial problems, as they might feel like "out-siders" compared to "normal" parents.

Programs aimed at parents to children already showing behaviour problems or are considered being at risk

In 1997, there was an expert conference on children with serious behavior problems set up by the Norwegian Research Council. The focus of the conference was causes, prevention, and effective treatment. A report was made (NFR report 1998) which recommended: 1) increased research on this issue, 2) (clinical) trials (evidence based) with promising methods for prevention and treatment of behavioral problems, and 3) dissemination of clinical research results to practitioners.

Mainly as a consequence of this expert conference and report, several trials aiming at prevention and treatment of behavioral problems were started. Examples of such trials were the Parent Management Training (PMT), Multi-System Therapy (MST), and Webster-Stratton.

PMT is an intervention aimed at parents of children 4 - 12 years old with stated or incipient behavioural problems. The intervention is understood as prevention as well as treatment. The theoretical basis for PMT is that parents play a vigorous part in children's lives and that they are the agents in turning negative behaviour into a more positive one. The parents are trained in using principles that encourage positive behaviour and stop negative behaviour from themselves and the child. The training is done through consultations (1 - 1 ½ hour a week with an average of twenty consultations).

MST is aimed at (parents of) adolescents aged 12 - 17 years with severe behavioural problems. MST is based on a belief that behaviour problems are maintained by weak points in the adolescent's context; e.g. in family, school, peers and neighbourhood. The parents are understood as the main persons in the adolescent's life who are best fit for formulating problems, the aim of the intervention/treatment, and they are also responsible for achievement of goals. Through supporting the parents and being present in the family, the therapists are working with parents, making them able to manage the adolescent and solve future problems by their own. Even if there is a goal to include the adolescent directly in the treatment, the parents are the main targets, and in some cases the therapists do not meet the young person. An average treatment period is about 5 months.

The Webster-Stratton Program is a treatment program aimed at parents and children aged 4 - 8 years with severe behavioural problems. The parents are entering a "parent school": a group activity where they learn to handle their children differently than before. Some of the children are offered a treatment program (Dinosaur School) where they learn to "behave well". The Webster-Stratton Program will be explained more in detail later in this article.

The programs have many common features: 1) they are mostly targeted at parents, 2) they are in accordance with the prevailing ideology in child protection, 3) they ensure the "double role" of the parents; parents are seen as the source, but also as the solution to the child's problems, 4) they are evidence based and have proved effective, and 5) they receive substantial governmental funding in the trial phase.

In the following we will present the Webster-Stratton Parent Training Program and a user evaluation made by parents who have received parent training through the program (Lurie & Clifford 2004). The program has been clinically-tested in randomized control trials on over 1000 families in US (Webster-Stratton 1984) with over 70% effectiveness. It is replicated in Canada (Taylor et. al. 1998) and United Kingdom (Scott et. al. 2001) and now in Norway.

The Webster-Stratton Parent Training

The program

The program was developed in the USA in the 1980s by Caroline Webster-Stratton and colleagues from clinical practice at University of Washington. It is aimed at parents of children 3 - 8 years old with severe behavior problems. It is designed to teach parents more effective parenting methods to improve interaction with the child and the child's behavior. The theoretical basis of the program is social learning, group dynamics, and communication theory. Itemphasizes the parent's importance for the child's positive development and stresses close cooperation between group leaders and parents. The keyconcept, "Positive Parenting", is based upon systematic positive reinforcement of desirable behavior and ignoring negative behavior from the child.

Treatment takes place in parent groups with trained leaders with 6 couples for 12 - 14 weeks. Some children also receive group training in social interaction skills in a "Dinosaur school". The program is manual-based, and leaders must cover all program themes in appropriate order. It is a multi-media program featuring video clips, role play, group discussions, and homework.

There are several key themes guiding the treatment. These are:

1. improvement of interaction between parent and child,
2. the attention rule,
3. children will live up or down to parents' expectations,
4. non-violent discipline,
5. accept each child's unique temperament,
6. use parental power responsibly,
7. practice makes perfect,
8. all children have behavior problems, and
9. all parents make mistakes.

Evaluation

The Webster-Stratton trial in Norway consisted of 127 families in the cities of Trondheim and Tromsø, treated in 2001 - 2003. It was anchored in child psychiatry (clinical). The trial was followed by systematic clinical research replicated from research done by Webster-Stratton in US. A 3-group random design was set up with the following groups:

1. Parent training only (PT),
2. Parent training and child training (Dinosaur school) (PT+CT), and
3. Waiting list/control group (WLC).

Preliminary results from the Norwegian clinical research show, among other factors, that group PT and PT+CT groups improved significantly better than WLC group measured by ECBI Intensity score, CBCL Total score, externalizing score and aggression score. The amount of positive parenting increased in both treatments, and negative parenting decreased significantly compared to the WLC group measured by Parenting Practices Interview (Mørch et al 2004).

Several clinical instruments were used in the clinical research. All parents taking part in treatment also had to fill out brief questionnaires to provide information about parents' evaluation of the treatment. These questionnaires were used in the original Webster-Stratton project.

In addition to instruments and questionnaires from "The Webster-Stratton Package", we carried out a more substantial user evaluation based on in-depth interviews with parents (Lurie & Clifford 2004). 19 parent sets (ten mothers, eight couples with both mother and father and one "other") who had completed Webster-Stratton Parent Training in Trondheim 2001 - 2002 were interviewed. The informants were selected strategically to ensure variation in child's age and gender, type of treatment, and in child's behavior before and after treatment (based on mother's ECBI rating scores).

The research questions were as follows:

1. What is parents' experience of raising a young child with serious behavior problems?
2. What was the situation for the parents and child before starting the Webster-Stratton program? What help have they received during this period?
3. What do parents think of the Webster-Stratton program? Are they satisfied and why? What aspects of the program have been most and least positive?
4. Have the parents learned and been able to use the methods taught?

5. Has the child's behavior changed?
6. How do parents view the situation for themselves and the child two years after treatment?
7. How do they view the future?

Perhaps the most important conclusion of this study was that while these families all shared a common challenge, they were nonetheless very different. Each family had its own story to tell, and while there were clearly important similarities, there were also fundamental differences and variation which are inevitably lost when a researcher attempts to summarize and draw conclusions from such a rich and complicated material. With this in mind, some conclusions which may be drawn from this study include the following:

1. Parents were generally the first to become aware of their child's problems and usually while the child was 3 - 4 years of age or earlier.
2. Raising a young child with serious behavior problems placed serious burdens on parents and other family members, especially siblings.
3. Most families were in contact with various community services before starting Parent Training but these were unable to provide parents with the type of systematic assistance which they needed to raise their children more appropriately.
4. Most families had to wait several years or more before they were referred to Parent Training, during which time the child's problems often became more serious.
5. Nearly all parents were very satisfied with Parent Training and particularly with the support and encouragement they received from other parents in the group.
6. Most parents understood the program's main message about positive parenting.
7. Parents were positive about the role of the group leaders, but more skeptical about some of the teaching methods used, particularly the use of video clips and role play.
8. Parents varied considerably in their ability to consistently and effectively use the new methods they were taught.
9. Some parents did not report improvement in their child's behavior after Parent Training.
10. Parents varied considerably in their views about the future.
11. Many parents wanted some form of follow-up help after Parent Training.

An important conclusion from the user evaluation of the Webster-Stratton Parent Training is that the training appears as a beneficial form of help for many parents of young children affected by severe behavior problems. The information provided by these 19 sets of parents indicates that the parent training they have received was a positive and beneficial form of help for many of them. Most parents liked the help they received and felt that it was right for them. Most said they would recommend the program to other parents in a similar situation, and some have suggested that the program should be offered preventively to all first-time parents. Parents largely accept the basic lessons about how to approach and manage their child. The mutual support which the parents provide to one another under the guidance of positive and enthusiastic group leaders goes a long way toward increasing parents' self-confidence and to overcoming years of self-doubt and frustration. Some parents also feel that they have acquired improved parenting skills which they are able to use to interact more constructively with their children, and which has led to improvements in their child's behavior.

Some Remarks

As we have seen, family preservation programs like the Webster-Stratton program have many positive features, and have shown to be beneficial for parents and children. Both the clinical evaluation and the user evaluation build up under such a statement. However, interventions mainly aimed at parents might raise several professional issues as to the status of the child. Among these are issues related to a child perspective and to the child's role in matters pertaining to its own life. In some of these approaches, the child is never seen. In the Webster-Stratton program some of the children were in direct contact with therapists in the Dinosaur School. The main targets for interventions were, however, the parents. As to the child, it can be difficult, in parent focussed approaches, to safeguard principles for client participation in social work. In modern social work with children, there is a clear

ideology asserting the child as subject, negotiating partner and an equal human being. It can also be difficult to safeguard principles for how to understand the child, and rules addressed in The UN convention for the rights of the child (1989). As to the principles for the UN convention, the child is to be understood as an active participant in own life, and an equal subject with own rights. The child is referred to as a communicating individual who is capable to have a say in matters of importance for its life.

The parent-focused approach to child behaviour problems will make children dependent on the parents' learning potential, their approach to child rearing and their ability to retain what they have learned. Research shows that many of the parents of children in child protection are not able to stand up for the child (Tjelflaat, Hyrve and Solhaug 2004). Many of them need help due to severe problems they cannot cope with, or they can be physically absent. Some parents are not able to change, and their learning ability is weak. We do not know how long parents retain the learning after being left alone with the child and as the child grows. We have little knowledge about how the child acts in the parent-child dyad before, during, and after intervention. It can be argued that balance of power between parents and child, by nature, is asymmetrical, and that parents will define how care and upbringing is to be understood and exercised. It is also possible that this asymmetry is strengthened after intervention as the parents now feel more confident in their parental role. The child might, in this manner, appear more as a passive receiver than an active participant in the dyad. The child might also have so severe problems that another form of psychiatric help is needed.

The Role in Evaluation

Children did not directly participate in the clinical research as standard measures were used to define their behaviour. The child's voice was not heard in the user evaluation, either. In many ways, this is a common phenomenon; children are research objects, and are seldom used as informants. This refers particularly to small children who are often invisible as subjects in research.

Literature

Lurie, J., Clifford, G. 2005. *Parenting a Young Child with Behavior Problems. Parents' experiences before, during and after Webster-Stratton Parent Training.* Rapport; The Regional Child Protection Research Unit.

Mørch, W-T., Clifford, G., Larsson, B., Drugli, M. B. & Fossum, S. (2004). *Treatment of Young Children with Conduct Disorders; The Incredible Years Program.* WEB: University of Tromsø, RBUP Nord.

NFR Rapport. (1998). *Ekspertuttalelse. Barn og unge med atferdsvansker.*

NOU 2000: *Barnevernet i Norge. Tilstandsvurderinger, nye perspektiver og forslag til reformer.*

Scott, S, Spender, Q., Doolan, M., Jacobs, B. & Aspland, H. 2001. Multicentre controlled trial of parenting groups for childhood antisocial behaviour in clinical practice. *British Medical Journal, vol. 323*, 194-197.

Taylor, T. K., Schmidt, F., Pepler, D. & Hodgins, H. 1998. A comparison of eclectic treatment with Webster-Stratton's Parents and Children Series in a Children's Mental Health Center: A randomized control trial. *Behavior Therapy*, 29, 221-240.

The UN Convention on the Rights of the Child (1989).

Tjelflaat, T., Hyrve, G. & Solhaug, H. (2003). *Barneverninstitusjonen – nødvendig men ikke god nok.*

Report No 10. The Regional Child Protection Research Unit.

Tjelflaat, T. & Midjo, T. (2000). *Foreldrekompetanse – et tema for læring*? Rapport No 7. The Regional Child Protection Research Unit.

Webster-Stratton, C. 1984. A randomized trial of two parent training programs for families with conduct disordered children. *Journal of Consulting and Clinical Psychology,* 52 (4), 666-678.

Back to Top