Children and Youth Services Review 51 (2015) 10–17

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

Exploring mental distress among immigrant mothers participating in parent training

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ARTICLE INFO

Article history:
Received 11 August 2014
Received in revised form 23 December 2014
Accepted 21 January 2015
Available online 30 January 2015

Keywords:
Maternal mental distress
Immigrant families
Parent training
Randomized controlled trial
Moderators

ABSTRACT

This study of ethnic minority mothers assessed the intervention effects of Parent Management Training — Oregon Model (PMTO) on maternal mental distress. Ninety-six mothers from Somalia and Pakistan and their 3-year-old to 9-year-old children were randomized with respect to enrollment in PMTO or a wait-list condition. Immigrants living in European countries report having significantly more mental distress than natives. Surprisingly, the results in this current study showed that there were low levels of mental distress at enrollment in PMTO among the sample. An analysis of covariance showed that PMTO was not effective in alleviating maternal mental distress in this sample. Ethnicity, family size and the child's age served as moderators on the relationship between enrollment in PMTO or the wait-list condition and maternal mental distress outcomes. None of the subgroup analyses were in favor of the intervention. The results emphasize the importance of research on parent training with immigrant families.

1. Introduction

Immigrating to a new country can be a stressful life event, particularly when the immigration occurs out of necessity — either due to the pursuit of a better life or escape from war or persecution. In 2014, immigrants represented 12% of the Norwegian population, and 52% of these immigrants were from Africa, Asia, Oceania and South and Central America (excluding Australia and New Zealand; Statistics Norway, 2014). These are defined as non-western immigrants. Upon their arrival in Norway, most non-Western immigrants find themselves in an environment that features not only an alien climate but also a society and culture that is different from their own. Moreover, many non-Western immigrants consist of either families or young people coming from cultures in which parenting and child-rearing practices differ from those in Norway (Kritz & Skivenes, 2010).

Acclimatizing to their new host-country home can be difficult, as has been illustrated by a study with data from 23 European countries (including Norway) that showed that immigrants living in European countries report having significantly more depressive symptoms than natives (Missinne & Bracke, 2012). In addition, a Norwegian study by Dalgard, Thapa, Hauff, McCubbin, and Syed (2006) reported that 23.6% of immigrants from low-income countries living in Oslo had symptoms of mental distress, such as depression and anxiety. In contrast, approximately 9.8% of those born in Norway and 11.6% of the immigrants from high-income Western countries had similar symptoms (Dalgard et al., 2006).

Thus the finding that a relatively large number of non-Western immigrant caregivers suffer from anxiety, depression or stress symptoms might suggest a reduction in the ability of such immigrants to parent positively and effectively. This decline in the inability to provide effective caregiving may in turn result in the children of these immigrants developing conduct problems (Barlow, Coren, & Stewart-Brown, 2002). From a theoretical perspective, this argument is supported by the social interaction learning (SIL) model (Patterson, 1982). The SIL model postulates that parenting practices have a causal effect on child behavior, whereas family situations (e.g., maternal mental distress) to a large degree influence child outcomes indirectly through parenting practices. From this perspective, immigration may be understood as a source of stress and tension that can exhaust parental resources and thereby increase levels of mental distress, disturb parenting practices and increase child conduct problems. Although there is research supporting the view that parenting practices influence child behavior (Hoeve et al., 2009), other studies suggest that the relationship may be reciprocal (Miner & Clarke-Stewart, 2008). Once child conduct problems have emerged, they may negatively influence parenting practices and parental mental health.

Since, as suggested above, one of the side effects of immigration may be the development of parental mental distress, which may have knock on effects on parenting practice and child behavior, interventions aimed at reducing conduct problems in children, are highly relevant for these particular groups (Oppedal et al., 2008). Conducting such interventions as well as increasing immigrant parents' understanding of local child-rearing practices may reduce both the levels of conduct problems and parental mental distress (Oppedal et al., 2008). Our previous research,

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http://dx.doi.org/10.1016/j.childyouth.2015.01.018
0190-7409/

using the same sample as the one presented in this paper, found that the Parent Management Training — Oregon Model (PMTO) had positive effects on parenting practices and child conduct problems (Bjørknes & Manger, 2013). Therefore, in the current study, we examined whether PMTO influenced the mental distress, defined as symptoms of depression and anxiety, levels of immigrant mothers.

1.1. Parent training, maternal mental distress and the role of moderators

Parent training is a collection of well-established evidence-based early intervention models that have been developed to improve parenting skills and to prevent child conduct problems (Weisz & Kazdin, 2010). In Western Europe and North America, parent training is effective in improving parenting practices and reducing child conduct problems in both ethnic majority (Furlong et al., 2012; Michelson, Davenport, Dretzke, Barlow, & Day, 2013) and minority populations (Bjørknes & Manger, 2013; Matos, Bauermeister, & Bernal, 2009; Scott et al., 2010). Parent training has also been found to have a positive effect on maternal mental distress, such as depression and anxiety (Barlow, Coren, & Stewart-Brown, 2002; DeGarmo, Patterson, & Forgatch, 2004; Hutchings, Appleton, Smith, Lane, & Nash, 2002; Kjøbli, Hukkelberg, & Ogden, 2013; Kjøbli & Ogden, 2012).

However, only a few studies have examined whether parent training reduces maternal mental distress. One such study of PMTO conducted in the USA (discussed more fully in Subsection 1.2) found that the intervention indirectly reduced maternal distress as a result of more effective parenting and fewer child conduct problems (DeGarmo et al., 2004). Two recent randomized effectiveness trials conducted in Norway revealed small to moderate effects (ESs ranging from .21 to .37) on maternal distress (Kjøbli & Ogden, 2012; Kjøbli et al., 2013). Kjøbli, Nærde, Bjørnebekk, and Askeland (2013) found that low levels of maternal distress combined with high levels of child conduct problems predicted more positive outcomes for child conduct problems in the parent training group than in the control group. However, the children of parents in the parent training group with high maternal distress had more negative outcomes for their conduct problems than in the control group (Kjøbli et al., 2013).

With respect to the role of moderators in parent training, two meta-analyses summarized the previous research on the predictors and moderators of child outcomes following parent training intervention (Lundahl, Risser, & Lovejoy, 2006; Reyno & McGrath, 2006). Both found that more disadvantaged families (single parents, low income, and depression) benefited less from parent training than did families with lower levels of adverse family factors. Other factors identified as possible predictors or moderators of parent training outcomes include maternal age, level of child conduct problems, education level, ethnicity, family size (Reyno & McGrath, 2006), and child gender and age (Gardner, Hutchings, Bywater, & Whitaker, 2010).

Given this mixed bag of results regarding the effects of parent training on maternal mental distress and the role of moderators on outcome, more knowledge is required about when – and for which groups – parent training has an effect on maternal mental distress. Moreover, studies on parent training have predominantly been conducted with middle-class Caucasian participants, and ethnic minority families are under-researched in this field (Michelson et al., 2013). In addition, therapists working with parent training groups are concerned that clients from ethnic minority populations may not be benefitting from treatment and might thus require extra therapeutic effort (Michelson et al., 2013). To our knowledge, no published studies have examined maternal mental distress in an immigrant sample living in Norway that has participated in parent training.

1.2. Parent Management Training — Oregon Model

PMTO's main goal is to teach parents how to promote a child's prosocial and competent behaviors and how to use mild and consistent disciplinary strategies to stop unwanted behavior. During PMTO therapy, families are taught five main parenting skills: monitoring, problem solving, effective discipline, positive involvement, and contingent skill encouragement. Several studies suggest that PMTO strengthens positive parenting practices and decreases observed child conduct problems (Bjørknes & Manger, 2013; Forgatch, Patterson, DeGarmo, & Beldavs, 2009; Forgatch & DeGarmo, 1999; Martinez & Forgatch, 2001; Kjøbli et al., 2013; Ogden & Amlund-Hagen, 2008; Patterson, 1982). Although the focus in PMTO is not on reducing maternal depression or anxiety, studies have documented that PMTO is effective in reducing maternal mental distress (DeGarmo et al., 2004; Kjøbli et al., 2013).

As discussed above, a randomized controlled trial was recently conducted to evaluate the effects of PMTO on ethnic minorities in Norway (Bjørknes & Manger, 2013). The findings from this study showed that mothers receiving PMTO significantly improved their parenting practices (i.e., decreased the use of harsh discipline and increased positive parenting) and that their children exhibited fewer conduct problems at home compared with children in the control group. Based on these results and drawing on the prior literature on mental distress and the moderators of outcomes in parent training (Gardner et al., 2010; Lundahl et al., 2006; Reyno & McGrath, 2006), the next step in this study was to investigate whether PMTO affected maternal mental distress in addition to examining potential moderators of the outcome.

In the present study, PMTO was offered to Somali and Pakistani families living in Norway. We conducted secondary data analyses to assess the intervention effects and potential moderators on maternal mental distress (see Subsection 1.3).

1.3. Research questions

The overarching aim of this study was to investigate maternal mental distress in ethnic minority mothers who participated in PMTO. Thus, we sought answers to the following research questions:

1) What were the levels of maternal mental distress upon enrollment into PMTO?
2) What were the post-test effects that PMTO had on maternal mental distress?
3) Which family, parenting, and child factors moderated the relationship between PMTO and maternal mental distress post-intervention? Based on previous research (Lundahl et al., 2006; Reyno & McGrath, 2006), the moderators explored included the following (a) family factors, including ethnicity, maternal education level, marital status, family size, maternal age and duration of residence in Norway; (b) parenting factors, including harsh discipline and positive parenting; and (c) child factors, including gender, age and level of conduct problems.

2. Methods

2.1. Study and participants

This study was financed and conducted at The Norwegian Center for Child Behavioral Development from 2007 to 2011. The study was designed as a randomized controlled trial with pre- and post-testing. Participants were recruited from December 2007 to March 2008 ($n = 118$) (reported in Bjørknes, Jakobsen, & Nærde, 2011). At initiation, 96 mothers were randomized either into PMTO ($n = 50$) or into the wait-list condition (WLC, $n = 46$). Families were randomized by ethnicity (Somali or Pakistani) and within the Norwegian community in which they lived. This procedure of stratified randomization was conducted because the intervention group was divided into ethnic groups and the intervention was community based. In the PMTO group, forty-six mothers completed the intervention (drop-outs: $n = 4$). The overall interval between initiation and termination assessments was 43.25 weeks ($SD = 5.87$).