



Internet-based parent management training: A randomized controlled study

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ABSTRACT

Objective: The current study evaluated the efficacy of an Internet-based parent-training program for children with conduct problems. Dose–response ratio and costs for the program were also considered. **Method:** Parents of 104 children (aged 3–12 years) were randomly allocated to either parent training or a waitlist control condition. Diagnostic assessment was conducted at baseline and parent ratings of child externalizing behaviors and parent strategies were completed before and after treatment and at 6-month follow-up.

Results: At post-treatment assessment, children whose parent(s) had received the intervention showed a greater reduction in conduct problems compared to the waitlist children. Between group intent-to-treat effect sizes (Cohen's *d*) on the Eyberg Intensity and Problem scales were .42 and .72, respectively (study completers .66 and 1.08). In addition, parents in the intervention group reported less use of harsh and inconsistent discipline after the treatment, as well as more positive praise. Effects on behavior problems were maintained at 6-month follow-up.

Conclusions: The results support the efficacy of parent training, administered through Internet, with outcomes comparable to many of the group-based parent training programs. The efficacy, low cost, and higher accessibility make this intervention a fitting part in a stepped-care model.

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Introduction

Early behavior problems, characterized by serious oppositional, aggressive and disruptive behaviors, often have a major negative impact on child development and family functioning (Loeber & Farrington, 2001). Both the personal and societal costs are huge, with a ten-fold increase in costs for social work, education and criminal justice when disruptive behaviors are untreated (Scott, Knapp, Henderson, & Maughan, 2001). Longitudinal research indicates that the earlier a child shows disruptive behavior problems, the greater is the risk that problems worsen and persist into adulthood (Loeber & Farrington, 2001; Moffitt, 1993). Children with these problems constitute one of the most common referrals to child and adolescent mental health clinics (Loeber & Farrington, 2001). For health-care agencies, it is of superior significance to provide evidence-based treatments at an early age for behavior problems not to become entrenched.

Abbreviations: CD, Conduct Disorder; ODD, Oppositional Defiant Disorder; PMT, Parent Management Training.

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Parent Management Training (PMT) programs focus on teaching parents parenting strategies for handling behavior problems, implementing behavior modification programs and improving the quality of the child–parent relationship. The main aim is to change negative interactions, coercive cycles and processes including harsh and inconsistent parenting, between parent and child (Patterson, 1982). This is for instance achieved through improved positive involvement with the child, parental attention on and praise for alternative good behaviors, enhanced parental communication with the child, shorter instructions, and celebration when a desirable behavior is accomplished. Treatment also includes teaching parents strategies for how to be constructively consistent and predictable in parenting, establish explicit rules for behaviors and how to handle misbehaviors. Several studies report improved parenting practices such as reduced harsh and inconsistent parenting and improved positive incentives to be related to good treatment effects (Beauchaine, Webster-Stratton, & Reid, 2005; Kling, Forster, Sundell, & Melin, 2010; Ogden & Hagen, 2008). PMT programs are among the most extensively studied treatments for conduct problems. There is considerable empirical support for their effectiveness (e.g., Dretzke et al., 2009; Eyberg, Nelson, & Boggs, 2008; Lundahl, Risser, & Lovejoy, 2006; Serketich & Dumas, 1996), suggesting that PMT leads to short-term reductions of conduct problem behavior, with moderate effects sizes. PMT is therefore recommended as selective

and indicated prevention programs for families with children below 12 years of age showing full syndromal or early sign of such problems (NICE, 2006). Today, a host of different PMT programs exists. Some programs are delivered with parents in groups (e.g., the Incredible Years, IY; Webster-Stratton & Reid, 2010) while other programs are delivered individually (e.g., Parent Management Training Oregon, PMTO; Patterson, Reid, Jones, & Conger, 1975). A few programs show video-vignettes of parent–child–interactions to promote discussions about positive parenting (e.g., IY; Webster-Stratton & Reid, 2010; Comet; Kling et al., 2010), and have parallel treatment sessions for children targeting themes such as development of social skills, problem-solving, and anger management (e.g., IY; Webster-Stratton & Reid, 2010), whereas other programs partly include children and parents together in therapy (e.g., Parent–Child Interaction Therapy; PCIT; Brinkmeyer & Eyberg, 2003). Parent Management Training Oregon Model (Patterson et al., 1975) was the first PMT-treatment developed and is regarded a well-established treatment for children with disruptive behavior (Eyberg et al., 2008). A Swedish group-based PMT program, Comet (COMMUNICATION METHOD) was developed including similar parent-training components as in the PMTO (Patterson et al., 1975) and the Incredible Years (Webster-Stratton & Reid, 2010). Comet has been evaluated in three studies (an initial pilot study by Hassler & Havbring, 2003; a pre-post design by Kling, Sundell, Melin, & Forster, 2006; and an RCT by Kling et al., 2010), with moderate to large effect sizes compared to a waiting list (Kling et al., 2010).

Unfortunately, not all families with a child that suffers from conduct problems have access to or possibility to participate in a PMT treatment. This is partly due to lack of professionals educated in PMT, or parental difficulties participating in a program because of working hours, day-care time limits or unawareness about the programs. Often, families have to wait to receive treatment, with a risk for escalating problems. Studies also indicate that about 1/3 of the parents who engage in PMT continue to report behavioral problems after treatment (Kazdin, 2005). In addition, 30–50% treatment-dropouts have been reported (Fonagy & Kurtz, 2002; Kazdin, 2005). To increase treatment availability and cost-effectiveness, different stages of prevention and full treatment interventions with various doses and formats are needed in stepped care models for this group of children and their families as in most other areas within psychiatry and psychosocial care. Self-help programs are becoming promising options as a first step in such models. Further, in psychiatry and psychotherapy in general, a dose–response pattern within some limits has been shown repeatedly (for a review and discussion see Hansen, Lambert, & Forman, 2002). To identify the adequate dose for a significant outcome to be obtained, the dose–response pattern of a specific treatment is an issue worth further investigation.

Internet as a way of distributing PMT

Parallel with the development of self-help programs for various psychiatric disorders, treatment programs are continuously being transformed into Internet-delivered treatments (Marks, Cavanagh, & Gega, 2007). Evaluations of programs for adult psychiatric problems, e.g. panic disorder (Carlbring, Westling, Ljungstrand, Ekselius, & Andersson, 2001), depression (Andersson et al., 2005), and eating disorders (Ljótsson et al., 2007) show similar effects as therapist-delivered treatments (for a review, see Marks et al., 2007). Until today, only a limited number of Internet-based treatments targeting children's problems have been evaluated. Positive effects have been reported for Internet-based CBT for chronic pain (Palermo, Wilson, Peters, Lewandowski, & Somhegyi, 2009), anxiety disorders (March, Spence, & Donovan, 2009), and behavior problems in children with traumatic brain injury (Wade, Oberjohn,

Burkhardt, & Greenberg, 2009; Wade, Wolfe, Brown, & Pestian, 2005). Taylor et al. (2008) describe an implementation of a computer-based Incredible Years with the addition of personal coaching through telephone calls, electronic messages, and home visits. Of the 90 parents of an at-risk population participating in the program, 66% completed the whole program and 76% completed more than half of the program. Generally, the families were positive (87% of 83 parents) and felt confident about how to handle future behavior problems (76%). Treatment effects were not reported. Advantages with Internet-based treatments are that information easily can be up-dated, the format is standardized and not therapist-dependent, and it is more easily accessible for participants. More specifically, the client can get access to treatment strategies when they have the time. For families with conduct-problem children, Internet might be a potent and viable channel for providing support and guidance at an early stage. If found effective, it could also be part of a stepped-care model, enabling families of children with less severe behavior problems to get access to treatment strategies whereas therapists could have time for families with children showing more severe problems or at high risk for continued problems.

Aims

The overall aim of the present study was to evaluate the effects of an Internet-based parent management treatment (PMT) for parents of children aged 3–12 years with conduct problems, compared to a waiting list control group in a randomized controlled trial. The first hypothesis was that the effect of the program, in terms of child behavior problems, child prosocial behavior, and parenting strategies would be both statistically and clinically significant compared to the waiting list control condition, and effects maintained after 6 months for the intervention group. The second hypothesis was that we would find a dose–response relationship to outcome, i.e. those who follow the PMT program to higher extent achieve more beneficial outcomes. The third hypothesis was that the internet-based program would be cost-effective.

Method

Design

The study was an experimental randomized controlled study. Parents were consecutively randomly assigned to either (1) 10 weeks of Internet-based PMT, or (2) a waiting list control group, receiving PMT training after their post-measurement three months after entering the study. Baseline data was collected at the university clinic and through Internet-based questionnaires, and otherwise through the Internet at post-measurement after the end of the treatment. The present paper covers data from pre- and post-measurement and a 6-month follow-up.

Participants

Parents of 129 children reported interest in the study. Of these parents, 109 entered the study after scoring above the criteria for clinically relevant problems, i.e., one SD above the mean in relation to each age group and gender, according to the Swedish norms (Axberg, Johansson Hanse, & Broberg, 2008) of the Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999). Five of these parents/families failed to complete the assessments due to technical complications at the web site and are not included in the analyses in the current study, resulting in a sample of 104 children. Of the children, 101 (97%) were born in Sweden. In total, 77 (74%) of

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