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Helping families change: The adoption of the Triple P - Positive Parenting Program in the Netherlands

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1 General introduction

1.1 Objective and research questions

This thesis is about the parenting program Triple P – Positive Parenting Program. This evidence-based program, which was originally developed in Australia, was designed to prevent and offer treatment for mild and severe behavioral, emotional and developmental problems in children from birth to age 16, by means of enhancing the knowledge, skills and confidence of their parents. Triple P incorporates five levels of interventions on a tiered continuum of increasing intensity. The rationale for this stepped-care strategy is that there are different levels of dysfunction and behavioral disturbance in children, and parents may have different needs and desires regarding the type, intensity and mode of assistance they require (Sanders, 1999).

In the Netherlands an implementation trial was executed to the Triple P program, because of the following reasons. First, there was a need for a tiered continuum of interventions of increasing intensity, from universal prevention to intensive care for parents and their children. Second, there was a need for an evidence-based parenting intervention. Implementing extensively evaluated interventions of another country are relatively inexpensive, easily accessible and convenient.

This thesis will examine the implementation trial of the Triple P – Positive Parenting Program by answering five questions:

1. Is Triple P effective for the improvement of parenting?
2. What are the effects of Triple P on behavior problems in children?
3. Is Primary Care Triple P an addition to the Primary Care Parenting Support in the Netherlands?
4. What is the impact of Group and Standard Triple P on children's behavior, parenting and parental psychopathology in the Dutch practice?
5. How to implement a multilevel program in another country?

Before we will address these research questions, we will clarify briefly the underlying key-concepts: behavioral and emotional problems in children, parenting interventions and the Triple P – Positive Parenting program. Then we will present the outline of the thesis.

1.2 Behavioral and emotional problems in children

Psychosocial problems in children are often divided into two parts: behavior problems (externalizing problems), such as aggressive or delinquent behavior, and emotional problems (internalizing problems), such as withdrawn behavior, physical complaints, anxiety, or depressive complaints.

Behavioral and emotional problems are quite common in children and adolescents. The prevalence of these problems varies among studies, because they depend on the age of the children, definitions of psychosocial problems, time of research or severity of the problems.

While psychological problems appear less frequently in younger children, there is still a reported incidence of about 6% in Dutch babies (0-14 months), and 6% in Dutch toddlers (Zeijl, Crone, Wiefferink, Keuzenkamp, & Reijneveld, 2005). For Dutch preschool children, the prevalence of behavioral and emotional problems is about 8% (Koot & Verhulst, 1991) to 10% (Van der Ploeg, 1997). In another Dutch study, 20.7% of Dutch elementary and high school students, aged 11 to 16 years, experienced externalizing behavioral problems and 18.6% have been found to experience internalizing problems (Ter Bogt, Van Dorsselaer, & Vollebergh, 2003).

For Dutch preschool and schoolchildren aged 0 to 12 years taken together, it is shown that 5% experience severe emotional and behavioral problems (Zeijl et al., 2005). The prevalence of clinical internalizing and externalizing problems in Dutch children aged 11 to 17 years is approximately 11 to 13% (Ter Bogt, Van Dorsselaer, & Vollebergh, 2003).

These Dutch findings resemble the findings in international samples. Several studies in Australia, Canada, Germany, New Zealand, United Kingdom and the USA, have shown that approximately 18% of all children experience behavioral or emotional problems at some point in their development (Sanders, Markie-Dadds, & Turner, 2003; Zubrick et al., 1995). Other international studies showed that 11 – 15% of children under 13 years of age (Sawyer et al., 2000; Silburn et al., 1996; Zubrick et al., 1995), and between 13-17% of youngsters aged 14-18 years experience significant mental health problems (Murray & Lopez, 1996).

1.3 Parenting interventions

Parenting interventions have been developed to support parents in undertaking their role in raising their children. The way in which a family interacts has a considerable influence on the psychological, physical, social, and economic welfare of children. Parenting is associated with the well-being of children. A high level of parental support and positive parent-child interactions have a positive impact on children (Mahoney et al., 1998), whereas the lack of a warm positive relationship, insecure attachment, harsh, inflexible, rigid, or inconsistent discipline practices, inadequate supervision of and involvement with children, marital strife and/or breakdown, and parental psychopathology (particularly maternal depression) increase the risk that children will develop major behavioral and emotional problems (Coie, 1996; Loeber & Farrington, 1998; Sanders et al., 2003).

Among all developed parenting programs, the Behavioral Family Interventions (BFI) based on Patterson's (1982) social learning theory have the strongest empirical evidence. BFI are interventions that target family interaction patterns. Parents learn

positive family interactions and child management skills. In a meta-analysis BFI programs have shown to be effective by creating large effect sizes in decreasing child behavior problems (Serketich & Dumas, 1996).

1.4 The Triple P – Positive Parenting Program

Triple P is a behavioral family intervention and aims to enhance family protective factors and reduce those risk factors known to be associated with severe behavioral and emotional problems on the part of preadolescent children. This is done by increasing the knowledge, skills, and confidence of the parents. The program was developed by Sanders and colleagues at the Parenting and Family Support Center of the School of Psychology at the University of Queensland (Sanders, Markie-Dadds, Tully, & Bor, 2000; Sanders, 2003).

1.5 Theoretical basis

Triple P is based on several theoretical foundations. First, the Triple P-program is based on social learning models of parent-child interaction that highlight the reciprocal and bidirectional nature of these interactions (e.g., Patterson, 1982). Second, the program is based on research in child and family behavior therapy, which has developed many useful behavior change strategies, particularly research that focuses on rearranging antecedents of problem behavior through designing more positive engaging environments for children (Risley, Clarke, & Cataldo, 1976). Third, in the developmental research on parenting in everyday contexts, Triple P teaches parents to use naturally occurring daily interactions to teach children language, social skills, developmental competences and problem-solving skills in an emotionally supportive context. Fourth, social information processing models are incorporated that highlight the important role of parental cognitions, such as attributions, expectancies and beliefs as factors that contribute to parental self-efficacy, decision-making and behavioral intentions (e.g., Bandura, 1977, 1995). Fifth, research from the field of developmental psychopathology that has identified specific risk and protective factors that are linked to adverse developmental outcomes in children is represented (e.g., Emery, 1982; Grych & Fincham, 1990; Hart & Risley, 1995; Rutter, 1985). Sixth, a population health perspective to family intervention that involves the explicit recognition of the role of the broader ecological context for human development (e.g., Biglan, 1995; Mrazek & Haggerty, 1994).

A central element in the program is the development of parents' capacity for self-regulation, which involves teaching skills to parents that enable them to become independent problem solvers. Self-regulation is a process whereby individuals are taught skills to modify their own behavior (Sanders, 2003).

1.6 Principle of self-regulation

Self-regulation is a central element in the Triple P program and it is suitable for both parents and professionals. Self-regulation is a process whereby individuals are taught skills to modify their own behavior. The self-regulation framework means:

1. Self-sufficiency: parents need to become independent problem solvers so that they trust their own judgment and become less dependent on others in carrying out basic parenting responsibilities.
2. Parental self-efficacy: This refers to a parent's belief that they can overcome or solve a parenting or child management problem.
3. Self-management: The tools or skills that parents use to become more self-sufficient include self-monitoring, self-determination of performance goals and standards, self-evaluation against some performance criterion, and self-selection of change strategies. As each parent is responsible for the way they choose to raise their children, parents select which aspects of their own and their child's behavior they wish to work on, set goals for themselves, choose specific parenting and child management techniques they wish to implement, and self-evaluate their success with their chosen goals against self-determined criteria.
4. Personal agency: Here the parents increasingly attribute changes or improvements in their situation to their own or their child's efforts rather than to chance, age, maturational factors or other uncontrollable events (e.g., partner's bad parenting or genes). This outcome is achieved by prompting parents to identify potentially modifiable causes or explanations for their child's or their own behavior. (The interested reader can read more in: Sanders, Markie-Dadds, & Turner, 2003).

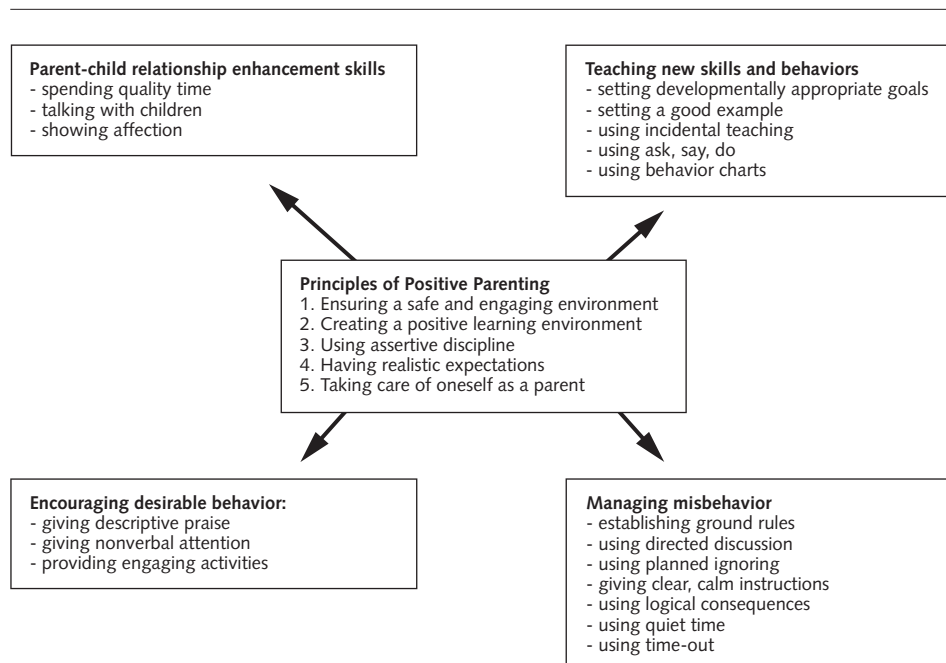
1.7 Principles of Positive Parenting

Five core positive parenting principles form the basis of the program. These principles address specific risk and protective factors known to predict positive developmental and mental health outcomes in children (Sanders, Markie-Dadds, & Turner, 2003):

1. Ensuring a safe and engaging environment:
Children of all ages need a safe, supervised and therefore protective environment that provides opportunities for them to explore, experiment and play.
2. Creating a positive learning environment:
This involves educating parents in their role as their child's first teacher. The program specifically targets how parents can respond positively and constructively to child-initiated interactions (e.g., requests for help, information, advice, attention) through incidental teaching to assist children to learn to solve problems for themselves.
3. Using assertive discipline:
Specific child management strategies are taught that are alternatives to coercive and ineffective discipline practices (such as shouting, threatening or using physical

- punishment). A range of behavior change procedures are demonstrated to parents including: selecting ground rules for specific situations; discussing rules with children; giving clear, calm, age appropriate instructions and requests; logical consequences; quiet time (non-exclusionary time out); time out; and planned ignoring.
4. Having realistic expectations:
This involves exploring with parents their expectations, assumptions and beliefs about the causes of children's behavior, and choosing goals that are developmentally appropriate for the child and realistic for the parent. There is evidence that parents who are at risk of abusing their children are more likely to have unrealistic expectations of children's capabilities (Azar & Rohrbeck, 1986).
 5. Taking care of oneself as a parent:
Parenting is affected by a range of factors that impact on a parent's self-esteem and sense of well-being. All levels of Triple P specifically address this issue by encouraging parents to view parenting as part of a larger context of personal self-care, resourcefulness and well-being, and by teaching parents practical parenting skills that all carers of a child are able to implement. Those core principles are translated into a range of specific parenting skills, which are presented in Figure 1. (The interested reader can read more in: Sanders, Markie-Dadds, & Turner, 2003).

Figure 1. Principles and parenting strategies



The interventions

Triple P incorporates five levels of intervention of increasing intensity for parents of children between the ages of 0 and 16 (see Table 1).

Table 1. The Triple P Model of Parenting and Family Support

Level of Intervention	Target Population	Intervention Methods	Practitioners
LEVEL 1 Media-based parent information campaign Universal Triple P	All parents interested in information about promoting their child's development	Anticipatory well child care involving the provision of brief information on how to solve developmental and minor behavior problems. May involve self-directed resources, brief consultation, group presentations, mass media strategies, and telephone referral services	Media parent support institutions and/or health promotion
LEVEL 2 Brief selective intervention Selected Triple P	Parents with a specific concern/s about their child's behavior or development	Provision of specific advice for a discrete child problem behavior. May be self-directed or involve telephone or face-to-face clinician contact or group sessions	Parent support during routine well-youth health care (e.g., child and community health, education, allied health and childcare staff)
LEVEL 3 Narrow focus parent training Primary Care Triple P	Parents with a specific concern/s about their child's behavior or development who require consultations or active skills training	Brief therapy program (1 to 4 clinic sessions) combining advice, rehearsal and self-evaluation to teach parents to manage a discrete child problem behavior. May involve telephone or face-to-face clinician contact or group sessions	As for Level 2
LEVEL 4 Broad focus parent training Standard Triple P Group Triple P Self-Directed Triple P	Parents wanting intensive training in positive parenting skills - typically parents of children with more severe behavior problems	Intensive program focusing on parent-child interaction and the application of parenting skills to a broad range of target behaviors. Includes generalization enhancement strategies. May be self-directed or involve telephone or face-to-face clinician contact or group sessions	Intensive parenting interventions (e.g., mental health and youth care and other allied health professionals who regularly consult with parents about child behavior)
LEVEL 5 Behavioral family intervention modules Enhanced Triple P	Parents of children with concurrent child behavior problems and family dysfunction such as parental depression or stress or conflict between partners	Intensive individually tailored program with modules including home visits to enhance parenting skills, mood management strategies and stress coping skills, and partner support skills. May involve telephone or face-to-face clinician contact or group sessions	Intensive family intervention work (e.g., mental health, youth care)

Level 1, an universal parent information strategy, provides all interested parents with access to useful information about parenting through a coordinated promotional campaign using print and electronic media that demonstrate specific parenting strategies. This level of intervention aims to increase community awareness of parenting resources and parents' receptivity to participate in programs, and to create a sense of optimism by depicting solutions to common behavioral and developmental concerns. Level 2 is a brief, one to two-session primary health care intervention, providing early anticipatory developmental guidance to parents of children with mild behavior difficulties or developmental issues.

Level 3, a four-session intervention, targets children with mild to moderate behavior difficulties and includes active skills training for parents.

Level 4 is an intensive eight to ten-session individual, group or self-directed parent training program for children with more severe behavioral difficulties.

Level 5 is an enhanced behavioral family intervention program for families where child behavior problems persist or where parenting difficulties are complicated by other sources of family distress (e.g., marital conflict, parental depression or high levels of stress) (Sanders, 2003).

The program is in continuous revision by new data, theory or feedback from program users and consumers (Sanders & Turner, 2005). Besides the core-program with the five levels of intervention, extra modules are being developed for specific target groups, such as parents of children with a developmental problem or disability (*Stepping Stones*), families who are at risk for child abuse, (*Pathways Triple P*), working parents (*Workplace Triple P*), aboriginal parents in Australia, (*Indigenous Triple P*), parents of children with obesity (*Lifestyle Triple P*), and divorced children or new families (*Transitions Triple P*).

1.8 Implementation trial

In 2006 an implementation trial of the Triple P – Positive Parenting Program was conducted in the Netherlands. In a one-year period interventions of different levels of the Triple P program were implemented in two regions in the Netherlands: universal Triple P, concerning a small local campaign (level 1), selected Triple P (level 2), Primary Care Triple P (level 3) and Standard and Group Triple P (level 4). The objective of the implementation- trial was to implement those interventions in two pilot regions, and to prepare a scenario for a broad implementation. Several institutions were involved in the implementation trial: youth health care, social work, school social work (school counsellors), parenting centers, day care, youth care and mental health care. The target population consists of parents of children aged 2 to 12 years.

1.9 Outline of the thesis

In chapter 1 and 2 we want to know whether the Triple P- Positive Parenting Program is effective. The research questions “What are the effects of Triple P on parenting?”, and “Is Triple P effective on behavior problems in children?” are discussed. In meta-analyses the results of a large and diverse body of studies can be summarized. Because most of the studies on Triple P are on level 4 Triple P interventions, the meta-analyses we conducted focus on this level. In chapter 1 the focus is on the effectiveness on parenting. Chapter 2 contains the effectiveness on behavior problems in children. The next chapters address the studies to evaluate the implementation trial in the Netherlands. Chapter 3 focuses on the research question: Is Primary Care Triple P an addition to the primary care parenting support in the Netherlands? We present the results from a quasi-experimental study of the Primary Care Triple P (level 3) and the regular primary care Dutch parenting consultations on the effects on children's behavior and emotional problems, parenting styles and parental competences. Chapter 4 deals with the results of four evaluations of the Standard and Group Triple P to evaluate the effects on parenting behavior and problem child behavior. The research question “What is the impact of Group and Standard Triple P on children's behavior, parenting and parental psychopathology in the Dutch practice?” will be discussed. Those four samples were: two single-group, pretest, posttest, one single-group, pretest-posttest-follow-up test, and one quasi-experimental design. Furthermore, this study focuses on the impact of the Standard and Group Triple P interventions on parental distress and psychological health of parents, and the mediating factors of parenting interventions on parental psychopathology. In the fifth chapter, we describe the successful implementation strategy using a practical framework for implementing evidence-based multilevel programs. Furthermore, we also evaluated the implementation trial by a process evaluation. This chapter leads up to the general discussion in chapter 6.

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