New tools for parents

Proposals for new forms of parent support

Sven Bremberg (editor)

SWEDISH NATIONAL INSTITUTE
OF PUBLIC HEALTH

www.fhi.se

New tools for parents

Proposals for new forms of parent support

Sven Bremberg (editor)

ISBN: 91-7257-443-7
ISSN: 1651-8624
Editor: Sven Bremberg
Cover photo: Eva Stööp/Eye-Q-net
Translator: Gary Watson. This is a translation of the Swedish report
Nya verktyg för föräldrar – förslag till nya former av föräldrastöd, published in 2004.
Graphic production: AB Typoform

Contents

Foreword

Johanna and David had their first child, Emma, in 2002. They had been planning to have Emma for several years. Johanna went to the maternity clinic and both Johanna and David participated in the parent education it provided. Johanna read the magazine *Vi Föräldrar* [Us Parents] and both watched a number of television programmes about children. Both Johanna and David have good relationships with their own parents who give them advice about what it is like having children all whilst respecting the fact that times have changed since they themselves were parents with young children. They also receive good advice from friends and acquaintances.

Do Emma's parents really need more support than they get already? This question is justified bearing in mind that Emma is growing up in a country where children's health is among the best in the world. You could also question whether it really is right to influence such a deeply personal task as parenting. There are plenty of examples throughout history, not least in Sweden, of experts thinking they know best – and thus undermining parents' faith in their own ability.

Despite these misgivings the Swedish National Institute of Public Health (SNIPH) hereby submits proposals for how parent support may be developed in Sweden. The report is the outcome of a government assignment given to the Institute. It is based on the child's perspective. Hence, it focuses on the needs of the child and not the parents. The report also focuses on the public health perspective. This means that the health problems that primarily affect us form the basis of the analysis. One of the most commonly occurring health problems during much of childhood and then later on in adulthood is mental ill-health. Of particular importance are the depressions that currently affect as many as every fourth woman at some time during her lifetime.

The task from the public health perspective is not to try and identify the parents who may have shortcomings. The point of departure today is the knowledge that exists regarding the factors that protect against mental ill-health – the "healthy" factors. It is during childhood that you can most easily open up the possibilities of promoting mental health. One way is offering parents support so that they can both be affectionate towards their children and set boundaries. Knowledge about how this can be done has

increased enormously in the last decade. There are reports that point at how this knowledge can be put into practice.

It has been evident for a long time now that public health problems can be reduced through broad efforts. Infections, injuries due to accidents and cardiovascular diseases are examples of this. It is often not possible to say in advance who may benefit from such efforts but it is quite clear that the population at large will gain. Similarly, it is possible to improve mental health among children through broad efforts directed at their parents.

This report is geared towards decision-makers and professionals who work with children and adolescents at the local, county and national level as well as NGOs and private companies.

Gunnar Ågren
Director-General

Sven Bremberg
Editor of the report

Summary

Point of departure

The point of departure for this report is the assignment given to the Swedish National Institute of Public Health (SNIPH) by the Government to collect, analyse and disseminate knowledge about how parent support of various kinds might be designed in order to do real good.

Support to parents can be both geared towards the needs of the parents as well as those of the child. What is beneficial to the parents is often beneficial to the child, but this should not, however, be taken for granted. It is in this light that primarily interventions geared towards fulfilling the needs of children are discussed.

Caring for children

Children need other people in order to survive and develop. Parents' efforts are crucial. Other children and other adults are also involved in most societies. This insight is best expressed in the African saying: "You need a village to raise a child." Throughout most of the history of mankind children have been surrounded by other people, both from within and without the family, who have taken a direct responsibility for caring for them.

Today the situation is different both for children and their parents. During the first year, it is usual for one adult to take care of one or two children in the family home. The parent can go out and meet other people, or talk to other people over the telephone, but normally there is no other adult in the home environment. This makes the situation more vulnerable than it used to be.

The question is to what extent is it justifiable for society to provide parents support in this task; during early infancy and later when the child is at preschool (daycare) and school.

Ethical conflicts

There was much debate in Sweden during the twenties regarding the importance of parents for the health and development of the child. The experts pointed at the mothers' lack of knowledge as one of the main threats against the welfare of the child. The experts believed that it was vital for the parents, and especially the mothers, to avail themselves of modern principles

when caring for their offspring. Paediatricians and other professionals proclaimed what their perception of good parenting was. An example of one such principle was that babies were only to be breast fed at fixed times, usually every four hours. The mothers had to learn to suppress any impulse to feed when the infant cried. Knowing what we know today we can see that much of the advice was wrong. It was also a way of belittling the experience the mothers themselves had gained. Advice given by experts to parents in more recent decades has been characterised by a greater humility. However, any interference in parenthood is difficult since it restricts the self-determination of the parents.

It is possible to defend interventions if it is generally agreed that they are very beneficial to the child. One example is the state school system. All children are not only offered the opportunity of attending but are indeed under an obligation to attend. Child healthcare and preschool are also very beneficial to the child. These services are provided on a voluntary basis. In Sweden it has, however, been possible to attain a high level of participation on a voluntary basis. Therefore, there are two requirements for parent support interventions – they must be generally considered to promote the health and welfare of the child and they must be provided on a voluntary basis.

Despite the voluntary aspect, however, the ethical problem of the influence of experts over our private lives still remains. When the current form of parent support was developed in the 1970s, the intuitive experience of parenting was set against the perceptions of the experts. Parent support that was scientifically based was regarded as counterproductive. These views were down to the lack of knowledge at the time of various forms of parent support. A leading American researcher observed even as late as at the beginning of the 1990s that there were no studies that showed that parent support had a positive effect on the child.

The situation as regards knowledge has changed radically over the last ten to fifteen years. There is a review of interventions during early infancy in Chapter 6. In total, 73 research studies of high scientific quality demonstrate substantial positive effects, even of relatively minor interventions. Fifty-eight analyses of parent support studies that have been carried out after early infancy are described in Chapter 4. Fifty-three of these analyses show that the interventions are beneficial to the health and welfare of the

child. Therefore, in the light of the substantially changed situation with regard to knowledge, it was considered justifiable to offer all parents in Sweden support based on the knowledge that is available today.

Preventing ill-health through interventions directed at parents

Mental ill-health, cardiovascular disease and cancer are the three most important public health issues. The trend for heart and vascular disease is favourable and comprehensive preventive efforts are being made. Knowledge about how cancer can be prevented is limited. Interventions aimed at dealing with the third most important public health issue, mental ill-health, are therefore vital in order to improve public health in general. The reviews that are presented in this report demonstrate that it is possible to do this through interventions aimed at parents.

One study that was initiated in Finland during the mid-seventies demonstrated how the prevalence of mental ill-health could be reduced through parent support. In the study, ordinary parents with newborn babies were randomly divided into two groups. One group were given advice at home once a month by a nurse trained in childcare and parenting skills. The other group only had access to the ordinary child healthcare services. The children in these families were then followed up in repeated studies. The children in the trial group had fewer mental problems. At the age of 20–21, the prevalence of mental ill-health in the trial group was reduced by a third. The proven reduction applies both to external and internal problems as well as mild and severe problems.

Affection and boundaries

The parental qualities that are particularly important to the health and welfare of the child are the ability to both show *affection* towards the children and control the children's behaviour (*set boundaries*). The parental quality that children themselves value most is the ability to care and be affectionate. The affection of the parents is more important than the material conditions and quite often more important than the child's relationship with friends. An adult who is affectionate with a child first notices something in the child, interprets its significance and then shows that he or she understands the child. Thus, being affectionate is not something intangible, a matter of course and something that therefore cannot be changed.

An affectionate parent must be able to interpret a child's expressions. The interpretation is crucial and determines the reaction that follows. For instance, if a parent interprets a baby's cries as an expression of anger, the reaction will be quite different from an interpretation of the cries as a signal that the child feels lonely. A further example: When a three-year-old refuses to get dressed he may be saying that he wants to continue playing indoors, but he may instead be saying that he is tired and has not got the energy to go out. The parents' reactions are completely different depending on their interpretations.

A parent's ability to interpret a child's behaviour is closely linked to how well the parent knows what the child thinks and does. With an older child this presupposes that the child tells the parents what he or she is doing, which in turn means that the child must have faith in his/her parents. This faith develops when the parents have shown that they understand the child at an earlier stage. Thus, child and parents have a mutual impact on each other. If the parents are affectionate it means that the child is better able to face them positively, which in turn makes it easier for the parents to show affection and so on.

The parent-child interaction affects the child's ability to interact with other people later in life. The link between interactive development during the first 18 months of a child's life and social skills later on in life is particularly clear. It is crucial that the child perceives him/herself as a cherished individual and the social environment as predictable.

A comparable interaction between parent and child also applies to the setting of *boundaries*. If the child knows what boundaries apply it does not need to test them. The child's energy, as well as that of the parents' for that matter, can then be used for interaction that is more positive in nature than a conflict about boundaries.

Having an impact on parents' relationships with their children

The external circumstances are decisive for good parent-child relationships. Parents who live in stressed social conditions may find it difficult to develop a good relationship with their children. Interventions such as parents' insurance, child benefit and labour market policies are therefore essential when it comes to promoting good parent-child relationships in families of various social backgrounds.

The question is how may parents be helped to develop the ability to be affectionate and set boundaries. It is reasonable to say that this type of support should be based on universal principles regarding how people normally learn different types of behaviour.

The first principle is based on *social learning theory*. The principle is a simple one – we learn behaviour by observing what others do. But we also learn by listening to other people's stories. This principle can be transferred to parent support. If parents meet other parents together with their children and see how others act, then certain parents can learn more about this ability. This is possible within, for example, the framework of the open preschool system.

A second principle for learning is based on what in English is called *self - efficacy*. This can be translated as meaning having faith in your own ability to act in a certain way. This may seem like a trivial principle: the chances of a person behaving in a certain way increase if he/she believes in his/her ability to do so. But what is important is the fact that it is possible to influence this faith. The main source of faith is previous success. Hence, it is possible to promote a certain type of behaviour by making it possible for parents to make changes taking *small steps*. This really gives parents the possibility of succeeding, which increases their faith and thus the possibility of making even greater changes. This is possible if the parents have access to a structured method or are given repeated advice based on this principle.

People's behaviour is also affected by *information and knowledge*. However, most types of behaviour that have to do with parents and children are complex. There is no simple link between knowledge and behaviour. This does not mean that knowledge is unimportant. Knowledge can influence behaviour if a parent has access to answers to a tangible question, when the question arises and when the reply is presented in a meaningful way to the parent. An answer from an expert may be most appropriate for certain questions. With other questions it may be more important that the answer comes from someone the parent is able to identify with, a relative, a friend or another parent.

Different types of parent support

The most important type of parent support is informal contact with others; relatives, friends and acquaintances. It is possible to increase access to informal contacts by creating specific *meeting places*, for example in the

shape of open preschools. It is, however, difficult to demonstrate the effects of meeting places on the children.

One common way of providing contacts is via special *parent groups*. This type of contact is, for example, provided by the maternity and child healthcare services. This may be done in a structured or open way. Structured groups can be formed on the basis of the pedagogical principles mentioned above. The positive effects of such methods have been demonstrated in both children and parents. The crucial parts of these methods are the practical element when parents can try out different skills. In an open parent group it is the parents who decide the content. There are usually no practical elements in that type of group. This type of activity may have beneficial effects. One precondition, however, seems to be that the participants have a major problem in common.

Parents can also get support via *individual contacts* with professionals and via *the media*: books, newspapers, magazines, radio, television and material that is published on the Internet. The media usually lacks the interactive element which limits the effects. One particular form is a *discussion group on the Internet*. This is similar to meeting in an open group since the parents themselves decide the issues they wish to discuss. An analysis that has been carried out within the framework of the assignment indicates young parents and less well-educated parents as being the main benefactors of such discussion groups.

The effects of parent support interventions

In the evaluation of a parent support intervention, it is essential to have knowledge about the effects. The surest way of evaluating whether a certain intervention has an effect is via a controlled experiment. This means that one group of parents has access to a certain intervention and another comparable group of parents does not have access to the intervention. The parents and children in both groups are then followed up. If the children in the group with parents that have participated in the intervention fare better, then this is a strong argument that the intervention benefits the children. This argument is reinforced if the same result has been seen in several studies and if the parents in the experiment groups and control groups have been selected randomly. It is therefore possible to argue in favour of different types of parent support based on the results in the experiments that have been carried out.

Support to parents with children aged between 0–1

Parent groups

Parent support in groups for this age group has existed for a couple of decades in Sweden and currently benefits a majority of all parents. It is important to try to resolve four problems that exist in the current scheme before it is developed further.

The *first problem* relates to the aim of the *scheme*. The official aim of parent support provided by the maternity and child healthcare services is to disseminate knowledge and information, to strengthen the parents in their role as parents and to provide a form of contact between parents. Nurses in child healthcare say, however, that they have trouble achieving these aims. Moreover, the nurses stress the importance of the first two aims but not the third. Parents, on the other hand, say that the main benefit of parent groups is having the chance to exchange information with other parents.

The *second problem* is that it seems unclear whether the scheme has produced any demonstrable *effects*. The current objectives of parent support provided by the maternity and child healthcare services stipulate that the schemes must aim to strengthen the parents in their role as parents and to help parents meet other parents. However, there do not seem to be any studies demonstrating that the schemes have this effect. Nor are there any other studies that demonstrate other effects that have to do with the welfare of children and parents.

One way of dealing with this problem is to introduce schemes with known effects. There are two such methods. *Från första början* [Right from the start] and *Vägledande samspel* [ICDP – International child development programme]. Both methods aim at enhancing parent-infant interaction and thus facilitating a secure attachment. A current review describes attempts with similar schemes. It has been demonstrated that there are clear positive effects on the sensitivity of parents to their babies' signals and secure attachment. A small number of group meetings (fewer than five) seems to produce to *better* effects than more extensive schemes. These positive effects have been demonstrated in both socially disadvantaged parents and average parents. It is obviously a good idea to spread these methods throughout the child healthcare services. This is also what is currently happening.

A method has been developed to promote good communication between parents, which has demonstrated good effects in a controlled experiment. The method is called PREP. It would seem to be an appropriate method to be included in the parent group schemes provided by the maternity healthcare services. There are empirical findings from the Swedish maternity healthcare services. These are, however, as yet only very limited.

The *third problem* is that the parent groups provided by the child healthcare services are primarily designed for women. Most forms of parent support attract *more women* than men. There is less equality within the child healthcare service schemes as compared to most other forms. When the current parent group schemes were designed in the seventies it was not taken for granted that both men and women would participate on the same terms. Today, the situation has changed. There are several ways of dealing with this problem. One first step would be to highlight the issue by showing the number of men and women who participate separately in the statistics that are routinely collected. With this data as a basis it would then be possible to carry out certain improvements.

A further measure would be to base the child healthcare parent groups on the maternity healthcare service parent groups where men and women participate on roughly the same terms. These groups are currently broken up in order to be replaced by new groups in the child healthcare services. In some parts of the country the groups that were formed by the maternity healthcare services are allowed to continue to meet after the birth of the babies. It seems that where this is the case, the men have also continued to participate. A further advantage of this structure is that the contact that has been established between parents during pregnancy can then be deepened. It is hardly expedient to break these groups up after birth bearing in mind the official aim of improving communication between parents. The municipality in Leksand has developed a useful model. There, the municipality that takes responsibility for organising parent groups together with other organisations, including the county council which runs the maternity and child healthcare services. In all probability the active role of the municipality has been crucial to the success of the model.

The *fourth problem* is the *social profile* of this type of parent support. According to the population questionnaire described in Chapter 5, the scheme is better suited to well-educated than to less well-educated parents.

There is a similar tendency for parent groups in general but the differences are especially marked in the child healthcare system groups. The Leksand model seems to point to a solution even here. In Leksand, the groups are led by one of the parents in the group. Midwives from the maternity healthcare services and nurses from the child healthcare services participate but do not lead the group. With a parent as leader it enables more parents from different social classes to feel relaxed in a parent group.

Most of the solutions that are proposed here entail the municipality taking a greater responsibility for parent support. This approach was already presented by the 1997 commission on parent support.

Open preschool and family welfare centres

Open preschool has a distinct value for parents, particularly when one of the parents is on parental leave. There is, however, a lack of studies demonstrating the effects of this intervention. Hence it is vital that such studies are conducted. It is justifiable to place an open preschool in the same facility as a maternity and a child healthcare clinic forming a family welfare centre. This makes it easier for all parents to come into contact with the open preschool since the vast majority of them visit the maternity and child healthcare services.

Organisation

Discussions regarding suitable forms of support for this age group and research studies are to take place during the period 2005 to 2006. A new agreement between the Swedish Association of Local Authorities and Regions is to stipulate how the municipalities and county councils should cooperate by 2007.

Parent support affects several different municipal administrations. It may therefore be appropriate for the municipality to appoint one person assigned the task of coordinating all parent support activities, including that proposed for other age groups. This person can have parent support as his/her main task. An alternative is that the coordinator for alcohol and drug-abuse prevention, who exists in many municipalities, should be given responsibility for the task. A nother option is to give the task to local crime prevention officers or municipal public health planners.

Support to parents with children aged 2–9 years

Parent groups

The literature on parent support for this age group is dominated by "interaction programmes" aimed at developing affection and emotional attachment in a parent-child relationship. One of the aims of the programmes is to reduce the risk of a child developing behaviour problems. *De otroliga åren* [The Incredible Years], Community Parent Education Program (COPE) and *KOMET* [COMET] are examples of interactive programmes. The effects are tangible and very well documented in controlled experiments.

These programmes help and encourage parents to give their children positive attention, to be clear in the way they communicate with their children and to find well thought-out ways of confronting the children when conflicts arise. The interaction programmes are usually carried out in groups consisting of ten to fifteen parents who meet for two or three hours once a week for a ten to fifteen-week period. The group discussions are normally based on everyday parent child situations shown in a short video. The parents discuss different ways of resolving the situation. Then the parents practise the solutions with each other in roleplays.

Home assignments are included in the programmes. Parents are asked to note down when they needed a particular skill and whether this was effective. They are also asked to make notes on the child. This can help parents to become more aware of how they themselves react to different situations involving the child. It can also help them to see more clearly how the child develops.

The interaction programmes do not question the ability of the parents but instead tries to utilise and develop the collected experience of all the parents in the group. It is often the parents themselves who suggest and discuss different alternative approaches. The programmes do not generally include ready solutions that are presented as a "lecture".

These interaction programmes help to enhance children's circumstances if organised on a broad basis. Interaction programmes are normally offered by the social services, child and adolescent health services or school administrations. They are often arranged in cooperation with county council child and adolescent psychiatry services or other units within the county council. The municipality is usually in charge.

The interaction programmes used in Sweden have been aimed at parents in general, at parents in socially disadvantaged housing areas and at parents who have already sought help because of their children's obvious problems. The combined effect is most visible if the scheme is provided at an early stage, let us say at the age of 2–3. It is at that age difficult to predict which children are going to develop major problems. Interventions at this age should therefore be offered on a broad scale to be effective on the population level. Reaching 20–50 per cent may be a reasonable target. When children develop behaviour problems it entails direct costs for the municipalities since it gives rise to a need for assistants and teachers. The calculations that are presented in Chapter 7 indicate that interaction programmes provided for parents result in reduced municipal costs after only three to four years.

Experiments in other countries have demonstrated that parents are able to avail themselves of the material presented in the interaction programmes by watching it on television/video. The cost of such dissemination is considerably lower than the costs for arranging groups. This means that it would be a good idea to make this methodology available. Material of this kind could be used both individually and in groups without specially trained and paid for leaders. Many parents would probably prefer to study the material in a group. Access to material such as video/DVD does provide more flexibility, however, since parents can study the material in the way that is best suited to each individual family.

Interventions for children of school age (10–15)

Parent support geared to the needs of children: communication programmes

Literature on this age group is dominated by programmes aimed at developing good parent-child communication, particularly in order to reduce the risk of teenagers starting to smoke, drink or take drugs and to reduce the risk of them starting to commit crimes. This is why the programmes are called *communication programmes*. The aim of these programmes is normally to try to get parents and teenagers to agree on standards and rules that the teenagers then abide by. If these agreements are to have any effect whatsoever, it is important that the parties trust each other. Trust of this kind is built up by parents giving their children positive attention and by parents and children doing things together. Hence the programmes include parts

aimed at promoting positive interactions. The programmes also help the parents to use well thought out ways of confronting the teenagers when conflicts arise. In this way, the communication programmes have similarities with the interaction programmes described in Chapter 7. The main difference is that the communication programmes are adapted to children and teenagers aged between 10–15 who are more independent than younger children and to the fact that there is a risk that the teenagers might start smoking, drinking, taking drugs or committing crimes.

The communication programmes are often carried out in groups of 10–15 parents who hold between five and ten weekly meetings lasting two hours. Normally the children are offered similar meetings at school in conjunction with the parents' meetings. At the beginning of the programme, the parents discuss the risk of the teenagers starting to smoke, drink and take drugs. The next step entails the parents discussing what expectations are reasonable and together they are encouraged to agree on the rules that should apply. Parents are given help and support to resolve conflicts with their children in a constructive way. The programme also deals with how parents and children can do different things together in a way that everyone perceives as positive.

Several varieties of communication programmes are organised in Sweden. There are two recommended programmes: *Step by step* (*Steg för steg*), built on the Iowa Strengthening Families Program, and *the Örebro Prevention Program*. It is also probable that further programmes of this type will be available in Sweden in the years immediately ahead. These two programmes are of differing scope. Both trials are aimed at preventing aggressive behaviour problems. That includes binge-drinking, violent behaviour and criminality. It is possible that the more extensive communication programme *Step by step* can also influence the prevalence of emotional mental health problems, as is the case with the interaction programme. However, that type of effect has not been reported.

Step by step is broader in scope and includes sessions for both parents and children together. Controlled experiments have been carried out on a number of similar programmes with well-documented and demonstrable effects. The effect of *the Örebro Prevention Program* is less broad and only documented in one Swedish experiment.

The communication programmes have been offered to all parents. The arguments brought up in Chapter 2 indicate that such measures are justified

even if it is possible to carry out interventions for a possible risk group alone at a lower cost. A broad distribution makes it necessary to train a large number of group leaders. Professional training as teachers, public-health experts, social workers and nurses may be appropriate for those persons who are to be responsible for leading parent groups.

Development of specific channels

A questionnaire has been sent out to a representative selection of parents within the framework of the report. The parents have answered questions about the types of parent support they are interested in and also the perceived benefits of the support that they have already been provided with. One conclusion is that there is a great deal of interest in counselling over the telephone. The schemes that are provided today are not in line with demand. Thus we propose that the three NGOs that currently provide telephone counselling with one joint telephone number should work more closely together.

Internet is the medium for the dissemination of information that is developing most rapidly. There are a number of advantages with the Internet, for example, the low costs per user and the fact that it makes it possible for parents to not only retrieve information but also to share their experiences with other parents. Thus we recommend an Internet site for parents. The site could combine information about frequently asked questions written by experts with the possibility for parents to put their views across to each other. Bearing in mind the fact that Swedish is a relatively limited language it would seem difficult to develop such a website without public funding.

Development of the municipal system

The model that was developed in Leksand and that has now spread to other parts of the countries has resolved several of the problems that are inherent in the current parent support scheme that is geared towards pregnancy and early infancy. The municipality takes responsibility for all interventions geared towards parents. Thus we propose that research is conducted during 2005 and 2006 with the aim of concluding an agreement between the Swedish Association of Local Authorities and Regions where the municipality takes responsibility for group-based parent support including schemes that are currently being organised by the maternity and child

healthcare services. County council staff are, however, expected to continue to participate.

Parents support involves various municipal administrations. Thus it is important that the municipalities appoint one or several persons to be directly responsible for parent support at the top municipal level.

Different forms of parent support suit men and women differently. The same applies to different social groups. There are no simple answers as to how to safeguard the interests of all groups. This is why one basic intervention is to register participants of different types of parent support according to their gender and education. This makes it possible subsequently to correct the focus of a intervention on a continual basis so that different groups are able to take of advantage of the scheme in an equivalent way.

Follow-up system

One of the main aims of parent support is to increase the number of children who have a good relationship with their parents, in order to increase the chances of the child to have a good life. This is why it is a good idea to follow up the development of the parent-child relationship. Such knowledge does not give direct answers as to which interventions may be justified. But the information can provide a basis for a broad assessment of development and can inspire initiatives with the objective of giving *all* children a good upbringing.

One way of doing this is to collect information regarding the parent-child relationship from the children. A suitable source of information would be *the Barn-ULF* study of the living conditions of children that was started in 2000. Information from nearly 1,000 children between the ages of 10 and 18 is collected every year via the Barn-ULF study. This study is being conducted in conjunction with an interview study of the living conditions of adults (The ULF study) carried out by Statistics Sweden. The study includes questions that can be used as parent-child relationship indicators. We propose that a follow up of this indicator is carried out as a part of the follow up of the national public health policy (objective 3).

Introduction

A child's relationship with its parents is the most important factor for the child's health and welfare. Children have always been dependent on adults and the adults who are most important to the children are usually the parents. Therefore, if society is going to promote the welfare and health of the child, it is necessary to do so by approaching the parents. Sweden has a long tradition of promoting the interests of children by providing family support, mainly by providing preschool and school services as well as different forms of financial allowances. This report deals with the direct support parents can obtain in their role as parents.

The report is divided into four sections. The first section deals with the basis, the second the possibilities of providing support to parents with children at different ages and the third a few aspects regarding parent support that is not linked to the age of the children. An comprehensive analysis is presented in the fourth and final section.

The basis is discussed in *Section I*. The assignment given to the Swedish National Institute of Public Health (SNIPH) and which forms the basis of this report is presented in Chapter 1. The assignment states that the support shall constitute a real benefit to the children. This basis is discussed from different perspectives in Chapter 2; from the historical and ethical perspectives as well as based on different approaches to knowledge. Parent support from the parents' perspective is dealt with in Chapter 3. The studies on social support that have been presented in recent decades form the point of departure. Chapter 4 includes a summary of a systematic review of controlled studies on parent support experiments. The findings of a questionnaire study on parent support answered by a representative selection of parents is summarised in Chapter 5. The material is subsequently used in discussions on support at various points in a child's life.

Section II deals with the possibility of providing parent support linked to the age of the child. Research that has been carried out, Swedish experiences, parents' interest in different forms of support, costs and scope for dissemination are discussed. Pregnancy and early infancy are discussed in Chapter 6, children aged between 2 and 9 in Chapter 7, between 10 and 15 in Chapter 8.

Parent support that is not linked to a specific age group is discussed in *Section III*. Chapter 9 deals with programmes aimed at reducing conflicts

in families, thereby also reducing the divorce risk. The methods are applicable regardless of the age of the child, but provide the best alternatives if they are offered already before the birth of the child. Counselling over the telephone is discussed in Chapter 10. One reason for devoting an entire chapter to this method is that many parents request this form of support.

One of the most important support sources is the information that parents can acquire from the media, newspapers, magazines, books, television, radio, the Internet and so on. This type of support is discussed in Chapter 11. The Internet is the source that is developing most rapidly. It enables parents to have access to specific information when they request it themselves. The Internet also makes it possible for parents to share their own experiences. These advantages have justified a special analysis of the need for a Website for parents.

The assignment clearly stipulates that the effects of parental influence in preschool and school must be analysed. Parents and the influence of parents in these institutions are two overlapping issues. The influence issue is discussed in Chapter 12. The assignment also stipulates that the question of children's influence must be analysed. This issue is included in the discussions regarding individual schemes and interventions. However, a special analysis has been made in accordance with the assignment: *The health of children and adolescents is affected when they are allowed to make more decisions. A systematic research review*, SNIPH; 2004. This study is published separately since it is not directly linked to how parent support should be designed.

It is customary in both North America and northern Europe to provide support to socially vulnerable families aimed at developing the mental development of the children. Hence Chapter 13 is devoted to this type of support despite the fact that experience of it is fairly limited in Sweden.

Interventions for different groups of parents are analysed in Chapter 14. Most forms of parent support are aimed at women, despite the fact that 50 per cent of all parents are men. This reflects an old-fashioned view of gender and parenting. Clear arguments are required to change this situation. Different forms of parent support are discussed in the chapter seen from the perspective of both men and women, from the interests of different social groups and parents born outside the Nordic region.

Section IV comprises only Chapter 15. An analysis of parent support is presented in this section.

The following people have contributed to the analyses that form the basis of the report and to the wording of the text: Anton Lager, public health scientist, SNIPH, Anna Sarkadi, MD, PhD, Uppsala University, Berit Hagekull, Professor of Psychology, Uppsala University, Ingrid Israelsson-Olsson, Doctor of Psychology, SNIPH, Lena Andersson Andalibi, B. A. , Uppsala University, Pia Wennerholm-Justlin, Doctor of Psychology, Uppsala University and Sven Bremberg, Associate Professor, paediatrician, SNIPH. Sven Bremberg has been in charge of the assignment and is responsible for the text unless otherwise stated.

A reference group has been linked to the assignment with representatives from the Office of the Children's Ombudsman, the Association of Local Authorities, the Federation of County Councils (now amalgamated into the Swedish Association of Local Authorities and Regions), the Swedish National Agency for Education, the Swedish National Agency for School Improvement, the National Board of Health and Welfare and the Swedish National Board for Youth Affairs. The group has submitted valuable points of view.

The report has been checked at various stages by a number of people who have all submitted valuable points of view. A special mention to Terje Ogden, Professor, Oslo University, Håkan Stattin, Professor, Örebro University, Claes Sundelin, Professor, Uppsala University, Ann-Christine Hallberg, postgraduate student, Lund University and Knut Sundell, Associate Professor, Research and Development Unit at the Social Services Department for the City of Stockholm.

It would not have been possible to carry out this inquiry without the range of contributions from a large number of people at conferences, via e-mail and by telephone. These people represent municipalities and county councils, the civil service, NGOs, companies and the research world.

1.

BACKGROUND AND AIM

1.

BACKGROUND AND AIM

Government decision 2001-06-20 S2001/6077/ST

Assignment to collect, analyse and disseminate knowledge about how different types of parent support may be formed.

Background

The Committee on Social Affairs stated in its report *Barnomsorg med mera* [Childcare, etc.] (report 1990/91:SOU2) that the preconditions for parent education geared towards parents of children past early infancy must be created. Parent education of this kind must be voluntary but be carried out in such a way that all parents actually have the possibility of participating. The education should be organised by the child healthcare, childcare and schools sectors with further interventions provided by NGOs, for example child and youth organisations, and adult education associations. The aim of the parent education should be to supply more knowledge about a child's development and to enable parents to communicate with other parents as well as with childcare and school staff. Finally, the committee stated that the Government, based on what the committee had drawn up and also based on the findings of the work carried out with regard to renewing parent education, should put forward proposals for the development and stimulation of parent education during preschool and school years.

Parliament endorsed the Committee on Social Affair's proposal that a report should be submitted to the Government. 1990/91:5).

Accordingly in March 1997 the Government set up the Commission on Parent Education. The commission submitted its report *Stöd i föräldraskapet* [Support in Parenting] (SOU 1997:161) in November of the same year. The report included a review of different activities linked to parent education and other forms of parent support. Parent education provided by maternity and child healthcare clinics, parent activities in the childcare and

school sectors and parent support organised by the social services and paediatric psychiatry were described. The descriptions included projects and activities that were good and innovative in nature. The report also included discussions on the type of support needs that parents' have, as compared with the schemes that are actually provided. The report points at the fact that parents with teenage children do not get enough help today. As regards special groups of parents, the commission found that parents of foreign backgrounds whose children meet different cultures are often in need of information. The commission also found that parents of disabled children should be offered complementary support adapted to their needs and wishes and the needs and wishes of their children and that the same applies to people with disabilities who have recently become parents.

The report contains no proposals for legislative changes or for specific state subsidies requiring a parliamentary decision. However, the commission emphasises the need to reinforce the status of parent support in municipalities and county councils, to ensure that NGOs are given support in their work of informing parents and that the boundaries between different authorities and organisations are clarified. Further the commission emphasises the need for development work to be carried out in the area, and that knowledge is compiled and disseminated to those who work with these issues in the organisations concerned. The commission proposes that resources are allocated and that the relevant authorities are tasked to do the work.

The Government dealt with the issue of parent support in its statement to the Parliament *Barn – här och nu – redogörelse for barnpolitiken i Sverige med utgångspunkt i FN:s konvention om barnens rättigheter* [Children – Here and Now – An account of child policy in Sweden based on the UN Convention on the Rights of the Child] (parliament communication 1999/2000:137) stating the following:

The government deems it important to provide parents with support in their child-rearing duties. This applies both to parent education in groups and to parent support geared more towards the individual. There is every indication that raising children is a more complicated matter today than it was in the past. Many parents also have limited networks.

Parent support must be organised locally. The role of the state in the development work is to support well-functioning models and methods emanating from work at the local level. SNIPH should therefore be

commissioned to compile, describe and disseminate examples of good practice. This also includes supporting the development of knowledge and carrying out an evaluation. One central issue is the form in which the support is offered to parents in order to ensure that an intervention is accessible to all the parents who require it.

The assignment

The impact of different types of parent support and parent education on a child's situation within the family is an important issue that should be highlighted. The Convention on the Rights of the Child stipulates that children in different contexts have the right to respect. Children have the right to express their views on issues that affect them. How these aims can best be fulfilled within the context of parent support is an important methodology issue.

It is interesting from a broader democratic perspective to study how children and parents can be involved in and decide measures that affect the children and the family in the childcare, school and other systems where the children are present. This is important to public health work.

If SNIPH finds that further development activities are required within certain areas or that certain measures that are regarded as urgent do not exist at all, the Institute may support such measures that are provided by county councils, municipalities or NGOs. It is important that such measures are evaluated so that it is made clear that the methods that are used are both good and effective. It is important to highlight the impact of such measures on children.

Working methods and conditions

It is the task of SNIPH to compile descriptions and analyse measures that are organised at the local level.

The Institute has a duty to cooperate with the Office of the Children's Ombudsman, the National Board of Health and Welfare, the Swedish National Agency for Education, the Swedish National Board for Youth Affairs, the Federation of County Councils, the Association of Local Authorities (now amalgamated into the Swedish Association of Local Authorities and Regions) and other authorities and organisations that SNIPH finds suitable. If deemed appropriate, a reference group can be formed.

The work is to be carried out in project form until 30 June 2004. The Institute is under the obligation to submit an account in the shape of an interim report on how the work is progressing by 30 June 2002 and 30 June 2003 at the latest. A final report is to be submitted by 31 December 2004 at the latest.

The government decision

The government hereby commissions SNIPH to collect, analyse and disseminate knowledge about how different types of parent support might be designed in order to be of real value.

Funds for 2001 have been allocated at an estimate of SEK 1,500,000 from expenditure area 9, Healthcare, Medical Care and Social Care, appropriation item 18:1, Grants for the development of social work etc as well as appropriation item 5, Interventions for the realisation of the UN Convention of the Rights of the Child in Sweden, sub-item 5.3.

On behalf of the Government
Ingela Thalén *Sören Kindlund*

Aim

The aim is to analyse how parent support may be designed in order to promote the health and welfare of the child as well as clarifying how these interventions might be disseminated. The term "children" refers to individuals aged between 0 and 17, in accordance with the definition given in the UN Convention on the Rights of the Child [1].

A definition of the term "parent support"

This report discusses direct parent support, defined as organised interventions for parents aimed at promoting the welfare of the child, but does not include indirect interventions such as family law and transfer payments (for example, child benefit).

Previous commissions

The need for parent support or parent education has been discussed since the 1960s. The issue has been dealt with in reports from three different commissions. As part of the Preschool Report included in the Day Nursery Commission of 1968, in two different reports from the Child Care Group 1978 and 1980 respectively and the report from the Parent Education Commission of 1997.

The Day Nursery Commission of 1968 outlined a 3-part parent education scheme: for parents-to-be at maternity healthcare clinics, for parents at child healthcare clinics and for pupils at compulsory school and upper secondary school levels. Parent education via radio and television and also via organisations for further education were highlighted as being complementary to the organised schemes. In the parent education that was outlined the focus was on conveying knowledge about the development, emotional needs and need for "intellectual stimulation" of the child. [2].

In 1973 the so-called Child Care Group was given the task of studying the issue further in a special Government statement. The commission submitted its report on pre [3] and post natal parent education in 1978 and on parents with children of preschool age and school age in 1980. [4]. The Child Care Group proposed three objectives for parent education: to enhance knowledge, create opportunities where parents meet other parents and create the possibility of an awareness of societal conditions and their impact. The Parliament's agreement with the Association of County Councils regarding the expansion of the public parent education schemes provided by the maternity and the child healthcare services was primarily based on the first report of the Child Care Group on parent education around the time of the birth of the child.

The 1980 report dealt with parent education for parents with children of preschool age and school age [3]. There was no proposal for systematic training for this age group like the education schemes offered by the maternity and child healthcare services. The group believed that parent education at an early stage in conjunction with the birth of the child created a knowledge base. Interventions for preschool and school age would instead primarily create the opportunity for parents to meet each other and improve the awareness of social conditions and their impact. The commission pointed

at three actors who might be important: NGOs, for example adult education associations, preschools and schools as well as the media.

Another commission first mapped out [5] and then submitted a report in 1997 [6]. The commission proposed that the term parent education should be replaced by the term "support in parenting". The Committee of Inquiry underlined that it was an advantage if parents themselves set up groups, instead of only participating in groups organised by the maternity and child healthcare services. It was emphasised that it was important that the questions and interests of the parents themselves formed the basis of discussions in the group. The commission also underlined the importance of discussing partner relationships.

The commission highlighted the value of parents' influence in preschools, schools and school childcare. The report focused on the needs of different groups. Support to parents with immigrant backgrounds and parents with disabled children are discussed in several chapters. The commission also proposed a renewed agreement with the Association of County Councils on parent education for parents-to-be and parents with infants as well as a more distinct municipal responsibility regarding information and the coordination of parent support schemes.

Referral bodies were in general positive to the term "support for the parental role" and to the review of the agreements between municipalities and county councils. They were, however, less satisfied with the fact that they perceived many of the proposals as being too general and vague and that the commission had not demonstrated how resources were to be allocated. They also claimed that the commission had not discussed existing research and had not taken the demands of parents into account.

Contributors

Sven Bremberg has the main responsibility for the text and Anton Lager has prepared the background material.

References

1. Barnombudsmannen. *Konventionen om barnets rättigheter*. Barnombudsmannen. URL: http://www.bo.se.
2. Socialdepartementet. *Förskolan: Betänkande*. SOU 1972:26. Stockholm: Liber förlag;1972.
3. Socialdepartementet. *Föräldrautbildning: Betänkande från Barnomsorgsgruppen*. SOU 1978:5. Stockholm: Liber förlag;1978.
4. Barnomsorgsgruppen. *Barn och vuxna: Barnomsorgsgruppens slutbetänkande om föräldrautbildning*. SOU 1980:27. Stockholm: Socialdepartementet; 1980.
5. Socialdepartementet. *Stöd i föräldraskapet. Kartläggning av föräldrautbildningen*. Ds 1997:6. Stockholm: Socialdepartementet; 1997.
6. Socialdepartementet. *Stöd i föräldraskapet: Betänkande av Utredning av föräldrautbildning*. SOU 1997:161. Stockholm: Socialdepartementet; 1997.

2.

PARENT SUPPORT GEARED TOWARDS THE NEEDS OF THE CHILD

2.

PARENT SUPPORT GEARED TOWARDS THE NEEDS OF THE CHILD

Support to parents can be both geared towards the needs of the parents as well as those of the child. What is beneficial to the parents is often beneficial to the child, but this should not, however, be taken for granted. For example, if a measure leads to a parent talking more with other parents this may enhance the quality of life of the parent. The child's situation may also improve indirectly but the link between the parent's contact and the child's situation may be negligible. In this light there is reason to discuss parent support that is primarily geared towards the needs of the child separately from support that is geared towards the needs of the parents. This chapter focuses on the needs of the child, the following chapter on the needs of the parents.

The point of departure is the child's need for care. First, a presentation of the reasons why the state should be involved in an issue that is primarily the responsibility of the parents. Thereafter a section that deals with the link between the parents' relationship with their child and the health and welfare of the child. The following section deals with ways of influencing this relationship and finally certain considerations regarding the design of interventions aimed at influencing the parent-child relationship.

Responsibility for the welfare of the child

Caring for the child – a short history

Children need other people in order to survive and develop. Parents' efforts are crucial. Other children and other adults are also involved in most societies. This insight is best expressed in the African saying: "You need a village

to raise a child. "For the greater part of the history of mankind children have been surrounded by other people, both within and without the family; people who have taken a direct responsibility for the care of the child.

During the 19th century, western European societies became increasingly industrialised, which entailed the separation of certain functions in time and place: Adults started carrying out an ever greater part of their work outside the home. The children were then handed over to a very small circle of adults, often only the mother. During this period, infant mortality rose in the regions that were first industrialised, for example areas of Great Britain [1]. There are several explanations for this: poorer quality food, water and housing. Caring for the child also became a more vulnerable occupation when only one adult was responsible and it is probable that this vulnerability contributed to the rise in infant mortality.

Sweden industrialised late, only towards the end of the 19th century. A number of measures had already been introduced to come to terms with the problems that were caused by industrialisation and urbanisation, for instance improved sanitary conditions. There was already a state school system in place for children over 7. However, the conditions for the younger children were still fairly vulnerable with only one adult, usually the mother, with the sole responsibility for the care of her children. This vulnerability was accentuated by the fact that many mothers had to work outside the home for financial reasons.

Material conditions improved dramatically during the 20th century. Caring for the child outside the home was also developed. It subsequently included preschool, school and an expanded and publicly funded after-school recreation system. Preschool and school encompasses most children from the age of approx. 2 to the end of upper secondary schooling at the age of approx. 18. However, even now at the beginning of the 21st century it is still the parents who are mainly responsible for the care of the child, particularly during preschool years.

It cannot be taken for granted that the parents' responsibility will be complemented by others. In the pre-industrialised societies of Europe, parents' obligations were balanced with the responsibility that lay on the close family, the extended family and the Church. This responsibility has to a great extent been transferred to the nation-state in the high-income

countries of today, a change that has been particularly marked in the Nordic welfare states [2]. However, in southern Europe the nation-state's responsibility for the child is less marked [3]. This is reflected in national legislation where children are not regarded as independent individuals to the same extent as in the Nordic countries. One reason for this difference may be the position of the Church. The Church is separate from the state in Southern Europe while it was until quite recently part of the state in the Nordic countries. The Church has had a great deal of influence over the raising of children in the whole of Europe, not least through schools. In southern Europe, greater emphasis on the responsibility of the state could reduce the Church's influence. This might be a reason why the role of the family is more pronounced there as compared with the Nordic countries.

The parents' and the state's responsibility for the child

Resources allocated for the child can be described in economic terms, see Figure 2.1. The time parents spend looking after their children is the single most extensive effort. The value of parents' care has been estimated with the help of data collected from time studies and information on average pay levels and forms the basis of the calculations in the figure. The time parents spend caring for their children accounts for about a third of all the resources. Municipalities, county councils, the state and NGOs account for a further third while the remaining third comprises the cost of food, clothes and housing.

The view that the welfare of the child is important for society as a whole justifies using tax revenue to fund slightly more than a third of all the resources. There is an ethical reason for such a view. A professor of political philosophy, Johan Rawls, discusses the issue in a broader context where it has to do with what characterises a good society [4]. Rawls bases his views on an imaginary situation where a human being is born into a society and is unaware of which group she belongs to. A fair society is constructed in the way this "ignorant" human being would have constructed it. A society where a child is born into a poor family and becomes undernourished cannot be regarded as a fair society. Nor is a society where a child's chances of being educated are dependent on the position of the parents. It is possible to imagine other scenarios. Seen from the "ignorant" human being's perspective

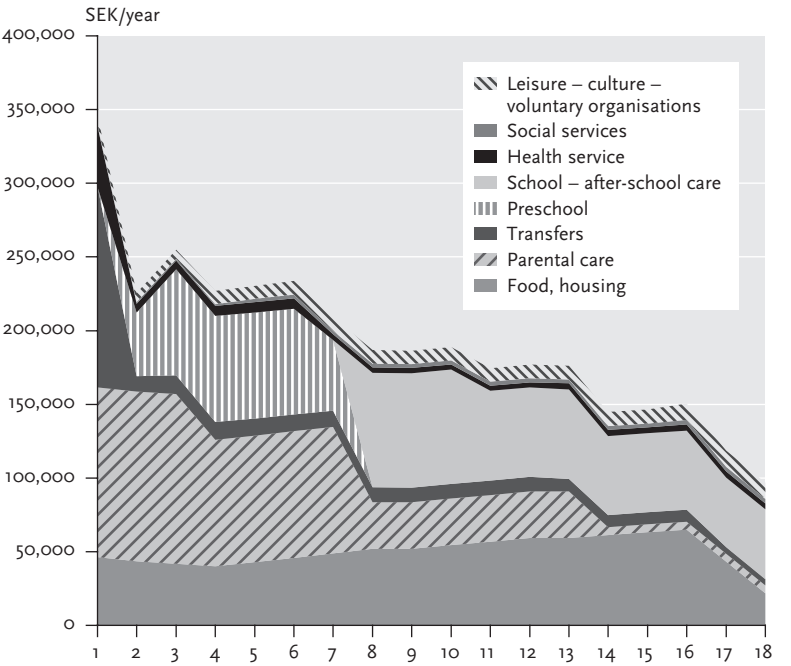

Figure 2.1 Interventions aimed at children in Stockholm County 1995.

a society that ensures similar conditions for all children can be regarded as more fair and good than a society that does not offer these possibilities.

This view is expressed in the UN Convention on the Rights of the Child [5]. The Convention stipulates, "States parties shall ensure to the maximum extent possible the survival and development of the child" (Article 6). Thus, according to this convention, the welfare of the child is not just regarded as the concern of the parents but also as the concern of the state.

Allowing children access to preschool and school regardless of their parents' financial situation is an expression of this joint responsibility for the child. It can be justified both from the child's and also the society's perspective. In order for a child to have a good life as an adult it is essential that the child is able to develop a number of skills that are fundamental in order to be able to participate in social life. Included in these skills are the three

Rs as well as social skills. A child partly develops these skills at school. A society that does not offer all children this possibility can hardly be regarded as a fair and good society. Skills of this type are also regarded as necessary in order to be able to participate in working life and thus be a part of the production that must be carried out for a society to survive. Therefore the shared interest in the welfare of the child is based both on ideas of what is fair and just and a shared interest in the survival of the society.

The Convention on the Rights of the Child stipulates further: For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities" (Article 18), that the "States Parties… shall take appropriate measures… to ensure that … parents… have access to education" (Article 24) and that the "States Parties … shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide… support programmes" (Article 27).

An issue of central importance is the extent to which it is reasonable for the state to provide parents with support. If the parents' care of their children does not live up to certain minimum requirements, Swedish legislation makes intervention an obligation of the social services. This minimum level affects a small number of children. A broader issue is whether it is justifiable for the nation-state to try to influence parents in general in their parenting duties. This issue can be discussed in ethical terms.

Ethical conflicts

An important aspect has to do with consequences for the autonomy of different parties, i. e. the question of self-determination. An intervention geared towards the child, either directly or indirectly via the parents, has an impact on the child's autonomy, the parents' autonomy and other adult citizens' autonomy. If the intervention promotes the child's skills, it will promote the autonomy of the child in the long and short term whilst the parents' autonomy is reduced. If the intervention is funded with tax revenue, it also infringes on the autonomy of other citizens since these funds might have been otherwise used for something determined by the individual. There is thus a conflict between the parents' right to autonomy and the child's right to welfare. There is no simple solution to this dilemma, but it is

possible to balance arguments about the child's right to health and welfare against the parents' right to autonomy.

The parents' freedom to make their own decisions on how to bring up their children is circumscribed by a legal provision by the state which is intended to support parents. Even an expert expressing views about how parents should take care of their children is an infringement. When Jean-Jacques Rousseau published his book "Emile, or Education" in 1762, he pleaded in favour of a child being allowed to develop in accordance with its own individual character. This book has been very influential and has thereby indirectly limited parents' possibility of freely using strict disciplinary methods.

There was a broad discussion in Sweden in the twenties regarding the importance of the parents for the health and development of the child [6]. The experts pointed at the mothers' lack of knowledge as one of the greatest threats to the welfare of the child and regarded that it was vital that parents, particularly the mothers, availed themselves of modern principles when caring for their offspring. Paediatricians and other professionals made their views on child-rearing known far and wide. An example of one such principle was that babies were only to be breast fed at fixed times, usually every four hours. The mothers had to learn to suppress any impulse to feed when the infant cried.

Knowing what we know today we can see that much of the advice was wrong. It was also a way of belittling the experience the mothers themselves had gained. During the last few decades advice given by experts to parents has normally been characterised by a greater humility. However, it is an infringement every time an expert of a state-funded measure expresses a view on how parents should act with their children [7, 8].

Something that might justify such an infringement of the parents' right to autonomy is if there is unanimous belief that a certain measure is very important for the child. Such an intervention is the state-funded school system. School is regarded as being so important that the parents do not have the right to refuse their children the right to an education. Child health-care and preschool are also regarded as being of great value to the child. Here, however, the parents are under no obligation to make use of these services, they are only offered them. The infringement in the autonomy of the parents is thereby mitigated. It would not, however, be satisfactory if

only the better-off parents made use of these services. The voluntary aspect would then have a price – a child from a lower income bracket would be disadvantaged.

In Sweden it has been possible to induce a huge proportion of parents to participate in these services even with the voluntary aspect. One important reason is that most parents perceive the interventions as meaningful. Therefore parent support interventions must be voluntary and many parents must want to participate. It is not easy to combine these two requirements. It is not uncommon for an organiser of a voluntary effort to state that "those who really need this measure don't participate". This means that the organiser places the responsibility for non-participation on the parents. However, in this discussion it would be more meaningful to say that the intervention in question is not well-designed.

Different societies view the right of the child on the one hand and the right of the parents on the other in different ways. Societies that put the emphasis on tradition normally focus on the rights of the parents, as in several EU states in southern Europe for example. In the Nordic region, however, the emphasis on tradition is weaker and thus the rights of the child are more in focus. This fact would indicate that there are particularly good opportunities for the development of parent support in Sweden.

The influence of experts

However, despite the voluntary aspect, the ethical problem of the influence of experts on the private sphere remains to a certain extent. It is not only limited to the way children should be brought up. However, it is more apparent here than in many other areas since the way you take care of your children is a very personal matter while at the same time parents are anxious for their children to have the best care possible. The German philosopher Habermas has written about the private versus the public sphere [9]. He makes a distinction between the "lifeworld" and "systemworld". The lifeworld consists of the world that we have direct experience of. The system-world is the world of rational thought stemming from science and bureaucracy, which increasingly penetrates our idea of what reality is. Habermas believes that the conflict between these two worlds can be settled through open discussion. This means that even if a study conducted scientifically should happen to indicate that a certain way of raising a child

is better this cannot be regarded as a given "truth". This truth must first be contrasted with the actual experiences of parents and these must be treated with the same respect as the scientific truths.

The psychologist Inga Gustafsson has been involved in the design of the current parent support schemes organised by the maternity and child healthcare services [10]. She sets parenting experienced intuitively against the views of the experts [11]. Inga Gustafsson maintains that the knowledge of experts has developed into a method that is geared towards that which is deviant. It is difficult for parents to make use of this knowledge when their children do not have any problems. Thus scientifically based parent support would be counterproductive. This criticism is linked to Habermas' lifeworld and systemworld. Other authors have also underlined the uncertainty felt by ordinary parents when childhood and parenting become the subject of scientific studies claiming to provide universal knowledge [12].

It is, however, doubtful whether good parenting is helped by rejecting the knowledge that is developed in the systemworld. One reason is that parents in general want to have access to existing knowledge [13]. Another reason is that all parents are exposed to the knowledge of the systemworld via the media. An example of this is the extensive discussions on ADHD/DAMP that have been conducted by the Swedish media during the last decade. It is therefore not particularly appropriate to try to dismiss the knowledge of the systemworld. Instead it is more advisable to promote critical reflection on the knowledge of children and parenting that is presented. It is also reasonable is use knowledge that might lead to improved health and welfare for the child providing you take a cautionary approach. This entails amongst other things that interventions must be evaluated continuously.

One risk of using knowledge that has been developed in the systemworld is that parenting becomes an intellectual act. Parents gain access to terms that might be useful in discussions but that might not have an impact on the everyday life of the child. The risk of intellectualisation is apparent in the current parent groups organised by the maternity and child healthcare services since the intervention is limited to the participants discussing various issues pertaining to parenting. However, the methods that have been evaluated and are referred to in Chapters 6–8 emphasise practical exercises for a number of different skills. There are indications that a practical

dimension of this kind is vital if a child is to benefit directly from the intervention; it also counteracts the risk of intellectualisation.

The impact on the autonomy of the taxpaying citizens is not resolved by the voluntary aspect for the parents. One common way of clarifying a conflict of this type is to set the value of the intervention's "benefit" to the child against the costs entailed. It is more difficult to defend costs if the arguments supporting parent support are primarily based on ideas of good parenting.

In the last decade there has been a marked increase in the knowledge about the impact of different forms of parent support. According to an extensive review of preventive interventions based on literature published up until 1990, it was doubtful whether parent support schemes have any demonstrable effects at all [14]. We now know, as is made clear in Chapter 3, that such interventions really do have an impact. Most of the studies referred to in the chapter were published after 1990.

Thus, it is imperative that a parent support intervention has been demonstrated to promote the welfare of the child and it is therefore necessary to discuss what this requirement actually entails.

The welfare of the child

Welfare is normally regarded as a collective term for the living conditions of people in Nordic welfare research. A description of people's welfare is based on a description of their working environment, housing, financial situation, leisure, health, material assets, civic activities, social relationships, employment, transport, security and training and education [15]. This idea of welfare is close to the meaning of the capability approach used by the economist Amartya Sen to describe the conditions required for people to be able to fashion the kind life they themselves wish to lead [16]. The philosopher Martha Nussbaum, who has worked together with Sen, has further developed the analysis of the conditions required to lead a full human life [17]. She specifies a number of capabilities, including the capability of using one's senses, being able to visualise, use one's common sense, appreciate and choose, form emotional relationships with other people, enjoy and play, reflect critically over one's own life, participate in social contexts and in political life and perceive oneself as an individual who is worthy of respect from other people) [17].

These concepts have been developed to describe people's welfare in general. This applies both to children and adults, and also to low income and high income states. A child's situation in a high income state like Sweden, however, has a number of distinctive features. The things that limit a child's living conditions are linked more to relationships between people than to material resources. The material conditions still play an important role, but primarily through an impact on social relationships. A teenager may for example feel left out of his/her group of friends if he/she cannot afford a ticket to a concert that everyone else in the group can. The impact is social even if the resource in question is material.

Variations in health between children are also generally strongly linked to relationships between people. Most health problems experienced during childhood are most common in socially less favoured groups [18]. This variation can often be linked to differences in the interaction between children and other people. The greatest individual health problem of children over the age of one is mental ill-health. This kind of ill-health is clearly linked to relationships between people.

Large groups of adolescents start taking substances that affect their feelings and experiences (mainly alcohol, tobacco and illegal substances) as teenagers and young adults. The health effects are more obvious in adulthood than in childhood. In Sweden, there is also a clear link between these ill-health risks and relationships between people rather than material conditions.

Relationships between people are therefore crucial for the health and welfare of the child. The single most important relationship during childhood is the parent-child relationship. This means that interventions that promote good parent-child relationships have a good chance of promoting the health and welfare of the child.

Mental ill-health

Changes in material conditions in the 20th century have led to a dramatic improvement in the *physical health* of the child. In the year 2000, for example, infant mortality had decreased to a twentieth of what it was a hundred years earlier. All physical health problems in children, bar asthma, have experienced a positive trend, including during the nineties.

The tendencies as regards the mental health of the child, on the other hand, give rise for concern, particularly as mental ill-health is the single most important health problem for the entire age group 1–44 [19]. Several studies indicate that mental ill-health in children and adolescents has increased since the beginning of the 1990s. Studies of the 16–24 age group indicates that symptoms such as worry, anxiety and insomnia have increased threefold during the same period [20] and studies of fifteen-year-olds indicate that symptoms such as headaches, stomach aches and depression have increased by up to 40 per cent during the same period [21]. A similar development has been reported in Norway [22]. There is no clear explanation for this development.

Risk factors for ill-health in adulthood are partly formed during adolescence. This applies to tobacco, alcohol and drugs, diet and fitness habits as well as excess weight. There is a clear interaction between these types of behaviour and mental ill-health. T his means that it is by improving the mental health of the child that you can best have an impact on this ill-health in adulthood.

Interventions for parents offer one of the most important ways of preventing this type of problem. According to one American study, serious physical and mental illnesses occurring at the age of 55–60, were three times less likely if both parents had been affectionate and caring throughout childhood [23]. The illnesses studied included cardiovascular disease and alcoholism. The assessments were made by the individuals themselves when they were in their early twenties. Neither of the parents had shown such an attitude towards their children in the control group. Other conditions which might have explained the results were taken into account in the study. However, it is not possible to be entirely certain that the parents' attitude was decisive. It is therefore important to carry out experiments where children are followed from childhood into adulthood.

One such experiment has been carried out in Finland, starting in the 1970s in Helsinki. In the study, ordinary parents with newborn babies were divided at random into two groups. The first group was provided with counselling in the home once a month by a person specially trained in childcare and parenting. The second group only had access to the regular measures. The children in these families were then followed up in repeated studies. Without exception, the children in group one suffered fewer mental

problems. 17 per cent of the control group suffered mental problems at the age of 20 to 21, which is a relatively average figure [24]. In the first group, however, the occurrence of similar problems was reduced by a third. This study indicates, as do a number of other studies, that interventions geared towards parents may have positive effects.

It is remarkable that the limited parent interventions in the Finnish study could give such tangible results more than 15 years after the home visits. The history of the development of childcare outlined above helps us to understand these results. Until the era of industrialisation about a hundred years ago, most children grew up together with several adults and many other children with whom they had close relationships. What has happened since then is that children have increasingly been left to one or two adults in a family where almost half of the children are the firstborn child. In this modern family, the parents rarely have easy access to other adults with previous experience of children, who can help them develop their own parenting skills. The Finnish scheme, just like other forms of parent support, might thus be perceived as one way of correcting the problems caused by the development of the modern family.

The child-parent relationship

Good child-parent relationships

Throughout history there have always been views about what characterises good parenting. These views are then conveyed in the shape of stories or pieces of advice. Views regarding good parenting are closely linked to ideas about what constitutes a good life in general. Today we are aware of the fact that such ideas are linked to time and culture. There are different ways of reacting to this. Some say that, since these views vary, it is up to each individual human being (parent) to decide for him/herself which view he/she sees as right. Generalisations are rejected. This standpoint can be characterised as post-modern or neo-liberal.

The philosopher Martha Nussbaum's analysis of welfare represents an alternative approach [17]. Nussbaum also rejects the idea of universally applicable descriptions of a good life. She claims that it is still possible to

make a preliminary identification of characteristics (skills) that are required to lead a full human life. Nussbaum approaches the issue by examining myths and other stories. She asks herself the question, as did Aristotle, what is it that sets humans apart from the Gods – and from beasts. This method allows her to identify a preliminary list of traits that characterise humans. The list includes the ability to bond emotionally with other humans.

This text is based on Nussbaum's view, i.e. that it is possible to give a preliminary description of desirable skills. In this context this has to do with certain characteristics in parents promoting the welfare and development of the child [25]. There are two characteristics that have long been perceived as valuable:parents giving their children *affection* and parents being able to control their children's behaviour (*set boundaries*). A large number of studies, in which children have been observed for many years during their childhood, have confirmed the importance of these characteristics [26, 27]. Moreover, there is clear evidence to support the view that parents can also promote the *cognitive development* of the child.

Some researchers who focus on the importance of genetic heritage on a child's behaviour claim that the environment in which a child grows up, namely the family, preschool and school, plays a very small role [28]. Parents may behave differently towards children, but this is seen as primarily being due to the characteristics of the child and not vice versa. Variations between children are explained by their contacts with friends. Children choose friends based on their own genetic preconditions. According to this research tradition, the attitude of the parents may play a role, but only if it deviates greatly from the average attitudes of parents.

Genetic research is primarily based on comparisons of identical and non-identical twins where the aim has been to distinguish between the importance of heredity and environment. These studies rarely include an assessment of different ways for parents to react towards their offspring. Thus the conclusion regarding the limited importance of the parents is indirect. The assessment of the importance of different factors can be better demonstrated in experiments than in these studies. Chapters 4 and 6–8 refer to a large number of experiments that have demonstrated that interventions that result in parents changing their attitude and approach also lead to changes in children's behaviour, both short-term and long-term.

Many of these programmes are based on promoting relationships where the parents are affectionate and able to set boundaries. This would indicate that behavioural genetic research paints an all-too narrow picture.

Affectionate parent-child relationships

The characteristic that children rate highest in parents is the ability to be affectionate and caring [29]. Parents' affection is more important than the material conditions of the family and quite often more important than relationships with friends. An adult who is affectionate with a child first notices something in the child, interprets its significance and then shows that he or she understands the child. Thus, being affectionate is not something intangible, a matter of course and something that therefore cannot be changed.

The first stage of parent-child interaction is the parents' interpretation of the expressions of the child. The interpretation is crucial and determines the reaction that follows. For example, if a parent interprets an infant's cry as an expression of anger, he/she will react very differently compared to if the cry is interpreted as being an expression of loneliness. A further example: When a three-year-old refuses to get dressed he may be saying that he wants to continue playing indoors, but he may instead be saying that he is tired and has not got the energy to go out. The parents' reactions are completely different depending on their interpretations.

A parent's ability to interpret a child's behaviour is closely linked to how well the parent knows what the child thinks and does. For an older child, this implies that the child tells the parents what he/she is doing, which in turn implies that the child has faith in the parents. This faith develops when the parents have shown that they understand the child at an earlier stage [30]. Thus, child and parents have a mutual impact on each other. If the parents are affectionate there is a greater chance that the child will act positively towards the parents, which in turn makes it easier for the parents to be affectionate and so on. The opposite is also true. If the parents do not understand the child there is a greater risk that the child will react negatively which in turn make it more difficult for the parents. Thus there are both vicious and "virtuous" circles.

The parents' interpretation of the child is probably the most important part of parent-child interaction. Even with a given interpretation there are a

number of different ways a parent could react. *Clear signals* facilitate interaction and reduce the risk of encountering problems at a later stage [31]. Clear and specific requests that the child easily understands ("Peter, pick up your jacket from the chair.") are better than vague ones ("Be a good boy now!").

When a parent gives *consistent messages* and does what he says, the continued interaction is facilitated and the risk of problems reduced. Empty threats are ineffective since a child learns not to trust or listen to what the parent says. Quite often what a parent does is more important than what he says. Consistent signals/messages that are both comprehensible and not combined with violence appear to be particularly important [32]. If parents react unpredictably it may lead to negative interaction. One example of this is when parents sometimes give in, in order to prevent a fit, and at other times inflict harsh punishment for minor offences.

There is less risk that the child will run into problems at a later stage if the parents leave the child some room for *self-determination* [33]. This can, on a practical level, mean that the parent offers the child choices. For a child of preschool age this might for instance, be the chance to choose between juice or milk to drink, or being able to choose which colour hat to wear.

According to the many studies that have examined the behaviour and reactions of parents and children in families fraught with conflict, the conflicts in these families are rarely resolved. The problems that arise make the parents react aggressively towards the child and the child responds with aggressive behaviour. The next time a conflict arises, the family does not start a small-scale argument but instead it rapidly escalates into a fierce one. In time even unimportant events will lead to bitter confrontation [34]. Thus a lack of affection can lead to an ever cooler climate in the family, and similarly an understanding between parents and children can lead to more affection and stability.

The parents' interaction affects the child's ability to interact with other people later in life. The link between the interactive pattern developed during the first 18 months of a child's life and social skills later on in life is particularly clear [35]. Thus affection between parents and children promotes social skills and several of the other skills mentioned above. It is particularly important for a child to learn to see him/herself as a valuable human being and to understand that the social environment is predictable.

Setting the child boundaries and providing stimulation

A similar interaction between children and parents also applies to the parents' ability to *set boundaries*. If the child knows what boundaries apply, he/she does not have to test them. The child's energy, as well as that of the parents' for that matter, can then be used for interaction that is more positive in nature than a conflict about boundaries.

There is also an interaction between stimulation and curiosity, and being prepared for further learning. "Virtuous" circles can thus be promoted by stimulating cognitive and linguistic development.

Conditions for good parent-child relationships

The external circumstances are decisive for good parent-child relationships. Parents who live in stressed social conditions may find it difficult to develop a good relationship with their children [36]. Interventions in the form of parent insurance, children's allowances and labour market policy are therefore central to the promotion of good parent-child relationships. This also applies to family law.

One such condition for good parent-child relationships is time. In the child welfare studies [Barn-ULF] that were started in 2000, the following question is asked of children aged 10–18: "How much time have Mummy and Daddy respectively got for you?"[37]. Eleven per cent of the children felt that their mothers had too little time for them and 14 per cent that their fathers had too little time. Two to three per cent of the children felt that their mothers and fathers had on the contrary too much time. Only three per cent felt that both parents had too little time. Thus most children are happy with the time their parents spend with them. It is worth noting that there is little difference between children of different ages when it comes to this issue of time. It is more common for children of white-collar workers to say that their parents spend too little time with them compared to the children of blue-collar workers.

The parents have a different picture of the situation at home. In the *Barn-ULF* study the parents are not asked about their relationships with their children, but they are asked to say to what extent they feel mentally exhausted when they come home from work. Feeling exhausted when they come home might have an impact on the relationship with their children. Seventeen per cent of the mothers and seven per cent of the fathers said they

felt exhausted. It was most common for mothers with the longest working hours to feel exhausted. However, the children of these mothers did not say that their mothers spent less time with them. Nor was there a link between the working hours of the fathers and the children's idea of how much time their fathers spent with them. This would seem to indicate that the children's and parents' perception of the situation at home have partly different justifications.

Sweden Statistics have carried out repeated studies of time use. A comparison between 1990/01 and 2000/01 shows that both men and women have more leisure time [38]. The women have more because their domestic work has been reduced and the men because they work less. There has been no significant change in the time parents spend with their children.

A special analysis of these time studies is based on the child [39]. This analysis indicates that the time parents spend with their children has diminished, particularly with regard to the younger children. There appears, however, to be a simple explanation for this. A major part of the change is probably linked to the fact that the childcare/preschool system was expanded during the nineties. Moreover, it has become more common for children with a parent on parental leave to go to preschool or family daycare and the children also participate in more activities outside the home. Parents also seem to spend more time with one child at a time. This means that every child gets less time with the parents, but also that the parents probably interact more with the one child during the time they spend together.

A relatively positive average picture of the time parents spend with their children emerges. It does not correspond at all with the picture that is portrayed in the media – an ever greater lack of time. It is possible that the picture portrayed in the media corresponds better with the situation experienced by certain groups, for example professional parents whose children are more prone to saying that their parents do not spend enough time with them. In conclusion it seems that a general lack of time is not the factor that most infringes on the ability of the parents to develop a good relationship with their children.

The child's perception of the parent-child relationship

In the *Barn-ULF* study, the children were also asked whether they normally talked to their parents about their concerns [37]. Half said that they did

whilst 19 per cent said that they did not talk to either their fathers or mothers and 46 per cent said that they did not talk to their fathers. This means that parent-child relationships, particularly father-child relationships, are not as good as they might be. Other data in the same study on how well children get on with their parents seems to support this view. Fifteen per cent said that they did not get on well with their mothers and 17 per cent that they did not get on well with their fathers. It was more common for blue-collar worker children not to get on well with their parents, particularly their fathers.

The Children's Ombudsman has asked school children about their relationship with their parents, using both questionnaires and interviews [40]. Most said that they were satisfied with their family relationships whilst 10 per cent said that they were not satisfied. The children in the Children's Ombudsman study were younger which might explain why the picture emerging from it is more positive. The positive parent characteristics that the children highlighted particularly were loving and understanding. The children also wanted to have parents who listened to them and who were involved in both their school and leisure time activities. A majority of the children felt that it was more important for their mothers to "be full of praise for their children" than their fathers.

In other words, most children seem to be happy with their relationships with their parents. However, a not insignificant group feel that they only get limited support from their parents. This is particularly noticeable in the father-child relationship, where 50 per cent said that they normally did not talk to their fathers about things they were worried about. It is possible to approach this data in different ways. If a corresponding study had been conducted 50 years ago, fewer children would probably have said that they felt that their fathers supported them. In that respect, the picture could be regarded as positive. On the other hand, if an adult person chose to live with a man and 50 per cent of such adults said that they usually did not normally talk to him about their worries, it would be rather odd if the person in question would continue to live with him. However, such is the father-child relationship and the children cannot generally choose where they are going live.

Thus, the parent-child relationship does not seem to be as good as it might be. The explanation is probably not a lack of time. This is why it is justifiable to examine to what extent it is possible to support a development towards a better parent-child relationship.

Having an impact on the parent-child relationship

Having an impact on parents' relationships with their children

The question is how to support parents in their ability to be affectionate, set boundaries and give stimulation. Such support should be based on how people normally learn different types of behaviour. These principles are used within the area of public health in the forming of programmes that are aimed at supporting behavioural changes of importance to health.

One principle is based on *social learning theory* [41]. The principle is a simple one – we learn behaviour by observing what others do. We primarily learn by directly observing other people. Other people's stories can also have an impact on us. This principle can be transferred to parent support. If parents meet other parents together with their children they can see how others act, for example, when other parents are affectionate with their children. This might help parents develop their own ability to be affectionate with their children. This happens in practice at the open preschool.

Seen from an historical point of view, learning through observation has probably been the dominant principle for the transferral of parenting skills from one generation to the next. One precondition for this is that several adults take care of the children together. In most cultures, several adults, normally women, take care of the children together. The adults are then able to learn from each other. Our culture, where one parent on his/her own normally takes care of one or two children, is probably an exception. This means that it is rather difficult for parents to learn these skills through observation.

It is to a certain extent possible to create meeting places where parents can spend time together. Open preschools are one such meeting place for parents with young children. Playgrounds and cafés are other places that may serve in this way. The main problem is the fact that the time the parents can spend there is very limited – far removed from a household with several children and several adults spending their days together.

Learning can to a certain extent take place when parents hear how other parents react in different situations. This type of learning is possible when parents meet and talk about what it is like to have children. There are, however, very clear limitations. The main limitation is that it may be difficult to describe in words most of the things we do. A parents' story

might also be interpreted in different ways. The transfer of skills through discussions is in all probability facilitated if the stories told are concrete, possibly requiring the discussions to be structured in advance. If a professional person talks about different ways of looking after a child, the stories might become more readily understandable. On the other hand, parents in general have greater difficulties identifying themselves with professionals as compared with other parents with similar backgrounds. Learning is therefore not enhanced.

A second principle for learning is based on what in English is called *self-efficacy*. this can be translated as meaning having faith in your own ability to act in a certain way [42]. This may seem like a trivial principle: a human being will have a greater chance of behaving in a certain way if he/she believes he/she can do it. What is interesting here is that it is possible to influence this faith. The main source of faith is having succeeded in doing something before. In practice it is therefore possible to promote certain behaviour by giving parents the chance to try changing the way they act with their children, taking it *in small steps*. The parents then have the chance of succeeding, which enhances their faith and thus their chances of making ever greater changes. This is possible if the parents have access to a structured method or are given repeated advice based on this principle.

Parents' faith in their own ability is primarily developed through first hand experience. Faith is, however, also affected to a certain extent by *what other people say.* A parent may, for example, be told that the way he/she looks after the children is good. This reinforces the parent's faith in his/her own parenting skills. The effect of the stated views of others is, however, not as strong as first hand experience of having succeeded at something.

The principle of promoting self efficacy may seem simple. Counselling within the healthcare services is quite often designed in such a way as to inform parents that they are making various *mistakes*. This naturally undermines parents' faith in their own parenting skills. This in turn might reduce the parents' ability to learn behaviour that promotes the welfare of the child.

People's behaviour is also affected by *information and knowledge*. The link is apparent in certain circumstances. One example is the situation that arose at the beginning of the 1990s when it became clear that it was possible to prevent a large number of cot deaths (sudden infant death syndrome) by

letting babies sleep on their backs instead of their stomachs. Two television programmes sufficed to ensure that a majority of all parents changed their behaviour.

Most behaviour that has to do with parents and children is, however, more complex than that. Normally, there are no clear links between knowledge and behaviour. This does not mean that knowledge is unimportant. Knowledge can influence behaviour if a parent has access to answers to a tangible question, when the question arises and when the reply is presented in a meaningful way to the parent. Answers given by experts are most appropriate in certain cases. With other questions it may be more important that the answer comes from someone the parent is able to identify with, a relative, a friend or another parent.

The principles described above are similar to those that apply when people acquire new skills – from cooking a new dish, to learning to play football, to handling a new job. Even if these are general principles this does not necessarily mean that all the principles are practicable in all contexts. It is therefore a good idea to give an explanation of the different types of parent support.

Different types of parent support

The most important type of parent support is informal contact with others; relatives, friends and acquaintances. It is possible to increase access to informal contacts by creating specific meeting places, for example in the shape of open preschools. However, it is difficult to demonstrate the effects of *meeting places* on the children.

One common way of providing contacts is via special *parent groups*. These are, for example, provided by maternity and child healthcare clinics. They may be open or structured. In completely *open* groups it is the parents themselves who decide the subjects that are going to be discussed. In *structured* groups there is a leader who uses a given method. The leader is trained in the method and uses material that has been developed for the measure. In this way the set-up is similar regardless of the leader. Between these extremes there are of course also other forms where a group leader has designed a model in which different subjects are discussed in a certain order. The model is not, however, written down and it is linked to a specific group leader. This is the way groups are usually organised at maternity and child healthcare clinics.

Parents are given support via *individual contact* with a professional. This type of communication may occur through meetings in the home, at a clinic or over the phone. An example of this type of communication is when a parent meets a nurse at the child healthcare clinic or a social welfare secretary at a social welfare office. These meetings may be *open* or *structured* in advance.

Parents also get support through the *media*; through books, newspapers, magazines, radio, television, video and material published on the Internet. The media often lack interactivity. Parents can choose what they want to see but cannot normally influence the contents. This limits parents' possibility of using the information in practice. One particular form is a *discussion group on the Internet*. This is similar to meeting in an open group since the parents themselves decide the issues they wish to discuss. But in this case the parents put their thoughts in writing rather than orally.

The effects of parent support interventions

In the evaluation of a parent support intervention, it is essential to have knowledge about the effects. This is because all types of parent support infringe to some extent on the autonomy of the parents, even if the parents participate voluntarily. One precondition for justifying parent support is that it contributes to the welfare of the child. Thus the effects of each separate form of parent support must be analysed.

The best way to get information about the impact of a certain intervention is through controlled experiments. This means that one group of parents are given access to a certain intervention while another control group of parents is not. The parents and children in both groups are then followed up. If the children in the group with parents that have participated in the intervention fare better then this is a strong argument that the intervention benefits the children. This argument is reinforced if the same result has been seen in several studies and if the parents in the experiment groups and control groups have been selected randomly.

It is therefore possible to argue in favour of different types of parent support based on the results in the experiments that have been carried out. There are, however, several limitations to the method. One is that studies based on experiments are costly to carry out. There are few methods that have been evaluated in this way in a small country like Sweden. It is therefore

necessary to use the results from other countries, above all the USA where most studies have been carried out. But the situation of children and parents in the USA differs from their situation in Sweden. Hence it cannot be taken for granted that the results would be the same here.

Another limitation is the fact that only certain types of parent support have been evaluated in experiment form. Structured methods, with a predetermined content, are most suitable for this type of evaluation. Hence these methods are better represented among the methods that have a proven effect. Open methods are on the other hand much more difficult to evaluate. It would, for example, be difficult to test the effect of the open preschool with the help of experiments. A controlled experiment would entail that certain parents in a housing area would have access to the centre whilst others would not – in order to have a control group. This would hardly be acceptable.

When it is not possible to carry out an experiment the next best alternative is an observation study. Applied to the open preschool this would mean that you first find out which parents normally go to the open preschool in a number of housing areas. The children in these housing areas are then followed up. If the children of parents who have been to the open preschool fare better that would be an argument in favour of the effect of the open preschool. One precondition would be that you have to take into account any differences between the parents who have visited and those who have not visited the open preschool. It is, however, difficult to be certain that all differences have been fully taken into account. Thus the results are less reliable than those of an experiment.

If neither experiments nor observation studies have been carried out the remaining alternative is to argue in favour of a certain intervention effect based on theory. One example of this is support for parents who are under a lot of pressure. It has not unexpectedly been demonstrated in a number of studies that these parents have greater difficulties fulfilling the needs of the children. In other studies, researchers have demonstrated that people who have access to close contacts, relatives and friends fare better than those who lack that type of social support. Theoretically it is therefore possible to claim that improved social support may lead to children faring better. There is, however, a risk that this theoretical claim does not correspond with reality. There is therefore a greater uncertainty than if it had been

possible to observe the link between social support and the welfare of the child.

It is thus possible to rank the reliability of claims regarding the effects of a certain intervention. The most certain method is an experiment, followed by an observation study and least certain are theoretical claims.

It is naturally possible to ask a parent who has participated in a certain intervention whether they feel their participation has given them anything. This type of study is common. In most such studies a majority say they are satisfied. There are two reasons for this. One is that those who are not satisfied quit. The second is that those who have participated want to persuade themselves that their participation was meaningful. To continue participating in something that is not regarded as positive would be to belittle one's own judgement. It is therefore difficult to draw any conclusions regarding the effect of various interventions based on information from the participants on how satisfied they are.

Ranking evidence

An evidence ranking system is currently (Autumn 2004) being developed at Swedish National Institute of Public Health (SNIPH). The system is based on medical [43] and social practice adapted to public health issues. The system is based on the design of a number of studies and their results. A preliminary ranking system is described below:

Determinants

*** 1) Good reliability. The importance of the determinant has been demonstrated in at least 2 cohort studies, case-control studies, controlled experiments or a systematic review of these studies. Without significant dropping out from the studies and a check of important confounders (disturbing factors) has been made.

** 2) Moderate reliability. At least 2 studies in accordance with 1) but not all conditions have been fulfilled or there is no systematic review of these studies.

* 3) Some support. A few well-made time series, case studies, cohort studies, case-control studies, controlled experiments or a systematic review that looks into these studies.

0 4) Vague support. Other studies, including cross-section studies.

Intervention methods

*** 1) Good reliability. The value of the method demonstrated in at least 2 randomised controlled studies without significant dropping out, where control and experiment groups are comparable, or where there is a systematic review of these studies.

** 2) Moderate reliability. At least 2 randomised controlled studies in accordance with 1) but where not all conditions have been fulfilled. Alternatively, at least 2 cohort studies, case control studies, non-randomisedcontrolled experiments or a systematic review of such studies. There is no significant non-response in the studies and a check of important confounders has been made.

* 3) Some support. A few time series, cohort studies, case-control studies, controlled experiments or a systematic review of these studies.

0 4) Vague support. Other types of studies including cross-section studies.

A scientific or post-modern view of knowledge

The effect of a method is dependent on the parents, the children, whoever is in charge of the activity and the environment. This means that any conclusions regarding impact can never be completely reliable, even if positive results have been obtained from several experiments in which parents have been randomly divided into groups. This lack or reliability can be dealt with in a number of different ways. Educational research in Sweden has for the last few decades represented one view. According to this view, the context is such a crucial factor that it is very rarely possible to draw any general conclusions as regards effects. This view can be termed post-modern.

Medical and scientific research represent the opposite view. Here there is great faith in the value of controlled experiments, particularly experiments where the experiment groups have been selected at random. The assessment of new drugs is entirely based on this type of knowledge. It is partly the type of intervention that is being studied that gives rise to the difference between the two standpoints in educational and medical research. The effects of a drug are obviously much less dependent on context than the effects of a certain educational method.

It is difficult to justify a given parent support intervention by using the post-modern research tradition. This latter tradition is instead more suitable

for any criticism of such initiatives. This means that it may be difficult to defend parent support interventions that are to a great extent dependent on context if the state and municipality have the main responsibility. Legitimacy must instead be based on the reliability ranking presented above, in accordance with scientific tradition. Preventive interventions in the medical field are subjected to these requirements [44].

The reason for discussing *parent support geared towards children* and *support geared towards parents* separately is knowledge of the positive effects on the child. Interventions aimed at promoting the welfare of the child have quite often been studied in experiments where the effects have been demonstrated in a large number of studies, see Chapter 4. It is therefore possible to say something about the value of these interventions with good or moderate reliability. Effects on the child of interventions that are primarily aimed at the parents have normally not been studied. This means that positive effects on the child can only be based on theory, making the conclusions less reliable. Thus such interventions are dealt with separately, see Chapter 3.

Even when a certain method has been studied in experiments and has demonstrated an effect in repeated experiments, there are still a number of problems as regards translating the results to Swedish circumstances. The structured methods that have been studied include several elements. The controlled experiments that have been carried out only give answers to whether all the elements together have had an impact or not. It is not possible to determine whether certain components, a few components or the entire combination have been crucial.

The methods that have been evaluated are based on the precondition that the group leader has been trained in them. Training not only entails that the prospective leader has gained the skill to carry out certain elements. Training also means that leaders learn to take a certain approach. It may be that this approach is more important than the ability to carry out certain elements [45]. Questions of this type are not answered by the experiments.

Many experiments have been carried out in the USA where the living conditions of the child are often not as good as those in Sweden. Socially vulnerable groups have also been the focus of many experiments. It is probable that the effects are more tangible than they would be in Sweden. Thus

basing a discussion of various forms of parent support on international scientific studies gives rise to a number of problems. One recourse would be to reject all possibilities of using scientific studies as a basis for the improvement of the situation of the child. This report takes the view that such an attitude is all too pessimistic. Instead this report supports the use of these scientific studies as guidelines rather than models that determine how interventions should be designed in Sweden.

This report focuses on interventions with demonstrated effects on the health and welfare of the child. Many of the interventions provided by the maternity and child healthcare services and open preschools have not, however, been studied from that perspective, which is why they are not discussed. This does not imply that they may not have any positive effects, only that it is not possible to say anything about them.

The design of interventions geared towards children

Interventions for parents in general or only for groups at risk

Parent support can both be aimed at parents in general and special groups of parents. The former is more costly than aiming at smaller groups and therefore a strong argument for concentrated efforts. Interventions aimed at smaller groups dominate in high income countries with liberal traditions like the USA and the UK. A majority of the scientific studies have been carried out in these countries. The literature is therefore marked by this viewpoint.

There are, however, strong scientific arguments against solely aiming interventions at smaller groups. Parent support that enhances the health and the living conditions of the child must have an effect on one of several determinants. The discussion above indicates that it is a good idea to try to help parents to be very affectionate with their children and at the same time set boundaries. Parents' ability to be affectionate and have control is probably spread widely in the population. Certain parents are very affectionate with their children, others less so. There is no support for the view that most parents behave in an optimal way towards their children and that it is only a small group of parents that are deficient.

The link between these determinants and different outcomes for children also seems to be constant. A little affection is less positive and a lot of affection is better [46]. Most parents do not behave in an optimal way. This does not really matter to an individual child as long as the child is not subjected to a lot of stress. In general, just being good enough is enough [47]. From the population perspective, however, it is important if more parents are able to be somewhat more affectionate and develop the ability to set their children somewhat clearer boundaries since small changes for many children have a greater impact at the population level than major effects on a few. This type of link, which is usually described as the preventive paradox [48], is common in public health issues. An example of this is the link between blood pressure and cardiovascular disease. It is generally believed that there is a large group of individuals with normal blood pressure that do *not* run a risk linked to blood pressure. The risk is instead perceived as being linked to a smaller group of individuals with high blood pressure. The link has, however, been shown to be constant and the risk increases constantly with rising blood pressure. Only a few individuals of middle age have an entirely optimal blood pressure [49]. This type of link means that from a population perspective it is more effective to provide many individuals with small interventions compared with providing a few individuals with major interventions. Dealing with already established problems entails a different perspective. You generally require major interventions in order to have any impact at all.

The interventions that are required for dealing with high blood pressure are different to those that can be used to promote normal blood pressure in the population at large. Blood pressure is normally treated with drugs. Promoting normal blood pressure is, however, based on health promoting factors, for example, physical activity or a reduced salt intake. This report focuses primarily on promoting protective factors rather than counteracting risk factors.

The arguments above are theoretical. They may seem alien to people working in the social services or paediatric and adolescent psychiatry since these services are aimed at relatively small groups with major problems. An often presented belief is that it is important to identify at an early stage those parents (and children) who run the risk of developing major problems. For this to be possible you must be able to predict reliably which

children run the risk of developing major problems. Stability over time varies with the degree of difficulty of the problems. Children with major problems show a greater stability over time than children with moderate or more minor problems.

From the population perspective it is sensible to take preventive measures in respect of the 1 in 20 children who have the most serious problems. Broadly speaking the problems of that particular group of children are so serious that they will in any event come into contact either with paediatric and adolescent psychiatry or the social services. There are several longitudinal studies on how this group develops over time. One example is a study from Uppsala where the children were followed from the age of 4 to 10 [50]. Three quarters of the original risk group normalised between the ages of 4 and 10. By definition this meant that there remained a problem group but that three quarters of it were recruited from the normal group. Other similar studies have been presented [33]. These results indicate that in order to prevent major problems at aged 10 it would be necessary to provide interventions for at least 4 x 5 = 20 per cent at the age of 4. Twenty per cent of all children comprises such a large group that the targeted methods normally used are less suitable.

There are also practical reasons that speak in favour of broad interventions. In many countries parent support is only provided for families that are evidently socially vulnerable. Families who accept this type of support are aware of the fact that it is only being provided because they belong to a socially marginalised group, perhaps causing those who would greatly benefit from such an intervention to have doubts about accepting it. On the other hand, if all families are provided with the intervention, and parents in general see the benefits of it, the chances are that also the socially vulnerable families will participate actively. This broad approach has been the guiding principle for interventions provided by the state and municipalities for families in Sweden. The maternity and child healthcare services are examples of this approach.

A guiding principle in the report has therefore been that it must be possible to use the methods presented broadly. One target has been that the method must be interesting to at least five per cent of all families within a given age group. This means that interventions aimed at parents, or children, with specific problems are not discussed in this report at all; in turn

meaning that the interventions discussed are of general interest. For example, interventions for depressed mothers discussed in Chapter 6 are important to 10–15 per cent of women and as such are discussed in this report, but there are no proposed uses outside this specific group.

One of the main reasons why interventions aimed at the 5 per cent of all children and parents with the most serious problems is not discussed is that there already are specific organisations whose task is to provide these parents with special support, for example paediatric and adolescent psychiatry, social services and child and adolescent rehabilitation. These organisations have professionally active staff with expert knowledge about how to support parents in problem families. A report of this kind cannot be expected to add anything of importance to the knowledge about methods that already exists within these organisations. A further special group is parents with adopted children. Support for these parents was discussed separately in a commission report presented in 2003 [51]. Hence, this group of parents is not discussed in this report.

Health-promoting interventions

When treatment is sought for a problem, one measure is rarely enough. For example, a child with ADHD might need interventions aimed at the parents, the teacher and the school environment. Drugs may also be required. It often is not enough to propose only one single measure. On the other hand, when it comes to preventive activities it is important to identify protective factors that reduce the *risk* of ill-health. Not everyone who smokes will have a heart attack, but when smokers stop smoking, the risk of getting cancer and heart problems is reduced in the population as a whole. It is normally not possible to predict just who will benefit.

The same thing applies to parent support aimed at reducing the risk of mental disorders in children. If parents are able both to be affectionate and to set boundaries, the *risk* of mental disorders is reduced. But children do have problems despite the fact that parents are affectionate and provide a secure environment, and children who experience a difficult childhood may still fare very well mentally. It is crucial, from the public health perspective, to identify factors that have been shown to be important and that can be influenced without causing harm. This means that even if the interventions

aimed at reducing the occurrence of insecure attachment, see Chapter 6, cannot prevent all mental disorders, they may be able to help reduce the *risks* of such problems if they are provided on a broad basis. Clinical activities are thus distinguishable from health-promoting inventions.

Interventions for different age groups

The brain develops most rapidly during the first few years of life. This might be why preventive interventions in general have a greater impact during preschool years than later on during childhood [14]. One contributing factor might also be that "skill gives rise to skill". If a child develops a positive form of interaction with other people during the first few years of life, it will enhance the child's ability to cope with different situations and in turn promote the development of the child. This in turn promotes the child's development. In this way virtuous circles are created and it would seem that parent support provided during the first few years of child's life has a greater impact than support provided later on.

Aggressive behaviour problems and internalizing mental problems

Many of the interventions that have been evaluated have been created to reduce the risk of aggressive behaviour problems, including problems normally referred to as ADHD, DAMP and behaviour disorders. These problems lead to drinking, taking illegal substances and committing crimes during adolescence [52]. The impact odifferent programmes on this type of problem has often been studied while Internalizingmental problems have been studied much less often.

Internalizingmental problems mainly include depression and anxiety. These types of disorders probably cause greater problems for the child itself as compared to the problems caused by aggressive behaviour disorders [53]. Emotional problems on the other hand do not give rise to any major problems for the child's environment. This is probably why aggressive problems are often paid more attention than emotional problems.

It is probable that an intervention aimed at parents that has been shown to prevent aggressive problems also prevents emotional problems. This is firstly because both types of problem often occur at the same time. An estimated 40 per cent of all children with aggressive behaviour problems also

suffer from emotional problems and vice versa [54, 55]. Giving parents the opportunity to develop the way they react towards their children is one way of preventing both aggressive and emotional problems.

Dissemination of different ways of looking after children

The discussion on the importance of parents being affectionate and setting boundaries would seem to indicate that not all ways of looking after children are equally good. If parents are able both to be affectionate and to set boundaries, children fare better. All parents are, however, not able to do this to the full; justifying the question why. If it is important to have a childhood characterised by affection and boundaries in order to cope with life, one might have expected that all families would have gradually developed such characteristics over the centuries. If children do *not* have such a childhood, their life chances are reduced as well as their chances of having children themselves. Humans adapt to the options at hand. Inappropriate attitudes will presumably gradually disappear.

Studies of children with so called insecure attachments point at a possible explanation [56]. An insecure attachment reduces the life chances of a person. Despite this, insecure attachments are relatively common. One explanation might be that the way parents look after their children reflects the parents' own experience of the environment that the child is being prepared for. Unfortunately, if this environment is unpredictable, materially speaking poor and conflict-ridden, it is not always appropriate to calmly trust everybody. It is better to be prepared for abrupt changes caused both by others and by the physical environment. This perspective also applies to the way parents look after their children. The way children are looked after probably reflects the parents' own experience of the social environment and in particular of childhood.

The living conditions of people in Sweden have changed drastically during the course of a few generations. At the beginning of the 20th century the conditions were materially-speaking poor for most. Starvation was a reality. Children ran a huge risk of hurting themselves physically and so it made sense to prepare the children for an environment filled with risks, conflicts and abrupt changes. During the second half of the 20th century most people enjoyed a material wealth that had earlier only been reserved for the fortunate few. These new wealthier living conditions probably gave

rise to the more relaxed attitude to children and child-rearing that developed during the post-war period.

Moreover, life became more individualistic and far less predictable in nature during the 20th century and particularly during the last 50 years. [57]. In the fifties it was common for young people to choose a profession that was close in nature to that of their parents; for both financial and traditional reasons. Still today, at the beginning of the 21st century, it is to a great extent the background of the parents that determines the professional choices of young people. However, mobility is much greater.

This change entails the individual becoming more responsible for different choices. This in turn means that the situation of the young today, compared with the generation that grew up during the mid-nineteenth century, is characterised both by greater freedom and by greater individual responsibility. In the past, traditions and poor material conditions exercised a type of control which now must be exercised by the individual him/herself. This freedom, both from limitations in material standard and from traditional values, seems to be more developed in Sweden than in any other country [58].

This means that new demands are placed on parenting. Having control over your child during their upbringing is not enough since it does not prepare them well enough for the freedom they encounter as adults. Being affectionate is not enough either since this does not prepare them well enough for situations where they themselves have to choose and plan, both for the short term and the long term. What children need is *both* affection and boundaries. At the beginning of the 20th century control was in focus whilst during the 1960s and 70s children's need for affection was in focus. Today it is more important than ever that parents are *both* affectionate and able to set boundaries.

During the spring of 2004 the phenomenon of "curling parents" was discussed in Swedish media. The debate was based on a book by Danish psychologist, Bent Hougaard – *Curling-forældre og service-børn* [Curling Parents and Service Children] [59]. Hougaard points at the fact that parents of today tend to "brush" intensively in front of their children (the curling stone) so that everyday life can be as friction free as possible. The children are given a lift to different activities and when the family has a meal together the parents try to oblige them as regards different dishes even if it means every child getting his/her own specially put together menu. This

would hardly have been thinkable a hundred years ago. In the short-term this probably reduces the number of conflicts with the parents, but it is doubtful whether this is the best way to prepare children for the life that awaits them as adults. This example shows that every era requires its own blend of affection and boundaries in parenting. The parents cannot just copy from their own upbringing.

Two extracts from a morning newspaper highlight this dilemma: "Only yesterday a friend and I – both of us with two children – sat and talked about how to get ourselves out of the vicious circle of doing everything on the children's terms and being a service family. Our 2.5-year-old decides almost everything at home. And I know why. 'What do you want to eat, to wear?' Our intention has been to create a democratic family and give him self-confidence. But he seems to have become confused by all these choices. "When I was little (born 1970) it was natural to play on my own. My mother would never have sat down next to the dolls house and played for two hours or spent an entire day on the sledging slopes drinking hot chocolate. And when the family visited relatives we enjoyed each other's company on the adult's terms. As an adult I value this enormously and I feel lucky to have been able to practise my social skills at an early age, to have learnt how to be bored and often got no for an answer." [60].

How parents should combine affection with boundaries is not given. Parents' views on good parenting are determined by their own experiences during childhood. Normally their own childhood is seen as "natural". Parents also understand that the demands that will be made on their own children will differ from those of their own childhood. The implications are unclear. A state initiative concerning the dissemination of new forms of parent support may *speed up* the process of adapting parenting to the conditions that today's children are expected to meet as adults. The initiative cannot create such a development; only promote an already ongoing process.

Methods can be disseminated in different ways. Experience of other areas indicates that it is a good idea to use a variety of methods for different groups [61]. Some people prefer to acquire the methods together with others in a group. Others believe it is better if they can study material in printed form or on video by themselves at home. Therefore it is good if these methods can be provided in different ways.

The dissemination of new methods normally follows a regular pattern as illustrated in Figure 2.2 [62]. To begin with there is a smaller group that uses a certain method and the method is disseminated slowly. After a while the pace increases. This is illustrated by the straight line in the figure. The pace subsequently slows down and reaches a degree of saturation at the end of the process. Distinct measures are required during the initial phase although the immediate effects are limited. However, the need for measures during the rapid phase is limited since the dissemination process at that stage is mainly about people talking to each other spontaneously independent of any organised activity.

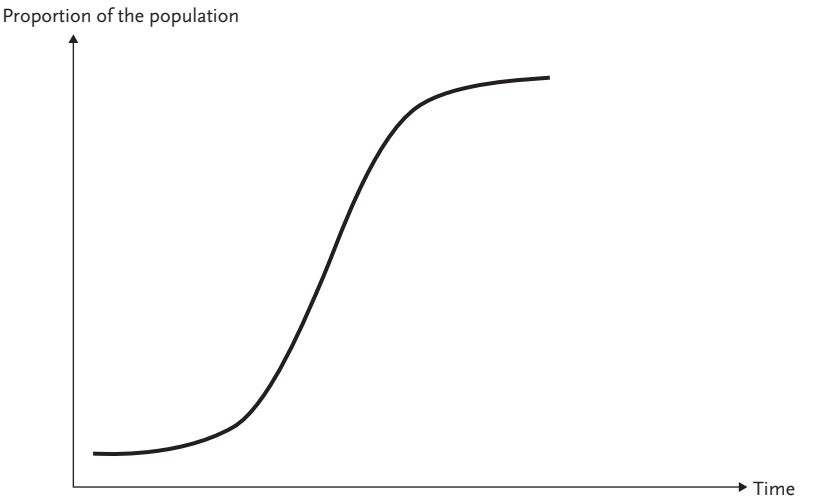

Figure 2.2 The course of the spread of an innovation.

This approach to the process of dissemination indicates how important it is that the viewpoint that is conveyed in different forms of parent support locally is the same that is given to professionals with a responsibility for children: teachers at preschool or school level, nurses and midwives in the maternity, child and school healthcare services, social workers and psychologists. Information concerning this approach and attitude is disseminated

through discussions between parents and between parents and professionals. In this light it makes sense to start dissemination in limited areas in one municipality where both parents and staff learn about the methods. This facilitates recruitment to parent groups as it increases the possibility of parents meeting people who have firsthand knowledge of these methods. This approach might also contribute to parents spontaneously exchanging experiences of a scheme they have participated in. A suitably sized area might be a housing area with 2,000–5,000 inhabitants where the children, aged 6–12, go to the same school.

The methods that will be recommended are aimed at supporting parents in their ability to give their children affection and set boundaries. The principle is a general one and parents are expected to come into contact with it in many different ways, above and beyond contact with groups led by trained professionals. This means that group leaders do not necessarily need to follow strictly the programmes that have been developed and evaluated. If the core is an approach people ought to be able to disseminate it freely. Requiring a group leader to have specific training might therefore seem a way of hampering a desirable spread.

Figure 2 indicates that the dissemination of new methods comes to a halt after a while without all individuals having absorbed information about the change. The reasons may vary, but often it is often a matter of certain groups that are under a lot of pressure. A large number of studies show that families who are subject to social pressures have greater difficulties than others in giving their children the optimal combination of affection and control. Therefore these groups need specific and more extensive interventions. These interventions are only discussed here briefly since these families already are to a large extent in contact with the social services and paediatric and adolescent psychiatry.

Contributors

Sven Bremberg is responsible for the text. Berit Hagekull has been involved in the section on parent-child relationships.

References

1. Steckel RH. Industrialization and health in historical perspective. In: Leon D, Walt G, Eds. Poverty, inequality and health. An international perspective. Oxford: Oxford University Press; 2000.
2. Esping-Andersen J. Three worlds of welfare capitalism. Cambridge: Polity; 1990.
3. Therborn G. The politics of childhood: The rights of children in modern times. In: Castles FG, Ed. Families of Nations. Patterns of public policy in Western democracies. Aldershot: Dartmouth; 1993, p. 241–92.
4. Rawls J. A theory of justice. New York: Harvard University Press; 1989.
5. *Konventionen om barnets rättigheter*. Barnombudsmannen. URL: http://www.bo.se.
6. Ohrlander K. *I barnets och nationens intresse*. Stockholm: Stockholms universitet; 1992.
7. Björkman J. *Barnexperterna lämnar oss ingen ro*. Svenska Dagbladet 2003-11-27.
8. Palmblad E, Börjesson M, red. *Problembarnets århundrade: Normalitet, expertis och visionen om framsteg*. Lund: Studentlitteratur; 2003.
9. Ritzer G, Goodman DJ. Sociological Theory. 6 ed. McGraw-Hill Higher Education; 2004.
10. Föräldrautbildning: *Betänkande från Barnomsorgsgruppen*. SOU 1978:5. Socialdepartementet; 1978.
11. Gustafsson I. *Det eviga projektet att göra föräldrar till bättre föräldrar.* Psykisk Hälsa 2004;2.
12. Halldén G, Sandin B. *Barnets bästa: En antologi om barndomens innebörder och välfärdens organisering*. Symposion; 2003.

13. Vallgårda S. *Ökad styrning av barns hälsa i både Danmark och Sverige*. Läkartidningen 2004;101(11):1021.

14. Durlak JA. Successful prevention programs for children and adolescents. New York: Plenum; 1997.

15. Statistiska centralbyrån. *Undersökningar av levnadsförhållanden – ULF*. URL: http://www.scb.se/tjanster/register/ulf.asp.

16. Sen A. Equality of what? Oxford: Oxford University Press; 1980.

17. Nussbaum M, Ed. Aristotelian social democracy. London: Routledge; 1990.

18. Bremberg S. *Sociala skillnader i ohälsa bland barn i Sverige – en litteraturöversikt*. Stockholm: Swedish National Institute of Public Health; 2002.

19. Bremberg S. *Bättre hälsa för barn och ungdom. En strategi för de sämst ställda*. Stockholm: Folkhälsoinstitutet-Gothia; 1999.

20. *Privatpersoners användning av persondatorer och Internet 2003*. Stockholm: Statistiska Centralbyrån; 2003.

21. Danielsson M. *Svenska skolbarns hälsovanor 2001/02*. Stockholm: Statens folkhälsoinstitut; 2003.

22. Wold B, et al. *Utvecklingstrekk i helse och livsstil blant barn och unge fra Norge, Sverige, Ungarn och Wales. Resultater fra landsomfattende spørreskjema-undersøkelser tilknyttet prosjektet "Helsevaner blant skoleelever. En WHO-undersøkelse i flere land" (HEVAS)*. Bergen: Universitetet i Bergen, Hemil-sentret; 2000.

23. Russek LG, Schwartz GE. Perceptions of parental caring predict health status in midlife: A 35-year follow-up of the Harvard Mastery of Stress Study. Psychosom Med 1997;59(2):144-9.

24. Aronen ET, Arajarvi T. Effects of early intervention on psychiatric symptoms of young adults in low-risk and high-risk families. Am J Orthopsychiatry 2000;70(2):223-32.

25. Dishion TJ, Patterson GR. The timing and severity of antisocial behavior: Three hypotheses within an ecological framework. In: Stoff DM, Breiling J, Eds. Handbook of antisocial behavior. New York: Wiley; 1997, p. 205-17.

26. Baumrind D. Child care practices anteceding three patterns of preschool behavior. Genet Psychol Monogr 1967;75(1):43-88.

27. Baumrind D. Effective parenting during the early adolescent transition. In: Cowan PA, Hetherington M, Eds. Family Transitions. Hillsdale, NJ: Erlbaum; 1991.

28. Scarr S. The development of individual differences in intelligence and personality. In: Reese HW, Franzen M, Eds. Biological and neuropsychological mechanisms: Life-span developmental psychology. Hillsdale, NJ: Lawrence Erlbaum Associates, Inc; 1997, p. 1-22.

29. Backett-Milburn K, Cunningham-Burley S, Davis J. Contrasting lives, contrasting views? Understandings of health inequalities from children in differing social circumstances. Soc Sci Med 2003;57(4):613-23.

30. Stattin H, Kerr M. Parental monitoring: A reinterpretation. Child Development 2003.

31. Forehand R, Rogers T, McMahon RJ, Wells KC, Griest DL. Teaching parents to modify child behavior problems:an examination of some follow-up data. J Pediatr Psychol 1981;6(3):313-22.

32. Patterson GR, Reid JB, Dishion TJ. Antisocial boys. In: Jenkins J, Oatley K, et al., Eds. Human emotions: A reader. Malden, MA: Blackwell Publishers; 1998, p. 330-6.

33. Campbell SB. Behavior problems in preschool children: A review of recent research. J Child Psychol Psychiatry 1995;36(1):113-49.

34. Ferrer-Wreder L, Stattin H. *Vad kan man göra i familjen för att förhindra ungdomsvåld och kriminalitet?* Stockholm: BRÅ; 2001.

35. Beckwith L, Rodning C, Cohen S. Preterm children at early adolescence and continuity and discontinuity in maternal responsiveness from infancy. Child Dev 1992;63(5):1198-208.

36. Lewis M, Feiring C, McGuffog C, Jaskir J. Predicting psychopathology in six-year-olds from early relations. Child Development 1984;55: 123-36.

37. *Barns och ungdomars välfärd.* SOU 2001:55. Socialdepartementet; 2001.

38. Rydenstam K. *Förändring av tidsanvändning under 1990-talet.* Välfärdsbulletinen 2002.

39. Nordström Å, Persson L, Landgren Möller E. *Barnens tid med föräldrarna*. Stockholm: statistiska centralbyrån; 2004.

40. *Vem bryr sig?* Stockholm: Barnombudsmannen; 2003.

41. Bandura A. Social learning theory. Englewood Cliffs, NJ: Prentice-Hall; 1977.

42. Bandura A. Self-efficacy: The Exercise of Control. Basingstoke: W H Freeman & Co; 1997.

43. Britton M. *Evidensbaserad medicin.* SBU, Statens beredning för medicinsk utvärdering. URL: http://www.sbu.se/www/SubPage.asp?CatID=127&PageID=689.

44. *Vårdens svåra val.* Slutbetänkande av Prioriteringsutredningen. SOU 1993:93. Stockholm: Socialdepartementet; 1995.

45. Crowly M. Which programme is best? The Parenting Education & Support Forum 2003; (March 25).

46. Baumrind D. A developmental perspective on adolescent risk taking in contemporary America. In: Irwing C, Ed. Adolescent social behavior. San Francisco, London: Jossey-Bass Inc., Publishers; 1987.

47. Bowlby J, Gut E, Wiking P. *En trygg bas: Kliniska tillämpningar av bindningsteorin.* Stockholm: Natur och Kultur; 1994.

48. Rose G. The strategy of preventive medicine. New York: Oxford University Press; 1998.

49. World Health Organisation. World Health Report. Geneva: WHO; 2002.

50. Mellbin T, Sundelin C, Vuille J. *Från 4 år till 10*. Stockholm: Socialstyrelsen; 1982.

51. *Adoption – till vilket pris? Betänkande från Utredningen om internationella adoptioner.* SOU 2003:49. Stockholm: Socialdepartementet; 2003.

52. Farrington D. The challenge of teenage antisocial behavior. In: Rutter M, Ed. Psychosocial Disturbances in Young People. Cambridge University Press; 1995, p. 83.

53. Peterson S, Backlund I, Diderichsen F. *Sjukdomsbördan i Sverige – en svensk DALY-kalkyl*. Stockholm: Karolinska Institutet, Folkhälsoinstitutet, Epidemiologiskt Centrum, Stockholms läns landsting; 1999.

54. Anderson J, Werry JS. Emotional and behavioral problems. In: Pless IB, Ed. The epidemiology of childhood disorders. New York: Oxford University Press; 1994, p. 304-38.

55. Merikangas K, Angst J. The challenge of depressive disorders in adolescence. In: Rutter M, Ed. Psychosocial Disturbances in Young People. Cambridge University Press; 1995, p. 131.

56. Coall DA, Chisholm JS. Evolutionary perspectives on pregnancy: Maternal age at menarche and infant birth weight. Soc Sci Med 2003;57(10):1771-81.

57. Bauman Z. The individualized society. Cambridge: Polity Press; 2001.

58. Inglehart R. Globalization and Postmodern Values. Institute for Social Research at University of Michigan; 2000.

59. Hougaard B. *Curling-forældre og service-børn*. Vejle: Hougaard; 2000.

60. Läsarbrev till Idagsidan. Curling parents. Svenska Dagbladet 2004-01-19.

61. Manoff RK. Social marketing: New imperative for Public Health. New York: Praeger; 1985.

62. Rogers E. Diffusion of innovations. New York: Free Press; 1983.

3.

SUPPORT GEARED TOWARDS THE NEEDS OF PARENTS

3.

SUPPORT GEARED TOWARDS THE NEEDS OF PARENTS

Children are dependent on their parents. If the parents are happy, then the chances are that the children will be happy too. This is why support aimed at parents indirectly benefits the children even if it has not been possible to demonstrate that the support has an actual impact on the children. The focus of this chapter is precisely this type of support.

Here is an example of a family: There is a three-year-old boy in the family who goes to preschool. His mother is concerned about the fact that her son is never still, so she discusses his behaviour with one of the teachers at preschool. After this discussion, the mother understands the situation better because she has been told that both her son and other boys of the same age at preschool behave in the same way. She feels better, which makes things easier for the boy even if it is not possible to directly demonstrate that the boy has benefited from the discussion.

In the example above, the mother talks to a person whose profession is focused on children. The mother might have talked to a friend instead with possibly the same effect. It is also possible that after some time the mother herself would have come to the conclusion that the boy's behaviour was perfectly normal without having discussed the matter with anyone else. It is therefore not possible to analyse support geared towards the needs of the parents in the same way as support geared towards the needs of the child. Instead it is better to make use of the concepts that have been developed to gain an understanding of how people generally give each other support.

Social support

Most people need human contact in order to fulfil their basic needs. This is something that could be described as a need for support. The concept "parent support" is linked to this. The importance of human contact has been the subject of several sociology and social psychology studies. The concept had its breakthrough in the field of public health towards the end of the seventies when a very important study was published demonstrating that human contact was probably the most important factor in people's survival and for their health in general [1]. This study gave rise to extensive research, which tried to clarify how human contact might affect health and well-being. Studies of this type also demonstrated that children fared better if parents had good contact with others [2]. Apparently the number of contacts is less important than whether the parents are happy with them or not [3].

However, subsequent studies on the impact of social contact often demonstrated contradictory results [4]. Some studies confirmed the effects of social support whereas others indicated the opposite. This was probably due to the fact that people with good social contacts also often have access to other resources. It therefore proved to be difficult to distinguish between the importance of social contacts and other resources.

Research on the importance of different aspects of social support has been carried out in order to try to understand how social contact promotes health and well-being. Some important aspects are access to information, practical help, emotional support [5], support in judging a situation in order to be able to make a decision (appraisal) [6] and access to companionship [5].

Parents need access to *information* on issues that have to do with children and parenting. It does not matter whether the information comes from friends and acquaintances, television or newspapers. What is important is that the information is comprehensible and that it is available when it is required, usually when a parent is faced with a new problem.

Practical help is naturally very important, not least for parents with young children who need a lot of supervision. Parents' access to practical help, for example a babysitter, depends on their social contacts. Many families move to a new housing area at the birth of their first child, at a time when they are in great need of practical help. It might be difficult to get that

type of help if you have not had the time to establish a relationship with others in the neighbourhood. It is therefore possible that interventions aimed at promoting contact between parents might also make it easier for parents to get practical help.

Support in *judging a situation* in order to be able to make a decision is important when parents are faced with new problems and need information about them, which they can obtain either orally or by reading up on the issue at hand. The parents also need to evaluate the information that is available, which they can do on their own but often it helps to discuss a matter with someone who is prepared to listen, for example a partner. It is also often important to be able to discuss the issue with a person who is well-informed. It is largely this type of contact that parents have with the child healthcare services.

Emotional support is given both through individual contacts between two people and in a group where parents meet several times. Emotional support is particularly important when an urgent problem arises. A parent might be in such a tense situation that it is difficult to find a constructive solution. By talking about the problem and by others describing their experience of the same problem, tension may be reduced.

A fourth form of social support is *companionship*. When people meet they can exchange information and support each other emotionally. This type of meeting is valuable in itself in that people can feel equal to the others in the group, which means that they can both give to others and get something in return themselves.

What is important is how support is provided and interpreted [7], which means that advice might be perceived in one way if it is given by a close friend and in a totally different way if it is given by a stranger. The context determines how the support is perceived.

Social support is particularly valuable when a parent is faced with a problem or is under some kind of pressure [8]. The support may lead to the parent coping better with the pressure. The child's situation may improve and companionship is in any case valuable in itself.

Social support is probably most important to people who are under a lot of pressure since most people are able to adapt to more minor problems. On the other hand, if there are major problems, one single brief contact will not suffice, presumably the support must be more extensive than that. This

would seem to indicate that there is *no* point in generally increasing parents' access to social support. In many fields, small improvements for many people have a greater impact on the population at large than major interventions for a few people. This principle is normally called the preventive paradox [9]. It is uncertain whether this principle applies to social support since most people are able to cope with minor problems on their own.

Informal social networks

Most parents are in touch with relatives, friends and acquaintances on a regular basis. This type of contact can be described as the parents' "informal social network" in contrast to their "formal network", i.e. their contact with professionals who are responsible for children and families.

Access to social support is mainly provided through the *informal* network. Contact with professionals acts as a complement to be used in certain situations. Thus the best way to give parents support is by trying to reinforce their informal network, both qualitatively and quantitatively speaking.

Statistics Sweden conducts a study of living conditions [ULF] on an annual basis where people selected at random are asked among other things about their social relationships [10]. The most recently published figures are from 2001 and it is clear from these that about 50 per cent of both singles and couples with children see a close relative at least once a week. There have been no major changes since the beginning of the 1990s.

In the same study, 2.8 per cent of single parents said that they did not see any close relatives and 11.6 per cent that they did not have any close friends. The corresponding figures for couples with children were 2.8 per cent and 18.1 per cent respectively. Only about 1 per cent of families with children (single parents and couples) said that they had little social contact. The number without close contacts other than close relatives, without close friends and with few social contacts has decreased somewhat since the beginning of the eighties in both types of families.

These figures indicate that most parents with children have sufficient informal social networks. Therefore there seems to be no justification for only trying to increase the number of contacts between parents and other people.

Informal social networks according to the parent questionnaire (Chapter 5)
Contact with others does not necessarily mean that you also have contacts who can give you support in your parenting role. In the questionnaire described in Chapter 5, parents were therefore asked whether they were given support in various situations by a partner, a relative or a friend, see Table 3.1. According to the table, only a few respondents said that they lacked this type of support for their parenting role.

	Number saying they get the support in question (per cent)		
Question	**Not from anybody**	**From 1–2 people**	**From more than 2 people**
If you were to get cross or irritated with your child(ren), is there anyone you can turn to and if so how many people?	2.8	38.5	58.7
If you have a minor problem with your child(ren), for example regarding food, how many family members or friends are you able to talk to in confidence?	2.2	25.6	72.2
If you needed someone to look after your child(ren) for a while one evening, how many people could you turn to?	5.1	36.2	58.7
If you are really upset or cross, do you have anyone you can really talk to regardless of what it is about and if so how many people?	4.7	49.8	45.5
If you are really happy, is there anyone you can tell who you know understands you and who will be happy for your sake? If so, how many people?	1.1	16.8	82.1
Do you currently have anyone you can share your innermost feelings with? If so, how many people?	10.1	65.6	24.3

Table 3.1 Access to different types of informal social support according to the population study presented in Chapter 5.

The respondents in the same study were also asked how often they met their social contacts and how often they could get help, see Table 3.2. The answers indicate that most (99 per cent) had contact with friends/relatives, but only two-thirds had close contact with grandparents or neighbours.

Question	Number who say they are given the support in question (per cent)		
	Not at all	Not often	Quite often
How often do you meet or telephone friends/relatives?	1	7	92
How often are you able to get help from the child(ren)'s grandparents (maternal and paternal)?	15	18	67
How often do you see your neighbours?	11	27	62
How often do you and the child(ren)'s other parent help each other with the child(ren) (food, playing, homework etc.)?	13	11	76

Table 3.2 The number of times the parents have access to informal support.

It is possible that the data in the questionnaire underestimates the number of parents with insufficient support since a fairly large proportion of the respondents did not fill in the questionnaire and since it is possible that those who did not respond might not have such easy access to support. However, the data from the ULF studies referred to above also supports the view that most parents have contact with others who can give them help in their parenting role.

The study also investigated access to support in various groups. Access to support was estimated as an index based on ten questions. The division into different groups is presented in Table 3.3. Access to informal social support was lower among single parents, parents with a low standard of education, low-income families, parents born outside the Nordic region and parents who felt that they were under a great deal of parenting pressure. There was no statistically reliable difference between men and women, between those living in cities compared with the rest of the country or between parents with or without children with disabilities or illnesses.

Aspect	Less advantaged group	Index for informal support (confidence interval)	More advantaged group	Index for informal support (confidence interval)
Civil status	Single	2.80 (2.71–2.88)	Married/ co-habiting	3.22 (3.19–3.26)
Level of education	Low	2.87 (2.76–2.98)	High	3.19 (3.12–3.26)
Family income	Low	2.81 (2.71–2.90)	High	3.32 (3.26–3.37)
Country of birth	Outside the Nordic region	2.80 (2.68–2.92)	Nordic	3.20 (3.17–3.23)
Parenting stress	High	3.03 (2.98–3.07)	Low	3.29 (3.25–3.34)

Table 3.3 Access to informal support in more advantaged or less advantaged groups (all differences are statistically reliable).

Even if most parents seemed to have good informal networks there were those who lacked contact with other people. The questionnaire did not give any answers about the reasons for this lack of contact. One explanation might be the parents' lack of ability to forge contacts with others. Another might be a lack of places to meet. The latter explanation is important in practice since it is possible to organise meeting places of this kind, for example in the shape of open preschools.

Different types of parent support

It seems therefore that most parents have access to support from others through informal social networks. These networks are insufficient for some parents. Certain issues might also become urgent if people in the informal networks are unable to provide any answers to them. Thus the parents' natural informal networks require supplementary measures, which might be in the *shape of meeting places*, open and structured *parent groups*, open and structured *individual contacts* as well as the media including *discussion groups on the Internet*.

Open preschools and other meeting places for parents

In the autumn of 2003 there were 550 *open preschools* in Sweden [11]. These are intended for children and parents in families where the children

do not go to preschool. The questionnaire study described in Chapter 5 did not indicate a link between access to open preschool and social support. In other words, further studies are required in order to be able to establish the importance of the open preschool system.

Family welfare centres combine maternity and child healthcare services with open preschool and access to a social welfare secretary. This combination increases access to open preschool and thus any effects it may have on the parents' social network. The study did not, however, include a separate analysis of the effects of the family welfare centres.

There are many other public places where parents can spontaneously meet and establish contact with each other: playgrounds, parks, markets, shops and many more. Parents also meet in other contexts, such as when children are dropped off/picked up from preschool, when parents participate in their children's leisure activities and at parent-teacher meetings. The way such meeting-places are designed and utilised is a major issue concerning society as a whole. Therefore there is no point in trying to distinguish one particular part of this issue, i.e. parents meeting parents. A number of sociologists, including Sennett, have analysed the issue , including Sennett [12] and Bauman [13]. However, an analysis of the importance of these meeting places in modern society is not within the framework of this study.

Structured parent groups

Parent groups with a structured programme are normally geared towards directly enhancing the situation of the child. Therefore the effects on the child or the parents' behaviour towards the child have been examined in the studies that have been conducted. This is discussed in Chapters 6–8.

Many other structured methods for different groups of adults have been evaluated. Normally a scheme is aimed at helping the participants with a specific problem, for example a depression. Naturally, the child may benefit from these schemes. They are not, however, within the framework of this report.

Interventions aimed at promoting a good relationship between parents who live together are particularly important for the children since family conflicts increase the risk of ill health in the child [14]. There is much support for the view that structured interventions aimed at improving communication between the adults in a family may improve the climate in the

family in the long term. Interventions geared towards the parents' relationship are therefore discussed separately in Chapter 9.

Open parent groups

Open parents groups can be organised in different ways; they can be geared towards all parents or just groups of parents with a common problem.

Open support groups geared towards all parents

The impact of totally open discussion groups where the parents themselves determine the contents entirely on their own has not been studied. However, the effects of group activities organised by midwives have been studied. A review of six controlled studies does not indicate that these measures have any demonstrable effects whatsoever [15]. No studies of similar group activities organised by the child healthcare services have been conducted. Therefore it is not clear whether open discussion groups geared towards all parents have any positive effects at all. These methods have not, however, been properly studied, particularly postnatal activities.

It is also possible to judge the value of open discussion groups by examining the methods that are used. There is a lot of literature on the different methods that are used to influence people's health and welfare [16]. A general conclusion might be that effects have mainly been demonstrated if the educational method used includes elements that may influence the behaviour of the participants. These elements might include helping the participants to identify important behaviour and then practising suitable approaches, for example using role play. Other elements might entail making the participants aware of how they interpret any given situation and how they subsequently react in accordance with this interpretation. It seems, however, not possible to demonstrate any effects on behaviour in methods that are only aimed at enhancing the knowledge and understanding of the participants.

Material used in parent groups has been examined for the purpose of this report and is presented in Chapters 7 and 8. There are very few factors aimed at influencing behaviour which would seem to indicate that the open parent groups do not have any impact on either behaviour or thus health and welfare.

In a lot of material, the emphasis is on describing the development of the parent-child relationship during childhood. This type of material may be used to ponder about parenthood and may enhance the parents' understanding of the child's situation and their own. This is naturally very important in itself. However, one might question whether this justifies the organisation of open parent groups because parents can ponder about parenthood in a number of other ways, for example through natural conversation or through newspapers, magazines, books, radio, television and the Internet. Adults in Sweden spend on average one hour a day on social gatherings and three hours a day on television, radio and reading [17]. Time spent on parent meetings and parent groups only amounts to two minutes a day. It is therefore reasonable to suppose that more than one per cent of the time spent on social gatherings and media is focused on questions that have to do with parenthood, which in turn suggests that these channels are becoming increasingly important sources of information for pondering about parenthood compared to the parent group meetings that are provided.

Open support groups geared towards groups with problems

In a literature search, four studies on open parent groups geared towards groups with problems were found. These were all controlled studies; three of them were randomised. Positive effects were demonstrated in three of the four studies. Depressed mothers discussing child-rearing participated in one of the studies [18]. The intervention reduced the number of family conflicts and helped the mothers to feel better about their parenting skills. In the second study, socially disadvantaged mothers met twice a week to discuss different topics [19]. The participants felt less isolated, under less pressure and that they got more support in their parenting role. Parents with epileptic children participated in the third study. These parents discussed matters like fear of the side effects of medicines and the ordeal of not being able to manage their children in the right way. The intervention reduced the parents' feelings of anxiety [20]. In the fourth study, the intervention was geared towards parents with diabetic children. However, it was not possible to measure any statistically reliable effects of the discussion group in this study [21].

Studies of open support groups for people with problems have been carried out in a number of other areas. A systematic review includes ten

studies with experiments and control groups, nine of which included randomly selected groups [7]. Positive psychological effects, for example reduced anxiety, depression, tension and fatigue were demonstrated in eight of the nine studies where such effects had been examined. In all the three studies that looked at the physiological effects, positive effects were demonstrated, for example reduced blood pressure.

Negative effects were demonstrated in one of the ten studies. Women who had recently been diagnosed with breast cancer participated in the study. The women who had participated in the support group suffered more mentally and functioned less well socially [22]. The study also found that the women had affected each other negatively during the group meetings. A further analysis, however, demonstrated that a smaller group of women had benefited from the intervention. These latter women did not get much support from their partners or their attending physicians [23].

The scientific publications often give a poor description of the contents. It is, however, probable that much of the time is spent on developing certain skills, for example coping with problems like anxiety and breaking out of social isolation.

It seems therefore that people with problems may benefit from participating in a support group. However, there seems to be a risk that some participants may be harmed by the activities.

Summary

In conclusion, the review seems to indicate that open discussion groups may improve the parents' situation if all the participants have a common problem. However, there are also negative effects of open discussion groups. Open groups geared towards all parents have no demonstrable effects.

Structured individual counselling

Parent counselling with structured programmes normally aim to improve the child's situation. Therefore the effects on the child or the parents' behaviour towards the child have been examined in the studies that have been conducted. This is discussed in Chapters 6–7.

Open individual counselling

Chapter 2 is devoted to experiments with open individual counselling for parents with a clear focus on the child and where the impact on the child has also been studied.

Parents are also provided with individual counselling in other contexts, normally when a particular problem arises. If the problem is perceived as a major problem, the parent will probably already have been in touch with one the organisations that provide support and treatment: primary care, school healthcare, paediatric and adolescent psychiatry and the social services. About three per cent of all families contact the paediatric and adolescent psychiatry service every year, the figure for the social services is two per cent [24]. For the most severe problems therefore, there are already organisations which have the task of providing support to parents. The organisation of child and adolescent psychiatry, including school healthcare, has already been the subject of a government commission [24] [25]. Interventions organised by the social services that are geared towards children and adolescents are being investigated at the moment [26]. This is why organisations that work with families with children that have serious problems are not discussed here. The analysis is limited to situations where families do not have any serious problems.

Scientific literature mainly deals with studies on counselling for people who have problems themselves or where a close relative has a problem. During a literature search in Medline, PsycInfo and a systematic review of interventions aimed at reinforcing social support [7], fourteen controlled studies of counselling of this type were found.

In three studies, the counselling was aimed at one family member where another member had problems. Two of these studies were on parents with children who suffered from various chronic diseases, for example a rheumatic disease. Another parent, who also had a child suffering from the same disease, visited the parents in their home [27, 28]. The mental health of the parents receiving the visit improved in both studies. The third study was on counselling for women who were physically abused by their male partners [29]. The intervention reduced neither the women's mental problems nor the abuse itself.

The other eleven interventions studied were aimed at adults with problems. In eight of these studies, the participants suffered from mental

problems, above all depression [30–37]. The participants met a counsellor, who was either a professional or a layman, on several occasions. In seven out of eight controlled studies, the mental health and/or the social situation of the person who was provided with counselling improved. In three studies, the participants suffered from cardiovascular disease. The outcomes of these three studies differed. One study led to fairly positive results in the trial group since the number of heart attacks decreased [38]. A second study did not demonstrate any effects at all [39, 40]. In the third study, the health of the people in the group that had been provided with individual counselling deteriorated [40]; the mortality risk almost doubled in one year.

The counselling in the studies presented has been provided in the home or at a clinic. No controlled studies on telephone counselling were found. It is, however, probable that similar effects would have been demonstrated if the counselling had been given solely by telephone.

In addition, effects of interventions aimed at families where the children, or the families, have specific problems are discussed in Chapter 14. Positive effects of interventions organised as open individual counselling are often demonstrated.

Informal contact with staff at preschool and school

Parents normally meet staff at preschool, school and after-school recreation centres. These discussions are much appreciated by parents. In the study presented in Chapter 4, about 40 per cent of the parents said that they had benefited from these discussions about their children. They are usually initiated by a parent taking up a specific problem. It is therefore probable that the results in the studies referred to regarding open individual counselling are also applicable to this type of discussion.

Teachers are trained to focus on children and they are employed to work with them. It is therefore natural for teachers to see the needs of a child clearly. A parent who brings up a problem will also have his/her own needs, for example a need to be acknowledged in the parenting role. Sometimes the needs of a child conflict with those of the parents and there is a risk that in a discussion of this kind the teacher will not meet the needs of the parent, perhaps making the parent feel unappreciated. This is a particularly serious risk if a parent already has a real problem with his/her parenting role. Discussions with a teacher might then make the situation worse for a

parent who is under a great deal of pressure. This might be why parents with a lower standard of education are less interested in this type of discussion compared to well-educated parents, see Chapter 5.

Negative effects of discussions with disadvantaged families have also been demonstrated in other contexts when parents are given advice by professionals who work with children, for example within the child healthcare services [41, 42], where there are similar conflicts between the needs of the child and those of the parents. A conflict of this type in the child healthcare services might have to do with breast-feeding for example. A nurse knows that being breastfed is in the child's best interests. On the other hand, she understand the feelings of a mother who experiences breastfeeding as a burden. If the nurse has problems dealing with the conflict, the mother may feel rejected.

If teachers put the emphasis of a discussion on helping the parents appraise the situation rather than express their own views, it is more likely that the parents will benefit from the discussion. However, many teachers have not received any training in that type of parent teacher discussion.

Summary

This survey indicates that open individual counselling may improve the parents' situation if they have a problem. However, this type of discussion might also have a negative impact.

Support via the media

The study that is presented in Chapter 5 demonstrates that almost 50 per cent of all parents felt that they had benefited from information on parenting that is available through television and radio, newspapers, magazines and books. There is no other form of support that has been so greatly appreciated by so many. We have not been able to find any studies that demonstrate how parents use the information that is presented in the media in general, but parents probably use the information in a variety of ways. It is clear that the media can provide parents with valuable knowledge and information. Articles in newspapers and magazines often combine statements from experts with interviews of parents with whom the reader is able to identify him/herself. In this way parents have access to parenting role models that they can either choose to take in or reject. Speaking more

generally, features in the media may also encourage parents to think about their own parenthood.

About 25 per cent of all parents said that they were interested in obtaining information via the Internet. The Internet is most popular amongst the youngest age groups, probably because they have grown up with it. This type of support gives rise to many possibilities since it can offer interactivity. The costs per user are also lower compared to other types of media. In addition, the Internet enables parents to discuss issues with each other. The indications are that young parents and parents with a lower level of education are those that benefit the most from this form of support.

Contributors

Sven Bremberg has the main responsibility for the text and Anton Lager has prepared the background material. Ingrid Olsson and Berit Hagekull have provided background data describing the link between access to preschool and social support.

References

1. Berkman LF, Syme SL. Social networks, host resistance, and mortality: A nine-year follow-up study of Alameda County residents. Am J Epidemiol 1979;109(2):186-204.
2. Schaffer H. Social Development: An Introduction. Oxford: Blackwell; 1996.
3. Tietjen A, Bradley C. Social support and maternal psychosocial adjustment during the transition to parenthood. Canadian Journal Behaviour Science 1985;17:109-21.
4. Östergren PO, Hanson BS. *Forskning om socialt nätverk och socialt stöd – metod eller teoriproblem?* Socialmedicinsk Tidskrift 1990;67 (1-2):38-42.

5. Orford J. Community psychology. Theory and practice. Chichester: Wiley; 1992.

6. Berkman L, Glass T. Social Integration, Social Networks, Social Support, and Health. In: Berkman L, Kawachi I, Eds. Social epidemiology. Oxford: Oxford University Press; 2000, p. 137-73.

7. Hogan BE, Linden W, Najarian B. Social support interventions: Do they work? Clinical Psychology Review 2002;22(3):381-440.

8. Cohen S, Underwood LG, Gottlieb BJ, Eds. Social support measurements and interventions. Oxford: Oxford University Press; 2000.

9. Rose G. The strategy of preventive medicine. New York: Oxford University Press; 1998.

10. Statistiska centralbyrån. *Undersökningar av levnadsförhållanden – ULF*. URL: http://www.scb.se/templates/tableOrChart____49708.asp.

11. *Barn, elever, personal och utbildningsresultat. Kommunal nivå – avseende år 2003*. Stockholm: Skolverket; 2004.

12. Sennett R. The fall of public man. New York: Vintage; 1978.

13. Bauman Z. The individualized society. Cambridge: Polity Press; 2001.

14. Lundberg O. The impact of childhood living conditions on illness and mortality in adulthood. Soc Sci Med 1993;36:1047-52.

15. Gagnon A. Individual or group antenatal education for childbirth/parenthood (Cochrane Review). The Cochrane Library. Oxford: Update Software. 2004(2).

16. Glanz K, Frances Marcus Lewis, Rimer BK, Eds. Health Behavior and Health Education: Theory, Research, and Practice. Jossey-Bass; 1996.

17. Rydenstam K. *Tid för vardagsliv – kvinnors och mäns tidsanvändning 1990/91 och 2000/01*. Levnadsförhållanden Rapport 99. Stockholm: Statistiska centralbyrån; 2003.

18. Sanford M, Byrne C, Williams S, Atley S, Miller J, Allin H. A pilot study of a parent-education group for families affected by depression. Canadian Journal of Psychiatry – Revue Canadienne de Psychiatrie 2003;48(2):78-86.

19. Telleen S, Herzog A, Kilbane TL. Impact of a family support program on mothers' social support and parenting stress. Am J Orthopsychiatry 1989;59(3):410-9.

20. Lewis MA, Hatton CL, Salas I, Leake B, Chiofalo N. Impact of the Children's Epilepsy Program on parents. Epilepsia 1991;32(3):365-74.

21. Wysocki T, Harris MA, Greco P, Bubb J, Danda CE, Harvey LM, et al. Randomized, controlled trial of behavior therapy for families of adolescents with insulin-dependent diabetes mellitus. Journal of Pediatric Psychology 2000;25(1):23-33.

22. Helgeson VS, Cohen S. Social support and adjustment to cancer: Reconciling descriptive, correlational, and intervention research. Health Psychol 1996;15(2):135-48.

23. Helgeson VS, Cohen S, Schulz R, Yasko J. Group support interventions for women with breast cancer: Who benefits from what? Health Psychol 2000;19(2):107-14.

24. *Insatser mot psykiska problem hos barn och ungdomar. Slutbetänkande av Barnpsykiatrikommittén.* SOU 1998:31. Stockholm: Socialdepartementet; 1998.

25. *Från dubbla spår till Elevhälsa – i en skola som främjar lust att lära, hälsa och utveckling. Slutbetänkande av Elevvårdsutredningen.* SOU 2000:19. Stockholm: Utbildningsdepartementet; 2000.

26. Regeringen. *Uppdrag avseende utveckling av arbetet med barn i utsatta situationer S2003/ST*. Stockholm: Socialdepartementet; 2003.

27. Ireys HT, Sills EM, Kolodner KB, Walsh BB. A social support intervention for parents of children with juvenile rheumatoid arthritis: Results of a randomized trial. Journal of Pediatric Psychology 1996;21(5): 633-41.

28. Ireys HT, Chernoff R, DeVet KA, Kim Y. Maternal outcomes of a randomized controlled trial of a community-based support program for families of children with chronic illnesses. [comment] Archives of Pediatrics & Adolescent Medicine. 2001;155(7):771-7.

29. Sullivan CM, Campbell R, Angelique H, Eby KK, Davidson WS, 2nd. An advocacy intervention program for women with abusive partners: Six-month follow-up. Am J Community Psychol 1994;22(1):101-22.

30. Chandler D, Meisel J, Hu TW, McGowen M, Madison K. Client outcomes in a three-year controlled study of an integrated service agency model. Psychiatr Serv 1996;47(12):1337-43.

31. Cole JR, Klarreich SH, Fryatt MJ. Teaching interpersonal coping skills to adult psychiatric patients. Cognitive Therapy and Research 1982;6:105-12.

32. Finch BE, Wallace CJ. Successful interpersonal skills training with schizophrenic inpatients. J Consult Clin Psychol 1977;45(5):885-90.

33. Goldsmith JB, McFall RM. Development and evaluation of an interpersonal skill-training program for psychiatric inpatients. J Abnorm Psychol 1975;84(1):51-8.

34. Harris T, Brown GW, Robinson R. Befriending as an intervention for chronic depression among women in an inner city. In: Randomised controlled trial. Br J Psychiatry 1999;174:219-24.

35. Heller K, Thompson MG, Trueba PE, Hogg JR, Vlachos-Weber I. Peer support telephone dyads for elderly women: Was this the wrong intervention? Am J Community Psychol 1991;19(1):53-74.

36. Linehan MM, Goldfried MR, Goldfried AP. Assertion therapy: Skill training or cognitive restructuring. Professional Psychology: Research and Practice 1979;21:482-8.

37. Renaud J, Brent DA, Baugher M, Birmaher B, Kolko DJ, Bridge J. Rapid response to psychosocial treatment for adolescent depression: A two-year follow-up. J Am Acad Child Adolesc Psychiatry 1998;37(11):1184-90.

38. Frasure-Smith N, Prince R. Long-term follow-up of the Ischemic Heart Disease Life Stress Monitoring Program. Psychosom Med 1989;51(5):485-513.

39. Burgess AW, Lerner DJ, D'Agostino RB, Vokonas PS, Hartman CR, Gaccione P. A randomized control trial of cardiac rehabilitation. Soc Sci Med 1987;24(4):359-70.

40. Frasure-Smith N, Lesperance F, Prince RH, Verrier P, Garber RA, Juneau M, et al. Randomised trial of home-based psychosocial nursing intervention for patients recovering from myocardial infarction. Lancet 1997;350(9076):473-9.

41. Heritage J, Sefi S. Dilemmans of advice: Aspects of the delivery and reception of advice in interactions between health visitors and first-time mothers. In: Drew P, Heritage J, Eds. Talk at work. Cambridge: Cambridge University Press; 1992.

42. Arborelius E, Bremberg S. Supportive and non-supportive qualities of child health nurses contacts with strained infant mothers. Scand J Caring Sciences 2003;17:1-7.

4.

METHODS WITH DIRECT IMPACT ON THE WELFARE AND HEALTH OF THE CHILD – A SYSTEMATIC REVIEW OF INTERNATIONALLY PUBLISHED LITERATURE

4.

METHODS WITH DIRECT IMPACT ON THE WELFARE AND HEALTH OF THE CHILD – A SYSTEMATIC REVIEW OF INTERNATIONALLY PUBLISHED LITERATURE

Knowledge of impact is essential for the evaluation of any type of parent support. One reason for this is that all types of parent support infringe on the autonomy of the parents to a certain extent, even if the parents participate on a voluntary basis, see Chapter 2. One precondition for justifying parent support is that it contributes to the welfare of the child. Thus the effects of each separate form of parent support must be analysed.

The most surestreliable way of evaluating whether a certain intervention has an effect is via a controlled experiment. This means that a group of parents have access to a particular intervention whilst another comparative group does not. The parents and children in both groups are then followed up. If the children in the group with parents who have access to the intervention fare better than the other children, this is a strong indication that the children benefit from the intervention. This is reinforced if several studies have arrived at the same conclusions and if the parents have been randomly divided into the two groups.

It is against this background that international scientific literature on parent support is analysed in this chapter. The chapter summarises a more extensive report that has also been published separately [1]. The chapter also describes more recent literature. Only high quality studies are included, which means that the review only deals with controlled experiments with randomly selected experiment and control groups.

The analysis has been carried out systematically which means that the studies included have been identified in databases of scientific literature in a way that can be checked by an independent person. Literature in a particular field can be dealt with in a variety of ways. Before the advent of modern databases it was common for leading researchers within a particular field to select articles that he or she perceived as representative. It was possible that this selection reflected the researcher's own understanding of the field, which perhaps differed from the general view of the literature of the field in question. It is now possible to analyse scientific work more objectively thanks to the databases that index scientific literature. This is the method used for this review.

An extensive review of controlled studies of interventions mainly geared towards parents with infants was published in 2003 [2]. The review is discussed in Chapter 6. Further reviews of interventions aimed at parents with infants have been published in recent years [3, 4]. Hence, this chapter concentrates on interventions that are aimed at parents with children who are over 18 months.

Aim

The aim was to answer three questions. 1) Does the mental health of the child benefit from parent support? 2) Does the mental health of the child benefit regardless of the type of parent support provided, whether it is provided in a group, on an individual basis for each parent or set of parents or remotely without contact between leader and participant? 3) Does the child's mental health benefit regardless of the age of the child?

Method

Firstly, a number of criteria regarding the studies that were to be included were established. Literature searches were subsequently carried out in databases and the studies that fulfilled the criteria were analysed.

Criteria for selecting interventions to be analysed

These interventions were aimed at parents and focused on the parenting role. The support was intended for the parenting role, i.e. the parents' thoughts, feelings, behaviour and knowledge of the children. Support in the shape of financial contributions, statutory rights or access to childcare and schools has not been included. This chapter includes support for parents either provided as a limited intervention or as a part of a scheme where other measures are aimed at the children or other actors in society.

These interventions were preventive in nature and aimed at broad groups of parents with children aged between 18 months and 18 years of age. The interventions analysed include both support provided before any problems have arisen and support provided at an early stage in order to prevent a negative development [5]. Interventions aimed at all parents have been included as well as those aimed at parents from social groups at risk, parents living in socially disadvantaged areas and parents whose children have already experienced problems. The review does not, on the other hand, include treatment interventions only aimed at families where either the parents or the children have a diagnosed chronic disease or major social problems which require urgent action on the part of the social services. The age of the children in this review has been estimated in accordance with the average age of the children at the start of an intervention.

The evaluations have measured the effects on the mental health of the child. In children, the dividing line between mental health and ill-health is often unclear. There are also a number of risk and protective factors for mental ill-health which are linked to a positive or negative health outcome despite not knowing the exact connection. This is why a broad definition of mental health is used in this review which includes emotional, cognitive and social components in a child as well as risk and protective factors in the parents that are directly important to the mental health of the child [4, 6, 7].

The evaluations have been carried out as controlled randomised experiments, i.e. a comparison has been made of the effects of an intervention between a group receiving support and a control group which is not provided with the support measure in question. Further, the participants have been

distributed at random between the groups. This structure reduces the risk of the outcome being explained as a result of something other than the intervention itself. The random distribution of group participants is done either by randomly selecting individuals or individual families (individual level), or by randomly selecting larger groups of participants, for example a school class (group level).

The evaluations have been published in international scientific magazinesjournals. Scientific magazines journals normally have a system for reviewing studies prior to their publication, i.e. other researchers have concluded that the study has been well conducted. This means that there is greater confidence that the results are well-founded.

The interventions have been included regardless of the form of support. Support interventions for parents can be provided in groups, individually or remotely. When the group form is used, one or more leaders meet several parents at the same time. One example is that a group of invited parents meet on the school premises. An individual intervention for each parent or family could take the form of the parents attending a meeting that can be likened to a therapy session. If an intervention is carried out remotely, the parents never meet the leader, they communicate in a number of other ways. Written material is, for example, sent to the parents' home.

The interventions have been included regardless of in which country they were carried out. Evaluations are included if they were published in Swedish, English, Norwegian or Danish.

Literature search

In order to cover studies from specific fields, for example psychology, medicine and sociology, the search was carried out in the following databases: Cochrane, *ERIC* (from 1966 onwards), PsychINFO (from 19721872? onwards), PubMed (from 1963 onwards) and Sociological Abstracts (from 1963 onwards). In the previously published report [1], searches were made up until May 2002. In this chapter, the searches have been updated to include the period from June 2002 to May 2004. in per cent and The searches were made with the following broad combinations of search words (in different

inflected forms and varieties) "*parent, child* and *randomised/zed*", "*parent, child* and *experimental*", "*parent, adolescent* and *randomised/zed*" as well as "*parent, adolescent* and *experimental*". Inquiries regarding references have also been submitted to people who are active in the field and four annual volumes of the magazine Journal of Consulting and Clinical Psychology have been examined manually.

One person (a Doctor of Psychology) examined all the articles and if there were any doubts as to whether an intervention fulfilled the criteria for being included or not a second person (a Professor of Psychology) assessed the studies. The assessments of these two experts were identical. Ten studies that were identified were not assessed since they were not available via the order services of the University of Uppsala.

Judgment of the effect

A study is regarded as giving rise to the desired effect if at least one relevant measurement for the mental health of a child or for the risk and protective factors of their mental health has been demonstrated as having the desired effect. It must then be demonstrated by statistical examination, with a reliability factor of not less than 95 per cent, that the effect measured is not by chance. If many measurements are used in a study a chance effect of this kind may arise for one individual measurement (mass significance). In these studies, the requirements have been adapted to the number of measurements that have been included in the study. Conclusions regarding effects of a particular form of support, or for a particular age group of the child, are drawn if at least two separate studies indicate the desired effects.

Results

Seventy-two studies fulfilled the requirements both qualitatively speaking and content wise. Sixty-three of these were included in the previously published report and nine studies were added during the updated search [8–16].

The leader has used a manual describing how the intervention should be carried out (a structured intervention) in most of the studies. This means that on the whole all the participants have had access to the same contents.

This method is sometimes combined with less structured stages. There is a leader in the group interventions. The support is aimed at helping the parents bring up and give their children encouragement, gaining an insight into what the children think and do, acquiring knowledge about children of different ages, enhancing communication in families, encouraging good interaction with school, increasing access to informal support and helping parents feel secure in their parenting role. These interventions ensure that the child interacts better with its parents and with others, takes fewer risks and performs better at school. Since parents and children have in most studies only been followed for a year after the intervention, it is difficult to say anything about long-term effects. However, there are a few studies where the families have been followed for 15–20 years after the intervention. More women than men have participated which is why knowledge about effects on men is more limited.

Effects of parent support on children's mental health

Positive effects on one or several measurements of the mental health of the child, or risk and safety factors for their health were demonstrated in 69 of the 72 studies.

Interventions with positive effects are described in Table 4. 1 based on the type of support, the age of the child and how the outcome was measured. If parents with children in more than one age group have been provided with one type of support, the analysis is only described for the age group that dominates. It was impossible to classify the table categories in three of the studies. These three studies all demonstrated positive effects but could not be described in the table.

Form	Preschool children (1.5–5 years old)		Schoolchildren (6–12 years old)		Teenagers (13–18 years old)	
	Outcome child	Outcome parents	Outcome child	Outcome parents	Outcome child	Outcome parents
Group	10/10	8/9	10/10	8/8	2/3	3/3
Group and individual	3/3	1/2	3/3	1/1	-	-
Individual	13/13	6/8	4/6	2/3	3/3	2/3
Remote	2/3	3/3	3/4	3/4	-	-
Total	**28/29**	**18/22**	**20/23**	**14/16**	**5/6**	**5/6**

Table 4.1 Number of interventions with positive effects on the child/parents based on the type of support, the age of the child and how the outcome was measured.

Some of the effects were analysed directly on the *child*, for example the prevalence of behaviour problems or self-reported mental ill-health. The table includes 58 analyses of that type where 53 demonstrated positive effects. In other analyses, the attitude of the *parents* and other parental characteristics that have an impact on the mental health of the child were studied. If outcomes for both the child and the parents were presented in one separate study, both have been included in the table. The table includes 44 analyses of outcome for the parents where 37 demonstrated positive effects.

Parent support in *groups* is a common form that is included in 23 analyses with outcome studied for the child. Analyses of support provided to *individual sets of parents* were almost equally common and outcome was studied in the child in 22 studies. The effects seem to be more evident if the support is provided in group form rather than individually. Remote support, i.e. via the media, television, video or printed material was only studied in seven analyses with outcome studied in the child.

Most of the analyses were carried out on interventions aimed at parents with preschool children, 29 with outcome studied in the child. Almost as many analyses were carried out of children aged 6–12. However, there were only six analyses of interventions aimed at parents with teenaged children. For children of *preschool age* it is common that interventions are provided

for parents who feel that they have children with problems. The support often focuses on child-rearing methods so that the children learn to behave in a socially acceptable manner. Interventions aimed at *children aged 6–12* are, on the other hand, often provided to broad groups of parents or to socioeconomically disadvantaged groups (for example divorcees or those living in areas where a large proportion of the population is regarded as poor). These interventions also often focus on child-rearing, but it is also common to give support to improve communication between parents and child. Just as is the case for school children, interventions aimed at parents with *teenagers* are geared towards broad groups of parents and socioeconomically disadvantaged groups. Most interventions are geared towards improving communication between parents and adolescents in order to enhance parents' insight into the lives of the teenagers and to make it easier to resolve problems within the family together.

Discussion

The analysis of the literature indicates that support to parents benefits the mental health of the child, that the support can be provided in a group, individually or in remote form and that effects are particularly well documented for interventions that are aimed at younger children. A number of interventions combine methods that promote parent-child interaction so that the parents are able to be affectionate and set boundaries.

The interventions described represent a broad spectrum of different working methods, as regards how the interventions are structured, the age groups aimed at, the kind of support you wish to provide the parents with and how the interventions are evaluated. The authors of most studies are able to demonstrate positive effects. This is in line with previously conducted though less extensive reviews [4, 7, 17, 18]. This research was to a large extent published after 1990. An extensive review of preventive interventions published as late as in 1997, states that it is doubtful whether support to parents has any demonstrable effects [19]. Today, international research clearly indicates that parent support is an effective way of enhancing the mental health of the child.

All the studies were carried out as controlled randomised experiments, making it relatively certain that it really was the interventions concerned that were responsible for the improvements that were demonstrated. This conclusion is reinforced by the fact that an outcome for both child and parents was demonstrated using a number of different methods. The researchers in many of the studies have used well-tried questionnaires where it is already known that the questionnaire measures what you aim to measure (validity) and that the person responding to the questionnaire does so several times in the same way (reliability). In some of the studies the child's behaviour has been registered directly by independent observers who have been unaware of whether the parents of the child have participated in an intervention or not. The reliability of the conclusions is reinforced by the fact that several different methods have been used to demonstrate the positive effects.

Most of the interventions were provided before adolescence. This means that the conclusions are more reliable with regard to younger children compared with teenagers. One probable explanation for the difference in the number of studies is that there has been a greater interest in providing support for younger children than older ones, for example in order to break negative patterns at an early stage [3, 4, 7].

There are a number of conditions that might reduce confidence in the reliability of the conclusions drawn in this review. One risk is the fact that parents and children change because they know that they are participating in a study, even if the support itself is of no importance [20]. However, the fact that in many cases even the parents in the control groups have participated in an intervention (but one that was not expected to lead to any positive effects) would seem to indicate that this risk did not have an impact on the conclusions. A second risk is that sometimes parent support is combined with support for the child making conclusions about effects of the parent support more difficult to make. Evaluations indicate, however, that support for children alone gives rise to fewer positive effects than interventions that also include parent support [21, 22]. There is also a risk that studies which do not demonstrate an effect are not readily publishable. This would mean that the picture portrayed in the review was over-positive. It is, however, difficult to regard this as one of the main explanations since the

literature from the beginning of the nineties did not support the view that interventions aimed at parents gave rise to any effects. It is, on the other hand, probable that the methods which have begun to be used in the last 10–15 years are much more effective than those used earlier. The change might be connected with the fact that the methods described are often geared towards getting parents to learn and train new skills. Previously it was more common merely to discuss different approaches. Though this gave the parents an insight, it was one that was hard to put into everyday practice.

Several of the studies had a relatively large fall-outnumber of drop outsand this reduces reliability. However, the authors of a number of studies took this problem into account by comparing parents in experiment and control groups that were the same prior to the study. These analyses would support the view that these conclusions are sustainable.

This report is aimed at giving suggestions for broad interventions aimed at parents in Sweden. The studies described in this chapter are, however, largely carried out in North America, and often on socially disadvantaged groups. An important question is thus whether this international research is relevant for the current Swedish context. The fact that the interventions are often based on general principles for how parents interact with their children that are applicable in different cultures and for people living in different social conditions supports this argument. However, presumably the effects would have been less positive had they been used broadly in Sweden compared to being used in socially less advantaged groups in North America. It might also be a good idea to adapt the methods to Swedish conditions since the views on good parenting are not always the same in Sweden compared with the USA. Despite this, this review supports the view that it is possible to enhance the health and welfare of the child through interventions aimed at parents. The generalisation into different groups of parents in Sweden must still be tested.

Contributors

Ingrid Olsson planned and conducted the literature searches, compiled the literature and was the main author. Sven Bremberg and Berit Hagekull were a part of the planning and implementation processes.

References

1. Olsson I, Hagekull B, Bremberg S. *Stöd till föräldrar för att främja barns och ungdomars psykiska hälsa – en systematisk kunskaps-översikt*. Stockholm: Statens folkhälsoinstitut; 2003.
2. Bakermans-Kranenburg MJ, van IJzendoorn M, Juffer F. Less Is More: Meta-Analyses of Sensitivity and Attachment Interventions in Early Childhood. Psychological Bulletin 2003;129(2):195-215.
3. Hwang P, Wickberg B. *Spädbarnets psykiska hälsa*. Stockholm: Statens folkhälsoinstitut; 2001.
4. Webster-Stratton C, Taylor T. Nipping early risk factors in the bud: Preventing substance abuse, delinquency, and violence in adolescence through interventions targeted at young children (0–8 years). Prev Sci 2001;2(3):165-92.
5. Wenar C, Kerig P. Developmental Psychopathology: From infancy through adolescence. Mass: McGraw Hill; 2000.
6. Stöd i föräldraskapet. *Kartläggning av föräldrautbildningen*. Ds 1997:6. Stockholm: Socialdepartementet; 1997.
7. Barlow J, Stewart-Brown S. Behavior problems and group-based parent education programs. J Dev Behav Pediatr 2000;21(5):356-70.
8. Brotman LM, Klein RG, Kamboukos D, Brown EJ, Coard SI, Sosinsky LS. Preventive intervention for urban, low-income preschoolers at familial risk for conduct problems: A randomized pilot study. J Clin Child Adolesc Psychol 2003;32(2):246-57.

9. Jackson C, Dickinson D. Can parents who smoke socialise their children against smoking? Results from the Smoke-free Kids intervention trial. Tob Control 2003;12(1):52-9.

10. Mason WA, Kosterman R, Hawkins JD, Haggerty KP, Spoth RL. Reducing adolescents' growth in substance use and delinquency: Randomized trial effects of a parent-training prevention intervention. Prev Sci 2003;4(3):203-12.

11. Patterson J, Barlow J, Mockford C, Klimes I, Pyper C, Stewart-Brown S. Improving mental health through parenting programmes: Block randomised controlled trial. Arch Dis Child 2002;87(6):472-7.

12. Taylor TK, Schmidt F, Pepler D, Hodgins C. A comparison of eclectic treatment with Webster-Stratton's parents and children series in a children's mental health center: A randomized controlled trial. Behavior Therapy 1998;29(2):221-40.

13. Webster-Stratton C. Randomized trial of two parent-training programs for families with conduct-disordered children. Journal of Consulting & Clinical Psychology 1984;52(4):666-78.

14. Webster-Stratton C, Kolpacoff M, Hollinsworth T. Self-administered videotape therapy for families with conduct-problem children: Comparison with two cost-effective treatments and a control group. J Consult Clin Psychol 1988;56(4):558-66.

15. Werch CE, Owen DM, Carlson JM, DiClemente CC, Edgemon P, Moore M. One-year follow-up results of the STARS for Families alcohol prevention program. Health Educ Res 2003;18(1):74-87.

16. Wu Y, Stanton BF, Galbraith J, Kaljee L, Cottrell L, Li X, et al. Sustaining and broadening intervention impact: A longitudinal randomized trial of 3 adolescent risk reduction approaches. Pediatrics 2003;111(1):e32-8.

17. Bremberg S. *Hur kan förskolan förbättra barns psykiska hälsa?* Stockholm: Statens folkhälsoinstitut; 2001.

18. Ferrer-Wreder L, Stattin H. *Vad kan man göra i familjen för att förhindra ungdomsvåld och kriminalitet?* Stockholm: BRÅ; 2001.

19. Durlak JA. Successful prevention programs for children and adolescents. New York: Plenum; 1997.

20. Zimmerman TS, Jacobsen RB, MacIntyre M, Watson C. Solution-focused parenting groups: An empirical study. Journal of Systematic Therapies 1996;15(4):12-25.

21. Dishion TJ, Andrews DW. Preventing escalation in problem behaviors with high-risk young adolescents: immediate and 1-year outcomes. J Consult Clin Psychol 1995;63(4):538-48.

22. Blake SM, Simkin L, Ledsky R, Perkins C, Calabrese JM. Effects of a parent-child communications intervention on young adolescents' risk for early onset of sexual intercourse. Family Planning Perspectives 2001;33(2):52-61.

5.

PARENTS' INTEREST IN VARIOUS FORMS OF PARENT SUPPORT

5.

PARENTS' INTEREST IN VARIOUS FORMS OF PARENT SUPPORT

Parent support can be provided in different forms. Demonstrated effects are not enough if the child is to benefit; the parents also have to be interested. A representative selection of parents was therefore asked about how interested they were in different types of parent support interventions. The study was designed so that it was possible to distinguish the interest of different groups, for example men and women, well-educated and less well-educated parents and parents who definitely suffer from parenting stress. This chapter is a summary of the study that is available in its full form from the website of the Swedish National Institute of Public Health (SNIPH) [1].

Method

Selection and procedure

Questionnaires were sent out in April 2003 to the guardians of 4,000 children aged between 0–17. A random selection of children was taken from the register of the entire population of Sweden. Only one caregiver per child, with equal numbers of mothers and fathers, were asked to participate. Those that did not fill in the questionnaire were sent reminders twice during the following month.

Questionnaire

The questionnaire included five sections; questions that were based on headings describing six different types of support, questions about thirteen other interventions, questions on parenting stress, questions about informal social support and questions about the background of the parents.

Six headings

Six comparable headings that the authors had constructed described the following forms of support:

1) *Structured support in a group* where the leader meets several parents at the same time on a number of occasions and where a set programme is followed.
2) *Unstructured* support in a group where the leader and parents meet several times and where the content is not pre-determined.
3) *Structured* individual support where one parent is invited to meet an expert on several occasions either alone or with his/her partner and where the content is pre-determined.
4) *Unstructured individual support* where one parent is given advice by an expert over the telephone on issues determined by the parent.
5) *Structured remote support* where the parent participates in an Internet-based course with a pre-determined content.
6) *Unstructured remote support* where the parent discusses optional subjects with other members on a website.

Structured parent groups are described as follows: "Imagine that you are invited to participate in a parent group. The group has an experienced leader and the aim is to learn more about parents and children. The group follows a set programme. The programme includes areas that are important to you, for example conflict management and communicating well with children. During the meetings you get to watch and discuss video material of ordinary situations with children. All the parents practise, for example conflict management, at home between the meetings. The group meets six evenings, every other week for about two hours every time. Tea or coffee is included." Other headings had a similar wording.

The parents showed their interest by taking a stand on three positive statements on the intervention: *I am interested in participating in a parent group of that kind, I could learn important things about children in a parent group of that kind* and *I would benefit enormously from participating in a parent group of that kind*. Alternatively the statements *ended with being a member of a website of that kind... calling for advice like that* and *participating in an activity of that kind*. The parents showed on a scale of

1–5 whether the statement *was not at all true, not very true, partly true, fairly true* and *absolutely true*, with not at all true being 1 on the scale and absolutely true 5. If the average answer to the three questions was at least 4, i.e. that the statements were fairly true, the parent was regarded as being positive to the support intervention.

In order to further illustrate interest in the intervention, the parents took a stand on statements about their reasons for participating, how well they would actually be able to attend and what their relatives felt about the support measures. The questions were worded as follows: *I will try to participate in a parent group of that kind, It would be difficult for me to participate because I have trouble getting a babysitter, It would be difficult for me to participate because of other practical obstacles, for example lack of time*, *I would be prepared to pay SEK 200 to participate in a parent group of that kind, Parents I know would participate in a parent group of that kind* and *People who are important to me would be in favour of my participating in a parent group of that kind.* Alternatively the statements ended with *being a member of a website of that kind, calling for advice in that way, participating in an activity of that kind, lack access to a computer or the Internet and cannot talk undisturbed on the telephone*. The reply alternatives were similar to those in the first three statements about the intervention.

The parents also stated whether they themselves had participated in an intervention by answering yes or no, and if they had participated, what the benefits were.

Interest in thirteen other interventions

Parents indicated their interest in thirteen other types of support by answering questions that started as follows: *I am interested in support through...* The interventions are presented in Table 5.5. The parents indicated their interest by marking it on a scale of 1–5 similar to the one used in the six headings. If respondents indicated that their interest in the intervention was *fairly true* or *absolutely true*, they were counted as being interested.

Experiencing parenting stress

The parents answered fifteen previously tried and tested questions about parenting stress [2, 3] that had to do with feelings of incompetence, role

limitations and relationship problems with their partner. Parents had to say whether the statements were true in accordance with the scale of 1–5 described above for the six headings. Parents with an average for the fifteen questions that lay above the mid-point on the scale were said to be under a lot of pressure, while parents under the mid-point were said not to be under much pressure.

Informal social support

The parents answered ten previously tried and tested questions on informal social support that [3] had to do with access to emotional and practical support from relatives, friends and acquaintances. Parents answered six questions on the number of people they could turn to (on a scale from *0* people to more than 6) and the other four questions were on how often they felt they got support (on a scale from *never* to very *often*). An index for parent support was estimated based on the answers to the ten questions.

Background information

At the end of the questionnaire there were questions about the respondents' housing, level of education, family finances, marital status, number of people in the household and their different ages and whether the child(ren) had been diagnosed with a disease or a disability that had an impact on everyday life.

Additional information regarding the respondents' gender, age and country of birth was retrieved from Statistics Sweden's register of the entire population.

Statistical methods

It was important that the differences between groups were not accepted as statistically reliable unless chance could be ruled out, with a reliability factor of not less than 95 per cent. In fewer than 50 answers no statements were made regarding differences. The Kolmogorov-Smirnov test for seeing whether the values obtained were normally distributed was used on 50–100 answers. If the values were not normally distributed differences were tested parametrically using the Mann Whitney U-test. With normal distribution and for over 100 answers the differences were regarded as reliable if the 95 per cent confidence intervals (unreliable intervals) for respective average value did not overlap each other.

Results

Participants

The questionnaire was answered by 2,077 out of a total of 4,000 people asked (52 per cent). Table 5.1 demonstrates how the participants were divided into groups according to different background factors. There were no statistically reliable differences between the parents who had responded and the selection based on the age, citizenship, marital status of the parents as well as the age of the children. There were, however, fewer male respondents than expected (44 per cent compared to expected 50 per cent), fewer respondents born abroad (13 per cent compared to 17 per cent) and fewer respondents from the lowest income group (11 per cent compared to 13 per cent) and more respondents than expected from the top income group (17 per cent compared with 15 per cent).

Information	Group	Per cent
Sex	Male	44
	Female	56
Age	–24 year	1
	25–29 year	6
	30–39 year	41
	40–49 year	39
	50–59 year	12
	60– year	1
Marital status	Married or co-habiting	85
	Single	15
Country of birth	Sweden	87
	Denmark, Norway, Finland, Iceland	3
	Outside the Nordic region	10
Citizenship	Swedish	95
	Not Swedish	5

Highest level of education	Elementary school/nine-year compulsory school	9
	Junior secondary school/folk high-school	1
	Upper secondary school 1–2 years	16
	Upper secondary school 3–4 years	16
	College/university –3 years	24
	College/university + 3years	22
Own income	–84,999 SEK	11
	85,000–159,999 SEK	19
	160,000–234,999 SEK	33
	235,000–309,999 SEK	20
	310,000– SEK	17
Place of residence	City: Stockholm, Göteborg, Malmö	25
	Medium-sized urban area	35
	Smaller urban areas and rural areas	40
Type of housing	Rented apartment	22
	Cooperative apartment	9
	House (detached house, terraced house, farm)	67
Age of children	0–5 year	37
	6–12 year	38
	13–18 year	25
Child's health	Severe allergy/asthma	12
	DAMP/ADHD	2
	Other disease/ disability	11

Table 5.1 Respondents in the survey.

Interest in the six interventions described with headings

All parents

The structured parent groups and telephone counselling were most popular, see Table 5.2. Structured parent groups were also the intervention that most parents had some experience of, followed by discussion groups on the Internet.

	Degree of interest		Number of parents with experience, per cent
Intervention	Number of parents interested, per cent	Average value of interest – high value = a lot of interest (confidence interval)	
Structured parent groups	42	3.17 (3.12–3.22)	16
Unstructured parent groups	34	2.97 (2.92–3.01)	9
Individual structured counselling	26	2.74 (2.70–2.79)	3
Telephone counselling (individual and unstructured)	41	3.13 (3.08–3.19)	9
Parent course on the Internet	15	2.33 (2.28–2.37)	1
Discussion groups on the Internet	17	2.34 (2.29–2.39)	13

Table 5.2 Parents' interest in support described in headings and the number of parents with experience of these support interventions.

Slightly fewer parents said that they would try to participate compared to those who indicated an interest. The ranking between the different support interventions was more or less the same as for reported interest. This also applied to the parents' understanding of their chances of participating and of what they believed their relatives thought about the interventions. This means that the data on interest probably leads to fairly reliable conclusions regarding whether parents really would avail themselves of the intervention in question.

Many more parents were interested in support in groups and individual compared to the number of parents who had experience of these interventions, see Table 5.2. For example, the number of parents interested in

structured parent groups was nearly three times as many as those who actually had experience of such groups. This would seem to indicate that there is a need for support that has not been fulfilled.

Most parents had experience of structured parents groups. It was also one of the most popular support interventions. This means that experience of an intervention probably increases general interest in that particular intervention. Parents who have already participated in a certain intervention will be more interested in that type of intervention than other parents (data is presented in the full report). This also indicates that experience increases interest in an intervention.

The parents were also asked whether they felt that they had benefited from the intervention that they had participated in. About 60 per cent of the parents who had participated in structured and unstructured parent groups said that they had benefited from the activities. Slightly more, 73 per cent, said that they had benefited from telephone counselling and fewer, 38 per cent, from discussion groups on the Internet. The results for the other interventions are unreliable as only a few parents had experience of those forms of support.

Different groups of parents

The ranking of interest between different interventions described in Table 5.2 was more or less recurrent in all the groups of parents studied. Women, well-educated parents and parents who were under pressure in their parenting role were generally speaking more interested in most forms of support compared to men, parents with a low level of education and parents who were not under much pressure, see Table 5.3.

	Quotients between number of interested parents in different groups of parents		
Intervention	**Women/men**	**Well-educated/ low level of education**	**A lot of pressure/ little pressure**
Structured parent groups	1.6	1.2	1.4
Unstructured parent groups	1.6	1.3	1.3
Individual structured counselling	1.3	1.6	1.5
Telephone counselling (individual and unstructured)	1.3	1.3	1.5
Parent course on the Internet	1.2	1.5	1.5
Discussion groups on the Internet	1.3	1.2	1.7

Table 5.3 Differences between different groups of parents as regards their interest in interventions described in headings. Statistically reliable differences are marked in italics.

By age of the child

Interest in most forms of support is greatest when the children are small, see Table 5.4. Telephone counselling is an exception, where interest among parents with teenagers was almost as great as parents with infants.

Intervention	Number of parents with a child in one of the age groups who is interested in the intervention, per cent			
	0–17 months	18 months –5 year	6–12 year	13–17 year
Structured parent groups	49	49	43	36
Unstructured parent groups	41	38	33	29
Individual structured counselling	31	29	27	22
Telephone counselling (individual and unstructured)	48	42	41	47
Parent course on the Internet	14	17	15	12
Discussion groups on the Internet	22	20	14	14

Table 5.4 Parents' interest in support described as headings by age of the child.

Interest in thirteen other forms of parent support

All parents

A further thirteen types of support were analysed, see Table 5.5. Information through books, magazines, television and radio was most popular. After that there were four types which were almost as popular – open preschool, parent groups at the child healthcare clinic and discussions with staff at daycare/preschool and individual contact with experts. Parents with children aged between 6 and 12 were almost as interested in discussions with staff at school/after-school activities as parents were in discussions with staff at daycare/preschool (34 per cent interested, not included in table).

		Degree of interest		Number of parents who have felt the benefits of the intervention, per cent
Intervention		**Number of parents interested per cent**	**Average value of interest – high value = a lot of interest (confidence interval)**	
Media	Books/magazines	45	3.20 (3.14–3.26)	51
	Television/radio	41	3.14 (3.08–3.20)	31
	Information via the Internet	22	2.33 (2.27–2.39)	10
Meeting places and parent groups at the child healthcare clinic	Open preschool[A]	39	2.92 (2.82–3.03)	30
	Parents groups at the child healthcare clinic[A]	37	2.86 (2.75–2.97)	43
Informal contacts	Discussions with staff at daycare/preschool apart from regular communication[A]	36	2.92 (2.82–3.01)	34
	Discussions with staff at school/ after-school activities apart from regular communication[B]	24	2.60 (2.54–2.67)	28
Individual counselling	Meeting with expert, e.g. doctor, psychologist, lawyer	39	2.92 (2.85–2.98)	27
	Individual counselling at child healthcare clinics/ primary healthcare centres/ family welfare centre	33	2.65 (2.59–2.72)	42
	Counselling in paediatric and adolescent psychiatry	24	2.37 (2.30–2.43)	9
	Individual counselling by child healthcare clinics/primary care services in your home	21	2.22 (2.16–2.28)	21
	Discussion with an expert/ experienced person where you remain anonymous (e.g. BRIS (Children's Rights in Society), *Anonyma föräldrar* [Anonymous parents])	17	2.08 (2.02–2.14)	1

	Counselling within the social services	10	1.72 (1.67–1.77)	3

A: Only parents with children aged between 0 and 5.
B: Only parents with children aged between 6 and 17.

Table 5.5 Parents' interest in support in thirteen existing interventions (the higher the value, the greater the interest). The support interventions are presented in a falling order based on the number of parents who were interested.

Different groups of parents

The ranking of interest in different types of support described in Table 5.5 can be found to a large extent in all the groups of parents studied. Women, well-educated parents and parents who are under a lot of pressure as regards their parenting role were more interested in most types of support, see Table 5.6. Parents living in cities were more interested in support than those living in smaller towns.

The difference between men and women was particularly evident for the parent groups at child healthcare clinics whilst the gender differences for informal contacts with staff at preschool and school were small. Well-educated parents were much more interested in written material in the shape of books, magazines and information on the Internet.

Intervention		Quotients between number of interested parents in different groups of parents		
		Women/men	Well-educated/ low level of education	A lot of pressure/ little pressure
Media	Books/magazines	1.5	1.9	1.4
	Television/radio	1.5	1.4	1.3
	Information via the Internet	1.0	1.7	1.5
Meeting places and parent groups at the child healthcare clinic	Open preschool	1.4	1.6	1.2[A]
	Parents groups at the child healthcare clinic	1.8	1.8	1.6[A]
Informal contacts	Discussions with staff at daycare/preschool apart from regular communication[A]	1.2	-	1.3
	Discussions with staff at school/ after-school activities apart from regular communication[B]	1.1	1.2	1.2
Individual counselling	Meeting with expert, e.g. doctor, psychologist, lawyer	1.3	1.6	1.4
	Individual counselling at child healthcare clinics/ primary healthcare centres/ family welfare centres	1.5	1.8	1.6
	Counselling in paediatric and adolescent psychiatry	1.4	1.2	1.5
	Individual counselling by child healthcare clinics/primary healthcare services in your home	1.2	1.2	1.5
	Discussion with an expert/ experienced person where you remain anonymous (e.g. BRIS (Children's Rights in Society), *Anonyma föräldrar* [Anonymous Parents])	1.4	1.1	1.5

	Counselling within the social services	1.4	1.0	1.5

A: Only parents with children aged between 0 and 5.
B: Only parents with children aged between 6 and 17.

Table 5.6 Differences between different groups of parents as regards the number interested in support through thirteen existing interventions. Statistically reliable differences are marked in italics.

By age of child
Interest in support was generally greatest among parents with young children. Support through books and magazines were popular with 64 per cent of parents with at least one child under 18 months, 52 per cent of parents with children aged between 18 months and 5 years, 43 per cent of parents with children aged between 6 and 12 and 37 per cent of parents with children older than 12.

Access to informal social support
Parents' access to informal support was estimated based on ten questions. The outcome is presented in Chapter 3. It is possible to distinguish a group of parents with less informal support than the average figure based on the answers to these questions. This group constitutes 7 per cent of all parents. This group was largely interested in the same types of support as parents in general. This data is presented in the full report. An analysis of the link between access to open preschool and informal support is presented in Chapter 6.

Discussion

Main conclusions
There are three types of support that are of interest to over 40 per cent of all parents: information via the media, structured parent groups and telephone counselling.

1) There is a lot of interest in information via the *media*. Interest in television and radio is relatively even socially speaking, while interest in books and magazines mainly attracts well-educated parents.

2) Interest in *structured parent groups* is more or less as great as for the media, even if this type attracts parents with different educational backgrounds in a relatively similar way. Unstructured parent groups are far less popular than groups with a set structure.
3) Interest in *telephone counselling* is also more or less as great as the interest in the media. It attracts both men and women and both well-educated parents and parents with a low level of education.

Parent groups organised at the child healthcare clinic are the type of support that most parents have some experience of apart from books and magazines. These groups, however, seem not to favour parents with a low level of education. Men also seem to be disfavoured.

The reliability of the conclusions

The number of drop outs in the study was relatively high since only 52 per cent of the parents asked answered the questionnaire. Men, parents born abroad and low-income parents were under-represented. For most of the other background factors, however, there were no statistically reliable differences between those that responded and all the parents selected. This would seem to indicate that it is possible to generalise the result for parents as a whole in Sweden. Further support for this is the fact that data on parental pressure in this study was comparable to results from a previous representative population study with fewer drop outs (72 per cent participation) [4].

One limitation was that the questions on different types of support had not been used previously. The questions were, however, first tested in a smaller pre-study that arrived at similar conclusions as the main study. Moreover, the wording of the statements had been used in a number of previous studies. Another limitation was that all the participants got the questions in the same order. The order may have had an impact on the results, for example by making parents become more positive or negative as they went through the questionnaire. However, no systematic link between order and interest in different types of support was found. Thus it seems that the order did not have an impact on the outcome. A further discussion on reliability is included in the full report. In conclusion there is support for the reliability of the main conclusions.

Contributors

Ingrid Olsson planned and carried out the study, compiled the results and was the main author. Sven Bremberg and Berit Hagekull were a part of the planning and implementation processes. Statistics Sweden in Örebro was in charge of selection, sending out the questionnaire and data collection. Lena Andersson Andalabi, Anton Lager and Monica Östberg (University Hospital in Uppsala) have made contributions to the study.

References

A full version of the report is available from the Internet [1].

1. Olsson I, Hagekull B, Bremberg S. *Föräldrars intresse för olika former av föräldrastöd. En empirisk kartläggning av föräldrar i Sverige – fullständig version.* Statens folkhälsoinstitut. URL: http://www.fhi.se.
2. Östberg M, Hagekull B, Wettergren S. A measure of parental stress in mothers with small children: dimensionality, stability and validity. Scandinavian Journal of Psychology 1997;38:199-208.
3. Östberg M. Parenting stress: Conceptual and methodological issues. Uppsala: Uppsala universitet; 1999.
4. Östberg M, Hagekull B. A structural modeling approach to the understanding of parenting stress. J Clin Child Psychol 2000;29(4): 615-25.

6.

INTERVENTIONS DURING PREGNANCY AND EARLY INFANCY

6.

INTERVENTIONS DURING PREGNANCY AND EARLY INFANCY

The initial stages of life are probably the most important. It is particularly desirable therefore to offer parents support during this period. The maternity and child healthcare services and open preschools have the task of providing such support. The family welfare centre is one way of organising these activities.

Effect

The effects are reported by individual intervention geared towards the needs of children and their parents. The background to how the interventions are broken down is presented in Chapters 2 & 3.

Parent support geared towards the needs of children
Studies of parent support during this period have been identified with the help of the Cochrane Library, a review of clinical preventive interventions [1], a state-of-the-art document discussing maternity healthcare [2], a state-of-the-art document discussing child healthcare [3], by searching in the Medline literature database and using information provided by researchers in the field.

Structured parents groups
The birth of a child signifies the beginning of a period of intensive interaction with its closest caregivers. The caregiver's first task is to learn to interpret the child's signals and respond to them [4]. The infant is programmed to connect with its caregivers. The quality of this connect can very somewhat, however. Studies from a number of countries, including Sweden, indicate that about 40 per cent of all children do not spontaneously develop

what is known as a 'secure attachment' [5, 6]. This may depend on the child's signals being difficult to understand or on the parents finding it hard to interpret such signals and to respond to them.

The attachment pattern has stabilised by the time the child has reached the age of 18 months. An individual who forms a secure attachment as an infant retains this sense of security throughout life [7]. This pattern affects how the individual interacts with other people, both during childhood and later on in adult life [7, 8]. Children classified as "securely attached" at the age of two or three proved to be more sociable, more alert and find it easier to interact with other children compared to children with an insecure attachment [9, 10].

An insecure attachment increases the risk of mental ill-health during childhood and later on. The differences between individuals with or without a secure attachment are most noticeable when they are exposed to stressful situations [11]. A secure attachment works as a protective mechanism. It is hence desirable for more infants to develop such a secure attachment.

Widespread interventions are justified since difficulties in caregiver-child interaction are common. In a review published in 2003, 73 scientific studies of trials aimed at improving child-caregiver interaction were analysed [12]. The majority of these studies (51) had random distribution between the trial and control groups, see Table 6.1. The review clearly showed that it is possible to influence the sensitivity of parents to the signals of their children as well as the chances of developing a secure attachment. The studies had been performed among parents both with and without specific problems. All the studies that were proven to have an effect were focused on influencing parents' behaviour, whilst generally supportive interventions seemed not to have any effect. The studies indicating a particularly marked effect on sensitivity also showed a noticeable effect on attachment pattern.

Outcome	Sub-group	Number of studies	Number of children	Effect size (SD)
Connection	All	23	1,255	0.20
Sensitivity	All	51	6,282	0.33
	< 5 sessions	14	1,146	0.42
	5–16 sessions	18	1,274	0.38
	> 16 sessions	19	3,862	0.21
	SES high/medium	16	1,842	0.25
	SES low	35	4,440	0.35
	Clinical group	8	541	0.46
	Non-clinical group	43	5,741	0.31
	Video: yes	8	375	0.44
	Video: no	43	5,907	0.31

Table 6.1 Interventions aimed at increasing the number of securely attached infants by improving the caregiver's sensitivity to the child's signals. Randomised controlled trials, in accordance with Bakermans-Kranenburg et al, 2003* [12]. *All effects are statistically reliable ($p < 0.05$).

Somewhat unexpectedly, it was shown that the interventions comprising just a few sessions were more effective than those that continued for a long time. One explanation might be that there are good biological prerequisites for the child and the caregiver to develop healthy interaction. An infant often smiles spontaneously at a face and an adult seeing such a smile will return it equally spontaneously. The most noticeable aspect is perhaps not the fact that 60 per cent develop a secure attachment but that large groups do not do so. Interpreting the results like this, only small-scale interventions seem necessary in order to encourage the development towards the biologically programmed pattern, i.e. good interaction. It seems therefore to be possible to offer methods that support good interaction and achieve good results on a relatively wide scale.

Effects are proven both in families with a socially less favourable status and in groups with a more favourable one. The effects are greater in the less favourable groups. This is not unexpected since insecure attachment is much more common in less favourable groups [7]. Effects are proven both

in groups that already have problems, denoted in the table as "clinical groups", and interventions offered as preventive measures. This provides support for the possibility of offering these methods on a wide scale. The effects also seem to be greater if video is used to record and show different kinds of behaviour. This finding is in line with studies in other fields indicating that changes in behaviour are encouraged by the use of concrete methods.

Somewhat less unexpectedly, the review shows that the effects were most marked if the intervention had been initiated early, prior to the infant reaching the age of six months. Several trials had been performed in groups of parents. The way the review presents the findings, however, does not enable us to determine whether there are any differences between individual contacts and parent groups.

Open parent groups

Controlled studies of open unstructured parent groups focusing on the needs of children have not been identified.

Structured individual counselling

Structured counselling to pregnant mothers aimed at making it easier for them to stop smoking has been analysed in 34 controlled studies [13]. Such counselling on average leads to six per cent fewer women continuing to smoke. Counselling to parents on tobacco use after the child has been born is also effective [14]. Such findings have also been indicated in studies of a Swedish variant, *Rökfria Barn* (Smoke-free children) [15, 16]. It also seems possible to influence alcohol use during pregnancy by providing counselling, but only one controlled study has been published that shows this to be the case [17].

Support for breastfeeding provides the intended effect, both when it is initiated during pregnancy and later when the baby has been born [18]. There is also a certain amount of evidence pointing to the effectiveness of counselling aimed at reducing the risk of accident injuries [19].

Depressive symptoms are common during the period immediately after delivery. Structured counselling of mothers has been proven to be effective in several studies [20]. The method has also been studied in Sweden [21].

Open individual counselling

ARONEN'S AND CULLEN'S TRIALS WITH GENERAL COUNSELLING GIVEN TO PARENTS

The effects of open individual counselling have been analysed in two trials with randomly distribution of parents between the trial and control groups [22, 23]. The first trial was performed in Finland. A random sample of parents in a city district of Helsinki were invited to participate in 1975. The trial group received a home visit by a nursed trained in child psychiatry once a month during the first five years of the child's life starting when s/he was six months old. The control group only had access to normal child healthcare services. Three studies of children in the two groups have been published by Aronen et al. [22, 24, 25]. The last study was performed when the children had reached the age of 20–21.

The counselling reduced both the prevalence of aggressive and internalizing mental problems. Effects were shown in both higher- and in lower-risk families. During the last follow-up, the effect size on depressive symptoms. The effect shown, 0.38 SD, is equivalent to a 60 per cent reduction in significant depressive symptoms in the trial group [26]. Since the trial was designed using random distribution of parents between the trial and control groups, it is possible to attibute the favourable effects to the parents participating in the intervention.

A comparable trial has been presented from Australia in which parents (mothers) received 20–30 minutes counselling by a general practitioner interested in child psychiatry about 20–30 times during the first five years of the children's lives. The effects are presented by Cullen et al in the trial and control groups on two occasions, when the children were 6 and 28 years old respectively [23, 27]. Effects on both aggressive and internalizing mental problems were proven at the age of six. As adults, the prevalence of depressive symptoms was 37 per cent lower among the women in the trial group. Furthermore, less smoking, less overweight and better study results were reported in the trial group.

In the two trials, effects were proven 15–22 years after the intervention. The effects of different interventions normally decrease over time. In the two trials, it is likely that counselling has led to a change in the way children and parents interact leading to good circles. Unfortunately, the content of the interventions has been poorly documented. It is therefore difficult to directly transfer the experiences into practical activities in Sweden without further studies having been performed.

AMERICAN TRIALS WITH HOME VISITS IN SOCIALLY DISADVANTAGED FAMILIES

Women living in socially and mentally disadvantaged circumstances often give birth to babies with a low birth weight. Several trials have therefore been performed to combat this problem by offering pregnant women extra support, often in the form of home visits. Unfortunately, such support seems not to provide the intended effect [28].

In the United States, many children live under socially difficult conditions with little or no child healthcare services such as those that are universally available in Sweden. In an attempt to improve the situation of such vulnerable children, maternity and child healthcare services have been developed for this type of family. One form employed is to offer the families home visits, normally between 30 and 50 in total and often starting while the mother is still pregnant. Previous trials performed in the 1980s indicate favourable effects in the form of improved parent-child interaction, better child development and less incidence of child abuse [29].

The promising effects on these first trials proved to be difficult to repeat, however [30]. Negative effects were even shown in one British trial [31]. According to a systematic review published in 2001, the effects were sufficiently positive to justify the activities [32], but this review has been retract in 2004 pending the findings from further studies having been processed. One explanation for the unclear effects might be the open nature of the counselling. Those performing the home visits (normally the nurses) interpret their task differently, resulting in a marked variation in content. Neither has there been any developed theoretical understanding of what the home visits are supposed to achieve, even though attempts have been made to describe such a basis [33]. Not unexpectedly, the effect of the home visits is influenced by the level of education/training of the person performing them. In one trial, home visits performed by nurses were compared to those made by volunteers. No effects could be proven in those families receiving visits from volunteers, whilst some effects were proven in the group receiving visits from nurses [34].

THE DIFFERENCE BETWEEN ARONEN'S TRIAL, CULLENS'S TRIAL AND THE AMERICAN HOME VISITS

Both Aronen's and Cullens's studies and the American trials involve recurrent contact with the families. The differences are palpable, however. Aronen

and Cullen focus in the mental health of the children and indicate clear effects whereas the American trials have an unclear focus and unclear effects. In Aronen's and Cullens's studies, the counsellors have specific training in child psychiatry whereas the backgrounds of the counsellors in the American home visit studies vary. Furthermore, the parents situations are markedly different. In Aronen's and Cullens's trials, the families have average living conditions. Their participation is entirely voluntary – which should mean the counselling must be designed with full respect for the parents' own choice. In the American trials with home visits, however, the families are in constant contact with the social services and often depend on social benefit for their livelihoods. Even though participation in the study was voluntary, we can expect the parents to have had limited scope for influencing their participation. This may in turn have affected the design of the counselling in which they participated.

Simply offering home visits is hence insufficient. Special methods are required in order to achieve the results presented by Aronen and Cullens.

Support geared towards the needs of parents

Meeting-places

There were 550 *open preschools* in Sweden in the autumn of 2003 [35]. The activities are intended for children and parents in families where the children are not registered at any other type of preschool. At the same point in time, 138 Swedish municipalities did not have an open preschool. There is then a national variation.

Open preschools can promote parenthood in several ways. The contact with other parents and with the staff provides the opportunity for open individual counselling, for example. The effects of such dialogue is discussed below. Another way is parents having the chance to observe how other parents handle their children. In this way, the open preschool offers scope for social model learning, see Chapter 3. Family Resource Centres are currently being built up in Canada (2004). These perform a similar function to the Swedish open preschools. They highlight the potential for parents to learn from each other when they are together with their children and for them to learn from the staff. There are no studies indicating that this is indeed the case in practice, however.

A third possible function of the open preschool is that it strengthens informal social networks among families. If access to open preschools is significant when it comes to developing informal support for parents, we can expect to find a link between access to open preschool and access to support. This hypothesis was tested in the questionnaire survey presented in Chapter 5. The responses from the parents with children aged 0–5 years – i.e. parents with children who are of an age when the parents will use open preschools – were processed. A total of 30 per cent of the parents had visited an open preschool and felt this had been a useful experience. Furthermore, 92 per cent of parents said they had good access to informal support. In the group who said they had benefited from open preschool, 92 per cent said they had good social support, which can be compared to 91 per cent in the group that *didn't* say they benefited from open preschool. An analysis of the women only paints a similar picture. Hence, there is seemingly no difference in access to informal social support between parents who have had access to open preschool and those who haven't. There is too little data, however, to show any statistically reliable differences. The issue was therefore also tested in analyses of the statistical correlation between experienced benefit of open preschool and the size of the parents' informal social network. Neither did these analyses prove any statistically reliable link. The study does not therefore provide evidence for the claim that open preschool can improve the informal networks of parents. More studies are required, however.

The activities are probably offered more in socially disadvantaged areas compared to more affluent areas. In an ongoing study, two-thirds of mothers with children aged about 18 months are reported to have participated in such activities in the socially disadvantaged trial areas [36]. Socially less favourable groups were underrepresented but no group utilised the service less than 50 per cent. Even mothers experiencing some post-natal depression have to a high degree (about 50 per cent) participated in open preschool activities. About 70 per cent of all respondents say they have become more closely acquainted with other parents at the open preschool. This implies that the benefit of open preschool in socially disadvantaged areas may be significant even if its value is more limited for parents in general.

Family welfare centres combine maternity and child healthcare services with open preschool and access to a social welfare secretary. This combination

increases access to open preschool and thus any effects it may have on the parents' social network. The questionnaire study did not permit a separate analysis of the effects of family welfare centres on informal social networks. It is clear, however, that access to a social welfare secretary increased the scope for individual counselling.

There are many other public places where parents can spontaneously meet and establish contact with each other: playgrounds, parks, squares, shops, etc. Parents also meet in other contexts, such as when children are dropped off/picked up from preschool, when parents participate in their children's leisure activities and at parent-teacher meetings. The way such meeting-places are designed and utilised is a major issue concerning society as a whole. It is therefore hardly meaningful to distinguish 'contacts among parents' as a single component. A number of sociologists, including Sennett [37] and Bauman, have analysed the issue [38]. An overall analysis of the significance of meeting-places in a modern society is outside the scope of this project.

Structured parent groups

Chapter 9 offers a description of methods aimed at improving the parents' relationship to each other and at reducing the occurrence of family conflicts and divorce. Effects have primarily been shown for a method called PREP which is geared towards improving the parents' relationship.

Open parent groups

It is common within the maternity care service to offer all parents the opportunity to participate in open parent groups. The groups are open since they are designed in different ways depending on the midwife and the parents. A review of controlled studies of such activities with random distribution of parents between trial and control groups was published in 2004. A total of six studies were identified fulfilling the established requirements [39]. Effects could not be proven in any of these studies.

In Sweden, Helena Fabian has studied the effects of the parent education offered by the maternity healthcare services. Fabian compares women who have participated in parent education with those who have not and taken differences in their backgrounds into consideration. She finds no difference between the groups as far as their experience of child-birth, the prevalence

of breastfeeding and various parental skills are concerned [40]. She also finds that women who are single, have a short education or smoke experience the groups as less valuable.

Parents are also asked by the child care services whether or not they wish to participate in open parent groups. No studies of the effects of such activities have been presented, either internationally or in Sweden.

Open discussion groups can improve the situation of parents if the participants have a common problem, see Chapter 3. Negative effects of open discussion groups have also been presented.

Structured individual counselling

Parent counselling with structured programmes normally aims to improve the child's situation. The studies performed to date have therefore examined the effects on the child or on the parents' behaviour towards him/her. The studies are hence presented as being geared towards the needs of children.

Open individual counselling

Controlled studies of the forms of open individual counselling offered to parents during this period have not been identified. It is however possible to generalise the findings from studies of such counselling offered in other contexts. Such studies are discussed in Chapter 3. The review indicates that open individual counselling can improve the parents' situation, *provided* that the parents actually have a problem. It is dubious whether open counselling to parents in general has any effect.

Negative effects of discussions in socially disadvantaged families have been proven within the child healthcare services, where parents receive advice from staff working to promote the child's best interests [41–43]. These negative effects may be connected to the nurse's task of satisfying the needs of both the children and the parents. These needs can come into conflict with each other, for example when it comes to breastfeeding. A nurse knows that being breastfed is in the child's best interests. On the other hand, she understands the feelings of a mother who experiences breastfeeding as a burden. If the nurse finds it difficult to deal with this conflict, the mother may feel she is a failure in front of the nurse.

Evidence in support of the effects of various forms of support – summary
Structured parent groups such as PREP can improve the parents' relationship. Structured methods individually or in groups aimed as improving parent-infant interactionand attachment patterns have clearly positive effects. Structured individual counselling on tobacco use, breastfeeding and accidents and in the event of depression have similarly proven positive effects.

Two controlled trials of *regular open individual counselling* to all families during the first five years of the child's life indicate palpable effects on the child, both during childhood/adolescence and later on in adult life. This intervention probably requires the staff who perform the counselling to be trained in child psychiatry.

When a family has a *problem*, the situation can be improved by open individual counselling and by participation in open discussion groups together with other parents with the same problem.

It is unclear whether meeting-places, of the type offered within the open preschool system, can improve the parents' informal social network. It is also unclear whether the open parent groups organised within the maternity and child healthcare services have any effect. To the extent that they focus on dealing with problems raised by the participants, they can be expected to improve the parents' situation. The directives governing these activities, however, state that the groups are to provide the participants with knowledge and information. They do not state, on the other hand, that the starting-point should be the problems raised by the parents themselves. It is therefore unclear whether such an approach is the dominant focus of such parent groups. As a result, it is also unclear as to the effect the parent groups might have.

The situation in Sweden

In Sweden, parents are offered support during pregnancy and early infancy within the maternity care services, child healthcare services, at open preschools and at family welfare centres. The maternity healthcare services have begun using an evaluated structured method called PREP. Two evaluated structured methods are used within the child healthcare services, at

open preschools, at family welfare centres and in other contexts. Both methods are founded on principles that have had proven effects in scientific studies. The strength of the evidence for different methods varies. For this reason, the methods have been divided up into 'recommended' and 'promising' programmes, where the evidence is stronger for the recommended programmes. A new organisational model for parent support has been developed in the town of Leksand.

Maternity healthcare

Ninety-nine per cent of all pregnant women make use of the maternity healthcare services in Sweden. On average, they have 11 individual contacts, mostly with midwives. Parent education in groups is offered to first-time parents at 98 per cent of all maternity healthcare clinics and to repeat parents at 60 per cent of all the clinics [44].

A survey performed in 1994 shows how the education are designed [45]. Parents normally meet about six times. Every group session is about two hours long and the size of the group is 6–7 couples or an average of 13 participants (personal message, Madeleine Kilsbeck, 2003). The aim of parent support in the maternity healthcare services is to offer knowledge, the opportunity to meet others, a feeling of solidarity, discussions among parents and the chance for parents to influence their own situation [46]. Much of the time is taken up by disseminating information, for example about the pregnancy, delivery, pain relief, nutrition, tobacco, alcohol and about the new-born baby. Lectures on a specific theme are common. Time is also set aside for discussion. An evaluation of 71 parent groups comprising pregnant women and their husbands/partners showed that the aspect most appreciated by the parents was in fact the chance to meet others who found themselves in the same situation [47].

Special groups exist for young mothers, for single mothers and for mothers expecting twins. The midwives said that about 8–10 per cent of their working time was taken up by parent education. Sixty-five per cent of midwives said they received regularly training in the subject themselves. Seventy-two per cent received instruction by a psychologist.

In some counties, the UN Convention on the Rights of the Child is discussed in the parent groups. In Gävleborg County Council, the project manager for the implementation of the Convention on the Rights of the

Child has written a special guide to how this can be used in parent education.

During individual contact sessions, the midwife employs the type of structured counselling on tobacco use that has been proven effective. Some maternity healthcare clinics have also started to test a structured programme intended to improve the parents' relationship (PREP).

The maternity healthcare services are in many places integrated into a family welfare centre. An organisational model for parent groups that continue after the child is born has been developed in Leksand and spread to several other municipalities. This model has provided a solution to several of the problems inherent in the current system of parent groups.

Child healthcare

Ninety-nine per cent of all families make use of the child healthcare services in Sweden. They have an average of 20 individual contacts, primarily with nurses. Parents are invited to join parent groups when the child has reached the age of one to two months. In Stockholm County, 61 per cent of all first-time parents participated in at least five sessions in 2002 [48]. Eighteen per cent of repeat parents participated in the activities. In Örebro, the percentage of children with parents participating in parent groups is reported without specifying whether it is the first or subsequent child. Attendance reached 51 per cent in 2003 [49]. It is probable that this data is representative of Sweden as a whole. Variations between individual healthcare clinics are considerable, however, where some have 100 per cent participation and others have no parent group activities at all [49].

The aim of parent support in the child healthcare services is to provide knowledge and information, contribute to strengthening parents in their parental role, provide scope for them to meet and spend time with other parents, break their isolation and enhance community spirit in the area where they live [46]. Aspects such as health problems, experience of parenthood and sibling relationships are common subjects discussed in the parent groups. The content has in all likelihood changed very little since the inception of parent groups back in the 1970s. An interview survey shows that the nurses who lead the groups find it difficult to achieve the set objectives [50]. Another interview study shows that parents and nurses have different opinions regarding the aim of the groups [51]. Parents pointed out that the

important thing was to be able to exchange experiences with other parents whilst nurses felt their primary task was to give parents information.

Two structured methods are used during individual counselling, both of which have been proven effective in studies. One method aims to reduce the risk of the infant being exposed to tobacco smoke, *Rökfria Barn* [Smoke-free children] [15] whilst the other is a method to be used in dialogue with depressed mothers [21]. Both methods are reasonably widespread across the country. In general, individual dialogue aimed at promoting breast-feeding and measures to prevent accident injuries are also offered.

An important part of the nurses' work is to give advice when parents have some kind of problem. The survey in Chapter 5 shows that this is a well-appreciated activity. For the nurses to be able to provide advice from which parents can benefit, they need to have knowledge and experience of issues connected to small children. Several studies show that parents are more satisfied with the advice they receive from nurses who spend at least half their working day dealing with children [52, 53] (Claes Sundelin, personal message, 2004). This is probably due to this giving them more experience within the field.

During contact with parents, nurses also try to identify individual high-risk families to give them extra support [4]. These interventions are not discussed in this report since our line of questioning is limited to measures that are relevant to at least five per cent of the population, see Chapter 2. One of the reasons for this limitation is that the healthcare services and the social services have already developed methods in order to offer these groups special support. Another reason is that it appears difficult to achieve effects on the population level using interventions aimed at such minor risk-groups, see Chapter 2. Some of the targeted methods have been described in a state-of-the-art document on child healthcare [3]. The justification for interventions aimed at minor risk-groups is primarily the idea that the children and families have substantial needs, rather than knowledge of the long-term preventive effects of previous interventions for this group.

Two structured methods have started to be employed in parent groups: *Från första början* [Right from the start] and *Vägledande samspel* [ICDP, International Child Development Programme]. Both aim at improving interaction between the caregiver and the child. ICDP is the more widely spread method.

Child healthcare services are in many places integrated into a family welfare centre, see below. The parent group model developed in Leksand is in use within the child healthcare services in several municipalities.

Open preschools

There were 550 *open preschools* in Sweden in the autumn of 2003, compared to 700 the year before [35]. At the end of the 1990s, there were nearly 1,000 open preschools around the country. Every other preschool has since then closed, however. Today, 138 municipalities have no open preschools at all. Ten or so municipalities, including Stockholm and Malmö, reported more open preschools in 2003 than in 2002. If every preschool is primarily used by families in its immediate neighbourhood, and this neighbourhood has an estimated 5,000 inhabitants, roughly 30 per cent of the population have access to an open preschool. These figures are in line with those obtained from the survey presented in Chapter 5, where 30 per cent of all parents said they had benefited from open preschool activities.

The activities are probably offered more in socially disadvantaged areas compared to more affluent areas. In an ongoing study, two-thirds of mothers with children aged about 18 months are reported to have participated in such activities in the socially disadvantaged trial areas [36]. Socially less favourable groups were underrepresented but no group utilised the service less than 50 per cent. Even mothers experiencing some post-natal depression have to a high degree (about 50 per cent) participated in open preschool activities. About 70 per cent of all respondents say they have become more closely acquainted with other parents at the open preschool.

Fifty-seven per cent of the open preschools are open up to 15 hours a week and 19 per cent are open 15–21 hours a week [54]. Open preschool has the task of offering pedagogical activities to children who do not attend a normal preschool. The open preschool also functions as a meeting-place for parents. The number of children registered in preschools has risen. The need for pedagogical activities for children who are at home with their parents has therefore decreased. This is why there are fewer open preschools today than at the beginning of the 1990s.

Family welfare centres and other meeting-places

Different forms of collaboration exist between organisations providing support to families with small children. The family welfare centre is one such form [55–57]. There were about 200 family welfare centres in the country in 2003, of which 120 came under the umbrella organisation *För-eningen för familjecentraler* [The association of family welfare centres] (Bing, personal message 2003). A family welfare centre normally consists of maternity and child health services, open preschool and a social welfare secretary who provides advice and support. This form has several advantages. Families come more into contact with the open preschool and social services since virtually all families have contact with the maternity and child healthcare services. It also promotes greater collaboration among different organisations.

One example of an activity that also functions as a meeting-place is the one established in the city district of Ekholmen in Linköping in cooperation with the county council. Parents meet there a few times a week. Parents and children can sing together, for example. The intervention was initiated as a result of problems among the children which had been highlighted by preschool staff. The activity has reached two-fifths of all the families in the city district. Participating parents have been very satisfied. "Baby-cafés", organised by several child healthcare clinics, are another example.

Social services

The primary aim of social services is to provide support to families with considerable problems. These interventions fall outside the scope of this study. The social services also offer interventions intended for broader groups. For example, it is common for the social services to organise special parent groups for young single mothers. An intervention set up by the social services in Luleå provides an example. Here, they have combined open counselling at the clinic with home visits. The aim of the intervention is to provide practical, everyday support. A graduate social worker is responsible for contact with about 300 families. Another example is the family welfare centre in Jordbro, where they have combined open counselling with home visits. The intervention has been organised by the municipality in partnership with the County Council, *Storstadssatsningen* [Metropolitan Initiative]

and Save the Children. Trained parents are responsible for home visits offered to parents twice a month for one year. A project in Dublin called Community Mothers has served as a model for this intervention. [58].

In some cases, services are offered for a shorter time without this being brought about by a specific issue. A common form is open counselling at the clinic. The intervention organised by Munkedal Municipality is an example. The parents come to the clinic after having received an invitation or having telephoned themselves. Depending on their problems, they can speak to either a social worker or special needs teacher. The intervention was the result of an initiative from the employees at the municipality.

The Leksand Model

In several Swedish towns and cities, parent support is organised by the municipality in partnership with the county council and adult education organisations. The model was first developed in Leksand [59, 60]. Parent groups start there, as in other parts of the country, within the maternity healthcare services whilst the mothers are still pregnant. The groups are run by midwives. The difference between the Leksand model and more prevalent models elsewhere is that the same groups of parents continue to meet after the baby has been born. This has been a long-standing ambition in many parts of the country, but has seldom been implemented in practice. The reason why success was achieved in Leksand is probably because the municipality has taken a collective responsibility for the parent groups. In more prevalent models around the country, the responsibility for parent groups after the baby has been born lies entirely with the nurses in the child healthcare service. They have subsequently organised the groups according to the way the child healthcare services are set up, which is different to the way the maternity healthcare services are organised. It has hence been difficult to keep the groups formed during pregnancy together. In Leksand, on the other hand, the municipality has taken overall responsibility, allowing the groups to be kept together. The same groups continue to meet as the children get older and acquire younger siblings. An adult education association then organises the activities in cooperation with the parents.

There are a number of advantages with this model. The first is the way the contacts among parents are strengthened. This is one of the intentions

of current parent education but is seriously disrupted by constant changes to the composition of the parent groups. The second advantage is that fathers participate in activities to about the same degree as the mothers. This is seldom the case in other municipalities around the country. The third advantage is that the parents can easily continue to meet and discuss themes they themselves choose, even after the children have grown beyond early infancy.

There is data from Leksand on the parent groups that started when the mothers were still pregnant with the family's first child (Thomas Johansson, personal message 18 February 2004). In 1999–2000, a first child was born in 96 families domiciled in the municipality. Parents from 91 of these families took part in parent group activities during pregnancy. The groups continued on through early infancy and the toddler years. In February 2004, when the children were between 3 and 5 years old, about half the parents were still continuing, 46 women and 46 men.

The whole model or parts of it have spread to other parts of Sweden, including Fagesta, Orsa, Rättvik, Söderköping [61], Söderhamn and Vaxholm and to a few municipalities in Värmland. In addition, there are several using parts of the concept and creating local models of their own. The model has also spread to Finland, where Ekenäs, Hangö, Karis, Pojo, Ingå and Sjundeå, St Karins and some city districts of Esbo and Helsinki are now using the model. The book describing the model has been translated to Finnish.

Structured methods for maternity healthcare: recommended programmes

The Prevention and Relationship Enhancement Program, (PREP)

PREP is a structured group programme for couples. The programme comprises a total of 10–15 hours spread over 5–6 weeks in the evenings or during a weekend. The most important goals for the programme are: 1) to improve communication and practise a constructive way of dealing with conflicts, 2) to clarify the expectations and basic principles people have when it comes to couple relationships, 3) to maintain and develop the fun aspect, friendship and spiritual togetherness of a relationship, 4) to help couples to draw up a common "rule book" for how to deal with conflicts, and 5) to provide tools to increase and maintain commitment. The participants discuss and practise skills. They practise with their usual partner, whilst some of the discussions take place amongst the entire group.

A workbook is used and the couples are given work to do at home. The programme leaders can also use role-play or narrative to illustrate a type of behaviour or demonstrate patterns. The original American model has been developed by Howard J. Markman, Susan L. Blumberg and Scott M. Stanley.

Scientific studies with control groups

There are 4 scientific studies of PREP using control groups [62–65]. In all four studies, a more beneficial pattern of communication is demonstrated in the group participating in the intervention, either in the entire group or just among men or a high-risk group. Effects in the form of couples experiencing a more satisfying relationship are shown in three of the studies. One of the studies provides evidence of a poorer relationship in a low-risk group. Statistically reliable effects on separation are indicated among unmarried parents in one study. The number of participants in the studies is so limited, however, that it is difficult to prove statistically reliable effects on the incidence of separation.

Use of the method in Sweden

PREP has been used in Sweden since 1999. There were about 200 trained group leaders in the autumn of 2004.

Information, practical experience and education/training

Information on the method and its theoretical background is available online in English [66]. For information on group-leader training and on practical experiences of the method, please visit the Swedish National Institute of Public Health (SNIPH) website [67].

Structured methods for child healthcare: recommended programmes

The two recommended programmes are based on attachment theory and aim to improve the ability of parents to interpret and respond to the infant's signals.

Right from the start

Right from the start is a manual-based parent group programme for parents of small infants. The programme is video-based and comprises eight meetings. At the first meeting, parents see a short video which acts as the

starting-point of a discussion on the significance of association. At the second meeting, parents, using video clips as the starting-points, discuss suitable approaches which they are then given the chance to practise. The varying temperaments of children are then discussed at the third meeting. At the fourth and fifth meetings, the focus is on recognising signals indicating that the child wants to be left in peace, or that s/he likes a particular situation. At the sixth meeting, attention is drawn to how parents can let the child dictate a game. The two last meetings are about the child-parent relationship. Some of the approaches discussed are also role-played. The Canadian *Right from the start* model has been developed by Alison Niccols.

SCIENTIFIC STUDIES WITH CONTROL GROUPS

There is a small-scale randomised controlled study of the Canadian model demonstrating proven effects [68, 69]. The study indicates conclusive effects on the occurrence of secure attachment. A larger controlled randomised study is currently ongoing in Canada.

USE OF THE METHOD IN SWEDEN

Right from the start has been used in Sweden since 2003. On 1 January 2004, there were about 30 parent group leaders and about 100 parents who had undergone the programme.

INFORMATION, PRACTICAL EXPERIENCE AND EDUCATION/TRAINING

Information on the method and its theoretical background is available online in English [68, 70]. For information on group-leader training and on practical experiences of the method, please visit the SNIPH Website [71].

Vägledande samspel [ICDP, International Child Development Programme]

ICDP is a group programme for parents with small infants. The programme also exists for parents of preschool- and schoolchildren. The aim is to develop positive interaction between adults and children. The programme is built around eight interaction themes. Parents discuss interaction situations recorded on video. In some places in Sweden the video sequences have been replaced by other visual material. There are eight themes included. These are based on research into potential for interaction and the

significance of emotional communication for social and cognitive development. There is a detailed guide in Swedish [72] and an English text describing the theoretical background [73]. The guide emphasises suitable approaches. It does not describe individual elements in detail. ICDP, International Child Development Programme, has been developed by professors Henning Rye, University of Oslo, Karsten Hundeide, University of Oslo and Phnina Klein, Bar-Ilan University, Israel.

SCIENTIFIC STUDIES WITH CONTROL GROUPS

Two controlled studies have been performed in Norway [72] (personal message, Karsten Hundeide, University of Oslo, 2004). These studies indicated proven effects on the sensitivity of parents to children's signals. The prevalence of secure attachment has not been analysed in these studies. ICDP efforts in Russia and Ethiopia have also been documented (personal message, Gunilla Niss, 2004). A Swedish controlled study was initiated in the autumn of 2004 under the management of Stockholm County Council.

USE OF THE METHOD IN SWEDEN

ICDP, International Child Development Programme, has been used in Sweden since 2000. On 1 January 2004, there were about 500 trained parent group leaders, 127 of whom hold a diploma. Over 5,000 parents have undergone the programme.

INFORMATION, PRACTICAL EXPERIENCE AND EDUCATION/TRAINING

Information on the method is available on-line in Swedish [74] and English [75]. For information on group-leader training and on practical experiences of the method, please visit the SNIPH Website [71].

Structured parent support focusing on children's needs: other programmes

Marte Meo

Marte Meo is a consultation and treatment model that has spread in Sweden over the last ten years [76]. The programme is partially based on the principles of the attachment programmes. Its effects have, however, not been evaluated in any controlled studies. A Swedish study without control groups does indicate favourable effects, however [77]. The method is used in families where the children display manifest problems. It demands more staff resources than the two recommended programmes above since every

single child is to be videoed. Simplified versions of *Marte Meo* are used at a few child healthcare clinics around the country. The effects of this activity have not been studied.

Active parenting

Active parenting is a manual-based preventive parent support programme for parents with children aged between nine months and four years. The programme is described in Chapter 7.

Level of parent interest

In parent groups within *the maternity healthcare services*, 81 per cent of first-time parents and 14 per cent of repeat parents participate in more than half the sessions [44]. In parent groups within *the child healthcare services*, 79 per cent of first-time parents participate in at least one session and 61 per cent in at least five [48]. Twenty-six per cent of repeat parents participate in this activity. According to the survey presented in Chapter 5, 47 per cent of all parents, women and men, say they have benefited from attending parent groups within the child healthcare service. When only women are asked, 82 per cent of first-time parents say they have participated in a parent group and 79 per cent say they were satisfied with their participation [78]. These sets of data are consistent with one another since men don't normally participate in child healthcare service parent groups.

An interview survey shows that parents like to see parent groups organised within the child healthcare services have a clear structure [79]. They also ask for more emphasis to be placed on parent-child interaction [79].

Sex

Forty-six per cent of the participants in parent groups organised within the *maternity healthcare services* are men. Father groups, or theme lectures aimed especially at men, are run at 35 per cent of maternity healthcare clinics. Twenty per cent of fathers participate in at least one (often only one) parent group session organised by the *child healthcare services* [80]. This means that roughly 10–15 per cent of the participants in each session are men (Gunnel Widlund, personal message, 2003). Interest among women in

these parent groups is 80 per cent higher than among men. Interest among women in open preschool is 40 per cent higher than among men.

Socioeconomic groups

At *maternity healthcare* service parent groups, Fabian et al have shown that women who have a short education, are single or who smoke feel the activity is less valuable [40].

At *child healthcare service* parent groups, working-class women are less satisfied with the activity than middle-class women [53]. Single parents are underrepresented [80]. The survey presented in Chapter 5 shows that the interest in parent groups within the child healthcare services is 80 per cent higher among the highly educated than among those with a low level of education.

Most parents are satisfied with the *individual contacts* offered by the maternity and child healthcare services [78]. The interest in individual counselling within the child healthcare services is also 80 per cent higher among the highly educated than among those with a low level of education. In interviews, mothers living under stressful circumstances say they sometimes feel belittled in their contacts with the child healthcare service [42]. This may be a consequence of the fact that the maternity and child healthcare services have sets of data than can come into conflict with each other. One role is obviously to provide support for parents. Another role is to convey certain ideas on how to suitably take care of children.

Country of birth

Interest in parent groups within the child healthcare services, in individual counselling within the child healthcare services and in open preschools is about the same among parents born outside the Nordic region than among those born in Sweden.

Costs

Total costs for maternity and child healthcare are estimated at about SEK 15,000, calculated in 2004 prices [81]. Roughly 15 per cent of these costs can be attributed to group parent support. This means that the cost is about SEK 2,000 per child.

Three structured and well-evaluated methods indicating proven effect are available in Sweden: *Från första början* [Right from the start], PREP and ICDP, International Child Development Programme. The direct cost for training a person in one of these methods is roughly SEK 10,000. This cost corresponds to about three per cent of a child healthcare nurse's annual salary. If the methods are integrated in existing activities, there are no extra costs over and above those for methodology training.

The cost per child for open preschool is roughly SEK 800. This estimate is based on the total costs for open preschool faced by municipalities in 2002, which were SEK 291,451,000. In the same year, there were a total of 648 open preschools under municipal management [54]. This is equivalent to a cost of SEK 450,000 per open preschool and year. If an open preschool is open 220 days per year and has 25 visiting parents per day, the total number of visits will be about 5,500 per year. The cost per visit will therefore be approximately SEK 80.

Dissemination

As far as the structured methods of parent support are concerned, there are organisations that train group leaders, see above, and updated information available on the SNIPH website [71].

Discussion

Parent groups

Parent support in groups for those with children in this particular age group has existed for several decades and currently reaches the vast majority of parents. When trying to improve this activity, it is appropriate to focus on finding solutions to five problems that current exist.

The *first problem* concerns the potential for achieving established *objectives*. The official aim of parent support within the maternity and child healthcare services is to provide knowledge and information, to strengthen parents in their parental role and to promote contact among parents [46]. Nurses within the child healthcare services say they find it

difficult to achieve these objectives [50]. Furthermore, Hallberg el al have shown that nurses give prominence to the first two objectives but not the third, promoting contact among parents [51]. Parents, on the other hand, say that the main benefit of parent groups is having the chance to exchange information with other parents.

Parents receive information about parenthood in several ways, via relatives and friends, via the media and via individual contacts with child healthcare nurses. If disseminating information was an important aspect of parent groups, one would expect parents to emphasise it. But this was not the case. One explanation might be that the information conveyed by the nurse at group sessions does not take a structured and delimited form. Instead, the information tends to be integrated into the dialogue pursued by the nurse with the group participants concerning subjects spontaneously brought up by the parents themselves, e.g. issues concerning food, sleep and development. It is possible that parents do not see these dialogues as information dissemination and cannot therefore concretely identify their value. It is also possible that the individual conversations with the nurse is seen as being a more appropriate form of providing answers tospecific questions brought up by parents, since the answers can be more easily adapted to suit individual parents. In the survey presented in Chapter 5, the parents say that in their opinion, the individual conversations with the child healthcare nurse are more valuable than the group sessions. This finding contradicts the belief that the dissemination of information by the nurse in parent groups is of central importance to the parents. The current state of knowledge is therefore unclear. There is no unequivocal evidence neither in support of or against the belief that the nurse's dissemination of information in the parent groups is important for the parents.

Parents do not say that their participation in parent groups results in them feeling more secure in their parental role. Neither is this aim emphasised by the nurses and they do not clarify how this objective is to be realised. The fact that parents with the lowest level of education show the least interest in parent groups is worth mentioning. Within several areas, individuals with a short education are less confident in their abilities. It is likely that this is also true regarding their confidence in their abilities as parents. The fact that child healthcare clinic parent groups do not attract this group suggests it does not understand that the groups feel the activity strengthens

them regarding their confidence in their own abilities. Further studies of the issue would however be justified.

Parents appreciate the opportunity to talk to other parents and learn from their experiences. This is one of the activity's expressed aims. Bearing in mind that nurses do not highlight this aim, we can perhaps question whether they have developed methods for promoting such exchange of experience. This task is of a different nature to the kind of tasks that dominate the work of a nurse, namely that s/he is normally expected to answer different questions or to her/himself highlight a particular issue which s/he feels is important. Facilitating communication between the participants in a group is a less common task for nurses. Those who received their basic education a long time ago often lack training in how to do this.

The *second problem* concerns the transfer of groups from the maternity to the child healthcare services. Normally, groups formed at maternity healthcare clinics break up and are replaced by new groups at child healthcare clinics. The reason for this is organisational. Groups are attached to the midwife or child healthcare nurse responsible for specific families. The remits of these two organisations differ. This is inappropriate seen from the perspective of trying to strengthen contacts between parents. Despite this being a known problem since the advent of modern-day parent groups, a solution has seldom been forthcoming.

The *third problem* concerns the inconclusive evidence as to whether the activity can have an impact on children's health and welfare. The reviews of different methods in Chapters 2 and 3 do not provide sufficient support for the claim that open group activities of this kind, normally arranged in the child healthcare services, actually have any effect. If the participants have problems, and these act as a starting-point for the parent groups, they can however be expected to have a positive effect.

The *fourth problem* is that child healthcare parent groups are primarily designed by women for women. Parent support generally attracts more women than men. Child healthcare service activities are however the least gender-equal of the forms of parent support analysed in Chapter 5.

In several parts of the country, special fathers' groups have been organised. The survey suggests however that these groups are on the whole few and far between. This may be due to the fact that they require special financing. Similar problems were inherent in the attempts to train men as group leaders

made in Värmland in 2002–2004, since the model demands special financing for its day-to-day running. Midwives at maternity healthcare clinics and child healthcare nurses have also criticised the idea of fathers without any professional training being appointed as parent group leaders [82].

The *fifth problem* concerns the *social profile* of the parent support. The survey presented in Chapter 5 shows that the activity is better suited to well-educated parents than to parents with only a short education. Similar tendencies can be found for parent groups in general by the differences are particularly marked for the groups organised within the child healthcare services. A possible explanation might be that parents with a short education can feel worried about being impugned by other parents and by the group leader.

These five problems can partly be solved by giving midwives and nurses further training. By means of further training, new methods with a proven effect can be introduced, ICDP, International Child Development Programme being a case in point. Further training in group methodology can also help group leaders to facilitate the exchange of experience among group participants and help the groups become more attractive to parents with a short education. Further training is not enough to achieve continuity for the groups from pregnancy to early infancy, however. Neither is it sufficient to make the groups more attractive to men. Considering additional measures is therefore justified.

The model developed in Leksand and which has since spread to various parts of the country has several interesting characteristics [59]. It has achieved continuity for the participants from pregnancy until the child reaches the age of five. Approximately the same amount of women as men participate in the groups during pregnancy. Because the same groups continue to meet, their sex distribution remains equal even after the baby is born. Attendance is high, suggesting different social groups are being recruited in equal measure. It seems, therefore, that the model has come to grips with three of the above-mentioned problems. It is also possible to introduce the evaluated methods that have a proven effect into these groups, similar to traditionally organised activities. The Leksand model therefore constitutes an interesting alternative way of organising activities.

A crucial factor in the success of the model seems to be the involvement of the municipality as an actor. Midwives from the maternity healthcare services and child healthcare nurses participate but they do not have the main responsibility for the activities. It is instead the parents who invite various professional groups. The parents themselves "own" the groups. Another argument in favour of the Leksand model is that parent groups which continue after early infancy constitute an excellent platform for the methods presented in Chapter 7.

A proposal for greater municipal responsibility for parent support was presented as early as 1997 as part of a commission into the subject [46]. This commission proposed a new agreement with the Federation of Swedish County Councils on education for expectant parents and parents of small infants and a clearer municipal responsibility for the information and coordination of parent support activities.

There are however risks associated with adopting the Leksand model. It is possible, for example, that it is less suited to larger municipalities. This is an important aspect as a large proportion of all families with children in Sweden live in medium-sized and large municipalities. The model involves a shift of responsibility from the county council towards the municipality. If too many actors are involved, there is a risk that no-one will take full responsibility. In the long term, therefore, it seems appropriate for a single actor to have the main responsibility for parent support. The municipality may seem to be more suitable for this role since it already bears responsibility for broad interventions aimed at families with children. The ongoing commission on social responsibilities points to a development towards reduced responsibilities for county councils within sectors such as maternity and child healthcare [83].

In light of this, trials of the Leksand model are justified, as are trials of other models that attempt to come to grips with the problems thatare currently inherent in today's parent support system.

Parent groups for special groups

Separate activities for foreign-born parents in Sweden seem not to be justified, provided the group, with or without an interpreter, can converse in the same language. Parents with a foreign background themselves stress the value of participating in groups of mostly Swedish-born parents. The

parent questionnaire does not suggest that the interest in parent support shown by this group is all that different from the interest of Swedish-born parents.

The discussion in Chapter 3 about support focusing on the needs of parents suggests that group activities can often be of particular value if the participants have a common problem. This can for example be true for young, single parents. Groups with tangible problems have normally already come into contact with the social services or the child and adolescent psychiatry services. Comments on the design of such group activities are therefore outside the scope of this report, see Chapter 2.

Individual contacts

Most parents are satisfied with the *individual contacts* offered by the maternity and child healthcare services. The parent questionnaire indicates, however, that parents with a short education are less interested in individual counselling offered by the child healthcare services compared to well-educated parents. This may be explained by the fact that mothers living under stressful circumstances often say they feel belittled by the child healthcare nurse [41, 42]. Training of midwives and nurses aimed at clarifying and dealing with this conflict can improve the situation for socially disadvantaged parents.

Open preschool and family welfare centres

Locating open preschools, maternity and child healthcare services under the same roof in a family welfare centre is justified. This makes it easier for all parents to come into contact with the open preschool since the vast majority of them visit the maternity and child healthcare services.

Organisation

The municipality has been nominated as the main responsible party for parent support during pregnancy and early childhood. The interventions in the maternity and child healthcare services are implemented in partnership with the county council. It has been proposed that the cooperation between the municipality and the county council be regulated by an agreement between the Association of Local Authorities and the Federation of County Councils (now amalgamated into the Swedish Association of Local Authorities and Regions).

Parent support affects several different municipal administrations. It may therefore be appropriate for the municipality to appoint one person assigned the task of coordinating all parent support activities, including that proposed for other age groups. One option is for the coordinator of alcohol and drug prevention already appointed in many municipalities to be given this additional task. Another option is to give the task to local crime prevention officers or municipal public health planners.

The need for research

Four questions are worth studying in particular.

The trials *with regular individual counselling in the home* presented by for example Aronen et al are very promising since only a small number of other trials have shown such a marked reduction in mental ill-health. The data available on these trials is however insufficient for them to be made into regular activities. New randomised controlled trials are therefore needed, in which parent support interventions are designed so that the method is easily disseminated.

One of the aims of parent groups, open preschools and family welfare centres is to strengthen the *informal social networks* of parents. There is a lack of surveys, however, showing that activities of this kind can have such effects. The issue should hence be studied in more detail.

The child's patterns of attachment to the caregiver are established during early infancy. A secure attachment promotes mental health. Two methods, *Right from the start* and *ICDP* (International Child Development Programme) have been recommended for general use within the child healthcare services. It is probable that the interventions promote the development of secure attachment. Effects on the prevalence of secure attachment need further study in Sweden.

It is unclear whether the official aims of open parent groups in the maternity and child healthcare services are being realised. Studies of this issue are therefore justified.

Proposal

The Swedish National Institute of Public Health (SNIPH) recommends trials with new organisational models of parent support during pregnancy and early infancy, especially trials where the municipality takes a collective responsibility for all parent support activities. Activities developed in for example Leksand can function as models in which parent support is designed by the municipality in partnership with the county council, adult education organisations and other non-governmental organisations (NGOs).

SNIPH proposes it be given the task of providing support in 2005 and 2006 to the actors so that changes can be made to parent group activities at maternity and child healthcare clinics. This task will also include converting the knowledge presented in this review into practical activities.

SNIPH recommends that the municipalities by way of experiment co-ordinate all parent support, including the activities currently run under the auspices of the maternity and child healthcare services. County council staff are, however, expected to continue to participate.

SNIPH recommends that the Association of Local Authorities and Federation of County Councils (now amalgamated into the Swedish Association of Local Authorities and Regions) enter into an agreement on parent support in 2007 based on the experiences from the trials.

SNIPH recommends widespread use of methods with known proven effective within existing activities. Two examples of such methods are *Right from the start* and *ICDP*, International Child Development Programme.

SNIPH recommends that central government provide support for development work and research regarding structured programmes during pregnancy and early infancy.

Participants

Sven Bremberg has the main responsibility for the text and Anton Lager has prepared the background material. Ingrid Olsson and Berit Hagekull have provided background data describing the link between access to preschool and social support.

References

1. US Preventive Services Task Force. Guide to Clinical Preventive Services. 2 ed. Baltimore, MD: Williams & Williams; 1996.
2. Berglund A, Lindmark G. *Ett förändrat mödravårdsprogram*. Stockholm: Socialstyrelsen; 1996.
3. Medicinska forskningsrådet. *Barnhälsovårdens betydelse för barns hälsa – en analys av möjligheter och begränsningar i ett framtidsperspektiv*. State of the art-konferens i Stockholm 23–25 september 1999.
4. Hwang P, Wickberg B. *Spädbarnets psykiska hälsa*. Stockholm: Statens folkhälsoinstitut; 2001.
5. Bohlin G. *Tidig anknytning – betydelse för utveckling och hälsa*. In: Socialdepartementet. Röster om barns och ungdomars psykiska hälsa. Delbetänkade av Barnpsykiatrikommittén. Stockholm: Socialdepartementet; 1997.
6. Cederblad M. *Från barndom till vuxenliv: En översikt av longitudinell forskning*. Stockholm: Gothia och Centrum för utvärdering av socialt arbete; 2003.
7. Fogany P. Patterns of attachment, interpersonal relationships and health. In: Blane D, Brunner E, Wilkinsson R, Eds. Health and social organization. London: Routledge; 1996, p. 125-51.
8. Thompson RA. Early attachment and later development. In: Cassidy J, Shaver PR, Eds. Handbook of attachment: Theory, research, and clinical applications. New York, NY: Guilford Press; 1999, p. 265-86.
9. Easterbrook M, Lamb M. The relationship between quality of infant-mother attachment and infant competence in initial encounters with peers. Child Development 1979;50:380-7.
10. Waters E, Wippman J, Sroufe L. Attachment positive affect and competence in the peer group: Two studies in construct validation. Child Development 1979;50:821-9.

11. Greenberg MT. Attachment and psychopathology in childhood. In: Cassidy J, Shaver PR, Eds. Handbook of attachment: Theory, research, and clinical applications. New York, NY: Guilford Press; 1999, p. 469-96.

12. Bakermans-Kranenburg MJ, van IJzendoorn M, Juffer F. Less is More: Meta-Analyses of Sensitivity and Attachment Interventions in Early Childhood. Psychological Bulletin 2003;129(2):195-215.

13. Lumley J, Oliver S, Waters E. Interventions for promoting smoking cessation during pregnancy (Cochrane Review). The Cochrane Library. Oxford: Update Software. 2003(3).

14. Roseby R, Waters E, Polnay A, Campbell R, Webster P, Spencer N. Family and carer smoking control programmes for reducing children's exposure to environmental tobacco smoke (Cochrane Review). The Cochrane Library. Oxford: Update Software. 2003(3).

15. Arborelius E, Bremberg S. Child health centre based promotion of a tobacco-free environment in children's homes – a Swedish case study. Health Promotion 2001;16(3):245.

16. Fossum B, Arborelius E, Bremberg S. Evaluation of a counselling method for child health nurses: An example of patient-centred communication. Prev Med 2004;38(3):295-301.

17. Reynolds KD, Coombs DW, Lowe JB, Peterson PL, Gayoso E. Evaluation of a self-help program to reduce alcohol consumption among pregnant women. Int J Addict 1995;30(4):427-43.

18. Sikorski J, Renfrew MJ, Pindoria S, Wade A. Support for breastfeeding mothers (Cochrane Review). Oxford: Update Software; 2003.

19. Roberts H. What works in reducing inequalites in child health. London: Barnados; 2000.

20. Ray K, Hodnett E. Caregiver support for postpartum depression (Cochrane Review). I. Oxford: Update Software; 2003.

21. Wickberg B, Hwang P. *Post partum depression – nedstämdhet och depression i samband med barnafödande.* Stockholm: Statens folkhälsoinstitut; 2003.

22. Aronen ET, Arajarvi T. Effects of early intervention on psychiatric symptoms of young adults in low-risk and high-risk families. Am J Orthopsychiatry 2000;70(2):223-32.

23. Cullen KJ, Cullen AM. Long-term follow-up of the Busselton six-year controlled trial of prevention of children's behavior disorders. J Pediatr 1996;129(1):136-9.

24. Aronen E. The effect of family counselling on the mental health of 10-11-year-old children in low- and high-risk families: A longitudinal approach. J Child Psychol Psychiatry 1993;34(2):155-65.

25. Aronen E, Kurkela S. Long-term effects of an early home-based intervention. J Am Acad Child Adolesc Psychiatry 1996;35:1665-72.

26. Carr A, ed. What works for children and adolescents? A critical review of psychological interventions with children, adolescents and their families. London and NY: Routledge; 2000.

27. Cullen KJ. A six-year controlled trial of prevention of children's behavior disorders. J Pediatr 1976;88:662-6.

28. Hodnett E, Fredericks S. Support during pregnancy for women at increased risk of low birthweight babies (Cochrane Review). Oxford: Update Software; 2003.

29. Olds DL, Kitzman H. Can home visitation improve the health of women and children at environmental risk? Pediatrics 1990;86(1):108-16.

30. Gomby DS, Culross PL, Behrman RE. Home Visiting: Recent Program Evaluations – Analysis and Recommendations. Future of Children 1999;9(1):4-26.

31. Oakley A, Rigby AS, Hickey D. Women and children last? Class, health and the role of the maternal and child health services. Europ J Public Health 1993;3(4):220-6.

32. Hodnett E, Roberts I. Home-based social support for socially disadvantaged mothers. Cochrane Database Syst Rev 2001;2.

33. Olds D, Kitzman H, Cole R, Robinson J. Theoretical foundations of a program of home visitation for pregnant women and parents of young children. Journal of Community Psychology 1997;25(1):9-26.

34. Olds DL, Robinson J, O'Brien R, Luckey DW, Pettitt LM, Henderson CR, Jr. , et al. Home visiting by paraprofessionals and by nurses: A randomized, controlled trial. Pediatrics 2002;110(3):486-96.

35. *Barn, elever, personal och utbildningsresultat. Kommunal nivå – avseende år 2003*. Stockholm: Skolverket; 2004.

36. Sundelin C, Lagerberg D, Magnusson M. *Öppna förskolan – värdefull för alla*. Uppsala Nya Tidning 2004-00-00.

37. Sennett R. The fall of public man. New York: Vintage; 1978.

38. Bauman Z. The individualized society. Cambridge: Polity Press; 2001.

39. Gagnon A. Individual or group antenatal education for childbirth/parenthood (Cochrane Review). The Cochrane Library. Oxford: Update Software. 2004(2).

40. Fabian HM. Childbirth and parenthood education classes in Sweden – Women's opinion and possible effects. (manuscript) 2004.

41. Heritage J, Sefi S. Dilemmans of advice: Aspects of the delivery and reception of advice in interactions between health visitors and first-time mothers. In: Drew P, Heritage J, Eds. Talk at work. Cambridge: Cambridge University Press; 1992.

42. Arborelius E, Bremberg S. Supportive and non-supportive qualities of child health nurses contacts with strained infant mothers. Scand J Caring Sciences 2003;17:1-7.

43. Fagerskiold A, Timpka T, Ek AC. The view of the child health nurse among mothers. Scand J Caring Sci 2003;17(2):160-8.

44. Svensk Förening för Obstetrik och Gynekologi. *Nationell sammanställning av årsrapporter för mödrahälsovård 2001*. URL: http://www.sfog.se/;2002.

45. *Kliniska riktlinjer – Riktlinjer för hälsovård under graviditet.* Stockholm: Socialstyrelsen; 1996.

46. *Stöd i föräldraskapet: Betänkande av Utredning av föräldrautbildning.* SOU 1997:161. Stockholm: Socialdepartementet; 1997.

47. Rydén B. *Föräldragrupp i förändring.* Göteborg: Folkhälsosekretariatets skriftserie; 1995.

48. *Barnhälsovården i Stockholms län. Årsrapport 2002.* Stockholms läns landsting. URL: http://www.sll.se/docs/L_BHV/Rapporter/VB_BHV_SLL_2002.doc.

49. Barnhälsovårdsenheten i Örebro län. *BHV statistik 2003.* URL: http://www.orebroll.se/upload/Prim/Kansli/BHV/Dokument/Statistik%202003%20webb.PDF.

50. Petersson K, Hakansson A, Petersson C. Parental education as viewed by nurses. An interview study. Scand J Caring Sci 1997;11(4):199-206.

51. Hallberg AC, Lindbladh E, Rastam L, Hakansson A. Parents: The best experts in child healthcare? Viewpoints from parents and staff concerning child healthcare services. Patient Educ Couns 2001;44(2):151-9.

52. Magnusson M, Garrett MJ, Sundelin C. Impact of child health centre organization on parental satisfaction. Scand J Caring Sci 2000;14(4):232-8.

53. Gralvik E, Bremberg S. *Vad tycker föräldrarna om barnavårdscentralen?* Socialmedicinsk Tidskr 1980;77:448-52.

54. *Beskrivande data om barnomsorg, skola och vuxenutbildning 2003.* Stockholm: Skolverket; 2003.

55. Bak M, Gunnarsson L. *Familjecentraler – framtidens stöd till föräldrar och barn?* Stockholm: Folkhälsoinstitutet; 2000.

56. *Familjecentraler.* Stockholm: Folkhälsoinstitutet; 2000.

57. *Vad är en familjecentral?* Föreningen för familjecentraler. URL: http://www.familjecentraler.org.se/main.htm.

58. Johnson Z, Howell F, Molloy B. Community mothers' programme: Randomised controlled trial of non-professional intervention in parenting. BMJ 1993;306:1449.

59. Johansson T, Jons I. *Föräldragrupper i praktiken.* Gothia; 2002.

60. Leksands kommun. *Familjecentrum*. URL: http://www.leksand.se/kominfo/kultur/barn_ungdom/familjecentrum.html.

61. Söderköpings kommun. *Delrapport Barn och Ungdomsprogram*. URL: http://www.soderkoping.se/we/main.nsf/SearchView/C1256C590024163DC1256E14004C683E.

62. Halford W, Sanders M, Behrens B. Can skills training prevent relationship problems in at-risk couples? Four-year effects of a behavioral relationship education program. J Fam Psychol 2001;15(4):750-68.

63. Stanley S, Markman H, Prado L, Olmos-Gallo A, Tonelli L, St Peters M, et al. Community-based premarital prevention: Clergy and lay leaders on the front lines. Fam Relations 2001;50(1):67-76.

64. Kaiser A, Hahlweg K, Fehm-Wolfsdorf G, Groth T. The efficacy of a compact psychoeducational group training program for married couples. J Consult Clin Psychol 1998;66(5):753-60.

65. Markman H, Renick M, Floyd F, Stanley S, Clements M. Preventing marital distress through communication and conflict management training: A 4- and 5-year follow-up. J Consult Clin Psychol 1993;61(1):70-7.

66. *PREP*. URL: http://www.prepinc.com/.

67. *Insatser för barn och unga*. Stockholm: Statens folkhälsoinstitut; 2004.

68. Niccols A. "Right from the start" and other attachment-focused parenting programs (Alison Niccols). URL: http://www.excellence-earlychildhood.ca/documents/Alison%20Niccols.ppt.

69. Niccols A, Mohammed S. Parent-child interaction skills training in groups: Pilot study with parents of infants with developmental delay. Journal of Early Intervention 2000;23:59-69.

70. Niccols A. Right from the Start: An Attachment-based course for parents. URL: http://www.fhi.se.

71. Statens folkhälsoinstitut. URL: http://www.fhi.se/.

72. Hundeide K. *Vägledande samspel: Handbok till ICDP, International Child Development Programmes*. Stockholm: Rädda Barnen; 2001.

73. Hundeide K. An outline of the ICDP Programme and its theoretical background. URL: http://www.fhi.se.

74. ICDP-Sweden. URL: http://www.icdp.se.

75. ICDP, International Child Development Programmes. URL: http://www.icdp.info/.

76. Hedenbro M, Wirtberg I. Samspelets kraft. *Marte meo – möjlighet till utveckling*. Stockholm: Liber; 2000.

77. Hansson K, Wirtberg I, Axberg U. *Preventiva insatser vid antisocialt beteende hos barn med hjälp av Marte Meo*. Socionomen 2004.

78. Widlund G. *Föräldrars tillfredsställelse med barnhälsovården 1989–1998. Enkätstudier i sydvästra produktionsområdet, Stockholms läns landsting åren 1989–1998*. Huddinge: Samhällsmedicin; 2000.

79. Petersson K, Petersson C, Hakansson A. What is good parental education? Scand J Caring Sci 2004;18(1):82-9.

80. Petersson C, Petersson K, Hakansson A. General parental education in Sweden: participants and non-participants. Scand J Prim healthcare 2003;21(1):43-6.

81. Dalman C, Bremberg S. *Hur satsar vi på barnen? Insatser för barn och ungdom i Stockholms län mätt i kronor.* Huddinge: Centrum för Barn- & ungdomshälsa; 1999.

82. Sveriges Radio. *Pappakurser för nyblivna fäder blev ingen succé*. Nyheter 12:00 P3, 2004-09-14.

83. Nuder P. *Pröva om landstingen behövs*. Dagens Nyheter 2004-06-28.

7.

INTERVENTIONS DURING PRESCHOOL AND EARLY SCHOOL YEARS (2–9 YEARS)

7.

INTERVENTIONS DURING PRESCHOOL AND EARLY SCHOOL YEARS (2–9 YEARS)

After early infancy, the responsibility for the child is normally shared between parents and preschool and then between parents and school. It is therefore natural to describe interventions during preschool and those during early infancy separately. Children become increasingly independent as they get older. An important change occurs at the age of 10–12 years, when children start to think abstractly [1] which increases their potential for acting on their own. This changes the demands placed on parents. Support to parents of children aged 10 and over is therefore discussed separately in Chapter 8.

Effect

The effects are broken down by individual intervention focusing on the needs of children and their parents. The background to this division is presented in Chapters 2 and 3.

Studies of parent support during this period have been identified using the Cochrane Library, the review presented in Chapter 4, and using supplementary searches in the Medline and PsycINFO literature databases.

Parent support geared towards the needs of children: interaction programmes
The scientific literature is dominated by programmes aimed at developing positive interaction between children and their parents in order to thereby reduce the risk of children developing conduct disorders. We refer to them below, therefore, as interaction programmes. Most of the interventions are based in the research carried out by George Patterson et al at the Oregon Social Learning Center in the United States since the 1960s [2, 3]. The

research group was able to show at an early stage that negative interaction between parents and their children developed and strengthened children's conduct problems. Based on this knowledge, pedagogical programmes were developed for parents of children with conduct problems. The principles have since been used to help all parents to interact with their children before problems actually occur.

The aim of the programmes is to develop a parent-child relationship characterised by affection and emotional closeness. Three central elements are common to the programmes: support to the parents in giving the child positive attention, support to promote clear communication and support to develop a well-considered strategy for dealing with the child in the event of a conflict. The first element, giving the child positive attention, is particularly important. For example, parents can discuss whether there are everyday situations in which they can give the child praise and in which they can join in the child's play. The second element concerns clear parent-child communication. If parents are clear and if they prepare the child for moving from one activity to the next, conflicts can be avoided. Parents can discuss everyday situations in which clear communication is particularly important, for example when the child is watching TV and it is time for dinner. The third element concerned well-considered strategies for dealing with children when conflicts occur. Parents can, for example, discuss alternative ways of dealing with the children when they don't do what they have been asked to. It is important for parents to be able to manage situations without resorting to violence. It is also important for parents to be consistent.

Interaction programmes are normally run in groups of between 10 and 15 parents, who meet 2–3 hours a week for 10 to 15 weeks. Group discussions are based on everyday parent-child situations, normally starting with a short video clip showing a typical situation. The parents then discuss different solutions to the problem. Then, they are given the opportunity to practise the solutions with each other using role-play. They also receive assignments to practise their skills at home.

The programmes may also include elements dealing with child development. These help parents to have realistic expectations of the child. Other programme components aim to create a good climate for dialogue in the home and good cooperation between the home and preschool/school. Some sessions give parents hands-on training in how to deal with a child's aggression.

Home assignments are included in the programmes. Parents are asked to note down when they needed a particular skill and whether this was effective. They are also asked to make notes on the child. This can help parents to become more aware of how they themselves react to different situations involving the child. It can also help them to see more clearly how the child develops.

The programmes do not bring the skills of parents into question but attempt instead to utilise and develop the collective experience of the parents group. It is often parents themselves who suggest and then discuss different alternative approaches. The programmes do not normally include ready-made solutions, presented in the form of lectures. They do, however, vary somewhat in this respect.

One example of an interaction programme is *The incredible years*, of which there are two variants, one for parents of children aged between two and seven and one for those of children between four and ten years old. The programme aimed at younger children is called *Basic* and comprises 12–14 sessions. There are four major components: play, praise and reward, effective limit-setting, and dealing with bad behaviour. Between 10 and 14 parents normally participate. The groups should have two leaders; a man and a woman.

The aim of the sessions on play is to develop the parents' skills in playing with the child in order to strengthen its self-confidence. Play can also enhance the child's problem-solving ability. Another component aims to strengthen parents in their ability to give the child praise and to deal with the child if it rejects the praise it receives. The section on effective limit-setting concerns clear communication and providing positive alternatives to what the child demands/wants. The last component concerns effective methods of dealing with bad behaviour without resorting to violence.

The programme includes 10 video films and a manual describing the tasks, role-plays and home assignments. The manual also highlights the most important parts of each element. There are also tips for further reading which the leader can inform the group about. The participants are each given an exercise book. The programme is also available in a book that has been translated into Swedish [4].

Another example of interaction programmes is *Community Parent Education Program* (COPE), developed in Canada. The programme consists

of about 15 group sessions and can comprise up to 30 parents with one or two group leaders. The aim of the group sessions is to enhance parents' skills so that they can promote positive behaviour in their children, set boundaries and avoid conflicts. The programme also aims to improve co-operation between parents and preschool/school [5].

Many of the sessions start with a video sequence depicting a situation with a parent needs to deal with his/her child. In COPE, parents can discuss in small groups different suggestions as to how to deal with the situation they have seen. The leader or leaders then role-play a suitable solution, which the parents then practise in their small groups. They then continue to discuss in what other situations the method might be useful. Finally, they agree on a home assignment to be completed by the following week. COPE also has a detailed manual, video films and tips for further reading. Parents track their own progress with the help of a simple pre-printed form.

Several reviews of interaction programmes have been published in Swedish [6, 7].

Evidence of the effect of interaction programmes when used in parent groups

A total of 11 studies of group interaction programmes for parents with children aged between two and nine have been identified [8–18]. Seven of the studies concerned interaction programmes offered during the preschool years [10, 12–17]. These have provided evidence of effects both on parents and on children. The data comes both from parents and from independent observers, who were unaware of the parents having taken part in a programme. The evidence can therefore be said to be reliable.

In a few studies, the effects of group interaction programmes during the preschool years have been compared to individual counselling that has adhered to the same principles [10, 13, 16]. Group interventions seem to have more effect than this type of individual counselling.

Four out of the eleven studies have examined the effects of interaction programmes on younger schoolchildren [8, 9, 11, 18]. The evidence found in three of the studies can be said to be reliable [8, 11, 18]. The fourth study only provides evidence of the effects on parents [9].

Children and parents have normally been tracked a year or two after the intervention. For ethical reasons, it has subsequently been necessary to

offer the same programme to the parents in the control group. This has led to it no longer being possible to compare the effects in the trial group with those in the control group and hence show whether they are long-lasting. The effects of corresponding individual programmes mentioned above have, however, been proven to last a long time. The behaviours of parents and children interact with each. If the child behaves as the parents want it to, it will be easier for them to give the child positive attention, which in turn reinforces the likelihood of the child behaving as its parents want it to, and so on. There are studies showing that such positive circles really do develop after the parents have participated in interaction programmes [19].

Interaction programmes have been developed to give support to parents with children who have aggressive behaviour problems. A large number of the studies performed have also concerned families in which children have shown varying tendencies towards behaviour problems of this kind. This report mostly discusses interventions aimed at parents in general, however. Arguments in favour of such a focus are presented in Chapter 2. A central issue is how justified it is to disseminate programmes that have been primarily developed for a smaller group of parents with problematic children. There are two reasons in favour of the widespread dissemination of such programmes.

The first is linked to the theoretical basis of the programmes. The starting-point is that children need both affection and boundaries, see Chapter 2. These needs concern children in general and are not limited to problematic children.

The other reason is based on the fact that children's tendencies towards aggressive behaviour problems in general constitute a spectrum ranging from a complete lack of such tendencies, through a large group displaying average tendencies and finally to an extreme group with explicit problems. Children with aggressive behaviour problems do not therefore constitute a well-defined group. This is true of mental problems in general [20]. The interaction programmes presented here have been tried out in families comprising either of an intermediate group [12, 14] or in groups with a slightly higher risk of behaviour problems. Groups requiring medical treatment have been completely excluded from the review.

It is therefore justified to use the extensive experience gained within the field in order to offer interaction programmes to wide groups of families.

Interaction programmes have been successfully tried out on parents of children as young as 12 months old [21]. The most well-documented effects are on children over the age of two, however.

The effects have been primarily proven on children with aggressive behaviour problems. In Sweden, these types of problems have often been denoted as ADHD (previously DAMP). The results in the trials presented point to the possibility of being able to prevent ADHD using interaction programmes. Such effects may seem remarkable, bearing in mind that the debate on ADHD has focused very much on its biological causes. It is clear that interaction programmes cannot influence biological factors. The most important biological factors discussed are heredity and changes in the nervous system. Relevant studies show that genetic factors are significant as regards ADHD but not that they are a decisive factor [22, 23]. There are also studies indicating that organic changes occur, but not that these in isolation determine the development of the disorder [24]. This means that there is considerable scope for prevention.

Behaviour problems in the preschool years often continue into adolescence. There is a markedly increased risk of alcohol and drug abuse as well as a greater risk of criminality. The positive parent-child interaction promoted by these methods can hence prevent such problems.

Seen from the child's perspective, internalizing mental problems, such as depression and anxiety, are significant. Interaction programmes can be expected to prevent these types of difficulties as well. Two reasons make this assumption reasonabel. Firstly, the programmes contain several elements that strengthen the child's self-image. Poor self-image is an important aspect of internalizing problems such as depression and anxiety. Secondly, the prevalence of internalizing problems has been analysed in several of the studies presented. Beneficial effects have been shown for this type of problem as well.

How effective interaction programmes are when used in parent groups

The studies of interaction programmes that have been presented enable us to estimate how effective they are. The prevalence of behaviour problems is normally described as a score total. The differences between the trial and control groups in this score total are specified using standard deviation (SD). In the studies referred to, effects corresponding to an SD of 0.7 are

normally indicated, one year after the intervention. In order to be able to assess the practical value of such an effect, we need to perform further calculations. These calculations are based on an assumption that the points total has, what is known in statistical terms, a normal distribution. From a practical point of view, we are most interested in influencing the prevalence of significant behaviour problems. It is hence appropriate to convert the effect expressed in SD into reduction in the group of children with significant problems. A suitable level is a twentieth of all children with the highest points total. These children's problems are so manifest as to be viewed as clearly burdensome by the surrounding world. The technique involved in carrying out this conversion of the effect indicator has been described previously [25]. Calculation show that an effect of 0.7 SD is equivalent to a reduction in the most problematic group of children by 80 per cent.

Total measurements of children's aggressive behaviour are specified in three out of the four studies of interactive programmes for young schoolchildren as mentioned above. The effects seem less therefore than when the interaction programmes are implemented during the preschool years.

A large proportion of the interaction interventions studied have been evaluated in the United States and have been aimed at parents with children who have a higher-than-average risk of behaviour problems. American children probably have more behaviour problems in general than Swedish children [26]. These circumstances lead us to conclude that the effect of interaction programmes can be expected to be less when offered on a wide scale in Sweden.

Evidence of the effect of interaction programmes which parents participate in during individual contacts

Six studies of interaction programmes, in which parents have participated during individual contact sessions, were discovered during literature searches [10, 16, 27–30]. The studies indicate effects on the behaviour of both parents and children. Both the parents themselves and other people unaware of which group the parents belonged to have observed and reported on the behaviour either of the parents or the children.

All interventions were aimed at parents with children of preschool age who have some form of behaviour problem. Counselling was normally given once a week for a period of 10–12 weeks. The counsellors were

professional practitioners. Only the parents participated as a rule, but there are examples of interventions where the children have also taken part [28, 29]. Clinic-based counselling was the norm, although some home visits were performed [28].

In one of the studies, the children (all boys) have been tracked from the time of the intervention at the age of 7–8 years until they had reached the age of 15 [31]. Effects could still be seen at this stage of adolescence. The boys managed better at school and displayed less abnormal behaviour. The intervention combined parent counselling with some measures aimed directly at the boys. The effect cannot therefore be solely attributed to counselling. The studies do show that the effects of individual counselling aimed at improving parent-child interaction persist a long time after counselling has ceased.

Literature searches identified two more controlled studies of individual counselling using methodology that is closely related to the methods used in the interaction programmes. In one programme, the intervention only took a few hours. Its aim was to prevent whining and disobedience in preschool children and positive effects were indicated [32]. The other programme was aimed at parents potentially at risk of abusing their children. The object of the intervention was to teach parents to deal with their own anger. Effects were indicated in the group receiving the most extensive intervention [33].

A Canadian study indicates that it is more difficult to reach socially vulnerable groups with individual, clinic-based counselling, compared to group counselling [10]. One explanation for this might be that parents may feel more guilty if they come individually, despite the fact that individual visits are easier to arrange time-wise and in terms of other practicalities.

Evidence of the effect of interaction programmes in which parents can participate via media (printed material or video/TV)

In four randomised controlled studies, parents have had the chance to participate in interaction programmes only in the form of video supplemented by other study material [30, 34], such as TV-programmes [35] or printed material and telephone contact. [36]. These studies are included in the review presented in Chapter 4, with the exception of one study that was only

identified after a supplementary search [34]. Positive effects on children's behaviour were indicated in all the studies. The findings from the study that used printed material are unreliable, however, since the data on the children's behaviour has only been reported by the mothers themselves and not by independent observers.

A systematic review of this type of intervention has also been published. The authors of this review draw the conclusion that interventions using only video/TV or printed material do have an effect [37].

The best documented effects are for programmes in which parents assimilate the material via video [30, 34]. The children in these trials already have manifest behaviour problems. The parents watch 10 video films. Each one is 30 minutes long and parents watch one or two instalments a week. The parents learn to deal with children in everyday situations in different ways. One element of the programme involves parents continuously noting down how the child behaves and what methods they use to deal with this behaviour. They are also asked to formulate goals and targets. In two of the trials, the effect of the video-based intervention is compared to that of the same intervention offered individually by a therapist [30] or alternatively in the form of a parent group [34]. The effects were about the same magnitude, irrespective of design. The prevalence of children with significant behaviour problems was reduced in the trials by as much as 70 per cent, estimated using the same methods as described above for group intervention programmes for parents.

In the *TV-based* trial, the interaction programme was interwoven into an entertainment programme [35]. The programmes were intended for broad groups of parents. This trial reported effects on moderate and serious behaviour problems taken together. A 70-percent reduction was also reported in these types of problems.

In two other trials, parents received *workbooks* by post supplemented by telephone contacts [28, 36]. Both interventions had desirable effects on children's behaviour. Since parents not only had access to printed material but also were contacted by telephone, it is unclear whether printed material alone would have the intended effect.

Parent support geared towards the needs of children: other structured programmes

A further six studies of structured controlled interventions were identified in literature searches. These interventions were of varying types. Two concerned cognitive development and are therefore discussed in Chapter 13. Of the remaining four studies, one contained a similar element to the interaction programmes [38]. In addition, there were components aimed at strengthening parents' self esteem, reduce their stress level and enhance their social networks. The programme had positive effects on parental behaviour towards their children, but it is not possible to determine whether these effects are linked to those components aimed at improving parents' interaction with their children or whether they should be attributed to the elements directed at the parents themselves.

Two of the studies examined a programme called Systematic Training for Effective Parenting [39, 40]. The programme focuses on parents' attitudes to the child. Effects were indicated in both studies, though not on children's behaviour.

The aim of the fourth intervention was to encourage parents to discuss the risk of sexual abuse with their children [41]. At on group session, a video film was shown and then discussed. The intervention led to several discussions between parents and children on the issue in question.

Support focusing on parents' needs

Chapter 3 discusses evidence for the effect of support focusing on the needs of parents in the form of open and structured individual counselling, open and structured parents groups and meeting-places. It is clear that *structured parent groups* such as PREP (Prevention and Relationship Enhancement Program, see Chapter 9) can improve the parents' relationship. It is also clear that if a family has a problem, the situation can be improved by open individual counselling and by participation in open discussion groups together with other parents with the same *problem*. This is also true for parents with children aged 2–9 years.

It is unclear whether meeting-places, of the type offered within the open preschool system, can improve the parents' informal social network, see Chapter 6. It is also unclear whether open parent groups, intended for parents without any common problems, influence parents' welfare.

The situation in Sweden

When children are between two and nine years old, there is a lack of comprehensive preventive activities for parents of the kind offered during early infancy. There are a number of organisations that do offer different forms of support to parents. The most important forms are individual contacts with the child healthcare services, preschool and school personnel, structured discussion groups focusing on children's needs and open discussion groups.

Individual contacts with child healthcare, preschool and school personnel
In the survey presented in Chapter 5, 60 per cent of all parents say they have derived benefit from individual conversations at the child healthcare clinic and within the primary care services in general. About the same number express an interest in such conversations. This means that the existing need seems to be covered by currently performed interventions.

In the questionnaire, 40 per cent say they have benefited from individual conversations with preschool staff, over and above regular development discussions. About the same number express an interest in such conversations. This means that the existing need seems to be covered by currently performed interventions. The situation is similar for conversations with school and after-school care personnel, where 37 per cent say that they have benefited from conversations and about the same number express an interest.

Conversations with preschool, school and after-school care personnel are hence a source of parent support. Under the Swedish Education Act of 2004, schools are obliged to inform parents and guardians about the school's activities and their children's development. The Act does not prescribe any obligation on the staff to provide support to parents in their role as parents.

Structured parent support focusing on children's needs: recommended interaction programmes
Methods for structured parent support, focusing on children's needs and used in Sweden, are dominated by different variants of interaction programmes. Four randomised controlled studies are running in Sweden in 2005. Information on the current range of activities/studies in Sweden is constantly updated on the SNIPH website [42]. The compilation at the

website differentiates between recommended and promising programmes. All the recommended programmes have been evaluated in controlled studies and there is a Swedish organisation that educates group leaders. The promising programmes do not completely fulfil both these demands.

According to the questionnaire described in Chapter 5, 16 per cent of all parents would have participated in a structured group-based parent support intervention. This is probably a considerable overestimation since structured methods for parents with children in this age group have only been introduced in Sweden in recent years. Structured methods presuppose that the group leader uses a manual in which each element is described in some detail. Questionnaire respondents may have confused this requirement with their awareness of the leader having decided beforehand which subjects to discuss. Data on the individual methods in use indicates instead that less than one per cent of all parents may have participated in activity employing this method in 2004.

The recommended programmes are manual-based. Parents watch a short video sequence in which a parent, played by an actor, makes an exaggerated mistake in an everyday parent-child situation. Parents identify mistakes, discuss possible consequences, find alternative ways of handling everyday parent-child situations and reflect on why other strategies might be better. Parents also discuss whether there are other everyday situations in which the new strategies can be used and what this might involve. The strategies are role-played and parents are given the task of testing the methods at home. The programme offers support to parents so that they can give their children positive attention, communicate clearly with them and handle conflicts in a structured and well-considered way.

COPE (The Community Parent Education Program)

COPE is intended for parents of children aged 3–12 years old. Parent groups consist of 15–25 parents who meet 8–14 times for about two hours at a time. Parents divide themselves up into smaller groups of 6–8 during the sessions. The programme provides parent with plenty of scope to suggest suitable approaches themselves. COPE also includes lessons on problem solving and on parent-school cooperation. The programme has been developed for widespread use, hence the use of the word "community" in the title. The original Canadian method was developed by Charles Cunningham.

SCIENTIFIC STUDIES WITH CONTROL GROUPS

There is one randomised controlled study of the Canadian original [10]. A Swedish study with control groups is ongoing under the leadership of the Department of Psychology at Uppsala University.

USE OF THE METHOD IN SWEDEN

COPE has been used in Sweden since 2000. A Swedish manual and Swedish video have been developed by the Child and Adolescent Psychiatry Clinic in Malmö. An extra element that discusses problem solving and an element linked to programmes that do not exist in Sweden have been left out. On 1 January 2004, there were an estimated 500 trained parent group leaders. Roughly 1,000–2,000 parents have undergone the programme. The programmes have normally been offered on a broad scale.

The Child and Adolescent Psychiatry Clinic in Malmö has invited personnel from schools, etc., to its group leader training and guidance sessions. During 2003, the programme has been offered to all parents in Malmö's 10 city districts. The programme has also been offered to immigrant groups on a wide scale. In one city district, for example, the video clips have been recorded in Arabic.

The first trials in Linköping were conducted in the city district of Ryd in 2000. Nine group leaders were trained: Four preschool teachers, two primary school teachers, a special needs teacher, a school nurse and a district nurse. Other preschool and school personnel in Ryd attended a half-day session to run through the methodology. As part of this first trial, the programme was offered to all 140 parents of children aged 3–9 years in a small part of the city district (Solhaga). Ninety-five parents expressed their interest in attending. Unfortunately, however, only 64 could be offered a place in one of the four parent groups. The parents were divided up according to the ages of the children. The groups met in the evenings in local premises – preschools, school staff rooms, open preschools and after-school leisure centres. The leaders were offered sandwiches and a hot drink and baby-sitters were organised with the help of a local upper secondary school class on the evenings when the groups met. The group leaders received a couple of hours' instruction after each group session.

Thirty-five parents attended the first group session, i.e. about half of those who had been offered a place. In other words, 38 per cent of the target

group participated (95/140 x 35/62). Twenty-three parents participated in the 14th and last session. The majority of parents were very satisfied with the content of the programme, the group leaders and the discussions. Most also felt that they had received help in their role as parents and that they had changed their approach to dealing with their children [43]. The activity is currently being offered in several other city districts. When the intervention has been repeated, attendance has been higher than during the first trail in Ryd.

INFORMATION, PRACTICAL EXPERIENCE AND EDUCATION/TRAINING

Information on the method is available on-line in Swedish [44–47]. For information on group-leader training and on practical experiences of the method, please visit the SNIPH Website [42].

The incredible years

The incredible years can be found in two variants, the first intended for parents of children aged 2–7 years and the second for parents of children aged 4–10. In the first variant, parent groups meet 12–14 times for two hours at a time and in the other they meet 8–10 times also for two hours at a time. As in other programmes, video-tapes play an important part. The solutions proposed are mostly dictated by the guide. In the first variant (2–7 years), there is also a special session on child play and in the other, there are two sessions on problem-solving. The American original, *The Incredible Years – Basic Parent Training,* has been developed by Carolyn Webster-Stratton.

SCIENTIFIC STUDIES WITH CONTROL GROUPS

There are seven randomised controlled studies of the American original. A Swedish randomised controlled study is ongoing (2004) under the leadership of the School of Social Work at Lund University.

USE OF THE METHOD IN SWEDEN

The incredible years has been used in Sweden since 2002, for example in Skövde and within the child and adolescent psychiatry service in Stockholm. The video-tapes are subtitled in Swedish. On 1 January 2004, there were about 200 parent group leaders with basic training and about 30

leaders who were about to become authorised. Roughly 200 parents have undergone the programme. The programme has normally been offered for smaller groups at risk of developing problems or with problems that were already manifest.

Skövde, for example, has offered the programme to parents in two school districts. The two group leaders, one preschool teachers and a graduate social worker, were trained for three days by one of Ms Webster-Stratton's assistants. The group leaders work together with several child and adolescent psychiatry clinics. In addition to parents, other people, such as grandparents, have also been invited to the programme. Coffee and baby-sitters were organised. There was considerable interest shown by the parents. The aim is to gradually be able to offer the programme to parents in the entire municipality.

INFORMATION, PRACTICAL EXPERIENCE AND EDUCATION/TRAINING

Information on the method is available on-line in English [48]. The methodology is described in a book that has been translated to Swedish [4]. For information on group-leader training and on practical experiences of the method, please visit the SNIPH Website [42].

Komet [Comet]

Komet [Comet] is intended for parents with children aged 3–12 years with aggressive behaviour problems as well as children who are difficult to come into contact with, who cannot concentrate or have difficulty making friends. The parent groups consist of the parents of six children and meet eleven times for 2.5 hours at a time. The programme has been developed by *Precens Preventioncentrum* in Stockholm in partnership with the R&D Unit at the Social Service Department at the City of Stockholm Administration and is partly based on a programme developed by Barkley et al.

SCIENTIFIC EVALUATIONS WITH CONTROL GROUPS

A small randomised controlled study with 22 participants has been performed. The study indicates statistically reliable effects on children's behaviour [6]. A larger controlled study in ongoing (2004) under the leadership of the R&D Unit at the Social Services Department, City of Stockholm Administration [49].

USE OF THE METHOD IN SWEDEN

Komet [Comet] has been used in Sweden since 2003. *Precens* and the Social Services Department at the City of Stockholm Administration have produced a manual and video-tapes developed in cooperation with Swedish parents. In June 2004, there were 60 trained parent group leaders. Over 200 parents have undergone the programme. The programme is offered both generally and to groups running a greater risk of behaviour problems.

INFORMATION, PRACTICAL EXPERIENCE AND EDUCATION/TRAINING

Information on the method is available on-line in Swedish [49]. For contact details regarding the training of group leaders and information about the programme and its application, please see the SNIPH website [42].

Structured parent support focusing on children's needs: promising interaction programmes

Promising programmes are designed in a similar way to recommended programmes. In contrast to recommended programmes, there are no randomised controlled studies, or, if they have been evaluated in this way, they are not routinely spread throughout the country.

Active parenting

Active parenting is a manual-based preventive parent support programme for parents with children aged between nine months and four years. Video-tapes are used to train parents to interpret children's needs and emotions, train communication skills and clarify theories. Active parents of small children looks at for example different styles of leadership and approaches, the different stages of a child's development, how to prevent problems, outbreaks of frustration, methods to build up the child's self-esteem, self-confidence and courage, methods of respectful limit-setting and ways of involving the child and methods that promote the child's independence. The American original has been developed by Dr. Michael Popkin, PhD.

SCIENTIFIC STUDIES WITH CONTROL GROUPS

There are no controlled studies. The method is very similar to the interaction programmes and has therefore been included as a promising method. The is an ongoing Swedish randomised controlled trial of the method.

USE OF THE METHOD IN SWEDEN

Active parenting has recently been introduced in Sweden, but has been going in the United States since 1996. The video-tapes are subtitled in Swedish. They are also available in English and Spanish. In Sweden, considerably more emphasis is put on process and reflection than in the American original and the training course is longer (nine hours) than the original (4.5 hours). In January 2004, there were over 100 group leaders in Sweden. The programme has been offered both on a wide scale and to groups with problems.

INFORMATION, PRACTICAL EXPERIENCE AND EDUCATION/TRAINING

Information on the method is available on-line in Swedish [50]. For information on group-leader training and on practical experiences of the method, please visit the SNIPH Website [42].

Active parenting today 2–12

Active parenting today 2–12 is intended for parents of children aged 2–12 years. The parent groups meet six times for three hours at a time. The programme includes a written participant's handbook. Video-tapes are also used to train parents to interpret children's needs and emotions, train communication skills and clarify theories. *Active parenting today 2–12* also discusses different styles of leadership and approaches, problem-solving, communication skills and methods to encourage children's independence. The American original *Active Parenting* has been developed by Michael Popkin.

SCIENTIFIC STUDIES WITH CONTROL GROUPS

There are no controlled studies. The method is very similar to the interaction programmes and has therefore been included as a promising method.

USE OF THE METHOD IN SWEDEN

Active parenting today 2–12 has been used in Sweden since 1997. The video-tapes are subtitled in Swedish. Active parenting today 2–12 puts more focus on process and reflection than the American original and the sessions are longer (3 hours as opposed to 2 hours). On 1 January 2004, there were about 100 parent group leaders and about 3,500 parents who

had undergone the programme. The programme has been used in preschools, open preschools, compulsory schools, treatment centres and prisons as well as being offered to the wider general public.

INFORMATION, PRACTICAL EXPERIENCE AND EDUCATION/TRAINING

Information on the method is available on-line in Swedish [50]. For information on group-leader training and on practical experiences of the method, please visit the SNIPH Website [42].

Parent power

In its first phase, the *Parent power* programme is intended for parents of children aged 2–5 years and in its second phase for parents of children aged 6–10 years. Groups consist of up to 30 parents and meet during 7–12 weeks for 2 hours at a time. The first phase also includes a play element. The second phase contains elements about spending time together and in school. The programme is based on an American original called the *Strengthening Families Program* [51].

SCIENTIFIC STUDIES WITH CONTROL GROUPS

There are no controlled studies. The method is very similar to the evaluated interaction programmes and has therefore been included as a promising method.

USE OF THE METHOD IN SWEDEN

Parent power has been tested in Eskilstuna during 2004. Swedish videoclips have been recorded. The programme is intended for widespread use.

INFORMATION, PRACTICAL EXPERIENCE AND EDUCATION/TRAINING

Information on the method is available on-line in Swedish [52]. For information on group-leader training and on practical experiences of the method, please visit the SNIPH Website [42].

Mellow Parenting

Mellow Parenting is intended for parents of children aged 3–12 years. The programme has been developed in the UK and is based on work carried out at the Oregon Social Learning Center in the United States.

SCIENTIFIC STUDIES

A minor uncontrolled study with 21 participants has been conducted in the UK, indicating effects on parental behaviour [53]. A larger controlled study is ongoing in the UK (2004). A minor Swedish uncontrolled study has also been conducted, but no effects could be proven [54].

USE OF THE METHOD IN SWEDEN

The method has been used within ten different activities in Sweden, primarily for groups with problems. In the southern Stockholm suburb of Botkyrka, the programme has bee offered to all the parents at a preschool. Preschool teachers were trained as group leaders.

Parent Management Training – Oregon (PMT-O)

The method of interaction training used at the Oregon Social Learning Center in the United States [3] is currently being spread widely in Norway [55, 56]. The method is used solely in families in which the children have manifest behaviour problems. A controlled randomised study is currently ongoing in Norway. A few people, working in Sweden, have been trained in *PMT-O* in Norway but there are currently no regular activities based on *PMT-O* ongoing in Sweden (October 2004).

Tripple P

Tripple P is an interaction programme developed in Australia and now in use in eight countries, including the UK and Germany [57]. The method is primarily used in parent groups. *Tripple P* is not currently in use in Sweden (October 2004).

Open discussion groups

In an inventory of Swedish parent support interventions more than half (34 interventions) were group activities that were either partly or entirely intended for parents of children aged 2–9 years. Four of these interventions concerned open preschool. Six of the remaining interventions were interaction programmes. The other 26 can be categorised as open discussion groups.

In a few of these 26 interventions, parents are offered completely open discussion groups, i.e. the entire content of the programme is determined by the participants. The intervention organised by the Social Services in the

northern Stockholm municipality of Järfälla *Parent dialogue* serves as a good example. The intervention began in 1998–2001 as the result of a municipal commission into parent support. The project leader, a lay welfare worker and graduate social worker, was trained to lead the group in a method called *Adult dialogue*. Participants agree on a certain framework for how the group should function, for example, that people don't interrupt each other or speak out of turn. The groups meet 6 times during a term. Afterwards, the group decides whether it wants to continue with more sessions. Participating parents are in general very positive and the intervention has continued after the end of the trial period. The project leader has been employed for 26 hours a week and has been able to lead 7 groups each consisting of 4–7 parents.

In 14 of the 26 interventions parents were offered discussion groups with a predetermined theme. In some cases, predeter-mined work material was used, whilst in others, the leader decided her/himself which subjects were to be discussed.

It was common to organise the discussion groups as study circles. This was the case for both groups that were entirely open, i.e. in which the participants could decide freely which subjects to discuss, and groups in which the theme had been determined beforehand.

Discussion groups with given themes are similar to the structured methods described above. There are two important differences between the methods, however. How to discuss the material is normally freely determined in the discussion groups, whereas the structured groups follow a given manual. Furthermore, the structured methods feature regular concrete exercises, often in the form of role-plays. Given themes are uncommon in discussion groups. In other words, the structured methods place more emphasis on the participants acquiring specific skills whereas the aim of discussion groups is primarily to enhance parental understanding. The difference can be illustrated by examples from the school system, in which all pupils receive instruction in Swedish. Some elements are devoted to acquainting pupils with literature written in Swedish, which they discuss in the classroom. Other elements are devoted to providing them with practical training in writing themselves. If pupils are to be skilled in the art of writing themselves, it is not possible to replace the practical training they receive with further orientation in Swedish literature. Similarly, practical training in approaches to children cannot be replaced by discussion on parenting.

The questionnaire described in Chapter 5 indicates that roughly ten per cent of all parents have participated in an open discussion group. This estimate is unreliable, however, since parents seem to find it difficult to interpret the description of various forms of group-based parent support.

Several different materials are used in themed discussion groups. A description of three widely spread materials is given below. They are designed so as to stimulate parents to discuss different aspects of parenting with each other. Another set of material has been developed by the temperance society, the Blue Band Movement and its *Children in the Danger Zone* project in order to encourage parent groups to talk about alcohol use and other life-style habits. None of the materials contains elements in which parents receive support in training different skills. It is therefore dubious whether or not they can influence children's welfare and health. Discussions on parenting are naturally of intrinsic value, see Chapter 3.

Människans barn [Human children]

The insurance company Skandia's *Idéer för livet* [Ideas for Life] project and the SNIPH have published 5 video cassettes under the title *Människans barn* [Human children] [58]. The material is intended to provide a picture of children's development and their needs from birth up to and including adolescence. Some parts are about how parents experience different situations and events and are retold by parents themselves. These include what it's like to be on paternity leave, for example. In other parts, children relate how they see different events and phenomena. One or more doctors, psychologists or other experts are interviewed in each instalment. These instalments are often about the physiological, mental and social development of children and about how important parents are to them. There is a manual for each cassette comprising a summary of each film and suggestions for discussion questions.

Om barn [About Children]

The Swedish educational broadcasting company, *Utbildningsradion* (UR) has produced a TV-series called *Om barn* [About Children] [59]. The series has been developed in cooperation with child and maternity healthcare clinics, fathers' groups and immigrant associations. According to UR, the aim has been to give parents of both sexes, not least young first-time parents, support and guidance in many different subjects; everything from

clearly practical problems such as food and breastfeeding, to how parenting and small children affect family finances, older siblings and sex life. Adoption, child abuse, disabilities and various pedagogical options are other examples of subject areas which the programme discusses. *About children* also discusses issues that are only relevant for small groups of parents, including premature babies, losing a small child, children with CP or Downs syndrome and fathers who abuse mothers.

In many of the programmes, a parent is given the opportunity to talk about events that have happened to him or her, for example what it's like to give birth at home or to adopt a child. In other programmes, children talk about their experiences, such as their first day at school. Experts in different fields are sometimes interviewed. Reports are mixed with short, humorous elements. There are articles available on-line at the UR website relating to many of the programmes.

The series broadcast by UR have so far been about parents and infants, children of preschool age and younger schoolchildren. Broadcasted programmes are available as theme cassettes for use in discussion groups. As of July 2004, 22 different theme cassettes had been published. UR provides a study handbook for each theme cassette. This contains advice to the parent group leader, for example about what can be done to attract more fathers, parents with foreign backgrounds and young parents.

Växa tillsammans [Grow together]

The *Studiefrämjandet* adult education organisation and *Hem och Skola*, a national parents teachers association, have published four books in a series called *Växa tillsammans* [Grow together]. The books are intended as background material for discussions between parents and preschool/school staff [61, 62].

The aim of the authors is to strengthen parents in their role as parents and to promote cooperation between parents and preschool/school personnel. All four books include chapters on preschool or school. Some chapters discuss the experiences of parents. The chapter entitled "What happens when the baby arrives on the scene?" in *Växa tillsammans: preschool* is an example of such a chapter. Other chapters discuss issues that are relevant to certain age-groups of children, for example the chapter entitled "Best friends and other mates" [61].

The authors emphasise the value of parents' own experiences and their freedom to choose which texts to discuss. The discussion questions in the material are based on the theme broached in the text. For example, in the chapter entitled "What happens when the baby arrives on the scene?", parents are encouraged to discuss "How did life change for you when you became a mother/father as regards your social life, leisure time and your relationship with your partner?". The chapter entitled "From child to teenager", which discusses parents' attitudes to raising children, asks the question "What do we do when we suspect that teenage 'diseases' aren't as serious as we first thought?".

Models for organising group parent support

There are different ways of organising group support for parents with children in these age-groups, regardless of the method used. Initiatives can be taken by the municipality, primarily the social services, by an open preschool, by a preschool or school. There are also groups organised by the county council (child healthcare clinics) and at family welfare centres. Non-governmental organisations (NGOs), especially adult education associations, can organise activities, as can private companies, either for their employees [63] or for parents in general. It is not possible to differentiate any particularly dominant form.

Parent groups can meet in different kinds of premises. The choice of premises can convey different ideas. For example, some parents may feel that the child healthcare clinic or school reminds them of the 'supervisory' roles these kinds of establishments play. It may be advantageous, therefore, to choose premises that are more neutral, for example an open preschool, family welfare centre, civic centre, city district office, parish house or premises supplied by an adult education establishment.

The model developed in Leksand and which is described in Chapter 6 is of particular interest since it offers good continuity, high attendance and even sex distribution. The content has until now been open. Parents in the group have invited people to start the meetings, the parents have formulated a question which has then been discussed in groups made up of mothers and fathers respectively. A structured interaction method (COPE) has also begun to be tested in these groups during 2004.

Level of interest among parents

In the questionnaire sent out to a representative sample of parents, see Chapter 5, 46 per cent of parents with children aged 1–5 years said that they were interested in participating in a structured parent group and 37 per cent expressed an interest in open discussion groups. This indicates a significantly high level of interest among parents.

Local experience of structured methods also points to substantial interest. Even the very first COPE trial in Linköping attracted 38 per cent of parents. Experiences from the trials in Malmö and Botkyrka also point to comparatively high levels of attendance, although there are no exact figures. Experiences from Linköping point to an increase in the number of participants when the method became well known in the local area. Local marketing by preschool staff and schoolteachers can also increase the level of interest among parents. It seems therefore possible to achieve attendance levels that are comparable to the numbers of participants in the parent groups currently offered by the maternity and child healthcare services.

Experiences of open discussion groups also indicate significant interest. Borås Municipality, for instance, in cooperation with the county council, the social insurance office and the police, has offered themed discussion groups to all parents of children aged two, four and six years old respectively. About 25 per cent of all parents have participated.

Meeting-places can also be popular. In the town of Knivsta, not far from Stockholm, open activities have attracted about 100 families in a 12-month period. There are about 500 families with children aged 0–5 years in Knivsta, suggesting that about 20 per cent of them took part in the activities.

Factors restricting participation do not then seem to include a lack of interest on the part of parents.

Gender equality

Women show a greater interest than men in most forms of parent support. The parent questionnaire shows that 70 per cent more women are interested in structured parent groups, compared to men. The sex differences are greater for unstructured forms, where 100 per cent more women than men are interested.

More women than men have normally participated in different types of parent groups, both open and structured. There are examples of activities, however, that have attracted similar numbers from both the sexes. Such an example is the Incredible Years project in Skövde in the south of Sweden. Here, the organisers successfully managed to encourage more men to participate by meeting all the fathers prior to the start-up of the groups. The sex of the group leader is also significant. If the leader is a man, more men tend to participate.

Another route to greater gender equality is to offer men special activities. There are open discussion groups with male leaders in several parts of the country, intended exclusively for men. One such example is *Jobbcoaching för pappor* [Coaching for Dad!], offered by the Swedish Workers' Educational Association, ABF, in cooperation with employers. Most of the themes discussed concern relationships. The participants are asked to do different exercises in between the sessions. Another example is the Kids & Dads club in Leksand, where fathers meet with their children for three hours every Saturday.

It seems that it is not a lack of interest that limits men's participation but rather the way the activities are designed. Parent support has been traditionally dominated by women and is therefore normally designed for them. If interventions were designed to suit men as well, more fathers would no doubt participate.

Socioeconomic groups

The parent questionnaire shows that 20 per cent more parents with a high level of education are interested in structured parent groups, compared to parents with a low level. The differences between various levels of education are slightly greater for open discussion groups. The differences between different social strata seem therefore to be significantly smaller than the differences between the sexes. The differences in interest among various social groups also seem to be smaller during the preschool and school years compared to during early infancy.

Several observations point to this type of intervention being able to reach different social groups to a relatively equal degree. A British study compared the parents who participated in group activities with other

parents in the local area [12]. No differences were indicated with respect to social class, ethnicity or family type (one/two parents). Canadian experiences point to greater success in recruiting socially less affluent families to group activities compared to individual counselling [10]. Swedish experiences in Botkyrka, Linköping and Malmö also indicate that the interventions may interest different social groups to a relatively equal degree. A precondition seems to be that the activity is held in the immediate vicinity. Access to babysitters is also significant.

Interventions aimed at the wider public cannot entirely satisfy the needs of groups with significant problems, however. Individualised solutions are needed for them. However, such groups comprise less than five per cent of the population and are therefore outside the scope of this study.

Country of birth

The parent questionnaire shows that the interest in structured parent groups is relatively equal among parents, irrespective of their country of birth. The interest in open parent groups is significantly less, however, among foreign-born parents. One explanation might be that open parent groups demand a high level of skill in Swedish. This suggests that structured methods are preferable if parent support is to be offered to parents relatively equally, regardless of where they were born.

Costs

Interaction methods

The costs involved in running parent groups using interaction methods have been calculated in a publication on economical allocation models regarding children's mental health [64]. The estimated total cost per child is roughly SEK 1,600. This estimate is based on the assessment that the cost of open and structured parent support primarily costs of the group leader's salary. If we assume the group leader is a preschool teacher with a monthly salary of about SEK 18,000 and additional payroll expenses of 42 per cent, the cost per working hour will be SEK 190. The working time devoted to each child (parent) is roughly 6 x 0.75 x 12/8 = 6.75 hours if we assume one parent per child participated 2 x 45 minutes at 12 group sessions of eight

participants and each session requires 6 x 45 of total working time for the preschool teacher, including preparation time. The cost per child is then 6. 75 x 0.19 = SEK 1,300. The costs for training and mentoring and the costs for premises and material are to be added and can be estimated at around 25 per cent of the gross salary cost.

Cost versus benefit

In foreign trials, structured interaction methods have reduced the prevalence of aggressive behaviour problems by up to 70–80 per cent. In Sweden these methods are assumed to reduce behaviour problems by 30 percent. Furthermore, it is assumed that the prevalence of behaviour problems is 50/1,000, the equivalent of about one child per school class.

Based on this assumption, if interaction methods were used so that all parents could benefit from them, the prevalence of aggressive behaviour problems would be reduced from 50/1,000 to 35/1,000. This would in the long run lead to considerable potential savings for the municipality. The financial value to the municipality of a reduction has been calculated using data on its expenses for children with aggressive behaviour problems. These costs are mainly associated with the social services and schools. The annual costs to the social services for children with aggressive mental problems have been estimated using data from Stockholm County Council [65]. The costs amounted to SEK 2.64 million/1,000 children for placement in foster homes and SEK 1 million/1,000 children for other measures, making a total of SEK 3.6 million/1,000 children. According to statistics from the National Board of Health and Welfare, 25 per cent of all care provided under the Care of Young Persons (Special Provisions) Act of 1990 was related to children's behaviour [66]. The costs to the social services for the care of children with aggressive behaviour problems can therefore be estimated at 25 per cent of SEK 3.6 million/1,000 children, which is about SEK 0.9 million/1,000 children per year.

The annual costs to schools for children with aggressive mental problems are based on data from Linköping Municipality, in which they say that four per cent of all expenses for compulsory school children go directly to pupils in need of special support [67]. This data is probably an overestimation of the direct costs associated with aggressive problems, since some of the pupils in need of special support may have different problems.

On the other hand, the figure of four per cent may be an underestimation, since schools have other extra costs; special needs teachers being a case in point. The figure of four per cent is therefore a rough one. The increased school costs for this group of pupils have been estimated at four per cent of one annual study place, the equivalent of about SEK 2.1 million/1,000 children in 2000 [68]. Total expenditure by the municipality for children with aggressive behaviour problems has hence been estimated at SEK 3 million/1,000 children and year.

The costs for children with aggressive behaviour problems refer not just to one year. It is reasonable to assume that the costs are true for the whole period when the child is between 3–17 years old. In other words, there are cumulative costs. The costs for aggressive behaviour problems between 3–17 years old can therefore be estimated at 15 x 3 = SEK 45 million/1,000 children. The value of a 30-percent reduction will then be 0.3 x 45 = SEK 13.5 million. The costs of the parent support interventions that are expected to lead to this reduction are 1,000 x 1,600 = SEK 1. 6 million. The economic benefit exceeds the costs several times over.

In practice, it is important for the reduction in costs not to be delayed by 10–15 years. Neither is it realistic to image all parents will participate in the intervention, even though the municipality is starting to offer interaction programmes to parents. It is therefore useful to sketch a feasible scenario, in which the methodology is gradually introduced. The scenario is based on a municipality with a total number of inhabitants of 75,000, which corresponds to 1,000 children born in each year. The first year in which the intervention is offered, it is assumed that 10 per cent of the parents of three-year-olds will participate, 15 per cent in year 2, 20 per cent in year 3 and 30 per cent in year 5. The reduction on the municipality's expenditure for children with aggressive behaviour problems is directly related to how many parents of a given cohort of children have been able to benefit from the interaction methodology. The envisaged development is presented in Table 7.1. As we can see, the intervention is expected to lead to municipal savings after just three years.

Year	Percentage of participating parents of three-year-olds	Cost of the intervention (SEK thousands)	Expected reduction in the total prevalence prevalence of behaviour problems in the 3–17 age group (15 cohorts in total)	Financial value of the reduction (SEK thousands)	Net expenditure (SEK thousands)
1	10%	160	0.2%	-	160
2	15%	240	0.5%	225	15
3	20%	320	0.9%	405	–85
4	25%	400	1.4%	630	–230
5	30%	480	2.0%	900	–420
6	30%	480	2.6%	1,170	–690
7	30%	480	3.2%	1,440	–960
8	30%	480	3.8%	1,710	–1,230
9	30%	480	4.4%	1,980	–1,500
10	30%	480	5.0%	2,250	–1,770

Table 7.1 Hypothetical development in expenditure and savings in a municipality with 1,000 children in each cohort starting to offer parents support in the form of interaction methods.

In the publication referred to above that discusses priority allocation concerning children's mental health, economic calculations of the costs are presented for the type of problem which interaction methods are expected to prevent [64]. We can see for example that the actual costs to society for a life as an addict amount to SEK 11.9 million assuming a discount rate of five per cent. This cost is the same as the costs for group parent support covering 6,900 children. In other words, the parent group intervention is economically justified if parent support leads to just one single case of abuse/addiction being prevented among the 6,900 children. Such an assumption is very cautious bearing in mind the substantially larger effect that has been shown.

Costs of individual contacts using interaction methodology

Ten or slightly more sessions are normal in individual interaction programmes. Basing calculations on 15 hours of actual counselling time at SEK 600 per hour, the cost per child will be SEK 9,000.

Costs of interaction methodology offered via video/DVD
The costs involved in designing a Swedish version of an interaction programme comprising five hours offered in the form of video can be estimated at SEK 2 million. Costs for evaluation of about SEK 1 million are to be added to this. If the costs are divided up into a circulation of say 30,000, the cost of the programme per user will be SEK 100. Costs for copying and distribution of video cassettes/DVD of approximately SEK 100 per user are to be added to this. The costs will hence be considerably lower using this method of distribution compared to if the parent groups are arranged using employed personnel.

Dissemination

As far as the structured methods of parent support are concerned, there are organisations that train group leaders, see above, and updated information leaflets available on the SNIPH website [42].

Does the intervention promote children's participation

The aim of the interaction programmes is to develop good parent-child interaction by enhancing the skills of parents. The focus is on the parents and the children do not participate in the intervention itself. The method does enhance the scope of children to participate in future decisions that concern them. This occurs as a result, for example, of the method improving parents' communication with their children.

Children don't normally participate in open discussion groups. Since the content varies, it is not possible to say whether the form promote children's participation in general. When parents and children together meet others at a meeting-place, for example an open preschool, children can however participate directly.

Discussion

Parent groups

Only small groups of parents, roughly speaking less than ten per cent, actually utilise the group parent support available during this age group. Several different models are used in Sweden but only structured interaction programmes and PREP have has proven effects. Widespread use of interaction programmes is our best opportunity of improving the welfare and health of children in this age group. The effects of these programmes are manifest and well documented. The intervention can be expected to lead to municipal savings within just two or three years. Furthermore, there are several centres in Sweden that offer group leader training. There are therefore a number of arguments in favour of interaction programmes being widely disseminated. It should also be possible to offer PREP to parents when their children are in this age group. From the child's perspective, however, it is better to do this earlier, preferably before the child is born.

Interaction programmes

Several variants of interaction programmes are used in Sweden. The presentation above has graded them into "recommended" and "promising" programmes. The grading is based on how well the variants are documented and on how well disseminated they are in Sweden.

Interaction programmes are normally offered by the social services, child and adolescent health services or school administrations. They are often arranged in cooperation with county council child and adolescent psychiatry services or other units within the county council. The municipality normally takes overall responsibility. This is reasonable since it already has the chief responsibility for the welfare of children and adolescents. Another reason is that the municipality has the financial responsibility for a large number of the measures required in the event of children developing aggressive behaviour problems. The savings that the parent support interventions can be expected to lead to will therefore accrue to the municipality.

The interaction programmes used in Sweden have been aimed at parents in general, at parents in socially disadvantaged housing areas and at parents who have already sought help because of their children's obvious problems. The programmes are clearly well suited to parents whose children

have manifest problems. Chapter 2 presents arguments justifying the use of broad interventions as well. The effect of the programmes is best documented for parents of children aged two years or older. The overall effect is most apparent if the intervention is offered as early as possible, at the age of 2–3 years. At this age, it is difficult to predict which children are going to develop significant behaviour problems. Interventions at this age should therefore be offered on a broad scale to be effective on the population level. Reaching 30–50 per cent may be a reasonable target.

A further reason for offering the programmes on a broad scale is that socially disadvantaged parents may find it more appealing to participate in an activity aimed at all parents, compared to if the offer is only aimed at families with problems. In the latter case, parents may justifiably feel stigmatised. Furthermore, knowledge on dealing with children is not only spread by parents participating in interaction programmes. Discussions among parents are also important. In other words, if many parents have had the opportunity to participate in a parent group, they can then spread their experiences to other parents who have not participated in a group.

To achieve such wide dissemination, we need organisations that can train a large number of group leaders. There are currently no such organisations. Support is therefore needed for those structures that currently offer training so that these organisations can increase their activities.

Interaction programmes can also be offered to parents at individual contact sessions. Foreign studies do not indicate that the effect is any better at such sessions compared to when parents meet as a group. Since the costs are also much higher, offering such activities as a preventive measure is not justified. Individual contacts may be justified however within the child and adolescent psychiatry services and the social services.

Video/DVD version of interaction programmes

The foreign trials referred to above indicate that parents can assimilate the content of an interaction programme simply by watching the material on TV or video. The cost of such dissemination is considerably lower than the costs for arranging groups. This emphasises the value of making the methodology accessible on video/TV. Such material could be used both individually and in groups without specially trained, salaried leaders. The costs can be estimated at around SEK 200 per user, i.e. substantially less

than the costs of contact in a parent group. Parent groups fulfil functions other than training in interaction methodology, however. It is therefore possible that many parents prefer to study the material as a group. Access to material such as video/DVD does provide more flexibility, however, since parents can study the material in the way that is best suited to each individual family. The main advantage of making the material accessible as video/DVD is therefore that more parents will be able to benefit from the method and that knowledge will be spread more widely among parents in general.

Forms other than interaction programmes

Parent support in groups that are of a more open character seem to have an effect if the participants have a common problem, see Chapter 3. The majority of the Swedish activities take place in groups. It is for example common for the social services in a municipality to arrange special groups for young single mothers. Another example is the discussion groups for immigrants who have yet to obtain residence in Sweden, organised by the local Child Ombudsman in Uppsala. A still further example is the discussion groups set up by the study organisation, *Studiefrämjandet Småland-Gotland* for parents of dyslexic children.

All interventions of this nature are aimed at groups that constitute less than five per cent of the population. The participants are normally in contact with an authority whose tasks include supporting families with problems, mostly the social services and the child and adolescent psychiatry services. It seems therefore to be outside the framework of this study to consider how appropriate these interventions are, for further information, see Chapter 2.

The Swedish experiences also present open parent groups, the activities of which are aimed at parents in general, without them having to have a common problem. Such activities may be of value for those parents participating. Since there are no controlled studies of such interventions, it is not possible to determine whether children's health and welfare benefit from the parents' participation. Neither is it possible on theoretical grounds to find clear arguments suggesting the situation of the children would improve. One component that is crucial in the effectiveness of the interaction programmes is the teaching method used. Interaction programmes develop the skills of

parents to deal with their children in a series of steps in which they role-play suitable approaches. Parents can then practise the same element at home. The material used in the open discussion groups does not suggest that such elements are included. There, the emphasis is on providing parents with the chance to reflect on their own parenting. This obviously has an intrinsic value, but there is no straightforward link between such reflection and the way parents deal with their children.

Parent groups for parents born outside the Nordic region

Several of the interventions are open parent groups aimed at parents born outside the Nordic region. The studies showing the benefit of meeting as a group to those with a common problem provide a good argument for such activities. It is also possible to find arguments against such activities, however. One reason is that parents in this group often say themselves that they want to participate in groups together with Swedish-born parents. This may have something to do with the participants' common "problem" being that they are not familiar with Swedish traditions. It is hence debatable whether offering them an activity in which Swedish-born parents do not participate is a good idea.

The interaction programmes recommended here have in foreign studies been shown to be effective even in ethnic minorities. Furthermore, the parent questionnaire shows that the level of interest in structured programmes is about the same regardless of which the parents' country of birth. This suggests that these programmes should also be offered to parents born outside the Nordic region. An interpreter is needed if the parents have an insufficient command of the Swedish language.

Open preschool and family welfare centres

Open preschools and family welfare centres have successfully arranged interaction programmes for parents. One of the advantages of such an arrangement is that the parents are normally already acquainted with the staff. Otherwise, however, open preschools and family welfare centres are less important for the parents of children aged 2–9 years, since most of them have by then gone back to work and such activities are normally not available outside working hours.

Individual contacts

The parent questionnaire shows that individual contacts with staff in the primary healthcare services, preschool, school and after-school recreation centres are a source of support for a large number of parents. It seems this need is mostly satisfied by existing activities, however. Further measures are therefore not warranted.

Organisation

The municipality has been nominated as the main responsible party for parent support in this age-group. Parent support affects several different municipal administrations. It may therefore be appropriate for the municipality to appoint one person assigned the task of coordinating all parent support activities, including that proposed for other age groups. This person can have parent support as his/her main task. One option is for the coordinator of alcohol and drug prevention already appointed in many municipalities to be given this additional task. Another option is to give the task to local crime prevention officers or municipal public health planners.

The need for research

The obvious effects of interaction programmes point to them having considerable potential for improving children's health and welfare. Three questions are worth studying in particular.

The proposed programmes are based on interventions developed in North America for the parents of children with aggressive behaviour problems. They have been reformulated to varying degrees for wide-scale use in Sweden. The further development of programmes for such use and the study of their effects is therefore warranted. Study of their long-term effects is also justified.

A precondition of the effectiveness of the interaction programmes is that parents can develop their ability to give their children an appropriate combination of affection and boundaries. There is however a lack of population-representative research into the skills of Swedish parents in this respect. There is also a lack of studies into the determinants of such skills. Further, if interaction programmes are introduced on a broad scale, improvement can be expected on the population level over time. More light needs to be shed on this issue as well.

Interaction programmes were developed for the treatment of children with behaviour problems. They have since been used as a preventive measure, which is one of the recommendations in this report. Concerning wide-scale use, the costs are more crucial than when the methods are used to treat children with manifest problems. The costs will be considerably lower if the methodology is spread via video/DVD in study circles without specially trained group leaders. Knowledge as to how the methodology can best be used in such a context is however very limited. This warrants further study of the issue.

Proposals

SNIPH recommends the municipalities to offer parents interaction programmes on a broad scale, primarily when the child has reached the age of two or three, but also later on during the preschool years.

SNIPH recommends the Government to provide support for NGOs, municipalities, county councils and research institutes working with the dissemination of interaction programmes.

SNIPH recommends the Government to finance the development and dissemination of a Swedish video/DVD version of interaction programmes for use individually or in study circles.

SNIPH recommends the Government to support research into interaction programmes.

Participants

Sven Bremberg has the main responsibility for the text and Anton Lager has prepared the background material. Ingrid Olsson has performed basic literature searches and Lena Andersson Andalibi has compiled the Swedish experiences. Knut Sundell has reviewed an earlier version of the text and submitted valuable comments.

References

1. Inhelder B, Piaget J. The growth of logical thinking from childhood to adolescence. New York: Basic Books; 1958.
2. Patterson GR, Littman RA, Bricker W. Assertive behavior in children: A step toward a theory of aggression. Monogr Soc Res Child Dev 1967;32(5):1-43.
3. Oregon Social Learning Centre. URL: http://www.oslc.org/.
4. Webster-Stratton C. *De otroliga åren*. Lund: Palmkrons förlag; 2003.
5. Silverberg G, Nilsson L. *COPE föräldrautbildning*. BUP-kliniken i Malmö; 2002.
6. Hassler M, Havbring L. *Föräldracirklar – en metod för att utveckla sitt föräldraskap*. Socialförvaltningens FoUenhet. URL: http://www.sot.stockholm.se/fou/rapporter/pdf/fou0308.pdf.
7. Hellström A. *Föräldrautbildning för föräldrar med barn med beteendeproblem*. Psykisk Hälsa 2004;2.
8. Barrera M, Jr. , Biglan A, Taylor TK, Gunn BK, Smolkowski K, Black C, et al. Early elementary school intervention to reduce conduct problems: A randomized trial with Hispanic and non-Hispanic children. Prev Sci 2002;3(2):83-94.
9. Csapo M. The effect of self-recording and social reinforcement components of parent training programs. Journal of Experimental Child Psychology 1979;27(3):479-88.
10. Cunningham CE, Bremner R, Boyle M. Large group community-based parenting programs for families of preschoolers at risk for disruptive behaviour disorders: Utilization, cost effectiveness, and outcome. J Child Psychol Psychiatry 1995;36(7):1141-59.
11. Martinez CR, Jr. , Forgatch MS. Preventing problems with boys' noncompliance: Effects of a parent training intervention for divorced mothers. J Consult Clin Psychol 2001;69(3):416-28.

12. Patterson J, Barlow J, Mockford C, Klimes I, Pyper C, Stewart-Brown S. Improving mental health through parenting programmes: Block randomised controlled trial. Arch Dis Child 2002;87(6):472-7.

13. Taylor TK, Schmidt F, Pepler D, Hodgins C. A comparison of eclectic treatment with Webster-Stratton's parents and children series in a children's mental health center: A randomized controlled trial. Behavior Therapy 1998;29(2):221-40.

14. Tucker S, Gross D, Fogg L, Delaney K, Lapporte R. The long-term efficacy of a behavioral parent training intervention for families with 2-year-olds. Res Nurs Health 1998;21(3):199-210.

15. Webster-Stratton C. Teaching mothers through videotape modeling to change their children's behavior. J Pediatr Psychol 1982;7(3):279-94.

16. Webster-Stratton C. Randomized trial of two parent-training programs for families with conduct-disordered children. Journal of Consulting & Clinical Psychology 1984;52(4):666-78.

17. Webster-Stratton C, Hammond M. Treating children with early-onset conduct problems: A comparison of child and parent training interventions. J Consult Clin Psychol 1997;65(1):93-109.

18. Wolchik SA, Sandler IN, Millsap RE, Plummer BA, Greene SM, Anderson ER, et al. Six-year follow-up of preventive interventions for children of divorce: A randomized controlled trial. JAMA 2002;288(15):1874-81.

19. DeGarmo DS, Patterson GR, Forgatch MS. How do outcomes in a specified parent training intervention maintain or wane over time? Prev Sci 2004;5(2):73-89.

20. *Insatser mot psykiska problem hos barn och ungdomar. Slutbetänkande av Barnpsykiatrikommittén.* SOU 1998:31. Stockholm: Socialdepartementet; 1998.

21. Barlow J, Parsons J. Group-based parent-training programmes for improving emotional and behavioural adjustment in 0–3 year old children. Cochrane Database Syst Rev 2003(1): CD003680.

22. Yeh M, Morley KI, Hall WD. The policy and ethical implications of genetic research on attention deficit hyperactivity disorder. Aust N Z J Psychiatry 2004;38(1-2):10-9.

23. Comings DE. Clinical and molecular genetics of ADHD and Tourette syndrome. Two related polygenic disorders. Ann N Y Acad Sci 2001;931:50-83.

24. Spencer TJ, Biederman J, Wilens TE, Faraone SV. Overview and neurobiology of attention-deficit/hyperactivity disorder. J Clin Psychiatry 2002;63 Suppl 12:3-9.

25. Bremberg S. *Hur kan förskolan förbättra barns psykiska hälsa?* Stockholm: Statens folkhälsoinstitut; 2001.

26. Crijnen AA, Achenbach TM, Verhulst FC. Problems reported by parents of children in multiple cultures: The Child Behavior Checklist syndrome constructs. Am J Psychiatry 1999;156(4):569-74.

27. Patterson GR, Chamberlain P, Reid JB. A comparative evaluation of a parent-training program. Behavior Therapy 1982;13(5):638-50.

28. Sanders MR, Markie-Dadds C, Tully LA, Bor W. The triple P-positive parenting program: A comparison of enhanced, standard, and self-directed behavioral family intervention for parents of children with early onset conduct problems. J Consult Clin Psychol 2000;68(4):624-40.

29. Schuhmann EM, Foote RC, Eyberg SM, Boggs SR, Algina J. Efficacy of parent-child interaction therapy: Interim report of a randomized trial with short-term maintenance. J Clin Child Psychol 1998;27(1): 34-45.

30. Webster-Stratton C. Enhancing the effectiveness of self-administered videotape parent training for families with conduct-problem children. J Abnorm Child Psychol 1990;18(5):479-92.

31. Tremblay RE, Pagani-Kurtz L, Masse LC, Vitaro F, Pihl RO. A bimodal preventive intervention for disruptive kindergarten boys: Its impact through mid-adolescence. J Consult Clin Psychol 1995;63(4):560-8.

32. Forgatch MS, Toobert DJ. A Cost-Effective Parent Training Program for Use with Normal Preschool Children. Journal of Pediatric Psychology 1979;4(2):129-45.

33. Whiteman M, Fanshel D, Grundy JF. Cognitive-behavioral interventions aimed at anger of parents at risk of child abuse. Social Work 1987;32(6):469-74.

34. Webster-Stratton C, Kolpacoff M, Hollinsworth T. Self-administered videotape therapy for families with conduct-problem children: Comparison with two cost-effective treatments and a control group. J Consult Clin Psychol 1988;56(4):558-66.

35. Sanders MR, Montgomery DT, Brechman-Toussaint ML. The mass media and the prevention of child behavior problems: The evaluation of a television series to promote positive outcomes for parents and their children. J Child Psychol Psychiatry 2000;41(7):939-48.

36. Connell S, Sanders MR, Markie-Dadds C. Self-directed behavioral family intervention for parents of oppositional children in rural and remote areas. Behav Modif 1997;21(4):379-408.

37. Montgomery P. Media-based behavioural treatments for behavioural disorders in children (Cochrane Review). The Cochrane Library 2004:2.

38. Miller-Heyl J, MacPhee D, Fritz JJ. DARE to be you: A family-support, early prevention program. Journal of Primary Prevention 1998;18(3):257-85.

39. McKay GD, Hillman BW. An Adlerian multimedia approach to parent education. Elementary School Guidance and Counseling 1979;14(1): 28-35.

40. Summerlin ML, Ward GR. The effect of parent group participation on attitudes. Elementary school guidance and counselling 1981;16(2): 133-6.

41. Burgess ES, Wurtele SK. Enhancing parent-child communication about sexual abuse: A pilot study. Child Abuse Negl 1998;22(11): 1167-75.

42. Statens folkhälsoinstitut. URL: http://www.fhi.se.

43. Carlsson U, Thunström P. *Föräldragrupper: Föräldrautbildning enligt COPE-metodiken*. Linköpings kommun. URL: http://www.linköping.se/utbildningRyd/slutrapport_barn_o_ung_basta. htm.

44. Jakstrand M. *Föräldrar lär sig undvika bråk*. Sydsvenskan. URL: http://w1.sydsvenskan.se/Article.jsp?article=10004876.

45. Eriksen J. *Stor framgång för stöd till föräldrar.* Östgöta Correspondenten. URL: http://www3.linkoping.se/bub/Corren_seCOPE2-filer/hbk74o7c350j0n8.htm.

46. Sinus ab. *Mer information om COPE*. URL: http://www.sinus.se/cope/mer_om_cope.asp.

47. Barn- och ungdomspsykiatrin i Västmanland. *COPE – föräldrautbildning i grupp*. URL: http://www.ltvastmanland.se/COPE.

48. The Incredible Years. URL: http://www.incredibleyears.com/.

49. PMT-projektet. URL: http://www.pmt-projektet.se/info.html.

50. Active Parenting. URL: http://www.activeparenting.se/.

51. Kumpfer K-L, Molgaard V, Spoth R. The Strengthening Families Program for the prevention of delinquency and drug use. In: Peters RD, McMahon RJ, Eds. Preventing childhood disorders, substance abuse, and delinquency. Banff international behavioral science series, Vol. 3; 1996, p. 241-67.

52. Eskilstuna kommun. Parent power. URL: http://www.eskilstuna.se/templates/Page____18717.aspx.

53. Puckering C, Rogers J, Mills M, Cox AD, Mattsson-Graf M. Process and evaluation of a group intervention for mothers with parenting difficulties. Child Abuse Review 1994;3(4):299-310.

54. Nyberg L, Lindberg L. *Utagerande förskolebarn – hur kan de hjälpas?* Stockholm: Samhällsmedicin; 2003.

55. Ogden T, Askeland E, Forgatch M, Bullock B, Petterson G. Large scale implementation of parental management training at the national level: the case of Norway. In: Stattin H, Ed. *Familjeprogram-föräldraträning inriktade på att minska beteendeproblem bland barn.* Örebro: Örebro universitet, Institutionen för beteende-, social- och rättsvetenskap; 2003.

56. Modellutviklingsprogram for PMTO i barnevernet. *Överføring og tilpasning av Parent Management Training – Oregonmodellen til det norske barnevernet*. URL: http://www.atferd.uio.no/f_prosjekt. htm.

57. The University of Queensland. Parenting and Family Support Centre. URL: http://www.pfsc.uq.edu.au/.

58. Skandia. Idéer för livet. *Människans Barn: Handledning och fem videokassetter*. URL: http://www.skandia.se/ideer/material/bestall. jsp.

59. Utbildningsradion. *Om barn*. URL: http://www.ur.se/ombarn.

60. Dejin-Karlsson E, Hanson BS, Ostergren PO, Sjoberg NO, Marsal K. Does passive smoking in early pregnancy increase the risk of small-for-gestational-age infants? Am J Public Health 1998;88(10):1523-7.

61. Rosslind E, Sterner J. *Växa tillsammans: årskurs 1–3*. 2:a uppl. Stockholm: Liber utbildning; 1995.

62. Lund K. *Växa tillsammans: årskurs 4–6*. 1:a uppl. Stockholm: Liber utbildning; 1996.

63. Mentor. URL: http://www. mentorsverige. org/.

64. *Tänk långsiktigt! En samhällsekonomisk modell för prioriteringar som påverkar barns psykiska hälsa*. Skolverket, Socialstyrelsen, Statens folkhälsoinstitut; 2004.

65. Dalman C, Bremberg S. *Hur satsar vi på barnen? Insatser för barn och ungdom i Stockholms län mätt i kronor.* Huddinge: Centrum för Barn- & Ungdomshälsa; 1999.

66. *Insatser för barn och unga 1999*. Stockholm: Socialstyrelsen; 2000.

67. *Kommunal budget 2000*. Linköping: Linköpings kommun; 2000.

68. *Beskrivande data om barnomsorg och skola*. Stockholm: Skolverket; 2000.

8.

INTERVENTIONS DURING SCHOOL YEARS (10–15 YEARS)

8.

INTERVENTIONS DURING SCHOOL YEARS (10–15 YEARS)

Children become increasingly independent as they get older. An important change occurs at the age of 10–12 years, when children start to think abstractly [1], which increases their potential for acting on their own. During their teens, adolescents begin to experiment with tobacco, alcohol and drugs. Nor is it uncommon for teenagers to commit crimes. Support for parents during this period is therefore often directed at preventing such problems. The effects are clearer for those interventions which begin in the early teens. It is also possible to give parent support during late adolescence. However, such interventions are less common and they are less well studied. In this report the presentation is therefore limited to support to parents with children in the ages 10–15 years.

Effect

Studies of parent support in this period have been identified with the aid of the Cochrane Library, the review presented in Chapter 4, and through complementary searches in the Medline and PsycINFO literature databases.

As in earlier chapters the descriptions of effects are divided according to whether the interventions are aimed at the needs of children or of parents. The background to this division is presented in Chapters 2 & 3.

Parent support geared towards the needs of children: communication programmes

The scientific literature is dominated by programmes of which the objective is the development of good communication between parents and children, in particular in order to diminish the risk that children will begin to use tobacco, alcohol and drugs and also to commit crimes. In what follows

these programmes are therefore called *communication programmes*. The aim of these programmes is normally to try to get parents and teenagers to agree on standards and rules that the teenagers then abide by. If these agreements are to have any effect whatsoever, it is important that the parties trust each other. Trust of this kind is built up by parents giving their children positive attention and by parents and children doing things together. Hence the programmes include parts aimed at promoting a positive form of interaction of this kind. The programmes also help the parents to use well thought out ways of confronting the teenagers when conflicts arise. In this way, the communication programmes have similarities with the interaction programmes described in Chapter 7. The chief differences are that communication programmes are adapted to the fact that adolescents in the ages 10–15 years are more independent than younger children and to the risks of their developing the use of tobacco, alcohol and drugs, as well as criminal behaviour.

Communication programmes are often conducted in groups of 10–15 parents who hold between 5 and 10 weekly meetings each lasting two hours. Normally the children are offered similar meetings at school in conjunction with the parents' meetings. One example of a communication programme is *Guiding Good Choices*, formerly called *Preparing for the Drug Free Years* [2]. It focuses on preventing use of alcohol, tobacco and narcotics during adolescence.

At the beginning of the programme, the parents discuss the risk of the teenagers starting to smoke, drink and take drugs. In the next stage the parents discuss what expectations are reasonable and together they arrive at an agreement on what rules are to apply. Parents are given help and support to resolve conflicts with their children in a constructive way. The programme also takes up the question how parents and children can do various positive things together.

Tasks are included in the programme. One example is when parents have to note who was important for them when they were at the same age as the children. They then have to reflect on what these people did. The programme includes role-playing where one parent has to play the part of the child and another to practise the different skills which the programme takes up. The manual for the programme describes the different elements very precisely. Timings are indicated for how long given elements must

continue and ideal wording is given for what the leader must say when she or he presents them. The programme also includes material in the form of prepared overhead pictures, as well as video films to show parents.

Proof of the effect of communication programmes which are used in parent groups
Fourteen analyses of communication programmes have been presented. Programmes called *Guiding Good Choices*, formerly called *Preparing for the Drug Free Years* [3–5], the *Iowa Strengthening Families Program* [5–7], *Linking the Interest of Families and Teachers* [8] and other programmes have been evaluated [9–15]. In ten of these studies the parent programme has been combined with a parallel intervention for children, alternatively the programme has been carried out with the children and parents together. In these studies, it is therefore impossible to determine whether it is the intervention for the children or the intervention for the parents which has produced the effect. In three studies, however, effects have been demonstrated when the communication programme has been conducted without the children being informed of any particular intervention. That is the case in a study of the programme *Guiding Good Choices*, in which effects on the behaviour of the children have been demonstrated [4]. Two other studies report effects on children's perceptions of themselves [10] and on communication in the family [9].

Long-term effects on smoking and alcohol-consumption have been demonstrated in two programmes, *Guiding Good Choices* and the Iowa *Strengthening Families Program* [5]. The interventions were carried out when the children were about 11 years old and effects were shown four years later.

Extent of the effect of communication programmes when used in parent groups
In two analyses it is possible to assess the effect at about the age of 15 of interventions which began to be carried out when the children were about 11 years old [5]. One analysis related to *Guiding Good Choices*. It demonstrated a reduction of 10–20 per cent in the proportion of adolescents who at the age of 15 report that they have at some stage drunk alcohol or smoked. This intervention was primarily directed at parents but on one occasion children also participated. The other analysis applied to the *Iowa Strengthening Families Program*, which demonstrated a reduction in the

consumption of alcohol and tobacco of 20–40 per cent. The greater effect for the *Iowa Strengthening Families Program* can be explained by the component in which children and parents learn things together. This programme is often carried out in the evenings. During the first hour children and parents meet separately while in the second hour they go through activities together.

Proof of the effect of interaction programmes which the parents learn about via the media (printed material)

Communication programmes can also be provided to parents as printed material. Three trials in families with children aged 10–14 have been presented. Printed material has been sent to their homes through the post on 4–5 occasions.

In two experiments the focus was on the consumption by children of tobacco and alcohol. In the most comprehensive trial the families also had contact with a health adviser who telephoned them at home [16]. On average each family had seven conversations which in total lasted one hour. The parents were not always at home when the health adviser rang. The health adviser therefore needed on average to ring another 37 times to each family. Sixty-two per cent of all families used the four brochures which comprised the material. Assessments after three months and one year showed that children in the experimental group had a lower consumption of tobacco and alcohol. In the other experiment, the families only had the brochures sent to them, without any contact by telephone [17]. These brochures contained histories of parents and children who were intended to serve as role models for the parents. The assessment one week after the family had received the final brochure showed that parents in the trial group put more questions about what the children intended to do. The parents had also more frequently made contact by telephone with the parents of their children's friends. The children's behaviour was, however, not studied.

In a third experiment the children received at school, over a period, instruction in sex and married life [18]. During this period the children were given five homework lessons which they should study together with the parents. The study showed that after the experiment parents in the experimental group more frequently talked to their children about how to prevent different risk behaviour. The behaviour of the children was not studied.

The three studies thus show that printed material can be of value. They do not however show that, by itself, printed material intended for parents can influence the behaviour of children.

Proof of the effect of structured programmes other than communication programmes

Chapter 4 identified two studies of structured programmes which were different from communication programmes. In one study the parents had been informed of solution-focused therapy. The effects of interaction in the family could not be demonstrated [19]. The other intervention was aimed at changing the parents' way of discussing sex and HIV with their children. The intervention produced effects on how often parents and children held such discussions [20].

Support geared towards the needs of parents

Chapter 3 discusses evidence for the effect of support focusing on the needs of parents in the form of open and structured individual counselling, open and structured parents groups and meeting-places. It emerges that *structured parent groups* such as *PREP* (see Chapter 9) can improve the parents' relationship. It also emerges that if a family has a *problem*, the situation can be improved both by open individual counselling and by participation in open discussion groups together with other parents who have the same problem. This is also true for parents with children aged 10–15 years. The effect of open parent groups directed at parents in general is, however, unclear.

The situation in Sweden

When children are in the age group 10–15 years there is a lack of preventive activity with broad coverage, directed at parents, and corresponding with the individual contacts and the groups that are offered during early infancy. There are, however, a number of different activities which offer parents support in different forms and in varying extent. The most important forms are individual contacts with staff in school and leisure activities, structured discussion groups directed at the needs of the children, open discussion groups, themed discussion groups and circulation of printed material.

There are a number of organisational forms for providing parents with support in groups. These forms are presented below.

Individual contacts with school personnel

In the questionnaire presented in Chapter 5, 37 per cent record that they had had benefit from individual discussions with staff in school and leisure activities, in addition to the ordinary parent-teacher meetings. About the same number express an interest in such conversations. This means the existing need seems to be covered by currently performed interventions.

Discussions with school and leisure activity staff are thus a source of support for parents. The current Education Act (2004) states that schools have a duty to inform those who have custody of children about what schools are doing and about the children's development. The Act does not prescribe any obligation on the staff to provide support to parents in their role as parents.

Structured parent support focusing on children's needs: recommended communication programmes

The methods of structured parent support which are directed at the needs of children and which are in use in Sweden are dominated by different variants of communication programmes. No other forms of structured programmes intended for parents with children in the age groups in question have been registstered. Rapid developments are taking place in this sector, with a number of controlled scientific studies in progress and extensive educational activity. Information on the current range of activities/studies in Sweden is constantly updated on the Swedish National Institute of Public Health (SNIPH) website [21]. This compilation differentiates between recommended and promising programmes. All the recommended programmes have been evaluated in controlled studies and there is a Swedish organisation that educates group leaders. The promising programmes do not completely fulfil both these demands.

Steg för steg

Step by step is a manual-based parent group programme for parents with children in school years 5–7 (children 11–13 years old). Parents have to discuss different ways of behaving towards their children in a number of

everyday situations. The discussions are based on short video-scenes recorded by actors. The parents have to discuss the advantages and disadvantages of different ways of handling children. They must then discuss whether the methods can be used in situations other than those shown in the video clips. Some of the methods of dealing with children, which have been discussed, are thereafter tried out in role-playing. The parents are subsequently encouraged to try some of these methods at home. Step by step also includes joint planning for time to be spent together.

The programme consists of two parts. In the first part the parents meet six times and on a seventh occasion parents and children meet together. In the second part, the parents meet four times and on a fifth occasion the parents and children meet together. In the programme is included also instruction for children for an equal number of occasions with linked themes. In addition, families meet, with parents and children together, twice. The programme is based on an American model, *Iowa Strengthening Families Program* [22]. In the American model the children's activities together with the parents are carried out on each occasion, while there are only two such meetings are arranged in the Swedish version. The Ministry of Health and Social Affairs has partly financed the development of *Step by step*.

SCIENTIFIC STUDIES WITH CONTROL GROUPS

Effects have been demonstrated in a randomised controlled study of the American model *Iowa Strengthening Families Program*, with follow-up until four years after the first interventions [5–7]. A Swedish controlled study is taking place in 2005 at some 20 schools in Stockholm, led by the organisation STAD [*Stockholm Prevents Alcohol and Drug Problems*].

USE OF THE METHOD IN SWEDEN

Step by step has been used in Sweden since 2002. STAD has produced manuals and video-films which are adapted to Swedish conditions. On 1 January 2004 there were about 40 parent group leaders with basic training and nine certificated. About 400 parents had completed the programme. In the first experiment, carried out in the city of Stockholm, one of the parents of 47 per cent of the children participated in the first part of the programme and of 27 per cent in the second part.

INFORMATION, PRACTICAL EXPERIENCE AND EDUCATION/TRAINING

Information on the method is available on-line in Swedish [23] and on the American model in English [24]. For information on group-leader training and on practical experiences of the method, please visit the SNIPH Website [21].

Örebro Prevention Program

The *Örebro Prevention Programme* was developed at the University of Örebro. It is directed at preventing binge-drinking and criminality. Short parent meetings were carried out in school years 6–8 (children 12–14 years old) once a term, in connection with the ordinary parent-teachers meetings. The meetings lasted 5–10 minutes and were conducted out by specially-appointed members of the staff, in the first experiment by students of psychology. These meetings have two objectives. The first is that the parents should come to a common agreement about how they should behave in regard to binge-drinking by youth and to other breaches of standards. The parents in each class draw up a written agreement which they all then sign. The second purpose is to encourage parents to clarify their own attitude to binge-drinking and to talk to their children about this question. The parents who do not participate in parent teachers meetings receive a memorandum sent to their homes. The parents also receive a regular newsletter.

The programme is in terms of time considerably less extensive than the communication programmes, contains no elements which promote positive attention, nor are there any elements in which the parents have to practise different attitudes. The similarity consists in the emphasis on clear communication as regards standards on alcohol-consumption and other risk behaviour.

The programme is reminiscent of the activity which is already pursued in many schools. It is common for parents and teachers to discuss alcohol and drugs problems at a parent-teacher meeting at some stage in the transition between school years 6 and 7. The *Örebro Prevention Programme* distinguishes itself from these parent-teacher meetings in a number of respects. An important difference is that the programme focuses on binge-drinking and not on the consumption of alcohol in general. The majority of parents agree that it is undesirable for a 15-year-old to get drunk. The attitude to the consumption of alcohol in general nonetheless varies. All

parents know, of course, that it is forbidden to sell alcohol to under-age children, but they know also that three-quarters of 15-year-olds consume alcohol. Therefore it can be difficult to agree on common standards on the consumption of alcohol in general. Another distinguishing characteristic of the Örebro experiment was that a specially appointed member of the staff conducted the discussion at the parent-teacher meetings and this person based himself on a number of clear principles. The same person maintained contact with the parents of pupils in the classes over the three years. It is possible that a teacher might be able to play that role. Such a model must however first be tested before it can be recommended in that form.

SCIENTIFIC STUDIES WITH CONTROL GROUPS

A Swedish controlled experiment has demonstrated effects which are in publication in the year 2006 (personal message, Nicolaus Koutakis, University of Örebro). In the experimental group there were four schools in each experimental and control group. In the control schools 40 per cent of the pupils in year 9 reported that they had been drunk at least once in the last month. In the experimental schools this proportion had been reduced to 25 per cent. It proved possible to demonstrate similar effects as regards the incidence of abnormal behaviour. The parents' attitudes to drunkenness were also studied. Here the differences between the control and experimental schools were even clearer. It is therefore very probable that the favourable outcome was a result of the intervention of which the parents had been informed.

USE OF THE METHOD IN SWEDEN

The method has been tested in Örebro County, Umeå, Kalmar, Laholm, Solna, Älmhult and Ragunda, and on Gotland. The Alcohol Committee has trained instructors in the so-called model schools and trial municipalities.

INFORMATION, PRACTICAL EXPERIENCE AND EDUCATION/TRAINING

Information on the method is available on-line in Swedish [25]. Material and training will be available in 2004–2005. For information on group-leader training and on practical experiences of the method, please visit the SNIPH Website [21].

Structured parent support focusing on children's needs: promising communication programmes

Active parenting for parents of teenagers today

This programme is based on written guidance which is used by all participants. Parents have to discuss different ways of behaving towards their children in a number of everyday situations. The discussions are based on short video-scenes recorded by actors. The parents have to discuss the advantages and disadvantages of different ways of handling children. They must then discuss whether the methods can be used in situations other than those shown in the video clips. Some of the ways of treating children, which have been discussed, are then tested in role-plays. The parents are subsequently encouraged to try some of these methods at home. The programme also takes up different styles of leadership and attitudes, problem-solving, communication skills, how to manage one's own and the teenagers' anger and methods of encouraging the development of independence in teenagers. The parents also discuss sexuality and violence as well as strategies for preventing the use of drugs. The parents also have an opportunity to reflect over the link between their own ideas, emotions and actions. The parent groups (8–12 people) meet 6–12 times, each meeting lasting 2–3 hours. The programme has been developed on the basis of an American model, *Active Parenting*, and has been adapted to Swedish conditions.

SCIENTIFIC STUDIES WITH CONTROL GROUPS

There are no controlled studies. The method has nevertheless great similarities with the assessed communication programmes and has therefore been included as a promising method.

USE OF THE METHOD IN SWEDEN

Active parenting for parents of teenagers today has been used in Sweden since 1998. The video-tapes are subtitled in Swedish. The programme puts greater focus on process and reflection than the American model and the meetings are longer (3 hours) than in the model (1 hour). In January 2004 there were over 100 parent group-leaders and about 500 parents had completed the programme. The training programme has been used in the nine-year compulsory school, by social administrations, in various drug-prevention projects as well as for the public in general.

INFORMATION, PRACTICAL EXPERIENCE AND EDUCATION/TRAINING

Information on the method is available on-line in Swedish [26]. For information on group-leader training and on practical experiences of the method, please visit the SNIPH Website [21].

Parent power

Parent power is a manual-based programme for parent groups which in part is aimed at parents whose children are about to begin school year 6. Parents have to discuss different ways of behaving towards their children in a number of everyday situations. The discussions are based on role-playing of various events. The parents have to discuss the advantages and disadvantages of different ways of handling children. They must then discuss whether the methods can be used in situations other than those shown in the video clips. Some of the ways of treating children, which have been discussed, are then tested in role-plays. The parents are subsequently encouraged to try some of these methods at home. The method also includes elements concerning tobacco, drugs and alcohol. The groups consist of up to 30 parents who meet over a period of 7–12 weeks per course, two hours at a time. The programme is based on an American model, *Iowa Strengthening Families Program* [22]. *Parent power* thus has similarities with Steg för steg but it comprises only 7 meetings, compared with 14 in *Step by step*. Furthermore it is based in part on role-playing of different scenes instead of video-recorded situations. Finally, all meetings are conducted with parents and children together, in contrast with *Step by step*, in which meetings for parents are commonly carried out separately from meetings with children.

SCIENTIFIC STUDIES WITH CONTROL GROUPS

Effects have been demonstrated in a randomised controlled study of the American model *Iowa Strengthening Families Program* [5–7].

USE OF THE METHOD IN SWEDEN

Parent power has been tested in Eskilstuna during 2004. Swedish video-scenes were recorded in 2004.

INFORMATION, PRACTICAL EXPERIENCE AND EDUCATION/TRAINING

Information on the method is available on-line in Swedish [27] and on the American model in English [24]. For information on group-leader training and on practical experiences of the method, please visit the SNIPH Website [21].

Teenage COPE

Teenage COPE is a parent group programme based on a manual. Parents have to discuss different ways of behaving towards their children in a number of everyday situations. The discussions are based on short video-scenes recorded by actors. The parents have to discuss the advantages and disadvantages of different ways of handling children. Some of the ways of treating children, which have been discussed, are then tested in role-plays. The method also includes elements concerning tobacco, drugs and alcohol. The groups consist of up to 30 parents who meet over a period of 7–12 weeks per course, two hours at a time. The programme is based on a Canadian model which has been produced by Ted Ridley.

SCIENTIFIC STUDIES WITH CONTROL GROUPS

There are no controlled studies of the effects on teenage behaviour. The principle of the programme nonetheless resembles that used in programmes in which effects have been demonstrated.

USE OF THE METHOD IN SWEDEN

Teenage COPE has been tested among other places in Malmö since the year 2003. The method has been adapted to Swedish conditions.

INFORMATION, PRACTICAL EXPERIENCE AND EDUCATION/TRAINING

For information on group-leader training and on practical experiences of the method, please visit the SNIPH Website [21].

Open discussion groups

The inventory of Swedish parent support interventions performed in 2002 includes 12 interventions in the form of open group discussions offered to parents of teenagers. In 2 of these 12 interventions, parents are offered completely open discussion groups, i.e. the entire content of the programme is determined by the participants.

The intervention organised by Mölndal Municipality is an example of a completely open parent group, aimed at create a forum for parents who are worried about their teenager. The intervention came into existence as a response to the fact that a number of parents had contacted the social services because of their anxiety about their daughters' contacts with older alcohol-abusing and criminal boys. The Social Services provide a meeting place and invite the parents.

The other example is the groups which Gothenburg City Council arranges, aimed at immigrant parents, among other places in the district of Angered. This intervention came into existence since the social service for individuals and families found that support was needed by parents of teenagers with an immigrant background. Groups of 8–10 participants meet 10 times. The groups are composed according to the mother tongue of the participants. The meetings are introduced by a lecture. Sometimes interpreters are used.

A further example is provided by the family groups which the school psychologist Barbro Goldinger introduced at a school in Solna in the 1970s and which has since been followed by similar initiatives in other places in Sweden [28]. By family groups, also called "five groups", is meant that the children in a school class are divided into smaller groups, usually with five children, and that these groups are kept in being for a relatively long period. Membership of a fixed little group gives each child a secure place. The parents of the children in such a family group meet regularly in the home of one of the families.

IOGT has translated and circulated a Norwegian programme called *Stark och Klar* [Strong and Clear]. A Swedish controlled study of the programme will be ready by 2006. *Ung och Kung* [Young and King] is a programme for parents of teenagers and is widely distributed in Sweden. It has not however been assessed.

In 10 of the 12 interventions described in annex 2, parents are offered themed discussion groups. In a number of cases previously determined working material is used, in certain cases lectures were the starting-point for discussion and in other cases the activity was organised as study circles and the group themselves decided what material should be treated. The activity carried out in Upplands Väsby furnishes an example. It was begun in the year 2000/2001 with parent groups at one school (Odenslunda) and

has since continued at other schools in the municipality, in cooperation with two adult education associations, Vuxenskolan and ABF. At the schools which took part all parents were invited to study circles at the first parent-teacher meeting of the autumn in both preschools and schools. One of the participating parents in each group takes responsibility to be the circle-leader. During the first year at Odenslunda School circles were run in approximately half of the school's classes. The parents met on average six times during the school year. Material from *Växa tillsammans* [Grow together] has been used.

A further example is the *Family Circles* which were run at Viksjöskolan in Järfälla Municipality. The initiative for these circles came from the parents in the school's very active parents teachers association. The meetings' objective is to strengthen the contacts among parents and between parents and school staff. The groups meet three times a term for two terms, for two hours or more each time. Each meeting is usually introduced by an invited speaker. The circles conclude with a larger collective meeting, at which parents are given a certificate, the pupils appear on stage and the head-teacher gives a short speech. The parents pay SEK 100 to take part. The class teachers are circle leaders.

It is not unusual for the school nurse to take the initiative to start parent groups. Teachers, the school welfare officer and the school psychologist may also take such initiatives. When the activity is directed at particular groups of parents, for example parents not born in Sweden, it is more common for the social services to take the initiative to set it in motion.

The questionnaire described in Chapter 5 indicates that roughly ten per cent of all parents have participated in an open discussion group. This estimate is unreliable, however, since parents seem to find it difficult to interpret the description of various forms of group-based parent support.

Several different materials are used in themed discussion groups. A description of three widely spread materials is given below. They are designed so as to stimulate parents to discuss different aspects of parenting with each other. None of this material contains elements in which the parents are given support in practising different skills. It is therefore doubtful whether they can influence the children's welfare and health, see Chapter 7. Discussions about parenthood have nevertheless of course a value in themselves.

Människans barn – Tonåringar [Human children – Teenagers]
Skandia's *Idéer för livet* [Ideas for Life] project and SNIPH have published video-cassettes intended for groups of parents with children in different age-groups. They include a series of 3 video-cassettes on *Människans barn – Tonåringar* [Human children – Teenagers] [29]. Certain items in them treat the way in which parents experience various situations. In other parts, children relate how they see different events and phenomena. Each section contains interviews with one or more doctors, psychologists and other experts. There is a manual for each cassette comprising a summary of each film and suggestions for discussion questions.

Om barn [About children]
The Swedish educational broadcasting company, *Utbildningsradion* (UR) has produced a TV-series called *Om barn* [About children] [30]. UR writes that the purpose was to give parents of both sexes, not least young first-time parents, support and guidance on a large number of topics, ranging from decidedly practical questions such as cooking to various pedagogical alternatives. The programme series which UR has so far (July 2004) broadcasted have primarily dealt with parents and infants, but programmes about parents and teenagers are planned. Broadcasted programmes are available as theme cassettes for use in discussion groups.

Växa tillsammans [Grow together]
The adult education associations *Studiefrämjandet* and *Riksförbundet Hem och skola* have published four books in a series called *Växa tillsammans* [Grow together]. The books are intended as background material for discussions between parents and preschool/school staff [31, 32].

The purpose of the authors is to support the parents in their role as parents and to reinforce cooperation between parents and staff at preschool and school. The authors emphasise the value of parents' own experiences and their freedom to choose which texts to discuss. The discussion questions in the material are based on the theme broached in the text. For example, in the chapter *From child to teenager*, which deals with upbringing by parents, the question proposed is: "What should we do when we suspect that teenage 'illnesses' are not so very important?". There are also chapters on alcohol, tobacco and drugs.

Distribution of printed material

The Alcohol Committee has a prepared a publication for parents of teenagers, *Tonårsparlören* [The teenage dictionary], of which 240,000 copies have been sent out to parents of children who are beginning year 7 in the compulsory school. The teenage dictionary is a hard-back edition of 128 pages which includes tips on parents' possible attitudes to teenagers and alcohol. Examples from this section are "Fixed times?", "Invite home?", "Parent-free", "If the teenager comes home drunk" and "Punishment and consequences". Factual sections are included. The Alcohol Committee has also produced views on how the material can be used. A questionnaire shows that 57 per cent of parents who have received this hand-book have acquainted themselves with the tips presented and 45 per cent have discussed the content with their daughter/son [33]. The study of it is not however so designed as to clarify whether it has led to changes in behaviour.

Models for organising group parent support

They are different ways of organising support for children in these age-groups, irrespective of whether the method is structured or open. The initiative can come from the municipal council, primarily the social services, school and leisure activity. NGOs, in particular the adult education associations, can organise activity as can private companies, either for those employed in a company [34] or for parents in general. Interventions organised by schools and adult education associations, often in cooperation, probably predominate.

Schools have a duty to inform parents about activities at school, which is done through general parent-teacher meetings and one-on-one discussions on the development of individual children. Both these forms can be developed to give the parents support in the parent role. Parent-teacher meetings give particularly important opportunities, because the majority of parents come to them. One way is to allow these meetings to develop into open discussion groups where parents exchange experience on their role as parents. The teacher's role then changes from being a person who conveys information about the school to being instead one with the task of facilitating discussion among parents. The Alcohol Committee has produced material which supports teachers in a conducting such discussions [35]. A similar model is used, among other places, in schools in Kramfors. Schools in

Kramfors cooperate with the County Council's health planners who have produced the material which is used. A further way is to present components in communication programmes at these meetings. That is the case in the Örebro Prevention Programme which is described above.

It is, however, far from the rule that parent-teacher meetings develop in that way. An important reason is probably that parent support is not a task for schools according to the current Education Act. That means, inter alia, that in their basic training teachers do not normally acquire training in the methodology of running discussion groups for adults.

Level of interest among parents

In the questionnaire sent out to a representative selection of parents, see Chapter 5, 32 per cent of those with children in the age group 13–18 said that they were interested in taking part in a structured parent group and 27 per cent registered interest in unstructured interventions. This indicates a significantly high level of interest among parents.

Local experience of structured methods also suggests significant interest. In the experiment with Step by step an average of 47 per cent of parents were represented. The proportion of parents who took part varied appreciably from class to class with participation ranging from 28 to 70 per cent. The Örebro Prevention Programme was included as part of the routine parent-teacher meetings, with the result that a larger proportion of parents took part. At the meetings in school year 7, parent participation varied from class to class. The percentage of children who had at least one parent participating at these meetings ranged from 50 to 95 per cent.

Experience at the open discussion groups also indicates major interest. Family circles at Viksjöskolan in Järfälla comprise an example. Activity there reaches approximately half of all parents with children in school year 7.

Factors restricting participation do not then seem to include a lack of interest on the part of parents.

Sex of the parents, socioeconomic groups and country of birth

The questionnaire, see Chapter 5, indicates that interest in the majority of forms of parent support is greater among women than among men, and is

somewhat greater among the well-educated as compared with the less-educated. On the other hand, interest is not influenced by whether or not the parents are born within or outside the Nordic region. This pattern applies also for parents with children in the age group 10–15 years.

Costs

Communication programmes

The costs per child can be assessed in the same way as for interaction programmes, see Chapter 7. There are nevertheless differences in the methods, with the result that the costs are different for the two recommended methods *Step by step* and the *Örebro Prevention Programme*.

Step by step contains both a parent section and a child section. The child section is assumed to be carried out within the framework for the school's general tasks. The intervention for parents comprises 10 meetings, estimated to last 2 x 45 minutes. It is further assumed that *Step by step* is conducted at meetings for all parents in a whole class with 25 children represented at each meeting. The salary of the leader is calculated as for the interaction methods, including additional expenses for training, guidance, premises and material. The total cost for the intervention can thus be estimated at SEK 425 per child.

The costs for the *Örebro Prevention Programme* are significantly lower. The intervention is assumed to require 2 paid working hours per meeting and class, including preparation. It is assumed that the children of 25 parents are present. Additional expenses for premises and the training are calculated as above. The cost per child is then SEK 85.

Cost versus benefit

The effects of the communication programmes have primarily been studied as regards the consumption of alcohol and tobacco, up as well as in the form of breaches of standards. It is possible that the programmes also promote children's mental health in general. The effects can nevertheless be assumed to be less than when the interaction programme is carried out during the preschool years. The reason for this is primarily that earlier interventions generally produce greater effects. Thus the studies of

communication programmes which have been carried out give a basis chiefly for analysis of the effects on the consumption of alcohol and tobacco. These effects can be studied in relation to the costs.

According to studies of adolescents in year 9 by CAN (Swedish Council for Information on Alcohol and Other Drugs), 4 out of every 100 adolescents in that age-group consume alcohol corresponding to four cans of full-strength beer at least once a week [36]. The studies in progress suggest that communication programmes can reduce this proportion to 3 adolescents per 100. In order to achieve this effect requires interventions for 100 adolescents, an intervention which according to the above calculation costs between 100 x 85 = SEK 8,500 respectively 100 x 435 = SEK 43,500, for the two recommended methods. Since these interventions also have an effect on tobacco consumption, the calculations may overstate the costs in relation to the effects. On other hand, the effects at 15 years of age are shown in only two studies. It is possible that the intervention as regards routine consumption is less and that the costs in relation to effect have therefore been underestimated. The order of magnitude for the cost of preventing a case of high alcohol consumption at the age of 15 ought reasonably to lie in the region of SEK 20,000.

In Chapter 7 there is a reference to a pamphlet which deals with priorities affecting children's mental health [37]. We can see for example that the actual costs to society for a life as an addict amount to SEK 11.9 million assuming a discount rate of five per cent. That cost corresponds to the expenditure on communication methods for the parents of 60,000 children. The effects of communication programmes have not been studied for drug abuse. It is however well known that drug-abuse often begins with alcohol-abuse during adolescence. That means that the intervention with parent groups can be financially justified if parent support leads to the prevention of a single case of abuse among these 60,000 children. It is probable that the effects of communication programmes are significantly greater.

Costs of communication programmes provided via video/DVD

The costs of producing a Swedish version of a five-hour communication programme provided in the form of a video may be estimated at SEK 2 million. Costs for evaluation of about SEK 1 million are to be added to this. If the costs are spread over a production run of, say, 30,000 the costs per

user are SEK 100. Costs for copying and distribution of video cassettes/DVD of approximately SEK 100 per user are to be added to this. The costs are thus lower with this method of distribution as compared with arranging parent groups with employed personnel.

Does the intervention promote children's participation in society

Children participate in the communication programmes because they contain elements directed specifically at children and parts where parents and children participate together. Furthermore, an objective of the communication programmes is to support the development of good parent-child interaction. The children's opportunities to take part in future decisions which affect them can thereby be expected to be improved.

In programmes with open discussion groups the content varies. Children are normally not participants but it can happen that certain elements are conducted with parents and children together, in the same way as for communication programs.

Dissemination

As far as the structured methods of parent support are concerned, there are organisations that train group leaders, see above, and updated information leaflets available on the SNIPH website [21].

Discussion

Parent groups

Only small groups of parents, roughly speaking less than ten per cent, actually utilise the group parent support available during this age-group. A number of different models are used in Sweden but only communication programmes have demonstrated effects. Broad use of communication programmes therefore represents the foremost possibility for improving children's welfare and health during this age period. The effects of these programmes are documented and training of group leaders is available in Sweden.

Communication programmes

Several varieties of communication programmes are organised in Sweden. There are two recommended programmes: *Step by step* and the *Örebro Prevention Program*. It is also a probable that further programmes of this type will be available in Sweden in the years immediately ahead. However, these two programmes are currently (2004) estimated to have the best preconditions, based on assessment of the studies which have been made and the programmes' accessibility. These two programmes are of differing scope.

Both trials are aimed at preventing aggressive behaviour problems. That includes binge-drinking, violent behaviour and criminality. Binge-drinking is perceived therefore as part of an overall pattern of aggressive behaviour [38]. It is possible that the more extensive communication programme *Step by step* can also influence the prevalence of internalizing mental health problems, as is the case with the interaction programme. However, that type of effect has not been studied.

Steg för steg is more comprehensive and more complicated to carry out, since it includes interventions both for parents and for children. On the other hand, the documentation for the effect is significantly better because controlled trials have been carried out with demonstrated effect for several comparable programmes. The effects of the *Örebro Prevention Program* are of course documented in a Swedish controlled trial but it is the only controlled study of this reduced variant.

It is possible to distinguish a variant of *Step by step* which includes only the parent component. It is then possible to grade the three variants, with *Step by step* including a pupil component, as the variant which has the best documented effect, but also the variant which is most demanding to implement. The next grade is *Step by step* targeted solely on parents. The *Örebro Prevention Program* is the simplest variant, but it is also the least satisfactorily documented.

The communication programmes have been offered to all parents. The arguments brought up in Chapter 2 indicate that such measures are justified even if it is possible to carry out measures for a possible risk group alone at a lower cost. A broad distribution makes it necessary to train a large number of group leaders. Professional training as teachers, public-health experts, social workers and nurses may be appropriate for those persons who are to be responsible for leading parent groups.

A video/DVD version of communication programmes

Trials abroad suggest that parents can absorb the contents of interaction programmes solely by acquiring the material on TV/video, see Chapter 7. Successful experiments in distributing communication programmes in this way have not, however, been presented. There are certainly some reported experiments in which parents have had access to printed material, but these studies have not demonstrated the effects on children's behaviour.

The cost of distributing this method via video/DVD is lower than that of arranging groups. The financial saving from putting communication programmes out in this way, as compared with interaction programmes, is however smaller since communication programmes cost less to carry out. Taking these matters together, there are thus arguments for testing the distribution of communication programmes via video/DVD, but the arguments are weaker than for interaction programmes because fewer studies have been carried out and the financial saving is less.

Forms other than communication programmes

Parent support in groups in which the form is open appears to have an effect if the participants have a *common problem*, see Chapter 3. The majority of open discussion groups available for parents with children in these age groups are aimed at all parents. Such activities may be of value for those parents participating. But in the absence of controlled studies of such interventions it cannot be determined whether children's health and welfare are promoted by the participation of the parents. Neither is it possible on theoretical grounds to find clear arguments suggesting the situation of the children would improve. One component which is decisive for the effect of interaction programmes is probably the pedagogical method used. Communication programmes develop the parents' skills for dealing with the children through elements in which they practise suitable methods by means of role-playing. The material used in the open discussion groups does not suggest that such elements are included. The emphasis is there placed instead on the parents reflecting on different parts of their own parenting. That obviously has a value in itself, but there are no simple links between reflection of that kind and the parents' way of treating their children.

One objective with open discussion groups is to strengthen the contacts between parents with children in the same class or same school. One

thought is that parents should readily be able to make contact with one another if a given child begins to show problematic behaviour, without the child's parents being aware of it. That is particularly important during adolescence, when children begin, for example, to experiment with drinking alcohol together with their friends. The contacts between parents mean that social control is strengthened. It is possible that open parent groups can increase the parents' chances of making contact with one another in such situations. It is, however, also possible that contacts among parents at the ordinary class meetings at school are sufficient to achieve this objective.

Nor is it clear whether access to venues for meetings improves the parents' informal social network, see Chapter 6. Likewise it is unclear whether open parent groups, intended for parents with no common problem, influence the welfare of the parents.

Parent groups for parents born outside the Nordic region

The arguments for open parent groups aimed at parents born outside the Nordic region are the studies which show that if the participants have a common problem, they may obtain benefit from meeting in groups. It is also possible to find arguments against such activities, however. One reason is that parents in this group often say themselves that they want to participate in groups together with Swedish-born parents. This may have something to do with the participants' common "problem" being that they are not familiar with Swedish traditions. It is hence debatable whether offering them an activity in which Swedish-born parents do not participate is a good idea.

A number of the successful foreign trials with communication programmes have included ethnic minorities. That argues that the programmes are also appropriate for such groups. Furthermore, the parent questionnaire shows that the level of interest in structured programmes is about the same regardless of which the parents' country of birth. That argues that these programmes can also be made available to parents born outside the Nordic region. An interpreter is needed if the parents have an insufficient command of the Swedish language.

Individual contacts

The parent questionnaire shows that individual contacts with staff – working in schools and leisure activities are a source of support for a large number of parents. It seems this need is mostly satisfied by existing activities, however. Further measures are therefore not warranted.

Organisation

The municipality has been nominated as the main responsible party for parent support in this age-group. Parent support affects several different municipal administrations. It may therefore be appropriate for the municipality to appoint one person assigned the task of coordinating all parent support activities, including that proposed for other age groups. This person can have parent support as his/her main task. An alternative is that the coordinator for alcohol and drug-abuse prevention, who exists in many municipalities, should be given responsibility for the task. Another option is to give the task to local crime prevention officers or municipal public health planners.

The need for research

The effects of communication programmes indicate a potential for improving children's health and welfare. There are particular grounds for studying two questions.

In the foreign studies the effects have been followed up for only a few years at most after the intervention. There is reason to expect effects over a longer period. This question needs to be analysed longitudinally.

A precondition for the effect of communication programmes is that parents can develop their ability to provide a suitable combination of giving children affection and setting boundaries. There is however a lack of population-representative research into the skills of Swedish parents in this respect. There is also a lack of studies into the determinants of such skills. Further, if interaction programmes are introduced on a broad scale, improvement can be expected on the population level over time. This question too needs to be studied.

Proposal

The Swedish National Institute of Public Health (SNIPH) recommends that the municipalities should make broad provision to parents of communication programmes which in the first instance should begin to be available when the children are in year 5 of the compulsory school.

SNIPH recommends that the state should give financial support to NGOs, municipal councils, county councils and research institutes working on the dissemination of communication programmes.

Contributors

Sven Bremberg has the main responsibility for the text and Anton Lager has prepared the background material. Ingrid Olsson has performed basic literature searches and Lena Andersson Andalibi has compiled the Swedish experiences. Gunborg Brännström (Alcohol Committee) proof-read the text and made valuable comments.

References

1. Inhelder B, Piaget J. The growth of logical thinking from childhood to adolescence. New York: Basic Books; 1958.
2. Families That Care – Guiding Good Choices: Sample Lesson. Channing Bete Company, Inc. URL: http://www.channing-bete.com/positiveyouth/pages/FTC/FTC_GGC_popups/501182A_FTC_ses1. pdf.
3. Spoth R, Redmond C, Haggerty K, Ward T. A controlled parenting skills outcome study examining individual difference and attendance effects. Journal of Marriage & the Family 1995;57(2):449-64.
4. Kosterman R, Hawkins JD, Haggerty KP, Spoth R, Redmond C. Preparing for the drug free years: Session-specific effects of a universal parent-training intervention with rural families. J Drug Educ 2001;31(1):47-68.

5. Spoth RL, Redmond C, Shin C. Randomized trial of brief family interventions for general populations: Adolescent substance use outcomes 4 years following baseline. J Consult Clin Psychol 2001;69(4):627-42.

6. Redmond C, Spoth R, Shin C, Lepper HS. Modeling long-term parent outcomes of two universal family-focused preventive interventions: One-year follow-up results. J Consult Clin Psychol 1999;67(6):975-84.

7. Spoth RL, Redmond C, Shin C. Reducing adolescents' aggressive and hostile behaviors: Randomized trial effects of a brief family intervention 4 years past baseline. Arch Pediatr Adolesc Med 2000;154(12):1248-57.

8. Eddy JM, Reid JB, Fetrow RA. An elementary school-based prevention program targeting modifiable antecedents of youth delinquency and violence: Linking the Interests of Families and Teachers (LIFT). In: Walker HM. Epstein MH, ed. (2001) Making schools safer and violence free: Critical issues, solutions, and recommended practices. Austin, TX, US: PRO-ED, Inc; 2000, p. 128-39.

9. Reiter GF, Kilmann PR. Mothers as family change agents. Journal of Counselling Psychology 1975;22(1):61-5.

10. Omizo MM, Omizo SA. Effects of parental divorce group participation on childrearing attitudes and children's self-concept. Journal of Humanistic Education and Development 1987;25(4):171-9.

11. Johnson CA, Pentz MA, Weber MD, Dwyer JH, Baer N, MacKinnon DP, et al. Relative effectiveness of comprehensive community programming for drug abuse prevention with high-risk and low-risk adolescents. J Consult Clin Psychol 1990;58(4):447-56.

12. Hawkins JD, Von Cleve E, Catalano RF, Jr. Reducing early childhood aggression: Results of a primary prevention program. J Am Acad Child Adolesc Psychiatry 1991;30(2):208-17.

13. Rollin SA, Rubin R, Hardy-Blake B, Allen P. Project K. I. C. K. , a school-based drug education research project: Peers, parents and kids. Journal of Alcohol and Drug Education 1994;39(3):75-86.

14. Dishion TJ, Kavanagh K. A multilevel approach to family-centered prevention in schools: Process and outcome. Addict Behav 2000;25(6):899-911.

15. Litrownik AJ, Elder JP, Campbell NR, Ayala GX, Slymen DJ, Parra-Medina D, et al. Evaluation of a tobacco and alcohol use prevention program for Hispanic migrant adolescents: promoting the protective factor of parent-child communication. Prev Med 2000;31(2 Pt 1): 124-33.

16. Bauman KE, Ennett ST, Foshee VA, Pemberton M, King TS, Koch GG. Influence of a family program on adolescent smoking and drinking prevalence. Prev Sci 2002;3(1):35-42.

17. Murray NG, Kelder SH, Parcel GS, Frankowski R, Orpinas P. Padres Trabajando por la Paz: A randomized trial of a parent education intervention to prevent violence among middle school children. Health Educ Res 1999;14(3):421-6.

18. Blake SM, Simkin L, Ledsky R, Perkins C, Calabrese JM. Effects of a parent-child communications intervention on young adolescents' risk for early onset of sexual intercourse. Fam Plann Perspect 2001;33(2): 52-61.

19. Zimmerman TS, Jacobsen RB, MacIntyre M, Watson C. Solution-focused parenting groups: An empirical study. Journal of Systematic Therapies 1996;15(4):12-25.

20. Lefkowitz ES, Sigman M, Au TK. Helping mothers discuss sexuality and AIDS with adolescents. Child Dev 2000;71(5):1383-94.

21. Statens folkhälsoinstitut. URL: http://www.fhi.se.

22. Kumpfer K-L, Molgaard V, Spoth R. The Strengthening Families Program for the prevention of delinquency and drug use. In: Peters RD, McMahon RJ, Eds. Preventing childhood disorders, substance abuse, and delinquency. Banff international behavioral science series, Vol. 3; 1996, p. 241-67.

23. Stad projektet. *Steg för Steg* [Step by step]. URL: http://www.stad.org/.

24. Iowa State University. Strengthening Families Program For Parents and Youth 10–14. URL: http://www.extension.iastate.edu/sfp/.

25. Mobilisering mot narkotika. *Information om alkohol och narkotika på föräldramöten*. URL: http://www.mobilisera.nu.

26. Active Parenting. URL: http://www.activeparenting.se/.

27. Eskilstuna kommun. *Föräldrakraft*. URL: http://www.eskilstuna.se/templates/Page____18717.aspx.

28. Goldinger B. *Familjegrupper i skolan: Skolklassen som mötesplats för barn, föräldrar och lärare*. 1:a uppl. Stockholm: Wahlström & Widstrand; 1984.

29. Skandia. *Idéer för livet. Människans Barn Tonåringar: Handledning och tre videokassetter*. URL: http://www.skandia.se/ideer/material/bestall. jsp.

30. Utbildningsradion. *Om barn*. URL: http://www.ur.se/ombarn.

31. Lund K. *Växa tillsammans: Årskurs 4–6*. 1 uppl. Stockholm: Liber utbildning; 1996.

32. Lund K, Nilsson N-E. *Växa tillsammans: Årskurs 7–9*. 4:e uppl. Stockholm: Liber utbildning; 1998.

33. USK Stockholms stad. *En effektmätning av Alkoholkommittens information till föräldrar med barn i årskurs 7*. Stockholm: Utrednings- och statistikkontoret; 2003.

34. Mentor. URL: http://www.mentorsverige.org/.

35. *Samtal om alkohol i skolan. Ett material för högstadielärare*. Stockholm: Alkoholkommittén; 2004.

36. Hvitfeldt T. *Skolelevers drogvanor 2002. Sammanfattande kommentarer och tabeller. Resultat från riksundersökningen i årskurs 9*. Centralförbundet för alkohol- och narkotikaupplysning. URL: http://www.can.se/.

37. *Tänk långsiktigt! En samhällsekonomisk modell för prioriteringar som påverkar barns psykiska hälsa*. Skolverket, Socialstyrelsen, Statens folkhälsoinstitut;2004.

38. Farrington D. The challenge of teenage antisocial behavior. In: Rutter M, Ed. Psychosocial Disturbances in Young People. Cambridge University Press; 1995:83.

9.

FROM PARTNERSHIP TO PARENTING

9.

FROM PARTNERSHIP TO PARENTING

"So that's how it went. I have no feelings left for him, more than for a loved older brother. I don't feel in the least sexually attracted to him and we have only had sex about five times in two-and-a-half years. And the last time but one resulted in our 11 months-old boy… All our attempts to find one another again are interrupted by the children who wake up every few minutes." That is what a mother of three writes on a Swedish website for parents [1].

The quality of a couple's relationship often falls off after the birth of the first child and 10 per cent of relationships do not survive the child's first birthday. Children in turn suffer if their parents feel dissatisfaction in their relationship and are quarrelling. It is therefore important to try to reduce the risk of such conflicts. There are promising methods in this field which have begun to be used in Sweden. One such method is *PREP* (Preparation and Relationship Enhancement Program), in which couples have to practise communication and conflict management. Positive effects have been shown up to five years after the training. It would be possible to offer this course during pregnancy, for example within the maternity healthcare services.

From partnership to parenting

When a child is born both fathers and mothers often experience strong positive feelings for each other. At the same time, the parents can be grappling with conflicting feelings of being left out and having lost control over their own lives [2]. Many new mothers experience pronounced mood swings and some become dejected. Eight to 15 per cent of all women are afflicted by post-natal depression [3]. Men too are affected by similar problems [4].

During the first year of the life of a child, conflicts between the partners become more common, the quality of their relationship often deteriorates and their satisfaction in the sexual relationship diminishes [5–8]. Women experience a negative change especially during the first six months after the child's birth, while men particularly experience the deterioration during the year that follows [5, 9]. Even if deterioration appears to be most common, 20–30 per cent of couples experience an improvement in their relationship after the birth of the child [6, 8].

The majority of couples are unprepared for the changes which parenthood means for their relationship [5]. Their expectations and values acquire a key role and can lead to difficult schisms if the couple have not previously reflected on them.

The child's birth therefore often brings a shift towards traditional sexual roles, even when the couple have previously had different views [10]. That increases the risk of conflicts about the division of labour in the family. The risks diminish if the man takes part in the everyday business of caring for the child [5, 11]. When the child is 18 months old both the men's and women's experience of stress in the parental role diminishes as does the prevalence of depression if the father gets involved in the daily routines [5].

The parents' relationship and the child's health and well-being

The way in which parents manage the transition from partnership to parenthood affects their style as parents. Parents with fewer marital conflicts after the birth of the child have a better ability to reinforce their children's independence as well as managing to give the children clear frame-works for behaviour [12]. On the other hand, if conflicts in the family are common, the children appear to have greater difficulties in coping with changes, for example on the transition from preschool to school [12]. The child can also have difficulty in establishing good social relationships with other children and with adults [13]. In a number of studies the link has been shown between the parents' perception of the quality of their relationship as a couple during the child's first year of life and the risk of internalizing and extrovert mental health problems later as the children grow up [14–18].

The father's involvement with a child is important for the child's social development and mental well-being [19]. The father's involvement with the child is in turn dependent on the quality of his relationship with his partner.

The more content the man is with his marriage, the more he devotes himself to the children, the more content he is as a parent and the more competent he feels himself to be as a parent [9, 20–23]. The contrary applies also. The more conflicts, the less affection and closeness the father gives the child, and the more he seeks to control [24]. In families in which the mother found that the father had a poor capacity for communicating, the children later were shown to develop worse social skills [13].

Separations

In 2002 over a quarter of all children and youth born in Sweden were not living with both their biological parents [25]. Up until around 1980 the proportion of couples in Sweden who separate increased, but thereafter the increase appears to have halted [26]. The risk of separation is greatest during the first year of the child's life, when 7–10 per cent separate before thereafter dwindling to an average annual frequency of 3–4 per cent. [27]. The risk of separating is greatest for relatively newly-established cohabiting couples in which the mother is younger than 24 and the man has a low income. Of these couples, 19 per cent separate during the child's first year [27]. Well-educated parents separate half as often as couples who have, at most, secondary school education. The lowest risk of separation is to be found among adoptive parents [26].

It is common that children react negatively to divorce, for example with behaviour problems, impaired attention or depression [28, 29]. Gradually, however, many of these reactions disappear. About two years after a divorce both children and parents usually seem to have recovered. The decisive question is therefore whether divorce leads to long-term damage.

The evidence of a range of American literature is that children of separated parents often achieve worse results in their education, have a worse self-image, worse social relations and more behaviour problems [30, 31]. Many of these studies have, however, left out of account the social circumstances of the families. In a family with less favourable social conditions, the children more frequently have problems and divorce is often more common. The long-term effects of a divorce may therefore incorrectly have been ascribed to divorce instead of to the social conditions of life or the domestic conflicts which led to divorce [32].

A Swedish study has shown clear links between the occurrence of conflicts in the home during childhood and sickness and mortality in adult years [33]. It is probable that the long-term negative effects of divorce are caused in the first instance by conflicts in the home and not by the divorce as such [34]. A study from New Zealand supports that perception. It found a 70 per cent increase in behaviour problems among boys in the preschool age who had experienced a divorce with prolonged conflicts between the parents [35]. Children who had experienced a divorce without such conflicts showed no increase in behaviour problems. There are also Swedish studies which show similar results [36].

Preventive interventions

It is thus desirable to try to prevent conflicts between parents. Several studies show that this is possible [37]. One such research-study has been carried out by Philip and Caroline Cowan who arranged for couples to meet in groups, in order to discuss their expectations and apprehensions during the mother's pregnancy [38]. These couples could take up important questions about values and expectations. The parents could also support one another after the birth of the child, because the groups continued to meet. It transpired that separations were less common among the couples who had taken part in the groups, as compared with a control group.

In many cultures it has long been the case that couples who are about to marry are given advice and rules on attitudes to marriage from a religious leader. In Hungary, for example, a couple wishing to marry in the Catholic Church must undergo "education for the engaged", in which the couple discuss their expectations and the ethics of marriage with the clergyman who is to marry them. In the USA, Australia and the UK, 25–30 per cent of all couples who are about to marry go through some prior form of preventive relationship-education.

In the USA, interest in relationship education has increased in recent decades. An important reason is that divorces have become more common. The majority of programmes are carried out in group form and their objective is to give the couple increased skills in maintaining a good relationship. Certain programmes emphasise conflict management and others the development of empathy. A number of programmes put the stress on developing the couple's capacity for positive communication.

The effect of preventive interventions

In a review published in 2003 the effects of various models of preventive relationship-education was analysed [39]. In all 12 studies were found carried out with control and experimental groups and with follow-up periods of least six months. Four programmes demonstrated positive short-term effects in the form of better capacity for communication. These programmes were Relationship Enhancement, Couples Communication [40], Minnesota Couples Communication Program [39] and Prevention and Relationship Enhancement Program (PREP). The effects after 12 months have been studied only in regard to PREP and the presentation in this report is therefore limited to that programme.

The Prevention and Relationship Enhancement Program (PREP)
PREP is a manually-based group programme developed for couples who have no serious problems. The objective is to prevent future problems in the couples' relationship [41]. The programme comprises a total of 10–15 hours and is carried out either in the evenings, spread over five–six weeks, or over a weekend. The most important objectives of the programme are 1) to improve communication and to practise constructive ways of handling conflicts, 2) to clarify the expectations and basic principles for marital relationships, 3) to preserve and develop the sense of fun, friendship and spiritual qualities in the relationship, 4) to help the couple to work out a common rulebook for the handling of conflicts and 5) to provide tools for increasing and maintaining their commitment to one another. The original American programme was developed by Howard Markman, Susan Blumberg and Scott Stanley.

Participants can discuss questions and also have the opportunity to develop various skills in practice. One example of a practical element is when the couples are trained in *active listening* in accordance with strict rules. The exercises are always conducted by actual couples, while certain discussions take place in the whole group. The leaders can also use role-playing or storytelling in order to illustrate behaviour or to show a pattern. They can, for example, show how to recognise important danger signs which threaten a relationship – escalation, depreciation, negative interpretations and withdrawal. Couples are given an exercise book and also homework. One example of homework is to discuss the four danger signs.

There are four scientific studies of PREP in which those who have declared their readiness to participate have been divided into comparable trial and control groups, see Table 9.1. One study has been carried out in Germany, one in Australia and two in the USA [42–45]. In three of the studies the couples have been followed for 1–5 years after the intervention while the effects in one study have been analysed on only one occasion shortly thereafter. In all four studies, a more beneficial pattern of communication is demonstrated in the group participating in the intervention, either in the entire group or just among men or a high-risk group. Three of the studies also show an effect in the form of a greater sense of satisfaction in the relationship. One of the studies, however, shows a deterioration in the relationship in a low-risk group. Statistically reliable effects on separation are indicated among unmarried parents in one study. The number of participants in the studies is, however, so limited that is difficult to establish statistically reliable effects on the incidence of separations.

Author, year, country	Markman, 1993 [42], USA
Study population, recruitment, number and median values	*Recruitment*: Couples recruited via articles and advertisements. They were paid USD 25 for each reading taken. *Number*: total 134 invited, 43 declined, 41 in trial-group, of whom 32 complete the programme, 50 in control group. Method of allocation to groups not apparent. *Average age*: 24 years. *Relation*: duration 2.5 years, 39% co-habiting, 60% engaged. *Length of education*: 5 years after start 15.8 years. No difference between trial and control groups.
Non-response	*After 3 years:* No data *After 4 years:* information from 17/32 in trial group, 26/50 in control group. *After 5 years:* information from 20/32 in trial group, 32/50 in control group.
Intervention	*Trial group:* PREP 15 hours, 3–5 couples per group. *Control group:* no intervention.
Effect: trial group compared with control group – only statistically robust differences	*After 3 years:* less negative communication. Only among unmarried: fewer separations. *After 4 years:* better communication skills and more positive communication. *After 5 years:* Less violence. Men only: better communication skills, more positive communication, increased satisfaction with the relationship.

Author, year, country	Kaiser, 1998 [43], Tyskland
Study population, recruitment, number and median values	*Recruitment:* Couples recruited via advertisements. *Number:* total 88 invited, 21 declined, 31 in trial-group, 36 in control group. Random allocation to trial group and control group. *Average age:* 39 years. *Relation:* duration 10. 9 years, 79% married, 21% co-habiting, 75% have children, 20% previously divorced. Dissatisfied with relationship: 70%, according to DAS [46]. *Length of education:* 60% at least upper secondary education.
Non-response	*After 4 months:* information from 67/67 *After 1 years:* information from 48/67
Intervention	*Trial group:* EPL II based on PREP, 4 couples per group. *Control group:* offered EPL II after one year
Effect: trial group compared with control group – only statistically robust differences	*After 4 months:* fewer relationship problems and more positive verbal and non-verbal communication. *After 1 years:* fewer relationship problems.

Author, year, country	Halford, 2001 [44], Australien
Study population, recruitment, number and median values	*Recruitment:* Couples recruited via articles and advertisements. *Number:* total 79 invited who participate, 42 in trial group, of whom 37 complete, 37 in control group, of whom 32 complete. Random allocation to trial group and control group. *Average age:* 31 years. *Relation:* duration 27 months, 59% co-habiting, 28% previously divorced, 24% children from previous relation; relation. Relationship quality according to DAS [46] 117 in trial group, 115 in control group. *Length of education:* 14 years education. No difference between trial and control group.
Non-response	*After 1 years:* information from 61/67 *After 4 years:* information from 56/67
Intervention	*Trial group:* Self-PREP, which emphasises self-regulation, i.e. the couple assess, develop and feed back information about behaviour, 15 hours, 3-5 couples per group. *Control group:* intervention in group with information, course-book and discussions but without skill-training
Effect: trial group compared with control group – only statistically robust differences	Separate analysis in a high risk group (separated parents and violence in original family) and a low risk group without these characteristics *After 1 years:* high risk group less negative communication. *After 4 years:* high risk group better quality of relationship, low risk group worse quality of relationship.

Author, year, country	Stanley, 2001 [45] USA
Study population, recruitment, number and median values	*Recruitment:* Couples about to marry in church in 45 parishes invited by clergyman to participate. *Number:* total 138 invited who participate, 106 in trial group, 32 i control group. Random allocation to trial group and control group. *Average age:* 26 years. *Relation:* duration 3 years, 88% engaged. Relationship quality according to DAS [46] 124 in trial group, 125 in control group.
Non-response	Not reported
Intervention	*Trial group:* PREP. *Control group:* naturally arising conversations with religious leader 1–4 hours per couple, 19 per cent including skill training.
Effect: trial group compared with control group – only statistically robust differences	Directly after intervention: more positive communication, less negative communication, better problem-solving capacity.

Table 9.1 Controlled studies of PREP.

These studies show promising results, but the studies also have limitations. About half the couples who are offered PREP refuse to participate. That means that there is a systematic difference between those couples who participate and are then assessed and those who have declined. Earlier studies of PREP have shown that while couples who decline to participate may have the same social background and equally good communication skills as the intervention group at the start of the study, they more frequently than the participating group separate before they have even had time to marry [42]. The men in the non-participating couples also declared a lower quality of marriage and less affection [42]. In one of the studies the drop out rate was significant, which makes the result unreliable [42].

Those participating usually had a middle-class background and were quite often religiously engaged. That means that the results cannot quite simply be transferred to broad groups in Sweden.

The situation in Sweden

There is in Sweden no church tradition of discussion or courses preparatory to marriage. Since 1999 however the Swedish Church has begun to test the use of PREP [47]. The choice of method is based on scientific documentation and good experience of the method at *Samlivssentret Modum Bad* [Marital Life Centre at Modum Bad] in Norway. As of the autumn of 2004 about 200 group leaders have been trained under the auspices of the Swedish Church. The group leaders are generally lay-workers, clergy, psychologists or teachers. Material has been produced in Swedish. Experience is very positive.

In Mora, family-counsellors give PREP, in Sweden called *Verktyg för varaktig kärlek* [Tools for Lasting Love] [48]. Experience there is that most couples complete the training. Men in particular have valued its concrete and structured arrangement. The emphasis on communication particularly appeals to women. Experimentally, the family welfare centre in Mora (combined maternity and child healthcare clinic) will offer PREP to all enrolled couples during the autumn of 2004.

Therapy for couples

Couples who have relationship problems are in the first instance offered family-counselling in the municipality. The Swedish Church arranges family-counselling in certain parishes. In Sweden there are about 300 municipal and about 100 church family-counsellors. Private marital-therapists exist in the major towns but the costs of treatment exclude many people. Family-counselling treatment methods are based on systemic, psychodynamic, cognitive, family-therapy, sexological and pedagogical theories and methods. It is common for there to be 1–5 discussions for each couple.

Controlled studies of marital-therapy commonly show favourable effects [40, 49]. Behaviour-oriented therapy is best documented, followed by cognitive therapy and insight-oriented marital-therapy. No one method can clearly be shown to be more effective than the others. In a majority of studies the couples have not been followed up for longer than 6–9 months after the end of the intervention, which makes it difficult to decide whether the treatment has long-term effects.

Level of interest among parents

The parent questionnaire presented in Chapter 5 contains no questions about relationship education. Swedish experience nevertheless shows an interest in this type of intervention. It is possible that the interest is particularly great in groups which come from countries where relationship education is common.

Costs

The cost of PREP can be estimated at SEK 1,600 per couple. The estimate is based on the calculations for the interaction programmes presented in Chapter 7. PREP consists of only about half as many as course hours as are needed for the interaction programmes, which ought to reduce the costs by half. Against that, both parents take part, which requires more leaders and therefore doubles the cost. The outcome is thus comparable.

Discussion

The occurrence of conflicts in families is a well-documented risk factor for poor health during childhood and for sickness and mortality later in life [32]. Preventive relationship education therefore appears likely to be able to reduce the occurrence of such conflicts, which can thereby be expected to be favourable to the welfare and health of children. The method that has begun to be used in Sweden, PREP, is that for which the effect is best documented. It has begun to be tested within the maternity healthcare services.

The statistical reliability of the studies which have been carried out is, nevertheless, only moderate because there are a number of shortcomings in them. Furthermore, while PREP appears to be appropriate for couples from the middle class, it is less certain how well this method is suited to socially less-advantaged couples. Against that background it appears justified to carry out a Swedish randomised and controlled study of the effects of PREP. The effects which should be studied in the first instance are parent-parent interaction and parent-child interaction. At the same time as this

study is carried out it is appropriate to conduct practical trials of the method within the framework which is best suited for broad dissemination, which appears to be the maternity healthcare services.

Proposal

The Swedish National Institute for Public Health (SNIPH) recommends that the maternity healthcare services should make trial use of PREP.

SNIPH recommends that the state should support research into preventive relationship education.

Contributors

Anna Sarkadi is the principal author. Sven Bremberg has designed the guidelines and processed the text.

References

1. *Allt för föräldrar.* URL: http://www.alltforforaldrar. se.
2. Nyström K, Öhrling K. Parenthood experiences during the child's first year: Literature review. J Adv Nurs 2004;46(3):319-30.
3. Wickberg B, Hwang P. *Post partum depression – nedstämndhet och depression i samband med barnafödande.* Stockholm: Statens folkhälsoinstitut; 2003.
4. Ballard C, Davies R. Postnatal depression in fathers. International Review of Psychiatry 1996;8:65-71.
5. Cowan C, Cowan P. What's happening to us? In: When partners become parents. The big life change for couples. Mahwah, NJ: Lawrence Erlbaum Associates, Publishers; 1992:91-113.

6. Belsky J, Rovine M. Patterns of marital change across the transition to parenthood. J Marriage Fam 1990;52:109-23.

7. Belsky J, Spanier G, Rovine M. Stability and change in marriage across the transition to parenthood. J Marriage Fam 1983;45:567-77.

8. Shapiro A, Gottman J, Carrère S. Tha baby and the marriage: Identifying factors that buffer against decline in marital satisfaction after the first baby arrives. J Fam Psychol 2000;14(1):59-70.

9. Belsky J, Pensky E. Marital change across the transition to parenthood. Marriage Family Rev 1988;12:133-56.

10. Holmberg C. *Det kallas kärlek. En socialpsykologisk studie om kvinnors underordning och mäns överordning bland unga jämställda par.* Göteborg: Anamma; 1993.

11. Cowan C, Cowan P. Who does what when partners become parents: Implications for men, women, and marriage. Marriage Family Rev 1988;13:105-32.

12. Cowan C, Cowan P. Parenting our children. In: When partners become parents. The big life change for couples. Mahwah, NJ: Lawrence Erlbaum Associates, Publishers; 1992.

13. Howes P, Markman H. Marital quality and child functioning: A longitudinal investigation. Child Development 1989;60:1044-51.

14. Hay D, Sharp D, Pawlby S, Schmücker G, Mills A, Allen H, et al. Parents' judgements about young children's problems: Why mothers and fathers might disagree yet still predict later outcomes. J Child Psychiatr 1999;40(8):1249-58.

15. Benzies KM, Harrison MJ, Magill-Evans J. Parenting Stress, Marital Quality, and Child Behavior Problems at Age 7 Years. Public Health Nurs 2004;21(2):111-21.

16. Soliday E, McCluskey-Fawcett K, O'Brien M. Postpartum affect and depressive symptoms in mothers and fathers. Am J Orthopsych 1999;69(1):30-8.

17. Matthey S, Barnett B, Ungerer J, Waters B. Paternal and maternal depressed mood during the transition to parenthood. J Affect Disord 2000;60(2):75-85.

18. Carro M, Grant K, Gotlib I, Compas B. Postpartum depression and child: An investigation of mothers and fathers as sources of risk and resilience. Development and Psychopathology 1993;5:567-79.

19. Sarkadi A, Kristiansson R, Bremberg S. *Fäders betydelse för barns hälsa och utveckling. En systematisk översikt av longitudinella studier.* Stockholm: Statens folkhälsoinstitut; 2004.

20. Kalmijn M. Father involvement in childrearing and the perceived stability of marriage. J Marriage Fam 1999;61(May):409-21.

21. Dickie J. Interrelationships within the mother-father-infant triad. In: Berman P, Pedersen F, Eds. Men's transitions to parenthood. Longitudinal studies of early family experience. Hillsdale, NJ: Lawrence Erlbaum Publishers; 1987.

22. Nugent K. Cultural and Psychological Influences on the Father's Role in Infant Development. J Marriage Fam 1991;53(2):475-85.

23. Harris K, Furstenberg F, Marmer J. Paternal involvement with adolescents in intact families: The influence of fathers over the life course. Demography 1998;35(2):201-16.

24. Coiro M, Emery R. Do marriage problems affect fathering more than mothering? A qualitative and qualitative review. Clin Child Fam Psychol Rev 1998;1(1):23-38.

25. Levnadsförhållanden. *Barn och deras familjer 2002*. Demografiska rapporter 2003:7. Stockholm: Statistiska centralbyrån; 2003.

26. *Barn och deras familjer 2002*. Stockholm: Statistiska centralbyrån; 2004.

27. Landgren Möller E. *Att hålla ihop när barnen kommer.* Välfärds-Bulletinen 1999(2):19-21.

28. Hetherington E, Stanley HM. Parenting in divorced and remarried families. In: Bornstein I, Ed. Handbook of parenting. Status and social conditions of parenting, vol 3. Mahvah, NJ: Lawrence Erlbaum Associates; 1995.

29. Cederblad M. Fifty years of epidemiologic studies in child and adolescent psychiatry in Sweden. Nord Psychiatry 1996;50(Suppl 36):55-66.

30. Amato P, Keith B. Parental divorce and the well-being of their children: A meta-analysis. Psychological Bulletin 1991;110:26-46.

31. Amato P. Children of divorce in the 1990s: An update of the Amato and Keith (1991) meta-analysis. Journal of FamilyPsychology 2001;15(3):355-370.

32. Troxel WM, Matthews KA. What are the costs of marital conflict and dissolution to children's physical health? Clin Child Fam Psychol Rev 2004;7(1):29-57.

33. Lundberg O. The impact of childhood living conditions on illness and mortality in adulthood. Soc Sci Med 1993;36:1047-52.

34. Schaffer H. Social Development: An Introduction. Oxford: Blackwell; 1996.

35. Fergusson DM, Horwood LJ, Lynskey MT. Family change, parental discord and early offending. J Child Psychol Psychiatry 1992;33(6): 1059-75.

36. Schaffer HR, Nilsson B. *Beslut om barn: Psykologiska frågor och svar.* Lund: Studentlitteratur; 1995.

37. Dalgas-Pelish P. The impact of the first child on marital happinness. J Adv Nurs 1993;18:437-41.

38. Cowan C, Cowan P. Interventions to ease the transition to parenthood: Why they are needed and what they can do. Fam Relations 1995;44:412-23.

39. Halford W, Markman H, Kline G, Stanley S. Best practice in couple relationship education. J Marital Fam Ther 2003;29(3):385-406.

40. Christensen A, Heavey C. Interventions for couples. Ann Rev Psychol 1999;50:165-90.

41. Freedman C, Low S, Markman H, Stanley S. Equipping couples with the tools to cope with predictable and unpredictable crisis events: The PREP program. Int J Emergency Mental Health 2002;4(1):49-55.

42. Markman H, Renick M, Floyd F, Stanley S, Clements M. Preventing marital distress through communication and conflict management training: A 4- and 5-year follow-up. J Consult Clin Psychol 1993;61 (1):70-77.

43. Kaiser A, Hahlweg K, Fehm-Wolfsdorf, Groth T. The efficacy of a compact psychoeducational group training program for married couples. J Consult Clin Psychol 1998;66(5):753-60.

44. Halford W, Sanders M, Behrens B. Can skills training prevent relationship problems in at-risk couples? J Fam Psychol 2001;21:750-68.

45. Stanley S, Markman H, Prado L, Olmos-Gallo A, Tonelli. L, St. Peters M, et al. Community-based premarital prevention: Clergy and lay leaders on the front lines. Fam Relations 2001;50:67-76.

46. Spanier G. Measuring dyadic adjustment. New scales for assessing the quality of marriage and similar dyads. J Marriage Family 1976;38:15-28.

47. Ersta diakonisällskap. *Svenska kyrkans centrum för familjerådgivning, arbetshandledning, personalsjälavård och familjerelationsfrågor.* URL: http://www. ersta. se/kyrka_diakoni/sv_kyrkans_centrum/prep.htm.

48. Mora kommun. *Kurs för par som vill utveckla sin relation.* URL: http://www.mora.se/ArticlePages/200303/04/20030304142016 _UK929/20030304142016_UK929. dbp. html.

49. Lundblad A-M, Hansson K. *Familjebehandling på goda grunder.* Stockholm: Centrum för utvärdering av socialt arbete (CUS) och Förlagshuset Gothia; 2003.

10.

TELEPHONE COUNSELLING

10.

TELEPHONE COUNSELLING

In the parent questionnaire discussed in Chapter 5 parents were asked to answer questions about their interest in receiving support by telephone: "… questions you have as a parent. You can ask about anything at all which is of concern to you, for example how to handle conflicts and to establish good contact with children. "A strikingly large number (41 per cent) registered interest in that form of support. That is four times as many as those who say that they have at some stage sought advice by telephone (9 per cent). The difference between expressed interest and actual experience is greater in regard to telephone support than it is for most other forms of parent support. One reason for this interest may be that support by telephone is readily accessible, while another may be that the caller can remain anonymous. The interest in this form of support justifies separate analysis of it.

Effect

Chapter 3 discussed the effects of individual open counselling. Counselling can convey information, provide access to resources, offer emotional support and enable the person making contact to evaluate his or her own situation. The effects of counselling on people who have some form of problem have been studied experimentally. In 7 out of 8 controlled studies the mental or social situation is improved by counselling. In one experiment, however, deterioration in the health of the study group was reported. Corresponding controlled studies of telephone counselling have not been reported. It is, however, probable that telephone counselling also gives positive effects.

A study of automatic telephone counselling with recorded messages providing advice for parents on child medical problems has been reported [1]. It shows that parents were very satisfied with this service. The trial did not study the health of the parents or the children.

The situation in Sweden

In Sweden there are extensive telephone counselling systems that are used by parents. The most developed of them is counselling on medical questions. It is offered by the general healthcare hotline (telephone information service) and by individual units in the field of child healthcare, other primary care and specialist care for both hospital and non-hospital patients. Telephone counselling is often offered as an alternative to healthcare clinic visits. However, it is relatively infrequent for support to be given through these telephone services in relation to the type of problems referred to in the questionnaire.

Telephone contacts are also common in the social services and family counselling services. Here the problems may be closer to those referred to in the parent questionnaire. In general, however, telephone support in these organisations relates primarily to aspects of the booking system, as is the case in healthcare.

Parents can make contact by telephone with preschool teachers and school teachers on questions of the kind referred to in the questionnaire. Ordinarily parents make contact with the teachers responsible for their child(ren). These contacts can therefore not be expected to meet the need for telephone counselling.

At the national level there are three organisations which offer telephone support specifically for parents, on a national basis – BRIS [Children's Rights in Society], Save the Children and the Swedish Association for Mental Health. Other national helplines can also meet some of the needs of parents.

Health and medical care

Healthcare hotline

In most counties there are nowadays healthcare hotlines that anyone may telephone. Fyrbodal is a representative example. Advice is available on a 24-hour basis, and service is provided to a population of 270,000. In 2003, the hotline dealt with approximately 100,000 calls. This service is run by nurses and is equivalent to 14.5 working years. About 50 per cent of all questions put are concerned with children, primarily children in the age-range from 0–3 years, and primarily about infections. Children in the ages

0–17 comprise about 20 per cent of the population. On this basis, the parents in Fyrbodal have contacts with healthcare advisers corresponding to 2,000 calls per 1,000 children per year.

The aim is by 2006 to consolidate the regional help-lines into a national network with a common telephone number: "1177 Care advice by telephone". The call-takers would have access to computerised support integrated with the public information which is currently available on Infomedica's website [2]. The network is to be very easily accessible, with 90 per cent of all calls being answered within three minutes.

Child healthcare clinics and family welfare centres

Parents have frequent contacts with the child healthcare services, particularly during early infancy, but seldom after the age six. Over the age ranges from 0–17 years the number of telephone contacts with a children's nurse is estimated at 200 per 1,000 children per year.

Child and youth psychiatry

Child and youth psychiatry in Västerås has in recent years developed support by telephone. Previously the clinic had routines similar to those in many other organisations. Referrals and inquiries received resulted routinely in appointments for a consultation. With the new routines the parents are given longer telephone sessions, normally 20 minutes. It is only thereafter that that the two sides reach a mutual decision on whether a visit is justified. Often it is possible to deal with a question satisfactorily during the telephone discussion. The clinic responds to approximately 300 calls per year for a total population of 150,000 people. That corresponds to 10 calls per 1,000 children per year.

Social services

Telephone inquiries to the social services from people not previously known to them often result in the arrangement of an appointment. However, in some parts of the country the social services have begun to try other ways of making use of the telephone. The social services in Falun can serve as an example. As a parent one can ring a given support service which is manned by social advisers three days a week between the hours of 13–16 [3]. This unit is separate from the social services administrative sections

and parents can if they so wish remain anonymous. In the first instance support is offered by telephone, but that can however be followed up by a visit to the clinic.

Family counselling

Family counselling in Skövde has developed telephone support which is widely used by parents. The telephone lines are open 2 hours on weekdays. Approximately 150 calls are received every year from a total population of 50,000 inhabitants. Each call lasts 10–15 minutes (personal information from Benita Haals Stiernstedt, 2004). If all calls are assumed to come from parents, this corresponds to 15 calls per 1,000 children per year.

National helplines for parents

A summary of information on the three parent telephone helplines available in Sweden is presented in Table 10.1.

Name of telephone and country	Financial sponsor	Annual number of calls	Number of calls per 1000 children per year	Percentage of men calling	Length of calls	Training of those manning the lines	Cost per per call in SEK
Sweden	BRIS [Children's Rights in Society]	2,239	1.2	25%	20 min.	Professionals	250
Sweden	Save the Children	1,400	0.8	25%	15 min.	Volunteers	350[1]
Sweden	SFPH [The Swedish Association for Mental Health]	1,262	0.7	20%	20–30 min.	Volunteers	250
Norway	*Mental barnehjelp* [Children's Mental Aid]	1,500	1.7	25%	20–30 min.	Professionals and volunteers	1 100
Denmark	*Børns Vilkår* [The Condition of Children]	2,500	2.3				
Finland	*Mannerheims Barnskyddsförbund* [The Mannerheim Union for the Protection of Children]	1,000	1.0				

Nether-lands	Cooperation between 15 NGOs	5,318	1. 7	20–45 min.	Professionals	140[2]
UK	Parentline Plus	75,000	6. 3	23 min.	Professionals and volunteers	280
France	*Education de Parents*	125,000	10			

1 Exclusive of marketing costs.

2 Including a call charge of EUR 0.20 per minute which is paid by the parents themselves.

Table 10.1 National helplines for parents in Sweden and certain other European countries. Number of calls in the latest year for which information is available, normally 2003. Figures for the cost per call are derived from information on the total budget of the unit, including marketing, and the number of calls per annum.

Calls to the BRIS adult helpline are answered by BRIS employees. Only 18 per cent of calls reaching the exchange are accepted [4]. Fiftynine per cent of the calls come from parents while the remainder come from other adults, for example grandparents. The most common questions are divorce (34 per cent), family conflicts (21 per cent), problems of the parental role (20 per cent) and the children's mental health (16 per cent). One example of a question which gives rise to many calls is jealousy between siblings. Another example relates to the rights of maternal grandparents to meet their grandchildren. Many callers seek information on what the social services do.

Save the Children's parental telephone support is provided by approximately 150 unpaid parents who have each been given 6 or 7 group training sessions, plus a whole day course. Each one of them works at least three hours a month and takes part in one meeting per month with fellow call-takers. Telephone support is available for three hours on weekday evenings and in the middle of the day at weekends. Single parents predominate among those who ring. The commonest questions relate to child-rearing (30 per cent) and divorce (30 per cent).

The parents' telephone helpline of the Swedish Association for Mental Health (SFPH) is provided by 18 unpaid psychologists. The commonest questions are doubts about the parental role (50 per cent), divorce (24 per cent) and problems in the parent-child relationship (20 per cent).

Other local and national helplines

There are a number of helplines directed at different groups. Some can be relevant also for parents. The formation of other helplines indicates also the possibilities for developing national helplines specially aimed at parents.

The helpline of the Swedish Church in Gothenburg receives 23,000 calls per annum. Ninety volunteers man the service 24 hours a day. Forty-five per cent of the calls come from women. Each call lasts on average 20 minutes. The commonest questions relate to mental health problems (30 per cent) and relationships (10 per cent). Assessed on the basis of the city's total population of 1 million, this amounts to a provision of 23 calls per 1,000 inhabitants per year. The cost of each call is estimated to be SEK 150.

The National Helpline is run by seven NGOs (Swedish OCD Association – *Ananke*, Swedish Depressive and Manic Depressive Association, Swedish Autism Association, RSMH, SPES, ÅSS and RUS) with support from the Swedish Inheritance Fund. Assistance is offered for people suffering acute mental stress. The call-takers are trained psychologists or nurses. This line received and dealt with 17,040 calls in 2003. Fifty-eight per cent of them came from women. Each call lasts on average 18 minutes. Based on the total population in Sweden of 9 million, that corresponds to 1.9 calls per 1,000 inhabitants per year. The cost of each call is estimated at SEK 400.

Parent telephone helplines in seven other countries in Europe

These details are based on information supplied by representatives of the respective services, with the sole exception of France, for which it comes from a Dutch representative who visited the French parent telephone helpline at the end of the 1990s.

Norway

15 employees and cooperation partners work in the Norwegian parent telephone helpline. The commonest questions relate to youth problems and problems with children in preschools. Lines are open 35 hours per week. The number of calls has diminished in recent years, which is thought to be a result of inadequate marketing. In order to reduce the high costs attempts are being made to increase the input from unpaid volunteers. Over the last year the organisation has tried to provide an e-mail reply service. It also offers training for group leaders for discussion groups for parents.

Denmark

The Danish parent telephone line is serviced by 130 volunteers who are active in the field of child care and teaching. The most common questions relate to child-rearing and divorce. Approximately 30 calls per year lead to the organisation getting in touch with the social services.

Finland

The Finnish parent telephone line is serviced by volunteers under the guidance of professionals. The organisation is currently developing an Internet service for parents with the aid of a grant of SEK 1.8 million from a supermarket chain.

Netherlands

In the Netherlands, the parents' telephone line is serviced by employees recruited for the purpose. Fifteen different organisations cooperate in manning lines and use a common telephone number. Each organisation mans the lines for half a day or at a time. The commonest questions relate to children's sleep, their development, upbringing, punishment, disobedience, attention-seeking behaviour and food problems.

UK

Calls to the British parent telephone line are dealt with by volunteers and paid staff in roughly equal proportions. They are spread over nine different help-line centres. The British service was created by winding up 12 small local organisations which then combined into a common organisation, with a common number. The telephone lines are open round-the-clock. The

commonest questions are family conflicts (73 per cent), mental and emotional problems of children (54 per cent) and children's schooling (20 per cent). Those calling seek practical advice (40 per cent), an opportunity to talk about their own feelings (34 per cent) and support and encouragement (23 per cent). The call-takers have access to a list of about a hundred other NGOs to which they can refer. The organisation also provides parent groups with 5–6 meetings of 45 minutes, both face-to-face and through the medium of telephone conferences.

France

The French parent telephone service offers advice from professionals with different professional backgrounds on a number of different questions relating to children's health, preschool and school, legal questions and leisure activities.

Level of interest among parents

The questionnaire showed that a large proportion of all parents (41 per cent) are interested in this form of support.

Sex

The telephone support offered in Sweden is largely aimed at women. The service is used by approximately three times as many women as men. Yet in contrast to many other forms of parent support, the interest expressed in telephone support is nonetheless relatively equally divided between the sexes. Only 30 per cent more women than men record interest in it. It thus appears that the interest among men is poorly provided for. A possible explanation for the fact that parent telephones in Sweden are used by only a few men may be that the majority of those answering the calls are women. Men may experience a need for their calls to be answered by a person of the same sex.

Socioeconomic groups

The survey shows that interest in telephone support is spread approximately evenly across the different social strata. Whether the Swedish parent

telephone lines also meet this need evenly is, however, not known. Foreign studies of telephone support on health questions suggest the service is in the first instance used by women with higher education unless particular efforts are made to target other groups [5]. It is possible that the social background of the call-takers also influences the use of parent support lines. Often it is an advantage to be able to speak with a person who has a similar social background. This means that it may be appropriate to try to meet this need when recruiting call-takers.

Country of birth

The extent of interest in telephone support appears to be roughly the same irrespective of whether the parents are born inside or outside the Nordic region.

Costs

Costs per call are on average SEK 200–300. There are no systematic differences between the length and costs of calls. Nor do costs appear to be linked with whether call-takers are unpaid volunteers or professionals. This may be the result of the fact that the volunteers require training and support from paid professionals. The gain to be made from the participation of volunteers thus does not lie in the opportunity to reduce costs, but in make use of the personal commitment of more people. Another advantage with volunteer call-takers is that they may have social backgrounds similar to those calling.

Many representatives of parent support services maintain that the costs of marketing are significant. This means that the costs per call are relatively high if the telephone line receives only a few calls. The high costs per call in Norway illustrate that relationship.

In order to be able to compare costs for this form with those of other forms of parent support, assumptions have to be made about how often poorer parents can be expected to use a parents' telephone support line. A possible assumption is that the 41 per cent who gave a positive response to this question want to use the telephone twice during the child's growth from 0–17 years. That corresponds to approximately 0.8 calls per child

during the whole of the period in which the child is growing up, giving a cost of about SEK 200 per child.

Discussion

Telephone support for parents can relate to many different sectors. The focus in this report lies on promoting mental health. That means that it is not appropriate to deal here with the support which is offered for physical health problems, for example infections. There are organisations which dispose of substantial resources, whose task it is to be responsible for such support.

There is indirect evidence that telephone support for parents can promote the child's health and welfare. The links between access to such support and the welfare of the child are, however, significantly less reliably established than they are in the best documented structured methods, for example the interaction programmes. The costs of telephone support are also not negligible. That argues that telephone support ought to have only limited interest.

There are nonetheless three reasons for emphasising telephone support as a method. The first reason is that that is the service demanded by parents. A second reason is that telephone support can be integrated with the existing services so that those services may be used more rationally. One example of such integration is constituted by the telephone support which the child and youth mental health clinic in Västerås provides. A telephone contact is estimated to cost SEK 250, while the cost of a visit to a clinic is many times higher. If it is well thought-out, the use of telephone support can increase the public benefits of the clinic's work. More parents obtain access to basic family-counselling, while work at the clinic itself can be concentrated on those families who derive the greatest benefit from visits there. Similar considerations can apply to municipal family-counselling and in some degree even to social services. The examples presented indicate that local family-counselling of this kind can provide of the order of 10 contacts per 1000 children per year within the existing framework, without new financing.

The third reason is that counselling can function as a point of entry to a number of other forms of parent support. It is expected to be possible to diffuse the structured group methods presented in Chapters 6–8 throughout the country in the years immediately ahead. Parents will have varying knowledge about which activities are provided locally. An adviser can provide such information by telephone. That presupposes that the adviser has knowledge of the local efforts. The most flexible method is to combine the information in a database which is accessible both to advisers and to the general public via the Internet (see Chapter 11). The benefit of telephone support is thus increased if a website for parents is developed in which different resources for parents are presented.

It is improbable that local telephones can provide even coverage for the whole country. These local services must therefore be complemented by telephone support with national coverage. Currently BRIS, Save the Children and SFPH provide such support. Together they deal with 2.7 calls per 1,000 children per year. The representatives of these telephone services maintain that the primary limitation on the volume of telephone calls is the cost of marketing. That cost falls if a number of organisations cooperate. That is indeed what happened when these three organisations began to put out information in common. They have, however, retained separate telephone numbers. Experience from the Netherlands and the UK suggests that extended cooperation between different NGOs is meaningful. In both those countries parents are offered a common telephone number, which significantly facilitates marketing. The volume of telephone services for parents in the UK, 6.3 calls per 1,000 children per year, is 2.5 times greater than in Sweden. That fact suggests that more parents in Sweden could obtain telephone support if cooperation between the existing organisations is developed.

Parent telephone help-lines have the capacity to reach both sexes, the different social groups and parents born in different countries, all on a basis of relative equality. However, that in all probability requires those staffing the help-line centres to be recruited in such a way that both sexes, the different social groups and different countries of origin are represented in ways approximately coinciding with the composition of the population in general.

Proposal

The Swedish National Institute of Public Health (SNIPH) recommends that child and youth psychiatric units, municipal family-counselling and the social services should provide a telephone support line for parents.

SNIPH also recommends that the state should give financial support to NGOs in respect of cooperation on a national parent telephone helpline with a common telephone number.

Contributors

The point of departure for the description of Swedish telephone helplines is the material which was presented by Allmänna Barnhuset Children's Foundation at a conference arranged in April 2004. Sven Bremberg has the main responsibility for the text and Anton Lager has prepared the background material.

References

1. Kempe A, Dempsey C, Poole SR. Introduction of a recorded health information line into a pediatric practice. Arch Pediatr Adolesc Med 1999;153(6):604-10.
2. Infomedica. *Information om hälsa och sjukvård från Sveriges landsting och Apoteket*. URL: http://www.infomedica.se.
3. Falu kommun. *Dialogen*. URL: http://www. falun.se/dialogen.
4. BRIS-rapporten 2003. Stockholm: BRIS; 2004.
5. McBride CM, Rimer BK. Using the telephone to improve health behavior and health service delivery. Patient Education & Counseling 1999;37(1):3-18.

11.

PARENT SUPPORT VIA THE MEDIA

11.

PARENT SUPPORT VIA THE MEDIA

In Sweden adults spend on average three hours per day on watching TV, listening to the radio and reading [1]. It is obvious that such a dominant activity is of importance for parents when they are forming their picture of parenthood. A major interest in support via the media also emerges from the parental questionnaire, Chapter 5, and from foreign studies. Parents want information about children's development, upbringing and health [2]. In particular, parents seek information on specific problems such as, for example, the refusal to eat, outbursts of aggressiveness, sleeping problems, and excessive time spent on video-games and TV. This information should preferably be instantly available when a specific question crops up. There are often different perceptions of what is right, even among experts. Therefore it should be possible for parents to orientate themselves, without becoming confused and without drowning in masses of information.

Effect

In Chapter 2 there is a general discussion of what influences the parent-child relationship. It emerges there that in the first instance we learn behaviour through experience of what others do, that is to say, that others play *role models*. We are more influenced by those whom we meet in real life and can interact with than by people of whom we only read or whom we see on TV. That argues that the media ought to have subordinate significance. However, the media make it possible to be informed about a greater variety of ways in which to live, compared with the experiences we can inform ourselves about in real life. In that way, the media can be of great significance, despite the fact that we cannot be in direct contact with the people we read about or see on TV.

The media can of course also convey *information*. Elementary aspects of behaviour can be directly influenced by information presented in the media. Parenthood is, however, so complex that major parts of the task can scarcely be acquired through reading and TV programmes. Such material can nevertheless provide a basis for reflection.

Access to information is of particular importance when parents are faced with a problem. If an answer to a specific question is to be found in a text or in a TV programme, the information can also influence the parents' behaviour. The proviso is nonetheless that the parents are actively looking for an answer and that the answer is available at the very moment when the question arises.

The effects of various delimited inputs via the media have in some cases been studied in controlled experiments. That applies to the effects of interaction programmes, see Chapter 7, and communication programmes, see Chapter 8. The effects of the media are, nonetheless, normally not analysed in that way. On the contrary, analysis goes no further than seeking answers as to whether the person who saw the programme or who read the article came to the view that the material was of value. In the questionnaire presented in Chapter 5, 51 per cent of parents record that they had had benefit from books and periodicals and 31 per cent that they had obtained benefit from TV and radio. In the questionnaire it is only individual counselling at the child healthcare clinic which a greater number of parents say has been of assistance to them. That means that support via the media is one of the most important forms of parent support.

The situation in Sweden

Books

The database of The Royal National Library of Sweden, *Libris*, covers all Swedish *book titles* from 1866. A search in June 2003 with the search word "f*öräldrar*" [parents] gave just under 4,000 book titles. Literature for parents can be sorted into four categories. The category which contains the greatest number of titles deals with different specific problems in children, for example autism or gluten intolerance. Another category deals with the parent-child relationship and with the upbringing of children. In this are

included books on the psychological development of children, along with books which give specific advice on upbringing. A third category deals with specific family situations and family problems, for example divorce. The fourth category deals with child- and family-policy and publicly financed work which affects children and family, for example schools and parental leave. Texts on the UN Convention on the Rights of the Child are also included in that category.

In early infancy, all parents receive a free copy of *Leva med Barn* [Living with Children], a book on the health and development of small children, which deals in broad terms with parenting in their first years.

Periodicals

Printed material comprising 16 or more pages is also catalogued in *Libris*. A search of *Libris* brought up 45 titles of Swedish *periodicals* which are aimed at parents. An estimated 30 of these titles were current in the year 2004. Most periodicals are published by NGOs and concern primarily their own sector. Two examples of such periodicals are *Oss föräldrar emellan* [Between us parents], which is published by a parents teacher association *Hem och Skola* [Home and School], and *Unga föräldrar* [Young Parents] which is published by the organisation *Unga föräldrars nätverk* [Young parents network]. There are a number of periodicals on adoption. Commercial enterprises and scientific organisations also publish periodicals on parenting. The Ministry of Industry, Employment and Communications publishes a journal, *Nya livet* [New life], which is aimed at new parents.

TV, video, radio and CD-ROM

The Swedish *public service* media sector consists of three separate and independent companies, *Sveriges Radio* (SR), *Sveriges Television* (SVT) and *Utbildningsradion* (UR, the Educational Broadcasting Company). *Sveriges Radio* produces a specific programme for parents, Föräldrarna [The parents] with its own webpage. UR has produced about 60 *TV programmes*, or programmes episodes, aimed at parents, and a roughly equal number of *radio programmes*. UR is also responsible for a website intended for parents. In addition there are an unknown number of programme items in other TV and radio channels. In 2005 different versions of "Supernanny" has been broadcasted both on commercial and public service channels.

A search for *video films*, using the search-word "*föräldrar*" [parents], in the National Archive of Recorded Sound and Moving Images produced 106 hits in August 2003. About 80 of them have parents as the obvious target group. There also CD-ROMs in Swedish intended for parents, for example a title such as *Barnet* [The Child] – everything for you who are, or are about to become, a parent.

Public libraries

Public libraries collect and display all types of media. Sometimes there is a special parent shelf for the display of books, periodicals, video films, and brochures, etc. In many municipalities the Public Library receives parent groups to show them around and to discuss the linguistic development of children.

Internet

There is a comprehensive material on the Internet aimed at parents. A Google search on the word "parents" gave 39 million hits. The search for Swedish Internet pages with the word "*föräldrar*" [parents] gave just under 220,000 hits in August 2004. "*Föräldrar*" combined with "*spädbarn*" [baby] gave 11,500 hits while a combination with "*tonår*" [teenage] gave only 3,670 hits. A hit means only that the word appears on a page. Therefore hits with the word "*föräldrar*" in the title of the page gives a better perception of the extent of the texts available. A search of that kind gave fully 5,190 hits from approximately 600 websites. A large number of these pages comprise information to parents about current events in a given municipality, school or association. A smaller number of the pages consist of articles, reports or replies to questions.

There are an estimated 50 or so websites which are wholly aimed at parents. The majority of these websites are aimed at specific groups, for example single parents or parents whose children have a specific problem. These pages are run by NGOs. About 10 pages are for parents in general, particularly parents with young infants. About half these pages comprise the Internet editions of various periodicals. Many websites contain news, factual articles and links.

Many of the questions dealt with are concerned with child health. Six websites were identified which deal in broad terms with health problems

among children:a Swedish insurance company, *Trygg-Hansa's*, website with more than 200 headings relating to child health; *Netdoktorn* [The On-line doctor] with about 100 headings; *Infomedica* (owned jointly by the County Councils and *Apoteksbolaget* [the state-owned monopoly pharmaceutical retail-chain]), with about 70 headings; Stockholm County Council's *Vårdguide* [Healthcare guide], with about 60 headings; and Growingpeople with about 600 headings. Only subscribers can use *Growingpeople*, while the other five websites are free. Children's mental health and family relations are dealt with in broad terms only on the *Trygg-Hansa* and *Growingpeople* websites.

All the websites present statements about the causes of various problems and proposals as to what those visiting the site should do. The Internet are carries many items of information which are directly misleading. A site-user may therefore need to check how well-founded a statement is. This possibility is missing from the websites quoted, enclosing the most extensive, *Growingpeople*. However such possibilities are offered in a number of websites in English, where via links the user can gain access to the studies on which various statements are based. Many users perhaps do not use these links, but they provide a check on the quality of the statements presented, which means that everybody derives benefit from them.

Some websites have discussion groups for parents. The biggest is *Allt för föräldrar* [Everything for Parents], previously called *FöräldraNätet* [Parent Network], which has 150,000 visitors every month (2004). An analysis of *FöräldraNätet's* discussion groups was carried out in 2003. On *FöräldraNätet* there are over 250 discussion groups which deal with different topics on which visitors can put questions, comment or provide answers to one another. A questionnaire was carried out directed to users of the discussion groups. Many (65 per cent) used F*öräldraNätet* as the first port of call when they need advice or information and the majority (73 per cent) were content with the advice they received. It further emerged that *FöräldraNätet* was also a source of community and contact with others. It quite frequently happened that contacts which began on a website continued with real-life contacts. In the study an assessment was made of the support participants felt they had obtained through FöräldraNätet's discussion groups. Those participants who had the least education were those who experienced the greatest benefit from the website's discussion groups.

Level of interest among parents

The parent questionnaire in Chapter 5 shows that there are approximately equal proportions of parents who are interested in parent support in the form of books and periodicals (45 per cent) and of those who say they derive benefit from them. That argues that the need for support in this form is largely met. Against that, there appears to be a greater proportion who are interested in support via TV and radio (41 per cent) than of those who record that they had benefited from these forms (31 per cent). The need for support via TV and radio therefore seems not to be met. One possibility is to distribute such information in the form of video cassettes. A high proportion of families with children have video cassette recorders (VCRs). In the year 2001 virtually all families with children (90 per cent) had VCRs (Statistics Sweden, 2003).

The Internet is the most recently developed channel of support. It is therefore remarkable that almost as many parents record that they have had experience of open discussion groups on parenthood on the Internet (16 per cent) as the proportion who have taken part in open or structured parent groups (9 and 16 per cent, respectively).

There appears to be a significant unsatisfied need for information via the Internet, in which 22 per cent record interest while only 10 per cent report that they acquired material through this medium and found it beneficial. In a study of households in Sweden in 2002 it emerged that among partners with children 94 per cent have computers in the home and 76 per cent use the Internet there [3]. Just under 50 per cent use the Internet daily, primarily for seeking information and for communications. Use of the Internet is growing rapidly. That argues that increasingly it will be possible to reach the majority of parents via this channel. Interest is greatest among parents in the age group 30–34 (31 per cent) and declines later with the age of the parents. For example, only 16 per cent of parents in the age group 45–49 are interested in this form of support.

Sex

Interest in parent support through books and periodicals is 50 per cent higher among women than among men. The same applies also to TV and radio. Interest in information via the Internet is, however, equally shared by

both sexes. Yet those visiting an Internet site for parents (*FöräldraNätet*) were mainly women (87 per cent). It thus appears that interest in various forms of parent support via the media is influenced by the particular form it takes (whether book, periodical or website).

Socioeconomic groups

There are clear differences between different social groups as regards their interest in parent support through books and periodicals: 90 per cent more of the better educated record interest, as compared with parents who had least education. Social differences are least as regards interest in radio and TV, with 40 per cent greater interest among those with higher education. The prevalence of interest in the Internet lies in between, with 70 per cent greater interest among those with higher education.

Country of birth

There are only small differences in interest in parent support via the media, as between those parents born outside and those born inside the Nordic region.

Costs

There are two components in the costs of parent support via the media. One comprises the costs of producing a text or images and the other is the cost of distribution.

The cost of producing material is the same irrespective of the number of users. That is the reason why use of the media is suitable for mass distribution. If the cost of production of a TV programme is SEK 500,000 and the programme is watched by 100,000 parents, then the cost of production per user is only SEK 5, that is to say, virtually negligible. The same applies as regards the production of text.

The cost of distribution varies according to the channel which is used. For distribution via broadcasting and Internet, fixed costs predominate and variable costs are of less significance. That means that if the number of users is large, the costs per user are small. The variable costs for printed material, video cassettes and DVD are on the contrary significant. The

production and distribution of every physical unit has a given cost, irrespective of the size of the circulation.

The broadcast media thus offer the lowest distribution costs. Their big disadvantage is that a user has no direct access to the material when she or he wants it. The Internet here provides an opportunity which combines low-cost distribution with accessibility controlled by the user. Texts, sounds and moving images (video) can all be distributed via this medium. In addition, the Internet permits interactivity, that is to say, the user can both receive information and share with others his/her own experience. An example of the latter is comprised by the discussion groups on *FöräldraNätet*.

Does the intervention promote children's participation in society

Children can absorb information through the media in roughly the same way as parents. That applies particularly for image-based media such as TV/video/DVD since it does not require the ability to read. Parent support via the media thus increases the chances for children to share in it.

Discussion

Printed material

Printed material in the form of newspapers, periodicals and books are primarily produced on a commercial basis. The supply is dominated by texts which relate to small children. That may be a consequence of demand, since parents devote more time to small children than to older children. It is also possible that commercial interests have an effect. During early infancy the parents use a number of products, ranging from nappies to particular sorts of food, which are only relevant during the short period when the children are small. The producers need to reach parents with advertisements, and these in turn can finance material for parents targeted on the age group in question.

They are two major limitations with books, newspapers and periodicals. The first is that the material is often not directly available when a given question comes up. The other limitation is that printed material is significantly more used by well-educated parents. These limitations are difficult to overcome, and there is an important role for the public library system both in making the material more widely available and in interesting less-educated parents in these particular forms.

The broadcast media

TV and radio are important sources of information on parenthood. UR (Swedish educational broadcasting company) is an important producer, and for a couple of years now it has been making a particular effort directed at parents. There is significant interest among parents for this form, indeed it exceeds the available supply.

One advantage of TV and radio is that the interest is approximately equally shared by the different social groups. A disadvantage, however, is that programmes are primarily available at particular broadcasting times which the parents have to observe. It is of course possible also for private individuals to apply to UR for cassettes on given themes and parents can also record programmes on video. But it can hardly be expected for a family to have at hand, at the precise moment when a question arises, information which has been distributed through the broadcast media. Availability is thus more restricted for TV and radio programmes as compared with printed material.

Internet

Information via the Internet is a channel which has developed in recent years. In the questionnaire, 22 per cent expressed interest in parent support via the Internet. As early as 2002, 76 per cent of two-parent families with children used the Internet at home and usage is increasing rapidly. Interest is significantly greater among the youngest parents who themselves have grown up with access to the Internet. That suggests that the majority of families will relatively soon be using this channel regularly, as is already the case as regards TV, video and radio.

There are a number of significant advantages with this channel, compared with all other media forms. The first is accessibility. Parents can instantly

access all information available via the Internet. That does not apply to any other mass-medium, which is of importance because research shows that parents seek information at the very moment when a question is current. If the medium requires that one must wait several days for the answer as, for example, is the case when the answer is to be sought in a book, then that medium becomes of less interest.

The second advantage is cost. Distribution costs are negligible, so that the only cost involved is that of producing the material. If there are many users, the costs per user are very small. In that way the Internet is like the broadcast media, the difference being that the Internet is available when the user himself wants it.

The third advantage is that this medium encourages interactivity. That does not apply to any other form of mass-medium. Parents can not only receive information from others, but can share their own experience. An example of this is comprised by *FöräldraNätet,* on which parents post questions and other parents contribute replies. In that way, the views of the experts can be complemented by those of other parents.

A fourth advantage is that users can have access to information at different levels. In many situations parents merely want to obtain confirmation that the perception they already have is reasonable. Elementary advice is then sufficient. In other situations, parents have heard various contradictory perceptions of a question, for example as regards vaccinations. There is then a need for information about the respective arguments of the two sides. On the Internet it is possible to respond to both these needs, since the information can be presented on different levels, via Internet-links.

A fifth advantage is that via the Internet it is possible to present information in various forms. Currently information is conveyed in the first instance by means of texts and still-pictures. Moving-images and sound can also be distributed via the Internet, though the quality is at present noticeably less good than with TV and video-tape. However, the technology is developing rapidly and within the foreseeable future parents will be able to receive via the Internet films dealing with parenting.

A sixth advantage is that there are only small differences in interest, as between the sexes, as between single parents and parents with partners, and as between parents born in different countries. The questionnaire shows that, in general, interest is greater among better educated parents. Analysis

of *FöräldraNätet* discussion-groups shows, however, that it is the less-educated parents who set the greatest store by the benefit experienced. That suggests that information via the Internet, which can be complemented by opportunities for parents to share their own viewpoints with one another, can meet the interests of different social groups in a relatively equitable fashion. There are few other forms of parent support which have a corresponding capacity for reaching different groups in that way.

A Swedish website for parents

There are a number of limitations affecting the range of websites today available to parents in Swedish and offering information about children. Those websites to which access is available without charge have a maximum of about 200 headings. There are therefore many questions which are not dealt with. A more comprehensive website, with 600 headings, is open only to subscribers, which limits the number of users. Furthermore, none of the existing websites gives users the opportunity to check the accuracy of the material they contain. Nor do the websites which present summarised information on children give parents opportunities to make their views known to each other, including their views about the experts' material.

An important reason why no such website has been developed is probably the problems of financing it, particularly in a language such as Swedish which is spoken by only about 10 million people. It has also been found to be difficult to finance websites entirely by advertisements. A commercial enterprise such as *Trygg-Hansa* can make certain information available on a website but that is not the company's primary task. Nor is it satisfactory to impose charges on a website for parents, since that reduces the number of users and particularly affects parents with low income.

It is technically relatively simple to give the reader access to information about the basis for the material on a website, by inserting links in the text. This technology enables anyone wanting a quick answer to obtain it, without being distracted by references. Any reader who so wishes can obtain either access to digests of the scientific studies on which website material is based, or an explanation that the material is no more than an expression of a common perception among the professionals on a given subject. The chief justification for making these links available is that they contribute to maintaining high standards of quality in the information presented.

No factual website for parents has combined such information with the opportunity for them to make their own views known to one another. The technology for doing this is nonetheless widely used in other sectors. One of the forerunners has been the on-line bookshop Amazon. On this bookshop's website users can post reviews of the books it sells. A reader can in turn give views on the usefulness of a review. Corresponding interactivity can very well be developed on a website with information intended for parents. In that way the views of experts are balanced by the experiences and views of ordinary parents

It is expected to be possible to diffuse the structured group methods presented in Chapters 6–8 throughout the country in the years immediately ahead. It is important for parents to obtain information about local activities at any given point in time. One method is to put such information on a website for parents. The information can also be used by those working in the healthcare services, and at preschools and schools, who have contact with parents. Such information will be particularly valuable if telephone-support for parents is developed (see Chapter 10).

Another possibility is for the website to give parents access to simple standardised questionnaires which help them to assess the situation in their own family. An example of such a questionnaire is *Styrkor och Svagheter* [Strengths and Weaknesses], which contains 25 simple questions giving a picture of a child's mental health [4]. An advantage of letting parents use such a form is that they obtain access to a broad reference framework when they have to make a judgement whether it is justified to seek help or not. There is a risk that parents place too much reliance on the questionnaire but that risk can be countered by making it clear that the answers to the questions give only supplementary guidance.

Organisation and costs

Against this background it is desirable to develop a Swedish-language website for parents presenting different forms of knowledge relating to children and parents, where parents can share their own experiences with others and offer their views of the experts' texts, and where information on the range of local activities in support of parents is presented. A suitable host for such a website would be a NGO in cooperation with the Swedish National Institute of Public Health (SNIPH). The NGO would ensure that the

project enjoys broadly-based support among parents, while SNIPH can guarantee high standards of factual quality in the material presented.

A website for parents involves three types of costs – the costs of producing and checking the accuracy of factual texts, the cost of maintaining discussion-groups and the technical costs of the platform. The fees for producing, checking and updating factual texts can be estimated at about SEK 4 million per year, depending on how ambitious the project is. The cost of maintaining discussion-groups for parents can be estimated at SEK 1 million per year, on condition that parents who themselves use the website undertake to act, without payment, as moderators for individual discussion groups. The cost of maintaining and updating the technical platform can be estimated at SEK 1 million per year. On the assumption that parents of all children use the system, the cost is SEK 6 million /1.8 million children = SEK 3 per child and year. The cumulative cost for the whole period of the child's growth from 0–17 years is SEK 60 per child.

Video/DVD

There are advantages in making a Swedish version of a teamwork programme on video/DVD, see Chapter 7.

The need for research

The Internet can be expected to become a channel of increasing importance for the distribution of information to parents. It is therefore justified to study how parents use such information with a view to matching the supply to users.

Proposal

SNIPH recommends that the state should give a NGO the task of developing, in conjunction with SNIPH, a website for parents which presents information relating to children and parents, on which parents can share their own viewpoints with one another and where current information about local parent groups and other resources for parents is presented.

Contributors

Sven Bremberg has the main responsibility for the text and Anton Lager has prepared the background material.

References

1. Rydenstam K. *Tid för vardagsliv – kvinnors och mäns tidsanvändning 1990/91 och 2000/01*. Levnadsförhållanden. Rapport 99. Stockholm: Statistiska centralbyrån; 2003.
2. Simpson R. The role of the mass media in parenting education. Boston: Harvard School of Public Health, Center for Health Communication; 1997.
3. *Dator och Internet i hemmet*. In: Statistiska centralbyrån, red. Fritid 1976–2002. Stockholm: Statistiska centralbyrån; 2004:159.
4. Goodman R. Information for researchers and professionals about the Strengths and Difficulties Questionnaires. URL: http://www.sdqinfo.com/.

12.

GREATER PARENTAL INFLUENCE ENHANCES EDUCATIONAL ACHIEVEMENT

This is a separate report published in 2006 and available on the SNIPH web site: www.fhi.se.

13.

INTERVENTIONS FOR PARENTS DURING EARLY INFANCY AND THE PRESCHOOL YEARS WHICH PROMOTE CHILDREN'S COGNITIVE DEVELOPMENT

13.

INTERVENTIONS FOR PARENTS DURING EARLY INFANCY AND THE PRESCHOOL YEARS WHICH PROMOTE CHILDREN'S COGNITIVE DEVELOPMENT

The individual's capacity to receive impressions, interpret them and put names to them, in order subsequently to make judgements and take decisions, has great significance for health and welfare. In psychological literature these abilities are termed "cognitive". They develop during the child's growth, in interaction between the child and its environment. The parents' behaviour towards a child influences the child's development, and these abilities are likewise influenced by what is going on in preschool, school and leisure activity.

This chapter deals with interventions for parents before the start of schooling.

Effect

Studies have been identified in searches of the literature on the data bases Medline and PsycINFO. These effects have primarily been analysed in programmes in which interventions directed at parents are combined with interventions directed at children. Some studies of more closely defined interventions in the form of individual counselling for parents have also been indicated.

Combined programmes which aim to promote children's cognitive development

During the 1960s, a number of comprehensive attempts were made in the USA to give socially vulnerable families extra support. The programmes were particularly aimed at promoting the cognitive development of children. By promoting that development the children's opportunities at school were improved, which in turn increased their opportunities on the employment market. The programmes contained a number of components, some directed at parents and others directed at children. This design makes it difficult to determine whether it was the interventions specifically for the parents which were decisive. It is, however, justifiable to discuss these studies since they form the framework within which research in this field has in the first instance been conducted. The presentation is based primarily on works giving a survey of this field [1–5].

Theoretical background

The individual develops in interaction with other human beings. Different people in the child's environment influence the child and the child influences them. A baby, who perceives the person caring for it as stimulating, develops in interaction with that person, which in turn further encourages that person to stimulate the child, and so on. Ramey and Ramey have identified five aspects of this attitude which promote the child's development [6]: 1) the carer encourages a child to investigate the immediate environment, 2) the carer assists the child to understand its environment, 3) the carer praises the child when it has learnt new cognitive skills, 4) the carer helps the child to exercise and develop the new skills, and 5) the carer stimulates the child's linguistic development.

The Infant Health and Development Program – an example

One example of programme which has been studied is the *Infant Health and Development Program* [7, 8]. It was aimed at American families whose children were born prematurely and had a low birth-weight. Similar programmes existed for socially disadvantaged families. These groups were often the same, since the risk of low birth-weight is significantly higher in families with social problems. The studies in question were designed as a controlled experiment with a random distribution between the experimental

and control groups. The programme began when the child was born and then continued until it reached the age of three years. It included among other things home visits, regular visits to an open preschool intended for children at risk of retarded development and parent groups.

Home visits were carried out once a week until the child reached the age of 12 months and thereafter twice a month. Home visits were based on a handbook which described 325 learning activities suited to children in different stages of development. These activities were structured according to a teaching plan which the parents were encouraged to use in order to stimulate the child's cognitive development. During the home visits the parents were also given help in managing their own personal problems.

Children and parents began to visit the open preschool intended for children at risk of impaired development when the child reached the age of 1–3. Children were given instruction in groups of a maximum of 6, by a teacher using a teaching plan. Each child received in all 17 toys in a special development order. In relation to 12 of the toys the parents were given a brochure on how they might best use the toy in order to stimulate the child's cognitive development in the home. The parents also took part in parent groups which met every other month once the child was 1–3 years old. At the meetings were discussed among other things health and security, linguistic development, municipal support for parents and family relationships.

Effects of the intervention

The Infant Health and Development Program, like a number of other comparable experiments, demonstrated definite positive effects on cognitive development in children. Children in the participating families developed better language skills and achieved better results at school, while their IQ was raised as compared with children in control groups. One experiment also showed effects during adolescence and early adulthood, in the form of a lower incidence of crime and unemployment [1]. Since these experiments combined interventions directed at parents with others aimed at the children it is impossible to determine which parts were of significance. Interventions which are aimed directly at children and are combined with interventions aimed at parents are, however, more effective than interventions intended solely for children. That argues that the parental part has an

effect. There are nonetheless also studies which show that programmes aimed directly at children, for example in the form of preschool, are more effective than programmes aimed at parents [9, 10]. This finding has practical significance. If it is necessary to choose, it is better to offer interventions for children at a preschool than to make indirect interventions via the parents.

In the studies presented it is also possible to distinguish other systematic effects which are of importance [4]. If the programme is begun during early infancy, the effect is more evident than if the work begins later. The effects increase also with the intensity of the intervention. That applies as regards the number of home visits per week and the number of hours at open preschool. Long-term effects ordinarily presuppose that the children also had access to a developmental environment, particularly at school, as they continued to grow up. Another observation which also has practical significance is that the interventions have different values for different children. Children with a very low birth-weight (less than 2,000 g), obtain greater benefit from programmes than children with moderately low birth-weight (2,001–2,500 g) [8]. Further, the interventions have greater value for children of retarded mothers (IQ less than 70) than for children of normally developed mothers [11]. These conditions argue against making this kind of intervention available to all families.

Defined individual counselling for parents with a view to promoting children's cognitive development

Three American controlled studies aimed at parents with children of school age were identified in the literature search [12–14]. All experiments were aimed at socioeconomically vulnerable parents. Positive effects on the children's development were shown in all three experiments.

In a Swedish doctoral thesis there is an account of a controlled experiment in which the purpose was to advance children's linguistic development [15]. The parents received visits at home twice weekly when the child was 2.5–6.5 years old. During these visits there was discussion of material which the parents themselves could use together with their children. At the end of the experiment, statistically reliable positive effects were shown.

The situation in Sweden

There are no existing interventions in Sweden corresponding with the assessed American programmes. However, small groups of children are afforded certain services which form part of such programmes. That applies to children with retarded development who are able to borrow special toys and equipment in an activity which corresponds with the special open preschools which are included in the American programmes. The social services also offer similar possibilities to some families who have social problems.

The child healthcare services give parents advice with a view to promoting cognitive development in children. This advice relates among other things to linguistic stimulation and the choice of toys. The effects of this advice have, however, not been studied. With a view to encouraging reading and linguistic development the public libraries, in cooperation with the child healthcare services, issue books for parents without charge. That happens in the great majority of municipalities. In the child healthcare services in Uppsala, there is a specific experiment of this kind, the effects of which will be analysed.

Level of interest among parents

The parents' interest in support in this field has not been analysed.

Discussion

Parent programmes aimed at promoting cognitive development in children show definite effects. Despite this, the programmes have, in general, only limited relevance for children and parents in Sweden. There are a number of reasons for this verdict. One is that the foreign studies have been carried out in socially vulnerable families, who live in conditions which seldom occur in Sweden. The effects of the programmes were most noticeable in those families where the conditions were least favourable. That argues that if such programmes were widely used in Sweden they would have only limited effect.

Another reason for the limited relevance is findings that the effect of interventions directed at parents was shown to be less than in those where the children directly participated in the activity. In Sweden all children have access to preschool from the age of 1 year. The contribution made by preschools is thus extensive. It is therefore doubtful whether additional activity aimed at parents with the objective of influencing cognitive development could give significant effects.

The need for research

Children's cognitive ability has important significance for their health and welfare. That justifies research in the field despite the fact that broad programmes of parent support do not appear to be justified. Cognitive development is closely linked with the emotional and social aspects. It is therefore expected that the structured programmes which aim at promoting good parent-child interaction (see Chapters 6–8) also promote cognitive development. This hypothesis needs to be tested in studies.

Contributors

Pia Wennerholm Juslin carried out the literature research and has main responsibility for the text, in cooperation with Sven Bremberg.

References

1. Haskins R. Beyond metaphor: The efficacy of early childhood education. American Psychologist 1989;44:274-82.
2. Barnett WS. Long-term effects of early childhood programs on cognitive and school outcomes. Future of Children 1995;5:25-50.
3. St Pierre RG, Layzer JI, Barnes HV. Two-generation programs: Design, cost, and short-term effectiveness. Future Child 1995;5(3):76-93.
4. Ramey CT, Ramey SL. Early intervention and early experience. American Psychologist 1998;53:109-20.

5. Anderson LM, Shinn C, Fullilove MT, Scrimshaw SC, Fielding JE, Normand J, et al. The effectiveness of early childhood development programs. A systematic review. Am J Prev Med 2003;24(3 Suppl):32-46.

6. Ramey SL, Ramey CT. Early educational intervention with disadvantaged children – To what effect? Applied and Preventive Psychology 1992; 1:131-40.

7. Ed. Enhancing the outcomes of low-birth-weight, premature infants. A multisite, randomized trial. The Infant Health and Development Program. JAMA 1990;263(22):3035-42.

8. Ramey CT, Bryant DM, Wasik BH, Sparling JJ, Fendt KH, LaVange LM. Infant Health and Development Program for low birth weight, premature infants: Program elements, family participation, and child intelligence. Pediatrics 1992;89(3):454-65.

9. Scarr S, McCartney K. Far from home: An experimental evaluation of the mother-child home program in Bermuda. Child Development 1988;59:531-43.

10. Wasik BH, Ramey CT, Bryant DM, Sparling JJ. A longitudinal study of two early intervention strategies: Project CARE. Child Dev 1990;61(6):1682-96.

11. Martin SL, Ramey CT, Ramey S. The prevention of intellectual impairment in children of impoverished families: Findings of a randomized trial of educational day care. Am J Public Health 1990;80(7):844-7.

12. Coleman M, Ganong L, Brown GE. Effects of multimedia instruction on mother's ability to teach cognitive skills to preschool children. Journal of Social Psychology 1981;115(1):89-94.

13. Magwaza AS, Edwards SD. An evaluation of an integrated parent-effectiveness training and children's enrichment programme for disadvantaged families. South African Journal of Psychology 1991;21(1):21-5.

14. Levenstein P, Levenstein S, Shiminski JA, Stolzberg JE. Long-term impact of a verbal interaction program for at-risk toddlers: An exploratory study of high school outcomes in a replication of the mother-child home program. Journal of Applied Developmental Psychology 1998;19(2):267-86.

15. Svensson A-K. *Tidig språkstimulering av barn.* Avhandling. Stockholm: Almqvist & Wiksell; 1993.

14.

NEEDS OF DIFFERENT GROUPS

14.

NEEDS OF DIFFERENT GROUPS

There are two reasons for analysing the need for parent support in different groups. Firstly, if parents are to benefit from general support it is relevant to discuss to what extent different groups are able to make use of various forms that are offered. Secondly, certain groups may have special needs. These two aspects are discussed separately.

General support to parents

General support to parents is discussed in terms of the parent's sex, socio-economic group and according to country of birth.

Sex

The general objective for the policy of equal opportunity adopted by Parliament is that women and men should have the same opportunities, rights and obligations within all significant areas of life. That means, among other things, shared responsibility for the home and child. This objective is formulated from an adult point of view. Reviewing scientific literature it can be seen that equality is also desirable from the child's perspective. The review indicates that a father who is involved in the child promotes the child's mental health and social adaptation. Evidence of such a link can be seen in 8 of the 9 analyses dealing with the effects of the father's involvement controlling for the family's social background.

Nevertheless, the parent support currently offered is primarily directed to women. This derives from the fact that women formerly bore the greatest responsibility for the children. Therefore, significant changes are needed if parent support is targeted towards men to the same extent as women.

Support to fathers should be available from the outset. A father who is involved in a child during the first months of its life will continue to be involved as the child grows up.

Level of interest among parents

The questionnaire presented in Chapter 5 analyses parental interest in various forms of support according to sex and other factors. Interest in some of the forms is relatively similar for both sexes: home visits from the child healthcare clinic, individual counselling, telephone counselling, interviews with personnel at preschool and school, and information via the Internet. One form which is particularly unfavourable for men is open discussion groups, which is the form used within the maternity and child healthcare services.

Men prefer structured forms of parent groups rather than open discussion. One reason may be that women generally spend more time talking to each other than men do. It is also possible that it is more important for men to know what they will be learning in advance than it is for women. It would seem that men equate parental counselling with coaching and training in sport. In such a context participants are expected to train certain specific skills. Such elements are more important features of structured methods but occur more seldom in open discussion groups.

Swedish experience

There are several trials attempting to make parent support more accessible to men. One approach is to remove any practical obstacles. If a parents' group is held during regular working hours it is unsurprising that only those who are on parental leave can attend. If more women than men take parental leave during early infancy, then primarily women will attend. This is the case at most places around the country. There are, however, also trials with parent groups in the evening.

Another approach is to arrange specific parents' groups and parents' activities for men, see Chapter 6. Yet another approach is to recruit male instructors for groups in which both men and women take part.

Costs

If specific parents' groups are arranged for men the costs increase. On the other hand, if existing activities are designed to become more accessible to

men the intervention can be implemented within the given financial framework.

One form of support which is of interest to men is individual contacts. The disadvantage of this form is that the costs are generally higher.

Discussion

A large portion of the support offered to parents today is designed for women. This is understandable considering women have traditionally taken more responsibility for children than men have done. On the other hand, such a focus cannot be defended if the policy of equal opportunity adopted by Parliament is to be implemented. Some feasible measures include the following.

The forms for parent support can be moved towards forms which suit both men and women. This means that open parent groups be replaced by groups with a structured content. Activities should be arranged in the evening with both male and female instructors. The range of individual telephone counselling and information on the Internet can be increased.

Many activities for parents may have an atmosphere which makes men feel less welcome. For example, child healthcare clinics are often decorated with posters of women and children and there are less frequently images of men with children. This is also the case with printed materials offered to parents. Simple measures could make premises and printed materials more attractive for men.

Many activities which offer support to parents routinely register details about various activities. These statistics could include information about sex. For example, child healthcare clinics register all visits made by parents. This information could easily be complemented with details about the sex of the parent. A similar record could be kept about those participating in parent groups held at child healthcare clinics and visits to open preschools. The collection of statistics does not change activities. However, the statistics can provide a basis for reflection and stimulate measures aiming to offer parents more equal support.

Socioeconomic groups

Health is unevenly distributed even in a relatively egalitarian country like Sweden. Around 20–40 per cent of all ill-health among children would be

eliminated if all children were able to grow up with similar conditions to the children who have the most favourable social conditions [1]. No other single factor has such great significance for children's health as the social background of their parents. In the light of this it is crucial that socially less advantaged groups are able to benefit from general support to parents.

Level of interest among parents

The interest in many forms of parent support is greatest among parents who are already socially advantaged. This is especially the case for parent groups arranged within the child healthcare services, individual counselling and child healthcare clinics, open preschools and books and journals. On the other hand, the interest in open and structured parent groups, telephone counselling, discussion groups on the Internet and counselling within child and adolescent psychiatry and social services, is relatively evenly distributed between different social groups.

Swedish experience

The interactive programmes described in Chapter 7 have often been successfully offered in socially less-advantaged residential areas. One factor contributing to the participation of less-advantaged groups has probably been that activities have been available in the neighbourhood and that babysitting has been made available. A further likely success factor is that invitations were issued to all the families rather than selecting the families who were particularly disadvantaged. They would in this case, quite rightly, feel negatively picked out for special treatment.

A third significant factor is that the spread was intensive in a few areas. Many people in the area were quick to find out about activities. Parents were therefore able to obtain recommendations from their own preschool teachers, school teachers and from other parents in the area. This suggests that it is better to spread activities intensively in a smaller geographical area which is subsequently expanded, than offer sparsely distributed activities throughout a municipality.

It is remarkable that the individual counselling and parents' groups within the child healthcare services appear to discriminate against socially less-advantaged parents.

Costs

It would not seem to involve significant extra costs to design activities to reach different social groups in the same way.

Discussion

It is possible to approach the social distribution of interventions in the same way as the issue of sex. It is therefore relevant to note as a matter of course the educational background, or other indicator of social group, of the parents who take part in various activities such as parents' groups. If activities tend not to favour parents with little education, it may be better to try to find different practical solutions to this problem with the parents themselves. There is naturally no value to be gained from placing a moral responsibility on those who fail to come. If socially disadvantaged groups do not come, it is rather an indication that the activity has serious shortcomings.

The shortcomings which exist in the child healthcare services suggest that significant change is needed. Such measures are discussed in Chapter 6.

Country of birth

Parents who have grown up in countries outside the Nordic region bring preconceptions of parenthood which may be different from those current in Sweden. The majority of parents from outside the Nordic region are interested in finding out about the view of parenthood dominant here. There are various ideas about which methods are most suited to providing support for these parents in this respect. One idea is to offer these parents special activities. Another is to do the opposite and invite non-Nordic parents to groups with parents born in Sweden.

Level of interest among parents

The patents' questionnaire indicated notably small differences in the interest in various forms of parent support between Nordic and non-Nordic parents. The non-Nordic parents were less interested in open parents' groups. This may be explained by such groups demanding a good command of Swedish. Some knowledge of this form is also required since it may not occur as frequently in other countries. Parents born outside the Nordic region are slightly more interested in home visits from the child healthcare clinic, and in interviews with preschool personnel.

Swedish experience

Parents born outside the Nordic region are generally offered the same support as parents born in the region. Some activities are conducted with the aid of an interpreter.

In certain smaller groups of non-Nordic parents the mothers feel prevented from talking in groups in which men are present. There are positive experiences of offering talks in separate groups for men and women.

Parents who have grown up in countries outside the Nordic region can feel alienated by the culture and organisation of Swedish schools. In Järfälla municipality, for instance, there is positive experience of offering parents discussions in groups on this issue [2].

Discussion

There are remarkably small differences in the interest shown in various forms of parent support due to country of birth. This would argue against the value of arranging special activities for this group. Individual spokesmen for these parents maintain that parents born outside the Nordic region are interested in getting to know Swedish-born parents. This indicated that offering separate groups would be less appropriate.

An important measure is probably to offer structured parents' groups rather than open ones.

Parent support for special groups

Intervention for families with severe problems

The main reason for offering special support for smaller groups of parents is to attempt to relieve the effects of pressure the family is exposed to, for example, when a child is born severely disabled. Parents may need to learn specific skills to care for their child. They may also need support to emotionally adapt to the situation of having a disabled child. Health and medical care along with child rehabilitation are obliged to provide such support for parents.

The social services also have an obligation to support families with problems. For example, the situation in a family in which a parent abuses

alcohol can be improved if the children can regularly spend time at weekends with another family.

Health and medical care and the social services are therefore responsible for providing support to parents in families where a child or the family in general are exposed to particular pressure. An analysis of how these interventions can best be designed lies beyond the scope of this report. Such activities should rather be formed by professionals from the health and medical care services and from the social services.

The interventions described in this report are intended for parents in general. The methods are of special value for families who live with problems. It is therefore necessary to offer these families specific support.

Intervention for families with less severe problems

Most families encounter difficulties now and then. The provision of special support for the problems that arise is not a simple matter of course. Delimitations can be made guided by the report on priorities in the health and medical care services established in 1995 [3]. The main two principles for prioritising are the principle that all people are equal, and the principle of need. The principle of need means that interventions for people in greatest need are prioritised. The guiding principle here is therefore not what effect the various interventions have, but the degree of severity of the problem. The report also discusses preventive intervention. These have high priority with the important requirement that the intervention should have documented effects.

The Priority Allocation Committee therefore states two completely separate principles for treatment and preventive interventions. The prioritising of treatment is directed by the severity of the problem while the prioritising of preventive intervention is dictated by the documented effect of the intervention. This report deals with preventive intervention and has followed the principles established by the Priority Allocation Committee. This means that the requirement for documented effects is central.

In discussions regarding support to parents the principles for prevention and those for treatment activities are sometimes combined. Families with considerable social problems can benefit from meeting in open groups or from individual counselling. This issue is discussed in Chapter 3. It follows

that one might expect that if more parents with less pressing problems also had access to such support, it could be possible to prevent the problems. This approach is common both within the medical and social services.

It is seldom the case, however, that extended activities have such effects. One reason may be that the effects of intervention are often not well-known, even though the intervention is offered to families with severe problems. Another reason might be that families with less serious problems are able to cope with these without external help. It is only when problems escalate beyond a certain threshold that the damaging effects become apparent. A third reason could be that it is often difficult to identify in advance which families will suffer difficulties. The relatively small group of families with very serious problems therefore represent an exception where it is relatively easy to foresee developments over time.

Some controlled studies of parent support in families with problems

Interventions for some groups of families are presented below. The presentation is based on searches for randomized controlled studies in the literature database Medline. The presentation is not comprehensive but is rather an attempt to illustrate what knowledge is available about the effects of parent support in this field.

Parents with mentally disabled children

Five randomised controlled studies of interventions directed towards parents with mentally disabled children were identified. Three studies evaluated programmes directed towards promoting positive parent-child interaction, similar to the programmes described in Chapter 7 [4–6]. These programmes also included elements aimed at developing the children's language and cognitive abilities. All the trials with parent groups showed positive effects both for the children and the parents. Two of the three studies also tested the impact of only exposing the parents to part of the material in the form of printed matter and video cassettes [5, 6]. The effects were seen to be almost as good as when parents participated in a parents' group.

The fourth study was directed towards promoting the children's language development through the parents. This had effects on the behaviour of the parents but not on the children's language [7]. The fifth intervention aimed to influence the parents' attitudes to their children [8]. Positive effects were found.

Parents with children suffering from chronic somatic disorders

Many scientifically evaluated interventions directed towards parents with chronically ill children were identified. In one study, the intervention was aimed at mothers with children suffering from diabetes, asthma and cystic fibrosis [9]. A support mother was linked to each mother. The support mother had a child suffering from the same illness. The support mother's child was older. The idea was that the support mother would transfer her own experience of children with the same illness. The intervention was evaluated after 15 months. The mothers who had received support were shown to suffer less anxiety and worry. If support to mothers is combined with interventions for the children, a reduction in psychological problems among the children can be seen [10]. The effects on the children can be both a consequence of the intervention for the mothers and those for the children themselves.

One intervention was directed towards parents whose children had recently been diagnosed with cancer [11] and aimed to prevent psychological problems among the parents using problem solving therapy. The parents met a psychologist for one hour on eight occasions. The intervention had effects on the problem-solving capacity of the parents and their negative feelings were reduced.

Parents of children with mental problems

Several studies could be identified from the literature search documenting interventions for parents whose children were suffering from mental problems. The largest group of studies was represented by interactive programmes like those described in Chapter 7.

Two studies involved families in which the children suffered from anxiety and worry [12, 13]. The parents took part in programmes based on cognitive behaviour therapy. In both trials the children's anxiety and worry were reduced in the test group.

Parents suffering from problems themselves

Four studies were identified in the literature search of interventions for parents who suffered from problems themselves. All the interventions were similar in that they were communication programmes like those described in Chapter 8. Two studies involved parents suffering from depression. The

communication programmes were shown to have positive effects for this group of parents too [14, 15]. A third study involved a parent suffering from AIDS [16] and a fourth included fathers serving terms of imprisonment [17]. These studies also showed positive effects of the programmes.

Discussion

A review indicates that the interventions generally proposed in Chapters 6–8 can also be of benefit for groups of families with different types of problems. Furthermore, other measures for parents may also be needed for groups with problems. The responsibility for these measures lies primarily with the health and medical care services and with the social services.

Proposal

SNIPH recommends that those responsible for different forms of broadly targeted parent support should register those participating according to their sex and social backgrounds (for example, level of education). This would enable continuous adjustment of the focus of activities so that different groups could gain access to interventions from an equal opportunities perspective.

SNIPH recommends that the government support the development of methods which aim to provide support to parents of disabled children.

Contributors

Sven Bremberg has the main responsibility for the text and Anton Lager has prepared the background material.

References

1. Bremberg S. *Sociala skillnader i ohälsa bland barn i Sverige – en litteraturöversikt*. Stockholm: Statens folkhälsoinstitut; 2002.

2. Larsson A, Granefelt L. *Vägen in: röster om integration och jämställdhet*. Norrköping: Integrationsverket; 2003.

3. Vårdens svåra val. Slutbetänkande av Prioriteringsutredningen. SOU 1993:93. Stockholm: Socialdepartementet; 1995.

4. Baker BL, Brightman RP. Training parents of retarded children: Program-specific outcomes. J Behav Ther Exp Psychiatry 1984;15(3):255-60.

5. Heifetz LJ. Behavioral training for parents of retarded children: Alternative formats based on instructional manuals. Am J Ment Defic 1977;82(2):194-203.

6. Kashima KJ, Baker BL, Landen SJ. Media-based versus professionally led training for parents of mentally retarded children. Am J Ment Retard 1988;93(2):209-17.

7. Tannock R, Girolametto L, Siegel LS. Language intervention with children who have developmental delays: Effects of an interactive approach. Am J Ment Retard 1992;97(2):145-60.

8. Russell PS, al John JK, Lakshmanan JL. Family intervention for intellectually disabled children. Randomised controlled trial. British Journal of Psychiatry 1999;174:254-8.

9. Ireys HT, Sills EM, Kolodner KB, Walsh BB. A social support intervention for parents of children with juvenile rheumatoid arthritis: Results of a randomized trial. Journal of Pediatric Psychology 1996;21(5):633-41.

10. Chernoff RG, Ireys HT, DeVet KA, Kim YJ. A randomized, controlled trial of a community-based support program for families of children with chronic illness: Pediatric outcomes. Archives of Pediatrics & Adolescent Medicine 2002;156(6):533-9.

11. Sahler OJZ, Varni JW, Fairclough DL, Butler RW, Noll RB, Dolgin MJ, et al. Problem-solving skills training for mothers of children with newly diagnosed cancer: A randomized trial. Journal of Developmental & Behavioral Pediatrics 2002;23(2):77-86.

12. Shortt AL, Barrett PM, Fox TL. Evaluating the FRIENDS program: A cognitive-behavioral group treatment for anxious children and their parents. Journal of Clinical Child Psychology 2001;30(4):525-35.

13. Kendall PC. Treating anxiety disorders in children: Results of a randomized clinical trial. J Consult Clin Psychol 1994;62(1):100-10.

14. Beardslee WR, Versage EM, Wright EJ, Salt P, Rothberg PC, Drezner K, et al. Examination of preventive interventions for families with depression: Evidence of change. Development & Psychopathology 1997;9(1):109-30.

15. Sanford M, Byrne C, Williams S, Atley S, Miller J, Allin H. A pilot study of a parent-education group for families affected by depression. Canadian Journal of Psychiatry – Revue Canadienne de Psychiatrie. 2003;48(2):78-86.

16. Rotheram-Borus MJ, Lee MB, Gwadz M, Draimin B. An intervention for parents with AIDS and their adolescent children. American Journal of Public Health 2001;91(8):1294-302.

17. Harrison K. Parental training for incarcerated fathers: Effects on attitudes, self-esteem, and children's self-perceptions. Journal of Social Psychology. 1997;137(5):588-93.

15.

SUMMARY ANALYSIS

15.

SUMMARY ANALYSIS

The starting point for the proposals presented in this report is to be found in the parent support which is available in Sweden today. This chapter therefore begins by surveying and contrasting current support with the proposals put forward. It thereafter considers the proposals and their significance for various actors. The chapter ends with a discussion of a national system for following up parent support.

Current parent support

An examination of the general parent support available in Sweden in the year 2004 brings out a number of characteristics.

Insignificant in scope and perhaps half-hearted

The combined financial value of the parent support available can be estimated at SEK 3,000 per child. The calculation builds on estimates of support in the field of maternity and child healthcare (Chapter 6) and the other interventions which in volume are significantly less extensive. The combined public expenditure per child to the age of 18 is estimated at about SEK 1.9 million per child [1]. That means that the cost of direct parent support comprises only 0.15 per cent of all public expenditure on children.

Parent groups have been available for several decades within the child healthcare services. About half of all parents participate. There is no definite tendency to increased participation. There are significant variations in participation as between different healthcare clinics. In Örebro County participation varies from 0 per cent at one healthcare clinic to 100 per cent at another [2]. It is probable that the variation reflects primarily the differing priorities the healthcare personnel attach to parent support. Participation also varies within other parts of the child healthcare services. However, that

variation is of a quite different order of magnitude. For example, the take-up of MPR vaccination (vaccination against measles, polio and rubella) in the same county is between 90 and 100 per cent at different healthcare clinics [2]. This variation is significantly smaller, which probably depends on the fact that the staff regard MPR vaccination as important. The big variation in the availability of the parent groups at the child healthcare clinics can therefore be interpreted as indicating that the attitude towards them is half-hearted.

The effect of this activity is not clear

When current parent support was developed during the 1970s knowledge about the effect of different interventions was very incomplete. In an analysis of the scientific literature published up until 1990 a leading American researcher noted that it is unclear whether interventions for parents influence the development and welfare of children [3].

Against that background it was reasonable to develop general parents support based on the practice which different professional groups were then familiar with. Many had experience of open discussion groups in which the leader, or the parents themselves, relatively freely determine the content. That form was already in use in support groups for families with problems. In those situations open support groups can be expected to have a positive effect. Against that, it is currently unclear whether such discussion groups have a positive effect on the child's health and welfare when the form is very generally used for parents without evident problems.

The activity is often characterised by professional groups whose objective is the treatment of medical and social problems

Within the maternity and child healthcare services, parent groups are conducted by medically trained personnel. The content therefore tends to be aimed at questions on which these professional groups have particular competence. Similar conditions may apply as regards groups arranged in the social services. The background of social workers in work with families with social problems can also put its stamp on the activity. In both groups parent support for all families can be perceived as an extension of the provision of a service which previously was made available only to families with problems.

The Priority Allocation Committee report which was submitted in 1995 nonetheless makes a definite distinction between the ethical principles which should guide the work of treatment and the principles which should be valid for preventive interventions [4]. In treatment, human need is the overriding principle as regards priority. Interventions must in the first instance be aimed at those individuals who have the greatest need, irrespective of the known effects of different methods of treatment.

The Priority Allocation Committee also states that preventive interventions should be accorded high priority. A decisive requirement is nevertheless that the effect of interventions must be well-documented. It is thus quite a different principle which guides preventive work. That makes it less appropriate to regard preventive interventions as an extension of those interventions which are carried out for individuals with problems. While it is true that the report on priorities deals in the first instance with medical questions, the principles ought all the same to be applicable in the social and psychological fields.

An activity designed by women for women

The task of taking care of children, particularly when they are small, has traditionally fallen to women. That circumstance is reflected in current support for parents. It developed largely during the 1960s and 1970s. Men then had a less clear role in relation to small children. Today the situation is different.

The Swedish Parliament has adopted a policy of equality which lays down that women and men must have the same opportunities, rights and duties in all important sectors of life. That means, among other things, shared responsibility for the home and child. A development in that direction is reflected in the proportion of days of parental leave which are taken by men. The proportion has increased from 0 per cent in 1974 to 17 per cent in 2003. As that development continues it becomes unsustainable that parent support should still be aimed primarily at women.

Parent support in the future

The surveys in this report indicate that future support for parents can more clearly be aimed at promoting the health and welfare of children.

Changes in the state of knowledge make it possible to put the focus on mental health

Mental ill-health, heart and vascular disease and cancer are the two major public health problems [5]. The trend for heart and vascular disease is favourable and comprehensive preventive efforts are being made. Interventions on mental ill-health, are decisive if further improvements in public health are to be achieved.

The studies which have been presented since the beginning of the 1990s indicate that it is possible to reduce this type of problem through interventions with parents. More than 100 high quality studies show that such interventions can prevent mental problems both in childhood and later in the adult age groups. The state of knowledge is thus quite different today compared with the situation only a decade ago [6].

Promoting the capacity of parents both to give children affection and to set boundaries

The core in a large part of the programmes reported in this study is that they promote parents' ability to give children affection and to set boundaries. Each individual parent must find his/her own way of giving affection and setting boundaries. They cannot simply copy the behaviour of their own parents since the conditions of life today are significantly different from what they were when they grew up. Parents must learn through their own experience with their own children. However, less than half of all children are the first child in the family. That means that a major proportion of all parents have no previous experience of their own to rely on. If parents are given support in the task of giving affection and setting boundaries, more can find the right answer earlier. From the perspective of individual children, that can be decisive.

Structured interventions with practical exercises

This report makes proposals for the broad use of a number of structured interventions. There are clear arguments for the training of group leaders who initially ought to follow relatively strict guidance. If the focus in a parent group were to be on general discussion of the principles of parenthood it is doubtful whether the parents' capacity for showing affection and setting boundaries would develop. Such a development is probably to be promoted primarily by practical exercises, with role-playing and exercises at home with their own children.

It happens that both parents and group leaders may see it as simpler to skip the practical exercises which form part of a method. It is therefore important that group leaders should acquire their own experience that the exercises are decisive as regards the effect of this activity. Only thereafter can it be appropriate for the group leader to treat the guidance less strictly. In the same way both parents and group leaders may believe that it makes no difference if it is the leader who provides the solutions to the tasks which form part of a method. If that happens, they miss the experience that the good solutions are to be found among parents themselves. It is thus important that leaders of structured methods begin by keeping strictly to the guidance. Only after a year or more is it right to integrate the methods more freely with previous teaching experience.

Parent support on an equitable basis

The report shows that certain forms of parent support are of roughly equal interest to parents irrespective of sex, education and country of birth. It is important that future parent support takes such methods as its starting point. They include structured parents' groups, telephone-counselling, support via TV and radio and eventually even support via the Internet.

If the same content can be presented through different channels it increases the possibilities that parents acquire it by whatever method best suits the individual family. Meetings in a group are excellent, but individual counselling may suit other families better. Spreading knowledge about parenthood via the Internet affords major opportunities, both because the costs are low and because this medium makes it possible for parents to interact with one another. Therefore the same method ought to be diffused through different channels.

A clear role for municipalities and NGOs

The municipality, together with families, is the leading actor as regards the welfare of the child. It is therefore natural that the municipality should take clear responsibility for general parent support. That can be achieved by the appointment by the municipality of a person with responsibility for this sector.

NGOs cooperate in parent support in a number of places in Sweden. Their role can also be clarified.

Proposals for new forms of parent support

In Chapters 6–14 are presented proposals for new forms of parent support. These proposals include the dissemination of specific methods and the development of municipal responsibility within this sector. In what follows there is also discussion of the priorities to be established among various interventions.

Dissemination of specific methods

Pregnancy and early infancy

The Swedish National Institute for Public Health recommends the broad use within the existing activity of methods which promote secure attachments. Two examples of such methods are *Från första början* [Right from the start] and *Vägledande samspel* [ICDP, International Child Development Programme]. Methods to promote a healthy parents' relationship should also be tested, in the first instance during the mother's pregnancy. *PREP* [Preventative Relationship Enhancement Program] is an example of such a programme.

Preschool

SNIPH recommends the municipalities to offer parents interaction programmes on a broad scale, primarily when the child has reached the age of two or three, but also later on during the preschool years.

School

The Swedish National Institute for Public Health (SNIPH) recommends that municipalities should make communication programmes widely available for parents, in the first instance when the children are in school-year five.

Development of specific channels

Certain channels are particularly well suited to provide support for parents. These channels may require support in order to develop further.

SNIPH recommends the Government to finance the development and dissemination of a Swedish video/DVD version of interaction programmes for use individually or in study circles.

SNIPH recommends that child and youth psychiatric units, municipal family-counselling and the social services should provide a telephone support line for parents.

SNIPH recommends that the state should give financial support to NGOs relating to cooperation on a nationwide telephone helpline for parents, with a common telephone number.

SNIPH recommends that the state should give a NGO the task of developing, in cooperation with SNIPH, a website for parents which presents information relating to children and parents, on which parents can make their views known to one another and where current information about local parent groups and other resources for parents may be displayed.

Development of the municipal system

SNIPH recommends trials with new organisational models of parent support during pregnancy and early infancy, especially trials where the municipality takes a collective responsibility for all parent support activities. The activity which has been developed among other places in Leksand, where parent support is shaped by the municipality in cooperation with the county council, adult education associations and other NGOs, can serve as a model.

SNIPH recommends that the municipalities should coordinate all parent support, including the activity which currently is run within the maternity and child healthcare services. County council staff are, however, expected to continue to participate.

SNIPH recommends that the Association of Local Authorities and Federation of County Councils (now amalgamated into the Swedish Association of Local Authorities and Regions) enter into an agreement on parent support in 2007 based on the experiences from the trials.

SNIPH recommends that those responsible for different forms of broadly targeted parent support should register those participating according to their sex and social backgrounds (for example, level of education). By that means it will be possible on a running basis to adjust the targeting of the activity in such a way that different groups obtain access to interventions on an equitable basis.

Involving parents in the taking of decisions in the preschool and school sectors

The analysis in Chapter 12 indicates that it is desirable to continue the development in progress in Sweden towards increased participation by the parents in decision-making in preschools and schools.

Priority proposals

Within each group of proposals it is possible to give priority to individual parts.

Dissemination of specific methods

The methods which it is proposed should be disseminated on a broad basis are compared in Table 15.1. The evidence of the effect is best for methods which aim to promote strong attachment and for interaction methods. For both groups of methods an effect is demonstrated in a number of controlled studies. The effects in relation to costs are also best for each of these two methods. These two methods therefore are accorded the highest priority.

Communication methods, intended for parents with schoolchildren, come next. The chief limitation on these methods is that only a few controlled studies of interventions aimed solely at parents have been conducted and that the effects which have been shown are primarily limited to life-style habits such as the use of alcohol and tobacco. The lowest priority is given to methods which promote healthy relationships between couples because there have been only a few studies of the effect of these methods.

Table 15.1 Specific methods which it is proposed to disseminate.

Method	Age	Evidence	Effect in relation to cost	Priority
Methods which promote good relationships between couples	Pregnancy	+	?	3
Methods which promote secure attachment	Early infancy	+++	+++	1
Interaction methods	Preschool	+++	+++	1
Communication methods	School	+	+	2

Development of specific channels

It is proposed to develop four channels:the development and distribution of a Swedish video/DVD version of an interaction programme, telephone support through existing organisations, telephone support via a national line, and an Internet site for parents. Telephone counselling through existing organisations is recommended only where no new costs are expected to arise. This intervention is therefore accorded the highest priority.

The combined cost per child for a video/DVD version of the interaction programme is estimated at SEK 100 for telephone support at SEK 200 and for an Internet website at SEK 60. The costs are thus comparable. The benefit of a video/DVD version of the interaction programme is best documented. On the other hand, it is proposed to give access to the same programme content via parent groups. It is therefore difficult to establish the marginal benefit of a video/DVD version. Telephone support is expected to be used by parents only once in every 10 years. The volume of usage is thus extremely small. On the other hand, the parent questionnaire shows that this service is in demand. The Internet website is expected to give parents both expert information about various problems and the opportunity both to give and receive advice from other parents. The content is thus multi-faceted and the cost is low. That argues for giving an Internet website the second highest priority.

Development of the municipal system
The proposals which apply to the municipal system relate to trials with new models, a coordinating role for the municipality and a new agreement between the state and the Swedish Association of Local Authorities and Regions. The core of the proposal is that the municipalities should assume a coordinating role for all parent support. That means that a memberor members of the municipal personnel should be given particular responsibility for parent support. The availability of such staff is probably decisive.

Actors

Putting these proposals into effect will require cooperation from the municipalities, the county councils, the state, NGOs, private enterprises and research institutes.

Municipalities
One of the central tasks of the municipalities is to promote the health and welfare of children and youth. Parent support is one method of carrying out this task. It is therefore logical that municipal responsibility for parent support should be clarified. Parents support involves various municipal administrations. It is therefore an advantage if municipal leaders appoint one or more persons with particular responsibility for parent support. It is also an advantage to formulate a local action plan in this sector.

County councils
Through the maternity and child healthcare services, the county councils provide broad support to pregnant mothers and to families with children. For the county councils these are relatively unique activities because they do not otherwise provide broad support for other population groups. The main task of the county councils is rather the healthcare services and preventive activity in defined areas such as dental-care and cancer screening. The units in question, the maternity and child healthcare services, are responsible for only about 1 per cent of the county council budgets. Parent support is thus an activity which has no real counterpart in the county councils at large. That is one reason for proposing that the municipalities should be given primary responsibility for parent support.

In Chapter 6 there is discussion of a number of problems with the parent support which the county councils currently provide. They include lack of evidence of its effects, poor access to it for men and its relatively low attractiveness to people with a less advantaged social background. These problems cannot simply be ascribed to the fact that the primary responsibility for it lies with the county councils. The professional background of the staff involved may also be of significance. Group parent support is provided by midwives and nurses. At the heart of their training lies the identification and treatment of health problems. It also includes elements which relate to health-promoting interventions, but these aspects are not at the core of their professional roles. That argues that the problems existing in parent support which is provided by the county councils may be related to the kind of activity which the county councils conduct in general.

In a number of areas in Sweden the county councils have had great importance for the dissemination of the methods of parent support which are recommended in this report. For example, the social medical unit in the Stockholm County Council has actively contributed to the dissemination of *Vägledande samspel* [ICDP, International Child Development Programme], a method which is expected to contribute to improved parent-child interaction during early infancy. A number of county councils have contributed to the dissemination of the interaction methods which are recommended during the preschool years. The child and youth psychiatry clinics have been particularly important. That applies, for example, in Malmö, Linköping, Västerås and Uppsala. Quite often the county councils' public health committees and public health planners have also been involved. The county councils seem therefore to have an important role in the development and dissemination of methods. That may relate to the fact that the municipalities often have too small a population basis for them to be able to assume responsibility for such tasks.

The state

Parent support is a welfare service which the municipalities, county councils and other organisations largely shape and conduct themselves. One of the tasks of the state is the overall regulation of these organisations. This report deals with one such overall question, the relationship between the responsibilities of the municipalities and the county councils. However, no change is

proposed in regulation by the state, but merely a new agreement between the municipal and county council associations, which it is thought will suffice.

The role of the state is also to carry out such tasks as the municipalities, county councils and other organisations cannot fulfil independently. This report identifies five such tasks.

The first is to identify effective methods of parent support. This work consists in the first instance in processing international scientific literature, assembling information about training in current methods and assessing the quality of such training. It is appropriate to carry out these tasks at the national level. The task lies within the remit of the Swedish National Institute of Public Health (SNIPH). It is therefore justified that SNIPH should in future continue to coordinate and disseminate knowledge in this sector. The work should be carried out in cooperation with other authorities which have tasks affecting parent support, in the first instance the Alcohol Committee, the Children's Ombudsman, the National Council for Crime Prevention, the National Agency for School Improvement, the National Board of Health and Welfare the National Agency for Education.

A second task is to give support to centres which can train leaders for the parent groups which use methods recommended in this report. The existing centres have either a strictly local function (for example, the Social Services' R&D unit at the City of Stockholm) or the basic task of conducting research and training at the higher education level, for example Örebro University). Therefore, if existing or new centres are to assume responsibility for the task of broad dissemination of the methods described, it is necessary to give financial assistance to such centres during the stage when they are being built up. It is expected, however, that with the passage of time the primary actor, the municipalities, will finance training and the running of the centres.

A third task is to support research in this sector. This requires no new structures but rather information to state providers of research funds, particularly the research council for working life and social science.

A fourth task is to give financial support to interventions of a nationwide character. Three such interventions are an Internet website for parents, a common national helpline for parents and the production of Swedish video/DVD material based on interaction programmes. These three interventions can with advantage be carried out in cooperation with NGOs.

At fifth task is to study the effects of the parent support which is being provided in Sweden. This task is described below under a heading of its own.

State-financed organisations

Five state-financed organisations have particular significance for parent support, SNIPH, the National Board of Health and Welfare, the National Agency for Education, the National Agency for School Improvement and Swedish educational broadcasting company, UR.

SNIPH has had the task of analysing and disseminating knowledge of effective methods. Tasks of that kind form part of the main function of the Swedish National Institute Public Health and it is therefore justified that it should continue with it after 2004.

An important part of the present proposal is that in the longer term the effect of parent support should be studied at a national level. The question is dealt with below, under the heading "follow-up system". It is there proposed that this follow-up should be included as part of the follow-up of public health policy. That is a task which belongs to SNIPH.

It was only in the course of work on this report that it emerged that there were important problems affecting existing interventions during pregnancy and early infancy. Knowledge of these problems has come out in two ongoing doctoral research projects relating, respectively, to maternity and child healthcare, as well as in the parental questionnaire which was conducted within the framework of the present study. The analysis in Chapter 6 suggests that discussions about research activities should be conducted before a clear proposal for reform can be put forward. It is therefore desirable that the Swedish National Institute for Public Health should be given the continuing task of promoting such a process, primarily during the years 2005 and 2006.

One of the proposals put forward is that an Internet website at for parents should be developed. It is appropriate that a NGO should take responsibility for this website, together with SNIPH. The assistance of this authority is desirable to guarantee high quality of the information conveyed on the website.

The Swedish National Board of Health and Welfare has the supervisory responsibility for health and medical care and the social services. That

means that when new forms of parent support are developed, supervision of this activity is incumbent on the National Board of Health and Welfare. It can also be justified that National Board of Health and Welfare should formulate views on parent support within the framework for the guidelines for different entities for which National Board of Health and Welfare has responsibility.

The informal contacts which parents have with teachers at the preschool and school levels are an important source of support, see Chapter 5. According to the currently applicable Education Act, that is not a task which directly rests with schools. Such contacts can however be expected to facilitate children's schooling. It is further proposed that there should be a number of interventions in cooperation with preschool and schools, see Chapters 7 and 8. It is therefore desirable to hold continue discussions on parent support with the *National Agency for Education* which has responsibility for supervision of the schools and with the *National Agency for School Improvement*, which among other things has the task of disseminating information, experience and results, both in practice and research findings, which relate to preschool and school.

UR [Swedish educational broadcasting company] has produced valuable educational material for parents. It is important that this production continues and that other media programmes, chiefly the development of a website for parents, should be carried out in consultation with UR.

NGOs

NGOs bring together people with common ideas, common interests or a common identity. They are active in this sector in the first instance through the arrangement of parent groups, including study circles, and telephone helplines for parents.

Adult education associations in Sweden conduct about 0. 3 million study circles annually and have a combined turnover of about SEK 2 billion. The activity is financed by participants' fees (31 per cent), a state contribution (33 per cent), municipal contribution (13 per cent) and other contributions (12 per cent) [7]. About 400 study circles on parenthood were active in 2003. The majority of them were arranged by the adult education association *Studiefrämjandet,* followed by *ABF* [The Workers' Educational Association].

In a number of municipalities general parent support is made available in the form of study circles. That is the case in, for example, Leksand. The adult education association arranges an organisational structure, can give support to group leaders and can market courses. The state contribution (SEK 80 per study hour) can only be expected to contribute SEK 10–15 per study hour for group leaders (*Lagewald, Studiefrämjandet,* personal messages, 2004). The justification for cooperation with adult education associations is thus primarily to ensure high quality and not financial reasons.

Adult education associations have also contributed to the production of material suitable for parent circles. One example of this is *Växa tillsammans* [Grow together]. ABF is testing particular parent groups for fathers, in Stockholm among other places. Adult education associations have thus contributed to modernising the forms of parent support.

Three NGOs, BRIS, Save the Children and the Swedish Association for Mental Health are responsible for the telephone helplines for parents. One organisation, Mentor, makes available to parents circles at the workplace. A further organisation, *Makalösa föräldrar* [Remarkable Parents], organises self-help groups for single parents. The Swedish Church has taken initiatives to disseminate one of the recommended methods, *PREP* [Preventative Relationship Enhancement Program], which aims to improve the parents' relationship.

Internationally, it is common for NGOs to have responsibility for welfare services with broad coverage [8, 9]. That is not the case in Sweden. The primary contribution by the NGOs in Sweden appears to have been chiefly to develop and test new forms of parent support.

Commercial enterprises

The private sector contributes to parent support chiefly in two ways, through media production and through the training of leaders for parent groups. Media production in the form of newspapers, periodicals, books and audio-visual material accounts for the greatest turnover. The availability of printed material appears on a whole to meet demand.

A number of private enterprises supply material for parents through the Internet. Demand appears to be significantly greater than supply. That may be connected with the fact that the circulation of material via the Internet is difficult to finance. One possibility is that a private actor should provide

material without charge in order to create goodwill. The website of *Trygg-Hansa*, an insurance company, furnishes an example of this. This kind of intervention is, however, limited in scope because comprehensive information on parenthood is not a task for commercial enterprises. Another possibility is to finance the website by advertisements. An example of this is *Allt för föräldrar* [Everything for Parents], formerly known as *FöräldraNätet* [The Parent Network]. There are, however, a number of disadvantages with this. One is that it tends to put most emphasis on early infancy, because that it is the period of greatest interest to advertisers. Another limitation is that such an actor has no incentive to make available comprehensive information of high quality. A third possibility is to finance a website with the aid of subscription charges, as is the case with Growingpeople. But even with subscription charges *Growingpeople* has not been able to develop a knowledge-base in which users can check the underlying accuracy of material carried on its website. A significant disadvantage with this method is that the website is less accessible for low income families.

The private sector's other contribution consists of training in methods of parent support. The advantage of private initiatives in this field is that dissemination can be accelerated. The risk is however that the training on offer is of inadequate quality. This risk can be reduced if it carries a quality control certificate based on a number of given requirements, and also through co-operation between private enterprises and NGOs, universities and colleges.

Research institutes

The proposals put forward in this report are substantially based on international research. Knowledge in the sector has developed rapidly. As late as the beginning of the 1990s it seemed doubtful whether parent support really could affect the situation of children [3]. Today the state of knowledge is quite different. A decisive precondition for successful parent support is thus access to research in the sector. The development of theoretical models is of great value, as is research conducted in close cooperation with practical activity. In a number of chapters there are proposals for research. The majority of the proposals relate to analysis of the effects on children's health and welfare of different forms of support. It is thus important to support development of research in the sector. One suitable method is to give support to a number of research groups which are active in the field.

Follow-up system

The external circumstances are decisive for a good parent-child relationship. Parents who live in stressed social conditions may find it difficult to develop a good relationship with their children. Interventions in the form of parent insurance, children's allowances and labour market policy are therefore central to the promotion of a good parent-child relationship. In addition, parents can receive specific support in the task of taking care of their children. This report contains proposals for ways in which this support can be developed.

Seen from the child's perspective, a good relationship with their parents is crucial. In Sweden, 72 per cent of all 13-year-olds say that it is easy to talk to their father and 87 per cent say that it is easy to talk to their mother [10]. This indicates that the majority of children in Sweden have a good relationship with their parents. There are significantly more young Swedes who say that it is easy to talk to their mother and father, as compared with those of the same age in, for example, the USA. Nonetheless, the situation in Sweden is not ideal. In a number of comparable countries, for example in The Netherlands, the proportion of the young who say that it is easy to talk to their parents is even greater.

One of the main aims of parent support is to increase the number of children who have a good relationship with their parents, in order to increase the chances of the child to have a good life. There are a number of ways to clarify whether the interventions on offer really contribute to this. The effects of a number of the interventions proposed can be studied scientifically by experiment. It can then be established with relatively good statistical reliability whether an intervention achieves the intended result. However, other interventions are significantly more difficult to assess. For example, parent insurance can in general be expected to contribute to a good parent-child relationship. The importance for children of a change in parent insurance, in the direction of the fathers taking a greater number of days of parental leave cannot, however, be studied in controlled experiments. Therefore additional methods are needed to study the effects of different forms of parent support.

It is thus important to follow over time how parent-child relationships develop. Such knowledge does not give direct answers as to which measures

may be justified. But the information can provide a basis for a broad assessment of development and can inspire initiatives with the objective of giving all children a good upbringing.

Indicators for parent support

Follow-up with indicators for important determining factors for health is one of the cornerstones in public health policy [11]. The objectives which relate to the conditions during childhood and adolescence (objective 3) include support for parents. The purpose is to reflect the development of parent support with the aid of an indicator.

An ideal indicator should reflect the parents' capacity to give the child a suitable combination of affection and boundary setting. Systems for gathering information of this kind are to be found, among other places, within the framework of the *Denver Youth Survey* (DYS) in the USA. It is nonetheless hardly realistic in the immediate future to develop such methods for routine use in Sweden. Against that, it is proposed in Chapters 6–8 that there should be research in this field.

A more realistic alternative is to collect information about the quality of the parent-child relationship, either from the children or from the parents. Both children and parents tend, however, to give a more favourable picture of the relationship than is in fact the case. The problem can be combated to a certain extent by ensuring the questions are precisely worded. This source of error can be expected to continue over time. The problem can, however, be countered in part by precise formulation of the questions and it therefore ought to be possible to study the development with the aid of such questions. Since children are the starting point for the interventions which are under discussion it is appropriate in the first instance to collect information from children.

Information from children younger than about ten years can hardly be used routinely. The centre of gravity in the proposals put forward in this report is related, however, to interventions for parents during early infancy and preschool. That means that there is a delay of five years or more between the time of the intervention and the effect which is to be assessed. The effects of an improvement in parent support which is introduced in the years 2005–2008 can therefore be assessed at the earliest in the years 2010–2013. This limitation can hardly be avoided.

The data source best suited for use with children is *Barn-ULF*, an official Swedish programme for investigating the living conditions of children. It may also prove possible to make use of the planned recording-keeping of data relating to mental health in children and young people.

Barn-ULF

Since 2000 *Barn-ULF* has annually been collecting information from just under 1,000 children in the ages 10–18 years. This study is being conducted in conjunction with an interview study of the living conditions of adults (The *ULF* study) carried out by Statistics Sweden. The investigation includes the following questions which can be used as indicators of parent relationships.

Question 36–39: How do you get on with your/mother/father/mother's partner or husband/father's partner or wife? Alternatives: Rather well, All right, Rather badly, Very badly.

Question 40–43. Does your mother/father/mother's partner or husband/father's partner or wife usually have time for you if you want to talk to her/him or want do something/? Alternatives: Yes always, Yes often, No not very often, or No never.

Question 51. If you are anxious or worried about something, who do you normally talk to? 15 alternatives, including: Mother, mother's partner/husband, father, father's partner/wife.

Collection of data on the mental health of children and youth

The *Centre for Epidemiology at the National Board of Health and Welfare* has the task of making proposals for methods for recurrent assessments of mental health. The methods will be based on questionnaires to be answered by school pupils. The final report was submitted in 2005. It includes a tool for assessing the quality of children's lives, called *Kidscreen* [12]. This questionnaire contains questions on the relationship with parents: "Do you feel that you can talk to your parents when you wish? Do your parents show understanding for you? Do you feel loved by your parents? Do you have a good life at home? Do your parents have enough time for you? Do your parents treat you fairly? Do you feel you can talk to your parents when you want to?" If these questions are included in the national enquiry they are obviously suitable as indicators. In this system information will then be accessible in all the municipalities in Sweden.

Denver Youth Survey

Denver Youth Survey (DYS) includes questions to children which assess the parents' capacity for giving children positive attention, for clear communication and for well-thought-out ways of dealing with a child when conflicts arise. All elements are included both in interaction programmes for preschool children and in communication programmes for schoolchildren. One example of a question which assesses a positive attention is "... when you have done something your parents like or approve of, how often do your parents say something nice about it?". An example of a question which relates to clear communication is "How often do your parents find time to listen to you when you want to talk to them?". An example of a question which relates to well-thought-out ways of dealing with child when conflicts arise is "… is there a difference in … punishment … depending on … your parents' … mood?". In Sweden however these questions are not used routinely in any system.

Proposal

Question 36–39 in *Barn-ULF* seems to be the best adapted to use as an indicator: "How do you get on with your/mother/father…". Systems for collecting data via *Barn-ULF* are already established. This question gives a rather more balanced picture of the relationship, as compared with other questions in *Barn-ULF.*

Proposal

The majority of the proposals which have been discussed in this chapter have also been dealt with in earlier chapters. The exception is the follow-up system.

It is proposed that the Swedish National Institute for Public Health should be given the task of following the development of an indicator for parent support. It is proposed that this task should be part of the follow-up of indicators of national health policy.

Contributors

Sven Bremberg has the main responsibility for the text and Anton Lager has prepared the background material.

References

1. Dalman C, Bremberg S. *Hur satsar vi på barnen? Insatser för barn och ungdom i Stockholms län mätt i kronor*. Huddinge: Centrum för Barn- & Ungdomshälsa; 1999.
2. Barnhälsovårdsenheten i Örebro län. *BHV statistik 2003*. URL: http://www.orebroll.se/upload/Prim/Kansli/BHV/Dokument/Statistik%202003%20webb.PDF.
3. Durlak JA. Successful prevention programs for children and adolescents. New York: Plenum; 1997.
4. *Vårdens svåra val. Slutbetänkande av Prioriteringsutredningen*. SOU 1993:93. Stockholm: Socialdepartementet; 1995.
5. Peterson S, Backlund I, Diderichsen F. *Sjukdomsbördan i Sverige – en svensk DALY-kalkyl*. Stockholm: Karolinska Institutet, Folkhälsoinstitutet, Epidemiologiskt Centrum, Stockholms läns landsting; 1999.
6. Konarski K. *Jordmån för ett gott liv. Psykosociala faktorers inverkan på folkhälsan samt åtgärdsförslag*. Idéskrift från folkhälsogruppen nr 16. Stockholm: Allmänna förlaget; 1992.
7. Persson ER. *Studieförbundens ekonomi, organisation, personal*. Stockholm: Rapport till Statens utvärdering av folkbildningen 2004, SUFO 2; 2004.
8. Johansson S. *Självständiga rörelser eller kommunala underleverantörer? Ideella organisationers roll i välfärdssystemet*. Göteborg: Centrum för forskning om offentlig sektor (CEFOS) Univ.; 2001.

9. *”Statens” bästa vän? Den ideella sektorns roll i ett internationellt och svenskt perspektiv*. Socialstyrelsens årliga konferens om den ideella sektorn år 2003. Stockholm: Socialstyrelsen; 2003.

10. Currie C, Roberts C, Antony M, Smith RWS, Samdal O, Barnekow Rasmussen V, Eds. Young people’s health in context. Health Behaviour in School-aged Children (HBSC) study: International report from the 2001/2002 survey; 2004.

11. *Mål för folkhälsan*. Proposition 2002/03:35. Stockholm: Social-departementet; 2002.

12. The Kidscreen Group. Kidscreen. URL: http://www.kidscreen.de/.

SWEDISH NATIONAL
INSTITUTE OF PUBLIC HEALTH

Swedish National
Institute of Public Health
Internet: www.fhi.se

R 2006:15
ISSN 1651-8624
ISBN 91-7257-443-7