

NONVIOLENT RESISTANCE: A TREATMENT FOR PARENTS OF CHILDREN WITH ACUTE BEHAVIOR PROBLEMS

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Nonviolent resistance (NVR) is a new training model aimed at helping parents deal effectively with their helplessness, isolation, and escalatory interactions with their children. The purpose of this study is to evaluate training in NVR with the parents of children with acute behavior problems. Seventy-three parents (41 families) were randomly assigned to a treatment group and wait-list control group. Measures were taken at pretreatment, posttreatment, and a 1-month follow-up. In comparison with the wait-list group, parents who received training in NVR showed a decrease in parental helplessness and escalatory behaviors, and an increase in perceived social support. The children's negative behaviors as assessed by the parents also decreased significantly.

The treatment of children with aggressive or other acute behavioral problems¹ is often conducted through the parents (Kotchick, Shaffer, Dorsey, & Forehand, 2004). Programs of parent training have been inspired by a variety of therapeutic approaches (Cavell, 2000; Forehand & McMahon, 1981; Henggeler & Borduin, 1990; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998; Patterson, 1976; Price, 1996; Sells, 1998; Webster-Stratton & Herbert, 1994). The data on the effectiveness of parent-training programs support this parent-based strategy (Brestan & Eyberg, 1998). Yet, although parents play the major role, the programs usually remain child-focused, viewing the parents as mediators or co-therapists who are responsible for changing the child's behavior.

Over the years, however, parents are growingly being viewed as clients in their own right. Some treatments now present themselves as "parent-therapies" (Cavell, 2000). In this view, improvements in the reactions, self-esteem, perceived support, and well-being of the parents should be viewed as goals in themselves. Parental variables should accordingly be no less important than child variables in estimating treatment success. After all, parental suffering is no less real and deserves relief no less than child suffering. Moreover, improvements in parental feelings would most probably benefit the child, particularly if achieved through an increase in parental presence, and a diminution of the parents' impulsive reactions and escalating behaviors.

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¹Among the problems most commonly described by the parents in this project were verbal and physical violence (against parents and siblings), severe discipline problems at home and school, truancy, substance abuse, stealing, and emotional blackmail (e.g., by threats of suicide or of running away from home). Although the children were not selected according to DSM diagnostic criteria (it was the parents who were interviewed and accepted to the program), the majority would probably fit in a continuum between conduct disorder and oppositional-defiant disorder.

Nonviolent Resistance (NVR)

Nonviolent resistance was originally developed in the sociopolitical arena. Groups that were power-disadvantaged or morally opposed to the use of violence in their fight against exploitation and oppression, but who felt that dialogue and persuasion by themselves were ineffective in helping them to their goals, developed a variety of nonviolent methods for conducting their struggle. Gene Sharp (1973, 2005), the foremost authority in the history, principles, and strategies of NVR, has described the wide scope of the approach and its influence in innumerable confrontations throughout the 20th century. Until recently, these ideas have received only sporadic mention in the psychological literature (Kool, 1990; Schiff & Belson, 1988). However, recently, the NVR training program has been developed to help parents cope with child and adolescent violent and self-destructive behaviors (Alon & Omer, 2006; Omer, 2001, 2004; Omer, Irbauch, & Schlippe, 2005; Omer & Schlippe, 2002, 2004; Omer, Shor-Sapir, & Weinblatt, 2006). Originally developed in Israel, this approach is presently being applied in many treatment centers in Germany, England, Switzerland, and Holland. This is the first controlled study of parental training in NVR.

Parental Helplessness and Escalation Processes

The theoretical rationale for using NVR with the parents of children with acute behavior problems has to do with parental helplessness. The parents of children with severe behavioral problems often view themselves as having less power than the child (Bugental & Lewis, 1998), believe that nothing can work, and feel defeated in advance when it comes to demands or confrontations (Webster-Stratton & Herbert, 1994). Some give vent to their frustration by reacting punitively or violently (Forgatch, 1991); others give in to the child's power-backed demands (Baumrind, 1991), and others still oscillate between impulsiveness and submission (Chamberlain & Patterson, 1995). Bugental, Brown, and Reiss (1996) argued that the parents' sense of powerlessness increases the risk of their lashing out, giving in, or oscillating between the two (Bugental, Blue, & Cruzcosa, 1989). These are precisely the parental responses that exacerbate escalation processes. Two types of escalation have been described: (a) complementary escalation, in which parental giving in increases the child's demands and threats and (b) reciprocal escalation, in which hostility begets hostility (Omer, 2001, 2004; Patterson, Dishion, & Bank, 1984; Patterson, Reid, & Dishion, 1992). NVR aims at countering both kinds, helping the parents overcome their helplessness by constructive responses that allow them to stop giving in or lashing out.

Parental helplessness has been linked to an increased risk for children's violent and self-destructive behaviors (Omer, 2004; Pleyer, 2003; Price, 1996). Children who are characterized by a restless, impulsive temperament have been found to be at high risk of developing acute behavioral problems, if the parents were unable to supply clear limits and to supervise their doings (Bates, Petit, Dodge, & Ridge, 1998; Florsheim, Tolan, & Gorman-Smith, 1998; Steinberg, 1987; Wilson, 1987). These findings pose a question that is at once practical and ethical: How can parents be helped out of their helplessness without becoming punitive and authoritarian?

Parent training in NVR tries to achieve these goals by a variety of means. First and foremost is the commitment to nonviolence. Parents commit themselves to restrain themselves from violent and humiliating responses. This commitment is made not only before the therapist, but also before the parents' support network (relatives and friends). The parents are also coached on how to prevent escalation by becoming aware of its signs as well as of their own contribution to the process. Alternative, nonescalating reactions can then be discussed and implemented. Parents soon make the discovery that developing an attitude of endurance against provocations and attacks can be inspiring and motivating.

Power, Resistance, and Control

One must not confuse NVR with the position that views all use of power as illegitimate. Gandhi, the most uncompromising apostle of nonviolence, emphasized that demands or

entreaties that are not backed by the power to resist have very little influence (Sharp, 1973, 2005). The language of NVR is thus explicitly a language of struggle. The philosophy of NVR postulates that a person or group that desists on principle from fighting ultimately contributes to the perpetuation of violence. The fight, however, should be a strictly nonviolent one. The nonviolent resistor must learn to avoid any form of physical or verbal attack, and to refrain from acts or expressions whose aim is to humiliate or insult. We therefore talk openly about the parents' fight against the child's destructive behaviors. This fight, however, is profoundly different from what is commonly viewed as a "fight," since (a) the parents commit themselves to a strictly nonviolent and nonhumiliating stance; (b) the parents assume responsibility for their own side in the escalation process; (c) whereas in a more usual kind of fight one's goal is to defeat the adversary, in NVR the goal of the parents is to resist the child's destructive behaviors, while protecting themselves and the children (both the perpetrator and the potential victims); and (d) the parents fight the child's violence while at the same time maintaining and furthering the positive elements in the relationship. These characteristics may justify us in characterizing parental NVR as a "constructive" rather than a "destructive fight" (Alon & Omer, 2006).

In NVR, the parents aim at *resisting* rather than *controlling* the child's negative behaviors. It is a central tenet of NVR, especially as propounded by Gandhi, that we cannot determine the opponent's response, but only our own. Engaging in NVR with the expectation that the opponent will immediately relinquish violence or oppression is illusory. Nonviolent resisters should therefore be prepared to withstand attacks and provocations without escalating, as the opponents attempt to make them return to the ways of violence, in which the opponents feel they have a clear advantage. The effects of NVR manifest themselves first of all on the resisting side, as the resisters overcome helplessness, restore their self-esteem, and become able to mobilize their frustration onto productive action. These processes create a new situation in which violence and oppression find it harder to survive. The same applies to our approach to parents. The parents learn to resist the child's negative behaviors, while at the same time developing endurance, controlling their own reactions, and countering escalation. Our message to the parents is: "You don't have to win, but only to persist!" The parents are thus relieved from the immediate goal of changing the child. The success of a parental *sit-in* (see below) is seen as a function of the parents' behavior and not of the child's response. This redirection of the parents' attention (away from the child's reactions and toward their own performance) reduces escalation and parental helplessness. It would therefore run counter to the philosophy of NVR if we made direct observation of the child's behavior into the foremost measure of effectiveness. The child's behavior is an important variable, but not necessarily the central one. In some of our cases, parents succeeded in protecting themselves, their children, and the house against the outbursts of a violent child, without any immediate far-reaching change in the child's style of behavior. As one parent said: "He is still a tornado, but the house has become a much better shelter!" In this light, NVR finds its place within recent therapeutic developments that emphasize commitment and acceptance rather than control (Alon & Omer, 2006; Hayes, Strosahl, & Wilson, 1999; Linehan, 1993).

NVR and Parental Presence

Nonviolent resistance is highly relevant for parents, because it is the only kind of struggle that is conducted through contact and presence. The strategies of NVR in the sociopolitical arena work chiefly through the resisters' personal interposition and tenacious presence in ways that obstruct the mechanisms of oppression. Classical examples are Gandhi's struggle against the British salt monopoly by marching in person to the sea with thousands of followers to mine salt with his own hands; the dismantling of discrimination in buses in Alabama by the decided action of a small number of black resisters, who boarded buses and sat in places that were reserved for whites; and the many cases of factory occupation by workers, who sometimes

chained themselves to the machinery, thus evincing their tenacity by committing their very bodies to the process of obstruction. Similarly, parental NVR works through decided manifestations of parental presence. Parents learn to come in person to the areas where a youngster engages in destructive activities, to interpose themselves so as to prevent violence against siblings, and to perform *sit-ins* to protest and resist the child's unacceptable actions. In all these, the message conveyed by the parents is: "We are your parents! We will not be discarded, ignored, intimidated, or paralyzed!" NVR consistently rejects authority practices that are based on distance, fear, or anonymous punishments.

Support, Openness, and Transparency

In contrast to clandestine movements of resistance, NVR rejects secrecy, opting for transparency and publicity. There are many reasons for this choice: (a) openness is the only way to mobilize a wide support; (b) publicity influences third parties or even members within the violent camp to take a clear stance against violence and destructiveness; (c) transparency increases the commitment of the resisters to nonviolence, which might perhaps waver if the resistance were conducted under the veil of secrecy; and (d) secrecy stems from fear and often perpetuates fear (Sharp, 1973, 2005). These processes are highly relevant for parents. Thus, we help parents to lift the veil of secrecy about the child's behavior, the situation at home, and their program of action, thus mobilizing the support of friends and relatives. This rescues the parents from isolation (Dumas & Wahler, 1983). In addition, the readiness to go public before friends and relatives strengthens the parents' commitment to abide by strict nonviolence and nonescalation. The presence of external supporters often has the additional effect of strengthening the inner voices of the child that oppose the child's own destructive acts. Finally, breaking secrecy is an act of courage that boosts the parents' morale and determination. For all these reasons, disclosure and the systematic mobilization of support is one of the mainstays of our program. Many parents require considerable persuasion to become ready to go public (even though the publicity is invariably a selective one: the parents decide the people who are to be let into the secret). However, the great majority of parents end by accepting the need to do so, gaining immeasurably from the transition from lonely to supported resistance.

Respect and Reconciliation

Leaders like Gandhi and Martin Luther King did not settle for the absence of violence alone: they demanded from themselves and from their followers that the acts of resistance be accompanied, as far as humanly possible, by real respect for the adversary. This position did not characterize every NVR movement. Some have even claimed that such demands might deter potential followers (Sharp, 1973). There is, however, a deep logic in Gandhi and King's position: it stems from the assumption that the opponent is not made of one cloth. Acts of respect and reconciliation would then serve to strengthen the positive voices on the opposing side. Eschewing such acts or engaging in humiliating behaviors would, in contrast, strengthen the violent voices. In the context of parent-child relations, this argument is particularly valid. Our basic assumption is that the parent loves the child, even if this love is temporarily hidden from view as a result of the constant conflicts. Parental acts of respect and reconciliation (that do not include surrender) are thus based on existent feelings and, in turn, increase the chances that these feelings may feed positive interactions. In our program, parents have often reported that initiating reconciliation moves (e.g., messages of appreciation, symbolic treats, proposing joint activities, or acknowledging past offenses), far from weakening them, strengthened their determination to resist. They said that the reconciliation gestures released them from the role of "the bad guys," allowing them not to feel guilty in their resistance steps.

In the present study, a parents' instruction manual was used in the context of a short-term parent-training program in NVR (five individual therapy sessions + 10 sessions of telephone support) for parents who exhibited high levels of helplessness in dealing with their children's

acute behavior problems. We asked ourselves how this treatment would affect the parents' sense of helplessness, their sense of isolation and support, their ability to avoid escalation and initiate positive interactions, and the child's problem behaviors. As the parents were viewed as the clients in the project, we were interested particularly in the change the training would bring about in their feelings and reports.

METHOD

Participants

The clients were 73 parents (41 families) of children and adolescents (boys and girls) aged 4–17 years who, according to parental reports, displayed acute behavioral problems, such as verbal and physical violence, vandalism, lying, truancy, substance abuse, and thefts. Thirty-two families were two-parent and nine were single-parent households (all mothers). Participants included 41 mothers and 32 fathers. Parents' level of education ranged from 8 to 21 years ($M = 14.14$, $SD = 3.21$). Age of parents ranged from 28 to 57 years ($M = 42.3$, $SD = 6.83$). Children's age ranged from 4 to 17 years ($M = 12.57$, $SD = 3.53$) and included 28 boys (68%) and 13 girls (32%). Thirty-nine families in the project could be categorized as belonging to the middle class, although many of them (20 families) would count as lower middle class. As the parents were self-referred, families with very low socioeconomic background were almost absent from the sample (a total of two families). In 31 families (75%), the parents and/or the child had been previously in treatment because of the child's problems. The treatments included individual therapy for the child (in 15 families), family therapy (four families), parent behavioral training (four families) or pharmacological interventions (10 families).

Inclusion criteria for the study were (a) the child should be between 4 and 17 years of age; (b) the child had not begun to receive medication during the last 6 weeks prior to the referral; (c) the parents were willing to commit themselves to attend all five treatment sessions and a 1-month follow-up session, to be available for telephone contacts twice weekly, and to fulfill all assessment requirements. Exclusion criteria were (a) current child's DSM-IV diagnosis of pervasive developmental disorder, mental retardation, or psychotic disorder; (b) the parents were in the process of separating at the time of the referral; and (c) the behavior problems were directly linked to medical problems or treatments.

The project was conducted in two locations: 29 families were seen in the Department of Psychology at Tel Aviv University and 12 families were seen in the Parent Counseling Center at Schneider's Children's Hospital (located in the Tel Aviv area). To evaluate possible effects for the location a $2 \times 2 \times 2$ analysis of variance (ANOVA) was conducted, with group (treatment and control) and location (university and hospital) as between factors, and time (pretreatment, posttreatment, and follow-up) as within factor. The ANOVA did not reveal a significant effect for the location or an interaction between location and other factors for all dependent variables.

Therapists and Treatment Integrity

The parents met individually with a therapeutic team composed of a therapist and a telephone supporter. Three therapists were included in the project, two male Master-level clinical psychologists (25 families, 61%), and one female Master-level family therapist (16 families, 39%). All therapists had prior experience in using NVR and each therapist treated a similar number of treatment and control families. The 28 telephone supporters were undergraduate psychology students who participated in a course delivered by the second author on "Parental Presence and NVR." Therapists and supporters had weekly supervision with the second author to ensure protocol adherence and assist in tailoring specific interventions from the parents' manual (Omer, 2004). Adherence to the treatment was further promoted by using the parents' manual during therapy sessions as a basis for the planning of specific interventions.

The treatment sessions themselves did not follow a strict therapeutic manual, with different families implementing different elements in the parents' manual, at their own pace, according to need. The therapist's role was a mix of expert in the specifics of NVR and in the escalatory nature of parent-child conflicts. We might characterize the therapist stance as rather didactic. The telephone conversations were devoted to a detailed examination of the parents' implementation of the different interventions. The telephone support guaranteed a high level of implementation, allowed for a better tailoring of the interventions to the family, and helped to spot crises and deal with them according to the principles of NVR. In addition, the telephone contacts served as a source of encouragement for the parents.

Procedure

Parents were screened for eligibility using a semi-structured telephone interview. Seventy-three parents (41 families) who were found eligible were assigned to groups according to a random-block design with two age categories: 4–11, 12–17. The wait-list group waited for 1 month between the intake interview and the beginning of treatment. Treatment included five weekly 1-hr sessions during 1 month of treatment. The follow-up session took place 1 month after treatment conclusion. During the treatment the parents received two telephone support conversations (of 30–45 min) every week. In these conversations parents were instructed and supported in the implementation of the interventions. At the start of each conversation, the supporter administered (by phone) a rating list of escalatory behaviors and reconciliation gestures referring to the last 3 days. Questionnaires were given to parents in the treatment group before the first session (pretreatment), at the end of five treatment sessions (posttreatment), and at the follow-up session a month later. Control group participants received the questionnaires before and after their waiting time. After the waiting time they were given the same treatment as the treatment group.

Treatment

The first session consisted of a semi-structured interview aiming to gain information about four domains: (a) the parents' modes of behaviors in dealing with the child's particular behavior problems; (b) escalation patterns between parents and child; (c) support issues including who knows about the problem and who would be willing to help; and (d) reconciliation issues—spontaneous positive gestures initiated by the parents or by the child. At the end of the session parents received an instruction manual, 26 pages long, describing the rationale and the different interventions of NVR (Omer, 2004). In the next four sessions four intervention areas were addressed: resistance by presence, support and public opinion, prevention of escalation, and reconciliation gestures.

Resistance by presence. Manifestations of parental presence, which are the chief means of parental empowerment and resistance in the program, take place within and outside the home, according to the child's specific problems. One of the chief techniques for manifesting presence in the home is the *sit-in* (Omer, 2001, 2004). In the *sit-in* the parents enter the child's room, sit down, and announce to the child that they will stay there and wait for the child's proposal to avoid the problem behavior that triggered the sit-in. The parents are instructed to remain quiet, strictly avoiding arguments and provocations. The *sit-in* lasts up to 1 hr (unless an acceptable proposal is made by the child). The therapist prepares the parents to withstand the various reactions that the child might evince without escalating. The *sit-in* thus serves also as a valuable training ground for the parents in the prevention of escalation. The *sit-in* is envisaged not as a punishment, but as a means of manifesting parental presence and increasing the parents' capacity of resisting without escalating. The success of the *sit-in* is not only viewed as a function of the change it creates in the child's behavior, but also as the ability of the parents to stay in the room, avoid escalation, and resist provocations. A highly successful *sit-in*, for instance, is one which not only gives the parents the feeling that they were clearly present, but also helped them

become more present in other situations. This contrasts, for instance, with a typical behavioral intervention, whose goal would rather be directly to influence the child's behavior through positive or negative reinforcement.

The chief techniques for manifesting presence outside the home are the *telephone round* and the *parental visitation*. In the *telephone round* the parents react to the child's refusal to come home at the specified hour by calling a number of the child's friends and their parents (usually 10 or more), telling them that their child has not come home, asking for their help, and requesting them (the child's friends) to tell their child that they had called to look for him or her. The parents are rigorously instructed on how to prevent escalation, once the child returns home in anger at their "tactless" intervention. The telephone round is not only a means of finding out where the child is, but also of leaving clear signs of parental presence (the messages relayed by the friends), and of extending the parental network (some of the friends' parents join the parental support network in the sequel). The *parental visitation* is the parents' actual arrival on the scene where the child spends his or her time without parental permission. Parents have made *parental visitations* to nightclubs, street corners, and friends' houses. The parents are instructed in detail on how to behave during the visitation so as to prevent escalation. In similarity to the *sit-in* the emphasis is to help the parents become more present while withstanding the risk of escalation. The parental stance is a strictly noncontrolling one. For instance, on coming to the place where the child is, the parents are encouraged to say in a quiet tone: "We want you to come home with us. But we cannot make you obey us. However, it is our duty to resist your negative behavior, and if you refuse to come with us, we will stay here." A similar parental announcement characterizes the telephone round: "We are not interested in making phone calls to anybody! If you tell us where you are going and if you come back at the agreed time, we won't make any calls. If you don't, we have no other choice." Thus although the telephone round and the parental visitation are usually quite unpleasant to the child, the noncontrolling parental stance makes them very different from a typical behaviorist intervention. Thus when the parent punishes or administers a negative reinforcement the implied message is: "You must change your behavior!" In contrast, the NVR message is: "I cannot determine your behavior! But I am obliged to resist!"

Support and public opinion. Involving other people in what is happening at home is a major factor in coping with the child's negative behaviors. Some typical roles of the supporters in NVR are (a) to back and legitimize the parents' acts of resistance (in the eyes of both parent and child); (b) to help in breaking the seal of secrecy surrounding the child's negative behaviors; (c) to mediate in situations of acute polarization or disconnection between parents and child; (d) to help defuse situations of acute escalation; and (e) to pressure the child through public opinion to reduce the negative behaviors. The pressure by public opinion is made in a positive tone. Thus, supporters call or visit the child, express their love and care, and say that they are ready to help him or her solve the problem, but add that the negative behaviors are unacceptable and must stop. The parents are helped to recruit a number of supporters to help them in these tasks. To this end they are given a letter "to the supporter," explaining the purpose and principles of the treatment. When possible, the second or third session of the treatment is devoted to a meeting with the supporters. The use of a supportive network in NVR has similarities to its use in other approaches, such as multisystemic therapy (Henggeler & Borduin, 1990; Henggeler et al., 1998). However, use of the supporters as an explicit source of public opinion to strengthen parental resistance is typical of NVR both in the sociopolitical and in the family arenas. For instance, the supporters are specifically instructed to contact the child after a violent outburst, tell him or her that they were told of the event, and that they are willing to help him or her overcome the difficulty. However, they make it clear that violence is unacceptable and that the parents have the obligation of resisting it.

Prevention of escalation. Self-discipline and anti-escalation steps are essential to all programs of NVR (Sharp, 1973, 2005). Three concepts were utilized to help the parents achieve

this goal: (a) *the principle of delay* stipulates that the parents should not react immediately to the child's difficult or provocative behaviors, but should tell the child that they will think about the problem and come back to the child later. This principle was illustrated by the maxim "Strike the iron when it is cold!"; (b) *withstanding provocations* refers to the part of the program that is devoted to identifying the child's and the parents' behavior patterns that result in escalation and loss of control, and in developing alternative, nonescalating alternative reactions; and (c) *the noncontrolling stance* refers to the systematic avoidance of acts and speech that convey the message: "I am the boss!" The parents are encouraged to convey the contrary message: "I cannot control you! I can only control myself and resist your negative acts!" This noncontrolling stance reduces the child's need to prove that the parent is wrong and frees the parent from having to make the child obey. Resistance thus becomes purified of its coercive elements.

Reconciliation gestures. Gestures of reconciliation are behaviors intended to repair damaged relationships and prevent further escalation. These behaviors include statements expressing respect for the child, suggestions of shared activities, expressing regret for past violent reactions, and symbolic gifts. The parents' reconciliation gestures are unilateral initiatives that are not conditional on the child's positive behaviors. In this they differ from positive reinforcements. The purpose of reconciliation gestures is to promote and maintain the positive aspects of the relationship. Reconciliation gestures run parallel to the parents' acts of resistance.

Measurements

Parental helplessness questionnaire. The Parental Helplessness Questionnaire (Cohen-Yeshurun, 2001; En-Dar, 2001) measures parents' sense of helplessness in dealing with their child. This 18-item questionnaire (e.g., "I am afraid of my child's physical violence" and "I have no influence over my child") rated on a 1- to 6-point scale was developed at Tel Aviv University and found valid in distinguishing between parents who seek professional help and parents who do not, and between families with high and low levels of sibling violence. The questionnaire has an Alpha Cronbach of 0.91. It was specifically designed to assess the degree to which parents feel that they have lost their voice, influence, self-reliance, and even their place in the home. The questionnaire is thus a measure of parental presence as experienced by the parents. NVR is a means of furthering parental presence and a way of resistance that is carried out through parental presence. This questionnaire thus assesses what is probably the central variable in the NVR program.

Child behavior checklist. The parents' perception of their child's problem behaviors was assessed using the 118-item Child Behavior Checklist (CBCL; Achenbach, 1991). The items are rated as 0 (not true), 1 (sometimes true), or 2 (often true). The externalizing and aggression subscales were used in our analyses. The Hebrew version (Zilber, Auerbach, & Lerner, 1994) that was utilized in this study has shown good levels of reliability (Alpha Cronbach of 0.78–0.91). Although the parents are at the center of the present program, their major complaint has to do with the child's behavior. The effectiveness of NVR should therefore become manifest also at this level. The CBCL is an appropriate tool for assessing whether the parents have a clear sense that they are improving the child's behavior and not only changing their own.

Perceived social support questionnaire. The Perceived Social Support Questionnaire (Elad, 2001) addresses the parents' need for support (e.g., "How much support do you feel you need from your partner?") and feeling of received support ("How much support do you receive from your partner?") from members in their social environment (partner, friends, extended family). The questionnaire has 14 items rated on a 1- to 6-point scale. The parent's level of support is calculated by the difference between the need for support and the received support. Thus a negative value indicates that the need of support is greater than the support received. The questionnaire has an Alpha Cronbach of 0.72. Social support is central to NVR. Improving the parents' feeling of support is an explicit goal of the program and one of the criteria of its success.

Parental authority questionnaire. The Parental Authority Questionnaire (Cohen-Yeshurun, 2001) was developed at Tel Aviv University and is based on Buri's Parental Authority Questionnaire (Buri, 1989, 1991). However, in the Hebrew version items were written from the perspective of the parent, thus evaluating his own parenting behaviors and attitudes. The questionnaire consists of 30 items rated on a 1- to 5-point scale. There are three subscales: authoritarian style (e.g., "I decide everything"), authoritative style ("I lead my child's behaviors in a consistent and rational way), and permissive style (e.g., "Children should do what they like"). The authoritarian subscale has an Alpha Cronbach of 0.84, the authoritative subscale, of 0.72, and the permissive subscale, of 0.70. Through NVR we attempt to help the parents become less permissive and more authoritative without becoming authoritarian. This questionnaire enables us to check whether the program achieves these goals.

Mental health inventory. In this study, we used the Mental Health Inventory (MHI; Veit & Ware, 1983) to assess parental distress. The questionnaire has 37 items rated on a 1- to 5-point scale. The items refer to the experience in the last 2 weeks (e.g., "How stressed were you in the last 2 weeks?"). The questionnaire was translated to Hebrew by Florian and Drori (1990) and has an Alpha Cronbach of 0.96. We hypothesized that NVR should reduce parental distress. This idea is made clear in the treatment, as we explicitly tell the parents: "The child's suffering is just as important for us as your suffering. We don't believe that the child can improve unless you also, as parents, can feel better."

Parental self-efficacy questionnaire. The Parental Self-Efficacy Questionnaire (Cohen-Yeshurun, 2001) was developed at Tel Aviv University and is based on the Cleminshaw & Guidubaldi Parent Satisfaction Scale (Guidubaldi & Cleminshaw, 1985) and the Teacher Efficacy Scale (TES; Gibson & Dembo, 1984). The 15-item questionnaire rated on a 1- to 6-point scale assesses the parents' sense of competence and satisfaction in their parenting ("To what extent are you satisfied with your level of involvement in your child's life?"). The questionnaire has an Alpha Cronbach of 0.81. This questionnaire refers to more global aspects of parenting than those that are reflected in the Parental Helplessness Questionnaire. We used it to check whether training in NVR would increase the sense of parental competence and satisfaction in other ways, and not only in the parents' ability to cope with the child's negative behaviors.

Parent behavior telephone checklist. This questionnaire was used as a partial outcome measure, which is an outcome that is measured during the therapeutic process. This 16-item yes/no checklist measures the parents' escalation behaviors (e.g., "I screamed at the child") and reconciliation behaviors (e.g., "I kissed the child"). The questionnaire is filled by the mothers every 3 or 4 days at the start of the telephone support conversation. This questionnaire assesses whether and at what pace the parents are helped to reduce escalation and promote reconciliation. Besides being an ongoing measure of the parents' progress, the questionnaire also serves as an indication of the parents' implementation of treatment steps.

RESULTS

Equivalency of Groups, Attrition, and Missing Data

Chi-squared tests and *t*-tests revealed no significant differences between the treatment and the control group in any of the demographic variables, including number of single-parent families, child age, child gender, and parent age. No significant baseline differences were observed on any of the dependent measures.

One family from the control group dropped out after one session (a single-parent family). Three families did not come to the follow-up meeting (two from the control group and one from the treatment group). Three fathers refused to fill out questionnaires at preassessment (one from the treatment group and two from the control group).

Effects of Intervention—Outcome Measures

To evaluate the effects of treatment on parents we conducted a 2×2 repeated-measures ANOVA with group (intervention vs. control) serving as a between-subject independent variable, and assessment time (preassessment vs. postassessment) serving as the repeated, within-subject independent variable (see Table 1 for the means and standard deviations at pre- and postassessment). Significant effects were followed by post hoc comparisons assessing the effectiveness of NVR in comparison with the control group. To examine whether the child's age had any effect on the results, we originally conducted a similar $2 \times 2 \times 2$ ANOVA with child age (young 4–11, adolescents 12–17) serving as an additional between-subject variable. The analysis, however, did not reveal any interaction between the child's age and the dependent variables; therefore we dismissed the child's age from future analyses. A second set of analyses addressed the effectiveness of treatment by measuring effect size (Cohen, 1988). Effect size was calculated as the difference in means between pre- and postmeasurements of a variable divided by the pooled standard deviation of the variable.

Parental helplessness. The ANOVA revealed significant group \times time interaction effect for mothers, $F(1,39) = 14.70$, $p < .001$. Duncan's post hoc test for each group separately showed that mothers in the treatment group reported a significant reduction in their helplessness ($p < .001$) whereas the control mothers remained stable over time (see Figure 1). The effects size was $d = 1.20$. The ANOVA also revealed a significant group \times time interaction effect for fathers, $F(1,27) = 4.65$, $p = .04$. Post hoc analysis showed that the fathers in the treatment group reported a significant reduction in their helplessness ($p = .01$) whereas the control fathers remained stable over time (see Figure 2). The effects size for fathers was $d = 0.81$.

Perceived support. Analysis of variance revealed significant group \times time interaction effect for mothers, $F(1,39) = 13.03$, $p < .001$. Secondary analysis revealed that the results found were in accord with the hypothesis, thus mothers in the intervention reported a significant increase in support ($p = .001$) whereas those in the control group remained stable. The effects size was $d = 1.13$. The analysis did not reveal any significant interactions for the fathers.

Parental authority. For mothers, ANOVA revealed significant group \times time interaction for the permissive parenting style factor, $F(1,39) = 4.46$, $p = .04$, but not for the authoritative and authoritarian parenting style factors. The effect size for permissiveness was $d = 0.66$. Similar results were found for fathers, although the ANOVA revealed only a close to significant group \times time interaction effect for the permissiveness factor, $F(1,27) = 3.93$, $p = .057$. The effect size for the fathers' permissiveness was $d = 0.74$.

Child behavior. For mothers, ANOVA revealed significant group \times time interaction effects for the child's aggressive behaviors, $F(1,39) = 5.90$, $p = .019$ and overall externalizing behaviors, $F(1,39) = 6.47$, $p = .015$. The effect size for aggressiveness was $d = 0.76$ and for externalizing $d = 0.80$. No significant interaction effects were found for fathers.

Parental distress and self-efficacy. For both measures, ANOVA revealed no significant findings.

Maintenance of treatment results. To examine whether treatment gains were maintained at a 1-month follow-up, we conducted for mothers and fathers an ANOVA with repeated measures comparing posttreatment with follow-up scores. The analysis revealed no significant differences between posttreatment and follow-up for all measures except for the perceived support for mothers, which was found to be significant. These findings suggest that treatment gains concerning parental helplessness, parental permissiveness, and child behavior were maintained after 1 month. However, mothers' parental perceived support returned to baseline level.

Partial Outcome Measures

We used the Parent Behavior Telephone Checklist to assess parental escalation and reconciliation behaviors during the treatment period (see Figure 3). After computing for each week of the treatment a mean score for these factors, we measured the effect of time by conducting

Table 1
Immediate Effects of Intervention on Parenting: Means, Standard Deviations, and F-Values for Treatment and Control Groups

Measure	Treatment		Control		ANOVA <i>F</i> Group × time
	Pre	Post	Pre	Post	
Mothers					
Parental helplessness	4.10 (.89)	3.04 (1.16)	3.69 (1.06)	3.81 (1.10)	14.70***
Parental style					
Permissive	2.43 (.83)	2.24 (.63)	2.46 (.63)	2.66 (.59)	4.46*
Authoritative	4.07 (.54)	4.08 (.43)	3.98 (.53)	3.93 (.59)	0.21
Authoritarian	2.49 (.54)	2.52 (.67)	2.71 (.73)	2.43 (.68)	2.78
Self-efficacy	4.23 (.67)	4.71 (.58)	4.03 (.71)	4.13 (.60)	3.41
Perceived support	-.58 (.85)	.09 (1.03)	-0.74 (1.20)	-1.03 (1.28)	13.03***
Child behavior					
Aggressiveness	20.24 (8.94)	15.19 (8.28)	20.05 (6.82)	19.60 (6.35)	5.90*
Externalizing	26.71 (11.19)	19.76 (9.96)	27.85 (9.02)	27.75 (9.32)	6.47*
Parental distress	3.17 (.79)	2.62 (.73)	3.05 (.51)	2.84 (.80)	2.06
Fathers					
Parental helplessness	3.47 (1.12)	2.85 (1.06)	3.46 (.95)	3.47 (1.10)	4.65*
Parental style					
Permissive	2.50 (.57)	2.23 (.47)	2.52 (.73)	2.56 (.60)	3.93
Authoritative	3.84 (.62)	3.73 (.48)	3.72 (.44)	3.66 (.60)	0.05
Authoritarian	2.51 (.80)	2.62 (.51)	2.73 (.78)	2.90 (.88)	0.64
Self-efficacy	4.42 (.69)	4.47 (.54)	4.01 (.83)	4.22 (.73)	0.01
Perceived support	-0.21 (.70)	-0.24 (.82)	-1.18 (1.24)	-1.04 (1.14)	0.33
Child behavior					
Aggressiveness	19.11 (10.28)	15.90 (9.41)	19.57 (7.02)	16.11 (8.31)	0.73
Externalizing	25.89 (14.12)	21.80 (13.99)	25.43 (9.74)	21.33 (12.76)	0.69
Parental distress	2.58 (.77)	2.60 (1.10)	2.82 (.68)	2.53 (.73)	0.87

Note. *n* = 21 (mothers in treatment group); *n* = 20 (mothers in control group); *n* = 15 (fathers in treatment group); *n* = 14 (fathers in control group). Pre = preassessment; Post = postassessment; ANOVA = analysis of variance.
 p* < .05; *p* < .01; ****p* < .001.

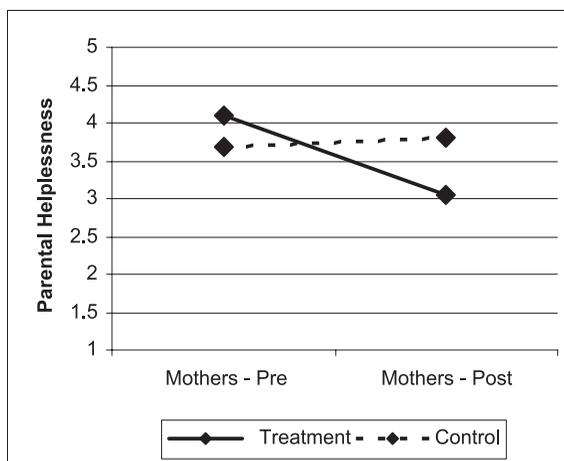


Figure 1. Effect of intervention on mothers' parental helplessness.

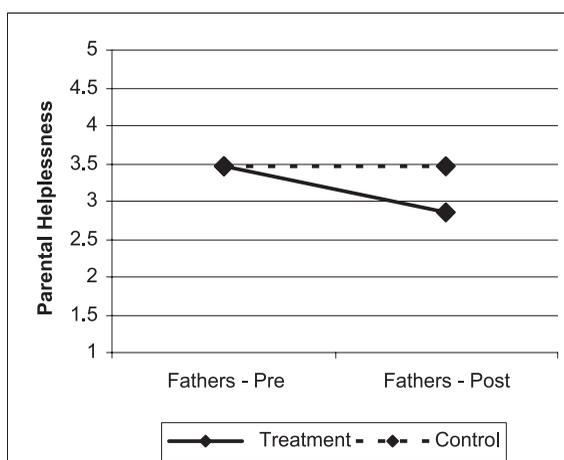


Figure 2. Effect of intervention on fathers' parental helplessness.

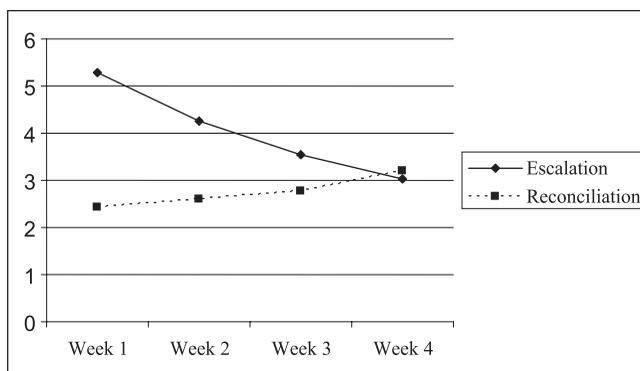


Figure 3. Parental escalation and reconciliation behaviors during treatment.

analyses of variance (ANOVA) with repeated measures (weeks 1–4). The ANOVAs revealed a significant main effect for time for escalation behaviors, $F(3,111) = 13.22, p < .001$ and for reconciliation behaviors, $F(3,111) = 5.08, p = .002$. Thus during 4 weeks of NVR, parents reported a significant reduction in their escalatory behaviors and a significant increase in their reconciliation behaviors.

DISCUSSION

The purpose of this study was to examine the effects of a 5-week program of training in NVR for the parents of children with acute behavior problems. Both the treatment and the assessment were focused on the parents, for reasons presented at the introduction. Results show that the parents reported less helplessness and less permissiveness in their parenting style. Mothers reported significant reductions in the child's aggressive and externalizing symptoms. Mothers also felt a significant rise in social support, although this was not maintained at the follow-up. The partial outcome measures showed a progressive decrease in parental escalating behaviors and an increase in reconciliation gestures. There were no significant effects on overall levels of parental distress and self-efficacy. In contrast to findings from the literature, showing that parent training is usually more effective for the parents of younger children (Kazdin, 1990), the present approach seemed no less effective for the parents of older children. In addition, dropout from the program was very low (only one family during the treatment). The positive findings on parental helplessness, child aggressive and externalizing behaviors, perceived parental support, and parents' escalation and reconciliation behaviors show that NVR was effective in achieving its main and most explicit goals. However, failure to find improvements in parental distress and self-efficacy, as well as the drop in social support after the treatment ended, require explanation. The disappointing finding regarding parental distress may be because of the general nature of the questionnaire: the questions refer to distress and well-being in all areas and not necessarily in the field of parenting. We know of no questionnaire that measures distress and well-being of parents *qua* parents and thus used a general questionnaire instead. Perhaps a more specific questionnaire might have revealed an improvement in parental well-being. The same point is relevant for the self-efficacy questionnaire. It measures improvement in all areas of parental involvement with the child. We would thus qualify our positive findings with the tentative conclusion that NVR has not shown itself effective in improving the parents' feeling of competence regarding their relationship with the child in areas that do not directly relate to their management of the child's acute negative behaviors.

The criterion that the parents should feel they are supported in their acts was fulfilled only regarding the mothers, and only during the treatment and not at follow-up. Fathers showed no increase in perceived support. The decrease in the support reported by the mothers between end of treatment and follow-up is probably because of the fact that the telephone support, which was an important source of help, was no longer available. We concluded that more effort was needed to mobilize enduring support from the parents' relatives and acquaintances, so as to raise and stabilize the level of support. We are presently strengthening this facet of our program. A therapeutic meeting with the supporters and the parents has now become an obligatory element of the program. In the sessions that follow this meeting, the issue of updating and involving the supporters takes a central place. We hope, in this way, to strengthen the relatively unstable support-link in the treatment chain. We are in addition developing maintenance strategies to deal with this issue (e.g., parents groups that meet at monthly intervals and supply mutual support as well as encouraging maintenance of other familial and extrafamilial sources of support).

Omer (2000) has suggested that a parent-sensitive strategy for helping the parents of difficult children should fulfill three criteria: (a) the parents should feel that the intervention is

acceptable for them; (b) they should feel that the intervention is effective in decreasing problem behaviors and interactions; and (c) they should feel supported in their actions. In developing NVR we tried to adhere to these principles, so that the parents could say to themselves, "This is right for me!" "This works!" and "We are not alone!" The results of this study suggest that NVR helps to achieve these goals.

The low dropout rate suggests that parents felt the intervention was clearly acceptable to them. This finding was reinforced by the parents' informal reports. When asked how they felt about the approach, many parents emphasized that what helped them most to stick to the program was that its ideas and methods seemed right for them, both in a moral and in a personal sense. Sometimes the parents made spontaneous favorable comparisons between NVR and more traditional methods of child discipline. This kind of positive repercussion is often also witnessed with professionals exposed to the approach. Thus, in a recent conference on NVR in Germany, Schlippe (2006) has raised the value issue posed by the need for parental authority, arguing that traditional approaches to discipline have become growingly problematic to many professionals and parents, a process that has left a vacuum regarding the need for a stable and safe family environment. NVR by its clear parental framework and its avoidance of the escalating traps of power and control offers a "model of parental authority that is meaningful and acceptable for our generation." Such positive responses, which have been abetted by similar ones by school and community workers (Omer et al., 2005), are especially important in view of the fact that work with these children usually involves not only the parents but also additional educational, therapeutic, and community agencies. The wide acceptability may well provide a common language to coordinate these various agencies (Jakob, 2006).

The present study is limited in its assessment of effectiveness, because of its exclusive reliance on parental reports. All we can say is that the parents felt the interventions to be effective. We do, however, have some corroborative information from two smaller parallel studies in which the children were interviewed. In one of them (Omer et al., 2006), nine children who were victims of sibling violence were given a semi-structured interview (Caffaro & Conn-Caffaro, 1998) before and after the NVR program. In six of the cases, there were clear improvements in the victimized children's reports of violence as well as in their experience of the parents' ability to protect them. The victimized siblings' reports agreed in most cases with the parents' reports, thus reinforcing the trustworthiness of the data. In a second study (Fritz, 2005), 10 children, who were the identified patients in the NVR program, were interviewed before and after the treatment. They were asked to answer the questions in the parental helplessness questionnaire from the point of view of their parents, and to describe any changes in the family atmosphere. The children reported that the parents had become less helpless. In addition, five children reported an improvement in family atmosphere (particularly, less fighting and screaming), four children reported no change, and only one child reported that the atmosphere had worsened. These findings corroborate the parents' reports.

We also have additional information from other families treated in the program about the extent to which the various treatment elements were implemented. About 65% of all families perform one or more *sit-ins*, 100% of the parents report in detail on their anti-escalation and reconciliation steps, 70% of the parents of adolescents perform either telephone rounds or parental visitations or both, and 90% of the parents decide to go public and involve external supporters. We can clearly conclude that training helps the great majority of parents to actualize the intended strategies. This still leaves open, however, the question whether the observed improvements were actually mediated by the specific treatment strategies. Probably only a detailed process-outcome study could answer this question.

The fact that the improvements reported by mothers were more pronounced than those reported by fathers may be because of the fact that mothers are the ones who bear most of the burden in bringing up children, particularly in the case of the difficult child (Patterson,

1980). In addition, mothers received most of the telephone support in our project. Another possible explanation is that the program might be inherently more appealing to mothers than to fathers. Viewed from a feminist perspective, an approach that emphasizes endurance, protection of self and other, and social support, rather than control, might well appeal more to women than to men (Chaplin, 1988). This suggests that better attuning the program to fathers and emphasizing their expected gains in terms of their place in the family might be of value in increasing their involvement and in mitigating their control orientation. We are presently investigating the factors that may be conducive to greater or lesser involvement of fathers in the program.

The finding that NVR yields clear improvements in self-reported parental functioning is perhaps not surprising in light of similar positive findings regarding other forms of parental training (Webster-Stratton, 1998). The question might thus be raised about the need for a new approach. We would argue that NVR offers parents and practitioners a much needed alternative to extant models of parental training. Whereas most research-backed treatment methods are based on social learning theory, NVR focuses particularly on presence and escalation. Approaches that utilize punishment, for instance, may lead to escalation, particularly with older children. When punished, the child threatens to punish the parents in return, and actually often does so. Following the assumptions of learning theory, the parents have then no alternative but to increase the dosage of their own punishment, with the danger of the child's reacting in kind. The model thus prescribes activities that may lead to a sharp escalating spurt. This is not merely a theoretical objection, as parents often say that their fear of the child's reaction is the main obstacle to their use of punishment. NVR offers a clear way out of this impasse (see Figure 3).

The reduction in escalation and the rise in reconciliation gestures are especially significant in view of the fact that during those weeks the level of potential attrition between the child and the parents was particularly high, as the parents were performing resistance acts like the *sit-in*, the telephone round, and the involvement of external supporters. Indeed, the child often reacted to these acts of resistance with a rise in hostile behaviors. The parents, however, were prepared to face these acts in strictly nonescalating ways. Thus, at the same time the parents were resisting the child's negative behaviors in a highly decided manner, they also showed the capacity to avoid escalation and to manifest positive regard toward the child.

Nonviolent resistance is also a viable method for parents who are unwilling to use praise and punishment for other reasons, such as a dislike for behavior control. High levels of parental resistance to training based on the social learning approach have been reported by the proponents and investigators of this approach (Patterson & Chamberlain, 1988, 1994; Patterson & Forgatch, 1985). This suggests that an alternative is needed. It might well turn out that parental acceptability (e.g., of the idea of prize and punishment or of the principles of NVR) could predict the chances of treatment success.

Nonviolent resistance might also be especially relevant for the parents of children who tend to show an "immunity" to behavior modification (Greene, 1998). NVR allows the parents to develop a commitment to resist the child's destructive behaviors, while also facilitating acceptance of their own limited influence. This committed/acceptant attitude (Hayes et al., 1999) may be of value in improving conflicts that are fueled by fights over control (Christensen & Jacobson, 2000).

The results of this study should be interpreted with caution in light of its limitations. First, the study based itself solely on self-report measures. Second, treatment integrity was not evaluated by independent judges. Third, the follow-up period was short. In addition, the study's population was mainly middle and lower middle class. We are sure that a five-session treatment would be insufficient with severe multi-problem families or with families from a disadvantaged socioeconomic background. Implementing NVR with such families would require considerable extension and adaptation. We are presently experimenting with a broader treatment framework

(between five and 10 treatment sessions, according to need). In addition, we are trying to develop a maintenance program. We hope the present findings may inspire additional attempts that would address these limitations and broaden the potential applications of NVR. As mentioned, this study has already helped us to revise and improve our practice.

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