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Wild and Willful Kids: Can We Help Parents? The Effectiveness of a Group Parent Training Program Without a Psychiatric Label

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Many children with a classification of attention-deficit/hyperactivity disorder exhibit mild-to-moderate problem behavior. For these children, a stepped diagnosis and stepped care approach has been proposed. Although a psychiatric classification may bring support to families, it may also have negative consequences. Therefore, in this preliminary study, the effect of a group parent training program without child-bound classifications (named Wild & Willful, Druk & Dwars in Dutch) was investigated. In 7 sessions, groups of parents (experimental, n = 63; waiting list control, n = 38) learned strategies to deal with wild and willful behavior in their children. Outcome variables were assessed by questionnaires. Multilevel analyses showed that, compared with the control group, the intervention group had significantly lower scores on parental stress and communication problems (Cohen *d* = 0.47 and 0.52, respectively), but not on attention and hyperactivity problems, oppositional defiant problems, and responsivity. Zooming in on the course of outcome variables over time in the intervention group, improvements on all variables were seen, with small to moderate effect sizes (Cohen *d* = 0.30 to 0.52). Overall, the group parent training program without the need for a classification for children seemed beneficial. The training is low cost, brings together parents who are facing similar problems in rearing their children, and may help to reduce overdiagnosis of mild and moderate problems, without risking undertreatment of severe difficulties.
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KEY WORDS: attention-deficit/hyperactivity disorder (ADHD), stepped diagnosis, wild and willful, parent training program

Attention-deficit/hyperactivity disorder (ADHD) is currently defined in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) and the 11th edition of the *International Classification of Diseases* (ICD-11) as a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. In recent decades, the number of children worldwide classified with ADHD has increased substantially.[1–5] [Note that, within our research group, we prefer to use the term "classification" for ADHD (and other DSM definitions), in recognition of the fact that a diagnosis refers to so much more than naming or categorizing problematic behavior.] This increase has led to growing concern[3,6,7] and calls for a more careful approach toward inattentive, hyperactive, and impulsive behavior problems. More than 80% of children classified with ADHD experience mild and moderate problems.[4] In a recent comprehensive systematic scoping review of 334 published studies, Kazda et al[8] found convincing evidence that ADHD is overdiagnosed in children and adolescents. The authors warned that, for children with milder problems in particular, the harm associated with an unnecessary ADHD diagnosis may often outweigh the benefits.

From 2012 on, Batstra and colleagues have advocated a stepped care and stepped diagnosis

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approach, aimed at reducing overdiagnosis without risking undertreatment.[9–11] This approach includes psychosocial interventions without a diagnostic label for children and families with mild and moderate problems. Only when behavior problems and dysfunction persist is the child referred to specialist care for DSM classification and treatment.[10–12] Stepped diagnosis takes advantage of the powerful healing effects of time, support, and placebo, saving psychiatric classifications and specialized treatment for those who need it most.

Although a DSM classification is only descriptive, does not include information about possible causes, and hardly predicts to what treatment a person will respond,[13] it may open the door to treatment and special education services at school. However, it may also have disadvantages, especially for the child, such as negative teacher expectations resulting in underperformance,[14–16] stigma and self-stigma,[17–19] and difficulties with life insurance and disability insurance.[20] Last but not least, a psychiatric classification may create the false impression that we understand the problem and have to look no further, thereby missing opportunities for interventions in the living conditions of the child.[21,22] Labeled children become owners of the problem, and environmental and societal factors may remain underrecognized and unaddressed. A more contextual approach may be helpful in understanding and treating (perceived) behavioral problems.[3,10,23–25] Instead of treating a disorder, the environment of children can be strengthened to better deal with the challenging behavior.

Treatments targeting the environment of a child include parent training programs in which parents learn strategies to deal with the perceived challenging behavior of their children. These programs are offered not because parents are seen as the cause of the problems, but because they may be part of the solution. The intervention is focused on empowering parents instead of "treating" the child. Parent training is an evidence-based intervention for parents of children with an ADHD classification,[26–30] and it is also effective as a group intervention.[31,32] While in many cases parent training is provided after a child has been diagnosed, it may also be appropriate for children without diagnoses. In clinical practice, personalized approaches are much more useful than classifications of problems, and specific interventions may depend more on the function of the behavior of the individual child than on his or her DSM classification.[10,33] Taking into account the disadvantages of a DSM classification, it seems interesting to investigate the effects of a group parent training program that is explicitly offered without the prerequisite of a classifying label. Effects may differ from therapies requiring a confirmed psychiatric classification, and the type of parent training described here may provide children and families with more individualized support and understanding.[34–37]

The present study focuses on the effects of a group parent training program named Wild & Willful (Druk & Dwars in Dutch). Parents can participate in this program without the need for a DSM classification for their wild and willful children. The difference from existing programs, such as Incredible Years (https://incredibleyears.com) or Triple P (https://www.triplep.net/gloen/home), is that Wild and Willful is explicitly offered as an alternative to immediate diagnostic procedures and treatment in psychiatric settings and that it specifically targets hyperactive and oppositional child behaviors. Parents of children who received a psychiatric diagnosis in the past 6 months were excluded. When psychiatric classifications were made further back in time and parents were considering new treatment options because of recurring problems, they were included in the program. Impacts on parent-reported behavioral problems of their children, parenting stress, and family functioning were investigated. In addition, potential moderating effects of the family situation and socioeconomic status (SES) were examined.

METHODS

Design

This study had a cross-over design with a control group (waiting list) and an intervention group to investigate the effects of a group parent training program over time (preintervention, postintervention, and follow-up). Effects on parenting stress, parent-reported behavioral problems of their child (ADHD problems and oppositional defiant problems), and family functioning (responsivity and communication) were measured. The moderating effects of the family situation and SES were also investigated.

Parents enrolled for the training via the website for Wild & Willful (https://drukendwars.nl) or were introduced to the training via their practitioner. Assignment to the experimental or control (= waiting list) group occurred as randomly as possible via simple randomization with an online tool, but, for practical reasons, it was sometimes based on the date of enrollment and the start date of a new training group. Ideally, parents were assigned to one of the study groups after filling in the first questionnaire, but due to the practicalities that influenced the randomization process, some participants already knew to which study group they were assigned before filling in the first questionnaire. The ethical committee of the Department of Pedagogical and Educational Sciences of the University of Groningen provided ethical approval for the study and parents gave informed consent based on an information letter.

Participants and Procedure

Participants were all residents of the province of Groningen, The Netherlands who participated in the parent group training program called Wild & Willful (in Dutch, Druk & Dwars) conducted by our research team and/or who were on the waiting list for the program. Eventually, half of those in the or withdrawal from participation in the study before cross over to the experimental intervention waiting list group subsequently also participated in the training program. The name Wild & Willful was chosen to positively label children's energy and individuality and this was actively communicated in the recruitment procedures and materials. When possible, both parents participated in the training. Parents who were experiencing mild or moderate problems with the wild and willful behavior of their child were the target population of the training program and of the study. In case of severe problems or a crisis, the family was referred to specialized care.

The indications for parents to participate in the training program were that they were experiencing pedagogical or communication problems related to wild and willful behavior of their child aged 4 to 12 years and that they were motivated to change the situation and were willing and able to do weekly assignments in which they practiced behavioral skills. Contraindications to participation were the child being diagnosed with a psychiatric classification in the past 6 months; the child having recently started (or there was a plan to start) pharmacological treatment for behavioral or concentration problems in the near future; the child exhibiting severe emotional or behavior problems (in that case, we referred the child and family to specialized care); predominant psychiatric problems in the parents; crisis in the family; or parents not able to make time for homework. During a comprehensive intake, one of the 2 trainers evaluated whether parents were suitable to participate in the intervention on the basis of these inclusion and exclusion criteria.

Figure 1 shows a flowchart of all participants. Initially, 117 parents signed up for the intervention. After the first contact and screening, 108 parents participated in the study and were assigned to one of the study groups. Since participants who did not complete any questionnaire (n = 7) could not participate in the study, the total n in this study was 101 (63 in the experimental group and 38 in the control group). Some participants in the control group were only part of this study during their waiting time (only control, n = 19), and others were part of the study during their waiting time followed by the intervention phase (control+experimental, n = 19). This distribution was not assigned in advance but occurred afterwards based on practical reasons such as the time period of the data collection or withdrawal from participation before the crossover to the experimental intervention.

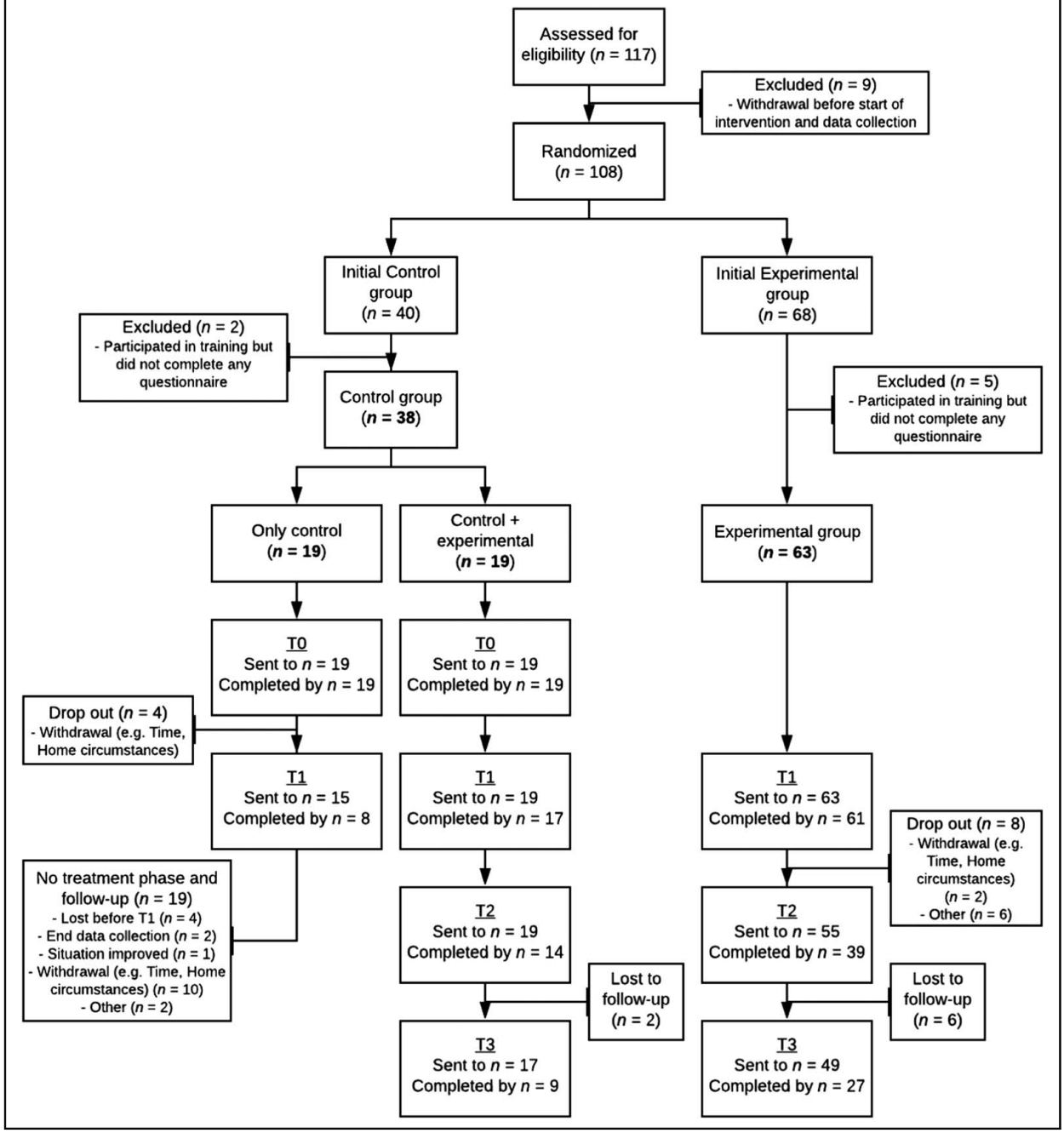
Depending on their assignment to the experimental or control+experimental study group, parents were asked to complete the questionnaires 3 or 4 times, respectively (Figs. 2A, B). Those who were in the control-only group received the questionnaires twice (at baseline and at T1). The questionnaires were sent via e-mail, in the secured portal RoQua, and anonymity was guaranteed.

Instruments and Variables

Intervention

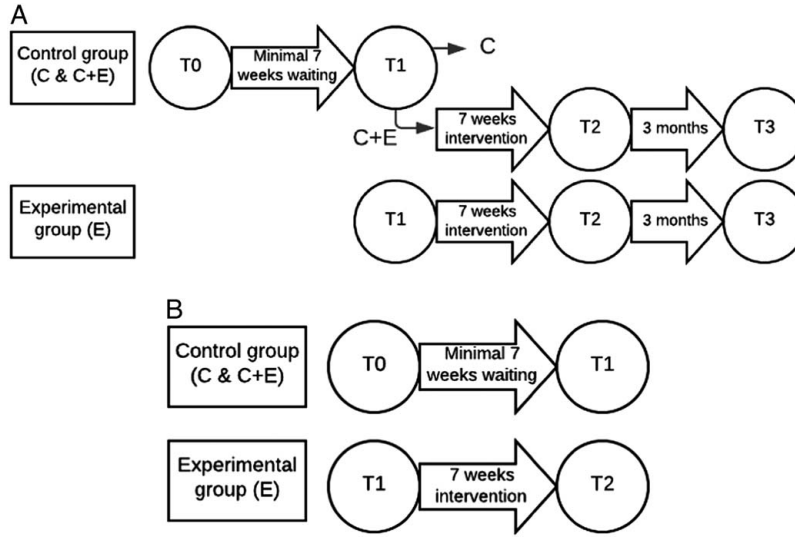
The intervention is the group parent training program Wild & Willful.[38] Two professionals in a local setting (eg, neighborhood team) offered the training to a group with a maximum of parents of 4 children. The professionals were experienced social workers

FIGURE 1. Flowchart of participants.



who worked with youth and received training concerning the intervention and were given an instruction manual[38] to guarantee the quality of the training and the intended implementation. The parent training program consists of 7 weekly group sessions, preceded by an individual intake and ending with an individual evaluation session. Every week the parents do homework by practicing

FIGURE 2. A, Schematic procedure of intervention and measurements. B, Schematic procedure of intervention and measurements for the comparison between the control and experimental study groups.



the discussed parenting skills in their home environment, and every week between the sessions one of the professionals contacts the parents by telephone to discuss potential difficulties and provide support to the parents. The 7 sessions are mainly built on the principles of behavioral therapy and contain different topics in a specific order, based on their importance and what skill should precede another skill:

- Session 1: Contact with your child, playtime.
- Session 2: Self-care and praising.
- Session 3: Overview and predictability.
- Session 4: Communication, do-instructions.
- Session 5: Rewarding.
- Session 6: Ignoring and correcting.
- Session 7: Questions and concrete plans for the near future.

Self-report Questionnaires

The first time the parents completed questionnaires, they also provided some written general information about themselves and their family. Several questionnaires were used to assess the effect of the training.

First, the Dutch questionnaire Opvoedingsbelasting Vragenlijst (OBVL, Parenting Stress Questionnaire) was used to assess parenting stress.[39] The questionnaire contains 34 items assessing 5 domains (Parent-child relationship problems; Parenting problems; Depressive mood; Parental role restriction; Physical health problems), that are rated using a 4-point Likert scale, with a total *T*-score ranging from 30 to 80. Higher scores indicate higher levels of stress. For this study, the *T*-score for total parenting stress was used. The reliability of the OBVL is good and its concept validity is sufficient.[40]

Second, the Dutch version of the Child Behavior Checklist (CBCL)[41] measured parent-reported behavioral problems of their children. For this study, the *T*-scores on the DSM-oriented "ADHD" scale (referred to in this article as "adh-problems") and the "oppositional defiant problems" scale (referred to in this article as "opp-problems") were used. In the version for children aged 1.5 to 5 years, the adh-problems scale and the opp-problems scale are each based on 6 items that are rated on a 3-point Likert scale. In the version for children aged 6 to 18 years, the adh-problems scale is based on 7 items and the opp-problems scale is based on 5 items, rated on the same 3-point scale. The *T*-score on both scales ranges from 50 to 100, with higher scores indicating more serious problems. The validity of the Dutch translation of the CBCL is sufficient but its reliability is insufficient.[42] Hence, results should be interpreted with some caution.

Third, the Dutch questionnaire Gezinsvragenlijst (GVL)[43] (Family Questionnaire) was used to assess family functioning and the quality of family relationships. For this study, the raw scores on the scales "responsivity" and "communication" were used as dependent variables, with a lower score indicating better family functioning. The responsivity and communication scales each contain 9 items, rated on a 5-point Likert scale, with the total raw score ranging from 9 to 45 for each scale. The reliability and validity of the GVL are good.[44]

Demographic Variables

The following demographic variables based on the general information provided by the parents when they completed their first questionnaires were used as possible moderating variables:

- Family situation: single-parent family (= 0) versus 2-parent family (= 1).
- SES status, a score between 0 (low SES) and 6 (high SES) based on combined information on family income and the educational levels of both parents.

Statistical Analysis

Effects of the group parent training program were analyzed with multilevel regression analyses. Multilevel analysis is suitable for nested data and makes use of all available data. For each outcome, a separate multilevel model was made. The analyses had 2 purposes. The first was to compare the intervention with the control group, and the second was to evaluate the effects of the intervention over time. Measurement moments were baseline (T0 for the control-only group and the control+experimental group and T1 for the control+experimental group and the experimental group), postintervention (T2), and follow-up (T3). The primary outcome was the effect of the intervention in the experimental group (change from T1 to T2; pre-post) compared to the effect of the waiting phase of the control group (change from T0 to T1). For these analyses, time, group, and the interaction of group-by-time were also independent variables, with time denoting the "pre- and post-" assessments for this analysis. To analyze possible moderating effects in the effect of the intervention over time for the pooled experimental and control+experimental groups, the variables "family situation" and "SES" were added to the analyses of step 1, with time (from T1 to T3), these moderator variables, and the interaction between time and these variables as independent variables.

To further evaluate the effects of the intervention over time, we first investigated whether we could pool the subjects in the control group who received the intervention after the waiting period (control +experimental group) with those in the intervention group, for an analysis of the effect of the intervention over time. To this end, we tested whether the effect of the intervention over time (from T1 to T3) was different for the experimental versus the control +experimental group, using time, group, and the interaction between group and time as independent variables. Because this interaction was not found to be significant, the experimental and control+experimental groups were pooled in the analysis of the effect of the intervention over time (from T1 to T3), using models with time as an independent variable.

In all multilevel analyses, a random intercept was used. Different error-covariance structures were tested and the best-fitting model was selected using the Bayesian Information Criterion. For the effect sizes of the effects over time, Cohen d was calculated by dividing the estimated mean difference by the pooled SD of the outcome measure of the groups concerned. For the effect sizes of the group difference, Cohen d was calculated by dividing the estimated group difference in time effect by the pooled SD of the outcome measure of the groups concerned. All analyses were done in SPSS26 and a P-value of 0.05 was used as the cutoff for significance.

RESULTS

Descriptive Data

Table 1 shows the descriptive statistics for the participants. t tests and χ^2 tests showed that there were no significant differences between the control (control-only and control+experimental) and experimental groups with regard to sex ($P = 0.471$), parent age ($P = 0.50$), child age ($P = 0.096$), family situation ($P = 0.464$), and SES ($P = 0.064$). Eleven parents (10 in the experimental group and 1 in the control group) indicated that their child had received a psychiatric classification (autism spectrum disorder or ADHD) > 6 months previously; for 2 parents this remained unknown. Perceived

TABLE 1. Descriptive Statistics of Participants

	Control-only (n = 19)	*Control+experimental (n = 19)*	*Experimental (n = 63)*	*Total (N = 101)*
Sex [n (%)]				
Female	13 (68.4)	11 (57.9)	34 (54.0)	58 (57.4)
Missing	0 (0)	0 (0)	2 (3.2)	2 (2.0)
Parent age (y)				
Mean	38.5	42.7	38.2	39.1
Median	39	42	39	39
SD	5.2	7.2	4.7	5.6
Missing (n)	0	0	2	2
Child age (y)				
Mean	6.4	7.9	7.7	7.4
SD	1.6	2.3	2.1	2.1
Missing (n)	1	0	1	2
Family situation [n (%)]				
One parent	5 (26.3)	0 (0)	5 (7.9)	10 (9.9)
Two parents	14 (73.7)	19 (100)	54 (85.7)	87 (86.1)
Missing	0 (0)	0 (0)	4 (6.3)	4 (4.0)
SES				
Mean	4.4	4.5	3.9	4.1
Median	5.25	4.50	3.75	4.25
SD	1.6	1.6	1.4	1.5
Missing (n)	0	0	2	2

SES indicates socioeconomic status, which was assigned a score between 0 (low SES) and 6 (high SES) based on combined information on family income and the educational levels of both parents.

attention-deficit/hyperactivity problems and oppositional problems did not differ between formerly diagnosed and never diagnosed children ($P = 0.951$ and 0.652, respectively).

Effects When Comparing the Experimental Group With the Control Group

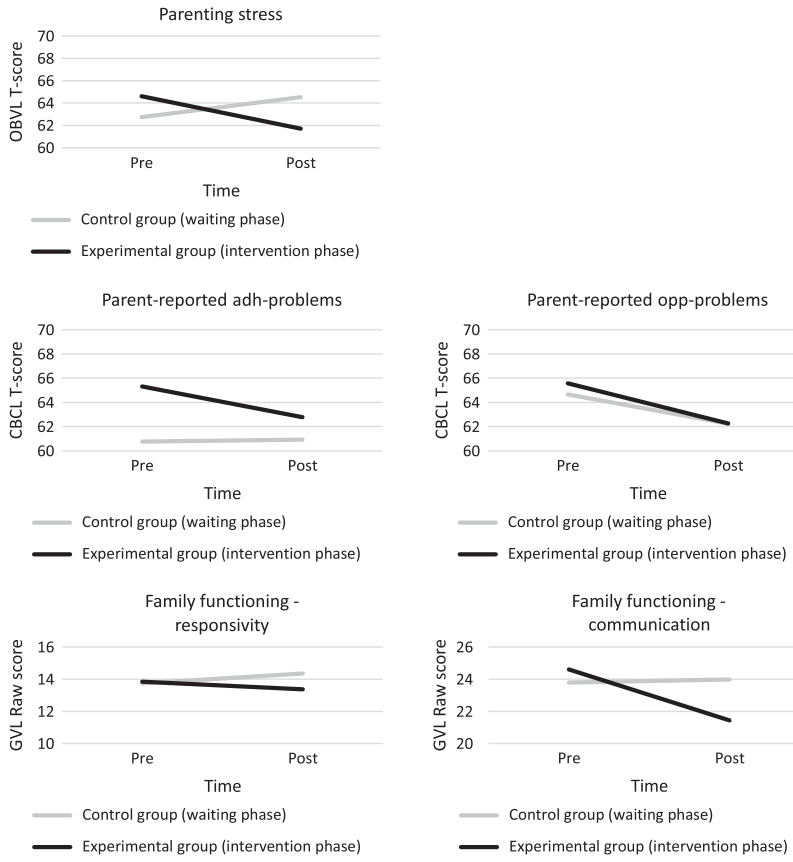
The effect of the intervention on the experimental group (n = 63) was compared with the effect of the waiting phase on the control group (control and control+experimental: n = 38). The raw scores are shown in Figure 3, and the results of the analyses are shown in Table 2. Pretest scores were not significantly different in the control and experimental groups, except for parent-reported adh-problems ($P = 0.006$). In the experimental group, at baseline CBCL scores for attention and oppositional problems fell at the border of clinical range (*T*-scores of 65 to 70; underlined in Table 2).

Table 2 shows that the effects of the intervention on the experimental group differed significantly from the effects of waiting time on the control group for parenting stress and communication with small and medium effect size, respectively, with a significant improvement in the experimental group and a nonsignificant deterioration in the control group. For adh-problems, the scores of the control group did not show a change and the scores of the experimental group decreased significantly, but the difference between the groups was not significant. For opp-problems, the scores decreased in both groups. Unlike in the control group, the decrease in the experimental group was significant, but the difference between the groups was not significant. For responsivity, none of the groups showed a significant change over time.

Moderating Effects

Interaction analyses showed that there were no moderating effects for SES. Family situation only

FIGURE 3. Control group (waiting phase) versus experimental group (intervention phase) on parenting stress, adh-problems, opp-problems, responsivity, and communication.



CBCL indicates the Child Behavior Checklist, with higher scores on the adh-problems scale (range: 50 to 100) indicating more serious attention-deficit/hyperactivity problems and higher scores on the opp-problems scale (range: 50 to 100) indicating more serious oppositional defiant problems; GVL, the Family Questionnaire, is used to assess family functioning and the quality of family relationships, with lower scores on the "responsivity" and "communication" subscales indicating better family functioning (range of raw scores on each subscale of 9 to 45); OBVL, the Parenting Stress Questionnaire, with total scores ranging from 30 to 80, with higher scores indicating greater levels of stress.

moderated the 3 months time effect on communication ($F = 4.377$, $P = 0.015$): for single parents: the difference in communication scores between T1 and T3 was 8.6 points larger than for participants from 2-parent families (Cohen $d = 1.31$), indicating that single parents showed a larger improvement in communication.

Intervention Effects Over Time

We first tested the effect of the intervention over time (from T1 to T3) in those who received the intervention. This was done in the pooled experimental and control+experimental group (n = 82), as the interaction between group and time showed that this time effect was not different for the experimental and control+experimental groups. Table 3 shows the scores on the different questionnaires per measurement.

Results of the multilevel regression analyses for the effect of the intervention over time are shown in Table 4. Table 4 shows a significant acute effect of time on all outcome measures except GVL-responsivity. For parenting stress, adh-problems, opp-problems, and communication, the scores decreased significantly during the intervention

TABLE 2. Effects of the Intervention Phase in the Experimental Group (N = 63) Versus the Waiting Phase in the Control Group (N = 38)

	Estimated means					
	Pre	***Post***	***Estimated mean difference pre-post***	***Estimated group difference in phase effect***	***Significance***	***Cohen d***
OBVL-parenting stress *T*-score				4.7	0.009*	0.47
Control	62.7	64.5	−1.8		0.188	−0.20
Experimental	64.6	61.7	2.9		0.010*	0.28
CBCL-adh *T*-score†				2.7	0.106	0.32
Control	60.8	60.9	−0.2		0.901	−0.02
Experimental	65.3	62.8	2.5		0.017*	0.32
CBCL-opp *T*-score†				0.9	0.568	0.12
Control	64.7	62.2	2.4		0.051	0.33
Experimental	65.6	62.3	3.3		0.001*	0.42
GVL-responsivity raw score				1.1	0.091	0.31
Control	13.7	14.4	−0.6		0.216	−0.17
Experimental	13.8	13.4	0.5		0.239	0.14
GVL-communication raw score				3.3	0.012*	0.52
Control	23.8	24.0	−0.2		0.851	−0.03
Experimental	24.6	21.4	3.2		< 0.001*	0.47

*Significant at $\alpha = 0.05$.
†Interpretation of the CBCL scores: <60 normal range; 60 to 65 borderline range; 65 to 70 clinical range (shown by underlining in the table).
CBCL indicates the Child Behavior Checklist, with higher scores on the adh-problems scale (range: 50 to 100) indicating more serious attention-deficit/hyperactivity problems and higher scores on the opp-problems scale (range: 50 to 100) indicating more serious oppositional defiant problems; GVL, the Family Questionnaire, is used to assess family functioning and the quality of family relationships, with lower scores on the "responsivity" and "communication" subscales indicating better family functioning (range of raw scores on each subscale of 9 to 45); OBVL, Parenting Stress Questionnaire, with total scores ranging from 30 to 80, with higher scores indicating greater levels of stress.

phase, with small effect sizes. From directly after the intervention to follow-up (T2 to T3), none of the scores showed significant change. The effects at 3-month follow-up (T1 to T3) showed significant improvements for opp-problems and communication, with small effect sizes. The improvements in parenting stress, adh-problems, and responsivity were not significant at 3-month follow-up.

Parents of children who had received a psychiatric classification longer than 6 months in the past were also welcome in the Wild & Willful parent training program. Since these children and families may differ in various ways from never classified children and their families, this may have influenced the results. Excluding the parents with a child with a psychiatric classification or parents for whom this was unknown (n = 13) from the analyses made the significant acute effect of opp-problems fall just short of significance ($P = 0.052$) but did not affect the results for all of the other outcomes and effects.

TABLE 3. Scores on Outcome Questionnaires for the Pooled Experimental and Control+Experimental Group, by Measurement

	Mean	*SD*	*n*
OBVL-parenting stress *T*-score			
T1	64.5	9.5	78
T2	61.3	11.4	53
T3	63.3	9.0	36
CBCL-adh *T*-score			
T1	65.1	8.5	78
T2	61.8	7.4	53
T3	62.4	8.6	36
CBCL-opp *T*-score			
T1	64.6	8.2	78
T2	61.8	7.1	53
T3	62.1	7.2	36
GVL-responsivity raw score			
T1	14.1	3.5	78
T2	13.6	3.2	53
T3	13.5	3.1	35
GVL-communication raw score			
T1	24.5	6.4	78
T2	21.4	6.8	53
T3	21.4	6.5	33

CBCL indicates the Child Behavior Checklist, with higher scores on the adh-problems scale (range: 50 to 100) indicating more serious attention-deficit/hyperactivity problems and higher scores on the opp-problems scale (range: 50 to 100) indicating more serious oppositional defiant problems; GVL, the Family Questionnaire, is used to assess family functioning and the quality of family relationships, with lower scores on the "responsivity" and "communication" subscales indicating better family functioning (range of raw scores on each subscale of 9 to 45); OBVL, the Parenting Stress Questionnaire, with total scores ranging from 30 to 80, with higher scores indicating greater levels of stress.

DISCUSSION

Principal Findings

This study showed beneficial effects of a group training for parents of children with (perceived) mild–to-moderate wild and willful behavior. For parenting stress and communication, the effects of the intervention on the experimental group differed significantly with small to moderate effect sizes from the effects of the waiting phase on the control group. Zooming in on the course of outcome variables over time, immediately after treatment significant improvements with small effect sizes were found for parenting stress, attention and hyperactivity problems, oppositional defiant problems, and communication. For attention and hyperactivity problems, oppositional defiant problems, and responsivity, the differences between the groups were not significant. Significant positive effects with small effect sizes after 3 months were found for oppositional defiant problems and communication. SES did not affect the effects of the intervention. The family situation only influenced the effect on communication, with more improvement found in single-parent than 2-parent families.

Strengths and Limitations

In this study, the participants were not completely randomly assigned to the control group or experimental group. Allocation in some cases depended on practicalities, but this was not related to parental characteristics. However, unmeasured systematic differences between the control and experimental groups at the start of the study cannot be excluded. In addition, some participants knew to which group they were assigned when completing the first questionnaire. This might have influenced their responses. This study does not meet all of the criteria for a randomized controlled trial and conclusions about efficacy are limited because the internal validity is compromised. However, since the design of the study corresponds with practice, external validity is high, suggesting the effectiveness of the intervention.[45] The sample size was relatively small, especially at follow-up waves, limiting the power of the analyses. Hence, the results of this study should be regarded as preliminary.

On average, the study participants experienced relatively mild-to-moderate parenting problems. Families experiencing mild problems were the target population for the intervention, so the intended population was reached and a favorable course for this population was established. However, this might complicate the comparison of the effects to other interventions, which often

TABLE 4. Effects of Intervention (Pooled Experimental and Control+Experimental Group, N = 82)

	Estimated mean difference	*CI*		*Significance*	*Cohen d*
		Lower	*Upper*		
Acute effects (T1 to T2)					
OBVL-parenting stress *T*-score	3.2	1.3	5.1	0.001*	0.32
CBCL-adh *T*-score	2.7	0.9	4.5	0.003*	0.33
CBCL-opp *T*-score	2.3	0.5	4.2	0.014*	0.30
GVL-responsivity raw score	0.5	−0.1	1.2	0.121	0.15
GVL-communication raw score	3.3	2.0	4.5	< 0.001*	0.49
Lasting effects (T2 to T3)					
OBVL-parenting stress *T*-score	−2.0	−4.3	0.2	0.078	−0.20
CBCL-adh *T*-score	−1.1	−3.2	1.0	0.312	−0.13
CBCL-opp *T*-score	0.1	−2.1	2.4	0.896	0.01
GVL-responsivity raw score	0.0	−0.8	0.8	0.987	0.00
GVL-communication raw score	0.0	−1.6	1.5	0.972	0.00
Effects at 3-mo follow-up (T1 to T3)					
OBVL-parenting stress *T*-score	1.2	−1.1	3.4	0.304	0.12
CBCL-adh *T*-score	1.6	−0.4	3.7	0.121	0.19
CBCL-opp *T*-score	2.5	0.3	4.7	0.024*	0.32
GVL-responsivity raw score	0.5	−0.3	1.4	0.180	0.15
GVL-communication raw score	3.2	1.7	4.8	< 0.001*	0.48

CBCL-adh indicates Child Behavior Checklist adh-problems (attention-deficit/hyperactivity problems) scale; CBCL-opp, Child Behavior Checklist opp-problems (oppositional defiant) scale; GVL-responsivity, Family Questionnaire responsivity subscale; GVL-communication, Family Questionnaire communication subscale; OBVL-parenting stress, Parenting Stress Questionnaire.
*Significant at $\alpha = 0.05$.

also include participants with more severe parenting problems. Furthermore, we do not know whether this intervention might also be helpful for parents and children with more severe problems. However, the results of this study support the idea that an easily accessible intervention may benefit parents and children in an early stage before problems worsen.

Further Considerations

Although parents are the target population of this intervention, it is important to mention that this does not imply that parents are being blamed for the problems that are present. Strengthening the environment is a child-friendly way of supporting families dealing with wild and willful child behavior. Regardless of causal and underlying factors, parents can fulfill an important role in dealing with challenging behavior in their children. The intervention helps parents reduce their stress, which consequently affects their children, resulting in positive interactions and reduction of problems.

Even if problems persist, come back, or worsen, and specialized care is needed, research indicates

that the use of low-intensity behavioral intervention as a first-line treatment may reduce or eliminate the need for medication in children with ADHD behaviors.[46] This is important in light of growing concerns about the adverse side effects of stimulants.[47–49]

Our preliminary finding that a group parent training program without a psychiatric classification for the child can be helpful is relevant to clinical practice in several ways. First, this intervention includes a double advantage: this type of treatment is without the disadvantages of medication as well as without the drawbacks of a psychiatric label, such as negative teacher expectations, underperformance, stigma, and self-stigma.[14–19] Second, the group element empowers parents and contributes to recognition, understanding, and a supportive social environment.[50,51] Third, the intervention can be inexpensively organized.[50] Fourth, the professionals who provide the training are educated with a more normalizing perspective. This might be translated to their professional actions in other interactions with parents and children, which might also contribute to normalization and demedicalization of challenging child behavior.

Directly after the intervention, positive trends were seen on almost all outcomes. Although the scores at follow-up were on average more favorable than at pretest, and 2 of the outcome measures even showed significant improvement in the longer run, effects at 3-month follow-up were less pronounced than acute effects and many parents showed a small deterioration from posttest to follow-up. Probably old patterns regained ground. Hence, booster or maintenance sessions might help parents to better maintain the skills they learned during the intervention.[52] However, it is difficult to determine whether some of the positive outcomes had actually faded 3 months after the intervention or were no longer significant because of the small sample size at the follow-up measurement. Nevertheless, follow-up contact with parents indicates promising long-term impact, since up until now many of them had no need for specialist youth care or a diagnostic procedure after the intervention.

Scores on responsivity did not significantly improve during the intervention, which may be due to the fact that these scores were already in the normal range on the pretest. Parents who participate in a training program to better understand their child are to some extent already responsive to the needs of their child. However, less responsive parents should also find a way to help. Home visits for at-risk populations might extend coverage to hard-to-reach families.[53]

An easily accessible intervention without the need for a diagnostic classification may result in more parents and families receiving appropriate help.[10] Although this may benefit them, low treatment thresholds also have a downside. Easy accessibility may function as a pull factor, resulting in parents who do not really need treatment receiving it anyway. In contrast, 7 weekly sessions require a high commitment, possibly deterring hard-to-reach families. It might be interesting to investigate the effectiveness of a "light" version of this intervention, with for example fewer sessions and the use of bibliotherapy or internet therapy.[11]

CONCLUSIONS AND IMPLICATIONS

This study showed benefits of a stepped diagnosis approach for children with wild and willful behavior. A group parent training program for parents of children without a classification showed a favorable course for parenting stress and parent-reported attention, hyperactivity, and oppositional problems of their children. In addition, the program was found to improve communication between parents and children. For parenting stress and communication these effects differed significantly from the waiting phase of the control group. Although significant improvements in the intervention groups were found, effect sizes were mainly small and only one was moderate. Adding booster sessions may prolong the beneficial effects of the intervention.

These positive findings concerning the implementation of a parent training program without a classifying label are preliminary and larger studies using a randomized controlled trial design should elaborate on these results, taking into account the cost-effectiveness of this so called stepped diagnosis[10] approach. The Wild & Willful approach is low cost, brings together parents who are facing similar problems rearing their children, and may help to reduce overdiagnosis of mild and moderate problems, without risking undertreatment of severe difficulties. More awareness and application of help without psychiatric classifications may contribute to the normalization and demedicalization of wild and

willful child behavior. Moreover, expensive specialized psychiatric care is saved for those children and families who need it most.

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