

Original article

# Effectiveness of modified parent training for mothers of children with Pervasive Developmental Disorder on parental confidence and children's behavior

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Received 29 October 2009; received in revised form 18 March 2010; accepted 20 March 2010

## Abstract

**Aim:** This study used parent training (PT), with modifications to smaller groups and shorter schedules (PTSS), for mothers of children with Pervasive Developmental Disorder (PDD). The usefulness of PTSS was evaluated according to the parent's confidence and child's behavior by questionnaire. **Method:** PTSS was used on 14 mothers of 14 children with PDD of preschool to elementary school age, and performed in small groups of 3–4 mothers each. One PTSS course comprised six consecutive sessions and was completed within three months. The sessions consisted mainly of training for parenting skills, understanding the children's inappropriate behaviors, and helping the children adapt to school. The effectiveness of PTSS was assessed by changes in the scores for confidence degree questionnaire for families (CDQ) and the child behavior checklist (CBCL), determined before and after each course. **Results:** The average CDQ scores increased for 17 of 18 items after completion of the PTSS course in all 14 mothers. The change was statistically significant in five items. Increases in average CDQ scores were also seen in 10 of 18 items assessed in fathers, although none were significant. The CBCL total *T*-score decreased in 10 of 14 children (71.4%). The remaining four children showed an increased CBCL total *T*-score. **Conclusion:** These results indicated that PTSS is useful based on changes in the parents' CDQ scores and children's CBCL scores.

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**Keywords:** Parent training; Pervasive Developmental Disorder; Confidence degree questionnaire; CBCL

## 1. Introduction

The prevalence of Pervasive Developmental Disorder (PDD) was recently estimated at 60 per 10,000 children

[1]. PDD is subclassified into Autistic Disorder (AD), Asperger's Disorder (Asp), and Pervasive Developmental Disorder not otherwise specified (PDD-NOS), according to the Diagnostic and Statistical Manual of Mental Disorders, version VI (DSM-VI). In addition, 50–70% of children with PDD show high intellectual ability, often referred to as high-functioning PDD [2,3]. Since 50–70% of children with PDD also show severe behavioral and emotional problems [4,5] if they do not receive optimal treatment, early intervention

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for children with PDD and continuous support for their families is essential.

A parent training (PT) program developed more than 20 years ago at the University of California, Los Angeles (UCLA) is reportedly one of the most effective programs for changing parenting behaviors in parents of children with Attention Deficit Hyperactivity Disorder (ADHD) [6]. The PT program for ADHD contains essential information for parents such as characteristics of the disorder and treatment policies. It also seeks to generate acceptance of the disorder by the parent and formation of an excellent relationship between children and their parents. PT has now been used in many countries to instruct parents on dealing with their ADHD children.

There are only a few reports on PT in Japan, including that by Iwasaka et al. [7]. The PT program described in their report [7] consisted of 10 sessions of 90 min each, which were held once every 2 weeks for the parents of school-aged Japanese children with ADHD. The program effectiveness was evaluated using the ADHD Rating Scale (ADHD-RS) and the confidence degree questionnaire for families (CDQ). On completion of the PT sessions, most children of the trained parents showed fewer behavioral and emotional problems, while all parents showed markedly reduced parenting stress and increased parenting self-esteem. Improvements were also achieved in the parent–child relationships [7]. Some reports have proposed applying PT for children with PDD and their families [8–11]. Butter et al. [12] and McIntyre [13] reported the effectiveness of a PT program for young children with PDD, although most of the children involved were of low IQ.

This study used a modified PT program involving smaller groups and shorter schedules (PTSS) for this study. While the original PT programs often targeted 6–10 parents [14], we planned for smaller groups of 3–4 people each, because the problems of children with PDD are more varied than for those with ADHD. Moreover, most of the original PT programs are designed for 8–12 sessions of 90–120 min each [14–19], requiring a total period of 5–6 months. The sessions in this study followed a shorter schedule (PTSS) to offer more parents the chance to join the PT program, and the purpose was to evaluate the effectiveness of PTSS for parents and their children with PDD.

## 2. Subjects and methods

### 2.1. Subjects

Explanatory leaflets about PTSS were distributed to the families of children with PDD at the outpatient clinic of Osaka University Hospital, and 14 mothers subsequently subscribed to join the PTSS program. All their children were diagnosed with PDD in the outpa-

tient clinic according to the DSM-IV-TR guidelines. Informed consent was obtained from all parents. The children were aged from 4.2 to 9.6 years, and were diagnosed as follows: seven with PDD-NOS, four with Asp, and three with AD. Five children with PDD-NOS or Asp also met the criteria for ADHD. In order to evaluate the definitive effectiveness of PT, the parents were instructed to not start any other medications or to not change the on-going medications for children during PTSS. The parents and children were also directed to not receive any other psychological therapies or training.

Guardians or mothers who had previous experience of PT or showed serious psychological conditions, including a history of child abuse or severe cognitive deficit (IQ/DQ lower than 35), were carefully excluded by the attending doctor and the research team.

The participation rate among the 14 mothers in the PTSS sessions was 94%. Two of the mothers could not be present in some sessions, and these were individually familiarized with the content and material of the missed sessions.

Table 1 details the demographic data of the mothers and their families. All mothers were living with a partner and had an average age of 37.5 years (SD = 4.09). All children were primarily cared for by their mothers.

### 2.2. Characteristics of children

Table 2 lists the clinical characteristics of the children involved in the study. The developmental levels were estimated using one or more developmental test batteries, i.e., the Wechsler Intelligence Scale for Children,

Table 1  
Family demographics.

<i>Mother (n = 14)</i>	
Age	
Mean (range of age)	37.5 yr (31.0–45.0)
Married	14
Living with partner	14
Level of education	
No university education	10
University education	4
Working	4
<i>Father (n = 14)</i>	
Age	
Mean (range of age)	39.4 yr (31.0–48.0)
Working	14
<i>Siblings</i>	
Siblings present	15
Siblings with developmental disorder	5*
Siblings quarreling with child	5
Siblings having trouble at school	6

\* Autistic Disorder: 2; PDD-NOS + ADHD: 1; Asperger's Disorder + ADHD: 1; Mild MR: 1.

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