Journal of Cranio-Maxillo-Facial Surgery 42 (2014) 953–958

Contents lists available at ScienceDirect

Journal of Cranio-Maxillo-Facial Surgery

journal homepage: www.jcmfs.com

Children with a cleft lip and palate: An exploratory study of the role of the parent–child interaction

Volker Gassling [a,*], Caroline Christoph [a], Kristina Wahle [a], Bernd Koos [b], Jörg Wiltfang [a], Wolf-Dieter Gerber [c], Michael Siniatchkin [d]

[a] Department of Oral and Maxillofacial Surgery, University Hospital of Schleswig-Holstein, Campus Kiel, Kiel, Germany
[b] Department of Orthodontics, University Hospital of Schleswig-Holstein, Campus Kiel, Kiel, Germany
[c] Institute of Medical Psychology and Medical Sociology, University Hospital of Schleswig-Holstein, Campus Kiel, Kiel, Germany
[d] Clinic for Child and Adolescent Psychiatry, Johann Wolfgang Goethe-University, Frankfurt, Germany

ARTICLE INFO

Article history:
Paper received 4 September 2013
Accepted 3 January 2014

Keywords:
Cleft lip and palate
Parent–child interaction
Craniofacial malformation
Family

ABSTRACT

Introduction: Having a child with an orofacial cleft may be associated with a specific pattern of parenting. In order to investigate the parenting style, the present study assessed parent–child interactions during a problem-solving task performed under pressure.
Material and methods: Parent–child interactions were video recorded for 15 families with a child with a cleft lip and palate (CLP), which were then compared to 20 healthy families and 20 families with a child suffering from migraines. The children had to solve a puzzle within a specified time with either their mother or father.
Results: In families with a child with CLP, mothers tried to support their children more often and children demonstrated more autonomous behaviour towards both parents than children in healthy and migraine-affected families. Moreover, the children with CLP relied less on their fathers for help and interrupted their fathers less frequently.
Conclusions: Autonomous behaviour among children with CLP which is supported by their parents may represent psychosocial compensatory mechanisms in the family environment.
© 2014 European Association for Cranio-Maxillo-Facial Surgery. Published by Elsevier Ltd. All rights reserved.

1. Introduction

Non-syndromic cleft lip and palate (CLP) represents the most common malformation of the midfacial region worldwide. In Europe, the incidence varies between 0.69 and 2.35 per 1,000 newborns depending upon the geographic location and ethnic identity (Gundlach and Maus, 2006). Today, treatment requires multidisciplinary care including maxillofacial surgery, orthodontics, otolaryngology, speech therapy, and dentistry. Owing to great efforts, particularly in the field of plastic-surgical treatment during the last few decades, the health outcome of affected patients seems to be good, particularly in developed countries (Hakim et al., 2013; Mossey et al., 2009; Wermker et al., 2013). However, the multiple burdens occurring from birth through to adulthood may compromise the affected individuals and lead to psychosocial difficulties in various aspects of life. Individuals with CLP present more often with behavioural problems, suffer from depression, and are unhappy because of their facial appearance and speech compared with subjects without a cleft (Hunt et al., 2006). It is unclear, however, how the disability impacts the social abilities and interpersonal relationships of patients with CLP and what consequences in the social environment may result from the malformation.

For example, adolescents with craniofacial anomalies (CFA) initiated contact less often, received positive responses from peers less frequently, and were engaged in conversations which were shorter in duration than healthy control subjects (Kapp-Simon and McGuire, 1997). Children with CFA were less responsive in socially reciprocal interactions and were rated personally as less attractive with regard to social contact (Krueckeberg et al., 1993). Furthermore, the severity of the cleft deformity was shown to have a significant impact on social competence in childhood, e.g., on the development of friendships. Given these examples, it is not surprising that even adult siblings with repaired clefts were less frequently married than their non-cleft siblings (Tobiasen and

* Corresponding author. Department of Oral and Maxillofacial Surgery, University Hospital of Schleswig-Holstein, Campus Kiel, Arnold-Heller-Straße 3, Haus 26, 24105 Kiel, Germany. Tel.: +49 431 597 2791; fax: +49 431 597 4084.
E-mail address: gassling@mkg.uni-kiel.de (V. Gassling).

1010-5182/$ – see front matter © 2014 European Association for Cranio-Maxillo-Facial Surgery. Published by Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.jcms.2014.01.016

Hiebert, 1993). Accordingly, parents of CLP-affected children rated them less socially competent regarding patterns of social interactions (Slifer et al., 2004). Furthermore, subjects with CLP did not differ from healthy individuals with respect to emotional and behavioural problems as well as hyperactivity. However, patients were six times more likely to report difficulties with respect to social abilities (Brand et al., 2009). In this context, the surgeon's assessment of facial aesthetics after cleft surgery seems to be of minor relevance and thus emphasize the role of social support of affected individuals (Cochrane and Slade, 1999; Gkantidis et al., 2013).

There may be different explanations for the described psychosocial problems of subjects with CLP. On the one hand, psychosocial deficits may have developed following a disability-related maladaptation in the psychosocial environment. On the other hand, they may be associated with a specific style of parenting in families with a CLP child. The birth of a child with a facial disfigurement is a profound experience for the affected parents. One investigation of parental reactions following the birth of a child with a CLP has provided evidence for negative parental emotions towards the CLP-affected child, e.g., frustration, disappointment, rejection, and feelings of guilt, sorrow, and pain resulting in less trust in and happiness about their children (Dolger-Hafner et al., 1997). It can be assumed that the pattern of social interactions within families with a CLP-affected child in general may be compromised by "stigmatization" and a negative attitude towards CLP children (Nelson et al., 2012). Based on these observations, it can be hypothesized that parents may demonstrate a negative pattern of parent–child interaction with more criticism and less positive reinforcement along with more direct control and less assurance which encourages the autonomous behaviour of a child with CLP.

The present study was aimed at testing this hypothesis. Dyadic parent–child interactions were studied using a standardized experimental design which enabled the microanalysis of communication patterns structured under laboratory conditions. This design has been successfully used in a number of studies which have demonstrated an abnormal pattern of parent–child interactions in families with children suffering from migrainous headaches and asthma (Gerber et al., 2002; Lykaitis, 1985; Siniatchkin et al., 2003, 2010). The construct allows for a detailed evaluation of the procedural side of interactions and describes familial relations in terms of the learning theory. Thus, the construct focuses on parental control of the child's activities either directly or by linking changes with specific consequences. In order to investigate the sensitivity and specificity of dyadic parent–child interactions in families with a CLP-affected child, actual interactions with the CLP-affected child were compared to previously recorded interactions with a healthy (sensitivity) and migraine-suffering (specificity) child (Siniatchkin et al., 2003, 2010).

2. Material and methods

2.1. Study participants

Only complete families including both the mother and father were studied. Fifteen families with a non-syndromic CLP-affected child were recruited from craniofacial malformation consultation appointments with the Department of Cranio-Maxillofacial Surgery, University Hospital of Schleswig-Holstein, Kiel Campus, Kiel, Germany. There was no recruitment bias and we had no refusals since all families which were consecutively asked to participate consented to inclusion in the study. All participating children had a repaired unilateral or bilateral CLP. According to our treatment protocol, the lip closure is performed at the age of 4–6 months, the soft and hard palate closure at the age of 10–12 months, and the secondary alveolar bone grafting at the age of 8–11 years. The control groups consisted of 20 families with a healthy child and 20 families with a child suffering from migraines. Healthy and migraine-suffering children were investigated previously within the framework of a German Research Foundation project (Ge 500/4-2). Therefore, the clinical and demographic characteristics of the healthy and migraine-affected group and parameters of the parent–child interactions in healthy and migraine-affected families have been published elsewhere (Siniatchkin et al., 2003, 2010). There were no significant differences between parents and children from each group according to age, gender, and other demographic characteristics (see Table 1). None of the recruited families refused participation in the study. All children from migraine-affected families suffered from migraines without aura (mean frequency of migraine attacks: 2.24 ± 2.5 day/months; mean attack duration: 8.17 ± 6.3 h; mean duration of disease: 5.5 ± 2.19 years). Structured headache interviews were performed with all participants. Migraine diagnosis was performed by an experienced neurologist according to the revised criteria of the International Headache Society based on an interview and prospective headache diaries (International Classification of Headache Disorders; (IHS, 2004)). Migraine diagnosis was excluded in families with a CLP-affected child and healthy families. There was no divorce in the histories of all families included in the analysis. None of the subjects investigated were undergoing psychiatric or psychological treatment nor were they taking any medication. Psychiatric comorbidity was excluded through the clinical interview with the parents and a psychiatric examination of the children. None of the children presented with symptoms which would fulfil the diagnostic criteria for any psychiatric disorders according to ICD-10. Although cognitive abilities were not tested in the children, all of them attended regular primary and secondary schools and demonstrated an average school performance (according to school report cards). All participants were Caucasians. Parents were informed about the course of the experimental procedure and gave written informed consent before the examination began. The study design complied with the Declaration of Helsinki, was approved by the local ethics board (AZ: D 433/10), and was registered in the German Clinical Trials Register (registration code: DRKS00004281; https://drks-neu.uniklinik-freiburg.de/drks_web/setLocale_EN.do).

2.2. Study of parent–child interactions

2.2.1. Paradigm

Observations were performed under laboratory conditions. The interactive behaviour was assessed by an achievement-oriented task: a puzzle adhering to the method described by (Lykaitis, 1985) and validated for clinical groups by (Gerber et al., 2002; Siniatchkin et al., 2003, 2010) was administered. All recordings were made in quiet, soundproof rooms free from outside disturbances. The child had to solve the puzzle autonomously with the mother or father, respectively. The order concerning the interaction with the mother or the father was counterbalanced between families. The puzzle was divided into 2 equal parts each with 53 pieces. Each half was to be solved within 15 min. The following instructions were given: (1) Only the child was permitted to touch

Table 1
Demographic characteristics of the groups (mean and SD for age and m:f for gender).

	CLP group	Healthy group	Migraine group	Difference
Age of mother	37.9 ± 6.7	40.6 ± 5.4	39.3 ± 4.1	n.s.
Age of father	40.4 ± 8.4	41.1 ± 4.2	43.7 ± 7.1	n.s.
Age of child	9.00 ± 1.25	10.6 ± 2.6	10.55 ± 1.5	n.s.
Gender of child	7:8	8:12	12:8	n.s.

Download English Version:

https://daneshyari.com/en/article/3143321

Download Persian Version:

https://daneshyari.com/article/3143321

Daneshyari.com