



Effects of parent management training programs on disruptive behavior for children with a developmental disability: A meta-analysis



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ABSTRACT

This meta-analysis determined the effects of parent management training (PMT) on disruptive behaviors in children with a developmental disability. Parent management training programs, based on behavioral theories of psychology, are commonly used in addressing disruptive behavior in children. Eleven studies met inclusion criteria with a total of 540 participants, with 275 in experimental groups and 265 in control groups. The effect of PMT on the disruptive behavior in children with a developmental disability was significant ($g = 0.39$). The moderator effects of type of PMT, delivery type and setting, and administrator level of education were also significant. The moderator effects of child age, and session number and duration were not significant in this meta-analysis.

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1. Introduction

1.1. Developmental disability and children

According to the Centers for Disease Control and Prevention (CDC, 2011), 13.9% of children between the ages of 3 and 17 years in the United States are diagnosed with a developmental disability. In the period between 1996 and 2008, the prevalence of developmental disabilities has increased 17% (Boyle et al., 2011). Boyle et al. (2011) suggest that developmental disabilities as a whole may be more prevalent due to increased rates of infants surviving from preterm birth and genetic disorders, such as Down syndrome. Regardless of cause, more children than ever are diagnosed with a developmental disability such as Autism Spectrum Disorder (ASD), Down syndrome, Cerebral Palsy and Special Learning Disability.

In addition to the functional and intellectual delays resulting from a developmental disability, a child with a developmental disability is more likely than a typically developing child to engage in maladaptive behaviors (Gadow, DeVincent, Pomeroy, & Azizian, 2004; Holden & Gitlesen, 2006), and also more likely to be diagnosed with a psychiatric disorder, such as anxiety disorder, depression, and conduct disorder (Emerson, 2003; Gadow, Guttman-Steinmetz, Rieffe, & DeVincent, 2012). Furthermore, the disruptive behaviors of children with a developmental disability are more severe than those behaviors with children who only have a mental health diagnosis (Gadow et al., 2004).

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1.2. Disruptive behaviors and effects on children

Maladaptive behaviors associated with children with developmental disabilities include yelling, screaming, aggression, and self-injurious behavior, such as head banging (Lecavalier, 2006). Lecavalier (2006) reports that over a two-year period, school-age children with pervasive developmental disorders experience high rates of emotional and behavior problems as compared to typically developing students. In their systematic review, Davies and Oliver (2013) report that aggression and self-injury increase with age in children with developmental disabilities even into adulthood. Maladaptive behaviors are often inadvertently reinforced by parents seeking to reduce the severity of behavior and giving into such behavior, and thereby offering a perceived reward (Eddy, Leve, & Fagot, 2001).

1.3. Disruptive behaviors and effects on parents

Parents of a child with a developmental disability are at greater risk for increased stress related to parenting when compared to typically developing children (Baker et al., 2003). Margalit, Shulman, and Stuchiner (1989) found that an increase in disruptive behaviors is correlated with a higher level of parent stress. Neece, Baker, Blacher, and Crnic (2011) report symptoms of comorbid attention-deficit hyperactivity disorder (ADHD) in children with a developmental disability were emergent earlier in childhood and that this, in part, is perhaps due to increased parent stress, which can exacerbate ADHD-related and disruptive behaviors in children. Besides causing stress, these disruptive behaviors also have a detrimental impact on maternal mental health. Gray et al. (2011) found that maternal depressive and anxiety symptoms are higher for mothers of children with a developmental disability than mothers of typically developing children and such symptoms worsen over time. Zablotzky, Anderson, and Law (2012) report that the more severe behaviors the child with autism displays, the higher the risk of depression for the mother, and maternal quality of life is also reported to be lower. In addition to depression, anger is also higher in parents of children with a developmental disability. The anger also causes increased depression and stress in parents (Benson & Karlof, 2009). The wide range of negative emotions and effects on parents resulting from the stress of raising a child with a developmental disability are evident. Increasing positive and proactive parenting practices is likely to reduce negative behaviors in children (Kazdin, 1997) which in turn is likely to reduce parent stress, thereby reinforcing more positive parenting practices. In addition, this will promote positive parental mental health outcomes.

1.4. Parent management training

Parent management training (PMT) is one of the different types of intervention that is commonly used by health care professionals working with families and individuals with emotional and behavioral disorders by teaching parents/families the necessary skills in managing children's disruptive behaviors. PMT programs are based on the following three theoretical approaches – social learning theory, coercion model of interaction, and applied behavior analysis, all of which are considered behavioral schools of psychological theory. Social learning theory (SLT), developed by Albert Bandura, maintains that children learn how to behave as observations are made about the behavior of others in reaction to their own behavior (Bandura, 1969; Grusec, 1992). In addition, a child learns how to behave based on how others behave. The ability of a child to manipulate and process the environment in which he/she lives changes as the child matures. One explanation for why such behavior might be continuously allowed by parents can be explained by the coercion model first described by Patterson (Patterson, 1980). In this model of family interaction, a child receives reinforcement for negative behavior by the response of the parent to this behavior. If this interaction occurs often, the family process might deteriorate to the point where the child receives more negative reinforcement for maladaptive behaviors than positive reinforcement for preferred behaviors and a coercive family process might become the norm (Eddy et al., 2001). A central aim of most PMT programs, such the Triple P Positive[®] programs (Sanders, 1999) is to alleviate or eliminate this coercive process.

Many PMT programs also utilize principles and practices of Applied Behavior Analysis (ABA). Applied Behavior Analysis is an approach to understanding behavior and encouraging the improvement of behaviors (Cooper, Heron, & Heward, 2007) especially those behaviors that are personally important to participants' everyday activities. Behavior change occurs when stimuli, such as reinforcers (to encourage desired behavior) and punishment (to discourage maladaptive behavior) directly follows the behavior. The key to change is timing the stimuli to directly follow the behavior. The application of ABA in PMT programs occurs through techniques such as observing and recording behavior, modeling, rewarding of appropriate behavior, and planned ignoring.

Just as there is overlap between PMT programs' theoretical bases, intervention strategies across PMT programs are often similar. These include the building of parent strengths and communication style to increase problem solving (Sharry, Guerin, Griffin, & Drumm, 2005); using role-playing and video-taped modeling (Sharry et al., 2005; Webster-Stratton & Herman, 2008); using descriptive praise and rewarding positive behavior and planned ignoring (Kazdin, 1997; Sanders, Mazzucchelli, & Studman, 2004). While processes and details sometimes differ between different PMT programs, all aim to improve child behavior via changing parental response to behaviors (Lucas, 2011).

Thus far, some evidence exists in supporting the benefits of PMTs for parents and children with developmental disabilities. For instance, Matson, Mahan, and LoVullo (2009) included "training packages" in a review of parent training methods for children with a developmental disability and concluded that parent trainings are cost effective, may reduce the

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