The Importance of Early Parenting in At-Risk Families and Children's Social-Emotional Adaptation to School

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Received for publication January 30, 2009; accepted June 22, 2010.

ABSTRACT

OBJECTIVE: The aim of this study was to determine the specific aspects of early parenting in psychosocially at-risk families most strongly related to children's social-emotional adaptation to school.

METHODS: A cohort study of families (N = 318) identified as at risk for maltreatment of their newborns was conducted. Quality of early parenting was observed in the home when the child was 1 year old. Social-emotional adaptation to school was reported by teachers in first grade. Multivariable models assessed the independent influence of early parenting variables on social-emotional adaptation.

RESULTS: Early parenting and social-emotional adaptation to school varied greatly across families. Parental warmth was associated with lower teacher ratings of shyness, concentration problems, and peer rejection. Parental lack of hostility was associated with decreased teacher ratings of concentration problems and peer rejection. Parental encouragement of developmental advance was associated with lower ratings of aggression and peer rejection. Provision of materials to promote learning and literacy was associated with lower ratings of concentration problems.

CONCLUSIONS: In this sample of families with multiple psychosocial risks for child maltreatment, specific aspects of early parenting were associated with better social-emotional adaptation to school in the first grade in theoretically predicted ways. Improving parental knowledge about positive parenting via anticipatory guidance should be a focus of well-child visits. Well-child visit-based interventions to improve the quality of early parenting, especially among at-risk families, should be studied for their impact on parenting behavior and on children's successful social-emotional adaptation to school. Primary care providers should reinforce complementary services, such as home visiting, that seek to promote positive parenting.

KEYWORDS: aggression; child rearing; parent-child relations; parenting; rejection; shyness; social adjustment; social behavior; vulnerable populations

ACADEMIC PEDIATRICS 2010;10:330–337

WHAT'S NEW

This study points pediatricians to early positive parenting skills to encourage in well child visits, specifically parental warmth, lack of hostility, encouragement of developmental advance, and provision of learning and literacy materials to support at-risk children's social-emotional adaptation to school.

PARENTING IS A strong influence on early childhood development, including social-emotional development.[1–3] Family psychosocial functioning is associated with the quality of parenting and with child outcomes.[1,4] Children who experience psychosocial stressors such as poverty, domestic violence, parental substance abuse, and physical and social disorder are at the greatest risk for social and behavioral problems.[1,4,5]

Among families with multiple psychosocial stressors, however, there is considerable variation in children's social and behavioral outcomes. Theories of human development, including models of vulnerability and resilience,[6] and a growing body of empirical evidence suggest the reasons for variation. Conger's family stress theory,[4] for example, posits that the economic pressures on poor families adversely affect children's development through their mediating effects on parental mental health, caregiver relationships, and parenting practices. Thus, in poor families where caregivers are able to provide nurturing parenting despite economic hardship and other stressors, children's behavioral outcomes will be more favorable. This argues for the growing importance of the pediatrician's role in addressing the "Millennial Morbidity"[7] through preventive efforts to promote positive parenting.

Older children and adults can take actions to reduce or avoid stressors. However, very young children have far less control over their exposure to stressors. Bowlby's attachment theory[8] holds that infant development is highly dependent on caregiver behavior. Infants need consistent warmth and nurturance: encouragement of their exploration to foster cognitive and social development and sensitivity to their distress to promote social development and

help them develop the ability to self-regulate in the face of stressors.

Because assuring positive child development is part of the mission of pediatrics, it follows that promoting positive parenting must be a part of the role of pediatric providers. This is especially true for primary care providers. The frequency of visits in early childhood and the growing focus on psychosocial health in pediatrics[9] put pediatric primary care providers in a unique position to promote positive parenting.

National professional associations such as the American Academy of Pediatrics offer guidelines to pediatric providers for activities to be carried out in health supervision visits. Their guidelines for health supervision, Bright Futures, for example, specify broad aspects of parent-child interaction to be observed during well-child visits and anticipatory guidance to be provided to promote positive parent-child interaction.[9] Given the time constraints of visits, it would be valuable to know what specific aspects of parenting have the greatest impact on children's social-emotional development, especially for families at psychosocial risk for poor parenting.

One of the key developmental tasks of life is making a successful transition to school. By improving our understanding of the specific early parenting behaviors associated with a successful transition to school among children in at-risk families, we can gain insight into what aspects of early parenting to promote during well-child visits. The goal of this study, therefore, is to determine what specific aspects of early parenting in psychosocially at-risk families are most strongly related to children's social-emotional adaptation to school.

METHODS

STUDY DESIGN AND SAMPLE

This was a cohort study of families enrolled in a randomized trial of Hawaii's Healthy Start Program (HSP), a paraprofessional home visiting program for families at risk for abuse or neglect of their newborns. The program serves families at risk for maltreatment of their newborns. The early identification component of the HSP identifies at-risk families through population-based screening and assessment using the Kempe Family Stress Checklist.[10] Families in which either parent scored ≥25 are defined as at risk and are eligible for the program. In this study, HSP early identification workers identified at-risk families by using the usual program protocol. When an eligible family was identified, the staff member described the HSP and the evaluation and obtained the mother's signed, informed consent to take part. By study protocol, the HSP staff member called the evaluation office for group assignment of all HSP-eligible families. Evaluation staff entered the name of the newly enrolled family in the next open study number in the study log, which indicated the group assignment. Group assignments were predetermined using a table of random numbers. Details regarding the HSP model, sample recruitment, random group assignment, and representativeness are described elsewhere.[11,12]

Study methods were approved by the institutional review boards of the Hawaii Department of Health, the hospitals at which families were recruited, the Johns Hopkins University School of Medicine, and the research offices of the Hawaii Department of Education. Signed informed consent was obtained from mothers at each annual follow-up; assent was obtained from children at the first-grade follow-up.

This analysis focuses on the 318 families with complete data from 3 sources: the maternal baseline interview, observation of the home environment when the child was 1 year old, and teacher ratings of the child's classroom behavior in first grade. Of the 643 families enrolled in the study at the time of the child's birth, 517 (80%) had a home observation of early parenting when the child was 1 year old, 79 (12%) were lost to follow-up, and 47 (7%) were followed at 1 year of age, but did not have a home observation of early parenting because the child was not present in the home during data collection. Of the 517 with a home observation at 1 year, 318 (62%) had a teacher report of social-emotional adaptation to school in first grade, 81 were lost to follow-up, and 118 were followed in first grade but did not have the teacher report for the outcome measure of social-emotional adaptation to school. Reasons for lack of teacher report include a family move out of state, data collection during the summer from school, and home schooling of the child.

DATA COLLECTION AND MEASUREMENT

Study data were collected by trained research staff who were unaware of group assignment. Structured maternal interviews were completed at the time of the child's birth and when the child was 1 year of age. Home observations were completed when the child was 1 year of age. Teacher report on the child's classroom behavior was collected when the child was in first grade.

DEMOGRAPHIC AND PSYCHOSOCIAL COVARIATES

Risk and protective factors that could moderate the influence of early parenting on child adaptation to school were measured. Child and family demographics were collected by maternal interview at the time of the child's birth. Variables included child attributes (gender and prematurity) and parent attributes (maternal age, race, parity, education, poverty, and relationship with father of baby). Four psychosocial aspects of maternal and family functioning were measured by maternal interview when the child was 1 year old: maternal parenting stress, depression, substance use, and intimate partner violence. Measurement of these attributes at 1 year allowed us to assess the influence of the quality of parenting behavior independent of maternal and family psychosocial functioning.

The short form of the Parenting Stress Index[13] was used to measure parenting stress by maternal interview when the child was 1 year old. Based on the developer's recommendation, high parenting stress was defined as a total score above the 90th percentile, ie, a mother was considered positive for high parenting stress if the total Parenting Stress Index score was above the 90th percentile as defined by Abidin.[13]