

Parenting programmes for attachment and conduct problems

Stephen Scott

Abstract

Parenting programmes are one of the best researched treatments for childhood psychiatric problems. As well as being proven effective for symptoms of conduct disorders in over 200 trials, there have now also been more than 60 trials, proving their effectiveness for insecure attachment patterns in infants. Their mechanism of action is now being confirmed, with both a reduction in harsh parenting and an increase in positive parenting appearing necessary to reduce conduct symptoms, and an increase in sensitive responding being necessary to promote secure attachment in infants. However, the less good news is that in 'real-life' everyday clinical conditions, as opposed to trials run in university clinics, the effects are often more modest. This is partly due to therapists having less well-developed skills, and partly due to cases being more difficult, with more comorbid conditions. The challenge now is to disseminate training in high-quality programmes and to develop these so that they are tailored to individual parenting needs, rather than offered as 'one size fits all'.

Keywords attachment; child aggression; conduct problems; parent training; psychological therapy

Evidence linking parenting to child psychopathology

The finding that parent-child relationship quality is associated with aggressive behaviour, conduct disorder and delinquency is one of the most widely-reported in the literature, repeatedly found in large-scale epidemiological investigations, intensive clinical investigations and naturalistic studies of diverse samples using a mixture of methods.¹ The sort of parenting behaviours associated with these outcomes are high criticism and hostility, harsh punishment, inconsistent discipline, low warmth, low involvement, low encouragement, and poor supervision.

The link with depression, anxiety and other emotional problems (e.g. somatic complaints, social withdrawal) is clear, although smaller than that found for disruptive outcomes.² There is also a connection between parenting and quality of a child's peer relationships, mediated by social cognitions and behavioural strategies learned from interacting with parents.

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Effects of harsh parenting on child physiology

Research on animal models has illuminated some of the physiological concomitants of poor parenting. For example, Kaffman and Meaney³ showed that after infant rats were separated from their mothers for short periods (less than 15 minutes) in the first two weeks of their lives, they showed sharp rises in cortisol in response to aversive stimuli compared with controls, but that this over-reactivity went back to normal after a few days. However, longer separations (3 hours per day) during this period led to large and lasting over-reactivity to stress, physiologically, with six-fold increases in adrenocorticotrophic hormone (ACTH) and cortisol production a year later in response to a mildly aversive stress (a puff of air in the eye), and behaviourally with far greater fearfulness, emotional arousal, and poorer sociability with other rats. The core component is likely not to be the separation, but the treatment of the infant rat on reunion by the mother, who largely ignored it, seldom licked or groomed it, and sometimes trampled over it. However, differences in physiological and behavioural responses to stress are not confined to cases of relatively extreme abuse, but also are important in the normal range of parenting. Various interventions can mitigate the effects of poor early rearing, including gentle handling by humans, provision of a more stimulating environment, and even antidepressants. These findings are likely to obtain for humans too. Thus, Nemeroff and colleagues found that compared with controls, women who had a history of child maltreatment showed a six-fold increase in HPA axis reactivity to laboratory-induced stress.⁴

These studies have implications for parenting programmes. The emotional over-reactivity seen in some children who have had experienced repeated deprivation and abuse is not likely to be due solely to learned habits in a background of typical physiology – reacting explosively in response to difficulties or frustrating situations may be far harder for them to control. They should be managed in as calm and non-stressful way as possible, to avoid setting off over-arousal with its concomitant outbursts of destructive aggression; they may take more learning trials to achieve goals, and may achieve less.

Programmes for infants based on attachment theory

Focused interventions typically last for 5–20 sessions, and mother-infant interactions should be video taped and replayed. During replay the idea of recognizing the infant's signals is brought out – in early stages, even if a mother is usually ignoring her infant, the therapist will try to find one piece of video where she does respond. Perhaps the infant will smile and she will smile back, leading the infant to gurgle with pleasure. The therapist might say, 'look, when he smiled you smiled back so warmly that he showed he loved it by gurgling!'. In later sessions, when the mother's confidence has been gained (more than 95% of participants are mothers, but the principle is the same for fathers or other carers), a less satisfactory piece of interaction may be examined. When a mother is not responding, the therapist can point this out, and ask 'what was going through your mind at that moment?'. This may elicit many interesting responses, from preoccupation with the mother's own needs or hassles ('I was wondering how to pay off my debt'), to misperception of cues ('I thought he was trying to wind me up' said of a messy eater), to strong negative emotions arising from her past experience ('when he does that I think he's just like his father,

who ruined my life'). The great strength of this approach is that it: allows parents to get an accurate picture of what is actually happening (rather than just talking about their perception of their relationship with their infant, as in traditional parent–infant psychotherapies); it enables them to see for themselves that when they change their behaviour, this impacts on their infant; it allows simultaneous exploration of the mother's mental state, so that mental blocks to more sensitive responding can be explored and often overcome.⁵

In contrast, Olds⁶ developed a home-visiting programme delivered by nurses (the Nurse–Family Partnership) that is not based on attachment theory and does not use video feedback. It is based on systematic evaluation of and evidence-based interventions for risk factors from pregnancy onwards. Thus, parents are encouraged to reduce cigarette and alcohol consumption in pregnancy through understanding the effects on their babies; once the baby is born, parent–child interaction is coached, including how to stimulate the baby appropriately, and wider issues such as partner violence and further general education for the mother are addressed.

Programmes for children based on social learning theory

Programmes based on social learning theory have evolved for more than 40 years and there is a large evidence base. Most are aimed at antisocial behaviour as their proximal target outcome. The content and delivery of a typical programme is shown in Table 1.

Most basic programmes take 8–12 sessions, lasting 1.5–2 hours each. Full accounts of programmes are given by the developers.^{7,8}

Format of a typical social learning programme

Teaching a child-centered approach – the first session covers play. Parents are asked to follow the child's lead rather than impose their own ideas. Instead of giving directions, teaching, and asking questions during play, parents are instructed simply to describe what the child is doing, to give a running commentary on their child's actions. If the parent has difficulty in getting going, the practitioner may suggest precisely what they should do, for example by saying 'I'd like you to say to Johnny 'you've put the car in the garage''. As soon as the parent complies, the practitioner gives feedback, 'that was a good descriptive comment'. After 10–15 minutes, this directly supervised play ends and the parent is 'debriefed' for half an hour or more alone with the clinician.

The second session involves elaboration of play skills. The previous week's 'homework' of playing at home is discussed with the parent in considerable detail. Often there are practical reasons for not doing it ('I have to look after the other children, I've got no help') and parents are then encouraged to solve the problem and find ways around the difficulty (solutions arrived at might include doing the play after the younger sibling has gone to bed; getting the oldest child to look after the baby while the parent plays with the toddler, etc). For some parents there may be emotional blocks ('it feels wrong – no one ever played with me as a child'), which need to be overcome before they feel able to practice the homework.

After this discussion, live practice with the child is carried out. This time the parent is encouraged to go beyond describing the

Features of effective parenting programmes based on social learning theory

Content

- Structured sequence of topics, introduced in set order during 10–12 weeks
- Curriculum includes play, praise, rewards, setting limits, and discipline
- Parenting seen as a set of skills to be deployed in the relationship
- Emphasis on promoting sociable, self-reliant child behaviour and calm parenting
- Constant reference to parent's own experience and predicament
- Theoretical basis informed by extensive empirical research and made explicit
- Plentiful practice, either live or role-played during sessions
- Homework set to promote generalization
- Accurate but encouraging feedback given to parent at each stage
- Self-reliance prompted (e.g. through giving parents tip sheets or book)
- Emphasis on parent's own thoughts and feelings varies from little to considerable
- Detailed manual available to enable replicability

Delivery

- Strong efforts made to engage parents (e.g. home visits if necessary)
- Collaborative approach, typically acknowledging parents' feelings and beliefs
- Difficulties normalized, humor and fun encouraged
- Parents supported to practise new approaches during session and through homework
- Parent and child can be seen together, or parents only seen in some group programmes
- Creche, good-quality refreshments, and transport provided if necessary
- Therapists supervised regularly to ensure adherence and to develop skills

Table 1

child's behaviour and to make comments describing the child's likely mood state (e.g. 'you're really trying hard making that tower', or 'that puzzle is making you really fed up'). This process has benefits for both the parent and the child. The parent gets better at observing the fine details of the child's behaviour, which makes them more sensitive to the child's mood. The child gradually gets better at understanding and labeling his own emotional states, a crucial step in gaining self-control in frustrating situations.

Increasing desirable child behaviour – praise and rewards are covered here. The parent is required to praise their child for lots of simple everyday behaviours such as playing quietly on their own, eating nicely, getting dressed the first time they are asked, and so on. In this way the frequency of desired behaviour increases. However, many parents find this difficult. Usually with

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