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Common components of evidence-based parenting programs for preventing maltreatment of school-age children

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ABSTRACT

Child maltreatment can lead to a variety of negative outcomes in childhood including physical and mental health problems that can extend into adulthood. Given the transactional nature of child maltreatment and the difficulties that many maltreating families experience, child protection services typically offer various kinds of programs to maltreated children, their parents, and/or their families. Although the specific difficulties experienced by these families may vary, sub-optimal parenting practices are typically part of the picture and may play a central role in maltreated children's development. Hence, to deal with child maltreatment, programs that focus on parenting practices are essential, and identifying the common components of effective programs is of critical importance. The objectives of the present study were to: 1) describe the components of evidence-based parenting programs aimed at parents who have maltreated their elementary school-aged children or are at-risk for doing so and 2) identify the components that are common to these programs, using the approach proposed by Barth and Liggett-Creel (2014). Fourteen evidence-based parenting programs aimed at parents who had maltreated their elementary school-aged children (ages 6–12) or were at-risk for doing so were identified using both a review of relevant online databases of evidence-based programs (California Evidence-Based Clearinghouse for Child Welfare, Blueprints for Healthy Youth Development, Youth.gov, and the National Registry of Evidence-based Programs and Practices). Common components were identified (operationalized as components present in two thirds of programs) and discussed. The identification of common components of evidence-based programs may help clinicians choose the best intervention methods.

1. Introduction

Child maltreatment can be defined as any act of omission (failure to meet a child's physical, emotional or social needs—also known as child neglect) or commission (actions inflicted on the child directly or indirectly—also known as child abuse) that may impair a child's safety, development or physical, psychological and emotional integrity (Clément, Chamberland, & Bouchard, 2016). These various forms of child maltreatment can co-occur; they can be classified into the categories of physical abuse (PA), sexual abuse (SA), emotional abuse (EA), and neglect (Clément et al., 2016; Government of Canada, 2010).

Stoltenborgh, Bakermans-Kranenburg, Alink, and van IJzendoorn (2015) combined and compared the results of previous meta-analyses in order to draw conclusions about the prevalence of various types of maltreatment. The authors found that the combined prevalence rates for SA, PA and EA reported in studies based on statistics from child welfare agencies were 0.4%, 0.3%, and 0.3%,

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respectively. In contrast, the combined prevalence rates found in studies based on self-reports were strikingly higher, with 7.6% for SA among boys, 18.0% for SA among girls, 22.6% for PA and 36.3% for EA. A recent U.S. study found that overall, 9.4 out of every 1000 children in the United States are victims of maltreatment every year (U.S. Department of Health & Human Services, 2015).

The World Health Organization has identified child maltreatment as a major public health problem (Krug, Dahlberg, Mercy, Zwi, & Lozano-Ascencio, 2002). It has serious consequences from childhood to adulthood, the most tragic, of course, being the death of the child through homicide or neglect. In the United States, the National Child Abuse and Neglect Data System identified 1560 deaths attributable to child abuse and neglect in 2010 (Krugman & Lane, 2014).

In regards to physical health, maltreated children experience more injuries, broken bones, head injuries, and growth delays (Gilbert et al., 2009; Trocmé, 2012; Widom, 2014). Maltreatment is also associated with problems in brain development, speech/language disorders and learning difficulties (Bernard, Lind, & Dozier, 2014; Widom, 2014), as well as with obesity, chronic pain and health problems in adulthood, such as diabetes, liver and kidney disease, and cardiac and respiratory diseases (Gilbert et al., 2009; Widom, 2014).

As regards mental health, children who are maltreated are more likely to have internalized problems, such as anxiety and depression, and externalized problems, such as aggressiveness, delinquency and criminality (Gilbert et al., 2009). Maltreatment in childhood is also associated with mental-health problems in adulthood, such as alcohol abuse (especially in women), post-traumatic stress disorder, personality disorders and suicidal behavior (Gilbert et al., 2009; Widom, 2014).

These consequences of maltreatment are accompanied by increased use of health and social services. Every year, affluent countries such as the United States and the United Kingdom spend hundreds of billions of dollars to pay the costs associated with child maltreatment, mainly for short-term and long-term health and social services (Ferrara et al., 2015), including programs provided to maltreated children and their families.

The ecological/transactional model proposed by Cicchetti and his colleagues (Cicchetti & Lynch, 1993; Cicchetti & Valentino, 2006) clearly illustrates how maltreatment influences children's development and adjustment. According to this model, when parents maltreat their children, their affective involvement with these children and their child-rearing practices are directly and mutually related to these children's behaviour problems, low self-esteem, and difficulties in school. According to Cicchetti et al., such parents' child-rearing practices are influenced directly by proximal factors such as the parents' limited psychological resources (limited self-control, limited ability to manage stress and frustration, mental-health problems, substance-abuse problems, history of maltreatment in childhood) and difficult family dynamics (conflict and violence), as well as indirectly, by distal factors such as cultural values and beliefs, community factors, and characteristics of the family setting. This model is supported by studies that describe maltreating families (Dubowitz, 2010; Pauzé, Déry, & Toupin, 1995; Smith & Fong, 2004). In general, the parents in these families have limited personal resources to cope with their own problems and meet their children's needs. These parents are often undereducated, socially isolated, and living in poverty. Many have a combination of mental-health problems and problems of drug or alcohol abuse, which directly undermine their parenting practices (Pauzé et al., 1995, Pauzé et al., 2004).

Given the transactional nature of child maltreatment and the difficulties that many maltreating families experience (Cicchetti & Lynch, 1993; Cicchetti & Valentino, 2006), child protection services typically offer various kinds of programs to maltreated children, their parents, and/or their families. Although the specific difficulties experienced by these families may vary, sub-optimal parenting practices are typically part of the picture and may play a central role in maltreated children's development. Hence, to deal with maltreatment and reduce its impacts and the demands that it places on health and social services, multidimensional support for families is essential, including programs that focus on parenting practices.

2. Parenting programs

Programs that help parents to play their parental role are thus central to the mission of child protection services, which is to protect children and ensure their well-being (Barth et al., 2005). That such programs are necessary is all the more apparent when one considers statistics such as those from two studies, which found that 95% of all children who had been maltreated were living with at least one of their biological parents at the time of the reported incident (Hélie, Collin-Vézina, Turcotte, & Trocmé, 2017) and that 49% of all children whose cases were taken in charge by child protection services remained in their family settings (Institut national d'excellence en santé et en services sociaux, 2017). But the services provided in parenting programs vary widely. For parents who are at high risk of maltreating or have actually maltreated a school-age child (age 6–12), the programs offered fall into three categories, all of which have the same goal: to help the parents take better care of their children and thus put an end to the situation that endangers the child's safety or development (Barth et al., 2005; MacLeod & Nelson, 2000). The first of these categories, parent support programs, typically offer parents various types of social and/or emotional support, while the second, parent education programs, typically aim to increase parents' knowledge regarding child development and/or positive parenting strategies (Andrews & McMillan, 2013). In contrast, parent training programs are designed to improve communication and the relationship between parents and their children. They also teach parents to apply positive child-rearing practices, such as using praise and rewards, following a daily routine, and employing effective disciplinary strategies in a consistent way (Andrews & McMillan, 2013; MacLeod & Nelson, 2000; Mikton & Butchart, 2009).

The meta-analysis conducted by Chen and Chan (2016), using randomly controlled trials with a variety of populations, showed that both parent education programs and parent training programs are effective in reducing child maltreatment. But most of the programs that studies have shown to be effective in producing changes in parents' behaviour (Barth et al., 2005; Hughes & Gottlieb, 2004; Letarte, Normandeau, & Allard, 2010; Lundahl, Risser, & Lovejoy, 2006a; Lundahl, Nimer, & Parsons, 2006b) and in children's behaviour (Letarte et al., 2010; Lundahl et al., 2006a,b) are parent training programs. Moreover, longitudinal studies have shown

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