



Contents lists available at ScienceDirect

Behaviour Research and Therapy

journal homepage: www.elsevier.com/locate/brat

Targeting couple and parent-child coercion to improve health behaviors

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ARTICLE INFO

Keywords:

Coercion
Parenting
Couples
Affect regulation
Conflict
Health

ABSTRACT

This phase of the NIH Science of Behavior Change program emphasizes an “experimental medicine approach to behavior change,” that seeks to identify targets related to stress reactivity, self-regulation, and social processes for maximal effects on multiple health outcomes. Within this framework, our project focuses on interpersonal processes associated with health: coercive couple and parent-child conflict. Diabetes and poor oral health portend pain, distress, expense, loss of productivity, and even mortality. They share overlapping medical regimens, are driven by overlapping proximal health behaviors, and affect a wide developmental span, from early childhood to late adulthood. Coercive couple and parent-child conflict constitute potent and destructive influences on a wide range of adult and child health outcomes. Such interaction patterns give rise to disturbed environmental stress reactivity (e.g., disrupted sympathetic nervous and parasympathetic nervous systems) and a wide range of adverse health outcomes in children and adults, including dental caries, obesity, and diabetes-related metabolic markers. In this work, we seek to identify/develop/validate assays assessing coercion, identify/develop and test brief interventions to reduce coercion, and test whether changes in coercion trigger changes in health behaviors.

This phase of the National Institutes of Health (NIH) Science of Behavior Change (SoBC) program encourages an experimental medicine approach to behavior change and improving health outcomes, with a focus on cross-cutting phenomena that have broad implications for changing behaviors associated with stress reactivity, self-regulation, and social processes. Behavior accounts for about 40 percent of risk associated with preventable premature deaths and problematic health conditions in the United States (NIH, 2017). Risky behaviors include substance use, physical inactivity, poor diet, poor sleep, and failing to follow through on medical advice to reduce morbidity (e.g., maintain healthy weight, take medications as prescribed, engage in good oral hygiene practices) among those at elevated risk. It is important to note that most of these behaviors occur in social contexts. Arguably, family provides the most potent socialization context for behaviors that can support or impede healthy behavior change. In fact, considerable research implicates family interaction in directly affecting proximal health outcomes, including, but not limited to, cardiovascular reactivity (Cartozian & Ybarra, 2005; Ewart, Taylor, Kraemer, & Agras, 1991), immunologic function (Kiecolt-Glaser et al., 1993), sleep quality (Troxel, Braithwaite, Sandberg, & Holt-Lunstad, 2016), metabolic responses to high fat meals (Kiecolt-Glaser et al., 2015), peripheral neuroendocrine activity (Malarkey, Kiecolt-Glaser, Pearl, & Glaser, 1994), the activity of brain regions implicated in stress (Graham,

Fisher, & Pfeifer, 2013), and wound healing (Kiecolt-Glaser et al., 2005). Furthermore, family processes can encourage or impede health behaviors by providing contexts in which diet, activity, engagement with primary health care, and other behaviors occur (Repetti, Taylor, & Seeman, 2002). Given such findings, it is encouraging that family processes can be considered as potential malleable targets to treat many medical disorders (e.g., DiMatteo, 2004) and prevent new ones (Brotman et al., 2012).

1. Experimental medicine approach

An experimental medicine approach involves (1) identifying an intervention target, (2) developing assays, or measures, to allow one to verify that one has engaged said target, (3) experimentally engaging said target, and (4) testing the degree to which the target engagement produces a desired behavior change. In the present paper, we will discuss plans for an experimental medicine approach to a destructive interpersonal process—coercion—that has ramifications for key health behaviors related to Type II Diabetes and oral health.

2. Coercive process

We have chosen to focus on coercive conflict in couples and

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<http://dx.doi.org/10.1016/j.brat.2017.10.003>

Received 26 April 2017; Received in revised form 29 September 2017; Accepted 9 October 2017
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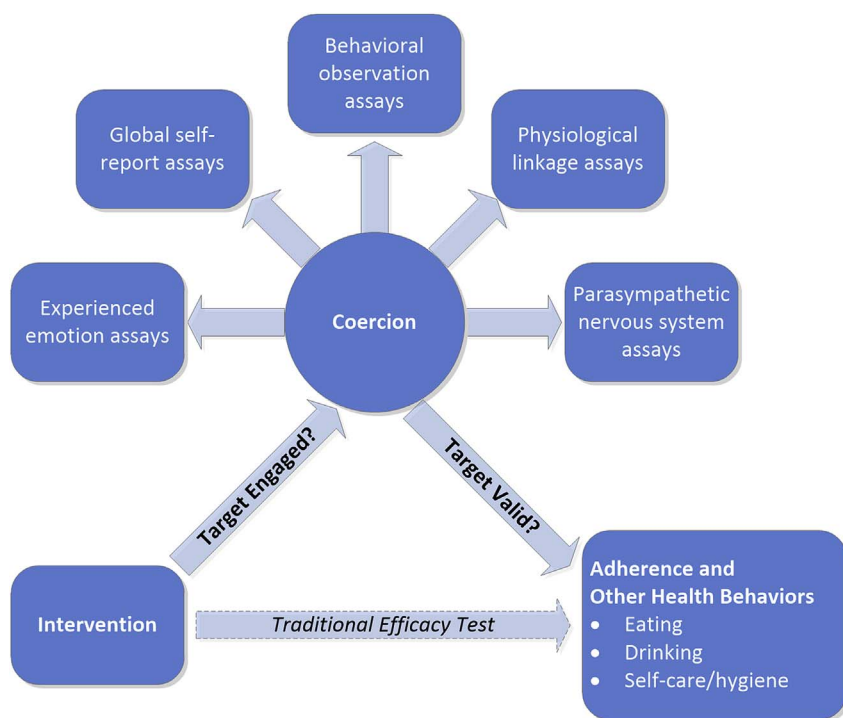


Fig. 1. Experimental medicine approach to behavior change model of coercion and health.

between parents and children. Coercion Theory (Patterson, 1982; Reid, Patterson, & Snyder, 2002) is one of the most highly developed and influential interpersonal models of dyadic family conflict. It explains how, despite their unpleasant and destructive qualities, hostile escalation in conflict is functional and reinforced for both parties. To the extent that dyads' conflicts are characterized by mutually reinforced, mutually escalating behavior and affect, they are coercive. Patterson posited that people learn coercive behavior through ways in which conflicts are resolved. Over time, if Person A responds to Person B's escalating aversive behavior by giving in, thus ceasing his/her own aversive behavior, B learns to escalate to get his/her way. Importantly, both persons' behaviors are maintained through reinforcement. B is negatively reinforced for escalating (via A withdrawing) and may be positively reinforced as well (via A doing what B was asking for in the argument). A is negatively reinforced for giving in (via the termination of B's aversive behavior).

Take, for example, a child who resists having her teeth brushed by her mother. The child might start to whine and pull away. In response, the mother might scold and yell at the child and more forcefully try to get her teeth brushed. At this point, the child screams and throws her toothbrush. Her mother, frustrated, leaves the bathroom and the screaming child. The child ceases her tantrum, but her teeth go unbrushed. In this scenario, the final behaviors of both the child and parent are negatively reinforced by conflict termination (i.e., escape conditioning). The child is negatively reinforced for screaming and throwing the toothbrush. The mother is negatively reinforced for acquiescing to the child's resistance.

Over time, these conflicts serve as learning trials. Of course, B does not always win. Sometimes, B backs down in response to A's aversive escalation. Thus, once a coercive process takes hold, both members of the dyad are faced with an unfortunate choice: (a) give in and lose the battle, or (b) win via out-escalating the other. This process leads to ever darker, bitter battles. In Patterson's (1976, p. 1) exquisite phrasing, each person is both "victim and architect of a coercive system." This very specific dyadic process is the operationalization of coercion we use as the target in our proposed research. We will return to the measurement challenges faced by this specific construct below.

In its original instantiation, Coercion Theory was defined primarily

in functional-analytic, operant reinforcement terms (as outlined immediately above), and provided the first truly transactional account of adverse family relations. These relations could now be understood as long term outcomes of dynamic, reciprocal aversive exchanges that occurred thousands of times across development in at risk families. Coercion Theory identified reinforcement contingencies that maintained anger and aggression within families, predicted longitudinal increases in such outcomes, and recognized that *both* parents and children negatively reinforce one another's aversive behaviors (Patterson, DeBaryshe, & Ramsey, 1989; Snyder & Stoolmiller, 2002). These observations enjoy overwhelming empirical support (e.g., Lansford et al., 2011).

More recent instantiations of Coercion Theory elaborate on this behavioral perspective by specifying *internal* mechanisms of reinforcement that maintain aversive family relations (see Beauchaine & Zalewski, 2016). In particular, Snyder and colleagues (e.g., Snyder, Edwards, McGraw, Kilgore, & Holton, 1994; Snyder, Schrepferman, & St. Peter, 1997; Snyder & Patterson, 1995), as well as our own group (Slep, Heyman, & Lorber, 2016), demonstrated that conflict escalation is accompanied by emotion dysregulation, that affected family members are more likely to escalate conflict when in dysregulated, irritable states, and that intense displays of negative emotion are more likely to terminate conflict in coercive families than in less aggressive families. Thus, not only does negative reinforcement occur through escape from aversive behaviors of others, but also through escape from one's own negative affective states. Escape from one's own negative affective state is a potent motivator for conflict behaviors that undergird coercive process (Lorber, Del Vecchio, Feder, & Slep, 2017).

As this discussion reveals, contemporary Coercion Theory explains active ingredients in both couple and parent-child coercion, which are marked by interrelated sets of affective, behavioral, and physiological signatures. Aversive behaviors, physiological reactivity/arousal, affective lability, and emotion dysregulation are all reinforced and maintained by coercive relationship dynamics (e.g., Beauchaine & Zalewski, 2016; Beauchaine, 2015). Coercion Theory provides specific targets for intervention. Indeed, all of these processes are implicated directly in the progression of type 2 diabetes and dental caries, as reviewed below.

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