



## Shorter communication

# Does Stepping Stones Triple P plus Acceptance and Commitment Therapy improve parent, couple, and family adjustment following paediatric acquired brain injury? A randomised controlled trial

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## ABSTRACT

**Objective:** To evaluate the efficacy of a behavioural family intervention, Stepping Stones Triple P (SSTP), combined with an Acceptance and Commitment Therapy (ACT) workshop in improving parent, family and couple outcomes following paediatric acquired brain injury (ABI).

**Participants and setting:** Fifty-nine parents (90% mothers) of children (mean age 7 years; 35 males, 24 females) with ABI.

**Intervention:** Participants were randomly assigned to a treatment (10-week group SSTP and ACT program) or a care-as-usual (CAU) control condition (10 weeks). Those in the CAU condition received the treatment after the waitlist period.

**Outcomes:** Self-report measures of parent psychological distress, parent psychological flexibility, parenting confidence, family functioning, and couple relationship, assessed at: pre-intervention, post-intervention, and 6-months post-intervention.

**Results:** Post-intervention, the treatment group showed significant, small to medium improvements relative to the CAU group (at the  $p < .05$  level) on parent psychological distress, parent psychological flexibility, parent confidence in managing behaviours, family adjustment, and number of disagreements between parents. Most improvements were maintained at 6-months.

**Conclusions:** Parent skills training and ACT may be efficacious in improving parent, family, and couple outcomes in families of children with an ABI.

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**Abbreviations:** AAABIQ, Acceptance and Action ABI Questionnaire; ABI, Acquired Brain Injury; ACT, Acceptance and Commitment Therapy; ASD, Autism Spectrum Disorder; CAU, Care as Usual; CI, Confidence Interval; DASS, Depression Anxiety and Stress Scale; EA, Experiential Avoidance; ES, Effect Size; FAD, McMaster Family Assessment Device; GCS, Glasgow Coma Scale; ITT, Intention to Treat; M, Mean; MDiff, Mean Difference; MMRM, Mixed-Model Repeated Measures; NA, Not Applicable; PPC, Parent Problem Checklist; PTC, Parenting Task Checklist; PTFQ, Parent Thoughts and Feelings Questionnaire; RCT, Randomised Controlled Trial; RQI, Relationship Quality Index; SD, Standard Deviation; SE, Standard Error; SPSS, Statistical Package for the Social Sciences; SSTP, Stepping Stones Triple P; TBI, Traumatic Brain Injury; Triple P, Positive Parenting Program.

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Paediatric acquired brain injury (ABI) not only has a significant impact on the child, but also affects individual family members and the family as a whole. Approximately one in two children will present with behavioural difficulties post-ABI and these can persist and worsen over time (Li & Liu, 2013). Parents and families can experience acute and long-term burden and distress, including psychological symptoms, and strained couple relationships (Anderson, Catroppa, Haritou, Morse, & Rosenfeld, 2005; Stancin, Wade, Walz, Yeates, & Taylor, 2008; Wade, Taylor, et al., 2006).

While a dose–response relationship may exist between injury severity and child cognitive and physical outcome (Anderson et al., 2005), psychosocial factors appear to contribute to child behavioural, social, and emotional outcomes, beyond characteristics of

the neurological insult. Contributing post-injury family factors include parent distress, parenting strategies and family functioning (Anderson et al., 2006; Li & Liu, 2013; Yeates et al., 2004).

Reciprocally, increased child behaviour difficulties significantly disrupt family functioning and increase parent distress (Anderson et al., 2005; Taylor et al., 2001). Family adjustment is also influenced by availability of material and social resources, stressors, and coping styles (Stancin et al., 2008; Wade et al., 2001). Importantly, parental coping styles characterised by behavioural and emotional avoidance or withdrawal (which could include strategies such as avoidance of reminders of the injury, or attempts to suppress emotions) are consistently linked to poorer parent psychological functioning post-ABI (Stancin et al., 2008; Wade et al., 2001).

The relationship between high parent distress and poorer child outcome may be partly explained through the adoption of maladaptive parenting strategies. Parents of children with ABI appear prone to either over-reactive or permissive parenting practices, and higher parent and family distress predicts poor parenting practices (Woods, Catroppa, Barnett, & Anderson, 2011). Superior child behavioural and adaptive outcomes from ABI are linked to high parental warmth and responsiveness, and low parental negativity, permissiveness, and authoritarianism (Micklewright, King, O'Toole, Henrich, & Floyd, 2012; Wade et al., 2011; Yeates, Taylor, Walz, Stancin, & Wade, 2010), while high authoritarianism appears to mediate the negative relationship between parent distress and child adaptive functioning (Micklewright et al., 2012). Qualitatively, parents report that struggling with internal experiences (such as guilt, frustration, anxiety, and flashbacks to the injury) can interfere with effective parenting (Brown, Whittingham, Boyd, & Sofronoff, 2013a).

Despite these findings, there is a paucity of published trials of interventions for parenting skills post-pediatric ABI (Brown, Whittingham, Boyd, & Sofronoff, 2013b) or for parent distress (Cole, Paulos, Cole, & Tankard, 2009). Given the bidirectional relationship between parent and child functioning post-ABI, a potential dual-intervention approach is to combine a parent-skills training intervention targeting child behaviour, with an intervention targeting parent wellbeing.

We have recently reported on a two-arm waitlist-controlled RCT of an evidence-based parenting program, group-based Stepping Stones Triple P (SSTP) (Sanders, Mazzucchelli, & Studman, 2009), plus an Acceptance and Commitment Therapy (ACT) workshop (Whittingham, Sheffield, & Sofronoff, 2010) for parents of children with ABI (Brown, Whittingham, Boyd, McKinlay, & Sofronoff, 2014). SSTP is an evidence-based intervention for parents of children with disabilities, demonstrating significant improvements in child and parent outcomes (Tellegen & Sanders, 2013). This is the first reported trial of an evidence-based behavioural parenting intervention with the pediatric ABI population.

ACT is a cognitive-behavioural therapy that aims to reduce experiential avoidance (EA; attempts to alter or control unwanted internal experiences of cognitions, memories, or emotions) and foster psychological flexibility, that is, the ability to interact flexibly with internal experiences and respond adaptively to given situations for the purpose of valued living (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). There is empirical support for the efficacy of ACT for treating psychological distress (A-Tjak et al., 2015). EA is related to psychological distress and burden for parents of children with various disabilities (Weiss, Cappadocia, MacMullin, Viecili, & Lunsky, 2012; Whittingham, Wee, Sanders, & Boyd, 2012), and may mediate the relationship between child behaviour problems and parent distress (Weiss et al., 2012). In support of the delivery of an ACT intervention in conjunction with a parenting intervention, a simultaneously conducted 3-arm study trialling SSTP alone versus SSTP plus ACT versus CAU for parents of children with cerebral

palsy found some additive benefits of ACT for child behavioural problems and problematic parenting strategies (Whittingham, Sanders, McKinlay, & Boyd, 2014).

Therefore in this trial we delivered the ACT-based intervention alongside SSTP with the aim to promote psychological flexibility in managing the emotional toll of ABI, and enhance parent effectiveness and confidence through reducing the impact of difficult thoughts and feelings on parenting behaviour. The ACT intervention aimed to teach parents strategies for managing difficult thoughts through 'defusion', accepting difficult emotions, identifying their values as a parent and other life domains, and taking action in line with those values.

We have reported significant short-term improvements in the combined intervention condition (ACT + SSTP), compared to the 10-week CAU condition, on the primary outcomes of child behavioural and emotional outcomes and parenting styles of laxness and overreactivity (Brown et al., 2014). Most outcomes were maintained at six-months. We have also reported additional analyses of the mediational role of improvements in psychological flexibility on treatment effects on parenting style and psychological distress, supporting the rationale for ACT in this population (Brown, Whittingham, & Sofronoff, 2015).

This paper reports on the same RCT, but considers the important secondary outcomes of parent and family wellbeing. We hypothesised that parents of children with ABI who participated in the ACT + SSTP intervention would also demonstrate improved parenting confidence, decreased psychological distress, and improved family functioning relative to the CAU condition. In two-parent families we hypothesised improved relationship satisfaction and reduced conflict over parenting. Improvements on the proposed process variable of parental psychological flexibility were also hypothesised. It was expected that these effects would be maintained at a 6-month follow-up.

## 1. Method

For a detailed description of trial procedures, including ABI definitions, intervention details, outcome measures, recruitment, sample size calculation, and randomisation, see the study protocol (Brown, Whittingham, McKinlay, Boyd, & Sofronoff, 2013).

### 1.1. Participants

Recruitment was conducted through two paediatric rehabilitation services in Brisbane, Australia between October 2010 and May 2012. Eligible parents had a child: (a) aged 2–12 years, diagnosed with an ABI; (b) at least three months post-injury/diagnosis; and (c) currently demonstrating at least one parent-reported emotional or behavioural difficulty. Parents were excluded if: (a) they did not have sufficient English proficiency to participate in the group sessions; (b) the child was still medically unwell or undergoing chemotherapy or radiation therapy.

### 1.2. Design and procedure

This study was a randomised controlled, parallel-group trial comparing ACT + SSTP to CAU. Ethical approval was obtained, and the trial was registered on Australian New Zealand Clinical Trials Registry (ID: ACTRN12610001051033, [www.anzctr.org.au](http://www.anzctr.org.au)). After providing written informed consent and completing baseline assessments, participating parents were randomly assigned to ACT + SSTP or CAU. CAU participants received the ACT + SSTP intervention after the 10-week waiting period. Data was collected at baseline, post-intervention, and 6-months post-intervention. As both groups received the intervention, maintenance of change was

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