



Addressing behavioral impacts of childhood leukemia: A feasibility pilot randomized controlled trial of a group videoconferencing parenting intervention



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ABSTRACT

Purpose: Child emotional and behavioral problems constitute significant sequelae of acute lymphoblastic leukemia (ALL) treatment. The aims of this study were to a) examine the feasibility, acceptability and satisfaction of a parenting intervention amongst parents of children with ALL and b) explore whether participation in a parenting intervention shows promise for improvements in child behavior.

Methods: 12 parents with a child aged between 2 and 8 years receiving maintenance phase treatment for ALL participated in a phase 2 randomized controlled trial comparing eight weeks of group online participation in Triple P: Positive Parenting Program with no intervention.

Results: The number of eligible parents who completed the intervention was low (31.6%). Main reasons for non-consent or dropout were program time commitment too high or content not relevant. For parents who completed the intervention, satisfaction and acceptability was high. Parents reported the intervention as highly relevant and topical, feasible, helpful and a positive experience. Results indicated a non-significant trend towards improved total child behavioral and emotional difficulties following the intervention. Qualitative results indicated that intervention group parents reported improvements in parenting skills and competence, and decreased child behavioral problems.

Conclusions: These pilot data highlight the difficulties of engaging and retaining parents in an 8-week parenting intervention in this context. For parents who completed the intervention, results indicated high feasibility, acceptability and satisfaction. Suggestions for further research and intervention modifications are provided to enhance uptake and strengthen efforts to assist parents in addressing child behavioral and emotional challenges during ALL treatment.

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1. Background

Despite high survival rates, treatments for pediatric acute lymphoblastic leukemia (ALL), contribute to psychological morbidity. A commonly reported and distressing psychological impact of ALL treatment, occurring in up to 86% of children, is

behavioral and mood disturbance (Pound et al., 2012; Williams et al., 2014; Williams and McCarthy, 2015). Child emotional “outbursts” including physical and verbal aggression, anxiety, moodiness, irritability, as well as behavioral difficulties, such as hyperactivity, social withdrawal and anger occur throughout treatment however, are particularly amplified during periods of corticosteroid administration (McGrath and Pitcher, 2002; Pound et al., 2012; Williams and McCarthy, 2015). Although these effects are likely transient, they are often endured for two-three years and are associated with elevated parent distress as well as reduced child and parent quality of life (QoL) (Pound et al., 2012).

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The stressors associated with childhood cancer and treatment can result in changes to parenting practices that may in turn influence child health outcomes including emotional and behavioral adjustment (Davies et al., 1991; Morawska et al., 2015; Vance and Eiser, 2004; Williams and McCarthy, 2015). Due to their child's health issues, parents of children with cancer are more likely to demonstrate overprotection, lax parenting and decreased discipline (Colletti et al., 2008; Long and Marsland, 2011; Williams and McCarthy, 2015), which have been associated with less optimal child emotional and behavioral outcomes (Fedele et al., 2013; Williams et al., 2014), and child health-related QoL (Hullmann et al., 2010).

These data highlight the potential modifiable role of parenting in alleviating child emotional and behavioral problems during treatment for ALL. Accordingly, a focus on strategies to assist parents manage their child's behavioral concerns may be beneficial, not only in the short term, but also in supporting parents in promoting the ongoing development of their child. Childhood is a critical period which sets the foundations for later physiological and psychosocial functioning; a developmental process vulnerable to disruption in highly stressful environments such as serious illness. For children particularly, several years of cancer treatment is developmentally significant. Accordingly, supporting parents to manage the behavioral and emotional challenges during this critical developmental period, may in turn foster developmental milestones and improved psychosocial functioning in the longer term.

To our knowledge, no previous study has assessed the efficacy of a parenting intervention, on improving child behavior during active cancer treatment. In one reported study, Fedele et al. (Fedele et al., 2013) delivered a cognitive behavioral intervention to parents, targeting parent mental health, in a pediatric oncology population and demonstrated improved child emotional and behavioral functioning. Similarly parenting interventions have been successful in other chronically ill pediatric populations (Morawska et al., 2015), with results indicating improved child behavior (Antonini et al., 2012; Bartholomew et al., 1997; Brown et al., 1995; Fedele et al., 2013; Hanzlik, 1989), and reduced anxiety symptoms (Chiang et al., 2009; Gebert et al., 1998; Wade et al., 2006).

Qualitative research has demonstrated that assistance with parenting and child behaviors are not a key priority for parents soon after their child's diagnosis (Williams and McCarthy, 2015), and optimal timing for interventions in a pediatric oncology setting warrants empirical attention (Stehl et al., 2009). Typically child behavioral concerns surface during the maintenance phase of ALL treatment. This is a phase of treatment generally occurring 12 months post-diagnosis, that includes corticosteroid administration, yet less intense chemotherapy overall, and a perceived shift to a more future oriented focus as some pre-illness activities are able to be resumed. This reportedly coincides with a marked effort to return to "pre-diagnosis" parenting (e.g., more firm, reactivation of family rules), and facilitation of "normal" child behavior and social functioning (e.g., return to school) (Williams and McCarthy, 2015).

In light of these findings, the current study aimed to trial an evidence-based parenting intervention, the Triple-P: Positive Parenting Program (Sanders et al., 2003), specifically focusing on parenting strategies and behaviors, in parents with a child in maintenance phase treatment for ALL. Triple P is a multi-level, preventative behavioral parenting and family intervention. It aims to prevent behavioral, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents (Sanders et al., 2000). There is strong evidence to support participating in Triple P is effective in reducing child behavioral difficulties (Sanders et al., 2014), including amongst childhood chronic illness groups (Clarke et al., 2014; Morawska et al., 2015; Whittingham et al., 2014), however, it is yet to be trialled in a pediatric oncology setting.

A necessary first step of a clinical trial is to i) pilot the accessibility, feasibility, and satisfaction of the intervention and ii) explore recruitment issues and potential treatment response (Thabane et al., 2010). This is particularly relevant in the oncology context, given the compromised parent physical and emotional resources.

2. Methods

2.1. Participants

Eligible participants were parents with a child aged between 2 and 8 years receiving maintenance phase treatment for ALL at the Children's Cancer Centre, Royal Children's Hospital, Melbourne Australia (RCH CCC). Study exclusion criteria included being a non-English speaking parent and having a child who had a co-existing developmental disorder or disability. Eleven of the 12 participants were in a married/defacto relationship. Maintenance phase treatment typically commences 12 months post-diagnosis and is up to 24 months duration. Sociodemographic characteristics of the sample (N = 12) is provided in Table 1.

2.2. Procedure

In line with CONSORT guidelines, a phase 2 randomized controlled trial design was undertaken comparing eight weeks of participation in Triple P with a wait list control group. Ethics approval for the study was obtained in 2014 (HREC # 34005A) and the trial is registered with the Australian and New Zealand Clinical Trials Registry (ACTRN # 12614000678695). Recruitment was undertaken from April to November 2014. Eligible parents (N = 38) were approached by the first author or a trained research assistant either i) face-to-face in the outpatient unit of the RCH CCC (N = 31), or ii) via a mail out invitation to parents who had previously participated in a previous cross-sectional survey study exploring parenting in a pediatric oncology context (N = 7). A total of 18 participants consented and were randomized to either intervention or control groups (see Fig. 1 recruitment CONSORT diagram).

Parents were randomized (using a random number sequence generated by an independent statistician which were placed in sealed envelopes, that were opened and allocated to the corresponding group by an independent researcher after each parent consent was received) to either intervention or wait list control. Participants completed three online surveys; baseline (within two weeks pre-intervention), time 2 (within two weeks post-intervention) and time 3 (8 weeks post-intervention). No incentives or rewards were offered for participation.

2.3. Intervention

A novel, live online group videoconferencing format of Triple P was identified as an appropriate delivery modality as many families reside in regional or rural areas (Daniel et al., 2013), and, based upon clinical experience, many families are reluctant to attend the hospital for additional appointments. Further, e-health psychological treatments, including Triple P, are increasingly being used in clinical practice and have been found to be effective (Andersson and Cuijpers, 2009; Barak et al., 2008; Reger and Gahm, 2009; Sanders et al., 2012; Spek et al., 2007) and acceptable to parents (Wade et al., 2011).

Two intervention groups were conducted in sequence with three parents in each group. The programs were delivered using GoToMeeting (GTM). Participants were provided with an internet-linked iPad tablet. Utilizing the tablets from home, participants engaged in weekly group videoconferencing sessions and individual telephone calls delivered by a psychologist (see Table 2 for full

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