



Shorter communication

Effects of Triple P parenting intervention on child health outcomes for childhood asthma and eczema: Randomised controlled trial

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ABSTRACT

Childhood chronic health conditions have considerable impact on children. We aimed to test the efficacy of a brief, group-based parenting intervention for improving illness-related child behaviour problems, parents' self-efficacy, quality of life, parents' competence with treatment, and symptom severity. A 2 (intervention vs. care as usual) by 3 (baseline, post-intervention, 6-month follow-up) design was used, with random group assignment. Participants were 107 parents of 2- to 10-year-old children with asthma and/or eczema. Parents completed self-report questionnaires, symptom diaries, and home observations were completed. The intervention comprised two 2-h group discussions based on Triple P. Parents in the intervention group reported (i) fewer eczema-related, but not asthma-related, child behaviour problems; (ii) improved self-efficacy for managing eczema, but not asthma; (iii) better quality of life for parent and family, but not child; (iv) no change in parental treatment competence; (v) reduced symptom severity, particularly for children prescribed corticosteroid-based treatments. Results demonstrate the potential for brief parenting interventions to improve childhood chronic illness management, child health outcomes, and family wellbeing. Effects were stronger for eczema-specific outcomes compared to asthma-specific outcomes. Effects on symptom severity are very promising, and further research examining effects on objective disease severity and treatment adherence is warranted.

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1. Introduction

Chronic child health conditions are common (Van Cleave, Gortmaker, & Perrin, 2010) and children experience more behavioural, emotional and academic problems compared to healthy children (Pinquart, 2013a; Pinquart & Shen, 2011; Pinquart & Teubert, 2012). The majority of conditions require daily management, yet non-adherence with treatment and prevention is around 50% (Morton, Everard, & Elphick, 2014).

Existing health care focuses largely on a medical education model which has shown limited success in improving adherence (Dean, Walters, & Hall, 2010; Ersser et al., 2014) and family-based approaches have also shown limited effects (Eccleston, Palermo,

Tonya, Fisher, & Law, 2012; Law, Fisher, Fales, Noel, & Eccleston, 2014). The theoretical and empirical literature provide compelling evidence that parenting plays a central role in children's health outcomes (Morawska, Calam, & Fraser, 2015; Wood et al., 2008); yet, current approaches to childhood illness management do not target parenting (Law et al., 2014). Parent and family factors impact on illness onset (Mrazek et al., 1999), and disease course (Rohan et al., 2014), and parents of chronically ill children engage in different parenting practices compared to parents of healthy children (Holmbeck et al., 2002; Pinquart, 2013b).

Parenting practices are readily modifiable and may serve as a pathway to better parenting and child outcomes, and potentially to better health outcomes (Morawska et al., 2015). Behavioural parenting interventions are recognised as best practice in the treatment of parenting and child behaviour difficulties (O'Connell, Boat, & Warner, 2009), however these have rarely been applied in the context of child illness management (Kirk et al., 2012). Recent studies have demonstrated some positive, albeit mixed, effects of parenting intervention for child chronic conditions (Clarke, Calam,

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Morawska, & Sanders, 2014; Doherty, Calam, & Sanders, 2013; Lohan, Morawska, & Mitchell, 2015; Sassmann, de Hair, Danne, & Lange, 2012; Westrupp, Northam, Lee, Scratch, & Cameron, 2015) providing promising signs that this approach may add value to existing health services.

To date interventions for parents of children with chronic health conditions have focussed on a medical model, and the evaluation of psychosocial interventions has been limited. Those parenting interventions which have been evaluated have had mixed evidence, potentially because they have generally not tailored programs for children with chronic health conditions (Westrupp et al., 2015); used interventions with multiple sessions which are burdensome for parents to attend (Sassmann et al., 2012; Westrupp et al., 2015) or included only a small parenting component within a more complex intervention (Lohan et al., 2015). Thus, our aim was to test the efficacy of a brief, group parenting intervention for parents of children with asthma and/or eczema, on parents' confidence with illness management, child illness-related behaviour problems, quality of life, symptom severity and parent competence in relation to administering their child's treatment. Our focus was on asthma and eczema as these are the two most common childhood chronic health conditions in Australia, affecting 20% and 17% of Australian children respectively (Asher et al., 2006). Australian prevalence rates for asthma and eczema are comparable to those seen in the UK (21% and 16%, respectively), and exceed those reported for most regions of North America (e.g., Canada, 18.2%, 12%), Europe (e.g., Germany, 13%, 8%), the Asia-Pacific (e.g., Hong Kong, 9% and 5%), and Africa (e.g., Nigeria, 6% and 5%) (Asher et al., 2006). We chose a heterogeneous illness group because these conditions commonly co-occur; there is limited evidence of a link between particular health conditions and specific behavioural and emotional problems, but rather a more general relationship between maladjustment and childhood chronic illness, and; practically it is easier for health services to deliver intervention to more heterogeneous groups (Morawska et al., 2015). We expected that participation in the parenting intervention would lead to: (i) fewer child illness-related behaviour problems; (ii) improved parental illness management self-efficacy; (iii) improved child, parent and family HRQL; (iv) better parental treatment competence; and (v) reduced symptom severity compared to care as usual.

This study is part of a larger trial, and general parenting and child behaviour, and parent and child adjustment outcomes, are reported separately (Morawska, Mitchell, Burgess, & Fraser, 2016). This paper focuses specifically on health-related outcomes of illness management, symptom severity, and HRQL.

2. Methods

A 2 (Intervention vs. Care as Usual[CAU]) \times 3 (time: pre-intervention[T1], post-intervention[T2], 6-month follow-up[T3]) design was used. Permission was granted by relevant ethics review committees. Recruitment was across the Brisbane metropolitan region via school and healthcare settings. Study information to be distributed in school newsletters was emailed to all primary schools and child care centres within a 50 km radius of the city centre. Posters and brochures were sent to all family medical practices and paediatricians, dermatologists, and respiratory physicians in Brisbane, as well as the emergency departments and outpatients' clinics of Brisbane's two specialist children's hospitals.

Recruitment was from July 2011 to July 2013. Parents of 2- to 10-year-old children with asthma and/or eczema, with concerns about the child's behaviour, emotions, or illness management were eligible. Confirmation of diagnosis was obtained from the children's treating doctors. Families were ineligible if children had a disability or developmental disorder, or parents were receiving professional

help for children's behaviour difficulties, or psychological help or counselling for themselves. Where both parents agreed to participate in the study, the parent who assumed primary responsibility for the child's health care was designated as the "primary" participant, and completed all study assessment. Secondary participants completed parent-report questionnaires only; these results are reported elsewhere (Morawska et al., 2016). Where families had multiple children with asthma and/or eczema, parents selected one child to focus on for the purposes of the study.

2.1. Procedure

Parents received study information, completed eligibility screening with the trial coordinator, and consented to participate via the study website. Prior to randomisation, participants completed T1 assessment, consisting of: (i) parent-report questionnaires, in online ($n = 95$) or hardcopy ($n = 12$) format depending on parent preference; (ii) two weeks of symptom monitoring; and (iii) participation in an observation of a typical home treatment session.

Allocation was by block randomisation, using computer-generated randomly-selected block sizes (4, 6, or 8 participants per block) and random group allocation within each block. An external researcher generated random allocation sequences, and prepared sequentially-numbered opaque envelopes to conceal group allocation. Envelopes were assigned by a research assistant in the order families completed T1 assessment. Neither researchers nor participants were blinded to intervention group.

Families assigned to the Intervention group attended the intervention and repeated assessments at 4 weeks (T2) and 6 months (T3) post-intervention. Families assigned to CAU repeated assessments at 6 weeks (T2) and 6 months (T3) post-enrolment. On enrolment into the study all families, irrespective of group allocation, were instructed to continue their child's usual medical management, for example, attending appointments with their child's doctor/s and other health care professionals, and continuing to follow the child's medical management plan as normal. CAU families attended the program after completing T3 assessment.

2.2. Intervention

The intervention consists of two interactive 2-h group discussion sessions, *Positive Parenting for Healthy Living* (Morawska & Sanders, 2011), and draws on theoretical principles that form the basis of Triple P (Sanders, 2012). Proximal targets of the intervention are parenting skill and confidence relating to both general child behaviour, and specific to illness management; and parenting practices and family stress, which constitute direct and indirect pathways of parenting impact on child health and wellbeing (Wood et al., 2007). Teaching methods included didactic instruction, video modelling, active skills training, and homework tasks.

The intervention targets parents of 2–10 year-old children and strategies and examples are tailored to specific developmental and other needs during sessions. This may involve asking parents to consider how a strategy applies to their child, for example by reflecting how involving a child in their illness management differs for a 3-year-old versus and 10-year-old. The underlying principles for each strategy are the central focus, with examples used to illustrate flexible application.

The first session focuses on strategies to empower parents to prevent and manage problem behaviours and ensure that illness prevention and management plans are implemented appropriately. Topics include continuing regular activities; having realistic expectations; reducing stress; helping siblings cope; condition-specific management steps; involving the child; communicating

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