



When can parents most influence their child's development? Expert knowledge and perceived local realities



Carol M. Worthman ^{a,*}, Mark Tomlinson ^b, Mary Jane Rotheram-Borus ^c

^a Department of Anthropology, Emory University, Atlanta, GA 30322, USA

^b Department of Psychology, Stellenbosch University, Private Bag X1 Matieland, 7602, South Africa

^c Department of Psychiatry and Biobehavioral Medicine, Semel Institute, University of California at Los Angeles, 10920 Wilshire Blvd., Suite 350, Los Angeles, CA 90024, USA

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ABSTRACT

Compelling evidence for the long-term impact of conditions in gestation and early childhood on both physical and psychosocial functioning and productivity has stimulated a focus in global health policy and social services on the “first 1000 days”. Consequently, related initiatives may assume that rationale for this orientation and the agency of parents during this period is self-evident and widely shared among parents and communities. In 2012, we tested this assumption among a sample of 38 township-dwelling caregivers in Cape Town, by asking a question identified during a study of cultural models of parenting, namely: At what age or stage can a parent or caregiver have the most influence on a child’s development? Formal cultural consensus analysis of responses met criteria for strong agreement that the period for greatest impact of parenting on a child’s development occurs at adolescence, at a median age of 12 years. In follow-up focus groups and structured interviews, caregivers articulated clear ecological and developmental reasons for this view, related to protection both of developmental potential and against powerful, context-specific ecological risks (early pregnancy, substance ab/use, violence and gangs) that emerge during adolescence. Such risks threaten educational attainment, reproductive health, and social derailment with enduring consequences for lifetime well-being that caregivers are highly motivated to prevent. Developmental needs in pregnancy and early childhood, by contrast, were considered more manageable. These findings resonate with emerging evidence for multiple sensitive periods with corresponding developmental needs, and urge the value of complementing efforts to optimize early development with those to sustain and enhance it during later windows of developmental opportunity such as adolescence. Our results also indicate the need to consult local views of developmental risk and parenting practice in communicating with caregivers and planning interventions, and the value of using available methodological tools to do so.

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1. Introduction

A tremendous body of work recently has emerged that documents the reliance of development on interactions between person and context (Shonkoff et al., 2009; Worthman et al., 2010). Findings from humans and other animals systematically have elucidated processes of biological embedding whereby the material and social conditions under which development occurs are embodied in structural and functional outcomes. These effects appear to be

particularly pronounced during fetal and early postnatal development, when systems architecture, organization, and regulation are being established (Hanson and Gluckman, 2014). Although environmental cues provide a major source of information to guide development, and capturing these cues is both essential and adaptive, such reliance opens a window of potential vulnerability when harsh early conditions trigger developmental trade-offs or direct impairments with subsequent cumulative long-term costs to function and well-being (Hanson and Gluckman; Hochberg et al., 2011). Hence, early exposures to adversity—both physical (such as crowding, poverty) and psychosocial (such as neglect or abuse, parental harshness or conflict) have been linked to later mental and physical health risk (Ferguson et al., 2013; Grant et al., 2014; Miller et al., 2011). Developmental neuroscience has found that the brain

* Corresponding author.

E-mail addresses: worthman@emory.edu (C.M. Worthman), markt@sun.ac.za (M. Tomlinson), MRotheram@mednet.ucla.edu (M.J. Rotheram-Borus).

is sensitive not only to nutrition but also to pattern and quality of early experience (Fox et al.; Petrosini et al., 2009). Under conditions of disadvantage and low socioeconomic status (SES) or toxic stress, such sensitivities translate into effects known to blunt executive function (working memory, attentional and inhibitory control) (Hackman et al., 2010), impair emotion regulation (Rothbart et al., 2011), and exacerbate vulnerabilities to stress (De Bellis and Zisk, 2014). Consequently, in addition to their effects on health, early conditions of poverty, adversity, and disadvantage also undercut school performance and lifetime earnings.

These recent scientific advances not only have recharged models of human development and elided nature-nurture distinctions, but also have galvanized public health priorities and policy with the understanding of how adversity and disadvantage lead to health disparities, reinforce socioeconomic inequalities, and exact personal and societal costs (Boyce, 2015; Shonkoff et al., 2009). Such insights converge with the established developmental and long-term health effects of early malnutrition that drive global policy (de Onis et al., 2013; Maternal Child Nutrition Study Group, 2013). Growth impairment (low birth weight, stunting) is a potent indicator of early malnutrition (WHO Expert Committee, 1995) closely associated with poorer cognitive function, school attainments, health, and adult household income (Adair et al., 2013; Hodidinott et al., 2013). Indeed, some have used multinational data to argue for a tight focus on gestation and early life, asserting that: “The window of opportunity for preventing undernutrition ends at 2 years of age” (Victora et al., 2010, p. e473). Malnutrition commonly co-occurs with a suite of adverse conditions that together synergistically impair a child's developmental potential at the outset. An influential *Lancet* review highlighted the consequent massive global loss of human potential and plotted pathways mediating that loss in terms of impaired physical growth, psychobehavioral development, and school performance (Grantham-McGregor et al., 2007). One of two prime pathways ran directly through primary caregivers, via their impact on home rearing conditions, which drew both emphasis and burden to caregivers. Subsequent models have expanded to include critical determinants of domestic environments, namely the distal political, structural, and economic forces that shape the quality of living conditions and determine access to material, social, and service resources (Black et al., 2013).

Thus, confluent streams of evidence, one demonstrating the enduring impact of material conditions and another that of psychosocial conditions during pregnancy and the first two years, have focused global and reproductive health policy and intervention on the “first 1000 days” (Black et al., 2013; Save the Children, 2012; Walker et al., 2011). Complicating this focus is evidence documenting later sensitive periods such as adolescence with concurrent opportunities for intervention to enhance outcomes (Wachs et al., 2014), and calls for an integrated life course perspective (Britto and Perez-Escamilla, 2013). Yet other research suggests that a crucial link between evidence-based intervention and improvement of early child outcomes is the agency of parents themselves, conditioned by perceptions, local culture, and structural constraints (Harkness et al., 2013). Cross-cultural studies of child development have found that ethnotheories of child development and appropriate caregiving guide caregiver behavior and shape the early environments of child development, or developmental niche (DeCaro and Worthman, 2007; Harkness et al., 2011; Super and Harkness, 1986). The rearing environment shaped by such ethnotheories and related parenting practices, in turn, demonstrably influences child socioemotional development and psychobehavioral outcomes (DeCaro and Worthman, 2008; Super et al., 2008; Taverna et al., 2011). For example, cultural differences in valued temperamental styles in seven European societies informed parents' organization of infant daily routines and

responses to infant emotional behaviors that conditioned distinctive infant arousal patterns (Harkness et al., 2007). However, evolving expert consensus on optimal conditions for early child development may not readily engender rapport with parent beliefs and related practices. Rather, comparison of knowledge held by scientists and local respondents routinely discovers a lack of agreement between them (Gartin et al., 2010). For instance, a study of perceived food value and preferences regarding appropriate young child (<2) feeding practices among working mothers in Mexico (Rodriguez-Oliveros et al., 2014) concluded that “Mothers' perceptions and values may differ from those of nutritionists and program designers, and should be addressed when promoting opportune introduction of complementary foods in social programs” (Rodriguez-Oliveros et al., 2014, p. 144).

These recent reports align with an early recognition that successful introduction of an intervention essentially entails a concomitant change in local culture (Paul, 1955), suggesting that evidence-based policy and interventions also should attend to caregiver agency if they are to yield improved early child outcomes. But agency rests not only on the agent's beliefs, goals, and practices but also on ability to act and influence pervasive factors that drive outcomes (Nussbaum, 2011). Caregivers cannot directly control ambient levels of pollution, public safety, availability and quality of health services, and other potent influences on early child development (Evans, 2006; Steptoe and Feldman, 2001; Theall et al., 2013). Poverty and social disadvantage both compound exposure to risky conditions and erode ability to manage them (Acevedo-Garcia et al., 2014; Pachter et al., 2006; Schulz et al., 2013), such that child outcomes improve when disadvantaged families are moved to better neighborhoods (Chetty et al., 2015) or poverty is alleviated (Costello et al., 2003).

We have been engaging these issues in ongoing work with a cohort of mother-child pairs recruited in the second trimester of pregnancy for participation in a randomized controlled trial of a home-visiting intervention for maternal and child nutrition in Khayelitsha neighborhoods (Rotheram-Borus et al., 2011). The intervention built on evidence for the efficacy of nurse-delivered home-visiting programs in the U.S. to durably improve health and socio-emotional outcomes, particularly among children of low income or at-risk mothers (Olds et al., 2002; Sweet and Appelbaum, 2004). Our program deployed trained community mentor mothers delivering home visits aimed to build maternal agency to address major prevailing maternal and child health problems (HIV, TB, malnutrition, alcohol ab/use) and check child growth. The intervention realized improvements in maternal care and infant outcomes postpartum and at age 6 months (le Roux et al., 2013), but sustaining infant growth depended on continued home visits (Rotheram-Borus et al., 2014). We considered whether local beliefs and practices around child development and appropriate caregiving might, along with material and contextual constraints, overwhelm the messages conveyed in the intervention and blunt its impact unless continuous reinforcement and support were provided.

Accordingly, we set out to understand parent ethnotheories about early child developmental needs, appropriate parenting, and effects of quality of early childcare, and in the process encountered respondent views suggesting caregiving priorities outside this domain. In this report, we ask whether the shared emphasis on the first 1000 days that infuses leading edge policy and intervention is matched by caregiver perceptions of where their effort is best placed. Consequently, the first hypothesis posits that caregivers in Khayelitsha share a common perception of early childhood as a significant sensitive period where care can exert the greatest long-term effect. We furthermore consider whether expert concerns about the long-term psychobehavioral and health effects of early

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