

Intensive interventions to improve parenting

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The way parents bring up their children has become a matter of increasing public and professional concern. There is strong interest in defining the elements of successful parenting so that all parents can help their children reach their potential and lead a fulfilling life. There is also a drive to prevent parenting failure and family breakdown, especially as manifested by child abuse and the rising tide of antisocial behaviour in children and young people.

In recent years the number of programmes and approaches for improving parenting has mushroomed.¹ Some cater for basically competent parents while others target those at high risk of parenting failure and family breakdown. This article describes the nature and effectiveness of a programme for parents who are experiencing serious difficulty looking after and controlling children aged 3-8 years.

Target of intervention

It is useful to distinguish between support for parents and support for parenting. General characteristics of parents such as being single and alone, poor, in a rough neighbourhood, a drug addict, of limited intellect, depressed, etc, make it harder to bring a child up successfully. However, if these adversities can be managed so that the immediate quality of parenting behaviour is adequate, the outcome for the children is not compromised.² Several community studies have shown that it is the quality of the immediate moment to moment behaviour of the parent towards the child that has the major influence on the child's wellbeing rather than the circumstances *per se*.³ These findings allow cautious optimism, insofar as there is no inevitably bad outcome for children brought up by parents who have to cope with stressful circumstances or mental illness.

There is now overwhelming evidence that particular parenting styles are harmful for children and are particularly associated with antisocial child behaviour.^{4,5} These are: a persistently hostile, rejecting emotional tone; harsh or erratic discipline; poor supervision; parental conflict; and low involvement in the child's activities. Conversely, close observation of parents of secure, well functioning children shows that the parents respond sensitively to the overtures and needs of their children. Such an upbringing helps protect the children if they are later exposed to adverse conditions.

This article focuses on interventions that support directly the parenting process itself. However, an equally important part of intervention, not covered in this article, is to support parents in their own right and remedy the indirect, underlying factors that interfere with competent parenting. Otherwise it may be impossible for them to deliver good care to their children despite strenuous efforts to do so. For example, maternal depression may need to be treated, informal support networks encouraged, applications made for nursery places to give respite, marital conflict reduced, and so on. Direct liaison with schools is often necessary to help manage any associated learning and behavioural difficulties in the child.

Assessment

As every family is different, a thorough assessment is essential of the parenting^{6,7} and of the child.⁸

- What are the strengths and weaknesses of current and past parenting?
- What is the underlying cause of the parenting difficulty, and is it remediable?
- What are the particular needs of the child?

With this information, an individualised intervention programme can be planned.

Content of intervention

Our programme is based on behavioural principles and has three parts.

PART I. TECHNIQUES FOR INCREASING DESIRED BEHAVIOUR

To give an idea of how sessions go, the first two will be described in some detail.

Basics of play

The first session starts with basics of play, perhaps the most fundamental aspect of improving the relationship with the child. Parents are asked to follow the child's lead rather than impose their own ideas. Instead of giving directions, teaching, and asking questions, parents are initially encouraged simply to give a running commentary on what their child is doing. If the parent has difficulty in getting going, the clinician offers suggestions—for example, "I'd like you to say to John 'you've put the car in the garage'".

After 10 to 15 minutes, this directly supervised play ends and the parent is "debriefed" for half an hour or more alone with

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the clinician. How the parent felt (often strange to begin with) and their reservations and difficulties are addressed. Typically, the parent notices that during the session their child settled faster and spent longer than usual playing purposefully with one game, rather than rushing round the room inconsequentially. Misbehaviour is usually at a lower level than normal. For parents who have got to a state of affairs where virtually all communication with the child is nagging and complaining, play is an important first step in mending the relationship. It often helps them begin to have positive feelings for the child again. Parents are asked to do homework by playing with their child using these techniques for 10 minutes each day.

Developing play skills

To start the second session, the previous week's homework of playing at home is gone over with the parent in considerable detail. Often there are practical reasons for not doing it. By eliciting whatever the difficulty may be and gently pushing for a solution, parents see that the clinician is quietly determined for the changes to be implemented. Getting over the hump of inertia is often very energising for the parents. In the live part of the second session with the child, the parent's play skills are developed further. They are encouraged to add comments describing the child's likely mood state—for example, "you're really trying hard making that tower". Through this process, the parent gets more in tune with the child's behaviour and mood, and the child feels begins to feel understood and appreciated. The ability to respond sensitively is central to competent parenting, and is deficient in unskilled parents.

Subsequent sessions cover the rest of the programme, summarised below.

Praise and rewards

As the parent learns to recognise and praise small elements of desirable behaviour such as playing quietly and getting dressed promptly, it is surprising how often tantrums and major aggressive episodes begin to reduce.

PART II. TECHNIQUES FOR REDUCING UNWANTED BEHAVIOUR

Commands

A hallmark of ineffective parenting is a continuing stream of ineffectual, nagging demands for the child to do something. Parents are taught to reduce the number, but make them much more authoritative.

Consequences for disobedience

Parents are helped to apply simple logical consequences for everyday situations. If water is splashed out of the bath, the bath will end; if a child refuses to eat dinner, there will be no pudding, etc. The consequences should be immediate but not punitive. Consistency of enforcement is central.

Ignoring

This sounds easy but is a hard skill to teach parents. Whining, arguing, swearing, and tantrums by children are not dangerous and

can usually safely be ignored. Children will soon realise they are getting no payoff for these behaviours and quickly stop.

Time out

The full name of this is "time out from positive reinforcement". The point is to put the child in some boring place away from a reasonably pleasant context. There are a number of pitfalls to avoid in carrying this out,⁹ but properly done it is one of the most effective techniques in helping the parent to regain control without resorting to physical or emotional abuse.

PART III. STRATEGIES FOR AVOIDING TROUBLE

Planning ahead

Parents are taught to keep a diary of what leads to problem behaviours, what exactly happens when they occur, and what happens after (the ABC of behaviour: **A**ntecedents, **B**ehaviour, **C**onsequences). They learn from this that there are certain high risk situations and times, and identify their own role in reinforcing the unwanted behaviour. By rearranging the child's schedule, many difficult situations can be avoided.

Negotiating

Getting parents to stop and listen to their children's wishes and fears is often a revelation for them. Then accommodating the child's wishes while fitting in with the family goals for the day usually leads the child to behave more calmly and contentedly, as they have some stake in the plan.

Developing a problem solving approach with the child

This approach helps stop impulsive reactions to frustration in children and helps them slow down and devise their own solutions.¹⁰ Over the longer term this promotes independence.

Wider principles of parenting

These include supervision (for example, how long should a 3 year old be out of view? Should an 8 year old be allowed to play with another child for an hour on the way home from school?); planning joint activities; reducing sibling rivalry; promoting friendships with other children; and how to deal with school and teachers.

Ways of delivering intervention

FORMAT AND DURATION

The above programme can be delivered as group or individual work.

Group work

For moderately severe difficulties, a group approach working with parents only can be effective. The programme used in our clinic comprises a two hour session once a week over 12 weeks for parents of 6–8 children. Video-tapes are shown of parents handling their children the "right" and "wrong" way, then parents are invited to role play these in the group and practise them at home.¹¹ The advantages of the group approach are cost effectiveness, and the support parents give each other. The disadvan-

tages are that parents are not seen directly with their children, and there is little opportunity to explore deeper personal issues for the parent in front of the group.

Individual work

For severe difficulties, an individualised approach where the parent and child are seen together allows one to go at the pace of the parents, observe precisely how they are relating to their child, and modify the intervention accordingly. This can be especially helpful where the child responds differently from the majority—for example, if he is hyperactive, has a hearing or learning disability, or has autistic traits. An individualised approach also enables one to do more work on other issues impinging on parenting such as interparental consistency, sibling relationships, coming to terms with abuse in the parent's own childhood, etc.

The duration of intervention can vary considerably. Our experience with individual work fits that of Patterson¹² who found a median of 21 hours of treatment were necessary to achieve substantial improvements (carefully defined using observational methods). In our clinic, we use a video suite with a one way mirror. The parent is given a small earpiece, through which they receive suggestions on how to handle their child while they are looking after him.

ENGAGING THE PARENTS

Sitting with parents telling them what to do is largely ineffective. They may agree with your suggestions in the clinic, but fail to put them into practice at home. As a doctor it is easy to slip into "I'm the expert in charge here" mode. This can be very effective when dealing with severe physical illness, but is often counterproductive with parenting difficulties as it can make parents feel sensitive about their abilities.

We try to be as accessible to parents as possible, and visit the family in their own home before beginning treatment. We attempt to establish a collaborative relationship,¹³ which is not unlike that between a PhD supervisor and a student: the professional contributes general expertise, but the parent is recognised as knowing their specific child best and being in charge of the upbringing. The aims of the intervention are explicitly shared with parents, so both sides are working together towards a common goal. We offer sessions to fit in with their daily routine and offer a child minding service for their other children. Travelling expenses are refunded if necessary. If they fail to attend, we telephone them the next day to discover what the difficulty is and how it might be overcome.

During sessions, as well as covering specific aspects of the immediate interaction between parent and child, we are continually addressing the parents' reactions to the material and exploring their beliefs and feelings about bringing up their child.¹⁴ This combination of specific techniques and emotional support is essential, as trials show that straight behavioural or instructional programmes on their own have limited impact because of low

compliance by parents. Equally, offering only general counselling and support to parents produces little change^{15 16}—both elements are necessary.

WHICH AGENCY?

The responsibility for organising assessments and interventions for serious parenting difficulties lies with social services departments. For less severe difficulties, several voluntary organisations now offer parenting programmes.¹ For early difficulties, and for parents at risk of later parenting failure, home visiting programmes using health visitors have been shown to reduce significantly child abuse and neglect.¹⁷ Referral is often made to Child and Adolescent Mental Health Services (CAMHS) where a disturbance of child behaviour is present, or if a second opinion is required. Many of the effective theories and interventions around parenting have originated from health disciplines such as psychology and psychiatry, and some CAMHS offer specialised parenting programmes.

With the shift in emphasis in the Children Act (1989)¹⁸ towards trying to keep children placed with their families of origin rather than have them fostered or adopted, there is an increasing demand for intensive interventions to improve parenting in those experiencing considerable difficulty. To organise a range of effective parent support services for a community requires cooperation across agencies as none alone has the responsibility, resources, or the "right" approach to cover all cases. Whatever mix is used, it is essential for workers to get much more training in the techniques proved to be effective.

Results

There is a wide diversity of parenting programmes, with different aims and methods. At the clinical end of the spectrum, they can be divided into those aimed at child behaviour problems, and those aimed at preventing abuse. In the USA, good improvements in the quality of parenting have consistently been found in several randomised controlled trials of behaviourally based parent training programmes targeting child difficulties. These lead to effect sizes of 0.5–0.8 of a standard deviation reduction in child behaviour problems on measures that include questionnaires, semi-structured interviews, and direct observation.^{19–23} In clinical terms this equates to about half of the children with diagnosable behaviour disorders being restored to the normal range of functioning. Gains have been maintained at 3–10 years' follow up.¹⁹ The parents themselves report a considerable increase in confidence in ability to handle children, which is accompanied by a rise in general self confidence and reduction in depression.

In the UK, our own experience suggests that good gains are made in child behaviour after parent training programmes of the kind described here, with good maintenance of effectiveness at one year of follow up but some decline at three years (Scott *et al*, unpublished data, 1998).

Well evaluated demonstration projects in the USA targeting child abuse and neglect show a reduction in the re-abuse rate over five years from 30–50% in untreated groups to around 20% in those receiving intervention.^{24 25} In these projects the great majority of parents showed improvements in behaviour and attitude, and over 70% of children gained in developmental status, social development, and emotional maturity compared with controls. In the UK, the *Mellow parenting programme*²⁶ improved parenting on several dimensions. Negative interaction as evaluated on videotapes dropped threefold and 80% of the parents involved were able to come off the local Child Protection Register.

Prognostic factors and management of treatment failures

Parental features associated with lack of improvement²⁷ include denial of problems, refusal to cooperate with the treatment, personality disorder, psychiatric problems such as alcohol or drug abuse, schizophrenia or severe depression, and having experienced abuse in their own childhood. Circumstances associated with a poor response include disorganised, poor living conditions, with little or no social support, and a hostile partner. Child characteristics that make change in parental behaviour less likely include severe antisocial behaviour, hyperactivity, learning difficulties, and other special needs.

If parents are not making progress despite a reasonable input, a reassessment of the situation is indicated. Depending on the outcome, measures taken might include addressing the parents' own mental health problems more intensively; setting clear, measurable goals for parental behaviour with explicit consequences such as removal of the child into care if they are not met; providing respite for the parent through temporary foster care, after school clubs, etc; or referral to more intensive services such as all day programmes or family residential units. If all this fails, a judgment may have to be made whether to apply for a care order to remove the child into local authority care.

Conclusions

Rigorous evaluation using randomised controlled trials has shown that behaviourally based parenting programmes considerably improve both the quality of parenting and the outcome for the child. Effective programmes address both the moment to moment minutiae of parents' handling of children, and the wider context of their lives that can get in the way of

good enough parenting. The task now is to disseminate effective interventions and convince purchasers of their cost effectiveness and human value.

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