King's Research Portal

DOI:

[10.1016/j.mppsy.2008.07.006](https://doi.org/10.1016/j.mppsy.2008.07.006)

Document Version

Peer reviewed version

[Link to publication record in King's Research Portal](#)

Citation for published version (APA):

Scott, S. B. C. (2009). Parenting programmes for attachment and conduct problems. *PSYCHIATRY*, 7(9), 367-370. <https://doi.org/10.1016/j.mppsy.2008.07.006>

Citing this paper

Please note that where the full-text provided on King's Research Portal is the Author Accepted Manuscript or Post-Print version this may differ from the final Published version. If citing, it is advised that you check and use the publisher's definitive version for pagination, volume/issue, and date of publication details. And where the final published version is provided on the Research Portal, if citing you are again advised to check the publisher's website for any subsequent corrections.

General rights

Copyright and moral rights for the publications made accessible in the Research Portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognize and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the Research Portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the Research Portal

Take down policy

If you believe that this document breaches copyright please contact librarypure@kcl.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

Volume 7:9 September 2008	Available online at www.psychiatryjournal.co.uk
<h1>Psychiatry</h1>	
The continuously updated review for mental health professionals	
Child psychiatry	
Part 4 of 4	
APPROACHES TO TREATMENT	
Cognitive-behavioural therapy for children and adolescents	363
Thomas G O'Connor Cathy Creswell	
Parenting programmes for attachment and conduct problems	367
Stephen Scott	
Paediatric liaison	371
Sebastian Kraemer	
Child protection issues and the law	375
Danya Glaser	
The place of family therapy in modern British child psychiatry	380
Philip Messent	
Paediatric psychopharmacology – special considerations	384
Paramala J Santosh Rakendu Suren	
Emerging severe personality disorder in childhood	389
Eileen Vizard	
Adolescent forensic psychiatry	395
Julia Withersomb	
The transition into adult care	399
Helen Bruce Navina Evans	
Chapter editors	
Helen Bruce FRCPsych is Consultant Child and Adolescent Psychiatrist at East London NHS Foundation Trust and is Honorary Clinical Senior Lecturer at Barts and the London School of Medicine and Dentistry, London.	
Editors-in-Chief George Szustakier MD DPM FRCPsych André Tylee MD MRCPsych FRCPsych	
David Skuse MD FRCP FRCPsych FRCPsych is Professor of Behavioural and Brain Sciences at the Institute of Child Health, London, UK, and Honorary Consultant Psychiatrist at Great Ormond Street Hospital for Children, London.	
Medicine Publishing An imprint of Elsevier Ltd	
© 2008 Elsevier Ltd ISSN 1473-1793	

This article appeared in a journal published by Elsevier. The attached copy is furnished to the author for internal non-commercial research and education use, including for instruction at the authors institution and sharing with colleagues.

Other uses, including reproduction and distribution, or selling or licensing copies, or posting to personal, institutional or third party websites are prohibited.

In most cases authors are permitted to post their version of the article (e.g. in Word or Tex form) to their personal website or institutional repository. Authors requiring further information regarding Elsevier's archiving and manuscript policies are encouraged to visit:

<http://www.elsevier.com/copyright>

Parenting programmes for attachment and conduct problems

Stephen Scott

Abstract

Parenting programmes are one of the best researched treatments for childhood psychiatric problems. As well as being proven effective for symptoms of conduct disorders in over 200 trials, there have now also been more than 60 trials, proving their effectiveness for insecure attachment patterns in infants. Their mechanism of action is now being confirmed, with both a reduction in harsh parenting and an increase in positive parenting appearing necessary to reduce conduct symptoms, and an increase in sensitive responding being necessary to promote secure attachment in infants. However, the less good news is that in 'real-life' everyday clinical conditions, as opposed to trials run in university clinics, the effects are often more modest. This is partly due to therapists having less well-developed skills, and partly due to cases being more difficult, with more comorbid conditions. The challenge now is to disseminate training in high-quality programmes and to develop these so that they are tailored to individual parenting needs, rather than offered as 'one size fits all'.

Keywords attachment; child aggression; conduct problems; parent training; psychological therapy

Evidence linking parenting to child psychopathology

The finding that parent-child relationship quality is associated with aggressive behaviour, conduct disorder and delinquency is one of the most widely-reported in the literature, repeatedly found in large-scale epidemiological investigations, intensive clinical investigations and naturalistic studies of diverse samples using a mixture of methods.¹ The sort of parenting behaviours associated with these outcomes are high criticism and hostility, harsh punishment, inconsistent discipline, low warmth, low involvement, low encouragement, and poor supervision.

The link with depression, anxiety and other emotional problems (e.g. somatic complaints, social withdrawal) is clear, although smaller than that found for disruptive outcomes.² There is also a connection between parenting and quality of a child's peer relationships, mediated by social cognitions and behavioural strategies learned from interacting with parents.

Stephen Scott *FRCP FRCPsych* is Professor of Child Health and Behaviour at the Institute of Psychiatry, London. Conflicts of interest: none declared.

Effects of harsh parenting on child physiology

Research on animal models has illuminated some of the physiological concomitants of poor parenting. For example, Kaffman and Meaney³ showed that after infant rats were separated from their mothers for short periods (less than 15 minutes) in the first two weeks of their lives, they showed sharp rises in cortisol in response to aversive stimuli compared with controls, but that this over-reactivity went back to normal after a few days. However, longer separations (3 hours per day) during this period led to large and lasting over-reactivity to stress, physiologically, with six-fold increases in adrenocorticotrophic hormone (ACTH) and cortisol production a year later in response to a mildly aversive stress (a puff of air in the eye), and behaviourally with far greater fearfulness, emotional arousal, and poorer sociability with other rats. The core component is likely not to be the separation, but the treatment of the infant rat on reunion by the mother, who largely ignored it, seldom licked or groomed it, and sometimes trampled over it. However, differences in physiological and behavioural responses to stress are not confined to cases of relatively extreme abuse, but also are important in the normal range of parenting. Various interventions can mitigate the effects of poor early rearing, including gentle handling by humans, provision of a more stimulating environment, and even antidepressants. These findings are likely to obtain for humans too. Thus, Nemeroff and colleagues found that compared with controls, women who had a history of child maltreatment showed a six-fold increase in HPA axis reactivity to laboratory-induced stress.⁴

These studies have implications for parenting programmes. The emotional over-reactivity seen in some children who have had experienced repeated deprivation and abuse is not likely to be due solely to learned habits in a background of typical physiology – reacting explosively in response to difficulties or frustrating situations may be far harder for them to control. They should be managed in as calm and non-stressful way as possible, to avoid setting off over-arousal with its concomitant outbursts of destructive aggression; they may take more learning trials to achieve goals, and may achieve less.

Programmes for infants based on attachment theory

Focused interventions typically last for 5–20 sessions, and mother-infant interactions should be video taped and replayed. During replay the idea of recognizing the infant's signals is brought out – in early stages, even if a mother is usually ignoring her infant, the therapist will try to find one piece of video where she does respond. Perhaps the infant will smile and she will smile back, leading the infant to gurgle with pleasure. The therapist might say, 'look, when he smiled you smiled back so warmly that he showed he loved it by gurgling!'. In later sessions, when the mother's confidence has been gained (more than 95% of participants are mothers, but the principle is the same for fathers or other carers), a less satisfactory piece of interaction may be examined. When a mother is not responding, the therapist can point this out, and ask 'what was going through your mind at that moment?'. This may elicit many interesting responses, from preoccupation with the mother's own needs or hassles ('I was wondering how to pay off my debt'), to misperception of cues ('I thought he was trying to wind me up' said of a messy eater), to strong negative emotions arising from her past experience ('when he does that I think he's just like his father,

who ruined my life'). The great strength of this approach is that it: allows parents to get an accurate picture of what is actually happening (rather than just talking about their perception of their relationship with their infant, as in traditional parent–infant psychotherapies); it enables them to see for themselves that when they change their behaviour, this impacts on their infant; it allows simultaneous exploration of the mother's mental state, so that mental blocks to more sensitive responding can be explored and often overcome.⁵

In contrast, Olds⁶ developed a home-visiting programme delivered by nurses (the Nurse–Family Partnership) that is not based on attachment theory and does not use video feedback. It is based on systematic evaluation of and evidence-based interventions for risk factors from pregnancy onwards. Thus, parents are encouraged to reduce cigarette and alcohol consumption in pregnancy through understanding the effects on their babies; once the baby is born, parent–child interaction is coached, including how to stimulate the baby appropriately, and wider issues such as partner violence and further general education for the mother are addressed.

Programmes for children based on social learning theory

Programmes based on social learning theory have evolved for more than 40 years and there is a large evidence base. Most are aimed at antisocial behaviour as their proximal target outcome. The content and delivery of a typical programme is shown in Table 1.

Most basic programmes take 8–12 sessions, lasting 1.5–2 hours each. Full accounts of programmes are given by the developers.^{7,8}

Format of a typical social learning programme

Teaching a child-centered approach – the first session covers play. Parents are asked to follow the child's lead rather than impose their own ideas. Instead of giving directions, teaching, and asking questions during play, parents are instructed simply to describe what the child is doing, to give a running commentary on their child's actions. If the parent has difficulty in getting going, the practitioner may suggest precisely what they should do, for example by saying 'I'd like you to say to Johnny 'you've put the car in the garage''. As soon as the parent complies, the practitioner gives feedback, 'that was a good descriptive comment'. After 10–15 minutes, this directly supervised play ends and the parent is 'debriefed' for half an hour or more alone with the clinician.

The second session involves elaboration of play skills. The previous week's 'homework' of playing at home is discussed with the parent in considerable detail. Often there are practical reasons for not doing it ('I have to look after the other children, I've got no help') and parents are then encouraged to solve the problem and find ways around the difficulty (solutions arrived at might include doing the play after the younger sibling has gone to bed; getting the oldest child to look after the baby while the parent plays with the toddler, etc). For some parents there may be emotional blocks ('it feels wrong – no one ever played with me as a child'), which need to be overcome before they feel able to practice the homework.

After this discussion, live practice with the child is carried out. This time the parent is encouraged to go beyond describing the

Features of effective parenting programmes based on social learning theory

Content

- Structured sequence of topics, introduced in set order during 10–12 weeks
- Curriculum includes play, praise, rewards, setting limits, and discipline
- Parenting seen as a set of skills to be deployed in the relationship
- Emphasis on promoting sociable, self-reliant child behaviour and calm parenting
- Constant reference to parent's own experience and predicament
- Theoretical basis informed by extensive empirical research and made explicit
- Plentiful practice, either live or role-played during sessions
- Homework set to promote generalization
- Accurate but encouraging feedback given to parent at each stage
- Self-reliance prompted (e.g. through giving parents tip sheets or book)
- Emphasis on parent's own thoughts and feelings varies from little to considerable
- Detailed manual available to enable replicability

Delivery

- Strong efforts made to engage parents (e.g. home visits if necessary)
- Collaborative approach, typically acknowledging parents' feelings and beliefs
- Difficulties normalized, humor and fun encouraged
- Parents supported to practise new approaches during session and through homework
- Parent and child can be seen together, or parents only seen in some group programmes
- Creche, good-quality refreshments, and transport provided if necessary
- Therapists supervised regularly to ensure adherence and to develop skills

Table 1

child's behaviour and to make comments describing the child's likely mood state (e.g. 'you're really trying hard making that tower', or 'that puzzle is making you really fed up'). This process has benefits for both the parent and the child. The parent gets better at observing the fine details of the child's behaviour, which makes them more sensitive to the child's mood. The child gradually gets better at understanding and labeling his own emotional states, a crucial step in gaining self-control in frustrating situations.

Increasing desirable child behaviour – praise and rewards are covered here. The parent is required to praise their child for lots of simple everyday behaviours such as playing quietly on their own, eating nicely, getting dressed the first time they are asked, and so on. In this way the frequency of desired behaviour increases. However, many parents find this difficult. Usually with

directly coached practice praise becomes easier. Later sessions go through the use of reward charts.

Imposing clear commands – a hallmark of ineffective parenting is a continuing stream of ineffectual, nagging demands for the child to do something. Parents need to be taught to reduce the number of demands, but make them much more authoritative. This is done through altering both the manner in which they are given, and what is said. The manner should be forceful (not sitting down, timidly requesting from the other end of the room; instead, standing over the child, fixing him/her in the eye, and in a clear firm voice giving the instruction). The emotional tone should be calm, without shouting and criticism. The content should be phrased directly ('I want you to...'). It should be specific ('keep the sand in the box') rather than vague ('do be tidy'). It should be simple (one action at a time, not a chain of orders), and performable immediately. Commands should be phrased as what the parent *does* want the child to do, not as what the child should *stop* doing ('please speak quietly' rather than 'stop shouting'). Rather than threatening the child with vague, dire consequences ('you're going to be sorry you did that'), 'when-then' commands should be given (when you've laid the table, then you can watch television').

Reducing undesirable child behaviour – consequences for disobedience should be applied as soon as possible. They must always be followed through: children quickly learn to calculate the probability that consequences will be applied, and if a sanction is given only every third occasion, a child is being taught he/she can misbehave the rest of the time. Simple logical consequences should be devised and enforced for everyday situations (e.g. if water is splashed out of the bath, the bath will end; if a child refuses to eat dinner, there will be no pudding). The consequences should 'fit the crime', should not be punitive, and should not be long term (e.g. no bike riding for a month), as this will lead to a sense of hopelessness in the child who may see no point in behaving well if it seems there is nothing to gain. Consistency of enforcement is central.

Time-out from positive reinforcement remains the final 'big one' as a sanction for unacceptable behaviour. The point here is to put the child in a place away from a reasonably pleasant context. Parents must resist responding to taunts and cries from the child during time-out, as this will reinforce the child by giving attention. Time-out provides a break for the adult to calm down also.

Effectiveness

Attachment approaches: there have been several trials for attachment-based approaches. A meta-analysis⁹ found 81 studies with more than 7000 parent–infant pairs assessed. Overall, they improved parental sensitivity by 0.33 standard deviations (sd) and attachment security by 0.20 sd. However, there were large variations between approaches used. Perhaps surprisingly, the most effective interventions were relatively short (fewer than 26 sessions) and started later (after the infant was aged 6 months). Both of these findings go against a belief that early intervention must be better, and that more effort should lead to more change (the mean effect size for long interventions was –0.03).

Social learning approaches: systematic reviews and meta-analyses of studies usually with 'no treatment controls' confirm

that these approaches work well for antisocial children aged 3–10 years.¹⁰ Mean effect sizes across studies vary from around 0.4–1.0 according to outcome, thus showing good effectiveness.

Mediators of change

In recent years, researchers have begun to investigate the factors that mediate outcome. This investigation helps to identify the 'active ingredient' of therapy. Both reductions in negative parenting (critical, harsh and ineffective practices)¹¹ and increases in positive parenting¹² have been shown to mediate a reduction in child symptoms.

Dissemination: the role of therapist skill

Therapist performance can be divided into three parts: the alliance, which could be defined as how well, both personally and collaboratively, the client and therapist get on together; fidelity or adherence to specific components of a model that concerns the extent to which the therapist follows the actions prescribed in the manual; and the skill or competence with which the therapist carries out the tasks (i.e. how well the therapist performs the actions). A meta-analysis of youth studies of the alliance found that it contributed on average an effect size of 0.21 sd to outcome; this finding held across treatment types, and across youth, parent, and family approaches.¹³ In a trial under regular clinical conditions,¹⁴ therapist skill had a large effect on child outcomes; the worst therapist made outcomes slightly worse. These findings have major implications for service delivery, since they suggest that at least for multi-problem, clinical cases, a high level of therapist skill is required; staff training will need to reflect this.

Conclusion

The best parenting programmes incorporate empirical findings from developmental studies and are effective in using these to alter dimensions of parenting, which in turn improve child outcomes. In future, better assessments of parenting are needed so that programmes can be tailored to specific needs rather than 'one size fits all'. ♦

REFERENCES

- 1 Denham S, Workman E, Cole P, et al. Prediction of externalizing behaviour problems from early to middle childhood: the role of parental socialisation and emotion expression. *Dev Psychopathol* 2000; **12**: 23–45.
- 2 Wood J, McLeod B, Sigman M, et al. Parenting and childhood anxiety: theory, empirical findings, and future directions. *J Child Psychol Psychiatry* 2003; **44**: 134–151.
- 3 Kaffman A, Meaney M. Neurodevelopmental sequelae of postnatal maternal care in rodents: clinical and research implications of molecular insights. *J Child Psychol Psychiatry* 2007; **48**: 224–44.
- 4 Heim C, Newport D, Bonsall R, et al. Altered pituitary-adrenal axis responses to provocative challenge tests in adult survivors of childhood abuse. *Am J Psychiatry* 2001; **158**: 575–81.
- 5 Velderman M, Bakermans-Kranenburg M, Juffer F, et al. Preventing preschool externalizing behaviour problems through video-feedback intervention in infancy. *Infant Ment Health J* 2006; **27**: 466–93.

APPROACHES TO TREATMENT

- 6 Olds D. The nurse-family partnership: an evidence-based preventive intervention. *Infant Ment Health J* 2006; **27**: 5–25.
- 7 Markie-Dadds C, Sanders M. Self-directed triple P (positive parenting programme) for mothers with children at-risk of developing conduct problems. *Behav Cognit Psychother* 2006; **34**: 259–75.
- 8 Webster-Stratton C, Reid J. The incredible years parenting program. In: Kazdin A, Weisz J, eds. Evidence-based psychotherapies for children and adolescents. New York: The Guilford Press, 2003.
- 9 Bakermans-Kranenburg M, van Ijzendoorn M, Juffer F. Less is more: meta-analyses of sensitivity and attachment interventions in early childhood. *Psychol Bull* 2003; **129**: 195–215.
- 10 Maughan B, Denita R, Christiansen E, et al. Behavioural parent training as a treatment for externalizing behaviours and disruptive behaviour disorders: a meta-analysis. *School Psych Rev* 2005; **34**: 267–86.
- 11 Beauchaine T, Webster-Stratton C, Reid J. Mediators, moderators and predictors of 1-year outcomes among children treated for early-onset problems: a latent growth curve analysis. *J Consult Clin Psychol* 2005; **75**: 371–88.
- 12 Gardner F, Burton J, Klimes I. Randomised controlled trial of a parenting intervention in the voluntary sector for reducing child conduct problems: outcomes and mechanisms of change. *J Child Psychol Psychiatry* 2006; **47**: 1123–32.
- 13 Shirk S, Karver M. Prediction of treatment outcome from relationship variables in child and adolescent therapy: a meta-analytic review. *J Consult Clin Psychol* 2003; **71**: 452–64.
- 14 Scott S, Spender Q, Doolan M, et al. Multicentre controlled trial of parenting groups for childhood antisocial behaviour in clinical practice. *Br Med J* 2001; **323**: 1–7.