Parenting and child psychosocial problems
Spijkers, Willem

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CHAPTER 1

Introduction
Introduction

1.1 OBJECTIVE AND OUTLINE OF THE THESIS

The object of this thesis is to contribute to current knowledge of the relationship between parenting and child psychosocial problems. To this end we investigated the effectiveness of Primary Care Triple P (PCTP), level 3 of the Positive Parenting Programme, in Preventive Child Healthcare (PCH). We also conducted research among children aged 9-11 years after an initial screening of child psychosocial problems. This introductory chapter focuses on the interaction between child psychosocial problems and parenting and further discusses the early detection and treatment of child psychosocial problems in Preventive Child Healthcare (further: PCH).

1.2 CHILD PSYCHOSOCIAL PROBLEMS

Child psychosocial problems comprise the behavioural, emotional and social problems of children. The following case-vignette provides an example of such problems:

Rosie is an eight-year-old girl who is doing quite well at school, but she is sometimes hyperactive in class and tends not to obey very well. At home, obedience is also a problem. Her parents sometimes experience her behaviour as very hard to deal with. Interaction of the parents with their child and disciplining interventions seem to be counterproductive and sometimes even worsen the problems. According to the parents, the interaction with their child leaves a lot to be desired. They long for effective support to handle the behaviour of their daughter. Rosie’s teacher noticed that the child has tantrums but also acts withdrawn and does not play much with other children. He advises Rosie and her parents to contact a child health professional (CHP). Both Rosie’s parents experience parenting stress and her mother feels sometimes depressed because she thinks that she is failing to raise her daughter properly.

This vignette describes a situation familiar to many parents of young children. It obviously concerns a child with psychosocial problems, and her parents experience difficulties in coping with her difficult behaviour.

This thesis applies the definition of psychosocial problems provided in the guideline for early detection by PCH in the Netherlands. The definition comprises three elements:

1. Emotional problems (often referred to as internalizing problems) such as anxiety, depressive feelings, withdrawn behaviour, psychosomatic complaints;

2. Behavioural problems (often referred to as externalizing problems) such as: hyperactivity, aggressive behaviour, and conduct problems. This concerns problems that are visible to the environment of the child;

3. Social problems; these are problems related to the ability of the child to initiate and maintain social contacts and interactions with others.
This definition is used in several settings, including the PCH local and National Monitor Youth Health in the Netherlands.\(^1\)

Several population-based studies in the Netherlands show that about 20%-28% of all children have been diagnosed with psychosocial problems.\(^3\) A study in primary and secondary education showed that 13% of all pupils had internalizing problems, 11% had externalizing problems and 3% had other problems, such as social problems. In 7.6% of all toddlers, CHPs identified one or more psychosocial problems.\(^5\) Some different types of problems occur jointly. Studies on trends in the prevalence of psychosocial problems are not consistent in their findings. According to a study of American 4- to 15-year olds by Kelleher et al.\(^8\), in the period from 1979 to 1996 clinician-identified psychosocial problems increased from 6.8% to 18.7%. Similar distinct trends could not, however, be found in the Netherlands. In the Netherlands, Tick et al.\(^9,10\) found evidence only for some small changes in self-reported child psychosocial problems. Decreases were noted for boys, mostly concerning their behavioural problems. Some increases were found for girls, especially in emotional and behavioural problems. Epidemiological studies in the province of Groningen (part of our study area) showed no consistent increase over the last eight years.\(^21\)

The prevalence and nature of psychosocial problems differ among specific groups of children, as mentioned above between boys and girls.\(^12,13\) Whereas externalizing problems are more prevalent among boys, internalizing problems are more common in girls. However, in young children differences between boys and girls are smaller.\(^2\) There are, moreover, a few groups with more than a normal risk of developing psychosocial problems. These include preterm born children\(^14\), immigrants\(^15\) children from non-industrialized countries, and children with low socio-economic status.\(^16\) Moreover, child psychosocial problems also occur more frequently in deprived areas, and research has shown that the environment in which children grow up affects their mental state.\(^17,18\)

**Consequences of early psychosocial problems**

Child psychosocial problems can seriously interfere with the normal psychological development of children. Changes in psychosocial problems over time appeared to have most negatively affected the functioning of young adolescent girls.\(^9,10\) Many authors emphasize that child psychosocial problems may be an important precursor of negative psychological consequences in adolescence and maturity. For example, childhood conduct problems are associated with a wide range of adverse psychosocial outcomes (e.g. crime, substance use, mental health, sexual- and partner relationships) even after controlling for confounding factors. Anxiety and depressive symptoms in adulthood are often preceded by emotional problems in youth. Research has shown that many adult delinquents exhibited intemperate and aggressive behaviour in their youth. Furthermore, child psychosocial problems are the major cause of long-term work disability in young adults and of future societal costs.\(^20,21\)

In their daily practice, Child Health Professionals (CHPs) often encounter parents who seek parenting support for their children with mild psychosocial problems. In the past, raising children seemed to be a collective activity conducted in their primary social environment, involving
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family, other relatives, and also neighbours. Parents sought advice and support within their social network. Nowadays, raising children has become more and more individualized and takes place within the context of the closed family. As a result, when things go wrong parents tend to lean more and more on professional care instead of their social network. In this respect, the burden of responsibility for raising children has shifted from the community to the parents alone.

1.3 PARENTING AND CHILD PSYCHOSOCIAL PROBLEMS

Problems in effective parenting have become an increasing public health problem, also reflected in public policy. Research suggests that different parenting styles and parenting practices have an important impact on child development and that child psychosocial problems and parenting stress are mutually linked. Parents of children with behaviour problems experience highly elevated levels of child-rearing stress which may make it more difficult for them to respond to their children in positive, consistent, and supportive ways. This can lead to a vicious circle in which parents and their children have a perpetual negative effect on each other.

Ineffective and inconsistent parenting styles, such as over-reactivity, verbosity, and laxness may contribute to and maintain child psychosocial problems. Over-reactivity refers to an authoritarian parenting style, which includes threats and physical punishment. Dishion and Patterson reviewed extensive literature supporting theories that harsh and coercive discipline is associated with antisocial behaviour in adolescents. Verbosity describes the approach of parents who tend to give lengthy verbal reprimands rather than taking direct action. Hakman indicated an association between rates of child compliance and levels of maternal verbosity; high levels of verbosity resulted in more noncompliance in children than did low levels of verbosity. Laxness describes the approach of parents who are permissive and inconsistent in providing discipline. Research has shown a relationship between permissive parenting, characterized by lack of consistency and ineffective setting of limits, and oppositional behaviour and conduct disorders. It is clear that parents are very important intermediates in the treatment of child psychosocial problems.

The child problem behaviours associated with the above-mentioned over-reactivity, verbosity and laxness have inspired many interventionists to develop methods or programs for parenting support. Moreover, several studies have emphasized that parenting stress may lead to parental depression. Early detection and treatment of child psychosocial problems therefore seem to benefit both children and their parents. This reinforces the need for greater investment in early detection and treatment of child psychosocial problems.

1.4 EARLY DETECTION AND TREATMENT OF CHILD PSYCHOSOCIAL PROBLEMS

Early treatment of child psychosocial problems is important for prevention of further aggravation of the problems. Early detection means as soon as the problems emerge. It also means early
in the life of the child and, most importantly, early in the developmental process of the problem itself.

As mentioned before, research has shown that early recognition of emotional and behavioural problems in children, if followed by adequate treatment, significantly improves their prognoses. Care for children with psychosocial problems has in recent decades become increasingly professionalized. In the Netherlands care is provided by healthcare organisations such as organisations for youth and parenting, and child and adolescent mental health care (Jeugd GGZ). These organisations play a role as soon as the problems have become clinically manifested.

Systematic screening of psychosocial problems in all children belongs to the domain of PCH. CHPs, i.e. doctors and nurses, working in preventive child healthcare offer the entire Dutch population routine well-child care, including the early detection and treatment of psychosocial problems. PCH would therefore seem to be the obvious organisation for the early detection of psychosocial problems among preschool children, comparable to community pediatrics in the USA. Following through on early detection, PCH can also play an important role in treatment at the onset of mild psychosocial problems in children.

Preventive Child Healthcare

PCH is a health service available at no cost to all Dutch parents and their child(ren) aged 0 to 19 years. PCH comprises regular activities offered to all children conform a uniform and protocolled routine arranged at a national level and established by law. Each municipality is responsible for the execution of PCH activities. In the Netherlands, PCH is part of the Municipal Health Service (Gemeenschappelijke GezondheidsDienst; GGD).

PCH was established in the past century. Initially, it was established mainly to offer physical healthcare for every child (focused on poverty, (mal)nutrition and arrears in growth, domestic hygienic circumstances, infectious diseases, et cetera). Nowadays the focus has shifted towards overweight, new infectious diseases and lifestyle. There is also more attention to the child’s psychosocial problems and problems within his family, neighbourhood and school environment. The aim of PCH is to promote, protect and safeguard children’s physical, mental, social, and cognitive health and development. PCH provides information for parents and children about a healthy development. It detects (imminent) problems and risks and offers support to the child and caregivers or refers them to more specialized care.

PCH organisations in the Netherlands have the duty to detect children with psychosocial problems and, if necessary, to assure that these children and their parents receive adequate support, treatment or care. In the last version of the so-called Basic Task Package (BasisTakenPakket Jeugdgedenheidzorg 0-19 jaar (BTP/JGZ) of PCH in the Netherlands, screening on psychosocial problems already had become one of the most important issues. The Basic Task Package was evaluated in 2013. The evaluation commission concluded that maintenance of most of the described activities was legitimate. The commission also emphasized that early detection and prevention of child psychosocial problems (including bullying) should be part of the primary tasks of PCH.
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In conclusion, in the field of healthcare for children, PCH has a unique position in the early detection and treatment of child psychosocial problems (i.e. primary and secondary prevention), including short interventions for children with subclinical level problems. This offers an ideal setting to provide parenting support following an evidence-based method of early detection of psychosocial problems in children. To reach this goal there is a need for standardized parenting support interventions that are short and that suit the competences of professionals in PCH. As yet, such interventions are not available.

Identification of psychosocial problems: the Strengths and Difficulties Questionnaire (SDQ)

For the identification of child psychosocial problems, PCH uses the Strengths and Difficulties Questionnaire. Accurate screening of psychosocial problems is necessary in order to intervene as early as possible. In the prevention of child psychosocial problems, the Strengths and Difficulties Questionnaire (SDQ) plays an important role in present-day PCH. This questionnaire is a brief behavioural screening questionnaire for children aged 3-16 years. The SDQ is available in several versions to meet the needs of researchers, clinicians and educationalists. All versions include questions about 25 attributes, some positive and others negative. These 25 items are divided among 5 scales:

1) Emotional symptoms (5 items);
2) Conduct problems (5 items);
3) Hyperactivity/inattention (5 items);
4) Peer relationship problems (5 items);
5) Pro-social behaviour (5 items).

Validation research in the Netherlands showed that the SDQ is a reliable and valid instrument for detecting psychosocial problems in children aged 7-12 years old, also in community samples. Implementation of the SDQ in PCH organisations was recommended by their umbrella organisation of Municipal Health Services (GGD Nederland). This resulted in a nearly universal use of this questionnaire by PCH in the Netherlands.

1.5 INTERVENTIONS AND THEIR EVIDENCE

Effective early detection is useless and even unethical if no effective early treatment is available. Therefore, evidence-based interventions targeting child psychosocial problems are needed. During the last decades, a battery of interventions have emerged. Examples of parenting interventions are: Video home training, Incredible Years, Families First, STEP, Parenting and more (Opvoeden&zo), and Firm Parenthood (Stevig ouderschap). The database from the Netherlands Youth Institute (NJI) contains several interventions related to parenting practices and parenting strategies. Regrettably, however, as yet only one program is considered to be evidence-based, which is Incredible Years. Most of the above mentioned parenting interventions are based on the same principles such as: reinforcing positive behaviour and negating negative
problem behaviour. The Positive Parenting Program (Triple P) is one of those programs. Recently, studies in the Netherlands and elsewhere on the evidence effectiveness of the more intensive variants of Triple P have been criticised. We can conclude that evidence on the effectiveness of PCTP is particularly scarce and inconclusive, and is lacking for the Dutch setting.

**The Positive Parenting Program (Triple P)**

This thesis describes a study of the effects of Triple P level 3, also known as: Primary Care Triple P (PCTP). Triple P is a multilevel system of family intervention that provides five increasingly intense levels of intervention. Level 1 refers to a media-based parent information campaign that targets all parents wanting to improve their parenting skills. Level 2 consists of a brief one- or two-session primary healthcare intervention providing guidance to parents of children with mild behaviour problems. Level 3 is one of the levels with mediate intensity. It is a brief, narrow-focus parent program aimed at parents with specific concerns about their child’s behaviour or development. It combines advice, rehearsal and self-evaluation to teach parents to manage discrete child problem behaviour during four individual consultations of 20-30 minutes with the parents and their child. Level 4 is an intensive eight-to-ten session individual or group parent-training program for children with more serious behaviour problems. Level 5 offers help to parents of children with very difficult child behaviour problems and family dysfunction.

Several studies showed that the Triple P interventions, including level 3, seem promising when compared with a wait-list control group receiving no help. In the Netherlands, a quasi-experimental study on the effects of Triple P level 3 showed significant decreases in the emotional and behavioural problems of children as well as effects on parental satisfaction, parental efficacy and overall parental sense of competence. A randomised controlled trial investigating the effects of parenting support with Triple P level 3 after an evidence-based, initial screening on psychosocial problems in children has not previously been conducted and long-term follow-up data are currently not available.

**1.6 RESEARCH QUESTIONS AND OUTLINE OF THIS THESIS**

To contribute to the knowledge on the relationship between parenting, the family and child environment, and child problem behaviour and parenting we collected data on:

- child psychosocial problems; parenting competences; parenting stress; and depression, anxiety and stress symptoms among parents.

Chapter 2 presents the design of an effectiveness study on Primary Care Triple P. It describes extensively the theoretical background of Triple P, the main reason for this research, the research question, the methods, the analyses, and the outcome measures. Chapter 3 assesses how living in a deprived area affects parenting stress; the aim of this study was to examine the impact of area deprivation and urbanisation. Chapter 4 describes the relationship between parental depression, anxiety, and stress and child psychosocial problems. The objective here was to examine the
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association between parental internalizing problems (symptoms of depression, anxiety and stress) and child psychosocial problems in a community sample, crude and adjusted for potential confounders (such as child gender, parental educational level, ethnicity) and whether parental concerns affect this association. Chapter 5 presents the results of a randomized controlled trial on parenting support. The objective of this study was to assess the effectiveness of Primary Care Triple P level 3 (PCTP) compared with care as usual (CAU) for parents of children with mild psychosocial problems after an initial, evidence-based screening in routine Preventive Child Healthcare. Chapter 6 presents the results of an evaluation of the psychometric characteristics of a scale measuring symptoms of depression, anxiety and stress among adult subjects in a non-clinical population. Chapter 7 provides a summary of Chapters 3, 4 and 5 and a general discussion of the main findings and their implications. Moreover, it addresses the question of whether Primary Care Triple P (level 3) is a suitable intervention to be adopted by the Dutch Preventive Child Healthcare and discusses the most important findings of the trial. It also reviews the challenges and (dis) advantages of conducting RCTs in PCH.
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