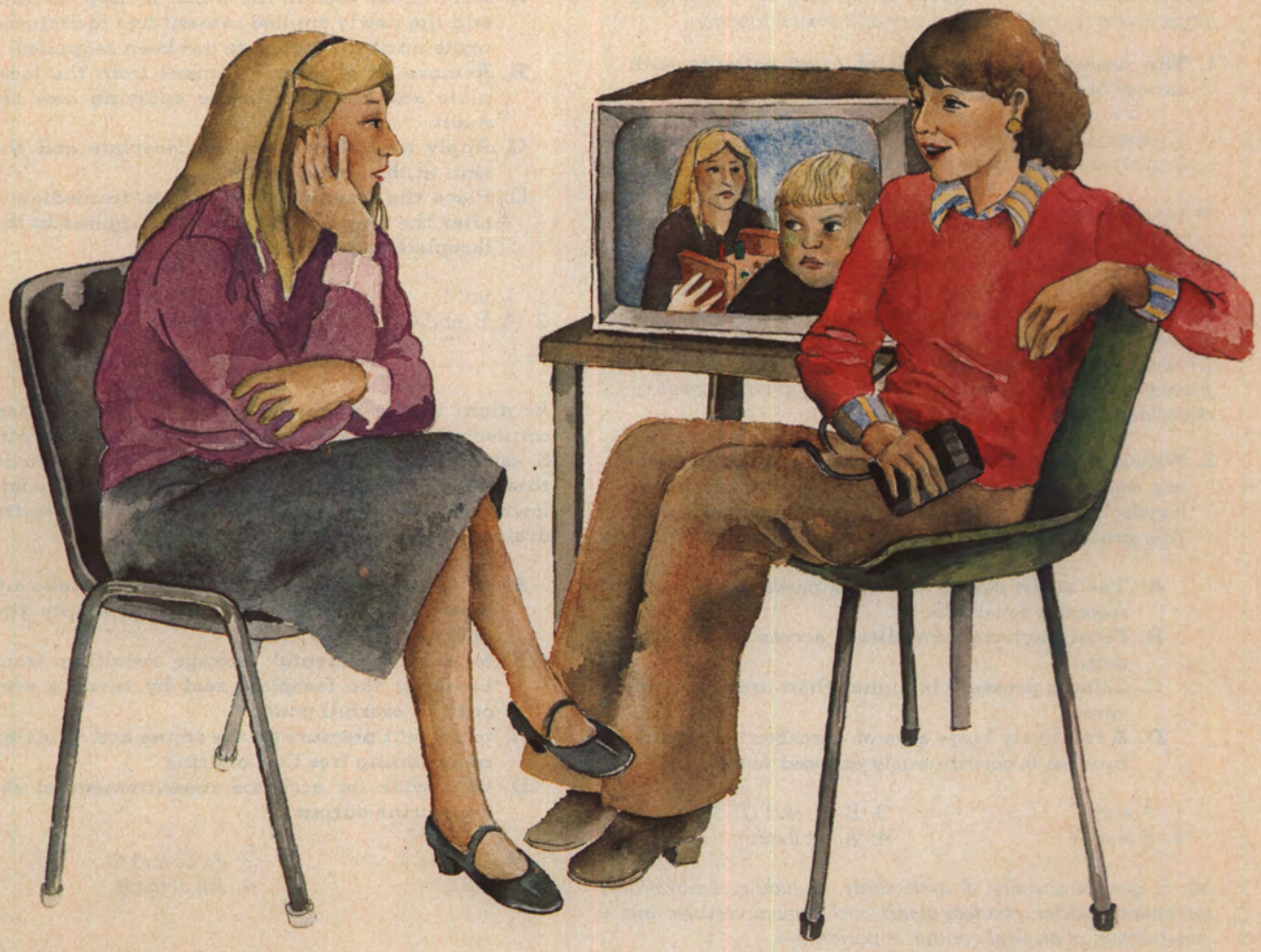
Helping Parents Parent



By Carolyn Webster-Stratton
Kate Kogan

Mary and John, well-educated parents, were describing the problems they were having with their three-year-old son. "He is unable to accept discipline, disobeys, has temper tantrums, demands attention, can't get along with other children, and acts irritable and unhappy." They needed professional help.

They had come to the Parenting Clinic at the University of Washington and were seeing the director and a nurse practitioner. After the initial interview, the mother and child were videotaped for two half-hour sessions, in order to obtain baseline behaviors.

Analyses of these videotapes suggested that Mary responded to her child in a competitive, negative way, that her responses to him were inappropriate, her expectations of him too high for a three-year-old, and that neither of them derived much pleasure from their interaction.

From the tapes, we selected examples of these behaviors and reviewed them with the parents. We suggested to Mary that she use every opportunity to give some positive attention and praise when her son was behaving properly; that she be an interested, animated "audience" to his play rather than compete with him; that she give him a

chance to develop his own ideas at his own level of interest and pace; and, finally, that she try to foresee arguments and avoid creating issues unless they were important and Mary could make clear, concise rules and follow through with them quickly. Mary was to practice these principles during monitored play sessions and also during play sessions at home.

After five instruction sessions over a two-month period, behavior changes were dramatic. "After seeing myself on those videotapes," the mother reported, "I cried all night. I had always seen my mother as a negative attention-giver but never realized that I was doing the same thing. I did so much nagging and complaining. Now we are so much happier. We are really enjoying our son and so are others. His imagination has blossomed, and he seems to show much more confidence in his own ideas and activities."

In our check-back appointment two months later, Mary and John reported they still felt confident in their parenting abilities.

Parenting Program

Success stories like this one rest on nearly 15 years of research and clinical experience conducted in a parenting-research program at the Child Development and Mental Retardation Center in the Department of Psychiatry and Behavioral Sciences at the University of Washington. This research program has developed and refined objective methods for the observation and analysis of interactive patterns between young children and their parents. The approach is not to look for discrete target behaviors to be changed. Instead, the "parent-child interaction system" is the basis for training parents to cope with disturbing behaviors and to prevent future interpersonal disturbance.

We believe that children are less affected by isolated episodes than by pervasive and continuing trends of parental attitudes(1). By applying a detailed examination of the behavior of each parent-child pair, the repetitive patterns that characterize each pair can then be distilled out.

We evaluate the interaction by observing a parent and child playing together in a small room equipped with a one-way mirror, a microphone, and specific toys. The pair play together for one half hour, on two different occasions usually a week apart, and the sessions are videotaped. Afterwards, these tapes are analyzed in 40-second segments in terms of 21 items which have been identified in past research as representing a range of important interactions that characterize the unique interpersonal style of a wide variety of mother-child dyads.

The analyses and interpretation of the tapes, both positive and negative, are shared with parents. We then give them a written list of specific suggestions to try to follow and ask them to have daily play sessions with their child.

Subsequently, they come in weekly for directed practice sessions. One of the parents is given a cordless communication device known as a "bug-in-the-ear," which permits the observer to communicate with the parent while the parent plays with the child.

The counselor watching through the one-way mirror can systematically acknowledge each time the parent makes a desired response. The purpose is to teach parents an effective approach for independently handling future child-rearing situations. Parents learn a completely undemanding form of play—praising the child's appropriate behavior and being careful not to reward any problem behavior.

The effect of this clinical approach is threefold: it removes the parents' feeling that they are to blame for their child's difficulties; it casts parents in the role of cotherapist or ally to the counselors in effecting desired changes, and it equips parents with the theory and techniques necessary for solving future problems and with alternative kinds of interchange. Parents report improvement after four to eight sessions(2-5). The methodology has also been refined to help many different kinds of families, including those who have children who are mentally retarded or physically handicapped(6,7).

The following are three cases for which we used the approach described with dramatic results.

Parent-Child Observational Assessment*

Attention
1. Watches
2. Does own thing
3. Works together

Notice whether the mother and child play together or whether each works on his own activity independently and ignores the other's activity. Also notice whether parent or child attend to and watch each other.

Communication
4. Quiet
5. Comments
6. Shared conversation
7. Clarity and lack of ambiguity

Do parents and child share in conversation together or is there silence or one-sided talking? How clear and effective are the parents in communicating or limit-setting?

Acceptance
8. Smiles, enthusiasm
9. Praise
10. Physical warmth

How much praise, warmth, affection, and positive acceptance occurs from parent to child and child to parent?

Nonacceptance

Emotional:
11. Negative voice, pout
12. Mixed messages†
13. Physical hostility

Intellectual:
14. Frustration
15. Actions ignored
16. Negative content

How much negative commenting, correcting, punishing, judging, and criticism occur? Does either child or parent seem not accepting of himself?

Control
17. Physical intrusion
18. Control and directiveness
19. Competition

How much ordering or competition for control is there? Who usually takes the lead or initiates suggestions for play?

Submissiveness
20. Approval seeking
21. Active compliance

Does one member of the pair constantly ask for approval from the other? Does either one accept and go along with rules set by the other?

**All items are checked for parent and child.*
† Teasing, smiling at same time as being negative.

Mary—Handicapped, Hyperactive

Mary was a four-year-old child with right-sided hemiparesis, petit mal seizures, and a developmental delay due to a stroke at age one. She had been treated with Dilantin and phenobarbitol for her seizures. She also had been seen for two years by a child psychiatrist who was treating her "hyperactivity" with play therapy and had suggested using Ritalin, which the parents had resisted.

Mary spent her days at a day care center. The staff said that she could not get along with other children, that she was aggressive, and that she had a short attention span. They told the parents that they did not feel they were equipped to deal with Mary's behavior problems and that she should be placed elsewhere.

Mary's parents brought her to the Parenting Clinic, stating that they were desperate. They felt that two years of play therapy had not changed her behavior and that, in fact, her behavior was deteriorating. They described her as "inattentive, unhappy, angry, demanding, unpopular, and destructive."

Mary's father went into the play session while her mother watched through the one-way mirror. We observed that Mary displayed little initiative for independent play but sustained her attention better when her father was very controlling; he frequently took the lead and injected a lot of structure into her play. Their interaction had many negative components, such as continual teasing, competition, mixed messages, negative commenting, hostility, and a complete lack of praise.

We reviewed and discussed the tapes with the parents and gave them these written instructions:

1. Be an attentive audience to Mary's play when she is playing appropriately and praise her for it.

2. Gear your comments and interest to her level and try not to insert your own ideas.

3. Try to make as few rules as possible, but make rules you do set as quickly, simply, and clearly as possible and in a positive tone of voice.

We asked them to have daily play sessions of at least 15 minutes, incorporating these principles. The purpose was to help Mary learn to work for attention and reward her when her behavior was constructive, rather than allow her to seek to gain attention in a negative form by being contrary and provocative.

After seven sessions, Mary's behavior changed dramatically. The day care teachers felt she was "a different child." She began to be accepted, and she was more capable of working on an activity by herself for longer periods and was able to engage in more creative and imaginative play. Our follow-up, eight months later, revealed that she continued to improve, and the parents felt more competent in their handling of her behavior.

Carolyn—Night Phobias

Carolyn, age seven, was brought in by her mother because she had fears of the dark and would not sleep in her own bed. These fears had apparently begun a year before when a neighbor's house was destroyed by fire during the night. Each night, Carolyn's mother went through elaborate rituals—locking doors, checking windows, and adding extra curtains. In spite of this, Carolyn inevitably got up each night to roam the house and sleep with either her parents or her brother. In the initial interview, the mother also described her as " a whining, crying child who had no friends, was jumpy and nervous, and demanded a lot of attention."

The baseline videotapes suggested that the mother responded to Carolyn with mixed messages, competition, low control, low direction, and that she was highly submissive, usually following the child's directions. Carolyn's behavior analysis showed her beyond the range of normal for controlling and directing, lead taking, and approval seeking. Messages between them were confused. Carolyn was an extremely controlling, manipulative child with a submissive mother.

We suggested to the mother that she pay no attention to the whining or to the fear-induced night behavior; that she give attention and praise for appropriate, healthy behavior; that she not engage competitively with the child but rather be an appreciative audience; and, finally, that she set clear, simple rules.

After five sessions, the mother told us that Carolyn was less whiny, had made some friends, was more self-sufficient in her play, and was less nervous. She had slept quite a few nights alone in her own bed.

CAROLYN WEBSTER-STRATTON, R.N., PH.D., P.N.P., is an instructor in the pediatric nurse practitioner program at the University of Washington, Seattle.

KATE KOGAN, PH.D., is professor emeritus, psychiatry and behavioral sciences, at the University of Washington.

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Matthew—Aggressive, Destructive

Matthew, age four, was brought in by his mother, a single working parent. She reported that her child was "aggressive, jealous, sassy, demanded a lot of attention, refused instructions, and resented discipline." He also tended to wake at night and wanted to get into her bed. She specifically asked us for help in setting rules for Matthew and handling temper tantrums.

In reviewing Matthew's tapes, we found that the mother frequently did not give positive attention to appropriate play and that she tended to dominate their joint activity by imposing her own adult-level structure and expecting adult-level conversation. She expected Matthew to respond to her in an adult way. She had little idea of behaviors that were normal for a four-year-old.

We shared selected examples of these behaviors and some more positive alternatives with the mother. We also gave her specific teaching in regard to normal four-year-old activities and level of play, and then gave her the following instructions:

1. Pay active attention to what Matthew is doing *at his level* and praise him for appropriate behaviors.

2. Follow his lead during play, letting him set the rules.

3. Try not to talk about outside things while he is playing.

As with the other parents, we asked her to consciously rehearse these behaviors in daily play sessions at home and use them whenever appropriate throughout the day.

Weekly, bug-in-the-ear instructional sessions were conducted over a one-month span. The mother then reported that she felt things were going much better. She felt that she and Matthew were enjoying each other a lot more, that she could set rules without precipitating an outburst, and that even her own parents had noticed changes in the boy's behavior. At a follow-up appointment six weeks later, the mother said that things were continuing to go smoothly, that she found playing with him more comfortable and interesting, and that there had been no major hassles.

The techniques we use can be helpful with a variety of child behavior problems. In general, we have found that the primary reason for referral is a negative and mutually unsatisfactory relationship between parent and child.

When to Seek Help

The parent is usually frustrated and distraught when his attempts to control the child, either physically or verbally are unsuccessful. Consequently, our approach is to teach parents not only optimal, positive play skills, but also effective control techniques for gaining reasonable compliance and cooperation from the child and for preventing or ending undesirable behaviors.

Often, children with behavior problems are not identified or given help until they are school-aged and a teacher asks for them to be seen by a school psychologist. But by this time, seven to eight years of patterns of interaction between parents and children will have been established. This is why primary health care providers should not only be able to identify behavior problems or conflicts in their earliest stages, but also to accept the responsibility to learn and carry out parenting training.

Screening for problems—Most parents bringing their child for a well-child visit do not spontaneously discuss their parenting difficulties with health-care providers. Active screening procedures can be used to elicit parents' concerns and conflicts. A simple checklist or questionnaire, given out at each visit, can identify problem behaviors. If screening turns up areas of conflict, then the practitioner needs to set aside enough time to analyze and clarify the problem and contributing factors.

Analysis or clarification of the problem—To gather the information needed, use a semistructured behavioral interview. This interview should cover types of parent-child behaviors leading to conflict; frequency and severity of problem behavior; circumstances, if any, that precede and follow problem behavior; and approaches parents have made to resolve the problem. The child's and the parents' histories are useful in identifying the parents' general way of reacting to the child's behavior and help the parents understand their own behavior and why their child is responding as he is.

Although most outpatient clinics will not have one-way mirrors, videotape equipment, or elaborate coding facilities, parent-child interactions still can be observed in your office by asking the parent and child to play a game together, or you can make a home visit to see them interacting in their natural environment.

After the parent-child behaviors have been observed, it is possible to identify the pervasive trends in the interaction: for example, child aggressive, parent insecure, inconsistent, and submissive; child dependent, parent manipulative, protective, and permissive; child insecure and fearful, parent aggressive, authoritarian, and hostile.

We have found it is also helpful to ask parents to keep a log for a few days, noting the child's behaviors in everyday situations, and specifically recording what factors

they feel encourage maladaptive behaviors, and what behaviors they find acceptable. This input, added to your own clinical observations, gives a more complete picture.

Intervention—The next step is to share with the parent your findings. Here, the practitioner focuses on the interaction between the pair, rather than blaming either the parent or child for the maladaptive behaviors. For example, point out when the parent was effective in using praise or when lack of praise or attention resulted in the child becoming frustrated and throwing a temper tantrum. In the same way, examples of how a child's behavior or temperament effects the parents' behavior should be discussed. Often, parents may be simply relieved to find out that some behaviors that they felt were abnormal were really appropriate for the child's age.

The direct training of parents includes five areas:

1. ***Reinforcement***—Ideally, parents should be appropriate reinforcement-dispensing agents, rewarding the child with praise and attention for desirable behaviors and ignoring undesirable behaviors, such as sulking, whining, and temper tantrums. In this way, the amount of spanking and scolding is reduced. All too often, parents give little or no positive attention when the child is playing happily but do give attention when he is doing something wrong. Likewise, the practitioner should consistently reward the parents with positive comments, acknowledging parents' positive or appropriate responses. This support and positive feedback enhances their self-esteem and helps them to feel more secure and competent in their parenting.

2. ***Modeling***—When taking parents seriously, paying full attention, and making an honest effort to understand their point of view, the practitioner is modeling an accepting, positive interaction that parents can use when interacting with their child. Or, the practitioner can model the role of the parent with the child. Often, parents repeated our words to their child.

3. ***Teaching***—Many parental concerns arise from a lack of understanding of typical age-related behaviors that are perfectly normal. We instruct parents that such behaviors as the short attention span of the toddler, the negativism of the two-year-old, the fantasy play of the preschooler, or the occasional lying, hitting, and sassy back-talk of four-year-olds are normal.

4. ***Control Skills***—Parents must be instructed in effective control techniques—when to ignore disruptive behavior, when to set rules, and how to carry out the rules. In our parenting clinic, we emphasize three approaches to limit setting:

1. State the rule clearly with a short explanation in a positive tone of voice.

2. Follow through with the rule patiently and persistently, once it has been set.

3. Divert and distract the child's attention by becoming interested and enthusiastic about another activity. Praise the child as soon as he begins to comply or behave appropriately.

We have found it very helpful to rehearse these skills. For example, we will ask a parent to set a rule and then will support him/her in carrying it out. Parents have told us that they have found it far easier to carry out rules at home once they have actually seen them work in the office. It helps us be sure parents understand how to state the rule and the principles of ignoring and diversion.

We have found it is particularly effective to discuss specific situations in which it is important to ignore and/or impose consequences. Other areas parents may request specific help with are bed wetting, weaning, temper tantrums, aggression, resisting going to bed, sleeping in parents' bed, whining, lying, stubborness, hitting, and refusing to eat. These behaviors and others can be handled by following the basic principles of ignoring the unacceptable behaviors, rewarding behaviors that are in opposition to maladaptive behaviors, and clear limit setting.

5. ***Play***—It is very helpful if parents spend at least 15 minutes daily in uninterrupted, nondemanding play interaction with their child. In this play time, we ask parents to attend to, praise, describe, or comment on the child's behavior. We ask them not to structure the play but simply to be an "appreciative audience" and to allow the creativity and ideas to come from the child himself.

The parent is also encouraged not to ask questions or judge the child's play, but simply to show interest by following the child's lead and by imitating his actions when he desires. We emphasize that it is the process and not the end result that is important. If the child is allowed some power or control in the play situation, such as setting the rules of a game, and if the parent can model acceptance of these rules, then outside of play, when the adult is setting the rules, the child will be more likely to accept them.

We also find that when a child is given a parent's complete attention and praise, even for just a short time each day, play becomes not only more creative and imaginative, but the child's self-confidence increases and hyperactivity and aggression decrease.

The fostering of good parenting skills, especially during the early periods of childhood, builds parents' confidence in their abilities. Guiding and supporting parents in appropriate management of common emotional disturbances and behavior problems prevents psychological problems from becoming permanent and detrimental and promotes positive parent-child relationships.

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