

FCSS



Positive parenting and family functioning

1. The issue

A stable and secure family life is vital to healthy child and youth development. Briefly, strong families are those in which family members get along and communicate well, follow routines, share tasks and enjoy time together, enjoy a positive outlook, have a support network, and where parents use positive parenting skills.¹ “Positive parenting” means expressing love and affection; being a good provider and household manager; setting and enforcing rules consistently and in specific ways; offering stimulating experiences and materials; modeling good values, attitudes, and behaviours; establishing positive links with school and community; and following daily routines.² Indeed, positive parenting can buffer children from the consequences of other hardships and adversity in life.

While few families fit this ideal profile at all times, negative parenting practices and ongoing family dysfunction place children and youth at serious risk. Poor parenting is “the single largest variable implicated in childhood illnesses and accidents; teenage pregnancy and substance misuse; truancy, school disruption, and under-achievement; child abuse; unemployment; juvenile crime; and mental illness.”³

The most extreme manifestation of poor parenting is, of course, child maltreatment, which includes emotional and physical abuse and neglect, sexual abuse, and exposure to domestic violence. Myriad studies have documented the profound, pervasive, and long-term effects of various forms of abuse on children and youth.⁴ However, poor parenting need not be as extreme as overt child maltreatment. Common forms of “poor

parenting” include inconsistent discipline, corporal punishment, lack of warmth and affection, detachment and hostility, rejection, and poor monitoring and supervision.⁵

The key differences between emotional abuse and poor parenting are “a) the chronic, severe and escalating pattern of emotionally abusive and neglectful parental behaviour toward the child, i.e., parents defined as emotionally abusive typically have shown qualitatively more extreme... and disturbing behaviours towards a child (compared to those described as poor parents); b) the pattern of chronic and severe parenting methods is associated with a proportionate increase in the likelihood of psychological harm or developmental disruptions, presumably because the child is exposed to ongoing stress that interferes with his or her ability to establish emotion regulation.”⁶

The key risk factors that can contribute to family instability and poor parenting include:

- Parental personality traits and parents’ own negative family and developmental histories.
- Parental mental health problems (including depression) and/or drug or alcohol abuse.
- Early, unplanned, and/or lone parenting; domestic violence.
- In some circumstances, parental cognitive impairment and/or child disability.
- A range of contextual stressors and life circumstances, most notably poverty and social isolation.

These risk factors often are interrelated and occur concurrently.

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POSITIVE PARENTING AND FAMILY FUNCTIONING

FCSS Calgary has adopted a social sustainability framework to serve as a blueprint for its social planning, investment decisions, and funding practices. Within this framework, FCSS has identified two investment priorities: strengthening neighbourhoods and increasing social inclusion.

This research brief is one of six originally commissioned by FCSS in 2009 and updated in 2013 to include advances in research. These research briefs are not intended to serve as program development toolkits. The purpose of the briefs is to provide guidance from the research, where it exists, to funders and organizations working to:

- Increase social inclusion among vulnerable Calgarians by increasing positive social ties, improving family functioning or parenting skills, improving adults’ personal capacity and individual and family economic self-sufficiency, and/or improving positive child and youth development outcomes.
- Increase neighbourhood capacity and social and individual capital in focus neighbourhoods.

For more information on the purpose and context for these briefs, please visit calgary.ca/FCSS.



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The more risk factors a child experiences, the greater the likelihood that he or she will experience problems such as behavioural and conduct disorders, hyperactivity, poor school performance, emotional problems, and delinquency. Such childhood problems are individually and collectively associated with negative outcomes in adolescence. These include criminal involvement, poor academic achievement and decreased likelihood of completing school, and young

parenthood. These adolescent outcomes are correlated with employment problems, poverty, ongoing criminal involvement, homelessness, health problems, including addictions, and perpetuation of the poor conditions and parenting practices that the young people experienced in childhood.

Strengthening families and supporting positive parenting are effective means of preventing the intergenerational cycle of

poverty and social exclusion. Not every developmental challenge and social problem can be prevented through strong families and positive parenting. However, reducing the risk factors that threaten family stability and well-being, and supporting programs and conditions that assist vulnerable families, will give all children, in this generation and those that follow, a better chance of health, happiness, and success.

FIGURE 1: POSITIVE PARENTING AND FAMILY FUNCTIONING OUTCOMES⁷

PARENTING DOMAIN	DESIRED OUTCOMES
Warmth and responsiveness	<ul style="list-style-type: none"> • Parents express love and affection. • Parents are responsive to their child's needs and requests.
Control and discipline	<ul style="list-style-type: none"> • Parents outline specific age-appropriate rules and expectations and enforce them consistently. • Parents use positive discipline strategies and do not use corporal punishment.
Cognitive stimulation	<ul style="list-style-type: none"> • Parents ensure that their child has materials that are stimulating. • Parents are verbally engaging and actively teach their children key concepts.
Modeling of attitudes, values, and behaviors	<ul style="list-style-type: none"> • Parents discuss their values, convey their attitudes, and act toward their child and others in the way they want their child to act.
Gatekeeping	<ul style="list-style-type: none"> • Parents influence which family and friends their child interacts with and what outside activities and programs they become involved in. • Parents become involved in school and other community activities to maintain connection with the child and outside influences.
Family routines and traditions	<ul style="list-style-type: none"> • Parents create a daily routine (e.g., meals, chores, bedtimes) as well as family traditions that help structure a child's expectations for the day. • Parents promote knowledge of cultural and family heritage.
FAMILY DOMAIN	DESIRED OUTCOMES
Positive outlook	<ul style="list-style-type: none"> • Parents are confident and optimistic about life and about the future. • Parents have a sense of humour; family members have fun together. • Parents enjoy good mental health.
Spirituality	<ul style="list-style-type: none"> • Parents demonstrate and model positive values.
Family member accord	<ul style="list-style-type: none"> • Parents enjoy a positive relationship and get along with one another. • Parents use positive parenting practices and positive discipline techniques. • Family members encourage and appreciate one another. • Family members are committed to the family as a unit.
Family communication	<ul style="list-style-type: none"> • Family members express their emotions clearly, appropriately and openly. • Problems are solved collaboratively.
Financial and household management	<ul style="list-style-type: none"> • The family has sufficient income to meet basic needs (food, shelter, clothing, health, transportation). • The household is organized, clean, and physically maintained. • Parents manage money well, adhering to a budget. • Family warmth is maintained when the family experiences financial problems.
Shared recreation	<ul style="list-style-type: none"> • The family does fun things together regularly (e.g., outings, games, events, volunteering).
Routines and traditions	<ul style="list-style-type: none"> • Parents create a daily routine (e.g., meals, chores, bedtimes) as well as family traditions that help structure a child's expectations for the day. • Parents promote knowledge of cultural and family heritage.
Support network	<ul style="list-style-type: none"> • The family has a network of useful individual, familial and community supports.

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2. What needs to be prevented: The risk factors for family instability and poor parenting

2.1 Parental personality traits and family histories: Intergenerational parenting practices

Parenting practices and style are largely shaped by parents' personalities, in the expected ways. Overall, parents (who, in the research, are most often mothers) who are extraverted (talkative, energetic, enjoy social interactions), conscientious (well-organized, dependable, responsible); agreeable (good-natured, cooperative, helpful, forgiving), open to new experiences, and not neurotic (emotionally unstable, nervous, easily distressed) are generally responsive and sensitive to their children and provide more cognitive stimulation. Parents who are neurotic usually score lower on tests of the four positive aspects of personality and tend to be less responsive and sensitive.⁸ Likewise, parents who are prone to negative emotional states, such as depression, irritability or anger, tend to behave in less sensitive, less responsive and/or harsher ways than other parents do. This applies whether they are parenting infants or toddlers, older children, or adolescents.⁹ Parents who are more cynical, vengeful and manipulative, and less trusting, helpful, and forgiving, control their children in more negative ways than do other parents, particularly in disciplinary situations.¹⁰

Parenting style, which is distinct from parenting practices, is related to parents' personality, family histories, and contextual factors. Originally defined by Baumrind¹¹ and refined slightly over time, parenting style sets the emotional climate for parent-child interactions and reflects parents' attitude toward the child across a range of situations. Extensive research over many decades has shown that an "authoritative" parenting style trumps both "authoritarian" (or "punitive" or "harsh") and "permissive" parenting in terms of child and youth positive development. "Authoritative" parents balance

encouragement of independence and sense of identity within warm and responsive relationships with high expectations about behaviour and maturity and compliance with their authority. "Permissive" parents may have warm and loving relationships with their children, but rules are few and expectations of children are low. "Authoritarian" parenting is verbally hostile and coercive, i.e., arbitrary, preemptory, domineering, and intended to demonstrate the power of the parent over the child.¹² Both permissive and authoritarian parenting styles are associated with child and youth internalizing and externalizing problems, including internalized distress, conduct disorder, and delinquency.¹³

Although most of the research on parenting style has been conducted on families of European or African descent in the Western world, recent studies (at least those which are published in English) suggest that these outcomes appear to be generally true across cultures,¹⁴ with a few variations.¹⁵ For instance, one study found that Indian college students considered permissive parenting to be the most effective but felt that authoritative was most similar to their own parents' style and was the style they would emulate with their own children,¹⁶ and many studies have attempted to sort out the intricate cultural factors that mediate the association between authoritative parenting by Chinese parents and positive child outcomes.¹⁷

Parenting style and parenting practices tend to be transmitted down generational lines.¹⁸ Inter-generational studies show that children who were poorly parented often become antisocial and aggressive. This experience predicts "harsh, aggressive, neglectful, and unstimulating parenting behavior toward offspring."¹⁹ Moreover,

parents who experienced "constructive" parenting (reflected by monitoring, discipline, warmth, and involvement) tend to interact with their own children in the same ways.²⁰ However, there is some evidence that positive parenting practices are passed on in a slightly different way than negative ones. Several studies indicate that positive parenting stems from the social and academic competencies that good parenting engenders in the next generation.²¹

There is some evidence overall that parents' personality traits and parenting styles are amplified by their children's temperaments, for better and for worse.²² Parenting is often a response to child temperament and behaviour: Some children are simply more difficult to parent than others, and "bad" parenting should not always be interpreted as "causing poor outcomes in a simple unidirectional sense."²³ Parents of children with disabilities face the additional challenge of "teasing out which behaviours are a consequence of physical and mental limitations and which are rebellious and require assertive parental intervention," and what sorts of consequences are appropriate.²⁴

That being said, personality characteristics shape parenting because they seem to partially influence the emotions parents experience and/or the attributions they make about the causes of child behavior. For example, a parent may interpret crying to be the result of tiredness or the child's desire to manipulate the parent.²⁵ Likewise, parenting a child with a disability sometimes carries with it a range of parenting challenges. A wide range of other stressors may exacerbate these challenges. As discussed below, stressors can compromise the skills of the most competent parents.

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2.2 Parental mental health issues and substance abuse

The most common type of mental health issue experienced by mothers (fathers are largely absent from the research on parenting, mental health, and substance abuse) is depression. Maternal depression is one of the most serious risk factors for poor child developmental outcomes:

- Infants of depressed mothers are at risk for developing insecure attachment and related problems.
- Toddlers and preschoolers are at risk for developing poor self-control, behaviour problems, and difficulties in cognitive functioning and social interaction.
- School-age and adolescent children are at risk for a range of problems including conduct disorders, affective disorders, anxiety disorders, ADHD, and learning disabilities.²⁶

A recent, large American study found that boys are more vulnerable to maternal depression than girls and that socioeconomic advantage does not buffer children from the consequences of maternal depression.²⁷

Maternal depression is a serious risk factor for poor child development because it can diminish mothers' ability to use good parenting skills. Studies have found, for example, that depressed mothers are often more negative in their interactions with their children,²⁸ judge their children more harshly,²⁹ use poorer discipline strategies,³⁰ and provide less consistency and structure³¹ than non-depressed mothers. Each of these behaviours contributes to poor child developmental outcomes.³² In addition, "the family environments of depressed parents are

characterized by major stressful life events and conflict. They also have lower social support and family cohesion than families not affected by parental depression,"³³ which are additional critical factors known to lead to poor adjustment of children.

Maternal depression is common among teenage mothers. They often suffer from both post-partum and long-term depression. The strongest predictors of post-partum depression include depression during pregnancy, experiencing stressful life events during pregnancy or shortly after birth, low levels of social support, and a previous history of depression. All these factors are more common among teenage mothers and low-income mothers.³⁴ Depression is also more common among mothers of a child with a developmental disability.³⁵ However, research suggests that depression may not be as common or widespread as previously believed.³⁶ Research also suggests that depression is often associated with the level of parental stress, which tends to be high in this population.³⁷

Teenage and lone mothers' ongoing depression can be caused and exacerbated by previous and current life circumstances.³⁸ These may include poverty, family conflict, and stressful life events.³⁹ Other parental mental health issues are also associated with a higher incidence of child psychiatric disorders, independent of parenting attitudes and competence. In conjunction with poor parenting, these have a highly adverse effect on child development outcomes.⁴⁰

Research indicates that parents of children with intellectual disabilities are at increased

risk of psychological distress and psychiatric disorder.⁴¹ Some research has identified increased stress as the cause.⁴² Other research has pinpointed low income or decreased income as the primary cause of the stress. One Australian study documented elevated rates of psychological distress indicative of serious mental illness among mothers, but not fathers, of children at risk of disability, although at least half of this distress was accounted for by living in poverty.⁴³ Australian research has also shown that families with a child with an intellectual disability were more likely than other families to be poor and to become poor and less likely to escape poverty,⁴⁴ in the U.S., higher poverty levels among such families were found only for parents under age 45 years and over age 54 years.⁴⁵

Parental substance abuse is associated with a higher incidence of physical abuse⁴⁶ and adverse developmental outcomes, including poor physical health, emotional well-being, and behavioural problems.⁴⁷ These problems may be the direct result of poor parenting⁴⁸ and/or to other parental and family risk factors such as low levels of education, poverty, and domestic violence.⁴⁹ The risk of poor outcomes is substantially larger when both parents have substance abuse problems, even when the substance abusing father no longer lives with the family.⁵⁰ Longitudinal research has shown that mothers' history of childhood sexual abuse predicts a higher likelihood of maternal substance abuse, which in turn predicts a higher likelihood that a mother will abuse her own children.⁵¹

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2.3 Early, unplanned and lone parenting

Lone parenting is generally more difficult than parenting in a stable two-parent family. Research has shown that older single mothers, for example, women in their 30s who plan a birth or adoption tend to have a strong support network and are at low risk of poverty. The development of their children is comparable to that of children in two-parent families.⁵² However, many lone parents are women living on low incomes and with little social support. More than half of single women with children come from poverty themselves and may remain there because young parents are less likely to have pursued educational goals and more likely to be unemployed. Families headed by young single mothers are much more likely than other families to endure multiple moves, multiple co-habitations and dissolutions, and a cycle of inter-generational poverty, all of which carry risks for children of all ages.⁵³

Teen pregnancy has been on the decline since the 1970s. Births to Canadian girls and women aged 14 to 19 years declined from 29.9 per 1,000 in 1974 to 19.1 in 1997 to 13.3 in 2007.⁵⁴ The teen birthrate for Aboriginal girls and women in Canada as a whole is much higher. At last report, one in five Aboriginal teens had given birth.⁵⁵ In 2007, Calgary's teen birth rate was 12.8 per 1,000 (compared with 20.6 in Alberta),⁵⁶ meaning that more than 500 babies are born each year to teenaged mothers in Calgary.

The most common antecedents of teenaged motherhood include:

- Low family socio-economic status, family dysfunction.
- Academic problems and high school drop-out.
- High aggression.
- Favourable views about pregnancy and/or early parenthood.
- Negative peer associations.
- Limited economic opportunities.^{57, 58}

Teenagers in low-income families, who have low self-esteem, low expectations for the future, and a history of family dysfunction, poor parenting, and/or child abuse have much higher rates of adolescent pregnancy.⁵⁹ Some adolescent girls and women become pregnant intentionally

or “drift” into pregnancy because they are experiencing academic and/or other difficulties, have low educational and career expectations, lack positive role models, and have or perceive that they have no other path to adult status.⁶⁰

This means that among the teenage population, many teenaged mothers are those who are the least equipped for adulthood and parenting and the most likely to perpetuate the challenges that they experienced in childhood in another generation of vulnerable children.⁶¹ Research indicates that teenaged mothers are less inclined to stimulate children's development, less likely to talk to and play with their infants, and more likely to use physical punishment; fathers of children born to teen mothers are more likely to have conduct disorders and to have engaged in criminal activity; and adolescents who engage in early sexual intercourse and who are at the highest risk of becoming teenaged parents are also more likely to use and abuse substances.⁶²

Rates of child abuse are higher among teenaged parents,⁶³ especially when the mother is aged 17 years or younger.⁶⁴ Also, teen pregnancy is often, although not always, associated with health risks for both the mother (e.g., hypertensive disorders, anemia, caesarian section births, post-natal depression) and the child (prematurity, low birth weight, intra-uterine growth retardation, congenital malformations, death in the neonatal, post-neonatal, and infancy periods).⁶⁵

Pregnancy in adolescence increases the risk of lifelong poverty. Most teenage mothers are lone parents, and single mothers overall are about five times more likely than married mothers to live in low income.⁶⁶ Moreover, single mothers who become mothers in adolescence run a higher risk of enduring poverty because they are less likely to get married and to stay married than their older counterparts and, since they had an early start, they tend to have more children than adult first-time mothers.⁶⁷ The younger a woman is when she becomes a parent, the more likely it is that both mother and child will always be poor,⁶⁸ and teenagers who have more than one baby while under the age of 20 may be at highest risk of long-term poverty.⁶⁹

Teenaged parenting is to some extent inter-generational: American data reveal that the daughters of teen mothers are three times more likely to become teen mothers themselves when compared to the daughters of adult mothers;⁷⁰ that teen girls in foster care are two and a half times more likely than their peers not in foster care to experience a pregnancy by age 19;⁷¹ and, although the research is dated, children born to teen parents are more likely than those born to older parents to end up in foster care or have multiple caretakers throughout their childhood.⁷²

Unintended pregnancies are defined as pregnancies that, at the time of conception, are either mistimed (the mother wanted the pregnancy to occur at a later time) or unwanted (mother did not want it to occur at that time or any time in the future).⁷³ As succinctly summarized by U.S. National Campaign to Prevent Teen and Unplanned Pregnancy, “*experiencing a birth or pregnancy that was unintended by the mother, who is most often studied, is associated with an array of negative outcomes, including delayed prenatal care, reduced likelihood of breastfeeding, poorer mental and physical health during childhood, poorer educational and behavioral outcomes of the child, poorer maternal mental health, lower mother-child relationship quality, and an increased risk of the mother experiencing physical violence during pregnancy. There is also some evidence that unintended pregnancy is associated with a greater likelihood of the mother smoking while pregnant and of the child being born at a low birth weight, as well as a greater likelihood of children from unwanted pregnancies being single or divorced when they reach adulthood.*”⁷⁴

Some research has found an association between unintended pregnancy and child abuse, even among adult mothers. For example, in the largest population-based study to date, researchers in the United Kingdom found that children who were registered with a child protection agency by the age of six were nearly three times more likely than others to have been the result of an unintended pregnancy.⁷⁵

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2.4 Marital conflict and domestic (intimate partner) violence

At risk of oversimplification, many studies have shown that inter-parental conflict (without violence) is often associated with poor parenting which is, in turn, associated with children's emotional and behaviour problems. For the most part, this pattern holds for families from a range of ethnocultural backgrounds, for children of both genders from early childhood through adolescence, and for families living in and out of poverty.⁷⁶ However, the relationship between marital conflict and child and youth outcomes is complex, and the effects on children may be buffered or exacerbated by factors such as the parents' own issues (e.g., depression, child-rearing disagreements)⁷⁷ and past and current parenting practices.⁷⁸

The immediate and longer-term consequences for children are far more serious when marital conflict includes intimate partner violence (IPV). Children and youth who witness violence are at increased risk of experiencing emotional, physical and sexual abuse, of developing emotional and behavioral problems, and of increased exposure to other adversities.⁷⁹ However, some children appear to be more resilient than others.⁸⁰ Protective factors that enhance resilience include:

- The absence of child abuse and neglect.
- Having supportive family relationships.

- Particular child and/or parent personality traits.
- Environmental factors such as supportive neighbourhoods and schools.⁸¹

Risk factors that increase the likelihood of poor developmental outcomes include:

- Parental mental illness (including maternal depression⁸²), and/or substance abuse.⁸³
- Lack of household stability and living in a high-crime/low socially-cohesive neighbourhood.⁸⁴
- Parents' unwillingness to acknowledge that their children are adversely affected by exposure to IPV.⁸⁵
- Poor parenting practices and child abuse.⁸⁶

The concurrent incidence of IPV and child maltreatment is well documented in Canada and elsewhere.⁸⁷ As summarized by Wells, *et al.*,⁸⁸ in 46 per cent of all substantiated child maltreatment investigations in Canada in 2008, at least one of the child's primary caregivers was a victim of IPV.⁸⁹ Research suggests that the frequency of child abuse generally seems to increase with the frequency of IPV and generally follows one of three patterns:

- (i) One parent abuses both the other parent and the children (least common).
- (ii) One parent abuses the other parent who then abuses the children.
- (iii) One parent abuses the other parent (or the parents abuse each other) and both parents abuse the children (most common).⁹⁰

Children who are exposed to IPV are at risk of becoming adults who are the victims or perpetrators of violence in their own intimate relationships. As summarized by Wells, *et al.*,⁹¹ in addition to physical harm, "*children who are abused and children who witness the abuse of a parent (which often occur in tandem)*"⁹² are at risk of significant, long-term emotional problems, along with a range of behavioural problems including violence toward others in childhood and adolescence,⁹³ abusive behaviours toward their own children in adulthood,⁹⁴ and abuse of and/or victimization by dating and marriage partners.⁹⁵ Of course, not all children who experience or witness violence develop these propensities, but the risk is high: one of the largest, clearest and most compelling studies conducted to date found that any one of three childhood experiences – physical abuse, sexual abuse or growing up with a battered mother – doubled the risk of domestic violence victimization or perpetration in adulthood. Having all three experiences increased the risk by three-and-a-half times for women and even more for men.⁹⁶

2.5 Parental cognitive impairments (CI) and intellectual disabilities (ID)

Parents with cognitive impairments (CI) are "those who have IQs under 70 and, more commonly, those who were identified as 'borderline,' slow at learning or developmentally delayed at school."⁹⁷ Research does not reveal a clear relationship between parental cognitive impairment and child outcomes, although these findings may be confounded by the high proportion of these children who are taken into custody at some point by child welfare. Canadian figures are not available but about half of parents with CI in the U.S. and in the U.K. do not have custody of their children.⁹⁸ It is widely acknowledged in the research that this may be partially attributable to discrimination against parents with CI.

That being said, parents with CI are over-represented in child abuse investigations in Canada, with neglect as the most common reason for investigation, and the maltreatment reports more frequently substantiated than for other parents.⁹⁹ For many parents with CI, issues other than intellectual challenges may exacerbate or even cause poor parenting practices. A high proportion of parents with CI in Canada investigated for child maltreatment faced one or more of the following challenges:

- Low income.
- Social isolation.
- Mental health issues.
- History of abuse in childhood.

In addition, in nine per cent of cases, their children manifested alcohol-related birth defects, suggesting parental substance abuse.¹⁰⁰ These findings are consistent with small, primarily descriptive studies unrelated to child maltreatment investigations. These studies reported that parents (usually mothers) with CI are much more likely to live in poverty,¹⁰¹ experience mental illness,¹⁰² be highly stressed,¹⁰³ be socially isolated,¹⁰⁴ and to have experienced abuse or neglect in childhood,¹⁰⁵ each of which is related to poor parenting and child abuse.

Recent research is inconclusive about the developmental outcomes of children with parents with CI as compared with parents without CI, controlling for other factors.¹⁰⁶

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A recent Canadian study indicated that, for children of parents with CI, child functioning could be predicted by parental social support and mental health, with parental mental health mediating the relationship between social support and child outcome.¹⁰⁷ This appears to be consistent with older research

showing that “good enough” parenting by parents with CI is related to the amount of support available to parents and their children via social and family networks.¹⁰⁸ At least two small Canadian studies have documented that mothers with CI experience higher levels of stress.¹⁰⁹ One also reported

that mothers with CI experienced poorer physical and mental health and higher levels of stress, with correlations between parenting stress, parenting style, and older child problem behaviours.¹¹⁰

2.6 Chronic low income

Extensive research has documented the negative consequences of growing up in poverty for children, especially during the early years.¹¹¹ In early childhood, the effects appear to be very significant both because the size of the association is largest at this stage and because problems developed early in life can “snowball” into larger problems later in life.¹¹² The 2002 Health Behaviours in School-Aged Children (HBSC) study found clear positive associations between family affluence and important outcomes at all grade levels.¹¹³ Likewise, analysis of data from the National Longitudinal Survey of Children and Youth (NLSCY) found that, contrary to expectations, there appears to be no upper income threshold at which income ceases to matter at any age: “Higher income is almost always associated with better outcomes for children. This is true regardless of the measure of income employed, the assumed functional form of the relationship between income and child outcomes, the age of the child, or the type of child outcome being studied.”¹¹⁴

Low income is clearly related to parents’ ability to meet basic needs, such as food, shelter, transportation and clothing, along with recreational and other forms of programming that are important for healthy youth development. The provision of safe, stable and secure housing is vital to all aspects of child and youth health and development. The quality, cost, tenure, and stability of housing, along with the neighbourhoods and communities in which children live, all play a role in the achievement of desired outcomes in the areas of health, safety, education, and social engagement. For example, low-income families are forced to allocate money that would otherwise be spent on basic necessities toward rent payments that exceed their means.¹¹⁵ Poor housing is usually situated in poor neighbourhoods. Risk factors associated with these neighbourhoods interact with low family socioeconomic status and contribute to unfavourable developmental

outcomes. Inadequate housing, frequent relocation, and financial instability cause parental stress, which can contribute to dysfunctional family relationships. In turn, dysfunctional family relationships can result in domestic violence, separation, and divorce, all of which have been identified to be among the most common reasons for frequent moves and housing disruptions.

It should be stressed that, at all ages, positive parenting, strong and supportive inter-personal relationships, high-quality schools, and other factors, can help to offset the negative consequences of low income and other developmental risks. However, even under the best of circumstances, it is well documented that the ability to parent is significantly weakened by the stresses associated with poverty. Low-income parents have been found to use less effective parenting strategies, including less warmth, harsher discipline, and less stimulating home environments.¹¹⁶ In conjunction with the higher levels of stress experienced by very low-income parents, this contributes to higher rates of child abuse than among higher income families, even when potential biases in reporting are considered.¹¹⁷ In addition, many low-income families demonstrate weak communication skills with either avoidance or difficulty talking about their problems.¹¹⁸

There is some research evidence that socio-economic disadvantage can be perpetuated across generations through poor parenting practices. As reported in one such 12-year longitudinal study, adolescents in low-income families were more likely to become young parents, these younger parents were more likely to use harsh parenting practices with their young children, who were then more likely to exhibit behavioural problems, which increased the likelihood of harsh parenting practices, and subsequently increased the likelihood of children’s ongoing or increased behavioural problems, which were predicted to exacerbate the longitudinal effects of the

socio-economic disadvantage.¹¹⁹ A recent 30-year Canadian study found that childhood aggression directly predicted early parenting for both mothers and fathers and high school drop-out for the fathers, indirectly predicting family poverty.¹²⁰

Limited access to basic resources, unstable environments, inter-spousal conflict, and economic strain are factors that individually and collectively threaten healthy family functioning.¹²¹ Research suggests that economic pressures first affect the emotional lives and marital interactions of parents and then diffuse into the caretaking environment of the children.¹²² However, analysis of NLSCY data showed that both family dysfunction and maternal depression are linked with income but, unexpectedly, the negative effects on children in families with these three characteristics had disappeared by early adolescence. In addition, contrary to the findings of many other studies, the NLSCY data showed no relationship between low income and punitive parenting practices.¹²³

Increased parenting skills are associated with improvements in the parents’ economic self-sufficiency.¹²⁴ As noted by Boots and colleagues, “[l]ow-income working parents struggle with the same challenges other working parents do but have far fewer resources, more vulnerabilities and less flexible jobs. For example, for low-income working families, shift work and changing schedules make it harder to stabilize meal and bedtime routines. Lack of paid leave challenges parents to make and keep their children’s regular doctor or dental visits. Similarly, lack of workplace flexibility can keep parents from attending school events regularly and having more than perfunctory conversations with their children.”¹²⁵ It should be noted that simply increasing parental employment in low-wage, insecure jobs with few or no benefits can undermine, rather than support, positive parenting and family functioning.¹²⁶

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2.7 Social isolation

Socially-isolated parents are more likely to use poor parenting practices. This is not to say, of course, that all isolated parents are at risk of poor parenting or child abuse. However, parents without supportive networks of relatives and friends are more likely to maltreat or neglect their children.¹²⁷

Social isolation is more common among low-income families,¹²⁸ families headed by young, single mothers, and families with a child or parent with a disability,¹²⁹ and reduced social support restricts the ability of family and community to offset the direct effects of poverty.¹³⁰ Low-income and at-risk families “living in the context of unemployment, poor housing, unsafe neighbourhoods, and so forth lack the informal social supports of family and friends to help them manage the acute stressors they face daily.”¹³¹ Some research indicates that at-risk families identify external services, such as voluntary associations, neighbours, police and, sometimes, social services as sources of social support.¹³²

Extensive research reveals that social support networks can buffer the debilitating effects of poverty.¹³³ Families experiencing stress can avoid some family crises if they have (i) formal and informal social networks, and (ii) the ability to positively reframe perceptions of stresses so that they feel that they are not the only ones struggling with these stresses and have increased hope and feelings of power to improve life circumstances.¹³⁴

Scores of studies have investigated the ways in which socially-isolated families can benefit from positive social ties and strengthened social support systems,¹³⁵ and an extensive body of research documents the benefits of both informal and formal community supports.¹³⁶ Much of the research on social support has focused on low-income immigrant, single, young and new mothers. All parents (and all individuals) benefit from positive social support systems; for low-income, isolated families, quality support systems can improve positive parenting skills, family functioning and child outcomes.¹³⁷

Recent research indicates that, for low-income parents, lower levels of social support are associated with higher levels of parental stress which, in turn, is related to ineffective parenting and children’s behavioural and developmental problems.¹³⁸ Social support helps to alleviate parental stress in part through emotional support and assistance with childcare,¹³⁹ and, for low-income mothers, moderates the indirect relationship between low family income and parenting.¹⁴⁰ Social support can also moderate depression among teenaged mothers¹⁴¹ and can prevent or buffer postpartum depression. One recent study found that being able to call on two or more friends or family members was associated with significantly lower levels of depression among new African American, Hispanic, and white mothers in the U.S.;¹⁴² another reported that social support moderated the effects of stress on depressive symptoms among new Chinese mothers in the U.S.¹⁴³

3. What works to prevent poor parenting and strengthen families

As noted in the introduction to this research brief, strong families are those in which family members get along and communicate well, follow routines, share tasks, enjoy time together, enjoy a positive outlook, and have a support network, and where parents use positive parenting skills.¹⁴⁴ “Positive parenting” means expressing love and affection; being a good provider and household manager; setting and enforcing rules consistently and in specific ways; offering stimulating experiences and

materials; modeling good values, attitudes, and behaviours; establishing positive links with school and community; and following daily routines.¹⁴⁵

This section of the brief describes programs and interventions that have been identified by research as effective in preventing or ameliorating the risk factors for family instability and poor parenting.

Research indicates that the most effective ways to strengthen families and prevent

poor parenting practices are by preventing teenage pregnancy and IPV in the first place, and through evidence-based home visitation and parenting training programs, parental and family social support initiatives, and poverty reduction strategies. Teenage pregnancy prevention, IPV prevention, and parenting supports are discussed below. Information on poverty prevention and reduction schemes is provided in Research Brief entitled: *Individual and family economic self-sufficiency*.

3.1 Preventing teenage pregnancy

Studies indicate that programming and interventions, most notably access to contraceptives and sexuality education, particularly in concert, are effective in preventing unintended teenage pregnancy for many, and probably the majority of, adolescent girls and women.¹⁴⁶

It should be noted, however, that for some at-risk youth this is insufficient. As summarized by Harden, et al., “young people who have grown up unhappy, in poor material circumstances, do not enjoy school, and are despondent about their future may be more likely to take risks when

having sex or to choose to have a baby.”¹⁴⁷ More comprehensive strategies are required to address the family, social, economic, and developmental antecedents of early parenting.

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3.1.1 Social and emotional well-being, positive peer and family relationships

Four factors have been found to reduce sexual risk-taking activity among youth:

1. Parental disapproval and a close relationship between the parent and the youth.
2. For girls, positive emotional development, particularly high self-esteem and “planfulness” (future orientation with realistic plan to achieve goals).
3. School attachment and success.
4. Positive peer associations;¹⁴⁸ i.e., having friends with good grades and who engage in few risky behaviours is associated with reduced likelihood of teen pregnancy.¹⁴⁹

Meta-analysis of data from comprehensive, longitudinal evaluations have shown that the following programs reduced teenage pregnancy rates:

- Highly intensive long-term early childhood interventions (the Perry Preschool Program, the Abecedarian Project, and the Seattle Social Development Project).
- Comprehensive, intensive youth development programs that target self-esteem, positive aspirations, and a sense of purpose through educational support, life skill development, and other youth activities (Teen Outreach, the Quantum Opportunities Program).

- One Sexuality Education program (the Children’s Aid Society Carrera Model Program).

A few stand-alone programs show promise in improving parenting efficacy with respect to their adolescent children’s sexual behaviours and enhancing adolescents’ ability to resist pressure to engage in unwanted sexual activity. One study found that including parent-child discussions and active role playing, where resistance skills were practised, increased program effectiveness.¹⁵⁰

3.1.2 Use of contraceptives

Characteristics associated with improved contraceptive use or consistency among teens include:

- Being older at the first sexual experience in the relationship.
- Being involved in a romantic versus a casual relationship.
- Experiencing a higher level of emotional intimacy in the relationship.
- Discussing contraception before having sex for the first time.
- Having a partner with whom one has much in common.

In addition, teens who used contraception consistently in past relationships are found to be more likely to continue to use contraception consistently in current and future relationships.¹⁵¹

Not surprisingly, access to free, confidential reproductive health services increases use of contraceptives.¹⁵² For example, early evaluation of the recently-implemented Effectiveness of Care demonstration projects in the U.S., which serve pregnant and parenting adolescents, has found increased use of contraception among participants, relative to a control group.¹⁵³

Research indicates that women with disabilities face “structural, attitudinal and informational” barriers to obtaining contraception.¹⁵⁴ According to the U.S. National Organization of Women’s Disability Rights Advisory Committee, methods of contraception promoted for women with disabilities focus on long-term options such as IUDs and Depo-Provera shots, rather than birth control pills and condoms. This may place them at heightened risk of health problems and contracting STIs.¹⁵⁵

3.1.3 Sexuality education

Research shows that sexual education is associated with lower teen pregnancy rates. For example, in a large U.S. study of 15 to 19 year-olds, youth who received comprehensive sexuality education were significantly less likely to report teen pregnancy than those who received no formal sex education or those who received abstinence-only education.¹⁵⁶ Countries where mandatory and comprehensive programs are provided boast significantly lower rates of teen pregnancy (e.g., the Netherlands, at 3.8 per 1,000 women aged 15 to 19 in 2006) than those in which programs are abstinence-based and parents can exempt their children from participation (e.g., the U.S., at 41.9).¹⁵⁷

This does not mean that all sexual education programs are effective, however. High-quality evaluations of curriculum-based programs reveal that some programs have no effect, some reduce sexual activity and/or increase the use of condoms or other contraceptives or both, and a few have been proven to prevent pregnancy and childbearing. The lack of clarity may be simply because of the small number of studies that include both longitudinal follow-up and a large number of participants.

The least effective programs are abstinence-based. In fact, there is no evidence that abstinence-only prevention programs delay the initiation of sexual activity or reduce teen pregnancy,¹⁵⁸ and they appear to have

negative impacts on adolescents’ willingness to use contraception, including condoms.¹⁵⁹ Rather, what works are comprehensive risk reduction programs that:¹⁶⁰

- (i) Focus on clear goals (e.g., prevention of STIs and/or pregnancy).
- (ii) Focus on specific behaviours leading to those goals (e.g., using condoms), with clear messages about these behaviours and how to avoid situations that might lead to them.
- (iii) Address risk and protective factors affecting sexual behaviour (e.g., perceived risks, self-efficacy).

To be effective, programs must include behavioural training provided through

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personal interaction between a facilitator/instructor and a group of adolescents, regardless of the setting in which they are delivered.¹⁶¹

In community-based programs for at-risk adolescents, a high dose (hours and duration) of programming may be required to change behaviours. In one effective program, teens attending an STI clinic met individually with counselors for five weekly sessions of 60 to 90 minutes. The individual sessions included three components, which were designed to prompt a decision to reduce risky sexual behaviour and set a safer-sex goal, increase social skills in handling difficult sexual situations, and increase willingness to experience unpleasant reactions to changes in behavior. In a strong randomized trial that measured impact over six months, the program reduced the number of partners, reduced the number of non-monogamous partners, reduced the number of sexual contacts with strangers, reduced the frequency of sex, and reduced the use of marijuana before or during sex.¹⁶² Another study found that adolescent girls at risk of pregnancy who received a combination of case management and peer leadership programming in addition to regular health services at a clinic over 12 months reported significantly fewer sexual partners and,

at 18 months, more consistent use of contraceptives than the control group, who received health services only.¹⁶³

The “key ingredients” of behaviourally-effective sexual health education programming are provided in: Sex Information and Education Council of Canada (SIECCAN). 2009. *Sexual Health Education in the Schools: Questions & Answers*. (3rd Ed.) (Toronto, ON: SIECCAN). Available at www.sieccan.org/pdf/she_q&a_3rd.pdf.

The Public Health Agency of Canada’s 2008 Guidelines for Sexual Health. Available at www.phac-aspc.gc.ca/publicat/cgshe-ldnemss/pdf/guidelines-eng.pdf.

Additional considerations for persons with intellectual disabilities

There is very little current research on effective sexuality education for youth or adults with disabilities. What does exist focuses on persons with intellectual disabilities, and much of it is so dated that it has little application in the 21st century. It appears to be generally agreed that people with intellectual disabilities often do not receive the information they need regarding sexuality,¹⁶⁴ possibly because some parents, health professionals, teachers, and members of society in general are not comfortable with

the idea of sexual expression by persons with intellectual disabilities and because some are unable to present difficult concepts in ways that people with these disabilities may understand.¹⁶⁵ Some may also be concerned about capacity to consent to sexual activity.¹⁶⁶

Specific sexuality education curricula for persons with intellectual disabilities are scarce;¹⁶⁷ in fact, many resources from the U.S. are no longer available. There appear to be no quality evaluations of any curricula or programs. Clearly, both the materials and delivery methods and pacing must be adapted to the needs of participants.¹⁶⁸

Summarizing other research, Jones, *et al.*, state that “[i]nformation should appeal to various learning styles, including auditory, visual and experiential materials. Youth with disabilities may have difficulty generalizing information to various settings, so providing teachable moment opportunities for real life relationships will assist in giving context to information about sexuality and reproductive health.”¹⁶⁹

Curricula should be broad-based, including human anatomy, contraception, sexually transmitted diseases, decision-making, and future goal setting, all of which are important issues for youth with disabilities.¹⁷⁰

3.2 Preventing intimate partner violence (IPV)

Prevention of IPV is a complex issue that cannot be fully addressed in this brief. A recent research paper by Wells, *et al.*, observes that prevention efforts must start with children, youth, and young adults and delineates strategies for the prevention of IPV. These include prohibiting corporal

punishment, preventing unplanned and teenage pregnancies, improving the parenting skills of at-risk parents, and improving young people’s healthy relationship skills.

For more detailed information about preventing IPV, see Wells, L.; Dozois, E.;

Cooper, M. 2012. *How Public Policy and Legislation Can Support the Prevention of Domestic Violence in Alberta*. (Calgary, AB: Brenda Stafford Chair in the Prevention of Domestic Violence, University of Calgary).

3.3 Improving parenting practices

3.3.1 Home visitation programs

Home visitation is a community-based strategy for delivering services that aims to improve outcomes for high-risk families through education and support. “Home visitation” refers to comprehensive, stand-alone programs or to occasional, semi-structured visits to the homes of program participants to supplement other programming.

Home visitation programs most frequently target high-risk families from conception to age three. The chief objective of home visitation is to improve child development outcomes by improving parenting practices and the parent-child relationship. Along with assessing aspects of child development, evaluations of home visitation programs often

focus on specific dimensions of parenting behaviour, parenting self-efficacy, and maternal depression. These all tend to be high for mothers in at-risk families. Most recently, home visitation has been identified as a viable means to reduce intimate partner violence for the benefit of both children and parents.¹⁷¹ Demonstration projects based

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on an enhanced version of the Nurse Family Partnership program are underway in the Netherlands, Germany, England, Australia, and four Canadian provinces.¹⁷² Policy researchers in many countries including Canada have called for closer fidelity to evidence-based home visitation models and embedding domestic violence training and screening protocols into all programs.¹⁷³

Home visitation programs have been offered for more than 60 years but the evidence of their effectiveness in improving child developmental outcomes is still not entirely conclusive. The strong reputation these programs enjoy rests largely on the incontrovertible success of the highly-intensive Nurse Family Partnership program. However, rigorous, longitudinal evaluations of some large, multi-billion dollar programs in the United States, such as Healthy Families America and the Comprehensive Child Development Program have found no effects, limited effects, or effects that were not sustained over time.¹⁷⁴ In general, the research suggests that the more rigorous the evaluation, the fewer benefits home visitation programs demonstrate.¹⁷⁵ With a few notable exceptions, most evaluations suggest that, at best, many home visitation programs may be insufficient on their own to offset the severe and multiple risks faced by children in highly at-risk families.

Segal, et al., recently noted that: *“despite decades of experience with program delivery, more than 60 published controlled trials, and more than 30 published literature reviews, there is still uncertainty surrounding the performance of these programs... For neonate/infant home-visiting programs, it means that in developing these programs, attention to consistency of objectives, theory of change, target population, and program components is critical.”*¹⁷⁶

Home visitation programs for teenaged mothers

It should be noted from the outset that there is a dearth of rigorously evaluated programs for adolescent parents and their children.¹⁷⁷

Many evaluations of home visitation programs for teenaged mothers identify positive outcomes for the mothers in areas such as parenting attitudes. However, most of these evaluations have not measured immediate or longer-term effects on parenting behaviours. For example, in a program targeting teenaged mothers at risk for child maltreatment, control group participants attended monthly peer group meetings; intervention group participants attended peer group meetings and received home visits and case management services. Mothers receiving full services improved on three dimensions of parenting and were significantly less at risk of child maltreatment than mothers in the control group. However, the mothers have not yet been followed longitudinally to determine whether these changes were sustained over time.¹⁷⁸

More rigorous research on intensive home visitation programs targeting teenage mothers have demonstrated positive impacts on infant health in the first weeks of life but mixed results with respect to parenting practices, school continuation, depression, drug and alcohol use, and delaying or reducing second pregnancies.¹⁷⁹ For example, one intensive program targeting low-income, pregnant, predominantly African-American adolescents in the U.S. used trained home visitors recruited from local communities to provide home visits from the prenatal period through the child's second birthday. Relative to the control group, mothers' parenting skills improved significantly in some domains and they were more likely to continue high school, but the program had no impact on second pregnancies or maternal depression.¹⁸⁰

Home visitation/home-based supports for mothers with intellectual disabilities

It is now generally agreed that parenting programs for parents with intellectual disabilities should be delivered in a home setting using concrete, sequenced, competency-based teaching methods that include role modeling and opportunities to practice skills, along with discussions.¹⁸¹ A

very small body of research supports this belief. A recent evaluation of a nurse home visitation program that included a small number of mothers with an intellectual disabilities revealed positive outcomes in a range of domains, including some parenting domains, for both the study group and the comparison group of mothers without intellectual disabilities. Although the changes were larger for control group of mothers without intellectual disabilities, they were also significant for mothers with intellectual disabilities.¹⁸²

A small but comprehensive outcome evaluation of an Australian home-based parent training program for parents with intellectual disabilities showed mixed results. In this program, parents were invited to participate in three training modules – child care and the home environment, parent-child interaction, and positive behavioural strategies. The program provides in 90-minute visits, weekly over six months, although the average number of sessions across families was 12 and only 19 families completed the program. The program resulted in sustained improvements in the quality of the home environment for families with children aged three to six years and children's behaviour, but there was no significant change in parent sense of competence or quality of the home environment for younger or older children. Parenting behaviours were not measured in the evaluation. The researchers speculated that the limited impact of the program may have been due to insufficient program strength, duration or focus, or that the skills learned by parents needed to be implemented over a longer period.¹⁸³

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3.3.2 Parent education/training programs

A wealth of studies completed in recent years have consistently demonstrated improvements in parenting practices and children's developmental outcomes resulting from participation in comprehensive parenting training programs.¹⁸⁴ Some of these programs¹⁸⁵ have been effective with members from a range of diverse populations (at least those minority populations who live in the U.S.). However, more research is needed to develop clear guidance about when and how programs should be culturally adapted while retaining fidelity to an evidence-based model.¹⁸⁶ Parents with the most risk factors for poor parenting practices may be the least amenable to change.

Summarizing the research, Mildon, et al., note that: *“research with parents who do not have an intellectual disability and whose children demonstrate problem behaviour repeatedly shows that parents who benefit the least from parent training, particularly behavioural parent training, often struggle with one or more of the following issues: poverty, low socioeconomic status, limited social support, high stress and depression.”*¹⁸⁷

This is not to say that particular groups of parents do not benefit from parent training; it means that the training must be comprehensive and tailored to their needs.

Drawing on the research on parenting programs targeting fathers, effective parenting programs:¹⁸⁸

- Are grounded in a clear theory of change based upon solid theories of child development and therapeutic support.
- Use an evidence-based program model with a proven track record of improving outcomes for parents and children, and implement the model with fidelity (i.e., make no changes to the content, structure, or delivery methods of the program).
- In most cases, use behavioural or cognitive behavioural training strategies.
- Promote authoritative parenting, which includes positive discipline skills.

Specific components of parenting programs that are consistently associated with improvements in parenting include:

- Increasing positive parent-child interactions and emotional communication skills.
- Teaching parents to use time out and the importance of parenting consistency.
- Requiring parents to practice new skills with their children during parent training sessions.¹⁸⁹

Programs that focus on (i) teaching parents problem solving; (ii) teaching parents to promote children's cognitive, academic, or social skills; and, (iii) providing other, additional services, are less effective or ineffective in changing parenting behaviours.¹⁹⁰

In addition, although research has yet to quantify a precise “dose” (frequency, amount, and duration) of program participation required to effect change, it is clear that, for at-risk parents and families, more participation leads to better outcomes. For example, a recent study of the Nurturing Parenting Program, found that, after six months of participation, parents who attended more sessions were significantly less likely to be reported for child maltreatment, holding other factors constant. In repeated, quasi-experimental evaluations, this program has been demonstrated to be effective in improving parenting behaviours and reducing child abuse and neglect.¹⁹¹ At two years' post-participation, parents who had attended more sessions were significantly less likely to have a substantiated maltreatment incident, controlling for other characteristics of families associated with maltreatment.¹⁹²

Effective parent training programs typically include eight to 10, 1.5 to two hour sessions, with more sessions provided in programs targeting parents at risk of child maltreatment. Systematic Training for Effective Parents (STEP)¹⁹³ and Triple P Level 4 (Standard Level P)¹⁹⁴ are examples of such programs. Triple P Level 1, a universal media-based information strategy, on the other hand, seems to have little or no effect. Nor does the abbreviated form of the otherwise effective Parent-Child Interaction Therapy program.¹⁹⁵ In addition, a recent large Alberta based, quasi-experimental evaluation of Triple P Level 2* reported high levels of parent satisfaction

with the program, but found no significant differences between Triple P Level 2 and ‘service-as-usual’ groups on parenting stress, parent-child interaction, family functioning, child problem behaviours, or any other secondary outcomes.¹⁹⁶

Parent training for parents with intellectual disabilities

A 2010 Cochrane review identified three small, experimentally-designed evaluations of parent training programs for parents with intellectual disabilities. The three evaluations suggested that parents with intellectual disabilities can benefit in some ways from group parent training. One study reported improved mother-child interaction. The second reported improvements in parents' ability to avoid and respond to life threatening emergencies. The third reported improvements in parents' child care and safety skills.¹⁹⁷ A small experimental evaluation of group training for parents with borderline or mild intellectual disabilities, which was not included in the Cochrane review, reported that a group parenting intervention supplemented with in-home training resulted in positive social and practical changes for parents and families. It did not improve parent-child interaction or parents' expectations of their children.¹⁹⁸ All of the parent training strategies were behavioural and included role modeling, opportunities for practice, and discussion. At this point it is not possible to identify effective elements of programming with certainty.

Parent training for parents of children with disabilities

Although many parents of children with developmental disabilities, including intellectual disabilities, cope very well with parenting,¹⁹⁹ some may need special skills to:

- (i) Assist children as required with social skills development,²⁰⁰ motor skills development,²⁰¹ learning issues, emotional challenges and psychopathology²⁰² and behavioural problems.²⁰³
- (ii) Manage the high levels of stress and anxiety that are experienced by some parents of children with disabilities, which, as discussed earlier, can lead to poor parenting practices.

*Triple P Level 2 (Selected Triple P) provides information on how to solve common child development issues (e.g., toilet training) and is delivered in one or two brief face-to-face consultations. Triple P Level 3 (Primary Care Triple P) targets children with mild to moderate behaviour difficulties, such as tantrums and fighting among sibling, and is typically delivered in four brief face-to-face consultations.

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There is strong evidence to support the effectiveness of some types of individual and group parent training most notably the training that focuses on children aged zero to six years, and uses applied behavioural analysis and behaviour therapy models. Matson notes that, “without remediation, social skills deficits, challenging behaviours, and co-occurring psychopathology, which are common in this population, are likely to persist.”²⁰⁴

In a meta-analysis of the research on group interventions for parents of children with developmental disabilities, Singer, et al., concluded that stress management approaches based on behavioural parent training (e.g., adapted Incredible Years Parent Training Series) and cognitive behavioural training (directly aimed at parents to learn stress-reduction skills) were effective in helping parents to manage stress and distress, particularly depression. The most effective training incorporated both approaches however. The researchers stress that virtually all of the research has focused on middle-class, Caucasian mothers, so the findings cannot be generalized to all parents of children with developmental disabilities.²⁰⁵

Research also shows that evidence-based parent training programs delivered to groups typically comprise five to seven parents result in improved child functioning and behavior via sustained improvements in parenting skills and parent well-being. For example, one outcome and one experimental evaluation of the Incredible Years program, adapted for parents of children with developmental delays, reported that the program resulted in decreased negative parenting behaviours, negative parent-child interactions, and challenging behaviours on the part of the child.²⁰⁶ Likewise, quasi-experimental evaluation of an adapted version of the Parent Plus Program (Triple P) resulted in sustained improvements in behaviour for half of the children in the treatment group.²⁰⁷ There appears to be very limited research on the effectiveness

of individual parent training. Matson reports that at least one study has shown it to be effective, but no more effective and considerably more expensive than group training.²⁰⁸

Parent training for fathers

The following information has been reproduced from Cooper and Wells.²⁰⁹

Despite the proliferation of positive fathering programs in recent years, only a handful of programs can be identified as evidence-based. An additional few programs have been evaluated using pre- and post-program assessment, but most of these evaluations have not included post-program follow-up to determine whether positive outcomes are sustained over time. Experimental evaluations of parenting programs targeting parents of both genders have shown that behavioural parent training can be effective for both mothers and fathers.

Examples of parenting programs that improved fathers' parenting include the Triple P - Positive Parenting Program and the Incredible Years Program.²¹⁰ Two evaluations have concluded that Triple P, with the exception of the Stepping Stones program, has a smaller effect on fathers' parenting practices than it does on those of mothers.²¹¹ However, most of the father involvement interventions that have emerged in recent years involve men's participation in programs led by male speakers, counselors, or group leaders, and these programs do not appear to have been evaluated.

The small body of existing high-quality research indicates that some features of programs for fathers contribute to positive outcomes. In addition to those features identified earlier as crucial features of parenting programs overall, the research indicates that successful fathering programs clearly target and recruit a specific group (e.g., young fathers, new fathers, at-risk fathers, fathers who have perpetrated IPV, fathers who have perpetrated child

maltreatment; fathers from specific ethnic-cultural groups); use behavioural or cognitive behavioural training strategies; and, promote good communication with the mother and effective co-parenting strategies.²¹²

The empirical research also suggests that positive fathering programs may be more effective if they fully or partially include mothers because the quality of the mother-father relationship strongly affects a father's willingness and ability to be involved with his children.²¹³ The need to involve mothers in programming targeting young or adolescent fathers²¹⁴ is particularly clear. This is because, according to some research, fathers are sometimes excluded by grandmothers who are involved in raising their daughters' children,²¹⁵ and because evaluations of some programs for teen fathers that did not include mothers reported a decrease in father involvement after the intervention.²¹⁶ The need to involve mothers in some capacity also applies to programs targeting fathers who have perpetrated IPV in that, while mothers may not attend the program along with the fathers, they may be engaged in separate support services and, at minimum, in the evaluation of the program.²¹⁷

What does not appear to be effective are services and programs that aim to “hook” fathers into family services by involving them in activities that they may like but are not linked to improved child outcomes. Father-child sports programs or “bring your dad to school” events fall into this category. While participants appreciate and enjoy these sorts of initiatives, they are not likely to improve child outcomes. In addition, often the majority of fathers who attend them are already highly involved in their children's lives.²¹⁸ The effectiveness of informal group programs, where fathers meet up to three or four times a month and receive information on parenting, co-parenting, and so on, is unclear, but these kinds of programs do not usually include the features associated with effective programs.

Positive parenting and family functioning

3.3 Strengthening social supports

Studies conducted over the past two decades indicate that both structured parenting and support groups and the development of personal networks can increase social support and may result in modest improvements in parenting behaviour.²¹⁹ It is not clear that all social support initiatives produce these benefits, or that the outcomes endure over time, however. For example, a Canadian study of a community-based support group for single mothers resulted in improved mood and self-esteem but had no impact on social support or parenting at the conclusion of the group. Also, any benefits had disappeared at three- and six-months follow-up.²²⁰ However, a follow-up study with a sample of the same group of participants suggested that the group's impacts on social support may have been too subtle to capture using standardized instruments.²²¹ Unfortunately, research has yet to clarify which participant and intervention factors contribute to positive outcomes.²²² There is some indication that the cohesion of the group itself may be related to both maternal well-being and parenting outcomes.²²³

Evaluations of lay social support interventions, in which “mentor mothers” are recruited and trained to provide one-on-one social support to other isolated mothers have produced limited results, but still offer some promise. For example, the MOSAIC (MOtherS' Advocates in the Community) project in Australia targeted English- and Vietnamese-speaking pregnant or parenting women at risk of or experiencing IPV. The project provided them with up to 12 months' support from trained and supported non-professional mothers. At 12 months' follow-up, the study found that mean abuse

scores were lower in the intervention group than in the comparison group. The program had limited effect on maternal depression, physical well-being, mental well-being, and social support, and no effect on parenting stress, however.²²⁴

A second Australian program using lay volunteers that focused exclusively on helping mothers to make friends in their own communities did not increase the likelihood of women making new friends or reducing women's sense of social isolation, despite participants' positive feedback about the program. The researchers speculated that the universal nature of the program failed to reach the most vulnerable groups of women or that the “dose” of befriending experienced was not sufficient to impact on friendships or depression.²²⁵

Overall, social support interventions may indirectly contribute to improved parenting practices but are probably insufficient to effect improvements on their own. As summarized by Balaji, et al., “[u]ltimately, combining treatment approaches intended to reduce or prevent mental health problems, expand social networks, and enhance mothers' knowledge of child development may be more effective than any single approach. Joining treatment modalities into one intervention offers a comprehensive model for addressing multiple problems.”²²⁶

Social support and mothers with intellectual disabilities

Challenges such as difficulties recruiting large numbers of study participants, matching the characteristics of study and control group members, and finding psychosocial instruments that are suitable for use by persons with intellectual disabilities have

limited the research on support interventions associated with improved parenting by mothers with intellectual disabilities.²²⁷ With these caveats in mind, extensive qualitative research and at least one quantitative study²²⁸ supports an association between social supports for mothers with intellectual disabilities and parenting skills, with some evidence that maternal psychological well-being is the linking factor. However, there appears to be no useful research on what kind of support interventions are associated with improved parenting by mothers with intellectual disabilities.²²⁹

Social support for families with a child with a disability

Some qualitative research indicates that support groups can improve the use of adaptive coping strategies by parents of children with autism spectrum disorder, although the benefits may only last during the period of participation in the group.²³⁰ At least one comprehensive study²³¹ and one qualitative study,²³² completed in 1999 and 1998, reported positive outcomes from a peer support group program. Although these appear to be the only two studies evaluating parent support groups in this context, one recent study concluded that parent-to-parent support groups could be a valuable resource to facilitate sharing of issues related to caring for an infant or child with a birth “defect.”²³³ Although most studies do not use an experimental or quasi-experimental design, other research certainly indicates that support from partners, friends, and extended family is associated with the emotional well-being and parenting of mothers of children with a range of disabilities.²³⁴

In this document:

- “Evidence-based” means that a program or practice has been tested in a well-designed and methodologically sound experimental (randomized controlled trial (RCT)) or quasi-experimental study (and, ideally, multiple studies and replicated in more than one site), and has been shown to produce significant reductions in poor outcomes or associated risk factors or significant increases in positive outcomes or associated protective factors.
- “Best practices” refer to programs or components of programs or delivery methods that have been identified as effective (i.e., produce significant

reductions in poor outcomes or associated risk factors or significant increases in positive outcomes or associated protective factors) by repeated methodologically sound studies using an experimental (RCT) or quasi-experimental design.

- “Promising practices” refer to programs or components of programs or delivery methods that have been identified as effective (“effective” as defined above) in at least one well-designed and methodologically sound study using at least a pre-post design with a large sample of participants that has been subject to peer review.

- “Prevention” means creating conditions or personal attributes that strengthen the healthy development, well-being, and safety of individuals across the lifespan and/or communities, and prevent the onset or further development of problems in each of these domains. In the research-based risk and protection prevention paradigm, prevention occurs by reducing risk factors and increasing protective factors.

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