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The Importance of Parenting Support in Child Psychiatry Outpatient Care: Actual Practice in Aiiku Clinic, Maternal and Child Health Center

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Abstract

Caregivers of children with developmental disorders tend to have strong emotional stress and higher rates of depression. Since developmental disorders often need various supports for a long period of time, parental supports from mental health professionals are important for the children's development.

Parenting support includes psychoeducation of the disorder itself and behavioral management techniques, along with supportive help and empathy. The main purpose of parenting support is to help parents understand their child's characteristics and needs and also to decrease the difficulties dealing with problematic behaviors.

The Department of Child and Adolescent Mental Health is a child psychiatry outpatient unit within Aiiku Clinic. This division opened in 2013 and specializes on children from 3 to 12yo at first visit. Most children are diagnosed as F9 or F8 category in ICD-10 and two-thirds of the children are diagnosed as a developmental disorder at their first visit. We deliver multiple parenting support programs; Circle of Security-Parenting (COS-P), Parent Training, Parent-Child Interaction Therapy (PCIT), Child Adult Relationship Enhancement (CARE). Mothers are often the main participants, but fathers' participations are increasing.

Fathers' participations in parenting programs are often linked to healthier outcomes of their children. In our Clinic, we have found that when both parents participate, they were able to share the same perspective and consistently interact with their child. This has contributed to a decrease in their child's problematic behaviors. In future, it would be helpful to identify which families might gain most benefit from these programs and also to find ways to help working caregivers to participate.

Keywords: developmental disorders, parenting support, parenting skill, CARE (Child Adult Relationship Enhancement)

Introduction

Parenting a child who requires child psychiatric care is generally psychologically stressful and places a heavy burden on the caregivers. In child psychiatry outpatient clinics, there is a marked need to provide not only medical care for children but also support for their caregivers, and such support can improve the children's prognosis. We would like to outline the characteristics of children who visit the Aiiku Clinic (hereafter referred to as "our clinic"), the actual parenting support provided at our clinic, and briefly describe our experience of changes in the children of caregivers who have participated in our parenting program.

I. Parenting Support in Child Psychiatry Clinical Practice

Stress factors for caregivers of children who requires child psychiatric care include various psychological, physical, and financial burdens, such as dealing with the child's behavioral problems, dealing with problems at school and in the educational environment, the burden of the child's commuting to and from the clinic, anxiety about the child's future, and feelings of self-blame. Factors reported to increase stress include the child's high level of destructive problems, long duration of problematic behaviors 2), and low social or developmental index 1). These are all characteristics frequently observed in children with developmental disorders. There is concern that increased psychological stress on caregivers may affect their interactions with the child and exacerbate the child's problematic behavior. Therefore, the inclusion of parenting support in child psychiatric practice, especially in the treatment of developmental disorders, is considered very important for improving the

children's prognosis.

In parenting support for children with developmental disorders, it is important to: (1) to increase the caregiver's responsiveness by helping the caregiver to understand the characteristics of the child and be able to interpret the child's behavior, (2) help the caregiver to respond consistently and clearly to increase the child's predictability, and (3) provide support according to the caregiver's own characteristics and the level of acceptance of their child's illness. To achieve this, psychoeducation on developmental disorders, behavior management through behavioral therapy, and psychoeducation on emotional control skills for caregivers are often conducted. Some of these components are packaged as psychological programs, but they are also routinely provided in the outpatient care. Providing such information, as well as empathy for the psychological distress and anxiety felt by the caregivers and sufficient encouragement by the therapists, is expected to reduce the stress of the caregivers themselves and promote acceptance of the children's illnesses.

Although most outpatient caregiver support is provided only to mothers, a growing body of research indicates that fathers' participation in programs designed to support parenting has a positive impact on children's development. It has been reported that fathers' protective and positive involvement with their children correlates with improved academic, behavioral, and psychological outcomes 3). This effect has been shown to continue through infancy, school age, adolescence, and adulthood. In addition, fathers' participation in parenting support programs is expected to improve the mental health of caregivers, improve the marital relationship, improve the relationship between father and child and between mother and child, and balance stressors and social support for the family as a whole 7). Such a pattern of caregiver-child relationships can be passed on to the next generation.

II. Characteristics of Children Visiting Our Outpatient Clinic

The following is an overview of the characteristics of our clinic. It is located in Minato-ku, Tokyo, and focuses on perinatal care. In collaboration with Aiiku Hospital, which has 160 beds, our clinic provides pre- and postnatal care, as well as medical and health care for children. The Department of Child and Adolescent Mental Health opened in 2013 and specializes in treating children from 3 to 12 years old at their first visit. In addition to children delivered at our clinic or hospital, more than half of the children visit our clinic for the first time at their initial visit to

our department. The range of patients is not limited to Tokyo, but also covers Saitama, Chiba, and Kanagawa Prefectures. From April 2013 to December 2017, 1,025 children aged 15 years or younger (695 boys and 330 girls) made their first visit to our clinic, with a male-to-female ratio of approximately 2:1, showing a male predominance, and a mean age of 7.8 years. The age distribution chart and initial diagnosis according to ICD -10 classification 14) are shown in Figures 1 and 2, respectively. The main diagnoses were F9, F8, and F4, in that order, and about two-thirds of the children were diagnosed with developmental disorders. Table 1 shows the proportion of boys in each category, mean age, and comorbidity rate with other F9 or F8 categories. Those who visited our clinic were characterized by a relatively high number of children with intelligence quotients in the normal range and level of developmental disabilities being mild, probably because the we see outpatients at the age of 3 years or above.

III. Parenting Support Program Implemented at Our Clinic

Some of the parenting support programs offered at our clinic are provided as part of outpatient care, while others based on evidence are provided in collaboration with the Aiiku Counselling Office, which is a psychological clinical center attached to our clinic (Table 2). The contents of each program are as follows. Selection of the program was determined by the physician in charge based on the characteristics of the children and caregivers and the requests of the caregivers, and a licensed psychologist/physician qualified for the program conducted the program.

1. Circle of Security-Parenting (COS-P) Program

While the following three programs are based on behavioral theory, COS-P is based on attachment theory and aims to promote the involvement of caregivers necessary for healthy attachment formation. As a simplified version of "Circle of Security-," it proceeds in a discussion format while watching a video DVD made by developers such as Powell, B., Cooper, G., Hoffman, K., and others, and is completed in a total of eight sessions. The importance of recognizing the sense of security and comfort that children seek from their caregivers and of being there for them, as well as how to be aware of and overcome problems when they are unable to calmly respond to their children's emotions, are introduced. The aim is to improve the parent-child relationship through reflection on the impact of the parent's own involvement on the child 11)12).

2. Parent Training

This program is designed for caregivers of children with a diagnosis of attention-deficit hyperactivity disorder (ADHD) to deepen their understanding of the characteristics of children with ADHD and enable caregivers to learn how to respond practically according to those characteristics. This program is based on the "Seiken method," by a team from the National Institute of Mental Health, National Center of Neurology and Psychiatry, which is a Japanese adaptation of the parent training program at the University of California, Los Angeles (UCLA), U.S.A., with minor modifications, and is conducted 11 times, including follow-ups. Parent training for ADHD has demonstrated effectiveness as an intervention method for ADHD, along with medication and environmental adjustment 13).

3. Parent-Child Interaction Therapy (PCIT)

PCIT is an individualized parent-child psychotherapy using behavior therapy techniques developed by Eyberg, S. in the 1980s in the United States, and focuses on improving the parent-child relationship. It involves live coaching so that caregivers can learn how to interact with their children. The therapy is designed for children between 2 and 7 years old and their caregivers. The number of sessions varies depending on the parents and children, and it takes about 20 sessions to complete. PCIT has been shown to improve children's problem behaviors by improving caregiver functioning 5)10).

4. Child-Adult Relationship Enhancement (CARE) Program

The CARE program is a psychoeducational intervention program for caregivers involving treatments based on several other behavioral theories, including PCIT 8)9). Skills are taught to caregivers through lectures and role-plays, and the program is completed in a total of four sessions at our clinic (details of implementation at our clinic are described below). Caregivers of children up to approximately 10 years of age can participate in the program, regardless of the child's diagnosis. Because the program is completed in a short period of time, it is selected when the caregivers are busy or when the parent-child relationship is expected to improve to some extent through psychoeducation alone.

Among these, we conducted a survey on the changes in children's behavior before and after the intervention, with regard to the caregivers who

participated in the CARE program individually, which included many fathers. The clinical information presented in this paper was collected with the approval of the Ethics Committee of the Aiku Research Institute.

IV. Changes in Children's Problem Behaviors Before and After Intervention for Individual Participants in the CARE Program

1. Methods of implementation of the CARE program for individual participants in our clinic

The CARE program is implemented in two formats, in small groups and individually, depending on the requests of the caregivers. When conducted individually, one therapist is in charge of one caregiver or both caregivers, and the content is divided into four sessions of one to one and a half hours each. After an explanation of each part, role-plays are conducted in which the therapist and caregiver, or both caregivers play the roles of the parent and child, using materials distributed by CARE-Japan 4) and supplementary materials provided by our clinic. Homework assignments are made to practice the acquired skills with the child, and in the following session, questions and problems are discussed in order to consolidate the skills.

The Eyberg Child Behavior Inventory (ECBI) 6) is administered at each session to assess the child's condition. ECBI is a caregiver-completed questionnaire that serves as an indicator of disruptive behavior in children aged 2-16. It consists of 36 items, each of which measures the number (ECBI Problem Scale) and degree (ECBI Intensity Scale) of problem behaviors. The mean scores in Japan are 6.57±6.46 and 100.1±24.6, respectively, and the cutoff values for the clinical range are 13 and 124, respectively.

At the end of the program, participants are requested to complete an anonymous questionnaire, in which they are asked to write freely about their impressions of the program and items related to caregiver stress.

2. Characteristics of individual participants in the CARE program

Next, we describe the characteristics of caregivers and children who participated the CARE program individually. The number of individual participants in the CARE program in our clinic from 2013-2017 was 44 (34 mothers only and 5 pairs of mothers and fathers). The average waiting time from the first visit to the start of the program was approximately 5.3 months. The children of participating caregivers were 29 boys and 10 girls, with a mean age of 7.5 (2-15) years. The primary

diagnoses of the children were: ADHD in 11, autism spectrum disorder (ASD) in 5, and adjustment disorder in 5, and other diagnoses included depression, obsessive-compulsive disorder, eating disorder, and unspecified psychological developmental disorder.

3. Changes in children's problem behaviors before and after the CARE program

Figure 3 shows a comparison of the ECBI intensity scale, which indicates the degree of problem behavior, and the ECBI problem scale, which indicates the number of problems, before and after the program for 36 of the 44 participants from whom valid ECBI responses were obtained. Both scores at the end of the program were above the Japanese average, but below the cutoff value for the clinical range. Eight participants had improved on the ECBI intensity scale by 25 points or more, nine participants had improved by 13 to 24 points, nine participants had improved by 0 to 12 points or remained unchanged, and ten participants had worsened. Analysis of Wilcoxon's signed rank test using the Statistical Package for the Social Sciences (SPSS) version 24 showed that the ECBI intensity and problem scales decreased significantly before and after the program ($P = 0.007$ and $P = 0.031$, respectively).

This indicates that the children of caregivers who participated the CARE program showed significant decreases in the intensity and number of problem behaviors, as reported by the caregivers.

Statistical analysis of the effect of fathers' participation on their children could not be conducted because only five fathers participated in the program. However, a decreasing trend was observed in the ECBI intensity scale from 149.8±10.4 to 131.0±16.8 points before and after the program, respectively, and an unchanged or slightly worsening trend in the ECBI problem scale from 19.8±4.2 to 20.8±5.3 points, respectively.

4. Results of the questionnaire survey

The following are the comments of the participants from the questionnaire survey conducted at the end of the program. Mother A: "I feel calm when I think that I have learned the skills and I can use them when I am with my child". Mother B: "I got used to praising my child and I was able to spend our time calmly. I felt 'family harmony' for the first time". Father C: "I could see some changes in my child when I became conscious of praising him. I'm glad that we were able to do this together so that I could support my wife". For the caregivers, the acquisition of skills was also helpful in reducing their own stress and controlling their emotions.

5. Discussion: Changes in caregivers who participated the CARE program

The results of this research indicated that the degree and number of children's disruptive problem behaviors subjectively perceived by caregivers were reduced among the individual participants in the CARE program at our clinic. CARE is a program that focuses on communication skills with children, but because the therapists discuss specific ways to respond to problematic behaviors with psychoeducation based on the children's characteristics, it is possible that the caregivers themselves were better able to understand and respond to their children's behaviors.

The major advantage of participating the CARE program for both caregivers was that they could share a common understanding of their children's problematic behavior and respond consistently to their child. In addition, some of the fathers who participated in the program said that they became more actively involved in their child's life after learning the importance of the father's role in parenting. Although most parenting programs are designed for female caregivers (mainly mothers), this program was shown to be fully applicable to male caregivers as well. Since the number of male caregivers participating in the program is still small, we would like to continue to examine this issue through further practice.

We recognize that there was a selection bias because this survey concerns cases in which outpatient physicians proposed the CARE program to caregivers and promoted its implementation in our clinic. In addition, the results should be interpreted with caution because a control group was not defined and the survey was conducted in parallel with outpatient care. However, the results of this study showed that in some cases, a significant decrease in problematic behavior were shown, and considering the fact that many of the children had developmental disorders that often have a chronic course, it is quite possible that the program showed a certain level of effectiveness.

The authors have the impression that the number of fathers visiting the outpatient clinic together has increased compared with 10 to 20 years ago. Compared with mothers, there are fewer parenting books targeted for fathers, and fathers themselves may have had less experience being raised by male caregivers and may have fewer models to follow. Raising a child with problematic behavior is often difficult and stressful, and we feel that the mental health of male caregivers (mainly fathers) and the relationship

between the father and child should be discussed more. Outpatient clinics and psychological programs are often conducted during the day on weekdays, and we would like to consider approaches to male caregivers (mainly fathers), including ways to increase the participation of working caregivers.

Conclusion

We have outlined our outpatient approach at our clinic, which has a large number of children with developmental disorders, and introduced a study of participants in the Child-Adult Relationship Enhancement (CARE) program, which has the advantage of being accessible and requiring fewer sessions than other parenting support programs. The CARE program is often carried out in small groups, and there is a great deal of emotional support between caregivers. In this report, the fact that the program was effective on an individual basis and that it was applicable to male caregivers is noteworthy. Support for children with developmental disorders is often long-term, and we hope that this report will be of assistance to mental health professionals who support children and their caregivers.

Conflict of Interest

Masaki Kodaira received speaker fees from Shire Japan K.K. and Shionogi & Co., Ltd. The other authors have no conflicts of interest to disclose in connection with this paper.

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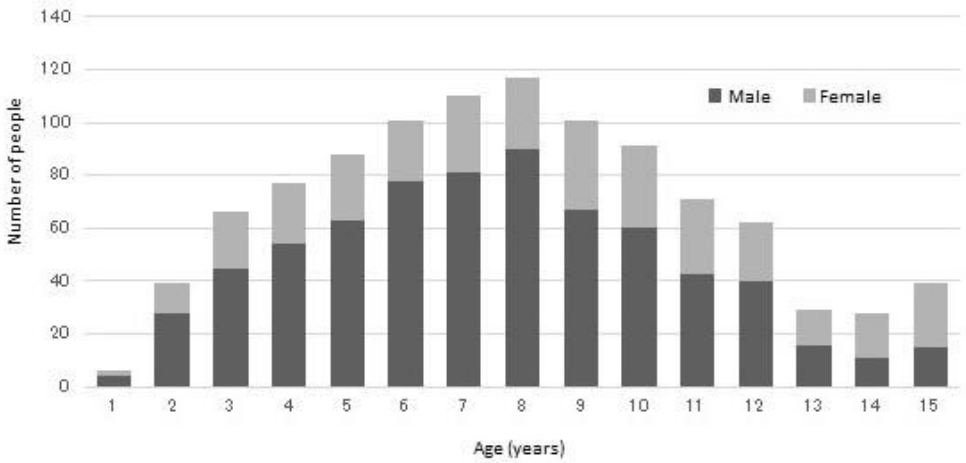

Figure 1: Distribution of patients who made their first visit to our clinic from 2013 to 2017
The distribution of children aged 15 years or younger who made their first visit to our clinic from April 2013 to December 2017 is shown by age. The male–to–female ratio was approximately 2:1, with more boys, and the average age was 7.8 years.

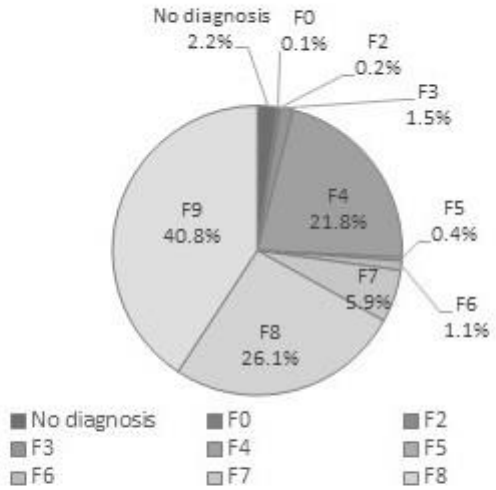

Figure 2: Diagnostic classification (ICD-10) of patients who made their first visit to our clinic from 2013 to 2017
The distribution of the ICD-10 diagnostic classification of the 1,025 children aged 15 years or younger who made their first visit to our clinic is shown. The main diagnoses at the time of the first visit were F9 (418 children), F8 (268 children), and F4 (223 children), in that order.

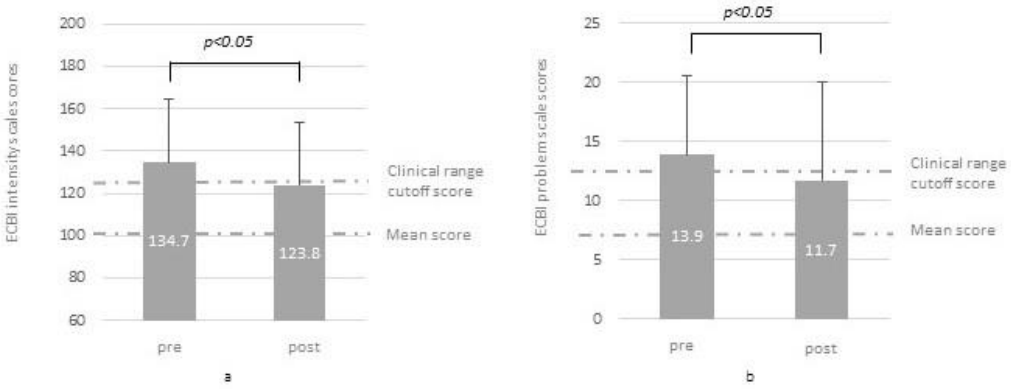

Figure 3: Degree and number of problem behaviors of participants' children before(pre) and after(post) CARE program.
a: The ECBI intensity scale (degree of problem behavior) was significantly lower after the completion of CARE, and was below the clinical range cutoff value.
b: Similarly, the ECBI problem scale (number of problem behaviors) was significantly lower after the completion of CARE and was below the clinical cutoff
ECBI: Eyberg Child Behavior Inventory

Table 1: Percentage of boys and mean age in each category in of the main initial diagnosis.

ICD-10 F classification (primary diagnosis)	Percentage of males (%)	Mean age (years)	Sub-diagnosis is F8/F9 (%)
F9	69.9	7.7	9.9
F8	81.7	6.8	9.0
F4	49.3	9.6	10.3
Total	67.8	7.8	9.8

Table 2: Parenting support provided in our outpatient clinic

- Outpatient Care
  - Parental guidance: psychoeducation, how to deal with problem behaviors, promotion of disease acceptance, empathy and encouragement
- Parenting support program: Introduction of evidence-based programs (numbers in parentheses indicate the number of completed cases implemented from 2013 to 2017)
  1. **Circle of Security-Parenting**（COS-P） (6 groups with 15 participants)
     - A simplified version of the Circle of Security, developed by Powell, Cooper, Hoffman et al. in 2007.
     - The goal is to promote the involvement of caregivers necessary for healthy attachment formation
  2. **Parent Training**（16 groups with 70 participants)
     - Parent training program at the University of California, Los Angeles (UCLA), U.S.A., arranged in Japanese style by a team from the National Institute of Mental Health, National Center of Neurology and Psychiatry
  3. **Parent-Child Interaction Therapy**（PCIT） (10 parent-child dyads)
     - Individualized parent-child psychotherapy developed by Eyberg in the 1980s
  4. **Child Adult Relationship Enhancement**（CARE） (15groups with 63 participants and 44 individual participants)