Letter to the Editor

Examining positive parenting

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Williams et al. ask clinicians to be self-reflective and acknowledge personal biases (1). I agree. We should apply this principle and see a few cultural influences in this very statement.

The idea that there exists an expert paediatrician role to guide parents is historically anomalous. It can be traced to the scientific revolution and the development of the instrumental mindset in the West. This mode of thought focused on obtaining knowledge for the purpose of applying it to conform the environment to people's wishes (2,3). For example, ingenuity in engineering and biology allowed us to produce food from the earth more efficiently. This contrasted with the idea that knowledge was for virtue and wisdom. As the mastery narrative evolved, it began to target not solely the natural environment (e.g., wind power) but people's minds (e.g., psychoanalysis) to control behaviours (4). Parenting techniques developed from this intellectual lineage. Other cultures, such as some Indigenous and South Asian cultures, consider collective wisdom and religious teachings as more relevant guides.

Positive parenting is also culturally conditioned. It is an outgrowth of therapeutic culture, which aims to produce positive self-evaluations and avoid shame or punishment to promote wellbeing (5). Aspects of positive parenting are built on the idea that criticism is harmful and that self-esteem must be protected as children are fragile (6). These ideas are not uncontested even within Western culture (7–9). Other countries such as Taiwan and Korea value criticism that can galvanize children to work harder to improve, which similarly reflects the idea that high self-esteem should be secondary to achievement. These cultures value children, but they operate on different assumptions about the nature of childhood (8).

Some cultures may similarly find the goal of 'emotionally intelligent adults' and wellbeing to be rather anemic. Wellbeing has historically been either subordinate to or a consequence of other, more important goals and not an end in itself. These have

included individual character and integrity, filial piety, honouring the divine, and communal responsibility (10). Thus, a Japanese man might put the team's needs ahead of his own even if it diminished his personal feelings.

My point is not to endorse or refute certain beliefs. It is rather to show that down to the method of parenting and the role of the paediatrician, our culture is at play. The paediatric community, just like any other well-educated and generally affluent group, constitutes its own subculture with a degree of homogeneity that shapes these recommendations (11). This hampers our ability to see our cultural biases.

We need cultural heterogeneity to rethink our blind spots. We must hold our convictions lightly in the realm of parenting, especially because our presuppositions about childhood's normative purposes are not empirically verifiable. Whether a child should be individualistic or collectivistic cannot be determined by an experiment. Yet these foundational ideas drive our recommendations. Diverging points of view should be raised and debated. When we acknowledge our assumptions, we can begin to defend rather than assume them. Recognizing these differences should help us understand and care for children in a multicultural context.

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