نصوص متخصصة في
علم النفس الإكلينيكي

الفرقة الثالثة علم النفس

كود المقرر نفس (٣١٦)

إعداد

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Chapter 1

Some Children's disorders

Intellectual Disability

(Intellectual Developmental Disorder)

Diagnostic Criteria

Intellectual disability (intellectual developmental disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains.

The following three criteria must be met:

(A) Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.

(B) Deficits in adaptive functioning that result in failure to meet developmental and sociocultural

standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

(C) Onset of intellectual and adaptive deficits during the developmental period.

الإعاقات الذهنية

اضطراب النمو الذهني

معايير التشخيص

الإعاقة الذهنية (اضطراب النمو الذهني)هي اضطراب، يبدأ خلال فترة التطور مشتملاً على العجز في الأداء الذهني والتكيفي في مجال المفاهيم والمجالات الاجتماعية والعملية يجب أن تتحقق المعايير الثلاثة التالية:

أ) القصور في الوظائف الذهنية، مثل التفكير، وحل المشكلات، والتخطيط، والتفكير التجريدي، والمحاكمة، والتعلم الأكاديمي، والتعلم من التجربة، والتي أكدها كلٌّ من التقييم السريري واختبار الذكاء المعياري الفردي.

ب) إن القصور في وظائف التكيف يؤدي إلى الفشل في تلبية المعايير التطورية والاجتماعية والثقافية لاستقلال الشخصية والمسؤولية الاجتماعية .ودون

الدعم الخارجي المستمر، فالعجز في التكيف يحد من الأداء في واحد أو أكثر من أنشطة الحياة اليومية مثل التواصل، والمشاركة الاجتماعية، والحياة المستقلة، عبر بيئات متعددة، مثل البيت والمدرسة والعمل والمجتمع.

ث) بداية العجز الذهني والتكيفي خلال فترة التطور.

Communication Disorders

Language Disorder

Diagnostic Criteria

A) Persistent difficulties in the acquisition and use of language across modalities (i.e., spoken, written, sign language, or other) due to deficits in comprehension or production that include the following:

1. Reduced vocabulary (word knowledge and use).

2. **Limited sentence structure (ability to put words and word endings together to form**

sentences based on the rules of grammar and morphology).

3. Impairments in discourse (ability to use vocabulary and connect sentences to explain or

describe a topic or series of events or have a conversation).

B) Language abilities are substantially and quantifiably below those expected for age, resulting in functional limitations in effective communication, social participation, academic achievement, or occupational performance, individually or in any combination.

C) Onset of symptoms is in the early developmental period.

D) The difficulties are not attributable to hearing or other sensory impairment, motor dysfunction, or another medical or neurological condition and are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay.

اضطرابات التواصل

اضطراب اللغة

معايير التشخيص

الصعوبات الثابتة في اكتساب واستخدام اللغة عبر الطرق المختلفة المنطوقة والمكتوبة ولغة الإشارة مثلاً، وذلك بسبب عجز الاستيعاب أو الإنتاج .

تشمل ما يلي:

1) قلة المفردات (المعرفة بالكلمات واستخدامها-

2) التحدد في بناء الجملة (القدرة على وضع الكلمات ونهايات الكلمات معاً لتشكيل الجمل استناداً- إلى قواعد اللغة والصرف.)

3) ضعف التخاطب (القدرة على استخدام المفردات والجمل المترابطة لشرح أو وصف موضوع- ما أو سلسلة من الأحداث أو إجراء محادثة)

B) القدرات اللغوية أدنى إلى حد كبير وكمياً أقل من تلك المتوقعة بالنسبة للعمر، مما يؤدي لتحدد وظيفي في- التواصل الفعال، والمشاركة الاجتماعية، والإنجازات الأكاديمية، أو الأداء المهني، بشكلٍ فردي أو في أي مجموعة.

C) ظهور الأعراض في فترة النمو المبكر .

D) الصعوبات لا تُعزى إلى ضعف سمعي أو حسي آخر، أو مشكلة حركية، أو حالة طبية أو عصبية أخرى.

Speech Sound Disorder

Diagnostic Criteria

A) Persistent difficulty with speech sound production that interferes with speech

intelligibility or prevents verbal communication of messages.

B) The disturbance causes limitations in effective communication that interfere with social

participation, academic achievement, or occupational performance, individually or in any combination.

C) Onset of symptoms is in the early developmental period.

D) The difficulties are not attributable to congenital or acquired conditions, such as cerebral palsy, cleft palate, deafness or hearing loss, traumatic brain injury, or other medical or neurological conditions.

اضطراب صوت الكلام

معايير التشخيص

A) صعوبة ثابتة في إنتاج صوت الكلام الذي يتداخل مع الكلام الواضح أو يمنع التوصيل اللفظي للرسائل- .

B) الاضطراب يسبب قيوداً للتواصل الفعال والتي تتداخل مع المشاركة الاجتماعية، والتحصيل الدراسي، أو-

الأداء المهني، بشكلٍ فردي أو في أي مجموعة.

C) ظهور الأعراض في فترة النمو المبكر- .

D) المصاعب لا تُعزى إلى ظروف خلقية أو مكتسبة، مثل الشلل الدماغي، والحنك المشقوق، والصمم أو فقدان السمع، إصابات الدماغ الرضية، أو حالات طبية أو عصبية أخرى.

Childhood-Onset Fluency Disorder (Stuttering)

Diagnostic Criteria

A) Disturbances in the normal fluency and time patterning of speech that are inappropriate for the individual's age and language skills, persist over time, and are characterized by frequent and marked occurrences of one (or more) of the following:

1) Sound and syllable repetitions.

2) Sound prolongations of consonants as well as vowels.

3) Broken words (e.g., pauses within a word).

4) Audible or silent blocking (filled or unfilled pauses in speech).

5) Circumlocutions (word substitutions to avoid problematic words).

6) Words produced with an excess of physical tension.

7) Monosyllabic whole-word repetitions

B) The disturbance causes anxiety about speaking or limitations in effective communication, social participation, or academic or occupational performance, individually or in any combination.

C) The onset of symptoms is in the early developmental period adult-onset fluency disorder.)

D) The disturbance is not attributable to a speech-motor or sensory deficit, dysfluency associated with neurological insult (e.g., stroke, tumor, trauma), or another medical condition and is not better explained by another mental disorder.

البدء الطفلي لاضطراب الطلاقة(التأتأة)

معايير التشخيص

A) اضطرابات في السلاسة الطبيعية وتوقيت الكلام مما يعتبر غير مناسب لعمر الفرد والمهارات اللغوية، وتستمر مع الزمن، وتتميز بالحدوث المتكرر والملاحظ لواحد(أو أكثر)مما يلي:

1) التكرار الصوتي واللفظي .

2) تمديد الصوت للحروف الساكنة وكذلك أحرف العلة.

3) تكسر الكلمات(على سبيل المثال، توقفات ضمن الكلمة)

4) إحصارات مسموعة أو صامتة -وقفات في سياق الحديث مملوءة أو فارغة-

5) الإطناب(استعمال بدائل الكلمات لتجنب الكلمات الإشكالية)

6) تنتج الكلمات مع زيادة التوتر الجسدي

7) التكرار الأحادي لكلمة كاملة- .

B) يسبب الاضطراب القلق حول التحدث أو يؤدي إلى قيود على التواصل الفعال، والمشاركة الاجتماعية، أو الأداء الأكاديمي أو المهني، بشكلٍ فردي أو في أي مجموعة.

C) بدء الأعراض يكون في فترة النمو المبكر

D) الاضطراب لا يُنسب إلى عجز حركي حسي كلامي، ولا يُنسب إلى سوء الانسياب المرتبط بأذية عصبية - مثل السكتة الدماغية، والأورام،

والرضوض)، أو حالة طبية أخرى ولا يُفسر بشكلٍ أفضل باضطراب عقلي آخر.

Social (Pragmatic) Communication Disorder

Diagnostic Criteria

A. Persistent difficulties in the social use of verbal and nonverbal communication as manifested by all of the following:

1. Deficits in using communication for social purposes, such as greeting and sharing information, in a manner that is appropriate for the social context.

2. Impairment of the ability to change communication to match context or the needs of the listener, such as speaking differently in a classroom than on a playground, talking differently to a child

than to an adult, and avoiding use of overly formal language.

3. Difficulties following rules for conversation and storytelling, such as taking turns in conversation, rephrasing when misunderstood, and knowing how to use verbal and nonverbal signals to regulate interaction

4. Difficulties understanding wliat is not explicitly stated (e.g., making inferences) and nonliteral or ambiguous meanings of language (e.g., idioms, humor, metaphors, multiple meanings that depend on the context for interpretation).

B. The deficits result in functional limitations in effective communication, social participation, social relationships, academic achievement, or occupational performance, individually or in combination.

C. The onset of the symptoms is in the early developmental period (but deficits may not become fully manifest until social communication demands exceed limited capacities).

D. The symptoms are not attributable to another medical or neurological condition or to low abilities in the domains of word structure and grammar, and are not better explained by autism spectrum disorder, intellectual disability (intellectual developmental disorder), global developmental delay, or another mental disorder.

اضطراب التواصل الاجتماعي(العملي)

Social (Pragmatic) Communication Disorder

A) صعوبات ثابتة عند الاستخدام الاجتماعي للتواصل اللفظي وغير اللفظي كما يتجلى بكلٍ مما يلي- :

1) العجز عن استعمال التواصل لأغراض اجتماعيه، مثل التحية ومشاركة المعلومات، بطريقة مناسبة للسياق الاجتماعي.

2) ضعف القدرة على تغيير التواصل ليتناسب مع السياق أو مع احتياجات المستمع، مثل التحدث بشكلٍ مختلف في غرف الصف عنه في الملعب، والحديث بشكلٍ مختلف إلى طفل عن التحدث إلى الشخص البالغ، وتجنب استخدام لغة رسمية للغاية.

3) الصعوبات في تتبع قواعد المحادثة وإخبار القصص، مثل التناوب عند المحادثة، وإعادة الصياغة عند إساءة الفهم، ومعرفة كيفية استخدام الإشارات اللفظية وغير اللفظية لتنظيم التفاعل.

4) الصعوبة في فهم ما لم يُنص عليه صراحةً(كالوصول للاستدلالات مثلاً) والمعاني المجازية أو الغامضة للغة(على سبيل المثال :التعابير، والنكتة، الاستعارات، المعاني المتعددة التي تعتمد على سياق الحديث للتفسير.)

B) يؤدي العجز إلى فرض قيود وظيفية في التواصل الفعال، والمشاركة الاجتماعية، والعلاقات الاجتماعية، والتحصيل الدراسي، أو الأداء المهني، كلاً على حدة أو مجتمعة.

C) تظهر الأعراض في فترة مبكرة من النمو(ولكن قد لا يتوضح العجز حتى تتجاوز متطلبات التواصل- الاجتماعي القدرات المحدودة.)

D) لا تُعزى الأعراض إلى حالة طبية أو عصبية أخرى، وليس إلى الانخفاض في قدرة تركيب الكلام أو- القواعد، ولا تُفسر بشكلٍ أفضل بحصول اضطراب طيف التوحد، أو الإعاقة الذهنية(اضطراب النمو الذهني)، أو تأخر النمو الشامل، أو اضطراب عقلي آخر.

Autism Spectrum Disorder

Diagnostic Criteria

A) Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and

failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures: to a total lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers. *Specify* current severity: Severity is based on social communication impairments and restricted, repetitive patterns of behavior (.

B) Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two

of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific

sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

***Specify* current severity:**

Severity is based on social communication impairments and restricted, repetitive patterns of behavior.

C) Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D) Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

اضطراب طيف التوحد

معايير التشخيص

A)عجز ثابت في التواصل والتفاعل الاجتماعي في سياقات متعددة، في الفترة الراهنة أو كما ثبت عن طريق التاريخ وذلك من خلال ما يلي،(الأمثلة توضيحية، وليست شاملة)

1)عجز عن التعامل العاطفي بالمثل، يتراوح، على سبيل المثال، من الأسلوب الاجتماعي الغريب، مع فشل الأخذ والرد في المحادثة، إلى تدنٍ في المشاركة بالاهتمامات، والعواطف، أوالانفعالات، يمتد إلى عدم البدء أو الرد على التفاعلات الاجتماعية.

2)العجز في سلوكيات التواصل غير اللفظية المستخدمة في التفاعل الاجتماعي، يتراوح من ضعف تكامل التواصل اللفظي وغير اللفظي، إلى الشذوذ في التواصل البصري ولغة الجسد أو العجز في فهم واستخدام الإيماءات، إلى انعدام تام للتعابير الوجهية والتواصل غير اللفظي.

3)العجز في تطوير العلاقات والمحافظة عليها وفهمها، يتراوح، مثلاً من صعوبات تعديل السلوك لتلائم السياقات الاجتماعية المختلفة، إلى صعوبات في مشاركة اللعب التخيلي أو في تكوين صداقات، إلى انعدام الاهتمام بالأقران.

B) أنماط متكررة محددة من السلوك، والاهتمامات، أو الأنشطة وذلك بحصول اثنين مما يلي على الأقل، في الفترة الراهنة أو كما ثبت عن طريق التاريخ، (الأمثلة توضيحية، وليست شاملة:)

1) نمطية متكررة للحركة أو استخدام الأشياء، أو الكلام(مثلاً، أنماط حركية بسيطة، صف الألعاب أو تقليب الأشياء، والصدى اللفظي، وخصوصية العبارات.)

2)الإصرار على التشابه، والالتزام غير المرن بالروتين، أو أنماط طقسية للسلوك اللفظي أو غير- اللفظي(مثلاً، الضيق الشديد عند التغيرات الصغيرة،

والصعوبات عند التغيير، وأنماط التفكير الجامدة وطقوس التحية، والحاجة إلى سلوك نفس الطريق أو تناول نفس الطعام كل يوم.)

3) اهتمامات محددة بشدة وشاذة في الشدة أو التركيز(مثلاً، التعلق الشديد أو الانشغال بالأشياء غير المعتادة، اهتمامات محصورة بشدة مفرطة المواظبة.)

4)فرط أو تدني التفاعل مع الوارد الحسي أو اهتمام غير عادي في الجوانب الحسية من البيئة مثلاً، عدم الاكتراث الواضح للألم/درجة الحرارة، والاستجابة السلبية لأصوات أو لأنسجة محددة، الإفراط في شم ولمس الأشياء، الانبهار البصري بالأضواء أو الحركة.)

C) تظهر الأعراض في فترة مبكرة من النمو(ولكن قد لا يتوضح العجز حتى تتجاوز متطلبات التواصل الاجتماعي القدرات المحدودة أو قد تحجب بالاستراتيجيات المُتعلمة لاحقاً في الحياة.)

D) تسبب الأعراض تدنياً سريرياً هاماً في مجالات الأداء الاجتماعي والمهني الحالي، أو في غيرها من المناحي المهمة.

E) لا تُفسر هذه الاضطرابات بشكلٍ أفضل بالإعاقة الذهنية(اضطراب النمو الذهني) أو تأخر النمو الشامل .إن الإعاقة الذهنية واضطراب طيف التوحد يحدثان معاً في كثير من الأحيان، ولوضع التشخيص المرضي المشترك للإعاقة الذهنية واضطراب طيف التوحد، ينبغي أن يكون التواصل الاجتماعي دون المتوقع للمستوى التطوري العام.

Attention-Deficit/Hyperactivity Disorder

Attention-Deficit/Hyperactivity Disorder

Diagnostic Criteria

A) A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with

functioning or development, as characterized by (1) and/or (2):

1) Inattention: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

a) Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).

b) Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).

c) Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).

d) Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).

e) Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).

f) Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).

g) Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, papenwork, eyeglasses, mobile telephones).

h) Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).

i) Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

2) Hyperactivity and impuisivity: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older

adolescents and adults (age 17 and older), at least five symptoms are required.

a) Often fidgets with or taps hands or feet or squirms in seat.

b) Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).

c) Often runs about or climbs in situations where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless.)

d) Often unable to play or engage in leisure activities quietly.

E) Is often “on the go,” acting as if “driven by a motor” (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).

f) Often talks excessively.

g. Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation).

h) Often has difficulty waiting his or her turn (e.g., while waiting in line).

i) Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

B) Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.

C) Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).

D) There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.

E) The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

اضطراب نقص الانتباه/فرط الحركة

Aنمط مستمر من عدم الانتباه وتأو فرط الحركة الاندفاعية يتداخل مع الأداء أو التطور، كما يتظاهر ب (1) أو (2)

1)عدم الانتباه :ستة من الأعراض التالية أو أكثر استمرت لستة أشهر على الأقل لدرجة لا تتوافق مع المستوى التطوري والتي تؤثر سلباً ومباشرةً على النشاطات الاجتماعية والمهنية والأكاديمية:

ملاحظة :إن الأعراض ليست فقط مظهراً من مظاهر السلوك الاعتراضي والعدائية، أو الفشل في فهم المهام أو التعليمات .بالنسبة للمراهقين الأكبر سناً والبالغين(سن 17 وما فوق)، فيلزم خمسة أعراض على الأقل.

(a) غالباً ما يخفق في إعارة الانتباه الدقيق للتفاصيل أو يرتكب أخطاء دون مبالاة في الواجبات المدرسية أو في العمل أو في النشاطات الأخرى(مثلاً إغفال أو تفويت التفاصيل، العمل غير الدقيق.)

(b)غالباً ما يصعب عليه المحافظة على الانتباه في أداء العمل أو في ممارسة الأنشطة مثلاً صعوبة المحافظة على التركيز خلال المحاضرات، المحادثات أو القراءة المطولة.

(c)غالباً ما يبدو غير مصغٍ عند توجيه الحديث إليه مباشرة(عقله يبدو في مكان آخر مثلاً، حتى عند غياب أي ملهي واضح.)

(d)غالباً لا يتبع التعليمات ويخفق في إنهاء الواجب المدرسي أو الأعمال الروتينية اليومية أو الواجبات العملية(يبدأ المهام مثلاً ولكنه يفقد التركيز بسرعة كما يتلهى بسهولة.)

(e)غالباً ما يكون لديه صعوبة في تنظيم المهام والأنشطة(الصعوبة في إدارة المهام المتتابعة مثلاً، صعوبة الحفاظ على الأشياء والمتعلقات الشخصية بانتظام، فوضوي، غير منظم العمل، يفتقد لحسن إدارة الوقت، والفشل بالالتزام بالمواعيد المحددة.)

(f)غالباً ما يتجنب أو يكره أو يتردد في الانخراط في مهام تتطلب منه جهداً عقلياً متواصلاً كالعمل المدرسي أو الواجبات في المنزل، للمراهقين الأكبر سناً وعند البالغين إعداد التقارير وملء النماذج، مراجعة الأوراق الطويلة.

(g)غالباً ما يضيع أغراضاً ضرورية لممارسة مهامه وأنشطته(كالمواد المدرسية والأقلام والكتب والأدوات والمحافظ والمفاتيح والأوراق والنظارات والهواتف النقالة.)

(h)غالباً ما يسهُل تشتيت انتباهه بمنبّه خارجي(للمراهقين الأكبر سناً وعند البالغين قد تتضمن أفكاراً غير ذات صلة

(i) كثير النسيان في الأنشطة اليومية (مثل الأعمال الروتينية اليومية، إنجاز المهام، للمراهقين الأكبر سناً وعند البالغين، إعادة طلب المكالمات، دفع الفواتير، والمحافظة على المواعيد.)

2) فرط الحركة الاندفاعية :ستة من الأعراض التالية استمرت لستة أشهر على الأقل لدرجة لا تتوافق مع المستوى التطوري والتي تؤثر سلباً ومباشرةً على النشاطات الاجتماعية والمهنية الأكاديمية.

ملاحظة : إن الأعراض ليست فقط مظهراً من مظاهر السلوك الاعتراضي والعدائية، أو الفشل في فهم المهام أو التعليمات .بالنسبة للمراهقين الأكبر سناً والبالغين(سن 17 وما فوق)، فيلزم خمسة أعراض على الأقل.

(a)غالباً ما يبدي حركات تململ في اليدين أو القدمين أو يتلوى في كرسيه.

(b)غالباً ما يغادر مقعده في الحالات التي يُنتظر فيها منه أن يلازم مقعده(في صفوف الدراسة أو المكتب أو أماكن العمل الأخرى أو في الحالات التي تتطلب ملازمة المقعد)

(c)غالباً ما يركض أو يتسلق في مواقف غير مناسبة (قد يقتصر الأمر عند المراهقين أو البالغين على إحساسات الشعور بالانزعاج.)

(d) غالباً ما يكون لديه صعوبات عند اللعب أو الانخراط بهدوء ضمن نشاطات ترفيهية.

(e) لا يرتاح للثبات في « مدفوع بمحرك » غالباً ما يكون متحفزاً أو يتصرف كما لو أنه شئ معين لفترات مطولة كما في المطاعم أو الاجتماعات حيث قد يلحظ الآخرون صعوبة التماشي معه.)

(f)غالباً ما يتحدث بإفراط

(g)غالباً ما يندفع للإجابة قبل اكتمال الأسئلة(يكمل الجمل للآخرين مثلاً، لا ينتظر دوره في عند الحديث.)

(h)غالباً ما يجد صعوبة في انتظار دوره(.عند الانتظار في الطابور مثلاً.)

(i)غالباً ما يقاطع الآخرين أو يقحم نفسه في شؤونهم(مثلاً، في المحادثات، والألعاب، أو الأنشطة، قد يبدأ في استخدام أشياء الآخرين دون أن يطلب أو يتلقى الاذن، بالنسبة للمراهقين والبالغين، قد يتدخل أو يستولي على ما بفعله الآخرون.)

B) وجود بعض أعراض فرط الحركة الاندفاعية أو أعراض عدم الانتباه قبل عمر 12 سنوات.

C) وجود بعض أعراض فرط الحركة الاندفاعية أو أعراض عدم الانتباه في بيئتين أو أكثر(في المدرسة مثلاً والعمل وفي المنزل، مع الأصدقاء أو الأقارب أو غيرها من الأنشطة.)

D) يوجد دليل صريح على تداخل الأعراضتأو إنقاصها لجودة، الأداء الاجتماعي أو الأكاديمي أو المهني.

E) لا تحدث الأعراض حصراً في سياق الفصام أو أي اضطراب ذهاني آخر ولا تُفسر بشكلٍ أفضل باضطراب عقلي آخر(مثل، اضطراب مزاج أو اضطراب قلق أو اضطراب تفارقي أو اضطراب شخصية، الانسمام أو السحب من مادة ما.)

Specific Learning Disorder

Diagnostic Criteria

A) Difficulties learning and using academic skills, as indicated by the presence of at least one of the following symptoms that have persisted for at least 6 months, despite the provision of interventions that target those difficulties:

1. Inaccurate or slow and effortful word reading (e.g., reads single words aloud incorrectly or slowly and hesitantly, frequently guesses words, has difficulty sounding out words).

2. Difficulty understanding the meaning of what is read (e.g., may read text accurately but not understand the sequence, relationships, inferences, or deeper meanings of what is read).

3. Difficulties with spelling (e.g., may add, omit, or substitute vowels or consonants).

4. Difficulties with written expression (e.g., makes multiple grammatical or punctuation

errors within sentences; employs poor paragraph organization; written expression of ideas lacks clarity).

5. Difficulties mastering number sense, number facts, or calculation (e.g., has poor understanding of numbers, their magnitude, and relationships; counts on fingers to add single-digit numbers instead of recalling the math fact as peers do; gets lost in the midst of arithmetic computation and may switch procedures).

6. Difficulties with mathematical reasoning (e.g., has severe difficulty applying mathematical concepts, facts, or procedures to solve quantitative problems).

B) The affected academic skills are substantially and quantifiably below those expected for the individual's chronological age, and cause significant interference with academic or occupational performance, or with activities of daily living, as confirmed by individually administered standardized achievement measures and comprehensive clinical assessment. For individuals age 17 years and older,

a documented history of impairing learning difficulties may be substituted for the standardized assessment.

C) The learning difficulties begin during school-age years but may not become fully manifest until the demands for those affected academic sl<ills exceed the individual's limited capacities (e.g., as in timed tests, reading or writing lengthy complex reports for a tight deadline, excessively heavy academic loads).

D) The learning difficulties are not better accounted for by intellectual disabilities, uncorrected visual or auditory acuity, other mental or neurological disorders, psychosocial adversity, lack of proficiency in the language of academic instruction, or inadequate educational instruction.

With impairment in reading:

- **Word reading accuracy**
- **Reading rate or fluency**
- **Reading comprehension**

Note: *Dyslexia* is an alternative term used to refer to a pattern of learning difficulties characterized by problems with accurate or fluent word recognition, poor decoding, and poor spelling abilities. If dyslexia is used to specify this particular pattern of difficulties, it is important also to specify any additional difficulties that are present, such as difficulties with reading comprehension or math reasoning Witli impairment in written expression:

- **Spelling accuracy**
- **Grammar and punctuation accuracy**
- **Clarity or organization of written expression**

With impairment in mathematics:

- **Number sense**
- **Memorization of arithmetic facts**
- **Accurate or fluent calculation**
- **Accurate math reasoning**

Note: *Dyscalculia* is an altemative term used to refer to a pattern of difficulties characterized by problems processing numerical information, learning

arithmetic facts, and performing accurate or fluent calculations. If dyscalculia is used to specify this particular pattern of mathematic difficulties, it is important also to specify any additional difficulties that are present, such as difficulties with math reasoning or word reasoning accuracy.

5-اضطراب التعلم المحدد

معايير التشخيص

A) صعوبات التعلم واستخدام المهارات الأكاديمية، كما يتبين من وجود واحد على الأقل من الأعراض التالية- التي استمرت لمدة ستة أشهر على الأقل، على الرغم من توفير التداخلات التي تستهدف تلك الصعوبات:

1) قراءة الكلمات بشكلٍ غير دقيق أو ببطء رغم الجهد(مثلاً، يقرأ كلمة واحدة بصوت عال بشكلٍ غير صحيح أو ببطء وبتردد، وكثيراً ما يخمن الكلمات، ولديه صعوبة في لفظ الكلمات.)

2) صعوبة في فهم معنى ما يقرأ(قد يقرأ النص بدقة مثلاً ولكن قد لا يفهم التسلسل، والعلاقات، والاستدلالات، أو المعاني الأعمق لما قرأ)

3) الصعوبات في التهجئة(فمثلاً، قد يضيف، يحذف، أو يستبدل أحد حروف العلة أو الحروف الساكنة.)

4) صعوبات في التعبير الكتابي(مثلاً، ارتكاب أخطاء نحوية متعددة أو أخطاء في علامات الترقيم وفي صياغة الجمل، صياغة سيئة التنظيم للفقرات، التعبير الكتابي عن الأفكار يفتقر إلى الوضوح.)

5) صعوبات التمكن من معنى الأرقام، حقائق الأرقام، أو الحساب(مثلاً، لديه فهم ضعيف للأرقام، قدرها، والعلاقات بينها، الاعتماد على الأصابع لإضافة أرقام من مرتبة واحدة عوضاً عن الاستعانة بحقائق الرياضيات كما يفعل الأقران، يضيع في خضم الحسابات الرياضية وقد يبدل الإجراءات.)

6) صعوبات في التفكير الرياضي(مثلاً، لديه صعوبة شديدة في تطبيق المفاهيم الرياضية، والحقائق، أو الإجراءات لحل المشاكل الكمية.)

B) المهارات الأكاديمية المتأثرة أدنى بشكلٍ هام ونوعي من تلك المتوقعة بالنسبة للعمر الزمني للفرد، وتتسبب في حدوث تداخل كبير مع الأداء الأكاديمي أو المهني، أو مع أنشطة الحياة اليومية، وهو ما أكدته المقاييس المعيارية الفردية والتقييم السريري الشامل .للأفراد في سن 17 عاماً فما فوق، فتاريخ موثق للضعف من صعوبات في التعلم قد يكون بديلاً للتقييم المعياري.

C) صعوبات التعلم تبدأ خلال سن المدرسة ولكن قد لا تصبح واضحة تماماً حتى تتجاوز متطلبات المهارات الأكاديمية القدرات المحدودة للفرد المتأثر(مثلاً، كما هو الحال في الاختبارات المحددة زمنياً، قراءة أو كتابة تقارير مطولة معقدة خلال مهلة محدودة، والأعباء الأكاديمية المفرطة الثقل.)

D) صعوبات التعلم لا تُفسر بشكلٍ أفضل كنتيجة لوجود الإعاقة الذهنية، الإعاقات في البصر أو السمع غير المصححة، واضطرابات نفسية أو عصبية

أخرى، المحن النفسية والاجتماعية، وعدم الإجادة للغة التعليم الأكاديمي، أو عدم كفاية التوجيهات التعليمية

- معدل القراءة أو الطلاقة
- فهم القراءة

عسر القراءة هي مصطلح بديل يستخدم للإشارة إلى وجود نمط من صعوبات التعلم التي تتميز بمشاكل في دقة أو طلاقة التعرف على الكلمات، وسوء فهم المعاني المستترة، والقدرات الهجائية الفقيرة .إذا تم استخدام عسر القراءة لتحديد نمط معين من هذه الصعوبات، فمن المهم أيضاً تحديد أي صعوبات إضافية قد تكون موجودة، مثل صعوبات في استيعاب ما يقرأ أو فهم المنطق الرياضي

مع ضعف في التعبير الكتابي:

- دقة التهجئة
- دقة قواعد اللغة وعلامات الترقيم
- الوضوح أو تنظيم التعبير الكتابي

عسر الحساب مصطلح بديل يستخدم للإشارة إلى وجود نمط من الصعوبات التي تتميز بمشاكل في معالجة المعلومات الرقمية، وتعلم الحقائق الرياضية، وتنفيذ عمليات حسابية دقيقة أو سلسة .إذا تم استخدام هذا الخلل لتحديد نمط معين من الصعوبات الرياضية، فمن المهم أيضاً تحديد أي صعوبات إضافية قد تكون موجودة، مثل صعوبات مع المنطق الرياضي أو دقة منطق الكلام مع ضعف في الرياضيات:

- المعنى العددي

- حفظ الحقائق الرياضية
- الحساب الدقيق أو السلس
- دقة المنطق الرياضي

Selective Mutism

Diagnostic Criteria

A) Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations.

B) The disturbance interferes with educational or occupational achievement or with social communication.

C) The duration of the disturbance is at least 1 month (not limited to the first month of school).

D) The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.

E) The disturbance is not better explained by a communication disorder (e.g., childhoodonset

fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder.

الصمت الانتقائي

معايير التشخيص

A)عجز ثابت عن الكلام في مواقف اجتماعية محددة(حيث يُتوقع فيها الكلام مثل المدرسة رغم الكلام في مواقف أخرى.

B) يتداخل الاضطراب مع الإنجازات التعليمية أو المهنية أو في التواصل الاجتماعي .

C) مدة الاضطراب هي شهر على الأقل(لا تقتصر على الشهر الأول في المدرسة)

D)لا ينجم العجز عن انعدام المعرفة باللغة المنطوقة أو بالإحساس بالراحة معها وهو الأمر المطلوب في الموقف الاجتماعي.

E) لا يُفسر الاضطراب من خلال اضطراب تواصلي(مثل اضطراب الطلاقة ذو البدء الطفلي) ولا يحدث حصراً في سياق اضطراب طيف التوحد أو فصام أو اضطراب ذهاني آخر.

Pica

Diagnostic Criteria

A) Persistent eating of nonnutritive, nonfood substances over a period of at least 1 month.

B) The eating of nonnutritive, nonfood substances is inappropriate to the developmental level of the individual.

C) The eating behavior is not part of a culturally supported or socially normative practice.

D) If the eating behavior occurs in the context of another mental disorder (e.g., intellectual disability [intellectual developmental disorder], autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is sufficiently severe to warrant additional clinical attention.

شهوة الطين

معايير التشخيص

A)الأكل المستمر لمواد غير غذائية وغير طعامية لفترة شهر على الأقل- .

B)أكل المواد غير الغذائية وغير الطعامية غير مناسب للمرحلة التطورية للفرد .

C)السلوك الطعامي ليس جزءاً من ممارسة مدعومة ثقافياً أو مناسبة اجتماعياً- .

D)إذا حدث سلوك الأكل أثناء سير اضطراب عقلي آخر(مثل، الإعاقة الذهنية [اضطراب الإعاقة الذهنية]، اضطراب طيف التوحد، فصام)، فإنه يكون من الشدة بما يكفي ليستحق انتباهاً سريرياً مستقلاً.

(ميل المواد المعتادة التي يتم تناولها إلى الاختلاف مع تقدم العمر ومدى توفرها وقدرتها تشمل الورق والصابون والقماش والشعر والخيط والصوف والتربة والطباشير ومسحوق التلك والطلاء والعلكة والمعادن ، الحصى أو الفحم أو الفحم أو الرماد أو الطين أو النشا أو الجليد.)

Chapter 2

Emotional and behavioral problems in children

Emotional and behavioral problems in children are typically divided into two general categories: externalizing and internalizing problems. Externalizing problems are outer-directed and involve acting-out، defiant, and noncompliant behaviors. Internalizing problems are more inner-directed and involve withdrawal, depression, and anxiety.

In addition, young children can be diagnosed with neurodevelopmental disorders, including autism spectrum disorder, and commonly exhibit problems that do not fall within either of these general domains (e.g., difficulties with sleep (schedules, eating problems, and toileting challenges.(In the sections that follow, brief descriptions of the more common emotional and behavioral problems of the early childhood years are provided.

Note that this discussion of disorders and problems is not exhaustive but focuses on the

disorders that clinicians are more likely to see in their practices when working with young children. These problems are summarized Is:

Externalizing problems

- **Attention-deficit/hyperactivity disorder**
- **Predominantly inattentive presentation**
- **Predominantly hyperactive–impulsive presentation**
- **Combined presentation**
- **Oppositional defiant disorder**
- **Conduct disorder**

Internalizing problems

- **Anxiety disorders**
- **Specific phobia**
- **Separation anxiety disorder**
- **Generalized anxiety disorder**
- **Social anxiety disorder**
- **Selective mutism**
- **Posttraumatic stress disorder**
- **Somatic symptom and related disorders**
- **Depressive disorders**

- **Major depressive disorder**
- **Persistent depressive disorder**

Other problems

- **Elimination disorders**
- **Enuresis**
- **Encopresis**
- **Feeding and eating disorders**
- **Pica**
- **Rumination**
- **Avoidant/restrictive food intake**
- **disorder**
- **Sleep problems**
- **Autism spectrum disorder**

Externalizing Problems

There are three generally recognized externalizing disorders: (1) *attention-deficit/ hyperactivity disorder (ADHD*), (2) *oppositional defiant disorder (ODD),* and (3) *conduct disorder (CD).* Although each of these disorders can be diagnosed in young children, it is rare for a young child to receive the diagnosis of CD, given

its more serious nature. However, as will be discussed later, ODD (often considered a developmental precursor to CD) is one of the more common disorders diagnosed during the preschool and kindergarten years. Each of these disorders is discussed in more detail in the following sections

Attention-Deficit/Hyperactivity Disorder

Over the past several decades, ADHD has received increasing attention in both the research and popular literature. Much of this attention has focused on school-age children, but increasingly researchers are studying ADHD as a syndrome that can be diagnosed in the preschool and kindergarten years. ADHD is defined as "a persistent pattern of inattention and/or hyperactivity–impulsivity that interferes with functioning or development"

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) specifies that ADHD is a neurodevelopmental disorder with a childhood onset

and requires that “several” symptoms must be present prior to age 12. Additional diagnostic criteria for ADHD include the presence of symptoms across at least two settings and evidence that symptoms interfere with functioning. Obviously, preschool and kindergarten children are, by nature, less attentive and more active than are older children. It is noted in DSM-5 that it can be difficult to differentiate symptoms of ADHD from those of typical young-child behavior prior to the age of 4 and that ADHD is most commonly diagnosed in the elementary school years. However, ADHD certainly is diagnosed in the preschool years, and there are an increasing number of studies on ADHD in preschool children, including the National Institutes of Health-funded Preschool ADHD Treatment Study (PATS) designed to evaluate the use of methylphenidate in preschoolers (e.g., Greenhill et al., 2006; Kollins et al., 2006). In studies specific to preschool children, prevalence rates of ADHD have ranged from approximately 2 to 13%.

In general, these studies have noted a higher rate of ADHD in boys than in girls. There are three subtypes of ADHD defined in DSM-5: (1) predominantly inattentive presentation (in which the child shows at least six of nine inattentive symptoms but fewer than six hyperactive–impulsive symptoms); (2) predominantly hyperactive–impulsive presentation (in which the child shows at least six of nine hyperactive–impulsive symptoms but fewer than six inattentive symptoms); and (3) combined presentation (in which the child shows at least six symptoms of both inattention and hyperactivity–impulsivity).

The factor structure of ADHD and the appropriate classification of subtypes has been a subject of much research for a number of years. Recent investigations into the factor structure of ADHD has taken a hierarchical modeling approach and have found support for a general ADHD factor, as well as the specific factors of inattention and hyperactivity–impulsivity ingeneral and clinical samples of school-age.

However, at least one study found that while hyperactive symptoms loaded on the general ADHD factor, they did not contribute to either of the specific factors (Ulleb, Breivik, Gillberg, Lundervold, & Posserud, 2012). This bidimensional aspect of ADHD has been seen not just in U.S. samples but across a variety of countries representing diverse populations.

More limited research has been conducted on the factor structure of ADHD in preschool-age children and it is not clear whether a two-factor model is most appropriate for preschool-age children or whether ADHD is better conceptualized as a unidimensional construct in young children, as has been found in some studies .

Interestingly, Hardy and colleagues (2007) found problems in terms of statistical fit with one-, two-, and three-factor models of ADHD for preschool-age children. For parent ratings, the two- and three-factor models were "marginally acceptable" but for teacher ratings none of the models had acceptable fit using

confirmatory factor analysis. Additional analyses did suggest that the two and three factor models were satisfactory—but with cross loadings of items on the factors.

Although the factor structure of ADHD symptoms in preschool children may not yet be clear, it is generally agreed that there is a developmental progression of symptoms. While hyperactive–impulsive symptoms may be more common in young children, over time children with hyperactive–impulsive symptoms are likely to show an increase in inattentive symptoms and therefore be moved to a combined presentation diagnostic category.

Oppositional Defiant Disorder and Conduct Disorder

ODD is defined in DSM-5 as "a pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness"

Individuals must have at least four symptoms across these three categories of behavior, and the symptoms must last for at least 6 months. ODD has been estimated to occur in 2–13% of preschool-age children . In these preschool-age samples, significant gender differences have not been noted, even though in older children ODD is reported to be more common in boys than girls (American Psychiatric Association, 2013). Symptoms of ODD often first appear in the preschool years and, if they occur in just one setting, are most typically seen first in the home setting (American Psychiatric Association, 2013). Although DSM-5 categorizes symptoms in the three areas just noted, there are no subtypes of this disorder.

However, increasingly researchers are noting that ODD may be best conceptualized as having multiple dimensions (e.g., Lavigne, Bryant, Hopkins, & Gouze, 2015), and the presentation type may have implications for the pattern of problems seen over time. While ODD has been noted as a precursor to CD for some children (particularly in boys; e.g., Rowe, Costello, Angold,

Copeland, & Maughan, 2010), ODD is also linked to internalizing symptoms such as depression and anxiety (Boylan, Vaillancourt, Boyle, & Szatmari, 2007).

In particular, researchers have noted that the irritability dimension of ODD may be linked to internalizing. ODD symptoms can be identified in the preschool years and, even at that age, different patterns of symptoms can emerge. Preschool-age children who presented with increasing or persistent levels of irritability were associated with poorer outcomes over time, including an increased risk for internalizing and externalizing problem behaviors.

CD is defined as "a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated"

Symptoms in DSM-5 include 15 specific behaviors across four categories: aggression toward people and animals, destruction of property, deceitfulness or theft, and serious violation of rules.

Individuals must have at least 3 of the 15 symptoms over the past year and at least 1 symptom over the past 6 months. As noted in DSM-5, CD can be of the childhood-onset type, where symptoms are first present prior to age 10, or of the adolescent-onset type where no symptoms are present prior to age 10. (DSM-5 also allows for an "unspecified onset" in which it cannot be determined when symptoms were first present.) Although CD can occur during the preschool years, the onset is typically later in childhood.

However, it is worthwhile for clinicians working with preschool- and kindergarten-age children to have a good understanding of both ODD and CD, given the link between the two. In addition, while preschoolers are unlikely to receive a diagnosis of conduct disorder, they may begin to display symptoms of CD in the preschool years, and these symptoms are predictive of later externalizing.

It is also important to note that researchers and clinicians often use the term "conduct problems" to

refer to general externalizing behavior problems, and this term should not be seen as synonymous with CD.

Internalizing Problems

Although prevalence rates for specific internalizing problems in young children are often lower than rates for specific externalizing problems, when rates are collapsed across specific diagnoses within these categories, there tend to be similar rates of "emotional" (internalizing) and "behavioral" (externalizing) disorders, and in one study, rates were much higher for emotional disorders (anxiety and depression) than for behavioral disorders.

In addition, many young children may not meet criteria for a specific internalizing disorder but may instead exhibit general symptoms such as anxiety, fearfulness, unhappiness, and so forth. If these symptoms are severe enough (whether or not a formal disorder is diagnosed), treatment should be considered.

Some of the more common internalizing problems in children are described in this section. Prior to the presentation of some of the specific internalizing disorders, a general discussion of fears and anxieties is presented.

Fears and Anxieties

The terms *fear* and *anxiety* are often used interchangeably; however, there are differences between the two. *Fear* is typically conceptualized as a set of intense physiological responses (e.g., increased heart rate, sweating, shaking) in response to a specific stimulus that is a normal response to a perceived threat. Fear is generally a protective and adaptive response that alerts a person to danger and thereby helps him or her to survive.

For example, a child who is face-to-face with a bear would likely experience fear. *Anxiety* is considered to be somewhat more vague and diffuse and is typically not a response to a specific or threatening stimulus. For example, the child who worries about going camping in

case a bear is encountered—even though there is no direct threat—may feel tense and apprehensive about the.

Fears are a normal part of childhood development as children learn to anticipate danger. The anticipation of danger motivates the child to be cautious, thereby preventing the child from being harmed. For example, as children learn that not all dogs are friendly, they may start being more cautious and asking for permission before petting an unknown dog. However, intense fear, anxiety, or a phobic response to seeing dogs and going out of one's way to avoid dogs would not be adaptive for a child. Thus, it is not necessarily the feeling of worry or fear itself that is problematic but the severity of the response and the associated behaviors. Children do commonly express some fears (although often not at a clinical level), and particular fears seem to cluster at certain ages. Fears in infancy typically occur as a reaction to the environment, such as fear in response to loud noises and, in later infancy, fear of strangers and separation from caretakers. In the

preschool and early elementary school years, fears broaden, often involving natural phenomena such as the dark, storms, and earthquakes, as well as animals, imagined supernatural figures, and loss of caregivers.

In the later elementary school years, physical injury and school-related concerns may emerge. As children enter adolescence, concerns about friendships and personal adequacy may become more prominent .

Nighttime fears are particularly prevalent in younger children , Gender differences related to fears seem to be present for some fears and not for others. For example, in one study with children ages 5–16, girls were more likely than boys to have fears of animals, strangers, and the natural environment but not loud noises, the dark, or supernatural figures. There are also age differences in how children express symptoms associated with fear and anxiety. Somatic complaints, including headaches and stomachaches, are commonly seen in preschool- and kindergarten-age children.

Whereas older children might talk about feelings of anxiety and distressing thoughts, as noted in DSM-5, younger children more often act out their anxiety through excessive and uncontrollable crying, anger outbursts, tantrums, or clinginess. In addition, children who have experienced some form of trauma, such as abuse, may express their anxiety through repetitive play, a symptom commonly seen in children with posttraumatic stress disorder

Anxiety Disorders

Specific phobias **are different from typical childhood fears in that they are more persistent and severe than would be expected for the age and developmental level of the child. As defined in DSM-5, specific phobias involve "marked fear or anxiety about a specific object or situation," and in children this fear can manifest by "crying, tantrums, freezing, or clinging"**

Upon exposure to the object or situation, the person experiences a fear or anxiety response; often the feared

object is avoided to prevent the anxiety response. Adults must recognize that their fear is excessive for the diagnosis to apply; however, children do not need to have this realization in order to receive a diagnosis of specific phobia. The fear must also be persistent, lasting for at least 6 months (American Psychiatric Association, 2013). Although fears are common in young children, as we have noted, specific, diagnosable phobias are less common, with prevalence estimates ranging from less than 1% to about 10% in preschool-age children.

Specific to children, particularly younger children, is anxiety surrounding separation from primary caregivers. Though this is a typical response in very young children starting in the later part of the child's first year, at older ages and when this anxiety is excessive, the child might receive a diagnosis of *separation anxiety disorder* (*SAD).*

SAD involves "developmentally inappropriate and excessive fear or anxiety concerning separation from

those to whom the individual is attached" (American Psychiatric Association, 2013, p. 190). Children with SAD exhibit a high level of distress when separated from their caregivers or in anticipation of separation. Children with SAD often fear that harm will come to their caregivers or that something bad will happen to them (e.g., kidnapping). Children with SAD will attempt to avoid separation. They may exhibit "clingy" behavior with their caregivers and may experience sleep difficulties (including nightmares) and have physical symptoms such as headaches or stomachaches when separation occurs or is anticipated and, for children who are in school, there is a high rate of school.

Specific DSM-5 criteria require that at least three of eight symptoms be present and that the fear, anxiety, or avoidance be persistent for at least 4 weeks in children (American Psychiatric Association, 2013). Prevalence rates of SAD in preschool children have been estimated to range from less than 1% to 10% with most studies not indicating significant differences in prevalence

based on gender; however, one study showed that girls were more likely than boys to have this diagnosis.

Generalized anxiety disorder (GAD) involves "excessive anxiety and worry . . . about a number of events or activities" that occurs "more days than not for at least 6 months". The focus of the anxiety can change over time, but the anxiety must remain excessive based on intensity, frequency, or duration.

DSM-5 lists six specific anxiety symptoms (e.g., irritability, sleep disturbance), and the anxiety worry must be associated with at least one of these symptoms in children (although for adults, there must be at least three symptoms.

Children with GAD may not necessarily have more worries than typical children but the intensity of these worries is greater (Higa-McMillan et al., 2014). The prevalence of GAD in preschool children has been estimated to be less than 1% (Lavigne et al., 2009), to close to 4% (Bufferd et al., 2011; Egger et al. 2006), to as high as 9% in some studies.

Gender differences were not noted in any of these studies on preschool prevalence of GAD. Although GAD can be diagnosed in the preschool years, there is little research on the specific symptom presentation during the early childhood years. DSM-5 notes that children with GAD tend to have excessive worry about school and sports; however, these issues seem likely to be less relevant for preschool-age children.

Social anxiety disorder (social phobia) **involves a "marked, or intense, fear or anxiety of social situations in which the individual may be scrutinized by others" and, in children, this fear must be in peer settings, not just with. These social situations provoke fear or anxiety that, in children, can be expressed by "crying, tantrums, freezing, clinging, shrinking, or failing to speak".**

Symptoms must be present for at least 6 months and must cause some impairment in functioning. Children with social phobia typically have fewer friends

than their peers and may be hesitant to join social activities.

Social anxiety disorder prevalence rates in preschool-age children range from less than 1% to as high as 7.5%, with several reporting rates in between these estimates (Bufferd et al., 2011; Egger et al., 2006). Gender differences were not noted in these studies.

Selective mutism **involves a "consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations" This disturbance must have lasted for at least 1 month, not be limited to the first month of school, and not be due to a lack of knowledge or comfort with the spoken language required in the social situation. The onset of selective mutism typically occurs during the preschool years, although it may not be recognized until the child is in a school setting.**

The course of this disorder may be variable, with some children outgrowing the disorder and others

continuing to struggle over time with it or other anxiety disorders (American Psychiatric Association, 2013). Selective mutism has been investigated in fewer prevalence studies than some of the other disorders discussed but has been estimated to have a prevalence of less than 2% (Bufferd et al., 2011; Egger et al., 2006). Differences by gender have not been reported. Prior to DSM-5, selective mutism was not categorized as an anxiety disorder. However, symptoms related to anxiety or actual comorbid anxiety diagnoses have long been noted in studies of children with selective mutism, and some researchers have proposed that selective mutism be considered as an early or special form of social phobia.

It is important to differentiate selective mutism from other difficulties associated with expressive language, including neurodevelopmental disorders such as autism spectrum disorder and communication disorders, which are likely to be more pervasive. Consultation with parents, as well as referrals to

speech–language pathologists, may help rule out some of these other reasons for language difficulties.

Other Internalizing Disorders

Posttraumatic stress disorder (PTSD) **is one of several disorders listed in the "Trauma- and Stressor-Related Disorders" chapter in DSM-5. Previously PTSD had been listed with the "Anxiety Disorders," and DSM-5 does note that there is a "close relationship" between trauma/stress disorders and anxiety disorders (as well as several other disorders). New in DSM-5 are criteria specific for children age 6 and younger. PTSD occurs following exposure to a traumatic event either by directly experiencing the event, witnessing the event (especially when directed toward a primary caregiver), or learning about a traumatic event that happened to a parent or caregiver. The traumatic event should involve "actual or threatened death, serious injury, or sexual violence.**

PTSD in young children requires the presence of at least one intrusion symptom (e.g., distressing memories,

dreams) and at least one symptom indicative of avoidance (avoiding places or people related to the event) or negative alterations in cognitions (increased negative emotional states; diminished interest in/participation in activities, including play; socially withdrawn behavior; and/or persistent reduction in expression of positive emotions).

There also must be changes in arousal and reactivity related to the event with at least two of the following symptoms present: irritable behavior/angry outbursts, hypervigilance, exaggerated startle response, concentration difficulties, and sleep disturbances.

The PTSD diagnostic criteria in DSM-5 removed the requirement for "fear, helplessness, or horror." The rationale for the removal of this requirement was that across all ages, it did not seem to improve diagnosis, and for preschool children specifically, their immediate reaction may not be known depending on whether someone was present in the situation. Also new in the DSM-5 is the modified criterion for the child to witness

or simply learn that a traumatic event occurred to a parent or primary caregiver, instead of only directly experiencing the event him- or herself.

In addition to anxiety and the reliving of the trauma, young children with PTSD often exhibit negative emotional states (e.g., fear, sadness, or confusion), behavioral problems, irritability and angry outbursts, and withdrawal from social contact.

However, it is important to note that preschool-age children may not always exhibit symptoms consistent with what adults might expect. For example, Scheeringa and colleagues (2011) noted that parents of some children reported a neutral reaction or excitement following exposure to a traumatic event, although anger, sadness, and fear were more common.

The prevalence of PTSD in preschool children is estimated to be less than 1%. However, higher rates are likely to be found in children who have experienced a traumatic event—at least initially. In an older study, Spence, Rapee, McDonald, and Ingram (2001) reported

that while close to 14% of mothers of preschool age children reported their child had experienced a traumatic event, the prevalence of PTSD symptoms was very low, with items reflecting PTSD being endorsed for fewer than 5 of the 65 children who had experienced a traumatic event. In a more recent study of preschool children who had experienced a traumatic event (being burned), PTSD was calculated to be present in 25% of the children at 1-month postinjury and in 10% of the children at 6-months. if utilizing modified DSM criteria with only one symptom present in each category. Using DSM-IV criteria resulted in a 5% prevalence rate at 1 month and a 1% rate at 6months.

also evaluated the use of DSM-IV criteria and modified criteria in the diagnosis of PTSD over time in a sample of 2- to 10-year-old children following a motor vehicle accident. At a 6-month follow-up, 14% of the children met diagnostic criteria using modified criteria and less than 2% met diagnostic criteria using DSM-IV criteria (based on parental report).

DSM-5 includes a new category of disorders, "Somatic Symptom and Related Disorders," replacing the somatoform disorders from the DSM-IV. Although children can be diagnosed with somatic disorders, typically they will not meet the criteria for a somatic disorder but, instead, may have somatic symptoms associated with an internalizing disorder, such as anxiety or depression. Although the DSMIV criteria emphasized that somatic symptoms had no medical explanation, and so were presumed to have a psychological origin, DSM-5 states that it is "not appropriate to give an individual a mental disorder diagnosis solely because a medical cause cannot be demonstrated".

In addition, it is acknowledged that somatic symptoms can be associated with a medical diagnosis. Somatic symptoms can be common in young children, although such symptoms do not mean that a disorder is present. For example, in a study of 319 kindergarten students, 64% were reported to have had at least one

physical complaint in the 2 weeks preceding the study, and 31% were reported to have frequent somatic.

Other studies have had similar findings, with abdominal pain, tiredness, leg pains, headaches, and dizziness among the most frequent complaints of children ages 3–5. In addition, tingling sensations or numbness in the extremities, skin rashes or itching, and breathing problems (e.g., shortness of breath, asthma-type symptoms, or hyperventilation) are also possible.

Children may be diagnosed with the depressive disorders outlined in DSM-5, including *major depressive disorder* and *persistent depressive disorder (dysthymia).* Although there are no specific depressive criteria for children, DSM-5 does note that instead of having a "depressed mood," children may exhibit an "irritable mood". DSM-5 also notes the symptoms commonly seen in children: irritability, social withdrawal, and somatic complaints. However, young children also can experience the core symptoms of depressed mood, such as loss of pleasure or interest in

activities during the day. Other symptoms young children may exhibit include weight loss or gain (including a failure to make expected weight gains in young children), insomnia or hypersomnia, loss of energy, psychomotor agitation, and difficulties concentrating.

The child must have had some of these symptoms for at least 2 weeks for the symptoms to be considered a depressive episode. A long-term mild depression (lasting at least 1 year for children) is called persistent depressive disorder (formerly dysthymia), whereas a depressed mood that occurs in response to a specific stressor and resolves usually within 6 months is called an *adjustment disorder with depressed mood.*

Younger children tend to have low prevalence rates of depression with rates for preschool children estimated at 2% or less. Most studies have not reported gender differences in preschool prevalence rates, although Wichstrom and colleagues (2012) found that

boys had a higher prevalence rate than girls (2.6% vs. 1.5%).

Other Problems

In addition to the disorders that fall within the externalizing and internalizing domains, there are a number of other problems with which children can present for treatment. Some of these more common "other problems" seen in preschool children, including toileting difficulties, feeding problems, and sleeping problems, are reviewed here. Toileting problems are commonly seen in young children, although many preschool children may be too young to receive a formal diagnosis of one of the elimination disorders.

Enuresis **involves the repeated voiding (whether involuntary or intentional) of urine in one's clothes during the daytime (diurnal enuresis) and/or while sleeping (nocturnal enuresis). To be diagnosed with enuresis, a child must be "having accidents" at least twice a week for at least 3 months, or there must be signs of significant distress or impairment in**

functioning. According to diagnostic guidelines in DSM-5, children must be at least 5 years of age to be diagnosed with enuresis. However, there is significant developmental variability regarding the age at which children achieve dryness. For example, daytime dryness is generally accomplished before nighttime dryness and boys tend to achieve dryness at a later age than girls.

Cultural norms have also impacted the age at which children master toilet training. For example, in the 1940s, toilet training commonly started before 18 months of age, while more recent data have shown that training now generally starts between 21 and 36 months of age. Enuresis is categorized as either primary or secondary.

Children with primary enuresis have never achieved continuous bladder control, whereas children with secondary enuresis have been dry for some period of time (generally 6 months to 1 year) but then cease exhibiting bladder control. Etiological explanations of enuresis are varied and include factors such as heritability,

delayed/abnormal physiological development, inadequate nighttime secretion of antidiuretic hormone, difficulty with sleep arousability, and inadequate learning history.

Less common influential factors include emotional difficulties, such as anxiety, environmental and/or family changes, and a history of trauma or abuse. Prevalence estimates for enuresis vary, with all estimates indicating a decline in prevalence as children age. It is estimated that approximately 15–20% of 5- to 6-year-old children continue to experience occasional nighttime wetting. At age 7, the estimated prevalence rate of enuresis is 9% in boys and 6% in girls. This rate decreases to 7% in boys and 3% in girls at age 10. In adolescence, the prevalence rate markedly declines, with approximately 1% of individuals meeting diagnostic criteria. This decline with age is due, at least in part, to the

fact that approximately 5–10% of children who engage in bed-wetting spontaneously remit each year. Enuresis is more than twice as likely in boys than in

girls. Nocturnal enuresis is three times more common than daytime wetting.

Encopresis **involves soiling in inappropriate places, such as clothing, at least once a month for at least 3 months. Children must be at least 4-years of age to receive this diagnosis. Prevalence rates of encopresis have been estimated at 5–6% in preschool-age children.**

Encopresis is typically due to severe constipation and is referred to as retentive encopresis. However, a smaller subset of children (approximately 10% of those with encopresis) exhibit nonretentive encopresis. Nonretentive encopresis includes children who were never fully toilet trained, children with fear-related avoidance of toileting, children who receive contingent reinforcement for soiling, and children with irritable bowel syndrome. Although children must be at least 4 years old to receive a diagnosis of encopresis, children under this age may exhibit toileting problems, such as refusing to use the toilet. Children who exhibit toileting

refusal are at greater risk of developing encopresis due to constipation.

Children with encopresis are significantly more likely to also exhibit difficult temperaments (e.g. stubborn, defiant), as well as emotional and behavioral problems. Feeding and eating disorders covered in DSM-5 include pica, rumination, and avoidant/ restrictive food eating. *Pica* involves eating nonnutritive, nonfood items. These items can include a wide variety of substances including paint, fabric, soil, and so on. It is relatively common for infants and toddlers to eat nonfood substances occasionally. This behavior does not necessarily imply the presence of pica, which should only be diagnosed if the behavior is inappropriate for the child's developmental level and persists for at least 1 month.

Rumination **involves regurgitation of food that then may be rechewed, reswallowed, or spit out. These**

behaviors must occur for at least 1 month and cannot be better accounted for by a medical condition.

Children with rumination disorder regurgitate partially digested food into their mouths (with no associated nausea, involuntary retching, or disgust) and then spit out or rechew the food. The disorder is most common in infants but is also diagnosed in older children, particularly those with intellectual disabilities or other neurodevelopmental disorders. Rumination is voluntary, and children may give the impression of gaining pleasure or satisfaction by engaging in the behavior.

***Avoidant/restrictive food intake disorder* involves a disturbance in eating and a failure to meet nutritional energy needs. Although all of these feeding disorders may be diagnosed in young children, more typically young children exhibit problems related to feeding and eating that do not meet criteria for a formal disorder. Children may be "picky eaters" or have other issues related to eating (e.g., behavior problems while eating,**

such as spitting out food) that are not diagnosable disorders. Although these problems do not meet the criteria for a clinical disorder, they can still be highly problematic for parents, and treatment is often warranted.

General childhood feeding difficulties are considered to be quite common, with up to 45% of young children exhibiting difficulties at mealtimes. Many childhood feeding difficulties, such as picky eating, mealtime fussiness, and emotional undereating (i.e., eating less in response to stress/negative emotions), are often related to other behavioral difficulties (e.g. emotional dysregulation, noncompliance, hyperactivity. Many of these difficulties are transitory in nature and resolve spontaneously without clinical intervention. However, a smaller subset of children will develop chronic feeding issues, with approximately 25% of typically developing children and 80% of children with developmental disabilities experiencing clinically significant feeding concerns.

Feeding disorders include an array of behaviors that involve failure to eat a sufficient quantity and/or variety of food resulting in chronic malnutrition, poor weight gain, and/or weight loss. The etiology of these problems is varied and includes medical or physical disorders (e.g. metabolic disorder, neu romuscular problems), developmental delays, and behavioral / psychosocial issues .

While younger children tend to have more feeding problems than older children, the general trend is for early feeding problems to persist; in fact, these feeding problems may predict eating disorders in adolescence and adulthood.

More recently, increased attention has also been given to early childhood obesity, as more than 20% of children ages 2–5 are already overweight or obese . While it is often assumed children will "grow out of it," childhood obesity tends to persist into later life and can increase the risk of obesity-related disease in adulthood. In fact, research has shown that a child who is

overweight at age 3 is nearly eight times more likely to be overweight as an adult in comparison to a 3-year-old who is not overweight. Of the various factors that can contribute to obesity, environmental factors have been heavily implicated. In a large-scale study conducted in 12 countries, Katzmarzyk and colleagues (2015) noted that environmental–behavioral factors were important in predicting obesity in children ages 9–11, with low physical activity, short sleep duration, and high TV viewing being some of the most predictive ones. In a study specific to preschool children, establishing routines such as eating dinner as a family, getting an appropriate amount of sleep, and having limited TV viewing were predictive of a lower prevalence of obesity (Anderson & Whitaker, 2010). Given the importance of such environmental factors, early childhood interventions may provide the best opportunities to alter habits and routines to help promote healthy lifestyles and healthy weights.

Sleep problems **are also commonly reported by parents of young children, with estimated rates of sleep**

disturbances ranging from 25 to 40%, although most of these problems will not meet official DSM-5 criteria for one of the many sleep–wake disorders. The most common sleep problems in early childhood include bedtime resistance and frequent nighttime wakings. Other common problems include nightmares, night terrors, sleep talking, and sleepwalking. This is also the peak age for obstructive sleep apnea due to enlarged tonsils and adenoids (Meltzer & Crabtree, 2015). These problems will be temporary for some children but will persist over time for others. Persistence of sleep problems is particularly likely to occur when children begin exhibiting sleep problems at a young age.

The long-term implications of early childhood sleep disturbances have been shown to be significant. Results of an 11-year longitudinal study of 490 children revealed that sleep problems at age 4 predicted behavioral–emotional problems in adolescence and were equally predictive of anxiety, depression, attention problems, and aggression.

Autism Spectrum Disorder

Autism spectrum disorder (ASD) **is another disorder that is often first diagnosed in the preschool years, especially with the increased emphasis on screening for ASD at well-child visits during the early childhood years. Due to the complex nature of ASD and the interdisciplinary approach needed to address the behaviors associated with this disorder, the treatment of ASD is beyond the scope of this book. However, given that it is commonly identified at an early age, it is important for clinicians working with young children to have some knowledge of this disorder. Therefore, we provide a brief overview here, as well as some information on the assessment of ASD in Chapter 2. Clinicians interested in reading more about the treatment of ASD may wish to consult several of the recent books in this area.**

Websites such as those from Autism Speaks (*www.autismspeaks.org*) and the UC Davis Mind

Institute (*www.ucdmc.ucdavis.edu/mindinstitute*) can also be sources of further information on ASD.

The definition of ASD changed rather substantially between DSM-IV and DSM-5. In DSM-IV, there were several pervasive developmental disorders, which included autism, along with Asperger's disorder (now termed Asperger syndrome), childhood disintegrative disorder, Rett's disorder, and pervasive developmental disorder not otherwise specified. In DSM-5, there is one disorder: autism spectrum disorder.

All DSM-IV disorders, except Rett's disorder, are subsumed under DSM-5's ASD diagnostic category. Rett's disorder is seen as a separate genetic condition; individuals with Rett's may qualify for an ASD diagnosis if they meet all of the ASD criteria, but they should not be diagnosed with ASD solely because they have Rett's disorder.

Criteria for ASD are divided into two primary categories. Children must show "persistent deficits in social communication and social interaction across

multiple contexts" and "restricted, repetitive patterns of behavior, interests, or activities". For each of these domains, a severity indictor must be provided: Level 1—requiring support, Level 2—requiring substantial support, and Level 3—requiring very substantial support.

There are three criteria listed under the social deficit category, and children must exhibit all three to receive an ASD diagnosis. These are deficits in the following areas: social–emotional reciprocity; nonverbal communication behaviors used in social interactions; and developing, maintaining, and understanding relationships.

Four types of restricted/repetitive behaviors are listed, and children must exhibit two of these four: (1) stereotyped or repetitive motor movements, use of objects, or speech; (2) insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior; (3) highly restricted, fixated interests that are abnormal in intensity or focus; (4)

hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment.

Symptoms of ASD must be present in the "early developmental period." The Centers for Disease Control and Prevention (CDC) funds the Autism and Developmental Disabilities Monitoring (ADDM) Network, which provides data on the prevalence of ASD in the United States. The current estimate of the prevalence of ASD is 1 in 68 children (14.6 per 1,000) as evaluated by medical and special education records of 8-year-old children in 2012). This estimate is almost identical to that from 2010 (14.7 per 1,000) but higher than estimates from 2008 (11.3 per 1,000) as well as other previous years dating back to 2000,

when the estimate rate was 6.7 per 1,000. The ADDM Network report notes that ASD is more common in boys than in girls, with 1 in 42 boys having an ASD diagnosis and 1 in 189 girls having a diagnosis. When looking at differences by race/ethnicity, non-Latino/ a, Caucasian children were more likely to

receive an ASD diagnosis than were non-Latino/ a African American children and Latino/a children. There were no gender or race/ethnicity differences in the average age of first diagnosis (50 months). However, a greater percentage of non-Latino/ a Caucasian children received evaluations at or before the age of 36 months than did Latino/ and African American children.

There were also differences in prevalence rates by geographic region. Of the 11 states included, the highest prevalence rates were in New Jersey (24.6%), Maryland (18.2%), Utah (17.3%), and North Carolina (16.9%), and the lowest rates were in Wisconsin (10.8%), and Colorado (10.8%). (Although it should be noted that in states with data from health and educational records, rates were higher than in states with only health records. In Maryland, which had rates calculated both ways, the rate was 8.2% with just health records.)

The causes and risk factors for ASD are complex and likely multifaceted, and a great deal of ongoing research in this area attempts to better identify them. Researchers have noted that ASD likely has a genetic/biological component, and various other factors such as prenatal/perinatal and environmental factors can lead to increased risk of ASD. Although there has been much discussion about the potential connection between childhood vaccines and ASD, this link has been disproven, and it is important for parents and clinicians to be aware of this fact.

Children with ASD are at higher risk for other disorders with high rates of comorbidity noted in several studies. For example, Salazar and colleagues (2015) evaluated comorbidity rates in a sample of 101 children ages 4–9 who had an ASD diagnosis and found that 90.5% of these children had another DSM diagnosis. The most common comorbid diagnoses were GAD (66.5%), ADHD (59.1%), and specific phobia (15.1%). These findings are consistent with an earlier study of 10- to 14-year-old children (Simonoff et al.,

2008), in which 70.8% of the sample had a least one comorbid disorder. In this sample, the most common comorbid disorders were social anxiety (29.2%), ADHD (28.2%), and ODD (28.1%).

In addition, a study with 9- to 16-year-old children with Asperger syndrome or high-functioning autism, also showed very high comorbidity rates (Mattila et al., 2010). Of this sample, 74% met criteria for a current comorbid disorder and 84% met criteria for a lifetime comorbid disorder, with the highest comorbidity rates for ADHD (38%), specific phobia (28%), and tic disorders (26%).

As should be clear from this discussion, ASD is a complex disorder and although there are core characteristics that every child needs to have to receive a diagnosis, actual presentation in terms of severity and comorbid disorders can vary widely. While early intervention for ASD seems to be critical, the research on evidenced-based interventions for ASD still leaves many unanswered questions about long-term outcomes,

the specifics of what interventions are the most effective, and what interventions work for very young children. In a recent overview of five meta-analyses

conducted on early intensive behavioral interventions (EIBIs) for ASD, the authors concluded that the effects of EIBIs were "strong and robust," while also noting the importance of a better understanding of the moderating factors on treatment, as well as a better understanding of what specific treatment components are most important and how EIBIs are being implemented outside of treatment studies.

Summary of Problems

There are a number of social–emotional– behaviora problems that young children may exhibit. Although the review of disorders was organized around DSM categories, as noted throughout, many preschool and kindergarten children who are referred for emotional andbehavioral problems will not receive a diagnosis of a specific disorder.

In many instances, a full diagnostic assessment may not be needed or warranted. For example, a clinician may choose not to attach a diagnosis to a preschool or kindergarten child who is exhibiting general acting-out behavior problems. Instead the clinician may complete an assessment (e.g., parent interview, rating scale) to gather information on the nature of the problems but not tie the assessment results to a formal diagnosis if it is not required for treatment purposes (e.g., insurance reimbursement, access to services).

In other situations, a full diagnostic assessment may be undertaken, and the child may not meet the criteria for a formal diagnosis, although the child may still exhibit sufficient problems of concern to the parent or teacher to warrant intervention. It is important that clinicians not fall into the trap of thinking that a diagnosis is necessary in order for treatment to be provided. Although a formal diagnosis may help guide treatment selection, it is typically more important to identify specific behaviors of concern to address in treatment than to assign a DSM-5 diagnosis.

PREVALENCE OF MENTAL HEALTH CONCERNS IN YOUNG CHILDREN

In the previous section, we cited several studies that examined the prevalence estimates of disorders in preschool-age children.

Until the past decade or so, the data regarding the prevalence of specific emotional and behavioral problems in young children were scarce. However, as interest in this population has grown, and clinicians and researchers have realized that young children can meet criteria for specific disorders, the number of studies related to the epidemiology of preschool disorders has increased. As diagnostic tools with young children have improved, epidemiological studies examining DSM diagnoses with preschool-age children have also increased. For example, a number of recent studies, have utilized the Preschool Age Psychiatric Assessment or the Diagnostic Interview Schedule for Children—Young Child .

Both of these are diagnostic interviews (conducted with parents) developed for the evaluation of symptoms in preschool-age children. Tools based on the DSM are certainly not without controversy. Arguments against the use of the DSM with young children include the following: (1) the symptoms are too subjective, (2) the symptoms do not apply to preschool- and kindergarten-age children, and (3) the reliability and validity of the diagnoses have not been established with young children. Increasingly researchers are finding support for the same structure of symptoms in preschool-age children as in older children. For example, Sterba, Egger, and Angold (2007) found that internalizing symptoms in preschool-age children followed patterns similar to those noted in older children with emotional symptoms, based on three factors: social phobia, social anxiety, and major depression/generalized anxiety.

A three-factor model was also the best fit for disruptive symptoms, with the factors being oppositional disorder/conduct disorder, hyperactivity–impulsivity, and inattention. Strickland and colleagues

(2011) obtained similar results in their study but found that a four-factor model (with major depression and generalized anxiety as separate factors) fit better than did the three-factor model.

However, contrary to these findings, Olino, Dougherty, Bufferd, Carlson, and Klein (2014) found that a two-factor model representing internalizing and externalizing symptoms best fit their data. They also found that all symptoms except phobic ones loaded on one common general factor. In a study specific to anxiety disorders (and based on DSM-IV diagnoses), researchers found support for differentiation among anxiety disorders, with GAD, obsessive– compulsive disorder (ODD), SAD, and social phobia emerging as separate factors and fitting the data better than one undifferentiated model. Given the limited number of studies in this area and the lack of clear consensus, it is likely that more research will be needed to help clarify the structure of symptoms in young children. Several recent studies that have been conducted on the prevalence of DSM disorders in preschool children are

briefly reviewed here. They include all those cited in the earlier discussion of the prevalence rates of individual disorders. In this section, a broader overview is provided. Studies specific to individual disorders are not included in this summary.

Wichstrom and colleagues utilized the PAPA to evaluate the presence of disorders in a large sample of Norwegian children. Parents of all children born in 2003 or 2004 in one Norwegian city were invited to participate. Initially 2,475 children were screened utilizing the Strengths and Difficulties Questionnaire (SDQ), and a subset of the parents (*n* = 995) of these children (representing children across the spectrum of SDQ scores) were administered the PAPA. A total of 12.5% of children met criteria for at least one disorder. Encopresis was the most common disorder reported (6.4%). When this disorder was removed, the overall prevalence of disorders was 7.1%, with no single disorder having a prevalence rate over 2%. Overall, more boys evidenced problems than did girls, with ADHD, depression, and sleep disorders being more

common in boys. Differences in prevalence were also noted for parental socioeconomic status (SES), with much higher rates of disorders in children from lower SES families (12.8% for any disorder except encopresis) than higher SES families (4.7% for any disorder except encopresis). Significant differences based on family SES were noted for ADHD, CD, ODD, dysthymia, depression, and SAD.

Lavigne and colleagues (2009) utilized the DISC-YC as well as the Child Symptom Inventory (CSI) checklist to examine the prevalence of disorders in a sample of 796 4-yearold children from the Chicago area. Using the DISC scores and any impairment level (incorporating any child who met minimum criteria for a disorder), ADHD (12.8% for any type) and ODD (13.4%) were considerably higher than those noted by Wichstrom and colleagues(2012).

Rates of internalizing symptoms (anxiety and depression) were lower, under 1%. Results utilizing the CSI were similar, although there were higher rates for

anxiety disorders (GAD was 2.1% and SAD—not measured with the DISC—was 3.9%) and ADHD (15.5%), but lower rates for ODD (5.2%). In this sample, gender differences were noted only for ADHD, with more boys than girls displaying symptoms of ADHD. No significant differences were noted by racial/ethnic groups when SES and the number of analyses conducted were controlled for.

Bufferd and colleagues (2011) utilized the PAPA in evaluating 541 3-year-old children residing in the Stony Brook, New York, area. Overall, 27.4% of children met the criteria for at least one disorder. ODD (9.4%) and specific phobia (9.1%) were the most common diagnoses. SAD (5.4%) was the only other disorder with a prevalence rate over 5%. Depressive disorders (1.8%), selective mutism (1.5%), and panic disorder (0.2%) were the least commonly reported diagnoses.

The authors reported that diagnoses were not associated with demographic variables such as SES, sex, or race/ethnicity, with a couple of exceptions (e.g.,

specific phobias were more common in lower SES families).

In an evaluation of the reliability of the PAPA, Egger and colleagues (2006) reported on the prevalence of disorders in a sample of 307 children ages 2–5. Youth in this study were drawn from a pediatric outpatient clinic in Durham, North Carolina. Because one of the purposes of the study was to evaluate the PAPA, researchers administered the measure twice to all participants with test–retest intervals ranging from 3 days to 1 month. The overall prevalence of any disorder (excluding elimination disorders) was 16.2% at time 1 and 14.1% at time 2.

In general, the prevalence of disorders at time 2 was lower than at time 1, although the difference was significant only for SAD, GAD, and CD in terms of the specific disorders assessed.

Although having the estimates of prevalence rates can be helpful for clinicians, it is important to keep in mind that the interventions discussed here are not

designed specifically for any one DSM disorder but, rather, are directed at treating the *specific set of symptoms* the child is exhibiting. This is in line with the more recent focus on transdiagnostic approaches to intervention in which treatment approaches are not tailored to a specific disorder but can be used across diagnostic categories to address common core mechanisms or processes. This approach may be particularly valuable in children given the comorbidity of problems as well as changing nature of symptoms over the time.

THE IMPACT OF BEHAVIORAL, SOCIAL, AND EMOTIONAL PROBLEMS IN SCHOOL SETTINGS

Problem behaviors in children can have significant and adverse outcomes on a variety of variables, including those related to the school setting. While it may not seem as though problems in the preschool and kindergarten years would adversely impact future school performance, this is not the case.

In fact, data indicate that prekindergarten (PreK) children in state-funded programs are expelled at 3.2 times the rate of K–12 students, with approximately 10% of sampled teachers reporting expelling at least one child over a 12-month period (Gilliam, 2005). There were notable differences by state (e.g., Kentucky reported no expulsions for PreK children and New Mexico reported 21.10 per 1,000 students), as well as age (older PreK children were more likely to be expelled), gender (more boys were expelled), and race/ethnicity (more African American children were expelled), which may indicate different applications of standards across different settings and groups.

On a positive note, access to a mental health consultant was related to lower expulsion rates. Social and behavioral problems in the early childhood years may have a sustained impact in the later grades. Researchers looking at both externalizing and internalizing problems in young children found that elevated levels of both of these types of problems were predictive of academic problems in first grade .

In a longitudinal study that followed children from grades 1–6, researchers found thatchildren with externalizing and internalizing problems in first grade had lower academic achievement and social competence in sixth grade than students without problems.

In another study, child aggression (but not general externalizing behaviors) in the early years (ages 2–3) predicted increased academic difficulties at age 7 .

Other researchers have found that inattention in the toddler years uniquely predicts reading problems in second grade. These behavioral issues at the classroom level (in addition to the individual child level) can have an adverse outcome on school readiness. For example, similar to other studies, Bulotsky -Shearer, Dominguez, and Bell (2012) found that both "overactive" and "underactive" behaviors in the preschool setting were predictive of more cognitive, social, and motor difficulties in the classroom setting. They also found that high classwide levels of underactive behaviors were associated with lower school readiness. Other

researchers have looked both at behavioral problems and behavioral competencies (noting that these are not necessarily mutually exclusive) and found that behavior competence predicts positive academic functioning even after taking into account externalizing problems and background characteristics .

This finding is consistent with other research findings that suggest child competencies mediated the relationship between problem behaviors in the preschool years and academic and social competence in first grade (McWayne & Cheung, 2009). These studies suggest that a sole focus on problem behaviors (without looking at positive behaviors too) may provide incomplete information regarding a child's trajectory.

In addition to the negative impact that child behavior problems can have on individual child outcomes, they can also have a negative impact on classroom and teacher outcomes. Friedman-Krauss, Raver, Morris, and Jones (2014) found that classroom-level behavioral problems in the fall predicted

increased teacher stress in the spring. In a longitudinal study from preschool to third grade, researchers found that child externalizing problems were related to teacher–student conflict and this relationship was bidirectional. Similarly, findings from a study with preschool-age children showed a bidirectional relationship between child externalizing problems and teacher–child conflict.

STABILITY OF BEHAVIOR PROBLEMS

An increasing body of literature has made it clear that behavior problems in preschool and kindergarten children are often (although not always) stable over time. An often-cited early review on the continuity of problems noted that of children who are identified as having externalizing problems during the preschool years, approximately 50% will continue to have behavior problems over time (Campbell, 1995). As discussed in more detail below, more recent studies have also indicated that many children who first evidence problems in the early childhood years will

continue to struggle with emotional–behavioral concerns as they grow older.

Much of the research on the stability of specific disorders diagnosed in the preschool years has been focused on externalizing disorders. While many studies have short-term follow-up periods, longer-term follow-ups are important in knowing of implications beyondthe preschool years. In a study specific to ADHD, children initially diagnosed at ages 3–5 were followed for 6 years. Researchers administered both the parent and teacher versions of the Conners Rating Scales at 3-, 4-, and 6-year follow-up periods.

Although symptoms showed a decrease from baseline to the 3-year follow-up, symptoms remained relatively stable over the following 3 years, and parent-rated scores tended to remain in the clinical range (although the same was not true for teacher ratings, with these falling below clinical cutoffs at follow-up periods). When looking at diagnosis stability, 76% met the criteria at year 3 and 77% at year 6 (regardless of

medication status). When taking into account behaviors while not on medication, diagnostic rates were higher (90% at year 6).

A comorbid diagnosis of ODD/CD substantially increased the likelihood of an ADHD diagnosis at year 6. When specifically looking at internalizing disorders in later years, preschool-age children with anxious-fearful behaviors as well as hostile-aggressive behaviors, as measured by parent -report questionnaires, were at increased risk for emotional difficulties at ages 10–12.

In a large longitudinal study on the stability of anxiety initially diagnosed in the childhood years (although not necessarily in the preschool years), there was a good degree of diagnostic consistency over time, with the highest consistency found for phobic and social anxiety disorders. Bosquet and Egeland (2006) also noted the moderate stability of anxiety symptoms over time from the preschool to adolescent years based on correlations between symptoms at different ages.

In a study not specific to diagnoses, in which Pihlakoski and colleagues (2006) followed a community sample of children from ages 3 to 12 using the Child Behavior Checklist (CBCL) and Youth Self-Report (YSR), approximately 30% of children who were in the clinical range on the CBCL at age 3 were also in the clinical range on the CBCL at age 12, with approximately 20% in the clinical range on the YSR.

When looking at specific syndrome scales, the aggressive behavior and destructive behavior scales were predictive of later problems across a variety of subscales. Better understanding of not just diagnoses but the stability of symptoms and symptom clusters is also important.

In particular, given that preschool children are not known for their behavioral and emotional regulation skills, understanding what behaviors may be more normative and not predictive of later problems and what behaviors may be more of a cause for concern is important. In a recent study, Hong, Tillman, and Luby

(2015) used diagnostic interviews to evaluate children in the preschool years (ages 3–5) and again in the early school years (ages 6–9). Behaviors that were not predictive of continuing problems included losing one's temper, low-intensity property destruction, and low - intensity deceitfulness /stealing.

In contrast, high intensity of property destruction, deceitfulness / stealing, argumentative / defiant behaviors, and peer problems, as well as both low- and high-intensity aggression toward people and animals, were predictive of later school-age conduct problems.

In a group of children who were identified as having CD at age 5, not only were they more likely to continue to display symptoms consistent with CD at age 10 (compared to controls without CD), they were also more likely to have poor academic performance, have a greater need for special education services, and require more teacher effort.

Even in the group of children who no longer qualified for a CD diagnosis at age 10 (62.5% of the

initial CD sample), they continued to have significantly higher scores than controls on multiple CBCL subscales (more by parent report, less by teacher report) and were more likely to require special education services.

Given these research findings, it seems likely that many children who are identified as having emotional and behavioral problems during the preschool years will continue to exhibit problem behaviors beyond preschool. Therefore, the preschool years are an ideal time to intervene. Although not all young children identified as having problems continue to have problems at later ages, certainly the substantial number of children who do so warrants more attention to treatment for this age group.

If interventions are successful with preschool- and kindergarten-age children, the number of children in need of interventions later in life and the complexity of the interventions needed should be reduced.

PREDICTORS OF PROBLEMS

With the mounting evidence that many preschool- and kindergarten-age children who are identified as having behavioral problems continue to have such problems, researchers have begun to investigate the factors that mediate long-term outcomes. If the factors that lead to initial and continued problems and those that contribute to a decrease in later problems can be determined, then it would be easier to develop interventions targeted to the populations that would benefit the most. In the following sections (and in Tables 1.2 and 1.3), the factors that have been noted to predict problems over time are summarized.

Predictors of Externalizing Problems

Many of the factors identified as contributing to both the initial expression of behavior problems, as well as their long-term stability, are related to characteristics of the child's family. Parenting behaviors are probably the most studied of these factors and have consistently been related to child behavior problems. Gerald Patterson is perhaps the

best known for developing models in this area, and Patterson's coercive parenting cycle model is cited extensively as a predictor of child externalizing problems. Many of the family-based interventions for child behavior problems are based, in large part, on this.

Parent characteristics

- **Parenting behaviors (e.g., coercive parenting,**
- **negative discipline strategies)**
- **Parental stress**
- **Parental psychopathology**
- **Family dysfunction**

Child characteristics

- **Insecure attachment**
- **Difficult temperament/poor self-regulation**
- **Physiological regulation**

Demographic variables

- **Low socioeconomic status**
- **Low birthweight**
- **High violent TV viewing**

model. In the coercive parenting pattern, parents make repeated requests of their children, who do not comply with these requests. Eventually the parent backs down from the request, due to the negative or aggressive behaviors exhibited by the child. Thus the parent negatively reinforces the child by withdrawing the aversive command or request. The parent, in turn, is negatively reinforced by the discontinuation of the aversive behaviors the child was exhibiting. Typically, there is an escalation in this pattern, with parents eventually resorting to more severe methods of discipline in attempts to obtain compliance. The use of these severe methods is often reinforced by the child stopping his or her negative behaviors only once the severe methods are used. In this pattern, both the parent and child tend to escalate their use of negative and aggressive behaviors. These parenting patterns are likely evident from an early age, with a number of

studies noting a link between parenting behaviors in the preschool years and later externalizing.

Parental stress and family dysfunction are important factors in predicting both the initial onset of problems, as well as the continuation of such problems. Preschool children whose parents experience significant distress are more likely to develop externalizing problem behaviors, although this effect may be mediated by ineffective parenting practices. The presence of parental psychopathology in children's preschool years has also been linked to the presence of externalizing.

Although much of the research on predictors of externalizing behavior problems has focused on parent characteristics, more recent research has examined child-focused factors that may contribute to the expression of externalizing problems. Child temperament and self-regulation are two child-focused factors that may be linked to later difficulties. Low levels of inhibitory control have been linked to

externalizing problems across samples representing different ethnic/cultural groups.

Child temperament has also been linked to later externalizing problems when the temperament is characterized as more inflexible and less persistent.

Physiological regulation (as measured by respiratory sinus arrhythmia which is involved in heart rate variability) in the early preschool years has also been noted to be related to later externalizing problems, with greater physiological regulation at age 3 associated with a decreased risk for later externalizing problems (although such a relationship was not seen at ages 4 and 5.

Attachment has also been evaluated as a child factor that may be related to the development of externalizing problems, with several studies noting a link between insecure types of attachment in the preschool years and the development of externalizing.

In addition, one study noted that a secure attachment may moderate the association between

harsh parenting and child aggression, in that a secure attachment can serve as a protective factor when harsh parenting practices are in place. Interestingly, researchers have noted that preschool-age children who have a less secure attachment with their mothers but have a high-quality relationship with their teacher do not show an increased risk level for behavior problems when compared to youth with a secure attachment to their mothers. Thus, the relationship between attachment and problem behaviors may be more complex than it appears based solely on the parent–child attachment relationship.

Demographic variables also have been related to externalizing behavior problems. For example, SES has often emerged as a predictive factor, with low SES related to high levels of externalizing problems (Piotrowska, Stride, Croft, & Rowe, 2015). Another predictor that has been linked to a potential increase in externalizing problems includes low birthweight, Interestingly, higher rates of television viewing have also been correlated with reports of increased

inattentive/hyperactive behaviors, as well as antisocial behaviors in young children, although the relationship with antisocial behavior seems to hold true mostly for television content that is violent in nature, while for inattention problems the association was more broadly with "noneducational" content rather than specific to a type of content.

As research methods and statistical analysis have become more sophisticated over time, researchers are increasingly able to examine the possibilities of more complex relations between some of these factors. For example, Barnes, Boutwell, Beaver, and Gibson (2013) examined poor parenting practices (spanking, specifically), externalizing problems, and self-regulation in a sample of twins. Their results suggest that shared genetic influences may account for some of the relationship between parenting practices and externalizing problems, as well as between self-regulation and externalizing problems. It is likely that in the future, nuances of the various predictive factors

mentioned here (and potentially others not mentioned) will become clearer.

Predictors of Internalizing Problems

Although researchers have been examining predictors of externalizing disorders for many years, historically they have been less focused on internalizing disorders.

It does appear that there are some similarities across these clusters of problem areas. Ineffective parenting practices and parental stress/distress during the preschool years may lead to an increased risk of internalizing problem behaviors for children in later years.

Parental psychopathology has also been found to be a risk for internalizing, as well as externalizing, problems. Social support has been noted to be a protective factor for children, with those with greater supports being less likely to develop internalizing problems at school age even if parenting practices are ineffective.

Parent characteristics

- **Ineffective parenting practices**
- **Parental stress**
- **Parental psychopathology**
- **Low social support**

Child characteristics

- **Difficult temperament**
- **Behaviorally inhibited temperament**
- **Negative emotionality**
- **Insecure attachment**
- **Delayed language**

Demographic variables

- **Low socioeconomic status**
- **Low birthweight**
- **Low parental education**

Child characteristics such as temperament, including behavioral inhibition and negative emotionality, as well as delayed language development,

have also been examined as predictors of internalizing problems. Researchers have examined the role of inhibition in predicting future problems. High inhibition in the preschool years has been linked to later internalizing problems. Negative emotionality in preschool has also been linked to later internalizing problems , although this variable may interact with parenting factors; at least one study notes that negative emotionality was a stronger predictor of later internalizing problems when mothers exhibited high levels of parental warmth. Delayed language in the preschool years has also been linked to internalizing problems in later childhood and early adolescence even when controlling for other variables (e.g., maternal intelligence, SES) that may impact these factors.

While an insecure attachment style has also been linked to internalizing problems, the relationship is not as strong as that with externalizing problems.

Demographic factors, including lower SES, have also been linked to an increased risk for later

internalizing problems, and this link has been shown to exist in studies within and outside of the United States .

Lower parental education levels have also been linked to an increased risk for internalizing problems in several studies. Specific to the child (rather than family characteristics), low birthweight has been linked to an increased risk of internalizing problems.

CHAPTER SUMMARY/PURPOSE OF THIS BOOK

Social, emotional, and behavioral problems during the early childhood years are clearly a real concern with potentially adverse long-term outcomes. Given that the problems identified during the preschool and kindergarten years put children at an increased risk for later problems, prevention and intervention efforts in the preschool and kindergarten years can be important in mitigating their potential to have long-lasting effects. A number of evidence-based psychosocial treatments support their use with young children or show

particular promise for use with this age group. The purpose of this book is to provide a review of, and implementation guidelines for, these evidence-based psychosocial interventions.

Clinicians should be able to use the information and materials provided to develop assessment strategies and treatment plans for most of the disorders commonly seen during the preschool and kindergarten years.

CHAPTER 3

Treatment of Externalizing/ Conduct Problems

BEHAVIORAL PARENT TRAINING AS AN INTERVENTION FOR EXTERNALIZING PROBLEMS

Overview

Behavioral parent training programs are heavily rooted in behavioral theory, particularly reinforcement and punishment procedures based on operant conditioning, as well as social learning theory. Operant conditioning

procedures involve modifying antecedents (e.g., giving effective commands) and consistently applying effective consequences. Consequences that function as reinforces will increase the likelihood of that behavior recurring, while punishers will decrease the future likelihood of that behavior recurring. For example, a child who offers to share his or her toys is praised; a child who grabs toys from a playmate is sent to time-out. These training programs assume that childhood

conduct problems are generally related to interactions the child has with significant others, most often parents, who provide important cues and consequences for their child's behavior. Thus, treatment gains are achieved by having parents consistently implement behavior modification strategies that they are taught in treatment sessions.

Although the child is typically present in most sessions, the clinician does not work individually with the child because parents are considered the primary change agent. Many prominent behavioral parent training programs now utilized are based on the operant two-stage parent-training model originally developed by Hanf (1969). The first stage emphasizes the development of parental attending skills and the use of differential attention to enhance the parent–child relationship and increase appropriate child behaviors. These skills are typically taught in a play-based context. After mastering the positively based behavior management skills, parents are taught to give effective commands and implement effective and consistent

methods of discipline (typically time-out). Empirical evidence that guides the order in which treatment components are taught is limited. Although at least one study has indicated that order does not influence treatment outcomes, most behavioral parent training programs continue to adhere to the original ordering of the Hanf model. Consideration of the coercive nature of the parent–child relationship found in this population provides theoretical support for teaching parents positive attending skills first, as these strategies will create a more positive social context and increase the likelihood of cooperative behavior. Active training methods are used to teach parenting skills. Skills are first taught didactically.

Handouts that describe the skills and their application are typically given to parents. Skills are then modeled in each session by the clinician. Most commonly this is done with the referred child present, although videotape models also may be used. For example, parents may be shown a videotape of one parent using the skills appropriately and another in

which the skills are used inappropriately, so that they can observe the difference in the application of the skills, as well as the response of the child. Following the initial modeling, parents practice the skills in session and receive feedback from the clinician. Parents are

also assigned homework in which they practice the new skills in the home environment and monitor their progress.

The feedback or coaching aspect of behavioral parent training is critical in helping parents learn how to use the skills effectively. When learning a new skill, parents may apply the skills inappropriately, or they may have difficulties with their application that were not anticipated prior to practice. This observation and coaching can help address these problems as they arise. In addition, directly observing the parent using the skills assists the clinician in obtaining an accurate picture of the parent's skill level. When providing feedback, it is important that the clinician provide

positive responses regarding what parents are doing well, in addition to providing corrective feedback.

Initial Considerations

Although behavioral parent training is often an effective intervention for families whose child displays disruptive and noncompliant behaviors, it is not appropriate for all families. Before deciding to use behavioral parent training, several factors must be considered. Often an initial consideration is the age of the child.

Behavioral parent training programs can be used with parents of children of varying ages, although most programs are focused on parents of younger children, rather than adolescents. The preschool age range is typically considered the ideal time to intervene, as early childhood misbehaviors are less complex and more transitory in nature. Additionally, coercive parent–child interactions are less heavily ingrained, making

these behaviors more malleable overall. Thus, many behavioral parent training programs are geared specifically toward the parenting of preschool and early elementary school-age children.

Parent-related factors such as socioeconomic status, marital conflict, parental psychopathology, and psychosocial stressors (e.g., social isolation, single parent household, limited family resources) have all been found to influence the effectiveness of behavioral parent training programs. Thus, the clinician should ask about such factors as part of a comprehensive intake assessment. Providing additional services that more completely address identified needs may be appropriate for some families. For example, if a parent is experiencing depression or a couple is having marital problems, it would be appropriate to refer these families for additional therapeutic services. Conversely,

behavioral parent training programs can be enhanced to include.

Children may also require additional services, such as programs targeting academic difficulties or medications. Comprehensive services targeting both parent and child issues may address the needs of the family more completely and thereby increase the overall effectiveness of behavioral parent training.

Parental motivation also plays a key role in the outcome of behavioral parent training programs and should be assessed prior to beginning treatment. Some parents react negatively to parent training because of its focus on working with the parents rather than with the child. When parents initially seek services, they may expect the clinician to meet with their child individually, and they may not expect to be extensively involved in the intervention. Some parents may perceive behavioral parent training as an insult to their parenting skills. Other parents may simply not have the time or energy to devote to parent training. Often, giving parents a rationale for the use of behavioral parent training (subsequently described) can resolve

some of these issues and help prevent confusion about services (which will hopefully reduce dropout rates).

Motivational interviewing has been shown to effectively address more significant parent resistance and/or low motivation. Motivational interviewing is a goal-directed counseling approach that utilizes a broad collection of techniques to help people explore and resolve ambivalence about behavioral change.

The clinician's role in using motivational interviewing is to increase a client's awareness of the implications of changing and/or of not changing their behavior through a nonjudgmental and collaborative approach. The four central tenets of motivational

interviewing include:

(1) expressing empathy,

(2) developing discrepancy,

(3) rolling with resistance,

(4) supporting a client's self-efficacy

Four specific therapeutic skills support these principles, including

(1) open-ended questions,

(2) affirmations,

(3) reflective listening,

(4) summarizing.

If, for example, a clinician was working to develop discrepancies with a parent presenting with low motivation, the clinician might say, "You have mentioned that you know learning effective discipline strategies is the best choice for your child but that attending sessions won't fit your hectic schedule. What are some of your concerns about fitting sessions into your current schedule?" If a parent continues to present as highly resistant during a conversation, a clinician can "roll with resistance" by making the following type of statement: "It's okay if you don't feel like any of these ideas will work for you. If you'd like to share what you've tried, perhaps together we can find

something that could work for you." Although motivational interviewing originated in the early 1980s, it has only recently begun to be evaluated as a therapeutic tool with pediatric populations.

A review of outcome studies evaluating behavioral health interventions and motivational interviewing techniques with pediatric populations offers initial evidence of its promising impact. Although most studies have focused on interventions involving physical health (e.g., diabetes, obesity), child behavior management interventions have also been

discussed. For example, one study compared a motivational enhancement technique with a treatment-as- usual control group. The motivational enhancement technique consisted of 5–15 minutes of motivational interviewing interventions delivered in three doses during the first few therapy sessions and addressed the importance of attending and adhering to treatment. Results showed that caregivers in the motivational enhancement group attended more sessions, reported

higher treatment motivation, and demonstrated greater treatment adherence, as rated by both the caregiver and the therapist.

The Family Check-Up is a unique ecological, family-centered prevention program for reducing child conduct problems that employs motivational interviewing techniques to stimulate parents to modify ineffective parenting practices. The Family Check-Up is a two-to-three session intervention that involves completing a comprehensive multimethod, multi-informant ecological assessment and providing feedback that emphasizes parenting and family strengths, as well as drawing attention to the family's unique challenges and areas of possible change.

The clinician takes into account the family's needs and motivation to change and then develops an individually tailored treatment plan based on an ecological parent management training perspective. A seminal study evaluating the Family Check-Up showed that mothers who received motivational interviewing

demonstrated significantly higher levels of maternal involvement. Children in the Family Check-Up group showed significantly reduced aggressive behaviors at 12-month follow-up, compared to the control group, although no significant differences were noted between the groups at 24-month follow-up.

A similar intervention, the Classroom Check-Up, has also been developed as a classroom-level consultation model within the school. Once a family has committed to participate in treatment, it is important to provide a rationale for behavioral parent training. Clinicians should emphasize that such training can be very effective in managing their child's conduct problems, and that early intervention is central to preventing the problems from worsening over time. It is important to link the parents' behavior with the child's behavior without blaming the parents for the child's conduct problems. Explaining to parents that their behaviors can influence their child's reactions, and that by changing their own behaviors they can improve

their child's behavior, is often effective. Children with conduct problems usually have different behavior patterns from those of other children, and thus, parents need to learn different ways to interact with their child in order to help decrease the negative behaviors and increase the positive ones.

In addition, it should be acknowledged that parenting can be stressful, and that parenting a child with conduct problems is even more so. Normalizing how this added stress can cause parents to react with frustrations is often helpful, while also noting that these reactions only serve to increase negative child behaviors. Parents can be empowered by emphasizing that by changing their parenting behaviors, the result will likely be a reduction in negative child behaviors, less parental stress, and a more positive parent–child relationship.

Conducting Behavioral Parent Training

A typical behavioral parent training program is outlined in the following sections. This program is very

similar to behavioral parent training programs discussed by others.

As mentioned earlier, many of today's prominent behavioral parent training programs are based on the operant two-stage parent-training model for noncompliant children developed by Hanf (1969). The first stage emphasizes the development of parental attending skills and use of differential attention in an attempt to enhance the parent–child relationship, while the second stage focuses on the effective implementation of consequences for misbehavior.

Explaining Behavioral Principles

As previously mentioned, behavioral parent training is based on social learning and operant conditioning principles. By teaching parents the scientific principles upon which specific parenting skills are based, parents are more likely to have an understanding and appreciation of why they are implementing a skill in a certain way.

In addition, parents are better able to problem solve as they encounter new behavior problems, by flexibly applying the behavioral principles they have previously learned.

Finally, there is an increased likelihood that parents will continue to implement the skills after therapy services are terminated. Obviously, too much theoretical detail may be overwhelming for parents, but a brief explanation of key behavioral principles can be quite helpful. Parents should be given a handout that contains succinct explanations of behavioral principles such as reinforcement, punishment, and extinction. The clinician should go over this handout with parents and attempt to elicit examples of their child's behavior to help illustrate these principles. It is often helpful for the clinician to provide an example and then ask the parent for an additional example, using an interaction the parent has recently had with his or her child.

Outline of Behavioral Parent Training

Treatment Components

- **Explanation and overview of behavioral terminology**
- **Using strategic attention**
- **Implementing child's game**
- **Effective commands**
- **Discipline techniques for inappropriate behaviors**
  Time-out Use of privileges
- **Managing behaviors in public places (generalization of skills)**
- **Maintenance phase (e.g., booster sessions)**

Using Strategic Attention

In the first stage of behavioral parent training, parents are taught to use their attention strategically by attending to and praising appropriate behaviors exhibited by their child.

By attending to appropriate behaviors, parents

(1) increase the likelihood that these behaviors will increase in frequency

(2) help teach their child which behaviors he or she *should* do rather than focusing solely on what the child should *not* do.

This positive component of behavioral parent training can help set the stage for a more positive and enjoyable parent–child relationship overall. In addition, positive feedback may help increase the child's self esteem, which is a common concern for parents.

Parents of children with behavior problems are oftentimes so overwhelmed by the need to monitor (and attempt to decrease) their children's negative behaviors that they neglect to notice the appropriate behaviors. This type of one-sided interaction can lead to the coercive parenting cycle. In order to form a positive parent–child relationship and increase the likelihood that their child will engage in appropriate behaviors, parents should focus on striking a balance between providing positive attention and implementing consistent discipline. During phase one of treatment, the clinician should speak with parents about the

“magical ratio” regarding the number of positive versus negative interactions they should have with their child (e.g., the 5:1 rule).

Specifically, for every one time they provide negative attention or discipline their child, they need to find five opportunities to interact with their child in a positive manner. This ratio creates a powerful contrast between which behaviors are desirable and which are inappropriate. Although this “magic ratio” was originally based on research with couples engaged in conflict resolution (Gottman & Levenson, 1992), it has been applied broadly to educational and family contexts (Armstrong & Field, 2012; Flora, 2000). However, it is worth noting that currently there is no empirical literature supporting an optimal ratio (e.g., 5:1 vs. 4:1) when parenting a young child.

In addition to teaching parents to offer positive attention for their child’s appropriate behaviors, they should also be taught how to use planned ignoring. Children frequently engage in inappropriate behaviors

to obtain their parent's attention. These attention-seeking behaviors may include whining, pouting, complaining, and crying. Parents may be inclined

to respond to these behaviors by reprimanding, scolding, or using other discipline methods. Unfortunately, this response is frequently reinforcing the child's undesirable behaviors, as it results in the child obtaining the parent's attention (albeit negative attention). Planned ignoring can be a very helpful strategy for reducing these types of behaviors. This strategy involves providing no attention (e.g., no eye contact, no physical response, and no verbal response) for this attention-seeking behavior. It is critical that the clinician prepare parents to expect that their child's behavior may briefly worsen when first using this strategy (e.g., extinction burst). Parents should be informed that if they give in to their child's behavioral escalation, this will likely result in a worsening in behavior, as they have taught their child that if he or she escalates, they will eventually receive

reinforcement. The importance of persistence should be emphasized, and parents should be given reassurance that these behaviors will eventually improve.

Implementing Child's Game

In addition to modeling and prompting parents to use their attention strategically during the natural interactions that take place within a session, positive attending skills should also be taught and practiced in the context of child-focused play situations, often referred to as "Child's Game" or "Time-In." A few different types of age-appropriate toys that promote constructive, interactive play should be available for this activity. Legos, wooden blocks, Tinker Toys, Lincoln Logs, and drawing materials are commonly used. Toys that should be avoided are those that do not allow for spontaneous interactions between the child and parent, games that have structured rules or expectations (e.g., board games, Legos specific to a building set), and those that have the potential to promote aggressive play. During this positive playtime,

the parent's attention should be focused completely on the child, and the child should be allowed to lead the play. In order to keep the play child focused, parents are told to refrain from asking questions, giving commands, or being critical. They are also instructed to ignore instances of minor misbehavior; however, for major misbehaviors, parents are instructed to end playtime. During this playtime, parents are told to

(1) describe what the child is doing (e.g., "You're putting the yellow block on top of the blue block."),

(2) reflect verbal statements the child makes (e.g., after the child says, "I like blue," the parent might say, "You like blue. I do too. Blue is a pretty color."),

(3) imitate/join their child's play (e.g., if their child is building a block tower, the parent is also building a block tower,

(4) praise the child for appropriate behaviors. Parents should be encouraged to use a combination of specific, labeled praise statements (e.g., "Thank you for

handing me the block I needed. You shared very nicely.”), as well as general, unlabeled praise (“Great job!”). Labeled praise statements are helpful in letting the child know specifically what it is the parent likes, so parents should be encouraged to incorporate such praise statements when interacting with their child. When teaching parents to use these positive, child-directed skills, the clinician explains the activity to the parents and provides a rationale for its use. Parents are also given a handout (see Form 3.3) that contains a detailed description of Child’s Game and the pertinent skills that parents should be using during this activity. Once this activity has been explained to parents, the clinician should model the skills with the referred child, so that the parents can see how the skills are put into practice. Although this activity sounds relatively easy to do, it is important to acknowledge that parents often feel silly doing this at first (especially in the presence of the clinician), and that many parents find that avoiding questions is particularly difficult when first learning this “game.” Because asking questions is a common way

for adults to interact with children, parents often ask why they need to refrain from asking questions during this positive playtime. The clinician should explain that the purpose of this play activity is for parents to overlearn positive attending skills and that anything that takes away from the child-directed nature of the activity should be avoided. Since questions tend to lead play (e.g., "Why don't you paint a picture of our family?") and conversation (e.g., "What color are those blocks?") and make the activity become parent directed, they are to be avoided during this time. However, parents should be assured that there is nothing wrong with asking questions of their child in their everyday interactions.

Once the clinician has modeled the skills, the parent should be encouraged to gradually join in the play. Eventually the clinician should allow the parent to take over the play with the child, and the clinician should coach the parent on his or her use of the child-directed skills. For example, if the parent asks a question (e.g., "These are colorful blocks, aren't they?") but does not

realize the error, the clinician would point it out to the parent (e.g., “Oops, that was a question. Try just saying, ‘Those are colorful blocks you’re playing with’ ”). If the parent is having difficulties knowing what to say (i.e., there are long periods of silence), the clinician should encourage the parent to provide a description or praise statement (e.g., “Now would be a good time to tell Ella you like how she’s sharing her crayons with you”). As just mentioned, the clinician should also give the parent positive feedback when the parent uses a skill well (e.g., “Nice job praising Sammy for sharing with you”).

In addition to coaching the parent on what he or she is saying to the child, the parent should also be coached on how the statements are delivered. Parents often sound unenthusiastic.

when first engaging in this activity and have little inflection in their voices. It is crucial that clinicians model enthusiasm when they are interacting with the child, and that they coach parents to be more

enthusiastic if needed. Parents who are unenthusiastic or do not appear genuine will often have problems keeping their child engaged and interested in this activity because children will pick up on their parents' lack of interest. For homework, parents are instructed to practice these skills for at least 5–15 minutes per day and to track their practice, as well as note any problems they encountered. If there are multiple children in the household, the parents should practice with only one child at a time. Parents are encouraged to use these skills with children other than the referred child, but each child should have his or her own time. If there are two parents in the household, it is ideal to have each parent practice these skills, although they should do this independently.

These skills are practiced in session until parents have mastered their use. Some behavioral parent training programs have specific guidelines for determining when mastery of these techniques is achieved. For example, in parent–child interaction therapy (one of the specific training programs

available), parents are considered to have mastered these skills when they can provide 10 labeled praise statements, reflective statements, and behavioral descriptions, as well as 3 or fewer commands, questions, or criticisms within a 5-minute period.

Giving Effective Commands

After parents have mastered the use of positively based parenting skills, they should be taught to give effective, appropriate commands before implementing discipline strategies. Parents often give commands that make it difficult or impossible for the child to comply. For example, parents may provide a long string of different commands without giving the child time to comply in between commands, or they give vague commands that do not contain enough information about what the child is expected to do. Parents also frequently phrase commands as questions (e.g. "Can you pick up the blocks?"), which inadvertently conveys to the child that compliance is optional. In addition, parents often phrase statements as commands but fail

to follow through with a consequence if the child does not comply, which only serves to reinforce the child's noncompliance. Parents should be mindful to give only developmentally appropriate commands and to ensure that the child is physically capable of completing any command given. Before giving a command, the parent should make sure that he or she has the child's attention. Saying the child's name, standing in front of the child, and making eye contact are possible ways to establish a connection with the child. Commands should be given one at a time. If a parent would like the child to complete a multistep task, the parent should break the task down into smaller steps. For each step, the parent should

(1) give a command,

(2) wait for the child to comply/not comply,

(3) provide an appropriate consequence.

Parents should also make sure that their commands are stated as directives, rather than as questions or suggestions. Statements such as "It would be nice if you

would clean up your toys" do not tell the child that the toys *must be cleaned up immediately*. If the parent wants this task to be completed, a more appropriate command would be "Please pick up the toys on your bedroom floor and put them in the toy chest." Commands should be as specific as possible, so that there is no doubt as to what is expected from the child. If a task involves a choice, parents can include the choice in their command. For example, if a mother is directing her child to put on her shoes—but the child can wear either her sneakers or her boots—the mother might say, "Addie, we're ready to go to the park now.

Please put on either your white sneakers or your brown boots." Rationales for commands should be brief and presented either before the command (as in the previous example) or after the child complies. For example, after complying with the command from the previous example the parent might say, "Thank you for putting on your boots as I asked. I wanted you to put on your shoes because we're ready to go to the park now."

Preschool children do not need lengthy rationales; they often *ask* for rationales (i.e., "Why?") simply to delay complying with the command.

Parents should be instructed to only give commands when they plan to follow through with an appropriate consequence for compliance or noncompliance. A conversation regarding the importance of "picking your battles" can be completed with parents, and the pitfalls of intermittent use of consequences can be highlighted. Using the metaphor of "playing the slot machines" can be helpful in describing how children will "gamble" (i.e., be noncompliant) with the hopes of "winning the jackpot" (i.e., not having to complete the task assigned and not receiving a consequence). Parents are encouraged to be mindful that the "house should always win" (i.e., parents must consistently follow through with a consequence for each act of noncompliance).

By (1) reducing the commands given to those that are most important to parents,

(2) always providing a consequence,

(3) phrasing commands appropriately, parents can expect to see an increase in their child's compliance.

These guidelines for giving appropriate commands are discussed in session with parents, and they are given a handout (see Form 3.5) that summarizes the use of commands.

Using Appropriate Discipline Techniques

After learning how to give appropriate commands, parents are taught to use specific disciplinary techniques for those occasions of noncompliance. It is very important that parents continue to use the positive parenting skills previously mastered as they learn new disciplinary skills. Parents should continue to engage in the structured play activity (i.e., Child's Game) on a regular basis and should be attuned to opportunities throughout the day to positively attend to their child's appropriate behaviors. Additionally, parents should

always provide positive reinforcement as soon as their child complies with a given command.

The discipline technique of choice with preschool- and kindergarten-age children is time-out. Most parents have had some experience with time-out and often insist that it "does not work" for their child. Thus, one of the first tasks a clinician faces is "selling" the parents on the use of a technique they may not be inclined to use. When time-out does not work, it is typically because parents do not use it in an appropriate manner.

An effective time-out involves removing the child from all reinforcers. Many parents continue to talk to their children while they are supposedly in time-out. Although the content of what is said may be negative (e.g., "Sit down. You need to learn to behave or you'll never get out of time-out"), the attention that the child is receiving is typically reinforcing. Thus, in such instances, the child is not truly experiencing a time-out.

Parents often leave their children in time-out for excessively long periods of time. The general rule of thumb is that children should be in time-out for 1 minute per year of age, not to exceed 5 minutes. Extensive time-outs can be difficult to enforce, and they deny children learning opportunities. The time-out should be brief so that children can reenter the situation, engage in negative or positive behaviors, and receive appropriate consequences.

Repeated instances of (1) the child performing an inappropriate behavior and being sent to time-out and (2) the child performing an appropriate behavior and receiving positive reinforcement help the child learn which behaviors are appropriate and which are not. Parents also may believe that time-out does not work because the child will not automatically stay in the time-out location. Parents may become frustrated that their child is continually leaving the time-out and, because they are unsure what to do, they simply let the child end his or her own time-out. In such situations, the child learns that he or she can escape with no

consequence, and consequently, time-out becomes ineffective. Time-out is explained to parents in session, and they are given a handout (see Form 3.6) on its use. Any information the parents have provided to the clinician about their previous use of time-out should be acknowledged and addressed. Parents are initially taught to use time-out in response to noncompliant behavior. After giving a command (e.g., "Please put on your coat"), parents are instructed to wait 10 seconds for the child to comply. Parents are encouraged not to count out loud, as children will learn to ignore the command and delay the initiation of compliance until their parent reaches a certain number. If the child does not comply within that time period, the parent repeats the command and tells the child he or she will go to time-out if the child does not comply (e.g., Please put on your coat or you will go to time-out"). Again, the child is given 10 seconds to begin to comply. If the child still does not comply, the parent should immediately send the child to time-out (e.g., "You didn't put on your coat, as I instructed, so you need to go to time-out").

Of course, most children will not willingly go to time-out, so the parent will often need to lead the child to the time-out location. If the child will not walk with assistance to timeout, the parent should physically guide or pick up the child from behind and place him or her in time-out, making one brief, directive statement such as "You need to sit and be quiet until I tell you to come out." While the child is in the time-out location, all verbalizations and activities by the child are ignored. It is extremely important that the parent understand why he or she should ignore the child during the time-out period; that is, that attending to the child is reinforcing and defeats the purpose of placing the child in time-out.

If the child leaves the time-out location, he or she should be placed back in time-out immediately, while the parent continues to actively ignore (e.g., no verbalizations). Initially, the parent may have to stand very close to the time-out location so that he or she can promptly return the child to time-out.

While the put-back method is generally sufficient, a back-up room may be required for some children who persist in their refusal to stay in time-out. When using this approach, the parent should first be supported in identifying an appropriate space in their home for the back-up room. This room should have a door that can be closed, is well lit, and has ample room to move around, and all items that could be considered entertaining (e.g., toys) or dangerous (e.g., medications, breakables, heavy furniture) should be removed. Once the back-up room has been established, the parent should be instructed to implement the following back-up room procedure. If the child leaves the time-out chair, the parent should say, "Because you left the time-out chair, you have to go to the back-up room." The child should then be physically guided or carried to the back-up room. The parent should close the door and hold it shut as necessary but should not lock it. After 1 minute, the parent should take their child back to the time-out chair. This procedure can be repeated as necessary.

A child should not be given "credit" toward his or her time-out time during this procedure. If a child requires a third trip to the back-up room during any given time-out, the child's time-out should then be completed in the back-up room. If this occurs, all previously discussed requirements for ending time-out should be met (e.g., time expired, child is quiet). Alternatively, parents can choose to use a room as the primary time-out location.

The necessary characteristics of a time-out room are identical to that of a back-up room (e.g., well-lit, ample room, all reinforcing items removed). In this case, the parent would place the child in the time-out room at the onset of the time-out and allow him or her to leave the room once requirements for ending time-out have been satisfied (e.g., time expired, child is quiet). It should be noted that if a child engages in significantly destructive and/or self-injurious behavior during time-out, parents are encouraged to discontinue use of time-outs until these concerns can be discussed further with a mental health professional.

When time-out is first used, children can often take a long time to quiet down and stop crying. Thus, initially parents may be instructed to let the child out of time-out as soon as he or she is quiet for a very brief period of time (e.g., 10 seconds). Gradually, this time would be increased, so that the child remains in time-out for the appropriate length of time (i.e., 1 minute per year of age, with a maximum time of 5 minutes). Ultimately, the child should be required to complete the full length of the time-out and should be let out of time-out once he or she has been quiet for at least 15–30 seconds. In this way, the parent avoids inadvertently reinforcing any misbehavior that might be occurring when the time has expired.

Additionally, this process allows a parent to support the child in developing appropriate emotional self-regulatory abilities, as the child's release from time-out becomes contingent on his or her ability to calm down. When the child has been quiet for the appropriate length of time, the parent should let the child out of time-out with the explanation, "You're being quiet, so

you may come out of time-out now." Once the child is released from time-out, the parent should repeat the original command and provide the appropriate consequence (i.e., praise for compliance, another time-out for noncompliance).

It is very important that parents complete this last step of reissuing the original command; otherwise, children may come to view time-out as a way of escaping a task they did not want to complete.

The location of the time-out should be discussed with parents in session. Parents sometimes have difficulty enforcing time-outs because they place the child in locations they cannot see (e.g., at the end of a hallway) or near something the child can reach and destroy (e.g., placing a child near a lamp he or she can reach and knock over). Parents are often instructed to use an adult-sized straight-back chair for time-out. Ideally, the child's feet should not reach the floor. The chair should be located in an area where the parent can see the child, but not where the child can access any

potential reinforcers (e.g., the child should not be able to see the TV). In addition, the chair should be in an area in which there is nothing within reach of the child. Although a chair can be easiest for parents to use, other defined spaces (e.g., a bottom step, a small rug placed on the floor) can also work for time-out locations.

Although many parents use timers to track the length of time the child is in time-out, the use of a timer can present a problem, specifically, that parents and children may come to view the sounding of the timer as an indicator that time-out is over. It should be stressed that it is *the parent* (not the timer) who releases the child from time-out and that the child is let out *once he or she is quiet* (not once the timer sounds). If a parent uses a timer, he or she should make it clear to the child that he or she will not be dismissed from time-out until the parent indicates it is time. Timers are typically most helpful for parents who might "forget" that their child is in time-out. However, given that parents should be taught to monitor their child during time-out so that they can (1) immediately return the child to time-out if

the child escapes and (2) release the child from time-out once the child is quiet, many believe that timers are not needed and may actually create problems for parents. Therefore, the use of timers is generally discouraged.

Given the potential problems that arise when using time-out, it is extremely helpful if parents have an opportunity to practice it in a therapy session. Once the clinician hasexplained the use of commands and time-out to the parent, the parent is coached on his or her application of it in session. This phase begins by asking the parent to interact with his or her child in a play context. Gradually the parent begins to give commands to the child. At first these commands should be relatively easy for the child to comply with (e.g., "Please hand me the red block" in reference to a block the child is not currently using), but gradually the parent should make the commands more demanding in an attempt to elicit noncompliance in session (e.g., "Please put the blocks away."). The clinician should coach the parent on his or her use of commands to ensure that the parent is phrasing them appropriately.

When the child complies with a command, the parent should always praise the child for compliance (e.g., "Thank you for handing me the red block like I asked you to do."). If the child does not comply, the parent is coached through the process of putting the child in time-out and ignoring him or her for that time period. Initially, it can be very difficult for parents to ignore their child during a time-out. Many young children scream and cry vigorously and may use hurtful words in their attempts to secure their parents' attention (e.g., "You don't really love me," or "I hate you."). Or some young children may express a need to go to the bathroom while sitting in a time-out. This scenario should be discussed with parents and aplan should be preemptively created so that parents are consistently approaching this situation in an identical manner. Two possible options to consider using in this situation include (1) ignoring the child's request until the time-out is over (even if the child has an accident) or (2) allowing the child to go to the bathroom and then immediately returning the child to time-out.

If parents use the second option, clinicians should stress the importance of providing minimal attention to their child during this interaction. Once time-out has been covered in session, parents are instructed to begin using it at home and tracking the results, as well as any problems they encounter. After parents have implemented the use of time-out for noncompliance, the clinician helps the parent identify some "house rules," which, if broken, will result in an immediate time-out for the child. Parents should be encouraged to set a limited number of house rules (two or three is a good number to begin with when working with young children) and save these rules for behaviors that are most important (e.g., "Keep hands and feet to yourself"). When the child fails to follow a house rule, he or she is immediately sent to time-out. No warning is given in this situation.

Additional Reinforcement/Discipline Methods

Although time-out is the discipline method of choice for young children, alternative methods, such as

contingency contracting, may also be used. Contingency contracting may involve a comprehensive token economy system, in which poker chips or points (that can be exchanged for tangible reinforces) are given to the child for appropriate behavior and taken away for inappropriate behavior. However, token economy systems can get quite complex and cumbersome for parents. Using privileges (instead of tokens or points that must be exchanged) is often easier for parents. When using privileges to manage behavior, parents should begin by listing the privileges their child can earn for appropriate behaviors and those that will be taken away for inappropriate .

The privileges that the child can earn by exhibiting positive, prosaically behavior would be extra privileges that the child receives, in addition to his or her everyday privileges (e.g., watching an hour of TV). The privileges that are removed for inappropriate behaviors would be those everyday privileges that the child automatically receives; when a rule is broken or an

expected task not performed, the child loses one of these everyday privileges.

Tangible reinforcers can be used in addition to privileges in this system. Parents can also set up a positive reinforcement system in which a child earns points toward a specific reinforcer. For example, if a child wants to see a certain movie, the parents could create a chart that has a picture of a character in this movie at the end of a "road." Each time the child engages in an appropriate behavior, he or she is able to move a marker down the road and one step closer to the movie character. When the child's marker reaches the character, he or she earns the reinforcer (e.g., going to the movie). When this method is used with young children, they should be able to earn the reinforcer quickly.

If they must wait for several days or weeks, the delay between the behavior and the reinforcer will be too long and the intervention will be unsuccessful. If the delay is longer, parents should consider giving small

reinforcers along the way. For example, if the child cannot earn the movie reinforcer for at least 2 weeks, parents could move the marker along the "road" on the chart and provide a small reinforcer for each move (or every other move). This small reinforcer should be something that can be delivered immediately (e.g., playing a game with a parent, a small treat).

Generalization and Maintenance of Skills

Initially the skills previously described are taught and practiced with the home setting in mind. Obviously, though, it is crucial for parents to learn to generalize these skills to behaviors in settings outside the home, such as grocery stores, restaurants, and department stores. Before attempting to apply the skills outside the home, the clinician should ensure that parents can easily use the skills in session. Parents who are still struggling with giving appropriate commands or using discipline skills in a consistent manner in the home will have added difficulties applying the skills in public places.

Teaching parents to generalize skills to other settings is typically the last component of behavioral parent training. See Form 3.10 for the handout explaining this step. When parents first practice these new skills outside the home, they should begin with relatively brief "training trips" that are not necessary to complete. For example, a parent may take a training trip to the grocery store to pick up just a few items that he or she does not have to obtain that day. Before embarking on this trip, the parent should set up some rules with the child. For example, rules for appropriate grocery store behavior might include:

(1) stay within arm's reach of the cart,

(2) do not take items off the shelf unless told to do so,

(3) talk in your indoor voice. A discussion of the consequences associated with failure to follow the rules should also be conducted.

Once in the store, the parent should make sure to praise the child for following the rules and for any other appropriate behaviors. The parent may want to

engage the child in the shopping experience by directing him or her to take certain items off the shelf and put them in the cart. The parent should also consider setting up a reward program for complying with the rules. For example, when the child follows the rules or engages in other appropriate behaviors, the child can be given a token. If the child has a certain number of tokens by the end of the shopping trip, he or she can exchange the tokens for a reinforcer (e.g., a candy bar, a movie to watch at home, a special trip to the park with a parent).

For inappropriate behaviors, parents can use time-out in the store if they are comfortable doing so. The child should be required to sit or stand in an out-of-the-way section of the store. The child should not have access to any preferred items, and no attention should be given to him or her. Typically, the regular time-out period is shortened, and time-out can be terminated once the child is quiet for 15–30 seconds.

If the child refuses to complete the time-out in the store (e.g. tantrums excessively, refuses to stay seated), a parent can also choose to walk the child to a more private time-out location (e.g., the car, the bathroom). The clinician should stress that the child always be returned to the original setting after a time-out, as immediately going home might encourage future misbehavior. For some parents, using a community time-out may not always be feasible and may feel too uncomfortable.

Instead, parents can add a response–cost component to the reward system in which the child loses tokens for inappropriate behaviors. If the child begins to throw a tantrum in the store, parents should be instructed not to give in to the behavior, however embarrassing. For example, if the child tantrums because his or her mother will not give the child the candy he or she wants, it is imperative that the mother not give the child the candy just to stop the tantrum. Doing so would only serve to teach the child that a long enough or loud enough tantrum will get him or her

what he or she wants. In this situation, the child should be completely ignored. If this is too difficult for the parent to ignore the child while remaining inside the store, the child should be taken outside.

However, clinicians should stress to parents that they should never leave their child unattended. Children should never be taken to the car and simply left there. As just discussed, once the child has stopped tantruming, the parent should be encouraged to return with the child to the original setting before going home.

In addition to learning how to generalize skills to situations outside the home, parents also need help in planning for generalization in situations in which they are not present (e.g., preschool), especially if their child is having problems across settings. The clinician could consult with the preschool teacher (along with the parent) and set up a similar behavior management program in school. Another option would be to use a home–school note system.

Ensuring that skills are maintained over time is also important. Unfortunately, treatment gains are often reduced at follow-up compared to gains immediately following intervention. While there is little empirical research regarding the best way to promote maintenance of treatment gains, several different approaches have been proposed. The most commonly used approach involves providing "booster sessions" for parents. Such sessions might involve brief (e.g., 30–60 minutes) monthly meetings, wherein skills are reviewed and practiced and any problem areas discussed.

Group Behavioral Parent Training

Conducting behavioral parent training in a group setting is an option clinicians may want to consider if they do not have the time or resources to implement individual parent training. Group behavioral parent training is conducted in the same manner as the individualized format. However, the child is typically not present, and the parents do not have the opportunity to practice skills in session with their

children. Instead, parents typically engage in role playing with other parents and then practice the skills at home with their children. Because children are not present, group behavioral parent training programs often make use of videotaped models so that parents can see the application of the skills with actual children.

Possibly the best known and most researched group behavioral parent training program is The Incredible Years videotape-based program. Employing

strategies based on the Hanf model (consistent with the basic format discussed earlier), this program emphasizes positive parenting and teaching parents to replace maladaptive parenting strategies with more effective ones. In addition, this program works to improve collaboration between parents and teachers to ensure consistency across settings. Skills are modeled in session through the use of videotaped vignettes. The vignettes depict parents modeling both the appropriate and inappropriate use of the skills. The vignettes then serve as a stimulus for group discussions, problem

solving, and collaborative learning. The use of these models seems to be a critical component in the program. Webster-Stratton and Hancock (1998) have noted superior effects of their program when the videotaped modelsare used in comparison to when they are not used. The program teaches specific strategies, including enhancing positive relationships between parents and children through child-directed interactive play, praising the child for desirable behaviors, and incentive programs. Parents are then taught appropriate disciplinary strategies such as effective commands, ignoring, monitoring, and time-out.

A recent meta-analytic

review of The Incredible Years behavioral parent training program revealed that this program is effective and is viewed favorably by parents. When the program is used with Head Start preschool parents, significant improvements in parenting skills have been observed, including a reduction in harsh disciplinary practices, as

well as increased nurturing and provision of emotional support to their children.

In other research, improved parenting practices and reduced childhood conduct problems were evident several years after termination of the parent program (Posthumus, Raaijmakers, Maassen, Engeland, & Matthys, 2012). A meta-analytic review involving 50 studies that used the Incredible Years Parent Program found it to be effective overall, namely reducing child disruptive behaviors, with the greatest results found in those children with more significant initial problem.

In addition to developing the basic behavioral parent training program, Webster-Stratton has created an add-on program that addresses other parenting needs. This includes additional vignettes that focus on parental self-control, communication skills, collaborative problem-solving skills, and strengthening social support and self-care. Research has demonstrated that participation in an add-on program results in additional improvements beyond those

obtained in the basic parent training intervention in the clinically targeted areas (e.g., improved communication), maternal depression, and a child's problem-solving abilities and social skills.

Group parent training seems to be as effective as individual parent training and is clearly more cost-effective. However, there are some potential disadvantages to using the group format. Although parents in a group may benefit from sharing knowledge and experience with one, this format, which encourages the sharing of personal information, may be uncomfortable for some parents. Parents with more significant skills deficits, psychopathology, and/or severe psychosocial stressors may need more individualized attention than can be provided in a group setting. Individual behavioral parent training allows the clinician to address the specific needs of the family and to pace the treatment program so that it is most appropriate for the family.

ENHANCING BEHAVIORAL PARENT TRAINING THROUGH THE USE OF ACCEPTANCE AND COMMITMENT THERAPY

Overview

Although behavioral parent training is considered the most widely empirically supported treatment for young children with conduct problem, recent research evaluating the added utility of incorporating acceptance and commitment therapeutic tech niques into treatment with this population has been conducted.

Acceptance and commitment therapy (ACT) is a therapeutic approach that emphasizes compassionate acknowledgement and acceptance of experiences, through the use of mindfulness and behavior change strategies, in order to increase psychological flexibility. Psychological flexibility is described as having contact with the present moment and changing or persisting in behaviors in the service of chosen values.

Clinicians can promote these ACT principles when working with parents through use of specific exercises,

metaphors, and behavioral tasks discussed in the following sections. Our intention is not to provide an exhaustive review of ACT or discuss the applicability of these principles when working directly with a child; rather, it is to provide a brief overview of several key ACT principles and offer practical suggestions for how to incorporate these principles into treatment with parents.

Values

Values are the principles that give our life's meaning, direction, and chosen purpose. Values are different from goals, which are tasks or achievements to accomplish. By identifying their values, individuals are provided with a purpose for facing unpleasant sensations/experiences and engaging in value-driven behaviors. For example, parents may find it easier to commit to implementing a time-out procedure, which can be time intensive and emotionally aversive, by reminding themselves of their parenting values (e.g., raising an emotionally well-adjusted child). When ACT

principles are integrated into treatment, a clinician shouldfirst spend time working with parents on values clarification. Values clarification involves asking parents to step back from their everyday struggles and identify what gives their life meaning.

Many different exercises have been proposed to assist with this process, including using an assessment measure (such as the Personal Values Questionnaire), a card identification task (parents choose from cards with pregenerated values written on them), or the "eulogy exercise.

An alternative to the card identification task is providing parents with 16 small pieces of paper and instructing them to write a different value on each piece of paper (this can be related to parenting specifically or could be broadened to encompass other life values). After writing down 16 values, parents would be asked to discard four values that they could do without.

Repeat this step until parents are left with their four top values. At the conclusion of this exercise, clinicians

should discuss parents' experiences in completing this exercise (e.g., "Did anything surprise you about the values with which you are left? Were there any values that were easy to discard? Any values that felt really difficult to discard?"). In the eulogy exercise, a parent would be asked the following question: "Imagine you had died and could attend your own funeral. What would you hope to hear people say about you during their eulogy?" Other variations of this exercise could include prompting parents to imagine the content of a speech given by their child at their 50th wedding anniversary or at their 80th birthday party.

Cognitive Defusion

In ACT, the power of language is heavily emphasized. As verbal beings, people have developed verbal rules that are used when interacting with the world. These rules are often helpful because they allow us to efficiently process and respond to information presented.

However, these rules can also become problematic when they are rigidly followed and/or when they provide an inaccurate representation of what is actually occurring. Cognitive fusion refers to a person's tendency to become overly focused on the content of his or her thoughts, which results in failure to acknowledge and incorporate other useful sources of behavioral regulation. The following passage," An Adapted Zen Koan for Parents, powerfully illustrates how cognitive fusion can negatively impact parenting.

***Question* 1: What is the sound of one hand clapping?**

***Answer*: The sound of one hand clapping is the sound of one hand clapping.**

***Question* 2: What is the sound of one child misbehaving?**

***Answer*: The sound of one child misbehaving is the sound of one child misbehaving.**

***Question* 3: What is the sound of my child misbehaving?**

***Answer*: The sound of "I cannot control my child," the sound of "I should be able to," the sound of "I am a bad parent," the sound of "I don't know what to do," the**

sound of "I hate this child," the sound of "I should not feel this way," and the sound of my failure When using an ACT approach, it should be emphasized that it is not the content of thoughts that is problematic; rather, parenting practices may be negatively impacted because of how parents *relate* to their thoughts.

For example, a parent that has the thought "I cannot control this child," and, as a result, struggles to initiate effective discipline practices because of perceived ineffectiveness would be considered more cognitively fused. In contrast, a parent that has the same thought and acknowledges it as just a thought, and nothing more, would be less cognitively fused and would be more likely to utilize effective discipline practices. Parents can be supported in learning more effective ways of relating to their thoughts through the use of cognitive defusion techniques. Cognitive defusion involves learning to view thinking as an ongoing behavioral process and to view thoughts as thoughts, rather than fusing to what these thoughts are implying.

Instead of attempting

to change the content of thoughts, a clinician works with parents to alter the context that relates the undesirable thoughts to undesirable behaviors. A frequently used cognitive defusion exercise is the “milk exercise”, in which parents are asked to imagine a glass of milk for a few moments. Next, they would be asked to repeatedly say the word “milk” out loud for at least 60 seconds. As this word is repeatedly spoken, parents will find that it begins to lose some or most of its meaning. They may also notice that other functions of this word become more dominant (e.g., the way the word sounds). This exercise can then be repeated with a more emotionally salient and difficult word for parents such as “failure.”

Another commonly used cognitive defusion exercise is “leaves on a stream”. This exercise aims to support parents in looking *at* thoughts rather than *from* thoughts. Through engagement in this exercise, parents are better able to recognize the difference between

having a thought and owning a thought. It also helps parents to recognize that they are constantly having thoughts, despite the fact that they may be largely unaware that this is occurring. To start, a clinician should begin by describing how a person's mind is constantly narrating, often without conscious awareness. Parents are then encouraged to get into a comfortable position, close their eyes, and spend time noticing any internal narration that might be occurring. The clinician should emphasize that they are to simply notice any thoughts they have including any opinions, comments, or questions.

Encourage parents not to judge or attempt to change these thoughts but to simply notice them. Next, parents are asked to visualize a gently flowing stream with leaves floating along the surface of the water. The clinician should then encourage parents to spend the next few minutes identifying thoughts as they enter their mind, placing them on a leaf, and letting the thoughts float down the stream. At the conclusion of

this exercise, the clinician can discuss parents' experience and then should encourage regular practice.

Contact with the Present Moment (Mindfulness)

Behavioral parent training programs largely focus on purposefully changing operant contingencies that are contributing to the presence of a child's disruptive behaviors. Unfortunately, for some families, these operant contingencies, particularly those implicated in the parent–child coercive cycle, have become automatized and highly resistant to change(Dumas, 2005). Given the central role of negative reinforcement in developing and maintaining the parent–child coercive cycle, clinicians may wish to enhance traditional behavioral parent training with ACT strategies that address parents' own experiential avoidance. Experiential avoidance is a term used to describe a person's attempts to avoid or suppress unwanted physical sensations, thoughts, and/or feelings. Experiential avoidance can lead to using inflexible

parenting strategies, being inconsistent with behavior management strategies, with drawing from interactions with their child, and causing parents to overreact to their child's negative emotions and/or behaviors.

Mindfulness-based parenting strategies have been developed in an effort to target parents' experiential avoidance, particularly as it interferes with their ability to successfully implement effective behavior management strategies and promote a more effective pattern of parent–child interactions. Mindfulness refers to focusing one's attention on what is occurring in the present moment in an open and nonjudgmental fashion.

More specific to parenting, mindfulness-based strategies encourage parents to be present-focused and nonreactive and to embrace an open, accepting attitude of their parenting thoughts, feelings, and behaviors, as well as their child's behaviors. Research has demonstrated that parents who are less likely to use mindfulness are more likely to use harsh punishment strategies, particularly if they are coping with

numerous stressors. In research conducted by Neece (2013), parents of 2½- to 5-year-old children with developmental delays who participated in a mindfulness-based stress reduction program reported significantly less stress and depressive symptoms, as well as greater life satisfaction when compared with wait-list-control parents.

Additionally, children whose parents participated in the program were reported to have fewer behavior problems following the intervention, specifically with regard to ADHD symptomatology. These findings are consistent with those found in other research. Furthermore, mothers of young children with autism who were trained in the use of mindfulness reported increased satisfaction with their parenting skills and interactions with their children, as well as reductions in their children's levels of aggression, self-injury, and noncompliance.

Many parents may find mindfulness to be a relatively easy concept to grasp but will find it difficult

to use in their daily interactions with their child. Parents should be made aware that mindfulness is a skill that requires cultivation through regular practice and often does not come easily to people. Clinicians are encouraged to identify exercises that can be easily integrated into a parent's daily life such as mindful breathing, mindful walking, and mindful eating.

Identifying activities that parents can engage in daily should increase the likelihood that parents will practice mindfulness more regularly. Mindful breathing is one example of a structured mindfulness exercise that can be introduced and practiced during a therapy session. In this exercise, parents are asked to get into a comfortable position, close their eyes, and draw their attention to their breath. Parents should be instructed to continue breathing regularly, not attempting to change or control their breath. If parents find that they are attempting to control or change their breath, simply encourage them to notice these efforts and let them go.

Parents should be prompted to continue breathing at their regular pace for several minutes During thi time, parents should continue focusing their attention on their breath, noticing any sensations that may be occurring throughout their body (e.g. the way their chest/stomach change, the temperature of the air as it enters/exits, the way their body feels). The clinician should comment that if parents notice that extraneous thoughts arise, as they inevitably will, they should acknowledge these thoughts and then gently bring their attention back to their breath. The concept of mindfulness can also be readily applied when parents are engaged in strategies taught in behavioral parent training (e.g., strategic attention, Child's Game). Not only should this help parents further develop their ability to be mindful, it will also likely increase parents' effective use of these strategies. Parents who are more mindful during interactions with their child are also more likely to consistently respond to and provide contingent consequences for their child's appropriate and inappropriate behaviors. When discussing

mindfulness within the context of Child's Game, a parent would be encouraged to notice, without judgment, everything that happens during this interaction with his or her child, which may include noticing what the child is doing and saying, as well as any thoughts, feelings, and emotions the parent may be experiencing. By engaging in Child's Game mindfully, parents are more likely to be able to successfully use the descriptive, reflective, and praise statements required during this special playtime (Coyne & Murrell, 2009).

Self as Context

Over the course of an individual's life, a largely unconscious process happens wherein we learn to develop coherent stories about who we are, what we do, and how our internal experiences influence and justify our behaviors (e.g., "I am a professional," "I am worthless"). In ACT, this is known as *self-as-content* (Hayes et al., 2012). More specific to parenting, a parent will develop a conceptualized self of who he or

she is as a parent based upon past experiences (e.g., "I am a bad parent").

Through mindfulness and cognitive defusion, individuals can begin to recognize that they are not the sum total of their physical sensations, thoughts, and emotions; rather, there is a *stable self* that is doing the observing. From this perspective, parents can learn to let go of unhelpful self-evaluations, while retaining their sense of self. This ACT process is known as *self-as-context.*

One commonly used metaphor that helps make the distinction between a conceptualized self and self-as-context involves imagining a chessboard. The stable self is the chessboard, while the conceptualized self are the chess pieces. The black pieces are unwanted thoughts and emotions, and the white pieces strive to refute these negative internal experiences. When a parent becomes fused with a thought and believes that thought is true and represents the sum total of who he or she is, he or

she is up on the board in the middle of the battle between the pieces.

When a parent is able to engage in cognitive defusion and mindfulness, he or she becomes the board, which is stable and unchanging, and allows the parent to observe this battle from a distance. While this battle may be unpleasant, the mind is able to recognize it as harmless and separate from the stable self, which allows a parent to let go of unhelpful negative self-evaluations and continue to engage in value-based actions.

Acceptance

As discussed earlier, experiential avoidance occurs when a parent attempts to avoid or suppress unwanted physical sensations, thoughts, and/or feelings, which then can result in engagement in ineffective parenting strategies (e.g., withdrawal, punitive/controlling, inconsistent). In ACT, acceptance is presented as an alternative to experiential avoidance. Acceptance involves being aware of and embracing one's internal

experiences without making any efforts to change them (Hayes et al., 2012). By encouraging parents to become more accepting of their internal experiences, they will then be better able to purposefully choose to engage in value-based actions. When introducing acceptance, it is helpful to first support parents in acknowledging the futility of emotional control and avoidance. Providing psychoeducation about the relationship between experiential avoidance and parenting styles will likely be helpful.

A clinician can describe how an experientially avoidant parent may become overly permissive and/or authoritarian in his or her parenting approach. The negative effect of these parenting approaches on a child's disruptive behaviors should be emphasized.

Acceptance can then be introduced as an effective alternative to experiential avoidance. Numerous metaphors have been developed to assist with this process. Simple examples that highlight the futility of "the struggle" (i.e., experiential avoidance) may include

getting caught in a riptide or quicksand, a tug-of-war, or a Chinese finger trap.

In each of these examples, the clinician should stress that the more an individual struggles in these situations, the worse they become. Alternatively, the pink elephant exercise can be used. In this exercise, parents are instructed not to think about a pink elephant, which inevitably causes the parent to think about a pink elephant. Once parents have begun to recognize the ineffectiveness of experiential avoidance, acceptance should be introduced as a viable and helpful alternative.

A clinician should explain to parents that by letting go of the struggle with their negative thoughts and feelings, they will have the energy and focus to engage in value-based actions. To help illustrate the concept of acceptance, a clinician should consider using the passengers on the bus metaphor. In this exercise, parents are encouraged to imagine that they are bus drivers, and the bus is their life. On this bus are

passengers, which represent our thoughts, feelings, and memories. Parents want to drive their bus in a certain direction (i.e., value-based actions), but there may be times when the passengers become angry and begin to demand that the bus be taken in a different direction. The bus driver may argue with the passengers or may strike a deal that he or she will drive the bus wherever they want, so long as they sit back and stay quiet.

This interaction highlights the concept of experiential avoidance. In contrast, parents should be challenged to consider the benefits of simply acknowledging the passengers, while continuing to drive the bus in the direction they would like to go.

Committed Action

A final ACT principle that can be used to enhance behavioral parent training is committed action. Committed action involves purposefully choosing to engage in behaviors, even thosethat are difficult, in order to move in a direction that is consistent with previously identified values. This phase of treatment

incorporates more traditional behavior change techniques, while continuing to employ other components of ACT.

Committed action involves taking four specific steps:

1. **Pick a high-priority valued domain and develop an action plan for behavior change.**
2. **Commit to actions that are linked to values.**
3. **Attend to and overcome barriers to action with other ACT techniques (e.g., mindfulness, cognitive defusion).**
4. **Return to step 1 and generalize to larger patterns of action, other domains of living, other areas of psychological flexibility, and so forth.**

Engaging parents in a conversation about committed action may be particularly worthwhile when discussing consistently using behavior management strategies, particularly those that may result in a child's behavioral and/or emotional escalation (e.g. planned

ignoring, time-out). For example, parents may have previously identified that they hold the value of raising a respectful child. A clinician could work with the parents to make commitments to refrain from engaging in experiential avoidance (e.g. withdrawing command, giving in to a tantrum) when their child begins misbehaving, and instead, utilize mindfulness and cognitive defusion techniques. In other words, parents are committing to consistently engaging in effective behavior management strategies, despite anticipated behavioral and/or emotional escalations displayed by their child, in order to move forward in a valued direction.

Evidence-Based Clinical Application

To date, there is limited published research on ACT-enhanced behavioral parent training. Several studies have been conducted in which a combined group curriculum involving ACT principles and parent training strategies were evaluated, although it should be noted that these studies specifically targeted children

with chronic medical conditions (e.g., cerebral palsy, traumatic brain injury). This combined curriculum involved two sessions discussing ACT principles, followed by six sessions of training in specific parenting strategies. In each of these studies, results demonstrated that an ACT-enhanced parent-training curriculum was associated with more significant improvements in targeted parent (e.g., overreactivity and verbosity) and child variables (e.g., ECBI intensity score) in comparison to standard parent-training interventions.

Coyne and Wilson (2004) described how to use ACT principles in conjunction with parent–child interaction therapy (PCIT) when working with a typically developing young child with conduct problems (e.g., noncompliance and aggression). In this illustrative case example, the child's mother was initially engaged in several sessions wherein ACT principles were discussed, including values identification, mindfulness, cognitive defusion, and acceptance, before participating in PCIT coaching sessions focused on parenting skills acquisition. Values identification was used to increase

treatment engagement, and committed action exercises were incorporated to facilitate participation in the PCIT coaching sessions. Previously learned ACT principles were then flexibly incorporated into the PCIT coaching sessions throughout treatment, as needed. For example, when the mother learned planned ignoring, she encountered difficulties with adherence due to experiencing negative thoughts about her own incompetence and imagined a terrible future for her child.

Mindfulness and cognitive defusion techniques were practiced (such as those described earlier), which resulted in increased feelings of competence and improved parenting skills. Taken together, clinicians are encouraged to consider how these ACT principles can be used to enhance behavioral parent training by targeting relevant parental processes (e.g., avoidance, cognitive fusion, parental disengagement) that may be hindering new skill acquisition.

Based upon the current literature, it is likely worthwhile for clinicians to allocate some time at the beginning of treatment to orient parents to ACT principles. Once this foundation has been established, clinicians can then flexibly integrate ACT principles into behavioral parent training sessions when any barriers are encountered.

SOCIAL SKILLS INTERVENTIONS

As discussed in earlier chapters, the preschool years are often the time that social problems develop or first become apparent. Two general types of approaches have been used to teach social skills and social competence to children. The *structured learning approach* to teaching social skills focuses on the step-by-step teaching of actual skills (e.g., how to start a conversation).

The *social problem-solving approach* focuses more on teaching problem-solving skills that can be applied in social situations (e.g., deciding on an appropriate course of action when feeling left out of a playground

game). Research has demonstrated that social skills training interventions often produce small but meaningful short-term gains; however, thoughtful development and implementation of these interventions is critical, as these gains are often cancelled out by problems with social validity, maintenance, and generalization.

There are a variety of social skills programs that use the structured learning method of training, all of which involve the following components:

(1) introducing and defining the skill through didactic means,

(2) modeling the skill,

(3) overseeing student rehearsal of the skill,

(4) providing performance feedback on how effectively the student performed the skill in the rehearsal/role play.

Programs that use this method are based on a group-training format, including small pull-out groups of four to eight children or a whole class of students.

With young children, in particular, it is often recommended that the classroom approach be used. For example, the widely used Skill streaming program recommends that training take place in the classroom, as well as in other locations in which social skills are important. For younger children who are not yet enrolled in a typical school classroom, an appropriate setting could also be in preschool or daycare. One of the difficulties with teaching social skills is the lack of generalization that occurs from training settings to real-life settings. Utilizing a classroom approach, in which the teacher is one of the trainers, allows for reinforcement of appropriate social skills throughout the day (not just during the training session), which is considered key to promoting generalization and maintenance of the social skills.

The first step in teaching social skills in the structured learning method involves having the clinician introduce and define the skill. Typically the clinician generally describes the skill and then specifies the steps involved in completing it. For example, the

skill of following directions, as defined by the Skill streaming program, includes the following steps:

(1) listen,

(2) think about it,

(3) ask, if needed,

(4) do it.

After teaching these steps to the students, the skill is modeled by the group leader so that the children can see how the skill is actually used. Children then take turns practicing the skill through role plays and receiving feedback from peers and group leaders. Children receive positive reinforcement for appropriate use of the skill and corrective feedback for inappropriate use. Following the session, children are assigned homework to practice the skill in real-life settings.

Since children often do not use the skill appropriately at first, feedback from parents and teachers is advisable. If social skills are taught in a pull-

out group format, the teacher should be kept apprised of the skills the children are learning so that he or she can assist with the training in real-life settings. In addition, parents should be involved by reviewing homework sheets the child brings home or through ongoing contact with the group leaders.

In addition to following these steps, clinicians need to establish basic group rules and behavioral contingences for appropriate and inappropriate behavior during group meetings. For example, children who are actively participating should earn points or tokens that can then be exchanged for tangible reinforcers at the end of the group meeting. If children are talking out of turn or engaging in aggressive behavior during meetings, they should lose points or tokens. Problem-solving skills training is the other main type of intervention that has been used with children in an attempt to decrease aggressive behaviors and increase prosocial behaviors. Such programs teach children to go through a series of problem-solving steps when they are faced with a problem.

Children are first taught to define the problem (e.g. wanting to play with other kids at the playground but not knowing how to approach them). Next, children are taught to brainstorm and identify multiple solutions to the problem. At this stage, the focus is purely on identifying as many solutions as possible, and these solutions will typically include prosocial, as well as antisocial solutions.

Teachers and parents should be coached to refrain from evaluating suggested solutions at this stage, as they are often tempted to dissuade any antisocial solutions that are offered. Some solutions children may generate in response to the problem of wanting to join a group on the playground may include asking to join in, throwing a ball at the group, and asking the teacher to tell the group to let other kids play too. After such a list of solutions has been generated, each solution is evaluated (e.g., "If I have the teacher ask if I can play too, the other kids might think I'm a teacher's pet"), and the most appropriate solution is chosenand implemented.

Following the implementation of the solution, the child evaluates the outcome of the chosen solution (e.g., "I was scared to ask at first, but they said 'sure,' so it was great").

Problem-Solving Steps

- **What is the problem?**
- **What are possible solutions to the problem?**
- **What would happen if . . . ? [Evaluate outcomes of each possible solution.]**
- **Which option should I choose?**
- **How did my chosen option work out?**

and implemented. Following the implementation of the solution, the child evaluates the outcome of the chosen solution (e.g., "I was scared to ask at first, but they said 'sure,' so it was great").

Problem-solving programs have had some positive effects for older children (ages 7–13), both as stand-alone interventions and in combination with other approaches. For example, a recent literature review on

the efficacy of problem-solving skills training, parent training, and a combination of the two found that the combined intervention generally yielded more positive outcomes than either intervention alone.

Research on the use of problem-solving skills with young children, however, is still limited. In a study with young children ages 4–8 that compared the efficacy of parent training; child training (using problem-solving skills training); teacher training; child and teacher training; parent, child, and teacher training; or no treatment, positive treatment effects were shown in all treatment combinations. Although the interventions involving parent training produced greater positive changes in child behavior problems, the child-focused intervention did lead to better problem-solving skills for the children and fewer negative peer interactions. Furthermore, adding teacher training to parent training and/or child training improved treatment outcomes for child misbehavior in the classroom.

The lack of research on social skills programs targeted to young children is not unique to the problem-solving approach. Although some social skills programs have been developed specifically for preschool-age children (e.g., the preschool version of the Skill streaming program), much of the outcome research with young children has focused on children with developmental delays, rather than on typically developing children. In general, the outcome literature on social skills training is not extremely positive. As mentioned previously, social skills interventions have demonstrated limited generalizability and poor social

validity In order for a social skills intervention to be most effective, these programs must have social validity, be taught and practiced in real-life settings, be coordinated and reinforced across settings, and be evidence based.

PREVENTION AND EARLY INTERVENTION PROGRAMS

As noted in Chapter 1, preschool-age children who exhibit externalizing symptoms are at risk for

continuing to display problem behaviors throughout childhood and adolescence. Unfortunately, young children with conduct problems represent a chronically underserved population, with approximately 70% not receiving any treatment and even fewer receiving treatment that is empirically supported. Some children

will eventually receive services, but these services may come too late. Given the serious consequences associated with the early display of conduct problems, effective prevention and early intervention programs must be initiated long before the child reaches school age. The longer a child and family go without treatment, the more difficult it becomes to make meaningful change.

Given the substantial advances that have been made in identifying the risk and protective factors associated with developmental pathways leading to conduct problems, increased attention has been paid to developing preventative and early intervention programs for children with externalizing behavior

problems. Preventative work has primarily focused on selective and indicated prevention programs. That is, children who are targeted for treatment are at risk of or already exhibiting conduct problems at an elevated rate and oftentimes at a clinical level. For example, targeted children may meet the criteria for ODD but not as yet for CD.

Many prevention programs involve multiple interventions across multiple settings combining many of the interventions previously reviewed into a comprehensive package. These programs typically target parenting skills (through behavioral parent training) child social competence (through social skills/social competence training) and general aggressive/disruptive behaviors (through home and school-based behavioral interventions).

Other risk factors associated with conduct problems in children, such as poor academic skills, are also sometimes targeted. Furthermore, these programs often work to improve collaboration between parents, teachers, peers, and the broader community to ensure consistency across settings.

As each of the main intervention components have been previously described in this chapter, we have not outlined a prevention program, per se, instead choosing to briefly review the literature on some of the existing prevention programs.

The Fast Track program is a comprehensive early intervention/prevention program that incorporates parent-focused treatment, classroom interventions, and child-focused interventions.

In this program, all children at targeted schools were provided with a class wide intervention that included training in emotional understanding, friendship skills, self-control skills, and social problem-solving skills. In addition, for children identified as "high risk," parenting interventions, social skills training, and academic tutoring were offered.

In an evaluation of the program after the first year (at the end of first grade), some significant positive effects were noted for the high-risk students (e.g., increased social problem solving, increased positive

peer interactions, and decreased parental physical punishment). However, on many of the variables related to disruptive behavior (e.g., CBCL and TRF externalizing scores), there were no significant improvements (Conduct Problems Prevention Research Group [CPPRG]). For the non-high-risk children who received the classroom prevention component, significant positive effects were reported for peer-rated aggression and hyperactive-disruptive behaviors, and intervention classrooms were rated as more positive. However, there was no improvement in teacher ratings of child behaviors (CPPRG, 1999b).

A longitudinal analysis completed after the third year of the program continued to show modest positive effects, including reduced aggression and increased prosocial behavior (by both teacher and peer report) and improved academic engagement. Of note, peer-reported effects were only significant for boys, stronger intervention effects were shown in less disadvantaged schools, and effects on aggression were larger for those who showed higher baseline levels of aggression.

Barkley and his colleagues have also investigated early intervention programs. They compared a comprehensive school-based early intervention program to a home-based program and a combined (school and home intervention) program. Children who participated were identified prior to kindergarten entry as having high levels of disruptive behaviors.

The comprehensive school-based treatment program included social skills training (incorporating structured learning of social skills, following the Skills treaming model, and self-control and anger-control training) a classroom token system, including a response–cost component; and other behavioral contingency interventions. The home intervention was standard 10-week group behavioral parent training program. Outcomes indicated that the school-based interventions were effective and led to improvements in children's disruptive behaviors, social skills, and self-control, whereas behavioral parent training was not effective.

The authors attributed the lack of significant results for the behavioral parent training, at least in part, to the fact that a large percentage of parents did not attend and that these parents did not actively seek out services. Although the school-based program was initially beneficial, these gains were not maintained at a 2-year follow-up (Shelton et al., 2000).

The Triple P—Positive Parenting Program is a multilevel model program, consisting of five levels of intervention on a tiered continuum of increasing strength and narrowing reach. This program was originally designed for children from birth to age 12, and has recently been extended to include youth ages 12–16.

Classified as universal prevention:

- **level 1 involves disseminating parenting strategies to the entire population through the use of media sources, tip sheets, and videotapes.**
- **Level 2 is a one-session, 20- to 30-minute consultation with a primary health care provider**

for mild behavioral concerns, who provides and discusses tip sheets outlining ways of solving common child management and developmental problems.

- Level 3 is a four-session, 20-minute consultation program conducted by a primary health care provider wherein parents are taught appropriate parenting skills designed to address mild to moderate conduct problem behaviors.
- Level 4 provides individual or group therapy for children with severe behavioral difficulties, and
- Level 5 offers intensive supports for families with serious difficulties (e.g., partner conflict,
- child maltreatment). These services are provided by a trained mental health professional and treatment is longer in duration (typically a minimum of 10–12 sessions).

To date, emphasis has been given to the two upper levels of the program (Levels 4 and 5), with these levels constituting standard clinical treatment using behavioral parent training principles.

In a randomized controlled trial of families and their 3-year-old children, Level 4, Level 5, and a wait-list control group were compared. At posttreatment, both treatment groups reported reduced child conduct problems, although significant improvements were only observed in the Level 5 group., parents in the treatment groups reported reductions in the use of aversive parenting practices, although there were not significant group differences on observational measures. At 1-year follow up, treatment gains were maintained.

More recently, efforts have been made to universally disseminate Triple P Level 4 to preschool-age children and their parents. In one study, 186 families were randomly selected from local preschools to participate in a group-based Triple P prevention program. Significant reductions in dysfunctional parenting behaviors and child behavior problems were reported at postintervention. At 4-year follow-up, improvements in dysfunctional parenting behaviors were maintained; however, there was no evidence o long-term effects on child behavior problems.

In general, all forms of Triple P have been shown to have moderate-to- large effects for both child and parenting behaviors, with the exception of Level 1 Triple P, which has been shown to have small effects who has examined group parent training extensively, extended the application of The Incredible Years program from one of intervention to one of prevention.

In one such study, mothers of Head Start children participated in 8–12 weekly 2-hour group behavioral parent-training sessions that used videotaped modeling. In addition, Head Start teachers received 2–6 days of inservice trainings that consisted of the same material taught to the parent groups (e.g., positive behavior management and appropriate discipline techniques). Results demonstrated differential program effects depending on the child's initial levels of problem behaviors and the mothers' use of ineffective parenting strategies at baseline. Children exhibiting high levels of conduct problems at baseline and mothers who were initially highly critical and using ineffective parenting strategies benefited the most from the program.

CHAPTER SUMMARY

This chapter has presented an overview of the more common and empirically supported techniques for working with young children who demonstrate externalizing behavior problems. Due to the potential for long-term adverse outcomes for these children, it is important to identify these problems early on and implement appropriate interventions. By far the intervention with the most empirical support for conduct problems is behavioral parent training. Thus, this intervention should always be considered when a child presents with disruptive behaviors. However, as recent studies have shown, combining multiple interventions that target functioning in different settings may produce a wider array of positive outcomes. Thus, clinicians should consider using a multifaceted intervention that targets the child's behavior at home, school, and daycare.

Behavior Basics

Knowing some basic behavioral principles can help you understand why your child behaves the way he/she does. Applying skills based on these principles will help you increase your child's good behaviors and decrease his/her negative behaviors. ABCs of Behavior

A = Antecedent: What is happening before a behavior occurs.

B = Behavior: The actual behavior that occurs.

C = Consequence: What happens after the behavior occurs.

If the consequence is desirable, the behavior is more likely to happen again; if the consequence is undesirable, the behavior is less likely to happen again. Let's look at the ABCs using a couple of examples.

Example 1:

Antecedent (“A”): A child in a store sees candy in the checkout aisle.

Behavior (“B”): The child pesters his/her mother to buy the candy.

Consequence (C) The mother buys the child candy.

Long-term consequence: The child will be more likely to pester his/her mother in the future when he/she wants something since it “worked” for him/her before.

Example 2:

Antecedent (A): A child in a store sees candy in the checkout aisle.

Behavior (B): The child pesters his/her mother to buy the candy.

Consequence(C)The mother ignores the pestering and does not buy the child the candy.

Long-term consequence: The child will be less likely to pester his/her mother in the future since this behavior did not “work” for him/her.

Positive Reinforcement

- **Providing a desirable consequence(a reinforcer) to increase a behavior. Reinforcers can include toys, privileges, attention, and praise.**

✓ **Some unpleasant things can also be reinforcers. For example, since children are often reinforced by parental attention, even negative attention (e.g., yelling) may increase behaviors.**

✓ **For reinforcers to be most effective, they must be provided immediately after a behavior.**

Escape

- **Also known as negative reinforcement. This involves removing something unpleasant to increase a behavior.**

✓ **For example, a child may be allowed to leave the dinner table (escape) after trying several bitesof food.**

✓ **Sometimes things we think are punishing actually reinforce a child's behavior. For example, if a child who doesn't like to sit at the**

dinner table is told she will have to leave unless she behaves appropriately, she may then act up more to leave the table.

Differential Reinforcement

- Reinforcing a desirable behavior, while ignoring an undesirable behavior.

✓ For example, if your child is throwing toys (in an effort to get your attention), ignore the throwing behavior and once he/she does any other appropriate behavior, reinforce him/her for it immediately.

Extinction

- When you stop reinforcing a behavior that was previously reinforced. This is a way to decrease behavior.

✓ For example, if you no longer purchase a candy bar for your child when he/she begins pestering you at the checkout line, this behavior will decrease.

Extinction Burst

- **When a behavior is placed on extinction, it may initially cause the behavior to worsen before it gets better.**

✓ **This reaction is very common and will eventually stop if you are persistent. Persistence is critical.**

If you initially ignore a behavior but eventually give in once the behavior has escalated, you have now taught your child that if he/she escalates, he/she will eventually receive reinforcement.

In other words, the problem will become worse! That is why you must be committed to using extinction before you initiate use of this strategy.

Punishment

- **Implementing a consequence to decrease a behavior. This may involve adding an aversive consequence (e.g., extra chores) or removing**

something desirable (e.g., loss of privileges). Generally speaking, removing something desirable is the most effective type of punishment.

Using Your Attention Strategically "Time-In"

The first step in effective parenting is the establishment of positive parent–child interactions (i.e., "time-in"). "Time-in" helps promote a positive parent–child relationship and helps create a critical balance between providing attention to children for appropriate behavior and discipline for inappropriate behavior.

Encouraging children with well-planned physical contact and verbal praise helps them develop appropriate social behaviors that lead to high levels of self-confidence and selfesteem.

The use of "time-in" coupled with consistent discipline creates a powerful contrast between what behaviors you want your child to engage in

and those you do not want your child to engage in. It is the balance between "time-in" and consistent discipline that is critical. There is thought to be a "magical ratio" regarding the number of positive versus negative interactions you should have with your child.

For every 1 time that you have to "get after" or discipline your child, try to find 5 ways to be positive. In other words, strive to maintain a ratio of 5 positive interactions for every 1 negative interaction.

Catch Your Child Being Good

Disciplining your child for inappropriate behaviors only provides information about what *not to do*. Verbally praising or giving attention to your child for appropriate behavior ("catching your child being good") teaches your child what *to do*. We often ignore our children when they are quiet and engaging in appropriate behaviors.

You don’t have to wait until your child does something extraordinary to provide praise and attention. For example, if your child does not interrupt you while you are on the phone and you do not praise him/her, your child will learn that if he/she behaves, this positive behavior is ignored.

Ways to Provide Positive Attention When you see your child engaging in desirable behaviors, immediately tell him/her that you like that behavior. When you praise your child, be specific about what is desirable. For example, “I really like when you play quietly with your toys.” You can also use special activities as a reward, but do not make all fun activities between you and your child dependent on good behavior. Additional examples of praise are:

Physical	Verbal
Hugs	“I like it when you . . ”
Pats on head or shoulder	“Thanks! That was terrific when you . . . ”

Smiles, kisses, eye winks	**“Great! Nice going! Excellent job! Super! Fantastic!”**
High fives	**“Just for behaving so well, you and I will . . . ”**
Thumbs up	**“I am very proud of you when you . . . ”**

Be sure to avoid insincere compliments. For example, avoid statements such as, “Thanks for playing nicely with your sister. Why can’t you do that all the time?” Praising your child should make him/her feel good about what he/she just did, not remind him/her of inappropriate behaviors from the past.

Planned Ignoring

There are certain “attention-seeking” behaviors such whining, pouting, complaining, and crying that many children display. Parents often respond to these behaviors with scolding or reprimanding. Unfortunately, this response may reward your child, as some attention (even if it is negative) is better than no attention.

Planned ignoring can be a helpful strategy to reduce these behaviors. This involves providing no attention (e.g., no eye contact, physical response, or verbal response) for the attention seeking behavior. When using this strategy, the behavior often gets worse before it gets better (extinction burst). If this happens, don't give in and know that persistent ignoring is key to improvement. When using this strategy, it is critical to respond with positive attention to the first instance of your child's appropriate behavior.

The Child's Game

In order to increase your child's good behaviors, it is important to reinforce these behaviors by paying attention to them. The best way to practice this is in a play setting. This type of interaction also helps with parent–child bonding and can increase the positive relationship between a parent and child.

Below are guidelines for conducting these play sessions.

1. Select a time. Select a 5- to 15-minute time period each day to play with your child.

2. Interact with just one child. During this playtime, you should play with only one child at a time.

You can engage in this activity with all of your children, but make sure to play with each child separately. Work to minimize distractions and avoid multitasking.

3. Select appropriate toys. Select three to four different toys you can use during this playtime. These toys should be constructive, unstructured, and nonviolent in nature (e.g., blocks, Legos, Lincoln Logs).

4. Use child-directed statements. As you begin playing with your child, use the following types of verbalizations and interactions:

a. Praise. Provide your child with praise for appropriate behaviors. Use specific statements when possible and praise effort (rather than outcomes). All praise should be genuine and enthusiastic.

Examples:

- “I like how still you’re sitting in your chair!”
- “Good job with your tower. You are being so careful stacking those blocks.”

b. Descriptions. Describe specifically what your child is doing. Be genuine and enthusiastic. Think of these verbalizations as a “play-by-play” of your child’s activity.

Examples:

- “You put the blue block on top of the red block”
- “You have a green crayon, and you’re drawing a circle.”

c. Reflections. Reflect back the basic message your child is communicating to show you are listening.

Examples:

- *Your child says:* "I'm gonna draw a monster." *You say*: "You're going to draw a monster. I
- can't wait to see it!" *Your child says:* "Green is my favorite color." *You say:* "You like green. That is a nice color."

d. Joining in/imitation. Play with your child and/or imitate your child's play.

Example:

- If your child is building towers with blocks, you should too.

5. Avoid directive statements. During your playtime, you should refrain from the following:

a. Asking questions: For example, “What are you drawing?” or “What color is this?”

b. Giving commands: For example, “Why don’t you draw a picture of our house?”

c. Being critical: For example, “That’s not a very good picture of our house—our house is white, not red.”

6. Occasionally during this playtime, your child may misbehave. If this misbehavior is minor, simply ignore it. When your child begins to behave appropriately again, reengage in play with him/her. If the misbehavior is severe, end the playtime.

Giving Effective Commands Providing strategic attention to your child’s appropriate behaviors is very important but does not guarantee desired behavior. Children thrive under conditions that provide structure, clear expectations, and predictability.

Giving effective instructions is a critical part of teaching children how to behave appropriately. Below are some simple and important guidelines for improving your child's compliance.

1. **Pick your battles. Only give commands in situations in which it is important that a command be given and at times when you can follow through.**

It is critical that you are consistent in providing consequences for noncompliant behaviors.

2. **Get your child's attention. Prior to giving a command, make sure you have your child's attention.**

Make eye contact, say your child's name, move closer to your child, etc. You should always be in the same room as your child when giving a command and you should reduce potential distractions (e.g., turn off the TV).

3. Only give commands your child can complete. Tasks involving activities that are too difficult for your child to understand or complete adequately should not be given.

4. Make commands direct and simple. Use a simple, direct instruction (e.g., “Pick up your shoes”) and use a firm tone. Do not use a question when you want your child to do something (e.g., “Can you go put your shoes on?”). Using a question implies a choice and you must be willing to accept “no” for an answer.

5. Give one command at a time. Children often have difficulties following through with multistep commands. Give one command at a time, with a consequence for compliance/noncompliance after each command.

6. State commands positively. Instead of telling your child what *not* to do (e.g., “Don’t jump on

the couch"), tell your child what *to do* (e.g., "Please sit down").

7. Make limited use of explanations. Often children ask for explanations or rationales simply to avoid complying with a command. Providing an explanation after giving a command also takes away the focus from the command.

If a rationale is provided, it should be given before the command (e.g., "We're going to visit Grandma and it's cold outside. Please go put on your coat now") or after the child has complied (e.g., "Thanks for putting your coat on like I asked; we're going to visit Grandma and it's cold outside").

8. If possible, give choices. When children are offered choices, it oftentimes leads to increased compliance. If the child can make a choice, let him/her know that in the command (e.g., "Please put on your red coat or your blue

coat"). Using Time-Out Effectively Time-out is an effective method to reduce your child's inappropriate behaviors.

However, it should always be used in combination with other positively based techniques you have already learned. Make sure you are positively attending to appropriate behaviors and using effective commands. Never give a command that you do not intend to back up and always provide praise when your child complies with a command. To effectively use timeout with your child, follow the guidelines below.

1. Give a simple and direct command. Always give appropriate commands in a firm, neutral voice.

2. Wait 10 seconds. After giving a command, be silent for 10 seconds and wait for your child to comply. You may want to count silently to yourself (don't count out loud).

3. Praise compliance. If your child begins to obey the instruction within 10 seconds, immediately praise him/her.

4. If no compliance, restate the command. If your child does not make any effort to obey within 10 seconds, repeat your instruction and include a time-out warning (e.g., “If you don’t [repeat the command], then you will go to time-out”). After giving this warning, wait another 10 seconds for compliance.

Note: When you are using time-out for something other than compliance (e.g., breaking a household rule, such as hitting a sibling), send your child to time-out immediately and do not use this warning statement

5. Praise compliance. If your child obeys a warning, immediately praise him/her.

6. If no compliance, send/take child to time-out. If your child does not comply with your command within 10 seconds, send/take your

child to time-out. Say, “Since you did not do as I asked, you must go to time-out.” Your child should not be allowed to argue, belatedly comply with the command, etc. Initially, you may need to use physical guidance to get your child to the time-out location.

7. Do not attend to your child. Do not give your child any attention while he/she is in time-out. Do not talk to your child. Continue what you were doing but keep an eye on your child so that you can put him/her back in time-out if he/she leaves time-out without permission. When your child has remained in the time-out quietly for the appropriate amount of time return to your child and say, Because you are quiet, you may come out of time-out now.”

8. Restate the command. After your child is released from time-out, repeat the original instruction your child disobeyed. Repeat steps listed above as needed.

Frequently Asked Questions about Time-Out

How long should my child stay in time-out? **The general rule of thumb is that children should remain in time-out for about 1 minute per year of age, not to exceed 5 minutes. However, when initially using time-out, this time frame is typically too much to expect, so plan on working up to it. When time-out is first used, it is common for children to cry, whine, scream, etc., for long periods of time. If this behavior occurs, postpone releasing your child from time-out until he/she has been quiet for 15–30 seconds. Do not use a timer during time-out but keep your eye on the clock.**

Where should my time-out location be?

Time-out in a chair is the preferable method. The chair should be an adult-size dining-room-type chair. The chair should be placed far enough away from all objects (including walls) so that your child cannot kick or hit anything while in the

chair. There should be nothing reinforcing that your child has access to from the chair (e.g., TV, toys). The time-out chair should be placed in a location that you can observe (e.g., in a hallway, not in a closet or bathroom).

What if my child leaves the time-out chair?

It is not uncommon for children to test the limits when parents first begin to use time-out. Children who squirm, bounce, roll around, etc., in the chair should not be considered out of time-out. This behavior should simply be ignored. Children will often leave the chair and may do so immediately after being placed in time-out.

It is important that, if this happens, you immediately return your child to time-out but remain silent. When first using time-out (when it is most likely your child will leave the chair), it is a good idea to stand right next to the chair (but do not look directly at your child or do anything to give your child attention).

That way, you can immediately put your child back in time-out as soon as he/she leaves the time-out chair. If your child persists in leaving the time-out chair, talk with your therapist about other options.

What should I do if my child says he/she needs to get out of the chair?

Your child is not to leave the time-out chair to use the bathroom or get a drink until his/her time is up and he/she has completed the task that was asked of him/her. If your child is permitted to leave timeout following a certain demand, he/she will come to use this demand as a means of escaping from time-out on each occasion he/she is placed in the chair. Simply ignore all requests your child makes.

Using Privileges to Manage Behavior

Privileges can be used to reinforce your child for appropriate behaviors and to discipline him/her for inappropriate behaviors. This method

may be used when it is not possible to use time-out or as an addition to time-out for specific behaviors.

Providing Privileges for Appropriate Behavior

1. With your child, make up a list of privileges he/she can earn. These should include extra-special privileges (e.g., getting a new toy, going out to eat with a parent) as well as other, common privileges (e.g., 15-minute later bedtime, extra dessert, watching an additional TV show).

2. Make a list of behaviors and chores that your child can do to earn privileges. Make sure that you do not place unreasonable expectations on your child. Good examples of chores/tasks for young children are: picking up toys, helping set the table, putting away clean clothes, helping feed the dog, etc.

3. When your child completes a chore or behavior on your list, give him/her one of the privileges,

making sure to praise your child for completing the behavior/chore. For example, when your child earns the privilege of watching an extra TV show, you might say, “Thanks for taking your toys out of the living room. Because you did such a good job cleaning up, you may watch one extra TV show today.” Provide your child with the common extra privileges on a regular basis and occasionally give him/her one of the extra-special privileges.

4. Provide lots of reinforcement, especially initially. When beginning the program, look for opportunities to give your child privileges for appropriate behaviors, and remember that you can reward your child for good behaviors that are not on the list you have made. Parents often expect too much at once and wait for “big” behaviors to occur before providing reinforcement. This makes it less likely that

the program will be successful because the child will rarely have access to the privileges.

Taking Away Privileges for Inappropriate Behavior

1. Make a list of privileges your child automatically receives on a daily basis. These privileges are those your child does not need to do anything special to obtain but are the everyday privileges you allow your child (e.g., an hour of TV, unlimited access to all toys, inviting a friend over).

2. Make a list of behaviors/chores that your child must do in order to keep these automatic privileges. This list should be relatively short and should include only those chores or tasks your child is expected to complete on a daily basis (e.g., getting dressed, brushing teeth at night).

3. Make a list of inappropriate behaviors that you will not tolerate from your child (e.g., hitting siblings, spitting out food at the dinner table).

4. As long as your child completes the daily tasks identified in step 2, he/she is allowed to keep his/her automatic privileges. If these daily tasks are not completed, or your child exhibits one of the inappropriate behaviors identified in step 3, then take away certain automatic privileges. It may be easiest to pair each negative behavior with a specific privilege that will be lost. Go over this list with your child so that he/she knows what is expected of him/her and what will happen when he/she does not complete a daily task or engages in an inappropriate behavior.

It is important to understand that you are not bribing your child. Many parents feel their children should obey house rules simply because it is their responsibility. Remember, though, that you get paid for working at a job. In the same sense, obeying house rules is your child's job, and he/she should be able to earn privileges in the same way you earn a paycheck.

Managing Behavior Problems in Public Places

After your child has learned to comply with rules and commands at home, it will be easier to teach him/her to behave as expected in public places, such as stores and restaurants. When out in public, it is important to praise appropriate behaviors and provide consequences for inappropriate behaviors, just as you would do at home. Below are guidelines to help you.

- **Take practice trips.**
  - ✓ **Take 15 to 20-minute practice trips where you practice the guidelines below.**
- **Set up the rules for expected behaviors beforehand and review these rules with your child.**
  - ✓ **Have a maximum of three to four rules.**

  Example: If you are taking your child grocery shopping, your rules might be: "Stay within arm's length of the cart, do not take any

items off the shelves, and talk in your indoor voice."

- Praise your child for good behaviors.
  - ✓ Provide your child with positive reinforcement for appropriate behaviors.
  - ✓ Use specific labeled praise when your child follows rules.

Example "Thank you for staying next to the cart

  - ✓ Consider providing a special reward after the trip.
  - ✓ Consider using a point or token system in which the child is able to earn points/tokens (items that can later be exchanged for special reinforcers) for appropriate behaviors.
- Set up consequences for misbehavior.
  - ✓ Establish predetermined consequences and explain these to your child ahead of time.

- ✓ If using a point or token system to reinforce your child, you can also add a response–cost component in which you take away points/tokens for inappropriate behaviors.
- ✓ Consider using a modified time-out in public if you have used it successfully at home.

Require your child to sit or stand in one location for a brief period of time (e.g., 30–45 seconds of quiet).

- Give your child something to do.
  - ✓ Talk to your child frequently and provide him/her with small tasks.

„„Example: If you are grocery shopping, you might ask your child to reach for the items on the lower shelves (only after you have pointed the items out to the child).

- If your child throws a tantrum—*do not give in.*

- ✓ **Ignore your child's tantrum behaviors.**
- ✓ **If necessary, leave the store, restaurant, etc., until your child calms down.**

(*Note:* Never leave your child alone—you should always accompany your child when it becomes necessary to leave the public place.)

„„Once your child is calm, you should always return to the original activity. Otherwise, your child will learn that tantruming is an effective way to escape a situation.