My Kid Won't Listen to Me! Empowering Residents to Coach Parents of Difficult Children

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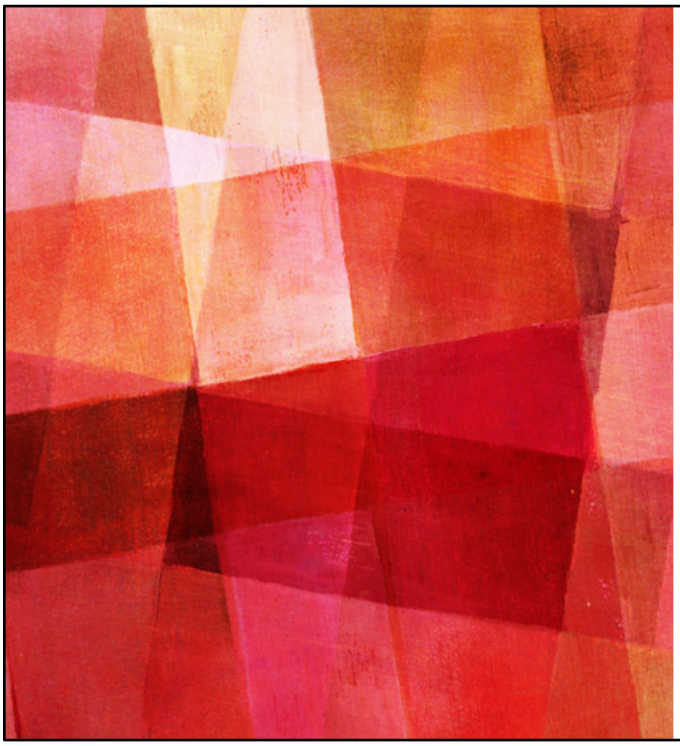
In His Image Family Medicine Residency
The 37th Forum for Behavioral Science in Family Medicine



HOUSEKEEPING

- **Disclosures** – none
- **Audience** – Behavioral medicine faculty & physician faculty tasked with teaching pediatric behavioral medicine interventions.
- **Goals & Objectives**
  1. Upon completion, participant will be able to identify evidence-based treatments for disruptive behavior disorders.
  2. Upon completion, participant will be able to list five simple parenting skills that can be taught in a primary care setting.
  3. Upon completion, participant will have identified one possible action step to better address parent education among residents at his/her home program.

IN HIS IMAGE

Child Psychologist

Behavioral Medicine Faculty from In His Image, a community-based family medicine residency in Tulsa, OK.

Explicitly Christian program. Important to understand several aspects of our culture as it relates to this discussion.

- Some of the interesting dynamics of discipline and punishment that I run into. (Both in a Christian organization and in Tulsa)
- Many alumni end up overseas or in under resourced areas stateside and so they desire more counseling skills than other residents might, so we have developed methods for providing more intensive training. Today will illustrate that.

Residents are often “shooting from the hip” and giving advice based on what their parents did when they were growing up or their own experiences having children. The irony is that they all end up cornering me at one point or another during residency to ask about their own parenting dilemmas.

Ex: Resident with the most evenly tempered children ever who swore that his version of sleep training was the end-all, be-all.

This is something that is incredibly easy to fall into. **I** find myself doing this at times and have to remind myself to reel it in.

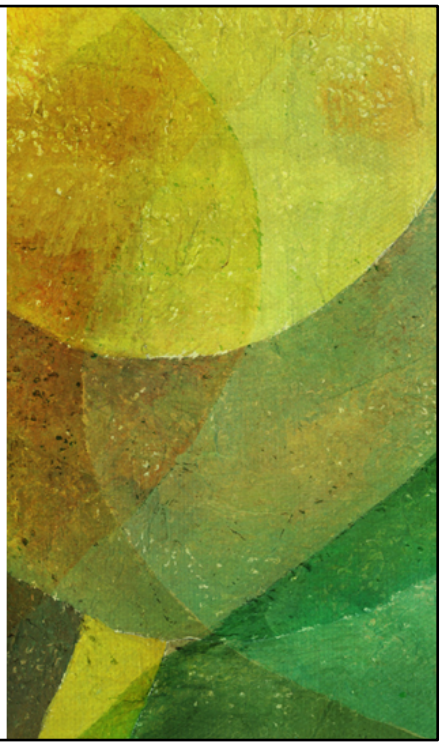
GOOD NEWS!

Source: http://prehospitalresearch.eu/?p=1176

The problem is that our opinions are not necessarily evidence-based and we actually have quite the evidence-base for behavior management, so we should use what we know if effective.
Good news – we actually have a good idea about what is effective and what works.

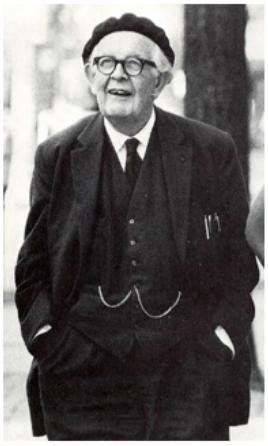
WHAT IS ALREADY OUT THERE?

- Focus on integrated care – Primary care adaptations of programs like Incredible Years, Triple P
- Training for PCPs and Pediatricians
  - Behavior management
  - Focus on parent-child relationship
- Broad prevention programs implemented at well child checks
  - Ex: Reach Out and Read

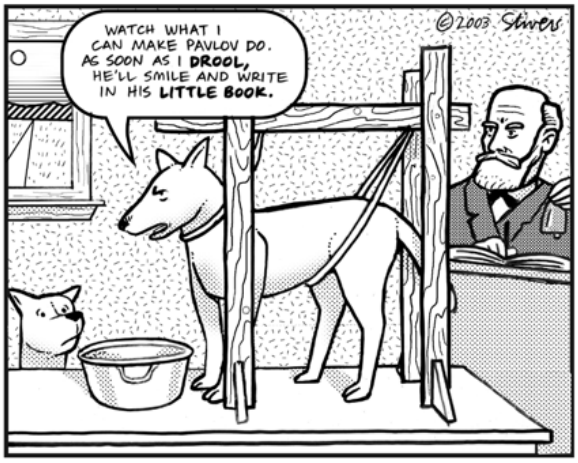


- Focus on integrated care – which is ideal and wonderful, but not reality for many of our alumni (or our residents right now)
  - Incredible Years, Primary Care Stepping Stones Triple P (Lavigne, et al, 2008a, Lavigne et al, 2008b, Tellegren & Sanders, 2012)
- Training for Primary Care Physicians and Pediatricians
  - Basics of behavior and behavior management (Augusytn, Zuckerman, & Caronna, 2011, chpts 14 & 16)
  - Focus on parent-child relationship (goodness of fit, warm relationship, flexible discipline boundaries) – (Augusytn, Zuckerman, & Caronna, 2011, chpts. 3, 4, 9)
  - Broader general guidance focused on early child development (Shah, Kennedy, Clark, Bauer, & Schwartz, 2016).
    - Ex: Reach Out and Read (http://www.reachoutandread.org)

START WITH WHAT YOU KNOW



Source: https://en.wikipedia.org/wiki/Jean_Piaget



Source: http://twistedsifter.com/2010/09/the-saturday-strip-week-27/

- I started by trying to make the residents all mini-child psychologists because, obviously, that is the best thing ☺

EVIDENCE BASED TREATMENT FOR DISRUPTIVE BEHAVIOR (ADHD, ODD)

- Behavioral Parent Training
- Parent-Child Relationship is Key

Source: http://lifehacker.com/baby-boot-camp-the-skills-every-new-parent-needs-to-le-1709234325

- Evidence-Based Treatment for Children with Disruptive Behavior (ODD, ADHD, CD)
    - Journal of Clinical Child and Adolescent Psychology (JCCAP) Evidence-Based Updates (See reference list)
    - Summary – (Evans, Owens, & Bunford, 2013, Eyberg, Nelson, & Boggs, 2008)
        - Behavioral Parent Training is Well-Established
        - Second line of treatment for older children with disruptive behavior is individual CBT (as they develop the cognitive abilities to engage with it).
        - Other well-established treatments for ADHD – Behavioral Classroom Management, Behavioral Peer Intervention, Combined Behavioral Management Interventions
    - Behavioral Parent Training –
        - Can mean many different things, but typically includes the following components:
            - Teaching about basic behaviorism (Antecedents-Behavior-Consequences)
            - Positive one-on-one time with parent and child
            - Praise
            - Active Ignoring
            - Giving Good Commands

        - Contingency Management – rewards, time out, loss of privileges
    - Parenting in General
        - Parent-Child Relationship is key
        - Use of effective techniques. Heavily based in behaviorism.
- I can't make them mini-child psychologists and that would be a terrible idea, actually, but I can teach them basic principles that will make them more effective in their interventions and be helpful to their patients. (Distilling the information)

Behaviorism – Basics = ABCs of Behavior

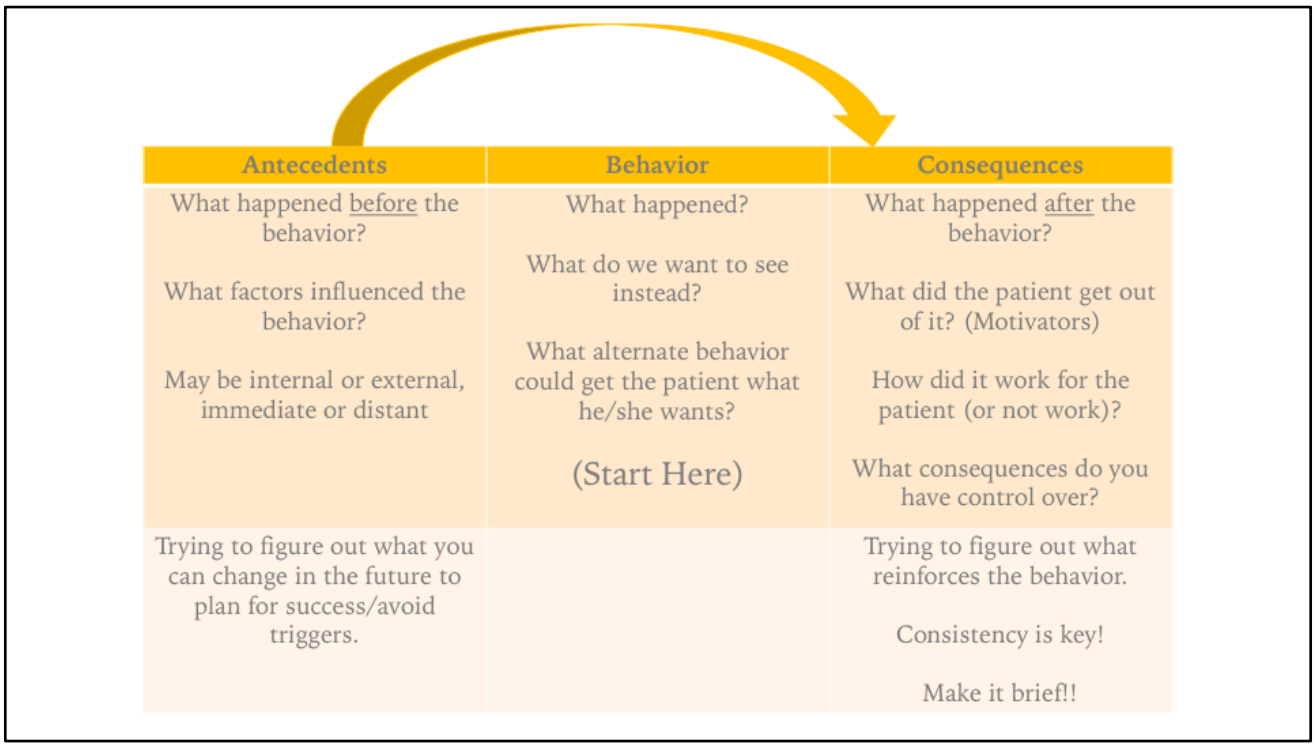
Antecedents – what happened BEFORE the behavior

Behavior

Consequences – what happened AFTER the behavior

Antecedents	Behavior	Consequences
	What happened? What do we want to see instead? What alternate behavior could get the patient what he/she wants? (Start Here)	

Antecedents	Behavior	Consequences
What happened before the behavior? What factors influenced the behavior? May be internal or external, immediate or distant	What happened? What do we want to see instead? What alternate behavior could get the patient what he/she wants? (Start Here)	
Trying to figure out what you can change in the future to plan for success/avoid triggers.		


Antecedents
Behavior
Consequences
What happened before the behavior?
What factors influenced the behavior?
May be internal or external, immediate or distant
What happened?
What do we want to see instead?
What alternate behavior could get the patient what he/she wants?
(Start Here)
What happened after the behavior?
What did the patient get out of it? (Motivators)
How did it work for the patient (or not work)?
What consequences do you have control over?
Trying to figure out what you can change in the future to plan for success/avoid triggers.
Trying to figure out what reinforces the behavior.
Consistency is key!
Make it brief!!

DEMONSTRATION

Antecedents	Behavior	Consequences
	6 year-old patient who does not sleep at night. If he sleeps, it is only for 1-2 hours. No Naps Quite Irritable	

Volunteers:

Child
10 others to be the As and Cs

Need: Yarn, scissors, and a sample scenario

Scenario – 6 year-old patient will not sleep at night, only sleeps 1-2 hours at the most, no naps, quite irritable.

Antecedents – anxiety, mom works at night, “always needed less sleep,” no routine at home
Consequences – aggression/fits, pulled out of school due to behavior, caregivers are not sleeping because he is a runner, plays games/watches TV at night

Set up the As & Cs connecting strings to the ‘child’ in the middle. Cut the strings as things are resolved or problem solved.

DEMONSTRATION

Antecedents	Behavior	Consequences
Anxiety & Worry Mom works at night "Always needed less sleep" No routine at home	6 year-old patient who does not sleep at night. If he sleeps, it is only for 1-2 hours. No Naps Quite Irritable	

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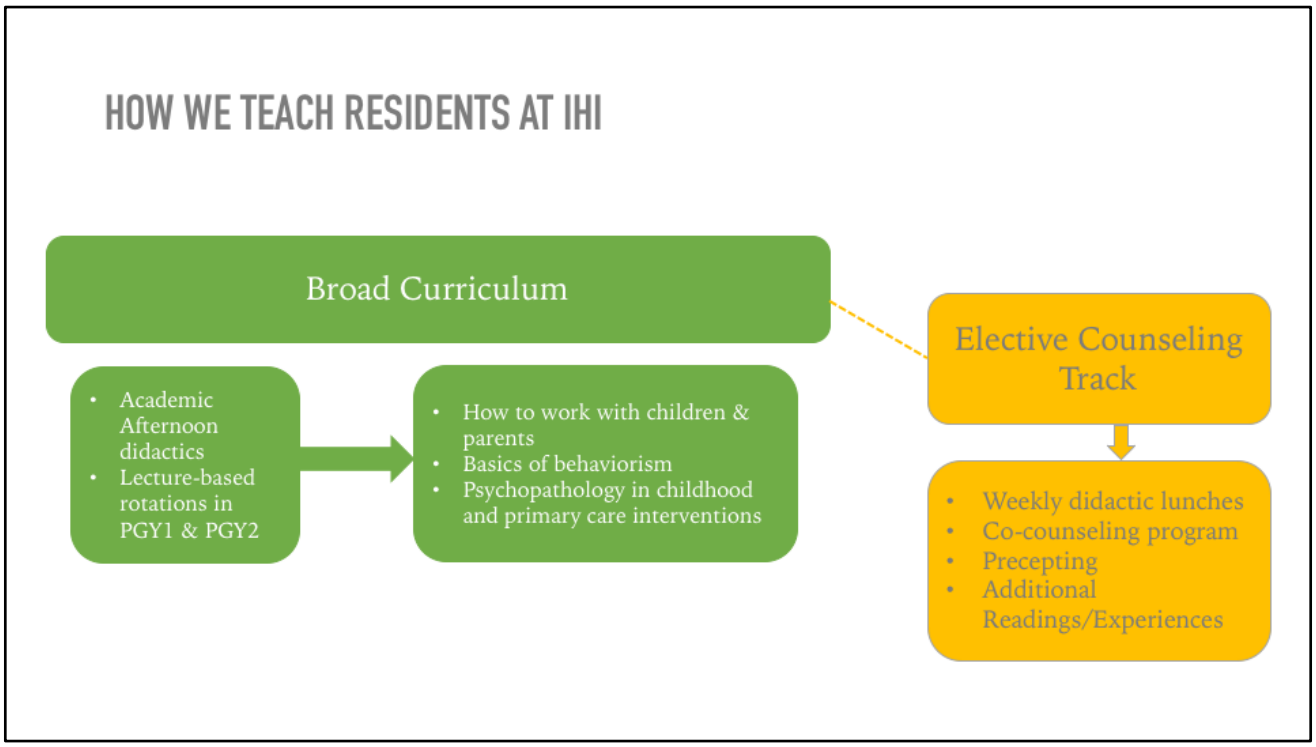


- Broad curriculum – all residents throughout the three years. Mostly in Academic Afternoon didactics, but also in rotations that are primarily lecture-based. Pediatrics behavioral medicine curriculum includes:
    - How to work with children and parents
    - Basics of behaviorism (ABCs of Behavior) – useful for addressing disruptive behavior, but also health-related behavior problems like sleep, feeding, toilet training, etc. AND super important for adult behavior change also like smoking cessation, sleep, weight loss, diabetes management, etc.
    - Pathology and primary care intervention strategies
- Counseling Track curriculum – residents self-select to join at the beginning of their second year.
    - Weekly didactic lunches – 18-24 month rotating lecture series
    - Co-counseling program – sit in with behavioral medicine faculty in typical therapy sessions
    - Precepting – elect to discuss patient encounters or presentations with behavioral medicine faculty
    - Additional reading/experiences
    - Pediatrics curriculum for Counseling Track – ever-evolving, but is primarily where I do the intensive teaching for what we are discussing today.

RECURRENT MESSAGES ABOUT PARENTING

- No magic bullet of parenting, but there are some things that are more effective than others.
- Every child is different (even in the same family)
- Every parent is different

Source: http://blog.24-7pressrelease.com/2014/03/06/whats-the-magic-bullet-for-your-marketing/

Some messages that I repeat over and over again

- No magic bullet for parenting – there are tens of thousands of books about parenting and each person thinks he/she has the perfect formula. In reality, every parent-child dyad is different and so parenting should look different for every child. BUT there are principles that can be applied across the board.

RECURRENT MESSAGES ABOUT PARENTING

- Foundational Principles with Flexibility and Creativity
- Focus on Parent-Child Relationship, if nothing else
- Consistency!!
- Simplicity!!

Source: http://www.davidchatak.com/keeping-it-simple/

Some messages that I repeat over and over again

- Key – good foundational principles with flexibility and creativity
- If they don't catch anything else – focus on the parent-child relationship. Warmth and positive interactions.
- Key to behavior change is consistency. Parents ideally are on the same page. Ideally, use same techniques with all children in the home in different ways.
- Keep it simple!!! Any intervention should be simplified as much as possible or it just won't be sustainable. (Praise, rewards, privilege removal, special time)

BASIC BUILDING BLOCKS

- Functional Analysis of Behavior using the ABCs of Behavior
    - Begin with behavior – define very specifically, including behavior you want to see instead
    - Identify antecedents (ie: what happened *before* the behavior occurred) – can be immediate or distant, internal or external to child
    - Identify consequences (ie: what happened *after* the behavior) – was there anything reinforcing/rewarding? What worked or didn't work for the child?
    - See what you can change with Antecedents and Consequences in the future to change the behavior.
- Special Time/One-on-One Time – rationale: children (particularly those with behavior problems) need positive time with parents. Need parents to remember that they *like* their kid, not just love them.
    - 5 minutes each day parent and child have one-on-one time. The rules:
        - Have fun!
        - Praise!
        - No instructions or question…narrate what they are doing like a sportscaster.
        - Let the child be in charge.
    - Choose simple activities to do at home…reading together, playing a

board game, building Legos, playing with dolls

- Praise
    - Immediate
    - Specific
    - Consistent
- Active Ignoring
    - For annoying behaviors, not blatant disobedience or physical aggression.
    - Preparation
        - Pick a target behavior, define it well
        - Pick behaviors you would like to see instead
        - Identify how to praise your child for behaviors you want to see more of
        - Explain the plan to the family (spouses work together, not always necessary to explain to the kid)
    - When the behavior occurs
        - Ignore it
        - Don't explain that you are ignoring
        - Try not to look upset
        - Catch them being good (praise as soon as the behavior changes)
        - Stick with it (often gets worse before better)
- Giving Effective Instructions
    - Avoid questions or 'Let's' statements
    - Be specific
    - Avoid lists (like this one)
    - Get the child's attention first (use name, eye contact)
    - Reduce distractions
    - Prepare child for transitions
    - Use calm and even tone of voice
    - Be clear
- Rewards
    - Choose a specific target behavior
    - Identify a small reward that will motivate child
    - Identify how to keep track of child's behavior to earn reward
    - Should be given immediately after target behavior occurs
    - Use If-Then sentence to explain to child
    - Slowly increase the difficulty to earn rewards
    - Use praise liberally
    - Keep it simple and cheap
    - Don't take earned rewards away (or stickers/points), have separate consequences for inappropriate behavior.

- Time Out – *Supernanny* videos are actually pretty good at laying out an appropriate timeout routine.
    - Use for behaviors that are not appropriate for Active Ignoring – physical aggression, disobeying, dangerous behavior, etc.
    - Planning
        - Identify 2-3 target behaviors to get rid of
        - Identify behaviors you'd like to see instead
        - Choose a time out place (make it easy to get to and boring to be in)
        - Get everyone on the same page
    - Implementation
        - Give an instruction
        - Count to 5 in your head
        - Give one simple, clear warning (if-then statement)
        - Count to 5 in your head
        - Tell child to go to time out
        - Don't explain or argue
        - Set timer (about 5 minutes depending on the child, could be as little as 30 sec)
        - Reset timer if necessary (child is yelling, etc.)
        - Talk calmly afterwards (make sure they know why they were in timeout, keep it brief, don't lecture)
        - Repeat instruction and if they don't comply, start process over.

SIDE NOTE ABOUT SPANKING

- I turned out okay…
- 80% of American parents spank their children at some point
- 5 Meta-Analyses –
  - "No evidence that spanking is associated with improved child behavior."
  - "Spanking (is) associated with an increased risk of 13 detrimental outcomes."
    - Caution - Not cause and effect, just associated risk
    - Relatively small, but considering that 80% of parents spank, still significant number of kids
- Kids who are physically punished are more likely to be physically abused.

Gershoff, E. T., & Grogan-Kaylor, A. (2016). Spanking and child outcomes: Old controversies and new meta-analyses. *Journal of Family Psychology, 30*(4), 453-469. doi: 10.1037/fam0000191

- The dreaded conversation…
- Highly charged opinions that don't tend to respond well to research, logic, reason, etc.
- 80% of American parents spank their children at some point
- 5 Meta-Analyses - (explained in Gershoff & Grogan-Kaylor, 2016)
  - "No evidence that spanking is associated with improved child behavior."
  - "Spanking (is) associated with an increased risk of 13 detrimental outcomes."
    - Caution - not cause & effect, just associated risk
    - Relatively small increased risk, but considering that 80% of parents spank, still a significant number of kids.
  - Kids who are physically punished are more likely to be physically abused.
- Helpful resource: Hitting Close to Home: Teaching about Spanking by Elizabeth T. Gershoff (Book chapter...see reference below)

http://abcnews.go.com/GMA/video/parenting-techniques-spank-spank-16716075

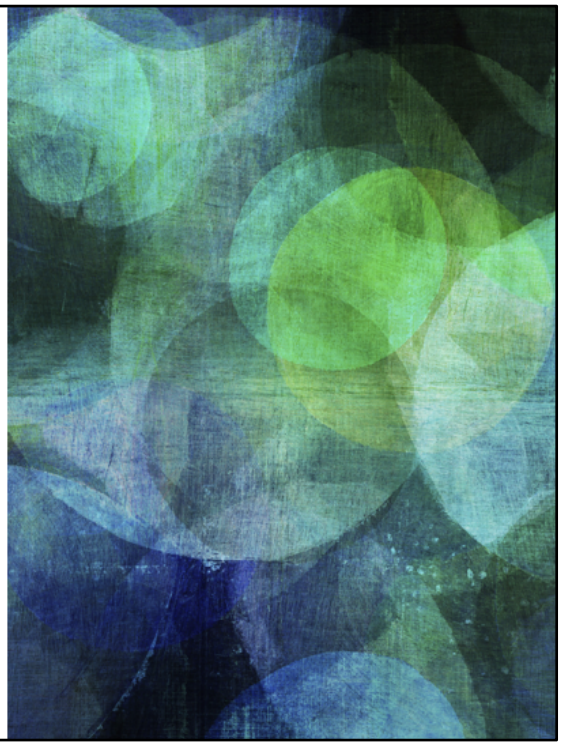
WOVEN INTO CURRICULUM

- **ABCs of Behavior** – during lecture about pediatric sleep, feeding, & elimination disorders; teaching about behavior change.
- **Special Time** – during parent-child relationship lecture; during ADHD teaching
- **Parenting Skills Series** – during Counseling Track series about psychopathology; parent-child relationship through childhood; developmental psychopathology

Source: http://www.crafthubs.com/loom-woven-potholder/8377

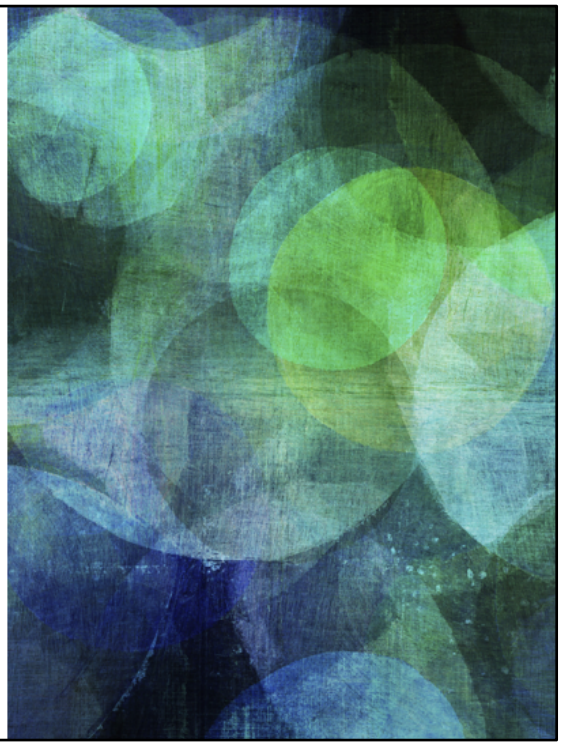
WAYS TO TEACH AND PRESENT

- Lecture form
- Practice ABCs of Behavior with vignettes
- Use case example and model teaching various tools
- Vignettes to practice what skills to choose for a presenting problem
- Parent brought in to model teaching



WAYS TO TEACH AND PRESENT

- Model & work together in co-counseling
- Precepting
- Parenting group – co-facilitators
- Co-intervention in residents' clinics



WHAT ABOUT YOU?

- How might this work in your residency?
- Where might it fit in your program?
- What are others doing to address parenting concerns or disruptive behavior?

CONTACT

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http://www.davidparmentrout.com
(our Behavioral Medicine director's web site with detailed information about our BM program)