My Kid Won't Listen to Me! Empowering Residents to Coach Parents of Difficult Children
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The Forum for Behavioral Science in Family Medicine
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I. **Housekeeping**
   a. Disclosures – none
   b. Goals & Objectives
      i. Upon completion, participant will be able to identify evidence-based treatments for disruptive behavior disorders.
      ii. Upon completion, participant will be able to list five simple parenting skills that can be taught in a primary care setting.
      iii. Upon completion, participant will have identified one possible action step to better address parent education among residents at his/her home program.
   c. Audience - Behavioral medicine faculty & physician faculty tasked with teaching pediatric behavioral medicine interventions.

II. **Introduction –**
   a. Child Psychologist
   b. Behavioral Medicine Faculty from In His Image, a community-based family medicine residency in Tulsa, OK.
   c. Explicitly Christian program. Important to understand several aspects of our culture as it relates to this discussion.
      i. Some of the interesting dynamics of discipline and punishment that I run into. (Both in a Christian organization and in Tulsa)
      ii. 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.

III. **Why?**
   a. 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.
      i. Ex: Resident with the most evenly tempered children ever who swore that his version of sleep training was the end-all, be-all.
   b. 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.
   c. 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.
   d. Good news – we actually have a good idea about what is effective and what works.

IV. **What is out there for primary care or pediatric parenting guidance for behavior problems?**
   a. Focus on integrated care – which is ideal and wonderful, but not reality for many of our alumni (or our residents right now)

i. Incredible Years, Primary Care Stepping Stones Triple P (Lavigne, et al, 2008a, Lavigne et al, 2008b, Tellegren & Sanders, 2012)

b. Training for Primary Care Physicians and Pediatricians
   i. Basics of behavior and behavior management (Augusytn, Zuckerman, & Caronna, 2011, chpts 14 & 16)
   ii. Focus on parent-child relationship (goodness of fit, warm relationship, flexible discipline boundaries) – (Augusytn, Zuckerman, & Caronna, 2011, chpts. 3, 4, 9)
   iii. Broader general guidance focused on early child development (Shah, Kennedy, Clark, Bauer, & Schwartz, 2016).
      1. Ex: Reach Out and Read (http://www.reachoutandread.org)

V. Start with what you know – Clinical Child & Adolescent Psychology/Pathology Model

a. I started by trying to make the residents all mini-child psychologists because, obviously, that is the best thing ☺
b. Evidence-Based Treatment for Children with Disruptive Behavior (ODD, ADHD, CD)
   i. Journal of Clinical Child and Adolescent Psychology (JCCAP) Evidence-Based Updates (See reference list)
   ii. Summary – (Evans, Owens, & Bunford, 2013, Eyberg, Nelson, & Boggs, 2008)
      1. Behavioral Parent Training is Well-Established
      2. Second line of treatment for older children with disruptive behavior is individual CBT (as they develop the cognitive abilities to engage with it).
      3. Other well-established treatments for ADHD – Behavioral Classroom Management, Behavioral Peer Intervention, Combined Behavioral Management Interventions
   iii. Behavioral Parent Training –
      1. Can mean many different things, but typically includes the following components:
         a. Teaching about basic behaviorism (Antecedents-Behavior-Consequences)
         b. Positive one-on-one time with parent and child
         c. Praise
         d. Active Ignoring
         e. Giving Good Commands
         f. Contingency Management – rewards, time out, loss of privileges
   iv. Parenting in General
      1. Parent-Child Relationship is key
      2. Use of effective techniques. Heavily based in behaviorism.
c. 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)

VI. The Core of All of This – Understanding Behavior

a. ABCs of Behavior
   i. Antecedent – what happened BEFORE the behavior
   ii. Behavior
   iii. Consequence – what happened AFTER the behavior
b. Teaching example with a case study
   i. Yarn exercise –

1. Use volunteers to be the ABCs in the scenario.
2. Wrap yarn from the antecedents to the behavior/child and also from the consequences to the child.
3. Discuss various ways to intervene to change the behavior and then reveal what actually changed in the situation by cutting the strings of the yarn.
4. Caution – your residents may end up in a literal tangled mess ☺

ii. Can also do this by having the residents quiz you as if you are the patient/parent and then talk through possible points of intervention.

VII. How we teach residents at IHI

a. 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:
   i. How to work with children and parents
   ii. 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.
   iii. Pathology and primary care intervention strategies
b. Counseling Track curriculum – residents self-select to join at the beginning of their second year.
   i. Weekly didactic lunches – 18-24 month rotating lecture series
   ii. Co-counseling program – sit in with behavioral medicine faculty in typical therapy sessions
   iii. Precepting – elect to discuss patient encounters or presentations with behavioral medicine faculty
   iv. Additional reading/experiences
   v. Pediatrics curriculum for Counseling Track – ever-evolving, but is primarily where I do the intensive teaching for what we are discussing today.

VIII. Curriculum for Teaching Parenting Skills to Residents

a. Weave it into many different ways of teaching. It is ever-evolving. I am actually currently in the middle of a new series with a different way of presenting the information.
b. Some messages that I repeat over and over again
   i. 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.
   ii. Key – good foundational principles with flexibility and creativity
   iii. If they don't catch anything else – focus on the parent-child relationship. Warmth and positive interactions.
   iv. 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.
   v. 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)
c. The basic building blocks that I want residents to catch:
   i. <u>Functional Analysis of Behavior using the ABCs of Behavior</u>

1. Begin with behavior – define very specifically, including behavior you want to see instead
2. Identify antecedents (ie: what happened *before* the behavior occurred) – can be immediate or distant, internal or external to child
3. Identify consequences (ie: what happened *after* the behavior) – was there anything reinforcing/rewarding? What worked or didn't work for the child?
4. See what you can change with Antecedents and Consequences in the future to change the behavior.

ii. <u>Special Time/One-on-One Time</u> – 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.
    1. 5 minutes each day parent and child have one-on-one time. The rules:
        a. Have fun!
        b. Praise!
        c. No instructions or question…narrate what they are doing like a sportscaster.
        d. Let the child be in charge.
    2. Choose simple activities to do at home…reading together, playing a board game, building Legos, playing with dolls

iii. <u>Praise</u>
    1. Immediate
    2. Specific
    3. Consistent

iv. <u>Active Ignoring</u>
    1. For annoying behaviors, not blatant disobedience or physical aggression.
    2. Preparation
        a. Pick a target behavior, define it well
        b. Pick behaviors you would like to see instead
        c. Identify how to praise your child for behaviors you want to see more of
        d. Explain the plan to the family (spouses work together, not always necessary to explain to the kid)
    3. When the behavior occurs
        a. Ignore it
        b. Don't explain that you are ignoring
        c. Try not to look upset
        d. Catch them being good (praise as soon as the behavior changes)
        e. Stick with it (often gets worse before better)

v. <u>Giving Effective Instructions</u>
    1. Avoid questions or 'Let's' statements
    2. Be specific
    3. Avoid lists (like this one)
    4. Get the child's attention first (use name, eye contact)
    5. Reduce distractions
    6. Prepare child for transitions
    7. Use calm and even tone of voice

8. Be clear

vi. Rewards
   1. Choose a specific target behavior
   2. Identify a small reward that will motivate child
   3. Identify how to keep track of child's behavior to earn reward
   4. Should be given immediately after target behavior occurs
   5. Use If-Then sentence to explain to child
   6. Slowly increase the difficulty to earn rewards
   7. Use praise liberally
   8. Keep it simple and cheap
   9. Don't take earned rewards away (or stickers/points), have separate consequences for inappropriate behavior.

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

d. Some iterations of different ways of teaching this –
   i. ABCs of Behavior in lectures about sleep, feeding, toileting problems in childhood. (For all residents in Academic Afternoon)
   ii. Behaviorism 101 – broader than just children – use of case examples to practice ABCs of behavior/functional analysis of behavior. (For 2nd year residents in Advanced Clinical Training rotation)
   iii. Behaviorism 101 hour-long lecture as part of a larger series – Applications in Exam Room, How to Create a Behavior Plan (Counseling Track)
   iv. Parent Management Training – 2 lectures as part of series on Child Psychopathology (after taught about ADHD and ODD) – taught parenting skills, used vignettes to practice (Counseling Track)
   v. Woven in with other teaching as appropriate – Developmental Psychopathology (Normal development, emotion regulation, temperament, relationships with

parents and peers, co-parenting relationship impact on children) (Counseling Track)

1. Ex: When discussing Emotion Regulation – teach Emotion Coaching Parenting. When discussing Parent-Child Relationship – teach Special Time.

vi. Series about Parent-Child Relationship throughout the lifespan – teach parenting skills during preschool and elementary school lectures. Focus on parent-child relationship throughout all lectures. (Counseling Track)

IX. **Side note about spanking**

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

X. Teaching Ideas

i. Present in lecture form
ii. Practice the ABCs of behavior with vignettes as a group (see resources for samples)
    1. Often I will play the parent and have the residents query me as they would in their clinic.
iii. Use a case example and either model how to teach or have the residents teach each other or me. (see resources for samples)
    1. Have two residents roleplay mother and father and I'm the therapist
    2. Break into dyads and have them practice teaching skills
iv. Vignettes for identifying what techniques to draw from (see resources for vignettes)
v. Consider bringing in a parent to model teaching this in vivo (dream right now)
vi. Model and work together in co-counseling
vii. Encourage them to use various techniques when precepting cases
viii. Parenting group in clinic that residents participate in as co-facilitators during their Behavioral Medicine rotation (planning right now)
ix. Co-intervention in residents' clinic (goal for future)

XI. What about you?

a. How might this work in your residency?
b. What might fit in your program?
c. What are others doing to address parenting concerns and disruptive behavior?

My Favorite Resources

For clinicians

Barkley, R. A., & Robin, A. L. (2014). *Defiant teens (2nd Ed).* New York, NY: The Guilford Press.

Barkley, R. A. (2013). *Defiant children (3rd Ed.).* New York, NY: The Guilford Press.

Chorpita, B. F. & Weisz, J. R. (2009). *MATCH-ADTC: Modular approach to therapy for children with anxiety, depression, trauma, or conduct problems.* Satellite Beach, FL: PracticeWise.

Greene, R. W. & Ablon, J. S. (2006). *Treating explosive kids.* New York, NY: The Guilford Press.

Parent-Child Interaction Therapy – trainings, theory, concepts, etc.

For parents

Any of Russell Barkley's books about ADHD or ODD – *Your Defiant Child; Taking Charge of ADHD; Your Defiant Teen.*

Phelan, T. W. (2010). *1-2-3 Magic (4th Ed.).* Glen Ellyn, IL: ParentMagic, Inc.

Greene, R. W. (2010). *The explosive child.* New York, NY: Harper.

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Shah, R., Kennedy, S., Clark, M. D., Bauer, S. C., & Schwartz, A. (2016). Primary care-based interventions to promote positive parenting behaviors: A meta-analysis.

Tellegen, C. L., & Sanders, M. R. (2012). Using primary care parenting interventions to improve outcomes in children with developmental disabilities: A case report. *Case Reports in Pediatrics.* doi:10.1155/2012/150261