A template for you to assess and address behavior problems

STEFFEN THALEMAN/VEER

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It goes by the acronym D-TECKT, and it's an easy-to-use guide to getting a handle on what's behind a child's or adolescent's behavior problems and lighting the way to an effective solution.

Parents may receive conflicting views about child rearing from the media and family and friends. As a result, they often turn to you for advice. Simple counsel and encouragement may be adequate, but often you need more information before you can either reassure the parent that the child's behavior is normal or offer effective intervention.

To help primary-care physicians gather information and address behavior concerns, the Emotional Health Committee of the Maryland Chapter of the American Academy of Pediatrics developed a template, the Developmental Troubleshooter's Eclectic Checklist for Kids and Teenagers (D-TECKT), that provides a comprehensive approach to parental concerns about child and adolescent behavior problems. The checklist has three sections:

- "Starting the investigation" (Table 1, page 74) provides a simple approach to a thorough behavioral history.
- "Searching for clues" (Table 2, page 77) provides a template for considering whether the problem is intrinsic or extrinsic to the child or, as in many cases, a combination of the two. The template further enables development of a differential diagnosis and working hypothesis by examining where within the D-TECKT schema the child and family are experiencing difficulty.
- "Solving the case" (Table 3, page 87) helps in choosing and implementing appropriate primary care mental health strategies matched to parental concerns once a working hypothesis has been developed.

The D-TECKT was developed as an outgrowth of the Emotional Health Committee's interest in teaching residents and practitioners ways to effectively assist struggling parents. It was first presented in a workshop at the national meet-

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TABLE 1
Starting the investigation

Who is engaging in the problem behavior?
What is the nature of the behavior?
Where does it occur?
When does it occur?
How often does it occur?
How is it handled?
What works?

ing of the Society for Behavioral and Developmental Pediatrics in March 2002. It has also been presented to residents at several pediatric training programs and has been used by a sampling of pediatricians in private practice. We hope to expand its use and obtain systematic feedback from practitioners regarding its efficacy in stimulating and supporting the clinical thought process during diagnostic evaluation of pediatric behavior problems.

Tips on using the D-TECKT

The D-TECKT provides a user-friendly method for organizing your thoughts when you're presented with child and adolescent behavior problems. Data may be collected in bits and pieces during telephone conversations, well-child visits, or more comprehensive behavioral visits. As you collect information, you can begin to develop a hypothesis about where, within the D-TECKT schema, the problem lies. You can then suggest interventions consistent with the working hypothesis. At times, an initial hypothesis and strategy may need to be revised and an alternate plan substituted. By reflecting on the dynamics behind the presenting behavior, you can select appropriate interventions and steer away from giving reflex suggestions for managing a given behavior.

Some behavior problems may arise from several areas of the D-TECKT schema. In such cases, you may need to implement interventions in order of perceived priority. You can implement strategies to the degree that you feel comfortable and refer patients to mental health consultants when the problem exceeds your comfort level. The "Searching for clues" checklist allows you to frame and record your impressions and hypotheses as you work with families. The cases on pages 81 and 82 provide some examples of the kinds of clues you might investigate for particular patients.

The checklist is not a questionnaire. It does not require that each item be asked or addressed when taking a history. Nor is the D-TECKT a checklist for parents to complete. Rather, it is a template designed to provide a methodical outline of cues and clues for you to consider during behavioral investigations.

Starting the investigation

A systematic history that provides a database of parental concerns launches the investigation:

- Who is primarily involved in the problem?
- What exactly is occurring?
- Where, when, and how often does the problem occur?
- How is it handled, and what interventions, if any, have been effective?

With the preliminary database in hand, you can begin to search for clues that will help determine where in the D-TECKT template the problem lies, thereby allowing you to develop a working hypothesis and differential diagnosis. Once you have a working hypothesis, you can pursue further lines of questioning to fill in the database.

Searching for clues

Use the second section of the D-TECKT to help determine whether the problems are intrinsic or extrinsic to the child or adolescent. Intrinsic problems can arise from biomedical or neurodevelopmental issues, normal development, temperament, or psychopathology.

Biomedical and neurodevelopmental concerns. Many medical problems present with behavioral symptoms. They include congenital disorders (such as Down syndrome or Prader-Willi syndrome), perinatal complications, seizure disorders and trauma to the central nervous system, CNS infections or tumors, endocrine disorders such as hyper- or hypothyroidism or Cushing syndrome, and obstructive sleep apnea. Patients can also develop behavioral symptoms as a side effect of medical treatment. Environmental toxins such as lead and mercury are other known causes of behavior problems.

Neurosensory problems such as hearing or visual impairment sometimes are accompanied by behavior difficulties. Neurodevelopmental problems such as attention deficit hyperactivity disorder present primarily with behavioral symptoms. This presentation may also be seen in autism spectrum disorders, where behavioral symptoms and impairments in social interaction can be more striking than the associated language impairments. Children with Tourette syndrome are likely to exhibit ADHD symptoms and sometimes obsessive compulsive symptoms before the hallmark tics of the disorder become apparent. Learning disabilities and executive function difficulties may manifest as behavioral problems in a classroom setting. A comprehensive medical history and complete physical exam

can be critical in pinpointing biomedical causes of behavioral problems.

Normal developmental stages. The work of pioneers such as Erikson,[1] Gesell, Piaget, and Mahler has provided models for understanding the developmental and emotional stages of childhood and adolescence. Behavior concerns may arise as a child strives to master each stage. In infants and toddlers, issues related to attachment to key caregivers, development of a sense of trust, and handling of separation may lead to problems such as crying, recurrent night awakening, or difficulty adjusting to day care. Emerging autonomy in toddlers may result in defiant behavior, tantrums, or resistance to eating, toileting, or going to bed. In the preschool period, emergence of imagination and magical thinking can produce fears of bodily harm and nightmares or phobias. School-age children, engaged in the tasks of mastering academic and athletic skills and refining social skills, must confront the challenges of peer acceptance and rejection as well as success and failure in schoolwork and sports. In adolescents, the struggle to become increasingly independent and develop a sense of personal and sexual identity can lead to behaviors that parents find challenging and confusing.

Temperament is defined by the traits of activity level, self control, distractibility, intensity, regularity, persistence, sensory threshold, initial reaction, adaptability, and mood, which are presumably biologically based and present from early infancy.[2-4] These traits have been clustered to describe three types of children: easy, slow to warm up, and difficult. Children

TABLE 2

Searching for clues: The D-TECKT checklist

Is the problem intrinsic to the child or adolescent?

Does the problem appear to stem from biomedical or neurodevelopmental issues?

- ☐ Congenital syndromes or problems
- ☐ Perinatal complications
- ☐ CNS insult, tumors, seizures
- ☐ Endocrine disorder
- ☐ Chronic illness
- ☐ Side effects of medical treatment
- ☐ Obstructive sleep apnea
- ☐ Lead poisoning or other environmental toxins
- ☐ Vision problems
- ☐ Auditory problems
- ☐ Neurodevelopmental concerns or delays (mental retardation, cerebral palsy, pervasive developmental disorder, autism)
- ☐ ADHD, attention problems
- ☐ Executive function problems
- ☐ Learning disabilities and problems
- ☐ Other _____

Notes _____

_____

Does the problem involve challenges relating to a normal stage of development?

- ☐ Attachment-separation issues in a young child
- ☐ Autonomy: defiant behavior, tantrums in toddler, resistance to eating, sleeping, toilet training
- ☐ Magical thinking, fear of injury: nightmares and phobias in preschoolers
- ☐ Self-esteem issues (peers, school, sports) in school-age child
- ☐ Identity and independence issues in adolescent
- ☐ Other_____

Notes _____

_____

Does the problem involve temperament traits of the child?

- ☐ Negative initial reactions to new situations
- ☐ Trouble with transitions
- ☐ Overreaction to situations
- ☐ Overreaction to sensory stimulation (sounds, smells, textures, clothing, crowds, foods)
- ☐ Intense personality
- ☐ Rigid
- ☐ Moody
- ☐ Easily distracted
- ☐ Overactive
- ☐ Other_____

Notes _____

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Table continues on page 78

TABLE 2 (Table continued from page 77)

Searching for clues: The D-TECKT checklist

Is the problem related to psychopathology in the child or adolescent?

Depression

- ☐ Sad
- ☐ Withdrawn
- ☐ Irritable
- ☐ Sleep disturbances
- ☐ Appetite or eating disturbances
- ☐ Poor school performance
- ☐ Suicidal ideation

Anxiety

- ☐ Nervous or tense, worried, easily upset
- ☐ Preoccupied with recurrent thoughts or fears
- ☐ Recurrent somatic complaints
- ☐ Sleep disturbances

Oppositional behavior

- ☐ Openly defiant toward adults in authority
- ☐ Problems with aggression

Signs of substance abuse

- ☐ Erratic behavior
- ☐ Changes in clothing style or music preferences
- ☐ Changes in peers
- ☐ Declining school performance
- ☐ Other

Notes _____

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Is the problem extrinsic to the child or adolescent?

Does the child's behavior appear to be related to situational factors (recent changes in the child's environment)?

- ☐ Birth of a new sibling
- ☐ Parental separation or divorce
- ☐ Change in parental job status
- ☐ Family illness or death
- ☐ Recent move
- ☐ Change in day-care or school setting
- ☐ Other_____

Notes _____

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Does the child's behavior seem to be associated with ineffective discipline by the parents?

- ☐ Difficulty setting limits
- ☐ Difficulty remaining consistent
- ☐ Overindulgence
- ☐ Overcontrolling or punitive style of discipline
- ☐ Passivity
- ☐ Disorganization
- ☐ Complaints that child never listens
- ☐ Escalating attempts at punishment
- ☐ Lack of knowledge and skills of effective discipline techniques
- ☐ Marital discord making effective discipline difficult
- ☐ Other_____

Notes _____

_____

Table continues on page 80

who are slow to warm up typically have negative initial reactions and trouble making transitions. Difficult children may be overactive, easily distracted, and intense and may go on to display more classic features of ADHD. Another common profile of difficult temperament is the intense child who is overly sensitive to sensory stimuli, has difficulty with transitions, and displays a negative mood. Such children may exhibit behavioral problems when bombarded with visual and auditory stimuli, as in a shopping mall, or complain incessantly about the way clothes feel or how foods taste. They are often described as rigid and moody and can become volatile when stressed.

The parenting literature has assigned various labels to temperamentally difficult children, including "highly spirited," "explosive," and "out of sync." Recognizing the difficult child can be critical to parents who are baffled by their child's behavior.

Psychopathology. Much of child psychopathology stems from the complex interaction between the child's intrinsic traits and the extrinsic factors described in the next section. You must attend to clues that suggest an underlying psychiatric condition such as depression, anxiety disorders, oppositional-defiant disorder, and substance abuse.[5]

In the case of depression, you may seek to establish whether the child or teenager is pervasively sad, withdrawn, irritable, displaying sleep or appetite disturbances, or performing poorly in school. Children and teenagers with an anxiety disorder may be nervous, worried, and easily upset, or may be preoccupied with

TABLE 2 (Table continued from page 78)

Searching for clues: The D-TECKT checklist

Is the child's behavior related to parent-child communication problems?

- ☐ Parental complaints of frequent verbal conflicts with child
- ☐ Parents and child overly critical of each other
- ☐ Limited positive time together
- ☐ Parent or child appears angry or disengaged
- ☐ Same conflicts occur repeatedly
- ☐ Family has difficulty engaging in constructive problem solving
- ☐ Other_____

Notes_____

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Is the child's behavior related to problems in family dynamics?

- ☐ Major conflicts between parents
- ☐ One parent overly involved in child's problem
- ☐ One parent more peripherally involved in child's problem
- ☐ Frequent conflicts between parents and siblings
- ☐ Frequent conflicts between siblings
- ☐ Child looking outside of family (to peers or media) to get needs met
- ☐ Other_____

Notes_____

_____

Is the child's behavior related to parental psychopathology?

Depression

- ☐ Postpartum
- ☐ Sadness
- ☐ Feelings of hopelessness
- ☐ Isolation
- ☐ Sleep or appetite changes

Anxiety

- ☐ Nervous or tense, worried, easily upset
- ☐ Excessive fears of harm to child
- ☐ Preoccupation with recurrent thoughts or fears
- ☐ Recurrent somatic complaints
- ☐ Sleep disturbances

- ☐ Substance abuse
- ☐ Domestic violence
- ☐ Child abuse
- ☐ Other

Notes_____

_____

recurrent thoughts or fears and experience recurrent somatic complaints and sleep disturbance. Children and teens with oppositional-defiant disorder may openly defy adults in authority and display aggression. In addition, remain alert to signs of substance abuse, including erratic behavior, declining school performance, a change in clothing style, and a shift in music and peer preferences.

Extrinsic problems

Issues extrinsic to the child or adolescent can arise from reactions to situational factors, ineffective parenting, poor communication, dysfunctional family dynamics, or parental psychopathology.

Situational factors. Consider whether the child's behavior appears to be a reaction to recent changes in the family or the environment. Many children display difficulties or regress after the birth of a sibling or in connection with parental separation or divorce, family illness, or death. Changes in the environment, including a recent move, day care or school, or parental job status also may contribute to the onset of behavior problems.

Ineffective discipline often gives rise to behavior problems in children and adolescents.[6-10] Parents may have difficulty setting limits or providing consistent discipline. They may be overly indulgent, caving in easily to their child's demands, or overly controlling and punitive. They may respond inconsistently to their child, sometimes overreacting and sometimes not reacting sufficiently. Homes in which discipline is ineffective are marked by a greater frequency of parental complaints about children who "never listen" or by escalating attempts at punishment.

Parents who have difficulty with discipline may be in a state of emotional crisis, or they may be intrinsically passive or disorganized. Some simply lack information or skills needed to be more effective. Overly indulgent parents often are experiencing feelings of guilt that may stem from having to work or from a recent divorce.

Continued on page 81

Case 1

A preschooler has sleep issues

A 4-year-old girl has been staying up until 11 p.m. and climbing into her parents' bed at 3 a.m.

After obtaining a thorough history (Table 1), you can use the D-TECKT template (Table 2) to ascertain where in the schema the problem lies:

Is the problem intrinsic to the child? It may result from a biomedical condition such as obstructive sleep apnea or simply drinking caffeinated beverages in the evening. Developmental issues around mastery of body integrity are common at this age, and the sleep problem may be a normal reaction to fears. Temperamental issues in an overactive child may lead to difficulties settling down and falling asleep at bedtime. Sleep problems may also surface in a child with a psychopathologic condition such as an anxiety disorder.

CAMILLE TOKERUD/GETTYIMAGES

Is the problem extrinsic to the child? Adjustment difficulties related to a recent change in the family or environmental situation, such as a new sibling or change in day care, may lead to sleep problems. Perhaps the child is staying up late because one of the parents is returning home late from shift work. Difficulties with limit setting by an overly indulgent or disorganized parent may prevent a consistent, firm approach to bedtime. Parents embroiled in negative communication patterns with their child may have established a tense environment that causes a problem falling and staying asleep. Family conflicts, particularly between parents, may prevent parents from collaborating effectively in addressing the sleep problem, or may inadvertently perpetuate it. The sleep problem may be related to "second family" issues such as overstimulation from video games or exposure to inappropriate movies or television shows. Parental psychopathology, such as depression, may result in a passive response to the child's problem by the affected parent.

Once the source of the problem has been identified, an appropriate intervention strategy (Table 3) can be designed.

Parents may adhere to specific scripts or parenting philosophies that influence how they respond to their children, such as belief in a "democratic" or "autocratic" home or the conviction that setting limits stifles creativity. They may also initiate a style of child rearing in an attempt to compensate for the way that they were raised as children. Sometimes parents "enable" child misbehavior to deflect attention from other issues, such as marital discord. Marital discord may also result in significant inconsistencies in handling behavior problems, making parental attempts at discipline ineffective. [Editor's note: For more on this topic, see "Promoting self-understanding in parents—for the great good of your patients" in the April 2005 issue, also accessible at www.contemporarypediatrics.com.]

Poor communication and "dysconnection." Clues that parent-child communication[11,12] is a central issue can be found when parents complain of frequent verbal conflicts with their child or teenager. Parents and children may be overly critical of each other. Often they are spending limited positive time together. They may feel stuck and have difficulty engaging in constructive problem solving. Parent and teens may be "dysconnected," appearing angry and disengaged. The same conflicts tend to occur repeatedly.

Family dynamics. Consider whether the behavior problem stems from more deep-seated intrafamilial conflict. Ineffective parent-child communication may extend to the family at large, resulting in ongoing conflicts between parents and between siblings as well as between parents and child. Ongoing conflict between parents[13] is an indication that the problem is rooted in the family. One common dynamic is for one parent to be peripherally involved in trying to manage the problem whereas the other parent is overly involved.

Children and teenagers who live in a family that lacks cohesion may become particularly vulnerable to the influences of what has been called the "second family"[14]—peers and media (movies, television, computers, music, and video games) that can be negative and destructive forces in the lives of youngsters who turn outward to meet needs not met within the family.

Parental psychopathology. When assessing child and adolescent behavioral problems, be sensitive to parental depression (including postpartum depression) marked by feelings of sadness, hopelessness, social isolation, moodiness, changes in job performance, and sleep or appetite disturbance. Anxiety disorder in par-

Case 2

Problems at school for an oppositional adolescent

A 13-year-old boy in eighth grade has become increasingly oppositional toward his parents over the past few months and resists doing homework. This has led to deterioration of his school performance.

ERIC LARRAYADIEU/GETTYIMAGES

Here is how the D-TECKT template can help delineate the source or sources of the problem after you have taken a comprehensive history:

Is the problem intrinsic to the adolescent? From a biomedical standpoint, difficulty at school may stem from undiagnosed ADHD or a learning disability that has surfaced as the teenager entered a more demanding school year. In the context of normal development, oppositional behavior in a 13-year-old may simply be developmentally appropriate behavior. From the perspective of temperament, a 13-year-old with a history of difficult temperament may be experiencing difficulty with transitions as he anticipates the upcoming move to high school. In terms of psychopathology, increasing oppositional behavior may reflect oppositional-defiant disorder. Increasing irritability and declining school performance may also be a sign of depression or substance abuse.

Is the problem extrinsic to the adolescent? Recent situational changes in the family, such as a divorce or change of school, may be contributing to the teenager's difficulties. The oppositional behavior may stem from a long-standing pattern of ineffective discipline that has escalated as the child has grown older. The teenager and his parents may be locked in a pattern of dysfunctional communication or dysfunctional family dynamics that results in ongoing conflict. The parents may not be working collaboratively to deal with their son's difficulties. One parent may be overly involved and the other, only peripherally involved. The influences of "second family," including peers or electronic media, may be pulling the teenager away from his studies. Parental psychopathology, such as depression or substance abuse, may be placing stress on the dynamics between parent and teenager.

Once you have clarified the potential issues, you can begin to help the family develop appropriate intervention.

ents may be expressed as excessive fear of harm to their children, leading to overprotectiveness. Also, be alert to indications of parental substance abuse, domestic violence, and child abuse.

Solving the case

Once you have used D-TECKT schema to discover where the problem lies, you can help the family address the problem through a combination of interventions such as demystification, education, provision of reading materials, reassurance, counseling, and problem solving. In some cases, referral to a mental health professional is in order.

Following are brief overviews of interventions that may be appropriate for intrinsic and extrinsic problems. Many of the articles and books in the reference list provide detailed descriptions of the interventions discussed here.

Intrinsic problems

If the behavior concern derives from a *biomedical* or *neurodevelopmental* problem, the key to intervention is identification of that underlying problem, whether it be a thyroid disorder, obstructive sleep apnea, lead poisoning, visual or hearing loss, or ADHD. A thorough medical history, physical exam, and appropriate laboratory studies are critical. Once a diagnosis is made, appropriate medical interventions can be pursued.

Intervention for behavior problems that have arisen from *normal developmental stages* depends on an understanding of the challenges associated with each stage. Infants and toddlers often display problematic behaviors stemming from developmental challenges of separation and autonomy. Difficulties may arise in the form of sleep disturbances in infants experiencing separation issues. Toilet training struggles and tantrums may emerge in the toddler experiencing autonomy issues. Preschool-age children face the challenges of emerging imagination and of magical thinking, leading to fear of bodily harm. For school-age children, development of self-esteem emerges through mastery of athletic, academic, and social skills. Behavior issues in this age group often stem from the degree to which the child succeeds or fails in acquiring these skills. Identity and independence are central issues in the adolescent years, often leading to oppositional behavior.

Continued on page 87

You can be a crucial resource for parents by educating and reassuring them about normal child development, thereby helping them anticipate the kinds of problems they can expect at each stage. Your ongoing counsel can aid parents in understanding and handling challenges as they occur.

When behavior problems arise from a difficult *temperament*, you can perform the important task of demystifying for parents their child's seemingly erratic behavior.[3,4] A careful explanation of temperament can help reframe a parent's perspective on why their child acts in a particular way. You can also refer parents to useful reading material or suggest helpful interventions. Being alert to when a difficult child is tired or hungry, for example, often prevents a temperamental meltdown. A child who has difficulty moving from one situation to another can be prepared in advance for transitions. Awareness of a child's aversion to physical stimulation can be critical in avoiding situations, such as a shopping mall, that abound with visual and auditory overstimulation. Some children are upset by the way clothes feel or the taste of certain foods. Parents can be taught to understand the source of these often aggravating behaviors, thereby avoiding unhealthy power struggles.

The key to addressing behavior difficulties related to *child* and *adolescent psychopathology* is identifying the underlying problem, be it depression, anxiety disorder, oppositional-defiant disorder, substance abuse, or something else. A careful history often reveals clues pointing to the diagnosis, enabling recommendation of an appropriate mental health consultation.

Extrinsic problems

When behavior problems arise during *situational changes* in the family, such as a birth, divorce, move, or change in school, you can help parents draw connections between the change and their child's behavior. You can also provide anticipatory guidance about the adjustment issues that can be expected during times of change. Providing reassurance and helping parents set realistic time frames for the child to adjust and adapt are often the only interventions necessary. A child or teenager who does not adjust to situational

TABLE 3

Case closed? Offering a solution to the problem

Is the problem intrinsic to the child or adolescent?

Biomedical and neurodevelopmental concerns

History, physical exam, and appropriate laboratory studies to make diagnosis

Normal developmental stages

Demystification and education of parents

Temperament

Identification of the child with difficult temperament

Preparation for transitions

Awareness of fatigue and hunger to avoid meltdowns

Avoidance of overly stimulating environments

Awareness of food and clothing preferences

Child and adolescent psychopathology

History to make diagnosis (such as depression, anxiety, oppositional defiant disorder, substance abuse)

Mental health referral

Is the problem extrinsic to the child or adolescent?

Situational factors

Allowance of adequate time for adjustment and adaptation

Ineffective discipline

Time out

1-2-3 Technique

Behavior modification (positive and negative consequences)

Poor communication and "dysconnection"

Awareness of nonverbal body language

"Active listening"

"I" messages

Positive time

Problem solving

Sense of humor

Family dynamics

Parental collaboration

Increased parental time together

Increased involvement of peripheral parent

Freeing up of overly involved parent

"Second family" interventions

- Restriction of negative influences of peers and media
- Increased access to sports, scouts, religious affiliations, social action, voluntarism, community service

Solution-focused interventions

- Miracle questions ("If a miracle occurred, what would you notice you and your daughter doing differently that would tell you the problem had improved?")
- Finding exceptions (what already works?)

Marital or family therapy referral

Parental psychopathology

Identification of problem and referral to mental health consultant

Time out is one of the most effective techniques by which overly indulgent parents can set limits and overly punitive parents can find an effective alternative.

changes in a reasonable amount of time may need further evaluation.

Problems may arise when parents provide *ineffective discipline*, being overly permissive or critical and punitive.[9,10] Time out[15,16] is one of the most effective techniques by which overly indulgent parents can set limits and overly punitive parents can find an effective alternative. Time out typically involves isolating a child for a short time—typically one minute for every year of age. Instruct parents to approach the child in a calm but firm manner, use time out for appropriate misbehaviors such as aggression, and apply the technique consistently each time the infraction occurs. Time out is most effective when the child and parent spend positive time together when the child is behaving well.

The so-called 1-2-3 technique[17] is a popular approach to the uncooperative child. The parent counts to 3 slowly, giving the child a warning at each count that a specific consequence will ensue if the desired behavior does not occur by the count of 3. The parent then carries out the consequence if the child does not comply.

You can also help parents employ consequences effectively by devising simple behavior modification strategies.[18] Successful behavior modification typically ignores or provides a negative consequence for undesirable behavior coupled with a positive consequence for appropriate behavior. Consistent follow-through is essential. The parent should select only one or two target behaviors and give careful thought to the positive and negative consequences chosen. Consequences that prove ineffective should be changed. The child may be allowed to participate in choosing consequences.

When formulating positive consequences, it is often helpful to combine an immediate positive consequence such as praise, a token, or a sticker with a long-term positive consequence such as a special activity at the end of the week. Positive consequences can also include extra time to pursue an enjoyable activity or special time with a parent. Negative consequences often involve the loss of a privilege such as computer time or play time.

When parent-child relationships are marked by *poor communication* and frequent verbal conflict, you can teach effective communication techniques to both parent and child.[11,12] Such techniques may include enhancing nonverbal communication skills by having parent or child make better eye contact or sensitizing a teenager to the ways in which body language, such as eye rolling, serves to disrupt communication. Parents and teenagers may need to be taught techniques such as active listening or the use of "I" messages. When using active listening, the parent focuses on reflecting back the teenager's statement. For example, if the teenager says, "I really hate my new teacher," the parent replies, "It sounds as if your new teacher is really upsetting you."

Learning to use "I" messages effectively helps to move an interaction out of the negative, overly critical mode. For example, instead of saying "I hate it when you come home late!" the parent might say, "When you come home late, I get very worried because I am concerned that something bad may have happened to you."

To enhance their relationship, parent and child may want to plan a special positive time together doing something mutually enjoyable, such as playing a game or going out to dinner or some other outing. Positive time should be planned and should not be interrupted other than for an urgent problem. Maintaining a sense of humor can also significantly thaw a frosty relationship.

Another effective technique is to help parents and older children or teenagers with problem solving.[12] Teach the parent and child or adolescent to approach problem solving in a sequence of steps: identify the problem, brainstorm potential strategies, select a strategy, implement that strategy, and evaluate the outcome. Opportunities to review and fine-tune the solution should be built into the overall plan. Problem solving requires a cooperative effort, with both parties willing to compromise in pursuit of a more harmonious relationship.

When negative *family dynamics* produce more pervasive conflict, you can help family members improve interactions with each other.[13,14,19-22] In a case of significant conflict, referral to a mental health provider may be necessary. A key component to approaching families in conflict is to encourage collaboration among the child's primary caretakers. Getting them to collaborate on child-rearing efforts and support one another—even when they are not in full agreement—can be a critical first step in decreasing intrafamilial tension.[13] Encouraging parents to spend positive time together

away from their child can be another effective strategy.

Often one parent is overly involved with the child and the other is more peripherally involved or disengaged. Increasing the peripheral parent's involvement with the child or teenager by encouraging the parent to spend positive time with the child, take the child to school, or assume a larger role in discipline can be an effective intervention. Encouraging the overly involved parent to shift some responsibilities to the more peripheral parent and to pursue interests outside the home also can be helpful.

You may want to work with families using a brief, solution-focused approach[20-22] that helps move families toward positive change. You can guide the process by asking family members to define their goals in specific terms ("If a miracle occurred, what would you notice you and your daughter doing differently that would tell you the problem had improved?"). You can also help the family recognize approaches that already work. By focusing on these "exceptions" to the problem, the family examines the times when the problem does not occur and builds on these more adaptive behaviors.

Parents also need to be sensitive to the sometimes negative influences of peers and media—what is known as the "second family"[14]—that may pull a child or teenager away from central family values. They should be aware who their child is choosing as friends and establish guidelines for watching television and motion pictures, listening to music, and playing computer and video games. Encourage parents to help their child find positive involvements outside of the home through religious affiliations, volunteer opportunities, and participation in scouting and sports.

If a parent displays signs of psychopathology or engages in substance abuse, domestic violence, or child abuse, referral to an appropriate mental health professional is critical.

If a parent displays signs of *psychopathology*, such as depression or anxiety, or engages in substance abuse, domestic violence, or child abuse, referral to an appropriate mental health professional is critical.

When to refer

Many children, teenagers, and families require referral to a mental health professional. Such referrals are in order if you identify psychopathology in the child or parent or severe marital conflict. Referral is also critical if you feel that the problem surpasses your expertise or if the problem persists after a series of primary interventions, such as the ones described earlier. If a parent requests referral to a mental health consultant at the outset, it is often best to help the family select an appropriate specialist and, because so many patients are insured by managed care oranizations, negotiate the complexities of mental health insurance systems.

The information you glean from the D-TECKT can help you make a referral to the mental health practitioner who is likely to be most helpful. That specialist might be an individual counselor for a child who has mild depression; a marital or family therapist for a child and parents who have significant intrafamilial conflict; or a psychiatrist for a child or parent who suffers psychopathology. ■

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