Psychological Perspective: Stepping Stones to Positive Behavioral Health

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3/12/18
Conflict of Interest

- AG Bell Board of Directors
- MED-EL Pediatric Advisory Board
- Research agreement - Advanced Bionics
- Research funded by:
  - NIDCD RO1 DC04797
  - NIDCD R03 DC014760
  - NIDCD R21 DC016265
Learning Objectives

• Describe age appropriate social and emotional skills
• Identify common comorbidities in children with hearing loss
• List assessments for behavior, social, and emotional functioning
• Identify when children should be referred to a psychologist or mental health specialist
• Discuss brief interventions for social and emotional difficulties
Social and Emotional Milestones
Early Childhood

2 Months
• Begin to smile at people
• Briefly calm themselves
• Tries to look at parent

4 Months
• Smiles spontaneously
• Likes to play with people and might cry when playing stops
• Copies some movements and facial expressions (smiling, frowning)

6 Months
• Knows familiar faces and begins to know if someone is a stranger
• Likes to play with others, especially parents
• Responds to other people’s emotions and often seems happy

9 Months
• May be afraid of strangers
• May be clingy with familiar adults
• Has favorite toys

Milestones are from CDC.gov
Early Childhood

12 Months
- Shy or nervous with strangers/situations
- Cries when parent leaves
- Repeats sounds or actions to get attention
- Plays games, such as “peek-a-boo”

18 Months
- Temper tantrums
- May be afraid of strangers
- Shows affection to familiar people
- May cling to caregivers in new situations
- Plays simple pretend games

2 Years
- Copies others
- Shows more independence
- Shows defiant behavior
- Plays mainly beside other children

3 Years
- Takes turns in games
- Shows a wide range of emotions
- May get upset with major changes in routine
- Separates easily from parents
- Shows affection for friends without prompting

Milestones are from CDC.gov
Early Childhood

4 Years
- Enjoys doing new things
- More creative with make-believe play
- Would rather play with other children than by himself
- Cooperates with other children
- Often can’t tell what’s real and what’s make-believe
- Talks about what they like

5 Years
- More likely to agree with rules
- Likes to sing, dance, and act
- Is aware of gender
- Can tell what’s real and what’s make-believe
- Shows more independence
- Is sometimes demanding and sometimes very cooperative
- Wants to be like friends

Milestones are from CDC.gov
School-Age

6-8 years old
• Shows more independence from parents and family
• Starts to think about the future
• Understands more about his/her place in the world
• Pays more attention to friendships and teamwork
• Wants to be liked and accepted by friends

9-11 years old
• Starts to form stronger, more complex friendships and peer relationships
• Experiences more peer pressure
• Becomes more aware of his/her body as puberty approaches
• Body image and eating problems sometimes start around this age

Milestones are from CDC.gov
Adolescence (12-14)

- Shows more concern about body image, looks, and clothes
- Focuses on themselves; going back and forth between high expectations and lack of confidence
- Experiences more moodiness
- Shows more interest in and influence by peer group
- Expresses less affection toward parents; sometimes might seem rude or short-tempered
- Feels stress from more challenging school work

Milestones are from CDC.gov
Adolescence (15-17)

- Has more interest in romantic relationships and sexuality
- Goes through less conflict with parents
- Shows more independence from parents
- Has a deeper capacity for caring and sharing and for developing more intimate relationships
- Spends less time with parents and more time with friends
- Feels a lot of sadness

Milestones are from CDC.gov
Common Comorbidities in Children with Hearing Loss
Behavior Problems

• Externalizing & internalizing behavior problems are consistent risk factors for future behavior, school and social difficulties

• Prevalence of Internalizing behavior problems:
  – Children with hearing loss: 24.6% to 38%
  – Hearing Children: 2 to 17%

• Prevalence of Externalizing behavior problems:
  – Children with hearing loss: 11.6% to 44%
  – Hearing Children: 3 to 18%

• Strong evidence that behavior problems, language and cognitive abilities are related

Barker, et al., 2009; Mitchell & Quittner, 1996; Van Eldik, et al., 2004
Social Skills

• Social competence has been defined as a construct with several sub-domains
  – Social adjustment
  – Social skills
  – Social performance
• Substantial evidence suggests that school-age children with hearing loss have lower social competence than hearing peers
• Children who are teased, isolated or maltreated are at a higher risk of depression
  – DHH children who are unable to make themselves understood are also at a higher risk of depression (Fellinger et al., 2009)
Common Internalizing Disorders

Anxiety

Depression

Bipolar
## Anxiety Disorder

<table>
<thead>
<tr>
<th>Normal Hearing</th>
<th>Hearing Loss</th>
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<tbody>
<tr>
<td>17-24%</td>
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*When broken up into Cochlear Implant (CI) vs. Hearing Aid (HA), children with a CI have similar anxiety to normal hearing peers, however children with a HA have more social anxiety*

Generalized Anxiety Disorder

- Excessive anxiety and worry, occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)
- The individual finds it difficult to control the worry
- The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):
  - Note: Only one item is required in children
  - Restlessness or feeling keyed up or on edge
  - Being easily fatigued
  - Difficulty concentrating
  - Irritability
  - Muscle tension
  - Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)
- The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
- Average onset at 8.5
- More common in girls

Diagnostic Criteria is from DSM-5
Separation Anxiety Disorder

• Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following:
  – Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures
  – Persistent and excessive worry about losing major attachment figures or about possible harm to them
  – Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure
  – Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation
  – Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings
  – Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure
  – Repeated nightmares involving the theme of separation
  – Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated
• The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents and typically 6 months or more in adults
• The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning

Diagnostic Criteria is from DSM-5
Other Types of Anxiety Disorders

• **Separation Anxiety**
  – Being very afraid when away from parents
  – Most commonly diagnosed between age 7 and 9

• **Phobias**
  – Having extreme fear about a specific thing or situation
  – Average age of onset depends on phobia
    ▪ Animal: 7, Blood: 9, Dental: 12

• **Social Anxiety**
  – Being very afraid of school and other places where there are people
  – Likely starts before adolescence

• **Panic Disorder**
  – Having repeated episodes of sudden, unexpected, intense fear that come with symptoms like heart pounding, having trouble breathing, or feeling dizzy, shaky, or sweaty
  – Observable before 14 years of age, but prevalence is very low. Rates gradually increase throughout puberty. Women are 2x more likely to experience panic disorder
<table>
<thead>
<tr>
<th></th>
<th>Normal Hearing</th>
<th>Hearing Loss</th>
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</thead>
<tbody>
<tr>
<td>Lifetime Diagnosis</td>
<td>13.6%</td>
<td>26.3%</td>
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<tr>
<td>Current Clinical Diagnosis</td>
<td>5.7%</td>
<td>7.4%</td>
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</table>
Depression: Manifestation

- Depression typically starts to manifest around adolescence or later into adulthood.

- Depression is more common in females.
  - Before puberty, males and females have similar levels of depression.

- Children who have been teased, isolated or maltreated are more likely to be depressed.
Depression

- Five (or more) of the following symptoms must have been present during the same 2-week period nearly every day (with the exception of recurrent thoughts of death or suicide) and represent a change from previous functioning; at least one of the symptoms is (1) depressed mood or (2) loss of interest or pleasure
  - Depressed mood (In children and adolescents, can be irritable mood)
  - Markedly diminished interest or pleasure in activities
  - Significant weight loss or weight gain, or decrease or increase in appetite
  - Insomnia or hypersomnia
  - Psychomotor agitation or retardation
  - Fatigue or loss of energy
  - Feelings of worthlessness or excessive or inappropriate guilt
  - Diminished ability to think or concentrate, or indecisiveness
  - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide

Diagnostic Criteria is from DSM-5
## Bipolar Disorder

<table>
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<tr>
<th>Normal Hearing</th>
<th>Hearing Loss</th>
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</thead>
<tbody>
<tr>
<td><strong>Lifetime Diagnosis:</strong></td>
<td><strong>Unknown</strong></td>
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<tr>
<td>4.4% of adults</td>
<td>However, one study (Shapira et al, 1999) did find that bipolar may be more common in prelingual patients with hearing loss</td>
</tr>
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</table>
Bipolar Manifestation

- Consists of both depression and mania
- First onset typically occurs between 15-19 years old
- No difference in women or men for likelihood of diagnosis
Bipolar: Manic Episode

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 1 week and present most of the day, nearly every day.
- During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep
  - More talkative than usual or pressure to keep talking
  - Flight of ideas or subjective experience that thoughts are racing
  - Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed
  - Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity)
  - Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
- The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

Diagnostic Criteria is from DSM-5
Bipolar: Depressive Episode

- Five (or more) of the following symptoms must have been present during the same 2-week period nearly every day (with the exception of recurrent thoughts of death or suicide) and represent a change from previous functioning; at least one of the symptoms is (1) depressed mood or (2) loss of interest or pleasure
  - Depressed mood (In children and adolescents, can be irritable mood)
  - Markedly diminished interest or pleasure in activities
  - Significant weight loss or weight gain, or decrease or increase in appetite
  - Insomnia or hypersomnia
  - Psychomotor agitation or retardation
  - Fatigue or loss of energy
  - Feelings of worthlessness or excessive or inappropriate guilt
  - Diminished ability to think or concentrate, or indecisiveness
  - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide

Diagnostic Criteria is from DSM-5
Common Externalizing Disorders

Oppositional Defiant Disorder (ODD)/Conduct Disorder (CD)

Attention Deficit/ Hyperactivity Disorder (ADHD)
Oppositional Defiant Disorder (ODD)/Conduct Disorder (CD)

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<th>Normal Hearing</th>
<th>Hearing Loss</th>
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<tr>
<td>Lifetime Diagnosis ODD: 10.2%</td>
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<tr>
<td>Lifetime Diagnosis CD: 9.5%</td>
<td>Many studies have shown that children with hearing loss exhibit more externalizing behavior problems</td>
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</table>

(Barker et al., 2009; Mitchell, Quittner, 1996)
ODD/CD

ODD
• Angry/Irritable mood
• Argumentative/defiant behavior
• Vindictiveness
• Higher rates in boys (3.2%) than girls (1.8%) prior to adolescence
  – Boys: Peak prevalence around ages 7 and 14-15 for diagnosis
• Preschool prevalence: 9-12%

CD
• Aggression to people and animals
• Destruction of property
• Deceitfulness or theft
• Serious violations of rules
• ~8% of children and adolescents will be diagnosed with CD
• Usually symptoms start in middle childhood or adolescence
• More common in males
ODD

- Child must have a pattern of at least four of the following criteria for at least 6 months and exhibit behavior during interaction with at least one individual with at least one individual who is not a sibling
- Angry/Irritable Mood
  - Often loses temper
  - Is often touchy or easily annoyed
  - Is often angry and resentful
- Argumentative/Defiant Behavior
  - Often argues with authority figures or, for children and adolescents, with adults
  - Often actively defies or refuses to comply with requests from authority figures or with rules
  - Often deliberately annoys others
  - Often blames others for his or her mistakes or misbehavior
- Vindictiveness
  - Has been spiteful or vindictive at least twice within the past 6 months

Diagnostic Criteria is from DSM-5
A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least three of the following criteria in the past 12 months from any of the categories, with at least one criterion present in the past 6 months:

- **Aggression to People and Animals**
  - Often bullies, threatens, or intimidates others
  - Often initiates physical fights
  - Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
  - Has been physically cruel to people and/or animals
  - Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
  - Has forced someone into sexual activity

- **Destruction of Property**
  - Has deliberately engaged in fire setting with the intention of causing serious damage and/or as deliberately destroyed others’ property

- **Deceitfulness or Theft**
  - Has broken into someone else’s house, building, or car
  - Often lies to obtain goods or favors or to avoid obligations (i.e., “cons” others)
  - Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

- **Serious Violations of Rules**
  - Often stays out at night despite parental prohibitions, beginning before age 13 years
  - Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period
  - Is often truant from school, beginning before age 13 years

**Diagnostic Criteria is from DSM-5**
## Attention Deficit Hyperactivity Disorder (ADHD)

<table>
<thead>
<tr>
<th>Normal Hearing</th>
<th>Hearing Loss</th>
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<tr>
<td>~5%</td>
<td>3.4%-6.8%</td>
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Children with hearing loss have a higher risk of attention problems (Cejas et al., 2015)
Attention Difficulties in Children With Hearing Loss

• Visual Attention
  – Despite the visual system developing normally, children with hearing loss still experience problems with their visual attention
  – Younger children with CI’s tend to “catch up” to their hearing peers

• Joint Engagement
  – By 36 months and older, normal hearing children spent about 93% of their time in symbol-infused joint engagement
  – Deaf children only spent about 34% of time in this state

ADHD: Manifestation

- Age of onset
  - Before 7: 50%
  - Before 12: 95%
  - Before 16: 99%

- ADHD is more commonly seen in males than females
  - 2.28 (males): 1 (female)
ADHD

Inattention

- Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.
- Often has trouble holding attention on tasks or play activities.
- Often does not seem to listen when spoken to directly.
- Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace.
- Often has trouble organizing tasks and activities.
- Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time.
- Often loses things necessary for tasks and activities.
- Is often easily distracted.
- Is often forgetful in daily activities.

Hyperactivity

- Often fidgets with or taps hands or feet, or squirms in seat.
- Often leaves seat in situations when remaining seated is expected.
- Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
- Often unable to play or take part in leisure activities quietly.
- Is often “on the go” acting as if “driven by a motor”.
- Often talks excessively.
- Often blurts out an answer before a question has been completed.
- Often has trouble waiting his/her turn.
- Often interrupts or intrudes on others (e.g., butts into conversations or games)
Screening Measures
Assessment Tools/Screeners

• Behavior
  – Behavior Assessment System for Children, Third Edition (BASC-3); (Reynold & Kamphaus, 2015)
  – Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000)

• Social
  – Social Skills Improvement System (SSIS); (Gresham & Elliott, 2008)
  – Social Responsiveness Scale; (Constantino, 2005)
  – Meadow/Kendall Social-Emotional Assessment Inventory for Deaf Students (Meadow, Kathryn P.; And Others, 1980)
Behavior Assessment System for Children, 3rd Edition

- **Self-Report**
  - Ages 6-college age
- **Parent & Teacher Report**
  - Ages 2-21:11 months
- **Student Observation System**
  - School-based setting
- Assesses internalizing and externalizing behavior problems and adaptive skills
- Multiple languages available
BASC-3 Results

VALIDITY INDEX SUMMARY

<table>
<thead>
<tr>
<th>Index</th>
<th>Response Pattern</th>
<th>Consistency</th>
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<tbody>
<tr>
<td>Acceptable</td>
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CLINICAL AND ADAPTIVE T-SCORE PROFILE

T Score

T Score (Plotted)

General Combined: 10 13 15 15 16 15 14 13 12 11

Percentile

General Combined: 10 15 14 13 12 11 10 9 8 7
Child Behavior Checklist

- Preschool checklist
  - 18 months to 5 years
  - 100 questions

- School-age version
  - 6 to 18 years
  - 120 questions

- Likert scale
  - 0 = Not True
  - 1 = Somewhat or Sometimes True
  - 2 = Very True or Often True
CBCL- Scoring
Vineland Adaptive Behavior Scales- Second Edition

- Birth to age 90
- Survey Interview, Expanded Interview, Parent/Caregiver Rating Form and Teacher Rating Form (3 to 21 years, 11 months)
- Validated in the following populations:
  - Intellectual & Developmental Disabilities
  - Autism spectrum disorders (ASDs)
  - ADHD
  - Hearing Loss

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<th>Domains &amp; Index</th>
<th>Subdomain</th>
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<td>Communication</td>
<td>Receptive</td>
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<td></td>
<td>Expressive</td>
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<td>Written</td>
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<td>Daily Living Skills</td>
<td>Personal</td>
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<td>Community</td>
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<td>Socialization</td>
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<td>Play and Leisure Time</td>
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<td>Internalizing</td>
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<td>Externalizing</td>
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<td></td>
<td>Other</td>
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</table>
Social Skills Improvement System (SSIS)

- Measures social skills, competing problem behaviors and academic competence
- Parent/Teacher Forms
  - Ages: 3-18
- Student forms
  - Ages: 8-12
  - Ages: 13-18
- Available in Spanish and English
- Completion time: 10-25 minutes
Social Responsiveness Scale (SRS)

- Measures severity of autism spectrum symptoms as they occur in social settings
- Ages: 4-18
- Parent/Teacher Forms
- Completion Time: 15-20 minutes
**Meadow/Kendall Social-Emotional Assessment Inventory for Deaf Students**

- Completed by teachers or other educational personnel
- Pre-School (3-6)
  - Sociable, communicative behaviors
  - Impulsive, dominating behaviors
  - Developmental lags
  - Anxious, compulsive behaviors
- School-Age (7-21)
  - Social Adjustment
  - Self-Image
  - Emotional Adjustment
Case Example

Parent Report Form

Teacher Report Form

Validity Index Summary

<table>
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</tbody>
</table>

Raw Score: 0

PRS T Score Profile

TRS T Score Profile

- General - Combined Sex
Case Example

- How do we interpret the results?
- What are the next steps/plan of action?
Case Example

Parent Report Form

Self Report Form
Case Example

- How do we interpret the results?
- What are the next steps/plan of action?
When should a child be referred to a psychologist?
When to refer to a psychologist?

• At-risk or clinically significant concerns reported on parent report measures
• Lack of progress – auditory or speech & language
  – Aid in ruling out other developmental or learning disorders contributing to child’s development
• Poor adherence to amplification or recommended interventions
• Concerns about abuse/neglect
Abuse Reporting

• Federal Definition: “Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm.”

Reporting Requirements in Florida

• In 2012, the Florida reporting requirements were changed to include that child abuse by any adult person be reported not just by parent, caregiver or legal guardian

• Any sexual abuse of a child by any person is also required to be reported

Mandated Reporters

Reporters in the following occupation categories are required to provide their names to the hotline staff:

1. Physician, osteopathic physician, medical examiner, chiropractic physician, nurse, or hospital personnel engaged in the admission, examination or treatment of persons
2. Health or mental health professional
3. Practitioner who relies solely on spiritual means for healing
4. School teacher or other school official or personnel
5. Social worker, day care center worker, or other professional child care worker
6. Law enforcement officer or judge
Brief Interventions For Behavior
Behavior Management Techniques

- Selective Ignoring. Logical & Natural Consequences. When...then...
- Time-out; Loss of privileges
Structuring the Environment

• Childproofing the environment
• Develop a consistent routine
• Provide prompts about changes in routine/activities
  – “Dinner will be ready soon. Finish up playing with your toys.”
• Remove problematic objects from the environment
• Provide expectations for child’s behavior
Distraction/Redirection

• Steer the child’s attention to another part of the room
• Give the child something else to play with
• Enthusiastically describe the new activity and child’s positive behavior
• Engage in play to warm child up to engaging in new activity
  – Cooking dinner and your child is in the kitchen
Labeled Praise

• Praise increases the behavior
• Define problem behaviors. Define the opposite behavior and then praise it.

• Problem Behavior- Child Whines
• Opposite Behaviors- talks with indoor voice, talks nicely, asks nicely, patient, quiet
• A system of reinforcement of behaviors you want to increase
• Reinforcement for increasing a behavior
• Common tokens- poker chips, points, stickers, smiley faces, play money
Selective Ignoring

- The purpose of the behavior should be to elicit attention – “To press parents’ buttons”
- Should not be reinforcing on its own – sneaking a cookie
- Should NOT be dangerous or destructive
- Must ignore until the behavior stops – even if momentarily
- First make sure the child knows the rule
- Ignore can be complete or selective
What happens when you ignore a behavior?

• EXTINCTION BURST!
• The behavior escalates
• It worked before, it should work now!
• Parents must be PREPARED for the escalation or they may get discouraged and give in
Natural & Logical Consequence

• Natural Consequences just happen
  – Example: Child who refuses to eat, gets hungry later. Child touches something hot.

• Parents create Logical Consequences
  – Example: Child hits parent with toy mop. Child’s mop is removed for a while.
When…Then…

• Gentle limit setting
• Defines expectation for behavior that needs to occur prior to providing permission for subsequent behavior
  – “When you finish eating, then you can go outside and play.”
Improving the Effectiveness of Discipline

• Clear definitions of the rules
• Label the negative behavior not the child
• Developmentally appropriate expectations
• Effective limit setting
• Consistency
• Pick your battles
• Let go
• Friendly yet firm
• Consequences should be immediate
Giving Effective Commands

• Move close to the child
• Have a stern facial expression
• Say his/her name
• Get and maintain eye contact
• Use a firm tone of voice
• Give a direct, simple and clear command
• Direct (telling, not asking)
• Positive (what to DO, not stop doing)
• Back up your command
The Command

- Command
  - No Opportunity
    - Whoops! (start over)
  - Obey
    - Praise (labeled)
  - Disobey
    - Time-Out Warning
  - Explain
The Warning

If you don’t (original command) then you will have to go to the time-out chair

- Obey
- Disobey
  - Praise (labeled)
  - Time-Out
- Explain
Common Time-Out Mistakes

• Time out is too long
• Parents talk to the child while in the chair
• Time out location/position is physically uncomfortable/painful (books, wall)
• Time out location is reinforcing (bedroom, living room)
For Time-Out to be Effective

• It must NOT be a way for the child to avoid compliance. Always return to the original direction.
• Parents should IGNORE attention-seeking behavior in the chair.
• Explaining is good, but AFTER the discipline process
Strategies to Improve Attention
Improving Attention

• Break long tasks into small steps, and check off after each one is completed
• Use directions that are brief and clear
• Make use of concrete reminders such as alarms, clocks, kitchen timers, and visual schedules
• Use areas of strong interest in order to focus/sustain attention
Improving Attention

• Give frequent feedback regarding assignment accuracy and progress
• Use physical proximity (e.g., a tap on the desk) to refocus
• Provide a variety of modalities to present materials (i.e., use both visual and verbal cues)
Brief Interventions for Anxiety/Emotional Difficulties
Tucker the Turtle

Turtle Technique

1. Recognize that you feel angry.
   - OUCH!

2. Go into shell. Take 3 deep breathes. And think calm, coping thoughts.
   - Step 1

3. “Think” Stop.
   - Step 2

4. Come out of shell when calm and thinking of a solution.
   - Step 4
Emotions Vocabulary Chart

EXHAUSTED  Confused  Ecstatic  Guilty  Suspicious

Angry  Hysterical  Frustrated  Sad  Confident

Embarrassed  Happy  Mischiefous  Disgusted  Confident

Enraged  Ashamed  Cautious  Smug  Frightened

Overwhelmed  Hopeful  Lonely  Lovestruck  Jealous

Bored  Surprised  Anxious  Shocked  Shy
Write 2 things or situations that make you feel each of the emotions listed below.

**Furious**
1. 
2. 

**Angry**
1. 
2. 

**Frustrated**
1. 
2. 

**Calm**
1. 
2. 

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Anxiety Thermometer

Write 2 things or situations that make you feel each of the emotions listed below.

Frantic
1. __________________________________________
2. __________________________________________

Anxious
1. __________________________________________
2. __________________________________________

Nervous
1. __________________________________________
2. __________________________________________

Calm
1. __________________________________________
2. __________________________________________
Flower/Candle Technique
More Coping Strategies

- Guided Imagery
  - Close your eyes and think of your favorite activity or favorite place
- Positive Self Talk
  - Think to yourself over and over, “I am okay; I feel calm.”
- Use a relaxation script

- Distraction
  - Go for a walk
  - Have a drink of water
  - Listening to music
  - Sing
  - Plan a fun activity
  - Watch TV
  - Blow up a balloon
  - Have a lollipop
  - Write a letter
  - Draw
Brief Interventions for Improving Social Skills
Improving Social Skills

• Making Friends
  – Ask questions
  – Give compliments
  – Introduce yourself
  – Listen
  – Start a conversation

• Cooperating With Peers
  – Follow rules
  – Join in
  – Share
  – Suggest activities
  – Take turns
Group Activity: Making a New Friend

1) Look at the other person
2) Say “Hi” or “Hello”
3) Tell the person your name
4) Ask for that person’s name
5) Ask the person to play
Improving Social Skills

- **Responding Positively to Peers**
  - Accept compliments
  - Help peers in trouble
  - Offer help
  - Show concern for peers
  - Stand up for peers

- **Communicating Needs**
  - Ask for help
  - Ask to borrow others’ property
  - Expressing negative feelings: “I feel __ because __”
  - Expressing positive feelings
  - Getting attention appropriately
Improving Self-Esteem

5 Things That I Like About Myself...

1) _____________________________
2) _____________________________
3) _____________________________
4) _____________________________
5) _____________________________

- Focus on strengths
- Don’t draw comparisons
- Give children choices
- Let child do certain tasks by themselves
Social Stories

Playing

Sometimes I like to play with other kids.

I can ask them, "Do you want to play with me?"

If they say "yes", I can play with them. I will have fun.

If they say "no", it's ok.

I can ask someone else or play by myself.

*Tracy Boyd, 2009*
THANK

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Save The Date

The world famous Diplomat Beach Resort will be the host site for CI2019 which features Ft Lauderdale and Miami Beach. See you in South Florida in 2019.

July 10 – 13 2019