The Brief Behavioral Intervention for Preschoolers With Disruptive Behaviors: A Clinical Program Guide for Clinicians

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Abstract

Introduction: Disruptive behavior problems are the most common referral reason to behavioral health professionals among preschool-age children. Parent management training (PMT) is the primary intervention for the treatment of disruptive behaviors, but current programs have high attrition rates in part due to their length. The Brief Behavioral Intervention (BBI) is a manualized parent management training PMT designed specifically to have fewer sessions in order to limit attrition associated with attending a long series of sessions and for easy implementation in hospital clinics and outpatient settings. Methods: BBI consists of five core sessions, each focused on a specific behavioral management skill. These sessions occur on a weekly basis and last from 45 minutes to 1 hour per session, with one booster session after the first 2 weeks if needed. Thus, the intervention lasts from 5-7 weeks. The BBI manual is intended to be used by experienced professionals as a self-teaching guide or by faculty for teaching graduate and medical students interventions for children with disruptive behaviors. Results: To date, we have trained seven faculty members, 14 postdoctoral fellows, 44 predoctoral interns, and 19 predoctoral practicum students using this manual. Many of those students use the BBI manual in their daily work. Over the years, we have received positive quantitative and qualitative feedback from the learners. Discussion: The creation of this manual, coupled with supervised implementation, has resulted in a new generation of therapists trained in evidence-based strategies within a model brief enough to maintain patient participation and easy to export to myriad settings.

Keywords

Intervention, Child, Psychology, Preschool, Child Behavior, Parent Management Training, Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), Attention Deficit and Disruptive Behavior Disorders

Educational Objectives

By the end of this curriculum, learners will be able to:

1. Identify the basic steps in behavioral parent training.
2. Conduct behavioral parent training in a pediatric medical setting according to principles of evidence-based practice.

By providing live supervision of other trainees, facilitators will be able to:

1. Distill feedback to give only what is necessary for the learner to finish the session.
2. Give feedback in a supportive and strengths-based manner.
3. Expand upon live feedback during private supervision outside of the clinic.

Introduction

Preschool disruptive behaviors can significantly impair early academic, social, and emotional development. While of clinical concern, preschool disruptive behaviors are also quite common, with over 20% of preschoolers estimated to exhibit these behaviors at significant levels at home or within preschool...
Disruptive behavior problems are the most common referral reason to behavioral health professionals among preschool-age children. Parent management training (PMT) is the evidence-based intervention in the treatment of preschool disruptive behaviors. PMT is shown to be effective for parents with young children who have a wide variety of presenting problems, including attention deficit hyperactivity disorder, intellectual disabilities, comorbid depression, and behavior in the context of complex medical presentation. PMT has also demonstrated effectiveness with parents and children from a variety of backgrounds, including historically underserved communities such as racial and ethnic minority groups and low-income families. Individual studies of PMT for young children have reported medium to large effect sizes for decreases in parent-reported child disruptive behavior, as well as large effect sizes for decreases in parent stress. PMT is based on social learning and operant behavioral theory and trains parents to use strategies of modeling, reinforcement, and feedback to positively shape their children’s behaviors. Although PMT programs may differ in their method of delivery and intervention curriculum, they commonly focus upon the primary goal of reducing negative or undesired child behaviors through the use of effective commands, differential attention (i.e., giving attention to desired behaviors and using planned ignoring for nondesired behaviors), logical consequences (immediate rewards and loss of privileges), and discipline strategies (most often time-out). The second goal of PMT is to increase prosocial child behaviors and improve parent–child interactions through the use of parental praise and parental engagement in a specialized play interaction.

A critique of many of the manualized PMT programs available for treatment of preschoolers is that they are too lengthy for families to reasonably complete. Treatment attrition rates for PMT are high, with recent individual studies reporting dropout from active treatment ranging from 32% to 47%. The high average number of sessions (ranging between 13 and 28 session hours) reported in the literature for families who complete and benefit from PMT likely contributes to the high attrition rates.

The manual was created to fill a clear gap in treatment literature. While many manuals using longer PMT treatment protocols (e.g., McNeil & Hembree-Kigin’s Parent-Child Interaction Therapy, Forehand & Long’s Parenting the Strong-Willed Child, Kazdin’s Parent Management Training) exist, using these protocols is often not feasible in a tertiary care setting due to time constraints. This resource was created by distilling the most effective behavioral strategies in a 6- to 8-week treatment protocol. Prior training and experience providing longer PMT interventions, as well as brief preventative programs (Sanders’ Triple P-Positive Parenting Program), informed the development of the Brief Behavioral Intervention (BBI).

The BBI is a manualized PMT program aimed at treatment of disruptive behavior among preschoolers. BBI was designed specifically to have fewer sessions to limit treatment attrition associated with attending many repeated sessions. It was also conceptualized to be easily implemented in hospital clinics and outpatient settings.

BBI consists of five core sessions, each focused on a specific behavioral management skill: exploring daily routines to help parents identify antecedents and consequences of problem behavior and make scheduling adjustments, parent provision of child-directed play, providing differential attention, delivering effective commands, and administration of consequences (including time-out). These sessions occur on a weekly basis and last from 45 minutes to 1 hour per session, with one booster session after the first 2 weeks if needed. Thus, the intervention lasts from 5-7 weeks. As this is psychological intervention, parents/guardians consent to the treatment. BBI has demonstrated feasibility in clinical settings, effective outcomes across a large pilot sample, and, recently, efficacy in a randomized controlled trial study (under review).

This manual was also created to fill a gap in training aspiring professionals in behavioral parent training. The live supervision and consultation context of the clinic provides an opportunity to coach both specific and nonspecific therapy skills. Each family has one consistent therapist throughout treatment, although the consultation team may vary depending on who is available to supervise.
The training protocol was first designed for teaching predoctoral psychology externs and interns and postdoctoral psychology fellows to deliver therapy as part of their clinical training rotations. However, it has since been used to train learners in other health-related fields who have an appropriate background level of training. The manual will likely be useful for clinical and counseling psychologists working as clinicians, developmental and educational/school psychologists, school counselors, nurses, child development specialists, early child interventionists, preschool teachers, social workers, health science librarians, and parents.

Suggested qualifications for learners include the following:

1. Graduate-level training (either currently enrolled or completed) in a relevant health care field, such as psychology, counseling, nursing, medicine, or social work.
2. Graduate-level course completion or equivalent training in:
   - Basic counseling skills (e.g., diagnostic interviewing, development of rapport, use of open and closed questions, reflections, summaries, etc.).
   - Behavioral principles of learning (e.g., classical, operant, and social learning theories and applications).
   - Child development and developmental psychology (e.g., typical and atypical pediatric development).
   - Pediatric psychopathology (e.g., DSM-5 diagnostic disorders of childhood).
   - Multicultural competencies in health care delivery.
   - Health care ethics (e.g., principles of informed consent, patient autonomy, confidentiality, etc.).

Interest in working with children with pediatric behavioral health issues (e.g., feeding, toileting, sleep, or health adherence).

**Methods**

Manuals are frequently used in psychology to teach learners effective therapeutic interventions. This resource includes a detailed manual, checkout process training, clinic observation, and live supervision. Therefore, a learner uses reading, watching, doing, and, eventually, teaching to achieve the learning objectives. Learners will be able to identify behavioral parent training (and thus refer patients appropriately) and confidently and expertly provide evidence-based behavioral parent training.

The Clinician Training Manual (Appendix A) includes all of the necessary materials and tools to complete the BBI. It is a stand-alone manual for behavioral parent training, to be used as is by qualified professionals, such as pediatric faculty or clinical staff with experience working with children with disruptive behaviors and some background training in behavioral interventions. The manual provides the background and rationale for the BBI and then guides the clinician through the intervention processes and procedures, from introducing the service to the family to psychoeducation, modeling, and coaching for families and providing handouts to families.

The Supervisor’s Guide (Appendix B) includes a step-by-step approach for qualified professional to teach learners (students, residents, or fellows) how to complete behavioral parent training. Additionally, it includes a training checklist and skills checkout rating forms for assessing a learner’s readiness to implement BBI. Learners will need to first read through the Clinical Training Manual and practice or observe each session before going through the checkout process with their supervisor.

The checkout tool uses standardized procedures and focuses on learners’ strengths and areas for growth. Its purpose is to ensure learners’ competence to conduct the BBI.

**Results**

These materials continue to meet the goal of providing mental health care professionals with a standardized evidence-based protocol for treating young children with disruptive behaviors. To date, we have trained seven faculty members, 14 postdoctoral fellows, 44 predoctoral interns, and 19 predoctoral practicum students using this manual. Many of those students use the BBI manual in their daily work. Six of
those professionals are now faculty members and have used the manual at other universities or medical centers, and together they have trained 22 doctoral-level graduate students, 27 masters-level graduate students, 16 masters-level licensed clinicians, three psychologists, and one psychiatrist. Over the years, we have received positive quantitative (Table) and qualitative feedback from the learners, including the following comments:

- “BBI live supervision is an exceptional training opportunity (and very appreciated).”
- “I feel grateful to have begun my doctoral-level clinical training in the Brief Behavioral Intervention program. I came away from that practicum experience with a very strong foundation of behavior management skills, something my subsequent clinical supervisors have consistently remarked on. Even as I have worked to treat different presenting problems in other settings with children and adolescents much older than those we saw in the BBI clinic, I have continued to draw upon my training with you.”
- “I feel strongly that every pediatric/clinical child psychology trainee also gain experiences providing behavior therapy and PMT at the outset of their clinical training, just as I did in BBI. No doubt I am a better clinician because of my training in this model.”
- “Live supervision model promoted learning/strengthening my skill set by observing others and also provided me feedback on ways to improve practice with families in the moment.”
- “Intervention encourages meeting each client where they are, which requires high levels of cultural empathy and multicultural skills.”

| Table. Quantitative Trainee Feedback on the BBI Program‡ |
|-----------------------------------------------|------|------|
| Content Area                                | Average | SD   |
| Appropriate expectations based on level of training | 4.85| 0.376 |
| Made expectations clear                      | 4.31| 1.440 |
| Encouraged greater autonomy as capabilities and skills allowed | 4.77| 0.599 |
| Provided helpful suggestions/guidance on clinical cases | 4.92| 0.277 |
| Increased my knowledge and skills            | 4.62| 0.650 |
| Encouraged independent thought               | 4.69| 0.630 |
| Promoted development of a professional identity as a psychologist | 4.85| 0.555 |
| Intervention augmented by modeling of clinical practice | 4.92| 0.289 |
| In vivo observation of my work               | 5.00| 0.000 |
| Increased knowledge of current evidence-based practice standards | 4.77| 0.699 |
| Increase critical thinking and scientific approach to practice | 4.69| 0.630 |
| Increased knowledge and identification of normal and atypical child development | 4.85| 0.555 |
| Promoted skills in individualizing patient care based on individual differences | 4.85| 0.376 |
| Multicultural training                       | 4.69| 0.675 |

Scale: 1 = needs improvement, 3 = average, 5 = superior. N = 30. Abbreviations: BBI, Brief Behavioral Intervention; SD, standard deviation.

This training program has been used at our institution over the past 10 years as part of our formal training program at the graduate student, intern, and doctoral levels. The toolkit itself was developed 10 years ago but has been refined each year based on experience and feedback from students. The manual in this finalized format was piloted with four social workers, three practicum students, and three interns. In addition, 10 postdoctoral fellows and one faculty member have been trained as instructors/supervisors using these materials. The service has become an integral part of our predoctoral psychology training program and has been fully embraced by the Psychology Service as well as the hospital at large. In fact, the manual is currently being exported to other services within our hospital system.

Discussion

This training program has been used at our institution over the past 10 years as part of our formal training program at the graduate student, intern, and doctoral levels. The toolkit itself was developed 10 years ago but has been refined each year based on experience and feedback from students. The manual in this finalized format was piloted with four social workers, three practicum students, and three interns. In addition, 10 postdoctoral fellows and one faculty member have been trained as instructors/supervisors using these materials. The service has become an integral part of our predoctoral psychology training program and has been fully embraced by the Psychology Service as well as the hospital at large. In fact, the manual is currently being exported to other services within our hospital system.

Lessons Learned

In our experience, when trainees first begin conducting the intervention, many find it challenging to manage their time with the family, especially when the family is having greater difficulty with behavior. This
can be managed by a skilled supervisor who provides feedback on ways to better structure their time. In our clinic, this is facilitated by the live supervision model, but we also suggest these additional tips:

- Use of a watch, perhaps with an alarm.
- A watch that can give a transitional warning to family and clinician when time is almost up.
- If working with a family that is having a hard time with behavior, try splitting content for each skill into two separate sessions.
- Recognize that modeling and coaching behavior management in the room is integral, even if all session content is not covered.

For those learners who may have difficulty learning session content, we recommend they do the following:

- Watch other clinicians when possible.
- Watch tapes when possible.
- Rehearse in the mirror or with friends and family.

There are two potential difficulties related to using a manual in general. One is overreliance on the manual and a preoccupation of use of the manual word for word. The opposite is also true—some clinicians believe that the structure of the manual curtails their creativity in the process. To strike a good balance when presenting, we recommend learners do the following:

- Do not bring the manual into room.
- Do not memorize the manual.
- Make notes on core parts of content and present those in your own words.
- Use behavior in the room to introduce concepts.
- Refer to parent handouts during the session to make sure all content is being covered.
- Ask someone else to observe or listen to tapes for meaningful drift, or movement away from manual content.

Additionally, both of these difficulties can be addressed by having conversations with clinicians about the importance of a structured approach to treatment and the benefit of some freedom within that structure to find one’s preferred style.

Lastly, learners are often anxious about others watching them in sessions, as this clinic is conducted with live supervision at our institution. This is partially addressed through the learner’s experience of watching others while in the clinic and hearing the supportive strengths-based nature of the live feedback. Most learners report reduced anxiety after experiencing the feedback for themselves. However, for those learners who continue to feel anxious, we remind them to do the following:

- Recognize that being watched can only make you a better clinician.
- Have a private conversation with your supervisor about his/her perception if you find feedback is not given in a strengths-based manner.
- Ask for feedback to be provided privately.

Limitations
This toolkit is focused on behavioral parent training with young children, limiting its scope. This is necessary due to developmental differences between a school-age child or adolescent and a toddler and preschooler, but it creates the need for learners to become skilled in more than one approach. Additionally, the toolkit was created within a large training program with many resources. Live supervision may not be possible in most places due to a lack of appropriate space with one-way windows, and not all users of the toolkit will have the luxury of an extended period of training. Likewise, some toolkit users will not have the opportunity to watch a supervisor/expert prior to implementing the toolkit. Lastly, the materials in the toolkit are limited to print, rather than being interactive, which could help more visual learners.
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References


