

OCD | Special Report

Problem Behaviors: Prevention And Treatment For Preschool-Aged Children

Problem behaviors ranging from defiance and aggression to shyness and separation anxiety are common among preschool-aged children. For most, they are age-related reactions to change and developmental challenges that disappear as the child matures.

For others, however, these behaviors may be early signs of clinically-significant problems that can worsen over time if allowed to persist. In this case, early intervention appears to be crucial, given evidence that suggests programs begun after children enter school are not always effective, even when they are comprehensive.¹

Fortunately, several approaches to prevention and treatment of early behavior problems hold promise, particularly those that are well matched to the child's developmental, involve the parents, and consider the broader context of the family.

This special report, based on publications written by Susan B. Campbell, Ph.D., University of Pittsburgh Professor of Psychology, offers a brief overview of common problem behaviors, discusses issues related to interventions with preschool-aged children, and examines the major empirically-supported approaches to treatment and prevention.

Common Behavior Problems

Common problem behaviors among preschool-aged children include high levels of negative and angry feelings, an unwillingness to cooperate, defiance with parents and other adults, frequent squabbles with other children that may involve physical aggression, failure to follow directions, and problems getting along with peers.^{2, 3, 4}

The most common reasons young children are referred to mental health services include defiance, temper tantrums, and excessive activity.⁵ Child care providers frequently complain about children who are noncompliant and cannot get along with siblings and peers.⁶

Other young children may be especially fearful, anxious, sad, and socially withdrawn. These behaviors are more likely when abuse, neglect, other serious disruptions in parenting or other family problems are present.⁷

Unfortunately, it is often difficult to determine if such behaviors are transient age-related reactions to changes and developmental challenges or symptoms of a significant disorder. Three common and serious problems each require certain frequent and persistent symptoms, (beyond what would be expected given the child's age) for diagnosis:

Symptoms of oppositional defiant disorder (ODD) include being angry, arguing, defying, or refusing to comply; being spiteful; and deliberately annoying others.

Attention deficit hyperactivity disorder (ADHD) is more common among boys and is defined by age-inappropriate symptoms of inattention and hyperactivity/impulsivity, which must be seen for at least six months and across a range of settings.⁸ Such symptoms include not paying close attention to details, trouble paying attention, not following instructions, forgetfulness, fidgeting, talking excessively, and having trouble playing quietly or taking turns.

Separation anxiety is the only anxiety disorder specific to children. Symptoms must persist at least four weeks and significant distress and/or impaired functioning must be seen. Symptoms include repeated excessive stress when anticipating separation, worry about losing a parent or other attachment figure, refusing to go to preschool or child care, and fear of being alone or of sleeping alone. It is important to recognize that these symptoms may be normal after a serious stress event or catastrophe such as the loss of a parent or a natural disaster.

Intervention With Pre-School Aged Children

The literature on intervention with preschool-aged children focuses on studies of programs that seek to prevent

problems from developing or worsening, rather than on studies of treatment programs given to children after a problem has been identified. They may be “targeted” at a specific group known to be at greater risk, or “universal” and extended to all children (e.g., immunization programs).

While few universal programs focus on social and emotional development, some targeted preventions emphasize social and emotional development and compensatory education that aim to improve cognitive and pre-academic skills in preschool-age children. Parent management training programs, for example, are sometimes tailored for parents of preschool and kindergarten children, especially children who display oppositional behavior and symptoms of ADHD.⁹

Also, some recent interventions focus on the mother-toddler relationship and family systems. The goal is to enhance socioemotional and cognitive development by promoting secure child-mother attachment and better family functioning.

Intervention Issues

Several issues must be considered when making recommendations for treatment and evaluating approaches.

Foremost is the basic assumption that treatment can enhance development for some children under some circumstances. That makes it necessary to evaluate the relative effectiveness of specific treatments for particular problems among children of a given age and consider several contextual factors at the same time. Such factors include the child’s stage of development, the nature of the problem, the age of onset and severity of the problem, the child’s developmental stage, the child’s immediate and long-term psychological needs, the child’s long-term developmental needs, and family resources.

Treatments most appropriate for preschool children and their families deal with the child in the here and now, are structured and goal oriented, and emphasize the child’s problems within a family and social context. Treatments focused only on the child seem misdirected, Dr. Campbell reports, because preschool children are very dependent on the family and other caregivers.

Intervention Models

Programs addressing problem behaviors in preschool-aged children fall into several general categories of therapeutic models. In many cases, programs with the most promise for working well with preschool children and their families are not wholly wedded to one specific model. Instead, they tend to cross the boundaries of several.

Major therapeutic models include the following:

- **Biological models.** These models assume that genetic predispositions underlie certain behavioral disorders. Treatments seek to alter the biological mechanisms of the

disorder. The use of psychotropic drugs with children showing symptoms of ADHD, depression, and other problems in psychosocial adjustment is well studied. However, much remains to be learned about the nature of their effects, long-term effects on biological functioning and psychological development, and other issues. For example, several small studies of the use of Ritalin to treat hyperactive preschool children suggest the negative side effects outweigh positive changes in behavior.¹⁰ Overall, the use of medication with preschool age children is highly controversial and is recommended only in extreme cases with careful medical monitoring.

- **Intrapsychic and cognitive processing models.** These focus on changing personality organization, resolving unconscious conflicts, or otherwise changing mental processes that cannot be observed or easily operationalized. The effectiveness of these approaches is not well studied. However, several cognitive-behavioral treatments for children have shown promise for problems such as depression and anxiety,¹¹ but they are less effective with disruptive children and are only appropriate for school-age children and adolescents.
- **Behavioral models.** These models, which often rely on learning principles to change overt behaviors, have been used for the past 30 years. Studies show behaviors such as tantrums, aggression, noncompliance, and social withdrawal can be modified by giving rewards when children behave appropriately and withholding them when they do not, and by modeling and reinforcing appropriate behavior. Common methods include time out, praise, and giving rewards, such as treats and toys, for good behavior. Many programs that train parents to use such methods now emphasize a particular age range and consider family processes that may influence the ability of parents to use what they learn. Recent trends also include placing more focus on constructive parents’ problem-solving and anger management.
- **Family systems models.** These models take the view that although one family member – often a child – may be identified as the problem, the problem actually lies within the family. From a family systems perspective, behavioral approaches that only attempt to modify the problem behavior of the child are likely to fail if other aspects of the family system are not considered in treatment. Family therapists examine family alliances, relationships within the family, how power is distributed, how decisions are made, and other issues. Family systems models appear promising and there is mounting evidence that they are effective with school-aged children and adolescent children and their families.¹² However, it is not known how well such models apply to the problems of preschool-age children.

• **Community interventions.** Community intervention and prevention initiatives are based on the premise that the well-being of children and families can be improved by programs that address health, nutrition, work and living conditions, and family life, as well as cognitive and social development. They tend to focus on enhancing competencies and adaptive functioning. Community prevention programs focus on large numbers of children in settings such as preschools, day care centers, and neighborhoods. Early intervention programs, such as Head Start, identify and seek to help high-risk groups. Evidence suggests compensatory education programs such as Head Start have a positive impact on cognitive and social development and may result in longer-term gains in social and academic functioning.^{13, 14}

Therapeutic Approaches To Early Behavior Problems

The following parent training approaches, therapeutic preschool programs, and primary intervention programs focus on the child and family from more than one perspective.

Parent Training For Oppositional Children

Parent training, the most widely used and studied intervention for behavior problems in preschool-aged children, has been evaluated most thoroughly with children considered oppositional and defiant.

Recent studies show the effectiveness of parent training in modifying a variety of behavior problems, especially aggression and noncompliance in children across a wide age range. One review, for example, concludes that parent training programs tend to be more effective and longer-lasting with younger children than with older children.¹⁵ However, not all programs are equally effective.¹⁶

Program characteristics and family factors tend to influence the effectiveness of treatment, how long effects last, and treatment follow-through. Successful programs teach parents to use praise, ignore annoying behaviors, limit criticism and vague commands, and use time out for destructive, aggressive, and noncompliant behavior.^{17, 18} These programs vary, however, on several dimensions, including use with groups vs. individuals, whether the child is present in treatment sessions, length of treatment, involvement of parents, and use of other treatments.

One study, for example, found that both regular parent training programs and programs that combined parent training with planned activities were effective with oppositional preschool children and that gains lasted at least through the three-month follow-up.¹⁹ All parents were taught management skills, such as the use of praise, clear instructions, and time outs. Parents in the combined program were also taught

problem-solving strategies to use in often-stressful situations, such as shopping trips, car rides, and birthday parties.

Another program found to reduce oppositional and noncompliant behaviors combined teaching parents child management strategies with training in how to interact in more sensitive and positive ways.^{20, 21} This program suggests that strengthening the parent-child relationship leads to broader and longer-lasting effects on family functioning.

The participation of fathers in parent training programs also appears to be important. In one program that involved parents and their oppositional children in treatment, mothers in both two-parent families and families without fathers made significant changes that lasted for at least one year. However, women whose husbands or boyfriends participated in treatment were more positive with their children, who, in turn, were more compliant.²²

Taken together, such studies suggest that parent training approaches are most likely to lead to changes in the family that tend to last when they are broad-based, take into account other aspects of family relationships, and involve direct intervention in parent-child interaction.

Prevention And Early Intervention

Most early intervention programs for preschool-aged children focus on academic skills; are given to children living in low-income and highly-stressed families; and seek to improve cognitive skills, school readiness, and social functioning to help the children adjust to elementary school and enhance their academic achievement.

Most of the programs that are effective begin early in the child's life and are intensive, comprehensive, and structured. Programs that deal with both the child's needs and the needs of the family appear to be most successful.

A study of 12 infant and preschool early intervention programs reported that low-income children who participated in comprehensive early intervention were less likely to repeat a grade and to be in special classes than a control group of children who did not participate.²³ Children's view of their competence and parents' aspirations for their children also were positively influenced by early program attendance.

That study and others suggest that early interventions are most likely to be effective when they are intensive, take a multidimensional focus on children and their parents, use structured curricula, and provide a range of services over time.^{24, 25} However, gains sometimes do not last once the intervention ends. Such findings suggest short-term early interventions alone cannot be expected to bridge the gaps in cognitive, language, and social development between children who live in poverty and middle-class children without addressing the wide differences in early experience, environmental conditions, and support for academic and social competence that

continue to separate them.

Studies of comprehensive interventions illustrate the need to modify the family environment and provide additional resources to help parents support their children's development. For example, recent reports from the Abecedarian Project offer evidence that long-lasting effects can be achieved with intensive early intervention for high-risk infants and their mothers.²⁶

Beginning at about four months of age, children in the project treatment group received high-quality child care 40 hours per week, 50 weeks per year, including adequate nutrition and age-appropriate cognitive, linguistic, and social stimulation. They attended the center until they entered kindergarten. Extra resources for language development and literacy skills were provided during the preschool period. Cognitive and academic gains were dramatic and sustained and the children were better adjusted, had higher self-esteem, and were less likely to need special education services or to repeat a grade than children in a non-treatment control group.

Studies of other early intervention and prevention programs raise issues about the extent to which even ambitious programs are able to modify long-term child and family functioning in an effort to prevent or stabilize behavior problems in young children. The motivation of parents, their perceptions of problem behaviors, and their theories about the causes and development of these behaviors all influence their willingness to enroll in prevention or early intervention trials and, if they do, to follow through with program requirements. These barriers are even more formidable when parents are recruited to treatments, rather than seeking them out themselves.

Early Mother-Child Relationship

Several therapeutic approaches focus on early parent-child relationships in an attempt to change negative parent perceptions and attributions of infant and toddler behavior and improve the sensitivity of parents and their responsiveness. These approaches are mostly based on a combination of psychodynamic and attachment theory. Few interventions of this kind have been evaluated in well-designed studies.

Several recently-developed treatment approaches emphasize enhancing the ability of mothers to accurately read and appropriately respond to infant social signals as a way of increasing their sensitivity and responsiveness. This, it is hoped, will change how the mother views the mother-infant relationship, change her behavior toward her baby, and ultimately modify the quality of the attachment relationship.²⁷

Approaches to mother-child psychotherapy also try to modify negative aspects of the mother-child relationship and make mothers more sensitive to their infants' cues. Most experts in this area feel the child-parent relationship is the key consideration and that it is not meaningful to consider the problems of very young children without considering this re-

lationship.

Several interventions focused on depressed mothers and their young children try to modify the mother's depression and prevent problems from emerging among her children. Results have been mixed. One study reports that using parent-toddler psychotherapy with depressed mothers and their children resulted in the children having more secure attachments and better cognitive functioning.²⁸ However, few effects on child outcome and mother-child relationship were seen in a program in which visiting nurses helped mothers read infant signs and provide age-appropriate stimulation.²⁹ Other studies also suggest that brief home-based interventions may not be sufficient to change the quality of mother-child relationships when the mother is depressed.³⁰

Other approaches have focused on early interaction as a way to improve mother-child relationships and establish secure attachment in infants considered at risk. In one of these prevention studies, irritable infants received three two-hour home visits during a six-to-nine-month period that were aimed at helping mothers read, interpret, and respond to infant signals.³¹ When the intervention ended, the infants were less irritable and more exploratory, and their mothers were better able to respond appropriately. At 12 months of age, the infants were more likely to be securely attached than those in a non-treatment control group, and the gains lasted at least through the 36-month follow-up. Secure attachment may facilitate the child's adjustment and development in social and cognitive domains.

Taken together, studies of parent training, primary prevention, early intervention, and approaches that focus on the mother-child relationship suggest each holds promise in preventing and treating behavior problems in young children, especially when parent and family issues are considered and addressed as part of the intervention.

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This Special Report is based on the above-referenced publications. It is not intended to be an original work but a summary for the convenience of our readers. References noted in the text follow:

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