Emotional Development in Behavioral Parent Training Programs

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Abstract: Behavioral approaches to parent training are recommended as the gold standard to treat disruptive behaviors in preschool-aged children (Kaminski & Claussen, 2017). However, 25-33% of children do not improve with behavioral parent training (BPT) programs (Larsson et al., 2009; Webster-Stratton & Hammond, 1997). Given the relation between emotion regulation and externalizing behavior problems in young children (Lavigne, Bryant, Hopkins, & Gouze, 2015), it seems likely these children may benefit from treatment that also focuses on emotion regulation. Emotional development components of BPTs include directly child-focused interventions such as teaching emotion recognition and regulation, as well as more indirect, parent-led strategies including emotion coaching. The aim of this literature review is to critically examine the effectiveness of BPTs that incorporate emotional development aspects in treatment and to determine for whom they are effective. There are currently several BPTs that teach parents emotion-focused strategies, including the Dina Dinosaur Treatment Program (Webster-Stratton & Reid, 2003), Emotion Enhanced Triple-P (Salmon et al., 2014), and PCIT Emotion Development (Luby, Lenze, & Tillman, 2012). Studies have found varying levels of effectiveness of these BPTs for children with significant symptoms of depression (Luby et al. 2012), Attention-Deficit/Hyperactivity Disorder (Chronis-Tuscano et al., 2016), and disruptive behavior disorders (Webster-Stratton & Reid, 2003). This review will summarize and integrate relevant findings and conclude with future directions for practice and research.

Background

BPT is the evidence-based treatment of choice for young children with disruptive behavior disorders (Kaminski & Claussen, 2017). However, approximately one-third of families who complete BPT do not show significant reductions in behavior problems from treatment (Larsson et al., 2009; Webster-Stratton & Hammond, 1997). Therefore, it is crucial to examine research on modifications and adaptations to traditional BPTs in order to determine which aspects of BPT are effective for specific sets of presenting symptoms, thereby maximizing the benefits of evidence-based treatments.

There is extensive evidence that difficulties in emotion regulation are highly correlated with disruptive behavior disorders. Oppositional Defiant Disorder (ODD) symptoms in preschoolers are best characterized by a two-factor model of oppositional behavior and negative affect (Lavigne et al., 2015). Additionally, a recent factor analysis found ODD symptoms to fit into one factor of emotion dysregulation, which included irritability and emotional lability (Cavanagh, Quinn, Duncan, Graham, & Balbuena, 2017). Similarly, according to the emotional reactivity model of mood disorders, young children with depression show deficits in emotion regulation skills, including how to monitor and modulate their emotional reactions (Luby & Belden, 2006). For children with Attention-Deficit/Hyperactivity Disorder (ADHD), symptoms of impulsivity interfere with their abilities to inhibit and regulate their emotions, including masking their

emotions (Walcott & Landau, 2004). Given that young children with disruptive behaviors and other common presenting symptoms often show emotion regulation difficulties, including emotion-focused strategies in a treatment program may prove to be beneficial for many children and families.

Problem Statement

Traditional BPT does not explicitly include an emotion-focused component, which may benefit young children who have comorbid difficulties with emotion regulation. The goal of this brief research summary is to determine whom may benefit from emotional development modifications to otherwise behaviorally focused treatments, and to make recommendations for future research to inform practice.

Solutions

Several BPT programs have been modified to include supplemental emotion-focused sessions to address common presenting symptoms in preschool, including externalizing behavior problems, depressive symptoms, and ADHD symptoms.

The Incredible Years Dina Dinosaur Treatment Program is a multifaceted treatment that includes child, parent, and teacher training, emphasizing both behavioral strategies and social-emotional skill development in order to reduce conduct problems in young children (Webster-Stratton & Reid, 2003). The parent and child training programs run concurrently, and consist of 20 weekly, 2-hour sessions. Results from two randomized, controlled trials showed that combined parent and child training was more effective than either group alone in decreasing behavior problems, increasing social skills, and increasing positive parenting skills, with all significant changes maintained at one year follow-up (Webster-Stratton & Hammond, 1997; Webster-Stratton, Reid, & Hammond, 2001).

The Incredible Years Parent Training Program is a traditional BPT that teaches play skills, praise, limit setting, and discipline strategies. The Dina Dinosaur Social Emotional and Problem Solving Child Training Program is designed for children ages 4 to 8 years, and directly teaches young children social and emotional skills, including emotion regulation strategies (Webster-Stratton & Reid, 2003). The child program consistently uses interactive strategies to teach skills, including videos and puppets that demonstrate appropriate behavior, role playing, and practicing. A token reward system is also utilized throughout the group to reinforce positive behaviors. The child program is broken down into five themes that are introduced in the following order: school rules, emotion recognition and regulation, prosocial problem solving, anger management strategies, and friendship skills. The first sessions of the child program focus on child compliance at school, teaching school rules such as raising your hand, using a polite voice, and following directions. In the second phase, children learn emotion regulation skills, including emotion recognition in themselves and others, perspective taking, and coping strategies for staying calm. In the third phase, children learn prosocial problem solving, while the next phase teaches anger management strategies. Finally, children learn friendship skills including how to play and converse with their peers (Webster-Stratton & Reid, 2003). This program provides thorough social-emotional training by explicitly teaching young children emotion recognition, coping skills for difficult emotions, and social rules that often involve emotions.

After generating favorable outcomes in children with conduct problems, the Incredible Years Dina Dinosaur Treatment Program, consisting of parent training plus child training, was examined in children with ADHD (Webster-Stratton, Reid, & Beauchaine, 2011). A randomized, waitlist controlled trial with 99 children ages 3 to 6 years found significant treatment effects for

parent-report of ADHD symptoms, externalizing behaviors, emotion regulation, and social competence. Children's emotion vocabulary and problem solving skills also improved in the treatment group (Webster-Stratton et al., 2011). Thus, the combination of intensive parent and child training that focuses on various behavioral and social-emotional strategies is effective for preschool-aged children presenting with disruptive behavior disorders or ADHD.

Several BPT programs have targeted caregivers as emotional "guides" for their children by teaching emotion coaching (Chronis-Tuscano et al., 2016; Luby, Lenze, & Tillman, 2012; Salmon, Dittman, Sanders, Burson, & Hammington, 2014). Emotion coaching involves caregivers' active recognition and acceptance of their child's emotions and verbal acknowledgement of their child's emotions. Caregivers learn how to help their child label, understand, appropriately express, and manage their emotions. This is done through modeling and the use of CDI skills (e.g., reflecting child's expression of emotions, giving labeled praise for appropriate emotional coping).

One study demonstrated no differences in treatment outcome between eight sessions of group-delivered BPT and BPT that included emotion coaching. The study compared group-delivered Triple-P Positive Parenting Program, an evidence-based treatment for disruptive behavior disorders (Kaminski & Claussen, 2017), to Emotion Enhanced Triple-P, which included the addition of emotion coaching to the standard Triple-P Program (Salmon et al., 2014). Both programs were eight sessions long. Families of 36 children ages 3 to 6 years with elevated disruptive behaviors on the Eyberg Child Behavior Inventory (ECBI) were randomly assigned to one of two treatment groups. Both groups showed significant improvements in parent-reported behavior problems, but the standard Triple-P group showed significantly greater improvements. At a 4-month follow-up, there were no differences in behavior problems between the two groups. There were no significant changes for either group in a measure of child emotional knowledge (Salmon et al., 2014). In comparing these two interventions, emotion coaching did not enhance an already established BPT at follow-up for a group of children with disruptive behaviors. Authors discussed potential reasons for the lack of significant findings, including the possibility that teaching parents to simultaneously focus on their child's behaviors and emotions may be overwhelming, or that standard BPT is sufficient for reducing child behavior problems (Salmon et al., 2014).

PCIT Emotion Development (PCIT-ED) was created for children ages 3 to 7 years with a primary diagnosis of major depressive disorder (Lenze, Pautsch, & Luby, 2011; Luby et al., 2012). PCIT-ED is 14 sessions total, beginning with 4 sessions each of Child-Directed Interaction (CDI) and Parent-Directed Interaction (PDI). The third and novel module, ED, is 6 sessions and targets both child and caregiver skills. The ED module provides caregivers with emotion coaching skills, and directly teaches children emotion recognition and ER strategies. The ED Module begins in the same way as CDI and PDI, with a teach session that outlines how the parent is a guide for their child's emotions (Elkins, Mian, Comer, & Pincus, 2016). Early on in ED, parents watch a video of their child and apply knowledge of emotional expressions in order to facilitate the parents' ability to recognize emotions in their child. Parents are also taught Support Steps for when their child is upset; these steps involve observing the trigger of emotions, calming oneself, problem solving together with the child, and validating the child's emotion. The ED module also includes GUIDE steps to be used after a child has calmed down from an emotional event: Go back and point out the emotional trigger, express Understanding of the child's emotion, discuss Ideas and thoughts the child has around the trigger, Describe true and not true things about the event, and Express affection and confidence. In the child portion of PCIT-ED, the therapist teaches the child how to recognize emotions through discussion of pictures of story characters and of the child showing different emotions. Preschoolers are also

taught diaphragmatic breathing as a coping strategy. In addition, families select a "relaxation station" at home for the child to use when experiencing intense emotions; however, it is not a punishment and is thus explained as different from time-out in PDI. After parents learn the essential skills, they are then coached and coded on their ED skills as with typical coach sessions. Homework is also given to practice emotion skills (Elkins et al., 2016; Luby et al., 2012).

In a randomized, controlled trial of 29 children comparing PCIT-ED to psychoeducation, PCIT-ED significantly increased child executive functioning and emotion recognition skills. Both groups showed significant reductions in child depressive symptoms (Luby et al., 2012). While PCIT-ED showed unique effects in increasing child executive functioning and emotion recognition, this study did not show that it was more effective than psychoeducation in the treatment of early childhood depression. A recent randomized trial sought to understand whether child outcomes differed after completing different components of treatment (i.e., CDI, PDI, ED) (Luby, Gilbert, Whalen, Tillman, & Barch, 2019). A sample of 229 children with depression were randomly assigned to waitlist control or PCIT-ED, with the waitlist control group receiving treatment afterwards. Compared to the 2012 trial, the number of sessions increased to 6 each of CDI and PDI, and 8 sessions of ED. In both groups, parent report of child depressive symptoms decreased significantly after completing the CDI and ED modules. When compared to the control group, child depressive symptoms in the treatment group decreased significantly during the ED module only. Parent report of externalizing behaviors in the treatment group decreased significantly during the PDI module only. Authors acknowledge the limitation that it was difficult to discern whether the significant effects were due to overall treatment length or the ED module specifically. Overall, results suggest a unique benefit of the ED module in treating depression in preschoolers; additionally, CDI skills may work to reduce depression symptoms as well.

An initial adaptation study examined PCIT-ED in a group of 9 children with ADHD ages 3 to 7 years (Chronis-Tuscano et al., 2016). The emphasis of the ED module in this population was on caregivers' responses to child emotions, their discussion of child emotions, and modeling appropriate emotions. Thus, the authors named this particular adaptation, PCIT – emotion coaching (PCIT-ECo). Modifications to the ED module were made specific to children with ADHD. First, parents were given a flowchart to convey when to use PDI skills versus emotion coaching (see Figure 1 in Chronis-Tuscano et al., 2016). For example, for a child who grew frustrated and hit their parent, the parent would first complete the timeout sequence, and then label the child's emotions and have a conversation about it, using CDI skills to reinforce the child talking about their emotions. For minor misbehaviors co-occurring with emotional responses, parents were told to label the emotion one time and then ignore the misbehavior as in regular PCIT. Other modifications included removing sessions that taught children relaxation strategies and emotion identification, and adding a school-home daily report card. Specific child-directed sessions that focused on feelings of joy and guilt were also removed for PCIT-ECo. In the pilot group of children who participated in PCIT-ECo, there was evidence to show a decrease in externalizing problems and an increase in emotion regulation skills (Chronis-Tuscano et al., 2016). Based on preliminary research, PCIT-ECo may be a beneficial treatment for children with ADHD.

Conclusions and Recommendations

Overall, there are several emotion-focused BPTs for preschool-aged children designed to decrease overall externalizing behavior problems, or more specifically, ADHD and depressive symptoms. Some programs directly teach children ER skills (Dina Dinosaur, PCIT-ED), that may include emotion recognition skills, problem solving, or relaxation strategies. Other programs

target parental emotion coaching skills (Emotion-Enhanced Triple P, PCIT-ED, PCIT-ECo), teaching parents how to recognize and respond to child emotions of varying intensity. See Figure 1 in Chronis-Tuscano et al. (2016) for a visual flowchart of how to implement emotion coaching with and without co-occurring misbehaviors.

The majority of treatment programs in this review included emotion coaching as part of the emotional development curriculum. Additional research is needed on emotion coaching and its potential to enhance standard BPT (e.g., Salmon et al., 2014). Routine and thorough assessment of child emotion regulation abilities is required in order to clarify how emotion regulation changes throughout treatment. It is also necessary to assess emotion regulation to determine which modifications, if any, benefit children who have higher levels of dysregulation at baseline, compared to children with more oppositional or behavioral presentations of disruptive behavior disorders. Similar to the Luby et al. (2019) study, further research should also examine whether certain phases of treatment are more beneficial to children's emotion regulation abilities and other outcomes (e.g., CDI vs. PDI). More broadly, studies examining mediators and moderators of treatment outcome in BPT will help inform which specific aspects of BPT make it effective. BPT programs are widely acknowledged as evidence-based treatments, but the questions of why and how they are effective remain largely unanswered.

Results from treatment programs that were longer (e.g., 8 vs. 20 sessions) and more comprehensive, directly targeting child's emotion recognition and regulation skills, showed more promising results, such as in PCIT-ED and the Incredible Years Dina Dinosaur Program (Luby et al., 2012; Webster-Stratton & Reid, 2003). However, committing to weekly therapy for 8-20 sessions at a time is a challenge for many families, particularly those with children displaying disruptive behaviors. Providers should assess for areas of greatest need when determining appropriateness of therapy fit. Thus, treatment providers should consider the balance between feasibility and individual families' needs when determining whether to use emotional development modifications to standard BPT. For children who present with more severe emotion regulation problems and/or those who do not respond to BPT, referrals to other types of therapies may be more appropriate, such as individual CBT for the child or caregiver, or family therapy to address stressful life events.

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