Tools for Treating Behavior Problems in Young Latino Children

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Origin of Behavior Problems

Disruptive behaviors including aggression, property destruction, hyperactivity, defiance, and self-injury are the most common reasons prompting a young child's referral to mental health services (Kazdin, 2008). These children may receive a diagnosis of oppositional defiant disorder (ODD), characterized by angry and irritable mood, argumentative and defiant behavior, and vindictiveness, or conduct disorder (CD), characterized by a disregard for the rights of others including aggression, destruction of property, deceitfulness or theft, and violations of rules (American Psychiatric Association, 2013). In the United States, 4.6% of children aged 3–17 years received a diagnosis of ODD or CD, with a higher prevalence among boys (6.2%) than girls (3.0%) (US Department of Health and Human Services, Centers for Disease Control and Prevention [CDC], 2013). Among Latino children, approximately 4% had received a diagnosis of a behavior problem (CDC, 2013). While relatively few preschool-aged children are diagnosed with a psychiatric disorder, researchers have estimated 13–21% of 1–5-year-old children consistently exhibit high levels of disruptive behaviors that pose significant challenges to their caretakers (Carbonneau, Boivin, Brendgen, Nagin, & Tremblay, 2015). Estimates of children living in urban environments who exhibit moderate to clinically significant emotional and behavioral problems may even range as high as 30% (Barbarin, 2007). The typical onset of these disruptive behaviors begins very early in life and, if left untreated, may lead to mental health and social adjustment problems as the child matures into adolescence and even adulthood, including academic impairment, peer rejection, and unemployment (Carbonneau et al., 2015; Odgers et al. 2007).

Many factors influence the development of behavior problems in early childhood, including the parental use of verbal (Berlin et al., 2009) and physical punishment (Gershoff & Grogan-Kaylor 2016), parent marital status and cohabitation (Fomby & Estacion, 2011), maternal mental health (Goodman et al., 2011), child temperament (Rubin, Burgess, Dwyer, & Hastings, 2003), attachment style (Fearon, Bakermans-Kranenburg, Van IJzendoorn, Lapsley, & Roisman, 2010), parental expectations (Mattek, Harris, & Fox, 2016; Solis-Camara & Fox, 1996), and a myriad

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of stressors endemic to poverty (Santiago & Wadsworth, 2011; Wadsworth et al., 2008). Latino children, especially those in immigrant families, may be exposed to additional risk factors due to acculturation stress, low English language competency, overcrowded housing, and being disproportionately affected by poverty (Leidy et al, 2012). In 2014, Latino children accounted for the highest proportion of children living in poverty (36%), relative to Caucasian (30%), African American (26%), and Asian (3.31%) children (US Census Bureau, 2015). Similarly, researchers have suggested that poverty affects children indirectly through their parents as poverty leads to an increase in parental stress (Wadsworth et al., 2008). Researchers also have demonstrated that Latina mothers of children referred to clinical services for their child's behaviors showed more frequent use of verbal and physical punishment and less nurturing than in non-referred mothers (McCabe & Yeh, 2009; Perez & Fox, 2008).

Latino Cultural Factors

While a similar presentation of early behavior problems appears across cultures (Crijnen, Achenbach, & Verhulst, 1997), cultural values unique to the Latino population may impact the course of such behaviors as well as inform best treatment methods. These Latino values include *familismo*, *machismo*, *marianismo*, *respeto*, *personalismo*, and *simpatía* (Arcia, Reyes-Blanes, & Vazquez-Montilla, 2000; Barker, Cook, & Borrego, 2010; Calzada, Fernandez, & Cortes, 2010; Castillo, Perez, Castillo, & Ghosheh, 2010). Adherence to and identification with these constructs vary greatly between and within families. However, a general understanding of these cultural constructs as well as their influence on family functioning will aid the clinician responsible for delivering culturally sensitive mental health services. Clinicians should be sure to have a conversation with the caregivers regarding their cultural beliefs and values and how they play out in daily family life.

Considered the foundational value of Latino culture, *familismo* is generally defined as the emphasis on family unity and collectivism (Ayón, Marsiglia, & Bermudez-Parsai, 2010). It encompasses many values such as loyalty and support, as well as the expectation that each family member respects, participates in, and places family responsibilities above individual desires (Santisteban, Muir-Malcolm, Mitrani, & Szapocznik, 2002). It also should be noted that *familismo* extends to non-blood members of the family, such as close family friends (*compadres*) and godparents (*padrinos*). Another expectation of *familismo* is keeping problems private and within the family, which has been shown to decrease mental health service utilization (Villatoro, Morales, & Mays, 2014).

Like *familismo*, *respeto* also encompasses a diverse array of values, including obedience, respect for elders, upholding family honor through appropriate manners and behavior, and adherence to traditional gender roles. It also functions in the hierarchical understanding of social relationships within Latino culture (Antshel, 2002). *Machismo* and *marianismo* are the culturally prescribed roles of men and women, respectively (Castillo et al., 2010; Glass & Owen, 2010). Although *machismo* often connotes male domination, holding power over women, and hypermasculinity, it also may include more family responsibility, a positive work ethic, and respect for women and the family (sometimes viewed as *caballerismo*). *Marianismo* encompasses the qualities and expectations derived from the Virgin Mary that Latina mothers are expected to embrace, such as virtue, chastity, humility, self-sacrifice, and spirituality, with women considered as the primary caregivers and nurturers within the home (Rocha-Sanchez & Diaz-Loving, 2005).

Definitions of *personalismo* and *simpatía* tend to overlap and generally refer to a dislike of competition and confrontation and a desire for warm, trusting relationships and social politeness (Antshel, 2002). These two constructs are especially important to consider in creating the therapeutic relationship, as they tend to include expectations for mutual self-disclosure of personal experiences over less impersonal information and warm interpersonal interactions (Donlan, 2011). Developing a warm, interpersonal relationship between the family and

therapist will aid clinicians working with Latino families to achieve better outcomes and client satisfaction (Parish, Magana, Rose, Timberlake, & Swaine, 2012).

Gold Standard Treatment for Behavior Problems

Research on the effectiveness of treatment programs for behavior problems in young Latino children has recommended they should be family oriented and culturally adapted and delivered by Spanish-speaking facilitators (Bandy & Moore 2011). However, there are relatively few evidence-based programs available for very young children with behavior problems in general and even fewer for children from diverse families living in poverty, including Latino children (Fung & Fox, 2014). *Early Pathways* (EP), a home-based mental health program for young children with behavior problems, was initially developed to serve children 5 years of age and younger, primarily from a diverse population of families living in poverty (Fox & Holtz 2009). EP has since been culturally adapted to serve young Latino children and their families and has undergone rigorous efficacy testing with very positive outcomes and large effect sizes (Fung & Fox, 2014; Fung, Fox, & Harris, 2014).

EP also has been recognized as a highly effective, evidence-based treatment program for addressing behavior problems in young children by the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP). EP's theoretical foundation includes a strong developmental perspective and a primary emphasis on the central importance and quality of the parent-child relationship, along with the use of cognitive behavioral strategies for both the caregiver and child. As such, EP initially requires the development of a trusting relationship between the clinician and caregiver(s), and most parent worksheets are designed to facilitate the therapeutic process as well as achieve positive outcomes for the child and family. EP was designed for use by qualified professionals who when working with Latino families in their homes should have the following: (1) cultural sensitivity and supervised experience working with Latino families; (2) either speak Spanish or have a translator available (which makes therapy a much more arduous process); (3) comfortable in conducting therapy in the child's home; (4) a solid foundation in early childhood development and its myriad of contributing factors; and (5) ability to tailor cognitive behavioral strategies to the unique circumstances of each family.

Treatment Plan

In general, the program requires 8 consecutive weeks of 1 h weekly sessions to complete, depending on how quickly the caregiver can learn and implement the strategies as well as manage the unique referral concerns presented by the child. The subject of each session plan may change in response to the individual needs of the caregiver and child, the goals of treatment, and the potential gaps in parenting knowledge. So, the EP therapist needs to be very flexible, "think on their feet," and be prepared to intervene with any strategy in the program that is warranted. As a general rule, *the child's safety trumps everything else.* Typically, clinicians have found it helpful to introduce a developmentally appropriate discipline strategy (e.g., time-out) much earlier if the child's challenging behavior poses a threat to their safety or the safety of others and if the parent becomes easily frustrated and has a history of using frequent verbal and physical punishment. Consequently, the following treatment schedule should be used only as a general guide.

Session 1: Establishing Rapport and Conducting Assessment

The first session should be used to develop initial rapport with the caregiver and child, as well as gain a clear understanding of the child's challenging behaviors by conducting an extensive intake interview. The intake typically includes an assessment of the child's challenging and positive behaviors (Worksheet 1a), a caregiver

interview, and therapist observation, during which the therapist and caregiver identify one to two challenging behaviors and one positive behavior as the foci of treatment. The therapist should assess the frequency, intensity, and duration of the child's behavior to determine whether it is typical or clinical and if it occurs across home and community settings; determine the degree to which a young child's behavior affects the child's and family's daily functioning; and identify potentially contributing risk factors relevant to a young child's behavior (e.g., mom's age and experience, how many children are in the home, caregiver support system, etc.). This is important to ensure appropriate, effective treatment is given and to prevent therapists from treating nonbehavior problems (i.e., medical problems) with psychological interventions. If there is a possibility of an underlying medical condition (e.g., ear infection), the child should have a thorough physical examination before starting EP. The intake information should be recorded and used to create treatment goals, which are then discussed, agreed upon, and written on the treatment plan (Worksheet 1b). It is important to introduce the EP treatment program and give the caregiver a concrete idea of their expected level of involvement and the daily effort it requires. Any advocacy needs of the family (e.g., housing, food, medical care) should be addressed and resources should be provided.

Session 2: Introduce the EP Treatment Program and Behavior Plan

The therapist and caregiver should begin by reviewing the treatment plan. The majority of the session should be used to establish positive family foundations by teaching, demonstrating, and practicing child-led play (Worksheet 2a). During child-led play, the child is allowed to select what they would like to play with as the caregiver takes a nondirective approach and comments positively on what the child is doing. Therapists should explain the caregiver's role as being "like a sports commentator," positively commenting on what is happening in play without questioning, criticizing, or telling the child what to do next. The therapist should also introduce praise and rewards as ways to improve the caregiver-child relationship and reinforce prosocial behaviors (Worksheet 2b). If the child does something the caregiver wants, such as cleaning up their toys following play, the caregiver can tell them "good job picking up your toys!" or give a reward (e.g., small prize or a sticker). The therapist should help caregivers identify positive nurturing activities, like child-led play or reading together, that the child and caregiver enjoy and can engage in together. At the end of the session, the therapist and caregiver should complete the behavior plan (Worksheet 2c). The behavior plan specifies what the caregiver should do to implement the treatment plan during the coming week and to track the caregiver's progress with treatment strategies. A new behavior plan is created each week to fit the treatment material covered in that particular week and includes both challenging and positive behaviors with their corresponding treatment strategies. The therapist may include reminders for areas that the caregiver may be struggling with and use the space provided for caregivers to track their implementation of treatment strategies through the week. The therapist may also use the treatment report to track progress (Worksheet 2d). The therapist should continue to address any advocacy needs of the family at each session.

Session 3: Psychoeducation: Cognitive Behavioral Strategies

The therapist should begin each session by reviewing the behavior plan from the previous week and allowing time for child-led play. The focus of session 3 is psychoeducation about developmentally appropriate expectations and cognitive behavioral strategies for understanding behaviors. The clinician may begin this conversation by introducing what a behavior is and help the caregiver identify differences between behavior and the child's personality/temperament (Worksheet 3a). The therapist should explain that children often behave in ways to get their needs met, and so they have learned a behavior because at some point in time it was effective. Behaviors are therefore not about the child being "good" or "bad" but about the child performing an action to get a desired response. An easy way to describe

behaviors is "anything you see or hear your child doing," while a label is a description of a child as an individual. Labeling a child as "bad" can hamper the child's self-concept development. Once this distinction has been made, the therapist can illustrate what contributes to behavior by identifying components of behavior cycles (Worksheet 3b). Behavior cycles are a way of describing how a caregiver and child interact in both positive and negative ways. It includes the child's behavior, the caregiver's thoughts and feelings, the caregiver's reaction to the behavior, and what the child learns from the interaction. The therapist and caregiver should use one of the target behaviors and go through the behavior cycle being sure to incorporate how the caregiver's thoughts and feelings contribute to their child's behavior. The therapist should then practice this strategy in session with the caregiver when applicable, fill out a new behavior plan with the caregiver, and complete the therapist treatment report.

Session 4: Psychoeducation: Promoting Positive Behaviors Through Thoughtful Responses

The therapist should collect the behavior plan from the caregiver and allow time to practice child-led play in session. The therapist should then review and build upon behavior cycles by introducing *PARE y PIENSE* (STOP and THINK) (Worksheet 4a). Following a behavior, caregivers should "*PARE*" ("STOP") before responding to give them time to calm down. Offering anger management suggestions may be appropriate if the caregiver has difficulty calming down. The second step is "*PIENSE*" ("THINK") to allow the caregiver to reflect on their thoughts and feelings (e.g., "My child is just like his father," anger, embarrassed). They should then think about their expectations for the child and examine if they are appropriate before engaging in a thoughtful response to the behavior. The therapist may add this component using "*PREGUNTE*" ("*ASK*") if it is easier for the caregiver to remember this very important step by using an additional "*P*" word. This strategy will help the caregiver begin to understand how they can alter behavior cycles by examining their reactions to their child's behavior. Their responses should discourage negative behaviors and encourage positive behaviors. For example, if the child has taken a toy away from a playmate, the response might be to have the child practice sharing a toy, instead of just reprimanding the child for the bad behavior. By offering the child what they should do instead, the caregiver has given the child a new, positive behavior to replace the old, negative behavior when the situation occurs in the future. The therapist should also use a prosocial behavior and explain how the caregiver can use *PARE y PIENSE* to reward good behaviors and encourage their future use (see Worksheet 2b for examples of rewards and praise).

Session 5: Improving Communication: Giving Effective Requests

The therapist should collect the behavior plan from the caregiver and allow time to practice child-led play in session. The therapist should then discuss giving effective requests with the caregiver. Very young children only comply with about 50% of parental requests, so giving effective requests that are necessary, clear, and simple is important in achieving optimal compliance. The caregiver can use *PARE y PIENSE* to consider if their request is developmentally appropriate. Similarly, instructions for tasks requiring several actions, such as getting ready for bed, should be broken down into small steps, such as "Time to brush teeth" and then "Now it's time to put on our pajamas." Preparing children for transitions between activities, especially if the child is involved in play or finishing a drawing, can help compliance. Using natural breaks, such as after dinner, can also be helpful for children who usually do not understand time concepts. Along with considering the timing of their requests, caregivers should pay attention to *how* they give the request, being sure to establish eye contact, and use very simple statements. The request should only be repeated once, and then assist the child with completing the task. Offering the child a choice ("either you can put on your pajamas or I can help you") sometimes persuades them to be independent and complete the task on their own. The therapist should stress that following through on the request is important to show the child that the caregiver

means what they say. The therapist can demonstrate following through during session, for example, by gently using a "hand-over-hand" technique if a child refuses to pick up toys where the therapist places his/her hand over the child's and gently helps him/her pick up a toy and put it away. Once the child complies with a request, even after using hand-over-hand technique, the caregiver should praise the child with direct feedback, "Thank you for picking up the toys!" The therapist can give the caregiver the "*escuchando*" ("listening") worksheet to practice giving good requests and rewarding compliance during the session (Worksheet 5a). The therapist and caregiver should also check in on goals and strategies used when filling out the behavior plan (Worksheet 2c) and therapist treatment report (2d).

Session 6: Establishing Home Routines, Supervision, and Planning Ahead

As young children do best when their world is predictable, the therapist should help the caregiver establish a daily home routine, taking into consideration the amount of close supervision a young child requires. To facilitate this discussion, the therapist should ask the caregiver to describe a typical day in the life of their child, from waking until bedtime. Using the "*routina diaria*" (daily routines) worksheets (6a, 6b) may be helpful to establish a daily routine of activities, with the therapist making suggestions to improve the routine, if needed. For example, establishing a standard bedtime is a good start. The therapist can also help the caregiver identify steps they can take to help the child with a disruption in the regular routine or with a transition. This may involve telling the child what they can expect well before the disruption will take place. For example, if the child must go to a doctor's appointment, the caregiver can tell the child the day before and remind him/her in the morning of the day's plans. The caregiver can also prepare to bring toys or other necessary things to help the child with the transition and at the appointment.

Session 7: Discipline Strategies

The therapist can begin the discussion of discipline with the caregiver by stating that the word discipline (both in English and Spanish, *la disciplina*) literally means *to teach*, and it should not be viewed as punishment. Discipline involves setting reasonable limits for children's challenging behaviors to teach them what behaviors are expected and what behaviors are not acceptable. Discipline helps young children gradually develop self-control and does not include teasing, name-calling, belittling, harassing, or physically hurting children. Research shows corporal punishment has an opposite effect than caregivers expect; that is, the more a caregiver uses physical punishment, the more problematic behaviors a child demonstrates (Gershoff & Grogan-Kaylor 2016). However, this is a sensitive topic that often is fully integrated into a caregiver's belief system about child-rearing. The therapist may find it helpful to have the caregiver describe their own experiences with verbal and physical punishment, listing the negative and positive aspects from their perspective. The therapist may introduce the EP discipline strategies as alternatives to punishment that have been proven to reduce challenging behaviors through years of research.

The first discipline strategy is redirection, to distract or redirect the child to more appropriate behavior before the challenging behavior can occur. For example, if a child is told he cannot have a toy, which normally results in a tantrum, redirecting his attention to another activity may prevent the tantrum. Taking precautions, such as "baby proofing" the house by locking cabinets and putting dangerous objects and substances out of reach, may prevent naturally curious children from getting into harm's way. Similarly, if a child is caught drawing on a wall, a caregiver can redirect the drawing to an appropriate piece of paper. The second technique, ignoring (Worksheet 7a), is useful for children who act out for attention. By not giving the child the attention they seek, the caregiver is not reinforcing the acting-out behavior. For example, if a child screams to get her caregiver's attention, the caregiver can ignore this behavior, wait until the child stops screaming, and then calmly redirect the child to a more appropriate way of getting the caregiver's attention. After ensuring the child is safe, a caregiver can also use ignoring during tantrums. The third technique,

natural consequences (Worksheet 7b), teaches children their actions have consequences. The consequence should not be fun or harmful to the child and should logically follow from what the child did. For example, if a child throws a toy, the natural consequence of throwing the toy is not getting to play with it. Similarly, if a child spills milk, the caregiver should have the child help clean it up. The last discipline technique, time-out, should be used after trying redirection, ignoring, and natural consequences, or if they are not practical given the behavior. It is recommended that aggressive behaviors such as hitting, kicking, or biting be given a time-out. The therapist should use the time-out worksheet (7c) with the caregiver and go through the time-out procedure, demonstrated during session when possible. As a general rule, the child should be in time-out 1 min for each year of age (age 2, 2 min time-out), and the time-out location should be neutral (chair in the corner of room), not scary (dark closet).

Session 8: Behavior Maintenance and Treatment Evaluation

The final session should be used to review the strategies, check in on goals, and conduct posttreatment assessment to compare progress with pretreatment assessment scores (Worksheet 1a). This time should also be used to problem-solve issues that arose in implementing the treatment plan. It is recommended that the therapist fill out a behavior plan (Worksheet 2c) with the caregiver as an "ongoing behavior plan" to help maintain treatment gains. The therapist should address any further advocacy needs and make appropriate referrals if necessary. Therapists may also choose to do a "closing activity" to congratulate the family on their progress and reflect on their time spent together. For some parents, additional sessions will be needed to reach the treatment goals.

Treatment Plan Summary

This treatment plan summary has been adapted from *Early Pathways.*

Component	Session plan/goals	Worksheet
Establishing rapport, conducting intake assessment, and creating a treatment plan	Complete an intake evaluation (1a) Introduce EP Develop initial treatment goals Develop initial treatment plan (integrate with intake assessment findings) (1b) Address advocacy needs of child/family	1a, 1b
Review treatment plan, establish positive family foundations, introduce behavior plan	Review treatment plan with caregiver (1a) Describe and implement child-led play (2a) Introduce praise and rewards, and identify ways for parents to effectively praise their children (2b) Introduce nurturing and identify positive nurturing activities Introduce behavior plan (2c) Complete therapist treatment report (2d) Address advocacy needs of child/family	2a, 2b, 2c, 2d
Psychoeducation, cognitive behavioral strategies	Collect behavior plan from parent Practice child-led play Introduce behavior, identify differences between behavior and personality/temperament, and discuss what contributes to behavior (3a) Identify components of behavior cycles (3b) Revise treatment plan (if need be) Complete behavior plan and treatment report (2c, 2d) Address advocacy needs of child/family	3a, 3b, 2c, 2d

Component	Session plan/goals	Worksheet
Psychoeducation, promoting positive behaviors through thoughtful responses	Collect behavior plan from parent Practice child-led play Identify main components of STOP and THINK (PARE y PIENSE) cognitive strategy (4a) Identify positive situations when using PARE y PIENSE is appropriate Identify appropriate developmental expectations Identify appropriate strategies to improve child's listening Identify how to teach families to develop household routines Complete treatment report Address advocacy needs of child/family	4a
Improving communication, giving effective requests	Collect behavior plan from parent Practice child-led play Review and practice child-led play and PARE y PIENSE Identify how to give effective requests using simple, goal-oriented language (5a) Discuss the use of positive reinforcement to promote listening Complete behavior plan and treatment report (2c, 2d) Address advocacy needs of child/family	5a
Establishing home routines, supervision, planning ahead	Collect behavior plan from parent Practice child-led play Complete treatment report Collect behavior plan from parent Practice child-led play Review and practice child-led play and PARE y PIENSE Help caregiver establish a daily home routine, taking into consideration the amount of supervision a child requires Identify steps caregiver can take to help child with a disruption in the regular routine or with a transition Address advocacy needs of child/family	6a, 6b
Discipline strategies	Complete treatment report Collect behavior plan from parent Practice child-led play Review and practice child-led play Review STAR parenting model Identify developmentally appropriate responses (discipline strategies) for a child's challenging behaviors Address advocacy needs of child/family	7a, 7b, 7c
Behavior maintenance and treatment evaluation	Complete treatment report Collect behavior plan from parent Practice child-led play Problem-solve issues that arose in implementing treatment plan Discuss maintenance of treatment gains with caregiver Review and practice child-led play Review STAR parenting model Review discipline strategies and their implementation Review overall treatment progress Address advocacy needs of child/family	

Worksheet 1a

Revisión del Comportamiento del Niño A Temprana Edad

Nombre del Niño/a_____ H/M Nombre del Padre: _____
Fecha de Nacimiento: _____ Fecha: _____

Instrucciones: A continuación habrá comportamientos comunes en los niños pequeños y Pre-escolares. Piense en el comportamiento que su hijo/a tuvo durante la semana pasada, y marque con que frecuencia ha visto este comportamiento. Circule A Menudo si este comportamiento pasa por lo menos una vez al día, circule Algunas Veces si este comportamiento pasa semanalmente, y circule Casi Nunca si el comportamiento rara vez pasa o nunca pasa.

Su Niño.....	**Con que frecuencia ocurre este comportamiento?**			Para uso de la Clínica Solamente	
1. Le Pega a otros	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
2. Come con una cuchara	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
3. Avienta cosas a otros	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
4. Te escucha	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
5. Tiene Berrinches	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
6. Rompe Cosas	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
7. Se Enoja	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
8. Lastima a otros	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
9. Entiende lo que le dices	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
10. Hace lo que le pides	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
11. Juega bien con otros	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
12. Duerme durante la noche	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
13. Le quita juguetes a otros	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
14. Comparte Juguetes	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
15. Le ayuda a otros	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
16. Molesta a otros	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
17. Come bien	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
18. Coopera al vestirse	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
19.Se rehúsa ir a la cama por la noche	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
20. Patea a otros	**A Menudo**	**Algunas Veces**	**Casi Nunca**		
			Raw Score Pro-Social		
			Raw Score Challenging		

Clinician Note: Sum each column after scoring each item according to the following scale: Often (A Menudo) = 3 ; Sometimes (Algunas Veces) = 2; Almost Never (Casi Nunca)= 1

Clinical significance is reached if child's RAW score meets or exceeds the following cutoff scores:

Age	**Male**	**Female**
0-11 months	15	15
1 year old	19	18
2 years old	21	19
3 years old	17	18
4 years old	18	17
5 years old	23	17

Worksheet 1b

Early Pathways Plan de Tratamiento Inicial

Fecha:_____ Nombre del Niño: _____ Nombre del Cuidador:_____

Edad: ___A ___M Edad de Desarrollo: ___A ___M Retrasos de Desarrollo: _____

Puntos Fuertes del niño: _____

Diagnostico: _____ Entrevistador Inicial: _____

Metas

Objetivo del Tratamiento	Estatus Actual	Meta a Corto Plazo (3 semanas)	Meta a Largo Plazo (8 semanas)
Comportamiento Problemático 1:	_____ Veces por semana	_____ Veces por semana	_____ Veces por semana
Comportamiento Problemático 2:	_____ Veces por semana	_____ Veces por semana	_____ Veces por semana
Comportamiento Positivo	0% < 25% 25% 50% 75% >75%	0% < 25% 25% 50% 75% >75%	0% < 25% 25% 50% 75% >75%

Métodos

El programa del tratamiento incluirá los siguientes componentes:

1. Juegos dirigidos por su hijo para fortalecer la relación entre usted y su hijo.
2. Estrategias que le ayudan al padre a pensar positivamente y a como responderle a su hijo calmadamente.
3. Desarrollar las expectativas apropiadas basadas en la etapa actual de desarrollo de su hijo.
4. Estrategias de reforzamiento positivo para reforzar los comportamientos positivos de su hijo.
5. Estrategias para poner limites en los comportamientos retadores y mantener un ambiente seguro.
6. Hable sobre las barreras que existen y que están afectando su participación, su progreso y la terminación del tratamiento.

Horario del Programa

La familia se reunirá en su casa con un consejero familiar una vez a la semana por 3 semanas, en el cual se hará una evaluación de las metas del tratamiento y su progreso se hará para determinar las necesidades y metas del tratamiento.

Evaluación

1. La participación en el tratamiento, su progreso y sus metas se registraran usando planes y reportes de tratamiento semanales.
2. La efectividad del tratamiento se determinara por medio del protocolo de evaluación administrado durante todo el tratamiento.

El padre o tutor tiene la oportunidad de participar en la planeación del tratamiento, leer y entender las metas iniciales del tratamiento.

_____ _____ _____

Padre o Tutor Fecha Profesional Certificado en Tratamiento

Worksheet 2a

Instrucciones para los Padres: Juego Dirigido por el Niño

¿Que es esta forma de jugar?

El Juego Dirigido por el Niño es una nueva forma de jugar con sus hijos.

¿Por que es importante?

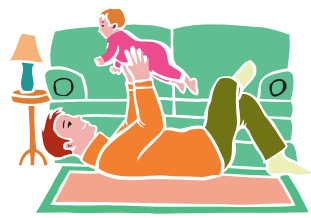
Esta forma de jugar ayuda a construir una relación más fuerte con su hijo/a. Queremos que su hijo/a lo/a vea como una persona divertida con quien jugar.

¿Cómo se usa esta forma de jugar?

- El niño/a escoge el juguete
- Deje al niño/a que dirija el juego
- El niño/a decide lo que quiere hacer con el juguete (ej. Pone el aro pequeño antes del aro grande)
- El padre usa comentarios positivos cuando describa lo que ésta haciendo el niño/a (ej. pusiste el bloque morado encima del bloque rojo)
- El padre pone limitaciones apropiadas en lo que el niño/a no puede hacer (no deben de correr adentro de la casa, no deben aventar los juguetes)
- No le haga una prueba/examen a su hijo, permítale a su hijo sentirse en control (ej. ¿De qué color es esto?)

Cuando deben de usar esta forma de jugar:

- Escoja aproximadamente la misma hora cada día para jugar con su hijo/a
- Juegue 10-15 minutos con su hijo/a



Worksheet 2b

Instrucciones para los Padres: Tipos de Premios

Premios Físicos

- Abrazos
- Besos
- Unas palmaditas en la espalda
- Un 5 (high 5, choque de mano)

Premios Verbales

1. Palabras no específicas: palabras generales diciéndole a su hijo que están portándose bien.
   - "¡Qué bien!"
   - "¡Buen trabajo!"
   - "Eso es muy bueno. ¡Ojala y yo pudiera hacer eso!"
   - "¡Que divertido!"
   - Usando una palabra: "¡WOW!" "¡Hermoso!" "¡Genial!"

2. Palabras específicas: Usando palabras diciéndole a su hijo exactamente lo que están haciendo bien.
   - "Me gusta cuando…."
   - "Gracias por…."
   - "Hiciste buen trabajo ayudando con…."
   - "Estas haciendo lo que quiero que hagas."
   - "Me gusta jugar esto contigo."
   - "Eres un/a niño/a grande por…."

Premios Tangibles

- Calcomanías (Stickers)
- Premios que se pueden comer: galletas, chocolates, dulces, gomitas
- Premios chicos como- pelotitas de goma, libro, crayón, peluche

Como debe usar premios

- Sea especifico/a
- Dar el premio inmediatamente
- Dar los premios consistentemente
- Enfocarse en la mejoría (use come elogio de paso-a-paso)
- No lo use como un soborn

Worksheet 2c

Plan de Comportamiento

Nombre: _____ Fecha: _____

Objetivo del Tratamiento	Estrategia del Tratamiento
Comportamiento Problemático 1:	
Comportamiento Problemático 2:	
Comportamiento Positivo:	

Recordatorios:

1. _____
2. _____
3. _____
4. _____

Pudo usted hacer:

	Si	No	# de Veces
Lunes			
Martes			
Miércoles			
Jueves			
Viernes			
Sábado			
Domingo			

	Si	No	# de Veces
Lunes			
Martes			
Miércoles			
Jueves			
Viernes			
Sábado			
Domingo			

Worksheet 2d

Early Pathways Treatment Report (Based only on what you see and hear from parents in session)

Child _____Caregiver _____Date_____Clinician_____Session #:

Behavior Target	Frequency
Problem Behavior 1:	_____ times/week
Problem Behavior 2:	_____ times/week
Positive Behavior:	<25% 25-50% 50-75% >75%

How many times did you do child-led play in the past week? ____

_____

Comments on Play:

Clinician Observation and Parent Report:

Does parent maintain appropriate expectations? ____ Rarely/Never ____ Sometimes ____ Most Times
Does parent stop and think before responding? ____ Rarely/Never ____ Sometimes ____ Most Times
Does parent utilize rewards appropriately? ____ Rarely/Never ____ Sometimes ____ Most Times
Does parent utilize appropriate discipline? ____ Rarely/Never ____ Sometimes ____ Most Times
What is the combined score of Tx variables? ____ Total (Rarely/Never = 1, Sometimes = 2, Most Times = 3)
What is parent's current level of engagement? ____ Minimal ____ Moderate ____ High

Revisión del Comportamiento del Niño a Temprana Edad

Instrucciones: A continuación habrá comportamientos communes en los niños pequeños y Pre-escolares. Piense en el comportamiento que su hijo/a tuvo durante la semana pasada, y marquee con que frecuencia ha visto este comportamiento. Circule Frecuentemente si este comportamiento pasa por lo menos una vez al día, circule A Veces si este comportamiento pasa semanalmente, y circule Casi Nunca si el comportamiento rara vez pasa o nunca pasa.

Su hijo….	Con que frecuencia ocurre este comportamiento?			
1. Le pega a otros	Frecuentemente	A Veces	Casi Nunca	
2. Le tira cosas a otros	Frecuentemente	A Veces	Casi Nunca	
3. Tiene berrinches	Frecuentemente	A Veces	Casi Nunca	
4. Rompe cosas	Frecuentemente	A Veces	Casi Nunca	
5. Se enoja	Frecuentemente	A Veces	Casi Nunca	
6. Lastima a otros	Frecuentemente	A Veces	Casi Nunca	
7. Le quita cosas a otros	Frecuentemente	A Veces	Casi Nunca	
8. Molesta a otros	Frecuentemente	A Veces	Casi Nunca	
9. Por la noche se rehusa a ir a la cama	Frecuentemente	A Veces	Casi Nunca	
10. Patea a otros	Frecuentemente	A Veces	Casi Nunca	
Clinician Note: Sum the columns after scoring each item according to the following scale Often = 3, Sometimes = 2, Almost Never = 1		Raw Score Challenging		
		Clinically Significant?		

Age	Male	Female
0-11 months	15	15
1 year old	19	18
2 years old	21	19
3 years old	17	18
4 years old	18	17
5 years old	23	17

How are things going?

Provide data on the family's general status and follow-up on recommendations: events of the week; implementation of treatment strategies; new concerns.

Clinician Comment on progress:

Provide an assessment of treatment progress, level of engagement and barriers to treatment. Indicate plan for focus of treatment and future sessions.

What was addressed during session? (Check all that apply) ___Behavior Cycles ___Child-led Play ___Stop and Think ___Listening ___Expectations ___Praise/Rewards ___Discipline Strategies ___Nurturing Activities ___Routines ___Trauma Care ___Advocacy

_____ _____ _____

Clinician Signature **Date** **Length of session (minutes)**

Worksheet 3a

Nombre:_____

¿Que es un Comportamiento?

La personalidad de un niño y sus comportamientos son diferentes.
Un niño tiene rasgos personales que heredan o aprenden.
El comportamiento es algo que usted puede ver o escuchar que su hijo hace.

Describa a su hijo/a:

1.) _____

2.) _____

3.) _____

4.) _____

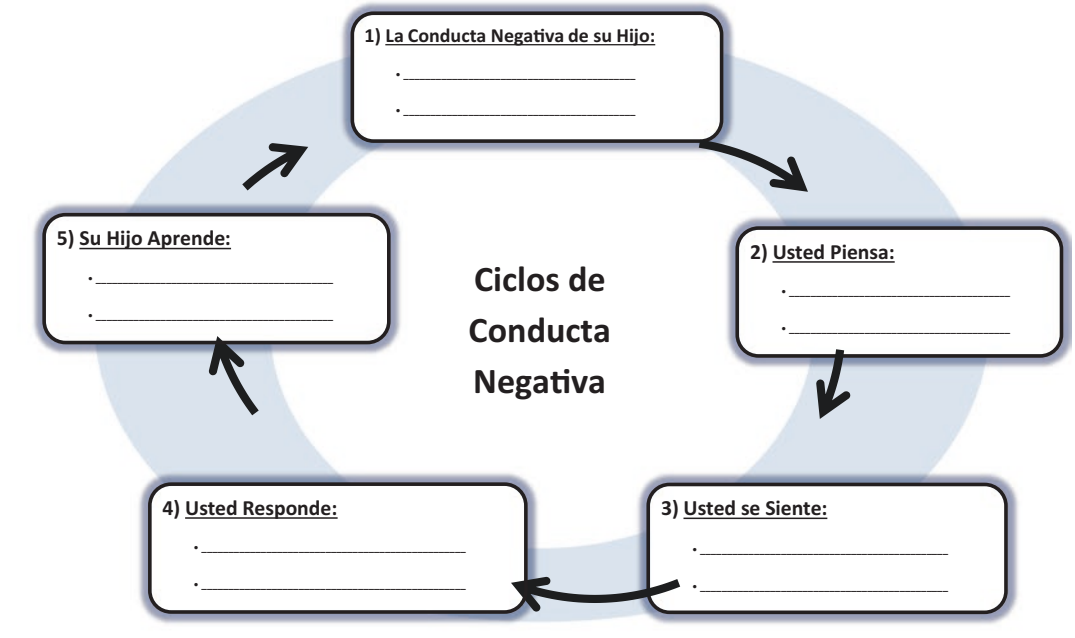
Separando a su hijo/a de su comportamiento

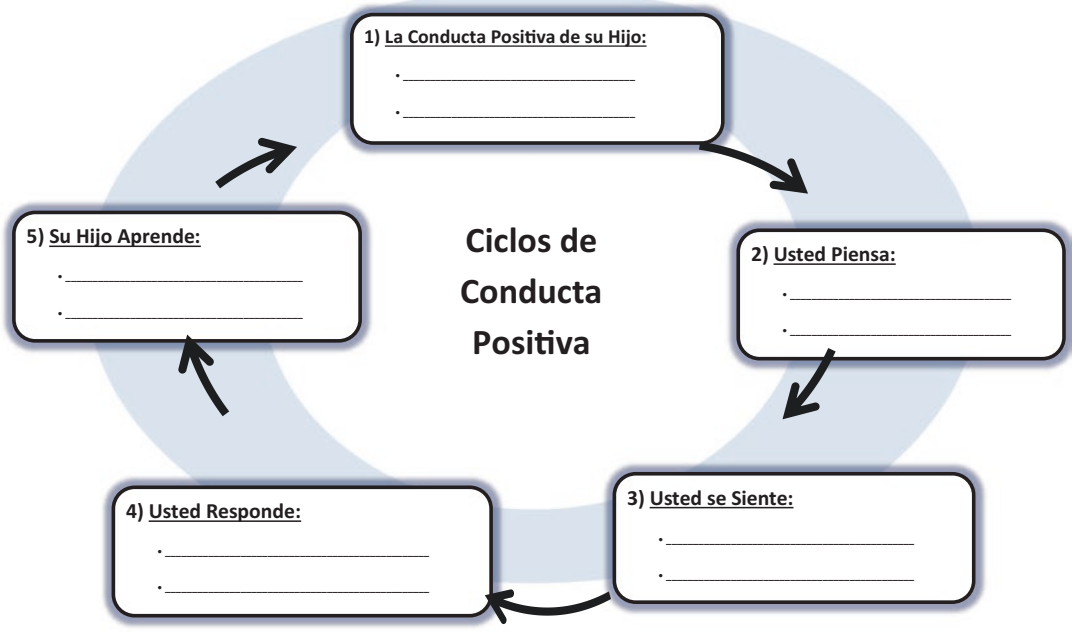
No hay niños malos, solo problemas de conducta.
Esta bien si usted le dice a su niño/a que no le gusta su *comportamiento*
No esta bien si usted le dice a su niño/a que *ellos* son el problema

No le diga:	Dígale
"Eres un niño malo por pegar!"	**"No me gusta cuando pegas."**
"Que malcriado eres, nunca me haces caso!"	**"Necesitas obedecerme cuando te diga que tienes que hacer algo."**
"Hay! Que niño tan malo eres!"	**"No esta bien que le quites los juguetes a tu hermanito."**

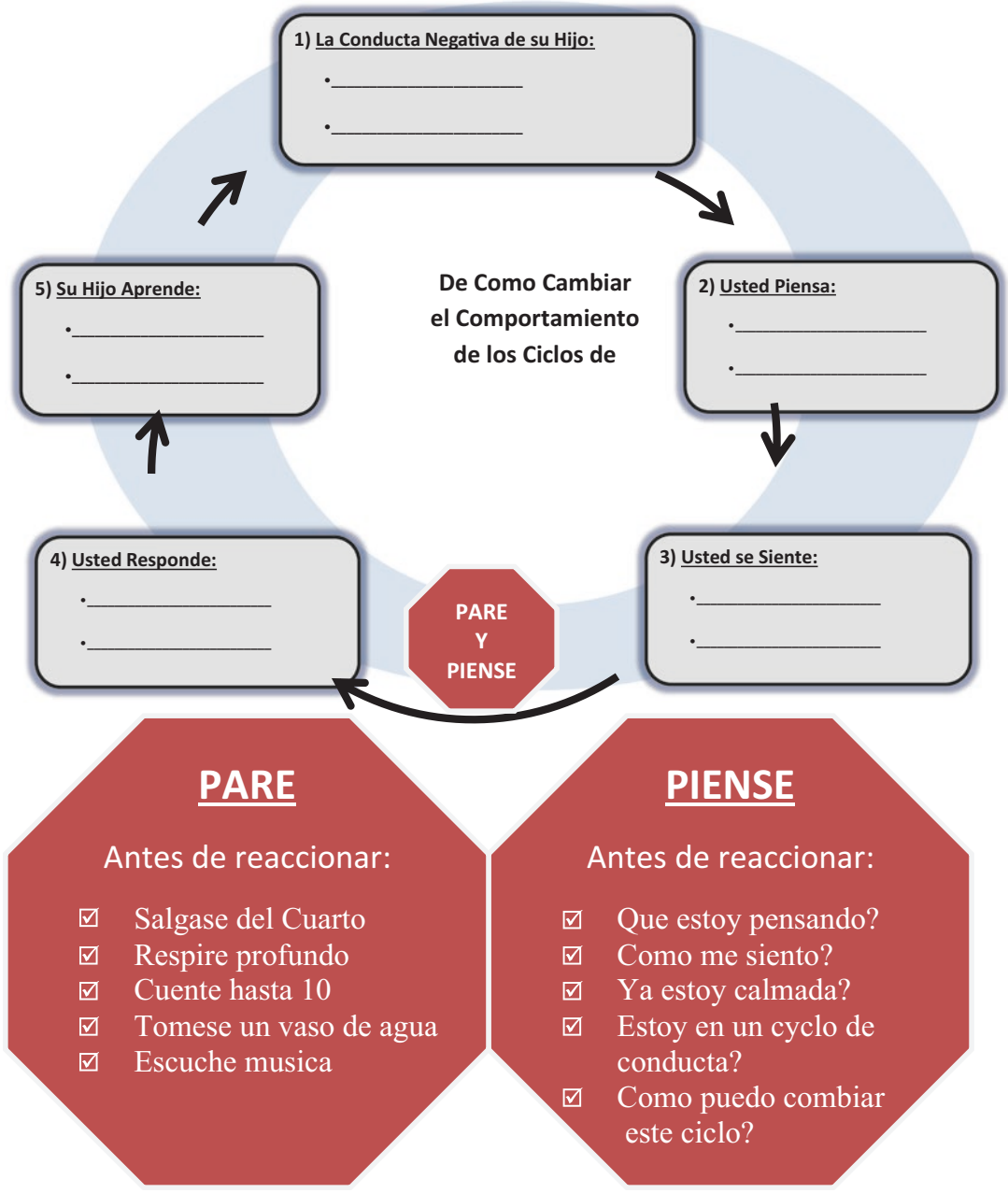
Worksheet 3b

Nombre:





Worksheet 4


1) La Conducta Negativa de su Hijo:
•_____
•_____
2) Usted Piensa:
•_____
•_____
3) Usted se Siente:
•_____
•_____
4) Usted Responde:
•_____
•_____
5) Su Hijo Aprende:
•_____
•_____
De Como Cambiar el Comportamiento de los Ciclos de
PARE Y PIENSE
PARE
Antes de reaccionar:
☑ Salgase del Cuarto
☑ Respire profundo
☑ Cuente hasta 10
☑ Tomese un vaso de agua
☑ Escuche musica
PIENSE
Antes de reaccionar:
☑ Que estoy pensando?
☑ Como me siento?
☑ Ya estoy calmada?
☑ Estoy en un cyclo de conducta?
☑ Como puedo combiar este ciclo?

Worksheet 5a

Instrucciones para los papas: Escuchando

¿Qué es un ejercicio de escuchar?

Estos ejercicios van a ayudarle a su hijo que te escuche mejor.

¿Por qué es importante?

Los padres saben lo que es lo mas mejor para sus hijos. Los niños necesitan escucharles a sus papas para ser más responsable cuando estén más grandes. Los padres necesitan tiempo, necesitan practicar y mucha paciencia.

¿Cómo debe de hacer un ejercicio de escuchar?

- Siéntese en la cocina, en la mesa.
- Gane la atención de su hijo/a, use su nombre.
- Antes de preguntarle a su hijo/a que haga algo, necesita verle en sus ojos.
- Dile que haga algo:
    - Levanta le mano
    - Toca la mesa
    - Aplaude
    - Recoge el juguete
    - Dame el juguete
- Si su hijo hace lo que le dijiste, de le un premio verbal. O si quiere una galleta o un dulce.
- Si su hijo no la/lo escucha, ayúdele y use muchos premios verbales.
    - Un ejemplo: agarré la mano de su hijo y levántela…déle un premio como si hubiera echo lo que le pregunto sin ayudo

¿Cuándo debe de hacer un ejercicio de escuchar?

- Escoge un tiempo cuando tenga 5 minutos para enseñarle a su hijo/a.
- Haga un ejercicio de escuchar cada día.

Usted debe de determinar cual premio quiere usar durante estos ejercicios. Unos ejemplos:

Premios:
Galletas, Stickers
M&M's, Jugo

Premios Verbales:
Que bien! Buen Trabajo!
Bravo!

Worksheet 6a

ESTRUCTURA A TRAVÉS DE LA RUTINA DIARIA:

¿QUÉ HACE LA ESTRUCTURA?

1) Niños/as **quieren y necesitan estructura** en su vida diaria para un desarrolle sano.
2) Estructura les da a niños/as una sensación de **seguridad**.
3) Estructura les da a niños/as **limites** en su comportamiento, les ayuda a desarrollar **relaciones sanas**, y **les enseñan** sobre el mundo en el que viven.
4) Estructura le provee a niños/as con herramientas para **manejar sus emociones** de una manera sana.
5) Estructura les enseñan a niños/as **responsabilidad**, el cual les ayudara tomar mejores opciones.

¿CÓMO LE PODRE DAR A MI HIJO/A ESTRUCTURA?

1) Provéale a su hijo/a con **actividades** para ocupar su tiempo: Ejemplo. Ir al parque, poner un horario al desayuno, almuerzo, y cena todos los días, cepillar los dientes con su hijo/a por la mañana y noche, etc.
2) Si tiene más de 1 hijo/a, es mejor si todos están en el **mismo horario**.
3) **Es mejor ser lo más consistente posible, para mantener la misma rutina todos los días.**
4) Explique le a su hijo/a lo que viene después en su "rutina diaria," para que se preparen para la transición.

*Ejemplo De Una Rutina:

8:00am → Despertar

Cepillar los dientes

Vestirse

9:00am → Guardería/escuela, ir al parque, ir a caminar, tiempo de jugar, arte & manualidades.

10:00am → Refrigerio

12:00pm → Almuerzo

1:00pm → Siesta

2:00-2:30pm → Despertar

2:30pm → Refrigerio

3:00pm → Actividades

6:00pm → Cena

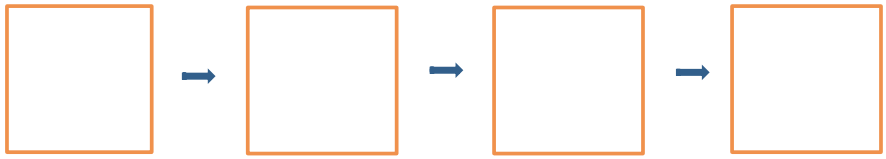
7:00pm → Comenzar la rutina para acostarse: baño, cepillar

5) **Sea flexible!** Sus rutinas y estructura que tiene para su hijo/a tendrá que cambiar como vaya creciendo y desarrollándose.
   - **Ejemplo:** Un niño/a de 4 años tendrá una hora para acostarse a dormir más temprano que uno/a de 12 años.

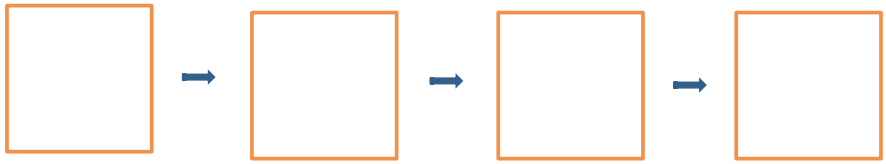
Worksheet 6b

¿CÓMO SE MIRARÍA LA RUTINA DIARIA DE MI HIJO/A?

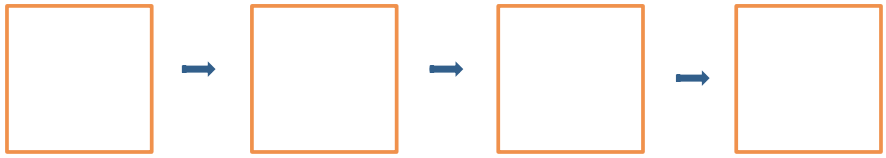
Rutina de la Mañana:



Rutina del Medio-Día (10:00am-3:00pm):

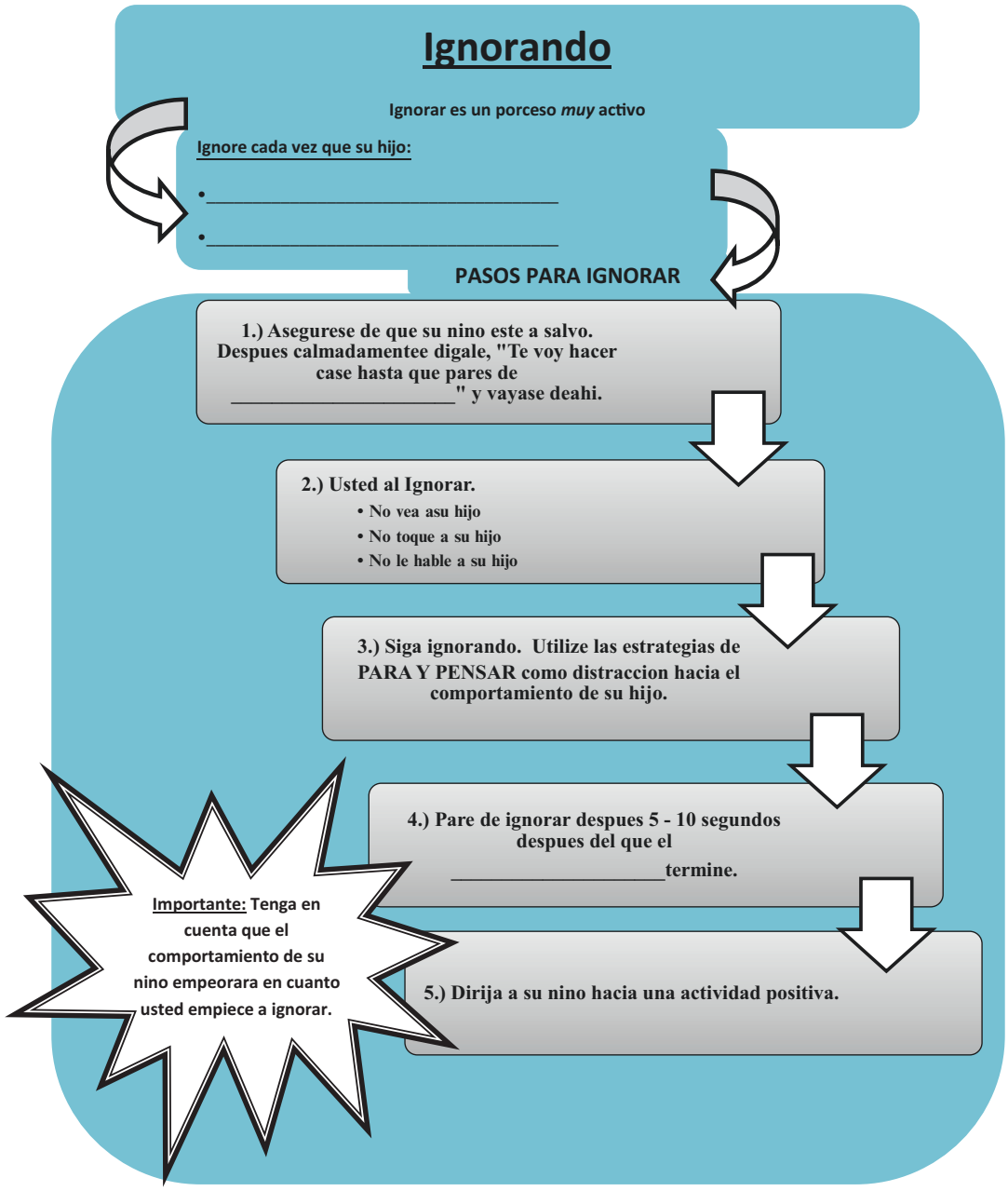


Rutina de la Noche/Para Acostarse:



****Unas muestras de Actividades para incluir en la rutina diaria de su hijo/a: ir** a la guardería/escuela, ir a caminar, jugar en el parque, el juego dirigido-por-el-niño, ir a la tienda del mandado, tiempo para comer o merendar, artes y manualidades, deportes, nadar, siesta, leer, etc.

Worksheet 7a



Worksheet 7b

Consequencias Naturales

Cuando tu _____ entonces yo_____.

Esta bien quitarles los privilegios/los objetos que no usen de la forma correcta.

Utilize Consecuencia Natural cuando:

- _____
- _____

1. Utilize el PARA Y PENSAR antes de tratar el comportamiento de su hijo.

2. Digale a su hijo que a usted no le gusta su comportamiento.

3. Dele consequencia natural a causa de su comportamiento.
(Ej: guitele el juguete)

Acuerdese de Nombrar el Comportamiento.

"No esta bien que le avientes el juguete a tu hermanito"

Cuando quite un privilegio o un objecto, deselo despues de _____ y uestrele a su nino como usarlo de la forma correcta.

Acuerdese de elogiar a su nino cada vez que se comporte correctamente y use un objecto de la forma correcta!

Worksheet 7c

Castigo

Castigue a su niño cada vez que el/ella:

- _____
- _____
- _____
- _____

Pasos a seguir para el Castigo

1. Calmadamente dígale, "Estas castigado por_____."
2. Lleve a su niño a _____ como lugar de castigo.
3. Empiece a contar el tiempo y déle _____ minutos.
4. Asegúrese de que su hijo este en un lugar seguro PERO
   - No vea a su hijo
   - No le hable a su hijo
   - Y no toque a su hijo
5. Si su hijo/a se sale del área de castigo, sin decirle nada regréselo al área de castigo.
6. Cuando se termine el tiempo.
   a. Si su hijo/a esta calmado/a dígale que ya termino el castigo y diríjalo a una actividad positiva.
   b. Si No se calma, dígale "Te quedaras castigado/a hasta que no te calmes."
      i. Cuéntele _____ minuto mas.
      ii. Revise a su hijo/a cada _____ minuto para ver si ya esta calmado/a.
7. Lo más que puede estar su hijo/a en el área de castigo son____ minutos.
8. Cuando termine el castigo de su hijo/a envuélvalo en alguna actividad positiva.

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