

Developmental and Behavioral News

Volume 19, No. 2, Fall 2010

Published by the Section on Developmental and Behavioral Pediatrics

Michael Ian Reiff, MD, FAAP, Editor

Copyright© 2010 American Academy of Pediatrics
Section on Developmental and Behavioral Pediatrics



American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Notes from the Chair



Michelle M. Macias, MD, FAAP
Charleston, SC

On the golden anniversary of the Section on Developmental and Behavioral Pediatrics (SODBP), I would like to reflect on the past contributions of the Section in its various renditions and look toward future accomplishments. The SODBP was initially organized as the Section on Child Development under Dr. Julius Richmond. He described child development as the ‘basic science of pediatrics’, and published the seminal article “An Idea Whose Time Has Come” in 1975 which provided the building blocks of what would ultimately become the field of developmental-behavioral pediatrics. The section formally became the Section on Developmental and Behavioral Pediatrics in 1988. Education and advocacy have been our primary goals. Over the years, the section has provided top-quality developmental and behavioral education for the primary care pediatrician and the subspecialist. These educational efforts include many CME activities, both live and online. The manual *AAP Developmental and Behavioral Pediatrics* will soon be in print. We have a superlative Web site, www.dbpeds.org, which contains cutting-edge articles, hand-outs for professionals and parents, and other useful items. The newsletter you are reading provides up-to-date articles on developmental and behavioral topics. The section is involved in policy development through its liaisons with the AAP Council on

continued on page 2

Section Executive Committee

Michelle M. Macias, MD, FAAP Chairperson
Charleston, SC
E-mail: maciasm@musc.edu

Carolyn Bridgemohan, MD, FAAP
Boston, MA
E-mail: carolyn.bridgemohan@childrens.harvard.edu

Jill Fussell, MD, FAAP
Little Rock, AR
E-mail: fusselljill@uams.edu

Edward Goldson, MD, FAAP
Denver, CO
E-mail: goldson.edward@tchden.org

Laura J. McGuinn, MD, FAAP
Oklahoma City, OK
E-mail: laura-mcguinn@ouhsc.edu

Carol Weitzman, MD, FAAP
New Haven, CT
E-mail: carol.weitzman@yale.edu

Educational Program Chair

Nathan J. Blum, MD, FAAP
Philadelphia, PA
E-mail: blum@email.chop.edu

Newsletter Editor

Michael Ian Reiff, MD, FAAP
Minneapolis, MN
E-mail: reiff001@umn.edu

Immediate Past Chairperson

Lynn Mowbray Wegner, MD, FAAP
Chapel Hill, NC
E-mail: lwegner@med.unc.edu

AAP Staff

Linda Paul, MPH, Manager
Division of Developmental Pediatrics
and Preventive Services
American Academy of Pediatrics
141 Northwest Point Blvd.
Elk Grove Village, IL 60007
Office: 800/433-9016, x7787
Fax: 847/228-7320
E-mail: lpaul@aap.org

Ngozi Onyema, CHES
Coordinator, Committees & Sections
Division of Developmental Pediatrics
and Preventive Services
American Academy of Pediatrics
E-mail: nonyema@aap.org

Mark A. Krajecki
Pre-Press Production Specialist
Department of Education
Division of Scholarly Journals
and Professional Periodicals
American Academy of Pediatrics
E-mail: mkrajecki@aap.org

Table of Contents

Notes from the Chair	1-2
Notes from the Editor.....	3
Identifying Components Associated With Effective Parent Training Programs.....	4-6
Evidence-Based Training Programs	7-8
Assistive Technology for Hearing and Speech	9-10
NCE 2010 Section on Development and Behavioral Pediatrics Sponsored Sessions	11
International Developmental-Behavioral Pediatrics – The PICAN Project.....	12-15
Worried Well and Behavioral Health.....	15-17
The Autism Treatment Network:	
Exploring the Medical Aspects of Autism Spectrum Disorders.....	18-19
Tips for Recognizing and Helping Children Who are Bullied	20-22
Developmental-Behavioral and Primary Care Pediatrics: A Time for Collaboration.....	23-25
Coding Conundrums.....	26
The Section on Developmental and Behavioral Pediatrics 2010 Award Recipients	27

Statements and opinions expressed are those of the authors and not necessarily those of the American Academy of Pediatrics.

Children with Disabilities and the Committees on Psychosocial Aspects of Child and Family Health and Early Childhood, Adoption and Dependent Care. There is also a formal external liaison with the Society for Developmental and Behavioral Pediatrics. Our advocacy and educational work extends to practice management. We anticipate that our determined and unflagging efforts regarding developmental-behavioral billing and coding will lead to appropriate payment and improved access to care. And (drum roll, please), I am happy to announce that the long-awaited PediaLink module on developmental-behavioral pediatrics billing and coding will soon be available!

The C. Anderson Aldrich award was established in 1964 for pediatricians who have made outstanding contributions to the field of child development and behavior. In

1974, the Dale Richmond (now the Richmond-Coleman) award was established as a career achievement award to recognize advocacy and outstanding contributions in development and behavior for professionals in all fields. This year, Leonard Rappaport, MD, MS, FAAP will receive the C. Anderson Aldrich Award, and Chris Plauché (Johnson), MEd, MD, MA, FAAP will receive the Richmond-Coleman Award. We are pleased to be able to honor these 2 well-deserving, superlative individuals.

We have a fantastic program scheduled for the 2010 National Conference and Exhibition (NCE) in San Francisco. Our SODBP program will take place on Sunday, October 3rd. In addition to our award recipient lectures, a joint program with the Council on Communications and Media is planned. The program will focus on bullying and the impact of media on

development and behavior. The general NCE program includes 24 sessions sponsored or co-sponsored by SODBP, so we maintain a strong presence at the NCE. Thanks to all section members who submitted ideas for proposals—your efforts are greatly appreciated.

We have a special reception planned at the NCE for section members (and non-section members—bring a friend!) on Saturday, October 2nd from 5-6:30 pm at the Marriott. We have much to be proud of, and I anticipate the next 50 years will be as productive in our work to improve the lives of children with developmental and behavioral concerns and their families. Please join us for our celebration of 50 fabulous years of SODBP!

My best,
Michelle

Congratulations!

Section on Developmental and Behavioral Pediatrics

On turning 50!

Join us for a celebration

Where: The National Conference and Exhibition in San Francisco, CA

When: Saturday, October 2, 2010

Location: San Francisco Marriott Marquis

Room: Nob Hill D

Time: 5:00 - 6:30 PM

Supported by Shionogi Pharma

Check out the newly redesigned dbpeds.org, the official Web site for the Section on Developmental and Behavioral Pediatrics. The Web site, developed with support from The Commonwealth Fund, will be officially launched at the 50th Anniversary Reception during the 2010 AAP National Conference and Exhibition.



Section on Developmental and Behavioral Pediatrics

WELCOME

Welcome to dbpeds.org! This new site, sponsored by the AAP Section on Developmental and Behavioral Pediatrics (SODBP), is aimed at professionals interested in child development and behavior, especially in the clinical setting.

A special thank you to Hank Shapiro, MD and Frances Page Glascoe, PhD for their dedication to bringing the initial dbpeds.org site to life! We'd also like to acknowledge The Commonwealth Fund for their support of the initial site and the transition to the new design.

HOT TOPICS

Register Today for 2010 National Conference Exhibition in San Francisco, CA

There are over 15 sessions related to developmental and behavioral pediatrics at this year's National Conference and Exhibition (NCE), covering topics such as learning disabilities, improving outcomes for individuals with cerebral palsy, managing sleep problems, and developmentally informed pediatric well-child care. The SODBP educational program will be held on Sunday, October 3, 2010 and will focus on bullying. View the full program and register for the NCE at <http://www.aapexperience.org/>

50th Anniversary, SODBP

Special activities are being planned to honor the 50th Anniversary of the SODBP. A special event will be held at the 2010 NCE on Saturday evening (5:00–6:30 pm), October 2, 2010. Check back for more details.

Spring 2010 Issue, Development and Behavioral News

Articles in this issue include:

- "What parents can do right now to reduce aggressive behavior in young children"
- "ABCD: Screening & Surveillance, Referral and Linkages to Community Resource in Primary Care"
- "Different Screens, Different Results: What Does This Mean for Primary Care?"
- and five more articles

Regular features include: "Notes from the Chair" and "Coding Conundrums." Go to [About Us](#) for back issues of the newsletter.

Register for the DB:PREP® Course, December 8-12, 2010, Chicago, IL

JOIN US

The SODBP was founded in 1960 for members primarily interested in developmental and behavioral pediatrics. Membership in the Section is open to all Fellows, Residents, International Members and Affiliates who are actively involved in the field of developmental and behavioral pediatrics and who are

© COPYRIGHT AMERICAN ACADEMY OF PEDIATRICS. ALL RIGHTS RESERVED.
American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL, 60007, 847-434-4000

Notes from the Editor

By Michael I. Reiff, MD, FAAP
Minneapolis, MN

This issue of Developmental and Behavioral News has a particular focus on parenting. The following 2 articles highlighted in this issue both address programs that are evidence based and have demonstrated improvements in outcome.

Identifying Components Associated With Effective Parent Training Programs

By Linda Anne Valle, PhD; Jennifer W. Kaminski, PhD; Jill H. Filene, MPH; and Cynthia L. Boyle

Occasional oppositional, impulsive, inattentive, and aggressive behaviors are not uncommon in young children. However, severe or continuous externalizing behavior problems such as these place children at risk for later adverse outcomes, such as difficulties in school and delinquency.^{1,2} Parenting programs, which seek to alter parents' behavior to affect changes in children's behavior, are recognized as one of the most effective ways, to address young children's behavior problems and promote positive child development.^{3,4} Parenting programs are also widely used to address other parenting problems, such as risk for child maltreatment;⁵ child welfare agencies refer over 800,000 families to parenting programs each year.⁶

With this heavy demand, hundreds of parenting programs have been developed. However, relatively few of these programs have been evaluated to determine if they are effective at changing parenting behaviors and child externalizing behavior problems. Of the programs that have been evaluated, the programs vary widely in their effectiveness and in the specific components that comprise the program, including their content and method of delivery. The number and multiple variations in parenting programs frequently make it difficult to determine which existing programs are most likely to be beneficial to families.



The Centers for Disease Control and Prevention (CDC) Meta-Analysis

Utilizing traditional meta-analytic techniques, CDC researchers conducted a review that allowed them to use quantitative methods to identify specific components associated with those parent training programs showing better outcomes for children and parents. In contrast to traditional meta-analyses, which typically examine programs in their entirety, the researchers essentially disassembled the packaged parent training programs to identify components that were associated with greater program effectiveness. The outcomes examined were parenting behaviors/skills and child externalizing problems immediately following the program.

Based on decades of research showing that active learning approaches are superior to passive approaches,^{7,8} the review focused on parent training programs, which were defined as programs in which at least some of the activities included were focused on parents' active acquisition of parenting skills (eg, homework, modeling, and practice). The researchers conducted an extensive search of literature included in the PsycInfo and Medline databases that were published in English between 1990 and 2002 and that evaluated parent training programs for parents of children aged 0-7. Starting with over 8,000 abstracts, the researchers identified 77 published evaluations suitable to include in the review. Analyses were used to identify the content and delivery components that were reliably associated with successful changes in parenting behavior and skills and early child behavior problems after accounting for differences in study methodology. Thus, the analyses provided a rich source of information about the key ingredients associated with effective parent training programs.

The content components examined in the review included teaching parents how to:

- Promote child development and provide developmentally appropriate care
- Interact positively in non-disciplinary situations with their children
- Increase nurturing behaviors and sensitive responding to their children's needs
- Increase their ability to communicate positively in non-disciplinary situations (eg, active listening, helping children identify and express emotions)
- Communicate effectively in disciplinary contexts (eg, set limits, give instructions)
- Use effective disciplinary and behavior management skills (including specific subcategories, such as teaching parents to problem solve and how to do time out)
- Promote their children's social skills
- Promote their children's cognitive or academic skills

Delivery components examined included:

- Use of an established curriculum or manual
- Use of modeling

continued on page 5

- Use of homework
- Use of rehearsal, role-playing, or practice (including specifying if the practice was with an adult peer or with the parent's own child)
- Provision of additional separate services for the child (eg, child skills training programs outside of the context of the parent training program)
- Adding supplementary non-parenting services (eg, parental mental health services, case management)

Components Associated with Better Outcomes in Parenting Behaviors and Skills

Three components (2 content and 1 delivery) were reliably associated with more successful programs: teaching parents to communicate positively in non-disciplinary situations, teaching parents to interact positively with their child, and having parents practice with their own child during the parent training sessions.

Components Associated with Better Outcomes in Child Externalizing Behavior

Four components (three content and one delivery) were associated with programs having better outcomes on child externalizing behaviors, such as aggressive and oppositional behavior: teaching parents to interact positively with their child, teaching parents to use time out correctly, teaching parents to respond consistently to their children's behaviors, and having parents practice with their own child during the parent training sessions.

Components Associated With Less Effective Programs

Three components were reliably associated with programs having less successful outcomes for parenting behavior and skills: teaching parents to problem solve in disciplinary contexts, teaching parents to promote children's cognitive/academic skills, and adding supplementary non-parenting services. In other words, parent training programs that included these components were less successful in promoting the desired parenting behaviors or skills. Similarly, programs that included parent training in promoting children's social skills had less successful outcomes for child externalizing behaviors. It is possible that these components are less relevant to families of children aged 0-7. It is also possible that these components are associated with other outcomes that were not examined in the review.

Other (Neutral) Components

All other components examined in the review were neither positively or negatively associated with more successful programs, suggesting that none of those components differentiated between more and less successful programs. It is possible that these components are effective, or only effective, in interaction with other components. As with components associated with less effective programs, these neutral components may also not be relevant for families with young children or could be associated with other outcomes that were not a focus of this review.

How Can Pediatricians Use This Information?

Pediatricians are mothers' most trusted source of information on parenting.⁹ Understanding which parenting components are associated with successful outcomes can assist pediatricians in identifying beneficial programs and providing guidance and referrals for families experiencing problems. Pediatricians can familiarize themselves with the available parenting programs in their area, and when parenting or child externalizing problems cannot be adequately addressed through brief guidance, ensure that referrals are made to parent training programs that appear most likely to result in positive outcomes for the families they see. The components associated with more successful parent training programs for these outcomes included training parents in creating positive interactions with their child, teaching parents to communicate positively with their children, teaching parents to use time out correctly and to respond consistently to their children's behaviors, and requiring parents to practice with their child during parenting sessions.

continued on page 6

Additional Sources of Information and References for the CDC Study:

Centers for Disease Control and Prevention. *Parent Training Programs: Insight for Practitioners*. Atlanta, GA: Centers for Disease Control; 2009. Available at: www.cdc.gov/ViolencePrevention/pub/parenting_meta-analysis.html. Accessed August 24, 2010.

Kaminski JW, Valle LA, Filene JH, Boyle CL. A meta-analytic review of components associated with parent training program effectiveness. *J Abnorm Child Psychol*. 2008; 36(4): 567–589

References

1. Broidy LM, Nagin DS, Tremblay RE, Bates JE, Brame B, Dodge KA, et al. Developmental trajectories of childhood disruptive behaviors and adolescent delinquency: A six-site, cross-national study. *Devl Psychol*. 2003; 39:222–245
2. Fergusson DM, Horwood LJ, Lynskey M. The childhoods of multiple problem adolescents: A 15-year longitudinal study. *J Child Psychol Psychiatry*. 1994;35:1123–1140
3. Maughan DR, Christiansen E, Jensen WR, Olympia D, Clark E. Behavioral parent training as a treatment for externalizing behaviors and disruptive behavior disorders: A meta-analysis. *School Psychol Rev*. 2005; 34:267–286
4. Serketic WJ, Dumas JE. The effectiveness of behavioral parent training to modify antisocial behavior in children: A meta-analysis. *Behav Ther*. 1996;27:171–186
5. Lundahl BW, Nimer J, Parsons B. Preventing child abuse: A meta-analysis of parent training programs. *Res Social Work Prac*. 2006;16:251–262
6. Barth RP, Landsverk J, Chamberlain P, Reid JB, Rolls JA, Hurlburt MS, et al. Parent-training programs in child welfare services: Planning for a more evidence-based approach to serving biological parents. *Res Social Work Prac*. 2005;15:353–371
7. Arthur Jr W, Bennett Jr W, Stanush PL, McNelly TL. Factors that influence skill decay and retention: A quantitative review and analysis. *Hum Perform*. 1998;11:57–101
8. Salas E, Cannon-Bowers JA. The science of training: A decade of progress. *Annu Rev Psychol*. 2001; 52:471–499
9. Bailey, M. New survey reveals moms' media habits. Marketing to Moms Coalition and Current Lifestyle Marketing (Non-peer reviewed research report; 2008). Available at: http://www.cdc.gov/healthmarketing/pdf/ThisJustIn/TJI_18_200912.pdf. Accessed August 12, 2010

About the Authors:

Linda Anne Valle, PhD, is a clinical psychologist and the lead behavioral scientist for the Child Maltreatment, Intimate Partner Violence, and Suicide Prevention Efficacy and Effectiveness research team in the Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Her research interests include family violence, parenting, evaluation research methodology, and dissemination and implementation of evidence-based practice.

Jennifer Kaminski, PhD, works as a Health Scientist on the Child Development Studies Team in the National Center on Birth Defects and Developmental Disabilities at the Centers for Disease Control and Prevention. Her current work includes prevention research related to typical and atypical child development. She also has previous experience in the development and evaluation of violence prevention strategies.

Jill Filene, MPH is a Senior Research Associate at James Bell Associates. She has more than a decade of experience in applied research, program evaluation, and technical assistance. Her work has focused on replication studies and evaluations of parent training and child maltreatment prevention programs.

Cynthia L. Boyle is completing her doctorate in child and developmental psychology at the University of Kansas and is currently consulting at the Center for Behavioral Sciences, Inc. in Los Angeles, CA. She has spent many years conducting research on parenting and working with families with children with autism, developmental delays, and behavior problems.

Correspondence concerning this article should be addressed to Linda Anne Valle, Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 4770 Buford Hwy NE, MS-F63, Atlanta, Georgia 30341. Email: LValle@cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Evidence-Based Parent Training Programs

By Susan M. VanScoyoc, PhD, ABPP and Edward R. Christophersen, PhD, ABPP

The spring 2010 issue of *Developmental and Behavioral News* reviewed the incredible efforts of numerous organizations across the country, including the AAP Task Force on Mental Health, to assist practitioners in identifying and addressing behavioral and mental health issues in young children. Early intervention with respect to disruptive behavior disorders is essential for minimizing the potentially lifelong, negative impact of such problems. As an example, Campbell and Ewing¹ reported that, in the absence of intervention, 67% of 3-year-old children who were seen as hard to manage still met the diagnostic criteria for an externalizing disorder at age 9. A comparison group of children who were identified as problem-free at age 3 continued, for the most part, to be well adjusted at age 9. Indeed, behavioral advice is a common request for practitioners from the parents of hard-to-manage children as well as from the “worried well.”

Several parent training programs exist to help families whose children exhibit behavioral problems. Some of these programs are grounded in theory, well-replicated, and offer evidence of successful outcomes related to child behavior and parenting efficacy. Other programs with less empirical evidence but perhaps more obvious accessibility to parents can also be found in the lay media. Parents may ask the practitioner about such programs as they search for behavior management help at their local bookstore or on the internet. The purpose of this article is to briefly review several parent training programs with extensive or preliminary evidence of empirical support. In addition to noting the level of empirical support for such programs, our review will focus on practical issues of importance to busy parents and practitioners—namely how are the programs delivered and how available they are to the parents who need them.

Table 1 includes a selection of parent training programs designed for children ages
continued on page 8

Table 1. Examples of Parent Training Programs

Programs with Extensive Empirical Support			
Program and Primary Author(s)	Examples of Evidence and Sample Populations	How is Program Delivered?	Resources for Practitioners and Parents
Helping the Noncompliant Child ¹ McMahon, Forehand, & Long	Multiple studies of the program's individual components and controlled comparison of program efficacy with children 3-8. ² Evidence reported for children with conduct and compliance issues. Other high risk populations such as children enrolled in Head Start, anxious children, and aggressive children.	Self-help; Community outpatient agency by trained provider, usually as individual family therapy.	Book for parents. ³ Program training for providers --workshops, manual, video. Training details found at www.strengtheningfamilies.org/html/programs_1999/02_HNCC.html
The Incredible Years ⁴ Webster-Stratton, & Colleagues	Numerous studies with random assignment to alternative treatments or placebo groups with long term follow up data. ^{2,6} Evidence reported for children with conduct and compliance issues. Multiple studies with at-risk children including those enrolled in Head Start. Recent studies with children referred through Protective Services and for families with culturally-diverse backgrounds. ⁶	Community outpatient agencies by trained providers, usually as parenting group.	Books for parents; Program training worldwide--workshops worldwide, manuals, extensive collateral materials. Resources in English and Spanish. www.incredibleyears.com
Living with Children ⁷ G. Patterson	Evaluated in controlled studies either comparing with placebo control or wait-list controls. Extensive empirical support with families of children 3-14.	Community outpatient agencies by trained providers.	Books for parents or clinicians ⁷ Program treatment manuals -- Information on program and additional publications at: www.ocls.org .
Parent Child Interaction Therapy (PCIT) ⁸ Eyberg, McNeil, & Colleagues	Extensive empirical support using random assignment with wait-list controls including work in the schools and long term follow up. ^{2,8} PCIT research conducted on an extensive variety of populations including children with conduct problems, mental retardation, and chronic illness. Cross-cultural studies also reported. ⁸	Trained community facilitators; 8 Research and Treatment Labs across the United States (see http://pcit.phhp.ufl.edu)	Program training--workshops, manuals; Parenting handouts and information on program at: http://pcit.phhp.ufl.edu Additional information including international programs found at www.pcit.org .
Programs with Preliminary Empirical Support or Self-help Popularity			
1-2-3 Magic ⁹ Phelan	One large randomized control study documenting improved parenting efficacy and behavior outcomes based on parent report. Sample was middle-class and well-educated with young children. Two unpublished studies (one with children in residential treatment). Details at www.parentmagic.com .	Self-help; Seminars from trained providers in the community.	Books for parents and children, Program training for providers (manuals, videos). Resources available in English and Spanish. www.parentmagic.com
Parenting with Love and Logic ⁴ Cline & Fay	Anecdotal testimonials, no controlled outcome studies. Unpublished research with families in divorce court and juvenile justice system. Details at www.loveandlogic.com/research.html	Self-help; Community programs with trained providers; Seminars held across the country	Books and audio CD's for parents. Program training (workshops, manuals, and videos in English and Spanish). 1-800-338-4065 www.loveandlogic.com

2-12 found in the professional literature and lay media. Shriver and Allen² offer a comprehensive review of evidence-based parent training programs and highlight those included in our table as representing the most effective programs for improving behavioral outcomes in young children. These programs implement similar strategies to assist parents with effective behavior management techniques including direct instruction, modeling, practice, and feedback. Two programs with less empirical evidence, 1-2-3 Magic³ and Parenting with Love and Logic⁴, were included as examples of frequently accessed, self-help programs based on high popularity ratings at Amazon.com.

The fact that behavior problems in preschoolers are predictive of behavior problems later in life has been well-established. Such problems are often brought to the attention of the practitioner during well-child appointments. Parents may also want to discuss resource options such as those found in the self-help media or through local hospitals and mental health providers. Unfortunately, the logistical constraints of a typical provider's practice can place limitations on how effectively one can address such issues for families. This article reviewed several parent training programs, with and without empirical support, which can assist practitioners in referring concerned parents to appropriate resources. The practitioner's initial investment required to identify empirically-supported programs easily accessed in ones' local community is well-worth the time and effort. For those programs without obvious access, contacting program personnel via the provided Web site should be a useful option for obtaining more information (We did in preparation for this manuscript and were pleased with the responses that we received). Such resources improve the likelihood that the child's behavioral issues and parenting efficacy will be improved, resulting in better health and well-being for the family. The interested reader is also referred to Shriver and Allen² and Christophersen and Mortweet⁹ for more comprehensive guidelines on identifying empirically-sound treatment strategies for behavioral issues and other mental health concerns.

References

1. Campbell SB, Ewing LJ. Follow-up of hard-to-manage preschoolers: Adjustment at age 9 and predictors of continuing symptoms. *Journal of Child Psychology and Psychiatry*. 1990;31:871-889
2. Schriver MD, Allen KD. *Working With Parents of Noncompliant Children: A Guide To Evidence-Based Parent Training for Practitioners and Students*. Washington, DC: APA Books; 2008
3. Phelan TW. 1-2-3 Magic: *Effective Discipline for Children 2-12*. 3rd ed. Glen Ellyn, IL: ParentMagic, Inc; 2003
4. Cline F, Fay J. *Parenting With Love and Logic*. Colorado Springs, CO: NavPress; 2006
5. McMahon RJ, Forehand RL. *Helping the Noncompliant Child: Family-Based Treatment for Oppositional Behavior*. 2nd. ed. New York: Guilford; 2003
6. Webster-Stratton C. *Incredible Years: A Troubleshooting Guide for Parents of Children Aged 3 to 8*. Seattle, WA: Umbrella; 2006
7. Patterson GR, Forgatch MS. *Parents and Adolescents: Living Together: Part 1. The Basics*. 2nd ed. Champaign, IL: Research Press; 2005
8. McNeil CB, Hembree-Kigin TL. *Parent-Child Interaction Theory: Issues in Clinical Child Psychology*. 2nd ed. New York: Springer; 2010
9. Christophersen ER, Mortweet SL. *Treatments That Work With Children: Empirically Supported Strategies for Managing Childhood Problems*. Washington DC: APA Books; 2001

About the Authors:



Susan M. VanScoyoc, PhD, ABPP is a faculty member at the University of Phoenix Online, Phoenix AZ. She can be contacted at svanscoyoc@email.phoenix.edu.

Edward R. Christophersen, PhD, ABPP is a Professor of Pediatrics at the Children's Mercy Hospitals and Clinics, Kansas City, MO. He can be contacted at echrist@cmh.edu.

Assistive Technology for Hearing and Speech

By Amy Hasselkus, MA, CCC-SLP, and Pam Mason, MEd, CCC-A
American Speech-Language-Hearing Association

Hearing Assistive Technologies (HATS)

Today, a vast majority of children living in the United States are screened for hearing loss prior to discharge from the birthing hospital. If all goes according to the Joint Committee on Infant Hearing (JCIH) 1-3-6 plan, available at <http://www.asha.org/uploadedFiles/aud/JCIHExecutiveSummary.pdf#search=%222007%22>, these newly identified children will receive a diagnosis of hearing loss by 3 months of age and integrated into early intervention by 6 months of age. During this time period, the families are informed of all communication modalities (eg, listening and spoken language, American Sign Language, cued speech) and hearing technology (hearing aids and cochlear implants). If the family chooses to use technology and a listening and spoken language communication modality, these children may find their way into a mainstreamed classroom.

Even the most advanced technology in hearing aids and cochlear implants cannot provide a perfect hearing solution in less than perfect situations such as a typical classroom. Many factors can affect classroom listening when a child has a hearing loss, including:

- Volume of wanted sound (the teacher's voice)
- Distance from the wanted sound (seat position in the classroom)
- Volume of unwanted sound (noise within the classroom, outside traffic and playground noise, air vents, and noise from other classrooms)

All of these things reduce the signal to noise ratio (S/N ratio). A reduced S/N ratio makes it more difficult for a hearing impaired child with hearing aids or cochlear implants to filter out the unwanted sounds from the signal message.



Hearing Assistive Technology (HATS) can improve the signal to noise ratio. These devices can be used by children using hearing aids and cochlear implants as well as for children with mild hearing loss (not using hearing aids) and others with different types of problems such as auditory processing disorders. The ultimate impact of HATS is to improve classroom performance and ultimately the child's academic achievement over the school years. To learn more about HATS, visit this Web site: http://www.asha.org/public/hearing/treatment/assist_tech.htm

Augmentative and Alternative Communication (AAC)

Augmentative and alternative communication (AAC) includes all forms of communication (other than oral speech) that is used to express thoughts, needs, wants, and ideas. Everyone uses AAC when they make facial expressions or gestures, use symbols or pictures, or write.

People with severe speech or language problems rely on AAC to supplement existing speech or replace speech that is not functional. Special augmentative aids, such as picture and symbol communication boards and electronic devices, are available to help people express themselves. This may increase social interaction, school performance, and feelings of self-worth.

It is important to emphasize that AAC should not take the place of speaking, if the child is able to speak. AAC aids and devices are used, however, to enhance communication when needed.

When children cannot use speech to communicate effectively in all situations, there are options available:

- **Unaided communication systems**- rely on the user's body to convey messages. Examples include gestures, body language, and/or sign language.
- **Aided communication systems** -require the use of tools or equipment in addition to the user's body. Aided communication methods can range from paper and pencil to communication books or boards to devices that produce voice output (speech generating devices or SGDs) and/or written output. Electronic communication aids allow the user to use picture symbols, letters, and/or words and phrases to create messages. Some devices can be programmed to produce different spoken languages.

continued on page 10

Access is the way an individual makes selections on a communication board or speech generating device. There are 2 primary ways that people access AAC:

- **Direct selection-** includes pointing with a body part such as a finger, hand, or toe, or through the use of a pointing device such as a beam of light, headstick, or mouthstick. Those with severe physical impairments may need to access systems by using a switch. The switches can be turned on with a body part, puff of air, or wrinkle of an eyebrow.
- **Scanning-** one type involves the use of lights on a system that pass over each choice and the user activates a switch to stop the light and pick a choice. Other types are auditory scanning and scan patterns (such as row/column, quadrant, step, and linear). Scanning requires less motor control but possibly more cognitive skill than direct selection access.

Selecting the best way to communicate is not as simple as getting a prescription for eyeglasses. It is important to obtain an evaluation by a group of professionals to develop the best communication system to meet your needs. A speech-language pathologist (SLP) is a primary professional involved in the assessment of AAC needs and the programming and use of the device. To locate an SLP for your patients, go to www.asha.org/findpro

For more information on AAC, visit <http://www.asha.org/public/speech/disorders/AAC.htm>.

About the Authors:

Amy Hasselkus, MA, CCC-SLP, is the Associate Director for Health Care Services in Speech-language Pathology at the American Speech-Language-Hearing Association (ASHA). In this role, Amy responds to member and consumer requests for information about policies, clinical issues, and professional issues, as well as develops resources for ASHA's Web site regarding the practice of speech-language pathology in health care settings. She liaisons with external organizations and internal teams, representing the interests of SLPs working in health care. Prior to coming to ASHA, Amy worked with children and adults in a hospital system in Harrisburg, PA. She provided speech, language, and swallowing services in a variety of settings within the system, including inpatient, outpatient, skilled nursing, and home health.



Pam Mason, MEd, CCC-A, is Director of Audiology Professional Practices at the American Speech-Language-Hearing Association (ASHA), Rockville, MD, where she has worked for the past decade. In her role, Pam leads the provision of outreach to consumers and professional support to audiologists and other health care professionals on issues related to hearing and balance. Pam also has a great deal of experience serving as an audiology and hearing expert for media.

Before she worked at ASHA, Pam directed the Audiology Center at the George Washington University Hospital, Washington, DC. During her time there, Pam began a universal newborn hearing screening program and trained residents in otolaryngology and graduate students in audiology.



Section on Developmental & Behavioral Pediatrics

Sponsored Sessions

San Francisco, CA

October 2-5, 2010

Selected Sessions Sorted by Date

For a complete list visit www.dbpeds.org



Saturday, October 2, 2010			
Time	Number	Title	Location
2:00 - 3:30 PM	S1084	Improving Outcomes for Individuals With Cerebral Palsy: What Is New?	Moscone Center 301
4:00 - 4:45 PM	F1123	Understanding Asperger Syndrome and Other Highly Functioning Autisms (Repeats as F2097)	Moscone Center 310
4:00 - 5:30 PM	S1115	Managing Sleep Problems in Young Children (Repeats as S2040)	Moscone Center 302
Sunday, October 3, 2010			
Time	Number	Title	Location
8:30 - 10:00 AM	I2029	Developmentally Informed Pediatric Care: Streamlining the Well-Child Visit	Moscone Center 123
8:30 - 10:00 AM	S2041	What's New in ADHD? (Repeats as S3085)	Moscone Center 102
8:30 - 4:00 PM	H2023	Section on Developmental and Behavioral Pediatrics Program: Bullying: Interpersonal and Electronic	San Francisco Marriott Marquis Golden Gate A
9:30 - 10:15 AM	F2050	Enuresis: To Treat or to Refer? (Repeats as F2131)	Moscone Center 306
4:00 - 5:30 PM	I2106	Addressing Concerns about Children's Speech and Language	Moscone Center 123
4:00 - 5:30 PM	I2108	Children's Drawings: A Picture Is Worth a Thousand Words	Moscone Center 110
4:00 - 5:30 PM	S2117	Helping Parents Find Appropriate Treatments for Children With Autism (Repeats as S3115)	Moscone Center 307
4:00 - 5:30 PM	S2123	Substance Abuse: What the Kids Today Are Using and Abusing	Moscone Center 300
Monday, October 4, 2010			
Time	Session	Title	Location
9:30 - 10:15 AM	F3060	Beyond Developmental Screening: Laboratory Testing of the Child With Delayed Development (Repeats as F3097)	Moscone Center 301
4:00 - 5:30 PM	S3118	Monitoring Psychiatric Medication Use in Youth (Repeats as S4063)	Moscone Center 302
Tuesday, October 5, 2010			
Time	Number	Title	Location
8:30 - 10:00 AM	S4028	The "Out of Control" Child (Repeats as S4086)	Moscone Center 307
2:00 - 3:30 PM	S4060	Depression and Anxiety Disorders: Evaluation and Management in Primary Care (Repeats as S4084)	Moscone Center 122

International Developmental-Behavioral Pediatrics – The PICAN Project

By Vikram Dua, MD

Vibha Krishnamurti, MD, International DBP Editor

It happened one afternoon in July, 2009. I was on vacation and at leisure on a deck over-looking the beautiful mountains and waters of British Columbia, my chosen home. The weather was perfect. I must have had time to read or listen to the news, because I somehow began thinking about international or *big picture* perspectives in my chosen area of specialty – autism and neuropsychiatric conditions.

The global *big picture* for those of us working in child and youth development is a hazy one. But this is how my train of thought went that one afternoon...

“On the one hand we know – for sure – that healthy development is ‘everything’ to sustained good health in life. We know that if we don’t identify and intervene for children with ‘developmental problems’, these problems will almost certainly broaden and generalize - resulting in far worse long term outcomes. We know that the combined prevalence of developmental and psychiatric problems in childhood and youth does not differ that much across the world – they are equally high anywhere – at least in the range of 15%, and likely more. We also know that corrective interventions for appropriately identified children can result in functional gains of at least 1 and perhaps 2 standard deviations – no small change. However, despite the last decade’s successes of Western nations to address this need, we know the same is not true for the majority of the children of the world.”



I was born in India, and spent a number of key years of my childhood living there. I had been in India again during medical school working on a research project in child development. On another previous trip, I had visited and lectured at some leading academic autism centers in India. My family had also really enjoyed the extended journey of India a few years back. So, talking about all these things, on that warm July afternoon, my wife and I decided to take our family back to South Asia for a “Discovery of Autism in India.”

I hoped our experience this time around would be more than just visiting and observing – I wanted to do real work and participate in something that was meaningful to local kids, families, and professionals. I wanted work that allowed me to utilize what I still sometimes view as a unique, or even obscure, professional skill-set in the developing world. In truth, I was a bit doubtful that my area of interest—autism and child neuropsychiatric disorders—was even on the *public health radar* in countries like India. After all, weren’t there “bigger” problems in public health that commanded public policy attention? [I was to learn within a few hours of my arrival in Mumbai that indeed autism spectrum disorders are very much on the *public radar* in India. Concurrent with my arrival was the release of the Bollywood hit, *My Name is Khan*, in which the lead character has an autism spectrum disorder (ASD)].

I also wanted to concentrate my time outside of formal academia – working with front-line professionals and non-governmental organizations (NGO’s). The problem was that I only knew a few people in India that fell into that category. So next I found an Indian autism Web group that gets a great deal of traffic from a wide variety of parents, professionals, and other interested parties (autismindia@yahoogroups.co.in). I posted a notice with my credentials and availability to volunteer my time. Within a few weeks I received several dozen interesting and worthwhile inquiries. In the email, telephone, and Skype™ exchanges that followed, I discovered great enthusiasm for more knowledge about child mental health in general, and disorders like autism in particular. It also became pretty clear how my skills would be best used just doing what I already knew how to do—a combination of seeing kids and families, medical education/professional training, public awareness talks, and ultimately capacity-building.

I quickly realized that a meaningful project meant that I needed a team and strong local partnerships. And I have been humbled by the generosity of colleagues who donated so much of their time. In North America, Karen Kalynchuk (Director, *Provincial Autism Resource Center*, Vancouver), along with project co-leads Dr. Jennifer Olson (psychologist/trainer from Chicago, Illinois) and Lawrence Sparling (IT consultant/developer from Vancouver, BC) who committed weeks of their lives - even after I told them I couldn’t pay them anything. In South Asia, many professionals from more than a dozen centers/NGO’s contributed countless hours in organizing local events and recruiting trainees and families. Particularly essential was the contribution Dr. Nandini Mundkur, a Developmental Pediatrician in Bangalore, and the key Indian project co-lead. Dr. Mundkur (Director of the *Center for Child Development and Disability-CCDD*) along with Jayshree Ramesh (Director of the *Academy for Severe Handicaps and Autism-ASHA*)

continued on page 13

were instrumental in arranging space, subjects, and other needed supports for the autism training institute (see below). Other key partners across South Asia included Ritu Juneja, PhD (*Tamana*, New Delhi), Gauri Divan, MD and Vikram Patel MD, (*Sangath*, Goa), Sunita Amatya, MD and Hem Baral, PhD (*AutismCare Nepal*, Kathmandu), Nandita De Souza, MD (*Sethu*, Goa), Merry Barua (*Action for Autism*, New Delhi), and Vibha Krishnamurthy, MD (*Ummeed*, Mumbai), amongst many others. All of us came together under the banner of *PICAN* (for the *Provincial Autism Resource Center Indo-Canada Autism Network*).

In the weeks and months that followed we decided on goals, activities, and timeframe for a 2010 project. The objectives of *PICAN* were to enhance public awareness and professional knowledge, provide direct expert consultation to children and families, increase capacity for autism research and service, and ultimately direct more children to the most effective interventions. Between February and April, 2010, we travelled to Mumbai, Goa, Bangalore, New Delhi, and Kathmandu where we held volunteer clinics, public lectures, and a professional training institute (see below).

There was the small matter of costs and funding. I had planned to volunteer my time, as did my North American and Indian colleagues. However there were some fixed costs that could not be “volunteered” - especially costly gold-standard *and* copyright training and assessment materials. Few centers had any of the materials. I did not believe that we could provide any useful training unless we stuck with the best tools, but knew we had to provide a means for the local teams to be able to continue to do the work once we left. It would cost at least \$2000 to outfit just 1 center with the requisite testing materials (to put this figure into perspective, one has to remember that clinics often provide complete diagnostic assessments for less than \$50!). Again, generosity saved the day when the clinic where I work in Vancouver – the Provincial Autism Resource Center (PARC) - came forward to donate Autism Diagnostic Observation Schedule (ADOS) kits, manuals, protocols, and training kits - without which the training arm of the project would have been impossible.

2010 PICAN Activities:

Expert Volunteer Clinics in 5 Cities

- Over 80 children and youth and their families counseled

Public Awareness Campaign

- Public lectures in 5 cities
- Engagement of key Indian policy makers and autism advocacy agencies
- PICAN activities draw media attention

Interactive Training Workshops for Paraprofessionals

- Directed at teachers, community health visitors, special educators, CDC and mental health clinicians

10 Day Clinician/Researcher Autism Training Institute

- Gold-standard assessment tools and procedures, including Autism Diagnostic Interview-Revised (ADI-R) and ADOS
- Trainees divided evenly between “research-reliable” and “clinical gold-standard” streams.

The cornerstone of the project was clearly the professional training institute in Bangalore. For 10 hot days, 14 clinicians and researchers of varied disciplines from 9 different centers attended intensive training in autism gold-standard diagnostic and clinical assessment practices. Even though many logistics were not what I had envisioned (like the “concrete bunker” training site and the barebones IT), this did not stand in our way - we were a driven group and the training was enormously successful. Not only did we effectively triple the number of Indian sites with gold-standard assessment capability, in written evaluations trainees consistently gave approval ratings of over 90% (mean rating over 4.5/5). It is also worth highlighting the days upon days of time donated by the trainees – either of their own, or through support from their sponsoring agency.

PICAN 2010 Trainees:

- Prachi Acharya, Pediatrician, *CCDD*, Bangalore
- Priti Bakre, Psychiatrist, *Sethu*, Goa
- Reena Bhattacharya, Psychologist, *Tamana*, New Delhi
- Gauri Divan, Pediatrician, *Sangath*, Goa
- Padma Lochani, Pediatrician, *Madhuram Narayanan Centre*, Chennai
- Supriya Malik, Psychologist, *Tamana*, New Delhi

continued on page 14

- Nandini Mundkur, Pediatrician, *CCDD*, Bangalore
- Santosh Nimbalkar, Pediatrician, *Sanwad CDC*, Kohlapur
- Chitra Sankar, *Pediatrician, CCDD*, Bangalore
- Savitha B.S., Special Educator, *CCDD*, Bangalore
- Rena Shrestha, Psychologist, *AutismCare Nepal*, Kathmandu
- Nidhi Singhal, Psychologist, *Action for Autism*, New Delhi
- Roopa Srinivasan, Pediatrician, *Ummeed*, Mumbai
- Vivek Vajaratkar, Occupational Therapist, *Sangath*, Goa

Ultimately, *PICAN* partnered with dozens of leading professionals from all disciplines and from all corners of South Asia. I “discovered” a great deal as well, some, a confirmation of the global nature of the conditions we deal with, and some of it speaking to the unique ethno-cultural variations in clinical/phenotypic presentations.

Discoveries of Autism in India:

- There is great enthusiasm for more knowledge about child mental health in general, and disorders like autism in particular in South Asia.
- There is an urgent clinical and research need to increase autism assessment capacity in South Asia. However, in order for this to be meaningful to children and families, efforts to enrich assessment resources must go hand-in-hand with developing and expanding intervention resources.
- In the majority of India, at this time, inclusive education remains only a conceptual target.
 - Many children with disabilities are not able to find educational placement, and simply remain at home.
- The value placed by Indian parents on “academic achievement” can overshadow attention to the core challenges that impact individuals with autism.
- Terms like “high-functioning”, “classical” or “mild” autism, problematic even in the West, are essentially useless in India where they are used in a very different manner.
- Individuals with ASD without significant intellectual disability remain largely unidentified in India at present, which must be taken into consideration in future planning, training, and research activities.
- Compared to my practice in Canada, challenges with aggression or self-injurious behavior, though not absent, are surprisingly limited in patients I saw. The reasons for this are not fully clear, but worth understanding.

So here I am again, in July, and on a deck in British Columbia, the weather less perfect than last year. Although the 2010 project is complete, *PICAN* has continued. For one thing, most trainees are participating in a 1-year *online* mentorship with either me or Dr. Olson. We know that professionals cannot learn how to assess autism solely by attending a workshop. Adult learners require ongoing mentoring and feedback as they exercise their skills. At home we would support trainees after the initial workshop by monitoring and supervising them in clinical or research settings, something that is obviously not logistically feasible across 2 continents. Thus we are creating a Web-based information sharing system that will allow trainees to send video and other documentation of their assessments to us regularly, to allow us to review and then provide feedback. We are also working to develop an online community with regular dialogue and video-conferencing. In truth, this last piece has been the most challenging to create, at least in part because of our essentially null budget and the complexity of the technology.

This is also where *PICAN* enters *Phase 2*. The overwhelming success of the 2010 project has spawned enthusiasm to continue and expand on the base we have created. Not only would I like to improve the Web-based networking capability of *PICAN*, but also to return to India in 2011 to continue and extend our activities. In particular, we would like to host a second training in autism assessment and diagnosis (including a ‘refresher’ for the 2010 graduates), but also focus on increasing autism intervention capacity, by offering training in evidence-based developmental, educational, and medical interventions. We also want to expand the public awareness efforts, and further engage government and other stakeholders.

As above, this kind of project can only be done with supports and partners. I would invite anyone is interested in contributing or learning more about *PICAN*, to please contact me at vikram.dua@ubc.ca.

continued on page 15

If you are interested in engaging in a venture like this one, here are some tips:

- Identify your unique skill-set(s) that may be in demand in the setting you want to go to.
- Expect a combination of activities: it is unlikely that a purely “clinical” exercise will work out; but some clinical work can be richly complemented by focused training, public education, or small projects.
- Be flexible and adapt your plans to ensure they are locally meaningful activities.
- Establish at least 2 or 3 strong partnerships locally and utilize them to do some of the preparatory logistics.
- If it is possible, for a few months beforehand, add a half day or more per week to what you normally work in order to compensate for the lost income while you are away (or at least continue to pay your bills!).
- Ask colleagues or clinics in your area to donate materials; even older versions of some instruments are in still in high demand in developing settings, and are likely just collecting dust in storage back home.
- Devise a means for effective communication with your international partners after you return.

*Notes from the International DBP Editor: **Vikram Dua, MD** is a child and adolescent neuropsychiatrist based in Vancouver, Canada, with a specialized expertise in autism spectrum disorders. Dr Dua is on the faculty at the University of British Columbia, and practices out of the BC Children’s Hospital.*

Worried Well and Behavioral Health

By Beth G. Wildman, PhD

What Does “Worried Well” Mean in Regard to Behavior Problems?

Pediatricians have to address parents’ concerns about their child’s physical, behavioral, and developmental status daily. Many of the concerns raised by parents are about observations of their child that are typical and appropriate and pediatricians routinely and appropriately provide assurance and education to parents. Some parents raise concerns more than others. Parents who frequently raise concerns about normative events and/or observations are often labeled as “worried well.” Also among the “worried well” are children whose behavior does not meet criteria for a problem on standardized screening measures for child behavior problems, such as the Strengths and Difficulties Questionnaire¹, Pediatric Symptom Checklist², Eyberg Child Behavior Inventory³, but whose parents raise concerns to the pediatrician about their child’s behavior.

Does “Worried Well” Make Sense in Regard to Behavioral Health?

Answer: “No” or “Rarely.”

- (1) If parents are concerned or bothered about their child with typical behavior or subsyndromal behavior problems, then that parent is likely to use parenting approaches and/or discipline methods that resemble those used by parents of children with clinically significant behavior problems.⁴
- (2) If the parent is bothered by their child’s behavior, anxious, or worried, they are less likely to perceive themselves as effective or satisfied as parents.⁴
- (3) Subsyndromal behavior problems are likely to maintain over time and interfere with child’s functioning at home, school, and with peers.⁵

Data on Child Behavior Problems, Parent Concern, and Outcomes

Some parents who are bothered about their child’s behavior in the absence of clinically significant behavior problems may be anxious or depressed; others may lack sufficient information about typical development, have unrealistic expectations of their child, and/or be concerned that their child is not developing as they expect/anticipate. While some of these concerns are appropriately managed with assurance and anticipatory guidance, data increasingly support that when a parent is bothered by their child’s behavior

continued on page 16

ior, the pediatrician should view the child as at risk for behavior problems and should view the parent's concerns as an early warning of problems that merit follow up, perhaps with screening and/or referral to a behavioral specialist for evaluation.^{4, 6}

Concerns raised by parents are likely to either reflect problematic child behavior, delayed development, and/or parenting practices that are likely to result in maintenance or exacerbation of the problem. The construct of "worried well" and the practice of watchful waiting are not generally appropriate for management of behavioral and developmental concerns raised by parents. Interventions for developmental problems are likely to be most effective when they are initiated early, especially prior to 3 years. Encouraging and teaching appropriate parenting practices are likely to decrease behavior problems, prevent the development of more severe behavior problems, and improve functioning in school, home, and with peers, and decrease parental stress and depression, which are also associated with negative outcomes for children.



In a recent study, parents of children who did not meet criteria for a clinically significant behavior problem, but reported concerns about their child's behavior were similar to parents of children with significant behavior problems with regard to parenting practices, reporting both overreactivity and laxness in response to their child's inappropriate behavior.⁴ These parents also reported reduced satisfaction and efficacy in their role as parents, similar to parents of children with behavior problems. These parents who report concerns about their child's behavior even though their child does not exhibit clinically significant behavior problems might be considered "worried well." Yet, their parenting practices and perceptions of themselves as parents resembled those of parents of children with clinically significant behavior problems, suggesting that their children are at risk for developing behavior problems. Rather than considering these parents as "worried well," pediatricians should view the discrepancy between the parents concerns and child behavior as an indication of risk for the development of significant behavior problems if the parents are not taught more effective parenting skills that will improve child behavior, as well as parent efficacy, satisfaction, and emotional well-being.

What About Parents of Children With Problem Behavior Who Are Not Concerned?

These parents also resemble parents who have children with clinically significant behavior problems in their use of ineffective parenting approaches that are either overreactive or lax and report a decreased sense of satisfaction as parents. Interestingly, they are more likely than parents who are concerned in the absence of child behavior problems to report feeling efficacious as parents. These parents would be less likely to admit feeling overwhelmed or irritated by their child's behavior.

What Can Pediatricians Do?

There have been calls for pediatricians to screen all children for behavior problems, given that approximately 20% of children meet criteria for a behavioral or emotional problem. In light of findings that children whose parents are bothered by their child's behavior even when the child's behavior problems are not clinically significant, a negative score on a screening measure is not sufficient to rule out risk for behavior problems that merit attention and treatment. Pediatricians are in an excellent position to appropriately assess and manage both children with clinically significant behavior problems as well as children at risk for developing behavior problems before they become clinically significant.

Implications of research findings for routine assessment and management of children's behavior:

1. Ask parents whether their child has behavior problems. Using standardized screening measures, such as the Strengths and Difficulties Scale, Pediatric Symptom Checklist, Eyberg Child Behavior Inventory, as well as others, would be helpful.
2. Ask parents if their child's behavior is a problem for the parent and/or if they are bothered or concerned about their child's behavior. Ask parents if their child's behavior is a problem for them even if children do not meet criteria for clinically significant behavior problems.
3. Children of parents who say "Yes" to **either** (1) presence of behavior problems or (2) concern/bother should receive further evaluation of the child's behavior and the parent's parenting practices.
4. Ask about parenting practices, including how the parent reacts when their child misbehaves. Ask if they tend to yell quickly and often. Ask if they tend to ignore problems or decide not to have consequences for inappropriate behavior. If parents over-

continued on page 17

react or do not have consequences for inappropriate behavior, refer them for behavioral parent training. Remember to ask parents whether they give positive reinforcement and praise for appropriate behavior.

5. Ask parents how they feel about their role as parents. Ask about their satisfaction and sense of efficacy as parents. Parents who report poor satisfaction and/or efficacy should be referred for behavioral parenting training.

There is a tendency for pediatricians to manage behavioral concerns with watchful waiting before evaluating and/or managing behavior problems. There is also a notion that children will outgrow their behavior problems, in spite of data indicating that behavior problems, even those that are subsyndromal tend to be stable.⁵ The practice of watchful waiting, particularly when the parent expresses concern in the absence of significant behavior problems, leaves the child vulnerable to developing behavior problems that will adversely affect their functioning in key areas of their lives, including school and social relationships. This approach of watchful waiting and lack of intervention for subsyndromal problems is in direct contrast to current foci on improving child health and preventing illness, rather than treating illness. There has been much focus on prevention of health problems and health promotion. For example, pediatricians have been proactive in addressing a variety of public health concerns. For example, pediatricians routinely teach parents to encourage appropriate eating and exercise in their children who do not meet criteria for obesity, but may be sedentary or eat diets high in fat and calories, even if their child's weight is currently in an acceptable range.

While use of anticipatory guidance about what to expect from a child's behavior and avoiding use of corporal punishment is a positive step, research indicates the need for more aggressive and consistent assessment and management of behavior problems and parenting practices and attitudes. Behavioral parenting practices are effective and efficacious for managing children's behavior and preventing future behavior problems.

References

1. Goodman, R. The Strengths and Difficulties Questionnaire: A Research Note. *J Child Psychol Psychiatry*. 1997;38:581–586
2. Jellinek MS, Murphy JM, Burns, BJ. Brief psychosocial screening in outpatient pediatric practice. *J Pediatr*. 1986;109:371–378
3. Eyberg S, Pincus D. *Eyberg: Child Behavior Inventory & Sutter-Eyberg Student Behavior Inventory – revised*. Odessa, FL: Psychological Assessment Resources; 1999
4. Lampe EM, Karazsia BT, Wildman BG. Identification of Families At-Risk for Behavior Problems in Primary Care Settings. *J Dev Behav Pediatr*. 2009;30:518–524
5. Costello EJ, Shugart MA. Above and below the threshold: severity of psychiatric symptoms and functional impairment in a pediatric sample. *Pediatrics*. 1992;90:359–386
6. Glascoe FP, MacLean WE, Stone WL. The importance of parents' concerns about their child's behavior. *Clin Pediatr*. 1991;30(1):8–11

About the Author:

Beth G. Wildman, PhD is a Professor of Psychology at Kent State University, where she coordinates training graduate students in clinical child and pediatric psychology. She conducts clinical research collaboratively with pediatricians at Akron Children's Hospital and is involved with research training of their developmental-behavioral pediatrics fellows. Her primary research focus is on improving primary care pediatricians' identification and management of behavior problems.

The Autism Treatment Network: Exploring the Medical Aspects of Autism Spectrum Disorders

By Daniel Coury, MD, FAAP

The Autism Treatment Network (ATN) began as a joint venture between the Northwest Autism Foundation in Oregon and Massachusetts General Hospital for Children in Boston. Initially their association focused on specific medical issues commonly experienced by children with autism. In the course of their studies they concluded that medical care for individuals with autism was far from ideal. Much of the problem was due to the lack of any organized group devoted to defining a high standard of medical care for autistic patients. The ATN was intended to fill this need, so its initial formation included the recruitment of a group of distinguished physicians and researchers who would define its mission and goals. Another organization, Cure Autism Now, recognized that this innovative network could play a valuable role in its own mission to identify the means of preventing, treating, and ultimately curing autism. To this end, Cure Autism Now joined forces with the Autism Treatment Network, incorporating it as one of its key research programs. Cure Autism Now and Autism Speaks subsequently merged with the National Alliance for Autism Research bringing together the 3 leading organizations dedicated to accelerating and funding research into the causes, prevention, treatments and cure for Autism Spectrum Disorders (ASD). In 2007, Autism Speaks undertook an expansion of the ATN through a competitive grant application process. This expansion resulted in the current ATN, consisting of 14 sites across the United States and Canada.

The ATN is the nation's first network of hospitals and physicians dedicated to developing a model of comprehensive medical care for children and adolescents with autism. The ATN offers families care from doctors highly experienced in helping individuals with autism and providing treatment for associated conditions such as gastrointestinal and sleep disorders. ATN doctors are dedicated to finding better ways to manage the health of children with autism and sharing their increasing knowledge across the wider medical community. In particular, the ATN is dedicated to developing better ways to identify, manage, and treat the physical health conditions of children with autism. Some of this work is described further here.

Gastrointestinal (GI) problems. There is a good deal of controversy surrounding GI problems in children with ASD. Smith, Farnworth et al (*Autism 13(4): 343-355, 2009*) compared bowel symptoms in children with autism to children with other developmental and neurological disorders as well as to typically developing children. They found children with autism did indeed have more bowel symptoms than typically developing children, but at rates similar to children with other developmental disorders. Ibrahim et al (*Pediatrics 124: 680-686, 2009*), in a large retrospective chart review, felt that there was not an increased incidence other than for constipation and food selectivity.

Upon entry into the ATN Registry, families complete a battery of questionnaires assessing possible gastrointestinal, sleep, neurologic and other symptoms. Review of over 1,200 questionnaires addressing GI symptoms found 45% of children in the ATN have GI complaints ranging from abdominal pain to GERD. Whether this is more frequent than the general population or not, the important point is that children with ASD merit the same attention to GI symptoms as typically developing children with GI symptoms. This has been a concern of many parents of children with ASD, and has been recently addressed (*Pediatrics. Jan; 125 Suppl 1:S1-29, 2010*). The ATN is presently evaluating an algorithm for management of constipation, and the data obtained from this will lead to evidence-based consensus statements in this area.

Sleep Problems. Difficulties with sleep are another problem area commonly reported by parents. In the ATN population, the Child Sleep Habits Questionnaire (CSHQ) is used to identify sleep disorders. Analysis of over 1,200 completed CSHQ found that 65% of children and adolescents with ASD had problems with sleep, ranging from initial insomnia to night waking to early waking. As with GI symptoms, there is a need to address these symptoms and it isn't always clear how far the clinician needs to go in evaluation – does each require a sleep study, should medication be used? Beth Malow, MD and colleagues have shown that non-pharmacologic methods can be effective in many children and adolescents with ASD. As with typically developing children, good sleep hygiene is essential. Their work, and work of others, has shown that families of children with ASD require significant support in their establishment and maintenance of bedtime routines to promote better sleep onset. Dr. Malow and others in the ATN are studying methods of providing families with the information and training needed to manage insomnia in children with ASD.



continued on page 19

Complementary and Alternative Medicine. Complementary and alternative medicine is a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine. Use of complementary and alternative medicine (CAM) is common in the United States. The National Health and Nutrition Examination Surveys (NHANES) in 2007 indicated that 38% of adults report CAM use, and 12% of children are receiving CAM. Data from the ATN Registry show that 250 of 1,212 (21%) children were receiving CAM, with 201 of these (17% overall) receiving special diets. The most common of these is the gluten free, casein free (GFCF) diet, used by 53% of CAM families or about 8.5% overall in the ATN. Other surveys have indicated higher rates of use. Recently, a review of the literature failed to find consistent proof of efficacy for the GFCF diet in the treatment of children with autism (*Pediatrics. Jan; 125 Suppl 1:S1-29, 2010*). A recent report of a randomized, controlled trial of the GFCF diet including periodic dietary challenges failed to identify any benefit for this population. Other reported CAM treatments included probiotics, vitamin and mineral supplements, and digestive enzyme supplements. The use of highly controversial treatments such as heavy metal chelation and hyperbaric oxygen therapy were reported in less than 1% of families.

The ATN Registry, like the Interactive Autism Network (IAN), provides information regarding children and adolescents with ASD across multiple domains—medical symptoms, cognitive abilities, and treatments reported. However, the ATN also provides an opportunity to pilot and evaluate new treatments (eg, nonpharmacologic treatment of insomnia), evaluate management recommendations to acquire evidence for better guidelines for clinical care (current work on constipation and insomnia), and develop better descriptions of health status (nutrition status, health related quality of life). Findings from the ATN are beginning to be disseminated through pediatric research meetings and publications, and there are plans to present workshops on providing a medical home for these children and their families. The ATN is working with the AAP Section on Developmental and Behavioral Pediatrics and the Council on Children With Disabilities to cultivate joint activities surrounding consensus statement development, assembling materials for clinical toolkits, workshops, and other opportunities to promote better care for this population.

About the Author:

Daniel Coury, MD, serves as chief of the Section of Developmental and Behavioral Pediatrics, and Administrative Medical Director for Behavioral Health for Nationwide Children's Hospital in Columbus, Ohio. He is a member of the Section on Developmental and Behavioral Pediatrics (SODBP) and the Council on Children with Disabilities (COCWD). His past work with AAP includes participating in the Bright Futures Education Center project, serving on the *Pediatrics* editorial board, and presenting workshops and lectures at several AAP CME activities. His current academic focus is in his role as Medical Director for the Autism Treatment Network.

Tips for Recognizing and Helping Children Who are Bullied

By Marcia Kelly and Julie Hertzog, PACER Center

When a pediatrician sees a patient with stomachaches, headaches, anxiety, depression, unexplained bruises, sleep problems, temperament changes, or school avoidance, a number of causes might come to mind. To pinpoint an increasingly common reason for such symptoms, the best diagnostic tool might be a question: “Are kids picking on you?”

Bullying is a pervasive and growing problem for children and teens—and it can have devastating physical and emotional effects. An estimated 160,000 children in the United States stay home from school each day to avoid bullying. As headlines increasingly remind us, too many cases of bullying end in the tragedy of suicide.

Primary care and developmental-behavioral pediatricians are in a unique position to identify and provide appropriate support to patients who may be affected by bullying. While children and teens may be too afraid, insecure, or ashamed to tell friends or family members they are being bullied, they may be willing to open up to a trusted doctor.

The following information is from the PACER Center’s National Bullying Prevention Center, which offers support and helpful information for professionals, parents, elementary school children, and teens. Its resources include 2 helpful Web sites for teens and children, PACERteensagainstbullying.org and PACERKidsAgainstBullying.org, in addition to its primary Web site, PACER.org.



Who Is At Risk?

Although any child can be bullied, children at highest risk of being a target are “different” in some way. They might have a different ethnic background, language, religion, disability, or appearance than other students in their school or neighborhood. Such differences can be the first thing a child who bullies notices. Difference alone, however, does not necessarily lead to bullying. Children who bully want someone who responds in a manner that allows them to feel powerful.

As a physician, you may want to look for the 4 traits common to targets of bullying.

- *They act vulnerable.* When bullied, they become visibly frightened, cry, or do not have an appropriate response. That is just what the child who bullies wants, so it becomes an invitation to even more bullying.
- *They have few or no friends.* Children who are socially isolated make easy marks. The child who bullies knows no one is likely to come to their aid.
- *They are not assertive.* To a child who bullies, people who are not assertive seem weak or easily dominated. They are also less likely to tell someone about the abuse, and that works in favor of those who bully.
- *They have low self-esteem and lack self-confidence.* Children with low self-esteem may feel they deserve the abuse.

If a child with these traits also has symptoms that suggest bullying, you may be able to confirm your suspicion by encouraging the child to talk with you.

What You Can Do?

If you suspect bullying:

- *Broach the subject gently.* Children may not answer candidly when asked if they’re being bullied. They may, however, begin to talk if you approach the subject indirectly. You might, for example, ask your patient:
 - o How is your bus ride to school?
 - o Who do you sit by at lunch?
 - o I notice that you seem to be feeling sick a lot and wanting to stay home; please tell me about that.
 - o Are kids making fun of you?

continued on page 21

- o Are there a lot of cliques at school? What do you think about them?
- o Has anyone touched you in a way that did not feel right?

You also could start the discussion by talking about recent bullying stories in the news, on YouTube or TV, or in a movie.

- *Listen patiently.* Children may not be ready to open up right away. They may fear retaliation from the bully or think that even if they tell an adult, nothing will change. In addition, children with some disabilities may not have the skills to communicate effectively or fully understand they are a target. Likewise, children whose families are from other countries may face linguistic or cultural challenges in communicating about bullying. In all these cases, the children may just say someone at school makes them “feel bad.” Bridging the communication gap is an important way you can address the issue and offer the child an avenue for support.
- *Believe and be supportive.* Children who are bullied need adults who believe them when they tell. If patients report bullying, one of the most important things you can do is to remind them it is not their fault and they do not deserve to be bullied. Avoid judgmental comments about the patient or the child who bullies. Your patient may already be feeling isolated, and negative statements may only increase that feeling.
- *Explore the issue.* Bullying is when a person with more power hurts another person with less power on purpose. The power imbalance can be physical, social, intellectual, or any other measure that results in one person having an advantage over another. Bullying can be physical, verbal, emotional, social, or sexual. The use of technology such as cell phones, texting, e-mails, instant messaging, or social networking sites to harass another child is called cyber bullying.

If you suspect a child may be a target, these questions can help you and the child determine if the problem is a misunderstanding, a routine childhood conflict, or bullying:

- o Did the child hurt you on purpose?
 - o Was it done more than once?
 - o How did you feel about what happened?
 - o Did the child know you were being hurt?
 - o Is the other child bigger than you or scary to you in some way?
- *Provide information about bullying and strategies for dealing with it.* When patients confide they are being bullied, empowering them to respond appropriately is one of the most important things you can do. Begin by reminding your patients at a level they can understand that if somebody hurts their body or their feelings on purpose, it is bullying.

You can then discuss options the child may have in dealing with bullying behavior. If possible, enlist the support of the parents. Depending on the situation and on the child’s age, abilities, and comfort level, you might offer this advice.

- o *Stay away from where bullying happens.* Kids who bully want to get you into unsafe areas where they can be in control. If you avoid danger spots, you’ll be safer.
- o *Stick with others.* Kids who bully are less likely to do anything if you’re with someone else.
- o *Don’t react visibly to the bullying, even if you feel scared or sad.* Acting upset only gives people who bully what they want. Save your feelings for later, when you’re in a safe place with people you trust.
- o *Yell or do something unexpected.* Kids who bully just want you to feel bad. They don’t want to attract attention or have to deal with surprise behavior.
- o *Tell a trusted adult*—a teacher, doctor, principal, counselor, parent, or relative, for example. Adults can help you figure out a plan of action and support you.
- o *Give some facts.* Sometimes kids bully because they don’t understand why someone is different. For example, explaining that you wear glasses because you have an eye disease that hurt your vision might help.
- o *Be direct.* If someone bullies you, say you don’t like it. It lets kids who bully know you don’t accept what they say and they’re not in charge.

continued on page 22

Tips for Recognizing and Helping Children Who are Bullied *continued from page 21*

- o *Stay safe in cyberspace.* Avoid putting personal information in texts, social networking sites, and the like. Others can use it to hurt you. If you are being cyber bullied, learn about ways to document the harassment and respond through legal channels if necessary.

Conclusion

All too often, adults hold harmful views of bullying. Common beliefs are that it's no big deal and a natural part of childhood; that boys will be boys, girls don't bully, words will never hurt you, some people deserve to be bullied, and being bullied will make you tougher.

All of those views have been proven untrue. In fact, research clearly shows that bullying damages self-esteem, increases anxiety, puts children at physical and mental risk, can result in missed school, and can lead to suicide.

The old advice to "ignore it" doesn't work. Ignoring a problem doesn't make it go away. In fact, it can give problems time to worsen.

Children and teens who are bullied need support from trusted adults. Primary care and developmental-behavioral pediatricians can play a unique role in identifying bullying; teaching children and youth how to respond effectively to it; and providing support, information, and resources to parents so they can protect their children. PACER's National Center for Bullying Prevention offers the resources that children and adults can use to put an end to bullying.

Resources

- "Bullying Fast Facts" (PACER.org/publications/bullypdf/BP-11.pdf)
- "Talk with Your Child about Bullying" (PACER.org/publications/bullypdf/BP-2.pdf)
- "Your Three-Step Plan to Stopping Bullying" (PACER.org/publications/bullypdf/BP-12.pdf)
- "What Every Kid Needs to Know about Bullying" (PACER.org/publications/bullypdf/BP-10.pdf)
- "Weight Status as a Predictor of Being Bullied in Third Through Sixth Grades" [*Pediatrics*. 2010;125(12):e1301-e1307]

Web Links

- PACERKidsAgainstBullying.org (for elementary school students)
- PACERTeensAgainstBullying.org (for middle- and high-school students)
- PACER.org/bullying (for parents, educators, and other adults)

About the Authors:

PACER Center's National Center for Bullying Prevention unites, engages, and educates communities nationwide to prevent bullying through creative, relevant, and interactive resources. Learn more at PACER.org/bullying or call 952-838-9000.

Editors Note: *The 2010 Section on Developmental and Behavioral Pediatrics Program at the AAP National Conference and Exhibition is on "Bullying: Interpersonal and Electronic." This session will take place on Sunday, October 3, 2011. Visit www.dbpeds.org for more specifics.*

Developmental-Behavioral and Primary Care Pediatrics: A Time for Collaboration

By Martin T. Stein, MD, FAAP and J. Lane Tanner, MD, FAAP

The historical roots of Developmental and Behavioral Pediatrics (DBP) derived from the work of a small group of academic general pediatricians who recognized that psychosocial principles and practices are at the core of primary care pediatrics. They concluded that this field of pediatrics would be most effectively taught by pediatricians with specific training. These discussions began in the last 1960's.¹ The results included fellowship programs, an academic journal, and a cadre of pediatricians who focused their work on research and education in DBP. As newly trained development-behavioral pediatricians focused their teaching efforts on residency training, the importance of this effort was reflected in a requirement that at least 1-month of a pediatric residency be devoted to learning about normal and abnormal development and behavior in children and adolescents.



Contemporary pediatricians and other primary care child clinicians are more attentive to the assessment of development, behavior, and parent-child interactions during well child visits.²

The recent publication by the AAP of *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (3rd edition)* is a testimony to the commitment of the pediatric community in these areas.³ It is a comprehensive manual on how to format each well child/adolescent visit with detailed and focused recommendations about developmentally appropriate preventative topics at each encounter. If it is incorporated into resident training programs in a systematic way, it should improve the quality of well child pediatric practices. *Bright Futures* has a strong emphasis on the use of screening instruments for the early detection of developmental delays and behavior problems. Another major feature is the recommendation that each well child visit begin with 5 priority topics that guide the clinician's observations, questions, and anticipatory guidance. *Bright Futures* also demonstrates how to extend the walls of the primary care office into the community by knowing about a broad range of community resources for children and families.

Recently, pediatricians have been calling for a "rethinking of well child care."⁴ What are the goals of a well child visit? What is the evidence-base for the use of screening tools and various preventive counseling topics? Are our current office and clinic settings the most effective and efficient way to provide well child care?

The core of a well child visit is focused on an assessment of a child's development, family function, and social maturation as well as counseling and anticipatory guidance in these areas, nutritional guidance, and a safe environment. Many pediatricians, especially those who are members of the AAP Section on Developmental and Behavioral Pediatrics, are keenly aware of the importance of knowledge about normal development and behavior when conducting an effective well child visit. There is an expanding group of primary care pediatricians who have a special interest in development and behavior. The availability of the biannual 5-day course in Developmental and Behavioral Pediatrics sponsored by the AAP and the Society for Developmental and Behavioral Pediatrics is an opportunity for primary care pediatricians to advance their clinical skills in this field.

In order to gain insights into the way pediatricians make use of their knowledge about child development and behavior during well child visits, we moderated a series of focus groups of primary care pediatricians throughout the country. Thirty-one focus groups (7-12 participants per group) met to share their perspectives and experiences about well child care visits.⁵ One of the most consistent findings in response to the question, "What is the aspect of your well child visits that makes you most effective with children and families?" was that most pediatricians responded that the quality of the relationship with the child and parents is the most important component. Knowing a child and the family centered on the value of relationships. Participating pediatricians told us that the quality and sustainability of the clinician-parent-child relationship was the most important source of effective well child care. In separate focus groups with parents, they independently agreed with pediatricians.⁶ Both parents and pediatricians observed problems that result from not eliciting and responding to a parent's main concerns. However, studies that look at topics of importance in well child care visits rarely include an analysis of what makes an effective clinician-patient relationship, how it can be taught and how it shapes responses in parents, children, and youth. We should be able to find methodologies that answer these important questions.

Pediatricians in the focus groups also emphasized the importance of embedding well child care within efficient and integrated systems of care—both within the office practice as well as community linkages. Examples given of changes made within practices

continued on page 24

included: pre-visit paper and Web-based informational systems⁷; co-location with other professionals in the pediatric office (eg, a social worker, psychologist, nutritionist, educational specialist); use of nationally available programs to support development and learning such as Reach Out and Read⁸ and Healthy Steps⁹; group well child care¹⁰; and tailoring the length or frequency of visits based on a family's need. Many examples were given of successful community connections; however, participants frequently noted the lack of sufficient resources for referral and collaboration, especially connected to developmental and behavioral concerns.

This is where we believe that pediatricians with a special interest in child development and behavior, as well as specialists in Developmental and Behavioral Pediatrics, can collaborate to improve the quality and breath of current practices. Over the past 15 years, many innovations to improve the content and process of well child visits have been described. (See Table 1) Although few of these programs have been tested in randomized controlled studies, they offer a starting point for collaborative work among colleagues. A single template will not fit all pediatric practices or all communities. Cultural and personal interests among clinicians and families will guide the choices for innovation. But trying out new ideas will stimulate new questions and alternative ways to look at traditional practices.

There is always one moment in childhood when the door opens and lets the future in.

Graham Greene (1940), The Power and the Glory

References

1. Haggerty RJ, Friedman SB. History of Developmental-Behavioral Pediatrics. *J Dev Behav Pediatr*. 2003;24:S1–S18
2. Stein MT. Strategies to enhance developmental and behavioral services in primary care. In: Wolraich ML, Drotar DD, Dworkin PH, Perrin EC. *Developmental-Behavioral Pediatrics: Evidence and Practice*. Philadelphia, PA: Mosby Elsevier; 2008:887–903
3. Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009
4. Schor EL. Rethinking well-child care. *Pediatrics*. 2004;114(1):210–216
5. Tanner JL, Stein MT, Olson LM, Frintner MP, Radecki L. Reflections on well-child care: a national study of pediatric clinicians. *Pediatrics*. 2009;124:849–857
6. Radecki L, Olson, LM, Frintner MP, Tanner JL, Stein MT. What do families want from well-child care? Including parents in the rethinking discussion. *Pediatrics*. 2009;124:858–865
7. Sterner R, Howard B. CHADIS www.childhealthcare.org
8. Needlman R, Silverman M. Pediatric interventions to support reading aloud: how good is the evidence? *J Develp Behav Pediatr*. 2004;25:352–363
9. Zuckerman B, Parker S, Kaplan-Sanoff M. Healthy Steps: A Case Study of Innovation in Pediatric Practice. *Pediatrics*. 2004;114: 820–826
10. Stein M. The providing of well baby care within parent-infant groups. *Clinical Pediatrics*. 1977;16:825
11. American Academy of Pediatrics. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics*. 2006;118:405–420
12. Robins D, et al. Modified Checklist for Autism in Toddlers. *J Autism Develop Dis*. 2001;31: 131–144; www.dbpeds.org (Search MCHAT)
13. Ages and Stages Screening Questionnaires: Paul H. Brookes Publishing Co. www.brookespublishing.com
14. Jellinek M et al. Pediatric Symptom Checklist. *J Pediatr*. 1988;112:201 <http://psc.partners.org/>
15. Dixon, SD, Stein, MT: *Encounters with Children: Pediatric Behavior and Development*, 4th ed. St. Louis, MO: Mosby Elsevier, 2006
16. Stein MT. The use of family drawings by children in pediatric practice. *J DevBehav Pediatr*. 1997;18: 334
17. American Academy of Pediatrics: Task Force on the Family. *Pediatrics*. 2003;111:1541–1571

Table 1: Innovations in Well Child Care in Promotion of Development/Behavior

1. Systematic screening for developmental delays and behavioral conditions with standardized tests	1. AAP recommendation for a standardized screening test for neurodevelopmental delays at 9, 18 and 30 months of age ¹¹ autism screening (eg, MCHAT), ¹² Ages and Stages Screening Questionnaires, ¹³ Pediatric Symptom Checklist ¹⁴
2. Developmental theme for each visit	2. Encounters with Children: Pediatric Behavior and Development ¹⁵
3. Risk categories	3. Defining low, medium, and high risk children/families based on chronic medical/psychological conditions or family level of function; organizing duration and frequency of well child care visit based on risk category
4. Co-locating	4. Incorporating other professionals into the pediatric office/clinic (eg, social worker, nutritionist, psychologist/psychiatrist, educator)
5. Healthy Steps	5. Child development specialist has responsibility for developmental and behavioral screening, initial counseling, and referrals. Works with office staff and clinicians to enhance the use of developmental and behavioral ideas into all clinical encounters. ⁹
6. Family drawings	6. Beginning at 4-5 years of age, all children are asked to “draw a picture of your family doing something.” Drawings are used to engage parents and children in talking about the picture with the goal that the drawing will open up new areas of communication important to parent/child concerns. ^{15, 16}
7. Attention to parent’s mental health	7. The new “family pediatrics” where observations about parental depression, anxiety, substance abuse, and other conditions of parents that affect a child’s development are a part of the pediatric visit. ¹⁷
8. Group discussions	8. Planned, interactive discussions with parents (and adolescents) about topic of interest (eg, sleep problems, oppositional behaviors/tantrums, social relationships, learning difficulties, puberty, substance abuse)
9. Group well child care	9. During the first 1-2 years of life, well child care visit are organized in groups of 5 parent-infant dyads. In the first 45 minute period, the clinician moderates a discussion of well child care topics that focus on the main concerns of the parents; sharing ideas, concerns successes and failures is encouraged. This is then followed by examinations (group participation optional), growth measurement and immunizations. ¹⁰
10. Reach Out and Read	10. Parents are encouraged to read to the child daily; reading is demonstrated during the visit with a book provided by the pediatrician. Goals: to increase reading aloud at home and to improve language skills of child. ⁸
11. Limit physical exams to increase time for dev-behavior screening/counseling	11. Use 1 visit in the first year for observations and counseling in areas of development and behavior. A suggestion when continuity of care is available and physical exams prior to this visit were all normal.
12. Computers for screening and information	12. Previsit screening at home for developmental delays and behavior problems. Generating handouts through available Web sites tailored to the visit. ⁷
13. Links w/ community resources	13. Concerted effort to maintain a directory of community services that are relevant to the needs of children in practice. Includes not only pediatric subspecialists but also educational opportunities, nutritional programs, sports programs, and libraries. Access to teachers and other school personnel as well.

About the Authors:

Martin T. Stein, MD, Division of Child Development and Community Health, Department of Pediatrics, University of California, San Diego, Rady Children’s Hospital

J. Lane Tanner, MD, Developmental and Behavioral Pediatrics, Children’s Hospital and Research Center, Oakland, California

Coding Conundrum

By Lynn M. Wegner, MD, FAAP

Dear Coding Cohort,

I am completely stuck! I have patients taking psychotropic medicines and many have significant side-effects. These side-effects may result in office visits (eg, CPT code 99213). Many of my payers have “carved me out” from using any 290.xx-319.xx ICD-9-CM codes and as you know well, these are the DSM-IV-TR “mental health” codes. How can I get paid for my time for these visits related to medication side-effects when the underlying etiology for the need for the medication is one of these “DSM” codes??

Signed,

Irate –and Irritable - About “the System”

Dear I x2,

We feel your pain! We have elected to turn our angst into action. Please see some ICD-9-CM codes “outside the box” of 290-319. Perhaps these can be remedies for your refusals.

278.00	Obesity, Unspecified
278.02	Overweight
780.54	Hypersomnia, unspecified
780.52	Insomnia, unspecified
780.59	Sleep disturbances, other
783.1	Abnormal Weight Gain
783.2	Abnormal loss of weight and underweight
783.3	Feeding difficulties and mismanagement
783.40	Lack of expected normal physiological development in childhood, unspecified
783.6	Polyphagia
783.7	Adult failure to thrive (for ages 18 yrs and above)
783.9	Other symptoms concerning nutrition, metabolism, and development
785.0	Tachycardia, unspecified
785.1	Palpitations
786.50	Chest pain, unspecified
787.01	Nausea with vomiting
787.02	Nausea alone
787.03	Vomiting alone
787.20	Dysphagia, unspecified
787.6	Incontinence of feces with constipation and overflow incontinence
787.7	Abnormal feces
787.91	Diarrhea
787.99	Other symptoms involving digestive system (change in bowel habits)
789.00	Abdominal pain; unspecified site
789.09	Abdominal pain; other specified site
799.21	Nervousness
799.22	Irritability
799.23	Impulsiveness
799.24	Emotional lability
799.25	Demoralization and apathy
799.29	Other signs and symptoms involving emotional state (excl. anxiety and depression)
799.9	Other unknown and unspecified cause
789.06	Abdominal pain, epigastric
789.05	Abdominal pain, periumbilic
787.20	Dysphagia, unspecified
783.21	Loss of weight
783.22	Underweight
783.3	Feeding Difficulty and Mismanagement

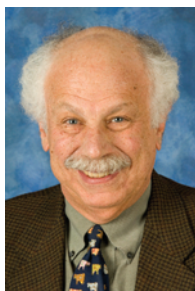
There are likely many other codes outside the 290-319 series pertinent to medication side-effects we have neglected to include. If you have some favorites, please send them to:

Lwegner@med.unc.edu

We are compiling as comprehensive list as possible for faithful readers of our column –so send them in and stand by!

The Section on Developmental and Behavioral Pediatrics would like to congratulate this year's award recipients!

The C. Anderson Aldrich Award in Child Development



**Leonard Rappaport, MD, MS, FAAP
2010 Award Recipient**

Leonard Rappaport MD, MS, FAAP is Chief of the Division of Developmental Medicine at Children's Hospital and Mary Deming Scott Professor of Pediatrics at Harvard Medical School. He has directed the Fellowships in General and Developmental-Behavioral Pediatrics for 20 years involved in the training of well over 100 fellows. He is principal investigator on 1 of 9 federally funded training programs in Developmental-Behavioral Pediatrics. In research, Dr Rappaport is a member of a multidisciplinary group examining the effects of cardiac surgery on neurodevelopmental outcomes through a series of randomized clinical trials. Dr Rappaport is also a member of a multidisciplinary research group in autism spectrum disorders and on the Steering Committee of the Autism Consortium of Boston. Dr Rappaport had a primary care pediatrics practice outside at Longwood Pediatrics for the past 27 years which he left in January 2009.

Dr Rappaport completed his undergraduate degree in economics at the University of Pennsylvania and the London School of Economics. He then received a Masters in Education from the University of Pennsylvania, and taught for 4 years in a public alternative high school, and for the final 2 years was Head Teacher (Principal). He subsequently attended Yale Medical School and completed a residency and a fellowship in Developmental and Behavioral Pediatrics at Children's Hospital, Boston. He was Program Chair for 2 terms for the Section on Developmental and Behavioral Pediatrics of the AAP and also served on the Executive Committee. He has been a member of the Executive Committee of PREP the Course. He is currently President of the SDBP.

The Dale Richmond/Justin Coleman Award



**Chris Plauché (Johnson), MEd, MD, MA, FAAP
2010 Award Recipient**

Dr. Plauché has a passion for improving the lives of children with developmental disabilities. Before becoming a physician, she was a physical education teacher for children with disabilities. She volunteered as the medical director and executive director of Children's Association for Maximum Potential (CAMP) Inc, which serves children with severe disabilities and their families. For developing and teaching the CAMP Developmental Disabilities Review Course, she received the "Professional Educational Course of the Year" from the AAP and Best Practices Award from the American Academy for Cerebral Palsy and Developmental Medicine. Dr. Plauché was the lead author of 6 AAP guidelines/clinical reports and the AAP Autism Toolkit. She served as editor of several journals and has lectured both nationally and internationally. She has been a Clinical Professor of Pediatrics at the University of Texas Health Science Center in San Antonio, Texas since 1986.

"Excellent speakers who were as engaging as they were informative. This is the best conference I have attended! The AAP slogan is 'The Best Pediatric CME for the Best Pediatric Care' – I agree."

— John D. Barbe, MD, FAAP
Longmont, Colorado



DB: PREP®

An Intensive Review of Developmental-Behavioral Pediatrics

Sponsored by the American Academy of Pediatrics (AAP), the AAP Section on Developmental and Behavioral Pediatrics, and the Society for Developmental and Behavioral Pediatrics (SDBP)

**Chicago, Illinois
December 8-12, 2010**

Swissôtel Chicago

You should attend DB:PREP® if you are:

- A pediatrician, family physician, primary care physician, or academic generalist seeking current and practical information in the field of developmental-behavioral pediatrics
- Preparing to participate in the Subspecialty Certifying Examination in Developmental-Behavioral Pediatrics or Maintenance of Certification™ (MOC)
- A developmental-behavioral pediatric specialist seeking a comprehensive review of developmental-behavioral pediatrics
- A pediatric resident or fellow seeking current and practical information in the field of developmental-behavioral pediatrics
- A physician assistant, pediatric nurse practitioner, or other allied health professional with a special interest in developmental-behavioral pediatrics

**Earn a Maximum of 35.25
AMA PRA Category 1 Credits™**



Register online at www.pedialink.org/cmefinder
or call toll-free, 866/THE-AAP1 (866/843-2271)

SDBP
Society for Developmental
& Behavioral Pediatrics

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

