**Policy 360 – Episode 69 - Can Poor Childhood Behavior Predict Teenage Troubles?**

Kelly Brownell (KB): Hello and welcome to Policy 360. I'm Kelly Brownell, Dean of the Sanford School of Public Policy at Duke University. We are in the middle of a series of podcast episodes looking at young children. My guest for this episode, Daniel Shaw, directs the Center for Parents and Children and the PIT Parents and Children Laboratory at the University of Pittsburgh. A highly regarded scholar, Dr. Shaw's work focuses on the development and prevention of early problem behavior among at-risk children. He's currently part of three NIH-funded longitudinal studies investigating early childhood conduct problems, what causes them, and how to prevent them. Danny, welcome to Policy 360.

Daniel Shaw (DS): Thank you. I'm glad to be here.

KB: First, the big picture: how do we know when toddler behavior is not normal?

DS: Great question, and one of the problems is we don't really, because until you get to about age 2 or 3, you can probably get a better sense of how that child is going to do from their context than the actual behavior. Once they pass two and a half to three, then you get a better handle, you start to get a pulse of how that child is going to turn out from there.

KB: And so what are the signs of problem behavior in children?

DS: At 2 or 3, in early childhood, usually it's going to be high rates of oppositional and aggressive behavior, along with some temper tantrums across contexts. So, we look at severity and pervasiveness- are the two big- so is it not just happening at home with one parent? Both parents? But also at daycare or preschool? That's a pretty good sign of trouble to come. And we know even kids who show this- these high levels of oppositional, aggressive behavior by two or three, two-thirds of them, maybe three-quarters are going to grow out of it as they get socialized by age five or six. The kids that retain it are going to go underground and show more covert levels of this behavior as they, kind of, get the message that, "This is not in my interest to be oppositional and aggressive in front of others." So, they're going to be more covert at it, and retain that behavior but then start to commit more serious acts at school, in the neighborhood, and even with their parents and siblings.

KB: So, what point can you begin to identify the one-third that won't grow out of it?

DS: Yeah, so that's been kind of our challenge of the last 20, 25 years, and I must say most of my work is done in high-risk contexts- so, low-income, urban samples. We actually are now able to predict even violent behavior from kids as young as one and a half and two living in these tough, urban environments and our big three variables seem to be: a lack of emotion regulation skills- and part of that could be this oppositional behavior-, parenting that is harsh- and usually in the context of a tough child-, and a parent who is depressed. Those are the three variables that really stand out, and then children not being regulated and then, kind of, taking that- much like a hero of mine, Jerry Patterson, has noted- that these kids start to act coercively with others and know they get away with things. And so, this has to be condoned or reinforced by parents, peers, teachers for it to continue over time, but we're getting correlations all the way from age two to violent behavior- and arrests for that- before age 18.

KB: So, you mentioned children who are at risk and it sounds like part of being at risk is the environment in which the children are raised, of course.

DS: Yes.

KB: And it sounds like some of those things are related to poverty, difficult life circumstances, and the like- like depression, for example, and stress, and things like that that make it challenging to be an understanding and forgiving, patient parent, for example. Is that true?

DS: It's exactly right, and it just puts- you know, you're carrying around a lot of pressure with you if you're living in poverty, so all things being equal these things are going to attempt- so, to give you a sense, we screened at Women Infant and Children nutritional supplement programs- WIC programs- and we didn't have any problems finding parents with young children who were clinically depressed. So, a score of, like, 16 on some on the Beck Depression Inventory or other scales. We had one-fourth of our sample with scores of 37 and- I mean, just astronomical scores. And, you know, if you have a score like that, you're barely getting out of bed in the morning, much less parenting, or taking care of your kids, or providing nutritional needs for your children very well. Yeah.

KB: Boy, it goes to show how much environment is influential in parenting, and what a parent can provide for a child, and how the child prospers or fails to prosper.

DS: Especially in the context of poverty, where things we take for granted that are going to be accounted for -and, you know, when you have good day care, or good schools and peers that aren't engaging in this, but if you take those resources away within the family and outside the family. All of a sudden, it's quite amazing for kids who do well, actually. It's almost surprising how many don't flourish but get by, and survive, and do okay.

KB: So, you're indicating that there's a subset of these children who show these behaviors early in life, and that these track in into their life, their subsequent years and into their later life. What sort of things show up later in life?

DS: So, the one sample we followed has been through early 20s and, and so the data I was talking about before, we were predicting to violent offenses, sexual assault, homicide, assault, carrying a deadly weapon, so fairly serious kind of- before age 18, we're now looking in the early 20s and finding similar kinds of predictions from early childhood. The sample is moving into their late 20s right now and so we don't have data yet, but we hope to get more funding to follow them as they move to 28 or 30.

KB: So, you're working on an intervention called- known as "The Family Checkup for Low-Income Toddlers and Older Children at Risk for Conduct Problems.” The "Family Checkup" model gathers information from families and helps them to set intervention goals. Can you tell us more about how this works?

DS: Yes! So, for years, you know, we were following this sample of kids and we tried to refer them to our clinics to come in and see clinical psych grad students- for $2 an hour they could come in, and we couldn't get families to come in. We referred almost half the sample based on the moms' depression scores, 148. We got three to come in. Three out of 148. So, I met this colleague, Tom Dishion who's at the University of Oregon, who was experimenting with this idea with mostly parents with troublesome adolescents who were about to get kicked out of school. And he had been using this intervention quite successfully following a sample of high-schoolers all way in their late teens, early 20s, getting these magnificent effects, incorporating motivational interviewing- where you really lay it on the line for the families, "This is what's going to happen to you. This is what's going on," using established norms and established procedures. I talked to Tom about, you know, "Would you be willing to try this with an early childhood? Because I think we have a lot of families in desperation there." So, he was and we joined forces and, you know, he adopted this version of the Family Checkup in early childhood and we, subsequently, followed two cohorts- those kids are now 16-years-old and we've followed them since age two. We went back to WIC clinics where we did all the recruiting and we're getting some very nice results, not only on reduced conduct problems, lower maternal depression, better parenting, but things like academic achievement, lower BMI, things we never dreamed up. And we just did some analysis and all the way up to age 14, the results were still there for lowered conduct problems. So, we're very happy about that.

KB: Impressive results. So, tell us what happens in the program.

DS: Yeah, so it's a little different than a family intervention because the difference, the big difference is that families are not expecting to go to therapy, right? They are going to their local WIC clinic, primary care, we're trying to use this within Head Start and Early Head Start, even Child Welfare, and we give them a screen of some kind to suggest that, "Your child is on this pathway for problem behavior," and then they get the option of wanting to do this or not. It's very collaborative, and we do our developmental assessment for about an hour-long doing observations of parent-child interaction, but also asking about depression and emotion regulation- all the things that predict bad outcomes down the road. And then, we give them feedback in a separate session of what lies ahead, trying to activate the parents and trying to create dissonance between what they want for their child and what's going on now, and showing them what's going to happen later. So, there's this huge feedback session that follows a, kind of, "get to know you", get acquainted, kind of, showing the parents, "We're there for you. We're going to do everything we can, but first we're going to do this assessment, feedback, follow-ups." That's the family checkup, but hopefully it then leads to follow-up or we can use evidence-based interventions to improve parenting skills, maybe get a referral for a psychiatrist if they wanted their depression treated that way, but it's really in the family's hands- and what we found is that it's getting to the feedback stage that's more important than the follow-up sessions. So, even though we're having social workers work with these families and they're doing great work, it's having these repeated feedbacks each year that seems to drive our intervention effects. So, families that have three or four of these from child ages two to five have much better results, you know, much stronger effects than if you only have one checkup from ages two to five.

KB: So, I'm imagining a parent hearing this news that they have an at-risk child. That must not come as welcome news, of course, and I wonder if parents, some parents take this as feeling like they've done something wrong.

DS: Yes.

KB: Does that become a barrier to them engaging in the program?

DS: It's a great point. One thing I failed to mention, which is really important, is how strength-based we are. So, even though we know that and as clinicians we might talk in- among a group of, "Oh my god, this is a really desperate case," when we convey information to them it's mostly going to, kind of, catch them being good. So, we're going to show them videotapes, even if we have to search the whole 15 minutes or 30 minutes, of something they're doing well that they can capitalize on. So, instead of saying, "Oh my god, you're depressed. What an awful thing," we'll talk about, "Times you're not depressed, and how do we find that?" We'll show the videotape of things doing well, so it's very much instilling hope that's kind of already- despite the consequences. In fact, when we do fidelity of our videotapes- everything is videotaped- the clinician needs to instill hope or they don't get certified. And sometimes, this is rather challenging if the families are rather dire straits. So, yeah, it's a really good point because the sessions themselves, even though we'll be very straightforward about it, there has to be an air of positivity and an air of "We're in this together, and we're going to do something about it." Yeah.

KB: So, you mentioned that, you, in the context of this program, will work with the parents on parenting skills. What sort of things get covered in that? What sort of skills are you trying to work with?

DS: Yeah, that's a great idea. A lot of it is positive parenting. We have some data to suggest that to eliminate, kind of, coercive, harsh parenting instead of saying, "Stop yelling at your child," it's better to replace those techniques with something they can use. So, setting up meals around dinner, anticipating- if you have a two-year-old and you're going to go in a car for a little while- what do you need to bring, when you're in the market, to avoid the child being disruptive during that car ride and while the child's in the basket during that? So, anticipating those moves, getting them to think ahead, two steps ahead of the child- that seems to be really important. So, it's funny, during our assessments, one of our colleagues, Francis Gardner, had this meal task, so we actually have observations of them preparing me on how they handle the child as they're doing something, as well, during that time and even giving them feedback on that can be very helpful.

KB: So, I can imagine a life for some of these parents being extremely challenging, given all the difficult life circumstances they engage in. Do they have the time and the energy to do something like this?

DS: Yeah, you touched on another big point. A lot of our parents, and I say "parents" including fathers and mothers, they're working two jobs, and they don't have a lot of time, and sometimes they have multiple kids- and that's part of the problem. Like, a lot of times, we'll see these beautiful interactions with the parent and child and it's actually one of the few times a week they got to spend 40 minutes alone with this child. So, we'll do things like, "Look, you don't have much time. Could you spend 10 minutes every other day with your child in some activities where you're not reacting to something they did wrong, but kind of setting the tone? Just sitting down with them." So, finding those pieces of time during the day, even if it's not every day, so that child gets that attention and doesn't have to get it from being oppositional and aggressive with their siblings. Yeah, but it is challenging, yeah.

KB: Well, it sounds like you've produced some very impressive results, and it would be nice if there were good uptake and scaling up of the kind of interventions. Do you see that as a possibility?

DS: We are trying to do that. Tom Dishion’s group in Arizona has something called "The Reach Institute" and people can go there to get contracts and work within agencies. We’re on something called the "HomVEE List of Home-Visiting Programs", so actually states can apply to get money to use the Family Checkup. In Pittsburgh, we're trying a little experiment where we're working with kind of nontraditional platforms- places like WIC, but also Early Head Start – Head Start where families with low-income children frequent, we can identify them and embed them there. What's nice about Head Start and some Early Head Start classroom-based work is we'll get the teachers', impressions as well as the parents', which really is nice to corroborate- again, this multiple-context issue. So, our goal is actually to make Pittsburgh a laboratory we can then expand and see where it works- in some places it doesn't work, depending on the setting.

KB: So what's the going to be the next generation of your research?

DS: Ah! Our next generation, we hope, is getting screens- another thing we noticed in our community agencies is, well, the measures they're using to, so-called "evidence-based measures" aren't terribly evidence-based, and to actually have some data on low-income children- boys and girls- going forward, to be able to screen whether it's Primary Care, Early Head Start, Head Start- who needs more than the status quo? Who needs more than WIC as treatment as usual, or meetings with your pediatricians? One thing we found in our work with WIC is that half the families did not respond to our intervention. Even though we screen them based on predictors of problem behavior, but it doesn't necessarily mean they'll respond to intervention. So, we need to screen for both what predicts problem behavior, but who is the best candidate. One of our surprises was that the most at-risk families responded best to our rather brief intervention, you're talking about three or four meetings a year, and then the intervention stops till next year where we do another family checkup.

KB: Well isn't that nice to know that, modestly, I mean, a very cost-effective way of approaching this can have such impact?

DS: Yes, it kind of surprised us, especially me. I was very cynical because we work for these families for years, they have multi-layers of problems and the idea that they could take control and do something about it, not all of them, but a lot of them, and especially some of the ones that had these outrageous depression scores, or had been addicted to substances for many years- it wasn't magical, but over the time they actually showed improvement, and their kids are doing pretty well.

KB: Well you certainly have painted a picture of an area where the stakes are very high. You know, you think about the families, the country as a whole, but also of course the children and what kind of a life they're destined to if they're growing up in tough circumstances. It's really very nice that you've done such impressive work with our population.

DS: Thank you.

KB: So, my guest has been Daniel Shaw. He directs the Center for Parents and Children and the PIT Parents and Children Laboratory at the University of Pittsburgh. Until next time, I'm Kelly Brownell.