



ORIGINAL ARTICLE

The efficacy of Conjoint Behavioral Consultation on reducing internalization of target behaviors in preschooler children

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ABSTRACT

The purpose of present study was "Determining the efficacy of Conjoint Behavioral Consultation on minimizing signs of internalization of preschoolers' children". A quasi-experimental research design with pretest-posttest and control group was used. The research population consist of all male and female preschool children of region #10 of karaj; which a sample of 30 child was randomly selected by multi step stratified sampling method. Data collected by using Achenbach behavioral checklist – teacher and parent report form. The conjoint behavioral consultation patterns identification meetings hold in eight 2 hour meeting with parents and teachers of treatment groups; the control group hold in waiting list. Collected data analyzed by mean of covariance analysis. Result show that conjoint behavioral consultation was effective in minimizing internalization sings in children, such as anxiety/ depression, isolation/ depression as stated by both parents and teachers. It is suggested that Conjoint Behavioral Consultation can be used as psychological remedy for reducing signs of internalization in children.

Keywords: Conjoint Behavioral Consultation, Signs of Internalization

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INTRODUCTION

One of influential factors on student's achievement is different behavioral problems. However, it is more important in the beginning of child scholarly period especially early years of preschool and primary school, when child learn first concepts and materials from someone out of his familiar environment and in school. Thus, behavioral problems can affect child learning; so that, without proper diagnosis and treatment, the learning process would not be impossible, but very hard and time consuming.

In child and adolescents, Excitement, affective and behavioral disorders divided in two main class, internalized disorders and externalized disorders. The externalized disorders have interpersonal nature and appear as hyperactivity, aggression, compositionality, not following social rules and regulation. On the other hand, internalized disorders have intrapersonal nature, hurting the child than others, appear as isolation from social interactions (withdrawal), bodily complaints (somatic complaint), inhibition, anxiety and depression [1]. Internalized disorders are including those psychological disorders that introduced as major depression, dysthymia, generalized anxiety disorders, separation anxiety disorders, social phobia and specific phobia in the appendage of diagnostic and statistical manual of mental disorders (DSM-IV). Based on this classification, internalized disorders are non-adaptive behaviors that central around mood and emotional disorders [2].

Green et al [3] found that there are direct and indirect relationship between mother's depression and anxiety and child psychological disorders. They also found that specific cognitive strategies such as self-guilt, self-blame, self-rumination, catastrophic behaviors have significant relationship with internalization disorders such as depression and anxiety [3]. Results of Kelley, Whitley and Campos [4] study show that children which raised by grandmothers have more behavioral problems and there is a significant

relationship between caregiver distress and child behavioral problems. It is notable that increased psychological distress in grandmothers was most predictive of child behavior problems.

Conjoint behavioral consultation between parents and teachers is one of the most effective treatment strategies for internalized disorders in children, which consider the role of family and school in treatment and prevention of behavioral problems simultaneously [5].

Consultation is a three-dimensional process between consultant (as advisor), teacher or parents (as consulted) and students (as client). In a consulting process, the consulted (teacher or parent) seek solution for problems and concern of client (student or child) from consultant (school consultant or psychologist). In fact, consultant (consoler or school psychologist) would be aware of client situation with help of consulted and not directly [6]. In conjoint behavioral consultation, consultant (psychologist or school counselor) work cooperatively with two related systems of home and school, using behavior therapy principals for solving client problems. In the other hand, consoler defining the context of client's problem and relate it to family and school in sought to increasing the cooperation and contribution of parents and teachers in solving student's problems and concerns [20].

Conjoint behavioral consultation is a cross-system problem solving and decision making model in which parents, teachers and other supporters are jointed to work together to address a consistent and positive achievement that help in children's academic, behavioral and social-affective development for whom both parties bear some responsibility. Parents, teachers and other supporters work collaboratively for identifying the child needs and also plan, intervene, evaluate the cooperative solutions [23].

The goals of Conjoint Behavioral Consultation is promote academic, behavioral, socio-emotional outcomes for children through joint, mutual, cross-system planning. The conjoint behavioral consultation goals achieved via four stages implemented in a collaborative manner. These stages include conjoint needs (problem) identification, conjoint needs (problems) analysis, plan implementation and conjoint plan evaluation [22].

Previous and ongoing studies demonstrate the efficacy of conjoint behavioral consultation. Ruble *et al* (2010) suggested that consulting program education has effect on outcomes of children with autism and also, study conducted by Sheridan *et al* [23] showed a significant relationship between conjoint behavioral consultation and students' academic achievements, reducing behavioral problem in doing school homework. In a research study conducted by Semke [16], conjoint behavioral consultation was effective on promoting healthy behaviors in obese children. Conjoint behavioral consultation pattern with collaboration of family and school as systems, could improve behavioral, academic and affective-social aspects of children and adolescents school life [18, 22].

Considering the above mentioned material, the main purpose of this study is: "determining the efficacy of conjoint behavioral consultation on minimizing the internalized behavior of preschooler students of Karaj 10 locale".

MATERIAL AND METHODS

Design

This study follows quasi-experimental research design with pretest-posttest and control group.

Participants

Participants consist of preschooler boys and girls from Karaj 10 locale kindergartens whom 5-6 years old. Study samples selected by mean of multi-steps stratified random sampling. First, 2 kindergarten selected randomly, then 2 class of each kindergarten was selected, again randomly. In the next step, the Child Behavior Scale Questionnaire applied to parents and teachers. From both kindergartens, there was 30 eligible children who divide in two equal groups randomly (15 child in each group) as treatment and control groups.

Eligibility criteria

In order to be eligible for this study, the following criteria must be met:

1. The parent or teacher rating of the child on Internalizing T-score of the Child Behavior Checklist (T-score above 60) especially on anxiety / depression and withdraw/depression scales
2. Comparison score of parents and teachers form
3. Indication of problem in the clinical inspection and interviews
4. Age range between 5-6 y/o
5. Parent informed consent for participation of child in study
6. Teacher readiness and willingness for participation in study

Exclusion criteria

Following condition have negative impacts on the study. So, participants who have one or more of following condition, excluded from study:

1. Low T-score or scores lower than set amount

2. Simultaneous participation in another program or projects
3. Sever psychological disorders of parents or child which affect study

Data collection tools

Child behavior checklist (CBCL) parents form and teacher reporting form (TRF) were used as research tool (Achenbach and Rescorla, 2001). The checklist have two distinct parts: first parts evaluate the child adapted activities and competencies and second part consist of 112 items for assessing specific maladaptive behaviors. The child condition determined on a 3-point ordinal scale of "not true" (0), "somewhat or sometimes true" (1), and "very true" (2). This scale could be evaluate and interpret based on diagnosis and also experimental criteria. In the present study, the first part of scale which evaluate adaptive activity of children were been ignored and parents asked to complete the second part only. This part differentiate 8 factors including "anxiety/depression", "isolation/depression", "somatic complaints", "social disorders", "thought problems", "attention disorders", "ignorance", "violent behaviors" [1]. We used only two profile of internalization including anxiety/depression, withdrawal/depression in the present study. The α - cronbach reliability was 0.93 and 0.95 for child behavioral checklist of parents in pretest and posttest, respectively. The reliability of teacher report form was 0.76 and 0.88 for pretest and posttest, respectively.

Procedure

Following the initial sampling and choosing study's participant and also assigning participants in two groups of treatment and control; an eight session meeting between consultant, parent (s), and teacher for conjoint behavioral consultation was planned and implemented for treatment group. Although the control group didn't receive any intervention. Conjoint behavioral consultation helps parents and teachers to serve as joint consultees with consoler, work together in identifying child's problematic behaviors and concerns of child, reaching a consensus on decisions regarding proper intervention for solving the problems. This shared collaboration increasing the parents and teachers interaction with growing child at home and educational setting; thus, useful in joint identification and solving the problematic behaviors of children. The content of conjoint meetings were: first step was problem assessment and identification including building relationships and setting shared goals of conjoint behavioral consultation for teacher and parents; assessing teacher and parents understanding of child problematic behaviors; defining the problem; changing their improper views on child's problems and replacing it with scientific knowledge; draw up a contract of shared collaboration. The second step was problem analysis including assessment of problem prevalence and appearance route in school and home; identification of maintenance and reinforcement factors for problematic behavior at school and home. Third and fourth steps were formulating a treatment plan and application of plan including teaching parents and teachers about how to developing children daily homework table (behavioral checklist), how to use positive reinforcement principles, how to use positive reinforcement for increasing the positive and rewarding behaviors of child in class or home; how to prompt the problematic child; how to use punishment and rewards, praise concurrent with positive reinforcement, relaxation and breathing exercises in the presence of anxiety, failures; how to use encounter ladder and problem solving skills for encountering fears and failures. The fifth step was assessment and evaluation of learned material by parents and teachers; including what they experienced between consultation meetings, predicting possible problems in future and how to deal with them; revising unsuccessful interventions in experienced situations and suggesting alternatives. Intervention plan was prepared based on conjoint behavioral consultation of Sheridan and Golton (1994).

RESULTS

Analysis of collected data revealed that mean (standard deviation) of participant's age for treatment group is 6.153 (0.520) and control group is 6.341 (0.312). Independent T-test was used for testing equality of age between two groups. Results show that there is not any statistical significant age differences between two groups consisting 15 student ($t=1.937$, $df=28$, $p>0.05$).

Table 1. Parents and teachers report measure's mean and standard deviation in pretest and posttest by group variables

Groups	Tests	Statistic	variables			
			Anxiety/Depression		Withdraw/Depression	
			teacher	parent	teacher	Parent
Treatment group	Pretest	M	7.133	7.600	3.819	4.933
		S	1.951	3.439	1.187	1.830
	Posttest	M	1.266	1.133	0.600	0.266
		S	0.844	1.201	0.713	0.593
Control group	Pretest	M	5.935	7.200	4.537	5.133
		S	1.387	2.242	1.263	1.597
	Posttest	M	5.933	7.866	5.603	5.400
		S	1.860	2.531	2.097	2.693

Parents and teachers opinions about each studied variables in pre and post tests are summarized in table 1 as mean and standard deviation of forms scores. It's contain evaluation of problematic behaviors (anxiety/depression, withdraw/depression) that conducted by parents and teachers in pretest and posttests.

Based on research design and intervention plans, covariant analysis was used for measuring the statistical difference of two control and treatment groups, in effort to minimizing error variance and ceiling effects of pretest scores on posttest. After securing the covariance analysis prerequisites and for determining the effect of each independent variable on dependent variables, one-way covariance test was used for each variable separately.

Table 2. Comparison of teachers reports on anxiety/depression, withdraw/depression by group, using one-way ANCOVA

Dependent variable	Sum of square	Degree of freedom	Mean of squares	F	Level of significance	Partial η^2
anxiety/depression	127.270	1	127.270	89.647	0.000	0.777
withdraw/depression	213.85	1	85.213	44.693	0.000	0.691

Table 3. Comparison of parents reports on anxiety/depression, withdraw/depression by group, using one-way ANCOVA for independent sample

Dependent variable	Sum of square	Degree of freedom	Mean of squares	F	Level of significance	Partial η^2
anxiety/depression	295.843	1	295.843	97.618	0.000	0.823
withdraw/depression	126.705	1	126.705	41.563	0.000	0.664

Based on multivariate covariance analysis findings shown in tables 2 and 3, we can concluded that performing independent variable (behavioral consultation) cause significant difference of anxiety/depression, withdraw/depression perception of parents and teacher between control and treatment groups. Because this study's variable has two levels only, pursuit test or pre-experiments are not applicable here. Thus, we can deduce the variables difference direction from analysis of means differences. A quick look at results presented in table 2 and 3 show that mean of variables in treatment group are lower than control group. Results show that problematic behaviors of anxiety/depression, withdraw/depression in treatment group reduced significantly as result of conjoint behavioral consultation.

DISCUSSION

The purpose of present study was investigation of efficacy of conjoint behavioral consultation on internalizing target behaviors (anxiety/depression, withdraw/depression) in preschooler children. Results show that conjoint behavioral consultation is effective on reducing target internalized behaviors including anxiety/depression, withdraw/depression, as reported by both parents and teachers. This results supported and in accordance with previous studies conducted by Warren and Garler [24], Collier-Meek [8], Sheridan *et al* [20], Sheridan and Bovaird [5], Semke [16], Bywater and colleagues [7], Ruble *et al* [15], Lee (2006), Sheridan *et al* [22,23], Guli [11]. For example, Sheridan and Bovaird (2012) investigate the effectiveness of conjoint behavioral consultation on academic achievement and minimizing problematic behaviors of student when doing homeworks; found that CBC is effective on reducing problematic behaviors of children at home and school. Ruble and colleagues [15] in a research on autistic children found that conjoint behavioral consultation have significant effects on autistic children outcomes (e.g. eye contact, verbal communication, and physical activities). Semke [16] results show that conjoint behavioral consultation may be promising approach for obese children; cause healthy feeding habits and physical activity in mentioned children. In a research on students with learning disability, Sheridan *et al* [19] found that conjoint behavioral consultation is effective in reducing learning disabilities and hyperactivity and attention deficit of this children. Gonzalez *et al* [12] found that family risk factors (such as socioeconomic status, parental mental health, medical condition, and functional limitation) in addition to social variables such as school and individual risk variables (e.g. childhood physical and sexual abuse, school performance and inabilities) are comorbid with depression; and proper treatment and intervention of this risk variables can reduce the chance of depression in children.

Whether school or home is influential factors in problematic behaviors in children, the collective roles of this factors is very important, nevertheless, there is a urgent need for approaches in which applied to both home and school, have useful outcomes; conjoint behavioral consultation methods used in present study is one of this approaches which show useful effect of collaborative efforts of school and family. As a

result, conjoint behavioral consultation with emphasis on school and home roles, collaboratively effective in maintaining and improving behavioral problems and also considering the potential and qualification of both systems in reducing problematic behaviors and psychological health promotion in children, both system have substantial and equal role. Intervention models used in present study view home and school system as influential factors in reducing target internalized behaviors in children. We can conclude that individual systems intervention in school cannot reach a desirable outcome in treating problematic behaviors, because much of child time passed in home and there are numerous factors that shape his/her behaviors. Even if we assess and deal with child concerns in school, child's problems in home can affect his school life. But approaches such as conjoint behavioral consultation have better outcomes and without harmful influence and with cooperative intervention cause communication which encourage empathy, positive attention, mutual understanding, acceptance and also cooperation. These factors have behavioral, social, affective and academic outcomes as result of systematic shared planning (such as family members, school employees and child consultants) and help in developing and improving skills necessary for reinforcement of this collaboration between family, home, and school. This collaboration help in needs and concerns identification, changing viewpoints, reinforcing relationships between systems; and finally cause distribution of responsibilities (between parents and instructors) for meeting educational objectives in which building a positive constructive relationship between key influential factors of home-school (parents and teachers) in children life.

Considering these findings, we can generally conclude that conjoint behavioral consultation is an effective approach for reducing internalization of target behaviors in preschool children. Academic and educational administration can use these results for teaching conjoint behavioral consultation model to school counselors, so that, they can provide necessary interventions and services for minimizing problematic behaviors in children.

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