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Advances in Psychotherapy –
Evidence-Based Practice

Time-Out in Child Behavior Management

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C.B.M.

Preface

The concept of using time-out for child discipline has been a topic of attention for both researchers and the lay public for many decades. Sarah Vander Schaaff summarized the issues well in her 2019 *Washington Post* article about time-out researcher Dr. Arthur Staats entitled, "The Man Who Developed Timeouts for Kids Stands by His Now Hotly-Debated Idea" (Vander Schaaff, 2019). In the article, Vander Schaaf points out the controversies associated with this evidence-based approach for managing child disruptive behavior:

> Today, the merits of timeout are hotly debated. Some argue it is harmful, provoking feelings of isolation, abandonment and anxiety while doing little to teach self-regulation. Others maintain the discipline is effective and not only helps a child acquire self-control but also gives parents the opportunity to cool off and reduces yelling or physical abuse. Staats, now 95 and with two adult children, five grandchildren and two great-grandchildren, stands by his work from the early 1960s. 'TYM-OUT' proclaims his license plate. (Vander Schaaff, 2019)

Dr. Cheryl McNeil, one of the authors of this text, added to this *Washington Post* article by stating,

> When families and children are trained in the proper techniques for timeout – learning a system that involves creating a positive 'time-in' environment of parent–child interaction, explaining the rules of timeout in advance, using warning statements and consistent follow-through – children show great success… And it's a big flop if it's done without training and ineffectively. (Vander Schaaff, 2019)

In this book, we strive to flesh out the issues discussed in the *Washington Post* article, providing an overview of the research, as well as clinical details regarding time-out techniques. Our goal is to provide an even-handed description of the pros and the cons of time-out, with particular attention to empirical evidence and behavioral theory.

Contents

1

Description

Time-out is short for time-out from positive reinforcement. In its most basic definition, time-out refers to "a period of time in a less reinforcing environment made contingent on a behavior" (Brantner & Doherty, 1983, p. 87). In other words, following a specific behavior, an individual is either moved to a less reinforcing environment or somehow limited in accessing reinforcement in the current environment. Time-out is typically used as a punishment procedure to discourage undesirable behavior. Although principles of time-out have been used in other arenas, for the purposes of this book we discuss time-out as it relates to child behavior management, predominantly in the United States.

Time-out is short for time-out from positive reinforcement

1.1 History of Time-Out

Some of the earliest discussions of time-out in the literature appear in studies of animal behavior from the 1950s (Ferster, 1958; Ferster & Skinner, 1957; Skinner, 1950). This research centered on training animals, such as pigeons and chimpanzees, to peck keys or press switches in order to access reinforcement in the form of food. When time-out from reinforcement was employed – animals no longer received food for responding (e.g., pressing keys or switches) – behavioral researchers discovered that rates of responding were impacted. This literature began to establish the study of time-out as a procedure in which animals' behavior mirrored behavior under conditions of other known forms of punishment. Most fundamentally, animals' responding for food decreased during periods of time-out. Relatedly, animals either responded more or less frequently before and after periods of time-out depending on how the experimenters arranged the contingencies (Ferster & Skinner, 1957).

Time-out was first introduced to reduce dangerous or destructive behavior

Later, in the 1960s and 1970s, researchers began to generalize time-out procedures to applied settings. Children with disabilities demonstrating dangerous or destructive behavior were some of the first subjects to appear in the time-out literature. For example, Risley (1968) attempted to use time-out from social attention to decrease dangerous behavior (e.g., climbing bookshelves, hitting others) in a child diagnosed with autism. Similar time-out studies targeted self-injurious behavior, aggression, tantrums, elopement, and problems related to eating, sleeping, and toileting (Harris & Ersner-Hershfield, 1978). Subjects were often individuals with cognitive deficits, neurodevelopmental disabilities, or serious mental health diagnoses, especially those who were institutionalized. Time-out was employed as a less aversive alternative to

way. For a more structured approach, the tell, show, try again, guide sequence (Girard et al., 2018) is a particularly useful time-out alternative for very young children (under 2 years) and those with autism and lower receptive language abilities.

2.4 Children With Internalizing Disorders

Children with internalizing disorders benefit from time-out

While most research involving time-out includes children diagnosed with disabilities and disruptive behavior disorders, children with internalizing diagnoses such as anxiety and mood disorders can also benefit. Although these children experience many symptoms privately (e.g., low mood, negative cognitions, worry), anxious and depressed children are more likely than anxious and depressed adults to demonstrate irritability. Highly irritable or anxious children may display emotional outbursts and engage in avoidance, which can contribute to problems with compliance and disruptive behavior. For example, children with generalized, social, or separation anxiety often refuse to attend school or interact socially with peers. Similarly, children diagnosed with depression or other mood disorders may have low motivation to engage in tasks of daily living.

Treatment incorporating time-out has demonstrated decreases in child depression and anxiety

Time-out and treatments incorporating time-out have been employed to increase compliance and decrease problem behavior in children with anxiety and mood disorders (Puliafico et al., 2012). Larger treatment packages promoting positive caregiver–child interactions, emotion regulation, and coping skill development in addition to time-out, have demonstrated decreases in depression (Lenze et al., 2011) and anxiety (Chronis-Tuscano et al., 2015; Pincus et al., 2008). It is important to note that children are not directly put into time-out for exhibiting anxious or depressive behavior. On the contrary, caregivers in these programs learn to differentiate anxious and depressive behavior from purely defiant behavior, and time-out can be employed with the latter.

Importance of avoiding overuse of time-out

While most evidence supports the use of time-out for children with depression and anxiety, one study seemed to contradict these findings. In a cross-sectional survey of parenting practices, data suggested that frequency of time-out usage was positively associated with mother-reported but not self-reported child anxiety symptoms (Gershoff et al., 2010). This finding highlights the importance of avoiding overuse of time-out (see Chapter 6) and administering time-out in a context of other positive parenting strategies (see Chapter 5).

2.5 Child Trauma

There is no data that suggest that time-out traumatizes children

The use of time-out in relation to concerns for child trauma has been hotly debated by clinicians and researchers alike. Currently, there are no data to suggest that time-out can traumatize or re-traumatize children. In fact, the Kauffman Best Practices Project to Help Children Heal From Child Abuse

up to 9 minutes, followed by restriction of privilege, for continued refusal. A back-up room is used for escape (i.e., leaving time-out without permission). Compliance with the original instruction is required to return to play. Time-out is followed by emphasis on reaffirming the positive relationship between caregiver and child (e.g., warm touches, positive affirmations).

5.5 Parent–Child Interaction Therapy (PCIT)

Program goal: Treating disruptive behavior problems

Parent–child interaction therapy (PCIT; Eyberg & Funderburk, 2011; McNeil & Hembree-Kigin, 2010) is an evidence-based BPT approach originally developed to treat disruptive behavior problems. PCIT is appropriate for children ages 2–7 years. During about 12–20, 1-hour weekly sessions, caregivers learn and practice skills with their child with bug-in-the-ear coaching from a therapist. Treatment unfolds in two phases. In the child-directed interaction phase, caregivers learn positive reinforcement skills (i.e., praise, reflect, imitate, describe, enjoy [PRIDE]). These are to be practiced daily during 5 minutes of one-on-one child-led play at home. Next, during the parent-directed interaction phase, caregivers practice calm, consistent discipline strategies for noncompliance. PCIT is competency-based, meaning that families' progression through treatment is guided by caregivers' attainment of competency goals (e.g., 10 praises, reflections, and descriptions in 5 minutes, 75% correct follow-through with discipline skills).

12–20-session program in 2 phases and appropriate for ages 2–7

Incorporation of time-out

Within the parent-directed interaction phase of treatment, time-out is used as a consequence for noncompliance. Children are given one warning before the time-out sequence is initiated. Time-out occurs in a chair and lasts for 3 minutes plus 5 seconds of silence. Following this period, the child must comply with the original instruction to end time-out. Caregivers are coached through the scripted steps of time-out with their child in clinic before practicing at home. Immediately following all time-outs, caregivers are encouraged to provide ample positive reinforcement using the PRIDE skills. This highlights the differential reinforcement of desirable behavior as compared with noncompliance. More details on the time-out procedure used in PCIT are provided in Chapter 8.

5.6 The Kazdin Method (Formerly Parent Management Training)

Program goal: Developing desirable behavior

The Kazdin method, formerly known as Parent Management Training (PMT; Kazdin, 2005, 2008), is an evidence-based BPT program. PMT was originally developed to address conduct problems (e.g., aggression, property destruction). The Kazdin Method now aims to develop desirable behavior and values. The Kazdin method is designed for families of children ages 2–15 years. Within 5–10, 1-hour weekly therapy sessions, caregivers learn basic behavior management skills such as shaping, modeling, prompting, fading, reinforcement, punishment, and extinction (Kazdin, 2008). Children do not attend

5–10-session program for caregivers of children aged 2–15

6

Parameters of Time-Out

Time-in enhances the effectiveness of time-out

Time-in should involve high levels of positive reinforcement

Before beginning our overview of commonly delineated parameters of time-out, we would first like to highlight a crucial factor related to time-out: time-in. As time-out is more fully understood as time out from positive reinforcement, its effectiveness is enhanced by increasing the quality and amount of positive reinforcement available in the child's environment. Therefore, to ensure the effectiveness of time-out, time-in should involve high levels of reinforcement (e.g., positive caregiver interaction, stimulating activities, and access to other reinforcers; Hernstein, 1955; Solnick et al., 1977). Experts have noted that this is one of the most vital components of time-out efficacy (Shriver & Allen, 1996). Partially for this reason, many evidence-based treatments that teach time-out also prescribe intentional practices aimed at enhancing the caregiver–child relationship. Parent–child interaction therapy trains and coaches caregivers to engage in positive parenting skills for 5 minutes each day with their children. These habits are intended to "spill out" to other times of day, wherein the caregiver continues to improve the reinforcing nature of caregiver–child interactions. Without this basic component of quality time-in, time-out would be far less effective.

Eight core components of time-out

Several reviews have been published covering research related to the core components of time-out (Brantner & Doherty, 1983; Corralejo, Jensen, Greathouse, & Ward, 2018; Everett et al., 2010; Harris, 1985; Hobbs & Forehand, 1977; MacDonough & Forehand, 1973; Turner & Watson, 1999). Originally, MacDonough and Forehand (1973) examined eight such components: (1) **verbalized reason** (presence vs. absence); (2) **warning** (presence vs. absence); (3) **administration** (instructional vs. physical); (4) **location** (isolated vs. nonisolated); (5) **duration** (short vs. long); (6) **stimulus** (signaled vs. nonsignaled); (7) **schedule** (continuous vs. intermittent); and (8) **release** (contingent vs. noncontingent). Most recently, Corralejo and colleagues (2018) revisited this list, updating their review to include more recent research. Overall, relatively little empirical evidence exists informing practitioners and parents about the comparative efficacy of each specific parameter of time-out.

Descriptions and summaries of the available evidence behind each parameter are provided below. Discussion of the **stimulus** parameter has been omitted from our review as no research on the comparative effects of different time-out stimuli has been conducted. However, we have included an additional parameter, **escape** from time-out, in our review.

or ineffective in the past, therapists are encouraged to describe the time-out in PCIT as unique and "therapeutic," given its focus on extreme consistency, predictability, and structure. Families can be asked about their willingness to "experiment" with this new version of time-out to see if its high level of structure will work for their child. For families with anxiety or trauma histories, the consistency and predictability of time-out can also be reassuring. Clinicians may discuss the fact that time-out should be delivered in a calm and controlled fashion. The goal is for caregivers to employ emotion regulation strategies when implementing time-out. In this way, a positive discipline approach can replace anger-based, punishment strategies such as yelling, delivering harsh consequences, and spanking. Therapists can assure families that there is no evidence that time-out traumatizes or re-traumatizes children. In fact, research shows that PCIT can actually reduce trauma symptoms in children. For more background, see Chapters 2 and 7.

8.2 PDI Teach Session

In PCIT, the strategies, rules, and procedures for discipline and time-out are typically taught to caregivers only (i.e., no children) in a 1-hour "PDI Teach." This session follows the caregivers' achievement of proficiency in the CDI skills within the CDI phase of treatment and prior to any discipline or time-out coaching or implementation in the PDI phase of treatment.

8.2.1 Effective Commands

During the PDI Teach session, caregivers learn about giving effective commands to improve child compliance. Briefly, effective commands are: (1) direct (told) rather than indirect (asked), (2) positively stated, (3) given one at a time, (4) specific rather than vague, (5) age-appropriate, (6) stated politely and respectfully, (7) explained before they are given or after they are obeyed, and (8) used only when necessary. Please, see Appendix 2 for examples of how to make less effective commands more effective. In PCIT, time-out is introduced as a consequence for noncompliance to direct commands only. This way, caregivers can control when they use commands and consequently when they may need to implement time-out. Once caregivers and children can follow the time-out procedure with integrity, time-out is generalized to other types of target behavior.

8.2.2 Effective Follow-Through

Effective commands are taught in conjunction with effective follow-through. See Appendix 3 for a concise visual summary of correct follow-through (Thanks to the WVU PCIT Lab and Erinn Victory for assistance with developing the images for these diagrams). If the child complies with a command, he or she receives a labeled (i.e., specific) praise (e.g., **"Thank you for following**

Praising child compliance

nights at her grandmother's home nearly every week. Eliana's grandmother enjoyed "spoiling" Eliana with treats and privileges. She reported good behavior from Eliana for the most part, except when her parents came to pick her up after a visit.

9.2 Treatment Plan and Goals

The family agreed to participate in a short-term, problem-focused family therapy model. They listed reducing tantrums and aggression and improving compliance as their top goals for treatment. Luis and Marcos stated their commitment to attending 1-hour, weekly appointments with Eliana for an estimated 6–10 sessions. They were encouraged to include extended family members in appointments as well if possible. Marcos expressed interest in having his mother attend. Eliana's parents were introduced to the idea that Eliana could benefit more if her parents learned behavior management and play therapy skills for daily use than if she simply visited her own individual therapist for a short time each week. They understood that their active participation and weekly skills practice at home would be a vital part of therapy.

9.2.1 Treatment Session 1 (Relationship-Building Didactic & Coaching)

Treatment began with psychoeducation for caregivers. Eliana, her parents, and her grandmother attended. Luis and Marcos learned basic behavioral principles such as reinforcement for positive behavior and differential attention, while Eliana's grandmother listened and played with her on the floor. The idea of child-led play was also introduced (Eyberg & Funderburk, 2011). This 5-minute, daily, 1-on-1 play session with each parent would be a time for Eliana to "be in charge," allowing her to lead the play in a preferred activity while having no demands placed on her. Marcos liked this idea and believed that Eliana would be more likely to listen to him if their relationship was stronger.

Introduction to behavior therapy

Luis expressed skepticism. He had hoped to increase behavioral expectations for Eliana and had difficulty accepting that playing with Eliana would improve her respect for authority. He explained that he had never played with Eliana before. These concerns were validated. Luis agreed to experiment by trying out "special playtime" for a week, however, and report any behavioral changes at the next session. Eliana's grandmother expressed understanding of content but seemed reticent to express her opinions. Eliana's family received handouts (in English and Spanish) and brief explanations about each of the PRIDE skills (i.e., praise, reflect, imitate, describe, enjoy) as well as the "Don't Skills" (i.e., questions, commands, and criticism; Eyberg & Funderburk, 2011). The therapist modeled each skill and had each caregiver take turns using them in role-plays. Eliana frequently interrupted during the didactic portion of the session, climbing on her Papi's lap, pulling his arm, and whining for him to come play with her.

Modeling and role play

12

Appendix: Tools and Resources

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Appendix 4: Direct Commands Handouts

Is This a Good Time for a Direct Command?

Consider the possibility that you may need to carry out a lengthy sequence including time-outs and trips to the back-up space if necessary.

The child must...	The caregiver must...	The environment must...
...be well-rested.	...have the time.	...have minimal distractions (siblings, screens, etc.).
...not be too hungry or thirsty.	...have the energy.	...be free of potential emergency and safety concerns (traffic, fire, water, spills, property damage).
...be alert.	...be calm.	...have a back-up space or alternative available.
...have recently used the toilet.	...be feeling well.	...have a clear path to the back-up space.
...be ready to learn. *Compliance training and time-out are opportunities to practice a new skill. Ask yourself if you would consider this an appropriate time to teach your child another new skill, for example, to write their name.*	...have patience and willingness in this moment to teach the child this new skill.	...have minimal potential for competing needs. *Ask yourself, am I in the middle of something (e.g., cooking) that will also require my attention? What will I do if the phone or doorbell rings?*
	...not have already given too many direct commands today. *Remember to pick your battles.*	...be free from others who may interfere with the procedure (e.g., co-parent, grandparent).

See p. 110 for instructions on how to obtain the printable, letter-sized PDF.