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Feeling Invisible to Your Kids? Try Keeping Quiet

If you're a parent living with small children, you may often feel like you're invisible to your kids. After spending a day cajoling, reasoning, threatening and even screaming in an attempt to get your kids to behave, you may feel as if you simply didn't exist. But all that talking is precisely the problem. If you feel like you're invisible, you're probably way too audible.

When it comes to discipline, silence often speaks louder than words. Many parents complicate the job of discipline by setting for themselves two goals instead of just one. Their first goal is to get the kids to do what they're supposed to do, which is fine. But when kids don't respond right away, many parents add a second goal: getting the youngsters to accept, agree with, or even like the discipline. So Mom and Dad start reasoning, lecturing and explaining.

One Explanation is Fine

All this extra talking accomplishes only two things—both of them bad. First, it aggravates the kids, and second, it says to the children that they really don't have to behave unless you can give them four or five reasons why they should.

One explanation is fine. But the mistake many parents make is trying to reason with their kids as if they were "little adults," and too often adult logic does not impress or motivate young children. Once you say "No" to an obnoxious behavior, you should save your breath. Further pleading will irritate you more and give the child a chance to continue the battle—and the behavior.

Mental Health Providers: Effectively Targeting Your Services

Any of you who have worked in community mental health settings know that evaluating and treating children on an outpatient basis presents many challenges. Years ago I worked at the *Loyola Child Guidance Center* in Chicago and later at the *Du Page County Community Mental Health Center* in Wheaton, IL. One of the biggest problems we faced in both settings was our waiting list. There was typically a wait of over six weeks between the initial intake phone call and the first face-to-face diagnostic interview.



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We used to jokingly say that when the family called it was about a child; when we did the evaluation it was about an adolescent; and when we finally got around to treatment, we were dealing with an adult!

That was one problem. Another problem was this: We eventually learned that some of the families who called us were sorely in need of treatment, while others had problems that could be handled by reassurance and practical advice. It would have certainly saved time and focused our energy better if we had been able to quickly tell the difference between these two groups.

In the mid 1990s, the *Young Children's Development Program* in Medicine Hat, Alberta, was chosen by that Canadian Province to pilot a new outcome monitoring system for community mental health agencies. Headed by Sig Taylor, MSW, the study used an instrument known as the Conflict Behavior Questionnaire (CBQ), which focused on parent-child issues, and it also employed a two-session *1-2-3 Magic* program. Here's how the study worked. The CBQ was given to parents who called the *Young Children's Development Program* for a child evaluation. While they were still on the waiting list, a two-session *1-2-3 Magic* program was then given to these Moms and Dads. Then the CBQ was repeated.

The Good News

The good news: Over 90% of the parents felt that the *1-2-3* sessions had made a significant difference in their child's behavior. Not only that, but the majority of children who had fallen into the clinical range on the CBQ prior to *1-2-3 Magic* fell into the normal range after three months. In other words, their parents no longer felt their children needed formal diagnosis and treatment. Parents of children who still fell into the clinical range, of course, could continue with their plans for evaluation and follow up.

This application of the *1-2-3 Magic* program might not be as useful—or even appropriate, of course, in treatment centers that specialize in particular childhood problems, such as autism or abuse. But for those community mental health settings where clients come from a broad population base, the Medicine Hat Study suggests a useful way for deciding who needs what and for providing effectively targeted services.



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