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# BEHAVIOURAL PROBLEMS in CHILDREN

## From preschool to school age

## Background

BEHAVIOURAL problems are not diagnoses but common symptoms for which a parent may seek help with their preschool or school-aged child. In Australia, help is more often sought from GPs than from other practitioners. More than 5% of Australian parents report that their children have problems with aggressive behaviour or inattention.

In a recent Australian survey, many GPs were motivated to address child mental health problems but described not having as many opportunities to develop their knowledge and expertise as they would like. Our goal with this article is to provide one such opportunity.

The most common diagnoses in children presenting with behavioural problems are:

- Disruptive behaviour disorders.
- Anxiety disorders.
- ADHD.

These are conditions for which first-line treatments are effective in community settings and are supported by a strong evidence base.

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## inside



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# Approach to assessment

THIS approach is most appropriate to a preschool or school-aged child (say, 3-12 years). It can be modified to suit younger children and older adolescents.

## History-taking and observing during the interview

### See everyone who has come — and see parents and older children or adolescents separately

*Mrs Jones, 33, brings her seven-year-old son, Thomas, to the GP after he was suspended from school.*

Our approach is to see all those who have come and invite other family members to the next appointment. This ensures you see the person seeking assessment, who is often a parent, rather than the child. This is an opportunity to observe relationships and lets the parents and child know that each of their viewpoints is important.

Doing the assessment over several appointments (when possible) assists the doctor in helping the family shift from a 'fix it now' approach to a more considered 'let's take a step back and think about this'.

### Get the family comfortable — establish rapport

*Mrs Jones says she usually sees another doctor but he is away. The GP introduces herself to Mrs Jones, and turns to greet Thomas. Mrs Jones interrupts explaining in a slightly annoyed tone that there is "no point in speaking to Thomas, as he won't speak to you anyway so he may as well wait outside". Thomas has been looking at the toy on the shelf and now looks at the floor.*

Briefly explain what will happen in the consultation, for example, that you will speak with everyone together and then with parents, older children or adolescents separately and then give some feedback and discuss the options.

*After the explanation, Mrs Jones agrees to Thomas remaining in the room. Thomas remains silent.*

Establishing rapport can start with asking each person (starting with the eldest) about their occupation/work or school.

Recognition of the child's good qualities by the doctor and, especially, by parents, helps the child cope with the subsequent discussion of 'bad' behaviour without distress or disruption of the interview. The rare but painful occasion when parents are unable to come up with any good qualities shows alienation in the parent–child relationship, which needs addressing in treatment.

**Practice point**

It is particularly useful to ask the 'problem child' what they are good at, then to turn to the parents to seek their additional comment.

*Mrs Jones explains that she works part-time as a librarian. The GP asks Thomas what school he goes to. Mrs Jones answers for him. The GP politely stops Mrs Jones and explains that she would like to hear from Thomas as well. Thomas declines to answer but comments, "School sucks". When asked which is worse — the classroom time or the playground — he says, "Classroom". When asked what Thomas is good at, Mrs Jones pauses and then answers that he is good at computer games and drawing.*

Our approach is to accept the answer offered as that person's opinion and to pause, but not insist on more complete answers. Trying to get more information from a reluctant child may lead to a battle of wills similar to the difficulties the parent and/or teacher is already caught up in with the child.

### Confidentiality

Let the family know about confidentiality and its limits, namely, that when there are safety concerns confidentiality does not apply, but that only those involved with improving safety or required by law will be told.

### Identify the concerns of each family member

**Ask the child "Whose idea was it to come?" and "What's your guess about what it's about?"**

Often children understand more than we (or their parents) realise and this reduces tension when discussing difficulties.

Thomas doesn't speak but points at his mother when asked whose idea it was to come.

*"It's 'cause I threw stuff at Mrs Smith."*

**Ask the most concerned adult what their concerns are.**

*Mrs Jones whispers, "He got suspended … didn't you see the note?"*

*The GP uses a normal voice to calmly restate the presenting problem to confirm she has understood.*

*"So, Thomas has been suspended from school because he has been hitting other children and threw a plastic glue container at a teacher?" Mrs Jones agrees then starts to talk more about how she can't see why he does it — his sister doesn't have any problems.*

*The GP nods but cuts her short, explaining that she wants to understand all of her concerns before finding out details. She ascertains that the concerns regarding Thomas are:*

- His aggression at school.
- Similar aggression at home.
- Refusal to do his homework.
- Trouble getting him off to sleep.

*Mrs Jones takes a deep breath to elaborate but the GP again cuts her short, explaining that first she would like to hear the concerns of all family members.*

**Ask the child if there is anything they wish was different in situations where symptoms occur.**

*"What you would like to see different in your family or at school?"*

*Thomas replies that he wishes he could play after school like the other kids. Mrs Jones interrupts to say in a frustrated tone, "But you know you have to go home because it takes you so long to do your homework."*

Many families with a child with behavioural symptoms alternate between angry, disrespectful communication and avoiding the issue so as to avoid provoking further conflict.

### Safety concerns

*The GP asks whether Mrs Jones or Thomas has any concern about safety they would like to raise now. As the GP is aware that people are often reluctant to discuss these issues in front of other family members, she also asks Mrs Jones and Thomas separately.*

*Mrs Jones hesitates, so the GP elaborates: "For example, any worries about Thomas being violent to himself or family members, or getting hurt through reckless behaviour? Any concern that you or your husband might be too harsh in discipline, or might get angry with him and hurt him?"*

*Mrs Jones answers that she thinks it is okay now, although in the past Thomas sometimes hurt his sister (leaving a bruise on her arm once), but Thomas' sister is now three and can tell her if there is a problem. However, at school the teachers are concerned that Thomas may injure another child. Neither Mrs Jones nor Thomas think Thomas will do something dangerous to himself or others at present.*

Although not common in children, suicide does occur in older children and needs consideration, particularly with depressive symptoms (sometimes masked by 'naughty behaviour'), hopelessness and isolation. Any violence, including violence to others, increases the risk of violence to self. Children who self-harm have often witnessed similar behaviour in adults.

Another important consideration is whether other people in the family or home use violence. Asking whether anyone else in the family hits or kicks (if this is the presenting symptom) or who does it the most are useful ways to raise this issue with families. Children with 'naughty behaviour' are at increased risk of abuse.

*Thomas tells the GP, "Daddy smacks me when he's angry." After speaking with Thomas, the GP is satisfied that the smacking, while not helpful, is not causing injuries (bruising, etc.), is not repeated (ie, one smack) and there is no other violence and has decided that there is not a legal requirement to notify a government department (such as the Department of Community Services) at this time.*

**Practice point**

A brief appointment in which the GP calmly but clearly allows each family member to have their say, shows respect for each person and guides the parents towards a constructive 'plan of action' can be a turning point for the family.

*The GP then speaks with Mrs Jones, who confirms the smacking and looks upset, saying that she and her husband argue about it. The GP asks more about the conflict between Mr and Mrs Jones, and she explains that it has been worse since she went back to work at the library, but that "I just can't be at home all the time … it does my head in".*

When the child is not at immediate risk, notification can await proper engagement and assessment. For example, had Mrs Jones reported more severe paternal punishment, the doctor might, before notifying, make an appointment to meet Mr Jones, confirm his wife's report of events, affirm the need for him to set boundaries for Thomas while challenging Mr Jones' methods, and explain the legal requirement to notify.

### First, ask broad questions

Other necessary information can be raised by asking some broad questions, "Before we get into the issue at hand".

### Medical and developmental history

*Thomas' medical history is notable for his slightly delayed speech, repeated middle-ear infections and "colic" as a baby (in which he cried frequently and was difficult to settle).*

In the medical history, hearing, speech and visual impairment and their causes are crucial information. Chronic illnesses such as epilepsy or asthma also increase the risk of behavioural problems.

### Symptom review of behavioural and mental health problems

Common mental health symptoms include worry, inattention and sadness. Other important considerations include self-harm and drug and alcohol problems.

*When asked about worry, inattention or sadness, Mrs Jones comments that "Thomas has been a bit grumpy lately, but I don't know if he's sad".*

*Thomas interrupts. "I'm NOT sad" he says (looking angry and slightly tearful), "It's you who is always grumpy and sad, not me!".*

*When asked about concentration, Mrs Jones explains that she isn't sure about school but Thomas seems to get bored and frustrated with the homework. "You'd have to talk to the school, I don't know …". Thomas interrupts to say "It's stupid". Mrs Jones adds in a hushed tone, "He can't really do the homework, you know, I have to help him. He isn't reading yet, either."*

## Family history — behavioural and mental health

*There is no family history of inattention or naughty behaviour, but Mrs Jones tells you of several family members with depression or excessive worry.*

### Family vulnerabilities and stressors

Family vulnerabilities can be explored in the context that a child with behavioural problems places stress on the family, and that you want to know if there are any other stressors. These include mental health or substance misuse in one or both parents, relationship difficulties in the nuclear or extended family and occupational or financial stressors.

Significant past stressors such as the arrival of a new sibling, parents' relationship difficulties, job loss or the death of a grandparent may be linked to the onset of symptoms. The level of stress at the time of a child's arrival in the family sometimes explains why *this* child (and not sibling/s who arrived in calmer times) has behavioural symptoms.

*Mrs Jones' mother died when Thomas was a few months old, after a long battle with breast cancer. Many people at Mr Jones' work were retrenched at the same time and he was spending long hours at work.*

## The presenting symptom

### History of the presenting symptom(s)

*Mrs Jones explains that Thomas is having some difficulties at school every few days and that this has been going on since he started school two years ago, but the naughty behaviour has become worse over the past six months.*

*Mrs Jones explains that she didn't think there were any problems before Thomas started school, "but he was always harder to manage than his sister Nicky is". She goes on to say that Thomas was hard to settle to sleep as a baby. Things were a bit worse in the year before he started school, after Nicky arrived.*

### The last time 'it' happened — a behavioural sequence

Obtaining a step-by-step description of what happened during a recent time when the unwanted behaviour occurred provides clues to the nature of the child's difficulties, parental vulnerabilities, and vicious circles of problematic behaviour between child and parent(s). For example:

**GP: What was going on before the behaviour started?**

*Mrs Jones: "Thomas was*

*playing with his Nintendo after school. He knows he's not allowed to but I didn't see him get it out because I was unpacking the car."*

**GP: What was the first thing that happened?**

*Mrs Jones: "I asked him to do his homework and he just ignored me."*

**Exactly where was each person and what they were doing?**

*"I was in the kitchen getting dinner, Thomas was in the lounge room, Nicky (his sister) was playing with Play-Doh."*

**What happened then?**

*"I asked him again and again and he kept ignoring me, then he threw his sister's Play-Doh on the carpet."*

**What happened afterwards?**

*"I was so angry with him by then, I told him he couldn't have his Nintendo for a week — look what he'd done to the carpet and he'd made Nicky cry. Thomas still wouldn't do his homework and started screaming and crying. I just gave up on homework.*

*After they had dinner, Steve got home and told Thomas to do his homework, Thomas told him he "was a bastard" and Steve smacked him." She pauses, "Then Steve and I were arguing and trying to get the kids to bed. Thomas wouldn't go to sleep until 10pm."*

**How did it get back to normal/how were things the next day?**

*"Thomas got up and went to school happily, as if nothing had happened, but I was still fuming and didn't talk to him much. I think he could tell because he kept saying sorry. I'd calmed down by that afternoon."*

### What not to miss — suicidal thoughts or plans

Failing to ask about these in a child or adolescent with depressive symptoms or symptoms of hopelessness may miss an opportunity to prevent suicide.

### Practice point

When behavioural symptoms in children are frequent, severe or chronic enough to warrant a diagnosis, comorbidity is the rule rather than the exception (see figure 1).

This type of questioning is less open to attitudinal distortion than questions about what 'usually happens', especially when more than one family member is asked. It is not usually necessary to describe every time the behaviour has happened.

### Legal requirement to notify a child at risk

In most states and territories in Australia, GPs are mandatory reporters of children at risk, and this includes considering physical and psychological abuse and harm that can result from parental neglect or inadequate supervision. It is important for GPs to familiarise themselves with mandatory reporting of children at risk under their state or territory laws.

A Federal Government summary of the different state and territory requirements can be found at www.aifs.gov.au/nch/pubs/sheets/rs3/rs3.html

Notifying Community Services can disrupt the doctor–patient relationship. Alternatively, parental fear or distress can be channelled into working with the GP to make a plan to address risk and demonstrate this to Community Services. Our approach is to be transparent with parents, explain legal requirements to notify, and offer parents an opportunity to call Community Services together or in addition to the doctor's call.

## Physical examination

THERE are no specific or diagnostic physical examination findings with common causes of behavioural symptoms, such as oppositional defiant disorder (ODD), ADHD and anxiety disorders.

There are specific findings for some causes of intellectual disability associated with behavioural symptoms (such as fetal alcohol syndrome) and there may be evidence of chronic medical illness. It is important to look for contributing factors such as hearing impairment or visual impairment (and their causes), and to perform a thorough neurological examination.

*On examination, Thomas is at the upper end of the normal range for height and weight and has a retracted, dull left eardrum. His hearing seems reduced in that ear. The rest of the physical examination is normal.*

## Investigations and diagnosis

FURTHER investigations are guided by the diagnoses considered.

### Diagnosis of behavioural symptoms at presentation

Making sense of behavioural symptoms in a child involves appraising:

- Child factors (including diagnoses).
- Family factors (including parent–child relationship and parenting practices) and community factors (eg, school, police and extended family).
- How these interact, in particular any vicious cycles that keep problems going.

This framework can be used by the GP to make a brief diagnostic survey to guide initial advice, treatment or referral. Alternatively, a more detailed assessment can be made, often over several sessions and/or in collaboration with specialist colleague(s).

### The normal range of behaviour

Whether behaviour is normal or a disorder depends on the child's developmental age and the frequency, chronicity and severity of symptom(s). Comparison with peers is useful.

It is useful to consider the child's symptoms and possible diagnoses in four domains (figure 1).

### Behavioural difficulties

Relevant diagnoses include ODD and conduct disorder. These disorders are really fancy names for naughty behaviour. They apply when this behaviour is severe and ongoing enough to cause clinically significant impairment in social, academic or occupational functioning.

For ODD, symptoms must last at least six months and be frequent. Behaviours include:

- Losing temper.
- Arguing with adults.
- Not complying with adult requests or rules.
- Deliberately annoying people.
- Blaming others for one's own mistakes.
- Misbehaviour.
- Being touchy, easily annoyed, angry, resentful, spiteful or vindictive.

With conduct disorder the behaviour is more severe, including significant aggression and violation of other people's basic rights.

These disorders are perhaps best understood as disturbances of the child's capacity to relate to people and broader social institutions. Their causes are usually multifactorial.

If the child's behavioural problems are severe or chronic enough to require treatment for ODD or conduct disorder, in addition to the underlying disorder, both diagnoses are appropriate.

Symptoms of ODD often first appear from the preschool years, but they can have a later onset. Most ODD does not progress to conduct disorder. Progression occurs most commonly in adolescence but can occur in mid to late childhood.

### Neurodevelopmental difficulties

Behavioural symptoms are common in children with disorders of brain development, including ADHD and intellectual disability.

Comorbidity is frequent within neurodevelopmental disorders, with behavioural and emotional disorders and organic problems, possibly reflecting a genetic or environmental insult affecting early CNS development.

*Thomas finds schoolwork more difficult than his peers, struggling with homework and not reading at age seven. The GP requests permission to contact Thomas' teacher and school counsellor for information about symptoms at school and any testing or intervention. If the GP decides referral is indicated, this information may be gathered by a professional or team to whom the GP refers.*

#### Intellectual disability and specific learning disorders

Intellectual disability involves overall lower intellectual function, measured by psychometric (including IQ) testing by a child psychologist. 'Specific learning disorders' implies overall intellectual function is within the normal range but the child struggles with specific areas academically (eg, reading or mathematics). A developmental paediatrician may assess, with a child psychologist doing specific testing.

#### Language disorder

Language disorder (or communication disorder) means expressive or receptive language (or both) are substantially below other measures of intellectual capacity and cause functional impairment. Diagnosis is confirmed by a paediatric speech therapist, who can often offer therapy.

#### Attention deficit hyperactivity disorder

ADHD is common and has been studied extensively in children but may be confused with other diagnoses such as anxiety disorders, and comorbidity is frequent. With ADHD, children have inattention and/or hyperactivity–impulsivity for at least six months that is maladaptive and inconsistent with developmental level.

ADHD symptoms cause problems before age seven. The inattentive subtype is more common in girls and often missed. Diagnosis of ADHD is clinical but requires good information about the child's functioning in two settings, usually home and school.

#### Autistic and Asperger's disorders

Children with restricted repetitive patterns of behaviour (such as preoccupation with particular objects or parts of objects or specific routines or movements) and/or odd verbal or nonverbal communication styles

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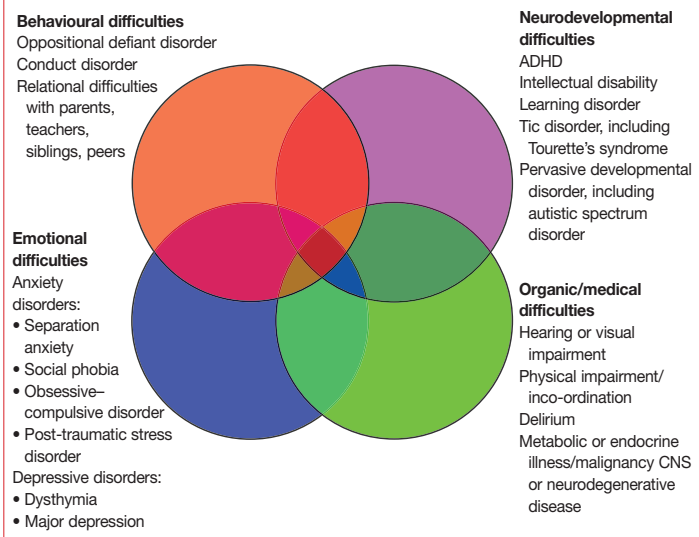
**Figure 1: Common symptom domains and associated comorbid diagnoses in a child presenting with behavioural difficulties.**




### Practice point

**No investigations are routine to diagnose the most common causes** of behavioural symptoms in children, as these are based on a careful clinical assessment.

On the other hand, **screening for hearing and visual problems is routine** and specific testing for speech or learning difficulties is often indicated.

### Practice point

Not all children with 'naughty' behaviour have ODD or conduct disorder. For some the behavioural 'symptom' will be fully explained by another cause such as an anxiety disorder, intellectual disability or ADHD.

*from previous page*

may have a disorder on the autistic spectrum. These children have difficulties in social interaction, which may be most evident in peer relationships. Autism and Asperger's syndrome are pervasive developmental disorders.

#### Tics

Tics (sudden, rapid, recurrent, non-rhythmic, stereotyped motor movement or vocalisation) are common and may be confused with behavioural symptoms. A child may be accused of deliberately disrupting class with their noises (grunts or coughs). They are most common in the same demographic group as ADHD and ODD (primary-school boys more than girls).

### Emotional difficulties

Most children with behavioural problems have some emotional difficulties. Sometimes an underlying anxiety or depressive disorder produced the behaviour. These children often have a family history and anxiety or obsessional symptoms from early childhood, for example, early social phobia (shyness), separation anxiety and/or specific phobias. Some children's mood symptoms relate partly to early aversive life experiences.

In other children emotional difficulties are secondary to the 'fallout' of behavioural problems, which in turn exacerbate and perpetuate the behavioural problems.

**Practice point**

Early intervention improves prognosis for children with neurodevelopmental disorders. Effective treatment and appropriate adjustment of expectations often reduces secondary behavioural problems.

#### Anxiety disorders

It can be difficult for children, particularly boys, to express fear or worry, which can lead them to the apparent naughty behaviour of refusing to do feared things. Anxiety and anger are associated with very similar physiological responses (tensing of muscles, increased heart rate, deeper breathing), and anxiety can trigger or merge into anger.

Anxiety disorders are diagnosed when anxiety is excessive in frequency or severity, causing distress and/or functional impairment. Which anxiety disorder depends mainly on what it is that is worried about or avoided.

*The GP recalls that Thomas is sleeping with a night-light and often tries to delay going to bed. Thomas wants Mrs Jones to stay in the room with him while he goes to sleep but, although she feels guilty doing so, she has refused and Thomas has been more settled going to sleep since.*

*If Mrs Jones were to stay with Thomas, she would be likely to increase his anxiety on subsequent occasions, as he would not learn to be relaxed in his bed, unattended. This pattern can develop into an anxiety disorder.*

**Practice point**

A multidisciplinary assessment is often the best way to assess children with neurodevelopmental disorders and facilitates early intervention.

#### Depressive disorders

The criteria for diagnosing major depression or dysthymia in children are similar to those in adults, except that symptoms may not be volunteered and behavioural symptoms are more common.

Depressive behavioural symptoms in children include reduced effort with school work, irritability and naughty behaviour.

*When seen alone, Thomas talks about things he enjoys (drawing, computer games and playing outside) and seems upset about school but not otherwise sad or hopeless. He denies any wish to "not wake up in the morning" or to die.*

*His mother confirms that his appetite and sleep are normal and that he appears to be happy as much as other kids except around school and homework.*

#### Eating disorders

Although uncommon, anorexia nervosa may start in late primary school, particularly when the behavioural symptoms are around food, for example, an 11-year-old girl refusing to eat a sufficient diet to maintain normal bodyweight.

### Organic and medical difficulties

#### Sudden onset of behavioural symptoms suggests serious medical causes

A sudden change in a child's behaviour (over hours or days), requires careful consideration of serious medical illness affecting the CNS. Causes include:

- Delirium, which is common in children with high fevers, regardless of the source of fever.
- Diabetic ketoacidosis.
- Intoxication from poisoning.
- Meningitis.

More gradual onset (days) and fluctuating symptoms may indicate herpes simplex encephalitis.

**Practice point**

Anxiety and depressive symptoms are not often volunteered by children and need be sought in assessing a child brought with behavioural symptoms.

#### Metabolic and degenerative disorders

These present with a child no longer progressing developmentally or losing previously acquired skills. There is a large group of relatively rare disorders that typically have behavioural symptoms (girls with Rett's disorder typically have hand-wringing movements) and for some of which early treatment can be life saving or significantly improve outcome.

#### Seizures

Some forms of epilepsy, such as the common absence epilepsy (petit mal epilepsy) may present with brief periods of looking blank in the midst of doing an activity (such as speaking or playing). Other less common forms of epilepsy can present with unusual behaviours.

#### Thyroid dysfunction and sleep disorders

Thyroid dysfunction and sleep disorders need consideration in differential diagnosis.

## Contributing factors within the family and broader community

MOST children brought with behavioural problems have characteristics making them hard to raise. Likewise most of their parents have vulnerabilities in their capacity to raise this child. The family has often experienced more stressors and/or less extended family support at significant times for the parent–child relationship.

Being an effective parent requires a balance of care (warmth, empathy, connection) and limits (guidance/clear boundaries). This balance can be disturbed by:

- Parental isolation.
- Parental mental illness.
- Substance misuse.
- Intellectual impairment.
- Parent(s) emulating or reacting against their own unresolved childhood experiences.

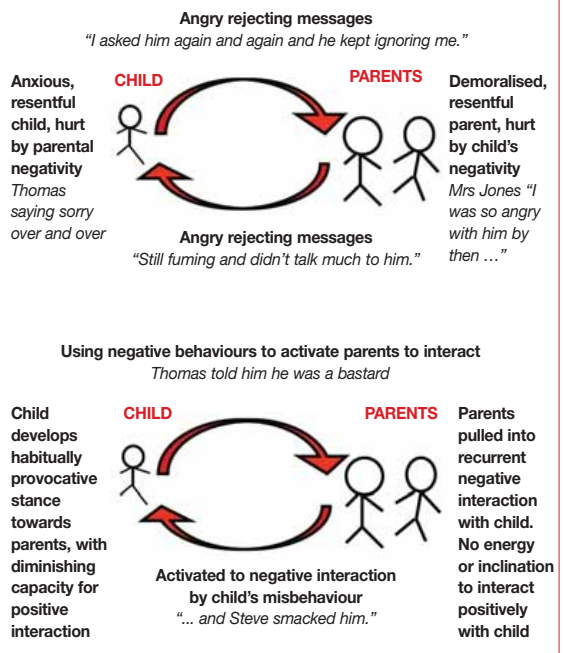
This can occur even in parents who function well in other relationship(s), for example, at work or with another child.

### Parental conflict

Conflict between parents can contribute to ineffective parenting directly by modelling negative behaviours and inconsistency, and indirectly through depression, anger and demoralisation of parents.

The broader community contributes, for example, when a child experiences bullying at school or joins a delinquent peer group, when the child's misbehaviour leads to alienation from the extended family or school, or when the family is experiencing poverty or violence in the neighbourhood.

**Figure 2: Two common parent–child vicious cycles and case history example.**




**Practice point**

When children present with ODD or conduct disorder, the most common parental vulnerabilities are maternal depression, marital conflict (especially about parenting) and maternal isolation.

*The GP suspects Mrs Jones' symptoms are significant. When alone, Mrs Jones confirms longstanding anxiety symptoms (worries about everyday things much more than other people). Since she and her husband have been fighting more (the past six months) she has had depressive symptoms. She is not suicidal, not psychotic and has no plans to harm others. Separately, Thomas offers that "Mum has stopped taking her antidepressants — after one of the fights with Dad where he said she was a hopeless pill-popper".*

#### Vicious cycles between child and parent/s, or child and the broader system

Even considering the child's and parents' vulnerabilities, one can puzzle over how a child's behaviour and family circumstances have deteriorated. This can often be understood through the interaction between the child and parent (or school), where factors in the child and parent are amplifying and perpetuating each other in a vicious cycle.

Understanding the vicious cycle is useful for parents, as it is not about blame and respects each person. Vicious cycles promote hope for change by opening up the possibility of parents turning the situation around by starting a 'virtuous cycle'.

**Practice point**

A thorough, balanced diagnostic assessment, sensitively fed back to the parents and child (as appropriate for their age), can in itself be a powerful intervention.

#### Diagnosis and feedback

*The GP seeing Thomas and Mrs Jones describes each group of symptoms they have presented with and what these are called in medical language, starting with ODD, as it explains the presenting complaint.*

*The GP explains that ODD is a common problem for which effective treatment is available and that the most effective way to treat these problems is through the parents (at home) and teachers (at school).*

*The GP also explains that she thinks that Thomas may have some learning difficulties, hearing problems or problems with attention that could explain why the homework is so hard and would also make it harder for Thomas to find more effective ways to solve problems.*

*She goes on to say that the stress in the family — where it is hard for Mr and Mrs Jones to get along together and where Mrs Jones has been feeling very stressed — make it harder to help Thomas deal with these problems.*

*Mrs Jones' reply follows in the next section.*

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# Management of common causes of child behaviour problems

## Effective, evidence-based treatments involve parents or carers

PARENTS are the key to preventing and addressing child behaviour problems, not because they are the sole cause of problems (they aren't) but because they are (often) the most important role models and/or coaches for their children.

## The GP's role in management

A suggested framework for the GP's role in management is:

- First manage risk(s) identified in the assessment.
- Encourage parents to look after their own health.
- Encourage parents to seek support, such as addressing marital conflict, extended family or community group support.
- Educate parents about child behaviour problems.
- Specific management based on your assessment (see below).

## Oppositional defiant disorder and conduct disorder

### Education of parents

Explaining naughty behaviours (ODD and conduct disorder) to parents in a way that facilitates parents' taking effective action is crucial. There is a balance between encouraging appropriate responsibility for parenting and not giving the impression that the problem is completely the parent's fault (which it is not).

The parenting style linked with ODD and conduct disorder is inconsistent or punitive parenting. Parenting style can differ between siblings (with the same parents). This sometimes relates to the stressful family events (eg, loss or death around the child's birth) which become linked to a particular child.

*Mrs Jones asks "But why? My daughter doesn't have any of these problems. How could it be my parenting? And what does it have to do with Steve? He's never there anyway."*

*The GP explains that ODD is multifactorial and that factors in Thomas (learning or attention difficulties) have combined with stress early on (the loss of Mrs Jones' mother) and recent stressors (marital conflict, lack of support, and depression) to make parenting harder with Thomas.*

*The GP then uses the concept of vicious cycles to explain how things have become 'stuck' between Mr and Mrs Jones and Thomas, for example, when Mrs Jones gives up after Thomas escalates his naughty behaviour, and then isn't firm with her request next time.*

**Recommendations for GP management of ODD and CD (EBM level)**

| | |
|---|---|
| • Education of the parents about the problem and solutions | |
| • Parent management training (eg, Triple P*) | 1 |
| • Teacher management training | 1 |
| • Address parental mental health and social support | 3 |
| • Manage comorbidity | 3 |
| • Medication is not indicated as first-line management | 2-3 |

*See Online resources, above right

**Practice point**

The most appropriate management depends on the findings of the assessment, including the diagnosis/es and the developmental age of the child.

*"But Steve is firm, isn't he — he smacked him?" The GP responds that being firm but kind means setting clear limits without physical punishment.*

*The GP also comments that there have been times when Mrs Jones has been able to be firm and kind with Thomas despite all the challenges, such as when she was able to let him put himself to sleep. The GP explains how this is a virtuous cycle.*

*Mrs Jones comments: "I wish Steve was here to hear this."*

*She and the GP arrange that she will ask her husband to come to the next appointment.*

### Parent and teacher management training programs

Parent management programs are brief (say, 6-8 weekly sessions) community-based interventions with parents (not children). They support parents observing their own behaviour with their children and teach parents behavioural management, including:

- Positive reinforcement of pro-social child behaviour.
- Reducing reinforcement of unwanted behaviour.
- Non-violent limit setting.

The change in the way the parent relates (to kind but firm) is thought to teach the child to relate better. These programs are widely available in Australia.

Teacher management programs use similar principles in a classroom context.

### Parental mental health and social support

*When Mr and Mrs Jones come, the GP invites the couple to consider "the stress their marriage has been under". They decide to try going out together again (which they stopped doing because of "Thomas' problems") and to consider marital therapy if that fails.*

*Mrs Jones agrees to return separately for assessment and management of her depression and anxiety, which she is much more interested in pursuing if it is important for Thomas.*

### Comorbidity

Effective treatment of comorbidity (specific learning difficulties, hearing problems, anxiety disorders) is a major predictor of outcome for these children.

### When to refer, and specialist management of ODD and conduct disorder

Referral is indicated when first-line management is ineffective or comorbidity is not able to be fully assessed or managed. Review of parental mental health is appropriate as a common cause of treatment failure. Referral may be to a child and adolescent psychiatrist, a paediatrician or psychologist with particular expertise in child mental health, or a child and adolescent mental health service.

**Practice point**

A GP addressing maternal depression, marital conflict and/or maternal isolation can be the most important intervention (by anyone), as these predict treatment failure for the child.

When first-line management is not effective, family therapy and treatment foster care (see below) may be indicated after specialist review. For children over seven, cognitive behavioural therapy specific to ODD or conduct disorder or multi-systemic therapy may be considered.

With specialist consultation, second- or third-line treatments may be considered if the benefits to child outweigh the risks, for example, using risperidone to reduce aggression. At low doses, risperidone has a lower risk of movement side effects than older medications such as haloperidol. Other important side effects include weight gain and increased risk of diabetes. Medication does not treat the underlying disorder but may calm the situation enough for other treatments to work.

Sometimes, despite intervention and support, the parents are no longer able to safely and effectively contain and manage the child. In these situations management may include placement of the child in foster care. This can be temporary or longer-term, formal or informal, and with relatives or foster carers.

Treatment foster care is an evidence-based treatment in which the child is placed with a carer who has received special training and is provided ongoing support to provide effective parenting to children with severe behavioural and relational difficulties.

The GP's ongoing role includes addressing parental mental health, encouraging parental social support and maintaining connection with the family.

## Neurodevelopmental disorders

Children with these disorders often benefit from specialist assessment initially, with the GP crucial in ongoing management, addressing social supports and parental mental health. ADHD is mentioned but details of management of neurodevelopmental disorders are beyond the scope of this article.

*By the second appointment, the GP has received feedback from the school. Thomas has managed to return to school more settled but his reading is significantly below his peers and he is inattentive. The GP raises her concern that Thomas may have difficulties with learning or attention relating to how his brain "is wired" and recommends referral to a multidisciplinary team including a developmental paediatrician.*

*Mr Jones asks, "But won't they just put Tom on drugs? I don't want that." The GP explains that learning difficulties are not usually treated with drugs and that the first-line treatment of ADHD is similar to the parent management training they are doing for ODD. The GP goes on to say that medication is often helpful for kids with ADHD when the other strategies aren't enough, and that medication is recommended in conjunction with the work the parents and teachers are doing with the kids, not on its own.*

*When asked if the GP will still be involved, she explains that the multidisciplinary team makes recommendations she is happy to work with the family on, and agrees to see the family to review progress on Thomas' presenting problems, Mrs Jones' anxiety and depression and Mr and Mrs Jones' marital relationship.*

### Emotional difficulties

*If Thomas' difficulty going to sleep alone had not already been addressed by Mrs Jones, specific management for separation anxiety disorder would be indicated.*

Details of management of anxiety and depressive disorders are beyond the scope of this article. In addition to the framework including managing risk (page 25), first-line treatment of anxiety and depressive disorders is CBT involving the parents. For children older than preschool, second-line treatment is SSRIs (fluoxetine is recommended because of better safety data).

### Organic comorbidity

*The GP followed up Thomas' unilateral reduced hearing, which resolved. This communication difficulty needs to be addressed so that it does not worsen the outcome.*

*cont'd page 30*

## Further reading and online resources

- Triple P Positive Parenting Program (parent management training website): www.triplep.net
- GP Psych Support. Patient management advice from psychiatrists for GPs: www.psychsupport.com.au. Ph: 1800 200 588

For GPs interested in assisting the parents of children with behavioural difficulties, we suggest the following parenting books and websites. In addition to knowledge of parenting concepts and skills, the reader gains ideas about how to convey these to parents.


- Sanders MR. *Every Parent: A Positive Approach to Children's Behaviour*. Penguin Books, Melbourne, 2004.
- Gottman J, Declaire J. *Raising an Emotionally Intelligent Child: the Heart of Parenting*. Simon & Schuster, Sydney, 1998.
- Apter T. *The Confident Child*. WW Norton & Co, New York, 2006.
- Rapee R, et al. *Helping Your Anxious Child: a Step by Step Guide for Parents*. New Harbinger, Oakland, 2000.

## GP's contribution

**DR MICHELLE CROCKETT**
Kingswood, NSW

### Case study

SARAH, four, is brought in by her mother because of behaviour problems. She is the third child of her mother, to three different fathers. This was an unplanned pregnancy and the father left her mother when she was eight weeks pregnant. The mother has never told the father about the pregnancy, so there has been no contact with him.

Sarah was born at 38 weeks after an uncomplicated pregnancy and there were no perinatal problems. She was an irritable difficult baby who was admitted to hospital at nine weeks of age after two days with colic. She has had breath-holding episodes.

Her behavioural difficulties have escalated over the last year. Her mother describes her as a very active unco-operative child who answers back. She has a short attention span and is a fussy eater. Mum describes her diet as "terrible" and she refuses to take multivitamins.

Sarah's sleep is a major problem. She goes to sleep late and only if held in her mother's arms. Once in her own bed, she wakes about 2am and goes into her mother's bed.

She is at preschool four days a week, where, her mother states, there are "no problems". In fact the preschool recently put her up to a higher class, as they felt that she was bored.

Family history includes a maternal half sister who has depression, and a paternal half brother who has ADHD. The family are disadvantaged, as the mother has recently had to leave work as

a result of a work-related injury. She is an unskilled worker and did not put in a claim for workers' compensation.

In the consultation room Sarah is very active and difficult to engage. She ignores her mother's and my requests not to climb on the consultation bed. With patience and encouragement she is eventually co-operative during her physical examination.

### Questions for the author

**This child's behavioural problems seemed confined to home. What is the significance of this?**

It is worth obtaining permission to talk to the teacher before concluding that 'no news is good news' from a preschool or school.

If the teacher confirms there are few problems at preschool, this suggests factors in the home and parent–child relationship are promoting negative behaviours (such as boredom, inconsistency, 'accidental reward' of misbehaviour with parental attention), and/or factors in the preschool and teacher–child relationship that are promoting positive behaviour (such as stimulation, predictability, praise, rewards and consequences).

**Diet is often difficult in preschoolers. Could you comment on any possible role of nutritional factors impacting on her behaviour problem?**

Dietary problems are more likely to be symptoms of relationship difficulties rather than the cause of behavioural problems. However, if there are other symptoms or signs (failure to thrive, unexplained vomiting, diarrhoea or abdominal distension) possible comorbid diagnoses such as coeliac disease warrant consideration.

Being undernourished or significantly overweight can adversely effect children's attention but are likely to be secondary to the difficulties for Sarah's mother in modelling healthy eating and providing healthy meals in a consistent and settled environment. The evidence for changing diet to improve children's behaviour or attention is inconsistent.

### General questions for the author

**What approach do you take when taking a history about preschool children?**

**What type of questions, if any, do you ask the child?**

Similar questions to those described in this article, but in simpler language and with a readiness to invite the parent to add to what the child has said. Questions about what the child likes doing or would like to change in their family or preschool (for example if they 'had a magic wand') are often useful.

**Around what age would you interview a child alone?**

From four or five, so long as the child is willing. The interview is often facilitated by the doctor and child drawing or playing together as they talk.

**How do we find out where local parent and teacher management training programs are being run?**

Contact the local Child and Adolescent Mental Health Service or Community Health Centre.

# How to Treat Quiz

## Behavioural problems in children — 13 August 2010

**INSTRUCTIONS**

**Complete this quiz online and fill in the GP evaluation form to earn 2 CPD or PDP points. We no longer accept quizzes by post or fax.**

**The mark required to obtain points is 80%. Please note that some questions have more than one correct answer.**

**ONLINE ONLY**
www.australiandoctor.com.au/cpd/ for immediate feedback

**1. Which TWO statements are correct?**
a) The most common diagnoses in a child presenting with behavioural problems are disruptive behaviour disorders, anxiety disorders, and ADHD
b) The GP should speak only with the parent of the child with behavioural problems, as it is usually the parent who has sought help
c) Seeing the child and parent together is an opportunity to observe relationships and to communicate that each of their viewpoints is important
d) The GP should focus exclusively on the problem behaviour of the child, rather than on good behaviours

**2. Which TWO statements are correct?**
a) It is important for the GP to insist on complete answers to questions asked, even in a reluctant child, to ensure the problem is clearly identified
b) The parent should be told that confidentiality cannot be maintained if there are safety concerns for the child or others
c) It is useful to encourage the parent to describe in detail certain aspects of the behaviour problem early in the initial interview
d) It is useful for the GP to ask the child if there is anything they wish was different in the situations where symptoms typically occur, such as school or family

**3. Which THREE statements are correct?**
a) In children, depressive symptoms are sometimes masked by 'naughty' behaviour
b) Depressive symptoms, hopelessness and isolation are usually volunteered by children
c) Any violence in the child's environment, including violence towards others, increases the risk of violence to self
d) The principles of mandatory reporting of children at risk include when there is physical or psychological abuse

**4. Which TWO statements are correct?**
a) Notifying Community Services can only disrupt the doctor–patient relationship, so should be avoided
b) The medical history should include hearing, speech and visual impairment, and chronic illnesses
c) Comorbidities are uncommon in children with severe or chronic behavioural problems
d) Family stressors that can influence behavioural problems include mental health or substance misuse in parent(s), relationship difficulties, occupational or financial difficulties

**5. Which TWO statements are correct?**
a) It is most useful to ask parent and child for general descriptions about what 'usually happens' when there are problem behaviours
b) Step-by-step descriptions of a specific occasion provide valuable information on the nature of the child's difficulties, parental vulnerabilities and child–parent vicious circles
c) Physical examination is generally unnecessary in the context of behavioural problems.
d) Specific testing for speech or learning difficulties is often indicated in children with behavioural problems

**6. Which TWO statements are correct?**
a) A useful GP assessment framework includes identifying child factors, family and community factors, and child–parent vicious cycles
b) Comparison with child peers is not a useful way of determining if a child's behaviours are normal or abnormal
c) Oppositional defiant disorder (ODD) and conduct disorder (CD) are disruptive behaviour disorders that are perhaps best understood as relational difficulties
d) Neurodevelopmental difficulties include hearing or visual impairment, physical impairment, or neurodegenerative disease

**7. Which TWO statements are correct?**
a) Anxiety disorders in children include separation anxiety and social phobia
b) All children with 'naughty' behaviour have ODD or CD
c) Most children with ODD will progress to CD
d) Early intervention for neurodevelopmental disorders improves prognosis and may reduce secondary behavioural problems

**8. Which THREE statements are correct?**
a) The term specific learning disorders implies that overall intellectual function is below the normal range and that the child also struggles with specific academic areas
b) In language disorder, expressive or receptive language (or both) are substantially below other measures of intellectual capacity
c) With ADHD, children have inattention and/or hyperactivity–impulsivity for at least six months that is maladaptive and inconsistent with developmental level
d) Autism and Asperger's syndrome are types of pervasive developmental disorders

**9. Which TWO statements are correct?**
a) A child's history of shyness, separation anxiety and/or specific phobias may indicate the presence of emotional difficulties
b) Children will usually volunteer symptoms of anxiety
c) Fear or worry may be expressed as the 'naughty behaviour' of refusing to do feared things
d) Anxiety rarely turns into angry behaviour in children

**10. Which TWO statements are correct?**
a) When children present with ODD or CD, the GP should ask about maternal depression, marital conflict and maternal isolation
b) Identifying vicious cycles apportions blame on those involved
c) Identifying vicious cycles may allow parents to alter their behaviour in a positive way
d) Parents are the key to preventing and addressing child behaviour problems because they tend to be the main cause of such problems

### CPD QUIZ UPDATE

The RACGP requires that a brief GP evaluation form be completed with every quiz to obtain category 2 CPD or PDP points for the 2008-10 triennium. You can complete this online along with the quiz at **www.australiandoctor.com.au.** Because this is a requirement, we are no longer able to accept the quiz by post or fax. However, we have included the quiz questions here for those who like to prepare the answers before completing the quiz online.

Australian Doctor Education

**HOW TO TREAT** Editor: **Dr Giovanna Zingarelli**
Co-ordinator: **Julian McAllan**
Quiz: **Dr Giovanna Zingarelli**

**NEXT WEEK** The next How to Treat investigates disorders affecting sleep and breathing. The authors are **Dr Anup Desai**, senior staff specialist, department of respiratory and sleep medicine, Prince of Wales Hospital, Randwick; consultant physician in private practice, Camperdown (Brain and Mind Research Institute) and Randwick; and clinical senior lecturer, Sydney medical school, University of Sydney; and **Dr Sultana Syeda**, respiratory advanced trainee registrar, Prince of Wales Hospital, Randwick, Sydney, NSW.