



## WHAT TO DO IF YOUR CHILD HAS BEHAVIOUR PROBLEMS

Behaviour disorders (sometimes referred to as externalizing disorders or disruptive behaviour disorders) are one of the most common reasons for which parents seek advice from General Practitioners. The most common behavioural disorders are **ADHD**, **Oppositional Defiant Disorder**, and **Conduct Disorder (CD)**.

**ADHD** (see also our ADHD Tip Sheet and Important Facts about ADHD for Parents and Teachers) has a strong genetic basis and involves delays in the cognitive mechanisms that control arousal/motivation and other executive functions the ability to inhibit behaviour and impulses. The child with ADHD should display at least some of the following to a more severe extent than his/her peers:

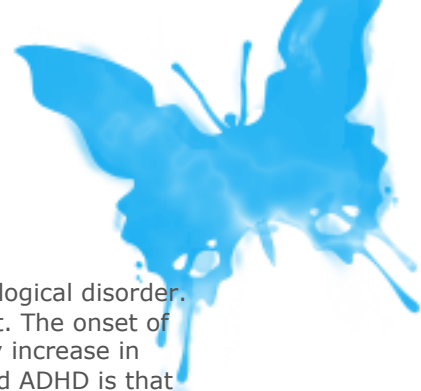
- Excessive motor activity (possibly hyperactivity such running, climbing etc) but often just a sense of restlessness (e.g., fiddling with things on a desk or swinging their legs constantly).
- Difficulty remaining focused or maintaining mental effort (although when the task is fast-paced, provides regular rewards, and is motivating – like a video game, the child with ADHD has no problems ‘paying attention’).
- Impulsivity – seeming to have difficulty *stopping* and *thinking*. Consequently, they make silly mistakes, interrupt, and have difficulty waiting their turn.
- Poor organisational and planning skills (may be manifested as difficulty getting ready for school in younger children and problems with school projects in adolescents).
- Seeming to have difficulty using the concept of time to guide behaviour – deadlines seem to it these kids before they even realise it.
- Seems to get distracted and forgets to do or to finish tasks given to them by parents or teachers.
- Talking excessively (often about nothing in particular or with there only being tenuous connections between ideas), difficulty playing quietly, or seeming to require constant stimulation

In ADHD, the child’s problems are often dependant upon the situation and should be present before 7 years of age. Impairment is often most obvious during repetitive and structured homework or academic tasks. Perhaps one of the most interesting characteristics of a child with ADHD is their inconsistency: some days they will, some days they won’t. It seems like the child knows what to do, but has a genuine difficulty in performing the correct behaviour when required. In pure ADHD, the child does not behave inappropriately deliberately and they are often apologetic when things are brought to their attention.

### Oppositional Defiant Disorder (ODD)

ODD can begin at any time during childhood or adolescence and involves the following features:

- Defiant and sometimes hostile and disrespectful behaviour towards authority figures.
- Regular temper tantrums.
- Refusing to comply with directions.
- Arguing.
- Blaming others for mistakes.
- Deliberately annoying others.
- Being touchy or easily annoyed.
- Sometimes being spiteful or vindictive.
- Physically or verbally aggressive towards parents and siblings.



The main difference between ODD and ADHD is that ODD is not a genetic/biological disorder. Rather, it results from an interaction between the child and their environment. The onset of symptom is therefore gradual and parents will often be able to recall a steady increase in frequency and severity in the behaviour. Another difference between ODD and ADHD is that the child with ODD is clearly behaving badly for a purpose (e.g., to get something they desire or to get out of something they find unpleasant) where the child with ADHD tends not to do things they are asked because they genuinely forget or because they become distracted by something more exciting.

The first step in treating ODD is to have a comprehensive psychological assessment undertaken. The assessment might start with diagnosis but to be useful the psychologist should spend considerable time defining the problem behaviours, the setting in which they occur, and the behaviour of the adults in that situation. In some cases it may be necessary for the psychologist to assess the mental health status of parents because these factors have the potential to impact on the ability to provide clear and consistent parenting.

There is no medical treatment for ODD. Treatment usually involves a period of parent and teacher training in behaviour management and modification techniques. Anger management and social skills training may be useful in some cases; however, therapy performed directly with the child is often not effective.

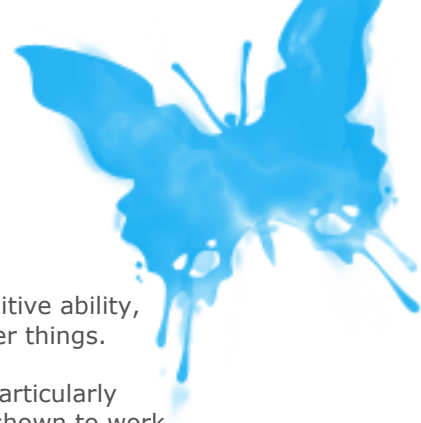
### **Conduct Disorder (CD)**

CD is a severe behavioural disorder, sometimes diagnosed in childhood, but usually in adolescence and early adulthood that is characterised by several or more of the following:

- Aggression that causes or threatens physical harm to others
  - Intimidation
  - Bullying
  - Physical fights
  - Cruelty to people or animals
  - Use of a weapon
  - Forced sexual activity
- Intentional destruction of property
  - Arson
  - Vandalism
- Deceitful behaviour
  - Lying
  - Theft (particularly theft conducted when confronting another as in a mugging or armed holdup)
- Age-inappropriateness of social rules
  - Truancy from school
  - Running away from home
  - Early sexual activity

CD differs from ODD in the severity of the behaviours rather than there being a qualitative difference in the behaviours. There is a clear developmental pathway from ODD to CD which should encourage parents of child with ODD to act early.

As with ODD, the first step is to have a comprehensive psychological assessment undertaken. Unlike ODD, CD often requires a medical component to the assessment which focuses on possible organic causes (this is particularly the case if there is a sudden onset to the behaviour; see below) and obtaining a urine or blood screens if there is evidence of substance abuse. The patient and their family should then be interviewed by a mental health professional



to investigate environmental demands, co-morbid psychiatric conditions, cognitive ability, engagement, and willingness and capacity to engage in treatment among other things.

Treatment may involve medications; however, none have been shown to be particularly effective for CD. Psychological interventions are often difficult but have been shown to work. Psychosocial interventions include: individual or group therapy for anger and impulse control, substance use, and social skills training; family therapy such as improving communication; school interventions which focus on maximal placement options and improving home-school communication; and interventions at the level of the peer group which often involve helping the patient replace a deviant peer group with a more adaptive one. Working with court-officials and juvenile justice workers on limit setting or court supervision is often useful.

### **When a behaviour disorder may not be a behaviour disorder**

In a minority of cases behavioural problems may be the direct result of another physical or psychiatric condition and treatment of that condition often resolves the behaviour problems. Examples include:

- Behavioural symptoms that occur only in the context of additional psychological symptoms or disorders (e.g., the child only acts out when forced to confront learning difficulties or when required to go to a social event if they have social anxiety).
- If the child seems to act inappropriately for a period before returning to a normal or even depressed state and if this cycle continues over time the presence of bipolar disorder should be considered.
- If there has been a sudden onset to the behavioural symptoms with no prior history of problems clinicians should consider organic (physical causes). These might include: head injury, substance-induced psychosis, substance withdrawal, infections, and tumours. Note that these things are statistically unlikely causes if there is a gradual onset of symptoms.