A BRIEF GUIDE TO

COMMON BEHAVIOR PROBLEMS

for pediatricians, teachers and SLP,OT AND PT

... and relevant recommendations plus bibliography

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

These symptoms are well known, hence will not be extensively elaborated here. ADHD has been divided into two types – hyperactive and inattentive. The latter type may not be diagnosed until later elementary or middle school years, due to the fact that they are not a behavior problem or not physically hyperactive. Such students will have difficulty focusing in activities they do not enjoy, e.g. difficult schoolwork, cleaning. Girls are underdiagnosed because they are well behaved or work harder to compensate for their behavior. ADHD is often diagnosed incorrectly but is also underdiagnosed. It is estimated that the real incidence of ADHD is double the number actually diagnosed.

Interesting Correlates with ADHD

- chews clothing
- many accidents
- high pain tolerance
- sloppy handwriting
- social problems
- academic inconsistencies
- probabilities of ADHD diagnosis increased if child earlier diagnosed with learning disabilities, is adopted or experienced prenatal or perinatal difficulties.
- *Asperger's, Anxiety and Auditory Processing Disorders are often misdiagnosed as ADHD. Bipolar children often have ADHD too, but the medication is less effective.*
- Parents often say "My child cannot have ADHD…they can watch TV all day." TV or video games are a poor measure of ADHD due to the fact that they are a very undemanding activity. In point of fact, the screen itself does most of the "work" of paying attention.
- Parents must understand that there are often biological or genetic factors involved in ADHD. Pediatricians will find that it is not uncommon that one parent or a family relation did have symptomatology that could have been diagnosed with ADHD.
- Other common precipitating circumstances for ADHD include perinatal factors such as toxemia during pregnancy, fetal distress, or other conditions producing anoxia at birth.

- ADHD does not "suddenly appear" at later elementary or middle school years. Hence a child with a good premorbid history is likely not to have ADHD, but could have other disorders such as bipolar or psychological problems.

The first line of treatment for ADHD is psychostimulants. Psychotherapy alone has been proven ineffective for ADHD but is helpful for correlated problems, such as self-esteem or behavioral acting out. Hence, the psychologist's role would be psychological evaluation and differentiating it from the above-mentioned diagnoses.

AUTISM

Symptomatology: The pediatrician is often the very first to see the autistic child. Parents may initially bring them in because of slow *development*, especially lack of speech development. It is not atypical that these children are *cold*, *in their own world*, with *limited eye contact* and obvious *nonresponsiveness to the parent* or even doctor's smile. Many children later diagnosed as autistic are *delayed in their initial cooing and babbling sounds*. By the time they could walk they often are *overinterested in a single repetitive event*, such as a spinning top.

Recommendations: Research has shown that early intervention is an absolute must for the future adjustment of these children. Depending on the child's needs, the following specialists are recommended:

a) Speech therapy – Speech is the vehicle by which we learn. Once the child's speech improves so do his human relationships and academic abilities.
b) Behaviorists – these in-home specialists are capable of teaching parents how to handle autistic children. Using highly scientific and controlled methods, they breakdown a child's behavior into it's most minute steps so that appropriate behavior can be reinforced. Parenting autistic children is completely orthogonal to normal parenting.
c) Child Psychologists – A child psychologist trained in autism is capable of diagnosing the severity of this disorder and discriminating the type of autism. Some children are higher functioning autistic or Asperger's Syndrome.
d) Dietary Interventions – Dietary interventions are now showing tremendous promise in improving the emotional connectedness of the autistic child. Children who undergo the Gluten-Free and Caesin-Free Diet have been shown to be less hyperactive, less moody and more responsive to parental direction. Eye contact and parent-child relations also improve. There are a group of doctors who specialize in this and other non-pharmacological interventions. They can be obtained through the Defeat Autism Now website.
e) Pharmacologically – Aggressive autistic children are often medicated with Respiradol at very small quantities. Obsessive and anxious autistic children often receive an SSRI such as Zoloft. The DAN alternative medical doctor or psychiatric specialist can make these recommendations.

Therefore, sending them for diagnostic workups through a child psychologist or neurologist is a necessity.

ASPERGER'S DISORDER children look much more normal than the autistic children, but still are *interpersonally cold* with a greater *interest in playing on their own* rather than their peers. It is harder to identify them at toddler ages relative to autistic children. By first grade age, most of them are described as *"weird"* because they prefer playing independently and have a series of intense, yet narrow hobbies. Asperger's children *like data*. Throughout their lifespan, they may have had a number of *"passions" – which were toys by which they were obsessed*. There may be a year of playing with Thomas the Train, followed by a year of dinosaurs. These children do not just play with dinosaurs, but memorize all the facts surrounding them. In later years, they might memorize sports statistics or how many cars each parking lot holds.

Treatment: Depending on the child's needs, the same specialists recommended above under Autism may also be appropriate. However, essential to parenting an Asperger's child is to understand how. They do not benefit from a long explanation. They do not experience empathy with their parent's demands. Hence communication must be short and sweet. Different types of consequences are required. Extensive reading is required to understand an Asperger's child so that they can be parented well. Please refer to the appendix.

The other essential component of treating an Asperger's child is social skills training. Social skills group therapies are available in most metropolitan areas. In addition, parents can try some of their own by utilizing social skills training books such as that by Judy Coucouvanis and Jeb Baker.

BED WETTING

Recommendations:
Elementary age schoolchildren should participate in the consequences of bed wetting, including stripping their bed and washing the sheets.
Use of star chart.
Urine retention exercises highlight child's sensitivity to the sensation of "fullness." Urine retention exercises can be played as a game on the weekend with the parent timing the intervals between toilet use.

- Find the muscles you use to stop urinating.
- Squeeze these muscles for 4 seconds. Then relax for 4 seconds. Your stomach and thigh muscles should **not** tighten when you do this.
- Repeat this exercise 10 to 15 times per session. Try to do this at least 3 times a day.

The optimal nonpharmacological remediation would be the bedwetting alarm. Worn by the child at night, and connected to a sensor in their underwear, it emits a loud noise when the child wets. The child awakes. Eventually the child builds a Pavlovian connection between a full bladder and waking therefore preventing bedwetting. Available at bedwettingstore.com.

DEATH

A child's loss of a parent or even a grandparent is usually a significant matter. The child's grief reaction will be highly correlated with that bond to that particular parent. Hence, a child will be less grief-stricken if the grandparent is one that is seen only annually. Death without warning, e.g. from car accidents, may be more difficult to handle.
Nevertheless, a child's reaction to death parallels the stages of an adult including shock and disbelief, followed by bargaining and a gradual acquisition to the point of acceptance.
At this point, real grief should set in and hopefully the parents will see some type of reaction, whether it be tearful or acting out.
Common reactions include child's fear of their own parents dying or guilt about their most recent naughty behavior.
Children who show no reaction may need one precipitated. Parent may wish to spend time with the child discussing their relationship with the deceased. Books and the attached bibliography may be helpful.
Regarding funerals, children older than five should be involved with the funeral. It is necessary for them to see the finalization of the process.

Such children who cry or act out for some period of time understand the finality of death and its importance. These children will recover, especially if they have a healthy premorbid history.

A more inward and repressed child could have grief-related problems later. Symptoms recurring several months after a death may require professional help. These include preoccupation about losing things, repetitive questions about death, anxieties, phobias, sudden unpredictable anger, daydreaming, or apathy. Most children, however, will wonder when the other parent will die.

DEFIANCE AND DISOBEDIENCE

Why: Contrary to popular belief, children want and need discipline. They often "test" as an effective means to understand their environment will be safe. Increased need for discipline is often exacerbated by:

- Parents who wait to discipline until their temper has reached a boiling point.
- Parents who are inconsistent within and among themselves.
- Child temperament – some children are so strong-willed or punishment-resistant that they need a confrontational approach just to put their shoes away.
- A home that is so "democratic" that it may be based on "what the child would like to do." Many parents put young children in a situation of making decisions when they are not so capable of doing so.

Recommendations: Parents must take themselves seriously and build credibility with their child:

- Hence should the child not listen on the first or maybe second occasion, the parent should approach the child by being close to their face and rephrase their statement via the use of a question – **"What did I just ask you to do?"**
- Should this still not yield a positive result, parent may approach the child closer, drop their voice an octave, firmly grip the child's upper arm, and repeat the sentence. Repetition can be dramatic. Emphasize your non-verbal communication (e.g. the "look", pointing) over wordiness. **Children block out words.**
- The 1-2-3 Technique is used as follows: "I asked you to pick up your socks." "One." -- "Two." -- "I need you to pick up your socks. I am about to say three." "Three." When "three" occurs, some discipline must be enforced immediately. Most effective discipline is short, dramatic, and immediate.
- Punishment should not be an overreaction. Punishment is best individualized to the infraction. Natural consequences tie the punishment into the problem. Examples include removing objects not put away, loss of a privilege that is broken, cleaning a mess with a little extra cleaning thrown in, work detail including cleaning pots and pans.
- Traditional punishment such as time-out are also effective, but should be used for short periods, such as one minute per child's year of age.
- In general, long-term punishments are no more effective than short-term punishments. A child or even a teen grounded for two weeks rarely remembers why by the end of one week. Loss of television for one day is not more effective than loss of television for a week.

DEPENDENT BEHAVIOR

Symptomatology:

I. Seeking excessive help, affection, or attention:
- Whining, crying, feigning incompetence.
- Interrupting conversations.

II. **Why:** Children enjoy manipulating adults by playing a babyish role:
- History of clinginess.
- High need parent may generate high need child.

III. **Recommendations:**
- Parent to be consistent, firm, repetitive, and boring to fend off child's efforts.
- Never give the child what they want without asking for something first e.g you can play after you clean your room
- Parent must demonstrate to the child that they believe that they are competent.
- Parent should demonstrate part of a task and then manipulate the child to do the majority for themselves.
- Use memory aids like lists.
- When child insists on help, remind child with only a fragment of the information.
- Eliminate the parental bed.

DIVORCE

1. Divorce needs no definition. However, the qualities of each divorce differ dramatically. It is preferable that a child of any age has some sort of saddened or even angry reaction to divorce at some time within six weeks of actual physical separation (e.g. parent moves out). Those who continue to be silent for months after are often a cause for concern.

   Research has given us several rules that determine the adjustment to divorce by the child. **Children who adjust best to divorce can be predicted almost 100% by the post-divorce relationship between parents.**

2. Adjustment to divorce is also predicted by the child's early and existing bond to the now separated parent. For instance, a parent who left home at child's age 3 and was only minimally tied to his 3-year-old girl may see little adjustment difficulties from her. In other words, the emotional climate of the house does not change much.

3. The conflict between divorced parents is now classified into low, medium, and high-conflict families. The latter have at least one parent who believes that they no longer need their spouse therefore so their child does not either. Every effort is done to exclude one parent from school activities and child contact. Often, these parents exaggerate the failings and "crimes" of this now alienated parent. The pediatrician should not believe any story in full from either parent in a medium or high-conflict family. The likelihood that their information is distorted remains strong.

LEARNING DISABILITIES

In younger child:

- Lack of interest in learning to read.
- Reading errors including inversions, mirror writing, skipping or confabulating syllables.
- History of speech delay or unintelligibility.
- Failure to retain letters, words, or facts learned 1 to 24 hours earlier.
- Slow to learn math concepts (including time, money, laterality, cannot retain times tables), difficulty remembering colors as a young child.
- Poor sight vocabulary (uses "thing" a lot).

In older child:

- Significant disparity between skills, e.g. math much better than reading.
- Still mispronounces, misspells, or delays acquisition of new words.
- Cannot transfer knowledge to tests even if well learned before.
- Skipping or confabulating small words.
- Does not like to read for leisure.
- Very slow reading.
- Unable to retain information even after honest attempts to study.
- In general, mathematics deficits are identified later in later elementary or middle school years, whereby reading learning disabilities are identified in kindergarten through second grade.
- Struggles in understanding concepts.

Central Auditory Processing Deficits (CAPD)

- History of otitis media or hearing loss.
- Could be correlated with speech deficits.
- Could be correlated with an oversensitivity to noise.
- Confuses similar words, such as "cone" for "comb."
- Asks "What?" frequently.
- Need repetition of oral instructions.

This disorder may interfere with reading or listening comprehension.

OBSESSIVE COMPULSIVE BEHAVIORS INCLUDING HAIR PULLING

Symptomatology:

- This diagnosis is soaring in this decade. Younger and younger children are inflicted with this disorder. Common symptoms include overconcern with cleanliness, hand washing, counting, repeating, and checking rituals. OCD is exacerbated by ambient anxiety, but may be a genetic temperament.
- OCD can be treated psychologically if caught early. Immediate referral should be made. **DRUG USE CAN BE AVOIDED BY FINDING A SKILLED PSYCHOLOGIST AWARE OF OCD TECHNIQUES FOR CHILDREN.** If OCD is entrenched, a combination of psychotherapy and pharmacology is often helpful.

Hair Pulling or Trichtotillomania

Symptomatology:

- Boys tend to pull at the crown of their hair, whereby girls play with split ends. Pediatrician may see a bald spot. Trichtotillomania is correlated with OCD and is partly an anxiety disorder.
- Trichtotillomania is amenable to behavior therapy, relaxation therapy, and possibly medication.

Treatment:

Parents often make the error of indulging obsessive habits. For instance a child who likes Pokemon may have a Pokemon bed, Pokemon bedroom, and Pokemon birthday party. This further ingrains the child's needs. OCD children sometimes demand that their parents repeat information in an exact way or perform certain actions in the same way. Examples include "Say it that way, Mommy" or "I'll only eat dinner if I can drink out of my Mickey Mouse cup." It is best that parents do not support these habits and in fact should place limits on these behaviors.

OCD is one psychological disorder that research has shown requires both psychotherapy and medication. One psychotherapeutic technique is called the "boss-back technique". This is where the child learns to "talk back" to their OCD. This empowers the child to have strength over their bad habits.

Parents should also limit OCD talk time. Number use is helpful. "We can only have 2 more Pokémon questions this morning." Then the child's third question is ignored, or a nonverbal signal is given that indicates "enough."

SAYING "NO"

Symptomatology: The modern parent has become rather fearful of using the "n" word for fear of hurting their little child's feelings. However "no" forms the basis of a child's need to understand limits. Remember that parents are preparing children for the real world, another place where they will not get everything that they want.

Parents must learn to say no crisply and cleanly without negotiation or follow-up discussion. Every child deserves one explanation, but beyond that the child will have ample opportunity to manipulate parent. Most raised voice battles begin here because parent and child debate their particular needs. PARENTS MUST STAY IN CONTROL, REPEAT THAT THEY HAVE SAID NO TO THE MATTER, AND THAT THE CASE IS CLOSED.

Parents often bring children to the psychologist saying, "My child is so angry he is always yelling at me." They often fail to mention that mother has asked him to pick up his socks ten times and *by the tenth time her voice is loud enough* to be heard in Cuba. The child now learns that communication between parent and child must be at a raised voice level, with no consequences to either's actions.

Solution: An alternative would be for the parent to respond in a three-step approach. First, one would say, "Pick up your socks." On the second occasion they would get closer to the child's face and ask the question, "What did I just say?" On the third occasion the parent would grab the child by the arm and repeat the question. This consistency will give the parent credibility. Should punishment be involved, it should be swift, immediate, and short-lasting. Parents who take away Game Boy starting tonight for the whole week rarely have a long-lasting impact on their child.

SEPARATION ANXIETY

Symptomatology: Children who are fitful and disturbed on the first day of school have been that way for some time, including similar behaviors when being left at a birthday party or separating at nighttime. Some of them may have even been sleeping with their parents. The older ones have unrealistic fears about what time they will be picked up or harm befalling their parent.

Parents usually exacerbate these morning problems by trying to negotiate separations or making their guilt obvious.

Solution: The trick for handling separation is to get the child into school by hook or by crook. Eventually, this will mean that the parent should crisply separate from the child even if they leave the crying child in the hands of a teacher or administrator. This will be communicating to the child that you intend for them to act independently and that you feel satisfactorily about that. Parents who are also crying will counteract their intentions. A "foil" is also useful. Sometimes fathers, who are less attached to children, are better at handling school drop-off than mothers. Other tricks include having a neighbor or friend's mother take the child to school.

To mitigate school separation anxiety the child should tour their new school and meet the teacher. The next day they should go through a dry run of being dropped off.

Those who continue to resist school by psychosomatic complaints should only be excused from school when they have a clear fever. Nurses should be instructed to return the child to class after some minimal attention.

Most separation anxiety that is not exacerbated by parental attention or too much negotiation will fade within one week. If not, professional attention is required.

SLEEPING WITH PARENTS

Recommendations:

- Parents must understand that independent sleeping is an important developmental task learned by a child and is integrally correlated with the later ability to handle stress and anxiety.
- Rule out that parents are not insisting on sleep with them for selfish reasons or for their "family bed philosophy."
- Treatment involves a step-wise procedure where the child is first moved out to a bed-like position (e.g. sleeping bag) near the foot of the bed. In subsequent weeks, the bed-like area can gradually be moved further from the parents' bed. Eventually, the leap has to be made to the child sleeping in their own room. Initially the parents could lay with the child to a point before the child falls off to sleep. The period of time laying with child is gradually decreased until nighttime becomes merely a brief backrub or short story.
- Any returns to the parents' room in the middle of the night should immediately result in a child being sent back to the room and the repetition of the above procedure.

Use of a tape recording of the parent's own voice, perhaps reading the child's favorite stories, can be used as an adjunct to helping comfort at nighttime. As soon as the parent leaves the room, they can turn on the tape recorder so the child hears "a piece of them" without the whole parent being present.

SOILING

Recommendations:

- Rule out whether it is correlated with other oppositional behavior.
- Rule out whether the parent is overwhelming the child with demands.
- Rule out whether parent has started toilet training too early. Young parents may consider early toilet training to be a status symbol or equate it with having a "gifted" child.
- The best therapy is regular toileting time, sometimes called "sits" or "potty practice." The child is asked to sit on the potty two to three times a day for a period of approximately four minutes. Sitting is <u>not</u> to include expectation of any actual defecation. The toilet sitting time should be a pleasant sitting time where the child receives attention and perhaps mother or father takes time to read to them. Yet, this child can and should perceive this as an inconvenience – then subtly get the message that if they defecate normally, this inconvenience will stop. Toilet sits should be associated with a star chart for appropriate toilet behavior. Star charts don't necessarily have to be associated with reward, but merely highlight the child's success.
- Diets high in fiber might also be helpful.

THUMB SUCKING

Recommendations:

- Star chart.
- Teach the child a "competing response," for instance petting a stuffed animal when one feels the need to suck.

Some parents use a transitional sucking device. In other words, they allow the child to suck something else other than a thumb or a binky as a way to graduate them out of the thumb-sucking behavior.

TICS AND TOURETTE'S DISORDER

Symptomatology:

- Pediatrician may see facial grimaces, shoulder shrugs, eye blinks or other eye movements.
- Tics can vary from simple repetitive ones to complex motor movements.
- Tics may or may not be correlated with vocal expressions, such as throat clearing.
- If tics are allowed to persist for a long period, they can become enmeshed and escalate to Tourette's Disorder.

Require immediate professional intervention. If caught early, they are amenable to a behavior therapy involving contradictory muscle movements. This therapy is called a habit reversal. Child and parents first become increasing aware of the tics. Parents may use self-monitoring sheets and mirrors to keep track of when the child is ticing and in what situations this may occur. A professional experience in habit reversal then teaches the youngster techniques that are physically inconsistent with the emerging tic.
At subsequent levels of escalation, medication may be required. Hence, the child could be referred to a child psychiatrist.

TRAUMA

Symptomatology: Exposure to actual harm by an actual severe and unusual event, such as traffic accident, hurricane, or observing a heart attack.

Traumatic reactions can follow, especially when they are precipitated by events that remind one of the original events. For instance, the child will feel anxious should they be close to the superhighway where the original accident occurred. Even more indirect reactions could occur like a child bit by a dog near a mailbox may get upset when seeing an advertisement for the US Postal Service.

Most children then avoid the events that remind them of the trauma and also develop anxiety, sleeplessness, outbursts of anger, and a constant "vigilance." Adults wish they could have done something different to save the problem.

Solution: A Post-Traumatic Stress Disorder is a natural sequela of human emotional response. However, its solution works before the symptomatology becomes enmeshed. Children and teens should be allowed to vent their fear, but also be told that quickly getting back to confront their trauma will help them. Hence, children that have had car accidents should quickly return to riding in cars and then after a few days … should be able to drive past the accident site. **Do not allow the effects of the trauma to interfere with life's functioning, even if the child must struggle to overcome their feelings.**

PTSD also responds quickly to brief psychological intervention.