PedsCases Podcast Scripts

This is a text version of a podcast from Pedscases.com on "**Behavioural Problems in Children.**" These podcasts are designed to give medical students an overview of key topics in pediatrics. The audio versions are accessible on iTunes or at www.pedcases.com/podcasts.

Behavioural Problems in Children

Developed by Michelle Hanbidge and Dr. Debra Andrews for PedsCases.com.
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Introduction

Hello everyone! My name is Michelle Hanbidge and I am a medical student at the University of Alberta. This PedsCases podcast was developed in collaboration with Dr. Debra Andrews, Associate Professor of Pediatrics at the University of Alberta in Edmonton, Alberta, Canada. This podcast will review keys to behavioural management and compliance during medical examination in typically developing young children.

Case Presentation

Let us begin with a clinical case to put everything in context. You are a third year medical student on your family medicine rotation in a rural centre. You are completing an assessment of a middle-aged man with hypertension, and as you are reviewing your plan with your preceptor, you hear loud crying coming from the exam room down the hall. You look at the electronic medical record and see that a 3 year-old child with fever and ear pain has just been put in that room. Your preceptor says, "Wow! What a great opportunity for you to review acute otitis media AND practice your pediatric physical exam! I'll finish up with your other patient. Why don't you get started with Sophie?" After reviewing Sophie's chart, you head into the room with Sophie and her father. The history her father gives is consistent with acute otitis media, but you are unable to complete any of your physical examination due to an extremely fussy and uncooperative Sophie. Her father apologizes and in an exacerbated tone says, "She's always like this…throwing tantrums and not doing anything we ask! How can we get her to follow instructions??" You respond that you will discuss with your preceptor and return with a plan shortly, and leave the room realizing you are going to need a different strategy to help Sophie and her parents. What can you do to increase Sophie's cooperation with your instructions so you can complete a thorough physical exam and impress your preceptor? And what advice are you going to give her father to help manage Sophie's behaviour at home?

Learning Objectives

At the end of this podcast, the learner will be able to:
1. Define “behaviour” and other key terms,
2. Take an appropriate behavioural history in a paediatric patient,
3. Characterize common behavioural problems into two main types, and
4. Learn techniques to increase compliance with physical examination in children with difficult behaviours.

Approach

Behaviour problems are common in primary care and pediatrics. Every physician should be equipped with skills to increase compliance in children and should be prepared to provide parents with advice on discipline for children.

First, let’s start with a few definitions. A *behaviour* is an action that occurs in response to a stimulus event. It is what you *see* a person *do*. Referrals for “behaviour” generally imply misbehaving, but it is important to note that behaviour is neither inherently good nor bad. *Pro-social behaviours* are generally things we want kids to do that facilitate getting along with others, whereas *aggressive* behaviours cause harm to others. It is tempting to quickly attribute a motive to a particular behaviour; however, since we cannot read children’s minds, it may be more useful to focus on observation, careful descriptions of what is going on, and identification of the stimulus. If we can change the behaviour first, the child’s feelings about the stimulus or situation will usually follow. A *reinforcer* is something that you do that increases the frequency of a given behaviour, and may include things like praise or stickers. A *punisher* is something that you do that decreases the frequency of a given behaviour; examples might be being removed from a fun activity or having a privilege removed. A punish*er* is not punish*ment*. We do not recommend punish*ment* as a way to change behaviour, since it usually does not work. But we do recommend paying attention to what things *do* change behaviour in a given child, and increasing approaches that increase desirable behaviours while decreasing those that promote undesirable ones.

Behavioural problems can be broadly categorized as either a deficit in desirable behaviours or a surplus of undesirable ones. Deficits of desirable behaviours might include not listening, not obeying, not eating, not going to bed, not using the bathroom, or not going to school when asked. Undesirable behaviours include hitting, kicking, biting, yelling, teasing, or swearing.

Common behaviour problems in typically developing children include:
- Non-compliance (with eating, sleeping, toileting, schooling, or in this case, a medical exam),
- Inattention,
- Tantrums,
- Aggression and bullying.

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Behavioural problems in children with developmental concerns and/or specific behavioural diagnoses like attention-deficit hyperactivity disorder (ADHD) or autism will not be discussed in this podcast. Rather we will stick to the common kinds of behaviours that many typically developing young children show at some point in childhood.

Common History

Taking a behavioural history is the same as any other history. It is important to remain objective and avoid premature conclusions about why the behaviour is taking place. Be sure to ask questions such as:

- When did the behaviour start? How long does it last?
- Can you describe the behaviour?
- What makes the behaviour better or worse? What have you tried? Who have you consulted?
- Does anyone else in the family have a similar behaviour?
- What do you think is the thing that sets off the behaviour? Does this occur in only one setting or multiple places?

Behaviour is multifactorial and is affected by genetic as well as environmental factors, which means different environments can elicit different behaviours. Behaviours can also be affected by the child's current state; for example, a more exaggerated response to a stimulus might be seen in a child who is in pain or fatigued.

Final Diagnosis

Back to the case, Sophie is a typically developing child who has been throwing frequent tantrums since the age of 2. She lies on the floor, cries, hits and throws objects. You elicit on history that these behaviours occur when she does not get her way or is asked to do something she does not want to do; they can last anywhere from 5-30 minutes. Further, Sophie frustrates her parents by refusing to go to bed when they try to put her down and being an extremely picky eater, throwing all meats and vegetables on the floor. They try to send her to her room or take away toys, but she rarely obliges, and her parents often give in to what she wants, especially if they are in public and feel embarrassed or judged. Sophie has two older brothers, aged 4 and 6. The oldest had similar episodes around Sophie's age, but these were less intense and he grew out of them quickly.

What you are witnessing in the exam room appears to be a typical tantrum for Sophie, likely due to a combination of her current discomfort, the unpleasant maneuvers you are trying to complete, her parents' past tendencies to give in to a tantrum to avoid unhappiness or embarrassment, and Sophie's inherent temperament.

Treatment Plan

You start by educating her father about behaviour while waiting for Sophie to settle down. You tell him that children's good behaviour is not innate - it must be learned, with parents being the main teachers of behavioural expectations before school age. And being good at parenting, especially the more difficult or unpleasant aspects, is not innate either - effective strategies for teaching and disciplining children must also be learned. On top of this, some children are more challenging to teach than others. You say that the goal of "discipline" is teaching children the differences between acceptable and non-acceptable behaviour, how to be part of a group, and the family's moral and cultural values. We tend to think of the word "discipline" as being a negative thing, but it really comes from the idea of studying or learning something carefully.

Problem behaviours are best addressed in young children, under the age of three. Problem behaviours should be prioritized so that only 2-3 are being worked on at a time. It is important to advise parents to be consistent in their approach and role model the behaviours they would like to encourage. There is only so much time in a day, so increasing desirable behaviours leaves less time for undesirable ones. This means that treatment plans must focus on spending one-on-one playtime and reinforcing good behaviours, in addition to addressing undesirable behaviours with consequences that have been thought out ahead of time. Parents should never promise or threaten consequences they can't deliver on, because then children learn that parents don't mean what they say.

Specifically, parents should give direct commands, not using questions if they aren't really giving the child a choice. These can be phrased as "You need to…" or "I need you to…" or "It is time to…" instead of "Do you want to. . .?" These instructions are more effective if the parent is standing close, no more than 1 metre away, with direct eye contact, so the child is sure who is being spoken to. Parents should give the child 3-5 seconds to comply, waiting calmly and silently while maintaining eye contact. "Non-compliance" is defined as taking more than 30 seconds to act on a request. Parents should repeat requests no more than twice and then should follow through with pre-determined consequences. No nagging or begging! Yelling should be avoided, and parents should keep their tone authoritative and firm.

Focus more on "start" or "continue" requests than "stop" requests. It is easier for children to continue doing the right thing than to guess what they should be doing instead. And these requests should be specific and actionable, rather than vague. A vague request could be "be good" or "act responsibly". A better request would be "stay close and hold my hand". Remember that young children are just learning and do not have the understanding that you do for why some things just need to be done. As a parent you need to make these important decisions. Give lots of immediate praise and focus on reinforcing good behaviours. Stay positive!

Children often appreciate rules and structure more than many parents realize. Consistency and clear limits on behaviour can help a child feel successful in meeting family expectations, and both parents and child will feel happier.

If a child does not respond to these informal suggestions, the parents may need more help. Parent training programs, such as “The Incredible Years” and “Triple P Parenting”, are often available through Child Mental Health, and can support parents while they work though more intensive approaches. These well-researched approaches have been shown to be effective in improving behaviour.

Physical Exam

Sophie has finally stopped crying and is sitting settled on a chair in the corner of the exam room. You decide now is as good a time as any to reattempt your physical examination. When completing a physical exam on a child, it is important to remember your role and primary responsibilities. Your job is to be the doctor, not the parent or a friend, and your main objective is ensuring the health of the child. Some of the actions we need to perform are unpleasant, and crying is often normal. Allow the parents to make the decisions and comfort the child. While you can and should be friendly, caring, and compassionate, you must not avoid doing the things that are necessary, but unpleasant; do the exam so that you can diagnose the problem. Follow the same advice you would give to parents - you do not need to be mean, but you do need to be authoritative and firm. And remember that children are always watching and learning - role model good health and behaviours!

You approach Sophie, squatting down to be at her eye level. You notice she is wearing a green t-shirt and boots and ask her if this is her favourite colour, because it is yours as well! While she is quiet, you listen to her heart and lungs, both of which are normal. You perform a quick abdominal exam, during which she giggles, but you determine her abdomen is soft and non-tender with no masses or organomegaly. Her MSK and neurologic exams appear grossly normal based on your observations of her activities throughout the visit. You defer your GU exam given the presenting complaint and her otherwise unremarkable history. You palpate her lymph-nodes and use the otoscope to examine her pupils and oropharynx.

Last, but not least, you move on to the ears. You instruct Sophie’s father to hold her sideways on his lap with his arms wrapped around Sophie’s body to restrain her arms with Sophie’s head resting on dad’s shoulder, turned to the side. Sophie begins to cry and squirm away when you start to insert to otoscope, but you talk to her in a calm, soothing voice encouraging her to “Hold still, we’ll be done soon!” With determination and dad’s firm hold, as well as a little help from the heel of the hand that holds the otoscope to stabilize her head, you quickly visualize both ear canals and tympanic membranes. You see a pale yellow, intact but bulging tympanic membrane consistent with middle ear inflammation. You refer to Sophie’s chart, and note that her vital signs are all within the normal range for her age, except she has a mild fever of 38.7. With the diagnosis of acute otitis media, you reassure her father that most cases of acute otitis

media like Sophie's are self-resolving, and he agrees to take a "watch-and-wait" approach. You instruct dad to return in 48 hours if Sophie's symptoms do not improve for a prescription for a course of high-dose Amoxicillin. Of course, you also praise Sophie for holding still and being a brave girl and you allow her to pick a sticker from your sticker box. You tell her she can pick another one the next time she comes and "holds still" for her check-up. If she wants, she can bring her teddy and you will check his ears too.

Summary of Learning Objectives

Let's review our learning objectives. A behaviour is an action that is triggered by a stimulus. It is neither inherently good or bad, but it is generally the "mis-behaviours" that are brought to the attention of a physician. These misbehaviours usually fall into one of two categories: not enough desirable, pro-social behaviours that parents hope for or too many undesirable or aggressive behaviours. It is important to fully characterize the behaviour with a thorough history. Include details such as when the behaviour started, possible stimuli, how long it lasts, a description of the action itself, what makes the behaviour better or worse, what has been done to manage the behaviour so far, and family history.

Remember that your primary role is as a physician and your responsibility is to ensure the health of the child. It is normal for a child to be uncomfortable and to cry during some physical examination maneuvers that doctors must do, and young children do not have the understanding to be talked into these things or the self-control to do them without being upset. Be friendly, caring, and compassionate, but do not avoid completing your physical exam because a child "doesn't want to" if there is something important that needs to be checked. Speak firmly and calmly, using short clear instructions, and allow the parent to help hold and then calm the child once the exam is completed. Reward kids with praise (and stickers!) for even small steps towards learning to be a good patient! And above all, role model an approach to good health and behaviours with the children and families you see!

Conclusion

This brings us to the end of this PedsCases podcast on behaviour and non-compliance. Thank you for listening!

References

Augustyn, M., Zuckerman, B., Caronna, E. (2011) The Zuckerman Parker Handbook of Developmental and Behavioral Pediatrics for Primary Care, Third Edition. New York, New York. Walters Kluver Health/Lippincott Williams & Wilkins.

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