

# **Challenging Behaviours in Childhood**

**A/Professor Alasdair Vance**

**Consultant Child and Adolescent Psychiatrist**

**Department of Paediatrics**

**University of Melbourne**

**Royal Children's Hospital**

**Email: [avance@unimelb.edu.au](mailto:avance@unimelb.edu.au)**

# Challenging Behaviours in Childhood

## Outline:

- 1. -common paediatric behaviour problems  
-their detection and brief assessment**
- 2. -range of available strategies to alter  
the cognitive, emotional, motor, and social  
aspects of presenting challenging behaviours  
-clinical principles to guide referral to specialist  
mental health services**
- 3. -behavioural modification programme that is  
age- and context-appropriate**

# Common paediatric behavioural problems

## Key Principles:

- 1. Common: -5-10% prevalence in our community**
  - anxiety symptoms/disorders and disruptive behaviour/disorders most common; similar prevalence estimates in other cultures**
  - anxiety symptoms include generalised anxiety disorder, specific phobia, separation anxiety disorder, social anxiety disorder; obsessive compulsive disorder; panic disorder +/- agoraphobia rare in childhood; bed wetting after alternative other physical causes excluded; somatisation-primarily headaches, stomachaches, nausea, dizziness, limb pain/reduced movement**

# Common paediatric behavioural problems

## Key Principles:

- 1. Common:** -rarely conversion symptoms occur, although these symptoms are more common in [1] childhood rather than adulthood and [2] in hospital rather than community settings; PTSD rare, although traumatic events unfortunately common  
-disruptive behaviour includes Attention Deficit Hyperactivity Disorder (ADHD), combined type (ADHD-CT) and inattentive type (ADHD-IA), oppositional defiant disorder, conduct disorder
- 2. Externalising and internalising symptoms are commonly linked:**  
-disinhibition, oppositional defiant behaviour, motor restlessness can be markers of anxiety

# Common paediatric behavioural problems

## Key Principles:

### 3. Multi-informant assessment:

- parent perspective, child perspective, teacher perspective, clinician/other perspective
- concordance between perspectives can be low
- parental attitudes towards, understanding of a given child's symptoms and behaviour are crucial to the priorities of the treatment plan at any given time

### 4. Family context:

- family system's flexibility and adaptiveness to change within the life cycle

# **Common paediatric behavioural problems**

## **Key Principles:**

### **5. Developmental context:**

**-the social and cultural forces that shape the nature and strength of the interpersonal links between a given child and their family members and school peer group/ teachers need to be considered in the assessment**

### **6. Comorbid developmental vulnerabilities**

**-speech/language, visuospatial, fine/gross motor coordination, specific learning**

# **Range of available strategies-psychological and medication**

## **Key Principles:**

- 1. Psychological strategies involve individual, parent-child dyad, family and group strategies:**
  - goals in the short-term (<6weeks) and the longer-term (>3 months) need to be clear**
  - goals include**
    - Individual:target symptom reduction, improved self-esteem,improved self-reflective capacity**
    - Interpersonal: improved problem solving, improved conflict resolution, improved and more frequent creative and imaginative play**
    - System: improved labeling of the problem**

# **Range of available strategies-psychological and medication**

## **Key Principles:**

### **2. Medication:**

- ‘do no harm; least number and the lowest dose possible’**
- clear goals that include the following:**
  - 1. arousal regulation**
  - 2. mood regulation**
  - 3. executive functioning-planning, organising prioritising abilities**
  - 4. motor activity, for example, restlessness**
- diagnosis driven medication use is debatable**
- systematic research is imperative**

# **Range of available strategies-psychological and medication**

## **Key Principles:**

- 3. Synergism between medication and psychological interventions:**
  - particular goals for both medication and psychological treatments that are interdependent and additive**
  
- 4. Developmental Context:**
  - the prioritisation of particular interventions given a child's developmental stage**
  
- 5. Monitoring of psychological and medication interventions:**
  
- 6. Coordination of other specialised treatment programmes:**
  - speech therapy**
  - occupational therapy**
  - psychology/educational psychology**

# **Range of available strategies-psychological and medication**

## **Key Principles:**

**7. Referral to specialist mental health services should be considered if any of the factors below fail to be achieved:**

- *Engagement***
- *Negotiate a management plan***
- *Gain multi-informant information***
- *Assess and monitor treatment goals***
- *Goals of treatment not being met***
- *Enmity between key informants prevents any of the above***

# **Behavioural Therapy Principles and Practice**

## **Fundamental Principles**

- 1. Classical Conditioning**
- 2. Operant Conditioning**
- 3. Social Learning Theory**

# Classical Conditioning

-learning through the association of two events with each other described in logical positivist philosophical theories (Bertrand Russell, A J Ayer)

-Pavlov (1927): Russian physiologist ; described the features of classical conditioning through experiment “Pavlov’s dogs”

-conditioned stimulus (CS) paired with unconditioned stimulus (US)

-unconditioned stimulus(US) naturally elicits unconditioned response ((UR)

-repeated contiguous pairing causes the conditioned stimulus to lead to the unconditioned response, which then is termed the conditioned response (CR)

Example: bell (CS)-food (US)-salivation (UR) initially then (CR)

# Classical Conditioning

- CS and US pairing has to be orderly and probable for learning to be rapid and efficient
- learning is both 'automatic' and 'conscious and effortful'
- extinction: the identification and removal of a reinforcer (US) from a person's environment in order to achieve  
conditioned inhibition:  $\angle$ US-  $\angle$  CS link to CR because of  $\angle$ UR
- think of clinical problems that you have encountered and organise them according to a CS US UR CR model

# Operant Conditioning

-“Thorndike’s cats” ; “Skinner’s box”; ‘trial and error learning’  
E L Thorndike (1931); B F Skinner (1951)

-Skinner’s philosophical stance of *radical behaviourism*-  
*overt behaviour alone is amenable to scientific study and thoughts and emotions are not able to causally influence behaviour*- led to the model of operant conditioning in which environmental events are the primary determinants (strictly only) of human behaviour and the individual is the only unit that should be studied. Skinner rejected group comparison study designs as flawed because they are unable to study the range and complexity of human individual behaviour

# Operant conditioning

## -positive reinforcement:

positive consequences of a given behaviour (reinforcers) increase the probability of that behaviour occurring again

primary reinforcers affect biological processes- example: food, psychostimulant medication, opioids

the overall probability of the association being present between a given behaviour and a positive consequence is required rather than a strict temporal contiguity, as for classical conditioning

desired behaviour is linked to a positive reinforcer

# Operant conditioning

## -negative reinforcement:

a given behaviour that leads to the removal of an aversive stimulus will be increased

it is essential to recognise that positive and aversive stimuli can vary between human beings and therefore need to be determined at an individual level

an aversive stimulus can be the removal of a positive reinforcer such as attention (shown through behaviour/emotional expression /thought expression)

strategic ignoring (aversive stimulus) of undesired behaviour

# Operant conditioning

## -punishment:

aversive stimulus is consequent upon undesired behaviour

traditional models of negative reinforcement are linked to punishment

more modern operant approaches to behaviour management do not use punishment or traditional models of negative reinforcement because particular developmental vulnerabilities associated with particular childhood and adolescent disorders frequently increase the likelihood of positive reinforcement of undesired behaviour through [1] social learning (modelling) and [2] positive reinforcement

# Social Learning Theory

-A Bandura (1969)

environmental events influence the acquisition and regulation of behaviour through cognitive processes

modelling involves the symbolic representation of possible future outcomes through vicarious learning

think of clinical problems that you have encountered and organise them according to an operant conditioning model

think of clinical problems that you have encountered and organise them according to a social learning theory model

## **Behavioural Modification Programme**

- step 1: ACE
- step 2: FAN
- step 3: PEP
- step 4: ROPE
- step 5: ROPE
- step 6: FED
- step 7: MET

-Step 1: identify the various stimuli and response factors that vary between individuals

**Age and Context appropriate Engagement-ACE**

-Step 2: discuss with the person these factors and negotiate an agreed set of factors

**Factors Agreed and Negotiated-FAN**

-Step 3: identify a particular example for practice

**Particular Example Practice-PEP**

-Step 4: record the outcome of the practice events

**Record Outcome Practice Events-ROPE**

-Step 5: review the results of the practice events outcomes

**Review Outcome Practice Events-ROPE**

-Step 6: develop further examples using the above steps

**Further Examples Developed-FED**

-Step 7: monitor the effectiveness of the practice of the various examples over time, for example, 3-monthly intervals

**Monitor Effectiveness over Time-MET**