

PedsCases Podcast Scripts

This is a text version of a podcast from PedsCases.com on “**Disruptive Behaviour**.” 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.

CPS Guideline Podcast- Screening for disruptive behaviour problems in preschool children in primary health care settings

Developed by Dr. Claire Nguyen and Dr. Alice Charach for PedsCases.com.
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Hello, my name is Dr. Claire Nguyen. I am a fourth year Developmental Paediatric Subspecialty Resident at Holland Bloorview Kids Rehabilitation Hospital at the University of Toronto. This podcast was produced by PedsCases and the Canadian Pediatric Society, and aims to summarize the recent 2017 Canadian Pediatric Society (CPS) statement on screening for disruptive behavior problems in preschool children in primary health care settings. This podcast was developed with Dr. Alice Charach, a Child and Adolescent Psychiatrist at the Hospital for Sick Children and Associate Professor at the University of Toronto. For further information, and to see the full length CPS statement, please visit www.cps.ca.

Let us first start the podcast with a clinical case. Picture this:
You are working in a community clinic. Your next patient is an almost 4-year-old girl with a long history of temper tantrums, hitting, refusal to follow instructions and running out of rooms without adult permission when she is upset. Her mother called the clinic because she is “at wit’s end” and wants to discuss how to manage at home. You notice that the appointment is designated a regular visit in the clinic schedule.

The girl is previously healthy and fully immunized. As you walk into the patient room you observe the mother attempting to get the child to sit in a chair. The girl is crying, shaking her head vigorously and resisting being seated. You see the girl pull away from her mother, run to the side and hit the wall with fisted hands while screaming. You wonder if this behavior falls within the normal range for behaviours in a pre-school child and how the behaviours can be managed.

Objectives

The objectives of this PedsCases podcast are:

1. To outline normative versus problem indicators for disruptive behaviours.
2. To review important sequelae of unmanaged disruptive behaviours.
3. To discuss an assessment framework and differential diagnosis.
4. To discuss screening tools and measures for identifying problematic disruptive behaviours.
5. To outline initial interventions.

Background

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To start off, let's briefly review disruptive behaviors. Disruptive behaviours can include severe temper tantrums, aggression and pervasive noncompliance. These affect an estimated 9-15% of preschool-aged children. The behaviours can have significant negative impacts on child function and increase family stress. Unchecked, the behaviours represent risk factors, and/or potential components of significant neurodevelopmental and mental health disorders. Examples of associated disorders include attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder, anxiety and mood disorders, as well as cognitive and language disabilities. For many, both clinical and subclinical levels of disruptive behaviours can persist into early primary school years, placing the children at risk for poorer academic, physical and mental health outcomes into adolescence and adulthood.

Identifying disruptive behaviours

Children's social, emotional and behavioral functioning can be quite variable between two to five years of age. Developmental level and environmental and caregiver contexts have a large impact. Aggression and temper tantrum frequency typically peaks around three years of age, and for most, it is a transient developmental stage. Thus, behaviors that are considered normative at age three may be clinically significant at age five. By maturation and through expectations set by caregivers, most children gain control over aggressive impulses and develop prosocial skills.

But how do we distinguish those children with disruptive disorders who are likely to benefit from early identification, evaluation and intervention from those whose disruptive behaviours will likely resolve over time? Clinicians must identify situations in which a child's behavior is causing significant distress or interfering with normal adaptive child and family function.

One approach is to consider patterns across 3 domains of disruptive behaviours.

1. noncompliance,
2. aggression, and
3. temper loss

It can be tricky to distinguish developmentally normative from atypical behaviours in preschool children, particularly when considering temper loss and noncompliance, however frequency, intensity and duration flag the child's behaviour as atypical. For example, while saying "no" when told to do something can be normative misbehavior, a problem indicator is when the misbehavior is dangerous such as refusing to hold a parent's hand and running into the street. A cluster of disruptive behaviours is considered to be at the disorder level when the following criteria are met:

1. Behaviours are atypical for the child's developmental age and persist for six months or more,
2. Behaviours occur across situations, and result in impaired functioning, and/or
3. Behaviours cause significant distress for both child and family.

Assessment framework and differential diagnosis

Disruptive behaviours in preschool children involve complex child-environment interactions. The clinician can use a bioecological framework which involves a systematic review of the individual child, the family, and environmental domains. This same bioecological framework can also be used to complete a mental health assessment and develop a management plan. At the child level, inquire about the pattern and persistence of disruptive symptoms, their triggers, especially noting what makes problem behaviours worse or better. Evaluating the child's adaptive functioning across settings will clarify pervasiveness and severity of impairment. Developed by Dr. Claire Nguyen and Dr. Alice Charach for PedsCases.com.

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It is also important to note protective factors – child and family strengths – such as cognition, stable employment or a supportive family network.

At the family level, parent-child interactions are key areas for observation and enquiry. Warm, nurturing relationships with responsive caregivers are key protective factors for any child. Interruptions in care due to a parent's absence, poor mental or physical health or preoccupation with other priorities can contribute to disruptive behaviours. Family dysfunction, domestic violence, financial stress or illness in an extended family member can interfere with a parent's ability to maintain nurturing attitudes, daily routines and effective parenting practices, which are foundational elements in building and maintaining behavioural and emotional self-regulation. Reviewing current parenting practices and approaches to a challenging behaviour may elicit opportunities for intervention. For example, disruptive behaviour and anxiety may be a response to adult expectations that are too high for a child's cognitive abilities, particularly in a context where a child may have a global developmental delay. Behavioural patterns can change as parental figures or settings are altered, with behaviours differing across settings: between home and child care, for example. Exploring such changes and differences can inform an understanding of etiology and indicate where best to intervene.

There are a few specific health conditions that can contribute to disruptive behaviours. As a general rule, the child should have been screened for hearing and vision impairments as well as for irregularities in feeding and sleeping. Excessive impulsivity, hyperactivity and inattention may signal early ADHD. Language and social communication delays may be associated with a primary language or communication disorder or with autism spectrum disorder not previously identified. Excessive and persistent anxieties or fears may signal separation or other anxiety disorders.

Identifying behavioural and emotional disorders in primary health care settings

Opportunities for identification arise whenever parents express concern over a child's behaviour, emotionality, social skills, or their own difficulties with parenting. Dedicated clinic time beyond a routine office visit may be needed to provide sufficient time for a systematic assessment of socio-emotional health. Well-child visits are also opportunities to inquire about recent changes in a child's environment or the effectiveness of parenting style if parents do not raise their concerns spontaneously.

Let's discuss some specific screening tools that can be utilized in a clinic setting. The Rourke Baby Record (RBR) and ABCdairé are currently used to monitor health and development in children under 5 years of age. These guidelines support a systematic, comprehensive and unhurried approach to periodic evaluations of child development, including the identification and monitoring of health risks, and particularly socio-emotional risk factors. It is especially important to ask parents whether they have any concerns about their children's behavioural or emotional functioning, such as "Do you have any concerns about how your child gets along with other children?"

When a concern arises, standardized screening measures can help to assess for and identify problematic disruptive behaviours or the symptoms of mental health problems. Most questionnaires can be completed by a caregiver or teachers in advance of an appointment. A variety of mental health screening measures are available on the website for the Canadian Paediatric Society (www.cps.ca).

Commonly used standardized measures for preschool children include the Child Behaviour Checklist, Strengths & Difficulties Questionnaire, Preschool pediatric Symptom Checklist and Eyberg Child Behaviour Inventory. Like many screening tests, they are more effective for ruling out significant problems than for confirming a diagnosis. Some measures are best used for identifying children who need further systematic assessment. Others, such as the Child Behaviour Checklist (CBCL), can be used within a diagnostic assessment to quantify dimensions for a broad range of problems. As with other screening procedures, we must be alert to the possibility of false positive and false negative results.

Interventions

Issues identified in the initial screening and assessment will guide preliminary recommendations for management.

First initiatives may include designating appointments to complete aspects of the systematic assessment, referral to a specialist and/or early intervention attempts. For children whose behaviours fall within the borderline or at-risk range, or that appear to be normative, anticipatory guidance for parents on effective discipline and psychoeducation (including directed reading) may be adequate. Topics can include age-appropriate expectations, the benefits of daily routines and the need for caregivers to be consistent in their expectations of a child's behaviour. For children with problematic disruptive behaviours, evidence-based parent behaviour training programs are typically the first-line intervention recommendation. Parent behaviour training may be offered in individual or group formats and should provide for intensive parenting skills development using explicit instruction, modelling, practice and feedback. Shifting established parenting patterns and developing new, more effective skills to manage significant disruptive behaviours can be very difficult.

A range of evidence-based parenting programs are available in Canada, depending on where families live. These include 'Triple P' (www.triplep.ontario.ca/en/practitioner_regions/north.aspx: www.manitobatriplep.ca), the Incredible Years Parent Programs (<http://incredibleyears.com>) and programs offered in remote and rural areas through Strongest Families (<http://strongestfamilies.com>). Other programs may be available in communities across Canada, and practitioners should familiarize themselves with local resources, what services they deliver and evidence for their effectiveness.

While not all children and parents respond to first-line parenting interventions, they can still provide significant 'scaffolding' for positive behaviour change and are a basic building block of mental health care for children with disruptive behaviours. For children who are disruptive primarily in preschool or child care settings, evidence-informed behavioural interventions have been designed for educators as well.

In exceptional cases, medication may be considered for use in combination with behavioural approaches. While there is some evidence for the safe and effective use of medications in this population, practitioners should generally refrain from prescribing pharmacotherapy for a disruptive disorder without first trying an evidence-based behavioural intervention. Children who do not respond adequately to an appropriately implemented parent behavioural training program may have a particularly severe disorder, a complicating comorbidity, a mistaken diagnosis, or a particularly complicated psychosocial environment.

Now that we have an approach to disruptive behavior problems, let's return to our case.

You review the mother's concerns. Her mother reports that she has always been "strong-willed" but her behaviours have gotten out of hand over the past year. She is very resistant to instructions and throws tantrums daily. The tantrums can last anywhere from 5-20 minutes and occur at home, at her pre-school, and on outings. The tantrums are typically triggered by a parental or teacher instruction to do something she does not want to do (such as cleaning up her toys) or if she does not get something she wants. When she has a temper tantrum she will throw objects, thrust her body on the floor and kick, or hit her parents or teacher. She has run out of the house towards the street and out the classroom into the hallway. She does not share well and hits other children if they try to play with her toys. Her parents respond by trying to distract her by giving her their cell phone or completing the task themselves. The teachers respond by placing her in a quiet area and the classroom now has security bells on the door for alerts. Her parents no longer bring her along on shopping trips as she throws tantrums when they do not purchase items that she wants. The behaviours often cease when she is given what she wants, is no longer expected to follow the instructions, or is distracted with an electronic device. The behaviours cause a lot of family stress and disputes between the parents as to how to best manage them.

You note that your patient passed a hearing and vision screen last year. Her medical chart also indicates that she has been meeting developmental milestones. You agree with her mother that the behaviours are problematic and empathize with how difficult it must be. You provide her mother with several questionnaires to fill out and bring at a return appointment the following week. You speak with the office administrator to ensure the follow up appointment is long enough to allow you to obtain further details and to review the questionnaires. In the meantime, you look up a local evidence-based parenting program in anticipation of initiating an intervention.

Your patient's mother is relieved that she will be receiving some help. She schedules a follow up appointment for next week and will ask her husband to attend the appointment as well.

Summary

Let us finish with some key take home points on disruptive behavior problems in preschool children.

1. Disruptive behavior problems are common in preschool-aged children.
2. In addition to having adverse impacts on current child function and increasing family stress, these behaviors may be a 'marker' for current or future mental health risks.
3. Problematic disruptive behaviours can cause distress, impair functioning and development, restrict family activities, compromise peer relationships and limit access to quality child care.
4. Screening for disruptive behavior problems can assist in positively altering outcome trajectory.
5. Community practitioners provide front-line care by identifying problem behaviours and assisting families to access needed resources.
6. As part of routine care for children two to five years of age, practitioners should always enquire about social, emotional and behavior concerns during periodic health examinations and book additional time for assessment as needed.
7. If concerns are identified, use standardized measures to help determine whether behaviours fall within the normative, borderline or at-risk, or clinically significant range.
8. Consider evidence-based parent-training programs as a first-line intervention for children with significant disruptive behaviours.

9. Provide anticipatory guidance and psycho-education to parents when a child's behaviors fall within the borderline/at-risk range.
10. Refer to specialized, more intensive services for children with significant behavior problems complicated by comorbidity or not responding to first-line interventions.

That concludes our podcast on disruptive behavior problems, brought to you by PedsCases and the Canadian Pediatric Society. Please check out the PedsCases podcast on Behavioural Problems in children for further information about behaviours. Thanks for listening to PedsCases podcasts!