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# Problem behaviour in children

*An approach for general practice*

## Background

Around 12% of Australian children aged 4–12 years experience externalising behavioural problems such as aggression and hyperactivity. Similarly, around 12% experience internalising problems such as anxiety and depression. Other common behaviour problems, such as temper tantrums, arise as the child strives to achieve developmental milestones.

## Objective

This article reviews externalising behavioural problems and common developmental behavioural problems in children from toddler to school age. Diagnosis, management and when to refer are discussed.

## Discussion

Behavioural difficulties arise as a result of an interaction between biological vulnerabilities and environmental stressors. In most cases, behavioural difficulties are temporary, and occur as children strive to achieve developmental milestones. General management includes reinforcing positive behaviour, using a consistent approach and setting limits and clear consequences for misbehaviour. Children should be referred when there are concerns about their safety or development.

**Keywords:** child behaviour; child behavioural disorders; child psychiatry



## Case study

Nathan, 3 years of age, presents with aggressive behaviour toward his younger sister, aged 2 years. When the sister is playing with a toy he wants, he hits her, sometimes causing injury. When he does this, the family sometimes put him in 'time out' and he emerges from this in a crying and distressed state. Mealtimes are very difficult as Nathan often refuses to sit at the table and eat. Mealtimes last 30 minutes and the television is on in the background. At bedtime Nathan has tantrums and refuses to stay in his bedroom. He runs in and out of his bedroom, trying to get his parents' attention. It can take 2 hours for him to eventually fall asleep. During the day he is tired and grumpy.

Nathan's developmental milestones are within normal limits and his mother says that when he is behaving well, she enjoys him. There is a history of parental depression and recent job loss for the father.

In your office, he plays quietly at first and then begins to throw toys. His examination, including height and weight, is normal.

Management of Nathan would include establishing the parents' goals for his behaviour and using reward charts to reward positive behaviour (eg. sitting at the table for mealtimes). 'Time out' should be reserved for serious behaviour and he should stay in 'time out' until he is calm. Meal times should be limited to 20 minutes with the television off, and the family should eat together. The parents should be supported in seeking mental healthcare.

Behavioural difficulties in children are common. In a community sample of 589 Victorian children aged 3 years, 12% displayed externalising problems (eg. aggression, opposition, hyperactivity) and 12% displayed internalising problems such as anxiety and depression.<sup>1</sup> A national study of children and adolescents aged 4–17 years found a similar prevalence of behavioural difficulties.<sup>2</sup>

Behavioural difficulties in children have wide reaching social and economic consequences.<sup>3</sup> Most behavioural problems are temporary in nature. However, up to 50% of preschool behavioural problems can



persist and develop into childhood mental health problems,<sup>4</sup> leading to an increased risk of substance misuse, family violence and later, crime.<sup>5</sup>

Children's behavioural difficulties arise from an interaction between biological vulnerabilities and environmental stress.<sup>5</sup> Child factors that may contribute to this interaction include:

- inadequate sleep<sup>6</sup>
- low iron levels<sup>7</sup>
- developmental delays.<sup>8</sup>

Family and parental factors include:

- disadvantaged background<sup>9</sup>
- family stress and trauma<sup>10</sup>
- parenting practices – particularly harsh parenting or neglect<sup>11,12</sup>
- insecure parent-child attachment relationship<sup>10–11</sup>
- parental mental health problems.<sup>10</sup>

Other behavioural problems arise when children strive to achieve milestones in normal development.<sup>13</sup> For example, when striving for autonomy the toddler may throw temper tantrums, while the preschooler may battle with their parents over toilet training.

## Common presentations

Toddlers are becoming more mobile and vocal and typically test parental authority.<sup>10,13</sup> Common behavioural problems include oppositional behaviour (refusing to comply with requests), aggression and temper tantrums (explosions of frustration).<sup>14</sup>

Preschoolers undergo rapid development in their language, cognitive and social skills, and may be exposed to a structured learning environment for the first time. Common behavioural problems include anger and aggression toward siblings and other children.

Starting school is an important transition point for children, and the demands of the school environment may highlight attention and behavioural difficulties. Common behavioural problems include hyperactivity, inattention and socialisation difficulties.<sup>13</sup>

## A general approach to behavioural difficulties

### History and examination

Parents may present with a range of concerns about their child's behaviour (eg. tantrums in the toddler, aggression in the preschooler and poor concentration in the primary school child) and their expectations may range from simply wanting to know 'Is my child normal?' through to needing specific behaviour management strategies and being concerned about major developmental issues such as autism. As well as taking a general medical history, ask about the child, parent and family factors that can shape behaviour (*Table 1*).

Using the mnemonic 'ABC' can clarify events surrounding the behaviour.

- **A**ntecedent – what were the events preceding the behaviour?
- **B**ehaviour – what is the behaviour exactly?
- **C**onsequence – what did the parents do to resolve the situation?

Clarify where the behaviour occurs. Behaviour occurring across two or more settings (home, educational and/or social setting) are more likely to be indicative of an underlying mental health problem, while behaviour occurring in only one setting (eg. home but not kindergarten) may reflect an issue specific to that setting (eg. lack of boundaries at home).

Ask about family functioning. A chaotic family with multiple stressors may have difficulty setting boundaries and providing consistent parenting practices. Warm but consistent parenting with clear rules is optimal for a child's development.<sup>10,11</sup> Harsh and abusive parenting is a risk factor for aggressive behaviour.<sup>10</sup>

Observe the child's behaviour in the consulting room but be aware that some children can behave well when they know they are being observed. As well as conducting a physical examination, consider conducting a brief developmental assessment. (See Oberklaid and Drever's article in this issue of *Australian Family Physician* for further information on developmental assessment.<sup>15</sup>)

Once you have completed the history and examination, decide whether there is a medical (eg. low iron) or developmental issue (eg. global developmental delay), which needs specific management. If not, consider the following approach.

### General management

First, establish the family's goals and their capacity to implement behaviour management. Some families simply want reassurance that their child is normal while others want specific management strategies such as those outlined below. Do they need extra support from parenting agencies or other family members?

Quality child care, play groups or kindergarten can offer children a structured, rewarding environment and may be good 'harm minimisation' strategies when you suspect parental mental illness but the parent is reluctant to seek assistance.

### Encourage positive behaviour

The child's physical environment should be modified to enable them to practise positive behaviour.<sup>11</sup> Parents can set an example by modelling desirable behaviour (eg. 'taking turns').

Positive behaviour can be reinforced through a reward system.<sup>11</sup> This might include a sticker chart for the preschool/school aged child or a 'special' stamp on the hand for toddlers. Never remove a reward and consider offering a small treat after four or more stickers/stamps have been achieved.<sup>16</sup>

### Ensure a consistent approach

All caregivers should strive to give the same response to the child's behaviour to avoid confusing the child.<sup>11</sup> Parents may need to discuss behaviour management approaches with the child's other carers to ensure consistency.

### Set clear boundaries and expectations

Children should have a clear understanding of what is expected of them. Expectations must be developmentally appropriate (eg. sharing



**Table 1. Child, parent and family factors that contribute to behavioural problems**

|                              | History   | Observation and examination  |
|------------------------------|---|--|
| <b>Child factors</b>         | <ul style="list-style-type: none"> <li>• Temperament (eg. 'slow to warm up', 'active')</li> <li>• Developmental milestones</li> <li>• Sleep patterns</li> <li>• Nutrition – iron intake</li> <li>• Early behaviour</li> </ul> | <ul style="list-style-type: none"> <li>• Child behaviour</li> <li>• Dysmorphic features</li> <li>• Developmental examination if concerned</li> </ul> |
| <b>Parent factors</b>        | <ul style="list-style-type: none"> <li>• Mental health</li> <li>• Parenting practices – warm versus harsh, engaged versus disengaged</li> <li>• Early parent-child attachment</li> </ul>                                      | Parent-child interaction – positive and negative reinforcement of child's behaviour, consistent response to child                                    |
| <b>Family/social factors</b> | <ul style="list-style-type: none"> <li>• Family risk factors – unemployment, drug and alcohol misuse, financial stress</li> <li>• Social support</li> <li>• Family history of developmental/behavioural problems</li> </ul>   |  |

a toy after the age of 4 years).<sup>11,17</sup> Parents and carers need to sit down and negotiate what they consider acceptable behaviour and agree on which behaviours they will ignore and which they will actively manage.

### Set clear consequences for actions and make sure parents can follow through

Consequences and management will differ according to age and are described below.

### Tantrums and oppositional behaviour in toddlers (1–3 years)

Oppositional behaviour and temper tantrums can occur at anytime, but commonly manifests during meals and sleep time.

#### Management of temper tantrums

- Stay calm, walk away and ignore the behaviour until the tantrum stops
- Praise the child when appropriate behaviour begins again
- Behaviour will initially escalate, but quickly decline.<sup>13</sup>

#### Management of aggressive behaviour

- Remain calm and do not raise your voice
- Ask the child to stop and redirect them to another activity
- If they do stop, praise them
- If they do not stop, go to 'quiet time' (in same room)
- If they keep coming out of 'quiet time' or are aggressive again, go to time out (in another room)
  - keep conversation minimal at this time as the child might be too agitated to understand explanations. Short explanations should be given (eg. 'You hit your sister. That is not acceptable behaviour. You are going to time out')
  - the child stays in time out until they are quiet and calm (this may be less than 1 minute per year of age).<sup>1,13,16</sup>

'Time out' stops the child gaining parental attention for their misbehaviour.<sup>17</sup> Initially it can be difficult to set limits, however if parents remain firm, the misbehaviours eventually decrease.

### Anger and aggression in preschoolers (3–5 years)

Management involves prioritising behaviours in terms of severity level. Low priority behaviours (eg. whinging) can be dealt with by:

- ignoring the behaviour
- distracting the child
- logical consequences for the child's action. For example, if the child is drawing on the wall with a felt-pen, take away the pen for a few minutes. Make sure the parent gives the pen back so the child can practise using it appropriately on paper.

High priority behaviour, such as behaviour with associated safety concerns (eg. kicking, punching, absconding) should be dealt with through 'time out', as described.

### Hyperactivity or inattention in school aged children (5–11 years)

Management needs to be implemented both at school and at home. In the school setting the first priority is to rule out comorbid learning difficulties. Hearing and vision should be assessed. If required, a special education and cognitive assessment can be organised through the school. Classroom strategies for attention problems include:

- sitting the child up front, next to a quiet student
- having frequent breaks
- rewarding for staying on task (eg. a raffle ticket that the child can 'cash in' at the end of the day for a small reward).

Parents should liaise with their child's teacher to plan how to manage behaviour.

At home, misbehaviour can be managed through withdrawal of privileges (eg. no television for 1 hour).<sup>16</sup>



## When to refer

Consider referring a child to a paediatrician, psychologist or child psychiatrist when:

- simple measures have failed
- the child is at risk:
  - physical harm (eg. absconding from home)
  - behaviour affects the child's function and/or their ability to achieve developmental tasks
  - accompanying features of a developmental or severe behavioural problem (eg. developmental delay, autism spectrum disorder, attention deficit hyperactivity disorder)
  - child protection issues
- there are parental mental health issues
- there are complex family situations (eg. ongoing family conflict or violence)
- the child care, kindergarten or school are not coping with the child's behaviour or are very concerned.

A paediatrician can assess a child's physical health and development and screen for comorbid problems such as attention deficit hyperactivity disorder (ADHD) or suspected hearing loss, while a psychologist is suitable for a family who needs more intensive support or family therapy.

## Summary

Behavioural problems in children are common and can be stressful for families. Taking a complete history to identify contributing factors and the family's capacity to implement behaviour management strategies is important. Management should reward desirable behaviour and include clear consequences for undesirable behaviour. Consider referring a child if simple management strategies fail or you have concerns about the child's safety or development.

## Resources for parents and GPs

- Council support services offer services ranging from parenting seminars to support in accessing adult mental health services and parenting education groups. Services vary widely between councils so contact your local council for more information
- Raising children network has an evidence based website with strategies for managing common behavioural problems: [www.raisingchildren.net.au](http://www.raisingchildren.net.au)
- Children of Parents with a Mental Illness (COPMI) has information for people who care for, or are cared by, parents with a mental illness: [www.copmi.net.au](http://www.copmi.net.au)
- Child Health is an excellent parent-friendly website for managing common child behaviours: [www.childhealth.com.au](http://www.childhealth.com.au)
- Parenting South Australia has parent tip sheets for managing common toddler and preschool behavioural problems: [www.parenting.sa.gov.au](http://www.parenting.sa.gov.au)
- Parentline telephone counselling service. Check your state government website for details as each state operates its own service
- Kids Helpline national counselling service via telephone, email or internet for children aged 5–25 years: [www.kidshelp.com.au](http://www.kidshelp.com.au) (1800 55 1800).

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