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BEHAVOR PROBLEMS IN YOUTH©

DEFIANT BEHAVIOR [ODD] • CONDUCT DISORDER [CD]
ATTENTION DEFICIT DISORDER [AD/HD]

Youths with behavior problems need help to change their behavior. Some of them develop alcohol and drug use and they need help to stop. Their families often need help to reorganize in order to make a positive difference.

Parents can feel hopeless, guilty, disappointed, frustrated, or hurt. Sometimes nobody in the family feels understood or happy. All feel powerless to stop doing what has not been working. All seem caught up in a cycle they can't escape, so the child reacts to punishment or threats with hostility that frustrates the parents who increase the punishment and threats until everyone is on edge.

Therapy can help families try new, positive, more effective approaches to change behavior.

When children show these symptoms or changes, careful assessment in individual, family, and school, settings are required. Psychotherapy with the youth, family therapy, and medication often help. These are the three main categories of behavior problems in children and adolescents.

I. AD/HD ATTENTION DEFICIT HYPERACTIVITY DISORDER

AD/HD is classes as a neurodevelopmental disorder rather than as a behavior disorder. We put it in this paper because 1) prior to 2013, it was classed with behavior disorders and 2) families experience AD/HD as a behavior problem.

In AD/HD these behaviors appear in childhood. Do you see a majority of these? Check the ones you observe.

- easily distractible much of the time, appears not to hear what is said or not to retain it
- fidgets, restless
- rapid mood swings, though negative moods may shift quickly to positive
- dangerous behavior out of careless thinking
- hard to discipline, punishment does not work to change behavior
- seemingly defiant, but not due to hostility, just does not shift what they are doing to do what you want or does not remember tasks
- interrupting in class or home, blurting out answers, difficulty waiting his/her turn
- shifts activities rapidly from one incomplete activity to another, without remembering the unfinished task
- symptoms worse when long attention is needed
- symptoms better when well supervised or in one-on-one situations
- symptoms better in stimulating setting, e.g., video games
- may lose self-esteem, perceived as “dumb” or “lazy“
- peer relations are strained, can't follow rules, interrupts others’ play, not waiting turn
- spaces out as if not attending to what is going on or what you say, in a distracted state
- impulsive
- low tolerance for frustration
- gives up on hard tasks without trying
- symptoms worse in unstructured settings
- work is often messy, careless, unfinished
- disorganized, though some kids with AD/HD can stay organized in order to get things done
- difficulty maintaining attention
- fails to finish chores and assignments, leaves a trail of unfinished tasks
- academic underachievement

AD/HD is a kind of disability these children can't purposely maintain attention or shift attention to what's important without outside help and direction. They are often misperceived as willfully misbehaving rather than unable to meet expectations for behavior. With help getting organized and with hard work, AD/HD children can often turn their problem into an asset due to their creativity and energy.

Lastly, some children with ADHD show patterns of hyperactivity. They just can't sit still and are always on the move. However, a large minority of the children do not have hyperactivity. They tend to look like they are more "spaced out" and distracted. When they're expected to concentrate, their mind are wandering Obviously, that is much less observable to a parent or teacher. Consequently, the diagnosis for that group of children often takes place later. Children who are quite good in school often do not receive a diagnosis until early adolescence. Occasionally, we have adults who never were officially identified as AD/HD when they were children. They are finally given a diagnosis as adults, which helps to explain a lot of their life experience.

II. OPPOSITIONAL DEFIANT DISORDER (ODD)

When we find five or six of these behaviors, lasting **six months** or more, we think of it as Oppositional Defiant rather than just a temporary reaction to life stressors.

- persistently angry, resentful, negativistic
- spiteful
- swears often
- touchy, easily triggered to be annoyed or angry
- moody

- temperamental
- argumentative
- blames others for own mistakes and deeds
- may be verbally abusive and may fight
- deliberately annoys people
- refuses to follow adult rules or structures in school and/or home
- actively defies authority
- loses temper at the drop of a hat

ODD often starts with changes in the family (e.g., divorce, a move, a parent drinking, a parent remarrying, disagreements between parents) or a conflictual period in school. It may begin as depressed mood or anger over changes in life. Eventually, the child's angry behavior and defiance become the main way of coping. Anger mismanagement and explosive temper are common behavior problems. Understanding the child's view of these life changes and developing new family patterns for handling the child usually make a positive difference. Parents need to be on the same page and back one another up, never contradict one another.

When ODD and CD behaviors mostly occur when the youth is with friends, and start after age fourteen, sometimes behavior improves when new friends and activities are arranged.

III. CONDUCT DISORDER

CD is a very serious problem. It usually does not go away without help, but evolves into adult antisocial behavior and chemical dependency.

When we find three or four of these for six months or more, we consider CD.

- stealing more than once, perhaps committed forgery
- enraged by frustration
- destroyed property, vandalism

- cruel or callous to people or animals
- used a weapon in a fight, initiates fights
- mugging, armed robbery, purse-snatching
- violates others' rights and social norms
- considers feelings and warmth as weaknesses
- drug and alcohol problems, tobacco use, often beginning age eleven to thirteen
- lies
- often truant
- cons others
- running away
- makes excuses for the behavior
- acts with bravado
- underachieving or disruptive in school
- harms animals
- sets fires
- broke into a car, home, building
- forced someone into sexual activity
- remorseless
- temper outbursts
- bullying
- recklessness

CAUSES OF DISRUPTIVE BEHAVIOR DISORDERS

A. Sometimes the behavior is age-appropriate, such as in a two-to-four year-old, but it is a concern if it continues beyond age five. After that, a careful assessment of the child, and the family too, may uncover reasons why the behavior continues.

B. Tantrums, destructiveness, and defiance begin as a child's way to tell us of their frustration and distress. But they can be reactions to changes in the family, such as a divorce, loss of a loved one, remarriage, the stress of a parent drinking, or the illness of a parent. In these cases, the behavior problem usually slows down when the problem is discussed openly and resolved. Crisis counseling and brief family counseling is usually effective in these situations where the child s reacting to some change or event.

C. Traumatic events, such as abuse, molestation, and catastrophes, can trigger many coping reactions in a child who cannot resolve the trauma on his or her own. Anger and defiance may the youth's way to respond to it. Brief trauma healing therapies, such as EMDR, can be helpful in restoring emotional health.

D. Medical causes should be evaluated. These include head injuries, some epilepsy, problems with certain brain chemicals or pathways, neurological problems, high lead levels, celiac disease, and certain allergies. Psychotropic medications can often help improve overall functioning.

E. Family stress may cause family patterns which increase behavior problems before anyone realizes how it happened. These include lack of supervision, abuse, changes in who takes care of a child, changes in whom the child lives with, overly harsh discipline, overly lax discipline, parental inconsistency and giving in to the child's demands or mood, parents who cannot get together about discipline, or accepting the "boys will be boys" idea when really the aggressive behavior should be curbed. Others include loss of positive role models for the youth, children seeking necessary attention but in negative ways, lack of recognition for the child's positive qualities and behavior, families in which conflicts usually escalate, children feeling weak inside but putting on a tough exterior. Family therapy can help get the family on the right track.

TREATMENTS FOR DISRUPTIVE BEHAVIOR DISORDERS

Researchers have spent decades developing the best methods for improving these problems. Let's review some of the best methods.

AD/HD

Many of the problems that these children face have to do with under-functioning of the frontal area of the brain. So, increasing activity in that area increases the ability to pay attention and to be less distractible. The treatment for attention deficit disorder begins with medications. A class of medications known as stimulants, when used in small amounts, help the frontal lobe of the client's brain to be more alert and engaged. Medication does not change some behaviors, and so parents are often disappointed in medication because they expected to do more than it is intended to do. It actual role is to free the child from to distractibility.

A child who is highly reactive in a negative way may benefit from another class of medications that includes Clonidine and Tenex (Guanfacine) or another class that includes Risperidone. The

stimulant class includes methylphenidate and it's numerous longer acting versions such as Concerta, or dexamphetamine, which also comes in longer acting versions such as Adderall and Vyvanse.

Once the child is more able to concentrate and is less distractible, a variety of behavioral methods are applied mostly using family therapy interventions. Again, family therapy is the primary method that has been found in research to have the greatest benefit for all behavioral problems. Normally in family and behavioral methods, we set very clear very simple goals to achieve behaviors that families feel are as important, such as getting homework done on time, controlling frustration, cleaning the bedroom, being ready for school in the morning, and many other basic behavioral routines.

Where the child has developed negative self-esteem and lacks self-confidence or has other traumatic or painful experiences, individual child therapy, is also beneficial.

A newer area of treatment in the AD/HD field is to recognize the concept of executive functioning. These are processes that are under-functioning in A/HD. For example, some of those functions are working memory, freedom from distraction, capacity to focus and concentrate, organization, and management of emotions. These are all sophisticated skill areas in which the AD/HD person's brain functioning may be at a lower level of efficiency. We examine which of these executive functions are stronger or more challenging for each person. We design remedial or coaching interventions to help them.

ADHD coaching is becoming more widely available as well.

ODD

All of the major treatments for oppositional defiant disorder that have strong research support are based upon family therapy, particularly PC-IT which is parent-child interaction training. There is also a treatment using behavior modification. Often a family therapist can use various behavioral and structural family therapy approaches in order to produce rapid and significant change. The most important part of the family therapy intervention is getting all of the adults lined up to treat the child in the same way and not overpower, contradict, argue with one another about how to manage the child's behavior.

CONDUCT DISORDER

If the intervention is early, soon after the behavior appears, we have more options for effective health help. The longer the behavior goes on, the more challenging it is to change these symptoms. Children with conduct disorder often find friends who also have behavioral problems and they reinforce one another. That increases the likelihood the behavior will become more lasting and more difficult to change.

Early interventions include structural and systemic family therapies and behavioral family therapy. Crisis psychotherapy and other individual treatments are used in order to find the root reaction causes from the changes in life trauma. Trauma therapy, such as EMDR, can help when the behavior is a reaction to some change that's happened in the child's life. Later on in the process of the development of content disorder, we use multi-systemic therapy. There is also a cognitive behavioral therapy called criminal thinking treatment.

In summary, we have very effective help for AD/HD and ODD. As to conduct disorder. The ability to help is somewhat more limited. Newer family therapies have shown some effectiveness, particularly if we catch the problem early on before it has become a more permanent feature of the child's style of living.

We sometimes encounter a family that is opposed to the use of medications with AD/HD. All of the research suggests that medication is necessary in order to get the best results. We hope that families will be willing to at least use a trial of medication to see if it is producing the kind of outcomes that they are hoping for.

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