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# Common behavioural problems in children

Behavioural problems in children can usefully be classified into psychosocial disorders, habit disorders, anxiety disorders, disruptive behaviour and sleeping problems.

Behavioural problems in children are relatively common. Such problems are often a reflection of the child's social stressors, environment and developmental state. Although a majority of behavioural problems are temporary, some may persist or are symptomatic of neurodevelopmental disorders or an underlying medical condition. Initial management of behavioural problems often involves helping parents to learn effective behaviour strategies to promote desirable behaviours in their children<sup>[1]</sup>.

## Psychosocial disorders

These may manifest as disturbance in:

- Emotions – eg, anxiety or depression.
- Behaviour – eg, aggression.
- Physical function – eg, psychogenic disorders.
- Mental performance – eg, problems at school.

This range of disorders may be caused by a number of factors such as parenting style which is inconsistent or contradictory, family or marital problems, child abuse or neglect, overindulgence, injury or chronic illness, separation or bereavement<sup>[2]</sup> <sup>[3]</sup>.

The child's behavioural problems are often multi-factorial and the way in which they are expressed may be influenced by a range of factors including developmental stage, temperament, coping and adaptive abilities of family and the nature and duration of stress. In general, chronic stressors are more difficult to deal with than isolated stressful events.

Children do not always display their reactions to events immediately, although they may emerge later. Anticipatory guidance can be helpful to parents and children in that parents can attempt to prepare children in advance of any potentially traumatic events - eg, elective surgery or separation. Children should be allowed to express their true fears and anxieties about impending events.

In stressful situations, young children will tend to react with impaired physiological functions such as feeding and sleeping disturbances<sup>[4]</sup>. Older children may exhibit relationship disturbances with friends and family, poor school performance, behavioural regression to an earlier developmental stage and development of specific psychological disorders such as phobia or psychosomatic illness<sup>[5]</sup> <sup>[6]</sup>.

It can be difficult to assess whether the behaviour of such children is normal or sufficiently problematical to require intervention. Judgement will need to take into account the frequency, range and intensity of symptoms and the extent to which they cause impairment.

## **Habit disorders<sup>[7]</sup>**

These include a range of phenomena that may be described as tension-reducing.

Thumb sucking	Repetitive vocalisations	Tics
Nail biting	Hair pulling	Breath holding
Air swallowing	Head banging	Manipulating parts of the body
Body rocking	Hitting or biting themselves	

All children will at some developmental stage display repetitive behaviours but whether they may be considered as disorders depends on their frequency and persistence and the effect they have on physical, emotional and social functioning. These habit behaviours may arise originally from intentional movements which become repeated and then incorporated into the child's customary behaviour. Some habits arise in imitation of adult behaviour. Other habits such as hair pulling or head banging develop as a means of providing a form of sensory input and comfort when the child is alone.

- **Thumb sucking** – this is quite normal in early infancy. If it continues, it may interfere with the alignment of developing teeth. It is a comfort behaviour and parents should try to ignore it while providing encouragement and reassurance about other aspects of the child's activities.
- **Tics** – these are repetitive movements of muscle groups that reduce tension arising from physical and emotional states, involving the head, the neck and hands most frequently. It is difficult for the child with a tic to inhibit it for more than a short period. Parental pressure may exacerbate it, while ignoring the tic can reduce it. Tics can be differentiated from dystonias and dyskinetic movements by their absence during sleep.

- **Stuttering** – this is not a tension-reducing habit. It arises in 5% of children as they learn to speak. About 20% of these retain the stuttering into adulthood. It is more prevalent in boys than in girls. Initially, it is better to ignore the problem since most cases will resolve spontaneously. If the dysfluent speech persists and is causing concern refer to a speech therapist.

## Anxiety disorders

Anxiety and fearfulness are part of normal development; however, when they persist and become generalised they can develop into socially disabling conditions and require intervention.

Approximately 6-7% of children may develop anxiety disorders and, of these, 1/3 may be over-anxious while 1/3 may have some phobia<sup>[8]</sup> .

Generalised anxiety disorder, childhood-onset social phobia, separation anxiety disorder, obsessive-compulsive disorder and phobia are demonstrated by a diffuse or specific anxiety predictably caused by certain situations<sup>[9]</sup> .

School phobia occurs in 1-5% of children and there is a strong association with anxiety and depression<sup>[10]</sup> . Management is by treating the underlying psychiatric condition, family therapy, parental training and liaison with the school in order to investigate possible reasons for refusal and negotiate re-entry. Behavioural and cognitive treatments show promise, although most evidence-based trials involve children with mental health problems rather than the general population of school refusers per se. More research needs to be done in this area<sup>[11]</sup> .

## Disruptive behaviour

Anger, irritability, and aggression are among the most common reasons for child mental health referrals. Two forms of behavioural interventions for these behavioural problems, parent management training and cognitive behavioural therapy, have been shown to be effective<sup>[12]</sup> <sup>[13]</sup> . Media-based cognitive behavioural therapies may, in some cases, be enough to make clinically significant changes in a child's behaviour<sup>[14]</sup> .

Many behavioural problems in children are probably undesirable but a normal occurrence at an early stage of development, and can be considered pathological when they present at a later age. In the young child, many behaviours such as breath holding or temper tantrums are probably the result of anger and frustration at their inability to control their own environment. For some of these situations it is wise for parents to avoid a punitive response and, if possible, to remove themselves from the room. It is quite likely that the child will be frightened by the intensity of their own behaviour and will need comfort and reassurance. While some isolated incidents of stealing or lying are normal occurrences of early development, they may warrant intervention if they persist. Truancy, arson, antisocial behaviour and aggression should not be considered as normal developmental features.

[Attention deficit hyperactivity disorder](#) is characterised by poor ability to attend to tasks (eg, makes careless mistakes, avoids sustained mental effort), motor overactivity (eg, fidgets, has difficulty playing quietly) and impulsiveness (eg, blurts out answers, interrupts others). For the diagnosis to be made, the condition must be evident before the age of 7, present for >6 months, seen both at home and school and impeding the child's functioning<sup>[15]</sup>. The condition is diagnosed<sup>[16]</sup> in 3-7% of children of school age<sup>[16]</sup>. Methylphenidate (initiated by specialists only) is a stimulant medication that provides reduction of symptoms, at least in the short term<sup>[17]</sup>. Behavioural modification and neuro-feedback are the non-pharmacological treatments with the largest evidence base<sup>[18]</sup> <sup>[19]</sup> <sup>[20]</sup>. Various dietary interventions have been mooted, of which the addition of essential fatty acids has the widest support<sup>[21]</sup>.

## Sleeping problems

Sleep disorders can be defined as more or less sleep than is appropriate for the age of the child. By the age of 1-3 months, the longest daily sleep should be between midnight and morning. Sleeping through the night is a developmental milestone but, at the age of 1 year, 30% of children may still be waking in the night. Stable sleep patterns may not be present until the age of 5 but parental or environmental factors can encourage the development of circadian rhythm. See the separate [Sleep Problems in Children](#) article.

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## Further reading

- [Health and wellbeing of looked-after children and young people](#); NICE Quality Standard, April 2013

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