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Attitude Adjustment: Tantrums, biting, crying — every parent struggles with them from time to time. But when misbehavior intensifies, it can traumatize the entire family.

by Courtney McGrath

Sixteen-year-old Travis Smith can't wait to try out for his Baltimore City high school's football team next fall. He's a lot like most boys his age—non-stop energy. Today, that energy is channeled positively, a big change from when he first started school. Back then, his mother Natasha Lewis was at her wits end, receiving phone calls practically on a daily basis telling her to come pick him up from school. The reasons varied: Travis had hit another child, Travis had lashed out at a teacher or an aide. Travis was threatening to jump from the roof of the school. No matter the cause, Travis was suspended more often than not, threatening Ms. Lewis' job security, a perilous situation for a single mom with two kids to support.

Kids will be kids, and every parent knows that even the best-behaved child can, at times, be a handful. It's natural for a child to test his limits; tantrums, crying and refusal to comply with reasonable requests are all part of growing up. But for an estimated three to six percent of children, behavior problems can become so severe they actually threaten the health and stability of the family, not to mention the child's success in school and adult life.

At some point, any child can engage in extremely inappropriate behavior—biting, hitting, running away, throwing things, hurting him or herself. The distinction between "normal" misbehavior and a behavior problem has to do with frequency and intensity. Some children engage in these problem behaviors many times a day. Their tantrums don't fade in minutes—they can go on for hours. Behavior problems like these are even more common – as high as 50 percent – in children with cognitive impairments, learning disabilities, ADHD and many developmental disorders. Parents often have tried every disciplinary technique in the book and consulted with pediatricians, school counselors and others, to no avail. For them, conquering some behavior problems requires assistance from an expert. Kennedy Krieger's Behavioral Psychology Department has offered behavior management services for children for 30 years and is considered a leader in the field.

Psychologists specializing in behavior management work to help families reduce the problematic behaviors by attacking them at their root causes and then working with parents on ways to keep behavior problems at bay. "Our patients typically come to us after the problem has started to affect many aspects of their lives, and several different caregivers have experienced the problem as well," says Susan Perkins-Parks, Ph.D., director of the Behavior Management Clinic at Kennedy Krieger. "By the time they get to us, they have usually exhausted other options."

The Behavior Management Clinic serves children aged two to 12 years and their families. Most of the children are developing fairly typically, except for their behavioral difficulties. While parent behavior and attitudes alone are certainly not the sole cause of a child's problems, impatience, insecurity and inconsistency in enforcing consequences can greatly aggravate the situation. As a result, the Clinic's treatment program emphasizes parent training. Parents play an active and critical role in the process by role-playing, modeling and rehearsing new skills for the psychologists as they develop them.

Following an initial evaluation, direct observation of parent-child interaction and sometimes interviews with the children themselves, Dr. Perkins-Parks and her colleagues begin training and coaching parents on the most effective means of managing their children's behavior. "Our strategies rely heavily on positive reinforcement—increasing the rate of parental attention to appropriate behavior, ignoring disruptive

behavior that is not unsafe, and using negative consequences such as restrictions only as a last resort," she says. "The goal is to have the parent demonstrate mastery of the new skills both in the clinic and in other settings. When a family isn't progressing outside the clinic, sometimes we'll make home and/or community visits to learn which aspects there might be preventing improvement in the child's behavior."

Treating the whole family

In some cases, the home environment and family dynamic can contribute to a child's problematic behavior. Issues such as a parent's job loss, relocation, financial strain, divorce or death of a loved one can be hard for many children to process, prompting some to act out. The stress surrounding one child's behavior can affect every member of a family, making it more difficult for other children in the household to perform successfully in school and other settings. Kennedy Krieger's Child and Family Therapy Clinic was established to help families in these situations work past behavioral challenges. "Although one child's behavior might be the crisis issue that pushes a family to come see us, we take the attitude that the whole family is our patient, not just a single child," says Gina Richman, Ph.D., director of the Clinic.

Dr. Richman finds that many of the parents she works with have limited control over the problems in their households. Caught up in dealing with financial crises, tragedies, health problems and other immediate issues, the issues of maintaining a consistent and structured environment becomes more challenging, and children sometimes lose sight of who is in charge and how to behave appropriately. "That's why it's so important for us to pull the whole family into the therapy room," she says. "We have to re-establish that hierarchy and put that parent back on top." This scenario is particularly common in families headed by single women, whose children might create romanticized notions of absentee fathers, but show little respect for the mother who holds their family unit together. In families where one child's behavior has become a source of stress for everyone, other children in the household may begin to feel like the sibling who is acting inappropriately has control over the family. The clinic's approach supports the idea that one child's behavior really isn't the issue—the important thing is to alter the family dynamic so that everyone interacts in a more healthy way.

Most of the families served by the Child and Family Therapy Clinic are seen for a few months, others for longer. "Families who stay with us for a longer period of time do so because their needs change," says Dr. Richman. "A few years down the line, new challenges arise. For example, another child may be causing concern."

Dr. Richman has worked with Travis Smith since 1998. Although Travis has been diagnosed with Oppositional Defiant Disorder, Disruptive Behavior Disorder and Reactive Attachment Disorder—all behavior disorders that frequently lead to the types of difficulties in school and home life he encountered when he was young, Dr. Richman says many of Travis' difficulties were aggravated by his environment. "Outside of his mom, Travis' doesn't have a lot of positive role models," she says. "He lives in a pretty tough neighborhood, and he's attended only struggling inner-city public schools."

In addition to counseling Ms. Lewis on the best ways to respond to Travis' behavior, Dr. Richman advised his school system on the most appropriate academic placement for Travis, collaborated with his psychiatrist on the effects of his medications and kept track of his involvement with a Big Brother. "No matter what was going on in Travis' life, I made sure I knew any time something changed, so I'd understand why his behavior might be different," she says.

In time, Ms. Lewis developed much more authority over Travis. "It was an uphill battle, but she worked so hard," says Dr. Richman. "She demonstrated to Travis that there were consequences for inappropriate behavior. She's demanded drug tests, barred him from hanging out with certain kids, kept close track of his extracurricular activities. It would have been easier at many times to give up hope, especially with the other stressors in her life, but she's so dedicated. She never misses an appointment, she never lets Travis think he's more in control than she is."

Now, as he approaches adulthood, Travis has grown into a wonderful young man. There haven't been any violent incidents at home, and Dr. Richman can recall just two fights at school in the past five years. "He pulls away from bad influences on his own now and has developed skills that assist him in problem-solving without resorting to anger. He has developed wonderful friendships, as well as relationships with teachers who like him and want to help him succeed."

Special challenges for children with developmental disabilities

While Dr. Richman estimates that 80 percent of the families in her practice have a child with ADHD, depression or a specific behavioral diagnosis such as oppositional defiant disorder, few of them are severely disabled. Addressing behavior problems in children with significant developmental disabilities can be an even greater challenge. The Pediatric Developmental Disorders Clinic, another part of the Kennedy Krieger Behavioral Psychology program, has developed a staff of individuals with expertise in the issues facing children with these conditions. For instance, children with mental retardation and autism spectrum disorders often have limited communication skills. Out of sheer frustration, the majority of children with these disorders demonstrate some degree of aggression, self-injury, destruction of property and elopement, or wandering. "Because children with developmental disorders have fewer resources to convey their feelings, they tend to be more prone to tantrums, which are often longer and more intense then those of a typically developing child," says Steven Lindauer, Ph.D., a case manager in the Pediatric Developmental Disorders Clinic. This clinic, which serves children with autism, mental retardation and other developmental disorders, focuses on behavior management in children under age seven.

The first step in treatment is often developing an alternative means of communication between parent and child, such as sign language. Nancy Grace, Ph.D., the program's director, stresses that parents don't need to become fluent in sign language to use it with their children—they just need to focus on signs for their child's most urgent concerns: "hungry," "tired," "sick," "toy" and such.

Once therapists have helped parents work around some of the communication barriers that exist between them and their children, the real work of managing behavior begins. Even though the child's frustration level over not being able to communicate has been reduced, some inappropriate behaviors may have become established. Although about half of the patients seen in the Pediatric Developmental Disorders Clinic are on medications, medication alone rarely works without changes in the parents' style of behavior management. Here, the rules stay the same as for typically developing children, specifically, the focus on positive reinforcement. "Pay attention to the behavior you want to keep," says Dr. Grace. "Unfortunately, most parents ignore it when their child does something right."

Dr. Lindauer agrees. "The problem with just telling a child 'no' is that all that does is tell them they can't do what they're doing," he says. "It doesn't help them find a more appropriate way to behave."

Too often, says Dr. Grace, parents expect children—disabled or not—to simply behave as expected without any sort of encouragement. But appropriate behavior is a learned skill, and some children have more trouble mastering it than others. "This is hard for some kids—they need an incentive to put forth that extra effort," she says. "Parents should not be afraid to use tangible rewards like candy or toys to encourage a child. As the child's own management of their behavior gets stronger, parents can begin to fade out the rewards."

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