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# Exploring behavior disorders in children and adolescents

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# Exploring behavior disorders in children and adolescents

## **Abstract**

Over the last century more and more children and adolescents have been diagnosed with behavior disorders. While problematic behaviors in adolescents have always been seen in and out of schools, it has only been in the last century that psychologists have looked deeper into the root of these behaviors. The term "behavior disorders" can in fact encompass a number of different disorders seen among both children and adolescents. The three specific disorders discussed in this paper will be attention-deficit/hyperactivity disorder (ADHA), conduct disorder (CD), and oppositional defiant disorder (ODD). A great deal of the time, children exhibiting these types of disorders are trying to find some type of balance in their environment and within themselves. Lacking the skills to manage their thoughts, feelings, and actions appropriately, these children display behaviors that are considered to be inappropriate or even unacceptable in the social norm. The reason for exploring these three disorders is based on the relationship that each plays on the impairment of children and adolescents socially, academically, and occupationally. It is often seen that children experiencing various behavior disorders also tend to experience learning disorders as well. At times it can be extremely difficult if not impossible to determine if the behavior disorder is a cause of the learning disorder, or if the learning disorder caused the behavior disorder. However, by identifying the disorders, it is a step towards determining ways to help the child or adolescent learn to cope with the issues he or she may be facing. This paper will give a definition of behavior disorders as well as describing what to look for in children and adolescents with behavior disorders. Specific examples of adolescents with behavior disorders will be discussed, as well as the prevalence of behavior disorders in young people today. The etiology of behavior disorders will be examined, and also preventive measures that can be taken. Finally, we will look at ways to deal with problematic behaviors in and out of the classroom.

**EXPLORING BEHAVIOR DISORDERS IN CHILDREN AND ADOLESCENTS**

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has been approved as meeting the  
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## Introduction

Over the last century more and more children and adolescents have been diagnosed with behavior disorders. While problematic behaviors in adolescents have always been seen in and out of schools, it has only been in the last century that psychologists have looked deeper into the root of these behaviors.

The term “behavior disorders” can in fact encompass a number of different disorders seen among both children and adolescents. The three specific disorders discussed in this paper will be attention-deficit/hyperactivity disorder (ADHA), conduct disorder (CD), and oppositional defiant disorder (ODD). A great deal of the time, children exhibiting these types of disorders are trying to find some type of balance in their environment and within themselves. Lacking the skills to manage their thoughts, feelings, and actions appropriately, these children display behaviors that are considered to be inappropriate or even unacceptable in the social norm. The reason for exploring these three disorders is based on the relationship that each plays on the impairment of children and adolescents socially, academically, and occupationally.

It is often seen that children experiencing various behavior disorders also tend to experience learning disorders as well. At times it can be extremely difficult if not impossible to determine if the behavior disorder is a cause of the learning disorder, or if the learning disorder caused the behavior disorder. However, by identifying the disorders, it is a step towards determining ways to help the child or adolescent learn to cope with the issues he or she may be facing.

This paper will give a definition of behavior disorders as well as describing what to look for in children and adolescents with behavior disorders. Specific examples of adolescents with behavior disorders will be discussed, as well as the prevalence of behavior disorders in young people today. The etiology of behavior disorders will be examined, and also preventive measures that can be taken. Finally, we will look at ways to deal with problematic behaviors in and out of the classroom.

## Part I

### Defining and Describing Behavior Disorders

All adolescents go through times of rebellion and may display behaviors that are considered to be unacceptable by their parents and society. Adolescents may show their “rebellion” in different ways. Some may refuse to clean up their bedrooms or wear clothes that are thought to be “out of the norm”. However, when young people have true behavior disorders these various forms of rebellion and mischief go far beyond changing one’s hair color or refusing to do one’s chores.

A single definition for behavior disorder does not currently exist, making it difficult to diagnose and serve those children and adolescents who suffer from this disorder. The lack of a single definition of behavior disorder is problematic, due there being no universal acceptance of a “social norm.”

According to Erickson, behavior disorders were rarely studied until the twentieth century, with concentration on children and adolescents with behavior disorders beginning during the 1930s (Erickson, 1998).

#### **Problematic Behaviors as signs of Behavior Disorders**

Adolescents with behavior disorders display a pattern of disruptive behaviors for at least six months, and typically show aggressive or hostile behaviors. Some of these disruptive behaviors include, but are not limited to the following: threatening to or harming one’s self or others, including pets; destroying property, lying, stealing; skipping school, or showing apathy while at school; smoking, drinking, doing drugs; being promiscuous, defiant, and impulsive; displaying hostility towards authority figures, excessive arguing and throwing tantrums, and various criminal activity.

In order to cope with their “perceived” or real deficits, either academically or socially, many kids with BD find their own ways to cope with their feelings and thoughts. Many times these coping skills simply add to the problem instead of improving it. It is very common for teens with BD to be sarcastic or to pretend to be “stupid”. Other teens become confrontational. This is because they perceive that they will eventually be confronted themselves. Some adolescents act as if they are on drugs, even if they are not, in order to get attention. They flaunt their ignorance and materialize any dreams they might have. In the

classroom, it is this sort of apathetic behavior that drives a teacher crazy (Rose, 1990). The end result for the adolescent is that they expressed their feelings (although not in a positive way) and they were able to frustrate an authority figure. Many hope that this authority frustration will lead to the student eventually being left alone and little being expected from the student while in the classroom.

### **Early Signs of Behavior Disorders**

Some of the behaviors associated with the previous mentioned behavior disorders can be seen as early as preschool. For example, children who display hyperactive behaviors, such as moving around too much during sleep, may be reported as early as age one and a half. Children with difficulty playing quietly or excessively running or climbing may be reported by age three. Many times attention problems and hyperactivity will show in a child gradually and are often combined with oppositional characteristics. Some children with ADHA, displaying hyperactivity, show high rates of delinquency and substance abuse throughout their teen years and into adulthood (American Psychiatric Association, DSM-IV-TR, 2000). While attention and hyperactivity problems usually appear to decline, as they reach adulthood, many adolescents and adults continue to deal with both of these issues. A large number of adolescents and adults experiencing ADHA also develop behavioral and emotional problems throughout their lives.

Children who display oppositional behaviors that are continuing beyond preschool often become more extreme and severe in nature (American Psychiatric Association, DSM-IV-TR, 2000). There appears to be two different types of oppositional defiant disorders seen among children. Those who display oppositional behaviors that are not physically aggressive tend to peak around age eight and the behaviors decline after that. The second type display delinquent behaviors after oppositional behaviors. Children who are physically aggressive early in life are more likely to have oppositional behaviors that become more severe and turn into disabling conduct problems (American Psychiatric Association, DSM-IV-TR, 2000).

Conduct disorder predominately first appears during middle childhood. When signs of conduct disorder are seen for the first time during adolescence, they usually tend to diminish by adulthood. However, if conduct disorder continues from childhood on, problems such as breaking rules, truancy from school, and aggression towards people and animals worsen. Males, usually older than age 13, with conduct disorder, may even resort to rape or mugging in order to get what they want (American Psychiatric Association, DSM-IV-TR, 2000).

## **Defining Behavior Disorders**

Children and adolescents with behavior disorders are described as, “those who behave in harmful or inappropriate ways that cause them academic and social problems” (Blackbourn, Patton, & Trainor, p.85)

DSM-IV-TR breaks behavior disorder down into three subcategories. These three main behavior disorders examined in this paper are attention-deficit/hyperactivity disorder (ADHA), conduct disorder (CD), and oppositional defiant disorder (ODD). While each of these disorders does have some differences in the diagnosis, it is often seen that individuals experiencing one of these disorders is also experiencing others simultaneously (2000).

### ***Attention-Deficit/Hyperactivity Disorder (ADHD)***

According to DSM-IV-TR, “ADHA is the persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than is typically observed in individuals at the comparable level of development.” (American Psychiatric Association, DSM-IV-TR, p. 158). DSM-IV-TR also lists three subtypes of ADHD: 1) relating to the mostly hyperactive-impulsive type, 2) the inattentive type, and 3) a combination of the two types. Symptoms relating to ADHD must be seen in children prior to the age of seven and exist in more than one setting for a child to be diagnosed with ADHA. For one to be diagnosed with ADHA the following symptoms may, but are not limited to existing for at least six months.

Children and adolescents displaying symptoms in the first subtype of ADHA, hyperactivity and impulsivity, are often fidgety and squirm in their seats a great deal. They have difficulties staying in their seats when it is expected, and may run around or even climb on things when it is inappropriate to do so. Children and adolescents with hyperactivity and impulsivity issues have a difficult time playing or participating in quiet leisure activities, and often talk excessively or interrupt others. They blurt out answers before questions are completed and have a hard time waiting to take turns (American Psychiatric Association, DSM-IV-TR, 2000).

The behavior of the individual is maladaptive and inconsistent with the appropriate developmental level. The child or adolescent displaying inattention issues does not attend to details and makes careless mistakes, often has difficulty attending to tasks at hand, appears not to listen when spoken to, has difficulty with organization, often avoids tasks that require mental effort, loses things necessary to complete tasks, is easily distracted, and is often forgetful in daily activities (American Psychiatric Association, DSM-IV-TR, 2000).

### ***Conduct Disorder (CD)***

In the DSM-IV-TR, conduct disorder is described as “a repetitive and persistent pattern of behavior in which the basic rights of others or major age appropriate societal norms or rules are violated.” (American Psychiatric Association, DSM-IV-TR, p.160). These symptoms are visible in various settings and may significantly impair the functioning of the individual. Children and adolescents diagnosed with CD must have displayed one or more of the following symptoms for at least six months.

Children and adolescents with CD are aggressive to other people and animals. They engage in, and initiate physical fights, and may have used a weapon that could harm others. These children or adolescents have been physically cruel to other people or cruel to animals. They may have stolen something from someone while physically confronting them. They may have even sexually abused another person (American Psychiatric Association, DSM-IV-TR, 2000).

The destruction or damaging of property is also common among children or adolescents with CD. While some may destroy property by setting fires, others may break into the home, car, or building of another and commit theft. Lying to obtain items, favors, or to avoid consequences is also a common occurrence. Young people with CD often stay out all night long, prior to the age thirteen, despite the prohibiting of their parents. They often times run away from home and are truant from school prior to the age of thirteen. These types of behaviors cause impairment to social, academic, and occupational skills among children and adolescents (American Psychiatric Association, DSM-IV-TR, 2000).

### ***Oppositional Defiant Disorder (ODD)***

DSM-IV-TR defines ODD as, “a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior towards authority figures that persists for at least six months” (American Psychiatric Association, DSM-IV-TR, p. 161). In order to be diagnosed with ODD, a child or adolescent must display four or more of the following behaviors for at least six months.

Symptoms of ODD include, but are not limited to: a child or adolescent often losing his or her temper, consistently arguing with adults, defying or refusing to comply with the requests or rules of adults, deliberately annoying others, lack of taking blame for one’s own mistakes, but instead blaming others, easily annoyed by others, often angry or resentful, displaying vindictiveness or spitefulness. As with children and adolescents experiencing other behavior disorders, these types of behaviors hinder one’s functioning socially, academically, and occupationally (American Psychiatric Association, DSM-IV-TR, 2000).

Many different approaches can be used when evaluating and diagnosing children and adolescents exhibiting the previously mentioned behavior disorders. Parent and children may both be clinically interviewed. Informational reports may be gathered by teachers and staff at school. The child or adolescent may also be observed or neuropsychological tests may be performed. While children and adolescents may be able to provide much important data regarding behaviors, adults seem to be the best at reporting disruptive behaviors that are inappropriate.

### **Habits and Behaviors of Adolescents with Behavior Disorders**

Students with behavior disorders tend to display behaviors and develop habits which make it difficult for them to break the cycle of their actions. Sean Covey identified seven different habits of “highly defective teens” (p.7). Covey also identified seven habits that many “highly effect teens” displaying how young people can go about changing their own behaviors by changing the way in which they think and view the world around them. Many times students with behavior problems feel that they have little or no control over what is taking place in their lives. Instead of taking control of their lives they become their own victims.

Adolescents that show “defective” thinking tend to react to situations and do not take responsibility for their own lives. They begin tasks with no end in mind. These teens have a difficult time developing goals or plans and do not worry about the consequences of their actions. Procrastination and missed placed importance are other habits teens with behavior issues exhibit. They tend to put things off, make excuses for why they do not do or finish important takes, and waste a great deal of times doing little to nothing.

Teens with “defective thinking” think that everyone else is “out to get them”. They believe that they are going to “lose” in life and so should everyone else. This same narcissistic attitude shows in the way that these teen have to talk first when faced with an issue and pretend to listen to the thoughts and opinions of others. It is very rare that teens with this defective thinking pay attention to someone else’s side of the story or the way the other person feels. Cooperation is not something that adolescents with behavior disorders are usually wiling in which to participate. They often flat out refuse to work with others. These same students will wear themselves out with “meaningless” behaviors and activities. They rarely, if ever, look for ways to improve or inspire themselves (Covey, 1998).

## **Habits of Teens with Effective Behaviors**

In contrast to these behaviors, Covey describes the seven habits which are displayed by effective teens (Covey, 1998). These habits can be learned and modified in order to help students become successful and develop more positive ways of thinking about their lives and the world around them.

Adolescents that are successful are proactive. They take responsibility for themselves and for what is taking place in their lives. These young people also have an end goal or plan. They prioritize the things that they do, finishing the things that of the most importance first. They have the mindset that everyone should be able to win. In order for both parties to win, one must “seek first to understand, and then be understood”. This means that these teens are willing to listen to the thoughts and opinions of others before they voice their own thoughts or opinions. They also take the feelings and opinions of others into consideration when making decisions. Teens that are willing to work with others are likely to achieve more. Successful teens also enjoy finding ways in which to “renew” themselves. They thrive by learning new things and look for ways to become inspired (Covey, 1998).

## **Part II**

### **Prevalence of Behavior Disorders and Rate of Incidence**

Behavior disorders among adolescents usually develop due to other factors in their lives. Adolescence can be a very emotional and trying time for young people. Their bodies are changing and their way of thinking begins to change as well. Some feel that they have no control over themselves or their own lives. It is this way of thinking that can lead to problematic behaviors both in and out of the classroom setting.

When examining the prevalence of children and adolescents with behavior disorders, one needs to think about the variability in community samples from which the information was gathered. For example, when looking at children or adolescents from an area that has a high poverty rate, the findings of children or adolescents with behavior disorders may appear to be significantly higher than those from a wealthy area.

Since the actual definition of behavior disorders varies from place to place the prevalence of children and adolescents with behavior disorders tends to vary as well. The federal estimate of children and adolescents with emotional/behavior disorders ranges from 1% to 25%, depending on the state. As many as 12% to 18% of young people under the age of eighteen are categorized as mentally ill (Blackbourn et al., 2004).

#### **Children and Adolescents with ADHA, CD, and ODD**

The estimation of prevalence of school-aged children with ADHD ranges from 2% to 7%, according to DSM-IV-TR (American Psychiatric Association, DSM-IV-TR, 2000). Some community surveys reported in DSM-IV-TR also indicate rates of prevalence as high as 17.1% (2000). While school-aged children are only recorded as having 0.9% prevalence for CD, adolescents rate as high as 8.7% (American Psychiatric Association, DSM-IV-TR, 2000). Overall, including both school-aged children and adolescents, the prevalence for ODD ranges from 5.7% to 9.9% (American Psychiatric Association, DSM-IV-TR, 2000). Numerous studies have indicated that school-aged boys have a higher rate than girls in all three disorders, with a prevalence of 3:1 (American Psychiatric Association, DSM-IV-TR, 2000).

## **Adolescents with Depression**

Many young people who develop behavior disorders often do so because they are dealing with depression and lack the skills to deal with it in an appropriate manner. "One out of twelve teens suffers from significant depression before the age of 18." (Bostic & Miller, p. 60).

By identifying children or adolescents experiencing depression, and helping them to learn coping skills, we can assist them in living more fulfilling lives as adults (Bostic & Miller, p.60). Many times these young people experiencing true depression need therapy to help change their way of thinking. Sometimes they even need medication along with therapy to help them learn to manage their behaviors in more appropriate and constructive ways.

Children and adolescents who externalize their problems tend to experience more problems with depression in early adulthood. Examples of externalizing problematic behaviors would be adolescent delinquency and conduct problems. Children and adolescents who experience ADHA are also more likely to suffer from depression as adults (Kosterman, Hawkins, Mason, Herrenkohl, Lengua, & McCauley, 2009). Insecure attachments during infancy can also have long term affects and cause depression in children and adolescents and last into adulthood (Babaee & Sachin, 2009).

## **Part III**

### **Causes – Etiology of Behavior Disorders**

While the exact cause of behavior disorders in children and adolescents is not known for sure, there are various factors that influence whether or not children develop behavior disorders. Some of the factors contributing to behavior disorders include but are not limited to: community and neighborhood problems, ineffective parenting, and deviant peer association (Huefner, Handwek, Ringle, & Clinton, 2009). They may also stem from neurological impairments and family genetics (American Psychiatric Association, DSM-IV-TR, 2000). Causes for behavior disorders may be a combination of several factors.

#### **Heredity and Biological Factors**

While it is extremely difficult to determine if heredity and biological factors alone cause behavior disorders, it appears that they may contribute to them. According to research conducted by Grigorenko et al., (2010), dopamine or DA, is “a neurotransmitter that is critically involved in the approach system and reward-related behavior. This means that if behavior disorders are related to dysfunction in the approach system, then DA is likely to be involved” (p.159). In other words, if an individual has dysfunctional dopamine neurotransmitters, he or she is more likely to develop a behavior disorder. Grigorenko et al., go on to suggest that “the dopaminergic system is the pathway to aggression and behavior problems, such as conduct disorder in children and adolescents” (p.159).

Since most individuals with behavior disorders also experience various other risk factors it is currently impossible to completely separate heredity from other factors. Perhaps studies in the future will lead to further understanding of how genetics plays a role in the development of behavior disorders in children and adolescents.

#### **Family Influence**

Children have contact with many different people inside and outside of the home. However, the most important influence in a young child’s life is that of the mother or mother figure. From the time a child is born s/he forms an attachment with the mother or mother figure according to how the child’s needs are met. Children grow not only physically, but also

emotionally. In order for a child to form a strong, secure attachment with his or her mother both physical and emotional needs have to be met at some level (Babae & Sachin, 2009).

When strong, secure attachments exist between mother and child, the mother is sensitive and responds to the behaviors of the child. The child feels that the mother supports him or her and develops a feeling of security and safety. A child having a secure and warm attachment to his or her mother is better able to adapt socially. Children with secure attachments tend to adjust better and quicker when leaving the home to attend pre-school or kindergarten.

Not all children develop secure attachments with their mothers or mother figures. Many times a child may not form a secure attachment with his or her mother because the mother is not meeting the physical and or the emotional needs of the child. Mothers, who are dealing with depression or other mental maladies of their own, are often much less likely to recognize and meet the needs of their child. Mothers suffering from depression are more susceptible to negative moods and their interactions with their children are much less positive (Babae & Sachin, 2009). A mother's depression can thus, lead directly or indirectly to mental and or behavioral problems in the child, or make the child more susceptible to develop emotional or behavior disorders.

Many mothers are consumed with are trying to deal with the meeting of their own needs and not meet all of the needs of their children. This leads to a weaker attachment between mother and child, resulting in a child who is less able to adapt to social changes. Children with weaker attachments to their mothers are much more likely to carry out these emotional and behavioral disorders throughout their childhood, adolescence and into adulthood.

Children often learn many of their traits through imitation. They watch their parents or others in their home and imitate their behaviors. If a child grows up in a home where the mother is depressed, or suffers from other mental ailments, the child is likely to imitate the behaviors displayed by the mother. A child who sees his or her mother display sad, angry, disappointment, agitation, or stressed behaviors a great deal of the time will imitate and begin to develop these same feelings. The more severe the mental problem the mother suffers from, the more the child is affected.

As mentioned earlier, children who lack secure attachments with their mothers tend to have a more difficult time adjusting to social changes. These children are more likely to develop depression and other behavior disorders. Many children suffering from depression express their thoughts and feelings in negative or inappropriate ways. Expressive anger and aggressive behaviors in children and adolescents are good indicators that the young person is

experiencing depression. Children with behavior disorders also tend to be deficit in their social skills and have poor anger management skills.

Children learn through watching the behaviors of their parents and family members. When their parents lack the skills to manage their own behaviors it is very likely that their children will have similar issues. If children are not presented with appropriate emotional outlets or taught the skills they need to manage their behaviors appropriately they are more likely to display their anger in unhealthy or destructive ways. Some children will harm others, pets, or property. Other youth will harm themselves to express the anger that they feel.

Youth who are able to handle changes in social situations with minimal stress or anxiety are better able to manage their behaviors appropriately. Helping children and adolescents improve their social skills and appropriate expressions of thoughts or feelings leads to better cooperation with both adolescents and adults. It also increases the numbers of positive interactions with other adolescents and adults (Flanagan & Henry, 2009).

According to DSM-IV-TR, the families of children experiencing behavior disorders tend to be “less stable, have higher divorce rates, and move more frequently.” These children also tend to have immediate relatives with higher rates of antisocial behaviors, substance abuse, and depression. Many times these difficulties are the result of “poor self-esteem, difficulty in interpersonal relationships, difficulties in keeping a job, as well as assaults, on even armed robbery in some cases.” (American Psychiatric Association, DSM-IV-TR, p. 166).

## **Environmental Influence**

Over the years, many psychologists have come to the conclusion that adolescents who come from lower income families are the ones who are the most likely to move around. As a result of this moving, students fall further behind in their learning (Hirsch, 1999). Students who feel frustrated with their education often display problematic behaviors in school. Embarrassment and frustration will often lead to anger over some real or perceived inadequacy (Rose, 1998). Often, adolescents from lower incomes are more likely to become stuck in negative behaviors because they do not feel that there is any way out of their situation. These adolescents and young adults feel that they have little or no opportunities to better themselves or their lives (Peterson & Leffert, 1995).

One of the greatest stresses in a young adolescent’s life is feeling that he or she does not fit in with peers. Children and adolescents may feel that they are not on the same academic or social level as their peers, and thus act out because they are frustrated, angry, or even embarrassed (San Antonio, 2006).

## **Other Possible Causes or Influences**

Any combination of the previous influences can contribute to the formation of behavior disorders in adolescents and children. Some adolescents express their frustration or depression through external, aggressive anger. Most of the kids who express their feelings in this manner do so because they have deficits in their social skills and poor anger management skills (Flannagan & Henry, 2009).

According to Blackburn, et al., there are seven different possibilities for causing behavior disorders. The first reason is that something internal is driving the person to behave in such a way. Or, "The devil made me do it" (Blackburn, et al. p. 87). The second reason stems from the child or adolescent having abnormal biochemistry in the brain. This could even be caused by not enough food, lack of proper vitamins and minerals, or poor quality of food. The third cause could be genetics. However, one tends to wonder if it is really heredity that is causing the behavior or the family rearing practices. The next possible cause is psychoanalytical, meaning that there are other underlying problems causing the behavior such as stress, anxiety, or other emotional issues. The lack of understanding one's own feeling or thoughts is also thought to be a possible cause. People with behavior disorders are thought to lack self-awareness. All behaviors are learned and appropriate behaviors can be taught to all children and adolescents. If one thinks this to be the cause for behavior disorder s/he may also think that the child "never learned how to get along". The final cause of behavior disorders is that the behavior itself tends to depend on where and with whom the child is interacting (Blackburn, et al., 2004).

## **Additional Contributing Factors**

Some factors contributing to behavior disorders can also take place during infancy. The following factors can have long lasting effects beyond childhood and adolescence: poverty, fetal alcohol syndrome, failure to thrive, abuse, neglect, homelessness, poor nutrition, environmental poisons, and violence (Blackburn et al., 2004). Being subjected to one of the factors could lead to problematic behaviors throughout childhood. However, being subjected to more than one of these risk factors makes the likelihood of developing behavior disorders all the more probable.

## **Part IV**

### **Preventing Behavior Disorders in Children and Adolescents**

Despite what some may think, most adolescents with behavior disorders are not deviant or deficient because they enjoy being that way. The behaviors that most young people with behavior problems display are a sign of a much deeper underlying issue (Vernon & Al-Mabuk, 1995). The child is most likely frustrated or hurting in some way and lacks the skills to express his or her feelings in an appropriate manner. In order to help a child develop these coping skills, one must first get to the root of the problematic behaviors.

#### **Identifying Children and Adolescents**

When dealing with children or adolescents with behavior disorders it is important to keep in mind that the behavior the individual is having is not the problem. The problem is actually how the behavior affects the individual academically or socially. Children and adolescents with behavior disorders have excessive behaviors. They may be too aggressive, too loud, too quiet, too euphoric, or even too depressed. These excessive behaviors usually last at least six months (Blackbourn et al., 2004).

These are three things that one must consider when working with children or adolescents with behavior problems. The first criterion is the severity of the behavior. Are the actions of the individual excessive or extreme? The next area of consideration is the chronicity of the behavior. This describes the period of time which the behavior has existed. The final item one must consider is the context in which the behavior is taking place. Is the behavior taking place during a specific time or in a specific place? If so, there may be steps one can take to remove the stimuli that is causing the behaviors (Blackbourn et al., 2004).

#### **Ways to Access Children and Adolescents**

Most young people that are assessed for behavior disorders are referred by professionals such as teachers or physicians, and many times parents. Some of the ways in which to assess include: interviews with parents and the child or adolescent, using behavior checklists or rating scales, standardized tests, and projective tests.

The use of structured interviews with parents and their children can be very helpful in determining what may be contributing to the behaviors the child is displaying. Teachers, parents, and other adults may also use rating scales to measure the behavior the child is displaying. The child may also be asked to use a checklist to measure his or her own behavior. Standardized tests are used as a way to assess intelligence. Children or adolescents may also be asked to take personality assessments as well, such as the Personality Inventory for Youth (Erickson, p. 34). Projective tests such as Rorschach, or inkblot tests are also used.

There are different ways in which to conduct behavior assessments. Children or adolescents may be asked to observe themselves and their own behaviors. They may be observed by others, such as parents or teachers. During these observations it is important to look for antecedents, consequences, and setting events. The observer needs to think about what may be causing the child to act a specific way. Is there a stimuli? One also needs to think about what happens immediately after the behavior occurs. Is the child really being rewarded in some way for his or her inappropriate behavior? Setting events are things that are already in place, including time and place, that may be contributing to the behavior as well (Erickson, p. 1998).

### **Classifications and Characteristics**

As mentioned previously, it is truly hard to define behavior disorders. Many classifications that exist describe the behaviors themselves and are not specific. There is a much simpler and more productive way to classify children and adolescents when working with them in a school setting. The classifications are mild, moderate, and severe. Children with mild behavior disorders are usually taught in a regular education classroom, but may have some slight accommodations to help them be more successful. Children who are classified as having moderate behavior disorders are also commonly taught in a regular education classroom, but will require more help and may also spend part of their time in a special education setting. Children with severe behavior disorders are most times taught in a separate setting or even an institution. The strict structure in these types of settings will help students to manage their own behaviors and learn to deal with other issues that may be contributing to their behavior (Blackbourn et al., 2004).

### **Preventing Behavior Disorders**

To present date there are no known preventions for behavior disorders. However, through the use of various intervention and prevention plans the number of individuals

experiencing behavior disorders can decrease. In our society, we currently have some programs in place that are designed to help compensate for the risk factors that some children face every day. Head Start and other similar programs are current programs in the prevention process.

According to Kauffman, there are three main types of preventions to help diminish behavior disorders in children and adolescents (p. 448). The first type of prevention is primary prevention, which is designed to keep the disorder from occurring at all. The focus of this prevention is based on “safety and health maintenance interventions” (Kauffmann, 2010). By reducing or eliminating risk factors in the lives of children and adolescents, we may be able to decrease the chance that they have for developing a behavior disorder.

The next type of prevention is secondary prevention. This type of prevention deals with reversing or correcting the undesired behavior. Many times children and adolescents display the earliest signs of behavior disorders outside of the school setting. It is extremely important that these behaviors be acknowledged and dealt with early on to keep future incidents from becoming more problematic.

The main idea of the third type of prevention, tertiary prevention, is to develop a plan to keep the disorder from overwhelming the individual or others in the environment around him or her. Students with the most severe behavior issues may not always be able to have their needs met in general population or in a regular education classroom. These children or adolescents are commonly removed from society and placed in a more structured setting to help them learn to manage their behaviors in an appropriate manner.

In order to keep problematic behaviors from occurring there are several things that we can do both in and out of the classroom. Children should be awarded and praised for appropriate behaviors (Kauffmann, 2010). We as educators and adults need to “catch them being good”. While this may not eliminate the undesirable behaviors all together, it may diminish or decrease those behaviors.

There are signs that teachers should recognize as indicators of developmental or behavior problems. Students display aggressive or disruptive behavior or fail to meet academic requirements. They may also experience social rejection and socialize with negative peer groups. All of these are signs that more problematic behaviors may lay ahead (Kauffman, 1999).

## **Part V**

### **Dealing with Behavior Disorders**

Dealing with children, adolescents, or students with behavior disorders can be very challenging both in and out of the classroom. Establishing relationships with students with BD can be not only very difficult, but also very time consuming. Many times the behaviors that these students display are really a mask for what is going on inside their minds and their bodies. In order to help students to modify their own behaviors, one must first help the student to identify why it is they are really behaving in a certain manner.

#### **In the Classroom**

Students, especially those with behavior issues, need to have positive adult role models in their lives. They need people to have the time and patience to teach them coping skills and how to do things that they do not know how to do on their own (Rose, 1998). As mentioned previously, children learn through imitation and through the development of solid, secure relationships. Adults who are strong, positive role models are very helpful for students with behavior issues. When young people see people whom they respect behaving in a positive, responsible manner, they are much more likely to want to act in that manner themselves.

Another important factor of the positive role model is that this adult has shown interest in the life of the young person with the behavior issues. As a teacher, one needs to show genuine interest in the lives of his or her students. If you show a student that you care about them and what is important to them, they are much more willing to try to maintain a relationship with you. In turn, this relationship that is built between the “caring” teacher and the student with BD is beneficial to both parties. The student feels that he or she has an adult that can be counted on, and the teacher is much more likely to have a cooperative student in the classroom.

Teachers must also be willing to change the way in which they were taught to teach their students. In order for teachers to get through to their students, they must make the information they are teaching personal and relevant to their students. This means that the information must relate to the life of the student in some way. By attaching a relatable meaning to the information that is delivered to the student, the teacher is better able to help change the student’s attitude towards the information that is being taught (Langer, 1997).

When teaching children and adolescents, whether they have behavior disorders or not, one must teach the whole child. It is important to identify, foster, and nurture the skills the child possesses. They may need help identifying their own positive attributes. Adults that work with them need to be realistic and honest about what the child has to offer him/herself, and the rest of society. It is also imperative that teachers and other adults know the background of their students. This provides them the opportunity to relate the information that they are trying to teach the child to something they can relate to their own lives (Hirsch, 1999).

When students display inappropriate behaviors they should also be provided with choices. If a child is given the choice to continue the behavior and thus deal with the consequences, or given a different choice that is appropriate it empowers him or her. Children, like everyone else need to feel that they have power of their own actions. By offering them a choice and explaining the consequences for inappropriate behavior, a teacher is giving the student the power and helping them to realize that the teacher or adult is actually hoping the child will make the right choice. When a child feels that the teacher is on his or her side they are less likely to continue to display inappropriate behaviors (Ramsey, Jolivette, Patterson, & Kennedy, 2010).

Proactive teaching is key to working with students with behavior disorders. By explaining and showing students what appropriate behavior looks like you may be able to keep inappropriate behaviors from occurring. Praising the proper behaviors immediately after they occur may also help to keep inappropriate behaviors from occurring in the classroom.

The best classrooms are those that are warm and supportive. Clear and consistent expectations are specifically defined and reinforced. When teachers make learning fun and interesting it also helps the students become more engaged in their own learning. If children know what is expected of them and structure is set up and reinforced, the likelihood of problematic behaviors in the classroom is diminished.

## **Instructional Models**

Over the years there have been several instructional models that educators have tried in the classroom. As educators we need to ask ourselves, what really works?

### ***Psychoanalytical Model***

The psychoanalytical model lets the child work through his or her underlying problems at his/her own pace. This model was supported by Sigmund Freud. However, there appears to

be several flaws with this particular model. There is not much scientific proof to show that it actually works. It really does not focus on improving the problem behavior that the child is exhibiting. The psychoanalytical model is also extremely time consuming (Blackbourn et al., 2004)

### ***Psychoeducational Model***

The psychoeducational model involves talking with the child or adolescent about his or her inappropriate behavior and trying to help him/her gain insight into his/her own behaviors. Most of the teaching that takes place with this model is done through projects and creative arts. Again, this theory is flawed, as there is little to no empirical support to show that it actually works (Blackbourn et al., 2004).

### ***Humanistic Model***

During the 1960s and 1970s the humanistic model was widely used to instruct students with behavior disorders. This model was designed around getting the child to look at “how it feels to be human”. The major flaw with this model is that it is not documented to be effective in improving behavior or academic learning (Blackbourn et al., 2004).

### ***Ecological Model***

The ecological model revolves entirely around the child’s family or community and how they contribute to modifying the child’s behavior. While this model does have some benefits, when solely used, the benefits are not that significant (Blackbourn et al., 2004).

### ***Behavior Model***

The main idea behind this model is that behaviors are learned and they can be altered or changed. The behavior model includes aspects of all the other models to some extent. It encompasses the whole child and by including the child’s family or community, the child stands a much better chance of managing his or her behavior both in and out of the classroom (Blackbourn, et al., 2004).

The following are tips that educators and other adults can use when working with children or adolescents with behavior disorders.

### **Tips for Working with Children or Adolescents with Behavior Disorders**

1. Don't get caught up in meaningless arguments with children or adolescents with behavior disorders. Instead distance yourself from interactions that are not productive. Revisit the problem later when you are both calm.
2. Do set clear and consistent expectations.
3. Do follow through with consequences, whether they are good or bad.
4. Do give children or adolescents with behavior disorders structure and support.
5. Do set realistic goals and expectations.
6. Do try to involve family when possible to ensure success at home as well.

(Blackbourn et al., 2004)

## Conclusion

Since many children and adolescents with behavior disorders have disruptive behaviors both in and out of the classroom, some educators and other adults are concerned about them being taught in regular education classrooms. Young people with behavior disorders need to work with adults who understand them and can help them use various strategies to learn to manage their own behaviors. By identifying children and adolescents with behavior disorders and helping them learn appropriate coping skills, we will help diminish further issues and problems for them down the road in life.

Concerns about children being “labeled” with disorders or disabilities are very real. Many parents feel that if their child is given the “label” of having a behavior disorder he or she will be looked down upon by his/her peers and the rest of society. In order to decrease this feeling of uneasiness, children with behavior disorders need to be identified with the least offensive labels possible that clearly described the problematic behavior.

Another concern that we face when dealing with children with behavior disorders is that many people tend to find it easier to blame the environment for the behaviors the child is exhibiting, not the child. While we know that there are contributing factors that lead to children and adolescents developing behavior disorders, when the child is eliminated from the equation we are taking away any responsibility that they child has for his or her own actions. Not only is this inaccurate, but is also takes all of the power of choice and decision making away from the child. If a young person knows what is expected of him or her, whether it is in class or out in society, he/she has a choice about the way he/she will behave.

One frustration that many face when working with children or adolescents with behavior disorders is how to judge whether or not we have been successful in our intervention. We often ask ourselves if the time and energy we spent working with that young person really helped them learn to make better choices in life. We wonder if they would have learned to make better choices on their own without our help. Success for each child or adolescent is different. For one, success may be only having one blow up in class a week instead of one every day. For another, success may be beating up someone that they are furious with, rather than using a gun and killing them. It is because of the different degrees of success that we often ask ourselves if we did enough. We ask ourselves if we taught the right skills and spent enough time with the student, or if we could have done more.

In order to help children and adolescents with behavior disorders, we as adults, parents, and teachers, need to not only be positive role models in their lives, but also be supportive of them. Everyone makes mistakes in life, but we need to show these young people how to learn

from their mistakes. We need to teach them the skills that they will need in order to be productive members of society.

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