

## CHALLENGING CASE: BEHAVIORAL CHANGES

### Maria: Stubborn, Willful, and Always Full of Energy\*

#### CASE

"Maria is stubborn, willful and always full of energy. For the past 2 months, I [haven't been able to] leave her for a moment without her grabbing me and crying. She refuses to sit on the potty seat. Yesterday, she threw herself on the floor, yelling and kicking after I suggested she use the potty seat. Tantrums occur every day—sometimes in response to a simple request."

Maria's mother offered this vivid description of her child's behavior at a 2-year health supervision visit in response to the pediatrician's question, "Tell me how Maria has been recently." Maria had been followed since birth by her pediatrician. Maria was born to a single mother who works part-time and is enrolled in two college courses, and the gestation and perinatal periods were uncomplicated. A review of the medical record reveals that she was an especially active infant, experienced mild to moderate colicky behavior in the first 3 months, and achieved all of her motor, language, and social milestones at appropriate times.

After it was established that the frequent tantrums, clinging behaviors, and "stubbornness" had escalated considerably during the past 2 months, the medical history was directed toward any recent changes in the family, caretakers, or living situation. The combination of job and school had been a major focus of her mother's life for the past year. Recently, school work was more demanding and, after a change in supervisors, her work in a clothing store was less satisfying. Finances were marginal, but she was making ends meet with medical assistance from Medicaid and with discounted child care at her college.

Maria's mother had always been a single parent, and her pediatrician was impressed with this mother's resiliency, flexibility, and ability to continue her education while raising a young child.

Sitting in her mother's lap throughout the visit, Maria played with a toy, snuggling close to her mother. She refused both eye contact and a play interaction with the pediatrician. (Her mother stated that this behavior was a typical response to people who Maria was not familiar with.) Verbal interchange was unsuccessful although it was noted that Maria responded to her mother's requests. Growth measurement, physical examination, and a screening developmental assessment were normal.

#### Dr. Martin T. Stein

The recognition, interpretation, and management of common behavioral problems in children and adolescents have developed into an important component of primary care pediatrics. Textbooks, review articles, and parenting guides are plentiful and available to pediatricians. However, the challenge for the active pediatric clinician with a characteristically busy practice is to discover strategies that address biological and psychosocial issues and problems within a time frame adaptable to contemporary medical practice.

Even before the recent dramatic changes brought about by managed care, general pediatric practice was fast-paced. All too often, the agenda for office visits is limited to the chief complaint; health supervision visits are notably packed with a long list of "things-to-do." As health care services to children become more efficiency- and outcome-sensitive, the challenge to create new models and strategies for effective delivery of services must be met.

Child and adolescent development behaviors are especially vulnerable to current political and economic changes in health care delivery. The following case study, a description of a mother's concern about specific behaviors in her 2-year-old daughter, illustrates the knowledge base, openness to discovery, and use of historical information that are outgrowths of continuity of care and a mature pediatric clinician. How many pediatricians hesitate to ask an open-ended question, such as, "Tell me how Maria has been recently," for fear that the answer will prolong the visit, redirect the clinician's agenda, or raise issues for which immediate solutions are not forthcoming? How can we guide primary care pediatricians so that this kind of discovery is encouraged and begin the diagnostic and therapeutic process in a limited time frame?

For the specialist in behavioral pediatrics, the case of Maria raises similar and contrasting questions. Managed care medical practice has put time limits on the diagnostic interview and length of therapy. As the medical field becomes more organized into "care units," how can the behavioral specialist work effectively with primary care clinicians to (1) screen for behavioral problems routinely, (2) address those problems in a step-wise fashion that respects practice limitations, and (3) discover new strategies for collaborative work among generalists and specialists who care for the same group of patients? Subspecialty pediatricians who treat patients with asthma and neonatal jaundice have developed guidelines that address these questions. Specialists who treat adults with a variety of chronic illnesses in a managed care environment have developed elaborate al-

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gorithms that sort out diagnostic criteria, therapeutic strategies for primary care clinicians, and specific criteria for patient referrals. Can there be similar collaborative efforts among primary care and behavioral pediatricians?

Three clinicians with different perspectives were invited to comment on this case. They were chosen to frame a clinical approach to Maria's behaviors and to her mother's responses from the point of view of (1) a child psychologist (**Dr. Anthony Graziano**) who trains graduate psychology students, coordinates research programs (most recently in discipline practices among middle class families), and practices clinical psychology, (2) a behavioral pediatrician (**Dr. Barbara Howard**) who teaches medical students, residents, and fellows in behavioral pediatrics with a focus on common behavioral problems and with an appreciation for the role of family dynamics on childhood behaviors, and (3) a pediatrician educator (**Dr. Howard Dubowitz**) with research experience in clinical and community interventions for emotionally and physically abused/neglected children.

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#### **Dr. Anthony Graziano**

As a clinical psychologist, I will assume that the physical well-being of the child has been assessed by the child's pediatrician. There are several psychological dimensions in the case history that may be examined: the child's negative, stubborn behaviors, such as refusal to use the potty seat; the frequent tantrums and crying and the child's apparent distress; her clinging and refusal to separate from her mother; and her refusal to interact (play and talk) with unfamiliar people. The common elements appear to be: (1) The mother's busy schedule as well as probable lack of sufficient help in caring for the child; this may be creating conditions for some disruption in attachment processes; causing: (2) strong insecurity expressed as anxiety, distress, or fear felt by Maria and her (3) rapid development of ultimately self-defeating attempts at demanding her mother's contact and attention. In time these can become (4) overlearned, maladaptive behaviors that can interfere with her normal rate of social and psychological development.

The child's insecurity and fear ought to be addressed with the mother. This can be accomplished in a variety of ways. Maria's mother needs to know that these behaviors appear to be escalations of common behavior by 2 year olds. To some degree, as Maria develops and gains social competence and security, interacts with peers, and develops new interests, these problems will diminish. It can be pointed out that normal developmental progress is on their side, but it will not be sufficient to wait until Maria "grows out of it." The intensity and frequency and the number of Maria's problem behaviors are beyond that expected of most children. The clinician can guide Maria's mother to an understanding that

critical components for success will be: a clear plan with goals; consistency; plenty of love and patience; a willingness to change her own schedule and behavior; and a robust sense of humor.

Two additional therapeutic components are suggested. It is hoped that the mother will understand that, although firmness is necessary at times, punitiveness (especially slapping, spanking, and out-of-control "yelling") may do more to create new problems than to solve the current problem, however successful such forceful responses might momentarily appear to be. Finally, she needs someone to help relieve the child-care burdens (relative, babysitter, community support group, etc.).

I would recommend to Maria's mother that she establish (or reestablish) a firm basis for good attachment,<sup>1,2,3</sup> i.e., create more soft, gentle times of cuddling, reading, fun, and quiet play. Give Maria attention, love, and patience. This might require changes in the mother's schedule, but it is worth it, no matter how difficult it might be. These attachment situations and interactions are the necessary bases for any attempts to change Maria's behaviors. I would ask Maria's mother to initiate these changes for perhaps 1 or 2 weeks before adding other therapeutic components (which might then not even be needed).

If appropriate after further observation, I would teach Maria's mother age-appropriate alternatives to the tantrums and clinging behaviors, for example, initiating "time-out" for tantrums.<sup>4</sup> I would instruct the mother to: explain the procedure clearly, implement it, and be firm and consistent; not add any other punishment; begin by demanding 10 to 15 seconds of quiet sitting before letting Maria up; and increase the time to no more than 1 or 2 minutes. I would also suggest that the mother find some play situation with other children, and possibly other parents of only a few children Maria's age, in a small place, where the mother can stay for awhile, and let Maria sit on her lap as necessary until she feels more comfortable. Maria's mother should encourage Maria to go get a toy, play on the floor, look at and be near other children, etc. In time, I would recommend a brief day care setting without the mother with gradual increases in the number and the amount of times per week per day care visit. After 2 months on this program, I would reassess the original problem. At that time, particular attention should be paid to any possible developmental delay<sup>5</sup> in language and social development.

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#### Dr. Barbara Howard

The pediatrician's facilitating trigger question<sup>1</sup> ("Tell me how Maria has been recently") was open not only to biomedical concerns but also psychosocial/developmental ones. The resulting complaints of clinginess, refusal to sit on the potty, and tantrums raise concerns about the child's and her parent's developmental progress. Maria's behavior might be dismissed as "terrible twos" (predictable, negative, transitory behaviors in toddlers) but probably represents a different developmental crisis calling for different management.

One unrealistic expectation may be successful toileting because most children have not completed this developmental milestone by their 2nd birthday. The average age is 2½ years old<sup>2</sup> for a child to successfully toilet, both neurodevelopmental readiness and psychological willingness are needed. Although Maria's developmental assessment was normal she might not be capable of toileting. Even if she is capable of voluntary sphincter control, her refusal shows a lack of willingness for this and other "simple requests." Maria's mother may be pushing toileting out of her own needs for Maria to be independent. A major reason for noncompliance, especially with abrupt escalation of developmental expectations, is that a child may feel that her needs are not being met.

Tantrums characteristically occur from 15 to 36 months but are more problematic in "difficult" temperament children like Maria; they can become attention-getting, especially when attention is inadequate. They tend to be more intense in association with developmental unevenness, especially in delayed expressive language.<sup>3</sup> Several factors in Maria's history are associated with tantrums, and any others should be elicited.

Exploration of recent changes is important to determine factors that may contribute to behavior because young children's behaviors are more environmentally reactive. Other clues might include illnesses that alter vulnerability and care and changed behaviors with caregivers that could signal abuse or neglect. For Maria's mother, increased school demands coupled with decreased work satisfaction may have increased her irritability and decreased her physical and emotional availability, producing unmet needs for nurturance. Children often respond to parental irritability and lack of nurturance with clingy, demanding, and noncompliant behavior. These behaviors are also characteristic of the period of rapprochement, occurring from 15 to 24 months.<sup>4,5</sup> This stage can begin suddenly or gradually, with the child seeking to be held or carried and to return to the bottle and having trouble separating, often with strong preference for mother. These behaviors may upset parents when coinciding with changes in day care because they heighten ambivalence and may raise misdirected concerns over quality of care. Rapprochement frequently overlaps a subsequent preg-

nancy with its fatigue, ambivalence, and worry about nurturing another child.

This pediatrician is well positioned to help when respect for Maria's mother is one major focus of the office visits. A useful opener might be "How is this new neediness for you?" followed by exploration about how Maria's mother has been so successful at independence, at what price, and with what supports for filling her own needs. Empathy during the clinical encounter for the mother will enhance receptiveness to suggestions about her child's needs, which include temporarily increasing responsiveness, holding (including during tantrums), and special time<sup>6</sup> and temporarily decreasing demands for independence, like separations and toileting. Acknowledgment of the mother's independence can help clarify her hopes for Maria's independence and help her to separate child from adult capabilities.

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#### Dr. Howard Dubowitz

Maria's tantrums and her mother's stress present an all-too-familiar picture. One must understand what is happening with this 2 year old and her family to tailor one's intervention to their specific needs.

Are Maria's temper tantrums within the normal range of "problem behaviors" for children at her developmental level?<sup>1</sup> Probably, but even if the tantrums are "normal," there is a red flag warning that her mother's noted resiliency and coping abilities are being overwhelmed.<sup>2</sup> There are other red flags, such as the mother's recent inability to "leave her for a moment without her grabbing me and crying." We need to clarify how the recent changes in the mother's life may have affected her relationship with her daughter, the caregiving arrangements, the nature of Maria's behavior, and the mother's responses.

Maria's refusal to interact with the pediatrician and strangers together with her history of colic, "stubbornness," and clinging suggests the temperament of a "difficult" child.<sup>3,4</sup> Another possibility is that she is "anxiously attached" to her mother.<sup>1</sup> This pattern of attachment describes infants whose cues are not responded to by a mother (or father) in a consistent and comforting manner, impeding the development of a secure and trusting relationship. As a result, a child may be clingy and anxious about ven-

turing out into a “strange situation.” It would help to know about past caregiving arrangements, the mother’s availability to Maria, and the degree of predictability in Maria’s life.

Maria’s refusal to sit on the potty could be part of her developmentally appropriate quest for greater autonomy and a measure of control, over her mother, not her bowels.<sup>5</sup> Maria’s mother seems quite upset about this behavior, and we should know her response; there could be a need for guidance against early and forceful toilet training.

Maria’s temperament and behavior and the stresses on her mother contribute to a problematic “fit,” illustrating the transactional theory where the interaction between child and parent helps explain the current difficulties.<sup>4</sup> There is a similar ecological theory for understanding the multiple and interacting influences on child development. This theory has also been adapted for explaining the etiology of child maltreatment;<sup>6</sup> this vignette raises concern about possible child abuse and neglect. Indeed, anxious attachment has been described in young children whose emotional needs were not met (neglect).<sup>7</sup> And there is risk of Maria’s mother losing control of her angry impulses as she struggles with Maria’s behavior (abuse). The “strains” and “hassles” in her life appear to be overwhelming her usual coping abilities.

We need to apply the ecological theory to this clinical setting and develop a comprehensive portrait of the relationship between Maria and her mother, the mother’s perceptions of the situation, her approach to Maria’s behavior, and available resources.<sup>8</sup> This evaluation is done via a combination of astute observation and careful interviewing. The intervention begins during this process as the pediatrician expresses empathy for the family and an interest in helping.<sup>2</sup>

The specific intervention depends on a good appreciation of the situation and its underpinnings and available resources, but a few general observations can be made. Maria’s mother has previously impressed the pediatrician with her strengths; these strengths offer an excellent opportunity for working with her.

Discussions on toilet training,<sup>5</sup> temper tantrums,<sup>4</sup> and temperamental differences with practical management advice should be reassuring and useful. There is also the need to explore ways for the mother to reduce the demands on herself for her own good and for her daughter. There are many possibilities, including measures within the family (some “special time” each day) and seeking external resources (child support?). But this area can be very challenging for many families and professionals trying to help. Maria is a reminder of another challenge: our need for policies and programs to assist families in caring for their children.

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### Dr. Martin T. Stein

Problematic behaviors of a toddler, parental responses to those behaviors as a reflection of expectations and current life events, and potential clinical approaches are illustrated by the case of Maria. Four important issues for clinicians are raised by this case and the commentaries.

(1) Maria’s behaviors are a reflection of her personal biological foundation (temperament) and her life situation (her mother is a single parent who is struggling to raise a young child while working and attending school and with limited financial resources). The therapeutic process starts with an empathic approach to understanding her temperament (by reviewing examples of Maria’s behaviors in response to a variety of events at different developmental stages) and exploring her mother’s knowledge of appropriate toddler behaviors, her expectations for Maria’s behavior, and her own life events. A prescription for behavior modification should be avoided before adequate data gathering that enhances a trusting therapeutic relationship.

(2) Primary care pediatricians see “the denominator” component of the prevalence formula for behavioral variation! Their clinical experience teaches them about the broad range of behaviors appropriate at a particular developmental age. Behavioral pediatricians are experts at “the numerator” component of that formula; from their experience, they know the “outliers” (the children whose behaviors reflect a more significant problem that may require an intervention). This difference in clinical experience may account for the concern among some behavioral pediatricians, child psychologists/psychiatrists, and pediatric neurologists that general pediatricians too often delay appropriate referral.

Although the boundary between normal and abnormal behaviors may be easy to determine, in some cases the diagnostic challenge is greater. The timid, slow-to-warm-up toddler with whom social and language communication is difficult, but eventually successful, in an office setting may be difficult to distinguish from a mute, socially inactive 2 year old who

produces occasional grunting sounds without social specificity and lacks consistent eye contact. Diagnostic distinctions between these two children may be blurred in the context of a primary care office practice. Most toddlers have tantrums. How many are beyond normal expectations? When should we be concerned? It is not sufficient to teach residents that "excessive tantrums" require further evaluation. They need clearer guidelines.

Although behavioral pediatric educators cannot provide trainees with the diagnostic specificity so often available in general pediatrics (e.g., a child with signs of an acute surgical abdomen), we can point out the clues that define the boundary between normal development and an abnormal behavior pattern. The commentators outlined the criteria to accomplish this critical differential diagnosis: frequency, duration, external triggers, and settings of the tantrums; the mother's responses to the tantrums; the role of temperament in initiating and sustaining tantrums; and the presence of other developmental milestones and behaviors consistent with an insecure attachment to the mother. This case is a good example of the diagnostic value of coupling developmental and behavioral data in several domains to generate clinical insights and suggest therapeutic strategies.

(3) The commentaries stressed the importance of

gathering data about Maria's mother. What we need to know about her mother, from the standpoint of a general pediatrician assessing the problems at an initial visit, is in the case summary. Is it enough? We know that behavioral reinforcement in a family as a result of multiple interpersonal transactions between a child and caretaker is a basic tenet of behavioral pediatric practice. However, how often do pediatricians seek information about a parent's own childhood and his or her past experience caring for young children? If we believe that childhood experience shapes and perpetuates many lifelong behavior patterns, it would seem important to know something about the childhoods of our patients' parents.

(4) That recurrent temper tantrums may lead to various forms of physical punishment is well known. That a variety of behavior modification techniques have been shown to be effective in stopping or modifying tantrums and are applicable in most families is also well known. Maria's case demonstrates a "clinical opportunity" to explore parental developmental expectations and previous responses to tantrums. The experience that comes from teaching a parent about alternative ways to manage difficult tantrums in a young child and then observing positive outcomes is a frequent reward of pediatric practice.

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