3.6 Disruptive Behavior & Aggression in Children Ages 2 to 10

SURVEILLANCE OF **DISRUPTIVE BEHAVIOR & AGGRESSION** IN AGES 2-10:
Symptoms: defiance, aggression towards self or others, anger

SAFETY CHECK
- Assess for risk of self-harm or harm of others
- Assess for safety of patient (maltreatment)
- If concerned, consider **emergency evaluation** (risk of harm by patient) or **Child Protective Services evaluation**

- **SCREEN BROADLY:** PSC-17 (positive ≥ 15), PPSC (positive ≥ 9), Brief ECSA (positive ≥ 9)
- Then **FOCUSED SCREEN**: Vanderbilt, PTSD, Anxiety

CONSIDER THE CAUSE OF THE BEHAVIOR
- ADHD
- Adjustment reaction
- Developmental delays or autism
- Mood disorder (depression or DMDD)
- Anxiety, OCD, PTSD, or chronic trauma exposure
- Sleep impairment
- Medication or supplement effect
- Unmet basic needs (e.g., food, parenting, appropriate daycare)
- Caregiver depression or other MH needs

Positive Screen

MILD TO MODERATE
aggression isolated to home setting

- Reduce attention for mildly oppositional/disruptive behavior
- Schedule frequent follow-ups
- Monitor with PSC-17 regularly
- Consider peer mentors, patient and family communication skills therapy

Preschool age:
- Consider referral for home visiting, Head Start (if eligible), Early Intervention (Infant Toddler Connection)

School age:
- Identify provocative behaviors
- Safe consequences for disruptive behaviors
- Relaxation skills ("Monster Meditations," mindfulness apps)

SEVERE
violent or occurs in multiple settings

Mild to Moderate PLUS

Preschool age:
- Parent behavior management training

School age:
- Request school Functional Behavior Assessment (FBA)
- Parent training/child behavior therapy focused on communication, problem-solving skills, effective parenting skills
- Consider medications for maladaptive, impulsive aggression: stimulants, alpha agonists, atypical antipsychotic agents, and mood stabilizers have evidence

Medications do not treat proactive, planned aggression

COMING IN v2.0
Care Guide for Disruptive Behavior and Aggression in Youth (ages 11+)

SCREENERS

General Surveillance and Screening

- Behavioral Health Questionnaire
- Brief Early Childhood Screening Assessment (ages 18-60 months)
- Preschool Pediatric Symptom Checklist (ages 18-65 months)
- Pediatric Symptoms Checklist-17, parent (ages 4-17)

Focused Screening and Rating Tools

- Vanderbilt, parent and teacher (over age 4)
- CATS
- SCARED, parent and child (over age 8)
- PTSD

EVIDENCE-BASED BEHAVIORAL INTERVENTIONS

Parent training programs

Focus on teaching parent and caregiver skills to promote positive behaviors by:

- Shaping child behavior through positive reinforcement, increased attention to positive behaviors
- Planned ignoring (decreased attention to low levels of negative behaviors)
- Using clear, effective directions
- Implementing clear, consistent, safe consequences for unsafe or unacceptable behaviors

Family-focused problem-solving treatments

- Support healthy problem solving and coping strategies for youth and caregivers
- Focus on effective communication strategies across the family and school settings
- Help caregivers understand behaviors as a sign of a problem, rather than the main problem
- Address family basic needs

Individual therapy with caregiver involvement

- Individual therapy focused on problem solving
- Generally not as effective unless co-occurring stressors, anxiety, and/or depression
- Focus on developing coping skills

Treatment Modality	Ages (yrs)	Program Name	Website/Resources
Parent training programs	3-13	Parent Management Training (PMT)	www.parentmanagementtraininginstitute.com/
	0-8	Incredible Years Series	www.incredibleyears.com
	2-7	Parent Child Interaction Therapy (PCIT)	www.pcit.org
	0-13	Triple P — Positive Parenting Program	www.triplep.net
Family-focused interventions that include problem solving	0-18	Center for Collaborative Problem Solving	www.explosivechild.com
	10-18	Functional Family Therapy	Functional Family Therapy (FFT) | Youth.gov
	12-18	Multisystemic Therapy	Multisystemic Therapy (MST) | Youth.gov
Individual treatment	All ages	Cognitive Behavioral Therapy	Best for children with co-occurring anxiety and/or depression

MEDICATIONS FOR CHILDREN WITH DISRUPTIVE BEHAVIORS

Medications are not first line treatments for children with disruptive behaviors.

- **First line intervention should be behavioral interventions that focus on either mitigating stressors** (educational supports, caregiver depression treatment) **or increasing a child's coping capacity.**
- Pharmacotherapy may be considered when behavioral interventions are ineffective or unavailable, or when treating co-occurring mental health concerns. Generally, stimulants and alpha agonists are considered before other classes due to safety profiles. Understanding where the aggression is coming from is paramount to deciding what to use, although these medications and their safety profiles make them good choices if the clinical scenario is unclear.
- If disruptive behaviors and aggression are present in a child with autism, see autism guidance.

Class	Generic	Brand Name	Available Forms/Doses	Dosing Information	Other Information + SE	Comments
Alpha Agonist	Clonidine, Clonidine ER	Catapres, Kapvay	**Tablets:** 0.1mg, 0.2mg, 0.3mg **Transdermal patch:** (0.1-0.4mg)	**Initial dose:** 0.05-0.1mg **Max dose:** 0.4mg in 24 hours **Therapeutic dose range:** 0.1-0.4mg nightly or divided up to TID **Duration:** 3-6 hours (patch 1-5 days) **PEAK:** 3-4 hours	**Common:** sedation, rash, dizziness, constipation Major side effects include hypotension, mood changes Potential for rebound hypertension with abrupt discontinuation, especially if given >0.1mg/day	FDA approval for ADHD for Kapvay in children over age 6. Also may be effective for tics. Monitor P, BP Kapvay tablets should not be crushed or cut **SEE SIDE EFFECT HANDOUT IN SECTION 1**
	Guanfacine, Guanfacine ER	Tenex, Intuniv	**Tablets:** 1mg, 2mg **ER:** 1-4mg	**Initial dose:** 0.5 (1/2 tab) -1.0mg **Max dose:** 3-4mg in 24 hours **Therapeutic dose range:** 1-2mg BID or divided up to TID, or if using long acting, nightly **Duration:** 12-24 hours, peak effect 4-8 hours for Tenex	**Common:** sedation, dizziness, constipation. Major side effects include hypotension, sedation, mood changes. Potential for rebound hypertension with abrupt discontinuation, especially if given >1.0mg/day.	FDA approval for ADHD for Intuniv in children over age 6. Also may be effective for tics. Monitor P, BP Wean 1mg/day q 3-7 days **SEE SIDE EFFECT HANDOUT IN SECTION 1**

Note: all medication information should be verified using current PDR

PROVIDER TIPS: RETHINKING DISRUPTIVE BEHAVIOR PROBLEMS

Disruptive behavior patterns are a non-specific presenting problem like pain. Using a pneumonic developed for pain can help organize the history for a child presenting with disruptive behavior patterns.

O: ONSET
P: PALLIATIVE and PRECIPITATING factors — What triggers it?
Q: QUALITY — What does it look like? Specific behaviors (talking back, verbal aggression, physical aggression)?
R: RELATIONSHIPS and REGION — What contexts (relationships and places) do the behaviors happen in?
S: SEVERITY — level of intensity, risk of injury, actual injury
T: TIMING — time of day, days of week, duration of the behavioral events

Differential Diagnosis: **The key to effective intervention for disruptive behaviors is identifying the underlying problem driving the aggression or difficulty with following rules:**

Driver of Disruptive Behavior?	Important Considerations	IMPORTANT: Evidence-based behavioral interventions are FIRST LINE	
		Non-pharmacologic intervention(s)	If medication is needed… *
Typical behaviors	Behaviors are problematic for family or classroom, but are typical for the child's developmental level. Consider caregiver stress, mood problems, or anxiety.		
ADHD	Impulsivity and inattention prominent. Child shows genuine remorse.	Parent Management Training (PCIT, 123 Magic, Triple P) in 2-6 year olds. Combination of therapy and meds for children over 6 years.	Stimulant or alpha-agonist See ADHD module
Adjustment reaction	Adjustment disorder should be considered when changes in behavior are sudden or context-specific.		
Anxiety disorders	Disruptive behaviors may represent a way of avoiding the anxiety trigger or because of overwhelming fears/emotions that spill out as anger and frustration.	Psychoeducation Child-parent psychotherapy (CPP) CBT can be effective in children over age 4 years	SSRI (sertraline or fluoxetine common first choices) See anxiety module
Autism, developmental delays	Disruptive behaviors may develop in the context of excessive developmental demands.	Early Intensive Behavior Intervention (including ABA, communication strategies, addressing sensory)	Research supports risperidone or other anti-psychotic but developmental behavioral peds is usually involved See autism module
Learned behavior	Children learn from the people around them.		
Mood disorder	Prominent mood symptoms (depression, irritability), behavioral difficulties decrease when mood normalizes, problems with sleep, appetite, concentration, energy.	Child-parent psychotherapy (CPP) Family focused therapy CBT (as children get older, behavioral intervention may be most effective in combo with medication)	SSRI (fluoxetine or escitalopram common first choices) See depression module

Driver of Disruptive Behavior?	Important Considerations	IMPORTANT: Evidence-based behavioral interventions are FIRST LINE	
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OCD	Compulsions and obsessions can present as disruptive behaviors when a child's internal "rule" from the OCD is broken or conflicts with adults' rules and expectations.	Psychoeducation CBT	Assess with Y-BOCs and consider referral to psychologist first for confirmation, because SSRI may be needed at higher doses for OCD than anxiety
Posttraumatic stress disorder	Includes irritability, distress, and avoidance of reminders (some of which may result in avoiding activities the adults expect a child to participate in). Dissociation patterns (brain turning off in response to reminders) may look like intentional ignoring.	Trauma-focused therapy, such as CBT, CPP Narrative therapy	Alpha-agonist See trauma module
Sleep disturbance	Sleep deprivation results in mood symptoms and easy frustration. R/o other sleep disorders.	Parent Management Training CBTi (for insomnia)	Melatonin, alpha-agonist See sleep module
Unmet basic needs	Food insecurity, instability of housing, and other unmet basic needs put stress on all elements of life, including coping strategies.		

*** IMPORTANT NOTE**

If medication is needed, identify prominent target symptom complex.
If more than one, pick the most impairing symptoms to focus on first.

Source: Gleason MM, Goldson E, Yogman MW; COUNCIL ON EARLY CHILDHOOD; COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH; SECTION ON DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS. Addressing Early Childhood Emotional and Behavioral Problems. Pediatrics. 2016 Dec;138(6):e20163025. doi: 10.1542/peds.2016-3025. PMID: 27940734.

PROVIDER TIPS: DISCUSSION GUIDE FOR FAMILIES

Disruptive behaviors generally represent a dysregulated emotional and behavioral response to stressors and usually are a sign that a patient's coping skills are not sufficient for the challenging stressors they face.

Emotional and behavioral coping capacity < Dysregulating force OR stressors

Indicators of need for specialty referral

- Extreme, unsafe behaviors (use of weapons, aggressive behaviors)
- Unresponsive to primary care interventions
- Extreme family distress/parental mental health problems

Online intervention supports

- Monster Meditations — Sesame Street Muppets teach mindfulness (available free on youtube.com)
- Pocket PCIT — www.pocketpcit.com/ (experimental intervention)
- Triple P Online ($79/12 months)
- Teen mindfulness and CBT Apps (Calm, Breath2Relax, Woebot, for example)

FAMILY RESOURCES: TIPS FOR MANAGING YOUR CHILD'S BEHAVIOR

- **Use specific praise:** Be very clear and specific! You should describe the behavior that you are seeing, that you like that behavior, and that you want to see more of that good behavior. Example: "Oh, thank you! I love it when you pick up your toys!"
- **Catch your child being good!** You should give labeled praise more than you correct. Aim for a goal of 4 labeled praises for every 1 time you respond to misbehavior.
- **Give clear and calm instructions:** Be sure to have your child's full attention, be at their eye level, and give a simple, calm instruction. Your child should be given 5 seconds to comply and praised for compliance. If your child is non-compliant, repeat the instruction and give another 5 seconds to follow through. Do not give the instruction more than twice. If they do not follow through with your instruction, it should be followed by an immediate logical consequence.
- **Teach your child to label their emotions:** If your child looks upset, say something like "It looks like you are upset that you have to wait your turn." Encourage your child to label their emotions throughout the day by asking "How are you feeling right now?" This can help to reduce tantrums, meltdowns, aggression, and destructive behavior over time.

Parenting children with aggression often requires specific training!

There are research-based Parent Management Training strategies available that caregivers can self-train in and/or seek the support of a Child Behavioral Counselor/Therapist.

- Child Mind Institute's Complete Guide to Managing Behavior Problems: childmind.org/guide/parents-guide-to-problem-behavior/
- Center for Effective Parenting: parenting-ed.org/parenting-information-handouts/early-childhood/
- CDC Parenting Essentials for Toddlers and Preschoolers: www.cdc.gov/parents/essentials/
- Empowering Parents: www.empoweringparents.com/
- Lives in the Balance: www.livesinthebalance.org

Websites and books for kids

- Self-care for kids: 6 ways to self-regulate (understood.org)
- Sesame Street in Communities
- *The Kid's Guide to Staying Awesome and In Control* (2014), by Lauren Brukner
- *Train Your Angry Dragon* (2018), by Steve Herman
- *Anger Management Workbook for Kids* (2018), by Snowden
- *Social Skills Activities for Kids* (2019), by Daniels

Websites and books for caregivers

- ZERO TO THREE parenting resources
- American Academy of Child Psychiatry Oppositional Defiant Disorder resource center
- *Your Defiant Child: Eight Steps to Better Behavior* (2013), by Russell Barkley, PhD
- *The Difficult Child* (2000), by Stanley Turecki, MD and Leslie Tonner
- *SOS Help for Parents* (2006), by Lynn Clark, PhD
- *1-2-3 Magic* (2016), by Phelan
- *Parenting Children with ADHD* (2014), by Monastra
- *How to Talk So Kids Will Listen & Listen So Kids Will Talk* (2002), by Adele Faber and Elaine Mazlish
- *The Explosive Child* (2001), by Ross Greene, PhD