Disruptive Behavior Disorders: Nuts and Bolts of Where to Start with your Patients

Pediatric Health Network

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Future of Pediatrics

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Disclosures and Conflict of Interests

Presenter	Disclosure	Type of relationship
Justine Larson	Consulting Editor, *Child and Adolescent Psychiatry Clinics of North America*	Honorarium received
Faith Kelley	*Guest editor, Child and Adolescent Psychiatry Clinics of North America*	Honorarium received

Learning Objectives

- - Understand the various diagnoses in which disruptive behavior can be the presenting problem
- - Recognize several screening tools to aid diagnostic clarification
- - Learn some initial steps in care of disruptive behavior disorders and when to refer for more specialized care

Agenda

- -Definition
- -Differential diagnosis
- -Discerning between the diagnoses

Case

- The patient is a 7-year-old who presents to the clinic with his father. His father says, “My son needs help! He’s so impulsive and he can’t keep his hands to himself!”
-
- Where do you start?

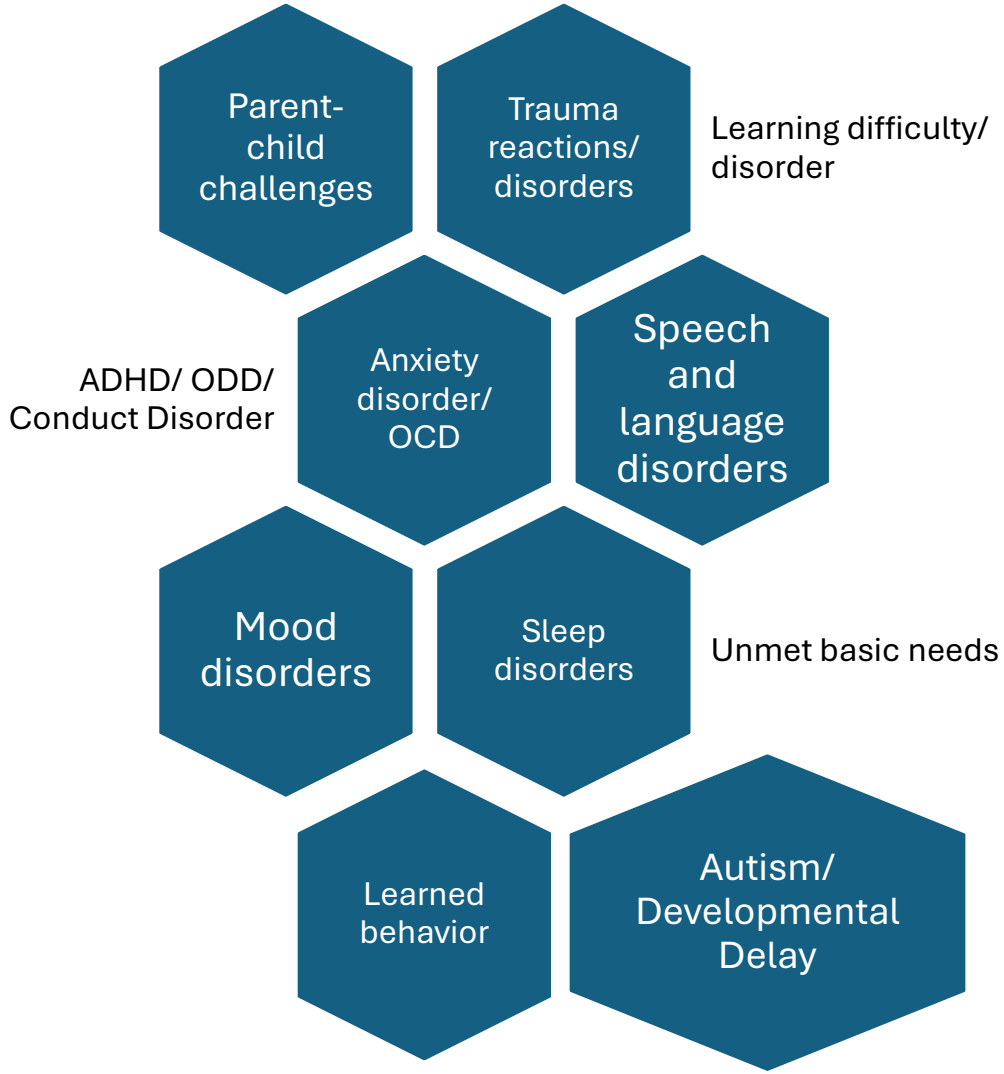
What are we talking about when we say, “disruptive behaviors?”

- ***Differentiated from “disruptive behavior disorders” which, in the DSM, are related to conduct and impulse control disorders, e.g. ADHD, Oppositional Defiant Disorder, Conduct Disorder***

- **“Disruptive behavior refers to** a persistent pattern of unruly, defiant, or aggressive actions that significantly interfere with a person’s functioning at home, school, or in social situations.”

- Disruptive behaviors include:
  - Temper tantrums or “meltdowns”
  - Getting into trouble in school
  - Impulsive behavior
  - Aggression towards others
  - Difficulties following the rules
  - Destruction of property
  - Trouble sitting still
- (neurolaunch, Disruptive Behavior: Types, Causes, and Management Strategies)

Differentia
l Diagnosis

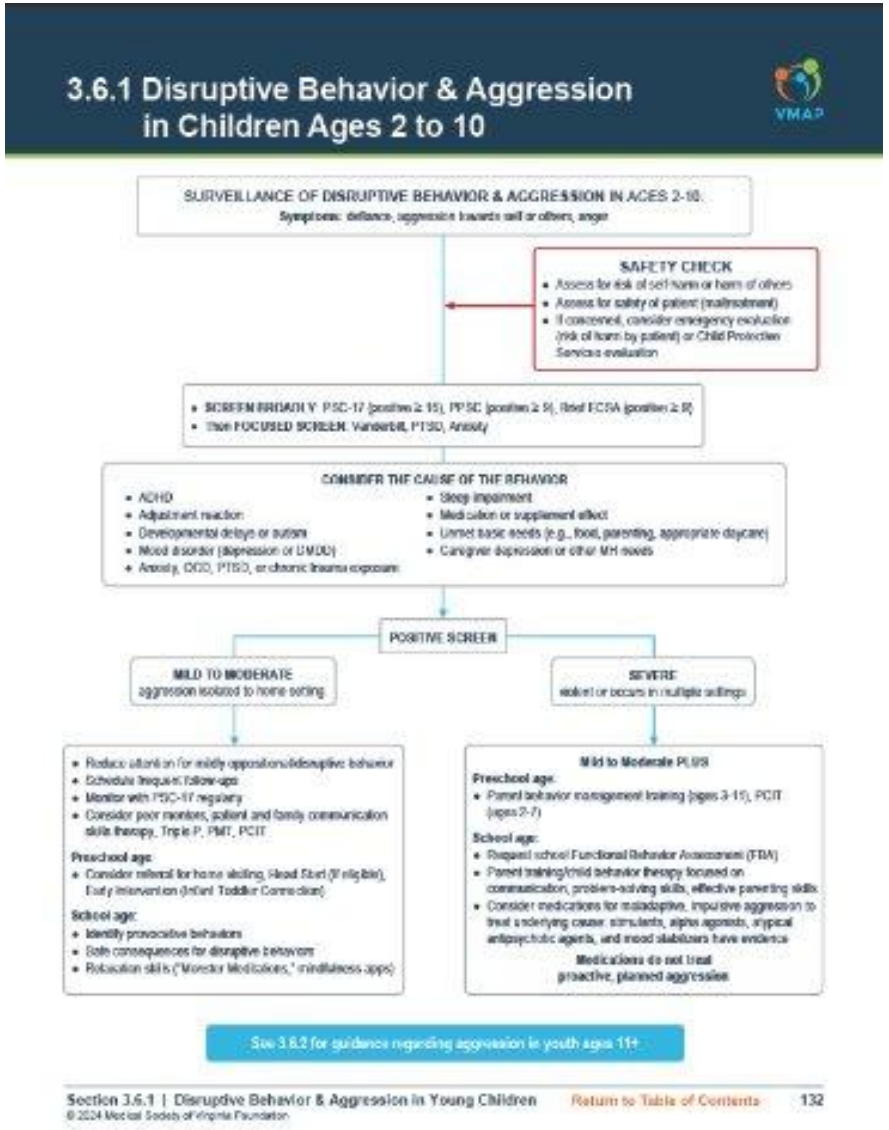


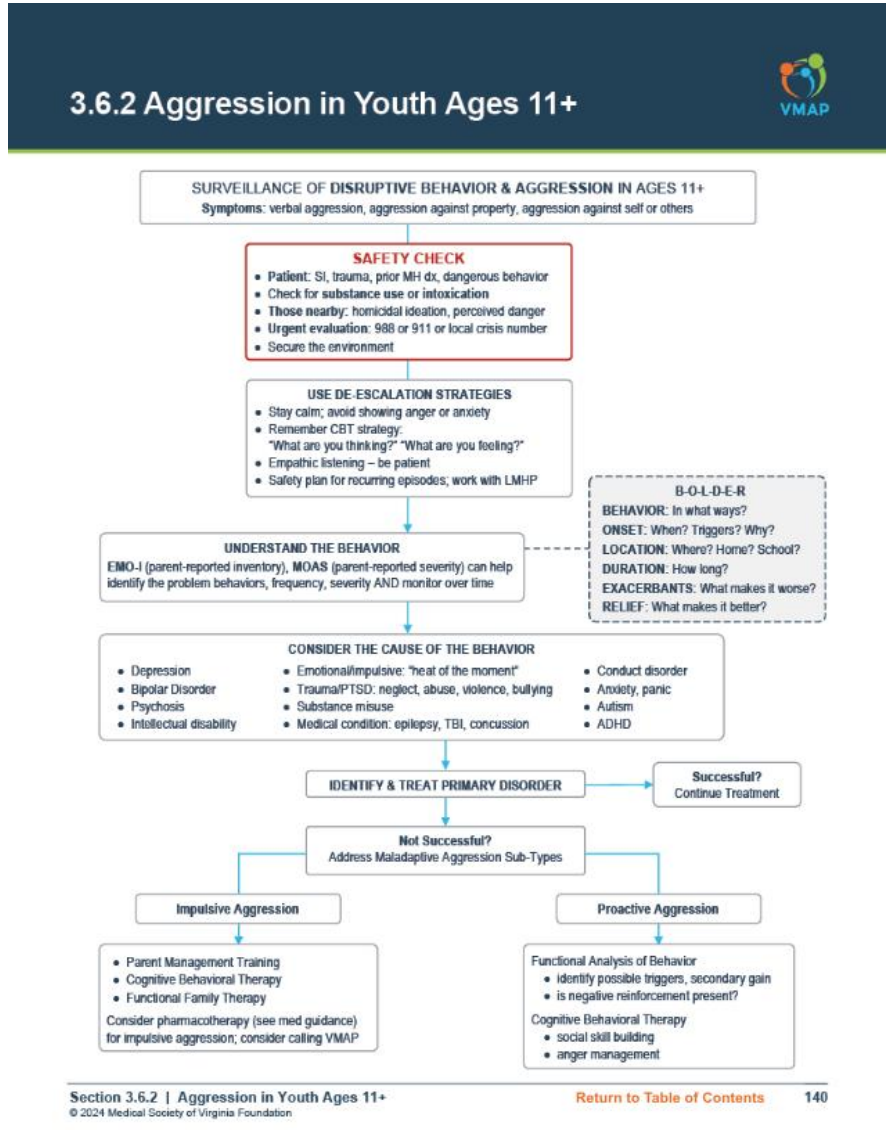
Remember…

Disruptive behaviors are often multifactorial!

You can intervene in multiple areas or start with one

Algorithms from VMAP





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.	Functional behavioral analysis, education consult, social skills therapy (if appropriate)	
ADHD	Impulsivity and inattention prominent. Child shows genuine remorse.	Parent Management Training (3-11yo), PCIT (2-7yo), 1-2-3 Magic (2-12yo), Triple P (birth-16yo) Combination of therapy and meds for children over 6 years.	Stimulant or alpha agonist See ADHD Care Guide (3.5)
Adjustment reaction	Adjustment disorder should be considered when changes in behavior are sudden or context-specific.	Psychotherapy	
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 Care Guide (3.3)
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 Care Guide (4.5)
Learned behavior	Children learn from the people around them.	Positive role models, mentorship programs	
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 Care Guide (3.1)

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 (exposure and response prevention therapy)	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 Care Guide (3.4)
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 Challenges Care Guide (3.11)
Unmet basic needs	Food insecurity, instability of housing, and other unmet basic needs put stress on all elements of life, including coping strategies.	Connect to social services/other resources to help meet basic needs	

* **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.

Remember…

Guiding Principle:

Behavior is a form of communication, especially when words fail us.

Ask:

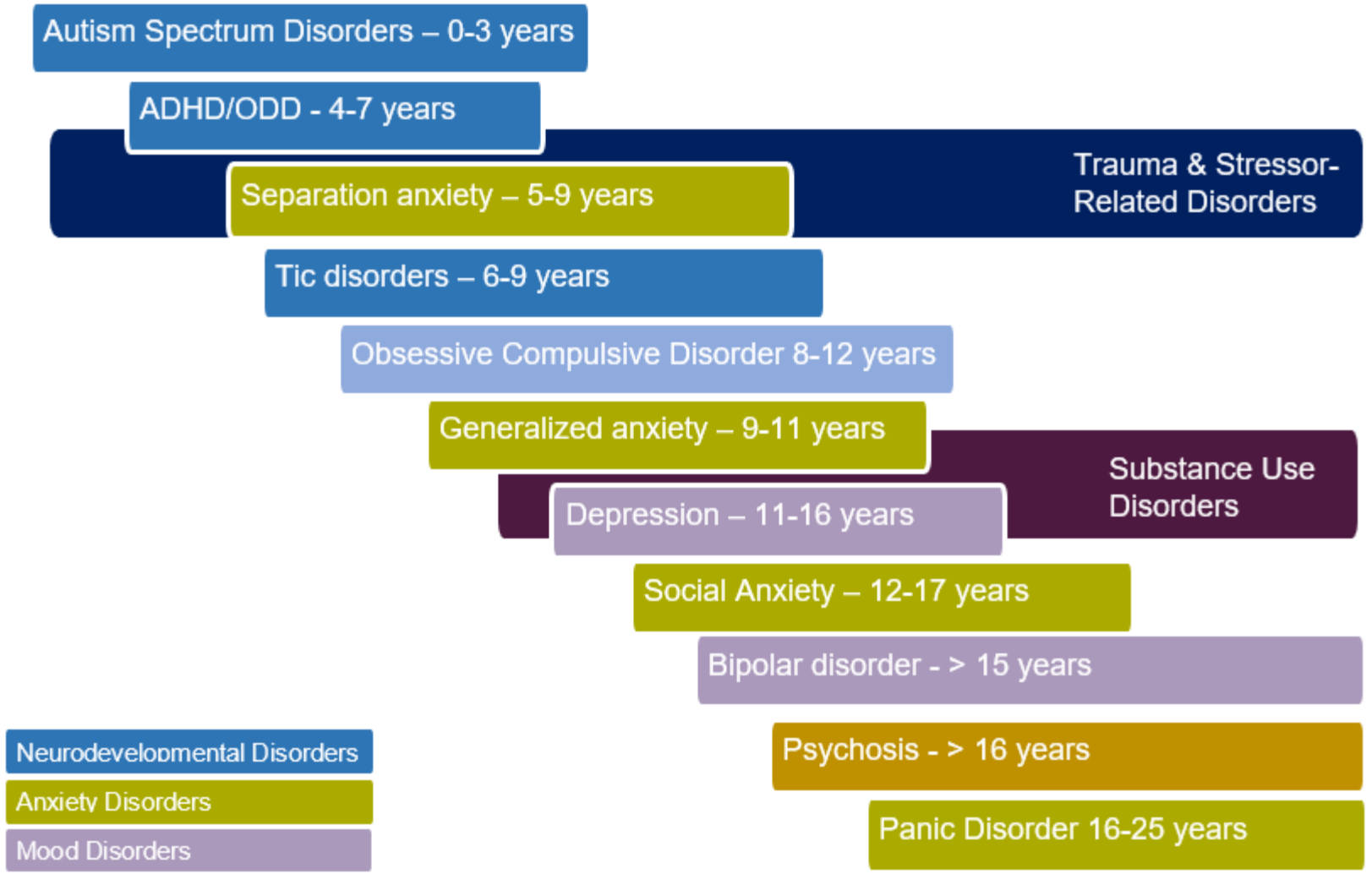
“What is this behavior trying to communicate?


Unsure
Uncomfortable
Confused
Frustrated
Irritated
Scared
Sad
Upset
Triggered
Impatient
Worried
Overwhelmed

Common non-ODD diagnoses associated with disruptive behavior

- ADHD / executive dysfunction (can't vs won't)
- Anxiety (fear-based avoidance), OCD-related rigidity
- Trauma/PTSD (hypervigilance, control seeking)
- ASD/Developmental delay (sensory overload/communication mismatch)
- Mood disorders (irritability)
- Speech and Language disorders/ Cognitive delay
- Learning difficulty/disorders
- Substance intoxication/withdrawal
- Unmet basic needs, including parental support
- Sleep disturbance

Onset of Pediatric Common Mental Health Disorders



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RAMP at Lurie Children's Hospital. Diagnoses and Conditions. Accessed from: Diagnoses & Conditions | RAMP . Accessed on 5/18/2026.

So, where do I start with my patient?

- **Assess safety first** (self-harm, harm to others, dangerous bxs, trauma/abuse), **Advise** (remove weapons), and **Refer PRN** (e.g. ED, CPS)
- **Ask details of symptoms (OPQRST): Onset, Palliative/Precipitating factors, Quality** (what does it look like), **Relationships and Region** (where and with whom does it occur?), **Severity, Timing** (time of day/week, duration)
- **Assess and address basic health needs**, e.g. sleep, food and housing insecurity, physical illness, unmet basic needs, caregiver depression or other MH needs
- **Consider differential diagnoses…**

ADHD

- Escalates with multi-step instructions and transitions
- Improves with structure, reduced demands, and coaching
- Look for emotional dysregulation and impulsivity +/- short attention span and forgetfulness
- Defiance often reflects:
  - Poor impulse control, poor executive dysfunction, low frustration tolerance, frustration with reminders, frustration w/struggles to comply or focus
- Behavior improves with structure; "Won't" often equals "Can't"
- Treatments: Parent management therapy/PCIT, Psychoeducation, academic/behavioral supports at school, medication (stimulants vs. non-stimulants)

Anxiety & fear-based avoidance

- Oppositional behavior is often tied to:
  - School, separation, new situations, unfamiliar people, being the center of attention

- Refusal is driven by fear, and avoidance is masking as defiance
  - Escalates with pressure
  - Responds to reassurance and predictability

- Use preparation, predictability, coping plans

- Treatments: psychoeducation, parental coaching, Cognitive Behavior Therapy (CBT)+/- SSRIs (sertraline, fluoxetine- 1st choice)

Trauma & Hypervigilance

- Defiance often masks self-protection and control-seeking when feeling unsafe
- Triggered by:
  - tone, proximity, sudden touch, unknown triggers
- Prioritize:
  - safety signals, consent, and predictable routines
- Authority = threat, not support
- Treatment: remove trauma, trauma-focused therapy, narrative therapy +/- alpha agonist (e.g. guanfacine, clonidine)

ASD & Sensory Overload

- Oppositionality may reflect sensory overload, demands > capacity, anxiety, the “unknown/unpredictable/unexpected” changes in routine, or communication mismatch
- Reduce stimuli; simplify language; use visual schedules
- Behavior improves with structure, predictability, increases in cognitive flexibility; “Won’t” often equals “Can’t”
- Treatment: Early intensive behavior intervention (e.g. ABA communication strategies, addressing sensory needs), symptom-targeted medications (e.g. ADHD, anxiety, mood, irritability incl. risperidone or aripiprazole but consider referral to behavioral/developmental peds if antipsychotics are needed)

Speech and Language disorders or Cognitive Delays

- Disruptive behavior may reflect language overload or communication mismatch
- Disruptive behavior may reflect frustration…
  - when others do not understand their needs or attempts to communicate
  - when they cannot understand others
  - with quick demands or requests
- Strategies: Reduce stimuli. Simplify language. Use visual schedules. Allow pauses after questions for processing and responses. Verify understanding before expecting compliance.
- In-home or clinic-based speech therapy +/- assistive devices as needed

Depression

- Chronic irritability, being easily annoyed with others, and outbursts can reflect mood disorders
- Ask about associated changes in baseline mood, enjoyment, sleep, energy, self-esteem and for the presence of self-harm or suicidality
- Ask about access to weapons and advise removal (or secure storage)
- Avoid mislabeling irritability as ‘just ODD’
- Treatment: psychoeducation, CBT +/- SSRI’s, optimize sleep/diet/exercise

Learning Difficulty/Disorders

- Disruptive behaviors tend to be confined to school or when presented with a difficult subject/academic assignment, e.g. homework, in math class if math is hard
- Behaviors worsen when publicly asked to share knowledge; related to embarrassment and confusion, e.g. read out loud, do work at the board
- Focus on in-school and extracurricular academic support, making learning interactive and fun
- Balance school challenges with engaging in a fun hobby they can learn (improves self-esteem) and adult praise for their effort and perseverance in the face of difficulty

Oppositional Defiant Disorder

- A diagnosis of exclusion
- Defined as a developmentally inappropriate and ongoing pattern of 6+ mos. of extreme negativity, hostility, and defiance usually directed toward authority
- **Treatment**: Parent management therapy (PMT), Parent-Child Interaction Therapy (PCIT), individual therapy, +/- medication,
- Consider referring to psychiatry if symptoms do not resolve with therapy

Sorting it out…

- **Screen broadly**
  - **Pediatric Symptoms Checklist (**PSC-17- ages 4-17), **Preschool Pediatric Symptom Checklist** (PPSC- 18-65mos), **Brief Early Childhood Screening Assessment** (Brief ECSA- 18-60mos)

- **Screen in focused areas**
  - **Anxiety**: SCARED; **Trauma**: SCARED Brief Assessment/CATS
  - **Depression:** PHQ
  - **ADHD/ODD**: NICHQ Vanderbilt ADHD Diagnostic Rating Scale

- **Don't forget to ask the child about the context of disruptive behaviors.**
  - Assume all children want to feel more in control and all behavior happens for a reason, even if they cannot readily identify one.
  - Use a calm, non-judgmental approach. First, discuss their interests. Discuss how life is going at home, school, with parents. Broach the topic of how things are going in the setting where the disruptive behaviors occur. Explore their thoughts on why they have the behaviors occur.

Explore targeted supports

- **School-based**: academic support, functional behavior an[illegible] psychoeducational testing, speech/OT/ABA, and 504/IEP accommodations to reduce stressors and manage stressors at school
- **Family support**: psychoeducation, parent management therapy (PMT; 3-11yo) or parent-child interaction therapy (2-7yo), 1-2-3 Magic (2-12yo), Triple P (birth-16yo), family focused therapy, ABA, communication strategies, social service support, peer support groups,
- **Individual (child-focused)**: psychotherapy (anxiety, mood, trauma), executive function coaching (ADHD), addressing sensory concerns, positive role models, mentorship programs

Quick Behavior Mgmt. Tips for Parents

- Use specific (“labeled”) praise
  - “Thank you for picking up your toys!” This gives the child feedback about which be to repeat.
- Catch your child being good!
  - Aim to give 4 more labeled praise than correction.
- Give clear, calm, and simple instructions
  - Get on eye level, use a calm voice, give 5 seconds to reply and (genuinely) praise for compliance.
- Teach your child to label their emotions
  - “It looks like you are sad that your friend took your car.” “How are you feeling right now?”
- Spend special play time.
  - Spend time in child-prompted, pre-planned fun. Limit correction to unsafe behavior. Focus on enjoying time between parent and child to rebalance the relationship.

Medications

- Start with therapy first.
- Consider medication for specific target symptoms that are significant and impairing, esp. as severity or safety risks increase.
  - Choose the most impairing symptom first for medication targets if there is more than one.
- Explain potential benefits and limitations of medications to parents.
- Emphasize a multimodal approach to parents.

Online tools

- Monster Meditations – Sesame Street Muppets teac mindfulness (available on YouTube)
- Pocket PCIT- www.pocketpcit.com/
- Triple P Online
- Unstuck and On Target (books and free YouTube videos to increase cognitive flexibility for youth with ASD and ADHD)
- Teen mindfulness and CBT Apps (Calm, Breath2Relax)

When to consider referring out…

- Extreme, unsafe behavior (e.g. use of weapons, aggressiv behaviors)
- Complex mental health concerns
- Behaviors are unresponsive to primary care interventions
- Extreme family distress/parental mental health problems

  - *Refer to Developmental Pediatrics, Psychiatry, or appropriate therapists for care*

Key Takeaways

- Behavior is a form of communication.
- Consider what each disruptive behavior is trying t communicate and what it might be masking.
- Screen for underlying needs/mental health concerns.
- Use a multimodal treatment approach that addresses underlying needs across settings.
- Encourage strategies that build child self-esteem and improve parent efficacy and understanding of the child's behavior and needs.

Key References

1. VMAP Guidebook: VMAP Guidebook - Virginia Mental Health Access Program | VMAP.org
   A. Screening tools
   B. Protocols for evaluating and treating disruptive behavior
   C. Parent resources (websites, books for kids and caregivers)

2. AACAP Parent Medication Handbooks: Parents' Medication Guides