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SUPPORTING CHILDREN AND YOUTH PRESENTING WITH CHALLENGING BEHAVIOURS PERCEIVED AS AGGRESSION

Webinar date: **May 25, 2022**
Recording & Presentation Slides**:** https://ubccpd.ca/2022-05-25-webinar-supporting-children-and-youth-presenting-challenging-behaviours-perceived

Disclaimer: This summary was prepared by Dr. Birinder Narang and not by the speakers.

Webinar Summary

What Challenging Behaviours Are We Talking About? – Dr. Baer

- Meltdowns/Tantrums; Verbal Aggression; Physical Aggression (e.g. Punching holes in ground, Knocking over desks in school, "loss of control")

Challenging Behaviours are a Flag for Underlying Issues

- Temperament: Any neurodevelopmental factors? How are they wired? Any language disorders?
- Mental Health Concerns, e.g., Depression, Substance Use, ADHD, Anxiety
- Community Factors, e.g., trauma, attachment disruptions, caregiver factors

Approach to Assessment

- Take a thorough history
    - interview caregiver and child/youth separately (if appropriate)
    - include development screen
    - consider whether behaviour is within normal range
- Assess safety issues
    - Siblings in the home, safety planning, need for Ministry for Child and Family Development?
        - Kelty's website has good safety tools
- Use rating scales: SNAP-IV (ADHD), SCARED (Anxiety), PHQ-9 (Depression)

Environmental Factors are Key

- Attachment disruptions
    - Frequent moves, changes in caregivers, parental separation, domestic violence, etc.
    - Parenting mental health issues/history of trauma
    - Intergenerational/community trauma
- Home
    - Social determinants of health: housing, food security
    - Parenting: What is the parenting approach? How does one respond to challenging behaviour? How is that working? Do both co-parents have similar approaches?
- School
    - Bullying
    - Peer/staff relationships
- Community
    - Sports, church, cultural connections

Challenging behaviours and caregiver distress can amplify each other!

Multifactorial Approach to Management

- Education for family/school
    - Goal is to promote understanding of factors contributing to difficult behaviours and problem solve ways to address them
- Strength-based approach: build connection, community, and feelings of competence
    - Cultural connections
- Treat comorbid disorders (pharmacologic/non pharmacologic)
- Supports for child/youth
    - Younger kids: play therapy/Zones of Regulation/How does my engine run?
    - Older kids: DBT/CBT
- Supports for family system such as attachment-based programs and behavioural-based programs

Aggression in Toddlers – Dr. Yeh

Temper Tantrums

- Severe temper tantrums, aggression, pervasive noncompliance are relatively common in 0-15% of preschool-aged children
- Peaks at age 3, and most outgrow by kindergarten
- Includes crying, kicking, stomping, hitting, pushing
- Children <4 years old can have up to 9 tantrums per week that last 5-10 min (Yale)

Emotional Development

- Critical component of healthy development
- Emotional growth guided by adults in child's life
- Emotional development leads to key skills: self-awareness, social awareness, emotional regulation, responsible decision making & relationship building
- In Canada 25-30% of children may not be developmentally ready for school entry

Stages of Social-Emotional Development

- Noticing emotions: 0–1-year-old
    - What makes them feel good or bad, i.e. smiling while cuddling
- Expression emotions: 2-3 years old
    - Greater vocabulary, experiment with expression emotions including tantrums/aggression
- Managing emotions: 3-5 years old
    - Testing limits, socially acceptable limits, relying on parents for guidance
    - Learning to share with others

Normal Development vs Disorder

- Aggression can be risk factor for, and/or potential component of neurodevelopmental or mental health disorders
- Must consider range of environmental, developmental, family and parent-child relationship factors
- Cluster of disruptive behaviours is at the disorder level when:
    - Atypical for child's development age and persists for ≥ 6 months
    - Occurs across situations, results in impaired functioning
    - Causing distress for child and family.

Take home messages

- Tantrums can be normal
- Aggression is a behaviour you must unpack
- Normal vs disorder remains ambiguous in preschoolers

What Comes Before the Aggression? – Dr. Neufeld

Attachment vs Separation Disruption

- Threat to humans
    - Pre-eminent stress to humans is attachment vs. separation
    - Attachment was a drive to survival
    - Probability of survival is greater when we are together
- Three primal separation emotions:
    - Frustration: the experience of something not working, leads to change

    - Alarm: tries to move us to caution
    - Pursuit: tries to lead to closure
- Stress
    - Related to separation, e.g. divorce, abuse, disability, isolation, psychological
- Aggression is rooted in frustration, but not all frustration leads to aggression
    - Traffic circle model, understand it as frustration is the key into the circle
    - Automatically you know child is frustrated, if it is persistent, then we know attachments are not working
        - First outcome – if we are unable to effect change, it is not up to us though, invitation comes from others
        - If we cannot change, futility encountered, is not felt, adaptation does not occur
        - Need sympathetic nervous system to change to parasympathetic nervous system where we rest from our work and where adaptation happens (healing)
        - This is often associated with tears for children, the tears are when we feel futility, associated with letting go
        - Lots of syndromes in children are dry-eyed, whatever we cannot change we must become changed by
        - Aggression is an indicator that adaptation hasn't happened yet
        - The challenge is to go from tantrums to tears
        - When a child gets from 5-7 years of age, lack of mixed feelings leaves attacking, impulses untampered
        - Emotional development and health are about whether this child can move from mad to sad, if they can't then they will be in trouble
    - When we see aggression, it shows us that something is not working, it's pervasive/persistent their attachments are not working, and it tells us that they are unable to change
        - They have not had their sadness yet
        - We make sense of aggression, then we can help parent navigate
        - First, we need to reduce the separation, and that can be huge for children, help them solve problems they are unable to themselves.
        - Try to help parents find the children's mixed feelings
    - Change is the focus, it goes to frustration, we need to use a friendly attitude to the frustration

What Can I Do? – Dr. Ryan

Screen/Diagnose/Treat

- Remember treatment can be pharmacological/nonpharmacological

- Remember the development factors, the ability of Primary Care Physicians to provide psychoeducation
- Normalize behaviours and welcome differences
- Can guarantee that there is a distressed caregiver as part of this process, the prefrontal cortex in caregivers is more developed in
- If there is trauma, please make sure that is addressed, and try to at community level as well
- A resource list can be found here: https://www.ubccpd.ca/2022-05-25-webinar-supporting-children-and-youth-presenting-challenging-behaviours-perceived
- Find the unmet NEED - all behaviour is a form of communication
- Time in vs Time Out – See Handout
    - "Child Directed Play" - A strength-based approach to overall child behaviour problems

Question & Answers

Q: There seems to be a large surge of school requests to medicate children who are neurodiverse, especially with traits or diagnosis of ADD. Parents often feel pressure to comply. Could you suggest an approach to this?

A: Frustration may manifest as aggression. Sometimes teacher can be exerting a lot of influence if they can't manage physical aggression. Think about whether there is a diagnosis there, if it is there, then diagnose it. Then you discuss whether a pharmacological approach is appropriate along with the rest of treatment.

Q: For parents who have elementary age children who feel that their attachment to their child is not as they desire, how do they repair this? Many have guilt that they have not achieved it.

A: The good thing about relationships is that they are never too late. As parents we are our child's best bet, even if they don't think it. Through that lens approach the difficulties. Try to play when you can, you're much more likely to connect during play. Collecting the smiles and nods is important. We need to prime attachment and activate it. The best way to do that is through friendly contact. Even spending 15-20 minutes per day can help with relationships.

Q: Are teachers and society losing tolerance what is considered developmental exploration of emotions and appropriate behaviour? For example, over diagnosis aggression or undesirable behaviours.

A: The amount of aggression in school has escalated, so the frustration levels are very high. This is very difficult for teachers to manage. The amount of peer-orientation that is happening but can't be the answer for each other. Aggression is escalating in all school systems internationally. If you don't know what is happening, then it is even harder. There is a tendency to diagnose because it is beyond what teachers should manage.

Q: Any recommendations on where youth/children can be referred to after presenting to the Emergency Department?

A: The situation depends on what the concern is and trying to unpack that. EFFT (emotion focused family therapy) may be useful. This is focused on the caregiver listening, validating, and really helping build that attachment in the parent-child relationship. They are offered monthly on zoom, (2-day workshops). Through the Family Smart support institution online, they have a workshop called Help for the Hard Times (for youth that have had presentations to hospital/psychiatric conditions).

Q: Any suggestions on how to manage children with challenging behaviours perceived as aggression in the school system, specifically at Elementary level?

A: The main issue is to be able to work with the child one-on-one in some way to begin a frustration focused approach. A lot of things that can be done to be able to help children but must be relational. Programs work for those who don't need help. Doesn't work for the 5-10% of children that need it the most. We have to make sure to minimize the consequences, if you try to use consequences such as timeouts, separation, not coming to school other than an in-house program, you will exacerbate the problem. It requires a paradigm shift. Looking at it from a strengths-based approach, the goal is to find connection a lot of the time. These are the children who are trying to find their identity/purpose in the school. You want to make sure you have screened for medical issues i.e. vision, hearing, screening for ADHD, ASD and other learning disabilities.

It is important to individualize approaches.

Q: Could you expand on how to bring your child to tears?

A: We are trying to teach children lessons all the time that aggression doesn't pay. We don't realize how adaptation works. The brain must sense futility or something before it comes to an end. Part of it is just knowing and being patient enough with it. When you understand the child is frustrated, you can reflect to them and realize the futility they are up against. When you care, you come alongside with the child. Reflect it in a way that it is futile. Also take frustration to play, feel a lot more things in emotional playgrounds, i.e. whether it is music or stories. There is a lot of science around play in the last 10 years - it is nature "incognito", if we want to know where healing exists, it is where the brain becomes resilient where we get to feel more. Aggression has been pathologized for a long time. We must reframe that. Aggression is the indicator that there's not enough sadness in the person's life.

Q: Remote, rural communities simply do not have supports, please address this disparity?

A: There are a lack of resources, and financial barriers exist to services that may be beneficial. You must know the resources that are available to you, must use people around you and around the patient. May require working outsides scope a bit as many in rural/remote settings. Virtual resources are now available that may not have been available before, but a lack of resources continues to be a barrier.

Thanks to the Speakers:

- **Dr. Susan Baer,** Child & Adolescent Psychiatrist, BC Children's Hospital; Clinical Assistant Professor, Child & Adolescent Psychiatry and Neurodevelopmental Disorders, UBC
- **Dr. Gordon Neufeld**, PhD, Retired Clinical and Development Psychologist; Founder, The Neufeld Institute
- **Dr. Jane Ryan**, Child and Adolescent Psychiatrist, Queen Alexandra Centre for Children's Health; Clinical Instructor, Child & Adolescent Psychiatry, UBC
- **Dr. Linda Uyeda** (moderating), Family Physician, Forensic Psychiatric Hospital and Fraser Health Youth Clinics; Child and Youth Mental Health and Substance Use Community of Practice; BC Mental Health and Substance Use Services Trauma Informed Practice Steering Committee
- **Dr. Stacy Yeh**, Consultant Paediatrician