New Mexico Early Childhood Education & Care Department | Family Support and Early Intervention Division
FAMILY INFANT TODDLER (FIT) PROGRAM

CENTER FOR DEVELOPMENT & DISABILITY

Early Childhood Evaluation Program – Technical Assistance & Consultation
Continuing Education series for NM FIT Providers

Dealing with Challenging Behaviors from an Interdisciplinary Perspective

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University of New Mexico Health Sciences Center
Department of Pediatrics - Center for Development & Disability



Introductions and Housekeeping

- Today's ECEP Team
- We want to see you- cameras on!
- We want to hear you
  - Please use the chat or jump in with comments, ideas, and questions.
  - Goal is to share experiences and knowledge.



Remember: New and Improved Format!

- Topical Information and Background
- De-identified Case Example and Discussion
- Volunteer case consultation and questions!

***Please note this zoom platform is not HIPAA-compliant - please de-identify any confidential/case-related information.**



Objectives for today



- ❑ Develop strategies to identify potential causes and triggers for behaviors.
- ❑ Identify red flags for behaviors that would warrant an outside referral/next steps.
- ❑ Identify cross-discipline strategies to support families in dealing with challenging behavior, and understand how to differentiate when to use each type of strategy.

How can we understand challenging behaviors in toddlers?



A framework for observation, gathering key information, and ruling out concerns:

1. Rule out possible medical concerns/causes and establish typical behavior range
2. Consider/question what is happening
   - Before
   - During
   - After
3. Use strategies to track behavior (calendar, data collection, notes) – Looking for "trends" over time
   - Always ask, What have you tried? and, For how long?
4. Look at the behavior from different perspectives – consider other discipline lenses (and overlap between these lenses)
5. Consider an outside perspective – consultation or possible resources!

Challenging Behaviors: What's Typical?



Typical

- **Tantrums** (most common between age 2-3 years)
- **Occasional** biting (usually stops by age 3-3 ½)
- **Occasional** hitting – often to communicate or when hungry or tired
- **Running away** (i.e., elopement) – common as toddlers are exploring and learning
- **Of Concern**
- Tantrums with **self-harm** or **Meltdowns**
- **Consistent and on-going** biting (not responding to teaching)
- **Ongoing** hitting and with no clear reason or pattern
- Running away **after age 4** with no response to being called.

Case Example #1

Tantrums with Head-Banging

Tommy is an 18 month old who recently came into early intervention due to concerns for speech delays and frequent tantrums. He said his first word at 16 months, has a few single words, but tended to be quiet as an infant. In terms of motor milestones, Tommy did not like tummy time as an infant and wanted to be held often. When put in a standing position, he often curled his legs and seemed sensitive to textures underneath his feet. He started sitting independently at about 9 months, did not crawl, but walked at 15 months.

Tommy was born full term and there were no complications during pregnancy or birth. He had reflux as an infant and was on medications for GERD. He continues to be a very picky eater. Tommy seems to become overwhelmed in new or crowded places, and this can be a trigger for his tantrums. When overwhelmed, when told "no" or limits are set, and often seemingly out of the blue, he has severe tantrums that last at least 10 minutes, and he bangs his head on the hard tile floor or the wall/furniture. Parents report "walking on eggshells" with him, and worry about him hurting himself.

On initial EI evaluation, Tommy shows delays in communication, self-help, social-emotional, and fine motor domains. He refused hearing testing, and had a moderately elevated M-CHAT score.

Medical Considerations



Types of rhythmic movements

- Babies and toddlers exhibit rhythmic movements in a few different ways. **The most common types include:**
- Head banging.
- Body rocking.
- Head rolling or shaking side to side.

Less common types include:

- Body rolling.
- Leg rolling (rhythmically moving legs back and forth).
- Leg banging.
- Head banging, body rocking and similar behaviors are normal in babies and toddlers, particularly during naps or at nighttime.

These behaviors only become an issue if they result in injury or disrupt your child's sleep. When they cause complications, healthcare providers call these behaviors rhythmic movement disorders (RMD). (Cleveland Clinic)

Medical Considerations



Consider how he is experiencing the world:

- Vision: Is he seeing well?
- Hearing: Is he hearing well?
- Always consider abuse/neglect or exposure to trauma for any unexplained behavioral presentation
- Detailed pediatric examination
  - To rule out underlying medical cause, for example ear infection or middle ear fluid, teething, headache, very rarely bone pain from malignancy
  - Temper tantrum may be caused by pain, such as abdominal pain (constipation)
  - Look for any additional signs of abuse or neglect (failure to thrive, unexplained injuries, bruising, etc.)

Medical Considerations



- GERD: Tommy is a little boy who did not like tummy time and had diagnosed GERD. He may still be experiencing GERD/reflux.
  - Signs may be hoarse voice, coughing after meals, frequent awakening at night, vomiting, irritability after certain foods.
- Additional medical conditions to rule out:
  - Rule out sleep apnea
  - Rule out Tourette Syndrome
  - Consider a genetic condition
- When to recommend a helmet for head banging and when to go to neurology
  - Head banging on hard surfaces or causing injury
  - Developmental regression: seek medical consult!

Speech and Language Considerations



Before: How much language is he understanding? How much language are we using?

Are there are communicative attempts – Behaviors? Gestures? Vocalizations? Words?

Can we re-direct before telling him “no?” Give choices? External cues before the tantrum: visual schedule, visual timer, auditory reminders.

During: When are we using language to help others regulate?

Does soothing language help or make it worse? Limit regulating language (reduce auditory load).

After: Reflect on what worked and didn’t. Setting up the environment and interventions. How do we improve functional communication? How are they currently communicating and are we responding to that effectively? Communicative temptations will help discover ways he is communicating.

Sensory Considerations



Before: Does he seek out intense sensation in other ways? Other rhythmic movement? Is headbanging part of this pattern?

What is happening in the environment?

Can we be proactive by providing or limiting sensory input throughout the day? Provide warnings for unexpected sensations?

During: What is happening in the environment?

Over-stimulated? Can you reduce sights, sounds, smells, etc?

Under-stimulated? Can you provide extra input like tight squeeze, tuck between big pillows or couch cushions? Toy with music and lights? Crunchy/chewy snack or ice cold drink?

Strategies for co-regulation while still meeting child's sensory needs (to touch or not be touched, etc.).

"Regulation support is not a reward but a way to help your child's nervous system." (Robyn Gobbel, MSW)

After: Strategize about sensory triggers, sensory needs. Continuous process with a sensory-informed approach to support overall regulation.

Infant Mental Health and Behavioral Considerations



Before: What seem to be triggers, and can we help child to better understand what will happen or prepare? For example, giving warnings, visual timers, reminding child before going into situation.

Can we be proactive in setting child up for success, including timing (e.g., going to the grocery store when not tired or not crowded) or creating a routine or natural reward?

During: Using caregiver relationship to soothe/stay present for child with big emotions while not rewarding behavior. Developing strategies for co-regulation and self-soothing.

After: When calm, talking to child about big feelings and strategies to use in the future.

Parent Support: How do parents react/respond in these situations? What comes up for parents when child tantrums? How can we support their regulation and concerns about observers' reactions, child physical safety, child emotional safety, etc.?

What have they tried, and what has/hasn't worked?

How long have these tantrums been an issue, and what was happening in the family/for child when they started?

Case Example #2

Biting and Aggression

Jamie is a 26 month old who came into early intervention as an infant due to concerns for overall development and premature birth. He continues to have speech delays, and is using about 50 single words. His motor milestones were generally at the later end of typical. Jamie has a younger sibling (13 months) and attends daycare regularly. He lives with his mother and maternal grandparents, and mother works long hours.

Over the past few months, Jamie has been showing increased aggression towards his younger sibling, hitting or pushing her when she tries to take his toys. He shows these behaviors when angry or frustrated, but also will hit her or other adults when excited. He also has become aggressive at daycare, and most days comes home with an incident report for having bitten another child. Jamie's mother is concerned that he will be expelled from school for biting.

Medical Considerations



- Consider potential causes for Impulse control issues:
  - Was there prenatal exposure to drugs or alcohol?
  - Was there prenatal/postnatal exposure to violence or aggression?
  - Is there family history of ADD/ADHD?
  - Prematurity (increased incidence of ADHD)
- Explore quality and quantity of sleep
- Iron deficiency (child may be irritable due to anemia, low iron stores) or any toxic exposures
- Media
  - The results are mixed regarding the effects of TV viewing by preschoolers. The important findings suggest that when a program provokes aggressive fantasies, preschoolers seem to be most susceptible. The impact of aggressive content can be toned down if children view TV with a trusted adult who can guide them.

Speech and Language Considerations



Before: Are the words he says meaningful and functional? How much language does he understand? Can he be redirected with words or contingencies?

Are there are communicative attempts before he escalates – Behaviors? Gestures? Vocalizations? Words?

Can we re-direct beforehand? Give choices? External cues: visual schedule, visual timer, auditory reminders.

During: When are we using language to help others regulate?

If he understands may use regulating language to redirect behavior, such as “that hurts,” “gentle touch,” “quiet hands” with gestures.

After: Reflect on what worked and didn’t. Does he understand the impact of his actions on others? Setting up the environment and interventions. Reinforce language used during the episode. How do we improve functional communication? How is he currently communicating and are we responding to that effectively?

Sensory Considerations



Before: Does he seek out intense sensation in other ways? Other hard impact or oral seeking? Is biting/hitting part of this pattern?

What is happening in the environment?

Are there supports in place for teaching other ways to cope?

During: What is happening in the environment?

Over-stimulated? Can you reduce sights, sounds, smells, etc?

Can you offer a substitute paired with social skill teaching – you can bite this or hit this.

“Regulation support is not a reward but a way to help your child’s nervous system.” (Robyn Gobbel, MSW)

After: Was this due to a sensory trigger? Is he learning and sometimes able to manage similar situations without hitting or biting? Need to practice skills in a quiet place or 1:1 or small group? Continuous process with a sensory-informed approach to support overall regulation.



Infant Mental Health and Behavioral Considerations



Before: What seem to be triggers, frequency, and duration of behaviors? Can we anticipate these and proactively help child in the moment? For example, keeping an adult nearby at daycare during specific times to redirect attention or provide substitute strategy/object to bite.

Be proactive – teach lessons to all kids around seeking help from adults, taking space, asking friends to stop. Use routines, pre-teaching how to act in these situations, prepare/practice coping strategies, and decrease stimuli or stimulating activities to decrease overwhelm.

During: Caregivers/teachers can substitute other strategies/coping activities (e.g., something soft to bite, stomp feet instead of hit) for child. Demonstrate use of simple feeling words. Help child use strategies for self-soothing (e.g., deep breathing).

After: When calm, talking to child about big feelings and strategies to use in the future. Model and role play actions to use instead (e.g., "gentle touches").

Parent Support: How do parents and teachers react/respond in these situations? What comes up for parents when child is aggressive? How can we support their regulation and concerns about observers' reactions, child physical safety, child emotional safety, etc.? Look at daycare environment, daycare providers knowledge of typical development and willingness to try different strategies.

What have they tried, and what has/hasn't worked?

How long has aggression been an issue, and what was happening in the family/for child when this started?

Case Example #3

Running off or "Elopement"

Hannah is a 33 month old who has been in early intervention since age 2. She has a history of delays in speech, cognitive, social-emotional, and self-help skills. She is an extremely active child, and rarely sits to engage with toys. She can attend to a favorite activity for a few minutes at a time, but usually moves from one toy to another and prefers to play outdoors. Her family has a large backyard that she spends time in, but they rarely take her out because of fear that she will run off. When they do take her on walks or errands, they hold her hand tightly or buckle her into a stroller or shopping cart. However, she is wanting to be more independent, and these strategies are not working as well.

Medical Considerations



- Vision
- Hearing
- Is this related to impulse control, so again, prenatal exposures increase the risk of impulsive actions and reduced awareness of risk, particularly prenatal alcohol exposure.
- Is there a family history of AD/HD and is Hannah at genetic risk for this?
- Autism/cognitive delay: Children with ASD or cognitive delay are at higher risk for elopement
- Consider general safety awareness and pain threshold
- Unusual number of injuries and context for injuries

Speech and Language Considerations



Before: How is her receptive and expressive language?

Are there are communicative attempts before she runs off– Behaviors? Gestures? Vocalizations? Words?

Can we re-direct beforehand? Give choices? External cues: visual schedule, visual timer, auditory reminders.

During: When are we using language to help others regulate?

Does she respond if you call her?

After: Reflect on what worked and didn't. Does she understand the impact of her actions on others? Setting up the environment and interventions. Social stories may help, or other visual strategies.

Sensory Considerations



Before: Are there concerns about lack of body awareness? Seeking intense movement? Is running away part of this pattern? When is she most calm and settled?

Are there supports in place for teaching safety rules?

During: What is happening in the environment? Can you modify? Add fun rhythmic movement?

How about pushing or pulling something heavy like a cart or wagon?

Can you use visual cues to support awareness of surroundings?

After: Can you practice outings in very small increments? Build in regular opportunities for calming input throughout the day? What about intense/organized movement prior to an outing. Continuous process with a sensory-informed approach to support overall regulation.

Infant Mental Health and Behavioral Considerations



Before: What seem to be triggers, frequency, and duration of behavior? Can we anticipate these and proactively help child in the moment?

Be proactive – Use routines, pre-teaching how to act in community settings, prepare/practice coping strategies, and decrease stimuli that cause overwhelm.

During: Consider cause of elopement to determine response (e.g., sensory overwhelm- take a break). Use tools child will tolerate- holding hand, leash/backpack, cart, stroller, holding a stuffy together, rewarding check-ins.

After: Talk to child about big feelings and strategies to use in the future. Share safety concerns. Consider evaluation for ASD and cognitive development.

Parent Support: How do parents react/respond in these situations? What comes up for parents when child runs away? How can we support their regulation and concerns about observers' reactions, child physical safety, child emotional safety, etc.? Look at environment and explore concrete strategies to support safety.

What have they tried, and what has/hasn't worked?

How long has elopement been an issue, and what was happening in the family/for child when this started?

Discussion



Case examples?

Successes?

Challenges?

Team considerations?

Next Steps?



Questions

Join us for more ECEP Office Hours in 2024!

Session 6: Brain Development: Typical Development and the Impact of Substance Use and Stress
June 5 at 3:30 and June 7 at 8am



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Resources



Zero to Three

https://www.zerotothree.org/

Pathways

https://pathways.org/

CDC

https://www.cdc.gov/ncbddd/actearly/milestones/index.html

AAP Bright Futures

https://www.aap.org/en/practice-management/bright-futures

What to Expect

https://www.whattoexpect.com/