The angry child and teenager are a frequent concern of families and schools but the underlying causes are quite variable. When the PCC is approached about management of the angry child, the first step is to try to uncover the underlying factors that may be contributing to the problem. The D-TECKT (see D-TECKT module) offers a means to create a differential diagnosis of the factors leading to anger and in turn assists the PCC in developing an appropriate intervention strategy. It is essential to try to determine the meaning of anger to the child and to the family as well as what functions it may have come to serve for the child.

**Intrinsic Problems:**

**Biomedical and Neurodevelopmental:**

Sleep: Sleep disruption and or lack of sleep can lead to irritability. The PCC can inquire about signs of obstructive sleep apnea such as snoring and irregular breathing. Is the child using caffeine products? How many hours of sleep is the child getting? Younger children may require an imposed nap or rest time during the day.

For teenagers, it is helpful to set parameters for bed time that will allow the needed 9 hours of sleep. Aim for completing school work an hour or so prior to bed time and restrict late night video games in order to facilitate a smoother transition to sleep. In some cases, school work load may need to be limited. Assure that there is no access to cell phones or games after bedtime.

Food: Inquire about meal routines. Younger children may be prone to tantrums if they do not eat and snack regularly, even every 2 hours.
Teenagers who skip meals or are restricted from snacks may also become fatigued and irritable.

Chronic Illness: Children and teenagers with chronic illness may experience pain, discomfort or isolation leading to moodiness. Chronic illness can result in school disruption and interruption of social activities that can lead to feelings of resentment. The PCC can aim to alleviate discomfort, problem solve social opportunities and refer for mental health consultation if deemed appropriate.

Learning problems: All children want to succeed. Children with underlying learning difficulty, particularly if not identified, may experience chronic frustration and humiliation and may react to their lack of success by acting out to escape areas of failure, refusing to do homework or by pretending to not care.

ADHD may be accompanied by aggressive behaviors stemming from impulsivity.

Medications: Some medications can lead to irritability. Stimulants used for ADHD may have a late afternoon rebound effect leading to emotional lability. SSRI’s can lead to agitation. Some patients report moodiness on asthma medications such as montelukast. Medicines may also contribute to sleep debt.

**Normal Developmental Stages:**

Oppositional behavior is a hallmark of toddlerhood and adolescence. Age appropriate negative behaviors typically occur in toddlers who are testing parental limits as they acclimate to separation and develop autonomy. Adolescents who are attempting to distance themselves from their families are also frequently oppositional but then may regret and be frightened by the effect of their behavior. The clinician can help educate families about the appropriateness of such behaviors and how to set effective limits.

The PCC can guide families of toddlers to establish an environment that provides routine, structure and limit setting. Toddlers do best when routines are established around getting up, mealtime and bedtime. Parents need to also provide consistent rules and appropriate, not harsh, consequences for
misbehavior. This is an important place for time out which is both effective at reducing unwanted behaviors and gives both parties a chance to regain composure. Toddlers can also be allowed to make some limited choices (e.g. foods or clothes) to satisfy their drive for autonomy (see Discipline and Behavior Modification modules).

Adolescents who are seeking increased independence pose a challenge to families. Parents need to be guided through the process of renegotiating their relationship with their teens by giving them opportunities to move outside of the family sphere while simultaneously assuring that the teens engage in responsible and safe behaviors or have consequences if they do not. Teens may use anger to escape responsibilities but also may go too far and feel rejected by and resentful of their parents.

**Temperament:**

Some children with difficult temperaments are intrinsically irritable. Such children may display negative and moody behaviors, can be rigid and have difficulty with transitions. These children may also over react to sensory stimuli such as noise, smells, taste and the way things such as clothes feel. They may also become visually overloaded in environments such as shopping malls.

The PCC can be helpful to parents of temperamentally difficult children by demystifying these behaviors. Teaching parents how to prepare the child for transitions and suggesting that identifying and avoiding specific stressors are helpful interventions.

**Child Psychopathology:**

There are a number of conditions that can lead to moodiness and irritability and should be considered when evaluating the angry child.

Children in the ASD spectrum may display rigidity and difficulty with transitions and engage in tantrums when routines are disrupted.
Obsessive Compulsive Disorder is often unrecognized in children but can also present as irritability with changes in routine or normal life demands.

Children with disorders of mood regulation can be irritable and angry. Children with anxiety may react to stressful situations by avoidance and negative behaviors. Anxiety is uncomfortable to children, especially boys, and can quickly flip into anger as a more tolerable emotion. Other signs of anxiety can usually be elicited in these cases such as sleep and separation issues, specific fears or social problems. Irritability is a feature of depression in young children and moodiness is a basic criterion for depression in teenagers.

Children with Oppositional Defiant Disorders display a chronic pattern of angry defiance. ODD most often accompanies ADHD which needs to be screened for and treated for the best outcome. Teenagers with Conduct Disorders engage in antisocial behaviors that include clashes with authority, lying, stealing and aggression. Such teens may also engage in gang activity and substance abuse and their behaviors may bring them to legal attention. PCCs should always consider trauma or abuse in the past of teens with Conduct Disorder and assure that this aspect is addressed. Children with Conduct Disorder generally require mental health referral.

Mood swings and irritability may be a sign of substance abuse. Inquire about changes in academic function, secretive and erratic behaviors and changes in clothing style and the presence of new peers.

Identification of psychopathologic conditions and referral for appropriate mental health consultation is a critical task of the PCC.

**Extrinsic Problems:**

Situational: Children and adolescents experiencing stressful situational changes may present with anger and oppositional behaviors. Such changes may include recent moves, the birth of a new sibling, parental discord, separation or divorce, and illness or death of a significant individual in the child’s life.
PCC’s need to ask about such changes as parents may not connect the child’s behavior to the stress. It is often helpful to advise parents to discuss the source of stress with the child as well as maintaining routines and consistency and assigning appropriate consequences for misbehavior. Encouraging parents to remain empathetic and to guarantee daily special time with the child, even if they have acted badly can demonstrate acceptance and promise security.

**Discipline:**

Anger and defiant behavior can be a result of inappropriate discipline. Children who are overly indulged may become inappropriately demanding and use anger to get the parent to give in to what they want. Children in an environment that provides irregular routines and structure or inadequate attention to normal bids from the child may react by engaging in negative attention seeking behaviors. Children who live in an overly punitive environment may pay back with anger and aggression. Corporal punishment is known to increase anger and opposition in children and needs to be discouraged.

Families struggling with discipline concerns can benefit from guidance on interventions such as time out and behavior modification and in some cases may require referral for mental health consultation. (see Discipline and Behavior Modification modules)

**Family Communication Problems:**

Communication problems between older children or teenagers and their parents may result in poor conflict resolution and can lead to anger and acting out behaviors as the child’s need to be heard is thwarted.

PCC’s who identify poor communication can guide parents to use techniques such as active listening and the use of “I” vs “You” messages. PCC’s can also guide families on appropriate ways to problem solve and negotiate compromise within the family. (see Family Communication Problems module)
Family Dysfunction:

Turbulent environments marked by significant discord between parents can result in anger and acting out behaviors by children of any age. In some cases, children become entangled in parental conflicts with one parent inadvertently or intentionally seeking to recruit the child to act out against the other parent to leverage custody or child support or simply prove their loyalty.

Identification of this pattern of family discord and appropriate referral to a mental health consultant or family therapist is important to avoid lasting relationship dysfunction.

“Second Family” issues refer to the pull of peers and social media that may influence a child’s attitudes and behaviors within the family. Inappropriate exposure to violent video and computer games may lead to angry or aggressive behaviors. PCC’s should inquire about peers and about the child’s exposure to media and help parents to provide appropriate supervision of peer activities and limitation of inappropriate media exposure. (see Family Communication Problems module)

Parental Psychopathology:

Children and teenagers who display anger may be reacting to parental psychopathology.

A depressed parent may be emotionally withdrawn and unavailable to their child leading to acting out and attention seeking behaviors.

Parental substance abuse may result in inappropriate and erratic engagement with the child creating an environment of chronic stress.

Domestic violence and physical, sexual or psychological abuse may be the underlying factor behind a child’s angry, aggressive or violent behaviors.

PCC’s can be critical in identifying parental psychopathology and referring such parents for mental health assistance.
The underlying conditions that lead to an angry acting out and defiant child are quite variable. Using an organized framework of history taking such as the D-TECKT can assist the PCC in developing an accurate differential diagnosis of the underlying conditions leading to the child’s angry behaviors. Some problems are amenable to education, demystification and guidance by the clinician. Referral for mental health consultation is appropriate when primary care interventions are not effective, if the parent requests referral or if the clinician uncovers significant psychopathology in the child, parent or family.

References:

Parenting:


*Parent/Teen*


Professional:


