CE ARTICLE

Assessment, management, and prevention of childhood temper tantrums

Elizabeth Daniels, MSN, NP-C (Nurse Practitioner)[1], **Barbara Mandleco,** RN, PhD (Professor)[2], & **Karlen E. Luthy,** DNP, FNP (Assistant Professor)[2]

[1]Mountain Springs Family Medicine, Spanish Fork, Utah
[2]College of Nursing, Brigham Young University, Provo, Utah

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Correspondence
Elizabeth Daniels, MSN, NP-C, Mountain Springs Family Medicine, 468 South Main Street, Spanish Fork, UT 84660.
Tel: 801-504-6117;
Fax: 801-504-6328;
E-mail: gardner.lizzy@gmail.com

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Abstract

Purpose: To provide an overview of normal and abnormal temper tantrum behavior as well as give recommendations nurse practitioners (NPs) can use in counseling families.
Data sources: Articles were identified from the following databases: CINAHL, Health Source: Nursing/Academic edition, Medline, Social Work Abstracts, Social Science Abstracts, Psych INFO, Psychology and Behavioral Science Collection. Textbook references were also identified using Stat!Ref.
Conclusions: Temper tantrums are one of the most common behavior problems in children. Although most children will have tantrums, with NPs' support and guidance in primary care encounters, most children will not require further intervention.
Implications for practice: NPs caring for children will need to identify normal and abnormal tantrum behavior as well as rule out other causes of tantrums in order to help parents handle the tantrum behavior.

Temper tantrums are among the most common childhood behavior problems and frequently a reason for referral to a pediatric behavioral therapist (Beers, 2003; McCurdy, Kunz, & Sheridan, 2006; Potegal & Davidson, 2003). In fact, approximately 5%–7% of children between 1 and 3 years of age have temper tantrums lasting at least 15 min three or more times per week (McCurdy et al., 2006). In addition, at least 20% of 2-year-olds, 18% of 3-year-olds, and 10% of 4-year-olds have at least one temper tantrum every day (Grover, 2008).

Temper tantrums are defined as extreme episodes of frustration or anger. Some behaviors associated with temper tantrums in toddlers and preschool children include shouting, screaming, crying, falling to the floor, flailing extremities, hitting, kicking, throwing items, and engaging in breath-holding spells (Davidson, 2006; Leikin & Lipsky, 2003; McCurdy et al., 2006; Potegal & Davidson, 2003). Tantrum behavior may continue into late childhood and adolescence; behaviors associated with this age group include becoming withdrawn or violent or having verbal outbursts. However, in all children and adolescents, mood and behavior should return to normal between tantrums (Grover, 2008; McCurdy et al., 2006).

Because tantrum behavior is among the most common concerns of parents with young children, nurse practitioners (NPs) working with this population will frequently be asked about management suggestions (Beers, 2003; Belden, Thomson, & Luby, 2008; Potegal & Davidson, 2003). Therefore, NPs should be able to differentiate normal from abnormal tantrum behavior and suggest effective management strategies in order to help parents, children, and families. Consequently, the purposes of this literature review are to discuss temper tantrums and provide recommendations NPs can use in counseling parents concerned about temper tantrums.

Methods

An electronic search was conducted using the following databases: CINAHL, Health Source: Nursing/Academic

edition, Medline, Social Work Abstracts, Social Science Abstracts, Psyc INFO, Psychology and Behavioral Science Collection. The search term entered was "temper tantrum." Inclusion criteria were peer-reviewed articles written in the English Language and published since 2000. A search using the term "temper tantrum" was also conducted through Stat!Ref to find textbook references. There were no exclusion criteria, and all articles, books, and book chapters found were included in this review. A total of eight journal articles, eight book sources, and information from the American Academy of Pediatrics (AAP) website were used.

Discussion of temper tantrums

It is important for NPs caring for young children to differentiate normal from abnormal tantrum behaviors according to the child's age so they can best help and give recommendations to parents. The following paragraphs will discuss normal and abnormal tantrums, as well as recommendations for NPs and parents.

Temper tantrums are defined as overt displays of unpleasant behaviors that are extreme and severe in nature and disproportionate to the situation (McCurdy et al., 2006). Tantrum behaviors can be as mild as whining or pouting, or as severe as head banging or breath holding until the child stops breathing and loses consciousness for a short time (Mills & Woodring, 2012; Murphy & Berry, 2009; Goldson & Reynolds, 2011). However, the most common behaviors associated with temper tantrums include crying, screaming, flailing the arms and legs, falling to the floor, banging one's head, hands, or feet against the floor or wall, kicking, throwing objects, pushing and pulling, or biting (Davidson, 2006; Kyle, 2008; McCurdy et al., 2006; Potegal & Davidson, 2003).

There are several reasons children have temper tantrums. Children who are tired, hungry, ill, or frustrated may have limited coping abilities, resulting in tantrum behavior (Kyle, 2008). Additional reasons include seeking parental attention, getting what one wants, or avoiding doing something the child does not want to do (McCurdy et al., 2006).

Temper tantrums are a normal part of development as children learn to control their emotions and gain independence; they occur most often between the ages of 2 and 3 years, but are also seen as early as 12 months or as late as 4 years (AAP, 2008). "Professionals and parents seem to agree that temper tantrums are a rite of passage into the toddler years and are rarely considered a serious emotional disturbance during this time" (McCurdy et al., 2006, p. 150). However, some forms of tantrum behavior, such as shouting, screaming, crying, withdrawing, or being violent, may even be seen in older children and adolescents (Grover, 2008; McCurdy et al., 2006).

Tantrums in 3- to 4-year-olds may indicate the children have not learned how to cope with frustration (Schonbeck, 2006). As children grow older they learn to identify feelings, communicate these feelings to others, and act appropriately, rather than having a temper tantrum (Murphy & Berry, 2009). Consequently, most temper tantrums decrease in severity, frequency, and duration as the child ages (McCurdy et al., 2006).

Temper tantrums persisting past 5 years of age, lasting longer than 15 min, or occurring more frequently than five times a day are abnormal and may indicate a more serious problem. As many as 5%–20% of children have severe temper tantrums that are both frequent and disruptive (Goldson & Reynolds, 2011); these tantrums are considered abnormal if the child or others are injured, or if property is destroyed. Tantrums accompanying sleep disorders, aggression, or enuresis may signal an underlying emotional problem. Finally, persistent negative moods, negative behaviors between tantrums, or recurrent tantrums at school are considered abnormal (Grover, 2008). See Table 1 for a comparison of normal/abnormal temper tantrums.

Recommendations for NPs

Temper tantrums have been identified as a common childhood behavior problem (McCurdy et al., 2006; Potegal & Davidson, 2003). Therefore, NPs working with children and families need to be able to provide recommendations on how to manage normal tantrum behavior as well as identify abnormal tantrum behavior needing further intervention.

First and foremost, it is critical to determine whether or not there is another explanation for the tantrum. An in-depth history and physical evaluation for developmental, psychological, or physiological explanations for the temper tantrums will help determine if this is the case (Beers, 2003).

It is also important to obtain a thorough history of the tantrum behavior because, in some instances, a thorough history of the behavior may provide insight into why the tantrums are occurring as well as lead to educational sessions for parents on ways to manage and prevent the tantrum behaviors. Questions asked during such a history are found in Table 2.

After obtaining a thorough tantrum history, it is important to obtain a full health history, family history, and review of systems. A full head-to-toe physical examination is then required. During the physical examination, NPs should assess the child to ensure growth and development are age-appropriate. However, the

Table 1 Normal and abnormal tantrums

	Normal temper tantrum	Abnormal temper tantrum
Age	12 months up to age 4.	Continuing past age 4.
Behavior during tantrum	Crying, flailing arms or legs, falling to the floor, pushing, pulling, or biting.	Injury to themselves or others during the tantrum.
Duration	Up to 15 min.	Lasting longer than 15 min.
Frequency	Less than five times a day.	More than five times a day.
Mood	Should return to normal between tantrums.	Persistent negative mood between tantrums.

Table 2 Questions to ask parents

When does the child have a tantrum?
How long does it last?
How often does the child have tantrums?
What circumstances provoke the tantrums?
What does the child do during the tantrum?
What is the child's behavior like between tantrums?
Have there been any changes in the child's home or school situation such as a new sibling, a recent move, or parental conflicts?
How does the parent react to the tantrum?
How have the parents handled the tantrums?
Is the child having any other behavioral problems accompanying the tantrums such as sleeping problems, anxiety, or enuresis?

physical examination is often normal (Grover, 2008). Even though no laboratory tests are needed in a child with temper tantrums, routine age-appropriate tests and exams of vision and hearing are indicated (Grover, 2008). Any developmental or speech and language delay should also be noted as this may frustrate the child, causing an increase in the number and severity of temper tantrums.

After a thorough history and physical examination, and no explanation for the behavior has been found, recommendations may be made on how to handle the tantrums. However, if a reason is found, such as oppositional defiant disorder, attention deficit hyperactivity disorder, autism, conduct disorder, or mood disorders such as anxiety or depression, a referral may be indicated. Pharmacological intervention may also be required.

Recommendations for parents

Children generally engage in temper tantrums for several reasons: to get what they want, to avoid or escape doing something they do not want to do, or to seek parental attention. In addition, they often occur when children are tired, hungry, ill, or frustrated (McCurdy et al., 2006). Therefore, the best way to handle temper tantrums is to prevent them. If they do occur, however, there are several ways to manage their effects.

Preventing tantrums

Because it is difficult to stop a tantrum once it starts, parents need to identify triggers in order to prevent them. Some triggers include changing activities the child is involved in when he/she does not want to change activities, becoming frustrated, or being away from home when the child is likely to become tired or hungry. Therefore, it is important to maintain consistency and developmentally appropriate behavioral expectations and rewards when changing an activity or taking the child on an outing (Beers, 2003). In addition, the child needs to have a daily routine as much as possible, especially one that includes meals and naps at specific times. This will help the child know what to expect every day and help parents avoid activities near naptime or mealtime (AAP, 2008) because tantrums may occur or become worse when the child is tired or hungry (Grover, 2008; Howard, 2003; Koch, 2003). If disruptions in routines are avoidable, it is important to have simple snacks available such as fruit snacks or crackers when away from home to avoid tantrums caused by hunger.

Children may have tantrums as a result of frustration. Therefore, parents should try to prevent frustration by childproofing the home or having age-appropriate toys. For example, children may become frustrated when they continue to get into cupboards they should not get into and parents continue to say "no." By installing cupboard locks, parents can prevent children from getting into things they should not and avoid constantly saying "no," thus reducing the child's frustration. It is also important to be aware of what is frustrating children and remove the source of frustration if possible (Grover, 2008). However, if children become frustrated, parents should try to distract them and remain calm so the frustration does not escalate into a tantrum.

As children get older and are better able to communicate wants, needs, and frustrations through words, it is important to teach them to express emotions verbally rather than through tantrum behavior. Also, asking children if they are feeling angry, sad, tired, or hungry when irritable may help eliminate the tantrum behavior if the parent appropriately addresses the feeling.

However, when children are young they do not yet have the vocabulary to express emotions, which is why they use behaviors seen during temper tantrums. Older children can be taught to express feelings through words (AAP, 2008). Therefore, it is important to provide examples of "feeling" words and teach children to start expressing feelings through words rather than through actions. For example, when children are angry because others take toys away, encourage them to say they are angry rather than express their anger through tantrums.

Another trigger for temper tantrums is to avoid doing something the child does not want to do. For example, if temper tantrums occur when asked to go to bed, it is important to be sure children know when bedtime is scheduled so they can prepare themselves earlier in the evening. If bedtime is 8 p.m. it may be necessary to remind children at 7 p.m. or 7:30 p.m. that bedtime is at 8 p.m. so they will be prepared (Grover, 2008).

Parents can also help children feel that they are in control of decisions by offering choices as much as possible, and avoiding saying "no" too often (Grover, 2008). It is always important, however, to make sure when offering choices, the choices are acceptable to the parent and the child. It is also critical for parents to choose their battles; it may not be worth arguing with a preschooler who wants to wear pajamas to school. In contrast, safety issues such as the child wanting to ride a scooter in the street need to be addressed. Parents should also listen carefully to the child's requests. If the request is reasonable, parents should consider saying "yes" as much as possible. On the other hand, the child or another person's safety should not be at risk when saying "yes."

Parents can be good examples when dealing with stress by not arguing or yelling in front of children (AAP, 2008). Parents should also be reminded that physical punishment may cause tantrum behavior to intensify and lengthen. Such parental behavior also teaches children that hitting is permitted when the punishment is physical (Kyle, 2008; Murphy & Berry, 2009).

Finally, it is important for parents to give children plenty of positive attention; those who do not receive such attention will try to obtain negative attention because negative attention from parents is better than no attention at all (AAP, 2008). Another suggestion supported by some authors is to provide five positive interactions for every negative interaction. Positive interactions include spending time alone with a parent, providing material objects such as a sticker chart to earn a reward which may be a favorite toy, or giving verbal praise such as saying "thank you for sharing," or "you are such a helpful boy/girl" (Abell, 2005; Beers, 2003).

What to do during tantrums

Many tantrums are triggered by the child being tired, hungry, ill, or frustrated. The best recommendation for parents in this situation is to remain calm, try to distract the child, and ignore the tantrum if possible. Children may need to have a "time-out" or cool down period in order to calm down. However, avoid using "time-out" too often because that strategy can lose effectiveness if over-used. It is recommended to use 1 min "time-out" for every year of the child's age (AAP, 2008).

Many times a child will have a temper tantrum as an attention-getting mechanism. Therefore, the best recommendation to give parents in this situation is to ignore the behavior until the child calms down and the tantrum disappears, as long as the child is not in danger or does not put anyone else in danger. Ignoring the behavior shows the child that acting out does not result in parental attention. However, if the child is hitting or kicking someone, the parent should hold the child until the behavior stops and the child calms down and not talk to the child until the child is calm (AAP, 2008; Grover, 2008).

Many tantrums happen when children are asked to do something they do not want to do. However, it is especially important for parents not to give in even if a tantrum occurs, because this may cause negative reinforcement. For example, if children are having tantrums because they do not want to go to bed and parents allow children to stay up, children will learn parents often give in to requests (AAP, 2008).

Finally, parents need to remain calm during the tantrum even though it is stressful. One way to remain calm is to leave the room where the tantrum is occurring and wait for it to stop. However, if children have a temper tantrum in a public place, like a grocery store or city park, it may be necessary to leave the store or park or stop the activity either by taking the child home or to the car until the behavior stops (AAP, 2008; Grover, 2008).

When a referral is needed

Tantrum behavior that is abnormal or suggests a more serious problem may need referral. Such tantrums include those that occur or are more severe after the age of 5 years or those that result in harm to the child, others, or to property. Tantrums accompanied by other behavior problems such as sleep disorders, enuresis, aggressive behavior, or extreme anxiety could signal an underlying emotional problem needing further evaluation. In addition, if the behavior between tantrums is negative, for example, the child is aggressive, withdrawn, or introverted, an underlying emotional problem may be present (AAP, 2008; Grover, 2008; Leikin & Lipsky, 2003;

Schonbeck, 2006). Belden et al. (2008) discovered healthy children have less severe, aggressive, and destructive tantrums and fewer self-injuries when compared to children of the same age who had mood disorders, disruptive disorders, or both. Reinberger (2008) cautioned, "Frequent rage attacks, together with violent or self-destructive behaviors, may signal a more serious problem and warrant professional attention. Not only are such extreme outbreaks emotionally exhausting for the parents and children, but they also may be a harbinger of psychiatric and behavior issues, including depression and a propensity toward violence" (p. 72).

It is important to recognize that teacher-reported recurrent tantrums at school may be related to learning disabilities or vision or hearing problems that are frustrating or embarrassing to the child. If these situations are present, the problem must be identified and addressed (Davidson, 2006; Grover, 2008).

Conclusions

With the support and guidance of the NP, most children will not require referral to a behavioral therapist for tantrums (Beers, 2003). Although most children will have tantrums at one time or another, it is important to reassure parents that as children better learn to verbally express themselves and understand their environment, tantrum behaviors will decrease (Kyle, 2008).

References

Abell, S. (2005). The defiant child. *Clinical Pediatrics*, **44**(9), 818–819.

American Academy of Pediatrics. (2008). *Temper tantrums: A normal part of growing up*. Retrieved from http: https://www.nfaap.org/netforum/eweb

Beers, N. S. (2003). Managing temper tantrums. *Pediatrics in Review*, **24**, 70–71.

Belden, A. C., Thomson, N. R., & Luby, J. L. (2008). Temper tantrums in healthy versus depressed and disruptive preschoolers: Defining tantrum behaviors associated with clinical problems. *Journal of Pediatrics*, **152**(1), 117–122.

Davidson, T. (2006). Temper tantrums. In K. Krapp & J. Wilson (Eds.), *Gale encyclopedia of children's health: Infancy through adolescence* (pp. 1803–1804). Detroit: Gale.

Goldson, E., & Reynolds, A. (2011). Child development and behavior. In J. M. Sondheimer, M. J. Levin, R. R. Deterding, & W. W. Hay (Eds.), *Current diagnosis & treatment in pediatrics* (pp. 64–103). Columbus, OH: The McGraw-Hill Companies.

Grover, G. (2008). Temper tantrums. In C. Berkowitz (Ed.), *Pediatrics: A primary care approach*. (pp. 199–201). Philadelphia, PA: W. B. Saunders.

Howard, B. (2003). Managing temper tantrums. *Pediatrics in Review*, **24**, 70–71.

Koch, E. (2003). Reflections on a study of temper tantrums in older children. *Psychoanalytic Psychology*, **20**(3), 456–471.

Kyle, T. (2008). Growth and development of the toddler. In T. Kyle (Ed.), *Essentials of pediatric nursing* (pp. 106–135). New York: Lippincott Williams & Wilkins.

Leikin, J. & Lipsky, M. (2003). Tantrum. In J. Leikin & M. Lipsky (Eds.), *American medical association: Complete medical encyclopedia* (p. 1191). New York: Random House Reference.

McCurdy, M., Kunz, G. M., & Sheridan, S. M. (2006). Temper tantrums. In G. G. Bear & K. M. Minke (Eds.), *Children's needs III: Development, prevention, and intervention* (pp. 149–157). Washington, DC: National Association of School Psychologists.

Mills, D., & Woodring, B. (2012). Growth and development of the toddler. In N. L. Potts & B. L. Mandleco (Eds.), *Pediatric nursing: Caring for children and their families* (pp. 273–305). New York: Delmar Cengage Learning.

Murphy A., & Berry A. (2009). Developmental management of toddlers and preschoolers. In C. E. Burns, A. M. Dunn, M. A. Brady, N. B. Starr, & C. G. Blosser (Eds.), *Pediatric primary care* (pp. 91–108). St. Louis, MO: Saunders Elsevier.

Potegal, M., & Davidson, R. J. (2003). Temper tantrums in young children: 1. behavioral composition. *Journal of Developmental & Behavioral Pediatrics*, **24**(3), 140–147.

Reinberger, S. (2008). Tempering tantrums. *Scientific American Mind*, **19**(5), 72–77.

Schonbeck, J. (2006). Acting out. In K. Krapp & J. Wilson (Ed.), *Gale encyclopedia of children's health: Infancy through adolescence* (pp. 13–17). Detroit: Gale.