

CHILD HEALTH · EARLY YEARS BEHAVIOUR

# Temper & Tears

## *in the twos and threes*

A practical guide to toddler tantrums — why they happen, how to help parents manage them, and how to spot the child who needs more than reassurance.

### ◆ WHY THIS MATTERS IN PRIMARY CARE

Tantrums are one of the most common reasons parents of under-5s come to see us. Most need only **calm reassurance and a few practical strategies**. Your real clinical skill lies in two things: giving that advice well, and recognising the small number of children whose behaviour signals a developmental, medical or safeguarding concern — and acting on it.

## 1 The toddler's dilemma

Going from a helpless baby to a semi-independent three-year-old is a huge journey in a very short time. The toddler wants to explore, copy others, use their first words and *join in* — they feel like a real person in an interesting world. But at every turn they bump into things they cannot yet do, cannot have, or feelings far too big to manage alone. That gap — between **what a toddler wants** and **what they can actually do or control** — is where tears and tantrums live.

### Normal & universal

Every toddler has tantrums. They are a stage of healthy development, not a sign of a "difficult" child or poor parenting.

### Peak in the twos & threes

They usually begin around 18 months and are most intense between one and three years.

### They fade with words

As language and self-control mature, tantrums become far less common by about age four.

Sources: NHS (*Temper tantrums*); NHS *Healthier Together*; NCT.

## 2 Why tantrums happen

A tantrum is not manipulation or bad character. At its core it is **frustration meeting an immature brain**. The toddler has powerful feelings and strong wants, but not yet the words to explain them or the brakes to hold them back. The feeling simply overflows.

### FULLY SWITCHED ON

#### The "feeling" brain

The emotional engine — anger, fear, excitement, want — is **already running at full power** in a toddler. Big feelings arrive fast and hard.

### STILL BEING BUILT

#### The "thinking" brain

Self-control, patience and reasoning — the **brakes** — are still under construction and won't be reliable for years.

### 🕒 A PICTURE TO REMEMBER

A toddler is like a **powerful engine whose brakes aren't fitted yet**. During a full tantrum the child is *flooded*—genuinely beyond reason. This is why trying to argue mid-tantrum never works, and why your calm matters more than your logic.

**Common triggers** — often more than one at once:

- ▶ **Tired or hungry** — the simplest and commonest cause
- ▶ **Frustration** — can't do it, or can't explain it
- ▶ **Overstimulation** — too much noise, crowd or excitement
- ▶ **Wanting something** they can't have, or losing something
- ▶ **Change or transition** — ending play, leaving, bedtime
- ▶ **Needing attention, comfort or reassurance**

Sources: NHS (*Temper tantrums*); NHS *Healthier Together*; Mayo Clinic.

## 3 The many faces of toddler distress

Tantrums are only the loudest version. The same struggle to manage big feelings shows up in several everyday behaviours — all normal, all needing a warm, steady response.

What you see	What's really going on	How to help the parent respond
<b>Being bossy</b>	Covering up how small and helpless they feel by trying to take charge.	Keep offering warmth and care <i>even when it's pushed away</i> — that's exactly what they need.
<b>Fads &amp; rituals</b> (the "fussy" stage)	Insisting on odd routines or clothes is a bid to have their <b>choices and preferences</b> recognised.	Give in gracefully over things that don't matter; hold the line on anything unsafe or impossible.
<b>Clinginess</b> (“I'd rather be small”)	Normal separation anxiety, common from about 6 months to 3 years, and flares with stress or change.	Reassure rather than rush. Babyish spells are not going backwards — they're refuelling.
<b>Fear of new situations</b>	New places or being left can feel genuinely frightening.	Be <b>honest</b> about changes and childcare; allow plenty of settling-in time.
<b>Hidden worries</b>	Fussiness can mask an anxiety the child can't yet name — controlling small things to manage big fears.	If behaviour becomes especially difficult, gently wonder what might be worrying them.
<b>Nightmares</b>	Bad dreams often first appear at this age, from daytime events or feelings within.	You may never know the cause; simple comfort and being understood is what helps.

Framing adapted from the original “*Tempers & Tears*” leaflet (*Association of Child Psychotherapists*) and current NHS advice.

## 4 Managing a tantrum: the toolkit

Think in three phases. The goal is never to *stop the child feeling angry* — it is to keep everyone safe and teach, by example, that big feelings can pass without disaster.

### BEFORE Prevent

- ▶ Keep a **predictable routine** for sleep and meals
- ▶ Offer small **choices** to give a sense of control
- ▶ **Prepare** the child for changes — talk through what will happen
- ▶ Spot the early warning signs and **distract early**
- ▶ Keep shopping trips short; avoid known flashpoints
- ▶ **Praise** the behaviour you want to see more of

### DURING Hold steady

- ▶ **Stay calm** — you are the model for handling feelings
- ▶ **Keep the child safe**; move nearby objects, or step back a moment if you're overwhelmed
- ▶ Stay **nearby** and wait it out — don't reason mid-storm
- ▶ Ignore the *behaviour*, not the child
- ▶ Try distraction — a window, a book, a sudden "Look!"

### AFTER Reconnect

- ▶ Once calm, **reassure** and offer a cuddle
- ▶ **Name the feeling** ("you were really cross")
- ▶ If old enough, suggest other ways to handle it next time
- ▶ **Praise them for calming down**
- ▶ Then move on — no lectures, no dwelling on it

#### ✓ During a tantrum — DO

- ✓ Stay **calm**
- ✓ Keep them **safe**
- ✓ Stay **near** and wait

#### ✗ During a tantrum — DO NOT

- ✗ You **must not give in** once you've said no
- ✗ You **must not bribe** with sweets or treats
- ✗ Do **not** reason mid-storm — and **never smack**

**Why these two are not optional:** giving in or bribing feels easier in the moment but reliably teaches the child that a tantrum works — making tantrums more frequent.

Sources: NHS (*Temper tantrums*); NHS *Healthier Together*; *Health for Under 5s (iHV)*; Mayo Clinic.

## 5 Breath-holding & reflex anoxic seizures

Some toddlers, at the peak of a cry or after a sudden fright, stop breathing, change colour and briefly lose consciousness. This is **terrifying for parents** but almost always benign. Knowing the two patterns lets you reassure with confidence — and pick up the rare child who needs more.

### Blue (cyanotic) spell

TRIGGER: UPSET · ANGER · FRUSTRATION

#### WHAT HAPPENS

After a hard cry the child stops breathing on the *out* breath, turns blue (especially the lips) and may briefly pass out. They recover within a minute.

#### MEMORY HOOK

**Blue = cross.** Provoked by *emotion*.

### Reflex anoxic seizure

PALLID SPELL · TRIGGER: PAIN OR FRIGHT

#### WHAT HAPPENS

A sudden pain or shock (e.g. a minor bump) triggers a strong vagal response — the heart slows or briefly pauses. The child goes *pale/grey*, drops, may stiffen or jerk, then recovers within a minute.

#### MEMORY HOOK

**Pale = pain.** A *faint*, not epilepsy.

### ✓ WHAT TO TELL PARENTS (THE REASSURANCE)

- ✓ The episodes are **involuntary** — not deliberate, not naughtiness, not your fault
- ✓ They are **not epilepsy**, are not dangerous, and do **not cause brain damage**
- ✓ They **improve with age** (they may become more frequent before they fade)

### 🕒 WHAT TO DO IN PRIMARY CARE

- ▶ **Check FBC and ferritin** — breath-holding is linked to iron deficiency anaemia
- ▶ **Treat iron deficiency** if present — it can reduce the frequency of spells (prescribe per BNF for Children)
- ▶ Ask parents to **video an episode** if they can
- ▶ Take a developmental, personal and family history

### ▲ REFER / THINK AGAIN IF...

- ✗ Loss of consciousness is **prolonged** or recovery is slow
- ✗ Features suggest **epilepsy** rather than a provoked faint
- ✗ Any **cardiac** concern, or family history of cardiac disease / sudden death (consider ECG)
- ✗ There are **developmental concerns**

Sources: NHS (*Breath-holding in babies and children*); NHSGGC pre-referral guidance; Iyer & Appleton, *Arch Dis Child* 2013. Prescribing per BNF for Children.

## 6 Discipline: firm and warm

Boundaries matter — but simply *telling* a toddler to behave better does not give them the self-control to do it. That control grows slowly, over years, and is learned mostly **by example**. The aim is to be firm and warm at the same time: clear limits, held kindly and consistently.

### ◆ WHAT'S CHANGED FROM OLDER TEACHING

Older leaflets treated tantrums mainly as an emotional puzzle to interpret. Current NHS advice keeps that empathy but adds a clear **behavioural backbone**: consistency, praising good behaviour, ignoring the behaviour safely, and never rewarding a tantrum. The biggest shift is on **physical punishment**.

**Do not advise smacking or any physical punishment.** It is ineffective, frightens the child, damages the relationship and teaches that hitting solves problems. Physical punishment is now **unlawful in Scotland (2020) and Wales (2022)**, where children have the same protection from assault as adults. In **England and Northern Ireland** a "reasonable punishment" defence still exists (s.58 Children Act 2004) but is under active review and is opposed by the RCPCH and NSPCC. Advise against physical punishment regardless of local law.

Sources: NHS *Healthier Together*; RCPCH; Children Act 2004 s.58; Children (*Equal Protection from Assault*) (Scotland) Act 2019; Children (*Abolition of Defence of Reasonable Punishment*) (Wales) Act 2020. Verify current legal position locally.

## 7 When it is *not* just ordinary tantrums

Most tantrums need only reassurance. A minority are a window onto something more — a developmental difference, an emotional disorder, or a family under strain. Use a simple **Recognise → Act → Refer** approach.

### STEP 1 Recognise

- ▶ **Very frequent** (almost daily), **severe or prolonged** tantrums, or tantrums that get worse after about age 4–5
- ▶ **Self-injury**, or aggression that hurts others or destroys property
- ▶ Tantrums that also happen consistently **outside the home** (nursery, childminder)
- ▶ **Developmental signs of autism**: delayed or absent speech, reduced eye contact, not pointing or gesturing, little pretend play, preferring to play alone, not sharing enjoyment, or a parent who senses a “barrier” between them and the child
- ▶ Disabling anxiety, developmental regression, or any **safeguarding** worry

### STEP 2 Act

- ▶ Take a **full history**: pattern, triggers, settings, and the child’s **development** (speech, play, social interaction)
- ▶ Examine the child; screen for **iron deficiency** where there is breath-holding
- ▶ Ask directly about **home life and parental coping**
- ▶ Involve the **health visiting team** early

### STEP 3 Refer

- ▶ **Developmental / autism concern** → local child development service or autism pathway. **Do not “wait and see”** — early referral matters (NICE CG128)
- ▶ **Significant behavioural or emotional disorder**, or disabling anxiety → CAMHS
- ▶ **Safeguarding concern** → follow local safeguarding procedures without delay

Sources: NICE CG128 (autism recognition & referral, © NICE 2026); RCPsych (worries & anxieties for parents); early-childhood behaviour research (Egger).

## 8 The parent at the end of their tether

Sometimes it is the **parent**, not the child, who needs help first. A parent may reach a point where they fear they will hurt their child — physically or emotionally. This must always be taken seriously and met with support, not judgement.

### ▶ WHAT OFTEN LIES UNDERNEATH

- ▶ Too little practical help or support
- ▶ Too many worries stacked up at once
- ▶ Parental **depression** or being unwell
- ▶ Exhaustion and isolation

### ▲ WHAT TO DO

- ▶ If a parent fears they might harm their child, **urgent help must be sought**
- ▶ Assess **parental mental health**; treat or refer
- ▶ Offer support — health visitor, family support, **safeguard the child**
- ▶ Signpost **Family Lives**: 0808 800 2222

### ◆ THE MESSAGE TO GIVE PARENTS

Struggling does not make someone a bad parent. The GP and health visitor are the right people to talk to first — and reaching out early protects both the child and the parent.

## 9 Key messages to take away

**1** Tantrums are **normal and universal**, and fade as language and self-control grow.

**2** A child in full tantrum is **flooded, not manipulative** — meet it with calm, safety and consistency.

**3 Prevent** (routine, choices, prepare, praise) → **Hold steady** (calm, safe, don't give in or bribe) → **Reconnect** (reassure, name feelings, praise calm).

**4 Never advise smacking.** Physical punishment is harmful, ineffective, and unlawful in Scotland and Wales.

**5** Breath-holding and reflex anoxic seizures are **benign** — reassure, and **check & treat iron deficiency**.

**6** Know the **red flags**. Refer developmental concerns early rather than waiting, and never overlook a parent at breaking point.

## ◆ Sources & further reading

**NHS.** Temper tantrums; Breath-holding in babies and children. [nhs.uk](https://www.nhs.uk)

**NICE CG128.** Autism spectrum disorder in under 19s: recognition, referral and diagnosis (© NICE 2026).

**NHS Healthier Together** (regional ICS sites). Tantrums & toddler behaviour support; Autism.

**Institute of Health Visiting** — Health for Under 5s: "Temper, temper!"

**RCPCH.** Position on physical punishment of children.

**Royal College of Psychiatrists.** Worries and anxieties; Dealing with tantrums.

**NHSGGC.** Reflex anoxic seizures — advice for referrers; Iyer & Appleton, *Arch Dis Child* 2013.

**Green C.** *New Toddler Taming* (Vermilion) — classic parent-facing guidance on normalising toddler behaviour.

**BNF for Children** — for any iron prescribing.

**Acknowledgement.** This teaching aid is a rebuilt and clinically updated version of the leaflet "*Tempers & Tears — in the Twos and Threes*", originally published by The Child Psychotherapy Trust and now hosted by the **Association of Child Psychotherapists**. The empathic developmental framing of the original has been preserved; the clinical, safety and referral content has been updated to current UK guidance.

### DISCLAIMER

This document is provided **exclusively for educational and training purposes** as a teaching aid for clinicians. It does not constitute formal clinical guidance. Clinicians must independently verify all medical information, prescribing guidance, referral pathways and legal requirements against current national guidance (NICE, BNF/BNFC, Royal Colleges), the relevant regulatory bodies, and their **local policies** before applying any of it in practice. The law and guidance in this area change over time and vary between the four UK nations.