

WHEN BEHAVIOUR FEELS EXTREME

A loving, practical guide to understanding and supporting destructive or violent behaviour in children and young people

For parents and carers of children who may be autistic, ADHD, otherwise neurodivergent, or still waiting for answers

LOVE AND SAFETY CAN SIT TOGETHER

A child can need firm safety boundaries and deep compassion at the same time. The aim is to protect everyone, understand what is driving the behaviour, reduce distress and build safer ways to communicate and cope.

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Research-informed family guide • UK focus • Reviewed 25 October 2026

Start here: immediate safety

If there is immediate danger, serious injury, a weapon, a fire, a child running into traffic, or you cannot keep people safe, move to safety and call 999. Do not put yourself or another child in harm's way. If you can, use a calm voice, create space and ask another trusted adult to help.

If urgent medical advice is needed
In England, call NHS 111 or use NHS 111 online for urgent health advice that is not a 999 emergency. In Scotland, call NHS 24 on 111; in Wales use NHS 111 Wales where available; in Northern Ireland contact your GP or GP out-of-hours service. If someone is in immediate danger, call 999.

If an episode involves a new or severe change, possible injury, sudden confusion, a seizure, unusual sleepiness, suspected poisoning, severe pain, or a major change after starting/changing medication, seek urgent medical advice. Do not assume a sudden change is "just behaviour".

This guide is educational. It cannot assess your child, diagnose a condition or replace advice from a GP, paediatrician, mental-health professional or other clinician. For current local pathways, contact your GP, health visitor, school/SENCO or local children's services.

If you are reading this after a frightening episode

- First check for injuries and immediate hazards. Get medical help where needed.
- Give everyone time and space to settle. Do not demand an explanation, apology or lesson while your child is still overwhelmed.
- When everyone is calm, reconnect gently, record what happened and identify one practical change that could make the next episode safer.
- If this is happening repeatedly, escalating, or affecting safety at home or school, ask for a prompt assessment and a coordinated support plan. You do not have to wait for a diagnosis to ask for help.

How to use this guide

"Extreme behaviour" is the phrase some families use when behaviour feels frightening, intense or hard to manage. It describes the impact and risk; it is not a diagnosis or a judgement about a child. This guide uses "behaviour that challenges" when referring to clinical and guidance language, while keeping the child's dignity at the centre.

Part	What it helps with
1. Understand	What the behaviour may communicate; possible neurodivergence, health, sensory and environmental contributors.
2. Stay safer	Planning ahead, recognising escalation and responding during an episode.
3. Find patterns	Keeping a useful, non-judgemental diary and asking for a proper assessment.
4. Build support	Making a practical home and school plan, teaching safer communication and reviewing what works.
5. Look after everyone	Siblings, caregiver wellbeing, recovery, repair and where to seek help.
6. Ready-to-use pages	Safety-plan template, incident record, appointment checklist and UK sources.

A guiding question
Instead of asking only "How do I stop this?", add: "What might be making this hard, what is my child communicating, and what change would make the situation safer?"

1. Start with the child, not the label

Autism, ADHD, language or learning differences, sensory processing differences, anxiety, trauma, sleep problems and physical health conditions can all shape how a child experiences demands, communication, change and stress. Some children have several overlapping needs; some have no diagnosis yet. A behaviour episode alone cannot establish why it happened.

Hitting, kicking, biting, throwing, breaking objects, running away, head-banging or other self-injury can be frightening. These behaviours need a safety response. They are not proof that a child is “bad”, manipulative, uncaring or destined to be violent. A child may be distressed, in pain, frightened, overloaded, trying to escape a demand, seeking a sensory experience, communicating “no”, or responding to a pattern they have learned. More than one factor may be present.

Keep this distinction clear
A behaviour can be unsafe and still have an understandable context. Understanding the context does not excuse harm or remove boundaries; it helps adults choose support that is more likely to work.

Possible contributors to explore

Area	Clues worth checking
Communication	Does your child understand the words, pace and number of instructions? Can they communicate pain, refusal, a break, “too much”, or “help” in speech, gesture, pictures, signs or AAC?
Sensory load	Noise, lights, touch, smells, crowding, temperature, clothing, food textures, movement, visual clutter or a lack of sensory input.
Demand and control	Too many steps, unclear expectations, time pressure, repeated prompting, transitions, tasks that feel impossible, lack of choice or a perceived loss of control.
Physical health	Pain, constipation, reflux, dental or ear pain, headache, illness, hunger, thirst, medication effects, sleep disruption, hormonal or developmental changes.
Emotional wellbeing	Anxiety, low mood, fear, shame, grief, trauma, bullying, relationship strain, social exhaustion, masking or autistic burnout.
Setting and relationships	What happens at home, school, transport, clubs or contact transitions? Who is present? Are expectations and responses consistent and safe?
Learning and development	Language delay, ADHD, dyslexia, learning disability, motor/planning difficulty, puberty, or a gap between what adults expect and what the child can manage.
Safety and safeguarding	Bullying, exploitation, abuse, frightening experiences, unsafe online contact, or the child witnessing conflict. Explore sensitively and involve professionals.

A child’s behaviour may look different in different settings. Some children hold themselves together at school and release distress at home; others struggle most in school or community settings. Neither pattern proves that the behaviour is deliberate.

2. Notice the build-up: early signs and escalation

Many families notice small changes before a crisis: a child goes quiet, speeds up, repeats a question, paces, covers their ears, clenches their hands, becomes more rigid, argues, tries to leave, stops responding, or seeks intense movement. Some children show very few visible warning signs. Learn your child’s individual pattern rather than expecting a standard sequence.

Possible stage	What you may see	Helpful adult response
Settled / available	Engages, communicates, plays, rests or	Protect predictable routines, connection,

	moves in their usual way.	food, sleep and access to preferred regulation.
Early strain	More fidgeting, repetition, refusal, silence, worry, irritability, sensory avoidance or “silly” behaviour.	Reduce words and demands; check basic needs; offer a break, choice, visual cue or quiet space.
Escalating distress	Louder voice, rapid movement, throwing, pushing, attempts to flee or difficulty processing language.	Prioritise space and safety. Move others away; use few calm words; remove hazards if safe.
Peak / crisis	Immediate risk of serious harm, property damage or self-injury; child may not be able to process language.	Keep distance and an exit route; call for help if risk cannot be safely managed; do not lecture, threaten or crowd.
Recovery	Fatigue, withdrawal, crying, shame, confusion, seeking comfort or needing solitude.	Allow recovery; check health and injury; offer quiet, water and familiar comfort without pressure.

Not every child follows a neat curve
An episode may start suddenly, or one setting may hide earlier distress. The table is a prompt for observation, not a prediction tool.

3. Prevention: change the conditions around the child

Prevention is not “giving in”. It is making daily life more understandable and manageable so the child has fewer reasons to reach crisis point. Start with the smallest adjustment that addresses a real difficulty, and observe whether it helps.

Practical adjustments to try

- Make the day more predictable with a simple visual timetable, countdown, “first–then” card or clear explanation of what will happen next. Tell your child about changes as early as you reasonably can.
- Give one short instruction at a time. Allow processing time before repeating or adding more words. Pair speech with a picture, written cue, gesture or demonstration.
- Offer meaningful choices within necessary limits: “Shoes first or coat first?” rather than an open-ended question when the child is already stressed.
- Reduce avoidable sensory strain: lower noise or brightness, provide a quiet place, allow headphones if safe, check clothing comfort and plan for crowded settings.
- Build in movement, breaks, food, drinks, toileting and decompression. Consider whether the child is coping through the day and then running out of capacity.
- Break difficult tasks into small steps; adjust the task, timing, environment or level of help. Praise effort, communication and recovery rather than demanding perfect compliance.
- Keep safe, preferred regulation available: movement, stimming, a comfort object, special interest, quiet time or a way to say “stop”, “help” or “break”. Do not suppress harmless stimming simply because it looks unusual.
- Agree a consistent adult response across home and school, while allowing individual flexibility. A plan should fit the child, not force the child to fit the plan.

Build communication that works under stress

When a child is overwhelmed, spoken language may become harder to understand or produce. Practise safer, easier ways to communicate when calm: a “break” card, “help” symbol, “no/stop” card, gesture, sign, communication app, objects of reference, or a short phrase. Keep it within reach and honour it whenever it can be safely honoured. A child who cannot speak in the moment still has preferences, feelings and a right to communicate.

4. During an episode: a calm, safety-first response

The order of priorities
Protect people → reduce demands and stimulation → communicate simply → allow recovery → reflect later.

1. Pause and regulate yourself as much as possible. Lower your voice, slow your movements and use a neutral, non-threatening posture. If you need to tag another adult in, do so.
2. Create space. Move siblings, pets and bystanders away. Remove dangerous objects only if you can do so without approaching or escalating risk. Keep a clear exit route for you and your child.
3. Use very few words. Try: “You’re safe. I’m giving you space.” “I won’t let anyone get hurt.” “Break or quiet?” Avoid questions that require a long answer.
4. Reduce what is adding pressure: stop talking, pause the task, lower noise and light, reduce the audience and avoid sudden touch. Do not corner, crowd, shame, threaten or demand eye contact.
5. If the child is moving towards immediate danger, focus on moving other people and hazards, and call emergency help if needed. Do not try a physical hold unless you have specific, appropriate training and lawful authority; this guide does not teach restraint.
6. Wait for signs that your child can process again. Offer water, a quiet familiar place, a sensory aid or a trusted adult if they want it. Do not insist on touch or conversation.
7. After the danger has passed, check injuries and health. Seek medical advice if needed. Give time to recover before discussing what happened.

Words that can help

Try saying	Why it may help
“I can see this is too much. I’m here.”	Names distress without demanding an explanation.
“I will keep everyone safe. I’m moving back.”	Sets a clear limit and makes your action predictable.
“You can point: help, stop, break, or quiet.”	Offers communication without requiring speech.
“We can talk when your body is ready.”	Removes pressure to explain during overload.
“I love you. We will work this out together.”	Separates the child’s worth from what happened.

Avoid long reasoning, arguing about what is fair, repeated commands, sarcasm, threats, punishment during a crisis, or asking “why did you do that?” at the peak. These approaches can add language and social demands when the child may not be able to process them.

5. Make a home safety plan before the next crisis

A written plan helps adults respond consistently and reduces last-minute decisions. It should be individual, proportionate and reviewed with relevant professionals. It must not become a plan to isolate, frighten or punish a child.

- List the people most at risk and where they can go during an episode. Agree a simple signal that means “please take the other children to the safe room/next door”.
- Store medicines, knives, tools, weapons, matches and other dangerous items securely. Consider how to reduce access to objects the child may throw, without turning the home into a threatening or restrictive space.
- Plan for exits, roads, windows, water, balconies, animals and other specific risks. If a child runs off, discuss an individual safety plan with health, education and safeguarding professionals.
- Agree who calls for help, who stays with the child, and how siblings are reassured afterwards. Keep emergency contacts accessible.
- If a child is injured, a caregiver is injured, or you cannot safely manage the risk, seek urgent help. Use 999 for immediate danger.
- Do not lock a child in a room, block them in as punishment, use pain or threats, or use improvised restraint. Seek professional advice about safer environmental adaptations.

Caregiver safety matters too

It is okay to step back to a safe distance, ask another adult to take over, or call for support. Protecting yourself and other children is part of caring for your child.

6. After the episode: recovery, connection and repair

A child may be exhausted, confused or ashamed after losing control. They may not remember events in the same way as an adult, or may not yet have the language to explain. Recovery time is part of the support plan, not a reward that has to be earned.

- Check for injury, pain, hunger, thirst, toileting needs and exhaustion. Seek medical care when indicated.
- Offer low-demand recovery: quiet, a familiar activity, a safe sensory tool, a drink, sleep or the presence of a trusted person. Ask before touching.
- Reconnect without pretending that harm did not happen: “I love you. Hitting hurt. We will practise a safer way to say stop.”
- When calm and ready, use a short, concrete conversation or drawing: What was happening? What felt hard? What helped? What can we try next time? The child can pass or respond non-verbally.
- Support repair in a developmentally appropriate way, such as helping to restore an item or checking on someone later. Do not force a public apology or make the child responsible for managing adult feelings.
- Adults can reflect too: Was my instruction clear? Did I notice the warning signs? Was there a safer adjustment I missed? Repair builds trust; it is not an admission that the adult is to blame.

7. Keep a short, useful behaviour record

A diary is for discovering patterns and describing support needs, not proving that your child is bad or building a case against them. Include strengths, successful days and what helped. Keep it factual and confidential; share it only with relevant professionals.

Record	Questions to capture
Date / setting	When? Where? Who was present? What was the activity or demand?
Before (A)	What happened immediately before? Any transition, noise, request, conflict, pain sign, change or tiredness?
Behaviour (B)	What exactly did you see or hear? Use observable words: “threw the cup” rather than “was naughty”. How long? How intense? Any injury or damage?
After (C)	What happened immediately after? What changed, stopped, started or was offered? How did people respond?
Child’s state	Sleep, food, illness, medication change, sensory load, communication, mood, recent events or known stressors.
Support tried	What did adults do? What helped, worsened it, or made no difference? How long until recovery?
Strengths / voice	What was the child trying to communicate? What did they do well? What would they say helped, using their communication method?

One caution about patterns

A pattern can suggest a question to explore; it does not prove motive. For example, if a task stops after an episode, the child may learn that the task stops, but the task may also be genuinely inaccessible or frightening. A qualified professional can help assess this without blaming the child or family.

8. Ask for a proper assessment and coordinated support

When behaviour is dangerous, frequent, suddenly changing or disrupting family life, contact your GP and explain both the risk and the change in your child’s wellbeing. Ask about physical health, pain, sleep,

mental health, communication, neurodevelopmental needs and the local pathway. A diagnosis is not a prerequisite for support.

Depending on the child and local services, relevant professionals may include a GP, paediatrician, CAMHS or other mental-health team, speech and language therapist, occupational therapist, educational psychologist, autism/ADHD assessment team, school SENCO, health visitor or social care practitioner. Ask who is coordinating the plan so that advice does not arrive as disconnected pieces.

You could say: “My child is having episodes involving [specific behaviour]. This happens [frequency] and has led to [risk, injury or impact]. I have noticed [patterns]. I am concerned about their wellbeing and safety. Please assess possible physical, communication, sensory, developmental and mental-health factors and tell me what support can start now.”

Bring concise evidence

- A short timeline and examples from home, school and other settings.
- A factual record of what the behaviour looks like, how often, how long, severity, injuries and recovery.
- What communication the child uses, including pictures, gesture, sign or AAC.
- Any change in sleep, eating, toileting, pain, medication, mood, school attendance or family circumstances.
- What has helped or worsened things, plus your child’s strengths, interests and preferences.
- A clear request for a written safety/support plan, a named contact, review date and advice for worsening risk.

Ask professionals to look beyond “behaviour management”
NICE recommends assessing communication, physical and mental health, medication effects, sensory and environmental factors, changes and predictability, and developing a care plan with the child and family. Ask for the reasons and function of the behaviour to be assessed, not only for a reward chart or consequence system.

9. What good support should aim to do

A useful plan starts with the child’s quality of life, safety, communication and participation. It should be individual and based on a careful understanding of the behaviour and its context. NICE guidance for autistic children recommends addressing factors that trigger or maintain behaviour and offering psychosocial interventions informed by functional assessment when needed.

- Define the specific behaviour in clear, observable terms and identify the risk it creates.
- Consider physical health, pain, mental health, sleep, communication, learning, sensory profile, trauma and environmental conditions.
- Ask what the child may be communicating or trying to change, while recognising that one behaviour can have several functions.
- Change avoidable demands, sensory conditions and routines that are contributing to distress. Teach a safer, accessible way to communicate the same need.
- Agree the adult response so that caregivers and school can act predictably and safely. Reinforce useful communication and recovery; do not rely on fear, humiliation or pain.
- Set a review date and simple measures: frequency, duration, injury, recovery time, access to learning/family life, and whether the child feels safer. Change a plan that is not helping.
- Include the child’s views and preferences in a form they can use. Involve parents/carers and relevant professionals.

Medication is not a parent-led behaviour technique. If medication is discussed, ask the prescriber what target symptom it is intended to address, likely benefits and risks, how it will be monitored, and when it will be reviewed. Do not start, stop or change prescribed medication without speaking to the prescriber.

10. Working with school and other settings

Share relevant examples with the SENCO and ask for a meeting focused on prevention, safety and access to learning. Ask what happens before and after episodes, what adjustments are already in place, how the child communicates distress, and how home and school will share information. A plan should include who does what, how incidents are recorded, and when the plan will be reviewed.

- Ask the school to consider a written individual support/behaviour plan, risk assessment and reasonable adjustments where applicable.
- Discuss predictable transitions, a trusted adult, a safe place the child can choose, reduced sensory load, adjusted demands and supported communication.
- Ask to be informed promptly about injuries, restraint, seclusion or significant incidents and how the school will review what happened.
- Keep communication factual and collaborative: “What was happening just before? What helped the child recover? What can we change next time?”
- If restrictive intervention is used in school, ask for the school’s policy, incident record, explanation, follow-up and review. Rules and duties differ across the UK; DfE guidance cited below applies to England.

11. Supporting siblings and caring adults

Siblings can love their brother or sister and still feel frightened, angry, overlooked or confused. Offer honest, age-appropriate reassurance: “It is not your fault. The adults are working on safety. You can come to me when you feel worried.” Make a simple safe-place plan and protect ordinary time with each child.

Parents and carers may feel grief, anger, fear, guilt or exhaustion. These feelings do not mean you love your child less. Tell the GP or support team how the situation is affecting sleep, health, work and relationships. Ask about family support, short breaks, parent programmes adapted to neurodivergence, carers’ services and local parent-carer forums. Seek help early; you do not have to wait until crisis.

A loving boundary
“I love you. I will not let anyone get hurt. I’m going to give you space and help us get safe.”

12. The Tom Tom Four Pillars: a gentle reflection tool

The Tom Tom Four Pillars can give families a child-friendly language for reflection after everyone is calm. Use the child’s own words and communication style. The pillars are educational prompts, not a diagnostic or clinical assessment.

Pillar	Gentle question
Brian’s	What might be going through my child’s mind? Is something confusing, worrying or too demanding?
Waves	What feelings or sensory experiences might be rising? What does my child’s body need?
Circles	Which routines, people, objects or familiar places help them feel safe and settled?
Bridges	What small, supported step could help reconnect, communicate, repair or move towards the next activity?

Use the pillars to increase curiosity and connection, not to label a child’s inner state for them. “I wonder if…” leaves room for the child to correct you.

13. Family safety and support plan: fill-in page

Plan item	Our notes

My child's strengths, interests and signs of feeling safe	
Early signs that stress is rising	
Known situations, health needs or sensory factors to check	
What my child can use to say "help / stop / break / pain / quiet"	
Helpful adjustments before an episode	
What adults will say and do during escalation	
Where siblings / others can go to stay safe	
Objects or places that need a safety plan	
Who to contact for urgent advice; who calls 999 if needed	
What to do after: injury check, recovery, reconnect	
Professional contact / plan owner / review date	

Keep the plan somewhere adults can find it. If your child is old enough, involve them in making it understandable and respectful. Share only what is necessary with people who need to support safety.

14. One-page incident record

Prompt	Record here
Date / time / place / people present	
What was happening in the 30 minutes beforehand?	
Possible health, sleep, food, sensory, communication or change factors	
What did I observe? Exact words/actions, duration, intensity	
Was anyone injured or at immediate risk? What hazards were present?	
What did adults do? What reduced or increased the pressure?	
What happened next? How long until recovery?	
What might the child have been communicating? What is uncertain?	
What helped the child feel safe afterwards?	
One change to try / professional follow-up needed	

15. Appointment checklist

- I can describe the behaviour without labels and explain its impact on the child and others.
- I know when it began, how often it happens and whether it is getting more intense or more frequent.
- I have checked for injury, pain, constipation, sleep changes, illness, medication effects and other health concerns to discuss.
- I have examples from more than one setting, including times when things went well.
- I can explain how my child communicates and what helps them understand.
- I have written down my questions and what I need today: safety advice, assessment, referral, school support, family help or a review date.
- I know what to do if the risk becomes urgent before the next appointment.

16. UK guidance and further reading

The guidance below informed this family resource. NHS and NICE pages may be updated; check the live page and local service details. This guide was prepared on 25 October 2026.

NHS — Supporting an autistic child

https://www.nhs.uk/conditions/autism/supporting-a-child/

Practical information about understanding behaviour, surroundings, routines, fatigue, health and school.

NICE CG170 — Autism spectrum disorder in under 19s: support and management

https://www.nice.org.uk/guidance/cg170/chapter/recommendations

Recommendations on identifying and responding to factors associated with behaviour that challenges; assessment and support.

NICE QS51 — Assessing possible triggers for behaviour that challenges

https://www.nice.org.uk/guidance/qs51/chapter/quality-statement-7-assessing-possible-triggers-for-behaviour-that-challenges

Factors to assess include communication, physical and mental health, environment, change, safety and predictability.

NICE NG11 — Challenging behaviour and learning disabilities

https://www.nice.org.uk/guidance/ng11/chapter/recommendations

Assessment, functional understanding and personalised support for people with learning disabilities; relevant where this applies to the child.

NHS — When to use NHS 111 or call 111

https://www.nhs.uk/nhs-services/urgent-and-emergency-care-services/when-to-use-111/

Urgent health advice in England and routes to emergency or urgent care.

Department for Education — Restrictive interventions, including use of reasonable force, in schools (England; April 2026)

https://www.gov.uk/government/publications/restrictive-interventions-including-use-of-reasonable-force-in-schools

England school guidance focused on prevention, de-escalation, SEND considerations, recording and reporting.

National Autistic Society — Behaviour

https://www.autism.org.uk/advice-and-guidance/topics/behaviour

Family information and practical resources. Check the site for the current page and related advice.

A final word

Your child is more than the most frightening moment they have had. Their behaviour may be difficult to live with and still sit alongside humour, tenderness, curiosity, strengths and a need to be understood. Keep people safe, seek help, make room for your child’s voice and take the next step one day at a time.

This guide is an educational resource from the Tom Tom Universe. It is not a clinical assessment, diagnosis, emergency service or substitute for individual professional advice. Local pathways, legal duties and services differ across England, Scotland, Wales and Northern Ireland.