

OPPOSITIONAL AND AGGRESSIVE BEHAVIORS

KEY FACTS

- It is estimated that 5.5 percent of U.S. children have behavioral problems of an aggressive nature (Offord et al., 1991).
- Of all the risk factors for conduct disorder (CD), age at onset of oppositional and aggressive behaviors seems to be the most important. Children who display antisocial and aggressive behaviors during elementary school are at the highest risk for conduct-related problems as adults (Eddy, 1996; Loeber, 1988; Patterson et al., 1989).
- Among children and adolescents with CD, 40–70 percent also exhibit attention deficit hyperactivity disorder (ADHD) (Essau and Petermann, 1997; Hinshaw, 1987; Hinshaw et al., 1993; Kazdin, 1993; Loney, 1987). Children and adolescents with CD are also more likely to exhibit anxiety and depression than children and adolescents without CD (Essau and Petermann, 1997; Zoccolillo, 1992).
- Learning disorders, ADHD, mild mental retardation, seizure disorders, schizophrenia, mood disorders,

dissociative disorders, and even dissociative identity disorder (multiple personality) may at some time in childhood or adolescence manifest themselves as oppositional and aggressive behaviors (Lewis, 1996).

- Adolescents with CD are at a higher risk for suicidal behaviors and suicide completions than adolescents without CD (American Psychiatric Association, 1994, 2000; Renaud et al., 1999).
- Physically abused children and adolescents are more likely to become seriously delinquent and violent juveniles (Lewis, 1996).

Children and adolescents frequently exhibit oppositional behaviors as they develop. Every parent is familiar with the toddler who is enchanted with the word “no” or the adolescent who pushes for a later curfew. Such responses are part of developing autonomy and independence. Some children and adolescents, however, experience periods of turbulence that are significantly disruptive and that may affect functioning. These children and adolescents may have an aggressive/oppositional problem, oppositional defiant disorder (ODD), or conduct disorder (CD).

DESCRIPTION OF SYMPTOMS

The assessment of oppositional and aggressive behaviors is complex and must take into account a child's or adolescent's social context and the degree to which patterns of undesirable behaviors are protective (e.g., aggressive behaviors in neighborhoods with a high incidence of violence may not indicate a disorder) (American Psychiatric Association, 1994, 2000). However, any symptoms of oppositional and aggressive behaviors significant enough to be disruptive or to interfere with functioning should be considered indicators for further intervention, even if the criteria for a formal diagnosis are not met.

The child or adolescent with an aggressive/oppositional problem sometimes acts in ways that interfere with routines at home, school, or play but still functions adequately in these areas (i.e., usually gets along with family, has friends, and complies with school routines). Various factors can result in aggressive or oppositional behaviors (e.g., expectations that may exceed a child's or adolescent's abilities, a neighborhood that elicits aggressive behaviors, attention deficit hyperactivity disorder [ADHD]).

Aggressive/Oppositional Problem

(Diagnostic code: V71.02)

Adapted from DSM-PC. Selected additional information from DSM-PC is available in the appendix. Refer to DSM-PC for further description.

Early Childhood

- May frequently shout at, hit, bite, or punch others

Middle Childhood

- May deliberately annoy others
- May argue for long periods

- May get into fights intermittently at school or in the neighborhood
- May swear or use bad language in inappropriate settings

Adolescence

- May argue; may vehemently defy requests
- May use obscene language or gestures frequently
- May occasionally hit others
- May exhibit inappropriately suggestive or aggressive sexual behaviors

A child or adolescent whose aggressive/oppositional problems persist or worsen despite efforts to provide support (e.g., family interventions, change in school program) may have an aggressive/oppositional disorder. Aggressive/oppositional disorders range from the milder oppositional defiant disorder (ODD) to the much more serious conduct disorder (CD).

Children and adolescents with ODD have significant difficulties at home, at school, or with peers because of oppositional behaviors, but they have not broken major societal rules.

Description of Symptoms (continued)

Oppositional Defiant Disorder

(Diagnostic code: 313.81)

Adapted from DSM-PC. Selected additional information from DSM-IV-TR is available in the appendix. Refer to DSM-PC and DSM-IV/DSM-IV-TR for full psychiatric criteria and further description.

Early Childhood

- May be extremely defiant
- May frequently “mouth off” and/or throw tantrums

Middle Childhood

- May be very rebellious and/or argue often
- May intentionally annoy others
- May blame others for his mistakes

Adolescence

- May have severe arguments; may be defiant and unwilling to compromise
- May precociously use alcohol, tobacco, or drugs

In contrast to children or adolescents with oppositional defiant disorder (ODD), those with conduct disorder (CD) may have harmed people, animals, or property. When evaluating a child or adolescent who has broken major societal rules, it is helpful to understand the context in which the child or adolescent acted. For example, a child or adolescent who commits an impulsive offense with encouragement from peers may have a better prognosis than one who plans and carries out such an offense alone.

Conduct Disorder

(Diagnostic code: 312.8x)

Adapted from DSM-PC. Selected additional information from DSM-IV-TR is available in the appendix. Refer to DSM-PC and DSM-IV/DSM-IV-TR for full psychiatric criteria and further description.

A child or adolescent with conduct disorder (CD) repeatedly violates the basic rights of others or major societal rules and norms. Behaviors, present for at least 1 year, may include

- Aggression toward people and/or animals
- Destruction of property
- Deceitfulness or theft
- Serious violations of rules

Middle Childhood

- May fight with peers, bully, be cruel to people and/or animals
- May display inappropriate sexual activity including sexually aggressive behaviors

- May engage in destructive acts (e.g., setting fires, lying, stealing)
- May violate rules, have academic problems, and/or be truant from school

Adolescence

- May show aggressive, delinquent behaviors, including harming people
- May engage in deviant sexual behaviors (e.g., have numerous sexual partners, engage in sexually assaultive behaviors)
- May destroy property
- May steal
- May have legal difficulties
- May use and/or sell illegal drugs
- May run away from home (note that the majority of runaways have experienced familial violence [Farber et al., 1984; Sells and Blum, 1996])
- May have academic problems and/or be suspended or expelled from school

COMMONLY ASSOCIATED DISORDERS

Attention Deficit Hyperactivity Disorder

(Diagnostic code: 314.xx)

- Attention deficit hyperactivity disorder (ADHD) is present in up to 60 percent of children with conduct disorder (CD) (Short and Brokaw, 1994).
- Consider ADHD if child or adolescent has history of hyperactive/impulsive behaviors or school difficulties.

Major Depressive Disorder

(Diagnostic code: 296.xx)

- Case-based evidence suggests that 40 percent of children and adolescents with major depressive disorder also have CD (Meller and Borchardt, 1996).
- Rates of depressive disorders, suicidal thoughts (suicidal ideation), suicide attempts, and completed suicide are all higher in children and adolescents with CD (Shaffer et al., 1996).
- Consider depression if a child or adolescent shows irritable mood; isolative behaviors; loss of interest in activities; or sleep, appetite, or energy changes.

Bipolar Disorder

(Diagnostic code: 296.xx)

- Research indicates that 20–70 percent of children and adolescents with bipolar disorder also have CD (Geller and Luby, 1997; Kovacs and Pollock, 1995; Kutcher et al., 1989). Symptoms associated with oppositional and aggressive behaviors (e.g., aggression, sexually inappropriate behaviors) can overlap with symptoms of mania in bipolar disorder (Sanchez et al., 1999); thus, a thorough evaluation is necessary for accurate diagnosis.

Child Maltreatment

- CD is frequently associated with a history of harsh discipline, abuse, or neglect.

Substance Use Disorders

- CD is frequently associated with substance use disorders. Substance use increases the risk for completed suicide in adolescents with CD (Renaud et al., 1999). Substance use also increases the likelihood that CD will persist (American Psychiatric Association, 1994, 2000).

INTERVENTIONS

Understanding that aggressive/oppositional problems do not necessarily lead to CD and that CD does not necessarily lead to adult criminality (Robins, 1966; Rutter and Giller, 1984) can help health professionals feel less pessimistic about addressing these issues.

For milder oppositional and aggressive problems, helping parents develop consistent responses and consequences appropriate to their child's or adolescent's developmental level is a reasonable first step.

For ODD and CD, combined interventions with both the child or adolescent and the family appear to be the most effective means of addressing problematic behaviors. These interventions ideally begin as soon as a disorder is identified, continue through adolescence, and address the child's or adolescent's functioning in the areas of family life, relationships with peers, and school (Henggeler et al., 1998; Kazdin, 1993; Webster-Stratton, 1998). Brief, crisis-oriented interventions, while often necessary, are less likely than ongoing, comprehensive interventions to change long-term

oppositional behaviors. Since children or adolescents with early onset of CD are at higher risk for adult antisocial personality disorder than those whose CD appears later, consistent, continued, and coordinated multi-agency, health professional, school, and family interventions are essential for children and adolescents with early onset of CD. Such interventions should be initiated early and proactively.

Primary care health professionals need to determine when mental health referrals for the child or adolescent and/or the family are appropriate and when social service and/or legal agencies should be involved. Once a referral is made, permission should be obtained from parents to allow communication among all the professionals involved.

Suggestions for interventions by primary care health professionals, as well as guidelines for referral, are offered below.

Family

1. Safety is the first priority in dealing with aggressive/oppositional problems and disorders.

- Is the child or adolescent safe? (Is there evidence of abuse, trauma, or neglect?) Child maltreatment is a highly specific risk factor for CD. If evidence of abuse or neglect is present, immediate steps to protect the child or adolescent must be taken. (See bridge topic: Child Maltreatment, p. 213.)
- Are family members and others safe? (Is the child's or adolescent's behavior endangering siblings, parents, self, or community?)
- If the child or adolescent is exhibiting dangerous behaviors, interventions by primary care health professionals may include the following:

- Helping families institute containment measures. Options are
 - Referring the child or adolescent for immediate psychiatric evaluation and/or hospitalization as indicated (e.g, for suicidal, self-injurious, and/or uncontrollable aggressive behaviors)
 - Working with family to notify local police of criminal activity
 - Supporting family in petitioning the juvenile court for services
 - Assisting family to access services through protective service agencies, the juvenile justice system, and/or mental health agencies
- Helping families engage long-term supports, including
 - Case managers, probation officers
 - Court support for mental health, substance abuse treatment
 - School support for following through with legal consequences for truancy and for aggressive or illegal behaviors at school
- Helping the family maintain contact with mental health professionals and agency staff after initial referral is made. The primary care health professional can
 - Make frequent phone calls to receive updates on treatment
 - Collaborate on treatment planning (e.g., placement issues, ongoing provision of support for the family)
- Families of children or adolescents who engage in delinquent or dangerous activity should be supported early on in following through with



referral to community agencies, including, if appropriate, the juvenile justice system. Such support may help the family set limits and may improve compliance with treatment.

2. Parental symptoms and distress should be assessed, and parents should be referred for mental health services as indicated.
 - Parents with substance/alcohol abuse problems, mood disorders, and/or marital conflict should be referred for treatment.
 - Parents should be encouraged to seek outside support (e.g., from relatives, parent support groups, faith-based communities, mental health services) to cope with stress. Parents should understand that a child's or adolescent's aggressive/oppositional behaviors are unlikely to improve in the context of ongoing family and parental stress.
3. Provide guidance and work with the family to develop reasonable expectations for the child or

adolescent based on her abilities and developmental stage.

4. Parents should be educated about the negative effects of physical punishment.
 - Discuss with families that physical punishment is likely to increase aggression in their child or adolescent.
 - Ensure that families understand that physical punishment is ineffective in decreasing negative behaviors.
5. Work with families on developing and using supports to help monitor and closely supervise their child's or adolescent's activities:
 - Remind parents that they should know where their child or adolescent is, whom he is with, and what he is doing.
 - Help parents to anticipate times when their child or adolescent is likely to get into trouble (e.g., during school vacations, after school) and to plan appropriate activities and supervision at those times.
 - Encourage parents to strongly discourage and set limits on associating with peers who are not a positive influence, while facilitating opportunities for involvement with peers who are a positive influence.
 - Encourage the family's and child's or adolescent's investment in academic success.
6. Teaching parents effective behavioral techniques early on may help prevent or limit their child's or adolescent's developing more severe aggressive/

oppositional problems and disorders. Research suggests that ODD and CD are associated with risk factors in the early caregiving environment. Early intervention that focuses on the home environment, parenting strategies, and stressors within the family may help mitigate future manifestations of these disorders (Shaw et al., 2001). (See the following Tools for Families in the *Mental Health Tool Kit: Principles of Limit Setting*, p. 81; *Charting Positive Behavior*, p. 83; *Time Out*, p. 88.)

Encourage parents to

- Praise and positively reinforce any positive behaviors and compliance with requests.
 - Give clear, specific directions that match their child's or adolescent's ability to comprehend and follow through (e.g., a child or adolescent with ADHD may not be able to follow more than one direction at a time).
 - Develop behavioral plans (e.g., star charts, reward systems) with input from their child or adolescent. Such plans can clarify expectations and increase compliance.
 - Respond consistently to negative behaviors, and request that other caregivers respond consistently as well, with the focus on containing the behavior (e.g., with time outs). A response to a behavior should be an immediate and logical consequence of that behavior.
 - Give children or adolescents a chance to make amends (e.g., a child who breaks his brother's toy can be helped to fix it or to save money to pay for it; an adolescent who damages the family car can be helped to find ways of paying for the repairs).
- Develop reasonable consequences for misbehavior. Consequences should not be so severe that they are unenforceable or that the child or adolescent loses the incentive to comply in the future (e.g., an adolescent who breaks curfew once is grounded for a month or is forced to discontinue a favorite activity).
 - Consider parenting education programs and support groups.
7. Consider referral to family therapy:
 - To improve communication and ways of negotiating conflicts
 - To reduce scapegoating and blaming interactions
 - To reach agreements about limit setting
 8. Work with families on increasing the amount of enjoyable time they spend with their child or adolescent.
 - Discuss that parental time and involvement are more effective behavioral incentives for children and adolescents than material rewards.
 - Encourage parents to make use of opportunities to model social and empathy skills with their child or adolescent. For example, while watching TV or movies with their child or adolescent, parents can help him identify how characters may feel in a variety of situations. Parents can select and discuss programs that show children and adolescents dealing constructively with situations such as being teased by peers, controlling anger, and cooperating with others.

Child or Adolescent

1. Look for associated difficulties that may be contributing to problem behaviors or interfering with treatment:

- ADHD, learning and communication disorders (Beitchman et al., 2001)
- Depressive and bipolar disorders; anxiety disorders
- Substance abuse
- History of abuse, neglect, or trauma
- Paranoid or delusional thinking
- Organic conditions (e.g., temporal lobe epilepsy)

If evidence of any of these problems is present, consider a medical workup, referral to a mental health professional, and/or school assessment as indicated.

2. Assess the child or adolescent carefully for suicidal thoughts or suicidal impulses. If any of these are present, refer for mental health evaluation. For further information, see discussion of suicide in bridge topic: Mood Disorders: Depressive and Bipolar Disorders, p. 271.

3. Ask the child or adolescent about exposure to violence in his home, neighborhood, and school, and through the media. Take any steps needed to

- Maintain the child's or adolescent's safety and sense of security (e.g., suggest that an adult walk the child to and from school; discuss with the family removal of weapons from the home).
- Help prevent the child's or adolescent's learning violent behaviors (e.g., suggest to parents that they monitor and discuss what the child or adolescent watches on TV; plan with the

child or adolescent how to handle peer pressure to join gangs). (See the following Tools for Families in the *Mental Health Tool Kit*: Top TV Tips: Building a Balanced TV Diet, p. 107; Controlling the Video and Computer Game Playground, p. 109.)

- Increase the child's or adolescent's sense of control over her environment (e.g., by encouraging involvement in neighborhood crime-prevention groups or student community-service organizations).

4. Early mental health interventions for the child or adolescent can be particularly effective when coupled with parent training. Therapy for the child or adolescent may focus on

- Improving coping skills and problem-solving skills (e.g., talking instead of hitting; asking how a peer feels instead of assuming he is hostile). (See the following Tools for Families in the *Mental Health Tool Kit*: How to Handle Anger, p. 102; CALM: Listening Skills for Diffusing Anger, p. 135.)
- Helping the child or adolescent begin to identify and control uncomfortable feelings such as frustration and anger before they become problematic behaviors (e.g., recognizing that "I am angry" and taking a break from the frustrating activity).
- Challenging or correcting the child's or adolescent's automatic negative thoughts (e.g., thinking that "no one likes me" or that "everyone thinks I'm stupid").
- Helping the child or adolescent use self-talk to cope with difficult situations (e.g., "I'm OK, I just made a mistake").

Friends

1. Children and adolescents with aggressive/oppositional problems and disorders often lack the social skills that would allow them to make friends and have positive experiences with peers. Thus, any treatment plan should include interventions that help the child or adolescent develop these skills, enhance self-esteem, and lower the chance that she will associate with delinquent peers.

- Encourage the child or adolescent to join group activities (e.g., sports teams, clubs, volunteer organizations) with peers, who can serve as role models, and adults, who can provide nurturing structure and supervision.
- Consider making referrals to social skills training groups that can help develop a child's or adolescent's ability to read social cues and to cooperate with peers.

2. Children and adolescents with aggressive/oppositional problems, ODD, or CD benefit from treatment that addresses their entire social system.

This type of treatment requires highly integrated services to address factors in the family, community, and school (Henggeler et al., 1998).

School and Community

1. For young children at risk for future aggressive/oppositional problems and disorders, early intervention and Head Start programs may prevent school failure and reduce rates of later delinquency (Berrueta-Clement Jr., 1984).

2. Children and adolescents should be carefully assessed and treated for associated problems, such as learning disorders or ADHD, that may be affecting school performance.

3. Parents should be encouraged to maintain communication and collaboration with school staff on their child's or adolescent's school performance, behavior plans, and ways of enhancing their child's or adolescent's self-esteem. Children and adolescents with ODD or CD may be eligible for special education services under the disability category of "emotional disturbance." Ensure that parents know that their child or adolescent may also qualify for services under Section 504 of the Rehabilitation Act. Some parents may appreciate assistance from the primary care health professional in contacting the school.

For further information about eligibility and services, families can consult the school's special education coordinator, the local school district, the state department of education's special education division, the U.S. Department of Education's Office of Special Education Programs (<http://www.ed.gov/offices/OSERS/OSEP>), the Individuals with Disabilities Education Act (IDEA) '97 Web site (<http://www.ed.gov/offices/OSERS/IDEA>), or the U.S. Justice Department's Civil Rights Division (<http://www.usdoj.gov/crt/edo>).

- Evaluate the child's or adolescent's academic and vocational strengths, and suggest to parents that they encourage their child or adolescent to pursue activities that take advantage of these strengths (e.g., an adolescent with mechanical aptitude may do best in a vocationally oriented high school).
- Determine the level of services that the child or adolescent needs. Ask whether the child or adolescent has received cognitive or achievement testing.



- Determine whether the child or adolescent is receiving appropriate services for cognitive or learning disabilities and whether his Individualized Educational Program (IEP) needs to be reviewed. (See Tool for Families: Individualized Education Program [IEP] Meeting Checklist, *Mental Health Tool Kit*, p. 120.)
- Find out what resources the child or adolescent needs at school (e.g., school counselor, resource room, classroom aides).
- Help parents work with teachers to discuss using a consistent behavioral program at home and at school (e.g., same time-out structure when the child is aggressive with peers, consistent praise when the child or adolescent cooperates with others or follows directions).

- Suggest that parents discuss with teachers ways of structuring the classroom to help the child or adolescent maintain positive behaviors (e.g., seating the child or adolescent next to a well-behaved peer, checking in with the child or adolescent frequently during less-structured periods).
 - Suggest that parents use school-related activities to enhance the child's or adolescent's self-esteem (e.g., they can encourage the child or adolescent to pursue talents in arts or sports, to join school clubs, etc.).
4. Encourage the child's or adolescent's involvement in school and community activities (e.g., teams, clubs, faith-based activities). Children and adolescents who feel connected to positive family, school, and community activities are less likely to be violent (Sampson et al., 1997, 1999).

Resources for Families

Greydanus DE, ed. 1991. *The American Academy of Pediatrics: Caring for Your Adolescent—Ages 12 to 21*. New York, NY: Bantam Books. Web site: <http://www.aap.org>.

National Council on Crime and Delinquency
1970 Broadway, Suite 500
Oakland, CA 94612
Phone: (510) 208-0500
Web site: <http://www.nccd-crc.org>

The National Council on Crime and Delinquency provides information on community delinquency programs.

National Youth Violence Prevention Resource Center
Phone: (866) 723-3968
Web site: <http://www.safeyouth.org>

The National Youth Violence Prevention Resource Center is sponsored by the White House Council on Youth Violence. The center's Web site offers annotated links for professionals, parents, and adolescents as a portal of information on youth violence prevention and suicide.

Prevention Research Center, Johns Hopkins University School of Hygiene and Public Health. *The Good Behavior Game and Mastery Learning*. Baltimore, MD: Prevention Research Center, Johns Hopkins University School of Hygiene and Public Health. (These innovative games can be used to help children cope with aggressive impulses and to enhance self-esteem. Manuals for these games are available online at <http://www.bpp.jhu.edu/publish/manuals/index.htm>.)

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