

**Please note: This guidance is based on the work of the World Health Organization ([www.who.int](http://www.who.int)) and may be updated annually. Check “Feedback & Updates” periodically.**

Disruptive and aggressive behaviors are common among children from toddlerhood through adolescence. They may be transient, influenced by temperament and environmental factors, or they may be persistent, rising to the level of oppositional-defiant disorder (ODD) or conduct disorder (CD) and causing significant impairment in the child’s and family’s functioning. ODD affects 1% to 16% of children, depending on the population studied; CD affects 1.5% to 3.4%. Male-female ratio varies with age and diagnosis from 3.2:1 to 5:1.<sup>1</sup> Many children progress from ODD to CD. They can be extremely challenging to manage and, if untreated, experience an increased risk of school failure, underemployment, difficulty with legal authorities, substance abuse, and antisocial personality disorder; furthermore, those with CD may be dangerous to themselves and others and, in some instances, require emergent treatment. All children manifesting disruptive or aggressive behaviors require intervention, education and support of parents and teachers, and careful monitoring.

### Screening Results Suggesting Disruptive Behavior or Aggression

**Pediatric Symptom Checklist (PSC)-35:** Total score  $\geq 24$  for children 5 years and younger;  $\geq 28$  for those 6 to 16 years; and  $\geq 30$  for those 17 years and older AND further discussion of items related to disruptive behavior and aggression confirms a concern in that area.

**PSC-17:** Externalizing subscale is  $\geq 7$  AND further discussion of items related to disruptive behavior and aggression confirms a concern in that area.

**Strengths and Difficulties Questionnaire (SDQ):** Total symptom score of  $> 19$ ; conduct problem score of 5 to 10 (see instructions at [www.sdqinfo.com/ScoreSheets/e2.pdf](http://www.sdqinfo.com/ScoreSheets/e2.pdf)); impact scale (back of form) score  $\geq 2$  indicates some degree of impairment; AND further discussion of items related to disruptive behavior and aggression confirms a concern in that area.

### Symptoms and Clinical Findings Suggesting Disruptive Behavior or Aggression

- In younger children, marked tantrums, defiance, fighting, and bullying.
- In older children and adolescents, serious law breaking such as stealing, damage to property, or assault.
- Repetitive, persistent, excessive aggression or defiance; behaviors out of keeping with the child’s development level, norms of peer group behavior, and cultural context indicating a disorder rather than a phase or transitional disruption.
- Aggression may be impulsive and associated with intense emotional states, or it may be predatory and premeditated. It is important to distinguish which pattern of aggression the child is showing.
- Behaviors characteristic of ODD: angry outbursts, loss of temper, refusal to obey commands and rules, destructiveness, hitting, and intentional annoyance of others, but without the presence of serious lawbreaking. Symptoms can be confined only to school, home, or the community.
- Behaviors characteristic of CD: vandalism, cruelty to people and animals (including sexual and physical violence), bullying, lying, stealing, truancy, drug and alcohol misuse, and criminal acts, plus all the features of ODD.

### Conditions That May Mimic or Co-occur With Disruptive Behavior and Aggression

#### Differentiate From Normal Behavior

All children are defiant at times and it is a normal part of adolescence to do the opposite of what one is told; a problem or disorder may be present if the behaviors interfere with family life, school, or peer relationships, or put the child or others in danger.

*Attention-deficit/hyperactivity disorder (ADHD).* This is a common comorbidity. Association of ODD and ADHD confers a poorer prognosis, and children tend to be more aggressive, have more behavior problems that are more persistent, suffer peer rejection at higher levels, and have more significant academic underachievement. See Inattention and Impulsivity guidance.

*Sleep deprivation.* Sleep problems can cause irritability and contribute to outbursts of anger and poor impulse control.

*Learning problems or disabilities.* Unidentified learning difficulties can contribute to frustration and oppositionality. If disruptive or aggressive behavior is associated with problems of school performance, the child may have a learning disability. See Learning Difficulties guidance to explore this possibility.

*Developmental problems.* Children with overall intellectual or social limitations may experience frustration and poor impulse control.

*Exposure to adverse childhood experiences (ACE).* Children who have experienced or witnessed trauma, violence, a natural disaster, separation from a parent, parental divorce or separation, parental substance use, neglect, or physical, emotional, or sexual abuse are at high risk of developing emotional difficulties such as adjustment disorder or post-traumatic stress disorder (PTSD) and may manifest outbursts of disruptive or aggressive behavior; this possibility should always be borne in mind because PTSD requires specific trauma-focused interventions. The clinician should tactfully explore the possibility that harsh physical or emotional punishment is related to the child's behavior problem, or that tensions might escalate to that point. Denial of trauma symptoms does not mean trauma did not occur; questions about ACE should be repeated as a trusting relationship is established. See Anxiety guidance.

*Bereavement.* The vast majority of children will experience the death of a family member or friend sometime in their childhood. Other losses may also trigger grief responses—separation or divorce of parents, relocation, change of school, deployment of a parent in military service, breakup with a girlfriend or boyfriend, or remarriage of parent. Such losses are traumatic. They may result in feelings of sadness, despair, insecurity, anger, or anxiety immediately following

the loss and in some instances, more persistent anxiety or mood problems, including PTSD or depression. In some children, such losses trigger aggressive or disruptive behavior. See also Depression guidance and the discussion of PTSD in Anxiety guidance.

*Anxiety.* Many children with disruptive or aggressive behaviors have anxiety. When faced with demands that make them anxious, they use oppositional behavior to manage their anxiety or avoid the expectations that triggered their anxiety. See Anxiety guidance.

*Depression or bipolar disorder.* Marked sleep disturbance, disturbed appetite, irritability, low mood, or tearfulness could indicate that a child is depressed. Symptoms of depression rapidly alternating with cycles of agitation may suggest bipolar mood disorder. Common symptoms of pediatric bipolar disorder include explosive or destructive tantrums, dangerous or hypersexual behavior, aggression, irritability, bossiness with adults, driven creativity (sometimes depicting graphic violence), excessive talking, separation anxiety, chronic depression, sleep disturbance, delusions, hallucinations, psychosis, and talk of homicide or suicide.<sup>2</sup>

*Substance use.* All children exhibiting disruptive or aggressive behavior should be screened for substance use and abuse because drug effects, or withdrawal from drugs, may cause irritability and reduced self-control.

*Autism spectrum disorders.* Children with this developmental pattern also have problems with social relatedness (eg, poor eye contact, preference for solitary activities), language (often stilted), and range of interest (persistent and intense interest in a particular activity or subject). They often will have very rigid expectations for routine or parent promises and become anxious or angry if these expectations are not met.

## **Tools for Further Assessment of Disruptive Behavior and Aggression**

**Vanderbilt ADHD Rating Scale** (teacher and parent scales): This tool has been developed for children 6 to 12 years of age.

**Modified Overt Aggression Scale (MOAS):** This tool was developed for adults but has been used with adolescents.

## **Evidence-Based and Evidence-Informed Interventions for Disruptive Behavior and Aggression (as of April 2010)**

Updates are available at [www.aap.org/mentalhealth](http://www.aap.org/mentalhealth).

### **Psychosocial Interventions for Disruptive Behavior<sup>3</sup>**

- **Level 1 (best support):** assertiveness training, cognitive behavior therapy (CBT), multisystemic therapy, parent management training, problem solving, social skills
- **Level 2 (good support):** anger control, communication skills, contingency management, functional family therapy, parent management training and classroom contingency management, problem solving, rational emotive therapy, relaxation, therapeutic foster care, transactional analysis

### **Psychopharmacologic Interventions**

The US Food and Drug Administration (FDA) has no approved indications for aggression in children and adolescents, apart from irritability-associated aggression in children with autism. In other populations, recent federally supported evidence-based reviews suggest efficacy for some psychotherapeutic agents, but primary care clinicians are urged to consult with mental health specialists before prescribing medications for aggression.<sup>4-5</sup>

### **Selected Informational Links**

- American Academy of Pediatrics Children's Mental Health in Primary Care Web site ([www.aap.org/mentalhealth](http://www.aap.org/mentalhealth))
- American Academy of Child & Adolescent Psychiatry ([www.aacap.org](http://www.aacap.org))
- US FDA Web site ([www.fda.gov](http://www.fda.gov))

## Plan of Care for Children With Disruptive Behavior or Aggression

### Engage child and family in care.

#### Engaging Children and Families in Mental Health Care: A Process for Pediatric Primary Care Clinicians\*

Reinforce strengths of child and family. Follow the mnemonic HELP to

- Build trust and optimism.
- Reach agreement on incremental next steps and, ultimately, therapeutic goals.
- Develop plan of care (see the following clinical guidance).
- Collaboratively determine role of primary care clinician, eg, provide intervention(s); provide initial intervention while awaiting family's readiness for or access to specialty care; coordinate with specialist(s), child care, school, or agencies; monitor progress; encourage child and family's positive view of treatment.

*\*Without engagement, most families will not seek or persist in care. Process may require multiple primary care visits.*

### Encourage healthy habits.

Encourage exercise, outdoor play, balanced and consistent diet, sleep (critically important to mental health), avoidance of exposure to frightening or violent media, positive and consistent (not punitive) experiences with parents (see the following), praise for good behavior, and reinforcement of strengths.

### Reduce stress: consider the environment

(eg, family social history, parental depression screening, results of any family assessment tools administered, reports from child care or school).

*Is stress on the parent(s) leading to parental irritability or low mood, drinking, or greater demands for the child to behave? Are there ways for parents to get more support for themselves? Explore parent's readiness to seek and accept help.*

*Do inconsistencies or differing beliefs about parenting among caregivers (eg, parents, grandparents) undermine*

*attempts to create rules, limits, or consequences? Can caregivers agree on priority behavioral problems and how to address them? Explore conflicts; seek agreement on common beliefs and achievable steps to help the child.*

If problems are mainly or exclusively at school, parents should request that the school assess the child for special educational needs and develop a plan to monitor behavior while at school; primary care clinicians can often provide support in these situations by communicating to the school the degree to which the parents are actively engaged in finding help for their child's problems.

Acknowledge and reinforce protective factors, eg, good relationships with at least one parent or important adult, pro-social peers, concerned or caring family, help-seeking, connection to positive organization(s).

### Offer initial intervention(s).

#### Promote daily positive joint activities between parents and child or teen.

- Reinforce compliant, pro-social behavior using parental attention ("Catch 'em being good" [Ed Christopherson]).
- Encourage praise and rewards for specific, agreed, and desired (target) behaviors. If appropriate, monitor with a chart. Negotiate rewards with the child. Change target behaviors every 2 to 6 weeks; change rewards more frequently. The choice of target behaviors and the time intervals for rewards should be developmentally appropriate.
- Some minor unwanted behaviors can be ignored and will then stop; others could increase if they are ignored. Pick battles and focus discipline on priority areas.

### Encourage parents to focus on prevention in the following ways:

- Reduce positive reinforcement of disruptive behavior.
- When possible, reorganize the child's day to prevent trouble by avoiding situations in which the child cannot control himself or herself. Examples include asking a neighbor to look after the child while the parent goes shopping, ensuring that activities are available for long car journeys, and arranging activities in separate rooms for siblings who are prone to fight.

- Monitor the whereabouts of adolescents. Telephone the parents of friends whom they say they are visiting. See if there are ways to limit contact with friends who have behavior problems and promote contact with friends who are a positive influence.
- Talk to the school and suggest similar principles are applied. Request the school evaluate the child for learning problems if you suspect this is a possibility because the frustration experienced by the child with a learning problem may be intolerable for him or her.

**Encourage parents to be calm and consistent. Suggest that parents**

- Set clear house rules and give short, specific commands about the desired behavior, not prohibitions about undesired behavior (eg, “Please walk slowly,” rather than “Don’t run”).
- Provide consistent and calm consequences for misbehavior. Consequences should not be drastic or, in the case of young children, go on for so long that the child is likely to forget what he or she originally did wrong.
- Find a way for children to make reparation for a negative behavior (eg, doing something nice for a sibling they have struck, cleaning up a mess they made while in a tantrum).
- When enforcing a rule, avoid getting into arguments or explanations because this merely provides additional attention for the misbehavior; defer negotiations until periods of calm.
- Consider parenting classes.
- See also suggestions in Inattention and Impulsivity guidance.

**Create a safety and emergency plan.**

- Care plan developed jointly with family should include listing of telephone numbers to call in the event that the child’s behavior causes a threat to his or her own safety or the safety of others.
- Instruct family to proactively remove weapons from the home.
- Instruct family to monitor for situations that trigger outbursts.

- Provide number for hotline, on-call telephone number for the practice, or area mental health crisis response team contact information according to community protocol.

**Offer child and parents resources to educate and assist them with self-management.**

**Brochures**

*Your Child’s Mental Health: When to Seek Help and Where to Get Help*

*How to Handle Anger*

*Parent’s Role in Teaching Respect*

**Web Sites**

The Incredible Years ([www.incredibleyears.com](http://www.incredibleyears.com)). Accessed April 29, 2010

HealthyChildren.org Web site ([www.healthychildren.org](http://www.healthychildren.org)). Accessed April 29, 2010

**Monitor child’s progress toward therapeutic goals.**

- See report “Enhancing Pediatric Mental Health Care: Strategies for Preparing a Primary Care Practice” for monitoring methods.
- Child care, preschool, or school reports can be helpful in monitoring progress.
- SDQ (parent, teacher) and PSC can be helpful in monitoring progress with symptoms and functioning.
- Provide contact numbers and resources in case of emergency (see “Create a safety and emergency plan”).

**Involve specialist(s) if child does not respond to initial interventions or if indicated by the following clinical circumstances:**

- Child is younger than 5 years.
- Child’s problems do not respond to primary care intervention.
- Family is not able to maintain calm, consistent, or safe environment.
- Child’s behaviors are injurious to other children or animals.
- Child has comorbid depression.
- Child is experiencing severe dysfunction in any domain.



- Child has comorbid anxiety. (The combination of shyness, anxiety, and behavior problems is thought to be particularly risky for future behavior problems of a more serious nature.)
- Problems at school are interfering with academic achievement or relationships.
- Child or adolescent is involved with legal authorities. (This situation requires coordination with probation officers and understanding the terms of probation; simply reminding the adolescent and family of the consequences of violating probation can help promote participation in treatment or changes to lifestyle.)

√ **Primary care tasks may include the following:**

- Monitoring response to treatment through use of parent and teacher reports and communication with referral sources or agencies involved in care
- Engaging and encouraging child’s positive view of treatment
- Coordinating care provided by parents, school, medical home, and specialists
- Observing for comorbidities

**Resources for Clinicians**

**Toolkits**

Jellinek M, Patel BP, Froehle MC. Oppositional and aggressive behaviors. In: *Bright Futures in Practice. Mental Health, Volume 1. Practice Guide*. Arlington, VA: National Center for Education in Maternal and Child Health; 2002:291–302

Jellinek M, Patel BP, Froehle MC. Problem solving strategy. In: *Bright Futures in Practice. Mental Health, Volume II. Tool Kit*. Arlington, VA: National Center for Education in Maternal and Child Health; 2002:106

**Web Sites**

Child Welfare Information Gateway. *Parent-Child Interaction Therapy With At-Risk Families*. Washington, DC: US Department of Health and Human Services. 2007. Available at: [http://www.childwelfare.gov/pubs/f\\_interactbulletin/f\\_interactbulleting.pdf](http://www.childwelfare.gov/pubs/f_interactbulletin/f_interactbulleting.pdf). Accessed April 29, 2010

Functional Family Therapy. Available at: <http://www.fffinc.com>. Accessed April 29, 2010

Multisystemic Therapy (MST). Available at: <http://www.mstservices.com>. Accessed April 29, 2010

National Center for Mental Health Promotion and Youth Violence Prevention. Aggression replacement training. Available at: <http://www.promoteprevent.org/Publications/EBI-factsheets/aggression-replacement-training.pdf>. Accessed April 29, 2010

Substance Abuse & Mental Health Services Administration (SAMHSA). Available at: <http://www.samhsa.gov>. Accessed February 24, 2010

SAMHSA is a public health agency within the Department of Health and Human Services. SAMHSA is responsible for improving accountability, capacity, and effectiveness of the nation’s substance abuse prevention, addictions treatment, and mental health delivery system.

University of Florida College of Public Health and Health Professions. Parent-Child Interaction Therapy. Available at: <http://pcit.phhp.ufl.edu>. Accessed April 29, 2010

World Health Organization Web site. Available at: <http://www.who.int/en>. Accessed February 24, 2010

## Articles and Reports

American Academy of Child & Adolescent Psychiatry Practice Parameters available at: [www.aacap.org/cs/root/member\\_information/practice\\_information/practice\\_parameters/practice\\_parameters](http://www.aacap.org/cs/root/member_information/practice_information/practice_parameters/practice_parameters).

- Conduct Disorders (Vol 36, October 1997 Supplement)

Brown RT, Antonuccio DO, DuPaul GJ, et al. *Childhood Mental Health Disorders: Evidence Base and Contextual Factors for Psychosocial, Psychopharmacological, and Combined Interventions*. Washington, DC: American Psychological Association; 2008

Hawaii Department of Health, Child and Adolescent Mental Health Division, Evidence Based Services Committee. 2004 Biennial Report: Summary of Effective Interventions for Youth with Behavioral and Emotional Needs. Available at: <http://hawaii.gov/health/mental-health/camhd/library/pdf/ebs/ebs011.pdf>. Accessed February 24, 2010

Hawaii Department of Health, Child and Adolescent Mental Health Division, Evidence Based Services Committee. 2007 Biennial Report: Effective Psychosocial Interventions for Youth with Behavioral and Emotional Needs. Available at: <http://hawaii.gov/health/mental-health/camhd/library/pdf/ebs/ebs012.pdf>. Accessed February 24, 2010

Special issue: evidence-based psychosocial treatments for children and adolescents: a ten year update. *J Clin Child Adolesc Psychol*. 2008;37(1)

- Eyberg SM, Nelson MM, Boggs SR. Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. *J Clin Child Adolesc Psychol*. 2008;37(1):215–237
- Huey SJ, Polo AJ. Evidence-based psychosocial treatments for ethnic minority youth. *J Clin Child Adolesc Psychol*. 2008;37(1):262–301

## References

1. Loeber R, Burke JD, Lahey BB, Winters A, Zera M. Oppositional defiant and conduct disorder: a review of the past 10 years, part I. *J Am Acad Child Adolesc Psychiatry*. 2000;39(12):1468–1484
2. Child & Adolescent Bipolar Foundation. About pediatric bipolar disorder: a guide for families. Available at: [http://www.bpkids.org/site/PageServer?pagename=lrn\\_about](http://www.bpkids.org/site/PageServer?pagename=lrn_about). Accessed February 24, 2010
3. Evidence-Based Child and Adolescent Psychosocial Interventions. American Academy of Pediatrics Children's Mental Health in Primary Care Web site. Available at: <http://www.aap.org/mentalhealth>. Accessed April 28, 2010
4. Knapp P, Chait A, Pappadopulos E, Crystal S, Jensen PS; T-MAY Steering Group. Treatment of Maladaptive Aggression in Youth (T-MAY). CERT guidelines I. Family engagement, assessment and diagnosis, and initial management. *Pediatrics*. In press
5. Scotto Rosato N, Correll CU, Pappadopulos E, et al. Treatment of Maladaptive Aggression in Youth (T-MAY). CERT guidelines II. Psychosocial interventions, medication treatments, and side effects management. *Pediatrics*. In press

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