Child Study Center Letter

Volume 10 • Number 3

March/April 2006

NEW YORK UNIVERSITY CHILD STUDY CENTER

• clinical care • advanced training • scientific research • educational outreach • prevention •

Editors' Comment

What is meant by disruptive behavior? When does normal behavior turn into problem behavior? Many problem behaviors are seen from time to time in most children and are not of great concern. As children develop, however, we expect different levels of self-control. When the frequency of misbehavior persists, causes distress and interferes with a child's daily functioning at home, with peers, and in school, consultation is warranted. Because behavioral problems impact other people in a child's life -- parents, peers, and schools -- they account for most referrals to mental health professionals. Accurate diagnosis is essential to evaluate the child's behavior in the context of factors such as the child's temperament, developmental capabilities, family environment, and other social issues. The diagnosis serves as the basis of an individual treatment plan and determines if the behavioral problems are accompanied by other disorders such as ADHD, anxiety, or depression.

In this issue of the NYU Child Study Center Letter we describe the symptoms and criteria necessary to diagnose Oppositional Defiant Disorder and Conduct Order, the developmental course of each disorder, and the areas in which their manifestations differ and overlap. In terms of causation, the complex interactions of biological, behavioral, familial, and social implications for treatment are discussed. Possible interventions for children and their families as well as programs for schools are included.

HSK/AG

Disruptive Behavior Disorders in Children and Adolescents

Introduction

Sally, 9, screams at her sister and is sassy to her parents

Steve, 6, has tantrums when he's frustrated and throws his toys

Molly, 5, always has her own agenda and resists following the directions of adults

Ariel, 13, steals DVDs and then lies about it

Jordan, 14, tore down his neighbor's basketball hoop in a rage when he lost a game

John, 11, doesn't complete his homework and rips up his sister's workbook

Olivia, 15, stopped going to school and ran away from home

Is something going wrong with these kids? How can we help them? Not all problem behaviors are equally serious. A child who is sassy and talks back is quite different from a child who runs away from home. When parents become concerned and seek help for their child's behavior, their complaints are quite varied, ranging from mild to serious. Some common concerns are: yells, whines, complains, defies, teases, sasses or talks back, screams, tantrums, argues, humiliates, annoys, ignores requests, fails to complete homework or routine chores, disrupts others' activities, ignores self-help tasks, throws objects, swears, steals, lies, runs away, physically resists, destroys property, physically fights with others. Obviously, such behaviors can interfere with a child's functioning at home, in school, and with peers. Although the disruptive behaviors on this list cover a wide range, they differ in level of seriousness and need for intervention. When parents consult a mental health professional, they may be told the child has Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD) (in accordance with the Diagnostic and Statistical Manual of Mental Disorders [DSM-IV] which helps to define the behavior problems of children and adolescents.) Although ODD and CD are both disruptive behavioral disorders, they differ in the nature, severity, and course of the symptoms. This article will discuss each disorder individually and will also consider the similarities and differences between them.

Defining Oppositional Defiant Disorder (ODD)

The child with ODD repeats a pattern of negativistic behaviors which include frequent arguing, defying rules and requests, opposing authority figures, temper tantrums and other characteristics such as intentionally annoying others, being easily annoyed or

SCHOOL OF MEDICINE

NEW YORK UNIVERSITY

Kenneth G. Langone
Chairman, Foundation Board of Trustees

Robert M. Glickman, M.D.
Dean
NYU School of Medicine

Editorial Board

Harold S. Koplewicz, M.D., Founding Editor
Arnold and Debbie Simon Professor of Child and Adolescent Psychiatry
Director of the Child Study Center
New York University School of Medicine

Anita Gurian, Ph.D., Editor
Senior Content Editor, AboutOurKids.org
Clinical Assistant Professor
New York University School of Medicine

Howard Abikoff, Ph.D.
Pevaroff-Cohn Professor of Psychiatry
Director, Institute for ADHD and Behavior Disorders
Child Study Center
New York University School of Medicine

Laurie Miller Brotman, Ph.D.
Corzine Family Associate Professor of Child and Adolescent Psychiatry
Director, Institute for Prevention Science

Gabrielle A. Carlson, M.D.
Professor of Psychiatry and Pediatrics
New York State University at Stony Brook

F. Xavier Castellanos, M.D.
Brooke and Daniel Neidich Professor of Child and Adolescent Psychiatry
Director of Research
Director, Institute for Pediatric Neuroscience
Professor of Radiology

Stella Chess, M.D.
Professor of Child Psychiatry
New York University School of Medicine

Glenn S. Hirsch, M.D.
Assistant Professor of Clinical Psychiatry
Medical Director, Division of Child and Adolescent Psychiatry
New York University School of Medicine

Rachel Klein, Ph.D.
Professor of Psychiatry
New York University School of Medicine

Maria Kovacs, Ph.D.
Professor of Psychiatry
University of Pittsburgh School of Medicine

Jess Shatkin, M.D., M.P.H.
Assistant Professor of Psychiatry
Director, Education and Training

resentful, and blaming others for one's mistakes. In general, ODD behaviors **do not** seriously violate rights of others or age-appropriate societal norms. In general, they **do not** involve aggressive behavior towards people or animals, destruction of property, stealing, or deceiving others.

DSM-IV Criteria for ODD

• A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:

- often loses temper
- often argues with adults
- often actively defies or refuses to comply with adults' requests or rules
- often deliberately annoys people
- often blames others for his or her mistakes or misbehavior
- is often touchy or easily annoyed by others
- is often angry and resentful
- is often spiteful or vindictive

• Behaviors need to occur more frequently than is typically observed in individuals of same age and developmental level.

• The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

• The behaviors do not occur exclusively during the course of a psychotic or mood disorder.

• Criteria are not met for conduct disorder or antisocial personality disorder.

Defining Conduct Disorder (CD)

The child with CD does not respect authority, has little regard for the rights of others, and breaks major societal rules; he/she demonstrates aggressive conduct that threatens physical harm or property damage, deceitfulness, theft, truancy, or running away from home; often vengeful and irascible and has a "chip on his shoulder."

DSM-IV Criteria for Conduct Disorder

• Aggression towards people and animals (e.g., bullies, stealing with confrontation)

• Destruction of property (e.g., fire setting, vandalism)

• Deceitfulness or theft (e.g., "cons" others, breaking and entering)

• Serious violations of rules (e.g., stays out all night, truancy)

Time Table

When problem behaviors emerge[1]

The age at which problems may first be observed is affected by a number of factors including the child's temperament, developmental capabilities, the opportunities for behaviors to be manifested, family factors, and broader social factors, such as poverty and access to intervention.

The following table shows the average age of onset of different symptoms, with ODD symptoms tending to emerge earlier than CD symptoms. It is important to note that CD symptoms that begin earlier in childhood (before age 12) tend to be more chronic and problematic than CD that develops in adolescence, which often improves in adulthood. In contrast with ODD, CD involves some combination of aggression towards people or animals, destruction of property, deceitfulness, and serious violation of rules.

Average emergence of some ODD symptoms

Age 3 - child acts stubborn

Age 5 - defies adults, has temper tantrums

Age 6 - irritable, argumentative, blames others

Age 7 - annoys others, is spiteful and angry

Average emergence of some CD symptoms

Age 8 - lies, fights

Age 9 - bullies, sets fires, uses weapon

Age 10 - vandalizes

Age 11 - engages in physical cruelty

Age 12 - steals, runs away from home, truants, breaks and enters

Age 13 - forced sexual activity

ODD and CD -- how they overlap

Behaviors of children with ODD and CD may overlap, though there are distinctions to be made between different types of problematic behaviors. Behaviors can be broken down into those that

1) are clearly seen by and affect others (**overt**) versus those that occur behind the scenes (**covert**) and

2) involve aggression or destruction of property (**destructive versus non-destructive**). There are major differences between behavior problems that involve fighting with others (**overt and destructive**), being argumentative and defying rules (**overt and non-destructive**), vandalism (**covert and destructive**), and cutting school (**covert and nondestructive**). Children may show some combination of these difficulties, though not necessarily all of them, and other factors, such as learning disabilities or personality differences, may contribute to very different presentations among children and adolescents who may fall under the same diagnostic category.[2]

Although ODD and CD represent very different types of behavior problems, follow-up statistics reflect the overlap between them. About 25% of children diagnosed with ODD will later exhibit behaviors associated with CD. At least 80% of adolescents showing symptoms of CD have a prior history of ODD. Thus, while most children with CD include a significant history and presentation of oppositional and defiant features, far fewer children with ODD will develop the more severe symptoms of CD. ODD occurs for 2% to 16% of children, while CD occurs for 6% to 16% of males and 2% to 9% of females.

ODD and CD can also co-occur with other childhood disorders.[3] Both CD and ODD often co-occur with Attention Deficit Hyperactivity Disorder. There are certain characteristics of ADHD, such as impulsivity and hyperactivity, that may put children at risk for developing the types of behavior problems associated with ODD and CD, though most children diagnosed with ADHD do not exhibit ODD or CD. Depression may occur in about a quarter of ODD children while up to 75% of CD adolescents exhibit symptoms of depression. Anxiety is more likely to be experienced by girls with disruptive behavior disorders than with boys. Adolescents with disruptive behavior disorders are 6% to 10% more likely to engage in tobacco, alcohol, and drug use.

Causes of ODD and CD

Both are believed to be an interaction of nature and nurture, including

- **Biological factors** such as genetic makeup and constitutional factors
- **Behavioral factors** such as:
  - child temperament -- some infants are harder to soothe, more active, more irritable, impulsive, less flexible in adapting to new situations, a disposition which tends to be typical of them as they grow
  - sensation seeking -- some children are drawn more to excitement
  - learning deficits and academic underachievement -- may contribute to frustration, anger, and acting out
  - immaturities in moral reasoning -- difficulty in reflecting on the consequences of one's actions and taking the perspective of another person
  - maladaptive peer relationships
  - association with a delinquent peer group
  - poor interpersonal problem-solving skills
- **Familial factors**
  - parental conflict and/or divorce; single parent
  - failure to supervise child properly
  - harsh or inconsistent discipline
  - ineffective communication
  - failure to become involved in child's activities
  - less attention to prosocial behaviors
  - use of physical aggression

A vicious cycle may occur in which the parent feels guilty, incompetent, inadequate, embarrassed, angry, despairing; child is less responsive to reinforcement, punishment, or modeling; as a result, the family shares fewer activities, avoids social contacts, and may become isolated.

- **Social environment** -- poverty, poor neighborhood influences

These factors, individually or in combination, contribute to the development of behavior problems and can also affect each other. For example, inconsistent disciplining can contribute to defiant behavior, just as chronically defiant behavior can lead parents to feel helpless and change their approach to parenting.

Reaching a Diagnosis and Treatment Plan

A psychiatric and/or psychological evaluation may be recommended. Evaluations generally include taking a careful history and review of records, such as prior psychological reports, school records, report cards. Questionnaire data may be obtained from parents and teachers to help compare the child or adolescent's current functioning with that of typically developing children of the same age. Observation and collateral interviews with teachers, caregivers, tutors may also be conducted. If necessary, psychological or neuropsychological testing can help to determine if there are cognitive deficits and/or learning disabilities that may contribute to the individual's difficulties. Most of these tests are standardized, which means that the child will be compared to large groups of children of the same age. Typical questions asked during a structured clinical interview are:[4]

About the child: what are the primary concerns, when do they occur, what are the antecedents and consequences, who is involved, what is child's temperament, self-care skills, relationships with peers and siblings, school behavior and performance, response to discipline, to parent's requests, to social attention, what motivates the child to change behavior

About the parents: is child's behavior associated with parent substance/alcohol use, are parents' expectations reasonable, parents' feeling about and communication with child

About discipline: methods used, what's effective and for how long, reaction of parents and siblings when child is disciplined, how are siblings disciplined

Treatment Modalities -- for children and families

The most well documented interventions are for problems associated with ODD in young children, such as Parent-Child Interaction Therapy,[5] which is a behaviorally based intervention that aims to teach parents ways of positively reinforcing their child's behavior, while also providing them with skills. Parents then practice with their children while being coached by the therapist until a level of mastery is reached. Typically, interventions involve the parents and/or family, and not the child individually.[6] Interventions generally include teaching parents skills for increasing pro-social behaviors, using effective punishments, establishing clear house rules, and increasing collaborative problem solving between parents and their children.

Interventions for adolescents with ODD and CD may involve similar approaches, though modified so that they are more appropriate for the adolescent's age and developmental level. Given the wide range of possible severity of behavior problems, approaches will vary significantly. For example, a generally oppositional adolescent who frequently defies requests from authority will be treated quite differently than an adolescent who engages in truancy, stealing, and physical fighting.

Interventions need to consider ways of increasing family unity, communication, and collaborative problem solving, while decreasing maladaptive patterns of interactions that develop over time. Many of the approaches outlined here can help, even with some severe cases, although there is no cure-all and some adolescents are extremely resistant to change. Some severe cases require inpatient hospitalization when someone is a danger to themselves or others, or a more extended residential therapeutic placement, particularly when there are multiple issues involved, such as chronic truancy, legal problems, and/or drug and alcohol abuse. Treatment with psychiatric medications depends on the overall symptoms picture, severity of difficulties, and any co-occurring disorders. In some cases, children and adolescents may be prescribed one or more medications to help reduce aggression, impulsivity, chronic anger and irritability, or other symptoms that may contribute to their difficulties.

Treatment Modalites -- for schools

Functional Behavior Analysis (FBA),[7] has been shown to be effective for identifying behavior function and for developing effective interventions in schools. FBA aims to **1)** define behavior in specific, objective and measurable terms, **2)** determine those aspects of the environment or situation that elicit the behavior, and **3)** identify what consequences maintain the behavior. Steps in the FBA process:

1) Describe the behavior. Example: J runs out of classroom.

2) Purpose of behavior. Ex: gain attention, relief, or escape.

3) Identify what predicts the behavior. Ex: Having to turn in homework.

4) Identify what maintains the behavior. Ex: Gets excused from next assignment.

5) Develop a working hypothesis. Ex: Wants to avoid revealing math deficiency.

6) Develop a working plan. Ex: Obtain appropriate academic help and positive class recognition.

7) Monitor the plan.

The goals of a positive support plan are to make the problem behavior less

- **Relevant --** change what happens before so the behavior is no longer needed
- **Effective --** change what happens after so it no longer has the same payoff
- **Efficient --** replace with an acceptable behavior and the child's need is satisfied

Referral to a mental health professional familiar with disruptive behavior disorders is the best first step towards helping parents and children understand the nature of behavioral difficulties and what options for help are available.

References

1. Lahey, B.B. & Loeber, R. (1994). Framework for a developmental model of oppositional defiant and conduct disorder. *In D. K. Routh (Ed.) Disruptive behavior disorders in childhood.* New York: Plenum Press.

2. Frick, P. J. et al (1993). *Oppositional defiant disorder and conduct disorder. A meta-analytic review of factor analyses and cross-validation in a clinic sample.*

3. Essau, C. A. (2003). Epidemiology and comorbidity. *In C. A. Essau (Ed.) Epidemiology, Risk Factors and Treatment.* New York: Lawrence Erlbaum.

4. Sattler, J. M. (1992). *Assessment of Children: Revised and updated third edition.* San Diego: Jerome Sattler Publisher.

5. Hembree-Kigin, T. L. & McNeil, C.B. (1995). *Parent-child Interaction Therapy.* New York: Springer Publishing.

6. Prinz, R.J. & Jones, T.L. (2003). Family based interventions. *In C. A. Essau (Ed.) Epidemiology, Risk Factors and Treatment.* New Jersey: Lawrence Erlbaum.

7. Blader, J., et al (2000). *Functional Behavioral Assessments and Intervention Plans Program Handbook.* Auspices of the New York University Child Study Center.

About the Author

Dominick Auciello, Psy.D., is a Clinical Neuropsychologist and Associate Research Scientist in the Institute of Learning and Academic Achievement at the NYU Child Study Center. Dr. Auciello provides neuropsychological and educational assessments to children, adolescents, and adults with learning disorders, psychiatric disorders, and various neurological conditions that affect learning and cognitive functioning. He also provides assessments and cognitive behavioral treatments at the Attention-Deficit/Hyperactivity (ADHD) and Behavioral Disorders Services of the Child Study Center.

AboutOurKids.org Related Articles

About Conduct Disorder
http://www.aboutourkids.org/aboutour/disorders/conduct.html

About Oppositional Defiant Disorder
www.aboutourkids.org/aboutour/parent_letter/2005/english_parent_letter_december_05.pdf