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The Oppositional or Angry Child

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Disclosure Statement

- I have been a facility site reviewer for Optum/WYHealth
- I have received a book royalty from the American Psychiatric Association
- I will be specifying all non-FDA approved uses of medications which appear in this presentation

- I am participating in a HRSA grant funded “PAL-PAK” consultation service with AK Department of Health

Partnership Access Line for Alaska (PAL-PAK)

Alaska prescriber calls with a mental health question on any pediatric patient

Hours: 7:00 AM - 4:00 PM

PAL Program Staff connects provider to Help Me Grow for assistance with local resources

PAL Program Staff connects provider to a PAL Psychiatrist for a phone consult

Summarized consult note is faxed back to provider:

- PAL Call: Within one business day
- Help Me Grow: Within one week

When appropriate, a one-time in person or telemedicine psychiatric evaluation may be available to patients with state insurance

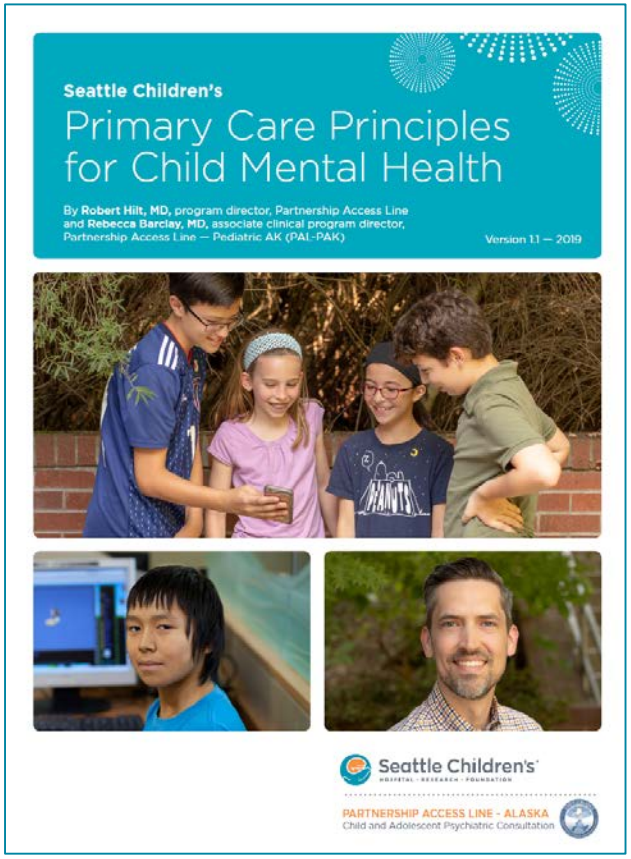
Evaluation report is faxed back to PCP within 5 business days

For PAL-PAK Call 855-599-7257

PAL PAK Resources

- Follow-up consult notes faxed the following business day
- Televideo consults available for Medicaid patients
- Additional education, webinars
- Help Me Grow will provide you with support in identifying care resources

- Care Guide is free, on the web, and we can mail you a hard copy



PAL-PAK number is 855-599-7257

Learning Objectives

- Origins of oppositionality/anger
- Engage parents as partners in reducing aggression
- Identify diagnoses which worsen oppositionality/anger
- Differentiate “moody” from bipolar disorder
- Limited role for non-specific aggression medications

Aggression brings the Angry kids in for Care

- Verbal anger (oppositionality) will also initiate care
- I picture verbal anger and aggression as:
  - Triggered by self-perceived vital conflict
  - Child unable to resolve conflict through non-forceful means

- Aggression can be either normal or abnormal

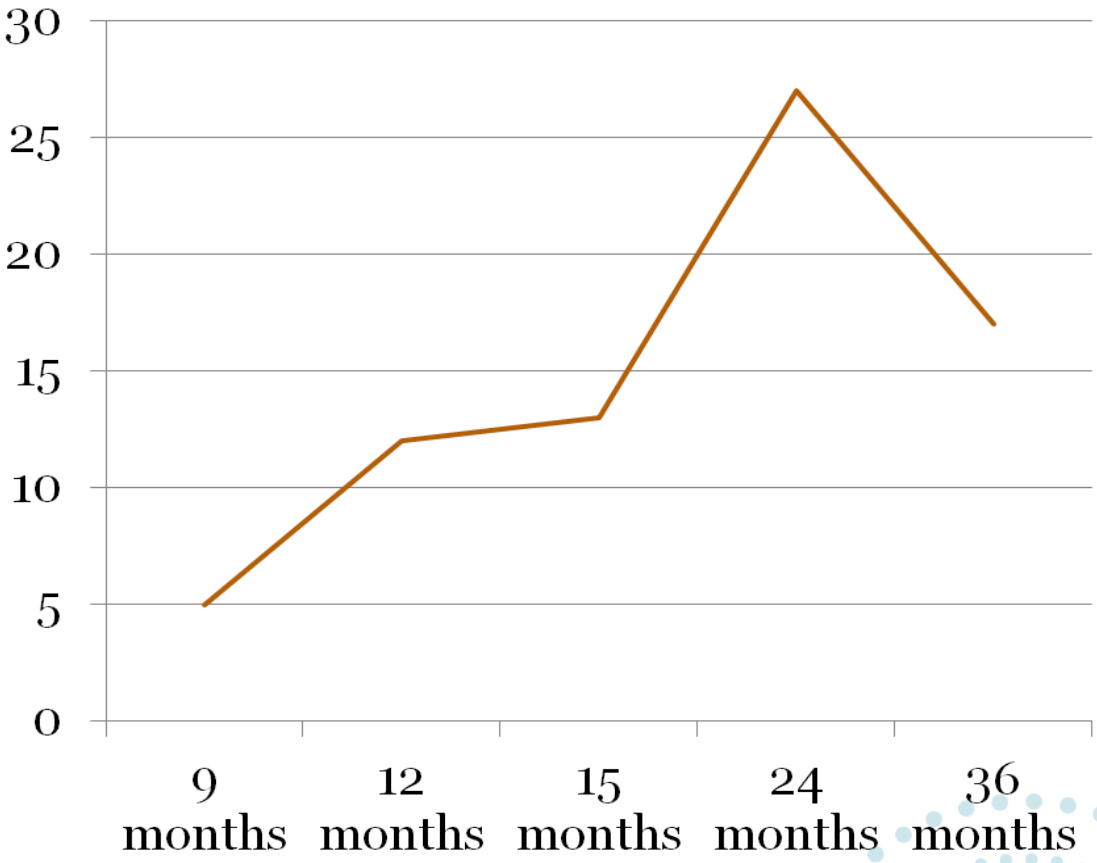
Developmentally Normal Anger/Aggression

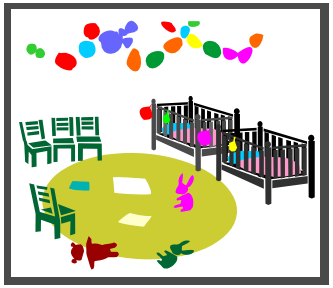
- Infants recognize anger in faces by age 3 months
- Infants' anger first appears around age 6 months
- By age 12-18 months ~50% of all peer social exchanges in a nursery school are conflictual
- Under 6 years, aggression is primarily used to get objects, territory or privileges
  - Before the child's linguistic skills have matured
- After age 6, aggression may be used in retaliation

Function of Aggression?

- Lacking language and social skills, kids use aggression to obtain a goal (toys, food, attention)
  - Diminishes as communication improves
- If protecting your personal safety, aggression can be normal
  - However *planned* aggression a concerning sign

Development and Aggression



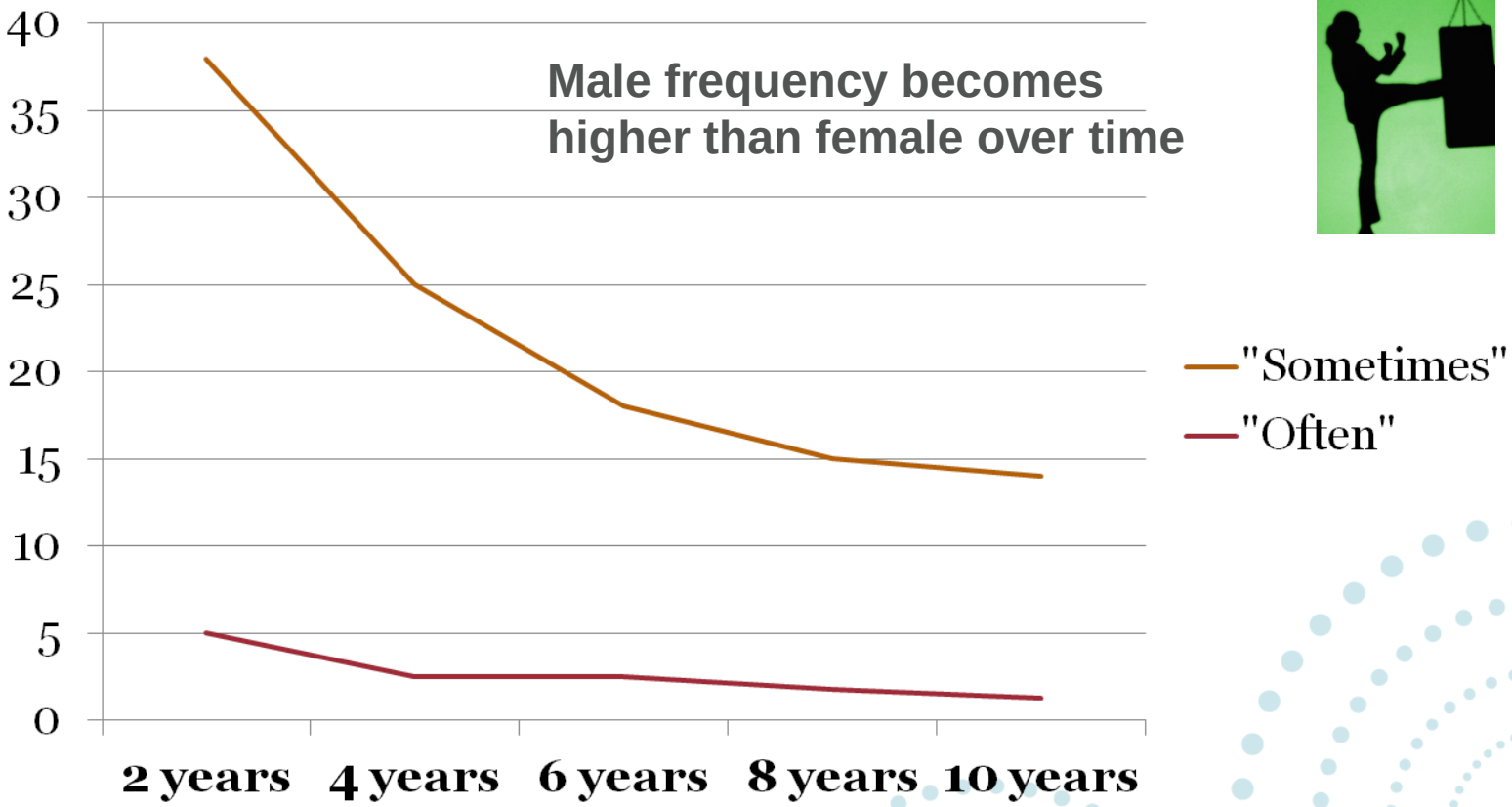


% Frequency of peer to peer aggression seen in preschool

(Male rates ≈ females)

From Tremblay et al (2005) and Restoin et al (1985)

Hitting, Biting, and Kicking Behaviors Typically Diminish as We Mature



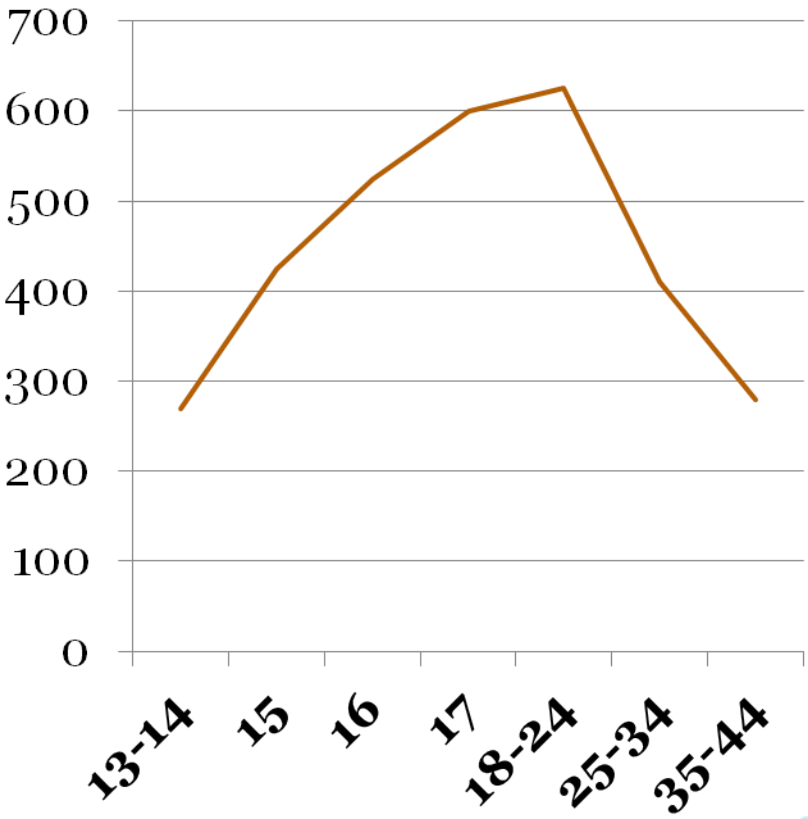
From Canadian Health surveys by Tremblay et al (1996) and (2005)

Usual evolution of aggression

- Physical → evolves into verbal
- Overt → evolves into covert

- "Relational aggression"
  - Harming others' relationships or social status
    - "You can't play with us" an early example
  - Occurs in both sexes, but seen more with girls

Violent Crime in Young Adults (2001)



(Male rates >> females)

"violent crimes" means robbery, murder, or assault
From "Developmental Origins of Aggression" by Tremblay, Hartup and Archer (2005)

Aggression Risk Factors

- Birth complications
- Low IQ
- Mental health disorders like ADHD, PTSD, ODD
- Poor emotion regulation skills (temperament)
- Poor communication skills
- Male gender (not in preschool)
- Living in disadvantaged neighborhoods
- Non-responsive parenting in first 2 years of life
- Coercive, escalating discipline in toddler years
- Parent modeled use of aggression
- Lack of supervision or monitoring in adolescent years
- Lack of parental warmth
- Parental maltreatment

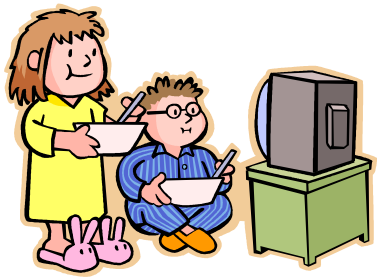
Early Maltreatment and Aggression

- Male maltreatment → physical aggression
- Female maltreatment → relational aggression

- Early neglect (age 0-2) strongly associated with later aggression

Media Exposure to Violence?

- Viewing TV/movie/game violence is a risk factor
  - But not in isolation
    - Only if other violence risk factors, and few protective factors
    - Desensitization is the main mediator per research
- Video game violence and video game “addiction” are risks only if combined with other risks
  - If video games are the child’s whole world, it isn’t a kind and friendly one



AACAP “TV Violence and Children,” 2014 and
AACAP, BeresinE “Impact of Media Violence on Children and Adolescents”

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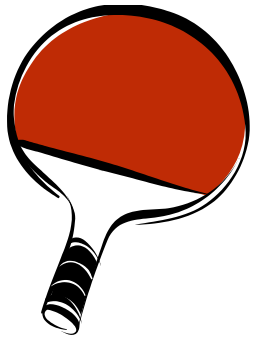
Violence as Discipline

- Still often used by parents
- Corporal punishment at age 3 associated with increased aggression at age 5
  - Corporal punishment leads to higher rates of adolescent/adult aggression, substance abuse, mental illness, crime and violence

- Teaching alternatives is more effective than just telling parents not to do it



Oppositional Defiant Disorder: What Is It?

- Recurrent pattern of negativistic, hostile, defiant behavior
  - More frequent/persistent than typical for age
    - daily if under age 5, less often when older
  - Causes impaired functioning
  - Not caused by other disorders
  - Persisting for >6 months
  - Usually present by age 8 years
    - But no official diagnostic age cutoff
    - Earlier onset associated with poorer prognosis

ODD Diagnosis Checklist:
4 + symptoms within past 6 months

1. Often loses temper
2. Often argues with adults
3. Often actively defies or refuses to comply with adult requests or rules
4. Often deliberately annoys people
5. Often blames others for his or her mistakes or misbehavior
6. Often touchy or easily annoyed by others
7. Often angry or resentful
8. Often spiteful or vindictive

Note: sibling interactions do not apply

Prevalence of ODD

- About a 5% prevalence rate
  - Pre-pubertal boys > girls
- Persisting symptoms
  - About 3/4 still meet criteria ~2 years after diagnosis
    - About ½ still meet criteria ~3 years after diagnosis

Three general patterns of ODD

- Brief
  - Noncompliance and defiance for short period of development
    - rebellious separation/individuation
- Persistent
  - Early oppositional problems persist throughout childhood
- Induced
  - Oppositional problems started after maltreatment, which then may persist

What About Conduct Disorder?

- More serious violations of rules
- Violation of the rights and needs of others
- Typically not diagnosed until adolescence
- Often follows ODD
  - ~30% of ODD kids progress to conduct disorder
- Is 3-4 times more common in males than females

Conduct Behaviors at Different Ages

- School age:
  - Bullying or threatening others
  - Cruel to animals
  - Fire setting
  - Property destruction
- Adolescence:
  - Truancy, running away
  - Breaking into another's house or car
  - Stealing
  - Conning others for goods/favors

Conduct Disorder Checklist: 3 in past 12 months with 1 in last 6 months

Aggression to people and animals

- Bullying or threatening others
- Initiates fights
- Using a weapon that can cause serious physical harm
- Being physically cruel to people
- Being physically cruel to animals
- Steal while confronting victim
- Forcing sexual activity

Destruction of Property

- Fire setting
- Destroying others' property

Deceitfulness or Theft

- Breaking into another's house or vehicle
- Frequent lying or conning others
- Stealing without confronting victim

Serious violations of rules

- Staying out late at night despite parental prohibitions
- Running away from home
- Being truant from school

Conduct Disorder Means:

- A failure of parental authority
  - Therapeutically: are there other parenting or authority arrangements that would work better?
- A rejection of available motivations to be “good”
  - Therapeutically: are there other ways to motivate child in a positive direction?

Conduct Disorder

- About ½ of conduct disorder children continue these problems into adulthood
  - The other ½ more likely to become depressed, anxious or socially isolated adults
- Onset prior to age 10 associated with worse prognosis

"… with limited prosocial emotions"

- DSM-5 diagnosis descriptor for conduct disorder
  - Lack of remorse/guilt
  - Callous/unempathic
  - Unconcerned about performance
  - Shallow affect

  - Possessing 2 or more of these traits for >12 months = poorer prognosis

Causes of ODD and Conduct Disorder

- Research consistently points toward a multifactorial origin:
  - Biology (includes temperament)
  - Social/School influences
  - Family environment influences
    - Internal Psychology from above of insecure attachment, poor social information processing, and expecting rewards from aggression
- Variance in aggression expression *about* 50% genetics, 25% family environment, and 25% community environment

Biological Contributing Factors

- Exogenous biological factors
  - drugs in utero, birth complications, toxins, malnutrition
- Endogenous biological factors
  - Genetics
    - Low sympathetic responsiveness
    - Low cortisol
    - High testosterone
  - Cognitive processing deficits
    - *Communication deficits especially*
- Temperament (traits present throughout life)

Social/School Contributing factors

- Academic failure
- Community violence
- Bullying
- Peer rejection
- Associating with other antisocial children

Family contributors to ODD/CD

- Poor supervision
- Erratic, harsh discipline
- Parental disharmony
- Low involvement in the child's life
- Offering attention primarily for yelling/tantrums
- Unresponsive to child emotional needs
- Insecure parent-child attachment

Psychological Factors in ODD/CD

- Disordered processing of social information:
  - Underutilize social cues
  - Misattribute hostile intent
  - Generate fewer solutions to problems
- Expecting a reward from aggression
  - Intermittent reinforcement
- Insecure attachment to others
- Fragile self esteem
- Confrontational view of the world

Comorbidities with ODD/CD

- ADHD
  - Most common, found in ~1/2 of ODD kids
- Mood disorders
- PTSD
- Anxiety disorders
- Substance abuse
- Tic disorders
- Learning disability
- Intellectual impairment

Performing the Evaluation

- Multiple Informants
  - School, parents, child
  - Discrepancies are common and diagn. helpful
- Medical History
- Educational Assessment
- Rating scales
  - General scales (i.e. PSC, CBCL, SDQ)
  - Specific scales
    - ADHD rating scales
    - Depression or anxiety rating scales

Behavior Focused History

- ABC's
  - Antecedents
  - Behavior itself
  - Consequences
- Frequency
- Duration
- Character
  - Hot or cold?

What is Temperament?

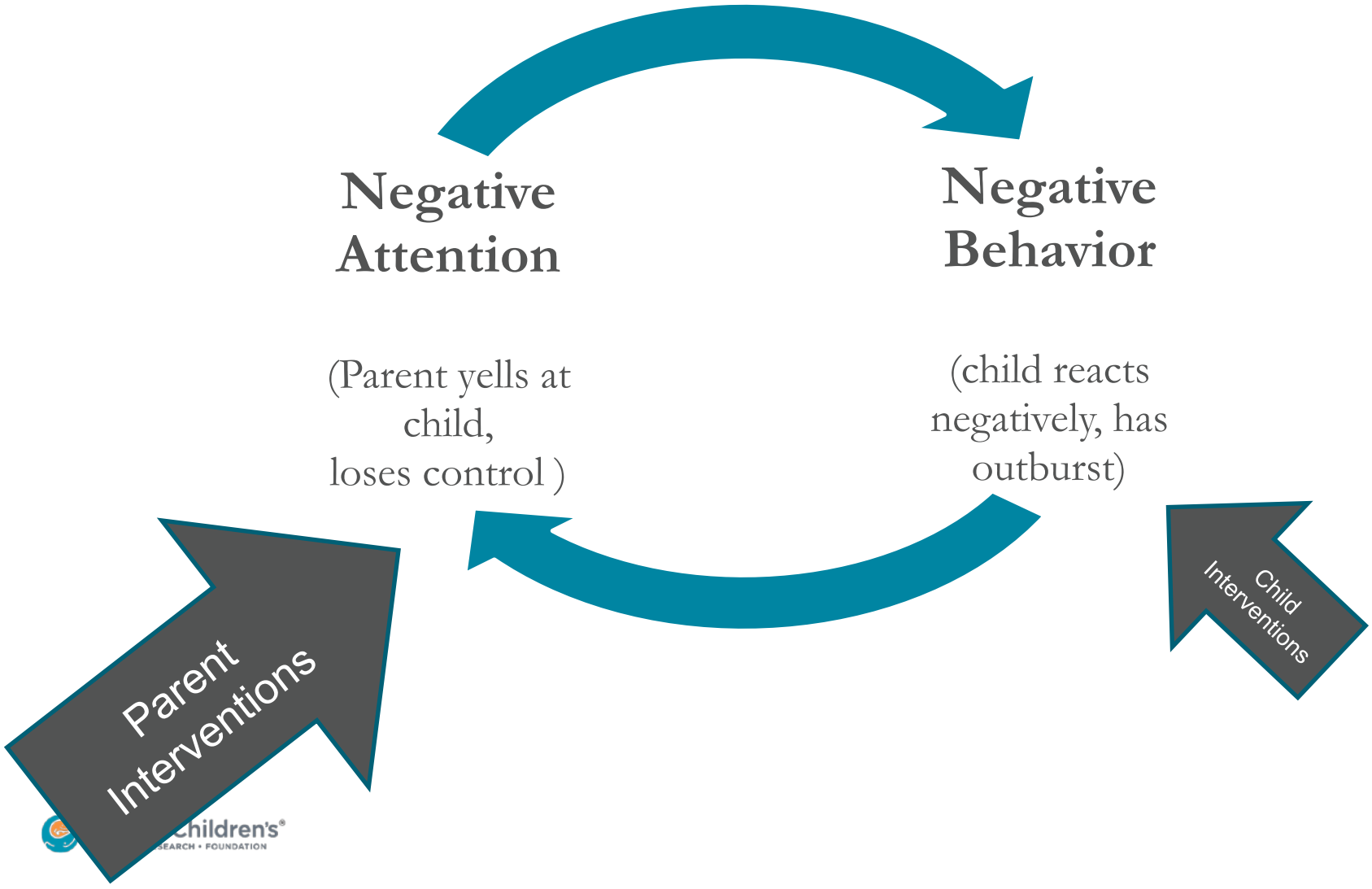
- Stable personality traits traceable from infancy through adulthood
- Some of these traits are noted as more difficult to parent:
  - High intensity
  - More negative moods
  - Irregular patterns
  - Negative first impressions
  - Less readily adaptable to change

Chess & Thomas, NY Longitudinal Study

Temperament and ODD

- Helpful to describe ODD as a mismatch between:
  - Child's temperament (i.e. "Your child would be challenging for any parent to raise")
  - Parents' (& society's) skill set and expectations

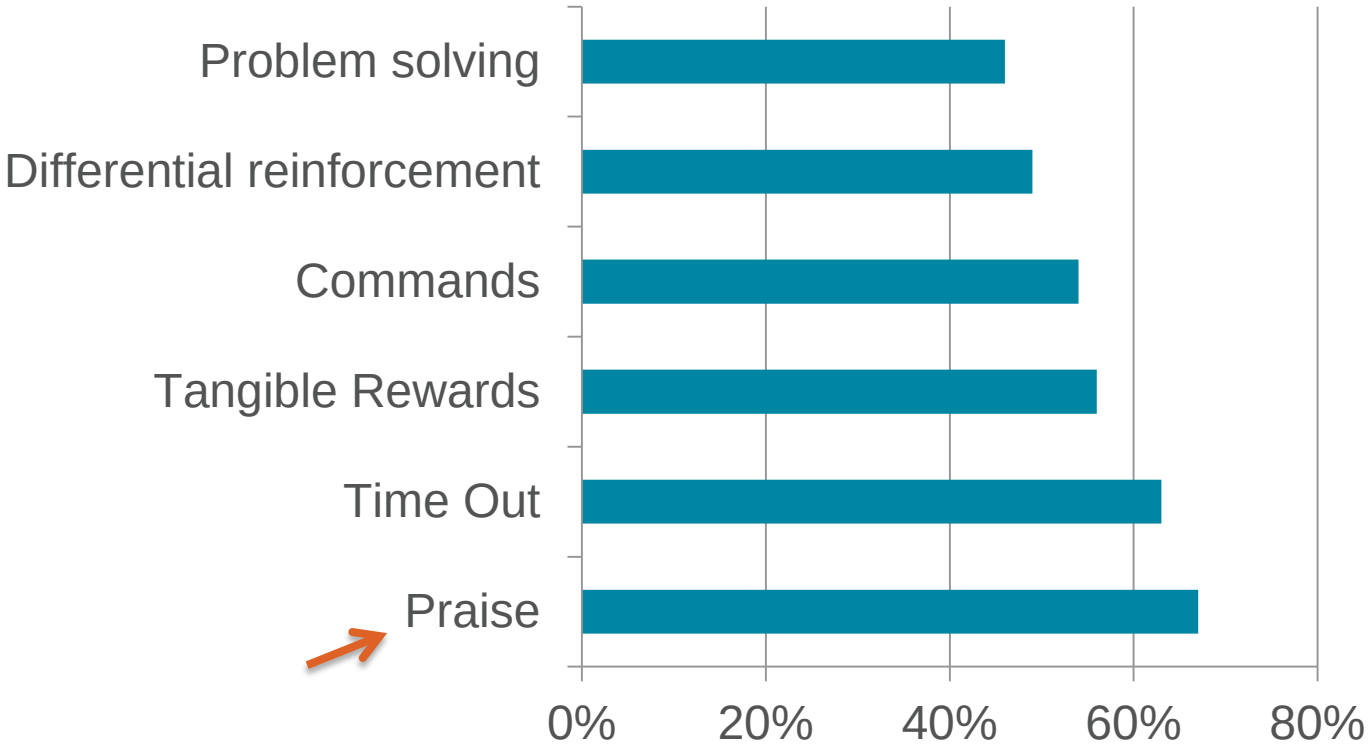
The Vicious Cycle



ODD Treatment

- Behavior management training
  - Need to engage parents in care for a chance of success
- Offer parent support, as an un-nurtured parent will struggle to help their difficult child
  - Parenting groups/classes
  - Individual counseling
- “Special” or “calendar” time for parent and child
  - Praise good behaviors

Common Practice Elements for Disruptive Behavior Therapy age <13



From Chorpita BF et al 2009,Hawaii CAMHD review, n=72 study groups

Similar Principles, Many Variations

- Functional Family Therapy (FFT)
- Behavior Management Training
- Collaborative Problem Solving
- Problem Solving Skills Training
- Anger Management Training
- Multisystemic Therapy (MST)
- Family Therapy
- Mentoring Programs
- Parent Child Interaction Therapy (PCIT)
- Positive Parenting Program (PPP). . . .

Age related psychotherapy choices

- Preschool
  - Behavior management training alone
- School Age
  - Behavior management training
  - School based interventions (social skills groups)
  - Individual therapy (cognitive problem solving)
- Adolescents
  - Behavior management training
  - Individual therapy

Other Treatment Strategies

- Treat comorbid conditions (like ADHD)
- Treat learning disabilities
  - Parent asking school for an evaluation
- Treat communication problems (speech therapy, correct hearing problems)
- Encourage pro-social activities
- Address parental mental health problems

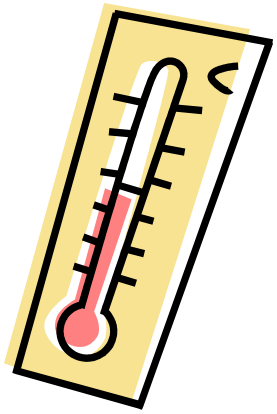
Medications for ODD and Conduct Disorder?

- There are NO FDA approved medications to treat ODD or Conduct Disorder
- Appropriate for treatable comorbidities
  - ADHD
  - Depression
  - Anxiety
  - Irritability associated with autism
- Substance abuse treatment comes before considering meds

Hot versus Cold Aggression

- “Cold” aggression is calculating, planned, instrumental to obtain a goal
  - Not reduced by medications

- “Hot” aggression is impulsive, poorly planned, has high CNS fight-or-flight arousal
  - Might be reduced by medications



Medication role with “hot” aggression

- Not to be a primary treatment
  - Primary treatment is psychosocial
- If necessary, could consider:
  - Alpha agonists (like clonidine/guanfacine)
  - Atypical antipsychotics (like risperidone) when severe
    - TRAAY guidelines one example explaining their use
  - Again, none FDA approved for this indication

Relative medication impacts

- Studies of maladaptive aggression:
  - Risperidone studies for Devel. Disability, Conduct Dis, ADHD
    - Effect size ~0.9
  - Methylphenidate for ADHD
    - Effect size ~0.9
  - Alpha2 agonist for autism or ADHD
    - Effect size ~0.5
  - Atomoxetine for ADHD
    - Effect size ~0.2

E Pappadopulos et al 2006

Key Points: Why Do Kids Have Aggression?

- Triggered by environment
  - i.e. family and school stress, trauma
- Facilitated by a disorder
  - i.e. depression, ADHD, panic disorder
- Facilitated by one's biology
  - i.e. genetics, in utero events, temperament
- Child finds is the best way to obtain a goal
  - i.e. has poor language ability

Key Points with Externalizing Problems

- Best intervention is with child's environment rather than relying on child self-reflection to change
- Self-help parent readings/videos can help motivated parents
- Look for treatable comorbidities (i.e. ADHD)
- Resolve any recurring conflicts (i.e. bullying)
- Medications usually not the answer for ODD/conduct disorder

What About Bipolar?

- Has become a controversial child diagnosis
- Label has been given to impulsive, chronically irritable, moody kids
  - No classic mania has occurred
  - SMD kids are not more likely to develop true bipolar
    - 33% higher risk for depression
    - 72% higher risk for GAD
    - 81% higher risk for dysthymia

- Without clear manic discrete episodes of days duration, a child bipolar diagnosis is not reliable

Stringaris et al, 2009

Definition of Mania (DSM-5)

- >1 week episode of irritable or expansive mood
- At least 3 of the following (4 if *only* irritable mood)
  - **D**istractible
  - **I**ndiscretions
  - **G**randiose
  - **F**light of ideas
  - increased goal directed **A**ctivities
  - little need for **S**leep
  - **T**alkative
- DIGFAST Mnemonic

ADHD vs. Bipolar

- Three bipolar symptoms are on the surface similar to ADHD symptoms
  - distractibility
  - activity increase
  - talkativeness
- Just add in “expansive mood” and voila, you have a “bipolar” child
  - This interpretation was one of the unfortunate triggers for the bipolar diagnosis explosion
- Recall, that treating ADHD with a stimulant is quite effective at reducing comorbid oppositionality/aggression

Discussion

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