



The Assessment and Treatment of Child and Adolescent Aggression

John F. Raizen, M.D.



The Assessment and Treatment of Child and Adolescent Aggression

- **Course description** - Child and adolescent aggression has a significant impact on children and adolescent lives. This presentation will assess the different types of aggression; discuss underlying mental illness and child dynamics; address levels of intervention indicated such as inpatient, outpatient and legal consequences; and address treatment in the inpatient and outpatient settings.



The Assessment and Treatment of Child and Adolescent Aggression

- The focus of this presentation will be to discuss harmful aggression that results in danger to others or property and for the remainder of this presentation, the term “aggression” will be used to mean harmful aggression. Aggression also includes behaviors that are dangerous to self although that will not be the focus of this presentation.



The Assessment and Treatment of Child and Adolescent Aggression

What is aggression?

- Harmful aggression is usually the outward projection of the feeling of **anger**. One might feel angry when emotional feelings are hurt, autonomy is challenged, or one feels threatened.
- Exceptions: Psychotic patients where aggression could result from delusional thinking or command hallucination, or sports (martial arts, football, boxing, soccer), combat in war situation, or self-defense.



How aggression toward others is manifested?

- Anger resulting in aggression can be directed inwards and/or outwards, but today we will focus on the outward expressions of anger.
- Outward manifestations of anger may be manifested via verbal threats or physically hurting others, or destruction of property. When anger becomes aggressive or violent it may take the form of verbal threats, use of profanity, yelling, hitting and even homicidal ideations and attempts, and destruction of property.



What are triggers for anger and/or aggression?

1. Perception of being put down or humiliated (name calling or being laughed at)
2. Feeling deprived as compared to others (food, objects or attention)
3. Personal space violations (getting in your face, cutting in line, being stared at, getting touched without permission, a car cuts you off while driving)
4. Past memories (rape, abuse, domestic violence, or any other trauma including severe neglect)
5. Being bullied
6. Competition and not playing by the rules or perception of not playing by the rules



What are triggers for anger and/or aggression? (continued)

7. Personal weaknesses (a physical deformity, obesity, a feminine appearance if male or a masculine appearance if female, a speech impediment, absent parents)
8. Families that do not look like other families (blended families, multiracial families, being reared by grandparents or older parents)
9. Hypersensitivity
10. Feeling threatened
11. Irritable mood
12. Psychotic processes
13. Medical Condition/Substance Abuse or side effects of medications




What determines the threshold to anger/aggression?

1. PERCEPTION IS EVERYTHING!
2. Level of fear
3. Degree of insult
4. Degree of past insults/hurts
5. Level of self esteem
6. Extent of sense of deprivation
7. Lack of sufficient communication skills or understanding
8. Learning disabilities/Mental Retardation
9. Degree of lack of inhibition (due to substance abuse, poor parenting/role modeling, brain injury, or brain damage from exposure to drugs and alcohol in utero)



What decreases or stops aggression?

1. Fear of consequences
2. Realizing consequences
3. Owning own behaviors/Learning personal responsibility
4. Ability to rationalize or empathize (he is having a bad day)
5. Good communication skills (Obama and other politicians)
6. Use of positive coping skills (changing self-talk, relaxation techniques, etc.)



What decreases or stops aggression? (continued)

7. Ability to cope with insults/provocation (barber example)
8. Increased understanding of the impact of past hurts and trauma on behaviors
9. Feeling safe
10. Having basic needs met (food, shelter, clothing, positive attention)
11. Higher Duties
12. Medications



What feeds anger and aggression?

1. Feeling disrespected
2. Habitual cycle of provoking/being provoked/anger/aggression
3. Not liking to be told or ordered what to do
4. Negative attention is better than no attention at all
5. Lack of frustration tolerance
6. Feeling justified “they deserved it”
7. Lack of other outlets for anger



What feeds anger and aggression? (continued)

8. Maladaptive parenting
 - a. inconsistent limits
 - b. incongruent affect
 - c. spanking as discipline
 - d. verbal or physical aggression between parents or toward child
 - e. favoring another child
 - f. unrealistic expectations
 - g. accept child's blaming others or voices for behaviors
 - h. defend child's behaviors in front of child and even encourage the child's aggression and brag about it)



What feeds anger and aggression? (continued)

9. Learned behavior to get needs met (the youngest in a family of 8)
10. Jealousy (cat and dog example, older child having to share attention with younger child)
11. Getting even, getting even more even



Face to Face Assessment:

- Assess for:
 1. DSM-IVR Diagnosis or Diagnoses
 2. Contributing factors (witnessing or witnessed domestic violence, use of drugs and alcohol, trauma history, medical history)
 3. Extent of danger to self/others and if a result of mental illness or not
 4. Level of intervention indicated: inpatient vs. outpatient
 5. Need for psychiatric medication
 6. Need for medical treatment as indicated
 7. Co-existing medical issues including: asthma, speech therapy needs, obesity, hearing, vision, dental and refer as needed



DSM-IVR Diagnoses Associated with Aggression:

1. **Intermittent Explosive Disorder:**

The occurrence of discrete episodes of failure to resist aggressive impulses that result in violent assault or destruction of property, the degree of aggressiveness expressed during an episode is grossly disproportionate to provocation or precipitating psychosocial stressor



DSM-IVR Diagnoses Associated with Aggression: (continued)

2. **Oppositional Defiant Disorder:** A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:
 - a. often loses temper
 - b. often argues with adults



DSM-IVR Diagnoses Associated with Aggression: (continued)

Oppositional Defiant Disorder continued

- c. often actively defies or refuses to comply with adults' requests or rules
- d. often deliberately annoys people
- e. often blames others for his or her mistakes or misbehavior
- f. is often touchy or easily annoyed by others
- g. is often angry and resentful
- h. is often spiteful or vindictive



DSM-IVR Diagnoses Associated with Aggression: (continued)

3. Conduct Disorder:

Subsection of Aggression to people and animals:

- a. often bullies, threatens, or intimidates others
- b. often initiates physical fights
- c. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
- d. has been physically cruel to people
- e. has been physically cruel to animals
- f. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
- g. has forced someone into sexual activity



DSM-IVR Diagnoses Associated with Aggression: (continued)

4. Schizophrenia or Psychotic Disorder, Not Otherwise Specified
5. Major Depression Disorder
6. Bipolar Disorder
7. Post Traumatic Stress Disorder
8. Substance Abuse and Dependence



Treatment of Child and Adolescent Aggression

1. Establish Diagnosis or Diagnoses
2. Determine inpatient or outpatient treatment warranted
3. Refer to the child psychiatrist for psychiatric medications
4. Refer for identified co-existing medical issues or social support needs.



Treatment of Child and Adolescent Aggression, continued

5. Multimodal Treatment:

A. Individual Psychotherapy:

- Assess for drug and alcohol abuse and treat concurrently
- Teach alternative ways of coping/resource building
 1. Positive self talk
 2. Relaxation skills
 3. Journaling



Treatment of Child and Adolescent Aggression, continued

Individual Psychotherapy, cont'd

- Build self esteem
 1. Identifying things the individual does well
 2. Identifying things the individual likes about him or herself
- Help the child recognize his triggers
 1. Practice alternative response when faced with triggers



Treatment of Child and Adolescent Aggression, continued

Individual Psychotherapy, cont'd

Help the child own his behaviors rather than blame others

1. Six Steps to Personal Responsibility:
 - STEP 1: Admit my behavior – Tell it like it is; Tell ALL of the truth about my behavior;
 - STEP 2: Accept the consequences for my behavior without arguing or pouting;
 - STEP 3: Identify the trigger – What was I thinking, feeling, or telling myself that made it okay to do the behavior;



Treatment of Child and Adolescent Aggression, continued

Individual Psychotherapy, cont'd Six Steps to Personal Responsibility continued:

- STEP 4: Identify how my behavior was harmful –To myself – To others – To property;
- STEP 5: Make a plan – that can I tell myself or what positive coping skill can I use to keep from doing that behavior the next time; and
- STEP 6: Do it – WORK THAT PLAN! – Use the plan you made. If you need to say, “I’m safe now” say it. If you need to use the Turtle Technique, your “Safe Place” or some other relaxation skill, use it



Treatment of Child and Adolescent Aggression, continued

Individual Psychotherapy, cont'd

- Appropriate apologies to those hurt or harmed
 1. No blaming other party
 2. No excuses
 3. Genuine apology AFTER the individual shows remorse
 4. Identify what the individual has learned and how that will help him or her avoid repeating the behavior



Treatment of Child and Adolescent Aggression, continued

Individual Psychotherapy, cont'd

- Pay restitution
 1. Get a job
 2. Work around the house for minimal pay per hour
 3. Do chores for a sibling harmed by patient



Treatment of Child and Adolescent Aggression, continued

Individual Psychotherapy, cont'd

- Find healthy outlets
 1. Use of exercise
 2. Art/expressive therapies and activities
 3. Sports
 4. Hobbies



Treatment of Child and Adolescent Aggression, continued

Individual Psychotherapy, cont'd

- Help recognize and verbalize feelings
 1. Practice in feelings identification in a variety of circumstances
 2. Use of vignettes
- Improve communication skills
 1. Learn and practice active listening skills
 2. Learn appropriate ways to ask for needs to be met, including needs for attention



Treatment of Child and Adolescent Aggression, continued

Individual Psychotherapy, cont'd

- Empathy Development
 1. Exercises in empathy development including identification of others' feelings in given circumstances
 2. Have the individual identify the needs of others and find ways to help meet those needs
 3. Make up for losses associated with the individual's aggressive behaviors



Treatment of Child and Adolescent Aggression, continued

Family Therapy

- Address parenting and parent child interaction
 1. Communicate with respect (parent to child, parent to parent, and child to parent)



Treatment of Child and Adolescent Aggression, continued

Family Therapy, continued

- Help parent realize that when they show anger to the child, they are modeling behavior.
- Speak calmly when giving negative consequences.
- Positive consequences should be addressed with great emotion...catch them being good and reward!!



Treatment of Child and Adolescent Aggression, continued

Family Therapy, continued

- Assess if favoring one child over another
- Use of age-appropriate discipline
- Creativity in discipline – find out what the child hates and what the child loves. When the child is misbehaving give him/her as little of what he/she loves as possible, while giving him or her as a lot of what he or she hates. Reverse that order when the child is behaving appropriately.



Treatment of Child and Adolescent Aggression, continued

Family Therapy, continued

- EXAMPLE: Child hates sweeping floors or writing essays on things like respect. When child is breaking the house rules, child is assigned to sweep floors or write essays.
- Basic needs of food, shelter, unconditional love and nurturing are NEVER to be withheld**



Treatment of Child and Adolescent Aggression, continued

Family Therapy, continued

2. Use of positive and negative consequences. The use of positive consequences (rewards) is more reinforcing than the use of negative consequences (punishment)
3. Teach alternatives to use of corporal punishment – some children will copy hitting behavior.



Treatment of Child and Adolescent Aggression, continued

Family Therapy, continued

- Educate the parents on the need for implementation of firm consistent limits from a caring and nurturing parent
- Teach and practice reward for desired behaviors
- Recommend involvement in healthy outlets in the community such as YMCA activities, Big Brother program, church activities



Treatment of Child and Adolescent Aggression, continued

Family Therapy, continued

- Utilize extended family for support
- Assess for drug and alcohol abuse in the parents and refer for treatment
- Recommend individual therapy, marital counseling, and/or psychiatric treatment for one or both parents when applicable



Treatment of Child and Adolescent Aggression, continued

C. Group Therapy

- Helps hold the child accountable
- Opportunity to teach and practice skills – planned and unplanned
 1. Listening skills
 2. Feelings identification and expression
 3. Appropriate apologies
 4. Use of adaptive/positive coping skills
 5. Acceptance of personal responsibility



Treatment of Child and Adolescent Aggression, continued

D. Use of Psychiatric Medications

- Key here is to determine the diagnosis or diagnoses and treat aggressively when indicated.
- If aggression is primarily driven by bullying then unlikely that it would respond to medications other than to sedate.



Treatment of Child and Adolescent Aggression, continued

Use of Psychiatric Medications, Continued

- If it is due to a mental illness then need to use adequate and active medication trials in an attempt to get a response. May need to resort to Lithium, Depakote, Lamictal or Clozapine to stabilize the aggression/bipolar/psychotic disorder
- Weigh risks/benefits of medications vs. risks of not treating



Treatment of Aggression: Inpatient or Outpatient?

Indications for inpatient:

Imminent danger to self/others and/or escalating behaviors in the past 2 weeks including behaviors of significant danger to self/others, making the risk to self/others too high for outpatient treatment



Treatment of Aggression: Inpatient or Outpatient?

Advantages of Inpatient Treatment

1. Intensity of treatment –
 - a. Individual Therapy
 - b. Family Therapy
 - c. Master's level process therapy groups
 - d. Recreational/Expressive therapy
 - e. Rehab groups
 - f. Milieu treatment



Treatment of Aggression: Inpatient or Outpatient?

Advantages of Inpatient Treatment, cont'd

2. Safe, structured, supportive environment
3. Increased supervision and monitoring
4. Can treat with medications more aggressively while monitoring for side effects
5. Can use NOW medications and therapeutic holds when necessary
6. More focused/faster treatment



Treatment of Aggression: Inpatient or Outpatient?

Advantages of Inpatient treatment, cont'd

7. Use of therapeutic passes provides a time-limited opportunity to practice what is being learned in treatment
8. School provided on-site with improved supervision
9. Treatment of co-occurring psychiatric needs and other behavior problems



Treatment of Aggression: Inpatient or Outpatient?

Disadvantages of Inpatient Treatment:

1. Patient learns negative behaviors from peers
2. Patients try to seek negative attention to compete for attention with their acting out peers
3. Disruption of family unit
4. When primary behavior problem is at home, 1 hour a week family therapy is not enough to work through conflicts within the family
5. Medication treatment may be less aggressive in inpatient than outpatient since not working to keep child from going inpatient



Treatment of Aggression: Inpatient or Outpatient? (continued)

Disadvantages of Inpatient Treatment:

6. In absence of sufficient rewards (passes, moving up discharge date with desired behaviors), the patients may give up
7. Some patients develop an stance that if I am bad enough they will get rid of me so become more aggressive and oppositional
8. The patient becomes institutionalized. That is, the patient begins to like the hospital life and gets more aggressive in order to remain inpatient indefinitely



Treatment of Aggression: Inpatient or Outpatient? (continued)

Optimizing inpatient treatment of aggressive behaviors:

1. Utilize a high staff ratio so the patients do not have to escalate to get attention (positively reward negative behaviors)
2. Need for relatively firm discharge date rather than keeping the child hospitalized indefinitely
3. Reward for positive behaviors-catch being good and reward, rather than punishing for negative behaviors
4. Model healthy interactions and interventions



Treatment of Aggression: Inpatient or Outpatient? (continued)

Optimizing inpatient treatment of aggressive behaviors:

5. Provide nurturing, therapeutic environment while maintaining consistent limit setting between shifts and patients
6. Active medication treatment in attempt to best stabilize behaviors that result from mental illness
7. Use the least restrictive interventions
8. Provide and teach healthy outlets such as nonaggressive sports and exercise, deep breathing, "safe place" , journaling



Treatment of Aggression: Inpatient or Outpatient? (continued)

Optimizing inpatient treatment of aggressive behaviors:

9. Expect the child to take responsibility for his or her behaviors rather than blaming others, the medications, or the voices
10. Provide natural consequences for behaviors (schoolwork/free time example)
11. Provide therapeutic passes with homework for child and parents to work on during the pass. This allows time to work on the family conflicts and gives the child hope he will discharge and incentives to work his treatment



Treatment of Aggression: Inpatient or Outpatient? (continued)

Optimizing inpatient treatment of aggressive behaviors:

12. Passes to be for therapeutic reasons and individualized. Passes are not a reward to be earned, but a vital part of treatment.
13. Avoid unrealistic expectations (by parents, by child, by hospital)
14. GIVE THE CHILD HOPE FOR BEST POSSIBLE OUTCOME (Pass or discharge)



Treatment of Aggression: Inpatient or Outpatient? (continued)

Advantages to Outpatient Treatment:

1. Child remains in the home with family
2. No disruption in school attendance (staying in the same school)
3. Treatment within the community



Treatment of Aggression: Inpatient or Outpatient? (continued)

Disadvantages to Outpatient Treatment:

1. Potential for the child to continue engaging in aggressive and violent behaviors, placing others at risk
2. May not be able to provide treatment for co-occurring disorders in one setting, requiring multiple settings and appointments each week
3. Less intensive treatment



Treatment of Aggression: Inpatient or Outpatient? (continued)

Optimizing outpatient treatment of aggressive behaviors

1. Utilize at least weekly 60 minute face-to-face IT and FT sessions
2. Home based and school based therapy
3. Coach parent child interactions
4. Refer to a psychiatrist



Case Vignettes:

Case 1: Jessie

- Jessie is a 9-year-old Native American male in DHS custody. He is living in a TFC home in Moore, OK. He has a history of aggression with most severe behaviors this morning when he punched Amy, a 3 year old toddler in the home; leaving bruises on her jaw and his knuckles.



Case Vignettes: Case 1: Jessie continued

When he was confronted about his aggressive act he said it was Amy's fault "because she took my toy" and he would "kill that bitch next time if she touches my toys again". His foster parents then told him would have to leave the home. Jessie cried and said they do not want him, just like his real parents, and he may as well just go ahead and kill himself like his mother did.



Case Vignettes: Case 2 - Debbie

- Debbie is a 5-year-old girl in DHS custody since age of 3, now living in a kinship foster home. Her foster parents brought her to see a psychiatrist at the insistence of her daycare teacher due to her explosive anger outburst with hitting and biting herself and others as well as head banging causing abrasions on her forehead. These episodes occur when she is told no.



Case Vignettes: Case 2 – Debbie continued

- She is described as a loving child when not angry but very hyperactive and easily distracted. At daycare she often gets in trouble for hitting her peers and teacher but she insists her peers start it by calling her “stupid” and “poopy pants”. The last episode of explosive violent outburst occurred 8 days ago when she did not want to go to church.



Case Vignettes: Case 3- Alex

- Alex is a 15-year-old white male in custody of his maternal grandparent's with whom he has lived since the age of six. They are seeking inpatient psychiatric treatment for him. They want him to mind them better and they also said they were told that if he completes the inpatient psychiatric program, his charges would be dropped.



Case Vignettes: Case 3- Alex continued

- They state Alex is defiant and steals the car keys, their money, cigarettes, and beer. A week ago, in a gang fight he beat up a kid in school and currently has charges pending. Since then, he has been behaving better because the police told him that one more incident will send him to jail. His grandparents point out that prior to that his behaviors had been getting worse.



Case Vignettes: Case 4 - Tonya

- Tonya is a 14-year-old white female whose parents are seeking inpatient treatment for her subsequent to Tonya punching and kicking holes in the walls. Tonya was suspended from school for pushing her desk over and calling her teacher a bitch. Tonya receives outpatient therapy and is prescribed Risperdal for her anger.



Case Vignettes: Case 5 - Trevor

- Trevor is a 13-year-old African American male admitted to the ICU following a suicide attempt by hanging in detention. He was in detention for violently stabbing his father and later in detention he assaulted a guard. He said his father was speaking to him without moving his mouth-telling him he was going to rape him in his sleep and the guards were waiting for him to sleep so they could also have sex with him in his sleep.



Case Vignettes: Case 5 – Trevor continued

- He explained since everybody is trying to sexually molest him, even his father, he did not see a reason to live anymore and so he tried to kill himself.



Parenting information and resources

- <http://www.positiveparenting.com/resources/resources.html>
- <http://www.parenting-resources.com/free-parenting-resources.htm>
- <http://www.loveandlogic.com/articles.html>
- <http://attachment.org/>
- <http://www.ciccparenting.org/>



Parenting information and resources

- Therapeutic Parenting by Deborah Hage, 2003 Design Publication
- Parenting with Love and Logic by Foster Cline and Jim Fay, 1990 Pinon
- Systematic Training for Effective Parenting Programs (STEP)
- The Explosive Child by Ross W. Greene, Ph.D. 2001 Quill