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Unit No. 4

OPPOSITIONAL BEHAVIOURS IN CHILDREN

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ABSTRACT

Oppositional behaviours in children and adolescents present significant challenges for parents, educators, paediatricians, and mental health professionals. These behaviours vary in intensity from mild noncompliance to severe defiance and refusal, with persistent and pervasive oppositional behaviours significantly impacting a child's or adolescent's immediate and subsequent academic and socioemotional functioning, hindering the delivery of necessary health examinations or medical care, and violating conventional social norms. Children and adolescents with atypical oppositional behaviours have the potential to face lifelong challenges with authority or in social settings.

There is currently insufficient evidence regarding the efficacy of pharmacological treatment for disruptive, oppositional, or conduct issues in children beyond the management of overt aggressive behaviour and impulsivity, with concerns about side effects. Non-pharmacological interventions should be explored as the first-line approach for managing oppositional behaviours.

A comprehensive investigation of the child or adolescent of their comorbid and/or underlying psychiatric and neurodevelopmental conditions, developmental and socioemotional needs, and familial or environmental influences, will allow for specific, tailored, and optimised treatment. Interventions to manage clinically significant oppositional behaviours require an integrated, transdisciplinary effort including the psychological, psychosocial, psychiatric, and medical disciplines together with the child and adolescent and their family and friends.

Keywords: Oppositional, Disruptive Behaviour, Children

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INTRODUCTION

Oppositional behaviours encompass a range of noncompliant, argumentative, and disobedient actions that significantly influence social interactions.[1] Instances of oppositional behaviour involve engaging in arguments with figures of authority; actively defying rules or instructions in the absence of reasonable factors; acts or displays of noncompliance with requests or directives; intentionally provoking others; and attributing responsibility for errors or transgressions to others.[2,3] However, oppositional behaviours *per se* are developmentally appropriate and expected in children in a variety of settings, such as in relationships with relational challenges, in interactions with siblings, against home or school relocations, or against antagonistic parents or educators who impose unreasonable demands.[2,3]

CLINICALLY SIGNIFICANT OPPOSITIONAL BEHAVIOURS

In contrast, atypical oppositional behaviours are enduring patterns of oppositional behaviours that transcend most if not all settings, manifest in interactions with a diverse range of individuals, hinder routine activities, significantly disrupt familial and social dynamics, impede academic advancement, and generate substantial distress for the affected child or adolescent and those in their immediate environments. These oppositional behaviours align with the distinct features attributed to Disruptive Behaviour Disorders (DBDs) such as Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD; see outline in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision (DSM-5-TR), and the International Classification of Diseases, 11th Revision (ICD-11)).

Atypical oppositional behaviours observed in children frequently coincide with a diverse spectrum of neurodevelopmental and mental disorders. These behavioural patterns, which deviate from anticipated developmental norms and exert substantial ramifications on a child's overall functioning, serve as indicators for underlying conditions necessitating clinical intervention.[2-4] Neurodevelopmental disorders, including Autism Spectrum Disorder (ASD) and Attention-Deficit/Hyperactivity Disorder (ADHD), often manifest with atypical oppositional behaviours. These behaviours are attributable to deficits in cognitive, social, and emotional developmental domains that impede a child's capacity to acquire knowledge, comprehend, and appropriately respond to social cues and interactions.[2-4]

Psychiatric disorders, namely ODD, CD or Conduct-Dissocial Disorder in ICD-11, Disruptive Mood Dysregulation Disorder (DMDD), and numerous mood and anxiety disorders in DSM-5-TR and ICD-11, exhibit distinct clinical profiles that are associated with the presence of oppositional behaviours that surpass the threshold of clinical significance.[2-4] These behaviours are influenced by a complex interplay of biopsychosocial factors and cannot be attributed to solely developmental delays or disorders. **Table 1** delineates specific exemplars for each associated disorder.

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Table 1. Disorders associated with Clinically Significant Oppositional Behaviours

Disorder	Presentations of Clinically Significant Oppositional Behaviours	
	Oppositional behaviours are observed to stem from:	*Oppositional behaviours are associated with:*
1. ADHD (neurodevelopmental)	- inability to sustain attention, poor impulse control, and difficulty self- regulating[2-4]	- complex or effortful tasks, rules, or instructions, waiting or staying still[2,3]
2. ASD (neurodevelopmental)	- a lack of understanding regarding social expectations or task rules, sensory overload, discomfort, and routine changes[2,3]	- unfamiliar or unwelcomed social communication, and restricted, repetitive, rigid behavioural patterns or interests[2,3]
3. ODD (psychiatric)	- a resistance to conform to others' demands - irritability and spitefulness[2,3]	- onset typically beginning in preschool years - requests, rules, or instructions issued by others[2,3]
4. CD or Conduct-Dissocial Disorder (psychiatric)	- a resistance to conform to social or age-appropriate conventions, norms, or rules, lack of remorse or guilt or concern about behaviour, and disregarding rights and feelings of others[2-4]	- imposition of social or civil rules, aggression towards others or animals, including behaviours such as bullying, lying, stealing, and damaging property[2-4]
5. DMDD (psychiatric)	- persistent anger, irritability, or frustration[2,3]	- general situations typically without provocation from others, disproportionate verbal and/or behavioural temper outbursts like yelling or aggression[2,3]
6. Other Depressive Disorders (psychiatric)	- diminished interest or pleasure in activities, hopelessness, and fatigue[3,4]	- engaging in usual hobbies and daily activities, tasks requiring concentration or effort like in school or house chores[2,3]
7. Anxiety Disorders (psychiatric)	- inability to effectively cope with feelings of anxiety[2-4]	- an anxiety-provoking task or situation like a presentation due to social anxiety, or separating from a primary caregiver[2,3]

Atypical oppositional behaviours generally emerge in childhood. In some cases, children may quickly progress to intermediate and advanced levels of CD involving behaviours like lying, fighting, and stealing.[4] The pathway from early oppositionality to ODD and CD involves multiple factors, including individual and family risk factors that hinder the development of social skills and self-regulation.[2-5] These deficits affect relationships within the home, school, and community, leading to peer rejection and limited learning opportunities. The frequency and presence of oppositional behaviour across various settings significantly predict future delinquency.

Additionally, multiple studies of clinical populations demonstrate high comorbidity rates between ADHD, ODD, CD, DMDD, and depressive and anxiety disorders.[2-5] In one study of lifetime prevalence and correlation with ODD, Odds Ratios (OR) were 12.6 ($p<0.05$) for CD and 10.4 ($p<0.05$) for ADHD. Another study in 2013 showed OR between DMDD and ODD (52.9-103.0), ADHD (2.6-12.6), depressive disorders (9.9-23.5), CD (3.8-11.9), and anxiety disorders (2.2-6.1).[9]

The presence of comorbid conditions further exacerbates the severity and persistence of oppositional behaviours, diminishing the likelihood of achieving a favourable prognosis in returning to baseline levels of functioning. Research indicates that in children and adolescents with ADHD, the coexistence of oppositional or conduct issues predicts greater diminished global functioning, heightened severity of ADHD symptoms, and greater likelihood of ADHD symptoms persisting into adulthood, above and beyond the levels faced by populations without comorbidities.[13,14] An informed understanding of the characteristics, aetiology, prognosis, evidence-based, and developmentally appropriate treatment strategies to target comorbid conditions is therefore essential.[4]

LIMITATIONS OF PHARMACOLOGICAL TREATMENT AS THE SOLE OR EXCLUSIVE APPROACH

Given the plethora of biopsychosocial reasons that contribute to the presentation of oppositional behaviours, pharmacological treatment as the sole or exclusive approach to oppositional or disruptive behaviour in children might not fully address root issues and is therefore generally not advised.

For example, psychostimulant medications might be prescribed to manage impulsivity and attention deficits given the high rates of comorbidity between DBDs and ADHD.[4,6,12] However, there is little evidence to suggest the efficacy of a combination of psychostimulants and antipsychotics in treating ADHD with comorbid DBDs and oppositional and aggressive behaviours may still remain.[4-6,12] Furthermore, stimulants have not been shown to produce long-term changes in achievement or long-term prognosis, or the beneficial effects of stimulants stop as soon as the medication wears off.[15]

Generally, with respect to other disorders, there are a limited number of available studies showing efficacy for pharmacological treatment, particularly longitudinally, with many studies examining antipsychotics and mood stabilisers primarily for overt aggression or impulsivity in children and adolescents with DBDs.[4-6,12] On the contrary, these studies highlighted the significant side effects associated with the use of pharmacological treatment, like sedation and extrapyramidal symptoms in first- generation antipsychotics, and weight gain, somnolence, and metabolic side effects in second-generation antipsychotics like risperidone.[4-6,12]

Be that as it may, anecdotally but not without irony, extrinsic reasons, such as gaps in access to medical, allied, or social services, or a lack of resources or familial support, may precipitate or necessitate pharmacological management of the concerning behaviours. A titration approach in the delivery of psychostimulants, antipsychotics, and mood stabilisers may be considered to manage severe symptoms as a final line of treatment, but side effects need to be closely explained and reviewed.[4-6,12]

PSYCHOSOCIAL ASSESSMENT AND FORMULATION

The relevant guidelines generally recommend employing evidence-based psychosocial interventions prior to using medication for DBD.[4-6,12] One systematic study found that the effect sizes demonstrated for psychosocial therapies are in the same range as the effect sizes of medications used to treat disruptive and aggressive behaviours but without the adverse effects.[16] Clinicians should be encouraged to recommend psychosocial therapy as initial management of disruptive and aggressive behaviour in children with ADHD, ODD, or CD.

However, there is significant complexity of accurately formulating the aetiology of oppositional behaviours in a child. Employing a multimodal approach in targeting behaviours means that it is essential that primary care providers collect and understand a child's detailed history with the onset, prevalence, and frequency of behaviours, and make early referrals with appropriate history and observations onto allied services or social agencies for appropriate intervention joint management and intervention.[10]

A comprehensive, multidisciplinary approach is recommended in evaluating factors on individual, dyadic, familial, and systemic levels.[4-7] Individual factors include temperament, neurobiological or developmental delays, genetic predisposition, and the presence of comorbid physical or psychological conditions. Dyadic factors include parent-child interactions, attachment and parenting styles, consistency in parenting, and therapist-caregiver or therapist-client dynamics. Family or parental factors include any prenatal or perinatal complications, family history of psychopathology or criminality, monitoring or supervision, and socioeconomic status. Systemically, factors require the consideration of the different settings to which a child would have been in or was exposed. These include schools and neighbourhoods, with consideration of associations with delinquent peers, social relationships, academic difficulties, neighbourhood crime levels, and exposure to violence.[4-7]

This multimodal, process-oriented approach is backed by an ecological perspective to conceptualise disruptive behaviour or conduct problems within the social structures and realities a child or adolescent lives in, emphasising that children and families exist within multiple contextual systems with mechanisms that influence a child's development, behaviours, and presentations.[4-7] These systems include the home, education and community settings with risk factors that require investigation, such as stressors, parent-child interactions, rule setting and enforcement, and prosocial or deviant peer relations.

Hypothesis testing and formulation of problem behaviours require clinicians to employ appropriate assessment tools such as interviewing, psychometrics, neuropsychological assessments, observations, and behavioural rating scales.[4] The information gathered from interviewing, clinical assessments, and formal assessment tools provide a diverse and comprehensive understanding of the child's functioning, in numerous domains, settings, and perspectives.

During the assessment and formulation stage, intervention and therapeutic goals should also be clearly identified in collaboration with clinicians, stakeholders, and family members.[4,7] Intervention barriers are identified and explained to caregivers, with a discussion of intervention strategies, options, duration, and frequency. During treatment, goals and barriers should be regularly evaluated to ensure alignment and consistency of successful strategies employed with stakeholders, like educators and family members, and to ensure intervention efficacy in overcoming barriers.

PSYCHOSOCIAL INTERVENTION

Psychosocial treatments are backed by strong evidence in the management of oppositional, disruptive, and aggressive behaviour, and conduct issues in children.[4-7,12] The approach is drawn from techniques of applied behaviour analysis, which directly targets problematic behaviour by identifying antecedents, underlying, maintaining variables, and using the same principles to modify and reinforce acceptable or positive behaviour.[6] Many of these treatments also factor in and address family or relational factors that contribute to the perpetuation of oppositional behaviours.[4-6,12]

Awareness and active participation from clinicians and stakeholders such as schools, family members, and social supports are critical in the effectiveness of transdisciplinary intervention. Significant effort and care should be made in the introduction, explanation, and repetition of the need for holistic intervention and the different types of psychosocial treatment.

Given its strong evidence base and limitations of pharmacological treatment, psychosocial treatments should be employed as the first-line approach to addressing oppositional and disruptive behaviours in children.[4-6] **Table 2** lists broad types of interventions accompanied by brief descriptions of treatment processes.

Table 2. Evidence-based Psychosocial Treatments

Intervention Type	Brief Description and Characteristics of Treatment
1. Multisystemic Therapy	Delivered through a home-based method, intervention is conducted directly in environments where problems present themselves like at home or in school. It typically lasts a few months and requires frequent contact with the therapist who is readily available. Intervention processes abide by nine core principles.[4,6,7,11]
2. Parent Management Training	Parents are trained to alter behaviour by reinforcing prosocial behaviour and implementing punishments for undesirable behaviour. As the main goal is to upskill parents, little interaction may be required between the therapist and child. Many variations of PMT programmes exist, notably Helping the Noncompliant Child, The Incredible Years, Triple P, and Parent-Child Interaction Therapy.[4-6]
3. School-Based Intervention	Some school-based interventions, like the Good Behaviour Game, are typically recommended to supplement non-systemic or unimodal approaches, and apply similar principles of learning, reinforcement, punishment, and behavioural analysis in the classroom.[5,6]
4. Family Therapy	Two evidence-based family therapy approaches, Functional Family Therapy and Brief Strategic Family Therapy, view children's behaviour in the broader context of their family, through interactions and communication habits that may contribute to the maintenance of problem behaviour. Intervention typically involves altering the perspectives on problem behaviours and improving interactions between family members.[5,6]
5. Cognitive-Behavioural Intervention	Programmes like the Anger Coping Programme or Coping Power Programme aim to help children enhance coping skills to effectively manage and cope with anger and stress, alter or challenge unhelpful thought processes, problem-solve, and manage challenging situations.[5,6]

CONCLUSION

Disruptive behaviours in children are often the result of neurodevelopmental and/or psychiatric disorders that manifest in the context of psychosocial or circumstantial considerations. A pharmacological approach as the sole or exclusive approach to oppositional behaviours may not fully address root issues and is generally not advised. Treatment of disruptive behaviours has been found to benefit from a holistic approach combining pharmacological and psychosocial intervention.

A comprehensive assessment of the underlying or comorbid psychological condition contributing to impulsive, disruptive, or oppositional behaviour prior to initiating treatment is required, with the treatment of any primary conditions taking precedence over addressing oppositional or aggressive behaviours.[12] Effective identification and intervention of oppositional behaviours in children necessitate the implementation of comprehensive and multimodal approaches, incorporating the consideration of psychosocial factors. Given the highly contextual nature of oppositional behaviours and the transdisciplinary approach required in effectively treating these behaviours, the active engagement and cooperation between the child, their family, and medical and mental health professionals together with other professionals are paramount for optimising prognosis, reducing oppositional behaviours, and improving later-life outcomes for children.

REFERENCES

1. Burke JD, Johnston OG, Butler EJ. The irritable and oppositional dimensions of oppositional defiant disorder: Integral factors in the explanation of affective and behavioral psychopathology. Child and Adolescent Psychiatric Clinics. 2021 Jul 1;30(3):637-47. https://dx.doi.org/10.1016/j.chc.2021.04.012
2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). Washington, DC: American Psychiatric Association Publishing; 2022.
3. World Health Organization. International Classification of Diseases, Eleventh Revision (ICD-11) [Internet]. 2011 [cited 2023 Jun 20]. Available from: https://icd.who.int/
4. Murrihy RC, Kidman AD, Ollendick TH, editors. Clinical Handbook of Assessing and Treating Conduct Problems in Youth. New York: Springer; 2010 Aug 26.
5. Ghosh A, Ray A, Basu A. Oppositional defiant disorder: current insight. Psychology Research and Behavior Management. 2017 Nov 29:353-67. https://dx.doi.org/10.2147/PRBM.S120582
6. Nathan PE, Gorman JM, editors. A guide to treatments that work. Oxford University Press; 2015 Jun 26.

7. Henggeler SW. Multisystemic Therapy for Antisocial Behavior in Children and Adolescents. New York: Guilford Press; 2009.
8. Nock MK, Kazdin AE, Hiripi E, Kessler RC. Lifetime prevalence, correlates, and persistence of oppositional defiant disorder: results from the National Comorbidity Survey Replication. Journal of Child Psychology and Psychiatry. 2007 Jul;48(7):703-13. https://dx.doi.org/10.1111/j.1469-7610.2007.01733.x
9. Copeland WE, Angold A, Costello EJ, Egger H. Prevalence, comorbidity, and correlates of DSM-5 proposed disruptive mood dysregulation disorder. American Journal of Psychiatry. 2013 Feb;170(2):173-9. https://dx.doi.org/10.1176/appi.ajp.2012.12010132
10. Lulla D, Mascarenhas SS, How CH, Yeleswarapu SP. An approach to problem behaviours in children. Singapore Medical Journal. 2019 Apr;60(4):168. https://dx.doi.org/10.11622/smedj.2019034
11. Henggeler SW. Multisystemic therapy. The encyclopedia of juvenile delinquency and justice. 2017 Oct 27:1-5.
12. Scotto Rosato N, Correll CU, Pappadopulos E, Chait A, Crystal S, Jensen PS, et al. Treatment of maladaptive aggression in youth: CERT guidelines II. Treatments and ongoing management. Pediatrics. 2012 Jun;129(6):e1577-86. http://dx.doi.org/10.1542/peds.2010-1361
13. Roy A, Hechtman L, Arnold LE, Sibley MH, Molina BS, Swanson JM, et al. Childhood factors affecting persistence and desistence of attention-deficit/hyperactivity disorder symptoms in adulthood: results from the MTA. Journal of the American Academy of Child & Adolescent Psychiatry. 2016 Nov 1;55(11):937-44. https://dx.doi.org/10.1016/j.jaac.2016.05.027
14. Elwin M, Elvin T, Larsson JO. Symptoms and level of functioning related to comorbidity in children and adolescents with ADHD: a cross-sectional registry study. Child and Adolescent Psychiatry and Mental Health. 2020 Dec;14(1):1-8. https://dx.doi.org/10.1186/s13034-020-00336-4
15. Pelham WE, Gnagy EM, Greiner AR, Hoza B, Hinshaw SP, Swanson JM, et al. Behavioral versus behavioral and pharmacological treatment in ADHD children attending a summer treatment program. J Abnorm Child Psychol. 2000 Dec;28(6):507-25. https://dx.doi.org/10.1023/a:1005127030251
16. Pringsheim T, Hirsch L, Gardner D, Gorman DA. The pharmacological management of oppositional behaviour, conduct problems, and aggression in children and adolescents with attention-deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder: a systematic review and meta-analysis. Part 2: antipsychotics and traditional mood stabilizers. Can J Psychiatry. 2015 Feb;60(2):52-61. https://dx.doi.org/10.1177/070674371506000203

LEARNING POINTS

- **Oppositional behaviours are typical in children given specific contexts and circumstances. However, persistent and frequent opposition towards multiple authority figures or peers presents an indicator for clinically significant oppositional behaviours.**
- **Intervention to manage oppositional behaviours in children requires a multimodal and comprehensive approach to assessment and treatment, to ensure the targeting of appropriate needs and any comorbid conditions.**
- **Psychosocial intervention is the primary approach to the management of oppositional behaviours, with pharmacological treatment recommended only if psychosocial interventions present little effective change after a period of implementation, and oppositional behaviours escalate.**