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Professors Cavell and Quetsch have produced the book that many in our profession have been waiting for. This book is grounded in the latest evidence and exhibits a humanity that speaks to the lived experiences of the parents who struggle with raising aggressive children and the therapists who seek to improve the lives of these families. I fully expect to find this book on the shelves of department clinics the world over and as required reading for graduate students' practicum coursework.

— **Andres De Los Reyes, PhD,** Editor-in-Chief, *Journal of Clinical Child and Adolescent Psychology,* and Professor of Psychology, University of Maryland at College Park

Drs. Cavell and Quetch are masters of translating and applying complex contextual concepts using clinically relevant language and examples. Their approach is remarkably compassionate, accessible, and practical, yet grounded in the latest evidence-based theories and research. The result is an important and timely resource for beginner or seasoned child clinicians interested in delivering the highest standard of care in diverse settings.

— **Terry Stancin, PhD, ABPP,** Clinical Child & Adolescent Psychologist; Fellow of the American Psychological Association; and Professor, Case Western Reserve University, Cleveland, OH

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1 AGGRESSION IN CHILDHOOD

This book is about how to work with parents of aggressive children.[1] It is based on three premises. The first is that *practitioners must be responsive to the needs of parents if parents are to be more responsive to the needs of children*. To be responsive, practitioners must learn to combine skill and motivation with an accurate understanding of the problems and opportunities that face parents of aggressive children. Working with these families can sometimes invite faulty assumptions. One is to question parents' concern for or commitment to their child's growth and development. Such questions can create a negative bias and missed opportunities to see real strengths every parent possesses. A second faulty assumption is being overly optimistic about or taking too much responsibility for changes parents and families make when

[1] Since the publication of the first edition of this book, person first language (PFL) has become convention. PFL puts the person before the disability in describing such individuals (e.g., children with ADHD). We considered the phrase "children with aggression" but found it awkward given that aggression is not a specific disability. In the end, we decided to retain use of the term *aggressive children*.

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working with us. Granted, there is considerable empirical support for parenting interventions for families with aggressive children (Kaminski & Claussen, 2017; McMahon et al., 2021; McMahon & Frick, 2019), but to believe every family with an aggressive child will be transformed and made indistinguishable from other families is neither sustainable nor recommended. Nor is it wise to overlook that parents—like all therapy patients—are active agents in the process of change, so it is important to recognize and facilitate their agency. Thus, the first lesson of this book is that helping parents of aggressive children requires a clear understanding of their strengths and struggles as well as a healthy dose of therapeutic humility. Practitioners who combine an inflated view of their therapeutic role with a narrow or biased vision of the parents with whom they work are likely to be frustrated by them and a source of frustration for them.

The second premise of this book is that *practitioners benefit from a flexible approach to working with parents of aggressive children, one that reflects accurately the state of the science on parenting and the socialization of aggressive children, as well as robust principles derived from evidence-based parenting interventions*. The next chapter offers a more detailed discussion of this point; for now, we simply note that our practitioner guide is not tied to any single intervention brand or protocol but draws from diverse sources to outline the process and practice of working with parents of aggressive children.

The third premise addresses parents' role in socializing children whose developmental trajectory is marked by early and heightened levels of aggression that signal significant risk for negative outcomes: *Socializing aggressive children requires their long-term participation in a parent–child relationship where parents effectively combine their capacity to accept, contain, and lead their children.* This premise has several implications. First, effective intervention for parents of aggressive children is not simply a matter of teaching skills or techniques that parents impose on their children; rather, it is an attempt to right a relationship that is struggling. Second, parenting strategies that promote children's long-term socialization warrant greater emphasis than strategies that promote children's short-term compliance. Third, parents' capacity to accept, contain, and lead is diminished when they experience recurring stress and their children are temperamentally difficult. Thus, a critical goal in working with parents of aggressive children is helping them find a combination of acceptance, containment, and leading that is realistic and sustainable given the circumstances of their parenting. This book is an attempt to articulate and illustrate strategies for that kind of parenting intervention.

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DEFINING AGGRESSION

Perhaps the most straightforward way to define *aggression* is as a class of behaviors that have an intrusive, demanding, and aversive effect on others (Olweus, 1979). Note that the emphasis here is on the impact of these behaviors and not their intent. Aggressive acts can be physical or verbal (e.g., hitting and shoving but also threatening others, purposefully disturbing others, being verbally combative, making derogatory remarks) as well as the destruction of property. Sometimes these behaviors are described as *coercive* or *agonistic* (Patterson, 1982), which again speaks to their impact more than their surface-level appearance or intent.

As noted in the Preface, very young children are as likely to use aggression as prosocial behavior when interacting with peers and others. They might grab, hit, scratch, bite, or throw tantrums. Fortunately, most of these behaviors fade over time as parents encourage the use of more prosocial forms of interaction. Research shows three main trajectories for physical aggression: (a) low desisting, (b) moderate desisting, and (c) high stable (Côté et al., 2006). Approximately one third of children are low desisting; they use aggression infrequently in toddlerhood and very rarely by preadolescence. Moderate-desisting children—about half the population—use aggression occasionally in toddlerhood and infrequently in preadolescence. Finally, about a sixth of children are high stable, meaning they maintain a high use of aggression over time. Although prevalence estimates vary based on research studies (e.g., Arsenio & NICHD Early Child Care Research Network, 2004), it is helpful for practitioners to understand developmentally normative forms of childhood aggression or coercive behavior and their different trajectories. In this book, the emphasis is on children whose aggressive behavior is persistent and signals a significant risk for negative developmental outcomes (e.g., school dropout, delinquency). This pattern of aggression tends to co-occur with other norm-violating acts and is often regarded as part of the larger construct of *antisocial behavior*, which can include both *overt* (e.g., verbal, physical aggression) and *covert* (e.g., stealing, truancy) forms (e.g., Hinshaw & Anderson, 1996). Finally, it is important to acknowledge that some forms of antisocial behavior (e.g., teen rebellion, smoking, drinking) are somewhat normative and limited to the adolescent period.

Three Kinds of Information: Normative, Idiographic, and Relational

A clear understanding of the challenges facing parents whose children are aggressive requires three kinds of information. The first is accurate information about what is *normative* for children who show heightened levels of

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aggressive behavior. The source of this information is empirical research documenting characteristics found generally or on average in samples of aggressive children. This is known as *nomothetic* research. The bulk of this chapter is devoted to reviewing that kind of information. The second type of information is *idiographic*, or that which is unique to the child in question. Examples include the child's race, ethnicity, family socioeconomic status (SES), medical history, level of intelligence, and particular diagnosis. Shirk and Russell (1996) suggested a lack of attention to idiographic information and an overreliance on normative or nomothetic data (and vice versa) can mislead the practitioner: In a purely nomothetic approach to clinical practice

> characteristics of the individual case tend to be equated with characteristics of the group as a whole. Consequently, it becomes tempting to move directly from diagnosis to intervention without an adequate assessment of the individual characteristics of the specific case. The logic goes something like this: If aggressive children have been shown to be deficient in problem-solving skills, and a child is identified as aggressive, problem-solving therapy is often judged to be the treatment of choice. (p. 266)

Other case-specific factors that could play a role are whether aggression is (a) a long-standing problem or a recent development, (b) evident in multiple domains or only at home, (c) an isolated problem or part of a mix of antisocial behavior (e.g., lying, stealing), (d) comorbid with other diagnoses (e.g., learning problems, hyperactivity), and (e) balanced in part by significant positive attributes (e.g., intelligent, athletic, attractive). It is also helpful to know whether parents are relatively healthy and knowledgeable about parenting and child development, whether the home is organized and safe or prone to chaos, whether teachers and peers have begun to reject the child interpersonally and emotionally, and whether the child shows remorse or guilt after hurting others.

The third type of information practitioners need pertains to the quality of the *relationship* between parents and their aggressive child—how they interact with and experience each other. The way children and parents behave in the context of their relationship is sometimes distinct from how they function in other relationships (Dumas & LaFreniere, 1993). Thus, the status and history of their relationship, as well as the meaning it holds for them, are important.

All three types of information—normative, idiographic, and relational—have bearing on how practitioners work with parents of aggressive children. Practitioners are advantaged when their work follows a solid case formulation that combines a general working knowledge of aggressive children, a focused

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idiographic understanding of the specific child in their office, and a sense of how the child and parent typically interact.

THINGS TO KNOW, IN GENERAL, ABOUT AGGRESSIVE CHILDREN

The remaining sections of this chapter are for readers who want to update their working knowledge of what is known generally about aggressive children. The goal here is to place the work of "parent-helping" into its proper nomothetic context. We begin by discussing the value of adopting a developmental psychopathology perspective when seeking to understand the history and future trajectory of at-risk children. We then address issues of definition, diagnosis, and temporal stability before reviewing the rather large literature on the causes and correlates of childhood aggression. We also discuss variability within samples of aggressive children and current trends in assessment and treatment. Readers familiar with this literature might wish to move on to Chapter 2. Readers who want an even deeper understanding of the science that underlies the development of aggression in children are referred to various other resources (Dishion, 2014; Frick & McMahon, 2008; Frieze et al., 2020; Kemp et al., 2020; Koops & de Castro, 2020; Lansford, 2018; Malti & Rubin, 2018; McMahon & Frick, 2019; Patterson et al., 1989, 1997; Walker et al., 2020).

A Developmental Psychopathology Perspective

A developmental psychopathology perspective emphasizes the interplay of genetic and environmental factors (Kuo et al., 2022; Su et al., 2018) as well as the reciprocal or transactional nature of children's interactions with the environment and the processes by which those transactions promote or disrupt children's ongoing development (Mash & Dozois, 1996; Richters & Cicchetti, 1993). Key assumptions of this model include the following:

- Children play an active role in their own development.
- Developmental outcomes are best predicted through consideration of genetic influences as well as prior experience and recent adaptations examined in concert.
- Individual choice and level of integration among children's biological, cognitive, emotional, and social systems play important roles in determining the course of development.

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- Transitional turning points or sensitive periods in developmental processes are most susceptible to positive and/or negative self-organizational efforts.

Developmental scientists view aggression as a form of antisocial behavior characterized by *heterotypic continuity* (Dishion, 2014; Kemp et al., 2020; Lansford, 2018), which means it can look different at different points in time: (a) strong-willed toddlers who are easily frustrated and difficult to soothe; (b) oppositional preschoolers who taunt siblings and defy parents; (c) hard-to-manage second-graders who disobey class rules and fight with peers; (d) socially rejected fourth-graders who fall behind academically and engage in lying and swearing; (e) troubled high schoolers whose peers are known for skipping classes, smoking cigarettes, vandalizing property, and shoplifting. The sequential unfolding of these processes has been described as a *developmental cascade* (Dodge et al., 2008), which has profound implications for the treatment of aggressive children (McMahon & Frick, 2019). A young child's use of aggression in the home becomes more serious when it is exported out of the home and used to influence peers and teachers at school. Aggressive school-age children are often rejected by classmates, which can lead to a disaffection with school-related values and a tendency to associate with more deviant peers. This last step is often followed by a rapid acceleration in delinquent behavior by like-minded peers (Dishion, 2014; Lansford, 2008; Patterson et al., 1989). Over time and with repeated episodes, antisocial behavior becomes a more deeply rooted aspect of a child's personality (Kemp et al., 2020).

Diagnosing Children Who Act Aggressively

Highly aggressive children typically meet criteria for a diagnosis of conduct disorder (CD), but aggression is a common feature for several disorders of childhood and adolescence (Buchmann et al., 2014). CD is a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated (American Psychiatric Association, 2022). To meet diagnostic criteria, children must manifest at least 3 such violations in the past 12 months, with at least 1 within the past 6 months. Violations are grouped into four categories: (a) aggression to people and animals, (b) destruction of property, (c) deceitfulness or theft, and (d) serious violations of rules (e.g., truancy, running away). Nock et al. (2006) used data from structured diagnostic interviews with respondents ($n = 3{,}199$) in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*; American Psychiatric Association, 1994) National Comorbidity Survey Replication to estimate the prevalence of CD in the United States. In reviewing

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prior studies, Nock et al. found estimates ranging from 6% to 16% for males and 2% to 9% for females based on *DSM-III* and *DSM-III-R* criteria. Using *DSM-IV* criteria, the estimated prevalence in the United States was 9.5% (12.0% among males and 7.1% among females), with a median age-of-onset of 11.6 years.

A diagnosis of CD requires specification on three indicators, all of which carry important implications for intervention. The first specification is for child-onset versus adolescent-onset CD, which is a distinction supported by extensive research (e.g., Moffitt, 2006). Moffitt and Caspi (2005) found important differences in the developmental trajectories of youth with child-onset CD (i.e., *life-course persistent offenders*) versus those with adolescent-onset CD (i.e., *adolescent-limited offenders*). Compared with their late-onset counterparts, children diagnosed with CD tend to have a higher incidence of comorbid hyperactivity, impulsivity, and inattention. They are also more likely to suffer deficits in verbal intelligence and executive functioning. There is additional evidence suggesting they are more likely to have a family history that is positive for substance abuse and criminality.

Another CD diagnosis specification addresses whether the child has limited prosocial emotions, which is indicated by one or more of the following: (a) lack of remorse or guilt (does not feel bad or guilty when he or she does something wrong), (b) callousness or lack of empathy (disregards and is unconcerned about the feelings of others), (c) unconcerned about performance (indifferent to poor/problematic performance at school, at work, or in other important activities), (d) shallow or deficient affect (does not express feelings or show emotions to others, except in ways that seem insincere or superficial). Callous-unemotional (CU) traits are characteristic of a small subgroup of children thought to be genetically vulnerable to developing CD symptoms and antisocial tendencies (Wilkinson et al., 2016). Children high in CU traits tend to exhibit a pattern of antisocial behavior that is more severe and aggressive than those without these traits. Early intervention is thought to be critical for children with CU traits, but it also appears that CU traits predict poor treatment outcomes (McMahon et al., 2021). There is also research showing that poor discipline is not a reliable predictor of key outcomes for children with CU traits (Oxford et al., 2003; Wootton et al., 1997). However, there is some indication that these children are responsive to parents' use of warm, positive parenting practices (e.g., Hawes & Dadds, 2007).

A final specifier refers to the level of severity of the CD symptoms, with options to designate symptoms as mild, moderate, or severe. Children with mild symptoms are engaged in behaviors that cause relatively minor harm to others. Examples include lying, truancy, and staying out after dark without permission.

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Young children whose levels of aggression and antisocial behavior are not severe enough to meet criteria for CD typically meet criteria for oppositional defiant disorder (ODD). Children diagnosed with CD often have a history of ODD, although few children diagnosed with ODD go on to develop CD (Moffit & Caspi, 2005). ODD is characterized by a persistent pattern of angry/irritable mood, argumentative/defiant behavior, and/or vindictiveness (American Psychiatric Association, 2022). Prevalence estimates for ODD range from 1.4% to 12.3%, with symptoms generally beginning during the preschool years (Demmer et al., 2017). A newer diagnostic category is disruptive mood dysregulation disorder (DMDD). Symptoms of this childhood condition are like those used to diagnose children with ODD but with greater emphasis on problematic mood and poor affect regulation. DMDD is marked by extreme irritability, anger, and frequent, intense temper outbursts. There is some speculation that children with DMDD will, over time, show less disruptive behavior but experience more frequent symptoms of anxiety or depression. Given this mix of symptoms and difficulty regulating emotions, these children often struggle in their relationships with family and peers (Lin et al., 2021).

Aggressive behavior is also commonly observed in children diagnosed with attention-deficit/hyperactivity disorder or ADHD (American Psychiatric Association, 2022). It is estimated that up to 50% of children diagnosed with ADHD display high rates of conduct problems (Connor et al., 2007). Other conditions likely to involve childhood aggression include autism spectrum disorder, anxiety disorders such as obsessive–compulsive disorder, and mood disorders such as depression and bipolar disorder (Buchmann et al., 2013; Connor & McLaughlin, 2006; Gabel & Shindledecker, 1992; Kohn & Asnis, 2003). Depending on the circumstances surrounding children's use of aggression, it is also possible they will meet criteria for adjustment disorder, acute stress disorder, or post-traumatic stress disorder. Nock et al. (2006) also found that a diagnosis of CD "typically precedes mood and substance use disorders, but most often occurs after impulse control and anxiety disorders" (p. 699).

THE STABILITY OF CHILDHOOD AGGRESSION

Aggression manifested early in life tends to be rather stable over time. In fact, the stability of childhood aggression has been likened to that of intellectual functioning (Huesmann et al., 1984, p. 1120). Huesmann et al. (1984) reported stability coefficients for aggression of .50 for boys and .35 for girls. The likelihood of changing the developmental trajectory of child-onset CD also tends to diminish over time (Moffitt et al., 2002). Campbell et al. (1994;

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Pierce et al., 1999) studied the stability of aggression in children 3 years of age. When the first cohort was assessed at age 13, Campbell et al. found that 41% of those in the hard-to-manage group received a diagnosis of ODD or CD compared with only 8% of control children. In a second cohort of hard-to-manage boys, 28% received ODD or CD diagnoses at age 9 compared with 8% of control children.

These researchers also examined the *persistence* of problem behavior among hard-to-manage preschoolers. In the first cohort, 50% of hard-to-manage young children exhibited significant levels of problem behavior when assessed at age 6 and again at age 9. The remaining 50% failed to show a persistent pattern of problem behavior across these two assessment points. Of those children who showed persistent problems, 65% received an ODD or CD diagnosis at age 13 compared with only 18% in the nonpersistent group. When any disruptive behavior diagnosis was considered (ODD, CD, or ADHD), children in the persistent problem group were 52 times more likely to meet diagnostic criteria than hard-to-manage children with inconsistent problems. In the second cohort, 27% of hard-to-manage preschool boys showed a persistent pattern of problem behavior and 73% improved when reassessed at age 6. When these boys were evaluated again at age 9, 59% of the persistent group met criteria for an externalizing disorder diagnosis (ADHD, ODD, or CD) compared with only 24% in the improved group. Findings from this study indicate children whose early problem behavior persists past school entry are very likely to meet diagnostic criteria for ODD, thus supporting the use of programs that assist parents and teachers of hard-to-manage preschool children. These findings also suggest that interventions for aggressive preschoolers are likely to yield greater gains than treatments targeting aggressive school-age children simply because a significant percentage of hard-to-manage preschoolers (50%–73%) do not persist in problem behavior past the ages of 6 or 9.

The stability of childhood aggression runs counter to what is sometimes referred to as the "50% rule" (Lahey et al., 1995), which suggests that roughly half of the children diagnosed with CD will improve over time and no longer show signs of aggressive or antisocial behavior. Challenging this clinical folklore are findings indicating that aggression beginning in childhood is quite persistent (Fergusson et al., 1995; Lahey et al., 1995). Fergusson et al. (1995) followed children whose behavior problem scores were in the top 10%, and Lahey et al. (1995) studied boys meeting *DSM-III-R* criteria for CD. Both studies involved children at least 7 years of age and both studies replicated the 50% rule: Approximately half of the cases no longer met criteria when assessed 1–4 years later. However, Fergusson et al. found that 86.4% of cases were likely to remain as cases 2 years later, and Lahey et al. found that 88% of boys who were

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diagnosed as CD in Year 1 met criteria for CD again at least once during the ensuing 3 years. Thus, whereas extreme levels of aggression may not be highly stable over time, persistent aggression is associated with more extreme levels of aggression (Moffitt, 1993).

As we noted earlier, the stability of childhood aggression is sometimes hidden by developmental changes in the manifestation of antisocial behavior. Thus, aggressive behavior in children can be thought of as a potential launching point for a lifetime of varied forms of antisocial behavior (Moffitt & Caspi, 2005). Indeed, many adults who commit violent and criminal acts have a history of early childhood aggression (Eron, 1987). In fact, aggression that begins early in childhood is the single best predictor of later criminal behavior (Loeber, 1990; Patterson et al., 1997). Eron (1987) reported that children rated as aggressive by peers at age 8 were 3 times more likely to have been entered on police records by age 19 than those not so rated. Of course, not all aggressive children become delinquents or adult criminals, but the risks are very real. Patterson and Yoerger (2002) found that 50% of children identified as aggressive by the age of 9 or 10 were likely to be arrested by the age of 14; moreover, 75% of those arrested at age 14 were likely to have three or more arrests by age 18. Another way to view the stability of aggressive behavior is in its tendency to be repeated from one generation to the next. Huesmann et al. (1984) found that aggression measured in children at age 8 was significantly related to their level of aggression at age 30 (i.e., path coefficient = .58). Likewise, among those 30-year-olds who had become parents, the level of aggressive parenting they used was significantly related (path coefficient = .55) to their own child's level of aggression.

THE CAUSES AND CORRELATES OF CHILDHOOD AGGRESSION

Variables most often implicated as causes and correlates of aggression can be organized into the following categories or contexts: (a) self-regulation, (b) family/parenting, (c) social cognitive, (d) peer, (e) academic, (f) teacher/school, and (g) neighborhood/community.

Self-Regulation

Children's capacity to self-regulate is heavily influenced by biologically based factors such as genetic tendencies (e.g., temperament) and perinatal events (e.g., low birth weight) that predispose some children to react to their environment in ways that impede their growth and their amenability to

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socialization. For example, persistent demands from a temperamentally difficult child can precipitate a cycle of interaction whereby parents' attempts to gain control over the child's behavior can lead to even more intense oppositional reactions. Other biological factors contributing to poor self-regulation include symptoms of ADHD and hormonal imbalances, including high levels of testosterone (see Allen et al., 2018).

The primary symptoms of ADHD (impulsivity, inattention, hyperactivity) are thought to place children at risk for a host of problems (e.g., frequent and intense shifts in negative emotions) that can set the stage for later aggression (Slaughter et al., 2019). For example, untreated ADHD symptoms can make it difficult for parents to manage a child's behavior, thus potentiating the occurrence of increasingly negative and coercive interactions that directly foster aggression (Breaux & Harvey, 2019; Patterson, 1986). Similarly, disciplinary conflicts with teachers can impede the academic progress of children with ADHD and lead to a negative reputation among peers (Metzger & Hamilton, 2021; Mikami et al., 2020; Na & Mikami, 2018; Rushton et al., 2020). Impulsivity is not limited to youth with ADHD and should be considered a risk factor regardless of a child's diagnosis, especially if combined with emotional reactivity. A lack of emotional control can interfere with children's play interactions and diminish their level of acceptance among peers. Difficulty sustaining attention can interfere with the acquisition of fundamental academic skills and when combined with peer rejection can precipitate school failure, association with deviant peers, and substance use (Farrell et al., 2017; Fried et al., 2016; Grygiel et al., 2018; Marshal et al., 2003). Another way to view the interaction between ADHD and aggression is to recognize that hyperactivity without co-occurring aggression, although still predictive of adjustment difficulties (e.g., lower academic performance), is far more benign than when it is accompanied by aggressive behavior (Hinshaw & Anderson, 1996; Walker et al., 1987).

Family and Parent Factors

Family and parent factors that can contribute to the development of childhood aggression include (a) family strain, (b) specific parenting behaviors or practices, (c) family transitions, and (d) parents' personality and emotional functioning.

Family Strain

Families can experience strain from economic deprivation, job instability, the challenge of parenting alone, having many children, cultural marginalization

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or racial injustice, or other stressors (Kendall & Hatton, 2002; Liang et al., 2019; Neppl et al., 2016; Nomaguchi & Johnson, 2016; Pereira et al., 2015; Utsey et al., 2008). The presence of youth oppositionality or aggression can also have a significant impact on parental strain and stress (Babinski et al., 2020). The influence of youth oppositional or aggressive behaviors on parental or family strain is generally thought to be bidirectional in nature (Labella & Masten, 2018).

Of the many factors that can increase family strain, SES has shown the most consistent and predictive links to antisocial behavior (especially severe forms; Loeber et al., 1991; Patterson et al., 1991; Piotrowska et al., 2015). Poverty can influence the development of aggressive behavior both directly and indirectly through mechanisms such as parental negativity, low warmth, high levels of harsh parenting styles, and family violence (see Labella & Masten, 2018). Practitioners should be purposeful in their assessment of contextual factors that affect family functioning when working with parents of aggressive children. Although early studies of family strain focused primarily on White, Western samples, more recent efforts recognize the importance of studying racially and ethnically marginalized populations and the role of intersectionality in the life of non-White families (Deater-Deckard & Dodge, 1997; Dixon et al., 2008). Indeed, strain from microaggressions and discrimination can take many forms, including legalized exclusion, disempowerment, and systemic injustice (Davis et al., 2022). Further, racial microaggressions can worsen the experience of co-occurring stressful events, negative emotions, and adolescent offending or delinquency (De Coster & Thompson, 2017), which can negatively affect the whole family. Practitioners who take a holistic approach to parent-based interventions know the value of having open discussions about and holding space for the diverse cultural experiences of their patients.

Parenting Practices/Tendencies

One of the strongest findings to emerge from the study of childhood aggression is the significant role parents play in the development of children's tendency to behave aggressively (Labella & Masten, 2018; Patterson, 1986). Several parenting variables have been studied, including parents' effectiveness as a disciplinarian, their tendency to be overly punitive or emotionally rejecting of children, their level of warmth and positive involvement, their ability to monitor children's whereabouts, and the level of stability and organization they create in their homes. Though it can be difficult to separate parent effects (e.g., overly punitive discipline) from child effects (e.g., difficult temperament), most researchers agree these two factors operate transactionally in the development of childhood aggression (Vitaro et al., 2006; Xu et al., 2009).

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Perhaps the most influential model detailing the relation between parenting and children's conduct problems is the developmental social interactional learning model put forth by Patterson and his colleagues (Forgatch, 1991; Patterson, 1986; Patterson et al., 1991, 1997, 2010). Using advanced methods of observational assessment and guided by the principles of operant and social learning theory, Patterson's research team painstakingly recorded moment-to-moment interactions among family members in the home. Patterson (1982) found that a child's level of aversive behavior could be predicted from interactions with other family members. These and other findings led Patterson to speculate that parents were essentially, though inadvertently, "training" their children to become aggressive. As he put it, "Failure by parents to effectively punish garden variety, coercive behaviors sets into motion interaction sequences that are the basis for training in aggression" (Patterson, 1986, p. 436).

Patterson's (1982) *coercion hypothesis* posits that children's natural tendencies to engage in coercive behaviors (e.g., whining, noncompliance), whether to assert autonomy or to elicit specific caregiving behaviors, are inadvertently and negatively reinforced by parents who yield to those demands. The basic training for aggressive behavior is also characterized by parents who escalate their own level of coercion via intermittent "explosive" discipline or engage in frequent and chronic "nattering" toward children. Aversive parental behaviors, in turn, occasion increasingly coercive behavior from children and function to establish extended chains of mutually aversive behaviors. As the frequency and duration of these mutually aversive interactions increase, the likelihood that aggression and other more serious forms of coercion will occur also increase. Therefore, Patterson (1982; Patterson et al., 1997) continually stressed that a primary goal of parenting interventions is to eliminate or to reduce coercive chains of interaction that involve children and other family members.

Partial support for Patterson's (1982) coercion hypothesis was found in the reports of other researchers who conducted similar microanalytic studies of the interactions of families with children displaying conduct problems (e.g., Forehand et al., 1975; Johnson & Lobitz, 1974; Snyder, 1977). Further, findings from this research were interpreted as evidence that parents of aggressive children lacked the kinds of behavior management skills that a trained behavior modifier might use. Importantly, several early studies (e.g., Griest et al., 1980) failed to support the notion that parents of conduct-problem children were inadvertently reinforcing their child's use of aggression. Snyder and Patterson (1995) noted that researchers who study clinic-referred and nonreferred families generally find very small differences in the rates at which aggression is reinforced. In fact, researchers initially speculated that training

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parents to extinguish (i.e., ignore) children's inappropriate behavior and reinforce their use of more desirable behavior was sufficient to eliminate coercive patterns of interacting. However, further research revealed that punishment techniques such as time-out were also needed if parents were to effectively discipline children prone to using aggression (Patterson & Fleischman, 1979).

For Patterson, inept discipline and ineffective monitoring constitute the "basic training" of childhood aggression. Although modeling and positive reinforcement are also part of this process, the training of aggressive behavior is thought to rely primarily on negative reinforcement and escape conditioning. Children who successfully use coercive behavior to escape situations in which their parents were attempting to exert control are likely to repeat such acts. Patterson and colleagues developed and tested how coercive processes operate in both micro- and macrolevel models (Dishion et al., 2014; Patterson et al., 1989, 1997, 2000). The *microlevel* model focuses on coercive exchanges between children and parents that serve to strengthen aggression over time, whereas the *macrolevel* model involves network dynamics outside the home and includes the tendency for aggressive youth to affiliate with deviant peers who reinforce one another's aggression and antisocial behavior (Lansford, 2018). As Lansford (2018) noted, interventions designed to prevent growth in aggression and antisocial behavior "will be more successful if they target microdynamic and macrodynamic social processes in a developmentally sensitive way" (p. 18).

Parenting that is harsh and overly punitive; that involves parental rejection; and that lacks sufficient warmth, nurturance, or positive parental involvement can also contribute to childhood aggression (e.g., Dodge, 2002; Eron, 1987; Greenberg & Speltz, 1988; Loeber, 1990; Parke & Slaby, 1983). The relation between factors such as parental warmth and childhood aggression can be understood from multiple theoretical perspectives. From an operant learning perspective, emotionally rejecting parents are thought to have less value as reinforcing agents than parents who are warm and attentive (Eyberg, 1988). Other researchers view a lack of parental warmth or parental rejection as an instigating factor, prompting children to respond to parents more defiantly and aggressively than they would otherwise (Eron, 1987; Putallaz & Heflin, 1990). Others have interpreted the role of parental warmth in terms of Bowlby's (1982) theory of attachment. Young children whose sense of felt security is threatened by insensitive parenting might use angry aggressive behavior to signal distress, and these early experiences are thought to be carried forward as internal or social cognitive models that can skew how children view and operate in interactions with peers, teachers, and others (Greenberg & Speltz, 1988).

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Another key aspect of parenting is family stability or organization (sometimes encompassed by the presence of routines, rituals). Here we refer to parents' ability to maintain a sense of order and predictability in the home (Fiese et al., 2002; Radke-Yarrow et al., 1988) as well as their use of appropriate generational boundaries (Andolfi, 2013; Lowe, 2004; Minuchin, 1974; Sroufe & Fleeson, 1988). Parents who do not distinguish between adult roles and child roles and who live in homes marked by frequent chaos will generally find that their capacity to perform other aspects of parenting (e.g., discipline, emotionally positive interactions) is greatly diminished (Maccoby & Martin, 1983).

Family Upheaval and Transitions

Family upheaval and transitions refer to stressful events and shifting circumstances that can have a significant and deleterious impact on family functioning. Marital dissatisfaction, separation, divorce, and parental alcoholism are common examples of family disruption or challenging transitions. Numerous studies have found an association between disruptive events and behavior problems in general; furthermore, researchers have also recognized the impact that externalizing behavioral problems and aggression can have on families. For example, compared with families of children without aggressive behaviors, parents of aggressive children tend to report more negative (less positive) feelings about parenting, tend to have higher stress related to their child, and tend to view their children as having a more negative impact on their social life (Donenberg & Baker, 1993). Some research has also demonstrated that child disruptive behavior and parent psychological concerns reciprocally interact over the course of a child's development (Gross et al., 2008).

Researchers have also explored how stressful events and disruptive circumstances can impact children indirectly. For example, children whose parents engage in frequent conflict—especially conflict that goes unresolved—tend to develop maladaptive ways of coping with emotional displays in others and with emotional arousal in themselves (Artz et al., 2014; Cummings et al., 1991). Also, family disruptions, particularly when severe and prolonged, are believed to interfere with essential parenting practices, which in turn leads to negative child outcomes, such as aggressive behavior, physical health concerns, delinquency, victimization, and academic issues (Artz et al., 2014; Patterson et al., 1989); moreover, these consequences can build upon one another over time. An important, treatment-relevant implication of these findings is that children are not fated to suffer from events such as divorce, parental alcoholism, and the

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like; indeed, children whose parents continue to respond warmly and firmly might be relatively unaffected by family disruptions (Kelly, 2012; Park & Schepp, 2015).

Parents' Personality and Emotional Functioning

Certain personality traits in parents have been shown to be related to children's level of antisocial behavior (Pinquart, 2017). For example, tendencies toward criminality, antisocial personality, and substance abuse are often evident in the parents of aggressive children. Other research has shown that parents' use of emotion-driven parenting that is overly harsh or psychologically controlling can also contribute to the development of child externalizing and aggressive behavior (Pinquart, 2017). Similarly, maternal depression is frequently found to be associated with children's conduct problems, with competing theories about the factors that specifically mediate this relation (e.g., DiMarzio et al., 2021). There is also evidence for an association between childhood aggression and antisocial personality traits that suggests a shared genetic endowment, although other processes could be operating (Silberg et al., 2012). For example, recent studies suggest antisocial personality traits in parents predict family disruptions (e.g., marital dissatisfaction, divorce, remarriage) that interfere with essential parenting practices (Harold et al., 2012).

Social Cognitive Factors

There is considerable empirical research indicating that aggressive children exhibit social cognitive deficits and distorted thinking that can crystalize in adolescence and lead to a persistent pattern of aggressive behavior (e.g., Langley et al., 2010). These deficits and distortions are usually described as gaps in a particular stage of social information processing (Crick & Dodge, 1994). Commonly cited stages include (a) encoding, (b) interpretation, (c) response search, (d) response decision, and (e) enactment. Socially competent responses are those in which an individual attends to the relevant aspects of the social situation, accurately interprets social cues, generates appropriate social responses, selects a response, and effectively implements the selected response in that situation. Skills used at these stages are thought to be interdependent such that performance at earlier stages affects performance at later stages. An aggressive response, therefore, is an outcome of the social information processing that preceded it.

Aggressive children tend to respond quickly to social situations and assume hostile intent without taking advantage of all available social cues (Dodge & Frame, 1982; Dodge & Newman, 1981; Slaby & Guerra, 1988). These tendencies

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are thought to be rooted in their early socialization experiences and are thought to operate at an unconscious level, although for preschool children, maladaptive emotion regulation likely plays a stronger role (Dodge et al., 1995; Helmsen et al., 2012). Aggressive children and adolescents also tend to exhibit deficiencies in generating effective, nonaggressive solutions to conflict situations and are prone to adopting retaliation as an interpersonal goal (Mathieson et al., 2011; Richard & Dodge, 1982). Implementing prosocial solutions to problem interactions is also difficult because aggressive youth often show deficits enacting various interpersonal skills, from either a lack of ability, errors or distortions in their social reasoning, or insufficient motivation (see Hubbard et al., 2010, for a review). It is worth noting that research on the behavioral enactment of children's social skills has often relied on behavioral role-play assessments rather than naturalistic observation (Feldman & Dodge, 1987; Yeager et al., 2013).

Beliefs

Researchers have also posited a role for children's general beliefs, motivations, and goals such that both social information processing skills and underlying beliefs are considered important codeterminants of children's use of aggressive versus nonaggressive response tendencies (Crick & Dodge, 1994). Children's beliefs and strategies for managing emotions and interpersonal conflict are thought to influence their processing of social information. For example, hostile attributional biases likely reflect a general belief that others are hostile adversaries, which can lead to felt anger and expressed aggression (Guerra & Slaby, 1989; Hiemstra et al., 2019). Similarly, aggressive children are more likely to believe aggression is a legitimate response to a wide range of situations, suggesting a view of the world and others as threatening.

Researchers have also studied children's beliefs about adult authority figures, including parents and teachers (Schneider et al., 2003). Schneider et al. (2003) developed a measure of *perceived containment*, defined as children's belief that a person in authority (e.g., parent, teacher) has the capacity to hold them accountable and limit their behavior (Cavell, 2000). Items on this measure were intentionally written to reflect the notion that few children believe they have greater power than the adults in charge (e.g., "You want to play with some friends outside. Your mom says you can't go. Can she make you stay inside?"). In a sample that included both aggressive and nonaggressive children, these researchers found that most children believed parents and teachers were in charge and, as expected, that better parental discipline predicted fewer problem behaviors. However, for those few children

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who lacked a sense of containment, their heightened levels of aggressive, antisocial behavior were unrelated to the quality of their parents' discipline.

Views of Self

A topic that continues to be debated is how aggressive children view themselves, both apart from and in relation to others. Outcomes have been mixed with some studies suggesting that aggressive children tend to inflate their self-views (high self-esteem, possible narcissism), whereas others suggest that low self-esteem is a leading contributor to aggression and violent behavior (Ostrowsky, 2010). Hughes et al. (1997) studied the tendency for aggressive children to engage in a kind of *self-idealization*, which was defined as a perfect score on measures of perceived competence and support from others. Also examined was *inflation*, which referred to discrepancies between a child's self-ratings and the ratings of others (e.g., teachers, parents, peers). Aggressive children evinced a tendency to do both, and their levels of idealization and inflation were significantly linked to their level of aggression.

Peer Factors

An important aspect of youth development is their peer network. Although peer relationships can positively influence children's development, associating with peers who engage in delinquent behavior is one of the more robust predictors of adolescents' antisocial behavior. As noted earlier, children who are coercive in their interactions with classmates and teachers, who are rejected by peers, and who struggle academically often gravitate to the company of similarly disaffected and deviancy-prone peers.

Peer Rejection

Social rejection—as measured by negative peer nominations—has been shown to be a robust predictor of children's later adjustment (Parker & Asher, 1987). A consistent finding to emerge from this research is that children prone to act aggressively are often rejected by their classmates (Lansford et al., 2010), which, as noted earlier, can lead to deviant peer affiliation and increased risk for delinquent behavior (Chen et al., 2015). Researchers estimate that nearly half of all rejected children are behaviorally aggressive (Coie et al., 1990). Approximately one third of children identified as aggressive avoid peer rejection whereas those numbers increase to two thirds during adolescence (see Youngblade et al., 2009). Both peer rejection and aggressive behavior are stable phenomena (Ladd et al., 2008; van Lier et al., 2009; Warman & Cohen, 2000), which reflects the reciprocal influence each has on the other (Coie et al., 1990;

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Price & Dodge, 1989). There is also a tendency for aggressive children to acquire a negative reputation among peers that further solidifies their rejected status (Hymel, 1986). In fact, prosocial acts performed by rejected children are likely to be interpreted by peers as uncharacteristic and due to external factors, whereas mild or infrequent displays of aggression are generally seen as fitting their negative reputation. The net effect of these circumstances is that aggressive rejected children have little incentive to change their use of aggression to influence others. We should also note that researchers are still trying to understand the role of gender in the relation between aggression and peer rejection (Ettekal & Ladd, 2015).

Friendships

Children's ability to form friendships overlaps with but is also distinct from their overall level of peer acceptance (Ettekal & Ladd, 2015; Parker & Asher, 1993). Ideally, friendships are characterized by symmetrical reciprocity, communion, solidarity, and agency (Hall, 2010), although boys' friendships involve less self-disclosure than girls' friendships (Almquist et al., 2014). Children who are aggressive tend to have friends who are also aggressive (Cairns et al., 1988; Powers et al., 2013; Rose et al., 2004) and to have greater conflict in their friendships (Deptula & Cohen, 2004), which contributes to additional growth in aggressive and antisocial behavior (e.g., Patterson & Yoerger, 2002; Snyder et al., 2005). Several studies involving laboratory observations have explored the relation between friendship quality and aggressive behavior in adolescents with CD and their friends (Dishion et al., 1995; Panella & Henggeler, 1986). Panella and Henggeler (1986) found that adolescents with CD showed less interpersonal skill and less positive affect than well-adjusted adolescents. Also, the authors reported anecdotally that several adolescents with CD had difficulty thinking of a friend who might participate with them in the study.

In the study by Dishion et al. (1995), antisocial boys (ages 13–14 years) and their close friends were interviewed and observed interacting together in a problem-solving task. The close friends of antisocial boys tended to have shared demographic and delinquent characteristics. The investigators also found that "relationships of antisocial dyads were somewhat low in quality, of relatively short duration, were perceived by the boys as marginally satisfactory" and were likely to end in bitterness (p. 148). Another interesting aspect of this study was that coders' global impressions of the boys' bossy and coercive style were more highly correlated with their antisocial behavior than were more objective behavior counts. It would follow, therefore, that other individuals who interact with these antisocial boys might also find offense in their behavior. These and other findings raise questions about whether friendships are protective for

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aggressive youth. It appears that children whose friends are also aggressive and antisocial are less likely to benefit from the socioemotional aspects of these relationships. There is also evidence that adolescents interacting with deviant friends tend to reinforce (via contingent laughter) each other's talk of rule-breaking behavior (Dishion et al., 1996). This same process was not found when deviant youth interacted with a nondeviant friend.

Academic Factors

Aggression and poor academic performance often co-occur. A lively and ongoing debate has surrounded the question of whether aggression is a cause or a consequence of academic difficulties. Some studies find that aggression and associated conduct problems are best predicted by earlier cognitive deficits or genetic influences (Koenen et al., 2006; Schonfeld et al., 1988), suggesting aggressive, externalizing behavior and academic deficiencies are both the result of common, underlying factors such as attentional difficulties and neurodevelopmental delay (Hinshaw, 1992). Other investigations, however, indicate that aggressive and antisocial behavior happen before school failure that results from problematic relationships with teachers and classmates, which are then followed by increased disengagement from academic tasks over time (e.g., Dishion et al., 1991; Patterson et al., 1991; Stipek & Miles, 2008). For our purposes, it is sufficient to recognize that academic difficulty is a frequent concomitant of childhood aggression.

Teacher and School System Factors

Teachers, like parents, can vary widely in their ability to discipline firmly and relate warmly to aggressive children (Gregory & Weinstein, 2008; Hughes et al., 1999; Mainhard et al., 2011; McLean et al., 2020). Variability in how teachers respond to children who are aggressive is significant in that classmates' judgments about their peers are often based on how teachers react to instances involving misbehavior and poor academic performance (Morrison et al., 1983; Retish, 1973). How schools respond to aggressive children can also vary, although most place heavy emphasis on compliance, cooperation, and academic engagement. Thus, the degree to which children are a good fit for their school context is an important consideration, especially for children of color. Compared with their White classmates, Black and Brown children are more likely to be viewed as aggressive and to be reprimanded and removed from school even when exhibiting similar behaviors (Bottiani et al., 2017; Gregory & Weinstein, 2008; Martin et al., 2016; Wun, 2016). Thus, it is

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important to recognize the potential role of racial bias when working with aggressive children referred by teachers or school counselors. Also relevant is whether schools are structured in ways that are likely to benefit children at risk for antisocial behavior (Dodge, 1993).

Neighborhood and Community Factors

For some children, a pattern of heightened levels of aggressive behavior could be an adaptive response to their neighborhood and community. In neighborhoods and communities in which extreme acts of violence are not uncommon, physical and verbal aggression could be construed as a necessary strategy for one's survival, albeit with both acute and enduring negative effects on youths' development (Garbarino, 1995; Kirk & Hardy, 2014; Richters & Martinez, 1991). Indeed, there is some evidence that exchanging verbal insults and threats can serve a communicative function when establishing a cohesive peer group in violence-prone communities (Goldman et al., 2014; Prinz & Miller, 1991). Thus, practitioners sometimes face the dilemma of discerning whether aggression used in dangerous environments is a "natural manifestation of normal peer group socialization" (Prinz & Miller, 1991, p. 380) and whether intervention to reduce aggression is appropriate if it is "equivalent to declawing the cat—removing the psychological and behavioral weaponry necessary to survive and control resources in one's local ecology" (Ellis et al., 2012, p. 610)

Key Takeaways

Implicit in this discussion of factors associated with childhood aggression are several key points. First, children who are prone to using aggressive and antisocial behavior at a young age (before age 12) are at much greater risk for adult criminality than late starters (Côté et al., 2006; Loeber et al., 1991; Moffitt, 1993; Patterson et al., 1991). Second, the strength of the association between aggression and other factors (e.g., positive parental involvement) can vary across ages (Loeber et al., 1991). Some factors show decreased association over time (e.g., SES), others show increased association (e.g., low school motivation), and still others seem important no matter what the child's age (e.g., CU traits). Perhaps the most critical point is that practitioners recognize that childhood aggression can be a persistent and pernicious pattern of maladjustment. Not only is it stable over time, it also contributes to the unfolding of other, serious problem behaviors including academic failure, peer rejection, and delinquency. Loeber (1990) referred to this phenomenon

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as the stacking of problematic behaviors one atop the other. As Stattin and Magnusson (1989) noted,

> it is rare to find a highly aggressive [child] who is not educationally or socially handicapped in many ways. They often are restless and exhibit concentration difficulties, they show low school motivation and underachieve, and they tend to have poor peer relations. (p. 717)

Unfortunately, as aggression becomes intertwined with other facets of a child's life, incentives for the continued use of aggression only increase whereas incentives to desist tend to diminish.

DIFFERENCES AMONG AGGRESSIVE CHILDREN

A discussion of characteristics that apply generally to aggressive children can hide their heterogeneity. Aggressive children vary in their level of interpersonal skills, in their nature of their antisocial behavior (e.g., overt vs. covert), and in their underlying motives and beliefs. Rather than lumping together all aggressive children, it is important to recognize that diverse forms of aggression can have contrasting etiologies and treatment needs. In fact, one reason for the limited success of child-focused skills training programs for aggressive children is that interventionists often fail to verify that treated children were deficient in the skills taught (Hughes & Sullivan, 1988; Weeland et al., 2021). Nor is the link between parenting practices and child behavior simple, direct, and unidirectional (Pettit & Arsiwalla, 2008).

Dodge and Coie (1987) distinguished between two types of aggression that can have implications for intervention planning (see also Polman et al., 2007). *Reactive* aggression refers to a defensive response to perceived threat that is accompanied by visible displays of anger. Children identified as high in reactive aggression are more likely to misperceive peers' actions as hostile and are deficient in generating nonaggressive solutions to social problems. Reactively aggressive youth tend to be socially withdrawn, are seen by peers as both unpopular and rejected, lack prosocial skills, and are inattentive and poorly self-controlled (Dodge & Coie, 1987; Dodge & Crick, 1990; Powers et al., 2013; Rose et al., 2004; Snyder et al., 2005). *Proactive* aggression refers to aggressive acts that are intended to achieve some instrumental goal, such as retrieval or possession of an object or domination over others. Children identified as engaging in high levels of proactive aggression, and not reactive aggression, tend to have average social cognitive skills, are often perceived by peers as leaders, and can be both popular and disliked (i.e., controversial peer status).

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Because most aggressive children display high levels of both reactive and proactive aggression, practitioners will generally need to target both types. For some children, however, a more focused treatment approach is needed. For example, treatments that teach emotion-focused, self-regulatory skills would likely benefit a child with reactive aggression more than a child who tends to use proactive aggression. As noted earlier, aggressive children can also differ in their level of callous and unemotional traits (Christian et al., 1997; Fanti et al., 2009). Other differences can include their use of physical versus relational forms of aggression such as gossiping and excluding others (Crapanzo et al., 2010; Crick & Grotpeter, 1995) and their tendency to show signs of narcissism (Hiemstra et al., 2020).

TREATING AGGRESSIVE CHILDREN

Recent decades have witnessed considerable progress in our understanding of childhood aggression and the development of interventions designed to reduce children's conduct problems. Moreover, research on the role of parent and family factors that contribute to aggression has led to the development of several efficacious parent-based interventions (e.g., Parent–Child Interaction Therapy, Triple P Positive Parenting Program, Incredible Years). There is also evidence for sustained impacts from these interventions on the negative trajectory of childhood aggression (Piquero et al., 2016; Thomas et al., 2017). On the other hand, Kazdin (1987) and others (e.g., Loeber, 1990) have noted that as aggressive children get older, they are decreasingly responsive to therapeutic interventions. Thus, most evidence-based parenting programs tend to target younger children, which takes advantage of this window of relative opportunity (Eyberg et al., 2008).

There has also been progress in our efforts to develop interventions that curtail antisocial behavior in adolescents, and a few, relatively intensive treatment modalities (e.g., multisystemic therapy, functional family therapy) have consistently yielded successful outcomes, including a reduction in the odds of rearrest for delinquent youth (Borduin et al., 2021; Sawyer & Borduin, 2011). These findings are notable exceptions to the more common finding of limited gains from interventions delivered by community-based mental health providers or provided to youth by educational institutions or juvenile justice agencies. In fact, disciplinary policies and procedures used in educational and juvenile justice systems often increase the risk for adult incarceration, which is especially true for children of color as well as queer and transgender youth

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(Dragomir & Tadros, 2020; Dutil, 2020; Mountz, 2020). Next, we offer a brief review of child- versus parent-focused interventions for aggressive children.

Child-Focused Skills Training

With some exceptions, studies of interventions designed to rectify social cognitive deficits in aggressive children have yielded positive effects on social cognitive measures but only limited gains on measures of behavioral adjustment (Beelmann et al., 1995). Kazdin et al. (1989) found that individually administered problem-solving skills training (with considerable involvement from parents) led to significant behavioral improvement in highly aggressive children that lasted up to 1 year posttreatment. However, most treated children continued to exhibit clinically significant levels of aggression and disruptive behavior. Tremblay et al. (1995) reported that disruptive kindergarten children receiving problem-solving skills training plus home-based parent training over a 2-year period were less likely to be placed in special classes at ages 10–13, but this effect was lost after age 13. Also, no changes were found for teacher-rated disruptiveness or for court-reported offenses in midadolescence. Lochman and Curry (1986) found that children participating in self-control and problem-solving skills interventions showed decreased levels of disruptive classroom behavior and parent-rated aggression relative to untreated control subjects. Three years after treatment, treated boys exhibited less substance use and behavioral deviance than control children but did not differ with respect to classroom behavior (Lochman, 1992). Finally, Prinz et al. (1994) found reductions in teacher-rated aggression 6 months after aggressive children completed a 9-month, coping-competence intervention that included socially competent peers. However, treated children were still within the clinical range on measures of aggression and did not improve on sociometric measures.

Parent-Focused Skills Training

Parenting plays a key role in the etiology of childhood aggression (e.g., Patterson, 1982; Patterson & Yoerger, 2002); thus, it is not surprising to find an abundance of research supporting parent-based interventions for children with conduct problems and disruptive behavior disorders. Much of this work has focused on behavioral parent training (BPT), which Maughan et al. (2005) defined as "training parents in the use of behavior modification" (p. 268). Strong support for the efficacy of BPT programs is found in hundreds of clinical trials, in a dozen meta-analyses (e.g., Bakker et al., 2017; Leijten et al., 2013; Lundahl, 2006; Maughan et al., 2005; Rossi, 2009;

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Serketich & Dumas, 1996; Weber et al., 2019), and in at least one *meta*-meta-analysis (Mingebach et al., 2018). There is also evidence that long-term outcomes associated with BPT are generally positive (Hood & Eyberg, 2003; Webster-Stratton, 1990). For example, Forgatch et al. (2009) found that BPT significantly reduced teacher-reported delinquency and police arrests 9 years postintervention. Chacko et al. (2016) summarized this robust body of work by noting that "BPT is considered the most well-studied and efficacious psychosocial intervention for school-aged children" with disruptive behavior disorders (p. 205). Several well-developed versions of BPT are available to practitioners (Eyberg, 1988; Forehand & McMahon, 1984; Patterson et al., 1975; Webster-Stratton et al., 1988).

BPT approaches parent-based treatment of childhood aggression from an operant and social learning perspective, drawing heavily from research indicating children learn to use coercion and aggression from parent-mediated contingencies (see our earlier discussions of Patterson's coercive cycle; Patterson, 1982; Patterson et al., 1992). Patterson's (1982) seminal work on the moment-to-moment contingencies that give rise to childhood aggression made a compelling case for developing interventions designed to alter those contingencies (Forgatch & Patterson, 2010). Patterson's focus on microsocial processes that govern parent–child interactions was also a sharp contrast to previous work that viewed parenting from a more molar perspective and emphasized global parenting styles (Baumrind, 1971). Baumrind (1971) used naturalistic observations of family interactions and extensive interviews to examine potential links between types of parenting and children's developmental outcomes. Adopting a person-centered approach to data analysis, Baumrind (2005, 2013) identified distinct categories or styles of parenting that differentially predicted child outcomes. For example, *authoritative parenting*, a style that combines emotional support, high standards, appropriate autonomy granting, and clear, bidirectional communication (Darling & Steinberg, 1993), was associated with children later being viewed as competent and well adjusted (e.g., Baumrind, 1991). The notion that good parenting involved an authoritative blend of responsiveness and demandingness was simple and appealing (e.g., Steinberg, 2004), but it failed to tell the whole story of children's socialization. It gave limited attention to the role of genetic endowment in child development or to the possibility that good parenting and good developmental outcomes are both a product of heritable characteristics (Scarr, 1992). It also lacked the specificity of Patterson's (1982) coercion theory and its focus on parent-delivered contingencies that lead to maladaptive child outcomes, which offered promising avenues for how to modify parenting behavior to avoid those outcomes.

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CONCLUSION

As practitioners, we must be mindful of what is at stake when working with parents of aggressive children. Altering the long-term trajectory of children who carry significant risk for later delinquency and other forms of antisocial behavior requires an intervention that is both potent and persistent in its impact. Universal programs such as parent education classes or class-wide social skills curricula are typically not powerful enough to address the complex factors contributing to the stubborn nature of childhood aggression. Effective interventions will be those that can counter the range of child, family, and contextual factors that lead to the emergence and course of childhood aggression. Needed is an accurate understanding of childhood aggression and facility with pragmatic strategies for how to treat it. In short, practitioners need to know which variables to target and how best to change them.