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Temper Tantrums in Healthy Versus Depressed and Disruptive Preschoolers: Defining Tantrum Behaviors Associated with Clinical Problems

Andy C. Belden, Ph.D., Nicole Renick Thomson, Ph.D., and Joan L. Luby, M.D.

Andy Belden, Ph.D. and Joan Luby, M.D. are affiliated with Washington University in St. Louis.

Nicole Thomson, Ph.D. is affiliated with the University of Missouri's MO Institute of Mental Health.

Abstract

Objective—To investigate whether differences in the tantrum behaviors of healthy versus mood and disruptive disordered preschoolers can be detected.

Study design—Caregivers of 279 preschool children (3-to 6-years-old) completed the Preschool-Age Psychiatric Assessment¹, which was used to determine preschoolers' diagnostic classification and to measure tantrum behaviors. Preschoolers were placed into one of four diagnostic groups: healthy, pure depressed, pure disruptive, and comorbid depressed/disruptive, based on the application of DSM-IV algorithms. Parametric and nonparametric analyses were used to examine characteristics of children's tantrums: intensity, frequency, context and recovery ability.

Results—Disruptive preschoolers displayed violence during tantrums significantly more often than the depressed and healthy groups. The disruptive group had significantly more tantrums at school/daycare than depressed and healthy groups. The disruptive group had a more difficult time recovering from tantrums than healthy preschoolers. In addition, depressed preschoolers were more aggressive towards objects and others than healthy children. Finally, depressed preschoolers displayed significantly more self-harmful tantrum behaviors than preschoolers in the healthy and disruptive groups.

Conclusions—These findings provide preliminary guidelines to parents, teachers, and practitioners in identifying tantrum behaviors that may be markers of a psychiatric disorder and therefore require mental health referral.

Keywords

preschool; depression; mood disorder; temper tantrums

Tantrums are common in early childhood, often prompting parents to seek consultation with pediatricians. Parents are often unsure about whether behaviors that occur during tantrums could indicate a serious behavioral problem. Although the popular press provides much information, surprisingly little empirical research has been conducted in this area.² The scant literature provides little information about potential "red flag" tantrum behaviors that cross the threshold into clinically significant problems or symptoms. Research providing empirical

For reprint requests and correspondence to: Andy C. Belden Washington University School of Medicine, Department of Psychiatry, Box 8134, 660 S. Euclid, St. Louis, MO 63110; phone 314-286-2702; fax 314-286-2732; e-mail: beldena@psychiatry.wustl.edu.

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evidence that distinguishes normative versus clinically significant tantrum behaviors has important implications for advising caregivers and professionals.

Potegal and Davidson³ found that common tantrum behaviors exhibited by 18–60 month olds included behaviors such as crying, hitting, and occurred once a day on average with a median duration of 3 minutes with (75%) lasting between 1.5 and 5 minutes. Researchers have also found that 70% of 18–24 month old children have tantrums.⁴ Others have noted that the highest incidence of tantrums occur in the 3–5 year old range (75.3% of children).⁵ A study of children exhibiting severe tantrums, found that 52% of children had other non-tantrum-related behavioral/emotional problems.⁶

In the current study, it was hypothesized that the three diagnostic groups would have greater tantrum frequencies, durations, intensities and have greater difficulty recovering from tantrums than the healthy group regardless of context. Specifically, it was expected that depressed preschoolers would display internally directed aggressive tantrums with higher frequencies, intensities, duration, and have more difficulty recovering from tantrums than children in the healthy group. It was also expected that preschoolers with a disruptive disorder (i.e., pure and comorbid) would have greater frequencies, durations, intensities and have more difficulty recovering from tantrums than preschoolers in the healthy and pure MDD groups.

Methods

Participants

Preschoolers between 3 and 5.11 years of age were recruited from multiple sites throughout the greater metropolitan Saint Louis area for participation in a study examining the nosology of preschool depression. Recruitment was done through pediatricians' offices, primary care practices, and preschools/daycares that were accessible to the general community in an effort to increase the socioeconomic and ethnic diversity of the final sample. Specific sites of recruitment were chosen at random using a geographically stratified method similar to studies that randomly choose zip codes. The Preschool Feelings Checklist (PFC),⁷ a brief, validated screening measure for early-onset emotional disorders, was used to increase the likelihood of obtaining a sample with symptoms of depression. Prior studies have indicated that the PFC is a useful tool for identifying children at-risk for or who have mood and/or disruptive disorders.⁸ Healthy preschoolers and those with symptoms of depression and/or disruptive disorders were recruited for study participation. Children with chronic medical illnesses and/or neurological problems and those with pervasive developmental disorders, language and/or cognitive delays were excluded from participation.

In the final sample, 302 children were ascertained, but only 279 were included in the analyses; 23 participants were excluded due to excessive missing tantrum data (Table I). All participants (N=279) were categorized into the healthy group or one of the three diagnostic groups of interest. To be categorized as healthy, preschoolers did not meet DSM-IV criteria for any psychiatric disorder. The second group had DSM-IV Major Depressive Disorder (MDD) without co-morbid Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder (CD) and/or Oppositional Defiant Disorder (ODD) and was referred to as the "MDD-no dis" group. The MDD-no dis group was included so that tantrum characteristics specific to depression could be evaluated. The third group was comprised of preschoolers with DSM-IV ADHD, ODD, and/or CD but who had no diagnosis of MDD and were referred to as the "DIS-no mdd" group. Preschoolers with MDD and a disruptive disorder were referred to as the "MDD/DIS" group. Diagnostic classification was based on application of DSM-IV algorithms to symptoms as reported by caregivers. Sample sizes for each of the four groups were as follows: healthy (n = 150), MDD-no dis (n = 21), DIS-no mdd (n = 54), and MDD/DIS (n = 54).

Procedure

Dyads participated in a 3-4 hour laboratory assessment during which primary caregivers (94% mothers) were interviewed about their children's behaviors, emotions and age-adjusted manifestations of psychiatric symptoms using the *Preschool Age Psychiatric Assessment* (PAPA).¹ The PAPA is an interviewer-based clinical diagnostic instrument for use in children 2 to 6 years of age that has been empirically validated and test re-test reliability has been previously established.⁹ Trained interviewers administered the PAPA, which was audiotaped for later quality control.

Characteristics of preschoolers' tantrums (e.g., intensity and frequency) were assessed using the temper tantrum section of the PAPA. It is important to note that items from this section were not used in the DSM-IV algorithm to determine diagnostic status. Interviewers determined whether preschoolers' had exhibited one or more tantrums in the past three months. If tantrums had occurred in the last three months, interviewers determined the intensity level of the tantrum(s) by asking caregivers structured questions based on a set of standard probes provided within the interview. If necessary, caregivers' responses were supplemented with unstructured follow-up questions by the interviewers in order to clarify participants' responses or elicit additional information about features of children's tantrums. Preschoolers were assigned one of three possible tantrum intensity classifications. Classifications included: normative tantrums which are tantrums that rarely escalate to excessive crying, shouting, and no destruction and/or violence), excessive tantrums without aggression (tantrums that do not include aggression or violence but that included shouting, crying, and/or non directed flailing movements), or excessive tantrums with aggression (tantrums that in addition to crying and screaming include episodes of violence and/or aggression toward objects and/or others). Based on the tantrum intensity level, interviewers proceeded to ask about the durational, frequency, contextual, behavioral, and recovery features of preschoolers' tantrums.

Results

Results from Chi-square and one-way univariate Analyses of Variance (ANOVAs) indicated diagnostic groups differed significantly in relation to age ($F(3, 274) = 3.93, p < .05$) and family income ($\chi^2(9, N = 279) = 18.36, p < .05$). The MDD/DIS group was significantly older than the healthy and DIS-no mdd groups (Table I). The MDD/DIS group had significantly lower household incomes than the healthy ($\chi^2(3, N = 188) = 13.40, p < .01$) and MDD-no dis groups ($\chi^2(3, N = 68) = 8.13, p < .05$). No other differences were found.

Temper Tantrum Intensity and Preschoolers' Diagnostic Classification

Results from a chi-square indicated an overall significant difference ($\chi^2(6, N = 275) = 55.05, p < .001$) between tantrum intensity and diagnostic group. Results from follow-up pairwise comparisons indicated that the MDD/DIS group was more likely to have engaged in excessive tantrums with aggression than the MDD-no dis (OR = 9.77, CI = 3.08 to 31.03, $p < .001$) and healthy groups (OR = 9.21, CI = 4.32 to 19.38, $p < .001$). Similarly, the DIS-no mdd group was more likely to have engaged in excessive tantrums with aggression than the MDD-no dis (OR = 5.78, CI = 1.89 to 17.61, $p < .01$) and healthy groups (OR = 5.14, CI = 2.73 to 10.73, $p < .001$). No other significant differences were found.

For the next analyses, the two non-aggressive tantrum intensity levels (i.e., normative tantrums and excessive tantrums without aggression) were combined to create a dichotomous tantrum variable (i.e., "non-aggressive tantrums" or "excessive tantrums with aggression"). Results indicated significant ($\chi^2(3, N = 275) = 54.16, p < .001$) diagnostic group differences between the proportions of preschoolers who engaged in non-aggressive versus aggressive tantrums. The MDD/DIS group was 9 times (CI = 3.08 to 31.03, $p < .001$) more likely than the healthy

and MDD-no dis groups to have displayed tantrums with violent and/or destructive aggression. Preschoolers in the DIS-no mdd group were 5 times (CI = 1.79 to 16.47, $p < .01$) more likely than preschoolers in the healthy and MDD-no dis groups to have displayed tantrums with violent/destructive aggression. No other differences were found.

Behavioral Characteristics of Preschoolers' Temper Tantrums

The dimensionality of 14 common tantrum behaviors was analyzed by conducting an exploratory factor analysis using an oblique (promax) rotation. The factor loadings are shown in Table II. Results from the exploratory factor analysis were used to create the four tantrum behavior scores, which were comprised of behaviors that significantly loaded onto each factor (Table II). Results indicated no effect of age or sex on the tantrum factor scores.

Results indicated that the DIS-no mdd group versus healthy ($t = -6.93$, $p < .001$) and MDD/DIS ($t = -6.07$, $p < .001$) groups had significantly higher destructive scores (Table III). The MDD-no dis versus healthy ($t = -2.19$, $p < .05$) and MDD/DIS versus healthy ($t = -5.28$, $p < .001$) groups had significantly higher self-injurious behaviors scores. Interestingly the MDD-no dis versus the DIS-no mdd ($t = 2.43$, $p < .01$) and MDD/DIS versus the DIS-no mdd ($t = 3.07$, $p < .01$) groups had significantly higher self-injurious tantrum behavior scores. The DIS-no mdd versus healthy ($t = 2.85$, $p < .01$), MDD/DIS versus healthy ($t = 3.35$, $p < .001$), and MDD-no dis versus healthy ($t = 4.70$, $p < .001$) groups had significantly higher non-destructive tantrum scores. Similarly, the DIS-no mdd versus healthy ($t = 2.03$, $p < .05$) and MDD/DIS versus ($t = 3.11$, $p < .01$) groups had significantly higher oral aggressive tantrum behavior scores.

Durational Features of Preschoolers' Temper Tantrum

Results from an ANOVA indicated a significant main effect of diagnostic group ($F(3, 194) = 3.88$, $p < .05$) on total tantrum duration. Post hoc analyses revealed the MDD/DIS group had significantly longer tantrum durations than those in the healthy ($t = 3.23$, $p < .01$) and DIS-no mdd groups ($t = 1.76$, $p < .05$) (Table III). No other significant differences were found.

Frequencies of Preschoolers' Temper Tantrums in Three Different Domains

Results from a Kruskal-Wallis nonparametric ANOVA indicated a significant effect of diagnostic group status on tantrum frequency at home ($\chi^2(3, N = 201) = 36.75$, $p < .001$), school ($\chi^2(3, N = 168) = 10.87$, $p < .01$), as well as outside of home ($\chi^2(3, N = 181) = 32.19$, $p < .001$). Results from Mann-Whitney U tests indicated that the MDD/DIS group displayed significantly more tantrums within the home compared to the healthy ($z = 3.27$, $p < .001$), DIS-no mdd ($z = 1.94$, $p < .05$), and MDD-no dis ($z = 2.19$, $p < .05$) groups. The DIS-no mdd group displayed significantly more tantrums within the home compared to the MDD-no dis ($z = 3.36$, $p < .001$) and healthy ($z = 5.61$, $p < .001$) groups. Within the school domain, the MDD-no dis ($z = 1.98$, $p < .05$), DIS-no mdd ($z = 3.06$, $p < .003$), and MDD/DIS ($z = 2.24$, $p < .05$) had higher tantrum episode frequency scores than the healthy group. Preschoolers in the DIS-no mdd group displayed significantly ($\chi^2(3, N = 181) = 32.19$, $p < .001$) more tantrums outside of home/school than preschoolers in the MDD-no dis ($z = 1.76$, $p < .05$), MDD/DIS ($z = 2.24$, $p < .05$), and healthy ($z = 5.43$, $p < .001$) groups. Preschoolers in the MDD/DIS group had significantly ($z = 3.38$, $p < .001$) higher tantrum frequency scores outside of home than the healthy group.

Tantrum Recovery

Results from a chi-square test indicated a significant ($\chi^2(2, N = 151) = 6.12$, $p < .05$) difference between diagnostic classification and preschoolers' recovery. Odds ratios indicated that preschoolers in the MDD/DIS group were 6 (CI = 2.19 to 13.95, $p < .05$) times more likely to

be reported by caregivers as having difficulty recovering from tantrums compared to children in the healthy group. No other diagnostic group differences were found.

Discussion

The behavioral characteristics of preschoolers' tantrums differed in relation to diagnostic group classification. Healthy children were reported to show significantly fewer violent, self-injurious, destructive, and orally aggressive tantrum behaviors than children with mood and/or disruptive disorders. Furthermore, healthy preschoolers had less severe, and shorter tantrums, and required less recovery time compared to children with DSM-IV diagnoses. Although replication of these findings is needed, results indicated that the "anatomy" of a tantrum in healthy preschoolers was significantly different from same age peers with mood and/or disruptive disorders.

Despite these robust findings, they do not suggest that a single or group of behaviors during a tantrum episode could definitively indicate whether a child had or was at-risk for a psychiatric disorder. In several behavioral domains, as many as 30% of preschoolers in the healthy group displayed the same maladaptive behaviors as those with a psychiatric disorder indicating that it was not uncommon even for healthy preschoolers to periodically display excessive or maladaptive tantrum behaviors. These findings underscore the notion that consideration for individual differences in emotion development as well as the enduring features of tantrum behaviors is of paramount importance. Based on the current findings, the assessment of preschoolers' "tantrum style" is key to the determination of common/typical versus atypical tantrum behaviors that warrant a mental health evaluation.

Our results suggest 5 high risk "tantrum styles". These styles and suggested cutoffs below were based on several quantitative characteristics of tantrum behaviors that most powerfully differentiated preschoolers in the healthy group from those in DSM-IV diagnostic groups. It is important to note that the clinical application of these tantrum styles and cutoffs as markers of early onset disorders has not been empirically established.

The five tantrum styles are as follows: First, preschoolers' consistent (i.e., more than 50% the time during the last 10–20 tantrum episodes) display of aggression directed at caregivers and/or violently destructive behavior toward objects may indicate clinical problem. Second, when preschoolers intentionally engage in self-injurious behavior during tantrums, regardless of tantrum frequency, duration, intensity, or context, this behavior should be considered very serious. Self-injurious behaviors during tantrums were rarely reported among preschoolers with the exception of those in the MDD groups. Third, preschoolers who display 10–20 discrete tantrum episodes on separate days at home, during a 30-day period, or on average who have more than 5 tantrums a day on multiple days while at school or outside of home/school are at greater risk of having a serious clinical problem. Fourth, extended tantrum duration, lasting longer than 25 minutes on average, may indicate problems that are more serious. Lastly, preschoolers who are typically unable to calm themselves (i.e., frequently require external assistance from a caregiver), regardless of tantrum intensity, frequency, or context, are at a much greater risk of having a clinical problem. Based on the current findings, we propose that preschoolers who consistently exhibit the behaviors outlined may be in need of a referral to a mental health clinician for further evaluation. However, it is important to note that certain tantrum behaviors, such as a sudden onset of tantrums because of hunger, sleep problems, or illness should not be considered alarming.

The second finding of interest was differences in tantrum behaviors between depressed and disruptive diagnostic groups. Consistent with the core characteristics of depression known in adolescents and adults, preschoolers with MDD displayed more internally directed anger (i.e.,

self-injurious) than preschoolers in the healthy and DIS-no mdd groups. Depressed preschoolers regardless of comorbidity were significantly more likely to have engaged in self-injurious tantrum behaviors compared to all other groups. Although such behaviors are well known in older samples, this finding was particularly notable among young children. Conversely and less surprising was that DIS-no mdd preschoolers displayed more aggression toward others, more tantrum behaviors out of home and school, as well as a poorer capacity to recover from tantrums compared to the MDD-no dis and/or healthy groups.

Limitations of the current study include relying solely on parent-report to characterize preschoolers' tantrums. A related concern is that both the diagnostic and tantrum data were derived from the same informant. The current study would have been strengthened by the inclusion of data about preschoolers' tantrums from teachers, babysitters, or family friends. Furthermore, the inclusion of observational data examining preschoolers' actual tantrum behaviors would have contributed additional support to the current findings. Therefore, an important next step for future research is to include multi-informant methods when examining preschoolers' tantrums.

An additional recommendation for future research would be to examine the relation between tantrum behaviors, parenting practices, and children's developmental and cognitive capacities. An additional and complicated issue that arose in the current study was whether it is accurate to equate the tantrums observed in "mentally healthy" children to normative/typical tantrums. Conceptually, children could easily be free of a psychiatric disorder but because of sensory integration dysfunction, cognitive, and/or neurological conditions could be prone to severe types of temper tantrums. In addition, age related differences should also be considered, that is, which developmental differences should be considered appropriate when comparing the tantrums of 3-versus 5-year-old children. In contrast to prior studies conducted by Potegal and colleagues¹⁰ the current results suggested no significant age differences between children's tantrums styles. One explanation for these differing findings is that previous studies have included very young children (e.g., 1 year-olds). That is, age difference may be due to the inclusion of very young children compared to the more narrow age range of preschool age children used in the current study. An important next step in temper tantrum research is to develop an operational definition of a "normal temper tantrum" that takes into account sensory issues, age, and mental status.

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Table 1
Demographic Characteristics of the Current Sample

	Healthy (<i>n</i> =150)	MDD-no dis (<i>n</i> = 21)	DIS-no mdd (<i>n</i> = 54)	MDD/DIS (<i>n</i> = 54)
Gender % (<i>n</i>)				
Male (<i>n</i> =145)	47% (71)	48% (10)	55% (29)	65% (35)
Female (<i>n</i> = 133)	53% (79)	52% (11)	45% (25)	35% (19)
Age in Years % (<i>n</i>)				
3	30% (45)	29% (6)	43% (23)	20% (11)
4	47% (71)	24% (5)	42% (22)	41% (22)
5	23% (34)	48% (10)	15% (8)	39% (21)
Ethnicity (child) % (<i>n</i>)				
White	63% (95)	62% (13)	39% (21)	44% (24)
Black	31% (47)	20% (4)	41% (22)	39% (21)
Hispanic	0	0	4% (2)	0
Mixed Race	5% (8)	10% (2)	17% (9)	15% (8)
Something Else	.7% (1)	5% (1)	0	2% (1)
Education % (<i>n</i>)				
Highest level some college	15% (23)	10% (2)	24% (13)	28% (15)
Highest level 4-year degree	58% (87)	76% (16)	63% (34)	56% (30)
Greater than 4-year degree	27% (40)	14% (3)	13% (7)	17% (9)
Marital Satus % (<i>n</i>)				
Married	66% (99)	62% (13)	54% (29)	43% (23)
Seperated	2% (3)	10% (2)	2% (1)	6% (3)
Divorced	4% (6)	10% (2)	9% (5)	15% (8)
Widowed	1% (2)	0	0	0
Never Married	27% (40)	19% (4)	35% (19)	36% (19)
Income % (<i>n</i>)				
0-\$20,000	22% (30)	16% (3)	36% (17)	35% (17)
\$20,001-\$40,000	13% (19)	11% (2)	15% (7)	27% (13)
\$40,001-\$60,000	17% (24)	21% (4)	17% (8)	18% (9)
\$60,000+	48% (67)	53% (10)	32% (15)	20% (10)

Table 2
Results from an Oblique Factor Analysis Examining Tantrum Behaviors

	Aggressive Destructive	Self- Injurious	Non-Destructive Aggression	Oral Aggression
Kicking Others	.810			
Hitting Others	.755			
Throwing Objects	.697			
Breaking Objects	.503			
Hitting Self		.805		
Head Banging		.628		
Holding Breath		.623		
Biting Self		.534		
Non-directed Kicking			.690	
Stamping Feet			.670	
Hitting Wall			.615	
Biting Others				.789
Spitting on Others				.503

Table 3
Means and Standard Deviations for Tantrum Behaviors between Diagnostic Groups

	Healthy (<i>n</i> =150)	MDD-no dis (<i>n</i> = 21)	DIS no mdd (<i>n</i> = 54)	MDD/DIS (<i>n</i> = 54)
Tantrum Frequency Mean(SD)				
Home	20 (.56)	12 (.22)	49 (.51)	40 (.75)
Daycare/School	.91 (.4)	.86 (.1)	15 (.47)	4 (.10)
Outside of home/school	2 (.5)	2 (.2)	19 (.34)	15 (.64)
Tantrum Duration Mean(SD)				
Duration in min. and sec.	11:48 (12:16)	15:38 (10:17)	14:35 (12:40)	20:30 (19:27)
Tantrum Behaviors Mean(SD)				
Aggression/Violence (4 behaviors possible)	1.32 (1.16)	2.00(1.44)	2.72 (1.16)	2.88 (1.12)
Self-Injurious (4 behaviors possible)	.16 (.44)	1.00 (1.16)	.28 (.68)	.96 (1.04)
Non-Aggressive (3 behaviors possible)	1.38 (1.05)	2.07 (.60)	1.89 (.93)	2.10 (1.02)
Oral-Aggression (2 behaviors possible)	.24 (.54)	.54 (.68)	.56 (.70)	.70 (.80)