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Disruptive Behavior Disorders in Young Children

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Disruptive behaviors in preschool children are challenging for parents, child-care providers, preschool teachers and clinicians. While many young children sometimes display aggressive and disobedient behaviors which are upsetting to adults, most do not exceed the normal range of misbehaviors seen during this developmental period. However, severe disruptive behavior problems comprise a growing public health problem. Increasing numbers of young children in child-care and preschool programs are being sent home, or to emergency rooms and mental health centers. Some young children are expelled from school. Intervention services for disruptive behaviors in preschool children are not widely available.

The preschool period is characterized by immature verbal skills, developing motor ability, the desire for autonomy and frustration with limit-setting. The inability to achieve a goal may be the impetus for some of the negative and oppositional behaviors seen at this age. In typically developing children, aggressive tendencies peak between ages 2 to 3 years of life. Most two year olds exhibit aggression and tantrums when frustrated or angry. Aggression typically declines during the preschool period when language skills evolve and children develop more self-control, the hallmarks for school readiness. Delaying gratification, tolerating frustration, using verbal reasoning and developing some flexibility, are self-control skills which emerge and become more consolidated during the preschool years. Strengthening these skills should be a focus of intervention.

Across community samples, the prevalence of oppositional behaviors has ranged from 4 to 16 %. Current research suggests that the more severe the behavior problem presents during early childhood, the more likely it is that the behavior problem will persist over time.

DISRUPTIVE BEHAVIOR DISORDERS

There are multiple terms for capturing behavior problems in young children. The most problematic behaviors are described as: oppositional, defiant, noncompliant, hyperactive, impulsive and aggressive. The psychology literature collectively classifies these behaviors as *externalizing* behaviors. The Diagnostic and Statistical Manual Fourth Edition, Text Revision (DSM-IV-TR; APA, 2000), classifies disruptive behavior disorders as Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD). Oppositional Defiant Disorder refers to a persistent pattern of negative disobedience. In

young children, salient features of oppositional and defiant behaviors might include: rudeness, disrespectful backtalk, use of sarcasm, foul language, sneakiness or provocative misbehavior. These children may be irritable, hostile, easily angered and may blame others for their mistakes or misbehaviors.

Conduct Disorder refers to a negative pattern of severe, deviant and anti-social behaviors. The features of this disorder may include: initiation of physical fights, lying, stealing, bullying, fire-setting, taking pleasure in other's misfortunes, cruelty to others or to animals, spoiling things for others and callous disregard for other's rights. Unlike Oppositional Defiant Disorder, Conduct Disorder is not a frequent diagnosis in preschoolers. In fact, the presence of marked aggression in the child, should raise concern that the child may be exposed to a violent or abusive situation.

A pattern of frequently observed behaviors in young children is characterized by clinically-significant symptoms of high activity level, poor impulse control, difficulties with boundaries, distractibility, inattentiveness and over-talkativeness. The presence of these symptoms may signify the presence of Attention-Deficit Hyperactivity Disorder (ADHD). While ADHD is not considered to be a disruptive behavior disorder by DSM-IV-TR standards, the presence of these symptoms may require intervention. Additionally, 40% of children diagnosed with ADHD, may have accompanying symptoms of oppositional and defiant behaviors.

The determination of whether a constellation of behaviors is abnormal ideally rests upon establishing if the behaviors cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (DSM-IV-TR). The evaluation of behavioral disorders in young children needs to be framed within a developmental context. For example, a certain degree of opposition is expected during the preschool period; however, it is the **quality** of the oppositional behavior (intensity) which makes it maladaptive. A short tantrum where a child falls to the floor screaming might be expected occasionally. Long-lasting, violent tantrums would be deviant at this point in development. With conduct problems, the emphasis is on the **kind** of behavior, as conduct disordered behaviors do not follow normal developmental trajectories and are characterized by the presence of antisocial behaviors.

Temperamental variation in emotional reactivity plays a significant role in behavior. Temperament describes the behavioral style of a child. Temperament was well-defined by The New York Longitudinal Study (NYLS) undertaken by Stella Chess, Alexander Thomas, and later, by Herbert Birch. The study was instrumental in supporting the theory that a child's constitutional

characteristics interact with the environment in different and important ways. The study identified nine temperament categories: activity level, rhythmicity, approach or withdrawal, adaptability, threshold of responsiveness, intensity of reaction, quality of mood, distractibility and attention span and persistence. Three temperamental constellations were defined: easy, slow to warm-up and difficult, all normal variations of child behavior. From the data of children in the NYLS, the concepts of "goodness of fit" and "poorness of fit" emerged. With a goodness of fit, it was felt that the child's optimal development was possible. Conversely, when there was a dissonance between the child's capabilities, temperament and the demands of the environment, the circumstance was felt to pose a risk for poorness of fit and a higher likelihood for maladaptive functioning.

RISK FACTORS FOR DISRUPTIVE BEHAVIOR DISORDERS

Child Factors:

Temperament

Difficult temperament is a risk factor for a problematic parent-child relationship and for attachment problems which can independently lead to oppositional and defiant behaviors. Temperamentally easy children require less effort to manage. Slow-to-warm up children may be somewhat negative in new situations, but behaviors tend to be fairly tolerable and are adaptable over time. In contrast, temperamentally difficult children are hard to manage. As infants they often manifest irregularities in feeding, are slow to accept new foods, take a long time to adjust to routines, have sleeping difficulties and cry quite often. As toddlers and preschool children, irregularities of eating and sleeping often persist. These children remain intense in their reactions, withdraw in new situations, are slow to adapt and are generally negative in mood. Their tendency to become frustrated often sends them into a tantrum. These children require a high degree of consistency and structure in their upbringing. A difficult behavioral style with poor fit for his/her environment can lead to conflict and negative interactions between parent and child, which can persist as oppositional behavior. On the other hand, caretakers who are better able to respect a child's behavioral style and to keep expectations in line with the child's abilities, tend to have less conflict even when the child has a difficult temperament.

Neurobiological factors

Family aggregation studies are increasingly indicating the role of genetics and heritability of disruptive behaviors. Studies of twins show significantly higher correlation of behavioral characteristics in identical, as opposed to fraternal, twins. Less inhibited children were noted to have the physical finding of a lower heart rate than typical children, when placed in stressful conditions. This suggests that nervous circuits linking the hypothalamus to the pituitary and sympathetic nerve chain may be less excitable in this group. In more oppositional boys, increased sex hormone levels have been found. In addition, anatomical differences have been found in some brains of children with oppositional defiant and conduct behaviors through the use of functional MRI scans. Lower cognitive ability, especially lower verbal intelligence, is linked to aggressive behaviors as well.

Parental Factors:

Pre-natal and peri-natal problems have been associated with the development of behavior problems in offspring (Hack, et al, 1992). Recreational drug and tobacco use during pregnancy are well-known risk factors associated with behavior problems in childhood. Numerous studies indicate that maladaptive care-giving (parenting) is related to the development of disruptive behaviors. Parenting factors associated with the development of disruptive behaviors in children include: parental under- or- over-involvement, attachment difficulties, inappropriate management of conflict, and harsh and inconsistent discipline. Physically punitive discipline by caretakers is a powerful risk factor among children with oppositional, aggressive, hyperactive and other externalizing behaviors. Unrealistic parental expectations can lead to child-parent conflict. Parents lacking empathy for their young child's attempt at autonomy, tend to see their child's oppositional behavior as a challenge to their parental authority. Negative parental response can trigger increased anger, which can escalate the disruptive behavior. Additional disruptive behaviors may be overly punished, perpetuating this negative cycle. The parenting methods of young and inexperienced single mothers, as well as mothers with depression and/or other mental health problems, often present as parental risk factors. These mothers may be emotionally overwhelmed, have fewer external supports and be less able to appropriately manage their child's behavior problems. Other significant parental risk factors for disruptive behaviors include the child's exposure to marital discord, domestic violence, parental alcohol or substance abuse, criminality and parental psychopathology. Some children living in these toxic environments may also have overlapping symptoms of a post traumatic stress disorder.

Environmental Factors:

Higher rates of behavior disorders are found in children living in disadvantaged neighborhoods due to social disruption and environmental toxins. Living in low-income housing where there may be exposure to overt substance use and criminality contributes to family stress. Family disorganization and physical violence (within the family or environment) are consistent contributing factors in the development of aggression and later antisocial behavior. In inadequately-maintained housing, exposure to lead, is a well-known risk factor for cognitive and behavioral problems.

IDENTIFICATION AND CLASSIFICATION OF DISRUPTIVE BEHAVIORS

There is no current research-validated classification system for disruptive behavior problems in young children. In 1994, the Zero to Three Task Force proposed a classification for behavioral disorders in children ages birth to 3 years. This was called DC 0-3 (revised in 2005 as DC 0-3R, Greenspan and Wieder), borrowing from the multi-axial approach of the original DSM-IV-TR. The recent tendency has been to utilize the DSM-IV-TR classifications to identify preschoolers with disruptive behavior problems. However, because the preschool years are characterized by a flux of concurring developmental and behavioral changes, many critics feel that downward extension of diagnoses from DSM-IV-TR are not reliable or valid. There is ongoing revision of the DSM, with the fifth edition due to emerge in 2013. Hopefully, the issues of classifying behaviors in younger

children will be addressed there.

The Child Behavior Checklist (CBCL), widely used by psychologists, characterizes behaviors as *externalizing* or *internalizing*. Externalizing behaviors consist of: aggression, defiance and oppositional behaviors. Internalizing behaviors refer to: anxiety, depression and withdrawal behaviors (Achenbach, T., 1992). This tool is effective for clarifying whether observed and described behavior problems meet clinical significance.

EVALUATION OF YOUNG CHILDREN WITH DISRUPTIVE BEHAVIORS

Comprehensive multidisciplinary evaluation is important for the identification and classification of behavior problems in young children. This evaluation should include information about prior evaluations or interventions. It should also include birth and any contributing medical history. Psychological testing will clarify cognitive status. A speech and language evaluation will reveal any language impairment. In a medical setting, a neurodevelopmental evaluation will explore medical, sensory or genetic abnormalities which may contribute to the child's presentation. Parent/teacher behavior checklists and observational assessment of behaviors are helpful in quantifying behavior problems. A psychosocial evaluation will yield information on parent-child interactions, attachment, discipline, family dynamics and caretaker's mental status. The social worker can also refer the child and family members for needed services. A psychiatric evaluation may be warranted for diagnostic clarification and for referral to a therapeutic treatment setting or for pharmacotherapy, if needed.

TREATMENT OF DISRUPTIVE BEHAVIOR DISORDERS

Parent and Family Focused Interventions

Over the past twenty years, there has been increasing emphasis on psychosocial interventions for disruptive behavior disorders in preschoolers. Behavioral parent training has been the treatment for ODD and ADHD in children as young as age two years with demonstrated reductions in observed and parent-reported misbehaviors (Miller, G., & Prinz, R., 1990). This type of therapy has led to reduced use of punitive parenting, resulting in decreased parental stress and improved sense of competence among parents and caretakers. Some studies have demonstrated continued improvement and stability over time. The focus is on the enhancement of a nurturing parent-child relationship. Parent training may include: modeling and role play, training caregivers' attending skills, use of rewards, purposeful ignoring, clear instructions, appropriate use of time-out and assigning home work practice.

The best known program is **PCIT or Parent Child Interactional Training** (Hembree-Kigin, T., 1995), which has a child-directed phase (parents follow the child's lead during play) with considerable coaching of the parent. It works best for children ages 2 to 8 years. The second phase is parent-directed interaction where parents lead the play while being coached in appropriate directives and in enforcement of consequences for compliance and noncompliance. **The Incredible Years** program (Webster-Stratton), is geared for children ages 3 to 8 years. The core parent training component is a 14-week videotape program of modeled parenting vignettes

followed by group discussion and homework exercises to practice with children. A separate program involves the children as well.

School Interventions

A preschooler with significant behavioral problems will likely need a very structured and therapeutic preschool setting with related services such as: speech and language therapy and counseling. Teacher-parent contact should be encouraged to monitor behavior. Several parent-child training programs also have a school-based model, used to train teachers on the techniques of appropriate management of oppositional and defiant behaviors in the classroom setting.

Medical Intervention

Medical intervention is the last resort in the treatment of young children with disruptive behavior disorders. Medical issues which may compound behavioral problems around feeding or sleeping would need to be addressed along with the behavioral issues. In very rare cases, hospitalization might be required to assess and stabilize behaviors.

Medication use is aimed at reduction of target symptoms. For example, highly impulsive and hyperactive children who meet criteria for Attention Deficit Hyperactivity Disorder might benefit from a trial of stimulant medication (Methylphenidate or Amphetamine derivatives). Alpha adrenergic medications such as Clonidine or Guanfacine, might assist in decreasing hyperactive or anxious behaviors. Mood stabilizers, used only with extremely violent or aggressive children, might include atypical antipsychotic medications. Medication should be used cautiously, if at all, for preschoolers. Medication is not apt to be effective unless other interventions are in place.

Prevention

While there are many factors involved in the development of disruptive behavior problems, a major goal in prevention is to promote positive attachments and relationships of the child with parents and siblings, peers and other adults. Identifying and treating developmental delays or contributory medical problems, providing support in the class or day care setting, as well as parent training, may prove valuable in counteracting some of the risk factors for the development of disruptive behavior disorders.

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