# Disruptive Behavior Disorders in Children 0 to 6 Years Old

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**KEYWORDS**

• Preschool children • Disruptive behavior • Oppositional defiant disorder
• Conduct disorder

**KEY POINTS**

- Disruptive behavior disorders (DBDs) are among the most common reasons preschoolers present for psychiatric care, and frequently presage later psychiatric, legal, and educational issues.
- Exposure to harsh and inconsistent parenting increases preschoolers' risk of DBDs, and partially mediates the adverse effects of economic hardship, neighborhood violence, and parental depression.
- Childhood DBDs are associated with decreased size and activity of bilateral amygdalae and insulae, and with related deficits in fear modulation and empathic emotional processing.
- Preschoolers with DBDs show executive functioning deficits, in part related to attention-deficit/hyperactivity disorder comorbidity. Decreased response inhibition to emotionally salient stimuli is particularly linked to reactive aggression.
- Parent management training programs focused on decreasing coercive parenting techniques and encouraging positive, consistent engagement with children are the gold standard treatments for preschool DBDs.

Disruptive behaviors are among the most common reasons preschool children present for psychiatric care. Disruptive behavior disorders (DBDs), specifically oppositional defiant disorder (ODD) and conduct disorder (CD), are some of the most common diagnoses in preschoolers. Prevalence of ODD in preschoolers is estimated at 4% to 16.6%, with CD incidence at 3.9% to 6.6%. ODD specifically is associated with later mood disorders; childhood-onset CD predicts later educational and legal

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Child Adolesc Psychiatric Clin N Am ■ (2017) ■–■
http://dx.doi.org/10.1016/j.chc.2017.02.005 childpsych.theclinics.com
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issues.[1] Preschool-age ODD is a less robust predictor than preschool CD of poor school-age and adolescent outcomes, but still confers the risk of later impairment, likely through progression to CD.[2] These disorders are costly, not only in terms of children and families' suffering but also for society as a whole in terms of mental health (and criminal justice) resources. Solid evidence supports treating DBDs with parent management training and other psychosocial methods, but early intervention offers the best chance for recovery.[3] Thus, identification and treatment of children with early-onset DBDs is vital.

In the last decade, evidence for and acceptance of the existence of DBDs in preschool-aged children has grown. There has been a proliferation of research into DBDs' earliest manifestations, with numerous studies showing it is possible to identify ODD and CD before 6 years of age.[4] In answer to concerns about the reliability and validity of DBD diagnoses in preschoolers, a series of studies by Keenan and Wakschlag[5] compared the incidence of ODD and CD symptoms between clinically referred and nonreferred preschool-aged children.[6–8] The seminal 2004 study compared 2.5-year-olds with 5.5-year-olds at a preschool behavior problems clinic with age-matched, non–psychiatrically referred peers. Of the referred children, 59.5% met criteria for ODD and 41.8% met CD criteria; only 2% of nonreferred children met criteria for either.[6]

Adopting a developmental perspective in DBD diagnosis has also helped to differentiate early mental disorder from normative individuation attempts. Some oppositional behaviors are common to all children (eg, occasional defiance in 2-year-olds). Differences in frequency, intensity, and kind demarcate the onset of disorder.[8] For instance, hitting is common among 3-year-olds, but for a child to use aggression frequently or as an initial interpersonal strategy generally indicates disorder.[6,8] Physical aggression, property destruction, deceitfulness, and theft are markers of preschool CD as well as predictors of CD persistence. In contrast, actions like loss of temper or telling stories not intended for gain are not associated with later CD.[1]

## COMORBIDITY

Almost all individuals with CD also carry an ODD diagnosis. ODD frequently progresses to CD, and roughly 10% of children with CD then develop antisocial personality disorder as adults. Attention-deficit/hyperactivity disorder (ADHD) is also frequently comorbid, particularly the hyperactive and combined subtypes.[4] Children with comorbid ADHD have greater executive functioning deficits and increased emotional impulsivity compared with pure CD or ODD.[9] Comorbid ADHD is also associated with earlier DBD onset.[10,11] In one study of children diagnosed with CD before the age of 9 years, more than 70% of patients previously carried an ODD diagnosis. Preschool-onset DBDs are associated with persistent conduct and psychiatric problems.[12]

## ENVIRONMENTAL RISK FACTORS

Perhaps the clearest case of an environmental exposure that predisposes to DBDs is exposure to active maternal smoking during pregnancy (MSDP).[13] MSPD has been shown to increase the risk of externalizing behavior in children as young as 18 months.[14–16] It increases the risk of ODD and CD during the preschool years and beyond, independent of ADHD.[17,18] Children exposed to MSDP were more likely to show conduct problems in a recent genetically sensitive analysis as well. Children of mothers who smoked more than 10 cigarettes daily during pregnancy showed the most disruptive behaviors.[19]

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