

Disorders of conduct in young children: Developmental considerations, diagnoses, and other characteristics

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Abstract

Disorders of conduct are the most common reason for preschoolers to be referred for psychological services. If these problems are severe enough, these young children will be diagnosed with a *DSM-IV-TR* diagnosis or a diagnosis from another diagnostic systems, such as the *DSM-PC* or *DC: 0-3*. Whether or not these young children receive a diagnosis for the constellation of conduct problems that they exhibit, it is well documented that young children who exhibit such problems at such an early age are likely to continue exhibiting similar behaviors and to have several related difficulties throughout their lifetime. In an effort to alleviate such problems for young children, several treatment options have been developed and validated. Treatment outcomes suggest that young children with disorders of conduct can be treated and experience more positive outcomes. In an effort to inform mental health and other professionals working with young children with conduct problems, this manuscript outlines the potential diagnoses that these young children may receive and discusses related issues that may be of importance for such diagnoses.

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Disorders of conduct and related disruptive or externalizing behaviors are cited as the most common reason for preschoolers to be referred for mental health services (Luby & Morgan, 1997). In addition to exhibiting higher levels of externalizing behavior problems (Renk, 2005), young children who are referred for mental health services exhibit

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significantly more negativity and noncompliance in their interactions with their parents (Speltz, DeKlyen, Greenberg, & Dryden, 1995) as well as negative skills with their peers (Webster-Stratton & Lyndsay, 1999). In fact, the incidence of conduct problems exhibited by young children can be as high as 35%, particularly in children from low-income families (Webster-Stratton & Hammond, 1998). Further, such problems are long-standing (Keenan, Shaw, Delliquadri, Giovannelli, & Walsh, 1998; Lahey, Loeber, Quay, Frick, & Grimm, 1992; Loeber, DeLamatre, Keenan, & Zhang, 1998; Moffitt, 1990), with approximately half of the preschoolers who exhibit such problems continuing to have similar problems in the future (Campbell, 1997).

Given the significance and longevity of conduct problems, as well as the frequency with which young children exhibiting such problems will be referred for mental health services, it is vitally important that mental health professionals gain a thorough understanding of these problems. It is only by gaining an understanding of this information that mental health professionals can diagnose and treat successfully disorders of conduct in young children. As a result, this manuscript will discuss the manifestation of disorders of conduct in young children, relevant developmental considerations, potential diagnostic labels that may be used to describe the behaviors of these children, correlates of conduct problems, and potential treatment options for these children.

Gaining an understanding of conduct and disruptive behavior problems in young children is unfortunately difficult, as there is no widely endorsed method for assessing such problems in young children (Keenan & Wakschlag, 2002). In particular, Pierce, Ewing, and Campbell (1999) suggest that the availability of systematic methods for distinguishing emerging behavior problems from transient developmental issues is lacking. In an effort to provide a systematic approach to understanding the nature and severity of conduct problems in young children, Keenan and Wakschlag (2000) propose four steps for diagnostic assessment. In particular, to understand conduct problems in young children, researchers much describe the prevalence rates of DSM-IV symptoms and disorders in these children, compare DSM-IV symptoms to the assessment measures that are available for use with young children, externally validate the DSM-IV disorders being assessed, and use longitudinal studies to assess the stability and predictive utility of these diagnoses in these children.

Although steps such as these have been outlined for use by researchers, information also must be disseminated to mental health professionals working directly with young children and their families. As mental health professionals appear to overgeneralize conduct and disruptive behavior problems, a practical understanding of disorders of conduct is warranted. Even more importantly, research now suggests that the conduct and disruptive behavior problems exhibited by young children are a precursor to later antisocial behaviors (Bennett, Lipman, Racine, & Offord, 1998). Thus, early identification and treatment is particularly important for the long-term outcomes of young children exhibiting these behavior problems. As the first step to identifying problematic conduct and disruptive behaviors is differentiating such behaviors from normative behavior, developmental considerations are discussed first.

Developmental considerations

As it often is assumed that temper tantrums, noncompliance, and aggression are expected during the toddler years (Keenan et al., 1998), conduct and disruptive behaviors in early

childhood have not been viewed as clinically concerning problems in the research literature (Campbell, 1995). When one considers how rapidly cognitive development occurs during the toddler years, distinguishing clinically concerning from normative conduct and disruptive behaviors is even more difficult. Among all the developmental gains that toddlers are making, they also are developing a sense of themselves as individuals, are learning about how their own behavior affects other individuals, are experimenting with the inanimate world, and are testing limits (Campbell, 1998). Thus, toddlers are making great strides in their development and in gaining a sense of themselves.

Unfortunately for parents, as toddlers are testing their sense of independence, they also exhibit an increase in negativity and oppositionality (Keenan & Wakschlag, 2000), particularly as they struggle with their parents over limits and control (Campbell, 1990). As a result of this tendency, some researchers (e.g., Crockenberg & Litman, 1990) even consider noncompliance to be an adaptive form of autonomous behavior. In particular, noncompliance co-occurs with young children's increasing sense of self and because young children have difficulty understanding adults' expectations (Crockenberg & Litman, 1990). In addition to noncompliance, young children initially may exhibit physical aggression during their first year after birth. Children's physical aggression then increases in frequency during their second year, peaks between 24- and 42-months of age, and then begins to decrease after this age (Tremblay, 2002). In other words, as children grapple with their own need for autonomy and seek appropriate limits from their caregivers, defiance and discipline problems are normative (Kaler & Kopp, 1990).

Certainly, these behaviors can be concerning to parents. In fact, parents express that disciplinary problems (e.g., how and when to set limits) are frequent concerns in their interactions with their 2.5- to 3.5-year-olds (Campbell, 1990). For example, a study by Jenkins, Bax, and Hart (1980) suggests that 23% of parents with 3-year-olds are unsure of how to discipline their children. Thus, young children are likely to exhibit noncompliance in their interactions with their parents, while parents are feeling uncertain about their discipline interactions with their young children. Given this combination of factors, it is particularly important for mental health professionals to be aware of effective discipline strategies for young children, whether or not these children are exhibiting clinically concerning levels of conduct and disruptive behaviors. In particular, the match between discipline strategies and young children's behaviors is important. For example, Lytton and Zwirner (1975) suggest that youngsters are more likely to comply after parental suggestions relative to parental commands or prohibitions and that physical control and negative interactions are associated with higher levels of noncompliance. In addition, they report that low conflict situations are associated with more compliant behavior (Lytton & Zwirner, 1975). Further, in the context of developing conduct and disruptive behavior problems, children between the ages of birth and 4-years of age may be most vulnerable to poor quality parenting (Loeber, 1990). Findings such as these suggest that authoritarian parenting (i.e., parenting that is low in warmth but high in control) will be associated with poor child compliance, whereas warmth and flexibility in parenting will promote better interactions.

Although conduct and disruptive behaviors will become problematic for some young children, mental health professionals should note that such behaviors should not be diagnosed clinically when they reflect normative development and when they do not impair the functioning of young children (Campbell, 1995). It is only when such behaviors become particularly problematic that a clinical diagnosis should be considered. For example, when

noncompliance reflects angry defiance, difficulties in the parent–child relationship, and/or coping difficulties with the developments of young childhood, then these behaviors should be considered out of the ordinary (Campbell, 1990). In particular, if behaviors such as these continue past the developmental timeframe in which they would be expected or if they worsen or interfere with the development of more age-appropriate skills (e.g., social and communication skills), then they may be indicative of an emerging diagnosable disorder (Campbell, Shaw, & Gilliom, 2000). Thus, mental health professionals must weigh carefully the normative nature of young children's conduct and disruptive behaviors before making a diagnosis.

Nonetheless, mental health professionals may be called upon to provide parenting information to families with children exhibiting such behaviors. When faced with their young children's conduct and disruptive behaviors, caregivers must set limits and provide support to their young children. By doing so, parents can assist young children in exploring and mastering their physical world, expanding their abilities (e.g., cognitions, language, sociability), practicing their developing motor skills, and learning about their peers (Campbell, 1997). As these skills develop, toddlers actually require more control but also more latitude to test their autonomy and differentiate themselves from others (Campbell, 1997). Although toddlers' tendency to say "no" is normative around the age of 2-years (Campbell, 1997), parents can be frustrated easily by this behavior. As a result, parents of toddlers must set limits with clear explanations and expectations, warmth, and support (Campbell, 1997). In addition, parents must learn to distinguish between angry defiant noncompliance and self-assertive noncompliance that furthers independence and self-definition (Crockenberg & Litman, 1990). By parenting in this manner (or being assisted to parent in this manner), parents may help their young children to balance their own strides for independence with their own expectations of cooperation (Crockenberg & Litman, 1990). Such parenting may help to prevent the development of clinically significant conduct problems and disruptive behaviors.

In addition to having knowledge about parenting, mental health professionals must be aware of the usual presentation of young children. For example, most young children can recognize the basic impact of their behavior on others and can comply with basic internalized social norms (Keenan & Wakschlag, 2000). The formation of peer relationships is one of the major developmental tasks for young children, however, and can be the context for learning several important skills (Stormshak & Webster-Stratton, 1999) related to interacting with other individuals. As young children are still learning about relationships, aggressive behaviors related to problems with sharing, taking turns, or considering the perspectives of other individuals may be normative in the early preschool years (Campbell, 1990; Tremblay, 2000). Further, aggression toward peers is a common complaint of parents and teachers regarding preschool behavior (Achenbach, Edelbrock, & Howell, 1987). In fact, Coleman, Wolkind, and Ashley (1977) note that 53% of 3-year-olds are described as having peer difficulty, and Crowther, Bond, and Rolf (1981) note that 25% of 4- and 5-year-old boys are described by daycare providers as moderately to highly aggressive with peers. Thus, mental health professionals will have to make some determination regarding the normative nature of conduct problems in peer relationships and in school settings as well.

As mental health professionals make this determination, they should consider closely the intent of young children's aggressive behavior, as this intent appears to differentiate nonclinical versus more problematic aggressive behavior. The intent of such behavior

may be difficult to identify, however. To assist in the identification of the intent of aggressive behavior, mental health professionals should consider nonclinical aggressive behavior to be instrumental or goal-driven (Feshbach & Feshbach, 1972). In fact, young children who exhibit self-assertion in the context of such behaviors actually may be making a positive developmental achievement (Campbell, 1997) or demonstrating signs of early social competence. Such achievements can be promoted when parents manage toddlers' strides toward autonomy and promote future cooperation without also escalating conflict with their toddlers (Crockenberg & Litman, 1990). In contrast, mental health professionals should consider more problematic aggressive behavior to be hostile or demonstrating an intent to hurt another individual (Feshbach & Feshbach, 1972). As most young children learn to inhibit their aggression over time (Tremblay, 2000), displays of such behavior should diminish over time as well. As a result, young children who are exhibiting dysregulated aggression may be signaling that they are having potential difficulties (Keenan & Shaw, 1994).

Given the various developmental milestones that young children are achieving, mental health professionals should remember that the preschool period is a critically important time when significant behavior problems can emerge (Keenan & Wakschlag, 2000). When conduct problems and disruptive behaviors beginning occurring as part of a constellation or syndrome of behaviors, a clinical diagnosis may be warranted (Campbell, 1995). Although the most widely accepted diagnostic system in the United States is described currently in the *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition-Text Revision* (DSM-IV-TR; APA, 2000), the DSM-IV-TR may not always appear to be developmentally appropriate for use with young children. As a result, mental health professionals also may look to other diagnostic systems that are available and that provide more developmentally appropriate descriptions of clinically significant problems in young children, such as the *Diagnostic Criteria: 0 to 3* (Zero to Three, 2005). In general, mental health professionals should consider clinically significant problems to be frequent and severe, evident across domains of young children's functioning and across situations, and expressed during interactions with a variety of different individuals (Campbell, 1990). To further mental health professionals' awareness of the characteristics of clinically significant conduct problems with young children, diagnoses that are available for use with young children across several diagnostic systems are discussed next.

Diagnoses

Diagnostic and statistical manual of mental disorders

When using the *Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition-Text Revision; DSM-IV-TR; APA, 2000)*, mental health professionals have three disorders of conduct that are usually first diagnosed in infancy, childhood, or adolescence from which to choose. These disorders are Oppositional Defiant Disorder, Conduct Disorder, and Disruptive Behavior Disorder Not Otherwise Specified. These disorders, along with the diagnosis of Attention-Deficit/Hyperactivity Disorder (AD/HD), are considered to be Disruptive Behavior Disorders. These disorders may be particularly relevant to young children who are displaying clinically concerning conduct problems and disruptive behaviors. Each of these disorders will be considered in turn.

As a first step into clinically concerning conduct problems, Oppositional Defiant Disorder (ODD) consists of a pattern of negative, hostile, and defiant behaviors (APA, 2000). To receive an ODD diagnosis, young children would have to exhibit four or more disruptive behavior symptoms, such as losing their temper, arguing with adults, defying or refusing to comply with adults' requests, annoying other individuals deliberately, blaming others for their mistakes, being annoyed easily by other individuals, being angry and resentful, and being spiteful and vindictive. These symptoms must occur over the course of at least a six-month period (APA, 2000). In addition, young children's behavioral patterns must cause clinically significant impairment in their functioning and must not occur exclusively during the occurrence of a Psychotic or Mood Disorder. Finally, Conduct Disorder and Antisocial Personality Disorder (for individuals who are 18-years of age and older) would have to be excluded as possible diagnoses (APA, 2000).

Although young children may meet the criteria described above for ODD, this diagnosis also may be difficult to identify in young children. In general, the *DSM-IV-TR* recommends that the criteria for ODD only can be met if the noted criteria occur more frequently than would be anticipated in individuals of a comparable age and developmental level (APA, 2000). In particular, the *DSM-IV-TR* recognizes the commonness of transient oppositional behaviors in preschool children and emphasizes that caution should be used in making this diagnosis in this age group (APA, 2000). Given that making a distinction between young children's normative and clinically significant behaviors tends to be difficult (Keenan & Wakschlag, 2002), mental health professionals should be certain that young children's behavior is clinical concerning relative to normative expectations. Thus, to make a diagnosis of ODD, mental health professionals should note that the ODD behavioral criteria should interfere with normal developmental functioning (Keenan & Wakschlag, 2002).

Some researchers suggest that a proportion of children who are diagnosed with ODD will eventually receive a diagnosis of Conduct Disorder (CD; Loeber & Hay, 1997), making CD the next step for young children into the disorders of conduct. According to the *DSM-IV-TR*, CD is characterized as a pattern of disruptive behavior in which young children would have to violate the basic right of other individuals as well as major age-appropriate societal norms or rules (APA, 2000). To meet diagnostic criteria for CD, young children would have to exhibit three or more specific criteria over the course of a twelve-month period, with at least one of the specific criteria being present in the past six months. Criteria in the *DSM-IV-TR* (APA, 2000) are categorized as aggression to people and animals (i.e., bullying or threatening, initiating physical fights, using a weapon that can cause serious harm to another individual, being physically cruel to people or animals, stealing, forcing someone into sexual activity), destruction of property (i.e., engaging in fire setting with the intention of causing damage, destroying others' property deliberately), deceitfulness or theft (i.e., breaking into someone else's house or car, lying to obtain goods or favors, stealing items of trivial value), and serious violations of rules (i.e., staying out at night without parental permission, running away from home on at least two occasions, being truant from school; APA, 2000).

In addition, the behaviors described as part of CD must cause significant functional impairment for young children. Further, in cases where the identified individual is over 18-years of age, criteria for Antisocial Personality Disorder must not be met (APA, 2000). Finally, CD can be categorized as Mild, Moderate, or Severe, depending on the number of criteria that are present, and can be described as Child-Onset Type (i.e., onset

before the age of 10-years; the category that would be applicable to young children), Adolescent-Onset Type (i.e., onset after the age of 10-years), or Unspecified Onset (i.e., the age of onset is not known; APA, 2000). Although it is suggested that onset may occur for young children, the *DSM-IV-TR* indicates that most cases of CD will emerge during middle childhood (APA, 2000). Thus, it appears unlikely that a CD diagnosis would be used in describing the conduct problems of young children; however, researchers have begun to examine the utility of the CD diagnosis with young children.

One investigation of the validity of the CD diagnosis was conducted by Kim-Cohen and colleagues (2005) using data from the Environmental Risk Longitudinal Twin Study, a representative birth cohort of 2232 children from 1994 and 1995. As part of their study, $4\frac{1}{2}$ - to 5-year-old children were diagnosed with CD if they were exhibiting three or more of the symptoms noted above (i.e., with the exception of “forced sexual activity,” as this symptom was deemed to be inappropriate for young children). In this sample, CD was found to have a prevalence rate of 6.6%, with the prevalence for boys being greater than that for girls (Kim-Cohen et al., 2005). In addition, aggression, theft, and destructive behavior were commonly identified symptoms, whereas rule violations were uncommon (Kim-Cohen et al., 2005). In a demonstration of convergent validity, children diagnosed with CD experienced significantly more risk factors (e.g., higher levels of hyperactive or inattentive symptoms) than children not diagnosed with CD. Finally, children who met CD criteria at 5-years of age were significantly more likely to exhibit higher levels of AD/HD, aggressive, and delinquent symptoms, as well as lower levels of prosocial behavior, at 7-years of age (Kim-Cohen et al., 2005). Thus, these findings demonstrate support for the use of the CD diagnosis with young children.

Other researchers have begun to think critically about the use of the CD behavioral criteria with young children. In addition to the CD criteria described previously, Keenan and Wakschlag (2002) consider the proposition that young children must have knowledge of rules, have the intent to break them, and then knowingly violate them. Although many young children do have the ability to understand and to control their behavior in a manner consistent with rules, many skills are in the process of emerging during this developmental period. For example, preschool children are in the process of developing their ability to inhibit their behavior (Kochanska, Murray, & Coy, 1997), to engage in deception about rule violations (Lewis, Stanger, & Sullivan, 1989), and to generate alternatives to problems (Reznick, Corley, & Robinson, 1997). Given this proposition by Keenan and Wakschlag (2002), it would be important for mental health professionals to consider young children’s understanding of rules and their ability to control their own behavior before utilizing this diagnosis with these children.

Finally, mental health professionals may use the diagnosis of Disruptive Behavior Disorder Not Otherwise Specified in cases where young children are exhibiting behaviors characterized by oppositional defiance or conduct problems that do not meet criteria for ODD or CD. This diagnostic label may be used in cases where young children are not exhibiting as many of the behaviors as are needed to meet criteria for ODD or CD or are not exhibiting clinically significant impairment in conjunction with their ODD- or CD-like behaviors (APA, 2000).

In general, the *DSM-IV-TR* (APA, 2000) states that the diagnoses of ODD and CD should be utilized cautiously in the diagnosis of young children. Unfortunately, the numbers of preschool children participating in the field trials for the most recent edition of the *DSM-IV-TR* were low and included many children who were not referred for difficulties

(Keenan & Wakschlag, 2003). Further, estimates of the prevalence of ODD in preschool children range greatly, from 7 to 25% (Offord, Adler, & Boyle, 1986). For example, in a sample of clinic-referred young children ranging in age from 2- to 5-years, Keenan and Wakschlag (2000) note that approximately 60% meet criteria for ODD, and approximately 42% meet criteria for CD. Findings from this study suggest that there are no significant differences in these rates or in the mean number of symptoms based on child gender (Keenan & Wakschlag, 2000).

Researchers also have begun comparing young children who are referred for services to those who have not been referred. Keenan and Wakschlag (2004) also compare rates of ODD and CD in referred versus non-referred children. Their results suggest that the occurrence of ODD and CD symptoms in young children referred for services is significantly higher than in non-referred young children. In this study, however, these researchers make developmental modifications to the symptoms of ODD and CD, so that stolen objects do not have to be of nontrivial value and weapons are defined more broadly (e.g., things such as sticks, rocks, or bats are considered; Keenan & Wakschlag, 2004). Thus, these criteria adjustments may actually make these diagnoses more suitable for young children. The diagnosis of these disorders also is related significantly with elevated scores on a widely used checklist of child behavior problems and with elevated levels of functional impairment (Keenan & Wakschlag, 2000).

When using these diagnoses, mental health professionals will be confronted with the differential diagnosis of comorbid disorders. For example, there are high levels of comorbidity documented among ODD, CD, and AD/HD (Keenan & Wakschlag, 2000). Keenan, Shaw, Walsh, Dellaquadri, and Giovanelli (1997) report that approximately 15% of their sample of preschool children from low-income families meet criteria for an externalizing behavior disorder, consisting of Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, and Conduct Disorder, and approximately 15% are within the subclinical range for such a disorder. Keenan and colleagues (1997) also note that these children are impaired significantly and that scores on the Child Behavior Checklist provide results consistent with their actual diagnoses. Wilens and colleagues (2002) further report that their sample of preschool children diagnosed with Attention-Deficit/Hyperactivity Disorder meet criteria for an additional Disruptive Behavior Disorder (i.e., 60% of these children with Attention-Deficit/Hyperactivity Disorder meet criteria for ODD, and 23% meet criteria for CD).

Such comorbidities raise concerns for some researchers (e.g., McClellan & Speltz, 2003) about the validity of diagnosing young children with disorders of conduct such as these until further research is completed. At the very least, mental health professionals should proceed cautiously when using such diagnoses for disorders of conduct with young children and consider the intent of young children's behavior as they note the presence or absence of behavioral criteria consistent with these diagnoses. In general, however, Keenan and Wakschlag (2002) provide support for the content, convergent, and predictive validity of these disorders in young children.

Diagnostic and statistical manual for primary care (DSM-PC) child and adolescent version

Wolraich, Felice, and Drotar (1996) provide other diagnostic descriptions in the *Diagnostic and Statistical Manual for Primary Care (DSM-PC) Child and Adolescent Version* that might be useful for young children with conduct problems or disruptive behavior

problems. The *DSM-PC* diagnoses are meant to be used in primary care settings with non-clinical samples. As a result, the *DSM-PC* recognizes the *DSM-IV-TR* disorders described previously and describes several other useful conditions for diagnosing young children as well as children and adolescents of older ages. In particular, the *DSM-PC* utilizes a continuum approach, in which behaviors are categorized as a Variation from what might be expected normatively for children's behavior, as a Problem when children's behavior is beginning to vary more dramatically from the norm, or as a *DSM-IV-TR* diagnosis when full diagnostic criteria are met (Wolraich et al., 1996).

With regard to the experience of negative emotions, Wolraich and colleagues (1996) describe two conditions. First, Negative Emotional Behavior Variation describes the negative emotional behaviors displayed typically by infants and preschool children (e.g., crying or whining, becoming frustrated easily, displaying anger by hitting or biting). Wolraich and colleagues (1996) suggest that the display of these behaviors may depend on the skill and understanding of young children's parents. Second, Negative Emotional Behavior Problem describes a more significant difficulty, in which children's negative emotional behaviors increase in intensity (e.g., temper tantrums), even with appropriate behavioral management by parents. This difficulty will promote frustration for parents and affect interactions with peers (Wolraich et al., 1996).

Although Wolraich and colleagues (1996) recognize ODD, as described previously, they also describe two other less severe conditions for consideration when dealing with aggressive and oppositional behaviors in young children. The least severe condition for behaviors in this realm is Aggressive/Oppositional Variation, in which young children exhibit either mild opposition or a normative level of aggressive behavior with a mild negative impact (i.e., no one is hurt, property is not damaged, and parents do not alter their plans significantly as a result of their children's behavior; Wolraich et al., 1996). Further, young children can be labeled with an Aggressive/Oppositional Problem if they display a level of opposition that is bothersome to their parents. Young children with this condition also may exhibit levels of aggression that interfere with family routines, result in negative responses from their peers, or cause disruption in their lives (Wolraich et al., 1996).

Finally, in addition to CD, as described previously, Wolraich and colleagues (1996) describe two less severe conditions that may apply to young children. Secretive Antisocial Behaviors Variation describes mild levels of cheating, lying, and stealing small objects that do not cause clinical concern. In contrast, Secretive Antisocial Behaviors Problem describes secretive antisocial behaviors that are problematic due to increases in the rate, intensity, or consequences following such behaviors. These conditions tend to occur infrequently in young children (Wolraich et al., 1996), however.

Thus, in addition to the diagnoses described by the *DSM-IV-TR*, the *DSM-PC* provides less severe alternatives for describing the conduct problems and disruptive behaviors of young children. Although the *DSM-PC* is meant to be used in primary care settings (Wolraich et al., 1996), the information provided as part of the Variations, Problems, and Disorders that it describes may prove useful for mental health professionals who may be trying to determine where young children's problematic behavior lies on a continuum of difficulties. Even if mental health professionals choose not to use the *DSM-PC* labels themselves, knowledge of this system may help them to differentiate more normative conduct problems and disruptive behaviors from those that are clinically significant.

DC: 0-3 diagnoses

When mental health professionals are examining clinically concerning behaviors exhibited by young children, the *Diagnostic Classification (DC): 0-3* may be particularly helpful. Although the *DC: 0-3* does not provide a specific diagnosis for conduct problems and disruptive behaviors in young children (Zero to Three, 1994, 2005), it recommends that DSM diagnoses be used (Zero to Three, 2005). Because of the unavailability of such disorders in the *DC: 0-3*, some researchers (e.g., Shaw, Gilliom, & Giovannelli, 2000) present arguments for and against the development of such disorders for the *DC: 0-3* system. For example, Shaw and colleagues (2000) point out that certain factors (e.g., young children demonstrating a lack of intentionality, a lack of comprehension of aggression, a likely transient pattern of aggressive behavior, a peak incidence rate of aggressive behavior at the age of 2-years) would argue against the use of the term ‘disorder’ when referring to aggressive behaviors in young children.

In contrast, other arguments support the need for such a disorder. For example, the fact that young children are unlikely to develop clinically elevated levels of aggressive behaviors later in their childhoods if they are not aggressive during their early years speaks to the usefulness of early identification of conduct problems and disruptive behaviors. In addition, predictors for conduct problems appear to be consistent across infancy and later childhood (Shaw et al., 2000), suggesting that such predictors would be as useful for young children as for older children. Further, given that young children may have the ability to inflict harm on other individuals, there has been an increase in research regarding conduct problems in young children (Shaw et al., 2000). Given these arguments both for and against having a *DC: 0-3* diagnosis for conduct problems in young children, agreement regarding the necessity and appropriateness of a *DC: 0-3* diagnosis has not yet been reached.

Thus, at this time, there are no to few options for using the *DC: 0-3* to label conduct problems in young children. If it is relevant to a particular young child, mental health professionals may find a diagnosis of Regulation Disorder of Sensory Processing (Zero to Three, 2005) to be useful in describing some conduct problems and disruptive behaviors. To receive such a diagnosis, young children must evidence difficulty in regulating their emotions, behaviors, and motor abilities in response to sensory stimulation. These difficulties must lead to impairment in young children’s development and functioning and must be exhibited by young children across settings and relationships (Zero to Three, 2005). In particular, there are three types of Regulation Disorder: Hypersensitive Type (i.e., young children find sensory stimuli to be aversive and may exhibit fearful/cautious or negative/defiant behaviors), Hyposensitive/Underresponsive Type (i.e., young children require high intensity sensory input or they will withdraw and lack responsivity), and Sensory Stimulation-Seeking/Impulsive (i.e., young children seek out stimulation moreso than do typically developing children; Zero to Three, 2005). In the case of young children who exhibit conduct problems and disruptive behaviors, the Hypersensitive Type may have the most utility to mental health professionals.

Diagnostic summary

When mental health professionals are diagnosing conduct problems and disruptive behaviors in young children, as with the diagnosis of individuals of other ages, the

DSM-IV-TR provides the most accepted system of describing individuals' behavior. As noted above, caution must be used when using *DSM-IV-TR* diagnoses to describe young children's conduct problems and disruptive behaviors, however (APA, 2000). When mental health professionals are uncertain as to whether young children meet criteria for a *DSM-IV-TR* diagnosis, the research literature or another diagnostic system, such as the *DSM-PC* or *DC: 0-3*, may prove useful. For example, in the case of disruptive behaviors, the *DSM-PC* provides useful descriptions regarding the manifestations of different degrees of problematic behavior in young children (Wolraich et al., 1996). It should be noted, however, that this information will not always cross-reference with the *DSM-IV-TR* directly. For example, even the research literature examining ODD and CD in young children has shown that developmental modifications may have been made to particular diagnoses so that they are more applicable to young children (e.g., stolen objects did not have to be of nontrivial value, weapons being defined more broadly; Keenan & Wakschlag, 2004). Thus, clinicians should consider the developmental appropriateness of the behaviors exhibited by young children relative to a normative reference group (Campbell, 1995), as well as the information discussed next, prior to diagnosing a disorder of conduct.

Stability of conduct problems

Regardless of the diagnostic label that may be applied, research suggests that behavior problems are relatively stable, particularly when such problems are in the extreme range. Further, such problems increase the risk that children will develop a diagnosable problem by the time they begin school. Having behavior problems as a young child is not a guarantee that such problems will continue, however. Some young children just experience age-appropriate, short-lived manifestations of stress (Campbell, 1997). Thus, young children who exhibit moderate or age-appropriate levels of aggression or noncompliance are less likely to continue to have behavior problems, whereas those who exhibit more severe early problems are more likely to have stable behavior problems. As mentioned earlier, Campbell (1997) suggests that there is about a 50% chance that young children who exhibit behavior problems during preschool will continue to exhibit such problems over time. If behavior problems are stable from preschool to school age, they are more likely to continue into adolescence (Ewing & Campbell, 1995) and, perhaps, adulthood (Moffitt, 1993).

When examining conduct problems in young children, difficult temperament often is mentioned as the first indicator of a problematic experience. Many studies (e.g., Earls & Jung, 1987; Prior, Smart, Sanson, & Oberklaid, 1993) suggest that difficult temperament in infancy is predictive of difficult temperament in the toddler period as well as later in life. Some suggest that difficult temperament acts to promote negative interactions between parents and their children. These negative interactions, in turn, further promote behavior problems in children (Lee & Bates, 1985). Thus, potential precursors to conduct problems and disruptive behaviors may be evident very early in children's lives.

Of the behaviors related to conduct problems and disruptive behaviors, aggression has strong evidence of its stability over time (Campbell, 1987; Garcia-Coll, Kagan, & Resnick, 1984). For example, Keenan and Shaw (1994) report that aggressive behavior in toddlers from low-income families is moderately stable from the ages of 18- to 24-months. Further, Shaw, Keenan, and Vondra (1994) report that boys' observed levels of noncompliance and lower levels of mothers' responsiveness predict boys' aggressiveness when they were 24-months old. In addition, early aggressiveness, as well as the interaction between early

aggressiveness and mothers' responsiveness, predicts boys' externalizing symptoms at 36-months old (Shaw et al., 1994). Cummings, Iannotti, and Zahn-Waxler (1989) also indicate that there are moderate to high correlations in the levels of peer aggression exhibited by preschoolers from the ages of 2- to 5-years. Finally, Rose, Rose, and Feldman (1989) report that there is moderate to high stability in the externalizing behavior problems (as rated by the Child Behavior Checklist) exhibited by children from the age of 2- to 5-years. Thus, there is substantial evidence of the stability of aggression in young children.

To examine issues of stability further, Keenan and colleagues (1998) assessed mother–child dyads at several points from the time that the children were approximately 12-months to 5-years of age using different instruments. Based on the findings for this sample, Keenan and colleagues (1998) suggest that behavior problems demonstrate moderate stability over time, with early behavior problems at 18-months of age being related to later psychological symptoms for both boys and girls. For example, their results indicate that aggression in boys and noncompliance in girls at 18- and 24-months of age are related to young children's experience of externalizing behavior problems at 3- and 5-years of age and that *DSM-III-R* externalizing disorders are predicted by aggression at 18-months of age and externalizing scores at 36-months of age (Keenan et al., 1998).

Further, in a study examining the stability of behavioral problems, McGee, Partridge, Williams, and Silva (1991) report that hard-to-manage preschoolers continue to experience a range of behavioral and academic problems when they reach elementary school. Their results also suggest that these hard-to-manage preschoolers exhibit difficulties in adolescence, with those demonstrating persistent problems at the age of 9-years being rated as less socially competent and more aggressive than comparison children. In addition, the mothers of these children rate them as being more hyperactive at the age of 13-years (Ewing, 1994, as cited in Campbell, 1995). Parents of children with Disruptive Behavior Disorders also report higher levels of behavior problems than parents of children with Attention-Deficit/Hyperactivity Disorder, whereas teacher ratings do not distinguish these groups (Ross, Blanc, McNeil, Eyberg, & Hembree-Kigin, 1998). This more recent work is consistent with that of earlier researchers, who suggest that as many as 60% of 3-year olds who fall within the extreme range on measures of their externalizing behavior would continue to have difficulties into middle childhood (Richman, Stevenson, & Graham, 1982).

The stability of *DSM* diagnoses also has been investigated. For example, Campbell and Ewing (1990) report that the majority of children who are labeled as hard-to-manage by their parents at the age of 3-years and who show persistent problems throughout the preschool period meet criteria for a *DSM-III* externalizing disorder at the age of 9-years. This finding is consistent with that of other studies (Campbell, Pierce, March, Ewing, & Szumowski, 1994). Thus, the occurrence of early disruptive behavior problems may elevate the risk of persistent problems and negative interactions with children (Fagot & Leve, 1998). Other studies suggest that children who exhibit elevated levels of aggression across settings (e.g., school and home) and who are experiencing high levels of family stress and negative parenting are more likely to continue having problems at the start of school (Campbell, 1990, 1997). Further, children with Disruptive Behavior Disorders are rated as experiencing more impairment than children without such diagnoses (Keenan et al., 1997).

Other researchers have begun to identify the characteristics of samples who exhibit deviant behaviors over the long term. For example, Côte, Vaillancourt, LeBlanc, Nagin, and Tremblay (2006) report that children who follow a highly stable trajectory of physical

aggression are more likely to be male, to have mothers who did not complete high school, and to experience hostile and ineffective parenting strategies. Further, [Lacourse and colleagues \(2006\)](#) examine data for 937 boys from Kindergarten through adolescence. In their study, Kindergarten characteristics including high hyperactivity, high fearlessness, and low prosociality in conjunction with family adversity serve as strong predictors of boys' involvement with early affiliation with deviant peers. Such affiliation may, in turn, be related to antisocial and conduct disordered behavior during adolescence and to a predisposition toward violent offenses ([Lacourse et al., 2006](#)). Thus, early characteristics may predispose children to conduct problems in both the short and the long term, with conduct problems demonstrating stability from early childhood to later life.

Other diagnostic considerations

When diagnosing conduct problems and disruptive behaviors in young children, it is recommended that mental health professionals use a developmental approach. As part of such an approach, normative development should be used as the context for the assessment of young children's behaviors and symptoms ([Keenan & Wakschlag, 2002](#)). This approach also considers the physical constraints in how symptoms may be manifested by young children (e.g., having access to certain weapons). Thus, although the symptoms may be the same across development, symptom manifestations may vary as children age ([Keenan & Wakschlag, 2002](#)). Such an approach may benefit from the incorporation of standardized developmental modifications to the collection of information regarding diagnostic criteria, the use of observational methods, and the assessment of young children's developmental level ([Keenan & Wakschlag, 2002](#)). Some individuals even suggest including the self-report of young children themselves in assessment procedures, as the information that they provide about their own conduct problems can be helpful in distinguishing whether they meet *DSM-IV-TR* diagnosis. Young children's self-reports also have shown a similar pattern of relationships to correlates of conduct problems relative to information provided by adults ([Arseneault, Kim-Cohen, Taylor, Caspi, & Moffitt, 2005](#)).

When considering disorders of conduct in young children, mental health professionals should identify the criteria that are being exhibited most commonly. Although not all children with conduct problems may meet criteria for one of the diagnostic categories described previously, they may still exhibit problematic behaviors falling in the realm of disorders of conduct. In particular, [Keenan and Wakschlag \(2000\)](#) indicate that the most frequent symptoms exhibited by a sample of young children who range in age from 2- to 5-years are starting fights, bullying, using a weapon, and lying, with siblings being common targets of these behaviors. Further, reports of tantrums and fighting with peers decrease between the ages of 3- and 5-years in nonclinical samples ([Crowther et al., 1981](#)). Thus, these symptoms may be seen more commonly than other conduct problems and disruptive behaviors.

Mental health professional also may want to consider young children's gender in conjunction with the behaviors that they are exhibiting. Unfortunately, findings are inconsistent regarding gender differences in disruptive behaviors for preschool samples. Some studies report that boys exhibit higher levels of conduct problems in general ([Kim-Cohen et al., 2005](#)) and higher levels of tantrums, fighting, and disobedience in particular (e.g., [Crowther et al., 1981](#); [Prior et al., 1993](#)). In contrast, other studies report nonsignificant differences ([Stallard, 1993](#)). For example, [Webster-Stratton \(1996\)](#) examines gender

differences in 3- to 7-year-olds who exhibit characteristics of early onset conduct problems. This study suggests that girls and boys exhibit similar levels of total externalizing behaviors, verbal deviance, and noncompliance when rated by their mothers and fathers. It should be noted, however, that the ratings of these children are qualified by differences across mothers and fathers. Fathers did not demonstrate differences in their ratings of externalizing behavior problems across boys and girls, whereas mothers rate boys as having more externalizing behavior problems than girls.

These gender differences in identifying conduct problems and disruptive behaviors may be related to the manner in which young children interact with their parents, peers, and other individuals in their lives. For example, in interactions with mothers and fathers, boys are more physically negative than are girls (Webster-Stratton, 1996). Similarly, Tremblay (2004) notes that boys tend to use more physical aggression by 2-years of age and to learn alternatives to physical aggression more slowly than girls. Interestingly, such reports seem to be consistent across different cultures (Campbell, 1995). Thus, in young children, it remains to be determined whether gender differences that are apparent in older samples of children and adolescents, where boys are more likely to receive a disruptive behavior diagnosis (APA, 2000), are present. Given findings such as these, mental health professionals may have more assistance with their differential diagnosis by considering assessment issues and the symptoms exhibited by young children rather than focusing on young children's gender.

Correlates of conduct problems

When considering conduct problems, mental health professionals also should consider reports of young children's early temperament and the manner in which parents and their young children interact as well as the level of impairment experienced by young children. In general, preschool children who exhibit symptoms of Disruptive Behavior Disorders exhibit more impairment in parent-child, preschool, and clinical contexts (Wakschlag & Keenan, 2001). Each of these factors may contribute to the later outcomes of young children with conduct problems and disruptive behaviors independently and interactively. For example, difficult temperament during infancy in interaction with the quality of the parenting that is experienced is accepted widely as a strong predictor of later behavior problems (Werner & Smith, 1977). Further, preschoolers who are difficult to soothe as infants likely exhibit elevated symptoms of Disruptive Behavior Disorders (Wakschlag & Keenan, 2001). In addition, mothers' ratings of difficult infant temperament, as well as ratings of mother-child interactions and mothers' ratings of aggression when their children are 3-years of age, predict significantly children's conduct problems when they are 9-years of age (Campbell & Ewing, 1990). Thus, mothers' ratings of temperamental difficulties and mothers' perceptions that their infants are difficult are related to mothers' ratings of later behavior problems (Sanson, Oberklaid, Pedlow, & Prior, 1991).

Consistent with these findings, Keenan and Shaw (2003) propose two possible pathways to later antisocial behavior within the context of toddlers' emotional regulation. In these pathways, toddlers may be either underaroused or overaroused and receive subsequent parenting that does not promote the most optimal outcome. Parents who provide appropriate support and responsiveness may assist their irritable infant to regulate their distress. In contrast, such difficulties may be exacerbated when parents are limited or harsh in their responses (Thomas, Chess, & Birch, 1968). Given findings such as these, young children's

early temperament may be an important consideration for mental health professionals who are considering the conduct problems and disruptive behaviors of young children. When considering young children's early temperament, mental health professionals also must consider the parenting style being used with these children.

In particular, parenting stress, low behavioral responsiveness, and the use of harsh discipline are related to elevated levels of Disruptive Behavior Disorder symptoms (Wakschlag & Keenan, 2001). Such relationships may make sense in that having young children who are exhibiting conduct problems and disruptive behaviors in the home may put extra demands on parents. In support, previous research suggests that mother–child interactions with a young child who has been identified as being hard-to-manage are more conflict ridden and negative and that negative maternal control may predict later persistent problems (Campbell, 1997). Other studies provide consistent evidence. For example, Calzada, Eyberg, Rich, and Querido (2004) indicate that both mothers and fathers report elevated levels of disruptive behaviors in young children who have been clinic-referred; however, mothers perceive their children's behavior to be more disruptive and problematic than fathers. Thus, parents' perceptions of their young children's behavior may provide important information and may be related to the parenting behaviors that parents then incorporate into their interactions with their young children.

Overall, the parenting styles used by mothers and fathers may be important for the outcomes of young children with conduct problems and disruptive behaviors. For example, child compliance and internalization of control are related closely to an authoritative parenting style (i.e., parenting that is characterized by warmth, firm but fair control, and use of reasoning; Baumrind, 1967), whereas child noncompliance and defiance are associated with arbitrary, inconsistent, negative, or uninvolved parenting behavior (Kuczynski, Radke-Yarrow, Kochanska, & Ginius-Brown, 1987). Noncompliant behavior in young children also is related to more negative maternal control concurrently (Campbell, Pierce, March, & Ewing, 1991) and over time (Campbell, Pierce, Moore, Marakovitz, & Newby, 1996). As further evidence of these relationships, Tremblay and colleagues (2004) suggest that mothers' coercive parenting behavior and family dysfunction when children are 5-months of age are the best predictors of children's physical aggression at 17-months of age. Other studies find consistent results (Romano, Tremblay, Boulerice, & Swisher, 2005).

Some of these findings may be qualified by parents' gender as well. For example, although both mothers and fathers exhibit high levels of demandingness and low levels of responsiveness with their noncompliant children, mothers show higher levels of responsiveness than fathers. Even so, children demonstrate lower levels of noncompliance with their fathers, and fathers' parenting stress and fathers' demandingness are significant predictors of the levels of disruptive behaviors exhibited by their children (Calzada et al., 2004). Further, when compared to mothers' interactions with their nonclinical young children, mothers of clinic-referred Conduct-Disordered children exhibit fewer positive affect behaviors, fewer praise behaviors, more critical and controlling behaviors, and fewer submissive behaviors. Their children also exhibit fewer expressions of enjoyment, fewer dominance behaviors, and lower levels of assertiveness and self-confidence (Webster-Stratton, 1985). Thus, in general, parents' ability to regulate their own emotions are related to their children's ability to learn to control their emotions (Tremblay, 2004). Mental health professionals, however, should be encouraged to look closely at the relationships among parents' gender, their parenting behaviors, and young children's conduct problems and disruptive behaviors.

Even in the face of findings such as these, mental health professionals should note that the relationship between parents' behavior and young children's conduct problems and disruptive behaviors is bidirectional. Thus, although negative maternal control predicts children's noncompliance or aggression, difficult children also may elicit more inconsistent behavior from their parents (Shaw et al., 1994). For example, mothers of preschoolers who exhibit problematic behaviors engage in more confrontation but are less likely to follow through to gain compliance. Further, these children are less likely to comply with the requests of their mothers (Gardner, 1989). Given interactions such as these, children with problematic behaviors have a history of higher rates of negative interaction and lower rates of harmonious interaction (Gardner, 1987). Some researchers emphasize readily that coercive interactions between young children and their parents are necessary in a long-term pattern of antisocial behavior that is related to other problems, such as in school or in other relationships (e.g., Patterson, 1982). Other research supports this supposition. For example, toddlers who have families exhibiting persistent conflict in parent–child interactions as well as other adversity experiences exhibit higher levels of externalizing behavior problems at the age of 18-months when compared to toddlers from nontroubled families (Belsky, Woodworth, & Crnic, 1996).

Although patterns of problematic exchanges between parents and their young children over time may result in problematic behaviors for these children over the long-term, mental health professionals are encouraged to consider the developmental appropriateness of these behaviors and to provide this information to parents. As mentioned previously, behaviors that are viewed as problematic during school age (e.g., noncompliance, tantrums, aggression) may be common during the toddler years and may signal that young children are undergoing age-appropriate transitions and autonomy struggles. During these transitions, parenting can be a vitally important component to the later behaviors that are exhibited by young children. In fact, levels of parental warmth, support, and control may help to determine whether a toddler exhibiting these behaviors will master these transitions or go on to exhibit concerning behavior problems (Campbell, 1990). As a result, although conduct problems, poor parental discipline, and negative interactions between parents and their young children are strong predictors of later disruptive behavior problems, such as criminality and delinquency (Loeber & Dishion, 1983), parents also may be able to help their young children find a different behavioral trajectory by incorporating more warmth, support, and appropriate control into their interactions.

Beyond the problematic interactions between parents and their young children described previously, peer problems also are common for young children with conduct problems and disruptive behaviors. For example, boys attending Head Start who receive elevated teacher ratings for noncompliance and overactivity are more likely to receive negative nominations from peers and to be described as problematic by peers (Olson, 1992). In addition, teachers', but not parents', ratings of externalizing behavior problems in preschool play groups are related to observations of noncompliance and aggression (Hinshaw, Han, Erhardt, & Huber, 1992). In contrast, young children's escalation and failure with peers are related to parents' reports of behavior problems at home and in parent–child interactions, whereas failure with peers, negative conflict tactics, and negative attributions are related to teachers' reports of young children's problems at school (Stormshak & Webster-Stratton, 1999). Overall, the co-occurrence of peer relationship difficulties and behavior problems in young children are important to assess as well, as this co-occurrence is predictive of later difficulties (Parker & Asher, 1987).

Treatments

Given the stability of conduct problems and disruptive behaviors in children, it is likely that young children will experience difficulties into adolescence and adulthood. As a result, mental health professionals must gain an understanding of when and how to intervene with these children. Such an understanding is particularly important when one considers that conduct problems and disruptive behaviors can be relatively resistant to treatment when diagnosed in school age or adolescence (Kazdin, 1993). Further, interventions that have been developed to treat conduct problems exhibited by children and adolescents have not been shown to be highly effective (Kazdin, 1995). Perhaps this lack of effectiveness is due in part to the number of risk factors experienced by many of the families who have children with conduct problems. For example, those children and families who are at the highest risk tend to benefit least from traditional parent training interventions because of treatment barriers such as social isolation and multiple competing barriers (Dumas & Wahler, 1983; Kazdin & Wassell, 1999).

Nonetheless, these findings suggest that early prevention should be emphasized (Conduct Problems Prevention Research Group, 1992) and that intervening as disruptive behavior problems are developing is important (Reid, 1993). With early treatment, conduct problems can be addressed before they become an entrenched pattern of behavior (Capage, Foote, McNeil, & Eyberg, 1998). In fact, treatments for young children with conduct problems have been developed and validated (Webster-Stratton, 1997). Further, some studies have demonstrated success in treating young children with conduct problems. For example, parent training has been validated as an effective approach, and may be the most successful approach, to preventing and reducing disruptive or externalizing behavior problems in young children (Brestan & Eyberg, 1998).

Kazdin and Wassell (1999) also demonstrate that child, parent, and family functioning improves significantly when children receive cognitive problem-solving skills training and parents receive parent management training. In particular, children evidence fewer antisocial behaviors and total behavior problems, parents evidence fewer symptoms of depression and parenting stress, and family functioning improves overall. Further, the improvements of children, their parents, and the functioning of their families are interrelated (Kazdin & Wassell, 1999). Some examples of the programs that have been developed for use with young children are described below.

Parent–child interaction therapy

Parent–Child Interaction Therapy (PCIT) is a therapy program developed by Sheila Eyberg based on the work of Constance Hanf (1969; Hembree-Kigin & McNeil, 1995). This therapy program is based in attachment theory, which suggests that responsive parenting will lead young children to expect that their needs will be met by their parents (Herschell, Calzada, Eyberg, & McNeil, 2002). Further, this therapy program incorporates operant conditioning, through which parents are taught to differentially attend to their young children's positive behaviors (Shillingsburg, 2005). Following a thorough assessment, PCIT has two sequential treatment modules. First, parents are directed in how to interact attentively through play with their young children (Child-Directed Interaction;

CDI). The second module consists of parents learning effective contingency management skills that can be used to manage child noncompliance (Parent-Directed Interaction; PDI).

During the course of both modules, parents receive direct coaching in the use of these skills from their therapist in session (Hembree-Kigin & McNeil, 1995). Therapists also expect parents to practice these skills at home (Eyberg, 2003) so as to maximize their mastery of these skills and to disrupt negative patterns of interaction between the parents and their young children (Capage et al., 1998). Therapy is completed when parents have mastered the interaction skills taught in therapy sessions, when they have reported an improvement in their young children's behavior, and when young children no longer meet criteria for the oppositional diagnosis made in the intake assessment (Eyberg, Boggs, & Algina, 1995).

During the course of CDI sessions, parents are taught to play with their young children in a way that allows the children to take the lead (Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993). CDI resembles traditional play therapy (Eyberg, 2003). Parents are asked to engage in special playtime with their young children (Greco, Sorrell, & McNeil, 2001) and are taught to describe, imitate, and praise their young children's appropriate behavior while reflecting appropriate speech and ignoring inappropriate behavior. In addition, parents are asked to avoid criticism, commands, and questions. Thus, the CDI stage attempts to create or strengthen the parent–young child relationship and make it positive and mutually rewarding (Eisenstadt et al., 1993). Traditionally, CDI is followed by PDI, as it is expected that discipline will be more effective if it is administered within the context of a positive parent–child relationship (Eyberg et al., 2001).

In contrast to CDI, PDI sessions are spent instructing parents in how to direct their young children's behavior using appropriate methods of discipline (Eisenstadt et al., 1993), such as time out procedures (Greco et al., 2001). PDI resembles more traditional clinical behavior therapy (Eyberg, 2003), in that parents are instructed to use commands appropriately, to use consistent consequences for their young children's behavior, and to manage their young children's behavior at home and in public (Eisenstadt et al., 1993). Thus, PDI is meant to help parents decrease their children's problematic behavior while increasing their children's prosocial behaviors (Eisenstadt et al., 1993).

PCIT has been shown to be effective in general (Eyberg & Robinson, 1982) and over time (Eyberg et al., 2001) in improving parent–young child interactions and in decreasing young children's behavior problems (Herschell et al., 2002). In particular, mothers demonstrate an increase in praise for their young children's behavior and a decrease in negative talk (i.e., sarcasm, critical statements; Eyberg et al., 1995). Young children also exhibit declines in disruptive behaviors, whereas parents demonstrate improvements in parenting stress and locus of control (Eyberg et al., 1995). When compared to families who discontinue treatment early, those who complete this treatment program show significant improvements in maternal ratings of the frequency of young children's disruptive behaviors, maternal tolerance for young children's misbehavior, and maternal parenting stress levels. Young children also are less likely to meet criteria for their initially diagnosed disorders upon completing treatment (Boggs et al., 2005).

Further, PCIT has been effective in decreasing problematic disruptive behaviors in a variety of settings (e.g., school; McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991) and with a variety of different types of families with young children. Families with young children who are Caucasian and those who are from African American backgrounds respond similarly to the PCIT program (Capage, Bennett, & McNeil, 2001). In

addition to being effective for families from different cultural backgrounds, PCIT is effective for families with other characteristics as well. For example, a case study by [Borrego, Urquiza, Rasmussen, and Zebell \(1999\)](#) shows that PCIT is effective for reducing a young child's behavior problems and maternal stress while increasing positive parent–child interactions in a family at risk for physical abuse. PCIT also has effects on the untreated siblings in families receiving treatment ([Brestan, Eyberg, Boggs, & Algina, 1997](#); [Eyberg & Robinson, 1982](#)). The generalization of such changes in behavior to other members of young children's families is likely important for maintaining behavioral changes in the young children that are targeted for treatment ([Eyberg et al., 1995](#)). Finally, participants appear satisfied with the treatment that they receive ([Boggs et al., 2005](#); [Eyberg et al., 1995](#)).

Videotape modeling

Videotape modeling is a treatment program developed by Carolyn [Webster-Stratton \(1981b\)](#) to address disruptive behaviors in young children through parent training. In this parent training program, parents are exposed to videotape parent models who engage in appropriate parenting behaviors, including effective play techniques, the setting of limits, the handling of misbehavior, and communication ([Webster-Stratton, 1981b](#)). In this program, parents view these videotape models, participate in parent discussion groups, and complete homework assignments to practice the skills that they saw demonstrated.

Initial results regarding this program indicate that mothers decrease their lead-taking behaviors, nonacceptance, and dominance ([Webster-Stratton, 1981b, 1982a](#)). Further, parents who participate demonstrate increased confidence and feel very positive about the program ([Webster-Stratton, 1981a](#)). These results are sustained over a two-month follow-up period ([Webster-Stratton, 1981b, 1982a](#)). Other studies demonstrate that mother–child interactions are more positive and significantly less negative, nonaccepting, and domineering. Children whose parents participate in this program also exhibit decreases in negative affect and submissive behavior and increases in positive affect behaviors ([Webster-Stratton, 1981b, 1982a](#)). Boys and girls whose parents participate in this program respond similarly, with both boys and girls showing reductions in externalizing problems and noncompliance. These children also maintain their reductions in problematic behaviors over 1- and 2-year follow-up assessments ([Webster-Stratton, 1982b](#); [Webster-Stratton, 1996](#)). These findings have been documented for different populations, including parents and their children in Head Start who participate in this program in addition to their usual Head Start program. These parents and their children exhibit significant differences in their behavior when compared to those parents and their children who only participate in the usual Head Start services ([Webster-Stratton, 1998](#)).

In an attempt to make this treatment program more cost-effective, [Webster-Stratton \(1992\)](#) evaluates an individually administered version of this parent training program, in which parents view the videotape models and complete a manual with cognitive exercises individually. Results of this individually administered program suggest that, following treatment, parents use significantly less physical discipline and hold increased positive perceptions of their young children's behavior. These changes are maintained at a one-year follow-up, with the young children of the parent participants exhibiting continued improvements ([Webster-Stratton, 1992](#)). Other studies have begun to compare this individually administered program to a videotape modeling program with group discussion

and a group discussion only program. Although mothers who attend the videotape modeling with group discussion or the group discussion only programs feel that these programs are more useful and easier to implement than those in the individually administered videotape modeling program, all three programs have comparatively similar and high levels of satisfaction over the course of the programs and at one-year follow-up (Webster-Stratton, 1989).

In an attempt to improve parents' communication and problem-solving skills, Webster-Stratton (1994) also added a 14-session component addressing parents' personal self-control, communication skills, and problem-solving skills as well as ways that parents could teach problem-solving skills to their young children and strengthen social support and self-care. This additional component is meant to follow the videotape modeling parent training program described previously. When compared to parents who participate in only the parent training program, those who complete the parent training program and the additional program demonstrate improvements in their communication, problem-solving skills, and consumer satisfaction. These parents also have young children who demonstrate increased prosocial problem-solving (Webster-Stratton, 1992).

The videotape modeling parent training and the additional problem-solving skills component have been packaged with additional training for teachers and social skills training for children (described next) into a treatment package called the Incredible Years (Reid & Webster-Stratton, 2001; Webster-Stratton, 2001). The goals of this program are to promote parenting competencies in an effort to strengthen families, promote teacher competencies, strengthen connections between young children's home and school settings, and promote social competencies in young children (Webster-Stratton, 2001). This program incorporates the videotape modeling described above, in that videotape models are presented to groups of parents, teachers, and children for discussion within the context of cognitive-behavioral principles and a collaborative process. The parent program is designed so that it is held for two hour weekly session over 22–24 weeks, the teacher program is designed so that it is held in four day long sessions, and the child program is designed for groups of six to seven children (and is described next). Each of these programs has been validated empirically (Reid & Webster-Stratton, 2001; Webster-Stratton, 2001).

Social skills training

Although parent training programs, such as those described previously, have been effective in treating the disruptive behaviors of young children, there may be occasions where other types of treatment may be warranted. For example, parent training programs may not result in improvements outside of the home setting, such as at school or with peers (Taylor & Biglan, 1998). Further, parents may not be able or willing to participate in parent training programs (Webster-Stratton & Reid, 2003). Thus, in these cases, attempts to work directly with young children themselves may be made. Due to the likelihood of young children with disruptive behaviors exhibiting cognitive and behavioral deficits in their social skills (e.g., Coie & Dodge, 1998), social skills may be a viable treatment option.

Webster-Stratton and Reid (2003) described one such program, the Dina Dinosaur Treatment Program. This program targets children with conduct and comorbid problems and consists of 18–22 weekly two hour sessions. Topics of these sessions include doing well in school and following rules, understanding and detecting feelings, gaining problem-solving skills, and making friendships (Webster-Stratton & Reid, 2003). The sessions include

activities with live and videotaped modeling, role-playing, and practice and homework activities. Each component is based on cognitive, affective, and behavioral themes to enhance learning (Webster-Stratton & Reid, 2003).

With regard to this program's effectiveness, Webster-Stratton and Hammond (1997) demonstrate that the combination of parent training and the Dina Dinosaur interventions is more effective than parent training alone, with this combination showing sustained effects over time. Further, the results of both parent training and the Dina Dinosaur interventions are superior when compared to a control group. Overall, children who receive the Dina Dinosaur program demonstrate improvements in their peer interactions and are more positive in their social skills and conflict management than those who have parents participating in the parent training group only and those in a control group (Webster-Stratton & Hammond, 1997).

Summary

Conduct problems and disruptive behaviors are cited as the most common reason for clinic referrals for preschoolers (Luby & Morgan, 1997). During their presentation to a clinic, mental health professionals may diagnose these young children with a *DSM-IV-TR* diagnosis of ODD or CD. For some young children who are not meeting the criteria of these disorders exactly, mental health professionals may view the difficult behaviors exhibited by these young children as normative for the developmental period. In cases where mental health professionals are uncertain about the appropriateness of a *DSM-IV-TR* diagnosis, they may choose to inform themselves regarding options in other diagnostic systems, such as the *DSM-PC* or *DC: 0-3*. Whether or not these young children receive a diagnostic label for the constellation of behaviors that they exhibit, it is well documented that young children who exhibit conduct problems and disruptive behaviors at this early age are likely to continue having similar difficulties throughout their life times and to experience several related difficulties, such as difficult interactions with parents and peers. In an effort to alleviate such difficulties for young children, several treatment options, such as Eyberg's PCIT and Webster-Stratton's Incredible Years treatment programs, have been developed and are being validated. To further the understanding of how these treatments work and how they may be applied to young children with different characteristics, further research that uses these treatments with rigorous methodology in applied settings is warranted. Although such treatments have provided hopeful outcomes thus far, continued work documenting that young children with conduct problems and disruptive behaviors can be treated and experience more positive outcomes overall is needed.

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