

# Disruptive Behavioral Disorders (DBD)

Last updated: April 24, 2019

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**DISRUPTIVE BEHAVIORAL DISORDERS** – affected children tend to disrupt those around them, including family members, school staff, and peers.

- most common DBD is ADHD → see p. Psy27 >>

## OPPOSITIONAL DEFIANT DISORDER

- recurrent / persistent negative, defiant, or even hostile behavior directed at authority figures.

N.B. patients are not aggressive and physically threatening (as in conduct disorder)!

- hallmark is interpersonal style characterized by irritability and defiance - lose temper easily and repeatedly, argue with adults, frequently defy adults, refuse to obey rules, deliberately annoy people, blame others for their own mistakes or misbehavior.
- most common in children from families in which adults model loud, argumentative, interpersonal conflicts.
- diagnostic criteria are highly subjective.
- PREVALENCE ≈ 15% children and adolescents (boys >> girls; after puberty, this difference narrows).

N.B. nearly all children and adolescents periodically demonstrate mild ÷ moderate oppositional behaviors! (esp. with untreated ADHD).

In some children with major depressive disorder, predominant mood is irritability rather than sadness (important distinction between childhood and adult MDD!).

Treatment - individual psychotherapy (of underlying problems) combined with family or caretaker therapy.

- drugs may be used to reduce irritability.
- most cases gradually improve over time (but ODD may be developmental precursor of conduct disorder).
- many of these children lack social skills - can benefit from group-based, skills-building therapy.

## CONDUCT DISORDER

- recurrent / persistent behavior that violates rights of others or major age-appropriate societal norms or rules.

N.B. no evidence of irritability (vs. oppositional defiant disorder)!

- onset - late childhood ÷ early adolescence.
- patients lack sensitivity to feelings and well-being of others and sometimes misperceive behavior of others as threatening; may demonstrate aggression by bullying and making threats, brandishing or using weapon, committing acts of physical cruelty, or forcing someone into sexual activity, all with little or no feelings of remorse.
  - may engage in destruction of property, deceit, and theft.
  - in some cases, aggression is directed at animals.
  - tolerate frustration poorly and are commonly reckless, violating rules and parental prohibitions (e.g. by running away from home, being frequently truant from school).
  - likely to use and abuse illicit drugs and have difficulties in school.
  - suicidal ideation is common!
  - aberrant behaviors differ between sexes: boys fight, steal, and vandalize; girls lie, run away, and engage in prostitution.
- etiology - complex interplay of genetic and environmental factors;
  - parents often have engaged in substance abuse and antisocial behaviors, and frequently have been diagnosed with ADHD, mood disorders, schizophrenia, or antisocial personality disorder.
  - CD can occur in children from high-functioning, healthy families!!!
- PREVALENCE of some level of CD ≈ 10% (boys >> girls).

No treatment has been proven effective - children require considerable supervision (separation from damaging environment and external discipline and consistent behavioral management systems).

- moralization and dire admonitions are ineffective and should be avoided.
- individual psychotherapy (incl. cognitive therapy and behavior modification) may help.
- most cease disruptive behaviors in early adulthood, but about 1/3 of cases persist as antisocial personality disorder.

BIBLIOGRAPHY for ch. "Psychiatry" → follow this LINK >>