



Disruptive behaviour disorders and DSM-5



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ABSTRACT

This article provides an overview of the revisions to the diagnoses of oppositional defiant disorder (ODD) and conduct disorder (CD) in DSM-5, and examines the key issues they raise. Particular attention is given to these changes in light of current treatment outcome evidence, including that published since the development of DSM-5. For both ODD and CD, DSM-5 retains the core features that previously defined the phenotypes for these diagnoses. DSM-5 nonetheless introduces a number of revisions pertaining to the guidelines for the application of these criteria, and markers for key individual differences in presentations of these disorders. These revisions reflect small but significant steps towards the perspective that children with disruptive behaviour problems are a highly heterogeneous population, and best characterised on the basis of both behavioural and emotional features. Importantly, there is growing evidence that the newly introduced changes to these diagnoses in DSM-5 may be better able to inform predictions regarding treatment response than previous diagnostic criteria.

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1. Introduction

Models of antisocial behaviour have evolved significantly since publication of the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994), as research has provided an increasingly complex picture of the developmental processes that shape disruptive behaviour problems across childhood and adolescence. It is for this reason that the relatively subtle revisions that were made to oppositional defiant disorder (ODD) and conduct disorder (CD) in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) came as a surprise to many. However, as subtle as they may appear, these revisions reflect some of the most noteworthy shifts in models of child psychopathology that have occurred in recent decades. This article provides a brief overview of these revisions and examines the key issues they raise. In particular, the revisions to these diagnoses are considered in light of current treatment outcome evidence, including that published since the development of DSM-5.

2. Oppositional defiant disorder

The core phenotype of ODD, as it appeared in DSM-IV, is retained in DSM-5. However, the criteria and guidelines for

formulating this diagnosis have been refined in four areas. First, based on factor analytic evidence for a model of ODD comprising three dimensions, symptoms are now grouped into three types: (1) angry/irritable mood (e.g., “Often loses temper”), (2) argumentative/defiant behaviour (e.g., “Often actively defies or refuses to comply with requests from authority figures or with rules”), and (3) vindictiveness (“Has been spiteful or vindictive at least twice within the past 6 months”). Due to high correlations between these dimensions, ODD remains a single diagnostic construct, with this grouping merely emphasising the notion that distinct symptom patterns may provide clinically meaningful information. This idea is supported by evidence of divergent associations between these dimensions and other forms of dysfunction. For example, the angry/irritable dimension is closely associated with anxiety/mood disorders, while the defiant/headstrong dimension is more related to attention deficit hyperactivity disorder. Alternatively, the spiteful/vindictive dimension has been related to callous-unemotional traits (Frick and Nigg, 2012).

Much of the evidence that these symptom dimensions are associated with distinct correlates with respect to aetiology and pathophysiology has come from research tracking large representative community-based samples (e.g., Stringaris and Goodman, 2009). Treatment outcome evidence regarding these dimensions remains particularly limited, however, findings from at least two clinical trials suggest that these dimensions are informative with respect to the prediction of treatment outcomes among children diagnosed with ODD. Kolko and Pardini (2010) examined predictors of treatment outcomes among children (6–11 years) diagnosed with ODD or CD, who were randomised to a modular

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intervention (parent and child skills training, medication, school consultation), or treatment as usual (TAU) in community health settings. The most robust predictor of persistent disruptive behaviour problems following treatment was the spiteful/vindictive dimension of ODD, which accounted for poor response independent of ODD severity and the presence of comorbid attention-deficit/hyperactivity disorder. Evidence reported by Scott and O'Connor (2012) subsequently indicated that these ODD symptom dimensions may be used to characterise children who are particularly responsive to treatment. In an RCT for young children with ODD (aged 5–6 years), the authors found that participants characterised by symptoms on the angry/irritable dimension were those most likely to benefit from a parent training intervention. Interestingly, these children were also found to be particularly vulnerable to the effects of negative parenting, leading the authors to propose that angry/irritable symptoms may be a marker for differential susceptibility to parenting among children with ODD (Scott and O'Connor, 2012).

The second area in which ODD has been revised concerns the previous exclusion criteria related to CD, meaning that it is now possible to apply both diagnoses to the same child. On the one hand this may seem at odds with the widely held view of ODD and CD as different stages of a common trajectory. However, the move towards a system in which a child may be diagnosed with both CD and ODD is supported by evidence that the presence of ODD provides important additional information to the diagnosis of CD, with respect to risk for the development of anxiety/mood disorders (Rowe et al., 2010).

Beyond these revisions to ODD, DSM-5 introduces changes that address the basis for characterising clinically significant patterns of ODD behaviours, and differentiating them from those that commonly occur in the course of healthy child development. A note has been added regarding the patterns of symptom frequency and persistence that designate diagnosable dysfunction, depending on the age of the child (older/younger than 5 years of age). Finally, a severity rating has been added based on the range of settings (e.g., home, school, peers) in which symptoms are present. This is based on the evidence that the pervasiveness contributes additional diagnostic information independent of symptom frequency and count (Youngstrom, 2011).

3. Conduct disorder

Much like the approach taken to the revision of ODD, the core diagnostic features of CD in DSM-5 remain unchanged. The most significant change here is the introduction of a descriptive features specifier for individuals who meet full criteria for the disorder but also present with limited prosocial emotions (e.g., a lack of guilt and empathy). The term 'limited prosocial emotions' represents a simple re-branding of the construct most often referred to as callous unemotional (CU) traits in the scientific literature. US-based research has indicated that between 10% and 50% of youth with CD would be designated with the specifier, depending on informant (Kahn et al., 2012). Alongside the age-based (childhood-onset/adolescent-onset) subtyping of CD retained from DSM-IV, this new specifier adds to the means by which a diagnosis of CD is able to capture clinically meaningful individual differences in presentations of the disorder.

From a theoretical perspective, CU traits correspond to the affective component of psychopathy. The application of the psychopathy construct to children has drawn understandable scrutiny, as well as recognition that it is crucial to understand antisocial behaviour from a developmental perspective (see Rutter, 2012). Among children and adolescents with disruptive behaviour problems, those with high levels of CU traits exhibit a particularly severe and chronic trajectory of antisocial behaviour that often

features high levels of proactive or instrumental aggression (Frick et al., 2013). Such individuals are also characterised by a range of unique social-cognitive and neurobiological correlates related to the processing of emotional stimuli and reinforcement learning (Viding et al., 2012).

Research into the parenting processes associated with CU traits has grown rapidly over the past decade, and there is now considerable evidence that CU traits interact with the family-based mechanisms through which the most effective interventions for disruptive behaviour problems currently operate. First, research has demonstrated that the association between parenting practices and child conduct problems is moderated by CU traits. While negative (harsh and inconsistent) parenting practices are highly proximal to the conduct problems of children without CU traits, those of children with high levels of CU traits appear to be less directly related to negative parenting, and more proximally associated with a lack of parental warmth (Waller et al., 2013).

There is also now much evidence to show that children with CU traits benefit less from current treatments for disruptive behaviour problems than those without CU traits (for a review see Frick et al., 2013). This finding was first reported by Hawes and Dadds (2005), who examined the treatment outcomes of boys with ODD (aged 4–8 years) whose parents participated in a 10-week parent training programme (Integrated Family Intervention for Child Conduct Problems; Dadds and Hawes, 2006) delivered individually to families. Mother-reported CU traits were found to uniquely predict diagnostic status at 6-month follow-up, independent of pre-treatment symptom severity and comorbid symptoms of ADHD.

Although findings regarding the treatment outcomes of children with CU traits have at times been mixed, and studies often limited by methodological issues such as a reliance on single-informant reports of CU traits and a lack of randomisation to distinct treatment conditions, a growing number of rigorous studies indicate that CU traits both predict and moderate response to family-based intervention among children with disruptive behaviour problems. It is apparent that the reduced treatment response among individuals with CU traits is not simply a by-product of diagnostic characteristics that may co-vary with CU traits, such as autism (e.g., Hawes et al., 2013). CU traits appear to predict poor outcomes across both standardised parent training interventions and more individualised interventions comprising both parent and child components. For example, CU traits have been shown to moderate response to multisystemic therapy – an evidence-based intervention characterised by a particularly comprehensive, formulation-driven approach involving both parent and child targets (Manders et al., 2013). Additionally, observational and self-report data on parenting indicate that CU traits do not moderate change in parents' skills across treatment, and that CU traits predict clinical outcomes when controlling for individual differences in these skills (Hawes and Dadds, 2005; Högström et al., 2013).

Importantly, there is emerging evidence that CU traits may identify children and adolescents who are likely to respond to specific treatment components that may be delivered as adjuncts to parent training interventions. Dadds et al. (2012) randomised children with disruptive behaviour problems to parent training versus parent training plus an emotion-recognition training (ERT) component. The ERT component was based on the mindreading programme originally developed to train children with autism to accurately identify and interpret emotional expressions in interpersonal contexts (Baron-Cohen et al., 2004). This component was delivered to families through a combination of four (90 min) child and parent-child sessions involving interactive computerised modules and homework in the form of parent-child emotion-focused games that were manualised for the purposes of the study. The combination of ERT plus parent training was found

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