

**Disruptive Behavior Disorders & ADHD in Preschool Children:  
Characterizing Heterotypic Continuities for a Developmentally-Informed Nosology for  
DSM V**

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In press: Regier, D., First, M. & Narrow, W. (Eds). Age and gender considerations in psychiatric diagnosis: A research agenda for DSM-V. Washington, DC: American Psychiatric Publishing Inc.

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## Acknowledgements

The writing of this chapter has been supported in part by support from NIMH grant MH068455 to Drs. Wakschlag & Leventhal, MH62437 to Dr. Wakschlag and R23 RR018334 to Dr. Thomas, and, by ongoing support to Drs. Leventhal & Wakschlag by the Walden and Jean Young Shaw Foundation, Irving B. Harris Foundation, Daniel X. & Mary Freedman Foundation and, Children's Brain Research Foundation. Ideas put forth in this chapter have been importantly shaped by treasured collaborations and critical discussions with our colleagues: Drs. Adrian Angold, Edwin Cook, Margaret Briggs-Gowan, Alice Carter, Barbara Danis, Helen Egger, Deborah Gorman-Smith, Nathan Fox, Carri Hill, Kate Keenan, Ellen Leibenluft, Daniel Pine, Chaya Roth and Patrick Tolan. Thoughtful input from our student, Anil Chacko, is also gratefully acknowledged.

## **I. Introduction**

There is no longer doubt that disruptive behaviors emerge in early childhood and exhibit moderate stability (Briggs-Gowan et al., 2005; Shaw et al., 2003; Tremblay et al., 2004). Additionally, preschoolers can exhibit behavioral patterns similar (but not necessarily identical) to those in older children with behavior disorders (Angold et al., 2005; Keenan & Wakschlag, 2000; Lahey et al., 1998; Speltz et al., 1999). These patterns of behavior often impair developmental functioning (Egger, et al., 2005; Wakschlag & Keenan, 2001). Yet there remains significant controversy about *diagnosing* behavior disorders in young children, due to questions about the validity of identifying behaviors as symptoms during a developmental period marked by variability and instability (Campbell, 2002). This chapter critically reviews the validity of DSM IV behavior disorders in preschoolers and generates a framework for a more developmentally-informed nosology.

Increasingly, there is agreement that early childhood is a critical period for brain development and, that early intervention is crucial for addressing cognitive and developmental delays and disorders (IOM, 2000). However, this agreement fades when it comes to mental disorders, because diagnosing psychopathology in young children is seen by many as overly deterministic (Silk et al., 2000). This is exemplified in the contradictory language of DSM IV itself. On the one hand, DSM IV cautions against diagnosing behavior disorders in young children due to behavioral variability common during this developmental period. On the other hand, DSM IV (a) requires early onset to meet criteria for Attention Deficit Hyperactivity Disorder (ADHD) (< age 7), (b) identifies “problematic temperament in the preschool years” as an “associated feature” of Oppositional Defiant Disorder (ODD) and, (c) notes that Conduct Disorder (CD) may have onset as early as age 5 (APA, 1994). Such inherent contradictions also reflect the fact that there are substantial methodological and conceptual challenges to

distinguishing typical and atypical behavior in a developmental period with an onset heralded by the “terrible twos.”

As the study of early childhood disruptive behavior has matured, it has spawned three generations of studies. Prior to clinically-focused research, numerous developmental studies on preschool behavior problems were conducted (see Campbell, 2002). Disruptive behavior in these studies was generally assessed with dimensional measures, either in terms of specific, individual behaviors (e.g., “non-compliance,” “aggression”) or, aggregated attentional, oppositional and conduct problems under the rubric of “externalizing behaviors.” These first generation studies established that behavior problems in young children were stable and measurable. However, these studies lacked clinical sensitivity and specificity, making it difficult to examine trajectories over time in a clinically coherent manner.

Second generation studies then applied DSM IV concepts to the study of preschool behavior problems (see Keenan & Wakschlag, 2002). In contrast to externalizing constructs, DSM IV behavior disorders distinguish (a) ADHD, i.e., problems modulating attention and activity from, (b) the Disruptive Behavior Disorders (DBDs – ODD & CD), i.e., negativistic patterns of social interaction. At the broadest level, these second generation studies demonstrated that DSM IV DBD and ADHD nosology could be applied to preschool children. However, in the absence of validated measures of preschool psychopathology, these studies used diagnostic instruments designed for older children with only minor modifications. As a result, this approach was relatively uninformative for examining the fit between DSM symptom constellations and actual preschool phenomenology. Testing “goodness of fit” is a central theme of the third, and current, generation of studies, which include an emphasis on validation of developmentally-sensitive clinical assessment methods.

When bridging generations, finding a common language is difficult. The distinction between attentional, oppositional and conduct problems has been called into question in research on older children due to high rates of co-morbidity. For heuristic purposes, however, we will maintain this distinction. When collectively referring to all three disorders, we will use the term “behavior disorders.” We will use the terms ADHD and DBDs (and further distinguish between ODD and CD where appropriate) when we are addressing disorder-specific issues.

In what follows, we present a synthesis of second and third generation studies. Our review of these studies, their contributions and their limitations, is designed to set the stage for our conceptualization of the next, and fourth, generation of studies for which the field is now poised. These fourth generation studies must draw on fundamental DSM principles to generate a developmentally-refined nosology with which to characterize behavior disorders in preschool children.

## **II. Current State of the Science**

Over the past decade, significant progress has been made in establishing the validity of DSM IV behavior disorders in preschool children. We will organize our review around three central questions:

**Question 1:** *Do DSM behavior disorder symptom constellations occur in young children and are they clinically meaningful?* More than a dozen, independent studies have demonstrated that DSM DBD and ADHD criteria identify preschool children with clinically significant behavior problems (see Connor, 2002; Keenan & Wakschlag, 2002). There has been concern that applying clinical criteria to young children would result in over-identification, including the “’psychopathologizing’ of childhood and the inappropriate treatment of transient developmental problems” (McClellan & Speltz,

2003, p. 128). In fact, this has not proven to be the case. For both DBDs and ADHD, symptoms are endorsed at significantly higher rates in clinically-referred versus non-referred children (Bryne et al., 2000; Keenan & Wakschlag, 2004) and, impaired versus non-impaired children in community samples (Angold et al., 2005; Kim-Cohen et al., 2005). For example, when developmentally-sensitive probing about intensity, duration and context is used, even the most seemingly normative of ODD symptom for preschoolers, “often loses temper,” is endorsed by only 4% of parents of non-referred preschoolers compared to nearly 75% of parents of referred preschoolers (Keenan & Wakschlag, 2004). As with clinic samples of older children, rates of diagnosis in referred preschoolers are high but quite low in non-referred comparison children (Keenan & Wakschlag, 2004; Lahey et al., 2004). Similarly, in community samples, prevalence is comparable to that in older children: ADHD 5.1%, ODD 7.3%, and CD 3.4-6.6% (Angold et al., 2005; Kim-Cohen et al., 2005). Finally, DBD and ADHD symptoms are impairing, including pervasive problems across school, home and clinic settings (Angold et al., 2005; Lahey et al. 2004,; Wakschlag & Keenan, 2001).

**Question 2.** *Do DSM symptom constellations “behave” in a manner similar to behavior disorders in older children? That is, do they have similar risk profiles, demonstrate comparable stability, and are they responsive to validated treatments?* Studies of construct, concurrent, predictive and treatment validity of preschool behavior disorders have demonstrated patterns comparable to those of older children. DBD and ADHD diagnoses are significantly associated with scores on developmentally-validated measures of behavior problems (Kim-Cohen et al., 2005; Wakschlag & Keenan, 2001). High rates of co-morbidity are also common (Angold et al., 2005; Thomas & Guskin, 2001). For example, nearly half of preschool children presenting with

behavior problems also have clinically significant emotional problems (Thomas & Guskin, 2001). Behavior disordered preschoolers also exhibit social-cognitive deficits and problems in inhibitory control (Coy et al., 2001; Sonuga-Barke et al., 2002). Preschool DBDs have also been associated with established parenting and parent-child relationship correlates (Wakschlag & Keenan, 2001; Thomas & Guskin, 2001; Webster-Stratton & Hammond, 1999). There are only a handful of studies that have examined predictive validity (virtually all of them with older preschoolers). Emerging evidence suggests that stability of preschool behavior disorders is similar to that in older children (Kim-Cohen et al., 2005; Lahey et al., 2004; Speltz et al., 1999) (although instability of ADHD subtypes in preschool children has been reported (Lahey et al., 2005). In terms of treatment validity, there is increasing evidence that preschool ADHD is responsive to stimulant medication, with large scale randomized trials currently underway (Connor, 2002; Kratochvil et al., 2004). A number of parent-training programs have been validated for treatment of preschool DBDs (see Webster-Stratton, 1997).

**Question 3:** *Have we achieved broad-based consensus about clinical criteria for preschool behavior disorders?* At first glance, one might conclude that the “work is done.” This conclusion is premature. Existing studies have unequivocally demonstrated that behaviors recognizable as DSM IV behavior disorder symptoms are evident and clinically meaningful in preschool children. These studies have done a superb job of setting the stage for the specification of valid clinical criteria for preschool behavior disorders. But they are also limited in several fundamental ways. First, most samples have been small and non-representative. Second, by necessity, early studies have used non-standardized methods to assess behavior disorder symptoms. Third, systematic testing of clinical criteria has been lacking.

Are these concerns “just details” or do they actually impede achievement of consensus? We contend the latter because valid clinical criteria for preschool behavior disorders cannot be established until distinct features of this developmental period are incorporated into the nosology:

*Duration Criteria.* Duration criteria distinguish normative behavior from “repetitive and persistent patterns” of behavior that have reached clinical significance (APA, 1994). One could argue that duration criteria for preschool behavior disorders should be *longer*, because “problem behaviors” normatively wax and wane rapidly within this developmental period. Conversely, one could make the case that duration criteria should be *shorter* because requiring that behavioral patterns be present for as much as 20-30% of a preschool child’s lifespan seems overly stringent. These alternatives must be systematically tested.

*Symptom Definition.* As noted in DSM IV, establishing that a behavior is “maladaptive and inconsistent with developmental level” is requisite to determining clinical significance (APA, 1994). Thus, establishing clinical significance within a developmental period rests on the central organizing principle that psychopathologic conditions manifest “heterotypic continuity” (Cicchetti & Richters, 1997). That is, the latent patterns of behavior that define specific types of psychopathology are coherent over time, although their phenomenology differs across developmental periods. Thus, accurate characterization within a developmental period requires translation of latent constructs into their developmentally specific manifestations. Yet, paradoxically, DSM-IV provides a single criteria set across the lifespan for most disorders (APA, 1994). The “problem” of preschool behavior disorders highlights how the absence of developmentally-specific criteria *fundamentally impedes* valid determination of clinical significance in young children.

In DSM IV, behavior disorder symptoms are defined in terms of manifestations in older children; this is inadequate for characterizing preschool symptoms because these are either:

(a) Developmentally Impossible - a number of CD symptoms are behaviors of which preschoolers are developmentally incapable (e.g., forcible sexual activity, truancy). In response, some studies have dropped these items without replacing them with appropriate early childhood manifestations, thereby creating a limited symptom pool;

(b) Developmentally Improbable - a number of CD symptoms of which preschoolers are physically capable (e.g., stealing without confrontation) emphasize extreme behaviors, with a particular focus on their illegal nature. If these behaviors are present in preschoolers at all, they only occur in extreme cases and are unlikely to adequately capture defining features of DBDs in young children (e.g., sneakiness). Similarly, many ADHD inattentive symptoms are defined in terms of interference with academically-oriented tasks. Since preschoolers are just mastering the requisite skills (e.g., independent completion of sequential tasks) and because academic performance is not central to this period, such symptoms are not likely to identify developmentally inconsistent capacities for sustained attention in young children. This may lead to misspecification. For example, several recent studies of preschool ADHD have reported that the “inattentive subtype” is rare and that ADHD subtypes in preschool children exhibit relatively low stability (Egger et al., 2005; Lahey et al., 2005). While this may be true, it is equally likely that inattention is stably present but overlooked in young children because the heterotypic continuity for these behaviors has not been well articulated across developmental periods;

(c) Developmentally Imprecise - many behavior disorder symptoms (e.g., non-compliance and aggression) are also normative manifestations of young children’s struggles to master the central developmental tasks of the preschool period, i.e., individuation and the

acquisition of self-control (Wakschlag & Danis, 2004). As a result, in contrast to older children, the presence of these behaviors *per se* does not necessarily connote clinical significance during this age period. In fact, their *absence* in preschoolers may be more concerning than their presence.

Thus, in order to distinguish symptoms from normative manifestations in young children, behaviors must be specified precisely for this developmental period. This has several key implications. First, behavior disorder symptoms reflect deficits in attentional and behavioral regulation, skills that are just being mastered during the preschool period (Kochanska, Coy, & Murray, 2001). As a result, some symptoms may not be discriminative in preschool children due to normative variation in the acquisition of regulatory skills. For example, emerging efforts to examine this issue for ADHD suggest that the symptom “often interrupts or intrudes” is not clinically discriminative because it is endorsed for nearly 50% of typically developing preschoolers (Byrne et al, 2000; Egger et al., 2005). Second, a number of behaviors that are reflected as a single symptom in DSM-IV may require disaggregation and a shift from a frequency-based definition to a conceptualization resting on qualitative features. For example, the ODD symptom “often loses temper” is not likely to capture the clinically distinct features of problems in anger modulation in young children because temper tantrums are normative during this age period and normative frequency varies for younger and older preschoolers (Egger & Angold, 2004). The problems of developmental impossibility and improbability may lead to *underidentification* whereas the problem of developmental imprecision may contribute to *overidentification*.

*Diagnostic Threshold, Distinctions between Disorders and Subtypes.* A number of behaviors in the DSM IV nosology occur normatively in preschool children but it is the accrual

of a *constellation* of such behaviors that determines when preschool children have crossed the threshold to clinical disorder. Thus, it is conceivable that higher symptom thresholds are necessary to ensure valid discrimination. Sex differences and age differences within the preschool period must also be examined in determining valid diagnostic thresholds. Further, it is not at all clear that DSM IV categorical distinction between ODD and CD are meaningful in preschool children. To a large extent, this distinction reflects variations in the seriousness of behaviors. CD is defined in terms of older children's increasing capacity to commit illegal acts and harm others. Along these lines, ODD is conceptualized as a developmental precursor to CD in DSM –thus, by definition the two can not co-occur. This conceptualization is illogical during a developmental period when disruptive behaviors are first manifest and disorders are in their earliest form. As an example, in DSM-IV, a primary distinction between ODD and CD is the presence of aggressive behavior. However, aggression is a very common feature in young children with behavioral symptoms and, there is no evidence that aggression is nosologically distinct from oppositional behaviors in this age period. Finally, the DBD spectrum of symptoms reflects problems in multiple domains of behavior, broadly construed as angry negativity, resistance to authority, violent aggression and callousness. Yet, unlike other DSM disorders, the *pattern* of behavior across these domains is not incorporated into diagnostic threshold criteria or reflected in subtypes. Given these concerns, systematic examination of diagnostic threshold and patterns is essential for clinically meaningful characterization in young children.

These and related challenges make it abundantly clear that specification of valid clinical criteria for preschoolers requires the application of the same rigorous standards that have been used historically to construct DSM criteria. As articulated in DSM IV, these standards rest on

replicable and replicated studies that use standardized methods in large, representative samples (APA, 1994).

### **III. Generating a developmentally-informed nosology for early childhood: Defining the clinical features of behavior disorders in preschool children**

“Considering normal and abnormal together is the essence of developmental psychopathology” (Sroufe, 1990). Given that (a) developmental processes in early childhood are well-described; (b) behavior disorders are identifiable in preschool children; and, (c) novel instruments specifically developed for the clinical assessment of disruptive behavior in young children now exist, we are well-situated to generate a developmentally-informed nosology for preschool behavior disorders.

Generating such a nosology requires a paradigm shift from a “top-down” to a “bottom-up” approach. To illustrate, a top-down approach starts with existing constructs and *confirms their generalizability* to a new context. Using this approach, we would ask “is the DSM IV ODD symptom ‘actively defies’ (validated for older children) clinically discriminative for preschoolers?” In contrast, a bottom-up approach *generates contextually-specific questions* and then tests their validity. Taking this approach we might ask “what are the central features of clinically significant oppositionality in young children that discriminate it from normative assertions of autonomy?”

Implementing a bottom-up approach must begin with the generation of a conceptual model that is developmentally-sensitive, clinically-informed and operationalized in an empirically testable manner. Drawing on the principle of heterotypic continuity, this requires an iterative process moving between latent constructs, knowledge of normative behavior in young children and indicators that normative processes have gone awry. Table 1 provides an

illustration of the result of this type of process for DBDs; here we propose the manifestation of the full range of DBD behaviors operationalized in terms of their expression in preschool children. For example, when operationalizing the latent construct “resistance to

**Insert Table 1 about here**

authority,” the first step was conceptualizing the features distinguishing symptoms from healthy assertions of independence in preschool children. Building on literature elucidating developmental processes of internalization and the implications of quality of compliance for adaptation (Kochanska & Aksan, 1995), we theorized that qualitative features define preschool behavior as symptomatic (Wakschlag et al., 2005). Salient features of resistance to authority in young children were then operationalized (e.g., rudeness, brazen misbehavior, intransigence and sneakiness.) Similarly, since symptoms of callousness and violent aggression in DSM IV CD reflect mature forms of these behaviors (e.g., forcible sexual activity, using a weapon to harm), we conceptualized principal features for preschoolers as deviations from age-expected norms for empathy, modulation of aggression and the early emergence of conscience (Kochanska & Aksan, 1995; NICHD, 2004; Tremblay et al., 2004). Atypical manifestations were then operationalized as purposeful efforts to harm and insensitivity (e.g., sabotaging others’ activities, intense, proactive aggression and, taking pleasure in others’ distress).

Clearly, methods specifically developed and standardized for the clinical assessment of young children are essential tools for establishing the validity and incremental utility of such conceptual models. Fortunately, such methods are being developed and their validation is currently underway. Evolving interview methodologies include the Preschool Age Psychiatric Assessment (PAPA; Egger & Angold, 2004), a comprehensive diagnostic interview for preschool children, and the Kiddie-DBDs (Keenan & Wakschlag, 2002), a preschool

modification of the behavior disorders module of the Kiddie-SADS. These interviews are designed to deconstruct DSM IV behavior disorder symptoms into their component parts so that clinically discriminative features for young children can be identified. This work has already led to a new perspective on the constituent behaviors of DBDs in preschool children. For example, for the ODD symptom “often loses temper,” PAPA probes include questions about frequency, duration, triggers and content of temper tantrums. Data from the PAPA indicate that, for preschool children, destructive tantrumming (e.g., hitting, kicking or biting others and/or breaking objects) is symptomatic but non-destructive tantrumming (e.g., crying, stamping, breathholding) is not (Egger, Erkanli, & Angold, 2005).

While the multi-informant, multi-method approach is the gold-standard for diagnostic validation, this has yet to be applied to the study of preschool behavior disorders. To complement information about discrete behaviors derived from parent-interviews, diagnostic observation methods are an essential tool for refining and testing a developmentally-informed nosology. For example, the Disruptive Behavior Diagnostic Observation Schedule (DB-DOS; Wakschlag et al., 2005) provides a standardized method of direct, clinical observation that yields nuanced and contextualized information about child behavior during interactions with both parent and examiner. Multiple levels of contextual information (e.g., situational, developmental and social) and qualitative aspects of behavior (e.g., its flexibility and regulation) are taken into account in defining the clinical significance of behavior. For example, assessment of non-compliant behavior is based on observations of whether the behavior (a) is typically elicited in response to limits or is characteristic regardless of situational demands, (b) results from poor language comprehension, (c) is restricted to interactions with the parent or occurs pervasively, (d) is responsive to adult support and, (e) is intense and poorly modulated. By enhancing the

clarity and specificity of behavioral description in this manner, diagnostic observation can substantially advance phenotypic characterization.

#### **IV. Summary and Conclusions.**

Over the past decade , a substantial body of empirical work has unequivocally demonstrated that behavior disorders are identifiable and clinically meaningful in preschool children. Clarity about this issue represents a substantial advance that rests on a rare level of integration across developmental and clinical science. With this clarity to guide us, it is also abundantly evident that much work lies ahead to establish a sensitive and specific nosology that will allow DSM V to accurately characterize clinical phenomena for young children. The promise of such work lies not only in its clinical significance for preschoolers but also its capacity to serve as a paradigm for honoring the DSM imperative to conceptualize symptoms within developmental and social contexts. Such efforts will result in a well-characterized phenotype that serves as the basis for translational investigation of basic processes underlying early emerging behavior disorders and, ultimately will enhance our capacity to treat and prevent these disorders.

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**TABLE 1: ILLUSTRATION OF DEVELOPMENTALLY-INFORMED NOSOLOGY FOR PRESCHOOL DBDS**

ANGRY NEGATIVITY	RESISTS AUTHORITY	VIOLENT AGGRESSION <sup>1</sup>	CALLOUS
<p><b><u>Reflexive No</u></b> Characteristically responds to a wide variety of social interactions in a negative manner (not only to limit-setting or directions). May include being contrary and argumentative, resistant to transitions, and controlling</p>	<p><b><u>Rude</u></b> Often speaks in disrespectful and sassy manner, including being brazen, mouthy, sarcastic, and/or cursing</p>	<p><b><u>Proactive Aggression</u></b> Acts aggressively “out of the blue.” Aggression is not an emotional reaction to immediate anger/frustration; aggression is used instrumentally to coerce or dominate May include covert aggression such as sneaky pinching.</p>	<p><b><u>Incites</u></b> Deliberately attempts to provoke others to anger, including taunting or teasing to provoke conflict. Intentionally does things to irritate and annoy others</p>
<p><b><u>Sullen</u></b> Characteristically angry and/or surly. Frequently pouts and/or whines.</p>	<p><b><u>Stubbornly Defies</u></b> Often says “no” or outright refuses to do what is asked; defiance persists in the face of adult prompts</p>	<p><b><u>Intense Aggression</u></b> Engages in driven, persistent aggression to hurt others on purpose; may use objects or exhibit serious aggressive behavior such as cutting, choking, stabbing or forceful hitting</p>	<p><b><u>Cruelty</u></b> Purposely causes pain or distress to others. May include spiteful comments, doing something to get even, and cruelty to animals</p>
<p><b><u>Easily Angered</u></b> Angry response is easily elicited across multiple social interactions and activities (not just in response to provocation or frustration). Is touchy and anger is often surprising and out of context</p>	<p><b><u>Persistently Ignores</u></b> Actively ignores directions and requests, even when repeated</p>	<p><b><u>Adult Aggression</u></b> Behaves aggressively towards adults</p>	<p><b><u>Indifferent</u></b> Unconcerned about others’ needs or feelings, including taking pleasure in others distress and/or being indifferent to pleasing others</p>
<p><b><u>Explosive Temper</u></b> Reacts intensely when angry or upset, escalates rapidly, including out-of-control behavior,destructive tantrums and/or loud tirades.</p>	<p><b><u>Disregards Rules</u></b> Often brazenly breaks rules, tests limits, does whatever s/he pleases. May provocatively engages in misbehavior in adult presence</p>	<p><b><u>Reactive Aggression</u></b> Frequently retaliates with aggression when angry; aggression is in response to perceived provocation or frustration with others</p>	<p><b><u>Sabotages</u></b> Purposely thwarts others play, plans and activities including knocking over, spilling and wrecking. Enjoys spoiling things for others</p>
<p><b><u>Insistent Anger</u></b> Anger is often sustained and unyielding. Once set-off, child may relentlessly engage others in angry/negative interactions (won’t “let-up”).</p>	<p><b><u>Sneaky</u></b> Deliberately hides mistakes and/or misbehavior, including lying to avoid responsibility and blaming others. Also may include sneaking items such as items from a store or others’ belongings</p>	<p><b><u>Destructive</u></b> Intentionally breaks and damages things, including smashing, tearing and/or destroying others’ belongings; and fire-setting</p>	<p><b><u>Intimidates</u></b> Picks on, bullies and/or intimidates other children, including verbal threats and forceful grabbing</p>

<sup>1</sup> Violent aggression is defined as physical aggression with intent to cause pain or harm defined as hitting, slapping, pinching, punching, choking, biting, spitting, hair pulling, cutting, stabbing. This is distinguished from dysregulated aggression resulting from explosive temper such as destructive tantrums.

### **Commentary by Daniel Pine, M.D.**

Research on early childhood manifestations of behavior disorders provides an ideal guide for addressing more general questions concerning future research directions on the classification of preschool psychopathology. Considerable work already exists in this area. Indeed, for this age period, perhaps only in the area of pervasive developmental disorders (PDD) has more research addressed the pertinent questions. Moreover, whereas extreme forms of PDD can be clearly differentiated from typical development, major questions remain in preschoolers concerning differences between even moderately extreme disruptive behavior and typical oppositional behavior, inattention, or aggression. The current chapter embraces the promise of research in this area, as it holds the hope of guiding a more developmentally-informed nosology, while recognizing the need to wade “with caution” into a field with such inherent pitfalls.

The current chapter comprehensively and concisely elucidates both the opportunities and potential dangers of addressing questions in this area. Given the breadth of available information and complexity of questions in the area, it is easy to miss the dramatic impact of two particularly salient points raised in the chapter that are worth repeating. First, in all areas of nosology, refinements in measurement represent a vital initial step towards building an increasingly valid classification scheme. Not only will this mean adapting currently available tools but also devising novel techniques that address the unique burdens associated with preschool assessment. The opportunity for such novel approaches is exemplified by the work of Wakschlag, Leventhal and their colleagues in developing a structured clinical observational assessment, the Disruptive Behavior Diagnostic Observation Schedule (DB-DOS). Second, criticism with the current DSM system has grown steadily louder in recent years, due to failures to embrace developmental concepts. To address these criticisms, investigators must collect considerable data in young

children to demonstrate the validity of alternative, developmentally focused classification schemes. This will require a “fresh look” at symptoms manifest among preschoolers, within the unique social context of this developmental period.

In considering the material within this chapter, one cannot help but emerge with a great sense of excitement and opportunity, regardless of one’s perspective, be it focused on development, psychiatric classification, or clinical care. In confronting the issue of preschool classification, research on behavior disorders demonstrates both the great promise and considerable work we face in producing a more informed, developmentally sensitive nosology.