Disruptive Behavioral Disorders in Youth: Latest Understanding (2024–2026)

As with so much of the available data on kids, findings are not as good as we might like (America's Health Rankings, 2023; Center for MH in Schools & Student/Learning Supports, 2018). Given that, the following draws on the best of what is available. The sources used are included in the reference list.

Also, it is important to recognize that data often are market-oriented and market analyses can influence policy – not always in good ways. For example, see what you think about how data are used in this market forecast "Disruptive behavior disorders Consumer Behavior Dynamics: Key Trends 2026-2034"

> The global market for disruptive behavior disorders is poised for significant expansion, driven by increasing awareness and improved diagnostic capabilities for conditions such as Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), and Attention Deficit Hyperactivity Disorder (ADHD). These disorders, which significantly impact a child's and adolescent's development and overall well-being, are receiving greater attention from healthcare providers, educators, and parents. The estimated market size is approximately USD 5,500 million in 2025, with a projected Compound Annual Growth Rate (CAGR) of 6.5% during the forecast period of 2025-2033. This robust growth is fueled by a confluence of factors including advancements in pharmacological and therapeutic interventions, a growing understanding of the neurobiological underpinnings of these disorders, and rising healthcare expenditure globally. The increasing prevalence of ADHD, in particular, is a major growth driver, necessitating a greater supply of effective treatment options.
>
> https://www.datainsightsmarket.com/reports/disruptive-behavior-disorders-1492983

Disruptive Behavior Disorders (DBDs) are a group of childhood mental health conditions characterized by ongoing patterns of uncooperative, defiant, hostile, or aggressive behaviors toward authority figures that interfere with social, academic, or family functioning. The primary DBDs include Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). Our focus here is on highlighting (1) trends and prevalence, (2) diagnostic and Treatment inequities and disparities, (3) risk factors, (4) improving diagnostic and treatment disparities and inequities, and (5) interventions – focus and approaches.

Trends & Prevalence

Before the COVID pandemic, overall trend data for childhood mental, behavioral, and developmental disorders (MBDDs) in the U.S. suggest rising rates – increasing from 25.3% to 27.7% between 2016 and 2021. MBDDs include ADHD, learning disabilities, anxiety, depression, and autism.

Reports specifically on disruptive behavioral disorders (DBDs) indicate 10-15% of children are affected globally. These include Oppositional Defiant Disorder (ODD) , Conduct Disorder (CD), Attention Deficit Hyperactivity Disorder (ADHD), and related disruptive/impulse-control disorders.

- Recent reviews indicate prevalence estimates of about 14% for ODD and about 3% for CD, with higher rates noted for ODD among younger children and CD among teens.

*The material in this document was compiled in 2026 and builds on work done by the national Center for MH in Schools & Student/Learning Supports at UCLA over many years.

The center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA.Website: **https://smhp.psych.ucla.edu/**

- As for ADHD, 1 in 9 children (11.4%) have been so-diagnosed, with higher rates for boys (15.0%) than girls (8.8%). Adolescents (12-17) are more likely to be diagnosed (15.5%) compared to children aged 6-11 (11.5%) or 3-5 (2.4%). Approximately 77.9% of children with ADHD have at least one co-occurring disorder, such as anxiety (39.1%) or behavior problems (44.1%). The highest prevalence is generally among White children and those with public insurance. Trend data note a 1 million child increase between 2016 and 2022, likely driven by increased awareness, the pandemic, and improved diagnosis in females.

Typically, organizations cite the findings reported by the federal government, such as the following from CDC in 2025:

> Approximately 16 million children (ages 3–17) in the U.S. live with a mental, emotional, developmental, or behavioral condition. Data indicate that nearly 1 in 5 children in this age group are diagnosed with such conditions, with rates increasing with age and affecting up to 31% of youth aged 12 to 17

Risk Factors – Causes and Correlates

Disruptive Behavioral Disorders arise from internal dysfunctions and differ significantly from the more commonplace behaviors that disrupt others. Advances in neuroimaging and developmental science are reshaping etiological models and hold promise for more precise diagnoses and targeted interventions in the coming years. In the meantime, however, caution is warranted when interpreting neurobiological findings related to behavior and learning disorders.

Concerns about current neurobiological assessments typically center on several themes: the wide methodological variability in research; the substantial heterogeneity among individuals who manifest similar behavioral symptoms; the risk of overemphasizing biological explanations; limited generalizability of findings; persisting diagnostic ambiguity; and uncertainty about causal pathways. These critiques do not invalidate neurobiological contributions. Instead, they highlight that biological data should not be interpreted in isolation and call attention to ongoing questions about the threshold at which behavior becomes severe or specific enough to constitute a diagnosable disorder. They also foreground concerns related to labeling, equity, and sociocultural bias (Center for MH in Schools & Student/Learning Supports, 2026).

> The exhibit on the next page summarizes and categorizes a range of factors that can instigate or exacerbate behavior, emotional, and learning problems. These factors may contribute to disruptive behavior, but they do not necessarily indicate the presence of a disorder. Indeed, most youngsters who display behavior that adults disapprove of do not have a disorder.

Exhibit

Factors Instigating Behavior, Emotional, and Learning, Problems*

Environment (E)

1. *Insufficient or inconsistent learning opportunities (*e.g., prolonged periods in impoverished environments; deprivation of learning opportunities at home or school such as lack of play and practice situations and poor instruction; food insecurity or inadequate nutrition)
2. *Excessive or dysregulating demands* (e.g., overly demanding home, school, or work experiences, such as overwhelming pressure to achieve and contradictory expectations; overcrowding; frequent transitions or unstable schedules)
3. *Intrusive, harmful, or discriminatory conditions* (e.g., medical practices, especially at birth, leading to physiological impairment; exposure to environmental toxins or unsafe housing; chronic conflict or violence in home, school, or workplace; ineffective, developmentally inappropriate, and/or abusive child-rearing practices; dysfunctional family; migratory family; environments not accommodating students learning English as an additional language; lack of culturally and linguistically responsive supports; bias, discrimination, and social marginalization based on race/ethnicity, gender, age, disability, or appearance)

Person (P)

1. *Neurological or physiological injury/illness* (e.g., traumatic brain injury; perinatal complications; endocrine disorders; illnesses affecting brain, sensory, or motor functioning)
2. *Genetic or neurodevelopmental differences* (e.g., inherited or de novo variations associated with atypical development trajectories)
3. *Cognitive and emotional factors that limit effective learning or coping* (e.g., gaps in foundational knowledge and skills (including executive function or learning strategies); negative attitudes about school; difficulties regulating emotions or stress; negative feelings about self determination, competence, and connectedness to significant others)
4. *Physical or sensory characteristics affecting learning and coping* (e.g., visual, auditory, or motor differences; atypical sensitivity to sensory input; health conditions that increase fatigue; characteristics that may elicit stereotyped responses from others)
5. *Behavior or performance patterns misaligned or with or deviant from environmental expectations* (e.g., high error rates on academic tasks; very high or very low activity levels; difficulties with sustained attention or task initiation)

Interactions and Transactions Between E and P*

1. *Severe to moderate personal vulnerabilities and contextual barriers are joint contributors* (e.g., personal and environmental factors simultaneously precipitate the difficulty, such as when a person with markedly slower development is placed in a highly demanding setting without appropriate supports)
2. *Modest personal vulnerabilities not accommodated by the situation produce mismatch* (e.g., student with mild auditory or visual challenges expected to learn primarily through lecture; highly active student in classrooms with limited movement opportunities)
3. *Contextual differences not accommodated by the individual produce mismatch* (e.g., student from a racial or cultural minority avoids participation because of anticipated exclusion or lack of belonging; newcomer student doesn't access available bridging supports)

Interactions may involve a single (P) and (E) variable or multiple combinations. The same factor can function as a risk or protective influence depending on context, intensity, timing, and available supports. Also remember that factors are not diagnostic; most youth with adult-disapproved behavior **do not have a DBD.*

Improving Diagnostic and Treatment Disparities and Inequities

A substantial body of research indicates that certain groups of young people – including rural youth, American Indian/Alaska Native youth, LGBTQ+ youth, and those living in socioeconomic adversity – are disproportionately affected by mental health and psychosocial challenges. Socioeconomically disadvantaged children, for example, are two to three times more likely to develop behavioral, emotional, and learning problems.

Significant racial and ethnic inequities also persist in the diagnosis of disruptive behavior disorders (DBDs). Studies show that mislabeling and implicit bias disproportionately affect racially minoritized children. In one analysis of more than 700,000 inpatient cases, Native American, Asian, Black, and Hispanic youth were all found to have significantly higher odds of receiving a DBD diagnosis than their white peers. These patterns highlight structural and systemic contributors to misdiagnosis and overdiagnosis.

Moreover, socially vulnerable and minority youth are more likely to receive diagnoses later and often during crisis points, increasing the likelihood of punitive responses rather than preventive or supportive intervention. Correcting these disparities requires the adoption of anti-racist, culturally responsive assessment practices that minimize bias, improve accuracy, and ensure fair access to early supports.

Treatment inequities mirror diagnostic gaps. Although an estimated 60% of children with mental health needs receive some form of care each year, large gaps remain in both access and quality. Unmet mental health needs among children with developmental and behavioral disorders have continued to rise—increasing by approximately 5% annually through 2021. For children with ADHD, treatment patterns are similarly uneven.

Among those with a current diagnosis:

- 30.1% receive no treatment at all
- 31.7% receive a combination of medication and behavioral therapy, the recommended standard for many case
- the rest receive only medication or behavioral treatment

These disparities underscore the need for systemic improvements, including equitable early screening, culturally competent assessment, proactive outreach to underserved families, and expanded access to evidence-based care. Addressing diagnostic and treatment inequities is essential not only for individual well being but also for building school systems capable of supporting all students effectively.

Intervention – Focus and Approaches

This brief report is not the place to reiterate the well documented concerns about interventions that are promoted as empirically supported. For a fuller discussion of major issues and cautions, see Center for MH in Schools & Student/Learning Supports (2019) and Schildermans, Vlieghe, & Wortmann (2024).

For youngsters diagnosed with a disruptive behavioral disorder, current guidance emphasizes beginning with family focused psychosocial interventions. Medication is viewed as a secondary option and is reserved for those whose assessments indicate a clear need. Within the family focused domain, interventions may include:

- Primary caretaker (e.g., parent) behavior therapy
- Primary caretaker management training
- Primary caretaker–child interaction therapies, such as Parent–Child Interaction Therapy (PCIT) and cognitive behavioral approaches targeting aggression and irritability
- Multicomponent interventions that integrate parent management training, direct child coping and skills training, and alignment with school based strategies addressing the youngster's behavior challenges

These interventions take place across traditional therapy settings as well as school environments. Increasingly, telehealth and digital platforms are being used to expand access and availability, particularly for families who face barriers to in person participation.

Exhibit

Disruptive Behavioral Disorder: The School's Role

Schools provide special assistance for students with disruptive behavioral disorders in a variety of settings, including classrooms, offices, and wellness or health centers. Some districts also operate centralized mental health clinics, and many schools have established formal partnerships with community agencies to expand available services.

A wide array of personnel intervene with students who have behavioral, emotional, or learning disorders. Some are district employees (e.g., school psychologists, counselors, social workers, nurses); others are professionals from the community. While the breadth of personnel and settings reflects the significant need for student support, it also highlights persistent problems—most notably the fragmented nature of school-based services and the counterproductive competition that can arise among providers. Additional complexities stem from differences in how schools approach special education.

Students diagnosed with disorders often require extensive accommodations and intensive, specialized help. Federal legislation outlines students' rights to such support. For example, Section 504 of the Rehabilitation Act of 1973 provides the basis for schools to offer accommodations to any student who:

- Has a physical or mental impairment that substantially limits a major life activity,
- Has a history of such an impairment, or
- Is regarded by others as having such an impairment.

Only one major life activity must be substantially limited for a student to qualify. Students receiving special education services under the Individuals with Disabilities Education Improvement Act (IDEIA) are also protected by Section 504. (cont.)

Exhibit (cont.)

Schools encounter a broad range of behavior problems daily. When it becomes evident that special assistance is required, decisions about what to provide should be guided by:

- An understanding of the underlying causes of the student's difficulties,
- An analysis of the current problems—including missing prerequisites, interfering behaviors, and attitudes,
- An appreciation of the student's strengths, both in motivation and capability.

Efforts to address disruptive behavior typically include:

- Direct actions to remove or reduce internal and external barriers to appropriate behavior,
- Helping students strengthen areas of weakness or vulnerability,
- Teaching coping and compensatory strategies,
- Providing special accommodations, and
- Guiding peers, teachers, and family members toward supportive, rather than interfering, behaviors.

In addition to systematic instruction and behavior management, interventions may draw on a wide range of educational and therapeutic principles. Common practices include rapport-building to reduce anxiety, mastery learning approaches, teaching coping strategies, and facilitating positive social interactions.

A school's student review team plays a major role in ensuring that appropriate accommodations are planned. A 504 Plan typically includes:

- An evaluation based on current performance data, teacher reports, and documented concerns,
- A written accommodation plan specifying reasonable modifications needed for the student to benefit from their education,
- Procedural safeguards, including written notice to parents about evaluation and placement decisions, and
- Regular review and re-evaluation of accommodations and placement, especially before any changes.

When special education services or placements are considered, the Individualized Education Program (IEP) team becomes involved.

Most students with mild to moderate problems can remain in mainstream classrooms when physical environments are modified, accommodations are provided, and ancillary services are added. Such services may include:

- Additional instruction (e.g., tutoring),
- Enrichment opportunities (e.g., hobbies, arts, recreation),
- Psychological treatments (e.g., individual or family therapy), and
- Biological treatments (e.g., medication).

Students with severe and pervasive problems are sometimes placed in specialized settings such as remedial classrooms, alternative schools, or therapeutic institutions. Even in such cases, schools are expected to provide opportunities for these students to participate in regular classes and mainstream activities whenever they can do so successfully with appropriate accommodations and support.

Concluding Comment

Research has significantly advanced understanding of DBDs. The consensus underscores early, family centered, culturally responsive, and a multifaceted and interconnected system of intervention. Growing consensus stresses that prevention must address structural conditions driving risk.

For more on what schools can do for students experiencing behavior, emotional, and learning problems, visit:

>*Embedding Mental Health as Schools Change*
https://smhp.psych.ucla.edu/pdfdocs/mh20a.pdf

>*Addressing Barriers to Learning: In the Classroom and Schoolwide*
https://smhp.psych.ucla.edu/pdfdocs/barriersbook.pdf

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