Mood & Disruptive Behavior Disorders in Children & Adolescents

Dr. Bruce Michael Cappo

Clinical Associates, P.A.
Overview

- Diagnostic Issues for children & adolescents
- Similarities / differences
- Treatment Strategies
Diagnoses

- Depression
- Bipolar Disorder
- Attention Deficit Hyperactivity Disorder
- Conduct Disorders
Diagnoses

- Oppositional Defiant Disorder
- Disruptive Behavior Disorder
- Adjustment Disorder with Disturbance of Conduct
- Child or Adolescent Antisocial Behavior
A Little History ...

- Diagnostic & Statistical Manual of Mental Disorders (1952)
- DSM - II (1975)
- DSM - III (1980)
- DSM - IIIR (1987)
- DSM - IV (1994)
Revision IV

- Literature Reviews
- Identify Conflicts or lack of evidence
- Field Trials
- 5 Volume Sourcebook on Decisions
Defining Mental Disorder

Clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability or an important loss of freedom.
Multiaxial System

- Introduced in DSM - IV
- Recognized Previous Limitations
  - Clinical Judgment
  - Forensic Use
  - Ethnic / cultural considerations
  - Treatment Planning
  - Distinction between Mental and Medical
Clinical Judgement ...

- Classification developed for use in clinical, educational & Research Settings
- Meant to be employed by individuals with appropriate clinical training & experience in diagnosis
Clinical Judgement

- Should NOT be employed mechanically by untrained individuals
- Guidelines to be informed by clinical judgement
- NOT to be used in a cookbook fashion
Axis I

- Clinical Disorders
- Other conditions that may be a focus of clinical attention
Axis II

- Personality Disorders
- Mental Retardation
Axis III

General Medical Conditions
Axis IV

Psychosocial & Environmental Problems
Axis V

Global Assessment of Functioning
Organization

- 16 Major Diagnostic Classes
- Other conditions that may be a focus
- Focus here is on a select few of the disorders of childhood
Educational Problems

- Illiteracy
- Academic problems
- Problem with teacher
- Problem with classmate
- Inadequate school environment
Housing Problems

- Homelessness
- Inadequate housing
- Unsafe neighborhood
- Discord with neighbors
Economic Problems

- Extreme poverty
- Insufficient welfare support
Health Care Access Problems

- Transportation
- Services unavailable or inadequate
- Inadequate insurance
Legal Problems

- Arrest
- Incarceration
- Litigation
- Victim of crime
Disorders of Infancy, Childhood & Adolescence...

- Mental Retardation
- Learning Disorders
- Motor Skills Disorders
- Communication Disorders
- Pervasive Developmental Disorders
- Attention-Deficit & Disruptive Behaviors
Disorders of Infancy, Childhood & Adolescence

Feeding & Eating Disorders
Tic Disorders
Elimination Disorders
Other Disorders of Infancy & Childhood
Additional Classifications...

- Eating Disorders
- Sleep Disorders
- Impulse Control Disorders
- Adjustment Disorders
- Personality Disorders
- Other conditions that are a focus of clinical attention
Depression

- 5 or more during a 2 week period which represents a change in function
- Depressed mood
  - Irritable mood in children & adolescents
- Markedly diminished interest in pleasure
- Significant weight change (5%)
Depression

- insomnia or hypersomnia
- psychomotor agitation or retardation nearly daily
- fatigue or loss of energy nearly daily
- feelings of worthlessness or guilt
- diminished ability to concentrate
- recurrent thoughts of death
- not due to substance, bereavement or medical condition
Age & Gender factors

- twice as common in females than males for adults & adolescents
- prepubertal males / females equally affected
Lifetime Risk Factor

- 10-25% for women
- 5-12% for men

Prevalence rates at a given time in community

- 5-9% of women
- 2-3% of men
Risk Factors

- Genetic predisposition (especially maternal)
- Avg age of onset is mid 20s
- Onset age decreasing
- Prepubertal onset may increase risk of bipolar
Suicide Risk

- 15% of persons with MDD die by suicide
- Older adult up to 4x that risk
- Take statements of self harm very seriously in children
“Connectedness”

- Connected to family & peers
- Too much AND too little involvement is bad
- Teach moderation and balance in life
Treatment

- Cognitive Behavioral Therapy (CBT)
- Pharmacological interventions
- Play Therapy in younger kids
- Family therapy / Involvement
CBT

- Re-interpret situations and responses
- Research supports effectiveness over 20 week period
- Faster, not necessarily better when combined with Medication

*Feeling Good* by David Burns, MD
Medication

Not always necessary and not a first option in most cases

SSRIs - Serotonin reuptake inhibitors (zoloft, paxil, prozac, etc)

Other classes also

2-3 weeks before improvement, optimal at 4 weeks, change at 5 weeks without improvement
Medication

- Minimal side effects
- 33% of adolescents take meds as prescribed
- "If I take meds then there must be something wrong with me...I don’t want anything to be wrong so I won’t take meds"
Play Therapy

- Often indirect
- Puppets, games, role playing
Family Therapy

- Systems Approach
- Clarify roles in family
- Identify and change dysfunction
Bipolar

I

- One or more manic or mixed episodes
- Often one or more depressive episodes

II

- Recurrent major depressive episodes with hypomanic episodes
Manic Episodes

- Elevated, expansive or irritable mood
- Inflated self esteem or grandiosity
- Decreased need for sleep
- More talkative, pressured speech
- Flight of ideas
Manic Episodes

- distractibility
- increased goal directed activity
- excessive involvement in pleasurable activities
- despite adverse consequences
- marked impairment
Hypomanic episode

- shorter, 4 versus 7 days min
- not as severe - need not cause marked impairment
Treatment

- Pharmacological
- Educate on chronic nature of disorder
- Coping strategy development
- Recognize early warning signs of mood shift
- Family education
Medication

- Lithium carbonate, Depakote, Neurontin
- Compliance is a chronic problem
- Very likely to discontinue meds and have problems
- Therapy to promote compliance and understanding
Attention Deficit Hyperactivity Disorder

- ADHD

- ADD

- Attention Deficit Disorder with/without Hyperactivity

- Name has changed in DSM through the years
Prevalence

- Estimates range from 2% of girls to 5% of boys
- Symptoms present & diagnosable by age 6
- ADD Symptoms decrease with age
- Comorbidity increases with age
DSM IV Criteria (summarized)

- Inattention, impulsivity or hyperactivity
- Onset by age 7
- Symptoms seen in at least 2 situations (home, school, etc.)
- Significant impairment in functioning
Diagnostic Criteria (type)

- Attention Deficit Disorder
  - Inattentive Type
  - Impulsive Type
  - Hyperactive Type
  - Combined Type
Attention Deficit Disorder Types

- Inattentive: 25 - 30%
- Hyperactive: 70 - 75%
- Impulsive
- Combined: 70 - 75%
Inattention

- Difficulty sustaining attention
- Does not seem to listen
- Makes careless mistakes
- Fails to complete tasks without being oppositional
Inattention

- Difficulty organizing activities
- Easily Bored
- Loses things
- Forgetful
- Easily distracted
Hyperactivity

❑ Runs about inappropriately
❑ Has difficulty staying in seat
❑ Fidgets or squirms
❑ Does not play alone quietly
❑ “Motor Driven”
Impulsivity

- Interrupts others
- Blurts out answers in class before called on
- Has difficulty awaiting his/her turn
Prevalence

2 - 5% Higher for boys than girls

Symptoms present & diagnosable by age 6

ADD
Symptoms decrease with age

Comorbidity increases with age
Comorbidity Factors

- 50% - 80% have some comorbid condition
- Oppositional Defiant Disorder
- Conduct Disorder
- Impaired Academic Functioning
- Mood Disorders
- Tic Disorders
Oppositional Defiant Disorder

- 40% of children
- 65% of adolescents
Conduct Disorder

- 21% - 45% of children
- 44% - 50% of adolescents
Impaired Academic Functioning

¬ 40% in special education classes

¬ 19% - 26% with at least one learning disorder
Mood Disorders

- 15% - 20% with Depression
- 20% - 25% with Anxiety
Tic Disorders

10% with Tourette’s Syndrome
Assessment

- Detailed history
- Objective assessment devices
- Norm-based symptom scales for parents
- Norm-based symptom scales for teachers
- Clinical impressions / interview
Detailed History

- Early growth & development
- Social
- Behavior
- Academic functioning
- Family functioning
Objective Assessment Devices

- Continuous Performance Tests (CPT)
- Intelligence Tests
- Achievement Tests
Norm-based symptom scales for parents & teachers

- Conners
- Auffenbach
- Yale

& Many Others
Treatment

- Parent Training
- Social Skills Training
- Educational Consultation
- Psychopharmacologic Treatment
Non-Medication Interventions

- Control Setting Variables
- Control Task Variables
- Token System
- Self-Monitoring
- Contracting
Summary

- Assess & diagnose properly
- Medication is a primary intervention
- Multi-modal approach is preferred to meds only
Treatment using a multi-modal approach

- parent training
- behavior management
- environment management
- classroom interventions
Conduct Disorders

- Repetitive pattern of behavior in which the basic rights of others or major societal norms/rules are violated
Conduct Disorders

- Repetitive pattern of behavior in which the basic rights of others or major societal norms/rules are violated
- Clinically significant impairment in social, academic or occupational functioning
Conduct Disorders

- 3 or more in past 12 months
  - aggression to people or animals
  - destruction of property
  - deceitfulness or theft
  - serious violations of rules
Prevalence

- Elementary - 2% girls, 7% boys
- Middle - 2-10% girls, 3-16% boys
- High School - 4-15% boys & girls
- Higher in urban than rural
Looking Ahead

 50% of those showing Sx in elementary school continue to do so during adolescence

 40-75% of adolescents continue Sx as adults
High Risk Signs

- ADHD
- Early onset before age 10 (most important)
- Multiple types of antisocial behaviors
  - stealing, lying, fighting
- High frequency of acting out
- Behaviors displayed in multiple settings
  - school, home, community
Comorbidity

- 21% Major Depression or Bipolar Disorder
- 24% Anxiety Disorder
- 31% ADHD
Treatment

- Behavior Therapy
- Cognitive Therapy
- Family Therapy
- Group Therapy
- Psychodynamic or Interpersonal Therapy
Behavior Therapy

- Parent training
- School based management programs
- Token Systems
- Reinforce desired behaviors through multiple settings
Cognitive Therapy

- Changing ineffective thought processes
- Consider potential and actual consequences of behavior
- Connect choices with outcomes
- Consider potential and actual consequences of behavior
Cognitive Therapy

- Connect choices with outcomes
- Problem solving techniques
- Social Processing Deficits
  - misinterpret situations
  - base response on misinterpretations
  - event - anger - run away
Family Therapy

- Changing family communication processes
- Identify and change dysfunctional systems
- Clarify roles
Group Therapy

✿ Facilitate contact with prosocial peers in structured setting

✿ “old guy in a tie” vs “experts”

✿ Confrontation by peers

✿ Mixed groups with experienced leaders did best
Psychodynamic / Interpersonal Therapy

- Attachment theory
- Improve relationship with parent and others
- Less research support
Effectiveness

🔹 Decreased Sx shown after 3-4 months of Tx
🔹 Some did well at 1 year follow-up
🔹 Some do not maintain Tx gains
🔹 Lowered recidivism rates 6 - 18 months out
🔹 Number of serious criminal offenses stayed the same

◆ These may be more difficult cases
◆ May require higher level of treatment
Oppositional Defiant Disorder

Pattern of negativistic, hostile & deviant behavior lasting at least 6 months during which 4 are present often

- loses temper
- argues with adults
- actively defies requests or rules
Oppositional Defiant Disorder

- blames others for his misbehaviors
- easily annoyed by others
- angry & resentful
- spiteful & vindictive
Oppositional Defiant Disorder

- There is clinically significant impairment in social, academic or occupational functioning
- not specific to a psychotic or mood disorder
- does not meet criteria for conduct disorder
Disruptive Behavior Disorder

- Ongoing pattern of CD & ODD behaviors that fail to meet criteria for full diagnosis
Adjustment Disorder with Disturbance of Conduct

- Can be with Mixed Emotional Features also
- Occurs within 3 months of identifiable stressor
- Can include mood swings
Child or Adolescent Antisocial Behavior

*Isolated antisocial behaviors not considered indicative of a mental disorder*

* i.e. shoplifting but no other problems
Time For Your Questions