Disruptive Behavior Disorders
ADHD, ODD, CD

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Disruptive Behavior Disorders

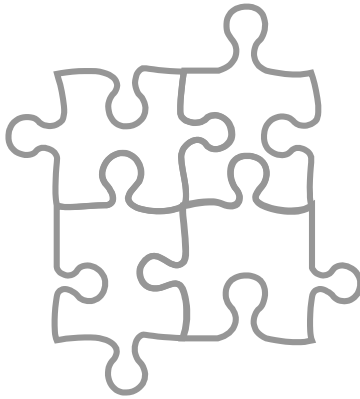
- Attention Deficit Hyperactive Disorder
- Oppositional Defiant Disorder
- Conduct Disorder
- Disruptive Behavior Disorder NOS

Learner Objectives

1. *Identify symptoms and characteristics of disruptive behavior disorders.*

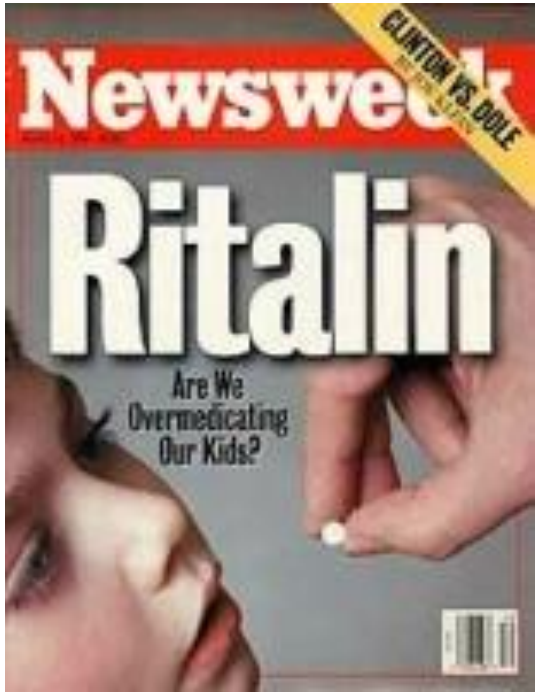
2. *Distinguish 3 potential causes of disruptive behavior disorders.*

3. *Describe 3 ways to proactively correct a child who is being disruptive.*



Case Study ADHD

- 15 yr old Caucasian male, gifted classes since elementary school.
- Energetic, talkative, engaging, disorganized.
- Grades began to slip in high school, blurts out comments in class, behavior wearing thin with teachers.
- Fa hx of ADHD & Mo hx of ADD.
- Eval and dx with ADHD
- Started Concerta 18 mg in am with additional 5mg after school to help with studying.
- Depressed by dx, angry with parents, stopped medication as “did not help”…. Experimented with marijuana
- Grades slipped further.


Newsweek
CLINTON VS. DOLE
Ritalin
Are We Overmedicating Our Kids?

1926 History of ADHD

- 1917 children had post encephalitic neurologic brain damage after flu epidemic, noticed to be “organically driven”…. “brain injured” concept
- 1926 Hans Hoffman –

noticed own son had an

- inability to concentrate
- short attention span
- impulsivity

1950s History of ADHD

- Minimal brain damage-used ped teachers, psychiatrists
- Minimal brain dysfunction >hyperkinesis>hyperactivity
- 5% US vs 1% England
- Redefined, looked at cognitive issues of *inattention & impulsivity*.

Epidemiology

3-7% school age children

Males 4 to Females 1

Females under diagnosed more >*inattentive* than hyperactive

Low self-esteem bc

- Comorbid learning disabilities; poor grades
- “too social” or “not listening”…leads to depression

50%> child/adolescents on inpatient units dx of ADHD

Higher in urban areas than rural

DSM 5
Attention Deficit Hyperactivity Disorder

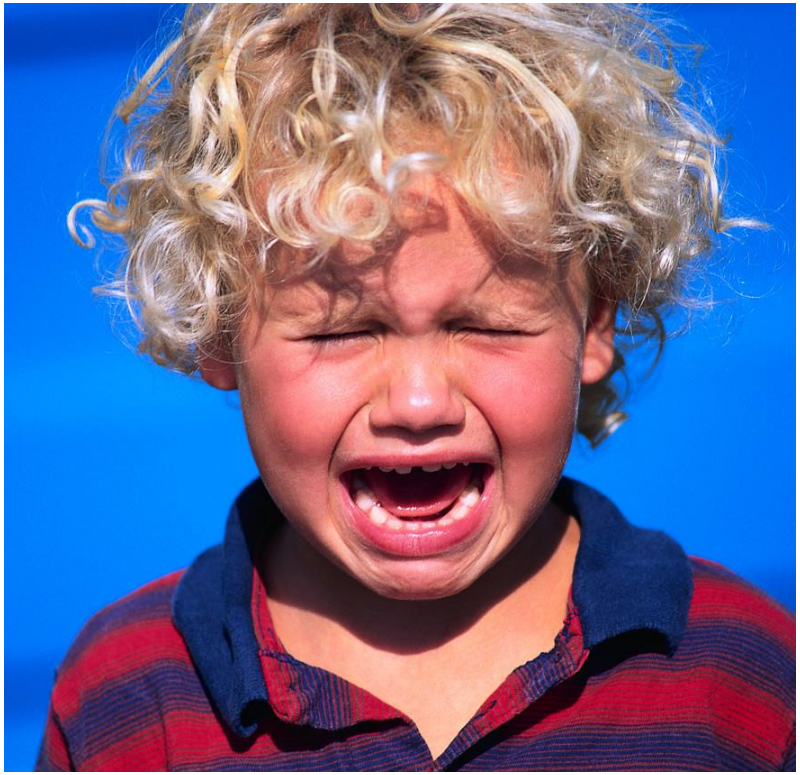
- Diagnosed < 7 years
- Cluster of symptoms that include
  - ✓ inattention
  - ✓ impulsivity
  - ✓ motor hyperactivity
- Causes *impairment* in 2 settings (home/school)
- Interferes w/ developmentally appropriate social, academic or occupational function

Attention Deficit Hyperactivity Disorder

Etiology

- Studies suggest:
  - genetic
  - biochemical
  - psychosocial factors
- Rates higher among monozygotic twins than dizygotic twins

Age Differences



- Toddlers & preschoolers – more motorically hyperactive, climbing, driven by a motor
- Older children- impatient, hyperverbalism & touching everything

Adolescents

- 20-60% of adolescents who had ADHD have it as teenager
- High risk for
  - conduct disorder
  - academic underachievement
  - low self-esteem
  - substance abuse
- Difficult accepting responsibilities
- Disagreements over rights & privileges

Goal of Psychopharmacology

- To increase attentiveness & decrease impulsivity/ hyperactivity
- No or limited side effects
- Improve school performance
- Improve social behavior
- Improve self efficacy

Stimulants
Mechanism of Action

- *Methylphenidate* releases stored dopamine & inhibits the reuptake
- *Dextroamphetamine*

  releases newly processed dopamine more selectively

- Dopamine receptors in prefrontal cortex & basal ganglia & brain circuits connect:

✓ attention

✓ organizing

✓ planning

✓ motivation

✓ reward

✓ motor control

Attention Deficit Hyperactivity Disorder

Pharmacological Treatment

Hyperactivity & Inattention

-CNS stimulants are drugs of choice

- Methylphenidate (Ritalin, Concerta)
- Dexedrine
- Dextroamphetamine salts (Adderall)

-Norepinephrine Reuptake Inhibitors

- Wellbutrin
- Straterra

Attention Deficit Hyperactivity Disorder

Pharmacological Treatment

Extreme Impulsivity, Hyperactivity & Aggression

- Clonidine
- Tenex

Dangerous & Aggressive behaviors

- Atypical antipsychotics
- Mood stabilizers

Other Explanations for Hyperactivity Inattention & Impulsivity

- Chronic fear
- Child neglect, abuse, sexual abuse
- Death of a friend, loved one
- Domestic Violence
- Change of *any kind*, moving, new school, new person in family, new baby, M's new boyfriend, parents loss of job

Therapies

- Multi-Focus Best
- Behavioral modification
- Family psychotherapy
- Coaching

- Counseling & behavioral management training for parents

Adult ADD/ADHD

- Occurs in up to 4% of all adults
- Most are completely unaware
- Symptoms will have started at a young age, but have probably gone unrecognized.
- 60-70% children with ADHD will retain symptoms into adulthood

Adults

- 50-70% persists into adult years
- Low stress tolerance
- Hot temper
- Impulsivity
- Restlessness, unable to relax easily
- Easily distracted can’t listen or concentrate
- Unable to complete projects, school, work
- Mood swings (common in ADHD adults)
- Probs w/interpersonal relationships.

Course of ADHD into Adulthood

- Symptoms may remit spontaneously with age, or continue into adulthood
- Hyperactivity is usually the first symptom that disappears

- Increase risk for:
  - mood disorders
  - substance abuse
  - learning disorders
- Prognosis dependent upon:
  - comorbid disorders
  - social functioning
  - family dynamics

ADHD/ODD and CD

- 40% of children dx w/ADHD will develop conduct disorder but majority of them will be dx w/ ODD at earlier age.

Psychiatric Co-morbidities

- Anxiety 38%
- Oppositional Defiant Disorder 38%
- Depression 9%
- Conduct Disorder 9%
- Learning Disabilities 12-22%

Substance Abuse

- Risk for substance abuse disorder (SUD) in children & adolescents with ADHD.
- MTA study, reported that the onset of SUD is during adolescence or early adulthood & suggested that a *correlation between ADHD & SUD* existed

SUD was more likely in ADHD children w/ comorbid oppositional defiance or conduct disorder

Contributing factors

✓ family dysfunction

✓ parental psychopathology

✓ low self-esteem

✓academic performance

✓inadequate social skills

✓inadequate support

Behavioral Interventions

Time Outs-

Initially use only for 2 serious forms of defiance that are problematic for child

1. Issue command
2. Wait 5 seconds, & give warning
3. Wait 5 seconds; immediately take child to time-out area
4. Recommended length of time 1-2 minutes per year of age of child

Child must do following before time-out ends

1. Served minimum time assigned
2. Must then be quiet for a brief period of time-a transition time
3. Must obey the command given earlier

Shopping-

Prior to entering tell child rules & what will happen if they are broken

- ODD Case Study

- Hank (also has autism spectrum and adhd) is a 14 yr old Hispanic boy who persistently disobeys authority figures (mother, teacher, therapist). Mo has bipolar disorder, is enmeshed with son, won't get help. Fights with teachers, school personnel, referred for evaluation by juvenile justice.
- Tx with Wellbutrin (bupropion) targeting irritability, depression, anger and multi systemic therapy

Oppositional Defiant Disorder

- Recurrent problem

✓defiance

✓disobedience

✓hostility toward authority figures

- Behaviors cannot occur exclusively during mood disorder or psychosis
- Leads to an impairment in school, home or social functions

Four behaviors for 6 months

- ✓Often loses temper
- ✓Often argues w/adults
- ✓Defies authority
- ✓Deliberately annoys people
- ✓Blames others for own mistakes
- ✓Is touchy, angry, resentful, spiteful, & vindictive

ODD
Epidemiology

- In early childhood, ODD behaviors may be considered normal, or age appropriate
- Usually begins by age 8, can be considered at 3 yrs of age
- More common in girls ***before*** puberty and in boys ***after*** puberty

ODD
Epidemiology

- Considered a pathological extension of normal development
- Normal rebellion against authority to establish autonomy
- Stressors, such as, trauma or illness may trigger ODD

Oppositional Defiant Disorder

Differential Diagnosis

- Conduct disorder
- ADHD
- Learning Disorders
- Mental Retardation
- Anxiety
- OCD

Oppositional Defiant Disorder

Course & Prognosis

- Mostly dependent on the severity of treatments
- Symptom duration and comorbid disorder affect the prognosis

Oppositional Defiant Disorder

Treatment

- Therapies:
  - Interpersonal psychotherapy
  - Behavioral therapy
  - Family therapy
  - Solution Focused Therapy
- Counseling & child management training

Behavioral Interventions

- Barkley- program for oppositional & defiant children
  - 2 hour weekly training sessions to families & to groups for 10 week block
  - Educated about ADHD & related issues
  - Learned to give praise, ignore inapposite behavior
  - Reward compliance with chips or tokens

Case Study Conduct Disorder

- Lonnie- 15 yr old Italian male, lives bio mo and step fa. Bio fa addict, rarely sees child. Hx ODD, defiance, lies, steals money from parents/teachers/kids, refused to do chores, had lengthy tantrums, little emotion, no remorse.

- At age 11 began **ditching school**, **watching pornography with friends in home when parents at work,** pervasive, **chronic pattern of violation of the rights** of others, violent fights, **breaks into house during the day to watch porn with his friends** causing $20,000 worth of damage. Parents called police for the first time and filed charges with therapists' urging

Conduct Disorder

- Lie
- Steal
- Cheat
- Destroy Property
- Struggle with authority

Conduct Disorder

Epidemiology

- Common psychiatric disorder, esp. with inpatient populations
- More frequently with boys
- Often co exists with:
  - ADHD
  - Learning Disorders
  - Depression
- Alcohol dependence and antisocial personality disorder are more likely to be present in parents

Conduct Disorder

Etiology

- Psychosocial & social economic factors play a significant role
- Parenting styles usually:
  - Strict
  - Punitive or
  - Aggressive
- Marital discord are common
  - May have been unwanted
  - Unexpected pregnancies
- Child abuse or exposure to domestic violence may be a factor

Conduct Disorder

Diagnostic Criteria

A. Repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriated societal norms or rules are violated for 3 months or more of the past 12 months

At least one of the following:

- Aggression to people and animals
- Destruction of property
- Deceitfulness or theft
- Serious violation of rules

Conduct Disorder

Differential Diagnosis

- Normal oppositional behavior
- Oppositional defiant disorder
- ADHD
- Learning disorders
- Substance abuse
- Mental retardation

Conduct Disorder
Course & Prognosis

- Usually begins before 13 yrs of age
  - may occur as early as 3
- Symptoms develop slowly over time
- At increased risk for substance abuse
  - antisocial personality disorder

- Prognosis is dependent upon:
  - Severity
  - Frequency
  - Age of onset
  - Intellectual functioning

Conduct Disorder

Treatment

- Treatment settings much have:
  - consistent rules
  - predictable consequences for breaking rules
- Family environment evaluated
- Parents:
  - techniques to facilitate appropriate behaviors
- School counselors and teachers informed of treatment plan
  - encourage compliance

Conduct Disorder

Treatment - Medications

- Low dose antipsychotics
- Mood stabilizers for aggression
- SSRI's
  - irritability
  - impulsivity
- Clonidine
  - may decrease aggressive, impulsive behaviors

Effective Strategies

- Provide positive attention with praise and reinforcement of desirable behaviors.
- Ignore inappropriate behavior unless serious.
- Establish token economy to be cashed in at the end of the week.
  - Do not remove tokens for at least 6-8 weeks
- When token economy is established:
  - use response cost (removal of tokens) for non compliance
- Time out:
  - 1-2 minutes per year of age
  - do not release child until quiet and agrees to obey
  - extend time out to non-compliance in public places

Disruptive Behavior Disorder Not Otherwise Specified (DBD NOS)[1]

Category created for children who display similar behaviors as children with ODD or CD but do not display the same frequency /severity and only met one or two of the behavior criteria for this disorder.

Like ODD and CD, this disorder causes significant impairment in the child's life.

Overlapping of disorders

It is rare for ODD/CD to occur outside the context of other psychiatric disorders[11]

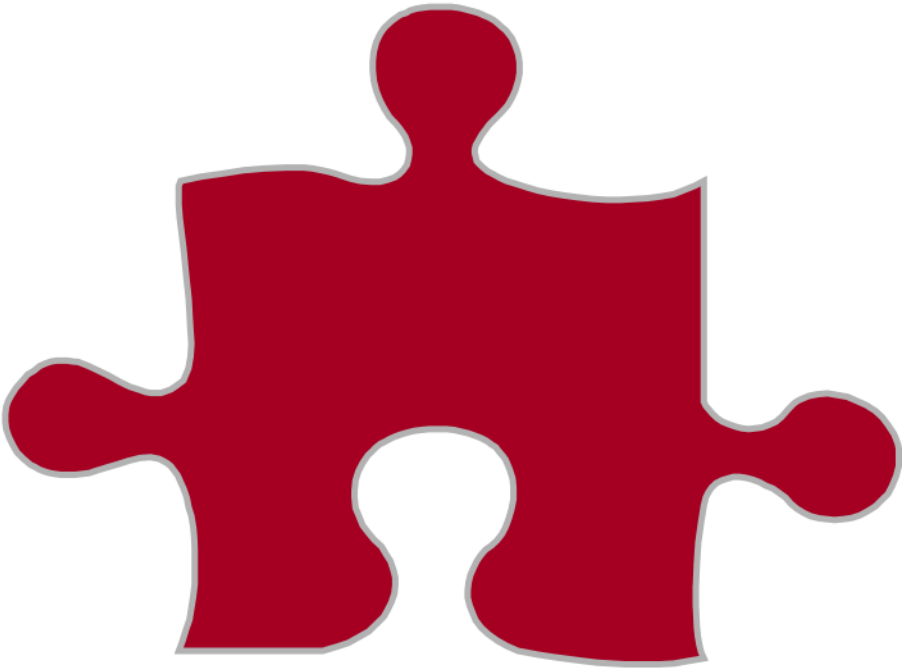
- Most common is ADHD
  - 65% of children diagnosed with ADHD also had ODD
  - 80% of children diagnosed with ODD also had ADHD
- Anxiety disorders
  - 45% of children diagnosed with an anxiety disorder also had ODD
- Severe depression
  - 70% of children diagnosed with severe depression also had ODD
- Bipolar
  - 85% of children diagnosed with bipolar disorder also had ODD
- Language processing disorder (LPD)
  - 55% of children diagnosed with LPD also have ODD

What Causes Disruptive Behavior Disorders?

- It is thought that children with severe behavior disorders may be more influenced by neurological and genetic factors[12]

- However mild to moderate DBDs are believed to appear in children who have an accumulation of a high number of risk factors and a low number of protective factors in all contexts of their lives[7]

- This imbalance of risk to protective factors may determines the presence and severity of a child's DBD. [5 6 7]

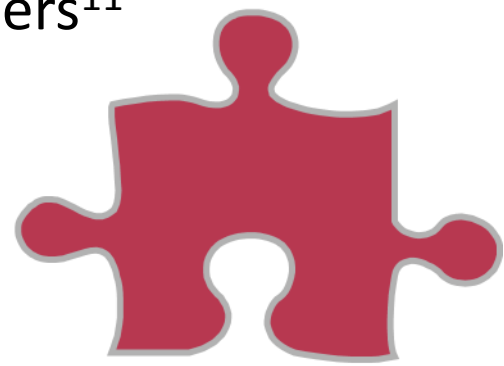


Risk Factors

Characteristic or circumstance of the individual
that increases the probability of a Disruptive Behavior Disorder.

Biological Risk Factors

- Difficult Temperament at birth – irritable, easily frustrated, angry and hard to soothe[13]
- Aggression is highly influenced by genetic factors in boys and girls.[12]
- In severe cases of DBDs neurological factors may cause the brain to function differently compared to how an average child's brain may function.[12]
- Children diagnosed with both ODD/CD and ADHD (ADHD being highly genetic) are likely to have greater symptom severity and increased risk of future disorders[11]



Individual Risk Factors

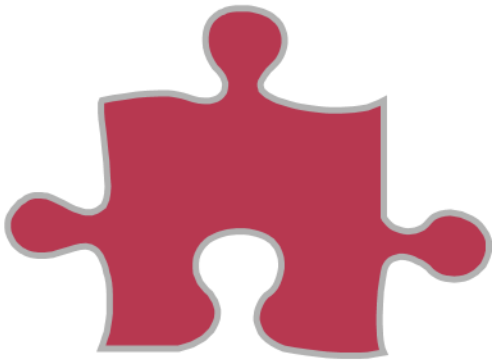
- Underdeveloped emotional regulation skills
- Low tolerance of frustration
- Little to no problem solving capabilities
- Inability to adapt to new situations
- Language development impairment[11]

Family Risk Factors

- Young age of the mother at birth of first child
- Insecure Parental Attachment
- Coercive parent – child interactions

Parental behaviors include inconsistent/harsh discipline, poor monitoring/ supervision, low levels of warmth/nurturance, high numbers of negative verbalizations towards the child.

- Depressed or “distressed” mother
- High levels of substance abuse and antisocial behaviors in parents[7 14]



Contextual Risk Factors

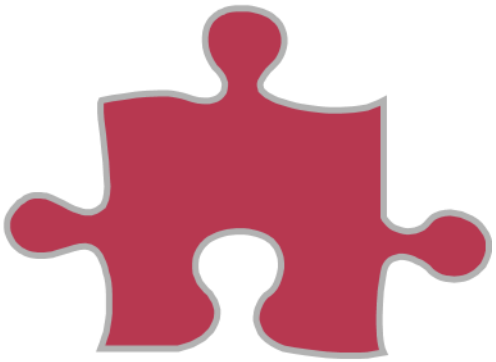
- Living in urban, low-socioeconomic settings.

  As the magnitude of poverty increases, so too does the severity of aggression and conduct problems[7]

- Living in a disadvantaged neighborhood

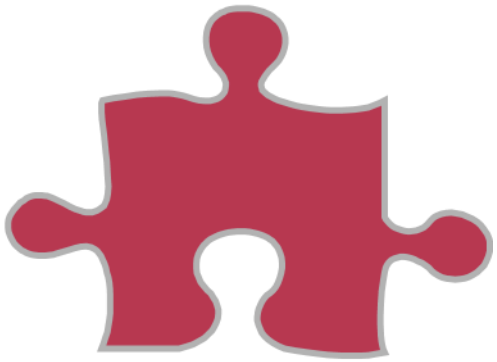
  Characterized by dilapidated housing, high crime rates, isolation, lack of economic resources and unsafe conditions.[15]

- Witness of violence or being the victim of violence or abuse[7]
- Stressful live events[16]



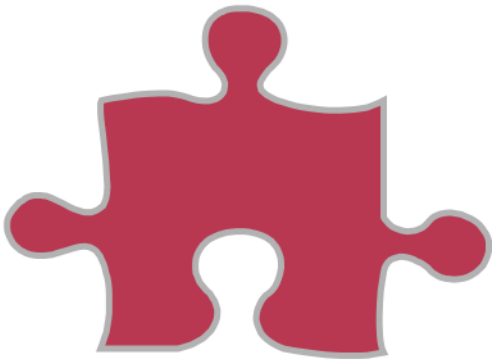
School Risk Factors

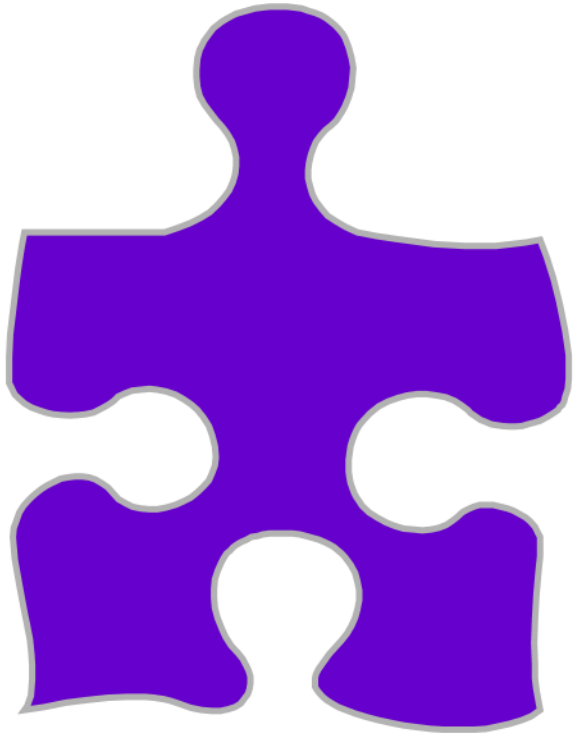
- Zero-tolerance discipline which is highly punitive and erratic, escalating with little or no attention to students' good behaviors or efforts to achieve[10 17]
- Negative interactions with adults, typical school experience for these students is highly negative[10]
- Discipline including punishments that takes students away from the academic environment[17]
- Deficits in social skills lead to rejection by prosocial peers[7]
- Affiliation with "deviant" peers[7 10]



Non – Factors

- No significant evidence has been found that demonstrates increased occurrence of DBDs in relation to race and ethnicity [7 18 19]
- Although controversial, most researchers have concluded that there are no IQ differences between children with and without CD.[7 19]





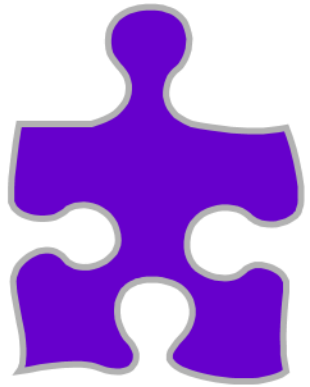
Protective Factors

Protective factors reduce the likelihood of children confronted with risk factors to develop maladaptive behaviors associated with Disruptive Behavior Disorders.

Resilience in Childhood

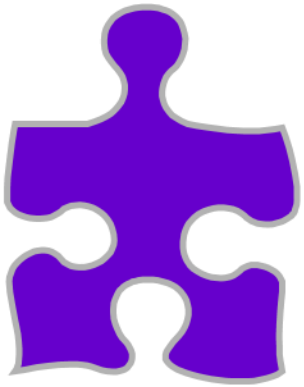
Resilience-

A positive adjustment occurring in children at-risk, seems to result from a combination of internal and external resources that function as protective factors.[7]



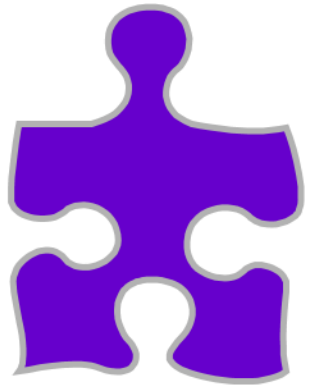
Child Protective Factors

- Easy Temperament
- Good intellectual functioning
- Self-confidence
- Empathy
- Talents[3 7]



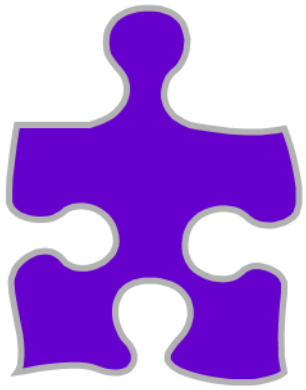
Family Protective Factors

- Good supportive relationship with a parent
- Close supervision by parents when not in school
- Positive parent-child relationships: warmth, structure, high expectations
- Connection to extended supportive family networks [5 7 8]



School Protective Factors

- Children with ODD/CD who had a positive teacher-child relationship showed a decrease in aggression.[20]
- Friendship with prosocial peers[7]
- Bonds to prosocial adults outside the family[7 17]
- Attending effective school[3]

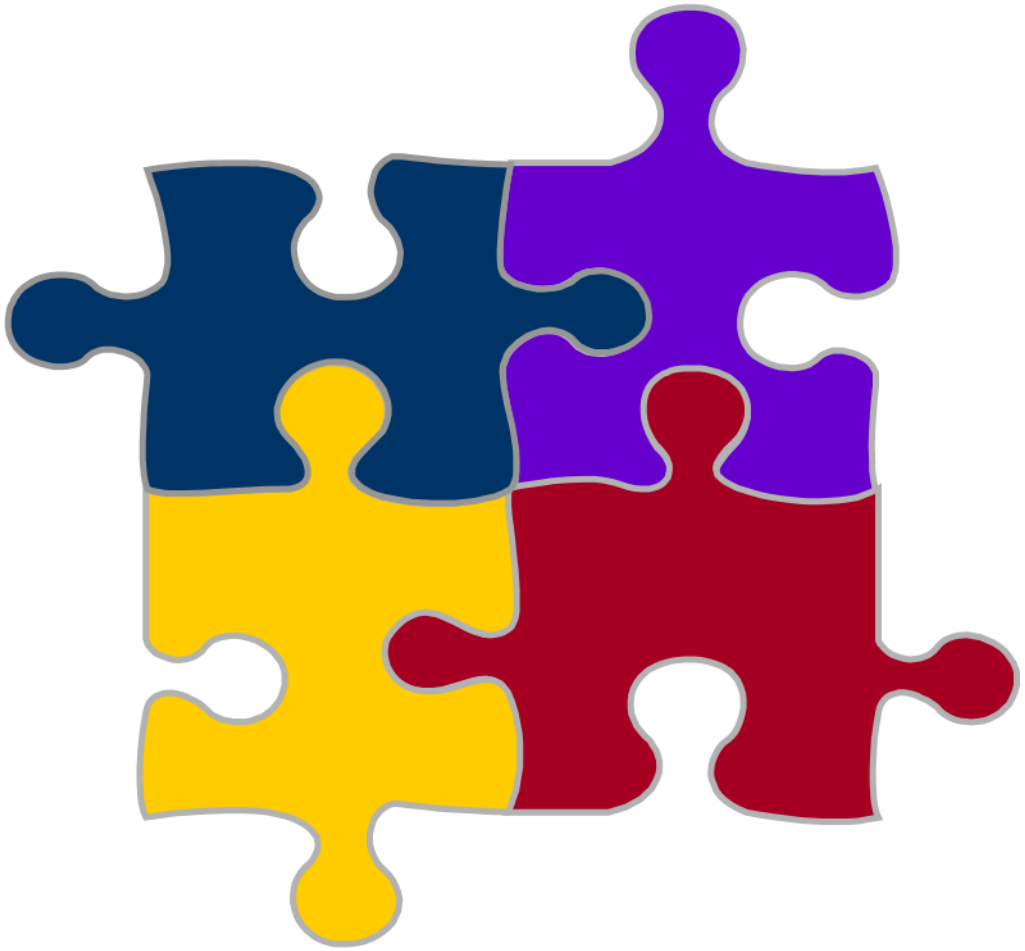


Classroom Interventions

- Establish and teach the classroom rules and procedures
  - Classroom rules and procedures need to be established and clearly stated, explicitly taught, closely monitored and consistently followed.
- Manage common problem times: transition, seat work, other unstructured times of the day
- Promote social and emotional functioning
- Use rewards effectively
- Use mild punishment effectively
- Manage angry/acting out behavior

Individual Interventions

- Consistently reinforce good behavior
- Use of proactive and instructive teaching strategies to teach adaptive behaviors and problem solve with the student
- Train student to self-monitor disruptive behaviors
- Use positive reinforcement when students reaches behavior goals.



Piecing it all together:
What does all of this mean for a teacher?

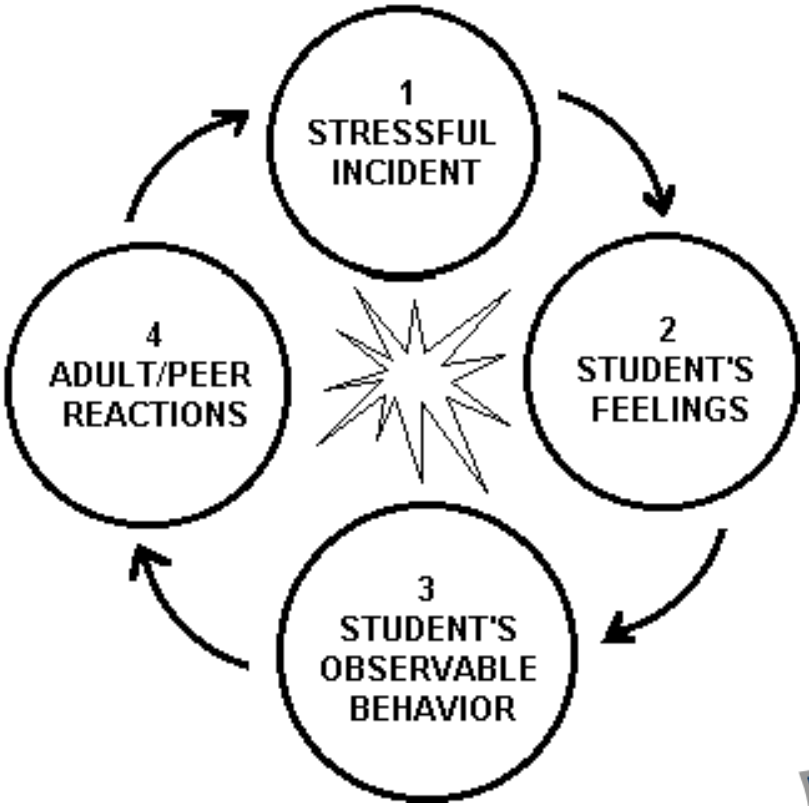
What Teachers Should Avoid

- Use of only reactive behavioral strategies
- Model antisocial behaviors by yelling or insulting student, instead teachers should model prosocial or problem solving behaviors.
- Use of harsh punishment
- Only coercive interactions with student

What Teachers Should Do

- Understand that teaching children with DBDs may take a "superhuman tolerance for interpersonal nastiness" [10]
- Directly teach adaptive behavior strategies
- Model and teach prosocial skills, problem solving, empathy and self-control
- Use individual interventions for students with DBDs
- Understand the teacher-student conflict cycle and how to avoid it

The Conflict Cycle



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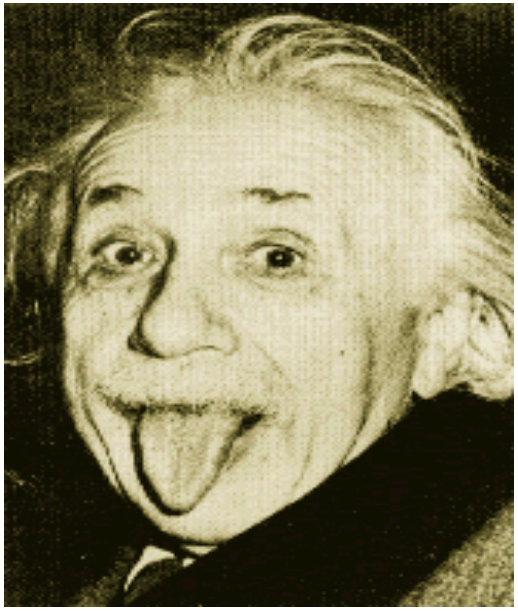
Albert Einstein



- Trouble in class as a child
- Poor academic results
- Easily Distracted
- Messy
- Forgetful