

# Mood & Disruptive Behavior Disorders in Children & Adolescents

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# 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 - IIR (1987)

⌘ DSM - IV (1994)

# Revision IV



⌘ Literature Reviews

⌘ Identify Conflicts or lack of evidence

⌘ Field Trials

⌘ 5 Volume Sourcebook on Decisions

# Defining Mental Disorder

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⌘ 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

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⌘ 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

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⌘ Arrest

⌘ Incarceration

⌘ Litigation

⌘ Victim of crime

# Disorders of Infancy, Childhood & Adolescence...

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⌘ 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

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⌘ 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

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⌘ twice as common in females than males  
for adults & adolescents

⌘ prepubertal males / females equally  
affected

# Lifetime Risk Factor

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⌘ 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

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- ⌘ 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

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## ⌘ 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

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⌘ distractibility

⌘ increased goal directed activity

⌘ excessive involvement in pleasurable activities

☒ despite adverse consequences

⌘ marked impairment

# Hypomanic episode

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⌘ 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

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⌘ 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)

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## ⌘ Attention Deficit Disorder

☑ Inattentive Type

☑ Impulsive Type

☑ Hyperactive Type

☑ Combined Type



## Attention Deficit Disorder Types

Inattentive

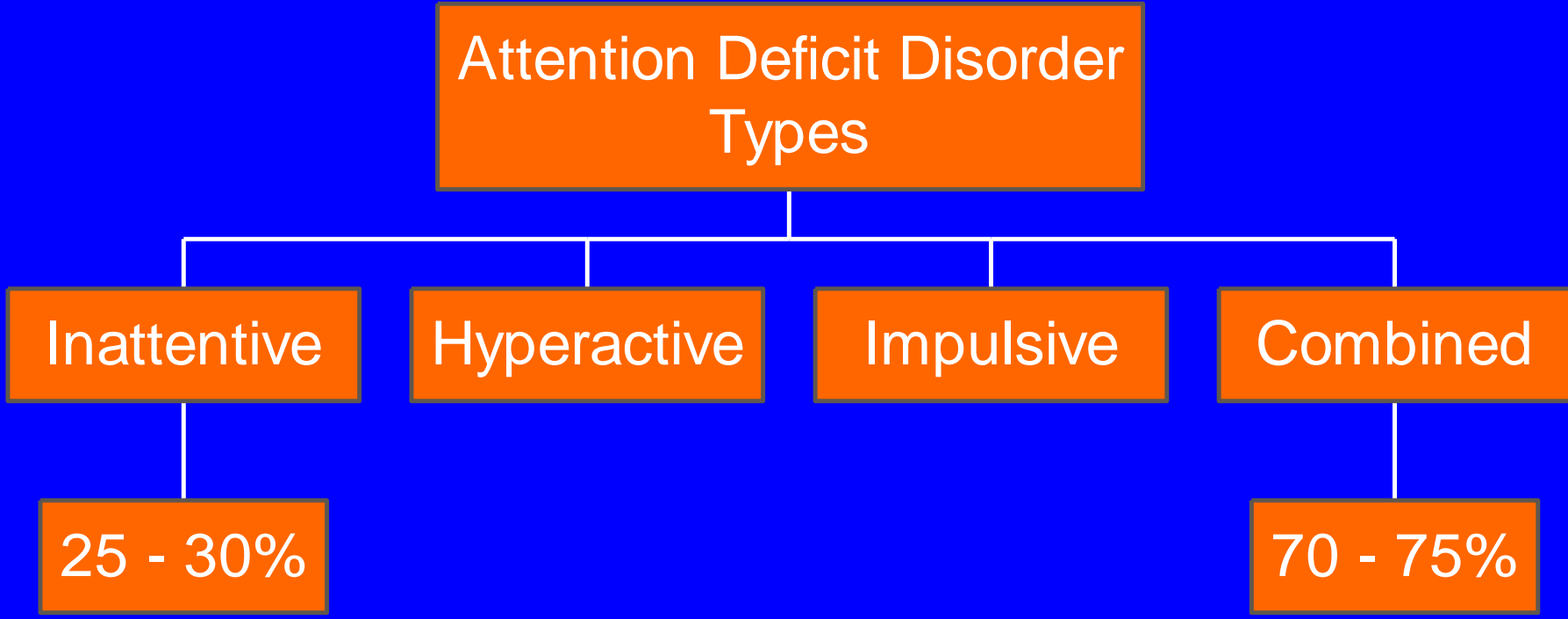
25 - 30%

Hyperactive

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

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⌘ 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

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⌘ 50% - 80% have some comorbid condition

⌘ Oppositional Defiant Disorder

⌘ Conduct Disorder

⌘ Impaired Academic Functioning

⌘ Mood Disorders

⌘ Tic Disorders

# Oppositional Defiant Disorder

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☒ 40% of children

☒ 65% of adolescents

# Conduct Disorder

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☒ 21% - 45% of children

☒ 44% - 50% of adolescents

# Impaired Academic Functioning

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▣ 40% in special education classes

▣ 19% - 26% with at least one  
learning disorder

# Mood Disorders

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☒ 15% - 20% with Depression

☒ 20% - 25% with Anxiety

# Tic Disorders

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 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

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☒ Early growth & development

☒ Social

☒ Behavior

☒ Academic functioning

☒ Family functioning

# Objective Assessment Devices

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☒ Continuous Performance Tests (CPT)

☒ Intelligence Tests

☒ Achievement Tests

# Norm-based symptom scales for parents & teachers

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⌘ Conners

⌘ Auffmanbach

⌘ 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

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⌘ 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

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⌘ 3 or more in past 12 months

☑ aggression to people or animals

☑ destruction of property

☑ deceitfulness or theft

☑ serious violations of rules

# Prevalence

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⌘ 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

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⌘ 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

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## ⌘ 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

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⌘ 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

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⌘ 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

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⌘ Attachment theory

⌘ Improve relationship with parent and others

⌘ Less research support

# Effectiveness

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- ⌘ 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

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⌘ 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

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☒ blames others for his misbehaviors

☒ easily annoyed by others

☒ angry & resentful

☒ spiteful & vindictive

# Oppositional Defiant Disorder

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- ⌘ 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

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⌘ 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

