Disorders First Apparent in Childhood
PSY 440
Abnormal Psychology
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Attention Deficit
Hyperactivity Disorder

• Clinical Features/Diagnostic Criteria
  – Persistent pattern of inattention and/or hyperactivity-impulsivity
    that is more frequent and severe than is typically observed in
    individuals at a comparable level of development
  – Some symptoms must be seen before age 7
  – Impairment must be seen in 2 settings

Attention Deficit
Hyperactivity Disorder

– Interferes with social, academic, or occupational functioning
– Does not occur as the result of another psychological disorder

• Inattention
  – May manifest in academic, social, or occupational situations
  – Individuals may fail to give close attention to details or may make
careless mistakes

Attention Deficit
Hyperactivity Disorder

– Work is messy and performed carelessly without considered
thoughts
– Difficulty sustaining attention in tasks or play
– Difficult to persist through completion of tasks
– Often appear as if their minds are elsewhere
– Frequent shifts from one uncompleted activity to another

Attention Deficit
Hyperactivity Disorder

– Don’t follow through on requests or instructions
– Difficulty with organization
Tasks requiring sustained mental concentration are seen as unpleasant and aversive
Work habits disorganized; materials needed are scattered, lost, or carelessly handled and damaged

Attention Deficit Hyperactivity Disorder

- Easily distracted by extraneous stimuli
- Forgetful in daily activities
- Frequent shifts in conversation, not listening to others, not keeping minds on conversations, not following rules of games

- Hyperactivity
  - Fidgetiness or squirming in the seat
  - Excessive running and climbing

Attention Deficit Hyperactivity Disorder

- Not remaining seated
- Difficulty engaging in quiet leisure activities
- Appearing to be “on the go” or “driven by a motor”
- Talking excessively
- Differs with child’s age and developmental level

Attention Deficit Hyperactivity Disorder

- Make diagnosis very carefully in young children
  - Dart back and forth
  - “out the door before the coat is on”
  - Jump or climb on furniture
  - Run through the house
  - Difficulties with sedentary activities
- School aged children display similar behaviors, but with less frequency as toddlers and preschoolers
  - Difficulty remaining seated

Attention Deficit Hyperactivity Disorder

- Fidget with objects
- Tap hands and shake legs and feet
• Get up from the table while eating, etc.
• Talk excessively
  • Adolescents and adults
    – Feelings of restlessness and difficulty engaging in quiet sedentary activities

• Impulsivity
  – Impatience

Attention Deficit Hyperactivity Disorder

– Difficulty delaying responses
– Blurt out answers before questions are completed
– Difficulty waiting turn
– Frequently interrupting or intruding on others
– Make comments out of turn
– Fail to listen to directions

Attention Deficit Hyperactivity Disorder

– Initiate conversations at inappropriate times
– Grab objects from others
– Touch things they aren’t supposed to
– Clown around
– Impulsivity may lead to an increase in accidents
– May also lead to involvement in potentially dangerous activities without considering the consequences

Attention Deficit Hyperactivity Disorder

• Behavioral manifestations seen in multiple contexts
  – Home, school, work, social
  – Need to be seen in 2 settings to make diagnosis
  – Symptoms worsen in tasks that require sustained attention or mental effort and that lack intrinsic appeal/novelty

Attention Deficit Hyperactivity Disorder
– Symptoms absent when
  • Under strict control
  • In a novel setting
  • Engaged in interesting activities
  • Under one-to-one supervision
  • Receiving frequent rewards for appropriate behavior
– More likely to occur in a group setting

Attention Deficit
Hyperactivity Disorder

• Subtypes
  – Combined Subtype
    • 6 or more symptoms of inattention and 6 or more symptoms of hyperactivity-impulsivity have been present for at least 6 months
    • Most children and adolescents have this subtype

Attention Deficit
Hyperactivity Disorder

– Predominantly Inattentive Subtype
  • 6 or more symptoms of inattention with fewer than 6 symptoms of hyperactivity-impulsivity are present for at least 6 months
  • Used to be called Attention Deficit Disorder
– Predominantly Hyperactive/Impulsive Subtype
  • 6 or more symptoms of hyperactivity-impulsivity with fewer than 6 symptoms of inattention are present for at least 6 months
  • Usually see preschoolers with this diagnosis

Attention Deficit
Hyperactivity Disorder

• Problems with the diagnosis
  – No consistent procedure for diagnosing
    • Number of kids are labeled as ADHD when, in fact, they are just being kids
    • Talk about comparison points
  – Diagnosed because of incorrect/insufficient information
  – Relying on behaviors in the physician’s office may lead to under diagnosis

Attention Deficit
Hyperactivity Disorder
-- Relying on parental report may lead to overdiagnosis
-- Primary Care Physicians are more likely than psychiatrists and pediatricians to:
  • Diagnose ADHD
  • Prescribe medication for it

• Prevalence
-- 3-5% of school-aged children
-- 50% of children referred to clinics have ADHD

**Attention Deficit Hyperactivity Disorder**

• Associated Features
-- May vary depending on age and developmental level
-- Low frustration tolerance
-- Temper outbursts
-- Bossiness
-- Stubbornness
-- Excessive and frequent insistence that requests be met

**Attention Deficit Hyperactivity Disorder**

-- Mood lability
-- Demoralization
-- Dysphoria
-- Rejection by peers
-- Poor self-esteem
-- Impaired and devalued academic performance
-- Poor self-application is often misinterpreted as laziness

**Attention Deficit Hyperactivity Disorder**

-- Family relationships are characterized by resentment and antagonism
-- Impaired behavioral inhibition and self-control
  • Executive functions
-- Associated disorders:
  • ODD, CD, Mood Disorders, Anxiety Disorders, LD, Communication Disorders, Tourette’s Disorder
Attention Deficit Hyperactivity Disorder

– Environmental correlates
  • Prenatal insult
  • obstetrical complications
  • history of child abuse/neglect
  • multiple foster placements
  • neurotoxin exposure
  • Infections
  • drug exposure in utero
  • Low birth weight
  • Premature birth
  • Mental retardation

Attention Deficit Hyperactivity Disorder

– Brain differences
  • Prefrontal cortex, cerebellum, and basal ganglia are all implicated in the development of ADHD
  • 1996 study indicated that the right prefrontal cortex, two basal ganglia, and the vermis region of the cerebellum are smaller in children with ADHD than in matched controls
    – These areas regulate attention
    – Unknown why these areas shrink
  • Also potential differences in the limbic system
    – Anterior cingulate

Attention Deficit Hyperactivity Disorder

– Lower activity level in this region during tasks that require attention for children with ADHD than in children without ADHD
  • Differences in the corpus collosum
    – Connections between the halves of the brain are fewer in children with ADHD

• Etiology
  – Genetics (as we just discussed)
  – Not necessarily a disorder of inattention
    • Rather developmental failure in inhibition, self-control, attentional processes, and sensitivity to reinforcement

Attention Deficit Hyperactivity Disorder

– Polygenetic
– Heritability estimate: 80%
– Nongenetic factors

• Age and Gender
  – Difficult to establish in very young children
  – As children mature, symptoms become more apparent
  – More common in males than in females
    • 4:1 to 9:1

Attention Deficit
Hyperactivity Disorder

• Course
  – First observe excessive activity in toddlers
    • Frequently coincides with development of independent locomotion
    • Not diagnosed
  – Disorder first diagnosed in elementary school years
    • Behavior patterns are seen between 3 and 5 years of age

Attention Deficit
Hyperactivity Disorder

– In school-aged children, inattention leads to poor classwork and academic performance
– Impulsiveness may lead to the breaking of rules
– In late childhood/early adolescence, signs of excessive gross motor activity are less common and hyperactivity may be confined to fidgetiness and a sense of restlessness
– In some to most individuals, symptoms remit by adulthood

Attention Deficit
Hyperactivity Disorder

– Depending on who you read, between 30-66% of children with ADHD have it into adulthood
  • Restlessness may lead to difficulties participating in sedentary activities and avoiding pastimes or occupations that limit opportunities for spontaneous movement

• Differential Diagnosis
  – Age appropriate behaviors, MR, understimulating environments, ODD, PDD, Psychotic Disorder

Treatment of ADHD

• American Academy of Pediatricians Guidelines
– primary care clinicians need to establish a treatment program that recognizes ADHD as a chronic condition.
– clinicians, parents, school personnel and the child himself/herself need to specify appropriate goals that relate to the specific problems of the child

**Treatment of ADHD**

– clinicians need to recommend stimulant medication and/or behavior therapy to improve specific symptoms in children with ADHD
– clinicians need to re-evaluate the original diagnosis when the treatment for a child with ADHD has not met its goals
– clinicians need to conduct periodic, systematic follow-up with children

**Treatment of ADHD**

- **What types of treatments are effective?**
  - Multimodal and multidisciplinary
  - Requires medical, psychological, and educational intervention and behavior management
  - Coordinated effort by a team of health care professionals, educators, and parents
  - First step in treatment is a proper diagnosis by a trained professional
  - Long term treatment

**Attention Deficit Hyperactivity Disorder**

– Components:
  - Parent training in behavior management
  - Appropriate education program
  - Individual and family counseling when needed
  - Medication when needed

- **Medication**
  - Psychostimulants
    - Ritalin (methylphenidate)
    - Dexedrine (dextroamphetamine)
    - Cylert (pemoline)

**Attention Deficit Hyperactivity Disorder**

– 70-80% of kids with ADHD respond to medication
  - So do 70-80% of kids without ADHD
– Decreases impulsivity and hyperactivity, increases attention, and, in some cases, decreases aggression
– Dosing is idiosyncratic
– Use of medication has increased since about 1960
– Not all children with ADHD need medication

**Attention Deficit Hyperactivity Disorder**

**Oppositional Defiant Disorder**

• Clinical Features/Diagnostic Criteria
  – Recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures
  – Persists for 6 months
  – Characterized by the frequent occurrence of at least 4 of the following behaviors:
    • Losing temper
    • Arguing with adults

• Actively defying or refusing to comply with the reasonable requests or rules of adults
• Deliberately doing things to annoy others
• Blaming others for their own mistakes
• Being touchy or easily annoyed
• Being angry and resentful
• Being spiteful and vindictive

– These behaviors must occur more frequently than is typical for individuals of the same age and developmental level

**Oppositional Defiant Disorder**

– Impairment in social, academic, or occupational functioning
– Diagnosis is not made if the behaviors occur during the course of another psychological disorder
– Also not made if criteria are met for CD or APD

**Oppositional Defiant Disorder**
– Negativistic and defiant behaviors are expressed by:
  • Persistent stubbornness
  • Resistance to directions
  • Unwillingness to compromise, give in, or negotiate
  • Deliberate or persistent testing of limits
    – Ignoring orders, arguing, and failing to accept blame for misdeeds
  • Deliberately annoying others (especially adults)
  • Verbal aggression

**Oppositional Defiant Disorder**
– Almost always see the behaviors in the home setting
  • May not be evident in school or community
  • Symptoms are seen in interactions with adults the child knows well
– Individuals with the disorder do not see themselves as oppositional
  • They are just reacting to unreasonable demands being placed on them

**Oppositional Defiant Disorder**
• Associated Features
  – Males
    • In preschool years, have problematic temperaments or high motor activity
  – In school years:
    • Low self-esteem
    • Mood lability
    • Low frustration tolerance
    • Swearing
    • Precocious use of tobacco, alcohol or drugs

**Oppositional Defiant Disorder**
– Conflicts with parents, teachers, or peers
  • Vicious cycle
– Comorbid disorders:
  • ADHD, LD, Communication Disorders

**Etiology**
– More prevalent in families in which child care is disrupted
– Parental behaviors also play a key role
  • Parental psychopathology

**Oppositional Defiant Disorder**
• Parenting behaviors
  – Poor supervision
  – Lack of parental involvement in children’s activities
  – Harsh/abusive punishment
  – Inconsistent discipline
– More overprotectiveness and less parental caring
– Appears that mothers play a larger role than fathers
– Maternal delinquency
– More common in families with a history of ODD, CD, Mood Disorder, ADHD, APD, or Substance-Related Disorder

Oppositional Defiant Disorder
– Maternal depression
  • Causality?

• Age and Gender Features
  – Remember, transient oppositional behavior is common in preschool children and adolescents
    • Be careful when diagnosing ODD in these ages
    • Behaviors must be more severe than would be expected
  – More prevalent in males before puberty

Oppositional Defiant Disorder
– Equal rates after puberty
  • Girls, though, are ignored in the research
– Symptoms comparable in both genders
  • However, males may be more confrontational

• Prevalence
  – 2% to 16%

• Course
  – Usually evident before 8 years of age and no later than adolescence

Oppositional Defiant Disorder
– Symptoms emerge in the home first and spread to other settings
– Onset is gradual
  • Occurs over the course of months and years
– Number of oppositional behaviors increases with age
– In 40-50% of the cases, ODD is a precursor to CD

Oppositional Defiant Disorder
• Differential Diagnosis
  – CD
  – Mood Disorder
  – Psychotic Disorder
  – ADHD
  – Normal adolescence/preschool behavior
  – Mixed Expressive-Receptive language disorder
Conduct Disorder

• Clinical Features/Diagnostic Criteria
  – Repetitive and persistent pattern of behavior in which the rights of others or other major societal norms or rules are violated
  – Four categories
    • Behavior that causes or threatens physical harm to other people or animals
    • Nonaggressive conduct that causes property loss or damage

Conduct Disorder

• Deceitfulness or theft
• Serious violations of rules
  – 3 behaviors must be present within the last year; 1 within the last 6 months
  – Significant impairment in social, academic, or occupational functioning
  – Can be diagnosed in those over 18, but they cannot meet the criteria for APD
  – Behavior pattern is seen in a number of different settings

Conduct Disorder

– Individuals tend to minimize their problems

• Subtypes
  – Childhood-Onset Type
    • One criterion characteristic before the age of 10
    • Typically male
    • Frequently physically aggressive
    • Disturbed peer relationships
    • ODD during early childhood
    • Meet full criteria for CD before puberty

Conduct Disorder

• More likely to turn into CD
  – Adolescent-Onset Type
    • Absence of criteria before age 10
    • Less likely to be aggressive
    • More likely to have normative peer relationships
    • More females diagnosed with Adolescent-Onset Type than Childhood-Onset Type

Conduct Disorder

• Associated Features
  – No empathy
– Decreased moral reasoning
– Cognitive deficits that interfere with ability to respond to problem situations
  • Interpret communications in a hostile manner
  • Reach incorrect conclusions about communications
  • Fail to consider strengths and weaknesses of possible responses

**Conduct Disorder**
– React aggressively to provocation
– Callous and lack feelings of guilt and remorse
– Poor social skills
– Blame others for their misdeeds
– Low self-esteem
– Poor frustration tolerance
– Higher accident rates

**Conduct Disorder**
– Early onset of sexual behavior, drinking, smoking, drug use, and reckless and risk-taking activities
– School suspension or expulsion
– Problems with work adjustment
– Legal difficulties
– STDs
– Unplanned pregnancy
– Physical injury

**Conduct Disorder**
– Females may have other problems:
  • Arrest
  • Substance abuse and dependence
  • Teenage pregnancy
  • Failure to finish high school
  • Early and violent death
– Suicide ideation, attempts, and completed suicide
– Low academic achievement

**Conduct Disorder**
– Comorbid psychological disorders:
  • ADHD, LD, Anxiety D/O, Mood D/O, Substance-Related D/O

**Etiology**
– Predisposing factors:
  • Parental rejection and neglect
  • Difficult infant temperament
• Inconsistent child-rearing practices with harsh punishment

**Conduct Disorder**

• Physical or sexual abuse
• Lack of supervision
• Early institutional living
• Frequent changes of caregivers
• Large family size
• Association with a delinquent peer group

– Parental functioning
  • Parental psychopathology
  • Poor parenting behavior (see ODD)

**Conduct Disorder**

– Boys with the worst problems have two patterns in common:
  • Abnormally high levels of sibling conflict
  • Mothers whose parenting style was particularly rejecting

– Mother and father negativity has been related to girls’ conduct problems

– Biological findings:
  • Some evidence that children with CD have lower heart rate and skin conductance

**Conduct Disorder**

• Culture, Age, and Gender
  – May be misapplied to individuals who come from threatening environments

– Age factors
  • Early onset is associated with more health and behavioral problems in adolescence

– Gender factors
  • More common in males
  • Mothers report more problems for boys than girls

• Girls are more likely to be diagnosed with one or more comorbid disorders

• Differences in type of aggression
  – Boys: hostile aggression
  – Girls: instrumental aggression

• Behaviors
  – Boys:
    » Fighting
    » Stealing
    » Vandalism
    » School discipline problems
    » Hostile-aggressive behaviors
    » Hyperactive behaviors
    » Physically assault others
Conduct Disorder

- Girls:
  » Lying
  » Truancy
  » Running away
  » Prostitution
- Boys and girls:
  » Externalizing behaviors
  » Verbal deviance
  » Noncompliance to parental requests

• Prevalance
  – On the rise

Conduct Disorder

- Males under 18:
  • 6-16%
- Females under 18:
  • 2-9%

• Course
  – Variable
  – Onset could be as young as 5-6 years
  – Symptoms start as less severe behaviors
    • Lying, shoplifting, physical fighting

Conduct Disorder

- Move to more severe behaviors
  • Burglary, vandalism
- Most severe conduct problems tend to emerge last
  • Rape, theft while confronting victim
- More conduct problems a child has at age 8, the worse off the child at age 18
- Majority of cases remit by adulthood
- However, a large percentage turn into APD
  • Especially Childhood-Onset Type

Conduct Disorder

• Differential Diagnoses
  – ODD, ADHD, manic episode, Adjustment D/O, APD

FUNCTIONAL AND LEARNING DISORDERS

• functional disorders –
  difficulties in performing one or more tasks
ELIMINATION DISORDERS

• *elimination disorders* – disruptions or developmental delays in control of the elimination of bodily wastes (urine and feces)

ELIMINATION DISORDERS

• *enuresis* – characterized by persistent voiding of urine, most often during the night, in children who are at least five years old

ELIMINATION DISORDERS

• *encopresis* – characterized by the repeated passage of feces into such inappropriate places as one’s clothes or the floor

COMMUNICATION DISORDERS

• *communication disorders* – deficits in the ability to understand or express verbal messages at an age-appropriate level

Communication Disorders

• Expressive Language Disorder
• Mixed Expressive-Receptive Language Disorder
• Phonological Disorder
• Stuttering
• Selective Mutism

Communication Disorders

• Reading Disorder (Dyslexia)
• Mathematics Disorder
• Disorder of Written Expression

AUTISTIC DISORDER

• autistic disorder is the best known of the pervasive developmental disorders
SYMPTOMS AND COURSE

- autistic disorder is characterized by markedly abnormal or impaired development in social skills and communication

MENTAL RETARDATION

- mental retardation – characterized by significant intellectual and functional deficits that begin before the age of 18

DIAGNOSING MENTAL RETARDATION

- two functional criteria that one must meet to qualify for a diagnosis of mental retardation:
  - sufficiently low IQ
  - significant social and functional deficits

Levels of Mental Retardation

- Mild Mental Retardation
- Moderate Mental Retardation
- Severe Mental Retardation
- Profound Mental Retardation

References


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