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 sever 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

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

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
- Blurting 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 appearant
  - 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

- Changing Behavior
  - Parent training
  - Behavior Modification
    - Ignoring behavior
    - Natural consequences
    - Logical consequences
    - Time out
  - RIP Program

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

Oppositional Defiant Disorder

- 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

Conduct Disorder

- 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

- *learning disorders* –
  significant deficits in reading, mathematics, or written expression

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***

- ***pervasive developmental disorders* – severe disruptions in social interaction and communication skills**

SYMPTOMS AND COURSE

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

- abnormalities are apparent early (usually before the age of three) and the course is chronic

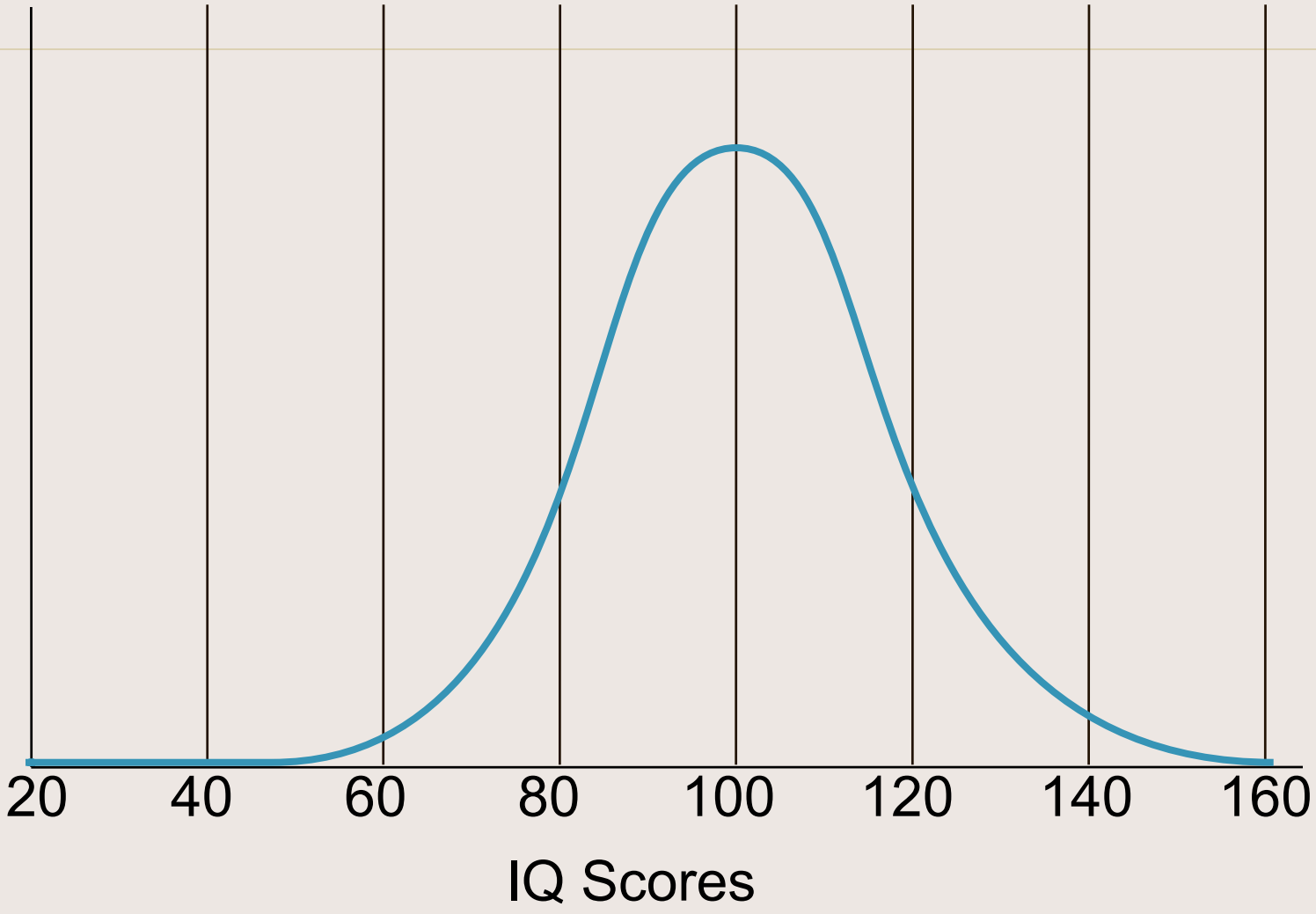
MENTAL RETARDATION

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

DIAGNOSING MENTAL RETARTATION

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

IQ DISTRIBUTION



Levels of Mental Retardation

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

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