Chapter Three

Developmental Effects of Emotional and Behavioral Disorders

3.1. Terms used to describe students with EBDs

Students demonstrate different kinds of behavioral disorders and the magnitude of exhibited behaviors also differs. Some of the terms associated with behavior disorders include: aggressive, aloof (distant), annoying, attention seeking ,avoidant ,compulsive, daydreaming, immature, irritable, negative, preoccupied, schizoid, un-socialized, depressed, delinquent, destructive, disruptive, disturbing, impulsive, jealous, obsessive, restless, self-conscious, withdrawn, erratic, frustrated , short attention span, hostile, hyperactive, autistic, inattentive, manic, passive, rowdy, tense, disobedient. Some of these terms used to describe students with EBDs are also used to describe students with learning disabilities and students with mental retardation.

3.2. Broad Dimensions/Classifications of Behavioral Problems

Several findings of systematic researches using behavioral rating scales have remarkably founded the main types of behavior problems children and youths exhibit. Based on findings of research emotional and behavioral problems can be grouped into two very broad classifications. These are:

1. **Externalizing Behavior**; sometimes also called under controlled, conduct disorder, acting out behavior. Externalizing behavior includes: disobedience, disruptiveness, fighting, destructiveness, temper tantrums, boisterousness, irresponsibility, impertinence, jealous, anger, bossiness and attention seeking. Socialized aggression (gang membership, truancy, stealing, delinquency, defiance of authority, irritability, troublesomeness and hostile aggression)

2. **Internalizing Behavior:** also called over controlled, anxiety, withdrawal, acting in behavior. Internalizing behavior includes: Social withdrawal, Anxiety, Feeling of in adequacy (inferiority), Guilty of feeling, Reclusive/isolated, Chronic sadness, shyness, Depression, Hypersensitivity,

Chewing finger nails, Infrequent smiling, Immaturity (short attention span, preoccupation, clumsiness, passivity, daydreaming, sluggishness, drowsiness, giggling, preference for younger player mates, chewing objectives, and a feeling of being picked on by others.

It is important to remember that a given individual can exhibit both externalizing and internalizing behaviors and that some individuals vacillate between the two extremes.

3.3. Common dimensions affected by EBDS

3.3.1. Cognitive

Students with EBDS have a lot of cognitive deficiencies. As a result these students have poor memory and attention span, and they are also preoccupied, overly active and anxious. In general, most students with EBDS score slightly below average in intelligence tests (IQ), although the scores of individual students are over the entire range.

3.3.2. Academic

Most students with EBDS do not do as well academically as one could expect from their scores on intelligent tests. As you remember one component of the definition of EBDS states that students with EBDS exhibit characteristics which affect educational performance. This means that students with EBDS perform poorly on measures of school achievement. In fact students with learning disability also perform poorly in at least one area school achievement.

Generally EBDS can led to academic problems, and academic problems can led to emotional problems. When students are suffering emotionally, they become very preoccupied and simply do not attend well to academics. Students who demonstrate EBDS in school may be subjected to disciplinary actions (suspension & expulsion), which in tern limit their time in school and exposure to academics. When students do not perform well academically, they may develop poor self-esteem (especially academic self-esteem).

Students who receive low grades may give up and begin acting out behaviors. In fact other factors such as life stressors like parental divorce or loss of parent/ sibling can lead students to experience both academic and emotional problems.

3.3.3. Physical

Most children with EBDS are acting out in class room, constantly defying the teacher's instructional and rules and procedures. Most students with EBDS are physically normal. The exceptions are those with psychosomatic complaints, a condition in which the physical illness actually is brought on by or associated with the individuals emotional state. Students who have serious physical problems can develop behavioral disorders, especially, when a physical disorder leads others to act negatively toward the student and the student develops low self-worth/self-esteem that reflected in behavioral characteristics.

3.3.4. Behavioral

This is the primary area in which students with EBDS greatly differ from others. The broad behavioral characteristics of students with EBDS are specified in the definition of EBDS as:

- An inability to learn
- An inability to build or maintain satisfactory interpersonal relationships
- Inappropriate types of behaviors or feelings
- A general pervasive mood of unhappiness or depression
- A tendency to develop physical symptoms or fears

3.3.5. Communication

Although many children with EBDs have language problems, these are not universal characteristics of most of these students. Students who are considered schizophrenic sometimes demonstrate abnormal language and communication skills. Many never speak, while others develop language and speech disorders like echolalia (illogical or disorganized speech) and inadequate comprehension of verbal instructions. These students represent a very small percentage of those who classified as having serious emotional disturbance.

2.1.Types of behavioral and emotional disorders

Although it is impossible to list all the specific behavioral characteristics of students with EBDS, it is possible to describe some general types of behavior that tend to attract the attention and concern of adults and that, if not corrected, are likely to handicap the child seriously. These include:

- Aggressive behavior
- Hyperactivity
- Withdrawn behavior
- Inadequacy/Immaturity
- Anxiety disorder
- Mood Disorders
- Attention-Deficit Hyperactivity Disorder (ADHD)

3.5.1. Aggressive behavior

What are aggressive behaviors?

The most common characteristics of students with EBDs are aggression and acting out. Aggressive behavior refers to a behavior intended to cause injury or pain (psychological or physical) or to destroy property. Even though all children sometimes cry, hit others and refuse to comply with the request of their parents and teachers, students with EBDs do so frequently.

The aggressive behavior of students with behavior disorders often occurs with little or no provocation. Aggression takes many forms like verbal abuse towards adults and other children, destructiveness, vandalism (damage), and physical attacks on others. Aggressive children are in continuous conflict with those around them. Their own aggressive behavior often causes others to trick back in attempts to punish them. Aggressive children are not liked by others or they establish few friendships

As many children with EBDs grow older their aggressive behavior causes conflict in the community leading to run-ins with law enforcement officials and arrests for criminal offenses.

Many believe that most children who exhibit deviant behavior patterns will grow out of them with time and becoming normally functioning adults. That is, some minor childhood behavioral problems might disappear during adult age. Although this popular wisdom may hold true for many children with EBDs such as withdrawal, fears and speech impairments, research indicates that it is not true for children who display consistent patterns of aggressive, coercive, antisocial and delinquent behaviors.

3.5.2. Hyperactivity

What are the characteristics of hyperactive students?

Hyperactivity refers to a high rate of socially inappropriate activity not simply to complete the activity or a high rate of movement per second. That is, it is characterized by abnormally excessive activity or movement. Hyperactivity is the characteristics of many children with learning disability, mental retardation and emotional problems.

The following are some of the behavioral characteristics of hyperactive children:

- ✓ Failure to follow instruction, failure to complete tasks, tantrums, fighting, clumsiness, recklessness/irresponsibility
- ✓ Hyperactive children usually do not get along well with other children and they have problems in social relations
- ✓ Hyperactive children often are also impulsive. They frequently respond quickly and without considering alternatives in social situations and on academic tasks. Typically, their impulses lead them to the wrong response, and they make socially unacceptable or academically incorrect responses.
- ✓ Many hyperactive children are also distractible, unable to pay attention to task long enough or selectively enough to learn efficiently or complete work.
- ✓ Many hyperactive children are unable to see alternative ways of behaving in situations involving interpersonal problems

3.5.3. Withdrawn behavior

Who are withdrawn children?

Withdrawn children keep others at a distance both physically and emotionally. They may lack social approach responses, responsiveness to others' social initiations or both. Although children who consistently withdrawn do not present threats to others as aggressive children do, their behavior still creates a serious problem to their development

These children do not usually play with other children of their own age. They do not engage in social reciprocity (a mutual satisfying exchange of reinforcements by pairs of individuals) that characterizes normal development. They do not have the social skills necessary to make friends. They do not have fun and often retreat into their own daydreams and fantasies. Some are fearful of things without reason, frequently complaining of sick/hurt and engage in deep depression. These behavior patterns limit the child's chance to take part in and learn from the school and leisure activities that normal children participate in. The social withdrawal of some disturbed children is not extreme, but that of others is so pronounced and persistent as to be considered autistic. Autistic withdrawal is characterized by unresponsiveness to social stimuli, avoidance of eye to eye contact, language disorders including inability to speak and excessive self-stimulation

3.5.4. Inadequacy/Immaturity

What are the characteristics of immature children?

Immature children may behave in ways that are the characteristics of much younger normal children or they may unable to meet reasonable demands of performance. They may unexpectedly cry or temper tantrums, act helpless, regress to primitive behavior, become extremely negative, show irrational fears. Some disturbed children use their negativism and tantrums to become little tyrants/oppressed, manipulating their parents into complying with their very whim

Others display a picture of helplessness and demand constant adult attendance just to get them through the activities of daily living. Still others are prisoners of their own extreme irrational fears and leads lives of seeming desperation in which avoidance of the feared object or situation is a constant concern.

3.5.5. Anxiety Disorder

Anxiety disorders are the most common mental disorders in many countries including the United States. In any given year 18.1 percent of the adult population suffer from one or another of the six anxiety disorders identified by DSM-IV-TR, while close to 29 percent of all people develop one of the disorders at some point in their lives (Koury & Rapaport, 2007; Kessler et aI., 2005). Only around one-fifth of these individuals seek treatment (Wang et aI., 2005). The disorders cost society at least $42 billion each year in health care expenses, lost wages, and lost productivity (Dozois & Westra, 2004).

People with *generalized anxiety disorder* experience general and persistent feelings of worry and anxiety. People with *phobias* experience a persistent and irrational fear of a specific object, activity, or situation. Individuals with *panic disorder* have recurrent attacks of terror. Those with *obsessive-compulsive disorder* feel overrun by recurrent thoughts that cause anxiety or by the need to perform repetitive actions to reduce anxiety. And those with *acute stress disorder* and *posttraumatic stress disorder* are tormented by fear and related symptoms well after a traumatic event (for example, military combat, rape, torture) have ended. Most individuals with one anxiety disorder suffer from a second one as well (Angst et al., 2005) (see Figure 5-1). Bob Donaldson, for example, experiences the excessive worry found in generalized anxiety disorder and the repeated attacks of terror that mark panic disorder. In addition, more than 90 percent of people with one of the anxiety disorders also experience a different kind of psychological disorder at some point in their lives (Garrett, 2009; Doughty et aI., 2004; Kaufman & Charney, 2000). An overlap with mood disorders strongest. As many as 60 percent of people with major depression also experience an anxiety disorder during their lives, and 16 percent of individuals with bipolar disorder also display a panic disorder at some point.

Anxiety disorders can be classified as:

1. Generalized anxiety disorder
2. Phobias
3. Panic disorder
4. Obsessive-compulsive disorder

3.5.5.1.Generalized Anxiety Disorder

People with generalized anxiety disorder experience excessive anxiety under most circumstances and worry about practically anything. In fact, their problem is sometimes described *as free-:floating anxiety.* Like the young carpenter Bob Donaldson, they typically feel restless, keyed up, or on edge; tire easily; have difficulty concentrating; suffer from muscle tension; and have sleep problems (Neckelmann et aI., 2007). The symptoms last at least six months. Nevertheless, most people with the disorder are able, although with some difficulty, to carryon social relationships and job activities.

Generalized anxiety disorder is common in Western society. Surveys suggest that around 3 percent of the U.S. population have the symptoms of this disorder in any given year, a rate that holds across Canada, Britain, and other Western countries (Ruscio et aI., 2007; Kessler et aI., 2005). Altogether, close to 6 percent of all people develop generalized anxiety disorder sometime during their lives. It may emerge at any age, but usually it first appears in childhood or adolescence. Women diagnosed with the disorder outnumber men 2 to 1. Around one-quarter of individuals with generalized anxiety disorder are currently in treatment (Burijon, 2007; Wang et al., 2005). A variety of factors have been cited to explain the development of this disorder.

3.5.5.2.Phobias

A phobia (from the Greek word for "fear") is a persistent and unreasonable fear of a particular object, activity, or situation. People with a phobia become fearful if they even think about the object or situation they dread, but they usually remain comfortable as long as they avoid the object or thoughts about it. We all have our areas of special fear, and it is normal for some things to upset us more than other things, perhaps even different things at different stages of our lives (Antony & Barlow, 2002). A survey of residents of a community in Burlington, Vermont, found that fears of crowds, death, injury, illness, and separation were more common among people in

their sixties than in other age groups (Agras, Sylvester, & Oliveau, 1969). Among 20-year-olds, fears of snakes, heights, storms, enclosures, and social situations were much more common.

How do these common fears differ from phobias? DSM-IV-TR indicates that a phobia is more intense and persistent and the desire to avoid the object or situation is greater (APA, 2000). People with phobias often feel so much distress that their fears may interfere dramatically with their lives.

Most phobias technically fall under the category of *specific phobias,* DSM-IV-TR's label for a marked and persistent fear of a specific object or situation. In addition, there are two broader kinds of phobias: *social phobia,* a fear of social or performance situations in which embarrassment may occur, and *agoraphobia,* a fear of venturing into public places, especially when one is alone. Because agoraphobia is usually, perhaps always, experienced in conjunction with *panic attacks,* unpredictable attacks of terror, we shall examine that phobia later within our discussion of panic disorders.

3.5.5.3. Panic Disorder

Sometimes an anxiety reaction takes the form of a smothering, nightmarish panic in which people lose control of their behavior and, in fact, are practically unaware of what they are doing. Anyone can react with panic when a real threat looms up suddenly (see *Psych Watch* on page 145). Some people, however, experience panic attacks-periodic, short bouts of panic that occur suddenly, reach a peak within 10 minutes, and gradually pass.

The attacks feature at least four of the following symptoms of panic: palpitations of the heart, tingling in the hands or feet, shortness of breath, sweating, hot and cold flashes, trembling, chest pains, choking sensations, faintness, dizziness, and a feeling of unreality. Small wonder that during a panic attack many people fear they will die, go crazy, or lose control.

3.5.5.4. Obsessive-Compulsive Disorder

Obsessions are persistent thoughts, ideas, impulses, or images that seem to invade a person's consciousness. Compulsions are repetitive and rigid behaviors or mental acts that people feel they must perform in order to prevent or reduce anxiety.

3.5.6. Mood Disorders

Most people's moods come and go. Their feelings of elation or sadness are understandable reactions to daily events and do not affect their lives greatly. The moods of people with mood disorders, in contrast, tend to last a long time. As in Beatrice's case, the mood colors all of their interactions with the world and interferes with normal functioning.

Depression and mania are the key emotions in mood disorders. Depression is a low, sad state in which life seems dark and its challenges overwhelming. Mania, the opposite of depression, is a state of breathless euphoria, or at least frenzied energy, in which people may have an exaggerated belief that the world is theirs for the taking. Most people with a mood disorder suffer only from depression, a pattern called unipolar depression. They have no history of mania and return to a normal or nearly normal mood when their depression lifts. Others experience periods of mania that alternate with periods of depression, a pattern called bipolar disorder. You might logically expect a third pattern of mood disorder, *unipolar mania*, in which people suffer from mania only, but this pattern is uncommon (APA,2000).

Mood disorders have always captured people's interest, in part because so many famous people have suffered from them. The Bible speaks of the severe depressions of Nebuchadnezzar, Saul, and Moses. Queen Victoria of England and Abraham Lincoln seem to have experienced recurring depressions. Mood disorders also have plagued such writers as Ernest Hemingway, Eugene O'Neill,Virginia Woolf, and Sylvia Plath. Their mood problems have been shared by millions, and today the economic costs (work loss, treatment, hospitalization) amount to more than $80 billion each year (Sullivan et aI., 2004; Greenberg et aI., 2003). Of course, the human suffering that the disorders cause is beyond calculation.

3.5.6.1. Unipolar Depression

Whenever we feel particularly unhappy, we are likely to describe ourselves as "depressed." In all likelihood, we are merely responding to sad events, fatigue, or unhappy thoughts. This loose use of the term confuses a perfectly normal mood swing with a clinical syndrome. All of us experience dejection from time to time, but only some experience unipolar depression.

Normal dejection is seldom severe enough to influence daily functioning significantly or persist very long. Such downturns in mood can even be beneficial. Periods spent in contemplation can lead us to explore our inner selves, our values, and our way of life, and we often emerge with a sense of greater strength, clarity, and resolve. Clinical depression, on the other hand, has no redeeming characteristics. It brings severe and long-lasting psychological pain that may intensify as time goes by. Those who suffer from it may lose their will to carry out the simplest of life's activities; some even lose their will to live.

What Are the Symptoms of Depression?

The picture of depression may vary from person to person. Earlier you saw how Beatrice's indecisiveness, uncontrollable sobbing, and feelings of despair, anger, and worthlessness brought her job and social life to a standstill. Other depressed people have symptoms that are less severe. They manage to function, although their depression typically robs them of much effectiveness or pleasure, as you can see in the case of Derek:

Derek has probably suffered from depression all of his adult life but was unaware of it for many years. Derek called himself a night person, claiming that he could not think clearly until after noon even though he was often awake by 4:00 A.M. He *tried* to *schedule his work as editorial writer for a small town newspaper* so *that it was compatible with his depressed mood at the beginning of the day. Therefore, he scheduled meetings for the mornings; talking with people got him moving.* He *saved writing and decision making for later in the day.*

Derek's private thoughts were rarely cheerful and self-confident. He *felt that his marriage was a mere business partnership.* He *provided the money, and she provided a home and children. Derek and his wife rarely expressed affection for each other. Occasionally, he had images of his own violent death in a bicycle crash, in a plane crash,* or *in a murder by an unidentified assailant. Derek felt that he was constantly* on *the edge of job failure.* He *was disappointed that his editorials had not attracted the attention of larger papers.* He *was certain that several of the younger people* on *the paper had better ideas and wrote more skillfully than he did.* He *scolded himself for a bad editorial that he had written ten years earlier. Although that particular piece*

had not been up to *his usual standards, everyone else* on *the paper had forgotten it a week after it appeared. But ten years later, Derek was still ruminating over that one editorial . ...*

Derek brushed off his morning confusion as a lack of quick intelligence. He *had* no *way* to *know that it was a symptom of depression.* He *never realized that his death images might* be *suicidal thinking. People do not talk about such things. For all Derek knew, everyone had similar thoughts. (Lickey* & *Gordon, 1991,pp. 183-185)*

As the cases of Beatrice and Derek indicate, depression has many symptoms other than sadness. The symptoms, which often exacerbate one another, span five areas of functioning: emotional, motivational, behavioral, cognitive, and physical.

Emotional Symptoms Most people who are depressed feel sad and dejected. They describe themselves as feeling "miserable,"" empty," and "humiliated." They tend to lose their sense of humor, report getting little pleasure from anything, and in some cases display *anhedonia,* an inability to experience any pleasure at all. A number also experience anxiety, anger, or agitation. This sea of misery may lead to crying spells.

Motivational Symptoms Depressed people typically lose the desire to pursue their usual activities. Almost all report a lack of drive, initiative, and spontaneity. They may have to force themselves to go to work, talk with friends, eat meals, or have sex. This state has been described as a "paralysis of will" (Beck, 1967). Terrie Williams, author of *Black Pain,* a book about depression in African Americans, describes her social withdrawal during a depressive episode:
I woke up one morning with a knot of fear in my *stomach* so *crippling that I couldn't face light, much less day, and* so *intense that I stayed in bed for three days with the shades drawn and the lights out. Three days. Three days not answering the phone. Three days not checking* my *e-mail. I was disconnected completely from the outside world, and I didn't care. Then* on *the morning* of *the fourth day there was a knock on my door. Since I hadn't ordered food I ignored it. The knocking kept up and I kept ignoring it. I heard the sound* of *keys rattling in my front door. Slowly the bedroom door opened and in the painful light from the doorway I saw the figures* of *two old friends. "Terrie, are you in there?" (Williams, 2008, p. xxiv)*

Suicide represents the ultimate escape from life's challenges. Many depressed people become uninterested in life or wish to die; others wish they could kill themselves, and some actually do. It has been estimated that between 6 and 15 percent of people who suffer from severe depression commit suicide (TaubeSchiff & Lau, 2008; Stolberg et aI., 2002).

Behavioral Symptoms Depressed people are usually less active and less productive.
They spend more time alone and may stay in bed for long periods. One man recalls, "I'd awaken early, but I'd just lie there-what was the use of getting up to a miserable day?" (Kraines & Thetford, 1972, p. 21). Depressed people may also move and even speak more slowly (Joiner, 2002).

Cognitive Symptoms Depressed people hold extremely negative views of themselves. They consider themselves inadequate, undesirable, inferior, perhaps evil. They also blame themselves for nearly every unfortunate event, even things that have nothing to do with them, and they rarely credit themselves for positive achievements. Another cognitive symptom of depression is pessimism. Sufferers are usually convinced that nothing will ever improve, and they feel helpless to change any aspect of their lives. Because they expect the worst, they are likely to procrastinate. Their sense of hopelessness and helplessness makes them especially vulnerable to suicidal thinking (Taube-Schiff & Lau,2008).

People with depression frequently complain that their intellectual ability is poor. They feel confused, unable to remember things, easily distracted, and unable to solve even the smallest problems. In laboratory studies, depressed individuals do perform more poorly than non-depressed persons on some tasks of memory, attention, and reasoning (Bremner et aI., 2004). It may be, however, that these difficulties sometimes reflect motivational problems rather than cognitive ones.

Physical Symptoms People who are depressed frequently have such physical ailments as headaches, indigestion, constipation, dizzy spells, and general pain (Fishbain, 2000). In fact, many depressions are misdiagnosed as medical problems at first. Disturbances in appetite and

sleep are particularly common (Neckelmann et aI., 2007; Genchi et aI., 2004). Most depressed people eat less, sleep less, and feel more fatigued than they did prior to the disorder. Some, however, eat and sleep excessively. Terrie Williams describes the changes in the pattern of her sleep:

At *first I didn't notice the change. Then things got worse. I always hated waking up, but slowly it was turning into something deeper; it was less like I didn't want* to *wake up, and more like I couldn't. I didn't feel tired, but I had no energy. I didn't feel sleepy, but I would have welcomed sleep with open arms. I had the sensation* of *a huge weight, invisible but gigantic, pressing down on me, almost crushing* me *into the bed and pinning* me *there. (Williams, 2008, p. xxii)*

Diagnosing Unipolar Depression

According to DSM-IV-TR, a *major depressive episode* is a period marked by at least five symptoms of depression and lasting for two weeks or more. In extreme cases, the episode may include psychotic symptoms, ones marked by a loss of contact with reality, such as *delusions-bizarre* ideas without foundation-or *hallucinations* perceptions of things that are not actually present. A depressed man with psychotic symptoms may imagine that he can't eat "because my intestines are deteriorating and will soon stop working," or he may believe that he sees his dead wife. People who experience a major depressive episode without having any history of mania receive a diagnosis of **major depressive disorder.** The disorder may be additionally categorized as *recurrent* if it has been preceded by previous episodes; *seasonal* if it changes with the seasons (for example, if the depression recurs each winter); *catatonic* if it is marked by either immobility or excessive activity; *postpartum* if it occurs within four weeks of giving birth; or *melancholic* if the person is almost totally unaffected by pleasurable events (APA, 2000). It sometimes turns out that an apparent case of major depressive disorder is, in fact, a depressive episode occurring within a larger pattern of bipolar disorder-a pattern in which the individual's manic episode has not yet appeared. When the person experiences a manic episode at a later time, the diagnosis is changed to bipolar disorder (Angst et aI., 2005; Bowden, 2005). People who display a longer-lasting (at least two years) but less disabling pattern of unipolar depression may receive a diagnosis of **dysthymic disorder.** When dysthymic disorder leads to major depressive disorder, the sequence is called *double depression* (Taube-Schiff & Lau, 2008; Dunner, 2005).

3.5.6.2.Bi polar Disorders

People with a *bipolar disorder* experience both the lows of depression and the highs of mania. Many describe their life as an emotional roller coaster, as they shift back and forth between extreme moods. A number of sufferers eventually become suicidal. Their rollercoaster ride and its impact on relatives and friends are seen in the following case study:

A person in the throes of mania has active, powerful emotions in search of an outlet.

The mood of euphoric joy and well-being is out of all proportion to the actual happenings in the person's life. One person with mania explained, "I feel no sense of restriction or censorship whatsoever. I am afraid of nothing and no one" (Fieve, 1975, p. 68). Not every person with mania is a picture of happiness, however. Some instead become very irritable and angry, especially when others get in the way of their exaggerated ambitions.

In the motivational realm, people with mania seem to want constant excitement, involvement, and companionship. They enthusiastically seek out new friends and old, new interests and old, and have little awareness that their social style is overwhelming, domineering, and excessive.

The behavior of people with mania is usually very active. They move quickly, as though there were not enough time to do everything they want to do. They may talk rapidly and loudly, their conversations filled with jokes and efforts to be clever or, conversely, with complaints and verbal outbursts. Flamboyance is not uncommon: dressing in flashy clothes, giving large sums of money to strangers, or even getting involved in dangerous activities.

In the cognitive realm, people with mania usually show poor judgment and planning, as if they feel too good or move too fast to consider possible pitfalls. Filled with optimism, they rarely listen when others try to slow them down, interrupt their buying sprees, or prevent them from investing money unwisely. They may also hold an inflated opinion of themselves, and sometimes their self-esteem approaches grandiosity. During severe episodes of mania, some have trouble remaining coherent or in touch with reality. Finally, in the physical realm, people with mania feel remarkably energetic. They typically get little sleep yet feel and act wide awake. Even if they miss a night or two of sleep, their energy level may remain high.

3.5.8. ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD)

The most recent revision of the *DSM* (APA, 2000) has once again reverted to sub typing the disorder. Currently classified as Attention-Deficit/Hyperactivity Disorder, the disorder recognizes three subtypes. The subtypes are identified on the basis of the degree to which the child demonstrates three core features of the disorder: inattention, hyperactivity, and impulsivity. The three subtypes are:

1. Primarily Inattentive Type
2. Primarily Hyperactive-Impulsive Type
3. Combined Type

As with many *DSM* disorders, there is an additional category, Not Otherwise Specified (NOS), for atypical cases that match most, but not all, of the symptoms. The *DSM-IV-TR* suggests that ADHD NOS be used for cases where onset is after 7 years of age or when inattentive symptoms are accompanied by *hypoactive* behavior patterns (e.g., sluggishness and daydreaming).

Case Study

For the third time in the past 5 minutes, Jeremy's fourth-grade teacher has had to tell him to sit in his seat and keep his hands to himself. It is as if Jeremy's feet are attached to springs. He doesn't walk; he bounces. He doesn't sit; he squirms. It's not just the motor activity that sets him apart from the rest of the class: Jeremy also has a motor mouth. He talks incessantly. He can't resist sharing his ideas with the class, whether they are welcomed or not, as soon as he thinks about them, regardless of whether the time is right, Jeremy blurts out answers, disrupts the classroom, and adds considerable stress to his teacher's already stressful job.

Jeremy is almost the polar opposite of his classmate Leonard. For Leonard, Jeremy's antics just fade into the background of other classroom stuff. Unlike Jeremy, Leonard is very quiet and rarely participates in classroom discussions, unless the discussions are about something that really interests him. Leonard spends most of his time staring out the window or off into space. The word *daydreamer* seems to fit Leonard perfectly.

Leonard always seems to be at least one step behind everyone else. Leonard is rarely on task; he drifts off in the middle of assignments and often has to be reminded to return to earth. Leonard is doing poorly academically. He just doesn't seem to tune in to whatever channel the rest of the class is on. Initially, the teacher thought that Leonard was a slow learner, until the class began to discuss different computer programs. The teacher was shocked at Leonard's sophisticated knowledge base and expertise in the area. That was when his teacher began to think that there was something else getting in the way of Leonard's academic success.

In this case study, Jeremy and Leonard share more than the same classroom and same teacher. As incredible as it might seem, they both probably share variations of the same disorder: Attention-Deficit/Hyperactivity Disorder (ADHD). How can two children who seem so different fall into the same diagnostic category? This is a question that has plagued theorists for the past 100 years. Although ADHD is among one of the most prevalent disorders in childhood, it continues to challenge professionals. It has been a topic for considerable discussion and controversy, especially regarding the over prescription of stimulant medications (Diller, 1996).

3.5.8.1.Primarily Inattentive Type

The *DSM-IV-TR* lists nine possible symptoms as diagnostic criteria for ADHD Inattentive Type. According to the *DSM-IV-TR* a diagnosis of ADHD Inattentive Type requires a match with six of a possible nine symptoms:

- ✓ Careless attention to details
- ✓ Problems sustaining attention over time
- ✓ Does not appear to listen
- ✓ Poor follow-through (schoolwork, homework, chores)
- ✓ Poorly organized
- ✓ Poor ability to sustain mental attention (e.g., homework, independent seatwork at school)
- ✓ Loses necessary materials (e.g., pencils, notebooks, assignment sheets, homework)
- ✓ Easily distracted
- ✓ Forgetful

In addition to having six of the nine symptoms listed here, the *DSM-IVTR* also stipulates that the child must meet four other conditions to be diagnosed with ADHD: (a) symptoms must have persisted for at least 6 months' duration, (b) symptoms must cause significant impairment (in relationships, performance, etc.), (c) the symptoms must be pervasive across situations, and (d) symptoms must be evident prior to 7 years of age.

Unlike their highly active and highly visible counterpart, children with the Inattentive Type of ADHD are often misunderstood and undiagnosed; they often suffer painful consequences of internalizing disorders and have academic problems.

According to Barkley (1998), the Inattentive Type of ADHD is characterized by a "sluggish" information-processing style (slow to process information) and problems with focused or selective attention. Therefore, against the backdrop of "academic noise," these children are unable to filter essential from nonessential details. Lack of attention to details often results from information overload and an inability to selectively limit the focus of attention. This processing deficit also reduces grade scores due to careless errors. Other academic concerns are evident in difficulties completing homework assignments (sustaining attention for boring tasks) and apparent lack of motivation. If homework assignments are completed, often under intense parent scrutiny, the disorganized student may forget to bring them to school or lose them somewhere in the mess of papers at the bottom of his or her backpack. Academic endeavors are a frustration for these children, their parents, and their teachers.

Do not forget

The symptoms of ADHD must have persisted for at least six months, must cause significant impairment, must be in excess of developmental expectations, and must occur in more than one setting (e.g., home and school). Symptoms must be evident prior to 7 years of age.

Children with the Inattentive Type of ADHD are often misunderstood. Frequently, inattention is misinterpreted as lack of motivation. Problems sustaining their attention, poor organizational skills, and ease of distractibility contribute to poor educational outcomes. These children often seem to be one step behind and regularly drift off into daydreaming when the task is monotonous or boring. Homework and seatwork assignments are often poorly attempted and often incomplete. These children often do poorly on tests, not only because of their tendency to miss important details but also because they have a very poor concept of time and manage time poorly. Many ADHD children do not complete tests in the allotted time, and lack of organizational skills also contributes to academic difficulty

3.5.8.2.Primarily Hyperactive-Impulsive Type

The *DSM-IV-TR* requires six of a possible nine symptoms for a diagnosis of ADHD Hyperactive-Impulsive Type. The nine symptoms include six hyperactive and three impulsive symptoms. The following are the symptoms of hyperactivity:

- ❖ Fidgety or squirmy behavior
- ❖ Problems remaining seated
- ❖ Excessive motion
- ❖ Problems engaging in quiet play
- ❖ Constantly being on the go
- ❖ Incessant talking

The following are the symptoms of impulsivity:

- ➢ Blurts out answers, comments
- ➢ Is impatient, has problems with turn taking
- ➢ Is intrusive to others

In case study above, Jeremy demonstrates many of the symptoms of ADHD Hyperactive-Impulsive Type: problems remaining seated, squirminess, always being in motion, incessant talking, blurting out answers, and problems with turn taking. If during the parent interview the clinician determines that Jeremy has always been that way, that Jeremy is the same way at home and school, and that this behavior is causing problems across situations (home, school, church), then it becomes increasingly likely that Jeremy has ADHD Hyperactive- Impulsive Type.

In addition to their social problems, children with ADHD Hyperactive- Impulsive Type also experience academic problems because of their impulsive nature. These children tend to rush through their assignments and often emphasize speed over accuracy. They often approach tasks incorrectly because they do not wait until all the directions are provided.

NB: Children with Hyperactive-Impulsive Type ADHD are at risk socially. Their inability to wait their turn does not make them very popular with their peers. Socially, children with ADHD often

present with poor social skills and experience difficulty making and maintaining friendships. Often these children will gravitate toward other troubled children, and they may engage in various forms of rule breaking and other behavioral problems.

3.5.8.3.Combined Type

According to the current *DSM-IV-TR* diagnostic criteria, children who meet the criteria for both ADHD Inattentive Type and ADHD Hyperactive-Impulsive Type meet the criteria for a diagnosis of ADHD Combined Type.

Developmentally different symptoms appear at different stages. While it may be possible to detect symptoms of hyperactivity-impulsivity by 3 years of age, problems with inattention are not likely to surface until school age.

Developmental considerations and associated features

For children with ADHD, the core features of over activity, impulsivity, and inattention will impact on learning and relationships based on the nature of developmental tasks emphasized at each stage of development.

Early Precursors to ADHD Hyperactive-Impulsive Type

Although ADHD is very difficult to diagnose prior to 3 years of age, retrospective parent interviews have identified a number of early precursors to the Hyperactive-Impulsive type of ADHD. As infants, children with difficult temperaments tend to be at greater risk for developing ADHD later on. Other early risk factors include excessive activity, poor sleep patterns, and irritability. Parents also report that these infants are more difficult to soothe when upset than their non-ADHD peers (Barkley, 1998). During the toddler period (1–2.5 years), children with ADHD demonstrate higher levels of under regulated behaviors (lack of self-control), and in the transition to preschool (3 to 6 years) lack of self-control persisted, at a time when non-ADHD peers were demonstrating increased maturity and greater self-control. During the preschool period, children with ADHD are described by parents and teachers as being more demanding, stressful, and problematic than their non-ADHD peers, especially in “free play” or unsupervised activities (Campbell, March, Pierce, Ewing, & Szumowski, 1991).

ADHD and the School-Aged Child (6 to 11 Years)

In the case study scenario, Leonard and Jeremy demonstrate many of the characteristic difficulties that ADHD children exhibit during the school age period. School-aged children are faced with the developmental task of increasing their sense of competence and mastery. However, children with ADHD face significant challenges in meeting increased academic and social demands. Although all children with ADHD are academically vulnerable, the nature of academic problems varies depending on how the symptoms of ADHD manifest. School-aged children with the Hyperactive-Impulsive Type of ADHD also experience academic difficulties, but the nature of their academic problems relates more to these children's impulsivity and their inability to inhibit responses that may compete with effective learning. Learning problems are evident in tendencies to jump into tasks prior to listening to all the directions and to rush through assignments, sacrificing accuracy for speed. These children often demonstrate low frustration tolerance and tend to abandon tasks that do not have an immediate solution. Their impulsive behaviors also place this group of children at greater risk for accidental injury (Barkley, 1998).

ADHD and the Adolescent (12–19)

At least half of the children diagnosed with ADHD will continue to meet the criteria for the disorder throughout adolescence. Adolescents with ADHD are poorly equipped to meet the challenges of managing the curriculum in middle school and high school, with its emphasis on increased workload and independent study skills. These students find that their poor work habits, lack of organizational skills, and poor follow-through often result in significant academic difficulties during this period. Other social and emotional concerns prevalent at this developmental stage include increased risk for reckless driving accidents and participation in other high-risk behaviors such as substance use that are reported to be higher in ADHD populations (Barkley, 1998).

A major developmental task in adolescence is the formation of a sense of personal identity, which includes the consolidation of a self-concept built on a foundation of peer acceptance and competence. Teens who have a history of poor academic outcomes and concomitant social problems are at increased risk for development of comorbid internalizing problems, such as anxiety and depression (Biederman, Faraone, & Lapey, 1992), and externalizing problems, such

as aggression, defiance, and forms of delinquent behavior (Barkley, Fischer, Edelbrock, & Smallish, 1990)

Prevalence and course

According to the *DSM-IV-TR*, estimates of ADHD in school-aged children range from 3% to 7% of the total population. Ninety percent of children identified with ADHD will be diagnosed with the Hyperactive-Impulsive Type. However, this figure may be somewhat misleading in terms of actual prevalence statistics, since many more children with the Inattentive Type can go undiagnosed because of the subtle nature of this subtype.

ADHD and Gender

Ratios of male to female frequency have been reported from 2:1 to 9:1. Currently, the question of whether there are gender differences in the prevalence rates for particular subtypes of ADHD symptoms continues to be an area of debate.

Course

According to Barkley (1998), the earliest age at which a diagnosis of ADHD might be possible is approximately 3 years, although symptoms of inattention are not likely to be noticed until much later. Approximately two thirds of elementary school–aged children who are diagnosed with ADHD have an additional diagnosable disorder (Cantwell, 1994). High rates of co morbidity with both internalizing and externalizing disorders make the course of this disorder particularly prone to poor outcomes. Given the comorbid nature of the disorder, the course of ADHD is best understood within the context of the different developmental pathways that might result based on the comorbid features.

ADHD and Co morbidity/co-existing problems

1. ***Academic and learning problems***

Academic problems are common in children with ADHD. As many as 30% of children with ADHD will repeat a grade; as many as 40% will be placed in special education programs; and as many as 30% may never finish high school (Barkley, 1998).

2. ADHD and specific learning disabilities

Prevalence rates for comorbid ADHD and specific learning disabilities (SLDs) are difficult to predict accurately, due to wide variations among published studies regarding how SLDs are defined and measured. Comorbid rates have been estimated to be between 16 and 21% for these two disorders (Frick et al., 1991).

3. ADHD and internalizing problems

Symptoms of depressive disorder and Bipolar Disorder present differently in children and adults. In children, symptoms of depression and Bipolar Disorder often overlap with symptoms of ADHD, making differential diagnosis difficult. One of the major symptoms of depression in children is irritability. Irritable behaviors often manifest in restlessness, agitation, short attention span, problems concentrating, and impulsive responses, which resemble symptoms of ADHD. Unlike the lengthy highs and lows of adult bipolar disorder, children with Bipolar Disorder often experience rapid cycles of shifting moods (elation to irritability), with brief and multiple mood swings. Bipolar symptoms of pressured speech (incessant talking), distractibility, and over activity can be easily mistaken for symptoms of ADHD. Symptoms of anxiety (distractibility, nervous agitation, restlessness, poor concentration) are also similar to symptoms of ADHD.

In one study, Biederman and colleagues (1995) found that up to 70% of depressed children also had comorbid ADHD. In another study, approximately 90% of the younger (prepubertal) children and 30% of the adolescent population referred for Bipolar Disorder had comorbid ADHD (Geller & Luby, 1997). Other studies have found higher rates of co morbidity for overanxious disorder and somatic complaints (e.g., headaches, stomach aches) than children without ADHD. In addition, many children who have ADHD also suffer from problems falling asleep and staying asleep.

NB: Internalizing problems represent the continuum of over controlled responses indicating "problems within the self, such as anxiety, depression, somatic complaints without known medical basis, and social withdrawal from contacts" (Achenbach & Rescorla, 2001, p. 93)

4. ADHD and externalizing disorders

Children and adolescents with comorbid ADHD and Disruptive Behavior Disorders (ODD and CD) are more seriously maladjusted (Moffit, 1990) and have significantly worse outcomes compared to children with ADHD alone (Barkley et al., 1990). Studies show that as many as 35 to 60% of children with ADHD will also have ODD, while as many as 50% of children with ADHD will go on to develop CD (Szatmari, Boyle, & Offord, 1989). It has been suggested that a diagnosis of ADHD in childhood can be as strong a predictor for substance use as having a family history of substance abuse. Barkley and colleagues (1990) found that hyperactive teens with ADHD were significantly more likely to use cigarettes and alcohol than their non hyperactive peers.

5. ADHD and social relationship problems

At least half of children with ADHD will also have problems in their relationships with peers. There can be a significant discrepancy between social skills and cognitive ability. Using this discrepancy criterion, Greene, Biederman, Faraone, Sienna, and Garcia-Jetton (1997) labeled this subtype "socially disabled" (ADHD+SD). Compared to children who have ADHD alone, Green and colleagues found that children with ADHD+SD demonstrate higher levels of substance abuse, family problems, anxiety, mood problems, and conduct problems.

Barkley's Model of ADHD

Barkley's (1997) model of ADHD focuses on understanding ADHD through the executive functions. The model is built around the concept of *behavioral inhibition*, a central feature of the disorder, and the ways deficits in behavioral inhibition relate to other executive functioning deficits and problems with sustained attention. Barkley is clear in delineating that this model was developed specifically to address deficits in processing that apply to the Hyperactive-Impulsive Type of ADHD. Barkley emphasized that this model does not attempt to explain the Inattentive Type of ADHD.

In Barkley's model, the child's degree of success in behavioral inhibition is central to determining the nature of outcomes of four central executive functioning tasks: working memory

(permits tasks of sequential ordering and planning), self-regulation (modulates activity states to initiate goal directed behavior and sustain effort), internalization of speech (slows down reactivity and promotes inner reflection), and reconstitution (analyzes and synthesizes information).

Deficits in behavioral inhibition result in poor problem-solving strategies based on an inability to integrate and coordinate information generated by the four central processes. Barkley addresses the role of inattention in his model by distinguishing between two forms of inattention that are qualitatively distinct: sustained attention and selective attention. While Barkley attributes deficits in selective attention (inability to filter essential from nonessential details) to the Inattentive Type of ADHD, he contends that children who have the Hyperactive-Impulsive Type of ADHD have problems with sustaining their attention over time. Barkley further distinguishes between sustained attention for essentially effortful tasks and what he calls "contingency based attention" or self-rewarding attention.

NB: The central feature of this model is the concept of behavioral inhibition. Barkley conceptualizes behavioral inhibition as the ability to inhibit a response (to refrain from responding or institute a delay) or stop an active response, and to maintain the delay over time. The delay (or termination) of the response is necessary as a manner of interference control, in order that goal directed behavior can be initiated and maintained (Barkley, 1997).

Barkley considers behavioral inhibition as the necessary first step in problem solving. Developmentally, behavioral inhibition is a precursor to the development of the other higher-order functions. The behavioral delay allows sufficient time to develop skills in the four major areas that are in turn focal points for the development and refining of other essential skills.

Barkley has emphasized that the behavioral inhibition model was developed to explain the Hyperactive- Impulsive Type of ADHD, not the Inattentive Type.

Diagnosis and Assessment of ADHD

Although an exhaustive review of assessment instruments is beyond the intention of this book, it is essential that clinicians obtain an accurate clinical picture of ADHD in order to rule out competing hypotheses. As has been discussed, ADHD shares many characteristic features with other disorders (Depression Bipolar Disorder, Anxiety, Post-traumatic Stress Disorder) and other problems of childhood and adolescence (abuse, maltreatment).

Detailed Clinical and Developmental History

A semi-structured interview should be conducted with the parent(s) or caregiver(s) to obtain information about the child's developmental history, including birth history, developmental milestones, medical history, educational history, social-emotional history, and family dynamics (including family stressors, clinical features, sibling relationships, and extended family). Obtaining parental expectations and impressions about the child's presenting problem is also important.

Treatment alternatives for ADHD

Treatment alternatives for ADHD will vary depending upon associated targets (comorbid features), symptoms, and the nature and extent of functional impairment. Interventions can be applied at home (parent training and family interventions), at school (behavior management and increasing on-task behaviors), and in interactions with peers (social skills training). Evidence-based research has for the most part focused on the effects of stimulant medications.

1. **Stimulant Medications**

A recent large-scale investigation of stimulant medications versus behavior therapy revealed that stimulant medication is more effective in alleviating the core symptoms of the disorder (MTA Cooperative Group, 1999). Stimulant medications can be found in various forms, including short-acting (Dexedrine and Ritalin) and slow-release forms (Ritalin-SR), and longer-acting forms (Ritalin-LA). Numerous studies have demonstrated positive effects of stimulant medication in controlling the core symptoms of ADHD in areas of impulsivity-hyperactivity (increased sustained attention, reduced restlessness) and inattention (increased attention, decreased off-task behavior, increased academic output; Elia & Rappaport, 1991; Pelham & Milich, 1991). In addition, behavioral benefits of stimulant medication have been demonstrated

in reduced aggressive behaviors (Hinshaw, Heller, & McHale, 1992) and improved parent child interactions (Barkley & Cunningham, 1978).

2. Behavior Management Programs and Functional Behavioral Assessments

While results of the MTA Cooperative Group studies (1999) revealed that medication was the single most effective treatment for ADHD, behavioral treatment did provide benefits in improving symptoms in other key areas, such as social skills, aggressive responses, and parent-child interactions.

3. Interventions in the Home and School Environments

Empirically, studies have demonstrated that parent training (PT) programs can be an effective method of improving parenting skills while reducing parent stress, core symptoms of ADHD, and noncompliance (Sonuga-Barke, Daley, Thompson, Laver-Bredbury, & Weeks, 2001). Successful interventions in the home and school environments often involve the use of contingency management programs based on information provided from a functional behavioral assessment. Treatment manuals are available to assist clinicians in developing programs for parents of children with oppositional behaviors, social problems, and parent child conflict (Barkley, 1997; Bloomquist, 1996).

While PT programs have demonstrated improved functioning at home, including teacher consultation in the PT program can also be helpful. Combining PT programs with teacher consultation allows for generalization of behaviors from the home to school environment. One of the more positive outcomes of parent and teacher collaboration is the enhanced communication between home and school that is monitored through the use of daily communication (often a student agenda can serve as the daily report for notes between parent and teacher). Studies have revealed that this combined approach can result in significant improvement in home and school behaviors (Pelham, Wheeler, & Chronis, 1998).

Case Study

Josh cannot concentrate on his homework and has to be continually monitored in order to stay seated, stop fidgeting, and get to work (sustained attention for effortful task). When he is playing video games, Josh is riveted to the screen and can play for an hour at a time (sustained attention for self-rewarding task).

3.5.9. PROBLEMS OF CONDUCT

Oppositional Defiant Disorder and Conduct Disorder: Two Unique Disorders or One?

Initially there was much debate regarding whether ODD and CD represented a continuum of severity, with ODD being a milder form or precursor to CD. More recently, several arguments have been raised in support of retaining the two disorders as distinct. One reason is that age of onset for ODD (typically 4- to 8-year range) is earlier than for CD (childhood onset, one symptom prior to age 10; adolescent onset, no conduct problem prior to age 10). Another reason is that 75% of children with ODD do not develop CD. Although ODD and CD share aggressive features, studies have revealed that these two disorders present with qualitatively distinct forms of aggressive behavior.

3.5.9.1. Oppositional Defiant Disorder (ODD)

The cardinal feature of ODD is a "persistent, hostile, defiant, disobedient and negative pattern of behaviors directed towards authority figures" (APA, 2000). Given this constellation of behaviors, it is not surprising that children with ODD create significant stress in any environment where compliance and rule-governed behavior are expected. The oppositional behavior pattern is persistent, relentless, and durable (must be evident for at least 6 months). Children with ODD display a number of behavioral symptoms that make them extremely difficult to manage because of their confrontational nature. A diagnosis of ODD (APA, 2000) requires four of the following eight symptoms, occurring on a frequent basis (often):

- Loss of temper
- Argumentative with adults/confrontational
- Defiant/refuses to comply with requests
- Deliberately annoying
- Blames others for mistakes or problems
- Touchy and easily irritated
- Angry and resentful
- Spiteful and vindictive

The behaviors must occur more frequently and in excess of what would be expected

The behaviors must occur more frequently and in excess of what would be expected given the child's age and developmental level. As would be anticipated, given the types of behaviors demonstrated

and the frequency and intensity with which they are expressed, significant impairment would be expected at home (family relationships), school (social and academic) and employment (part-time work, etc.).

Children with ODD are often stubborn and noncompliant. They can be very contrary and argumentative with others; however, they are quick to shift the blame to other people, defending their actions as necessary given others' unreasonable demands. These children may also appear to be passively aggressive, as they systematically ignore repeated requests to follow directions. They will not compromise, refusing to bend even a little, and often adhere stubbornly to a refusal to negotiate.

Oppositional Defiant Disorder behaviors initiate in the home and often carry over to familiar adults with whom they will push the boundaries and test the limits. These children may deliberately annoy others, especially well-known peers and siblings, who may also be a constant source for intimidation and verbal aggression. Children with ODD may present with either a low self-concept or a sense of inflated self-esteem. Often, like David, children with ODD will engage parents in battles that escalate into a high level of emotional turmoil on both sides. Parents often ultimately employ a coercive and negative parenting style in response to their children's aggressive and defiant behaviors. However, it has been well documented that these negative and coercive practices often serve to perpetuate the problem (Patterson et al., 1991).

Prevalence

Prevalence rates have been estimated between 2% to 16% of the population (APA, 2000). Prior to puberty, more males than females are diagnosed with ODD; however, the rates equalize in adolescence. High rates of comorbidity have been established for ODD with CD, learning disorders, and ADHD. Over 80% of children diagnosed with ODD have comorbid ADHD while 65% of children with ADHD will have ODD.

Developmental Course

Path analysis suggests a sequence of maladaptive behaviors that begins with ADHD, progresses to ODD, and ultimately culminates in CD (Loeber, Green, Lahey, Christ, & Frick, 1992). However, there is also evidence that discontinuity can exist (behaviors dissipate with age) in the milder forms of the maladaptive behaviors (Loeber & Stouthamer Loeber, 1998).

3.5.9.2. CONDUCT PROBLEMS AND CONDUCT DISORDER (CD)

Literature often uses the term *conduct problems* (CP) to refer to behaviors associated with the more serious end of the disruptive behavior spectrum. The diagnostic category used by the *DSM-IV-TR* (APA, 2000) for the more severe disruptive behavior disorder is conduct disorder.

According to the *DSM-IV-TR* (APA, 2000), the main clinical feature of CD is "a repetitive and persistent behavioral pattern" that involves the "violation of social norms or the rights of others." Criteria for CD are based on symptoms that fall into four categories of aggressive behaviors and violations of rules and age-appropriate norms:

• Acts of aggression toward others and animals bullying, threatening initiating fights use of a weapon to cause harm cruelty to others cruelty to animals theft while confronting (e.g., mugging) forced sexual activity

• Destruction of property fire setting with intent to harm property destruction

• Deceit or theft committing break-ins (e.g., house, car) conning others theft (e.g., shoplifting, forgery)

• Rule violations staying out all night* running away frequently playing truant*

A diagnosis of CD requires at least 3 of the preceding 15 criteria. The criteria must be present for the past 12 months, with evidence of at least one symptom within the previous 6 months. If the youth is older than 18 years, then CD can only be diagnosed if Antisocial Personality Disorder is not the more appropriate diagnosis. For items with the asterisk, behaviors should have evidence of occurring prior to 13 years of age.

Youth with CD often initiate aggressive acts and will often engage in physical altercations or threaten, bully, and intimidate others. Often these youth can manipulate others through skillful

ability to con others through lying, deceit, and a failure to follow through on promises and obligations. Rule violations begin at an early age (prior to 13 years of age). Youth may run away from home (at least twice) for a lengthy duration.

Youth with CD may show little remorse or empathy and demonstrate minimal concern for the feelings and thoughts of others. Aggressive tendencies may be heightened in situations that are more ambiguous, as they may have a bias toward reading hostile intent into the motives of others and react accordingly.

Often youth with CD may feign feelings of guilt or remorse in order to avert a harsher punishment or to divert blame to their companions. Other associated features include engaging in high-risk behaviors, which may include increased risk of accidents, substance use or abuse, sexually transmitted diseases, and teen pregnancy (APA, 2000).

There are two subtypes of the disorder based on age of onset (childhood versus adolescence) as well as specifiers for the disorder severity (*mild:* few criteria and minor harm; *moderate;* and *severe:* many criteria causing significant harm to others).

Prevalence

Prevalence rates for CD have been estimated to be between 1% and 10%. There are indications that the prevalence rate for CD has increased over the past (APA, 2000). Conduct disorder is one of the most frequent presenting concerns of youth who are referred to mental health settings. Males outnumber females; however, gender differences have been reported for different behavioral outcomes. Males tend to exhibit symptoms of vandalism, physical altercations, theft, and have more school discipline issues. Females with CD manifest symptoms in running away, substance use, truancy, and prostitution (APA, 2000).

Comorbidity

As with ODD, high rates of comorbidity exist for CD. Due to increasing age of the population, in addition to those areas of comorbidity already mentioned for ODD, youth with CD also have high comorbid associations with substance abuse and depression. Half of youth with CD have substance abuse problems (Reebye, Moretti, & Gulliver, 1995).

Developmental Course (Pathways and Progressions)

Within the realm of disruptive behavior disorders, CPs represent the most serious, complex, and problematic behaviors. Considerable research focus has been placed on the major pathways delineated by the onset of conduct problems: childhood onset, also called *early starters;* and adolescent onset, also referred to as *late starter*

Early-Onset Pathway: Early Starters

Longitudinal studies suggest that overt aggression should desist in a downward progression after the age of two. However, young children who evidence conduct problems at a very early age often persist and develop more serious conduct behaviors over time that generalize across situations, reaching further out into the community at large (Patterson & Yeorger, 2002). Outcomes for children and youth in this category are poor, and ingrained behaviors can be highly resistant to intervention.

Late-Onset Pathway: Late Starters

There is less research information available about this subgroup, who seem to have less deviance and end up getting into trouble by association with the more deviant peer group, often due to inadequate parental monitoring (Patterson, Capaldi, & Bank, 1991). This group may be more resilient because they have developed more adequate coping skills (socially and behaviorally) at earlier levels.

Etiology: Risk Factors and Protective Factors

Biological, Neurological, and Genetic Factors

Neurological investigations have found less frontal lobe activity in the brains of youth with CD (Moffit & Henry, 1989). Twin and adoption studies have also indicated that CD can be influenced by both genetic and environmental factors.

Increased risk for Disruptive Behavior Disorders has been noted in families where the biological or adoptive parent has Antisocial Personality Disorder or when biological parents suffer from alcohol dependence, Mood Disorders, Schizophrenia, or a history of ADHD (APA, 2000). Based on findings from studies conducted with adult populations, elevated levels of the hormone

testosterone (Dabbs & Morris, 1990) may be implicated in the genetic transmission of aggressive impulses. In addition, low levels of DBH (which converts dopamine to noradrenaline) may produce higher thresholds for sensation-seeking behaviors in some children (Quay, 1986).

Psychodynamic Theories

A *psychodynamically* oriented therapist might interpret aggressive and defiant behaviors as a manifestation of deep-seated feelings of lack of parental love, absence of empathy, and inability to trust (Gabbard, 1990).

Behavioral Theories

Within a behavioral framework, noncompliant and aggressive behaviors would develop in response to a prescribed set of learning principles. A clinician from a *behaviorist perspective* would attempt to isolate the factors in the environment responsible for reinforcing and sustaining the behavior. Within the family context, *coercion theory* (Patterson et al., 1991) might be used to explain how patterns of noncompliance and aggression have been sustained by the parents' repeated giving in to demands.

Cognitive Theories

Looking at hostile and aggressive behaviors from the vantage point of the *cognitive perspective,* emphasis would be placed on determining how maladaptive thoughts influence hostile and defiant behaviors. Studies by Dodge and colleagues (Dodge, 1991) have revealed that aggressive children often have a *hostile attribution bias* and misread ambivalent cues as being inherently hostile (e.g., a half smile is interpreted as a sneer) or rejecting. In these instances, children may respond in a hostile and defensive manner because they attribute hostile or rejection intentions to others.

Family Patterns, Attachment, and Parenting

A *family systems* clinician might focus on the parent-child relationship and childhood aggression may be interpreted as the child's attempt to shift the balance of power due to inconsistent, or extreme boundaries and or limit setting by parents. With respect to theories of attachment and parenting, research evidence has linked insecure attachment to aggressive preschool behaviors (Greenberg, 1999), while Baumrind (1991) would suggest that an *authoritarian parenting style* could set the stage for latent aggression giving way to expression in the adolescent years.

Treatment

Empirically Supported Treatments for Disruptive Behavior Disorders

One of the problems in finding evidence-based treatments specifically for ODD or CD has been that many findings are grouped under the broad category of Disruptive Behavior Disorders. Brestan and Eyberg (1998) reviewed and evaluated 82 studies involving more than 5,000 youth (with Disruptive Behavior Disorders: ODD and/or CD) according to criteria established by the APA Task Force of the American Psychiatric Association (1995) on evidence-based treatments. The authors found that the majority of programs reviewed were based on cognitive behavioral methods, with or without a parent component. The authors found two parent training programs that met the higher criteria: a parent training program developed to reduce behavior problems in young children (Webster Stratton, 1984) and a behavioral parent training program based on a manual called *Living with Children: New Methods for Parents and Teachers* produced by Patterson and Gullion (1968). The manual provides lesson plans for parents directed toward improving skills in areas of prioritizing and targeting behaviors for intervention and developing reinforcement programs to reduce unwanted and increase desirable behaviors. Brestan and Eyberg (1998) highlighted two programs as probably efficacious: a children's problem-solving skills program (Kazdin, Esveldt-Dawson, French, & Unis, 1987) and a program targeting anger control (Lochman, Burch, Curry, & Lampton, 1984). Both programs focus on skill training over a relatively large number of sessions. The Problem-Solving—Skills-Training (PSST; Kazdin, 1996) program is a 20-session program developed to teach children how to solve problems in a highly predictable and logical manner. The Coping Power (Larson & Lochman, 2002) program is a 33-session program developed to promote anger control.

Specific Interventions for Oppositional Defiant Disorder

Intervention programs for ODD have met with difficulties due to the highly resistant nature of the disorder (Rey, 1993) and have been highly criticized for not considering contextual factors that impact on high-risk families (Kazdin, 1996). However, programs specific to ODD have recently begun to attract increased attention.

In their review of existing interventions for ODD, Greene, Ablon, Goring, Fazio, and Morse (2003) criticize the majority of existing programs for targeting interventions almost exclusively at parenting practices in families that are often highly stressed and who drop out of programs at

high rates. The authors suggest that the results of many of these studies present a bias picture of only the most motivated families who completed the program. The authors suggest the need to target cognitive distortions and deficiencies evident in children with ODD. Greene and colleagues (2003) have developed an alternative intervention program, Collaborative Problem Solving (CPS; Greene & Ablon, 2004) to address deficiencies in the ODD child's processing in areas of emotion regulation, frustration tolerance, problem-solving, and flexibility. The CPS program is designed to increase parent awareness of the underlying parent/child characteristics that propel the ODD behavior through the development of three strategies to manage behaviors. Empirical investigations comparing the CPS program to parent training (PT) using Barkley's defiant-youth program (Barkley, 1997) revealed superior short-term and long-term improvement for ODD children, which was statistically and clinically significant.

Conduct Disorder

Children and youth with serious emotional and behavioral disorders have been serviced by a continuum of care from the least-restrictive (outpatient) to most restrictive (residential treatment centers [RTC]) alternatives. Until recently, the majority of empirical support for treatment effectiveness has come mainly from clinic-based studies. Despite the extensive use of RTC placements for the most severely disordered youth, empirical evidence has been minimal and lacking in experimental controls (U.S. Department of Health and Human Services, 1999). Home-based alternatives, such as family preservation programs, also have suffered from a lack of empirical support or have demonstrated inconsistent outcomes (Meezan & McCroskey, 1996). Yet studies of the effectiveness of multi systemic therapy (MST) have demonstrated that providing services in the community can be successful for juvenile offenders (Henggeler & Borduin, 1990) compared to hospitalization as an alternative (Schoenwald et al., 2000). Success of the MST approach, which focuses on multiple determinants of deviant behavior, has been attributed to ecological validity (community outreach) and cognitive behavioral methods.

Other community-based alternatives that have been supported empirically include comparisons by Chamberlain and Reid (1991, 1998) of the success of juveniles placed in specialized foster care programs (SFC) using methods developed by Patterson, Reid, Jones, and Conger (1975) compared to juveniles assigned to RTCs. In another study, Wilmshurst (2002) found that youth with severe emotional and behavioral disorders (EBD) who were randomly assigned to a community-based family preservation program (using cognitive behavioral methods) made

significant gains (statistically and clinically) compared to peers assigned to a 5-day residential alternative.

Multi systemic Therapy (MST)

Henggeler and colleagues (1998) have developed a manualized multidimensional program for working with juveniles in their community, involving family, schools, and peers. The multimodal program is a strengths-based approach to family empowerment and uses a wide variety of techniques: family therapy and cognitive and behavioral approaches (contingency management, anger management, etc.). The MST approach has been researched extensively, and there is wide empirical support for the use of MST across a wide variety of serious juvenile problems: sexual offenders, chronic offenders, violent offenders, and youth with comorbid substance use and abuse (Henggeler & Borduin, 1990; Schoenwald et al., 2000).

Summing up

- **Mood disorders** People with mood disorders have mood problems that tend to last for months or years, dominate their interactions with the world, and disrupt their normal functioning. *Depression* and *mania* are the key moods in these disorders.
- **Unipolar depression** People with *unipolar depression,* the most common pattern of mood disorder, suffer exclusively from depression. The symptoms of depression span five areas of functioning: emotional, motivational, behavioral, cognitive, and physical. Depressed people are also at greater risk for suicidal thinking and behavior. Women are at least twice as likely as men to experience severe unipolar depression.
- **Explanations of unipolar disorder** Each of the leading models has offered explanations for unipolar depression. The biological, cognitive, and sociocultural views have received the greatest research support.

According to the *biological view,* low activity of two neurotransmitters, *norepinephrine* and *serotonin,* helps cause depression. *Hormonal factors* may also be at work. So too may deficiencies of key proteins and other chemicals *within* certain neurons. Brain imaging research has also tied depression to abnormalities in a circuit of brain areas, including the *prifrontal cortex, hippocampus, amygdala,* and *BrodmannArea* 25. All such biological problems may be linked to *genetic factors.*

According to the *psychodynamic view,* certain people who experience *real or imagined losses* may *regress* to an earlier stage of development, *introject* feelings for the lost object, and eventually become depressed.

The *behavioral view* says that when people experience a large reduction in their positive rewards in life, they may display fewer and fewer positive behaviors. This response leads to a still lower rate of positive rewards and eventually to depression.

The leading *cognitive explanations* of unipolar depression focus on *negative thinking* and *learned helplessness.* According to Beck's theory of negative thinking, *maladaptive attitudes,* the *cognitive triad, errors in thinking,* and *automatic thoughts* help produce unipolar depression. According to Seligman's learned helplessness theory, people become depressed when they believe that they have lost control over the reinforcements in their lives and when they attribute this loss to causes that are *internal, global,* and *stable.*

Sociocultural theories propose that unipolar depression is influenced by social and cultural factors. *Family-social* theorists point out that a low level of social support is often linked to unipolar depression. And *multicultural* theorists have noted that the character and prevalence of depression often varies by gender and sometimes by *culture.*

- **Bipolar disorders** In *bipolar disorders,* episodes of mania alternate or intermix with episodes of depression. These disorders are much less common than unipolar depression. They may take the form of *bipolar I, bipolar II,* or *cyclothymic disorder.*

- Explanations **of** bipolar disorders Mania may be related to *high norepinephrine activity along with a low level of serotonin activity.* Some researchers have also linked bipolar disorders to *improper transport of ions* back and forth between the outside and the inside of a neuron's membrane; others have focused on deficiencies of key proteins and other chemicals within certain neurons; and still others have uncovered abnormalities in key brain structures. Genetic studies suggest that people may *inherit* a predisposition to these biological abnormalities.