Thoughts on behavioral issues in children

Joanne Edwards

https://www.youtube.com/watch?v=_JmA2ClUvUY&feature=youtu.be

2 year old boy

- Comes to GP because childcare are concerned that he is not speaking

Video

- https://www.youtube.com/watch?v=hpYpKHKR0S0#action=share

- From 16 seconds to 60 seconds

Further history

- Only child of scientists
- Parents were not concerned prior to childcare attendance in last few months and have little concerns at home
- No interest in toilet training
- Sleeps well
- Eats well
- Limited interactions and seems unhappy in childcare setting

Play
Shared enjoyment and recruitment

- https://www.youtube.com/watch?v=YtvP5A5OHpU
- From 1.00 to 1.46

Video – restricted play

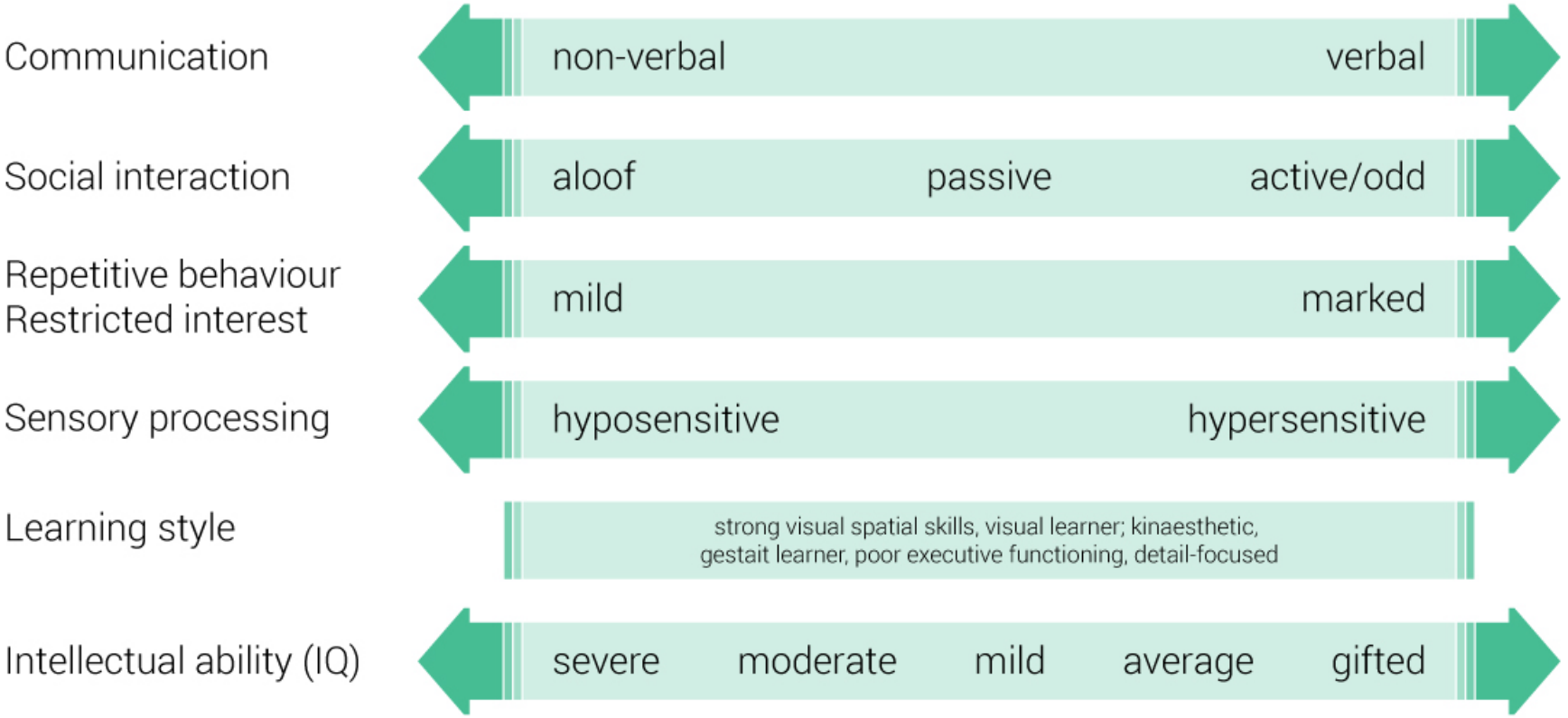
- https://www.youtube.com/watch?v=YtvP5A5OHpU
- From 6.58 to 7.38

Video – shared attention and enjoyment

- From ASD detect
- Showing video from 22 seconds until end

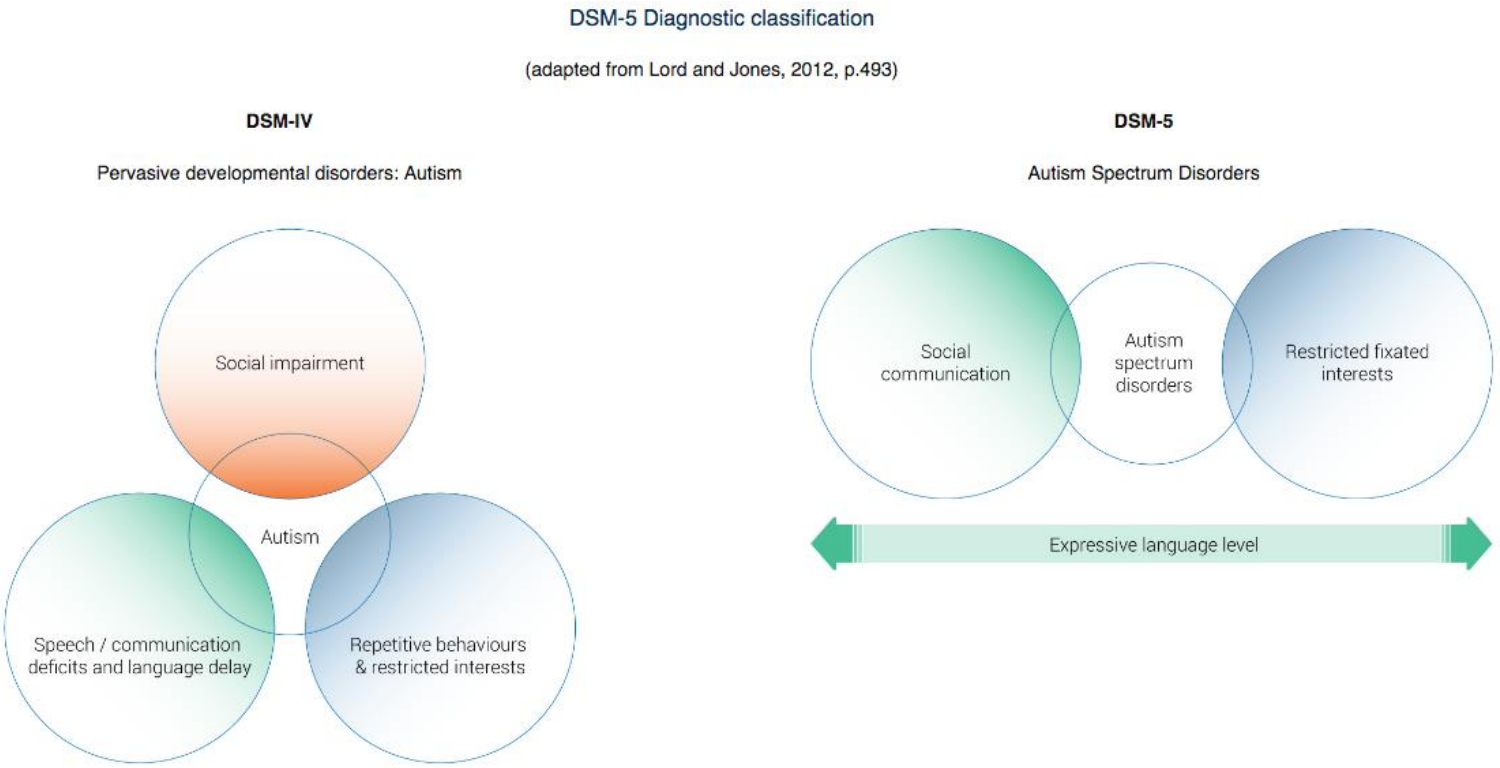
Categorical play

ASD diversity



https://gomelb.unimelb.edu.au/webapps/blackboard/content/listContent.jsp?course_id=_2485_1&content_id=_34267_1&mode=reset

DSM changes


DSM-5 Diagnostic classification
(adapted from Lord and Jones, 2012, p.493)
DSM-IV
Pervasive developmental disorders: Autism
Social impairment
Autism
Speech / communication deficits and language delay
Repetitive behaviours & restricted interests
DSM-5
Autism Spectrum Disorders
Social communication
Autism spectrum disorders
Restricted fixated interests
Expressive language level

Why do parents seek medical help in children who are later diagnosed with ASD

- Delay in talking/language problems (40.9%)
- Abnormalities in social development (19.3%)
- General behavioral problems (12.7%)
- Delays in motor milestones (7.1%)
- Concerns about hearing (5.6%)
- Ritualistic & obsessional behaviour (3.7%)
- Medical problems (eg epilepsy) (2.2%)
- Failure to develop normal play (1.5%)

Howlin, P. and Moore, A. (1997). Diagnosis in autism: a survey of over 1200 patients in the UK. Autism, 1(2), 135162.

Infancy signs

Some early characteristics of autism usually seen in the first two years are:

- fewer big smiles
- fewer back-and-forth sharing of sounds, smiles, or other facial expressions
- lack of back-and-forth gestures, such as pointing, showing, reaching, or waving
- lack of response to name
- lack of babbling or 'baby talk'.

Preschool signs

In preschool social communication can be a red flag. At this age, children with autism usually:

- are not interested in others; they prefer to play alone
- avoiding sensory play
- upset by sensory triggers, such as loud noises or being bumped in line
- upset by changes in routine or are very focussed on routines
- showing restricted interests in their play
- engage in imaginative play that is scripted from favourite shows.

Primary school signs

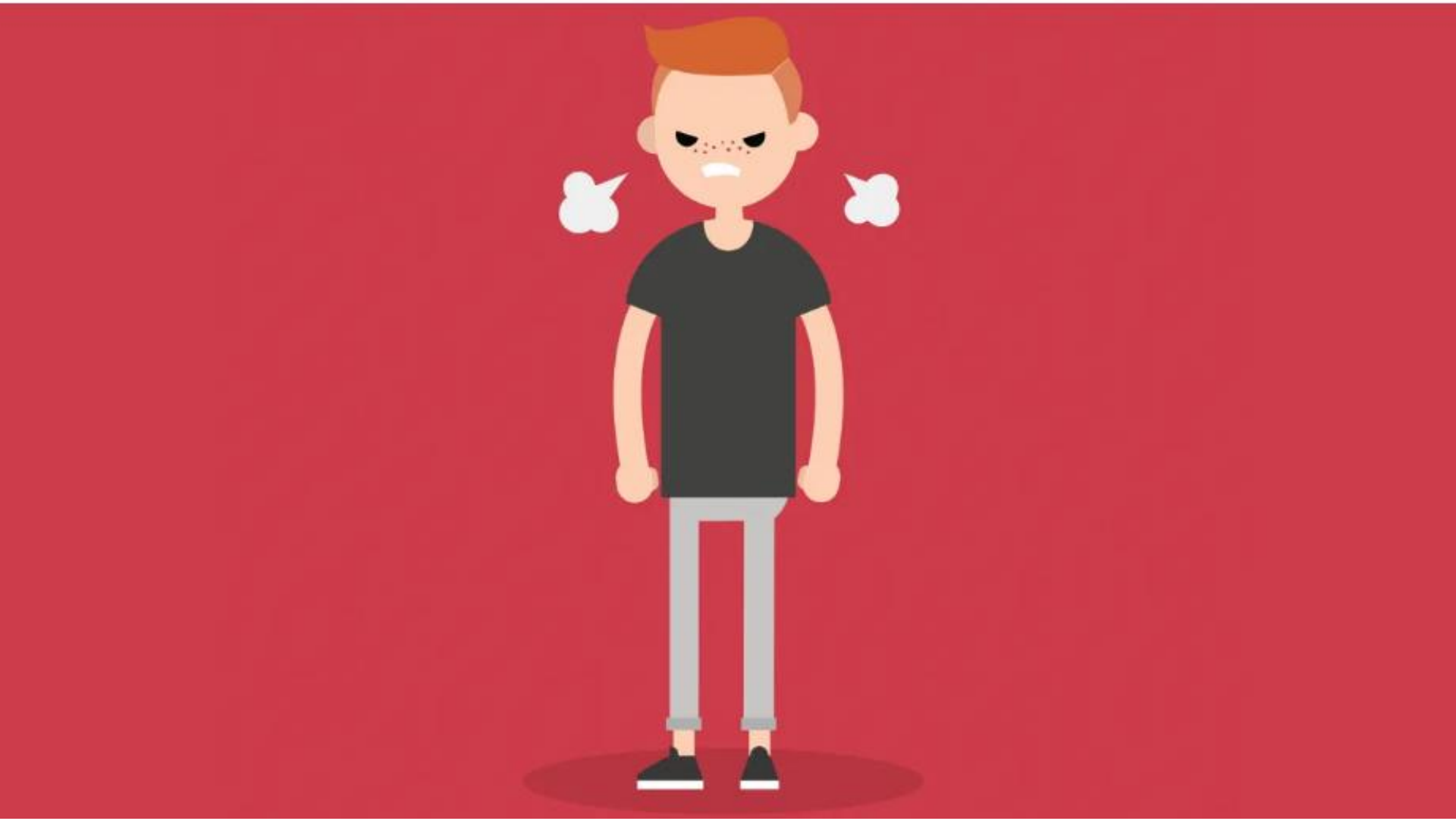
Primary school children with autism continue to exhibit issues, such as:

- not knowing how to play with others
- difficulties understanding and managing their own feelings as well as those of others'
- not playing 'pretend' games
- exhibiting a narrow range of interests
- struggling with change in routine and finding transitions very difficult (e.g., going from home to school, or stopping and starting an activity)
- using less facial expression and fewer gestures than their peers
- exhibiting more disruptive and obsessional behaviour.

Girls with ASD

- The general consensus is that females with ASD:
  - Are better able to imitate social actions, which hides their symptoms
  - Are more socially aware and have a greater interest in social interaction
  - May have one special friend
  - Are able to engage in pretend play and have better imaginations than their male counterparts
  - Often have similar interests to other girls, such as animals, horses etc. though their interest in these may be intense

Lai, M., Lombardo, M.V., Auyeung, B., Chakrabarti, B. and Baron-Cohen, S. (2015). Sex differences and autism; setting the scene for future research. *Journal of the American Academy of Child & Adolescent Psychiatry*, 54(1), 11-24.



Challenging behaviour at school

- 7 year old boy
- Feedback from a number of teachers regarding disruptive behaviours
  - Physically and verbally aggressive
  - Academically struggling
  - In school suspensions
  - Not well liked by other children
  - Similar issues in home setting

First steps

- Sleep history
- Successful parenting strategies for those behaviours at home
- Behavioral strategies used in the school setting
- Hearing and vision
- Developmental history – query global delays / intellectual disability; learning disabilities
- Mental health assessment – anxiety, social difficulties
- Stressors – family, learning, victimization
- Genetic vulnerability

Understand behaviours (and responses)

- Antecedents and triggers
- Behaviour
- Consequences

Possible diagnoses (DSM-5)

- ADHD
- Oppositional defiant disorder
  - Constant anger or irritability
  - Argumentative and defiant
  - Vindictive
- Conduct disorder – purposeful aggression
  - Destruction of property
  - Serious violation of rules
- Intermittent explosive disorder
- Disruptive mood dysregulation disorder

ADHD DSM-5

Table 1 Subtypes of attention deficit hyperactivity disorder (based on DSM-5)

Subtypes	Predominantly inattentive (ADD)	Predominantly hyperactivity/ impulsivity	Combined ADHD
Criteria	6 of 9 inattentive symptoms	6 of 9 hyperactivity/ impulsivity symptoms	Both criteria for (1) and (2)
Details	Fails to pay close attention to details or makes careless mistakes	Squirms and fidgets	
	Has difficulty sustaining attention	Can't stay seated	
	Does not appear to listen	Runs/climbs excessively	
	Struggles to follow through on instructions	Can't play/work quietly	
	Has difficulty with organization	"On the go"/"driven by a motor"	
	Avoids or dislikes tasks requiring a lot of thinking	Blurts out answers	
	Loses things	Is unable to wait for his turn	
	Is easily distracted	Intrudes/interrupts others	
		Talks excessively	
Other criteria	Onset before age of 12, lasting more than 6 mo, symptoms pervasive in 2 or more settings, causing significant impairment of daily functioning o development		

ADHD: Attention deficit hyperactivity disorder.

Oppositional Defiant Disorder

Diagnostic Criteria **313.81** (F91.3)

A. A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling.

Angry/Irritable Mood

1. Often loses temper.
2. Is often touchy or easily annoyed.
3. Is often angry and resentful.

Argumentative/Defiant Behavior

4. Often argues with authority figures or, for children and adolescents, with adults.
5. Often actively defies or refuses to comply with requests from authority figures or with rules.
6. Often deliberately annoys others.
7. Often blames others for his or her mistakes or misbehavior.

Vindictiveness

8. Has been spiteful or vindictive at least twice within the past 6 months.

Note: The persistence and frequency of these behaviors should be used to distinguish a behavior that is within normal limits from a behavior that is symptomatic. For children younger than 5 years, the behavior should occur on most days for a period of at least 6 months unless otherwise noted (Criterion A8). For individuals 5 years or older, the behavior should occur at least once per week for at least 6 months, unless otherwise noted (Criterion A8). While these frequency criteria provide guidance on a minimal level of frequency to define symptoms, other factors should also be considered, such as whether the frequency and intensity of the behaviors are outside a range that is normative for the individual's developmental level, gender, and culture.

B. The disturbance in behavior is associated with distress in the individual or others in his or her immediate social context (e.g., family, peer group, work colleagues), or it impacts negatively on social, educational, occupational, or other important areas of functioning.

C. The behaviors do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also, the criteria are not met for disruptive mood dysregulation disorder.

DSM-5 Criteria, found within Disruptive Disorders

Diagnostic Criteria for Disruptive Mood Dysregulation Disorder

296.99 (F34.8)

A. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.

B. The temper outbursts are inconsistent with developmental level.

C. The temper outbursts occur, on average, three or more times per week.

D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, peers).

E. Criteria A–D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A–D.

F. Criteria A and D are present in at least two of three settings (i.e., at home, at school, with peers) and are severe in at least one of these.

G. The diagnosis should not be made for the first time before age 6 years or after age 18 years.

H. By history or observation, the age at onset of Criteria A–E is before 10 years.

I. There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.

Note: Developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.

J. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder (e.g., autism spectrum disorder, posttraumatic stress disorder, separation anxiety disorder, persistent depressive disorder [dysthymia]).

Note: This diagnosis cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder, though it can coexist with others, including major depressive disorder, attention-deficit/hyperactivity disorder, conduct disorder, and substance use disorders. Individuals whose symptoms meet criteria for both disruptive mood dysregulation disorder and oppositional defiant disorder should only be given the diagnosis of disruptive mood dysregulation disorder. If an individual has ever experienced a manic or hypomanic episode, the diagnosis of disruptive mood dysregulation disorder should not be assigned.

K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition.

DSM-5 diagnostic criteria, found within Depressive Disorders

DSM-5 2013

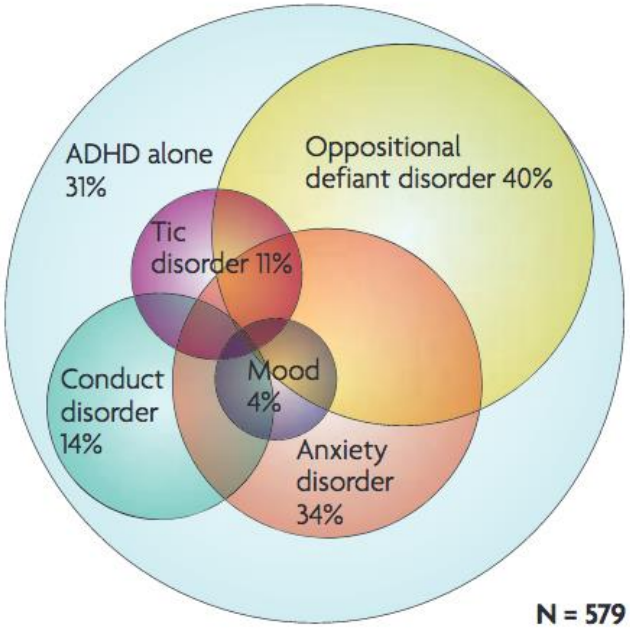


Figure 1 | **Co-occurring disorders in the Multimodal Treatment Study of children with ADHD.** Participants in the National Institute of Mental Health Multimodal Treatment Study for attention-deficit hyperactivity disorder (ADHD) reflect the complex mental-health profiles of US children with ADHD. Only a third of the children in the study had a diagnosis of ADHD alone. More than half of the children had conduct or oppositional defiant diagnoses in addition to having ADHD, and a significant proportion of those with conduct and oppositional diagnoses also had an anxiety disorder. Figure modified, with permission, from REF. 18 © (2001) Lippincott Williams & Wilkins.

Singh I. Beyond polemics: science and ethics of ADHD. Nature Reviews Neuroscience. 2008;9(12):957-964

Overlapping diagnoses

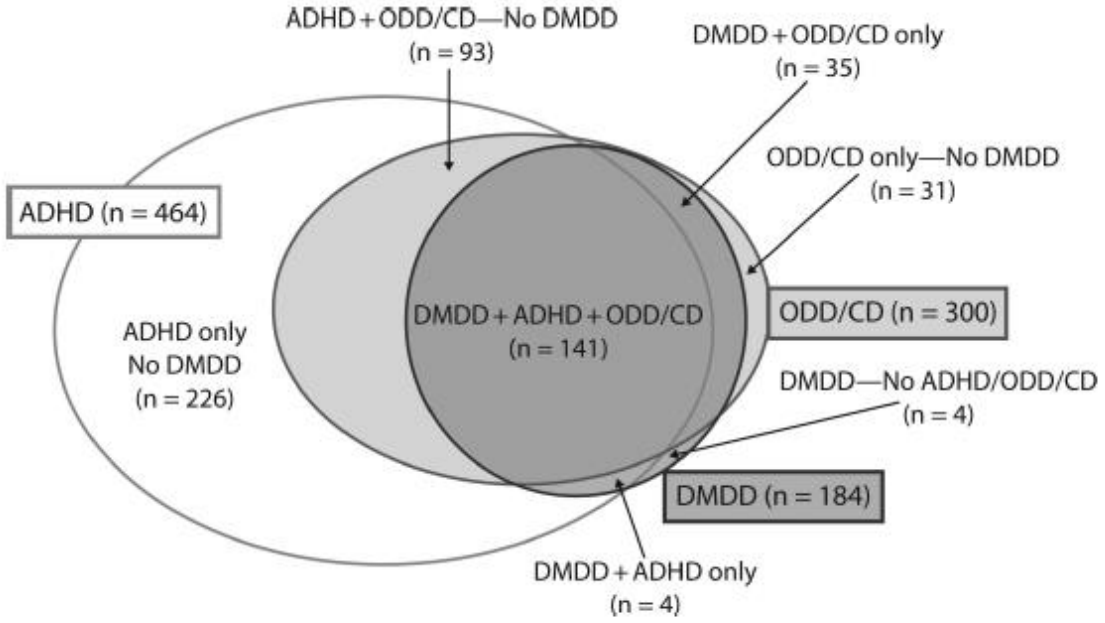


Figure 1.
Overlap of Disruptive Mood Dysregulation Disorder (DMDD), Attention-Deficit/ Hyperactivity Disorder (ADHD), and Oppositional Defiant Disorder (ODD)/Conduct Disorder (CD)

Almost all children with DMDD have ODD; conversely 34% of children with ODD do not have DMDD – query severity indicator

Axelson, D., *Taking disruptive mood dysregulation disorder out for a test drive.* Am J Psychiatry, 2013. **170**(2): p. 136-9.

ADHD and Co-occurring Conditions

More than two-thirds of individuals with ADHD have at least one other coexisting condition.

This infographic is supported by the Cooperative Agreement Number NU38DD00553756 from the Centers for Disease Control and Prevention (CDC). The contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

- ADHD and Coexisting Disorders. National Resource Center on ADHD: A Program of CHADD, 2015.
- ADHD, Sleep and Sleep Disorders. National Resource Center on ADHD: A Program of CHADD, 2015.
- American Speech-Language-Hearing Association
- Kooij JJ, Huss M, Asherson P, et al. (2012 July). Distinguishing comorbidity and successful management of adult ADHD. Journal of Attention Disorders. 16(5 Suppl):3S-19S.
- Mestre, Cristina. Substance Abuse Rates Higher in Teenagers with ADHD, Molina-Led Study Finds. PittChronicle, March 11, 2013.

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Anxiety

- 13 year old girl in year 7 refusing to attend school
  - Complaints of headaches, fatigue, abdominal pain, lightheadedness

Consider

- Organic pathology
  - Menstrual issues
  - Eating disorder
- Mental health issues
  - Generalized anxiety
  - Social anxiety disorder
  - Learning difficulties
  - ASD
  - Trauma, victimization

After history, exam, investigations and psychology assessment

- Generalized anxiety disorder diagnosed
  - Obsessive compulsive traits
  - Social withdrawal
  - Triggered by transition to high school and victimization on social media
  - Predisposed by personality and genetic vulnerability
  - Maintained by family accommodations, ongoing cognitions and avoidance behaviours
  - Complicated by poor sleep, restricted eating

Mental health disorder in Australian children and adolescents

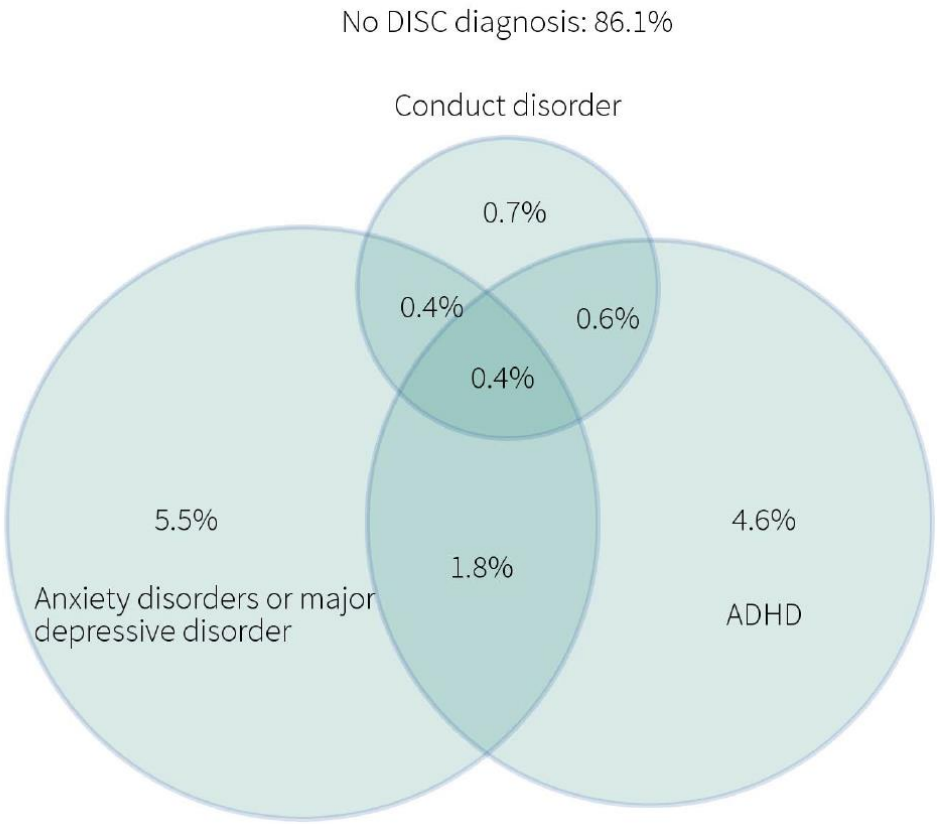
Table 2-2: 12-month prevalence of mental disorders among 4-17 year-olds by sex and age group

Disorder	Males 4-11 years (%)	Males 12-17 years (%)	Females 4-11 years (%)	Females 12-17 years (%)	Persons 4-11 years (%)	Persons 12-17 years (%)
Anxiety disorders	7.6	6.3	6.1	7.7	6.9	7.0
Major depressive disorder	1.1	4.3	1.2	5.8	1.1	5.0
ADHD	10.9	9.8	5.4	2.7	8.2	6.3
Conduct disorder	2.5	2.6	1.6	1.6	2.0	2.1
Any mental disorder	**16.5**	**15.9**	**10.6**	**12.8**	**13.6**	**14.4**

Lawrence et al, The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, 2015, Department of Health, Canberra

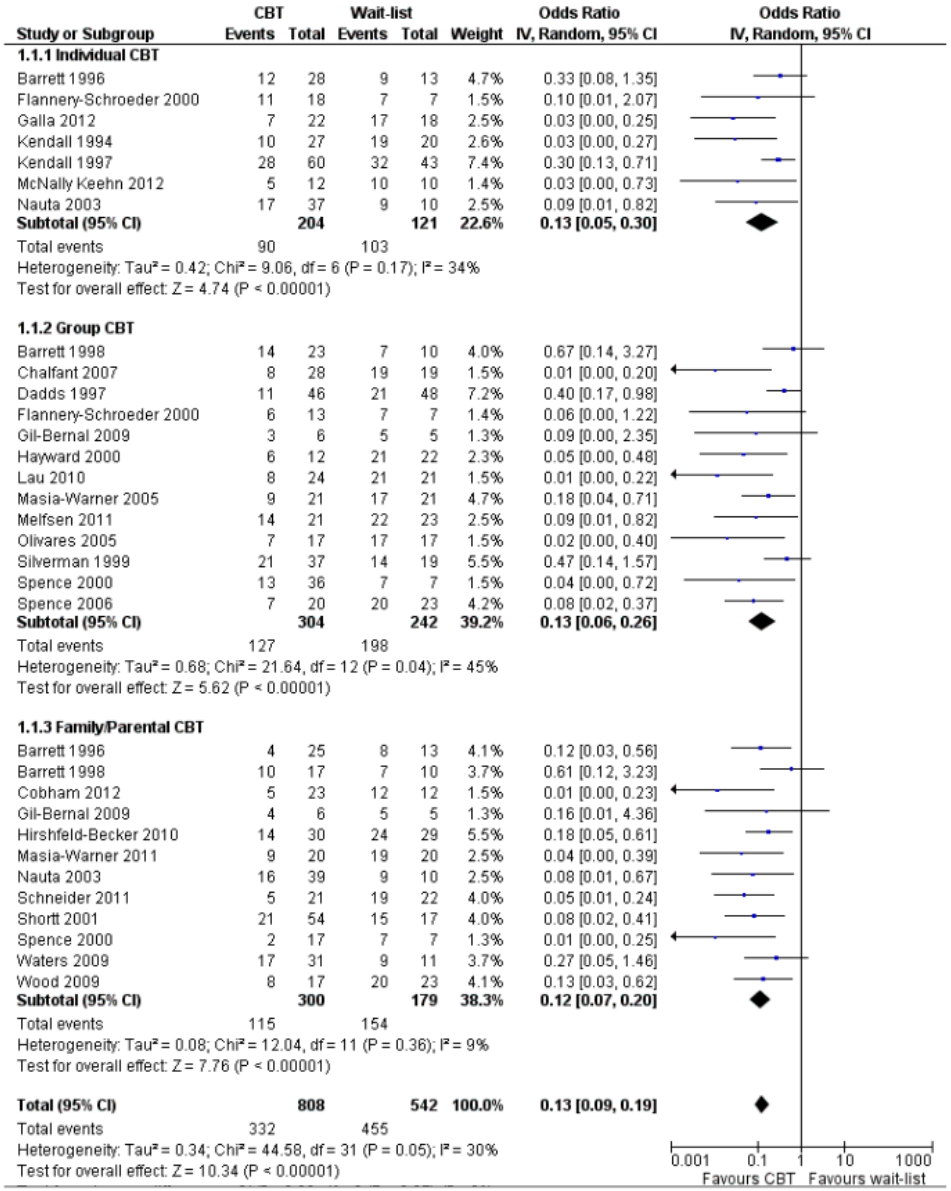
Comorbidity

Figure 2-2: Comorbidity of anxiety or major depressive disorders, conduct disorder and ADHD among 4-17 year-olds



Lawrence et al, The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, 2015, Department of Health, Canberra

Figure 4. Forest plot of comparison: 1 CBT versus wait-list, outcome: 1.1 Remission of anxiety diagnoses (ITT analysis).



Screen time

- Demonstrated associations with
  - Worse depression in adolescence
  - Obesity
  - Sleep interference

Increased internet use & brain development

- Reduced attentional capacities in ‘real’ world
- Long term storage and valuing of information may be diminished
- Impaired brain maturation and poor verbal intelligence

The "online brain": how the Internet may be changing our cognition

By: Firth, J (Firth, Joseph)[1,2,3]; Torous, J (Torous, John)[4]; Stubbs, B (Stubbs, Brendon)[5,6]; Firth, JA (Firth, Josh A.)[7,8]; Steiner, GZ (Steiner, Genevieve Z.)[1,9]; Smith, L (Smith, Lee)[10]; Alvarez-Jimenez, M (Alvarez-Jimenez, Mario)[3,11]; Gleeson, J (Gleeson, John)[3,12]; Vancampfort, D (Vancampfort, Davy)[13,14]; Armitage, CJ (Armitage, Christopher J.)[2,15,16] ...More
View ResearcherID and ORCID

WORLD PSYCHIATRY
Volume: 18 **Issue:** 2 **Pages:** 119-129
DOI: 10.1002/wps.20617
Published: JUN 2019

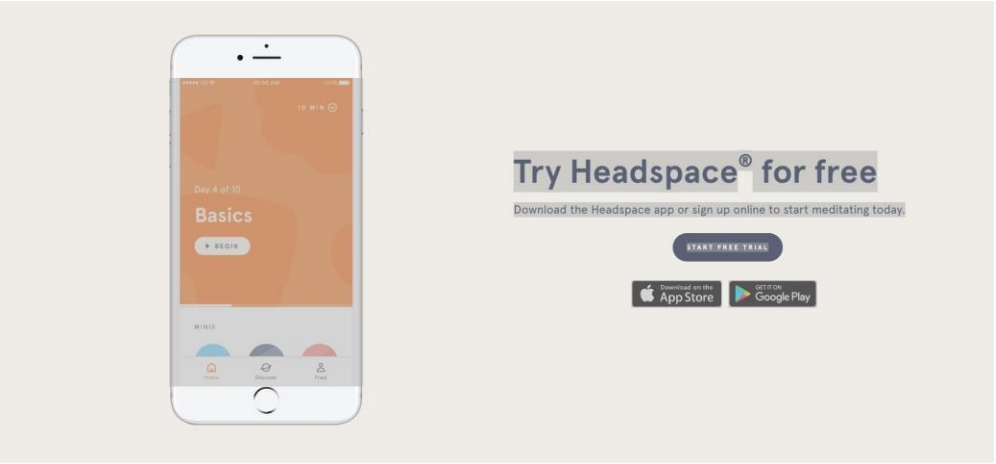
Social media

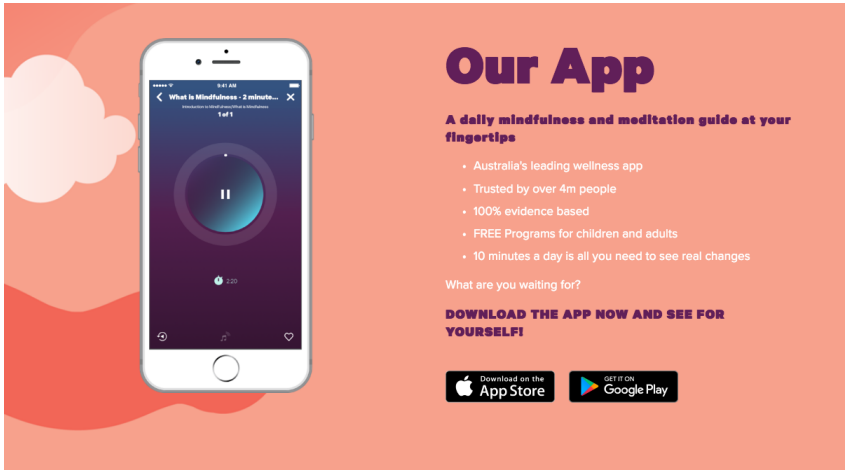
- Social comparisons
  - Negative evaluations of one's worth
  - Unattainable expectations
- Adolescents
  - Time on social media is probably related to severity of depression (Boers, et al 2019)

Mindfulness Apps

Headspace

Smiling Minds





Brave – online CBT - UQ

Image 2. Using the BRAVE Ladder Tool

https://brave4you.psy.uq.edu.au/uploads/brave-professionals-guide-2016.pdf

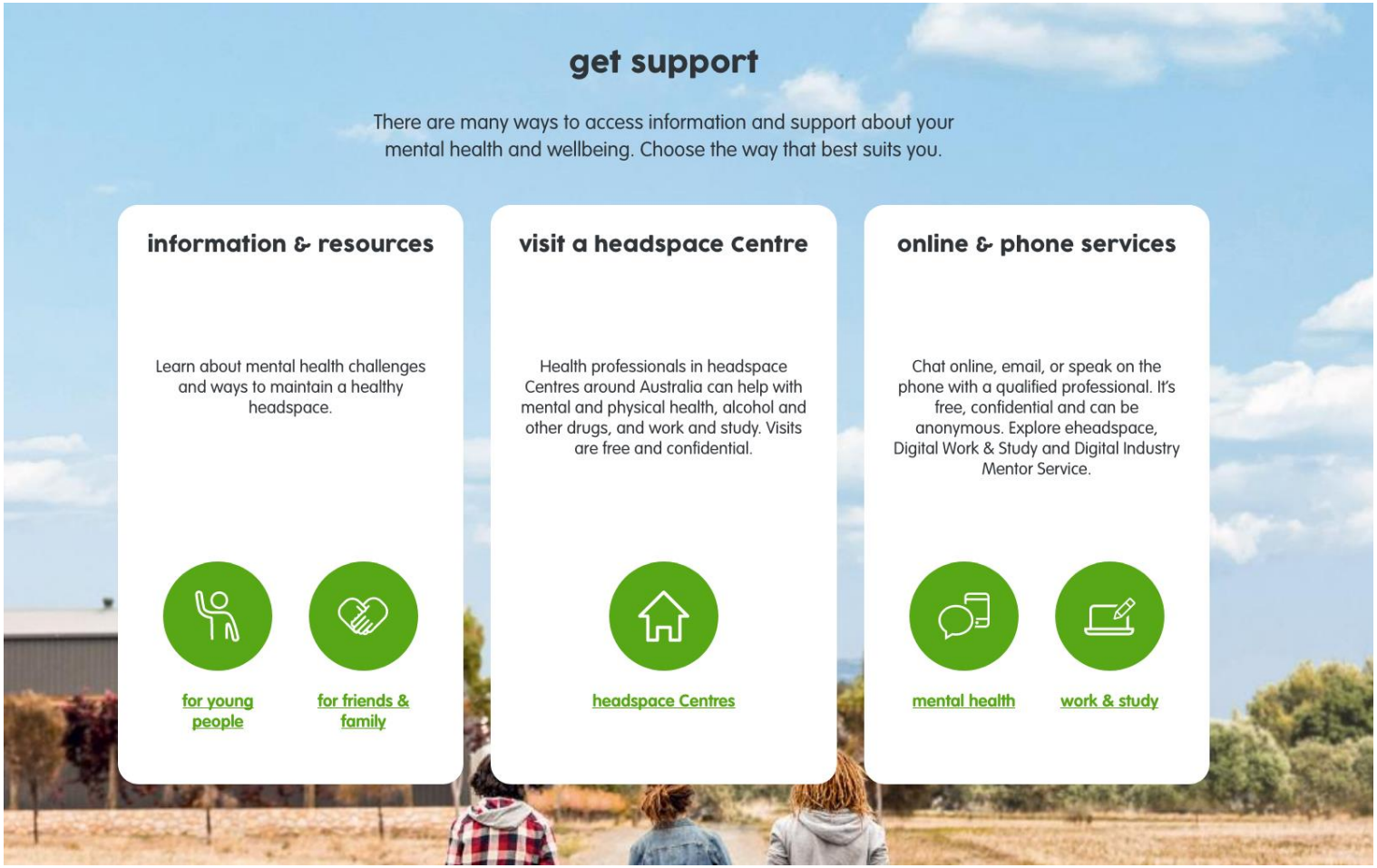
Brave - online CBT (UQ)

https://brave4you.psy.uq.edu.au/uploads/brave-professionals-guide-2016.pdf

Online support

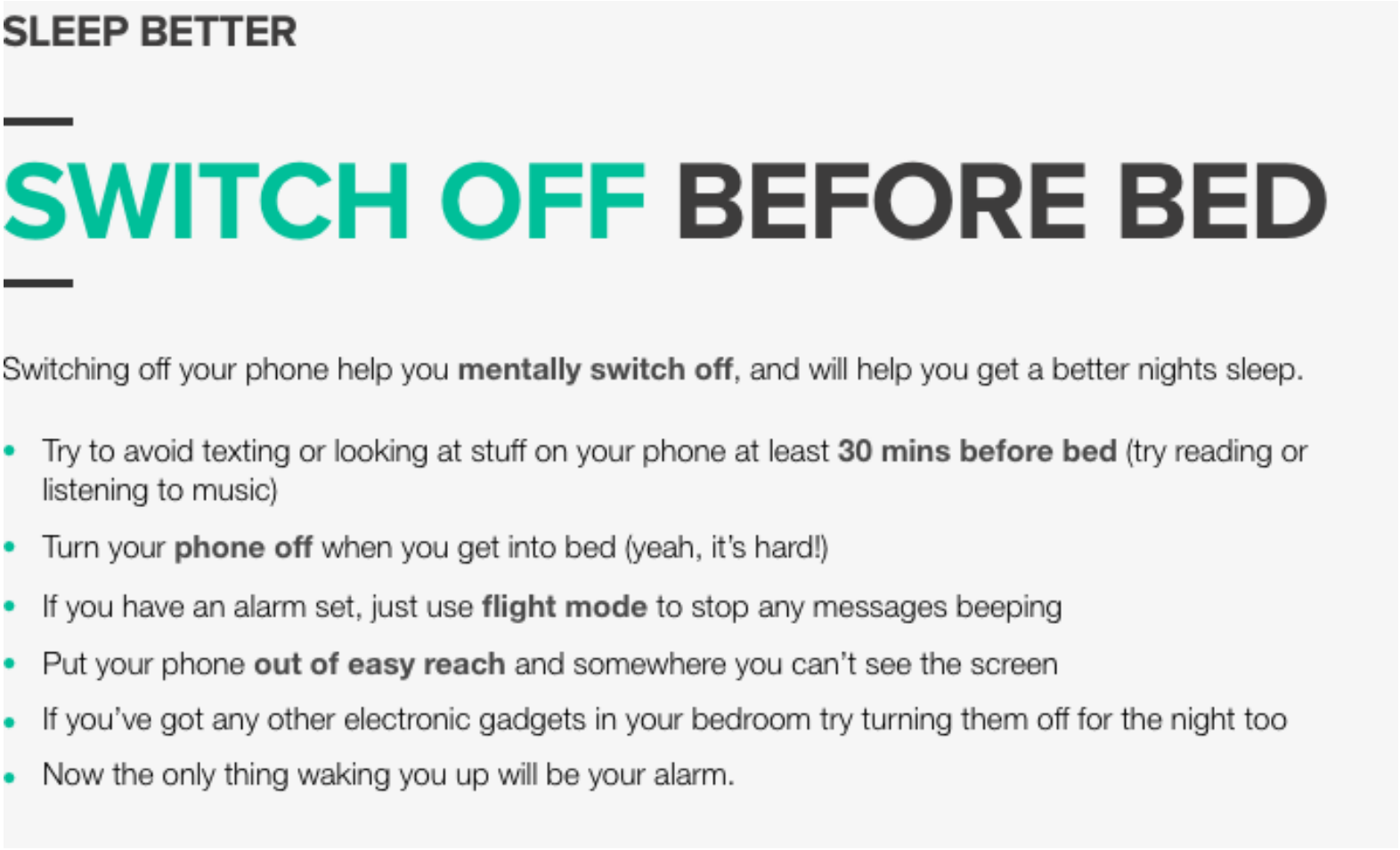
- Headspace
- The lowdown

Headspace



https://headspace.org.au/

The lowdown



SLEEP BETTER

SWITCH OFF BEFORE BED

Switching off your phone help you **mentally switch off**, and will help you get a better nights sleep.

- Try to avoid texting or looking at stuff on your phone at least **30 mins before bed** (try reading or listening to music)
- Turn your **phone off** when you get into bed (yeah, it's hard!)
- If you have an alarm set, just use **flight mode** to stop any messages beeping
- Put your phone **out of easy reach** and somewhere you can't see the screen
- If you've got any other electronic gadgets in your bedroom try turning them off for the night too
- Now the only thing waking you up will be your alarm.

https://thelowdown.co.nz/categories/lifejustsucks/lifejustsucks/switch-off-before-bed

Adjuncts to clinical care

- Blueice app
  - NHS app used between CAMHS appointments for youth with self harm
  - Monitor mood
  - Provide distress management tools and tips to manage self harm urges
  - Emergency contacts

Is screen time a problem in your house?

The health impacts of screen time:

a fact sheet for parents

There are no 'safe' amounts of screen time, and the amount of screen use that is right will vary from family to family. We suggest you ask yourself the following questions:

1: Is screen time in your household controlled?

This means BOTH the screen use of children, teenagers AND adults in the family.

2: Does screen use interfere with what your family want to do?

This will obviously vary from family to family, but remember, for younger children, face-to-face social interaction is vital to the development of language and other skills, and screen-based interaction is not an effective substitute for this.

3: Does screen use interfere with sleep?

We recommend that screens are avoided for an hour before a planned sleep time.

4: Are you able to control snacking during screen time?

It can be very easy to lose track if meals are eaten in front of screens!

https://www.rcpch.ac.uk/sites/default/files/2018-12/rcpch_screen_time_parent_fact_sheet_-_final.pdf

Want to reduce screen time?

Have a plan and stick to it: It is helpful to sit down in calm moment, as a family, and discuss the boundaries of screen use that you will be adopting, using the above questions as a guide. It is important that: everyone understands the boundaries; family members are praised and, if appropriate, rewarded for respecting these boundaries; and boundaries are consistently applied and, if necessary, consequences are put in place.

Be aware, but not intrusive or judgmental, when it comes to teenagers' use of the internet

Think about your own media use: maybe what you are doing on your phone is important, but can it wait?

Prioritise face-to-face interaction: online interaction is great, but no substitute for the real thing!

Be snack aware: If you are going to combine snacks with screen use, do so as part of an overall diet plan.

Protect sleep: No screens for an hour before planned sleep time is a sensible rule of thumb

https://www.rcpch.ac.uk/sites/default/files/2018-12/rcpch_screen_time_parent_fact_sheet_-_final.pdf