

# **Human Behavior Course 2004**

## **Childhood Disorders**

**Doug Waldrep, MD  
Colonel, Medical Corps, US Army  
Department of Psychiatry  
Walter Reed Army Medical Center**

# HUMAN BEHAVIOR COURSE 2004

## CHILDHOOD DISORDERS - SLIDES

### LEARNING OBJECTIVES AND STUDY QUESTIONS FOR DISCUSSION.

1. Know the meaning of the terms and concepts listed in slides one and two below.
2. How does clinical depression differ in children versus the more “classic” presentations that occur in adolescents and adults?
3. How does clinical mania & bipolar disorder differ in children and adolescents versus presentations in adults?
4. Contrast mood disorder comorbidity in children and adolescents with mood disorder in adulthood.
5. Describe the epidemiology of suicidal ideas, attempts, and completed suicide in childhood and adolescence.
6. What is known about the use and efficacy of antidepressants for childhood depression?
7. What are the main mood stabilizing medications used for children with bipolar disorder?
8. List the childhood disorders covered in the text and categorize them as ‘very common’ (point prevalence > 5%), ‘common’ (1-5%) or ‘uncommon’ (<1%) in the general population.
9. Which childhood disorders are more common in boys? In girls? Which disorders occur in a similar proportion of boys and girls?
10. Describe aspects of social phobia and generalized anxiety disorder that is unique to children?
11. What are the diagnostic features of separation anxiety disorder? How is it different from school phobia?
12. What is selective mutism? In what age range is it most common? What are the most common treatment approaches employed? What are the commonly comorbid mental disorders?
13. For many childhood anxiety and mood disorders there are few clinical trials evaluating antidepressant therapies. Even so, SSRIs have generally overtaken TCAs as the antidepressant medications of choice for children. Why?
14. What is reactive attachment disorder of infancy or early childhood? What does the case-criteria for this disorder share with the case-criteria for PTSD? What are the most important treatment approaches?
15. Do personality disorders diagnosed in childhood? Which personality disorder is the exception? Why?
16. What are the diagnostic features of attention-deficit hyperactivity disorder? What evidence suggests this disorder is a biological condition?
17. Are stimulant medications over-prescribed in US children? Take a position and defend it using statistics provided in the text, lecture, and notes.
18. What comorbid psychiatric disorders are most common in children with ADHD?
19. What psychosocial therapies are available for children with ADHD and their families?
20. What pharmacotherapies are most effective for ADHD? Which one is most frequently prescribed?
21. What medication alternatives to stimulants exist for ADHD?
22. What are the diagnostic features of conduct disorder?
23. What factors predispose a child to conduct disorder? What factors are associated with poor prognosis?
24. How do boys and girls manifest conduct disorder differently?
25. What is the general approach to treatment of conduct disorder? What are the common barriers to effective treatment?
26. What are the diagnostic features of oppositional-defiant disorder (ODD)? What differentiates it from conduct disorder? From antisocial personality disorder?
27. What is the most common comorbid psychiatric disorder in children with ODD?
28. What is a common factor that predisposes a child to ODD?
29. Name the Feeding and Elimination Disorders (FED). Describe the key diagnostic features of each.
30. Which of the FEDs is associated with a high mortality?

## Childhood Disorders – Terms & Concepts

- ★ major depressive disorder
- ★ bipolar disorder
- ★ dysthymic disorder
- ★ tricyclic antidepressants
- ★ selective serotonin reuptake inhibitors
- ★ obsessive-compulsive disorder
- ★ panic disorder
- ★ post-traumatic stress disorder
- ★ generalized anxiety disorder
- ★ benzodiazepines
- ★ buspirone
- ★ social phobia
- ★ schizophrenia
- ★ separation anxiety disorder
- ★ behavioral inhibition
- ★ school refusal
- ★ transition object
- ★ selective mutism
- ★ reactive attachment disorder
- ★ attachment
- ★ pathogenic care
- ★ attention-deficit hyperactivity disorder (ADHD)
- ★ inattention
- ★ hyperactivity
- ★ impulsivity
- ★ frontal-striatal pathways
- ★ akathisia
- ★ psychostimulants
- ★ methylphenidate
- ★ RitalinSR®



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## Childhood Disorders – Terms & Concepts

- ★ Concerta®
- ★ Metadate CD®
- ★ Ritalin LA®
- ★ dextroamphetamine (Dexedrine®)
- ★ Aderall® & Aderall XR®
- ★ dexmethylphenidate (Focalin®)
- ★ pemoline (Cylert®)
- ★ Parents Rating Scale
- ★ Wender Utah Rating Scale
- ★ conduct disorder
- ★ antisocial personality disorder
- ★ oppositional-defiant disorder
- ★ feeding & elimination disorder
- ★ pica
- ★ rumination disorder
- ★ encopresis
- ★ enuresis
- ★ insufficient nocturnal antidiuretic hormone
- ★ imipramine
- ★ desmopressin (DDAVP)



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## Overview -Childhood Disorders

- Serious and Treatable Conditions
- Precursors of Adult Psychopathology
- Co-morbidity
- "Adult" Psychiatric Disorders Apply



## Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescents

- Disruptive Behavior Disorders
- Feeding and Eating Disorders
- Tic Disorders
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence



## Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescents

### Developmental Disorders

- Mental Retardation\*
- Learning Disorders\*
  - (Academic Skills Disorders)\*
- Motor Skills Disorder\*
- Pervasive Developmental Disorders\*
- Communication Disorders\*

\*to be discussed in detail elsewhere



## Vignette Name that DX

The parents of an 8 y/o girl are called to the school to discuss her progress. The teacher reports she rarely turns in her assignments, never has the proper school supplies and needs to be told things repeatedly to make sure she gets things done. Her grades are poor and there is concern she does not read well. The teacher asks with some concern, "Are things OK at home?"

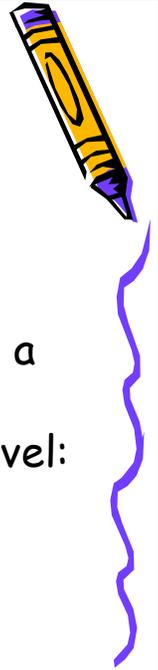
Her parents, perplexed, deny any problems at home. They report their daughter has always been somewhat of an "airhead"; not seeming to listen to things at home, needing to be told to do things repeatedly, often cannot find her schoolwork. Mom needs to pack her school bag to make sure the correct things make it to school. Unable to stay focused on schoolwork unless a parent sits with her. They report she has "always been that way" and they will be happy if she can just "get by"



## Diagnostic Criteria for Attention-Deficit/Hyperactivity Disorder

### A. Either (1) or (2):

- 1. Six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:



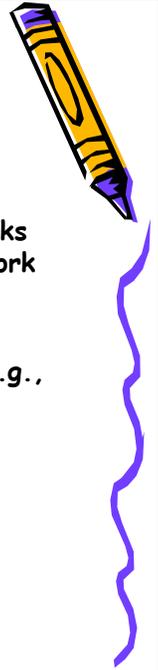
## Inattention

- a. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
- b. often has difficulty sustaining attention in tasks or play activities.
- c. often does not seem to listen when spoken to directly
- d. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)



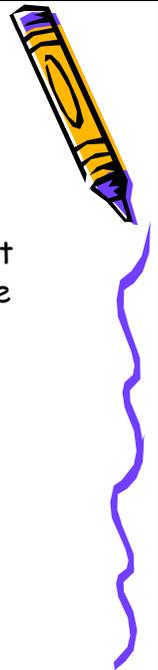
## Inattention continued

- e. often has difficulty organizing tasks and activities
- f. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- g. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
- h. is often easily distracted by extraneous stimuli
- i. is often forgetful in daily activities



## Hyperactivity-impulsivity

- 2. six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:



## Hyperactivity

- a. often fidgets with hands or feet or squirms in seat
- b. often leaves seat in classroom or in other situations in which remaining seated is expected
- c. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- d. often has difficulty playing or engaging in leisure activities quietly
- e. is often "on the go" or often acts as if "driven by a motor"
- f. often talks excessively



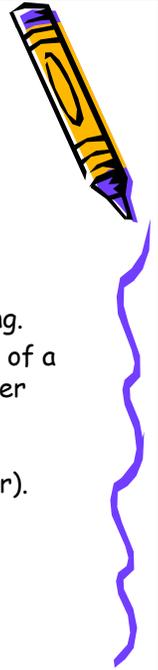
## Impulsivity

- g. often blurts out answers before questions have been completed
- h. often has difficulty awaiting turn
- i. often interrupts or intrudes on others (e.g., butts into conversations or games)



## Criteria B-E

- B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present **before age 7 years**.
- C. Some impairment from the symptoms is present in **two or more settings** (e.g., at school [or work] and at home).
- D. There must be clear evidence of **clinically significant** impairment in social, academic, or occupational functioning.
- E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).



## CODING

- Code based on type:
  - Attention-Deficit/Hyperactivity Disorder, **Combined Type**: if both Criteria A1 and A2 are met for the past 6 months
  - Attention-Deficit/Hyperactivity Disorder, **Predominantly Inattentive Type**: if Criterion A1 is met but Criterion A2 is not met for the past 6 months
  - Attention-Deficit/Hyperactivity Disorder, **Predominantly Hyperactive-Impulsive Type**: if Criterion A2 is met but Criterion A1 is not met for the past 6 months
  - Coding note: For individuals (especially adolescents and adults) who symptoms that no longer meet full criteria, "**In Partial Remission**" should be specified.



## Attention-Deficit/Hyperactivity Disorder summary

- Primary problem with inattention or hyperactivity/impulsivity or combination
- Impairment present before 7 y/o
- Six or more symptoms in each category
- Persisted for more than 6 months
- Disrupts/impairs life of patient
- Occurs in at least two different places



## ADHD - Epidemiology

- 10% boys and 2% girls carry disorder diagnosis in U.S.
- 6% of school population
- M:F > 4:1 (general pop.) to 9:1 (clinical populations)
- Dx increasing in females.
- Probable gender bias



## ADHD - Etiology

- No clear simple etiology identified
- Genetic contribution based upon family studies. Seems to transmit in M>F.
- Families have higher rate of psychopathologies.



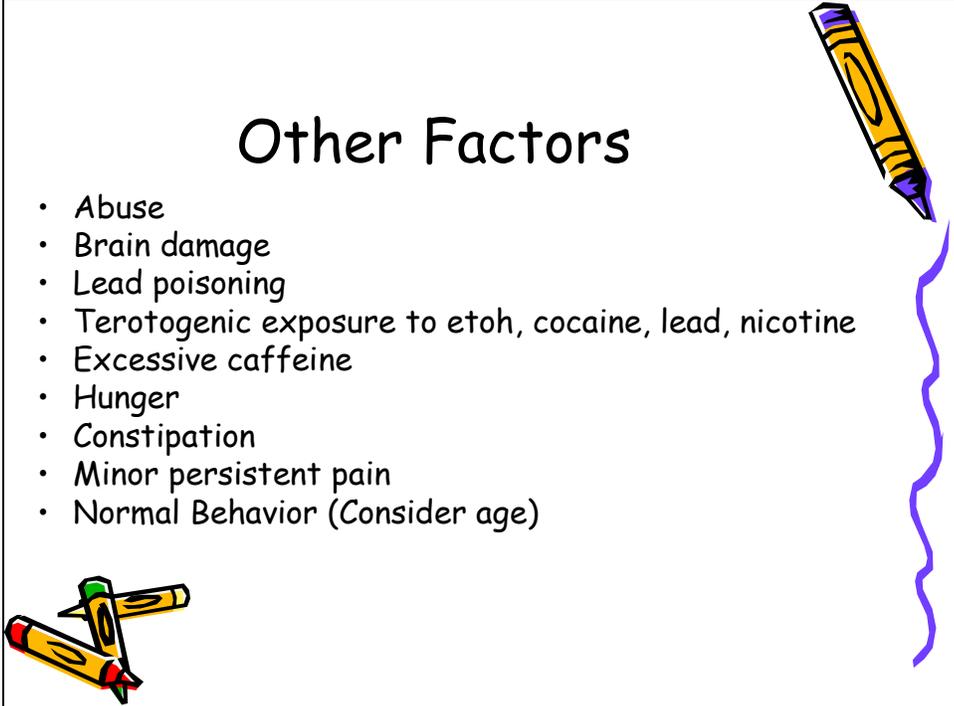
## General Medical Factors

- Medications
  - Recreational stimulants
  - Medical stimulants (pseudoephedrine)
  - Barbiturates, benzodiazepines
  - Carbamazepam
  - Theophylline
- Thyroid disorders
- Malnutrition



## Other Factors

- Abuse
- Brain damage
- Lead poisoning
- Terotogenic exposure to etoh, cocaine, lead, nicotine
- Excessive caffeine
- Hunger
- Constipation
- Minor persistent pain
- Normal Behavior (Consider age)



## ADHD - Differential Diagnosis

- Bipolar Disorder
- Oppositional Defiant Disorder
- Conduct Disorder
- Learning Disorders
- Psychosocial Considerations
- COMORBIDITY WITH ALL



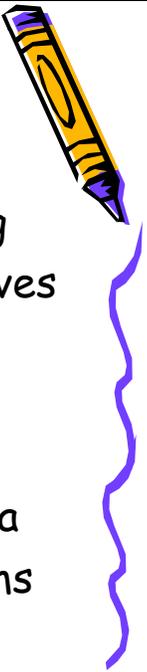
## ADHD - Pathophysiology

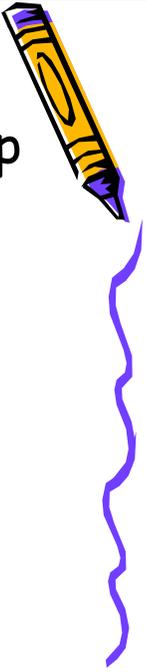
- Unknown
- Theories of Dopamine and norepinephrine
- Medications that enhance both used in treatment.
- Stimulants most effective (dopamine agonists) (75-93% response rate)



## ADHD-Developmental Psychopathology

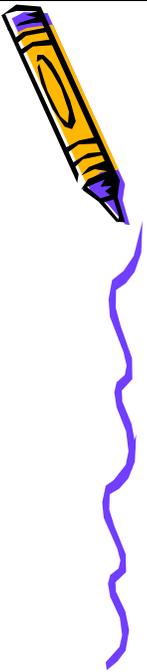
- Most cases congenital and life-long
- Traditional myth that ADHD resolves in adolescence
- NOT benign
- 30% resolve by adulthood
- 30% involve some continued residual
- 30% develop worsening of symptoms





## ADHD-Poor Prognosis Group

- Early onset aggression
- Co-morbid Conduct Disorder
- Worsening of symptoms in adolescence
  - Substance Abuse
  - Mood Disorders
  - Higher Incidence of Suicidality



## ADHD - Treatment

- Environmental changes
- Psychostimulant treatment
- Other psychopharmacology
- Behavioral/parent management
- Other treatment



## Vignette Guess the DX

- 12 y/o male who has been a "handful" all his life was recently returned home by the police for breaking the windows at school. Three months before a neighbor saw him tying fire crackers to the tails of cats and setting them off. A month ago he got even with the neighbor by beating up her 10 y/o son and threatened to kill him if he told anyone. He often carried a knife to scare kids to give him money. His mother fell to the ground crying. She thought things had gotten better after he was given 200 hours community service for stealing bikes a little over a year ago.
- You are consulted to determine "his problem"



## Diagnostic Criteria for Conduct Disorder

- A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:



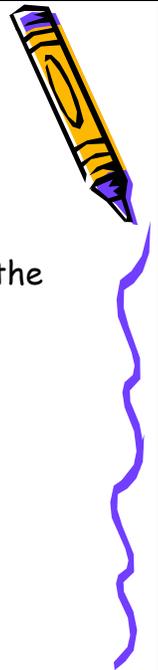
## Aggression to people and animals

1. often bullies, threatens, or intimidates others
2. often initiates physical fights
3. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
4. has been physically cruel to people
5. has been physically cruel to animals
6. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
7. has forced someone into sexual activity



## Destruction of property

8. has deliberately engaged in fire setting with the intention of causing serious damage
9. has deliberately destroyed others' property (other than by fire setting)



## Deceitfulness or theft

10. has broken into someone else's house, building, or car
11. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
12. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)



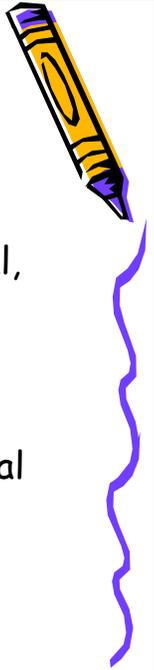
## Serious violations of rules

13. often stays out at night despite parental prohibitions, beginning before age 13 years
14. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
15. is often truant from school, beginning before age 13 years



## B & C criteria

- B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.
- C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.



## Code based on age at onset:

Conduct Disorder, **Childhood-Onset Type**:  
onset of at least **one criterion**  
characteristic of Conduct Disorder **prior to age 10 years**

Conduct Disorder, **Adolescent-Onset Type**:  
**absence** of any criteria characteristic of  
Conduct Disorder **prior to age 10 years**

Conduct Disorder, Unspecified Onset: age at  
onset is not known



## Specify severity:

Mild: few if any conduct problems in excess of those required to make the diagnosis and conduct problems cause only minor harm to others

Moderate: number of conduct problems and effect on others intermediate between "mild" and "severe"

Severe: many conduct problems in excess of those required to make the diagnosis or conduct problems cause considerable harm to others



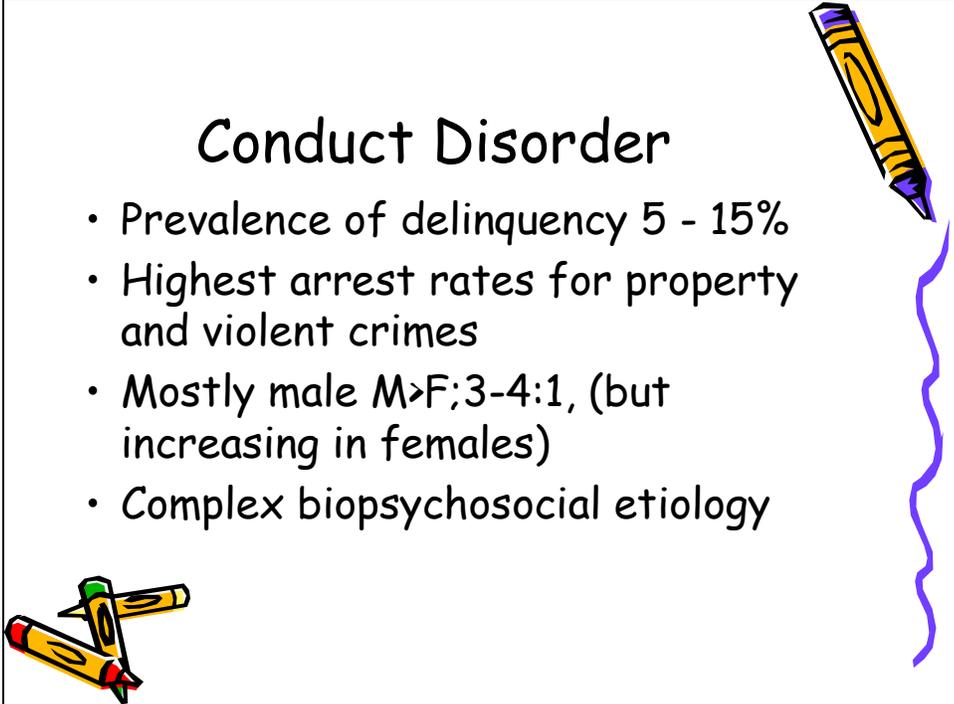
## Conduct Disorder

- Violation of personal rights of others
- Most severe behavior disorder in childhood
- Requires 12 month history of at least 3 DSM-IV criteria
  - Aggression to people and animals
  - Destruction of property
  - Deceitfulness or theft
  - Serious violations of rules



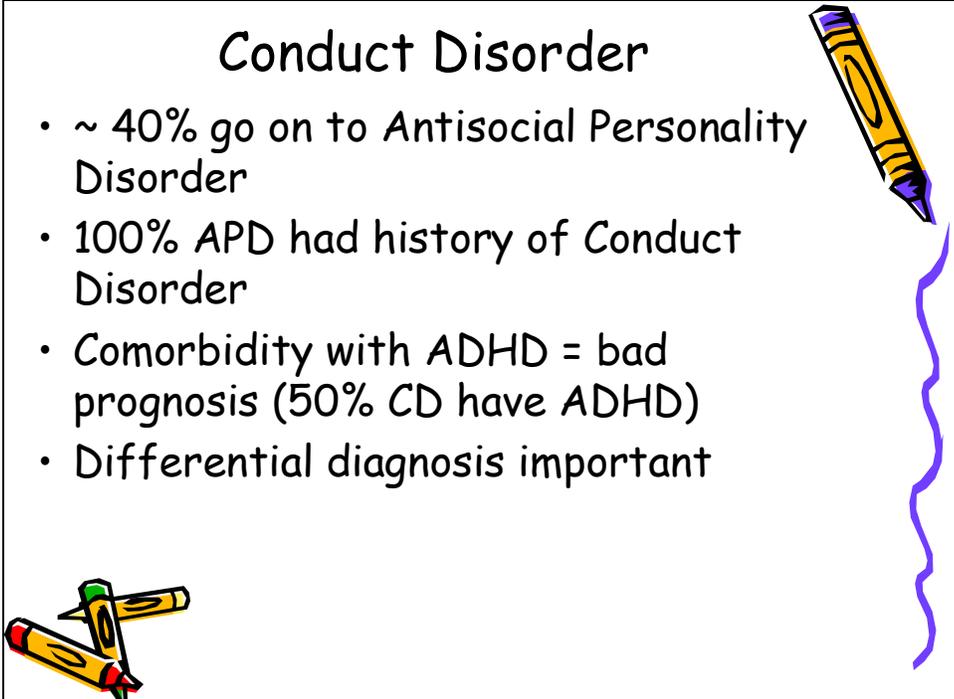
## Conduct Disorder

- Prevalence of delinquency 5 - 15%
- Highest arrest rates for property and violent crimes
- Mostly male M>F;3-4:1, (but increasing in females)
- Complex biopsychosocial etiology



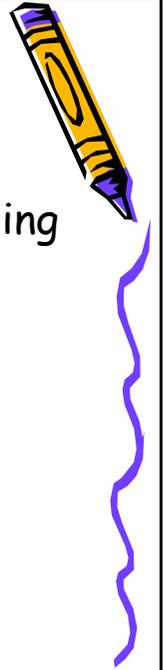
## Conduct Disorder

- ~ 40% go on to Antisocial Personality Disorder
- 100% APD had history of Conduct Disorder
- Comorbidity with ADHD = bad prognosis (50% CD have ADHD)
- Differential diagnosis important



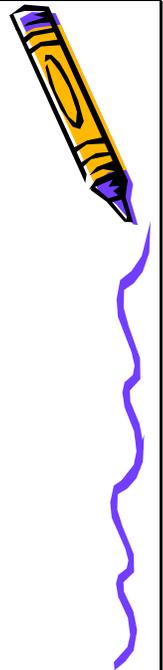
## Factors implicated in the etiology of CD

- Genetic Transmission of predisposing psychiatric disorder
- Neurobiology
- Temperament
- Other psychiatric disorders



## Poor prognosis

- Early onset
- Conduct symptoms
  - Greater frequency
  - Number
  - Variety
  - Comorbid ADHD



## Multimodal treatment

- Psychotherapeutic Interventions
  - Cognitive
  - Behavioral
  - Family
  - Group therapy; beware of contagion
  - School interventions
    - » Boot Camp not shown to be effective



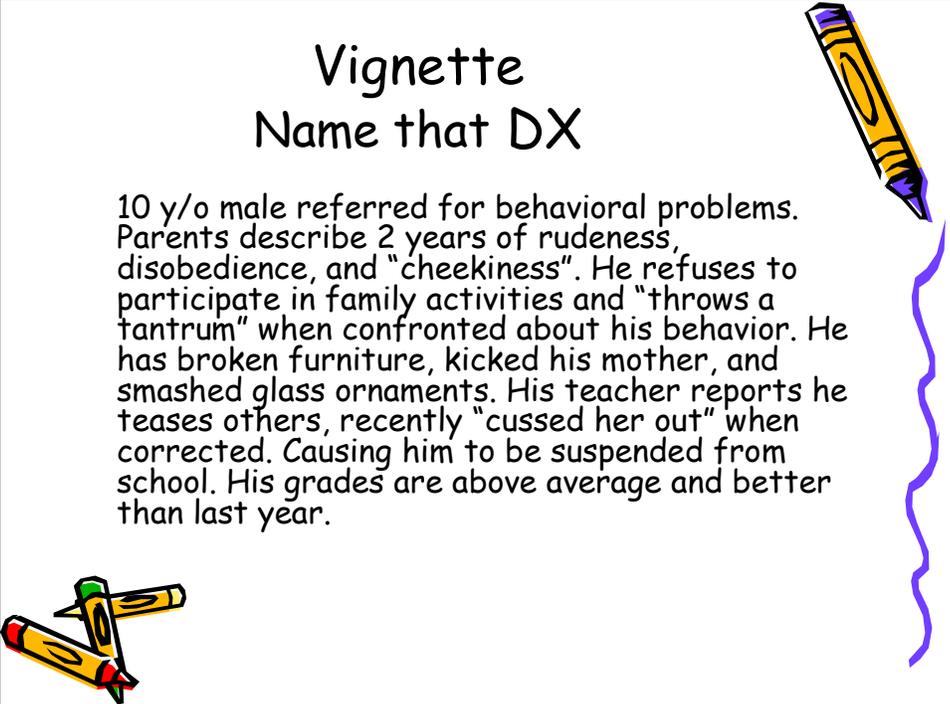
## Psychopharmacology

- Treat target symptoms
- Severe aggression
  - » Mood stabilizers
  - » B-Blockers
  - » Neuroleptics



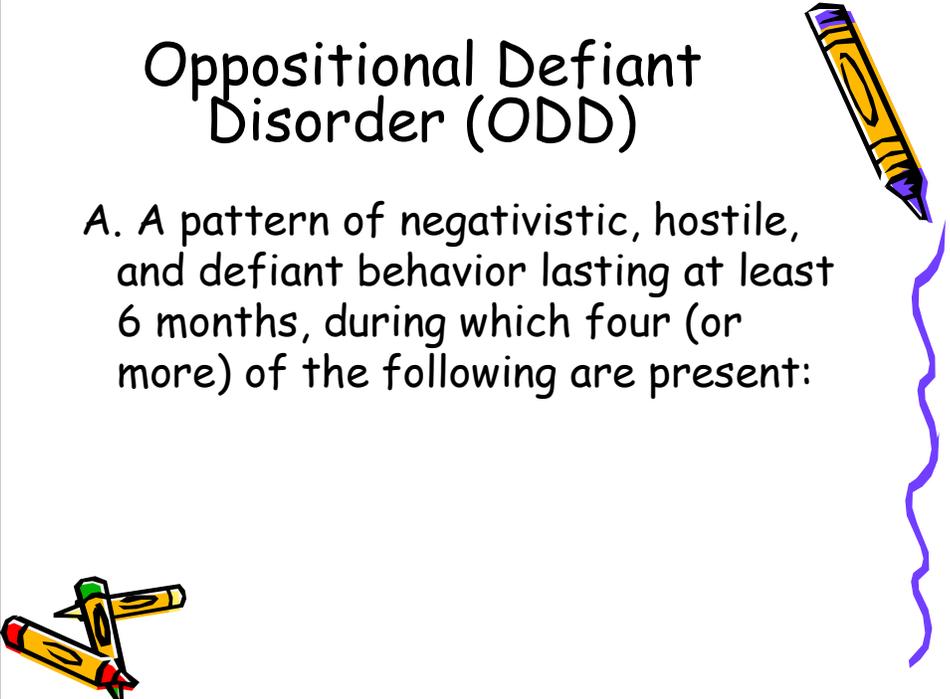
## Vignette Name that DX

10 y/o male referred for behavioral problems. Parents describe 2 years of rudeness, disobedience, and "cheekiness". He refuses to participate in family activities and "throws a tantrum" when confronted about his behavior. He has broken furniture, kicked his mother, and smashed glass ornaments. His teacher reports he teases others, recently "cussed her out" when corrected. Causing him to be suspended from school. His grades are above average and better than last year.



## Oppositional Defiant Disorder (ODD)

A. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:



## ODD Criteria

1. often loses temper
2. often argues with adults
3. often actively defies or refuses to comply with adults' requests or rules
4. often deliberately annoys people
5. often blames others for his or her mistakes or misbehavior
6. is often touchy or easily annoyed by others
7. is often angry and resentful
8. is often spiteful or vindictive

Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.



## B-D criteria

- B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.
- C. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.
- D. Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.



## Proposed Etiology

- Inconsistent parenting
- Parents model similar behaviors
- Parents with insufficient time and energy for the child
- Difficult temperament in child
- May have genetic traits to adult antisocial personality disorder.



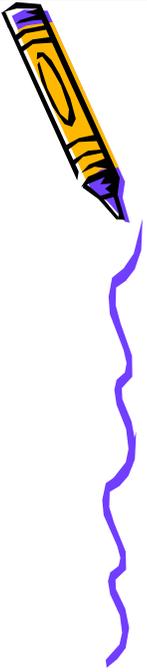
## ODD Summary

- A pattern of negativistic, hostile, and defiant behavior.
- Meets 4/8 DSM-IV criteria for six months
- 6% prevalence rate
- Temperament, psychological and familial factors likely contribute
- Distinct from, but may result in Conduct Disorder



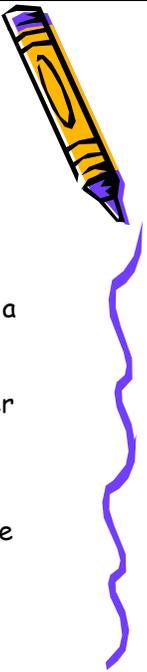
## TREATMENT

- Similar to Conduct Disorder
- Parenting classes probably most helpful



## Vignette

A 13y/o boy treated for ADHD since age 7 keeps getting in trouble at school. Initially his pediatrician increased the stimulant medication to the maximum and nothing changed. Finally, he referred the boy to a child psychiatrist. It is learned that the boy makes noises like barking during the class. He "refuses" to keep quiet. Sometimes he makes faces at the teacher by grimacing. She has had all she can take from this trouble maker who does not respect her authority. His parents have been warned that if they don't do something fast he will be terminated from his private school.



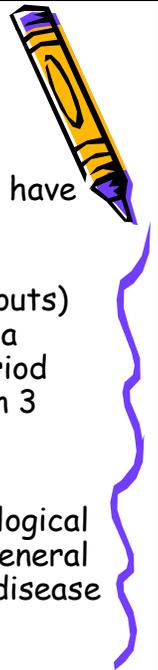
## Tourette's Disorder and other TIC Disorders

- Definition: A TIC is a sudden, rapid recurrent, nonrhythmic, stereotyped motor movement or vocalization.
- Involuntary but can be suppressed by a conscious effort
- Preceded by an "Urge" to make a certain TIC
- **FUNTIONAL IMPAIRMENT IS NOT REQUIRED!**



## Diagnostic Criteria for Tourette's Disorder

- A. Both multiple motor and one or more vocal tics have been present at some time during the illness, although not necessarily concurrently.
- B. The TICS occur many times a day (usually in bouts) nearly every day or intermittently throughout a period of more than 1 year, and during this period there was never a tic-free period of more than 3 consecutive months.
- C. The onset is before age 18 years.
- D. The disturbance is not due to the direct physiological effects of a substance( e.g., stimulants) or a general medical condition (e.g., Huntington's disease or postviral encephalitis).





## Diagnostic Criteria for Chronic Motor or Vocal Tic Disorder

- A. Single or multiple motor or vocal tics (i.e., sudden, rapid, recurrent, nonrhythmic, stereotyped motor movements or vocalizations), but not both, have been present at some time during the illness.
  - B. The tics occur many times a day nearly every day or intermittently throughout a period of **more than 1 year**, and during this period there was never a tic-free period of more than 3 consecutive months.
  - C. The onset is before age 18 years.
  - D. The disturbance is not due to the direct physiological effects of a substance (e.g., stimulants) or a general medical condition (e.g., Huntington's disease or postviral encephalitis).
- E. Criteria have never been met for Tourette's Disorder.



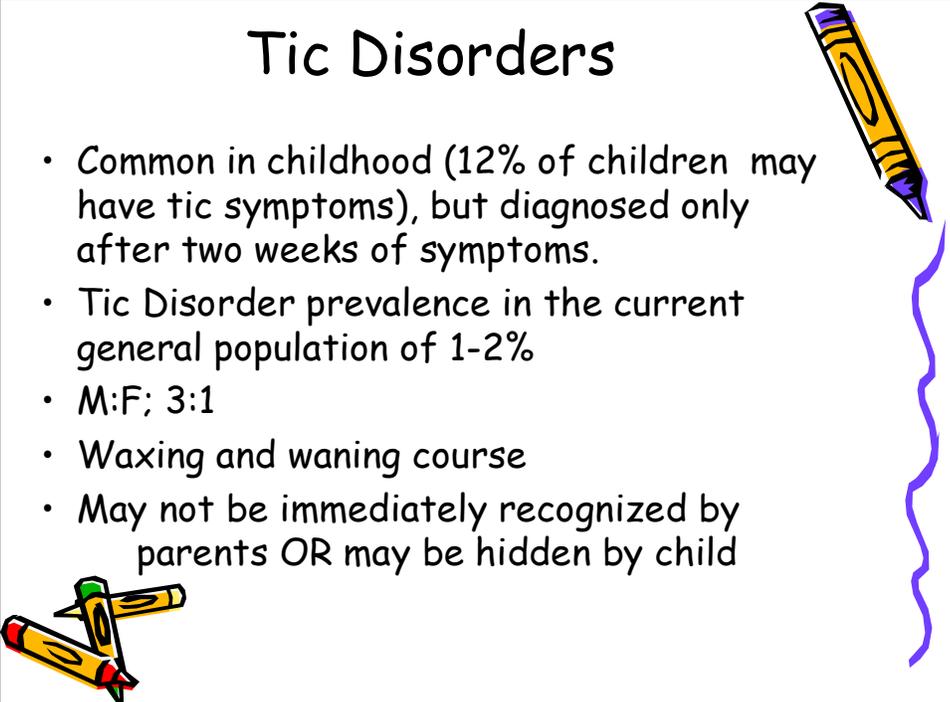
## Transient TIC Disorders

- A. Single multiple motor and/or vocal TICS (i.e., sudden, rapid, recurrent, nonrhythmic, stereotyped motor movements or vocalizations)
  - B. The tics occur many times a day nearly every day or for at least 4 weeks but not longer than 12 consecutive months.
  - C. The onset is before age 18 years.
  - D. The disturbance is not due to the direct physiological effects of a substance (e.g., stimulants) or a general medical condition (e.g., Huntington's disease or postviral encephalitis).
- E. Criteria have never been met for Tourette's Disorder or Chronic Motor or Vocal TIC Disorder



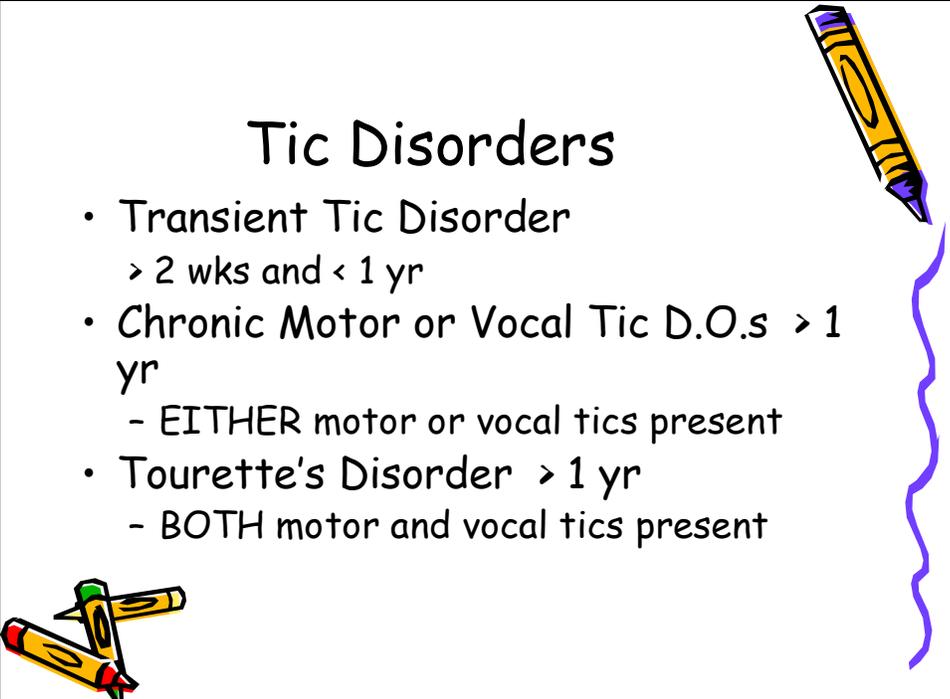
## Tic Disorders

- Common in childhood (12% of children may have tic symptoms), but diagnosed only after two weeks of symptoms.
- Tic Disorder prevalence in the current general population of 1-2%
- M:F; 3:1
- Waxing and waning course
- May not be immediately recognized by parents OR may be hidden by child



## Tic Disorders

- Transient Tic Disorder
  - > 2 wks and < 1 yr
- Chronic Motor or Vocal Tic D.O.s > 1 yr
  - EITHER motor or vocal tics present
- Tourette's Disorder > 1 yr
  - BOTH motor and vocal tics present



# Tourette's Disorder

- Usual onset between 2 and 13 years
- Some developmental pattern (e.g. motor tics at 7 y/o and vocal tics at 11 y/o)
- High co morbidity with ADHD and OCD
- Treatment options include psychopharmacology, individual therapy, educational interventions
- Rule of thirds
  - 1/3 recover by adolescence
  - 1/3 improve by adult hood
  - 1/3 same or worse



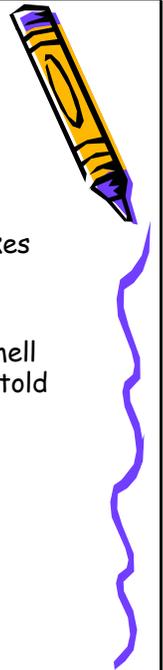
# Treatment for TICS

- Transient tics > psychoeducation
- Psychosocial;
  - School, Family, Individual treatment
- Psychopharmacology
  - $\alpha_1$  adrenergic agonists
    - Guanfacine, Clonidine
  - Neuroleptics; still DOC, most will try above first depending on severity
    - Haldol
    - Pimside (reports of Sudden Death)
    - "atypicals" now being used more
      - Risperidone



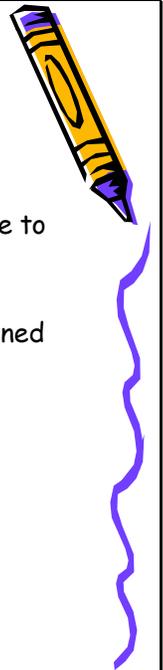
## Vignettes

1. 5 y/o male with unremitting stomach pains has coins, rocks and string on his abdominal films. "He really likes pennies" his mom says with a laugh.
2. On walking down the pediatric ward a horrendous smell becomes apparent from room 1, the room the intern told you to check on. You see a one year old with vomit everywhere smiling at you



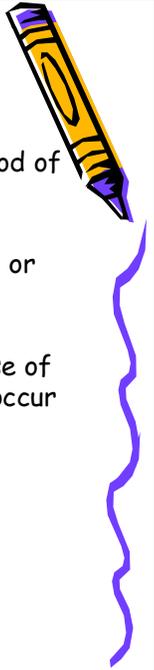
## Pica

- A. Persistent eating of nonnutritive substances for a period of at least 1 month.
- B. The eating of nonnutritive substances is inappropriate to the developmental level.
- C. The eating behavior is not part of a culturally sanctioned practice.
- D. If the eating behavior occurs exclusively during the course of another mental disorder (e.g., Mental Retardation, Pervasive Developmental Disorder, Schizophrenia), it is sufficiently severe to warrant independent clinical attention.



## Rumination Disorder

- A. Repeated regurgitation and rechewing of food for a period of at least 1 month following a period of normal functioning.
- B. The behavior is not due to an associated gastrointestinal or other general medical condition (e.g., esophageal reflux).
- C. The behavior does not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa. If the symptoms occur exclusively during the course of Mental Retardation or a Pervasive Developmental Disorder, they are sufficiently severe to warrant independent clinical attention.



## PICA and RUMINATION

- Both rare; rumination very rare
- Both more common in MR and PDD
- Pica more common than Rumination
- Etiology-
  - Strongly associated with Psychosocial problems
  - Prevalence unclear for both
  - Treatment: Behavioral for both



## Feeding Disorder of Infancy or Early Childhood

### Diagnostic Criteria

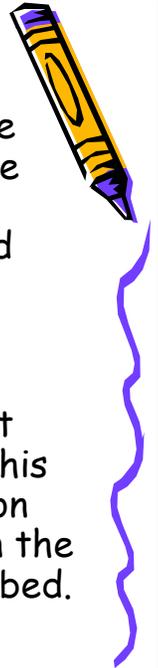
- A. Feeding disturbance as manifested by persistent failure to eat adequately with significant failure to gain weight or significant loss of weight over at least 1 month.
- B. The disturbance is not due to an associated gastrointestinal or other general medical condition (e.g., esophageal reflux).
- C. The disturbance is not better accounted for by another mental disorder (e.g., Rumination Disorder) or by lack of available food.
- D. The onset is before age 6 years

\*\*\* New disorder and mostly related to Failure to Thrive



## Vignettes

1. Angry 7 y/o leaves a "present" for the child psychiatrist on his new rug in the waiting room. His mom says "oh no, he poops on my on my pillow too! I should have told you this sooner."
2. Mom proudly reports hr 7y/o slept through the night for a month without wetting the bed for the first time in his life. One night she hears a noise and on investigating sees her son standing on the ladder and peeing on the top bunk bed.



# Encopresis

- A. Repeated passage of feces into inappropriate places (e.g., clothing or floor) whether **involuntary or intentional**.
- B. At least one such event a month for at least 3 months.
- C. Chronological age is **at least 4 years** (or equivalent developmental level).
- D. The behavior is not due exclusively to the direct physiological effects of a substance (e.g., laxatives) or a general medical condition except through a mechanism involving constipation.

Code as follows:

With Constipation and Overflow Incontinence

Without Constipation and Overflow Incontinence



# Enuresis

- A. Repeated voiding of urine into bed or clothes (**whether involuntary or intentional**).
- B. The behavior is clinically significant as manifested by either a frequency of twice a week for at least 3 consecutive months or the presence of clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
- C. Chronological age is **at least 5 years** (or equivalent developmental level).
- D. The behavior is not due exclusively to the direct physiological effect of a substance (e.g., a diuretic) or a general medical condition (e.g., diabetes, spina bifida, a seizure disorder).

Specify type:

Nocturnal Only;

Diurnal Only;

Nocturnal and Diurnal



## Elimination Disorders

- Encopresis
  - Either involuntary or intentional passage of feces into inappropriate places
  - One event per month for at least 3 months
  - Chronological age at least **4 years**
- Enuresis
  - Involuntary or intentional voiding of urine into bed or clothes
  - Clinically significant frequency or distress
  - Chronological age of at least **5 years**



## Vignettes

- 10 y/o refuses to go to school. Mom reports he worries about her safety all the time. Cries in the night about dreams of harm to her. Has begun to sleep in the parents bed again.
- Teacher reports to the parents that their 8y/o daughter will not talk in school. Refuses to give answers. Children speak for her and she has a friend she confides in. She asks the parents if everything OK at home. Parents are surprised, "she is always talking". Teacher is suspicious this child is being abused.



## Separation Anxiety Disorder

A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:

1. recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
2. persistent and excessive worry about losing, or about possible harm befalling, major attachment figures
3. persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
4. persistent reluctance or refusal to go to school or elsewhere because of fear of separation



## Separation Anxiety Disorder

5. persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings
6. persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
7. repeated nightmares involving the theme of separation
8. repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated



## B-E

- B. The duration of the disturbance is at least 4 weeks.
- C. The onset is before age 18 years.
- D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
- E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder With Agoraphobia.

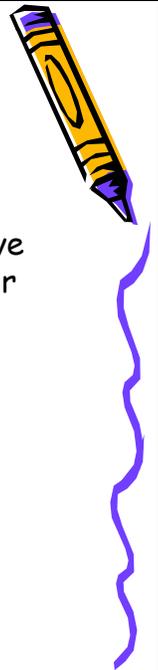


Specify if: Early Onset: if onset occurs before age 6 years



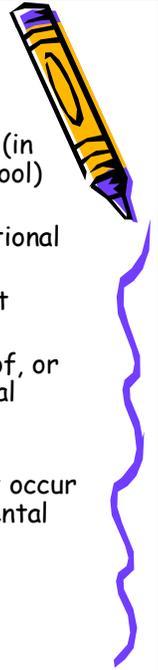
## Other Disorders of Infancy, Childhood or Adolescence

- Separation Anxiety Disorder
  - Developmentally inappropriate and excessive anxiety concerning separation from home or from attachment figures
  - Common and familial disorder
  - School absenteeism common
  - Probable risk factor for future anxiety disorders
  - Treatment includes psychopharmacology, individual and parental counseling



# Selective Mutism

- A. Consistent failure to speak in specific social situations (in which there is an expectation for speaking, e.g., at school) despite speaking in other situations.
- B. The disturbance interferes with educational or occupational achievement or with social communication.
- C. The duration of the disturbance is at least 1 month (not limited to the first month of school).
- D. The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
- E. The disturbance is not better accounted for by a Communication Disorder (e.g., Stuttering) and does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder.



# Other Disorders of Infancy, Childhood or Adolescence

- Selective Mutism
  - Failure to speak in specific social situations
  - Psychodynamic factors
  - Temperamental factors - heritable shyness
  - Treatment options include psychopharmacology, behavioral therapy and parent counseling



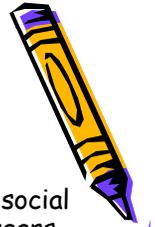
## Vignettes

- 6 y/o child is reported by her teachers to her third foster mother as having very few friends. Always seems "hypervigilant" and is difficult to get close to. She has been this way most of the school year but lately she seems to be extra scared, tired and thin. She seems difficult to comfort. The foster mother says, "Well she has been trouble for the past several caregivers, but don't worry I will make her come around."
- 6 y/o child is reported by her teachers to her third foster mother as having "too many friends". She is always hugging and kissing the boys and seems clingy to most of the teachers. She is not afraid of strangers and will get too close to anyone whether she knows them or not. Recently a new male cook in the cafeteria told someone he thought she was "coming on to him" he was scared and reported it. The foster mother says, "Well she has been trouble for the past several caregivers. She will hug and kiss just about anybody. We worry about someone taking advantage of her."



## Reactive Attachment Disorder of Infancy or Early Childhood

- A. Markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years, as evidenced by either (1) or (2):
1. persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent and contradictory responses (e.g., the child may respond to caregivers with a mixture of approach, avoidance, and resistance to comforting, or may exhibit frozen watchfulness)
  2. diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments (e.g., excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures)

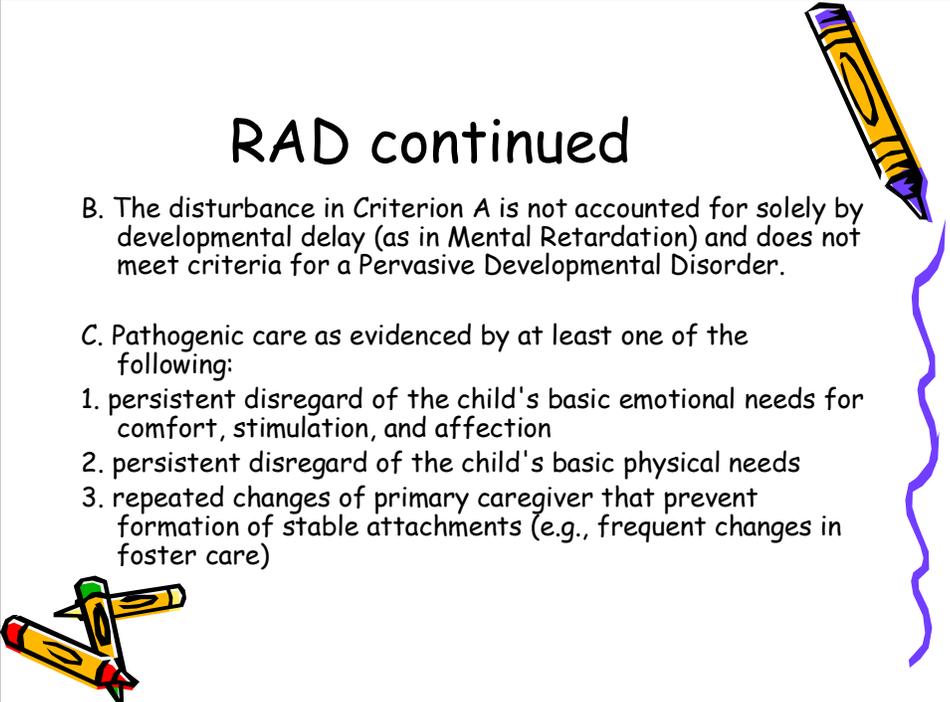


## RAD continued

B. The disturbance in Criterion A is not accounted for solely by developmental delay (as in Mental Retardation) and does not meet criteria for a Pervasive Developmental Disorder.

C. Pathogenic care as evidenced by at least one of the following:

1. persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection
2. persistent disregard of the child's basic physical needs
3. repeated changes of primary caregiver that prevent formation of stable attachments (e.g., frequent changes in foster care)



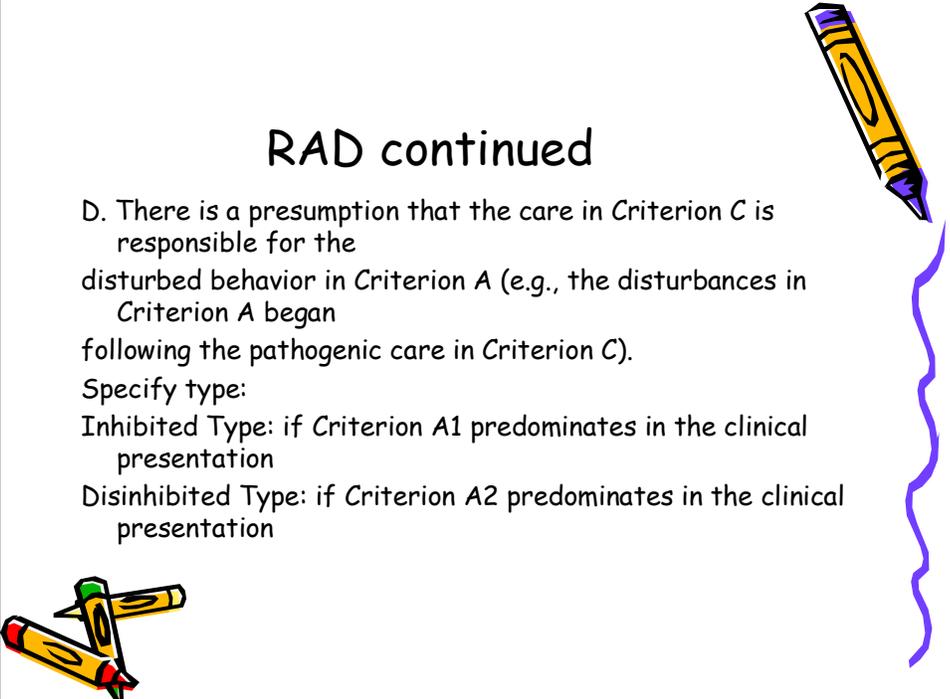
## RAD continued

D. There is a presumption that the care in Criterion C is responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).

Specify type:

Inhibited Type: if Criterion A1 predominates in the clinical presentation

Disinhibited Type: if Criterion A2 predominates in the clinical presentation



## Other Disorders of Infancy, Childhood or Adolescence

- Reactive Attachment Disorder
  - o Persistent failure to initiate or respond in a developmentally appropriate fashion
  - o diffuse and indiscriminate attachments
  - o generally related to child abuse or neglect
  - o Psychosocial failure to thrive
  - o Paradoxical presentation to strangers
    - o Overanxious vs. Overfriendly



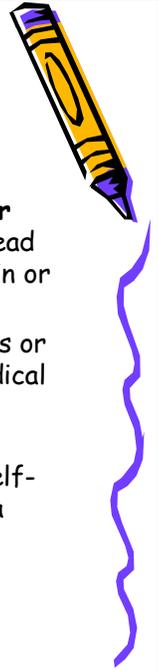
## Vignette

- Mother reports her 9 y/o son, with mild MR, sits on the floor and rocks rocks while watching TV. He gradually increases with such force that he bangs his head hard on the coffee table. Yesterday he kept hitting it until his head began to bleed. "He acts like it is nothing."



## Stereotypic Movement Disorder

- A. **Repetitive, seemingly driven, and nonfunctional motor behavior** (e.g., hand shaking or waving, body rocking, head banging, mouthing of objects, self-biting, picking at skin or bodily orifices, hitting own body).
- B. The behavior markedly interferes with normal activities or results in self-inflicted bodily injury that requires medical treatment (or would result in an injury if preventive measures were not used).
- C. If Mental Retardation is present, the stereotypic or self-injurious behavior is of sufficient severity to become a focus of treatment.



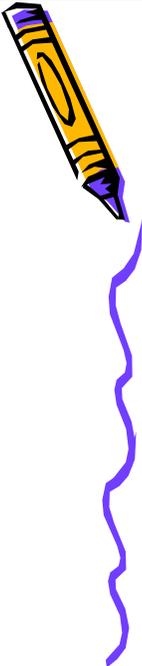
## Stereotypic Movement Disorder continued

- D. The behavior is not better accounted for by a compulsion (as in Obsessive-Compulsive Disorder), a tic (as in Tic Disorder), a stereotypy that is part of a Pervasive Developmental Disorder, or hair pulling (as in Trichotillomania).
- E. The behavior is not due to the direct physiological effects of a substance or a general medical condition.
- F. The behavior persists for 4 weeks or longer.

Specify if:

With Self-Injurious Behavior: if the behavior results in bodily damage that requires specific treatment (or that would result in bodily damage if protective measures were not used)





## Treatment

- Mostly likely behavioral
- Occasionally medications for severe cases
  - Neuroleptics
  - SSRI's



## EXTRA CREDIT

- 7 y/o boy referred for severe behavioral problems. He suddenly began to be very "hyper", constantly fidgeting, forgetful, losing things. Sudden onset of fear of the # 3. Would not write the number. Would not get out of bed when the time included three. Simultaneously developed an awkward wrinkling of his nose and forehead and kids were making fun of his "rabbit face". History is only significant for chronic OM and recurrent sore throat most recent one cultured as GABHS.
- What are your thoughts?

