Diagnosis and intervention of disruptive behavior disorder: conflicts and confusions

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Talk plan

- Briefing concept of DBD
- Classification and characteristic features
- Epidemiology-prevalence and correlates
- Diagnostic dilemma and debates
- Intervention and interventional issues
- Conclusions

Introduction

Disruptive Behaviour Disorder: conceptual framework

- Deviant social behaviour
- Kind of social cognition deficit
- Emotional problems run side by side
- Irritability-impulsivity dimension in features
- Predominantly psychosocial cause
- Neurobiological factors play critical role

Introduction

Disruptive Behaviour Disorder: conceptual framework

- DBD-identified as persistent failure to control behaviour appropriately within socially defined rules

- Cultural perspectives is crucial for considering disorder

Classifications

Evolution of classification

- Broder classification
- Narrow classification

Currently, both ICD 11 and DSM 5 classifications are aliened to each other

Classifications

ICD 11

Disruptive behaviour or Dissocial disorder

- Oppositional defiant disorder
- Conduct-dissocial disorder
- Other specified disruptive behaviour or dissocial disorders
- Disruptive behaviour or dissocial disorders, unspecified

Classifications

ICD 11

Oppositional defiant disorder(ODD)

- -with chronic irritability-anger
    - with limited prosocial emotions
    - with typical prosocial emotions
- -without chronic irritability-anger
- -unspecified

Classifications

ICD 11

Conduct-dissocial disorder

Childhood onset

- -with limited prosocial emotions
- -with typical prosocial emotions
- -unspecified

Classifications

ICD 11

Conduct-dissocial disorder

Adolescent onset

- -with limited prosocial emotions
- -with typical prosocial emotions
- -other specified
- -unspecified

Classifications

DSM 5

Disruptive, Impulse-Control, and Conduct disorder

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder
- Antisocial Personality Disorder
- Pyromania
- Kleptomania
- Other Specified Disruptive, Impulse-Control, and Conduct disorder
- Unspecified Disruptive, Impulse-Control, and Conduct disorder

Classifications

DSM 5

Disruptive, Impulse-Control, and Conduct disorder

- **Oppositional Defiant Disorder**

  Mild, Moderate, Severe

- **Conduct Disorder**

  -Childhood onset

  -Adolescent-onset

  With limited prosocial emotions

  Mild, Moderate Severe

Classifications

Axial Classification

Axial assessment is essential for making comprehensive Dx and Rx plan

Characteristic features

ODD

- Angry/irritability
- Defiant/challenging behaviour
- Vindictiveness
- Onset:3 years, notable at 8 years of age
- Duration: 6 months or more
- Distress or impairment

Characteristic features

CD

- Aggression-threatening, bullying, intimating
- Violation of the rights and rules-theft, destruction, truancy, out of home
- ODD features usually present
- Onset: before the age of 13 years of age
- Impact: significant
- Duration: 12 months or more

Prevalence

- Roughly 6-16% of children and adolescents
- ODD 2-16% CD 1-10%
- 2 times more than whole emotional problems
- Reason of variations of prevalence
- Universality and relativity- Developed vs Developing
- Trends: increasing prevalence- COVID & Post-COVID

Correlates

- More in boys than girls-difference increased with age
- More complex in adolescents than childhood
- More among disadvantageous population
- More among neurodevelopmentally challenged-low IQ
- More with other brain and physical disorders,deformity

Correlates

- ACEs- abuse and neglect, violence
- Current stress-acute and enduring, toxic
- Difficult temperament
- Family factors-
    - getting gain- from tantrum to ODD
    - family history
    - disorganized family
    - unhealthy parental attitude and behaviour
- Low SES
- Low social capital

Correlates

- Rural-urban distribution: more in urban, drifting issue
- Neighbourhood-unsupportive, crime prone
- School factors-poor organization & supervision
- Bully-victim problem & cyber-bullying
- Lack of healthy recreation
- Negative effect of internet and devices
- Breaking of social norms and values
- Negative influence of global changes- economic crisis, migration, inequity of all forms

Diagnostic dilemma and debates

- Criteria-both categorical and dimensional
- Externalizing, Internalizing or both?
- Reliability and validity of Dx

    -'marked', 'persistent' features

    - culture, subculture perspectives on features

    -onset

    -frequency

    -persistency/duration

    -perversity of symptoms and situation

    -informant issues: degree of understanding

Diagnostic dilemma and debates

- Assessment setting/s
- Distress and impact assessment process
- Over and under diagnostic issues
- Stigma and labelling
- Feature, or crime, or both ?

Diagnostic dilemma and debates

- Developmental influence
- Consequences of impact and burden
- Age factor
- Family factor- scapegoating
- “Pure” vs “Mixed”

Diagnostic dilemma and debates

Comorbidity issue

When we consider comorbidity?

- Almost all form of neurodevelopmental disorder have disruptive behaviour in course of time
- Associated features-other externalizing & internalizing

Emotional features are part of the DBD initially and as consequences

Diagnostic dilemma and debates

Comorbidity issue

When we consider comorbidity?

- Acute or recent onset-DBD or paediatric onset of other psychiatric disorder?

  Stress related, anxiety, depression, psychosis, bipolar
- Comorbidity across the age-SRD,MDD
- Adulthood continuity- DBD vs PD (Predominantly Dissocial/Antisocial)
- Comorbidity as usual with increased probability

Few words on Juvenile Delinquency

- The terminology related to law and criminal justice system
- Children & adolescents with psychiatric disorders can be delinquent
- Necessarily, not all delinquent children and adolescents have to have psychiatric disorder
- Law breaking behaviour is usually part of socially deviant behaviour
- However, not all law-breaking behaviour are noted as socially deviant

Few words on Juvenile Delinquency

- CD is the most common cause of JD because its features go with delinquency
- ID, other neurodevelopmental, SRD, paediatric psychosis are the other causes of JD
- Psychiatrist must be familiar with JD as part of learning related with justice system and psychiatry
- Knowledge and skills related to JD is essential

Diagnostic dilemma and debates

Techniques to overcome diagnostic conflicts in clinical setup

- Multiinformant-based history
- Gathering collateral information
- Structured assessment
- Multisetings observation
- Multiple assessment

Diagnostic dilemma and debates

Techniques to overcome diagnostic conflicts in clinical setup

- Lab tests and psychometrics
- Critical clinical judgement
- Careful assessment of symptom extensions, associated symptoms
- Sceptical judgement for comorbidity

Treatment

Approaches

- Multiagency involvement
- Multidisciplinary team
- Biopsychosocial
- Personalization
- Liaison and cross referral

Treatment

Broad types

- Patient focused
- Family focused
- School focused

Treatment

Nonpharmacological is the core

- Counselling- individual, family and school
- Psychoeducation
- Psychotherapy- behavioural, cognitive behavioural
- Parenting- parenting technique packages
- Family therapy
- Family support

Treatment

Nonpharmacological is the core

- Social skill training
- Stress management and coping with stress training
- Family social work
- Remedial teaching
- Wellness treatment
- Recreational therapy

Treatment

Nonpharmacological

- School-based intervention
- Home-based intervention
- Community-based intervention
- Hospital-based intervention-OPD &IPD

  Hospitalization-for whom and when?
- Residential care-for whom and how?
- Juvenile correction centre-for whom and how?

Treatment

Pharmacotherapy

- Manging comorbid disorders
- Manging symptoms
- Facilitating nonpharmacological intervention

Intervention issues

- Reporting and intervention- nearly always delayed
- No comprehensive intervention exists
- Poor access of existing service-neither reachable nor affordable
- Extreme lack of community-based services
- Multidisciplinary team-no or poor existence
- School-based services- not available
- Multi-agency and multi-sectorial involvement- poorly observed

Outcome

Good prognostic factors

- Early identification and intervention
- Average or high IQ
- Social-having good friends
- Having demonstrated strengths and potentials
- Family support
- “Pure”-no comorbidity or very few comorbidity

Outcome

Bad prognostic factors

- Opposite the all-good factors
- Pathognomic family
- Parental psychiatric disorders
- Poor scholastic achievements or failure
- Unsocial, isolated
- Callous-unemotional
- Delinquent and trouble with law
- High comorbidity-neurodevelopmental, addiction, depression

Outcome

Natural course is persisting in nature if not intervened

Disease continuity

- ODD >CD>PD
- Dx of PD below 18 years
- Dx of CD above 18 years

Prevention

- Education and awareness
- Parenting training
- Teacher's training
- Antibullying programme and policy
- Cyber control policy

Conclusions

- DBD is the single most prevalent diagnostic group in CA Psychiatry
- Still it is underdiagnosed and not in the right pathway of care in Bangladesh
- Early intervention and treatment is very rewarding and can prevent the worse outcome and adulthood continuity
- It is often persistent, costly for society if not treated successfully

Conclusions

- We do not have comprehensive treatment options for DBD though intertestamental is proved to be cost-effective
- It should be prioritized for investment to establish effective intervention and to prevent the worse and devastating impact on the sufferers, families and society

Questions

- Summarise the present trend of prevalence of disruptive behaviour disorder.
- Write down the effect of COVID pandemic on the prevalence of behavioural disorder.
- List the major correlates of conduct disorder.
- Write down the common comorbidities of conduct disorder. Outline the techniques of assessing these comorbidities.
- What are the common comorbidities of DBD? When should such comorbidities consider in routine clinical practice?

Questions

- Mention the cardinal approaches of treatment of DBD. What are the major barriers for intervention exists in Bangladesh?
- What are the major psychological treatment options for conduct disorder in clinical settings?
- List the major parenting training packages proved to be effective to manage DBD. What are the cardinal component of this technique?

Questions

- Outline the adulthood continuity of conduct disorder. Mention the recognized points for the diagnosis of personality disorder in let adolescence.
- List the major prognostic factors for favourable outcome of treatment of conduct disorder.
- What are the major barrier in diagnosis and intervention of DBD in Bangladesh? Outline the preventive strategy of DBD.