Childhood Disorders and Treatments

Quick Facts and Potential Interventions

MENTAL CLARITY COUNSELING

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Attention Deficit Hyperactivity Disorder

Definition

Attention-deficit/hyperactivity disorder (ADHD) is a brain disorder marked by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development.

- **Inattention** means a person wanders off task, lacks persistence, has difficulty sustaining focus, and is disorganized; and these problems are not due to defiance or lack of comprehension.
- **Hyperactivity** means a person seems to move about constantly, including situations in which it is not appropriate when it is not appropriate, excessively fidgets, taps, or talks. In adults, it may be extreme restlessness or wearing others out with their activity.
- **Impulsivity** means a person makes hasty actions that occur in the moment without first thinking about them and that may have high potential for harm; or a desire for immediate rewards or inability to delay gratification. An impulsive person may be socially intrusive and excessively interrupt others or make important decisions without considering the long-term consequences.

Signs and Symptoms

Inattention and hyperactivity/impulsivity are the key behaviors of ADHD. Some people with ADHD only have problems with one of the behaviors, while others have both inattention and hyperactivity-impulsivity. Most children have the combined type of ADHD.

In preschool, the most common ADHD symptom is hyperactivity.

It is normal to have some inattention, unfocused motor activity and impulsivity, but for people with ADHD, these behaviors:

- are more severe
- occur more often
- interfere with or reduce the quality of how they functions socially, at school, or in a job

Inattention

People with symptoms of inattention may often:

- Overlook or miss details, make careless mistakes in schoolwork, at work, or during other activities
- Have problems sustaining attention in tasks or play, including conversations, lectures, or lengthy reading
- Not seem to listen when spoken to directly
- Not follow through on instructions and fail to finish schoolwork, chores, or duties in the workplace or start tasks but quickly lose focus and get easily sidetracked
- Have problems organizing tasks and activities, such as what to do in sequence, keeping materials and belongings in order, having messy work and poor time management, and failing to meet deadlines
- Avoid or dislike tasks that require sustained mental effort, such as schoolwork or homework, or for teens and older adults, preparing reports, completing forms or reviewing lengthy papers

- Lose things necessary for tasks or activities, such as school supplies, pencils, books, tools, wallets, keys, paperwork, eyeglasses, and cell phones
- Be easily distracted by unrelated thoughts or stimuli
- Be forgetful in daily activities, such as chores, errands, returning calls, and keeping appointments

Hyperactivity-Impulsivity

People with symptoms of hyperactivity-impulsivity may often:

- Fidget and squirm in their seats
- Leave their seats in situations when staying seated is expected, such as in the classroom or in the office
- Run or dash around or climb in situations where it is inappropriate or, in teens and adults, often feel restless
- Be unable to play or engage in hobbies quietly
- Be constantly in motion or "on the go," or act as if "driven by a motor"
- Talk nonstop
- Blurt out an answer before a question has been completed, finish other people's sentences, or speak without waiting for a turn in conversation
- Have trouble waiting his or her turn
- Interrupt or intrude on others, for example in conversations, games, or activities

For a person to receive a diagnosis of ADHD, the symptoms of inattention and/or hyperactivity-impulsivity must be chronic or long-lasting, impair the person's functioning, and cause the person to fall behind normal development for his or her age. The doctor will also ensure that any ADHD symptoms are not due to another medical or psychiatric condition. Most children with ADHD receive a diagnosis during the elementary school years. For an adolescent or adult to receive a diagnosis of ADHD, the symptoms need to have been present prior to age 12.

ADHD symptoms can appear as early as between the ages of 3 and 6 and can continue through adolescence and adulthood. Symptoms of ADHD can be mistaken for emotional or disciplinary problems or missed entirely in quiet, well-behaved children, leading to a delay in diagnosis.

ADHD symptoms can change over time as a person ages. In young children with ADHD, hyperactivity-impulsivity is the most predominant symptom. As a child reaches elementary school, the symptom of inattention may become more prominent and cause the child to struggle academically. In adolescence, hyperactivity seems to lessen and may show more often as feelings of restlessness or fidgeting, but inattention and impulsivity may remain. Many adolescents with ADHD also struggle with relationships and antisocial behaviors. Inattention, restlessness, and impulsivity tend to persist into adulthood.
Treatment and Therapies

While there is no cure for ADHD, currently available treatments can help reduce symptoms and improve functioning. Treatments include medication, psychotherapy, education or training, or a combination of treatments.

Medication

For many people, ADHD medications reduce hyperactivity and impulsivity and improve their ability to focus, work, and learn. Medication also may improve physical coordination. Sometimes several different medications or dosages must be tried before finding the right one that works for a particular person. Anyone taking medications must be monitored closely and carefully by their prescribing doctor.

Stimulants. The most common type of medication used for treating ADHD is called a "stimulant." Although it may seem unusual to treat ADHD with a medication that is considered a stimulant, it works because it increases the brain chemicals dopamine and norepinephrine, which play essential roles in thinking and attention.

Under medical supervision, stimulant medications are considered safe. However, there are risks and side effects, especially when misused or taken in excess of the prescribed dose. For example, stimulants can raise blood pressure and heart rate and increase anxiety. Therefore, a person with other health problems, including high blood pressure, seizures, heart disease, glaucoma, liver or kidney disease, or an anxiety disorder should tell their doctor before taking a stimulant.

Talk with a doctor if you see any of these side effects while taking stimulants:

- decreased appetite
- sleep problems
- tics (sudden, repetitive movements or sounds);
- personality changes
- increased anxiety and irritability
- stomachaches
- headaches

Non-stimulants. A few other ADHD medications are non-stimulants. These medications take longer to start working than stimulants, but can also improve focus, attention, and impulsivity in a person with ADHD. Doctors may prescribe a non-stimulant: when a person has bothersome side effects from stimulants; when a stimulant was not effective; or in combination with a stimulant to increase effectiveness.

Although not approved by the U.S. Food and Drug Administration (FDA) specifically for the treatment of ADHD, some antidepressants are sometimes used alone or in combination with a stimulant to treat ADHD. Antidepressants may help all of the symptoms of ADHD and can be prescribed if a patient has bothersome side effects from stimulants. Antidepressants can be helpful in combination with stimulants if a patient also has another condition, such as an anxiety disorder, depression, or another mood disorder.

Therapy

Cognitive behavioral therapy (CBT) is a type of psychotherapy that can be used with children. It has been widely studied and is an effective treatment for a number of conditions, such as depression, obsessive-compulsive disorder, and social anxiety. A person in CBT learns to change distorted thinking patterns and unhealthy behavior. Children can receive CBT with or without their parents, as well as in a group setting. CBT can be adapted to fit the needs of each child. It is especially useful when treating anxiety disorders.

Some children benefit from a combination of different psychosocial approaches. An example is behavioral parent management training in combination with CBT for the child. In other cases, a combination of medication and psychosocial therapies may be most effective. Psychosocial therapies

often take time, effort, and patience. However, sometimes children learn new skills that may have positive long-term benefits.

Additionally, therapies for ADHD are numerous and include behavioral parent training and behavioral classroom management.

Behavioral therapy is a type of psychotherapy that aims to help a person change his or her behavior. It might involve practical assistance, such as help organizing tasks or completing schoolwork, or working through emotionally difficult events. Behavioral therapy also teaches a person how to:

- monitor his or her own behavior
- give oneself praise or rewards for acting in a desired way, such as controlling anger or thinking before acting

(National Institute of Mental Health)

Conduct disorder is a severe condition characterized by hostile and sometimes physically violent behavior and a disregard for others. Children with CD exhibit cruelty, from early pushing, hitting and biting to, later, more than normal teasing and bullying, hurting animals, picking fights, theft, vandalism, and arson. Since childhood and adolescent conduct disorder often develops into the adult antisocial personality disorder, it should be addressed with treatment as early as possible; the earlier treatment starts, the better the outlook.

One of the hallmarks of conduct disorder is a seemingly callous disregard for societal norms and the rights, feelings, and personal space of other people. Children and adolescents with CD seem to "get a rise" out of causing harm. For them, aggression, deceit, coercion—behaviors that result in a power differential—are gratifying. Picking fights, trespassing, lying, cheating, stealing, vandalism, and emotionally or physically abusive behavior, including wielding a deadly weapon or forcing sex, are all signs that an older child may have conduct disorder. Signs of the disorder in younger children may be harder to discern from more normal acting out, but are similarly coercive: relentless bullying, lying for the sake of lying, stealing items of no apparent worth.

Conduct Disorder: Treatment

Conduct disorder is difficult to overcome, but it is not hopeless. In situations where an effective support network of parental figures, teachers, and peers can be assembled, the disorder is manageable.

Psychotherapy: Treatment for conduct disorder is complicated by the negative attitudes the disorder instills. As such, psychotherapy and behavioral therapy are often undertaken for long periods of time, and the entire family and support network of the child is brought into the loop. The earlier the condition is diagnosed, the more successful the therapy will be. While a child learns a better way to interact with the world at large, the family learns the best ways to communicate with him.

In younger children, treatment for CD can resemble treatment for ODD—parent management training may be undertaken by a therapist to teach parents how to encourage desired behaviors. In adolescents, therapy may target not just the home life but interactions with authority figures at school, and ensuring that peer relations are beneficial, not harmful.

Since conduct disorder is often (but not always) diagnosed along with a number of other conditions that can be treated pharmacologically, medication may figure into treatment plans for the disorder.

Conduct Disorder: Risk For Other Disorders

ADHD and oppositional defiant disorder occur with frequency in children with conduct disorder. Other disorders that may occur with CD include specific learning disorder, anxiety disorders, depressive or bipolar disorders, and substance use disorders. (Child Mind Institute)

Oppositional Defiant Disorder –Quick Facts

A brief overview of the signs and symptoms of oppositional defiant disorder, as well as treatments.

Overview:

Oppositional Defiant Disorder (ODD) is a behavior disorder that puts children persistently at odds with authority figures. Children with ODD are temperamental, disobedient, spiteful, or vindictive to a highly unusual degree. The disorder significantly undermines the child's ability to get along with family, peers, and other adults.

Symptoms:

- Unusually quick to lose his temper
- Ignores or rebels against rules, at home or at school
- Quick to blame others for mistakes or misbehavior
- Prone to annoy others and be easily annoyed himself
- Disruptive behavior appears to be intentional rather than impulsive
- Refuses to cooperate reflexively—even before he knows what is being asked

Treatment:

ODD is usually treated with a type of behavioral therapy that includes parents, or a combination of behavioral intervention and medication. Treatment like Parent-Child Interaction Therapy is designed to increase positive parent-child interactions and teach the parent limit-setting skills that enable children to control disruptive behaviors and increase desired behaviors.

Medicines are not specifically indicated for ODD, but may be administered for co-occurring conditions such as ADHD, or to help the child get the most out of therapy sessions. (Child Mind Institute)

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Treatment

Medication, psychotherapy and a combination of the two are used as treatments for DMDD. Because the diagnosis is a new one, clinicians are still researching which treatments work best. Stimulant medications, antidepressant medications like SSRIs, and a kind of therapy known as applied behavior analysis have all been used. Parents should work closely with the doctor to learn what works best for

your child. Parents and other caregivers should also be taught specific strategies you can use when responding to a child's disruptive behavior. (Child Mind Institute)

Intermittent Explosive Disorder –Quick Facts

A brief overview of the signs and symptoms of intermittent explosive disorder and how it's treated in children and adolescents.

Overview

Kids with intermittent explosive disorder (IED) exhibit short episodes of intense, uncontrollable anger or aggression with very little or no apparent cause. It usually shows up in late childhood or adolescence, and eventually leads to a higher risk of self-harm or suicide in adolescents and young adults. Children with IED tend to feel a lack of control over their behavior, resulting in both verbal and physical outbursts of anger.

Symptoms

- Frequent but mild outbursts such as tantrums or fights
- Inability to resist impulses of anger
- Rare, more intense explosions that can cause physical harm to people or animals, or damage to objects
- Low tolerance for frustrating situations, resulting in disproportionately large and aggressive outbursts
- Explosions that last less than 30 minutes during which anger isn't directed at anything tangible

Treatment

There are two components to the typical treatment for IED. One is the psychotherapeutic component, which uses cognitive behavioral therapy (CBT) to help kids identify triggers for their episodes and manage their anger when faced with these triggers. This component may also involve the child's parents and teachers.

The other is the pharmacological component, which combines various medications such as antidepressants and anti-anxiety medication to treat the symptoms of IED. There are no medications specifically designed to treat IED.

Bipolar Disorder

Bipolar disorder, also known as manic-depressive disorder, is characterized by bouts of major depression and periods of mania — euphoria, poor judgment, and extreme risk-taking activity — in an often debilitating cycle. Onset usually occurs in mid-to-late adolescence, though there are cases in children. Explore information about bipolar disorder, including the best treatments for children and adolescents and advice for parents raising kids with difficult behavior. (Child Mind Institute)

Disruptive Mood Dysregulation Disorder (DMDD) -Quick Facts

A brief overview of the signs and symptoms, and how it's treated in children and adolescents.

Overview

Disruptive mood dysregulation disorder (DMDD) is a condition in which a child is chronically irritable and experiences frequent, severe temper outbursts that seem grossly out of proportion to the situation at hand. DMDD is a new disorder created to more accurately categorize some children who had previously been diagnosed with pediatric bipolar disorder, but who didn't experience periods of elevated moods, or mania.

Symptoms of DMDD

- Severe temper outbursts that occur, on average, three or more times per week
- The child's mood between outbursts is consistently angry or irritable
- This pattern of frequent outbursts, plus consistent anger or irritability between outbursts, continues for 12 or more months, without a break in symptoms of 3 or more months
- Onset typically takes place before age 10 (Child Mind Institute)

Major Depressive Disorder

A brief overview of the signs and symptoms and how it's treated.

Overview

Major depressive disorder is a severe episode of depression that tends to last from seven to nine months. A child with major depression experiences persistent, intense feelings of sadness and hopelessness that significantly impact her daily life and ability to function.

Symptoms

- Unusual sadness, persisting even when circumstances change
- Reduced interest in activities she once enjoyed; reduced feelings of anticipation
- Involuntary changes in weight
- Shifts in sleep patterns
- Sluggishness
- Harsh self-assessment ("I'm ugly. I'm no good. I'll never make friends.")
- Thoughts of or attempts at suicide

Treatment

Major depression is sometimes treatable with therapy alone, but experts agree that a combination of therapy and medication is usually the best approach.

Childhood and adolescent depression is often treated with interpersonal therapy (IPT), behavioral activation or cognitive behavioral therapy (CBT).

Medications combating depression are designed to increase the supply of certain neurotransmitters whose absence is linked to depression. These drugs include selective serotonin reuptake inhibitors (SSRIs), which are safe if properly managed. The FDA has decided that all antidepressants run the risk of encouraging suicidal thoughts, and they all carry warning labels. But the phenomenon is rare and has been tied only to suicidal ideation, not actual suicide attempts. (Child Mind Institute)

Persistent Depressive Disorder -Quick Facts

A brief overview of the signs and symptoms of persistent depressive disorder (dysthymia) and how it's treated in children and adolescents.

Overview

Persistent depressive disorder, also called dysthymia, is a form of chronic depression, with symptoms less severe but longer lasting than other forms of depression. It is a new diagnosis that combines two earlier diagnoses: dysthymia and chronic major depressive episode. Since symptoms are less acute than major depressive disorder, it may go unnoticed for some time.

Symptoms of persistent depressive disorder:

- Irritability or a depressed mood most of the time for more than a year
- Inability to take pleasure and perform well in the activities of daily life
- Behavior problems
- Poor performance at school
- Low self-esteem
- Difficulty interacting with other children in social situations
- Poor appetite or overeating
- Trouble sleeping
- Persistent tiredness or lack of energy
- Hopelessness
- Trouble concentrating
- Difficulty making decisions

Treatment and Prognosis

Treatment for persistent depressive disorder include medications and psychotherapy. A combination of the two is believed to be the most effective treatment. Psychotherapy includes cognitive behavioral therapy and interpersonal therapy. Medications include selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs) and tricyclic antidepressants (TCAs). (Child Mind Institute)

Post-Traumatic Stress Disorder -**Quick Facts**

A brief overview of the signs and symptoms of post-traumatic stress disorder, as well as treatments

Overview:

Post-traumatic stress disorder (PTSD) is an anxiety condition brought on by exposure to a disturbing event. Children who suffer from PTSD may exhibit detachment, difficulty sleeping, and irritability. They also often dream about the traumatic event, or reenact it during playtime. Though PTSD-like symptoms are common among children and adolescents exposed to trauma, the disorder is rare in young people.

Symptoms:

- Difficulty sleeping and frequent nightmares about the traumatic event
- Detachment, irritability, and frequent headaches or stomachaches
- Recreating the traumatic event during play
- Young children may regress—begin wetting the bed again, stop speaking, or become overly clingy with parents
- Adolescents may exhibit feelings of guilt and engage in self-destructive behavior

Causes:

PTSD is a failure to rebound or recover in a healthy way after experiencing a traumatic event. Violence, physical or sexual abuse, extreme neglect, bullying, bad accidents, and natural disasters can trigger PTSD. What causes one child to bounce back from a disturbing experience and another to develop PTSD? Susceptibility seems to run in families but it's not known whether that reflects a genetic component or that children learn unhealthy responses to trauma from their parents.

Treatment:

The treatment for PTSD often requires both behavioral therapy and medication.

Behavioral: Psychotherapy that helps children speak, draw, play, or write about their trauma has been successful in easing symptoms. In other cases, your child's clinician might recommend cognitive behavior therapy to teach your child to cope with his or her fear instead of addressing the trauma directly. Therapy sessions for children almost always involve a parent, a family member, or another caregiver.

Pharmacological: Medication may be prescribed to help alleviate fear and anxiety, starting with antidepressants and anti-anxiety drugs. If your child has persistent bad dreams, a drug used to treat hypertension called Prazosin has proven effective in curbing them.

Trauma in Children: A Look

Normal Grief

“Everyone grieves at a different pace,” Dr. Bubrick says, and an immediate reaction—or lack of one—is not really an indicator of how a child will cope with the loss. “If a child seems to be coping well now, they might still have a poor reaction later,” he says. “Or it could also just be a sign that they’re handling it well.” So while we want to help our children as much as possible immediately after the event, a lasting and hurtful response usually won’t be evident until 3 or 6 months later.

Increased Thinking About Death and Safety

One common sign of PTSD or a PTSD-like reaction is what Dr. Bubrick calls a “hyper-focus on mortality or death.” And while some kids become notably morbid and fascinated by death, others will develop an obsession with their own safety and the safety of those close to them. In the case of a fire or another disaster, their thoughts might return with disturbing regularity to the possibility of a fire in their own home, or of the earthquake or flood happening where they live.

Problems With Sleeping, Eating, Anger, and Attention

Some of the symptoms of trauma in children (and adults) closely mimic depression, including too much or too little sleep, loss of appetite or overeating, unexplained irritability and anger, and problems focusing on projects, school work, and conversation. Sometimes the symptoms appear more like an anxiety disorder—obsessive or pervasive worry, difficulty separating from parents.

Triggers

A year after a tragic event, we tend to look back, take stock, and memorialize those whose lives were lost. But as Dr. Bubrick observes, there are other anniversaries connected to children’s lives that could have unexpected consequences for them—the birthdays of friends or classmates who died, for instance. Children “could be basically OK between now and then, maybe with some rocky periods,” he says. “And then around the time of the birthday, they could have more symptoms. It’s a trigger.”

School Refusal

When an event is connected to school, such as the loss of classmates or violence at school itself, an unhealthy reaction could take the form of avoiding school. As Dr. Bubrick points out, school is “where the most reminders of the kids’ deaths will be.” While episodes of depression, heightened anxiety, trouble sleeping, and a fixation on the accident may be transient, avoiding school is a clear sign that something is wrong. “For the most part, everyone is going to experience some form of those things, altogether or in pieces,” says Dr. Bubrick. “But if, over time, it’s not really lifting and it’s continuing, it may result in school refusal altogether. At that point we definitely know the child needs help.”

You should also know that stress and trauma can manifest differently in girls and boys. Although this is by no means definitive, boys often react more quickly and with more irritation and anger, while girls can have delayed reactions that are more internal. (Child Mind Institute)

Angry Kids: Dealing With Explosive Behavior

How to respond when a child lashes out

When a child—even a small child—melts down and becomes aggressive, he can pose a serious risk to himself and others, including parents and siblings.

It's not uncommon for kids who have trouble handling their emotions to lose control and direct their distress at a caregiver, screaming and cursing, throwing dangerous objects, or hitting and biting. It can be a scary, stressful experience for you and your child, too. Children often feel sorry after they've worn themselves out and calmed down.

So what are you to do?

It's helpful to first understand that behavior is communication. A child who is so overwhelmed that he is lashing out is a distressed child. He doesn't have the skill to manage his feelings and express them in a more mature way. He may lack language, or impulse control, or problem-solving abilities.

Sometimes parents see this kind of behavior as manipulative. But kids who lash out are usually unable to handle frustration or anger in a more effective way—say, by talking and figuring out how to achieve what they want.

Nonetheless, how you react when a child lashes out has an effect on whether he will continue to respond to distress in the same way, or learn better ways to handle feelings so they don't become overwhelming. Some pointers:

- **Stay calm.** Faced with a raging child, it's easy to feel out of control and find yourself yelling at him. But when you shout, you have less chance of reaching him. Instead, you will only be making him more aggressive and defiant. As hard as it may be, if you can stay calm and in control of your own emotions, you can be a model for your child and teach him to do the same thing.
- **Don't give in.** Don't encourage him to continue this behavior by agreeing to what he wants in order to make it stop.
- **Praise appropriate behavior.** When he has calmed down, praise him for pulling himself together. And when he does try to express his feelings verbally, calmly, or try to find a compromise on an area of disagreement, praise him for those efforts.
- **Help him practice problem-solving skills.** When your child is not upset is the time to help him try out communicating his feelings and coming up with solutions to conflicts before they escalate into aggressive outbursts. You can ask him how he feels, and how he thinks you might solve a problem.
- **Time outs and reward systems.** Time outs for nonviolent misbehavior can work well with children younger than 7 or 8 years old. If a child is too old for time outs, you want to move to a system of positive reinforcement for appropriate behavior—points or tokens toward something he wants.
- **Avoid triggers.** Dr. Vasco Lopes, a clinical psychologist, says most kids who have frequent meltdowns do it at very predictable times, like homework time, bedtime, or when it's time to stop playing, whether it's Legos or the Xbox. The trigger is usually being asked to do something they don't like, or to stop doing something they do like**.** Time warnings ("we're going in 10 minutes"), breaking tasks down into one-step directions ("first, put on your shoes"), and preparing your child for situations ("please ask to be excused before you leave Grandma's table") can all help avoid meltdowns.

What kind of tantrum is it?

How you respond to a tantrum also depends on its severity. The first rule in handling nonviolent tantrums is to ignore them as often as possible, since even negative attention, like telling the child to stop, can be encouraging.

But when a child is getting physical, ignoring is not recommended since it can result in harm to others as well as your child. In this situation, Dr. Lopes advises putting the child in a safe environment that does not give her access to you or any other potential rewards.

If the child is young (usually 7 or younger), try placing her in a time out chair. If she won't stay in the chair, take her to a backup area where she can calm down on her own without anyone else in the room. Again, for this approach to work there shouldn't be any toys or games in the area that might make it rewarding.

Your daughter should stay in that room for one minute, and must be calm before she is allowed out. Then she should come back to the chair for time out. "What this does is gives your child an immediate and consistent consequence for her aggression and it removes all access to reinforcing things in her environment," explains Dr. Lopes.

If you have an older child who is being aggressive and you aren't able to carry her into an isolated area to calm down, Dr. Lopes advises removing yourself from her vicinity. This ensures that she is not getting any attention or reinforcement from you and keeps you safe. In extreme instances, it may be necessary to call 911 to ensure your and your child's safety.

Help with behavioral techniques

If your child is doing a lot of lashing out—enough that it is frequently frightening you and disrupting your family—it's important to get some professional help. There are good behavioral therapies that can help you and your child get past the aggression, relieve your stress and improve your relationship. You can learn techniques for managing his behavior more effectively, and he can learn to rein in disruptive behavior and enjoy a much more positive relationship with you.

- **Parent-child interaction therapy.** PCIT has been shown to be very helpful for children between the ages of 2 and 7. The parent and child work together through a set of exercises while a therapist coaches parents through an ear bud. You learn how to pay more attention to your child's positive behavior, ignore minor misbehaviors, and provide consistent consequences for negative and aggressive behavior, all while remaining calm.
- **Parent Management Training.** PMT teaches similar techniques as PCIT, though the therapist usually works with parents, not the child.
- **Collaborative and Proactive Solutions.** CPS is a program based on the idea that explosive or disruptive behavior is the result of lagging skills rather than, say, an attempt to get attention or test limits. The idea is to teach children the skills they lack to respond to a situation in a more effective way than throwing a tantrum.

Figuring out explosive behavior

Tantrums and meltdowns are especially concerning when they occur more often, more intensely, or past the age in which they're developmentally expected—those terrible twos up through preschool. As a child gets older, aggression becomes more and more dangerous to you, and the child. And it can become a big problem for him at school and with friends, too.

If your child has a pattern of lashing out it may be because of an underlying problem that needs treatment. Some possible reasons for aggressive behavior include:

- **ADHD:** Kids with ADHD are frustrated easily, especially in certain situations, such as when they're supposed to do homework or go to bed.
- **Anxiety**: An anxious child may keep his worries secret, then lash out when the demands at school or at home put pressure on him that he can't handle. Often, a child who "keeps it together" at school loses it with one or both parents.
- **Undiagnosed learning disability:** When your child acts out repeatedly in school or during homework time, it could be because the work is very hard for him.
- **Sensory processing issues**: Some children have trouble processing the information they are taking in through their senses. Things like too much noise, crowds and even "scratchy" clothes can make them anxious, uncomfortable, or overwhelmed. That can lead to actions that leave you mystified, including aggression.
- **Autism:** Children on all points of the spectrum are often prone to major meltdowns when they are frustrated or faced with unexpected change. They also often have sensory issues that make them anxious and agitated.

Given that there are so many possible causes for emotional outbursts and aggression, an accurate diagnosis is key to getting the help you need. You may want to start with your pediatrician. She can rule out medical causes and then refer you to a specialist. A trained, experienced child psychologist or psychiatrist can help determine what, if any, underlying issues are present.

When behavioral plans aren't enough

Professionals agree, the younger you can treat a child, the better. But what about older children and even younger kids who are so dangerous to themselves and others, behavioral techniques aren't enough to keep them, and others around them, safe?

- **Medication.** Medication for underlying conditions such as ADHD and anxiety may make your child more reachable and teachable. Kids with extreme behavior problems are often treated with antipsychotic medications like Risperdal or Abilify. But these medications should be partnered with behavioral techniques.
- **Holds.** Parent training may, in fact, include learning how to use safe holds on your child, so that you can keep both him and yourself out of harm's way.
- **Residential settings.** Children with extreme behaviors may need to spend time in a residential treatment facility, sometimes, but not always, in a hospital setting. There, they receive behavioral and, most likely, pharmaceutical treatment. Therapeutic boarding schools provide consistency and structure round the clock, seven days a week. The goal is for the child to internalize self-control so he can come back home with more appropriate behavior with you and the world at large.
- **Day treatment.** With day treatment, a child with extreme behavioral problems lives at home but attends a school with a strict behavioral plan. Such schools should have trained staff prepared to safely handle crisis situations.

Explosive children need calm, confident parents

It can be challenging work for parents to learn how to handle an aggressive child with behavioral approaches, but for many kids it can make a big difference. Parents who are confident, calm, and consistent can be very successful in helping children develop the skills they need to regulate their own behavior.

This may require more patience and willingness to try different techniques than you might with a typically developing child, but when the result is a better relationship and happier home, it's well worth the effort. (Child Mind Institute)

Approaches and Interventions

Cognitive behavioral therapy (CBT) is a type of psychotherapy that can be used with children. It has been widely studied and is an effective treatment for a number of conditions, such as depression, obsessive-compulsive disorder, and social anxiety. A person in CBT learns to change distorted thinking patterns and unhealthy behavior. Children can receive CBT with or without their parents, as well as in a group setting. CBT can be adapted to fit the needs of each child. It is especially useful when treating anxiety disorders

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DBT (Dialectical behavior therapy)

If you have a child with psychiatric or behavior problems, there's a good chance you've heard of mindfulness and cognitive behavioral therapy (CBT), two different approaches to helping kids with everything from test anxiety to depression. But there's another very promising therapy that combines elements of both. DBT, or dialectical behavior therapy, is an intensive, highly structured program that's been adapted specifically for adolescents with extreme emotional instability, including self-harm and suicidal ideation.

The "dialectical" in DBT means the therapy works by dealing with two things at once that might seem contradictory: acceptance of feelings (mindfulness) and learning to use thinking to change feelings (CBT). It's basically "'I'm doing the best I can' on the one hand," notes Dr. Alec Miller, professor in the Department of Psychiatry and Behavioral Sciences at the Albert Einstein College of Medicine "*and* 'I need to do better.' That's a dialectical truth."

How Does DBT Work?

DBT is designed to help with extreme emotional instability, which clinicians call "dysregulation" — the inability to manage intense emotions. Dysregulation leads to impulsive, self-destructive, or self-harming behaviors. The goal of DBT is to teach adolescents techniques to help them understand their emotions without judgment — the mindfulness component — and also to give them skills and techniques to manage those emotions and change behaviors in ways that will make their lives better. But it takes work and commitment.

DBT for adolescents involves individual therapy and group skills training, where parents and teenagers learn together. The feedback from parents, says Dr. Jill Emanuele, a clinical psychologist at the Child Mind Institute, is, "Where have these skills been all my life? I need these skills too." Other components

include telephone consultation (patients are encouraged to call their therapists when they feel the urge to self-harm), family therapy, and weekly consultation team meetings where the therapist checks in with other professionals to consult on the case.

What skills does DBT teach?

DBT skills training is very structured; for adolescents, it consists of five modules:

1. Mindfulness skills: Being present in the moment and understanding the signs of unregulated emotions
2. Emotion regulation skills: Coping with difficult situations by building pleasant, self-soothing experiences to protect from emotional extremes. "Especially with teenagers," says Dr. Emanuele, "there's a big focus on the physical body: eating properly, getting enough sleep, taking their medicine and avoiding drug use."
3. Interpersonal effectiveness skills: "It's often interactions with others that are the negative triggers for impulsive behaviors," Dr. Emanuele says. The purpose is to teach adolescents how to interact more effectively with others, and enable them to feel more supported by others.
4. Distress tolerance skills: "It's being able to recognize urges to do things that would be ineffective, such as hurting themselves or trying to kill themselves" and consciously controlling them, says Dr. Emanuele.
5. Walking the middle path skill: Kids and parents learn how to validate one another, how to compromise and negotiate, and how to see the other person's side of things. "It has to do with acknowledging multiple truths in the teenagers' and the parents' worldview as opposed to 'I'm right and you're wrong,' " explains Dr. Miller. (Child Mind Institute)

TF-CBT (Trauma Focused Cognitive Behavioral Therapy)

TF-CBT is the best evidence-based intervention for children who have impairing reactions to traumatic events. Studies that followed children for as long as one to two years after the end of treatment found that these improvements were sustained. This supports the promise of TF-CBT to potentially prevent the long-term problems associated with childhood trauma. TF-CBT is a short-term treatment approach that can work in as few as 12 sessions. It also may be provided for longer periods of time depending on the child's and family's needs.

1. Psychoeducation for both child and parent. What are normal traumatic responses (trouble sleeping, trouble concentrating, trauma triggers)
2. Skills building-relaxation training, thought stopping techniques. Also skills for parents in dealing with troubling behavior. Once skills and a sense of mastery we go to #3
    a. Relaxation and stress management skills are individualized for each child and parent.
    b. Affective expression and modulation are taught to help children and parents identify and cope with a range of emotions.

    c. Cognitive coping and processing are enhanced by illustrating the relationships among thoughts, feelings and behaviors. This helps children and parents modify inaccurate or unhelpful thoughts about the trauma.
3. Trauma Narrative-revisiting of trauma. Telling the story and the cognitions that go with it. Must be done so as to avoid the "I'll be fine if I just don't talk of it"; this is a core symptom of PTSD-Avoidance. If we just shove it in there, we can't close the suitcase. We need to examine issues which will allow us to "really put it away" without negative thoughts about self. Look at cognitions and make the link to how it affects your behavior and your emotions. Write a story or do this with cartoons or art project. Share with the caregiver. (Child Mind Institute)
4. In vivo mastery of trauma reminders is used to help children overcome their avoidance of situations that are no longer dangerous, but which remind them of the original trauma.
    a. In-Vivo Exposure
        i. Goal: • Separate harmless trauma reminders or triggers from fear (learned anxiety response) (e.g., fear of the dark) • Reduce avoidance that interferes with daily functioning
        ii. Methods: • Create a fear ladder list (triggers and specifics related to the trigger) • In session practice combined with weekly practice at home • Need to utilize/get buy-in from caregivers and support people in the client's environment • Utilize incentives and rewards (in session; at home: Parenting Skills of Praise and Rewards) • Can utilize coping skills (including cognitive coping) taught in earlier sessions. (University of Washington)

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