Externalizing Disorders in Children and Adolescents: An Evidence Based Practice and Personal View

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Keynote

- Apology Again
- Long Term Indicators
- What is an Externalizing Disorder and the Course and Stability of the Behaviors
- Causes
- Evidence Based Interventions that Work and Do Not Work-Resources

Long Term Indicators for Outcome for Externalizing Disorders

- Aggression and Noncompliance
- Arguing Behavior
- Impulsivity
- Academic Failure
- Reading
- Substance Abuse-Legal Snares
- Inappropriate Peer Group Association

Long Term Outcomes for Externalizing Disorders

- Higher rates of anti-social violence
- Increased arrest and imprisonment rates
- Higher rates of comorbid psychiatric disorders
- Higher rates of depression and suicide
- Increased substance abuse
- Higher divorce and domestic violence rates
- Multiple employment failures

Commonly Used Labels for Tough Kids

- Behaviorally Disordered (BD)
- Seriously Emotionally Disturbed (SED)
- Conduct Disordered (CD)
- Oppositionally Defiant Disordered (ODD)
- Attention Deficit Hyperactivity Disordered (ADHD)
- Reactive Attachment Disordered (RAD)
  - Disinhibited Social Engagement Disorder (DSED)
- Intermittent Explosive Disordered (IED)
- Mood Disordered Bipolar (MD)
  - Disruptive Mood Dysregulation Disorder (DMDD)

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Researchers Fail to Reveal Full Drug Pay

Possible Conflicts Seen in Child Psychiatry

By GARDINER HARRIS and BENEDICT CAREY

A world-renowned Harvard child psychiatrist whose work has helped fuel an explosion in the use of powerful antipsychotic medicines in children earned at least $1.6 million in consulting fees from drug makers from 2000 to 2007 but for years did not report much of this income to university officials, according to information given Congressional investigators.

By failing to report income, the psychiatrist, Dr. Joseph Biederman, and a colleague in the psychiatry department at Harvard Medical School, Dr. Timothy E. Wilens, may have violated federal and university research rules designed to police potential conflicts of interest, according to Senator Charles E. Grassley, Republican of Iowa. Some of their research is financed by government grants.

Like Dr. Biederman, Dr. Wilens belatedly reported earning at least $1.6 million from 2000 to 2007, and another Harvard colleague, Dr. Thomas Spencer, reported earning at least $1 million after being pressed by Mr. Grassley's investigators. But even these amended disclosures may understate the researchers' outside income because some entries contradict payment information from drug makers, Mr. Grassley found.

In one example, Dr. Biederman reported no income from Johnson & Johnson for 2001 in a disclosure report filed with the university. When asked to check again, he said he received $3,500. But Johnson & Johnson told Mr. Grassley that it paid him $58,169 in 2001, Mr. Grassley found.

The Harvard group's consulting arrangements with drug makers were already controversial because of the researchers' advocacy of unapproved uses of psychiatric medicines in children.

In an e-mailed statement, Dr.

Continued on Page 28

Child Experts Fail to Reveal Full Drug Pay

From Page 1

Biederman said, "My interests are solely in the advancement of medical treatment through rigorous and objective study," and he said he took conflict-of-interest policies "very seriously." Drs. Wilens and Spencer said in e-mailed statements that they thought they had complied with conflict-of-interest rules.

John Burklow, a spokesman for the National Institutes of Health, said: "If there have been violations of N.I.H. policy — and if research integrity has been compromised — we will take all the appropriate action within our power to hold those responsible accountable. This would be completely unacceptable behavior, and N.I.H. will not tolerate it."

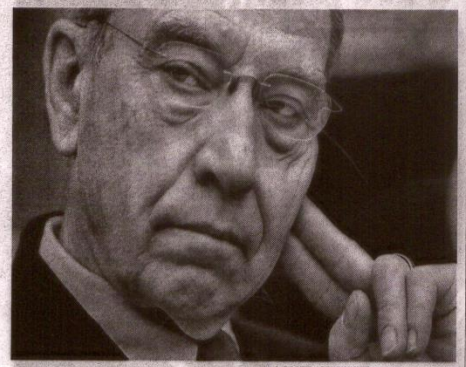
The federal grants received by Drs. Biederman and Wilens were administered by Massachusetts General Hospital, which in 2005 won $287 million in such grants. The health institutes could place restrictions on the hospital's grants or even suspend them altogether.

Alyssa Kneller, a Harvard spokeswoman, said in an e-mailed statement: "The information released by Senator Grassley suggests that, in certain instances, each doctor may have failed to disclose outside income from pharmaceutical companies and other entities that should have been disclosed."

Ms. Kneller said the doctors had been referred to a university conflict committee for review.

Mr. Grassley sent letters on Wednesday to Harvard and the health institutes outlining his investigators' findings, and he placed the letters along with his comments in The Congressional Record.

Dr. Biederman is one of the most influential researchers in child psychiatry and is widely admired for focusing the field's attention on its most troubled young patients. Although many of his studies are small and often financed by drug makers, his work helped to fuel a controversial 40-fold increase from 1994 to 2003 in the diagnosis of pediatric bipolar disorder, which is characterized by severe mood swings, and a rapid rise in the use of anti-



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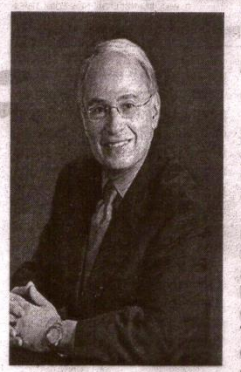
Senator Charles E. Grassley pushed three experts in child psychiatry at Harvard to expose their income from consulting fees.



Dr. Joseph Biederman belatedly reported at least $1.6 million in consulting fees.

pays them $80,000 a year, I don't even know how to check on that."

Some states have laws requiring drug makers to disclose payments made to doctors, and Mr. Grassley and others have sponsored legislation to create a national registry.

Lawmakers have been concerned in recent years about the use of unapproved medications in children and the influence of industry money.

Mr. Grassley asked Harvard for the three researchers' financial disclosure reports from 2000 through 2007 and asked some drug makers to list payments made to them.

"Basically, these forms were a

Universities ask professors to report conflicts, but do little to verify accuracy.

atrists in the world.

In the past decade, Dr. Biederman and his colleagues have promoted the aggressive diagnosis and drug treatment of childhood bipolar disorder, a mood problem once thought confined to adults. They have maintained that the disorder was underdiagnosed in children and could be treated with antipsychotic drugs, medications invented to treat schizophrenia.

Other researchers have made similar assertions. As a result, pediatric bipolar diagnoses and antipsychotic drug use in children have soared. Some 500,000 children and teenagers were given at least one prescription for an antipsychotic in 2007, including 20,500 under 6 years of age, according to Medco Health Solutions, a pharmacy benefit manager.

Few psychiatrists today doubt that bipolar disorder can strike in the early teenage years, or that many of the children being given the diagnosis are deeply distressed.

"I consider Dr. Biederman a true visionary in recognizing this illness in children," said Susan

psychotic medicines in children. The Grassley investigation did not address research quality.

Doctors have known for years that antipsychotic drugs, sometimes called major tranquilizers, can quickly subdue children. But youngsters appear to be especially susceptible to the weight gain and metabolic problems caused by the drugs, and it is far from clear that the medications improve children's lives over time, experts say.

In the last 25 years, drug and device makers have displaced the federal government as the primary source of research financing, and industry support is vital to many university research programs. But as corporate research executives recruit the brightest scientists, their brethren in marketing departments have discovered that some of these same scientists can be terrific pitchmen.

To protect research integrity, the National Institutes of Health require researchers to report to universities earnings of $10,000 or more per year, for instance, in consulting money from makers of drugs also studied by the researchers in federally financed trials. Universities manage financial conflicts by requiring that the money be disclosed to research subjects, among other measures.

The health institutes last year awarded more than $23 billion in grants to more than 325,000 researchers at over 3,000 universities, and auditing the potential conflicts of each grantee would be impossible, health institutes officials have long insisted. So the government relies on universities.

Universities ask professors to report their conflicts but do almost nothing to verify the accuracy of these voluntary disclosures.

"It's really been an honor system thing," said Dr. Robert Alpern, dean of Yale School of Medicine. "If somebody tells us that a pharmaceutical company

mess," Mr. Grassley said in comments he entered into The Congressional Record on Wednesday. "Over the last seven years, it looked like they had taken a couple hundred thousand dollars."

Prompted by Mr. Grassley's interest, Harvard asked the re-

Three child psychiatry experts at Harvard made millions from drug makers.

searchers to re-examine their disclosure reports.

In the new disclosures, the trio's outside consulting income jumped but was still contradicted by reports sent to Mr. Grassley from some of the companies. In some cases, the income seems to have put the researchers in violation of university and federal rules.

In 2000, for instance, Dr. Biederman received a grant from the National Institutes of Health to study in children Strattera, an Eli Lilly drug for attention deficit disorder. Dr. Biederman reported to Harvard that he received less than $10,000 from Lilly that year, but the company told Mr. Grassley that it paid Dr. Biederman more than $14,000 in 2000, Mr. Grassley's letter stated.

At the time, Harvard forbade professors from conducting clinical trials if they received payments over $10,000 from the company whose product was being studied, and federal rules required such conflicts to be managed.

Mr. Grassley said these discrepancies demonstrated profound flaws in the oversight of researchers' financial conflicts and the need for a national registry. But the disclosures may also cloud the work of one of the most prominent group of child psychi-

Kesko, director of the Child and Adolescent Bipolar Foundation, "and he's not only saved many lives but restored hope to thousands of families across the country."

Longtime critics of the group see its influence differently. "They have given the Harvard imprimatur to this commercial experimentation on children," said Vera Sharav, president and founder of the Alliance for Human Research Protection, a patient advocacy group.

Many researchers strongly disagree over what bipolar looks like in youngsters, and some now fear the definition has been expanded unnecessarily, due in part to the Harvard group.

The group published the results of a string of drug trials from 2001 to 2006, but the studies were so small and loosely designed that they were largely inconclusive, experts say. In some studies testing antipsychotic drugs, the group defined improvement as a decline of 30 percent or more on a scale called the Young Mania Rating Scale — well below the 50 percent change that most researchers now use as the standard.

Controlling for bias is especially important in such work, given that the scale is subjective, and raters often depend on reports from parents and children, several top psychiatrists said.

More broadly, they said, revelations of undisclosed payments from drug makers to leading researchers are especially damaging for psychiatry.

"The price we pay for these kinds of revelations is credibility, and we just can't afford to lose any more of that in this field," said Dr. E. Fuller Torrey, executive director of the Stanley Medical Research Institute, which finances psychiatric studies. "In the area of child psychiatry in particular, we know much less than we should, and we desperately need research that is not influenced by industry money."

Functional Definition of Externalizing Disorders Definition

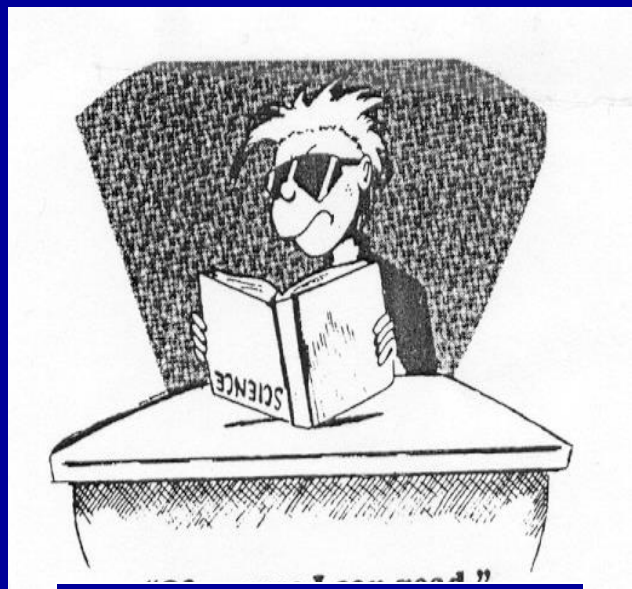
Make Me

- ***Behavior Excesses***

- Noncompliance
- Aggressive
- Argumentative
- Destroys Property

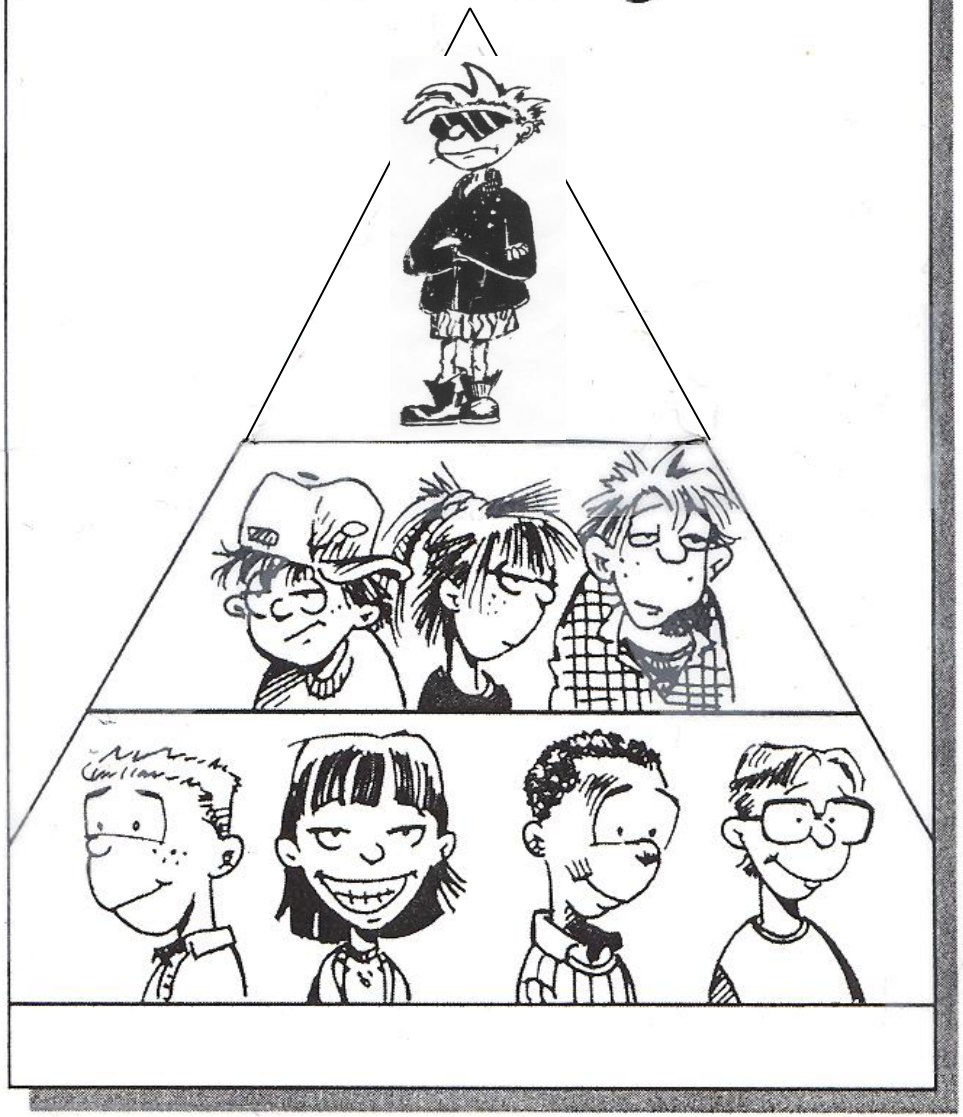
- ***Behavior Deficits***

- Contingency Governed – Not rule governed
- Poor Social Skills
- Academic Deficits



Of Course I Can Read

Student Intervention Needs Triangle



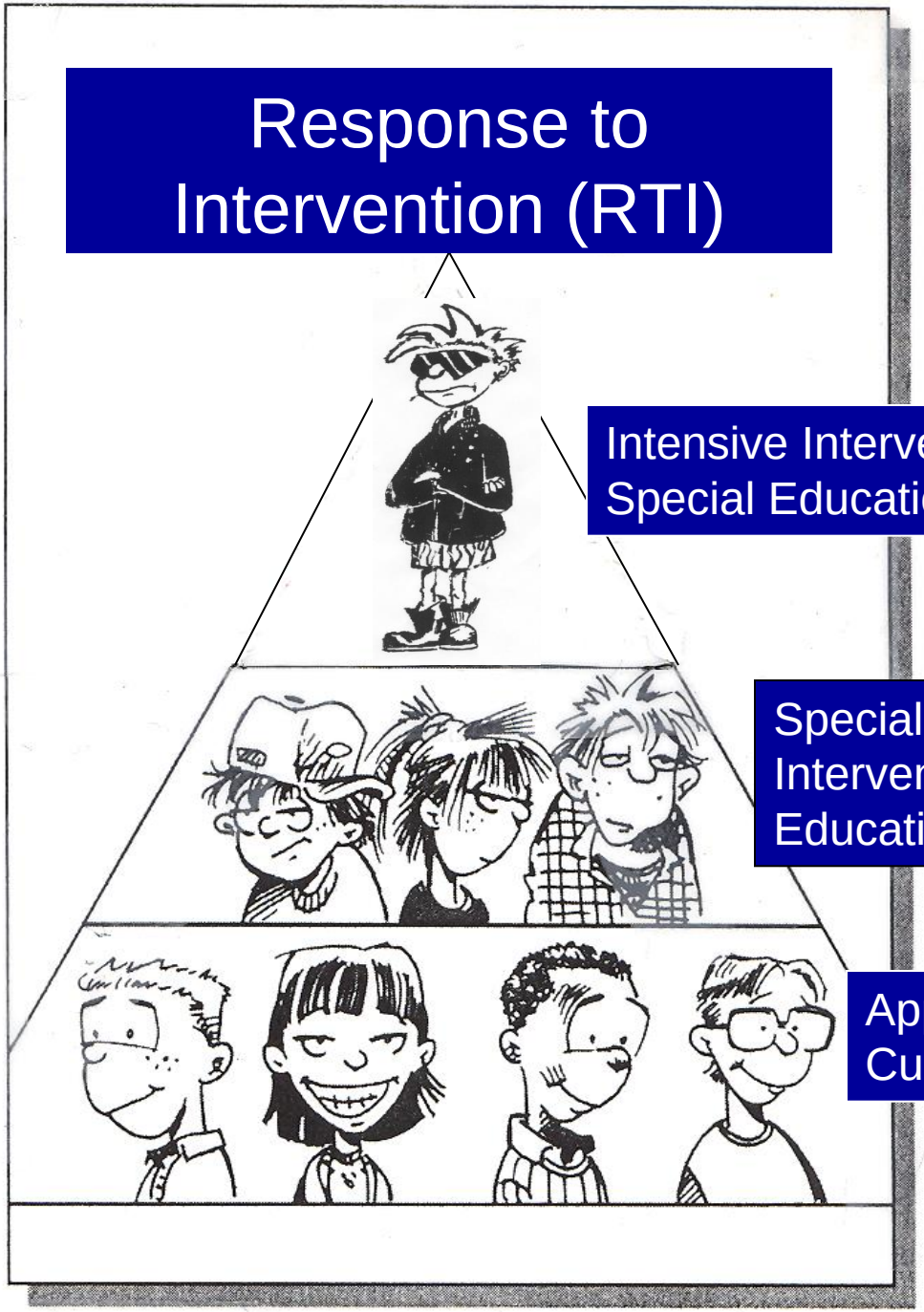
Self-Management Deficits and Externalizers

- Non-disabled students are Rule Governed and internalize values
- Tough Kids are Contingency Governed- First thing that catches their attention impulsively controls their behavior
- **Supervision** is the most effective intervention

Academics Deficits and Externalizers

- Eight percent have academic difficulties
- Reading is their largest deficit
- When entering secondary school 90% have study skills deficits
- Their on-task rates are 35% below nondisabled students

Response to Intervention (RTI)



Intensive Interventions-Special Education

Specialized Academic Interventions-General Education

Appropriate General Curriculum-Reading

Academics and the Tough Kid

- Reading is the most important skill
- 80% of Tough Kids have an academic deficit
- Programs that work: Direct instruction, phonetic based, word attack approaches, CBM-Dibels
  - *National Reading Panel Report*
- **Not** whole language, developmentally based, literacy based, balance literacy, or reading recovery programs

Learning to read

The reading scores of many first-graders in San Diego city schools plummeted last year — which also was the first year teachers abandoned a skills-based approach to teaching reading in favor of "whole language" instruction. Under the new approach, students begin with real works of literature, then learn skills, rather than learning skills and working up to literature. Some teachers say the scores — on nationally standardized tests — are proof that the switch isn't working. Others say the test is designed to measure the skills-based approach and simply can't gauge what whole language is trying to do. The first-graders tested attended schools where more than half of the students were ethnic minorities.

Year	% of first-graders scoring above national median*	Year	% of first-graders scoring above national median*
1980	34.4	1986	57.2
1981	40.5	1987	59.4
1982	36.2	1988	52.8
1983	48.4	1989	53.5
1984	59.7	1990	51.0
1985	54.3	**1991**	**25.7**

*The 1980-90 scores are from the Comprehensive Test of Basic Skills. The 1991 scores are from the abbreviated Stanford Achievement Tests, equated to CTBS.

SOURCE: San Diego city schools

Sample pages inside

SKILLS FOR SCHOOL SUCCESS

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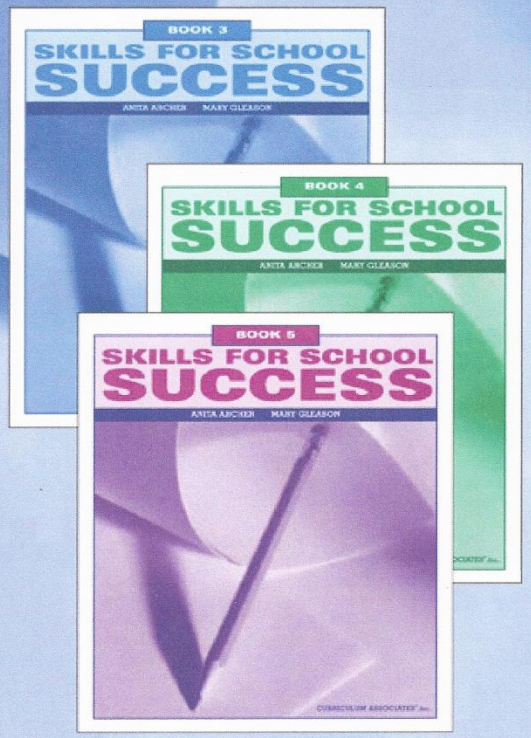
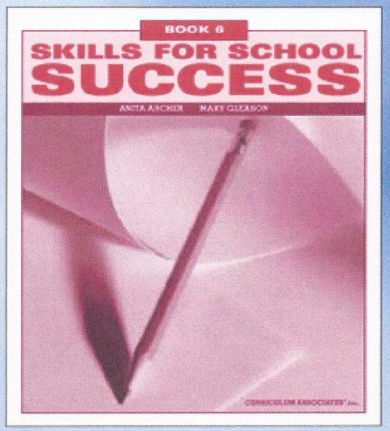
GRADES 3–6



Effective learning strategies for highly successful students

A RESEARCH-BASED PROGRAM



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Skills for School Success—Scope and Sequence

	Book 3	Book 4	Book 5	Book 6
School Behaviors and Organization Skills				
Using Appropriate Before-Class Behaviors	I	E	R	R
Using Appropriate During-Class Behaviors	I	E	R	R
Organizing and Using Notebooks	I	R	R	R
Writing Entries on an Assignment Calendar	I	E	R	R
Using a Calendar to Plan Homework	I	E	E	E
Getting Ready to Do Homework	I	E	R	R
Completing Homework	I	E	E	R
Organizing Assignments on Papers **(HOW)**	I	R	R	R
Organizing Desks and Other Materials	I	R	R	R
Learning Strategies				
Strategies for Gaining Information and Responding in Class				
• Completing Assignments with Directions	I	E	R	R
• Memorizing/Studying Information **(RCRC)**	I	E	R	R
• Answering Chapter Questions	I	E	E	E
• Proofreading Written Assignments	I	E	E	R
• Previewing Chapter Content **(Warm-up)**		I	R	R
• Reading Expository Chapters **(Active Reading)**		I	E	R
• Taking Notes on Written Material			I	E
• Taking Notes on Lectures				I
Strategies for Studying for and Taking Tests				
• Multiple-Choice Tests	I	E	R	R
• True-False Tests		I	E	R
• Short-Answer Tests			I	E
• Content-Area Tests			I	E
• Skill-Based Tests			I	E
Textbook Reference Skills				
Using the Table of Contents	I	E	R	R
Using the Glossary	I	E	R	R
Using the Index	I	E	E	R
Selecting the Appropriate Reference Source	I	E	E	R
Locating Information on the Title Page			I	R
Using the Copyright Page			I	R
Using Other Reference Lists				I
Graphics				
Reading and Interpreting Graphics				
• Pictographs	I	E	E	E
• Pie Graphs	I	E	E	E
• Vertical Bar Graphs	I	E	E	E
• Line Graphs		I	E	E
• Horizontal Bar Graphs			I	E
• Tables			I	E
Comparing Information on Graphs of Same Type			I	E
Interpreting and Comparing Information from Different Types of Graphs				I
Reference Books				
Alphabetizing	I	R		
Locating Words Quickly in a Dictionary	I	R	R	R
Reading and Interpreting Dictionary Entries	I	E	E	E
Locating Entries in an Encyclopedia			I	E
Locating Information in Encyclopedia Entries			I	E

I= INTRODUCED The skill or strategy is introduced at this level.
E=EXTENDED The skill, strategy, and/or instructional examples are extended and are, therefore, more difficult.
R=REVIEWED The skill or strategy is systematically reviewed and maintained.

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8/03

Things That Need to Be Considered for Levels Two and Three for RTI

- ***Condition Aversion*** to Academics Because of Failure (Heavy Metal Poisoning)-Skiing Example
- Problem-Students have to do more of what they dislike (***Motivational Issues***)

Social Skills Deficits and Externalizers

They are approximately 2 years behind their peers in social skills by the 6th grade (Patterson)

They are impulsive socially

They use coercion to dominate social situations

It takes approximately 45 minutes for them to be excluded by their nondisabled peers (Walker)

They gravitate socially towards other externalizing students

Traditional social skills programs do not work with externalizing students

Assumptions for Externalizing Students

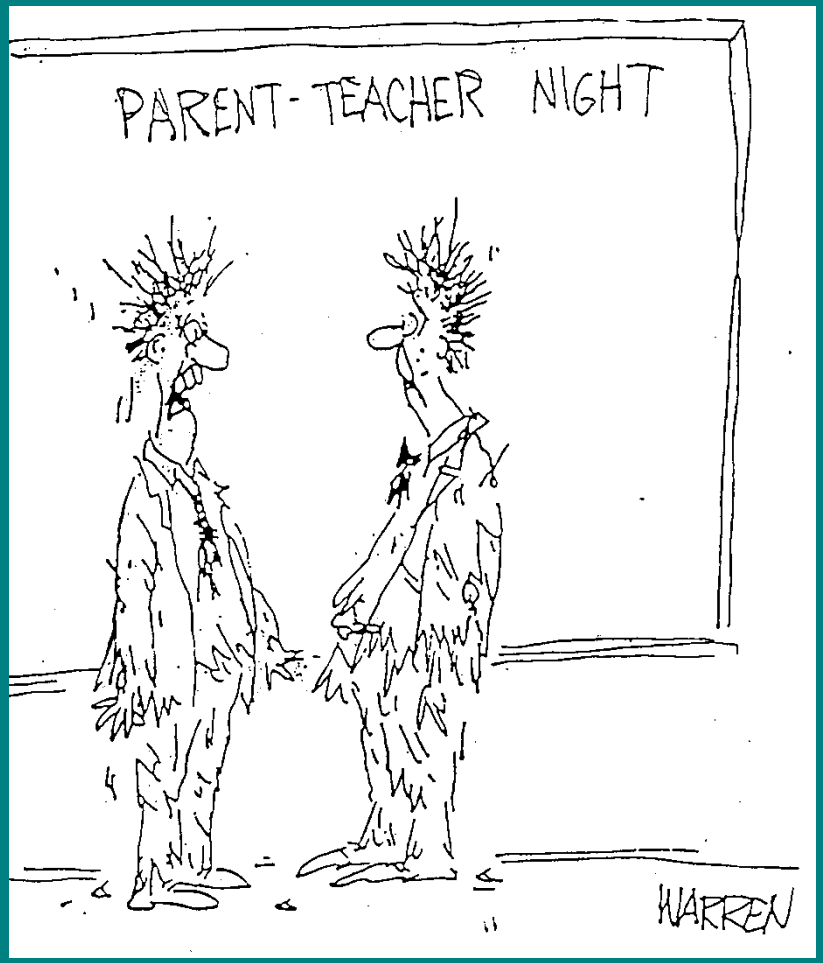
Assumption 1:
Tough Kids are managed not cured

Assumption 2:
There are multiple causes for Tough Kids

Assumption 3:
Positives work best with Tough Kids

Assumption 4:
Mystery assumption?

(You have to like the kids and their behaviors)

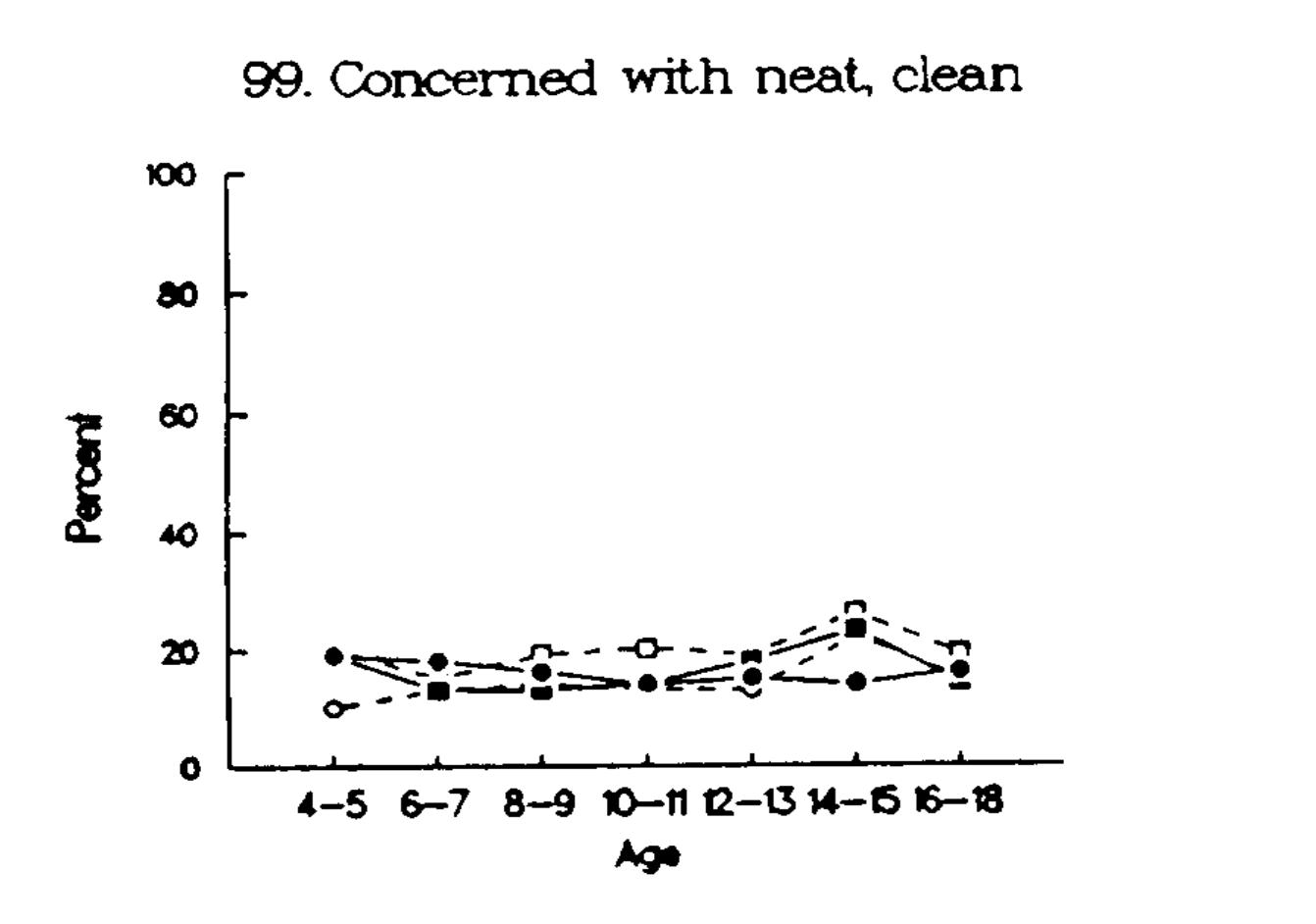


You Must be Timmy's Dad. I'm Timmy's Teacher.

Behaviors That Go Away or Don't Go Away

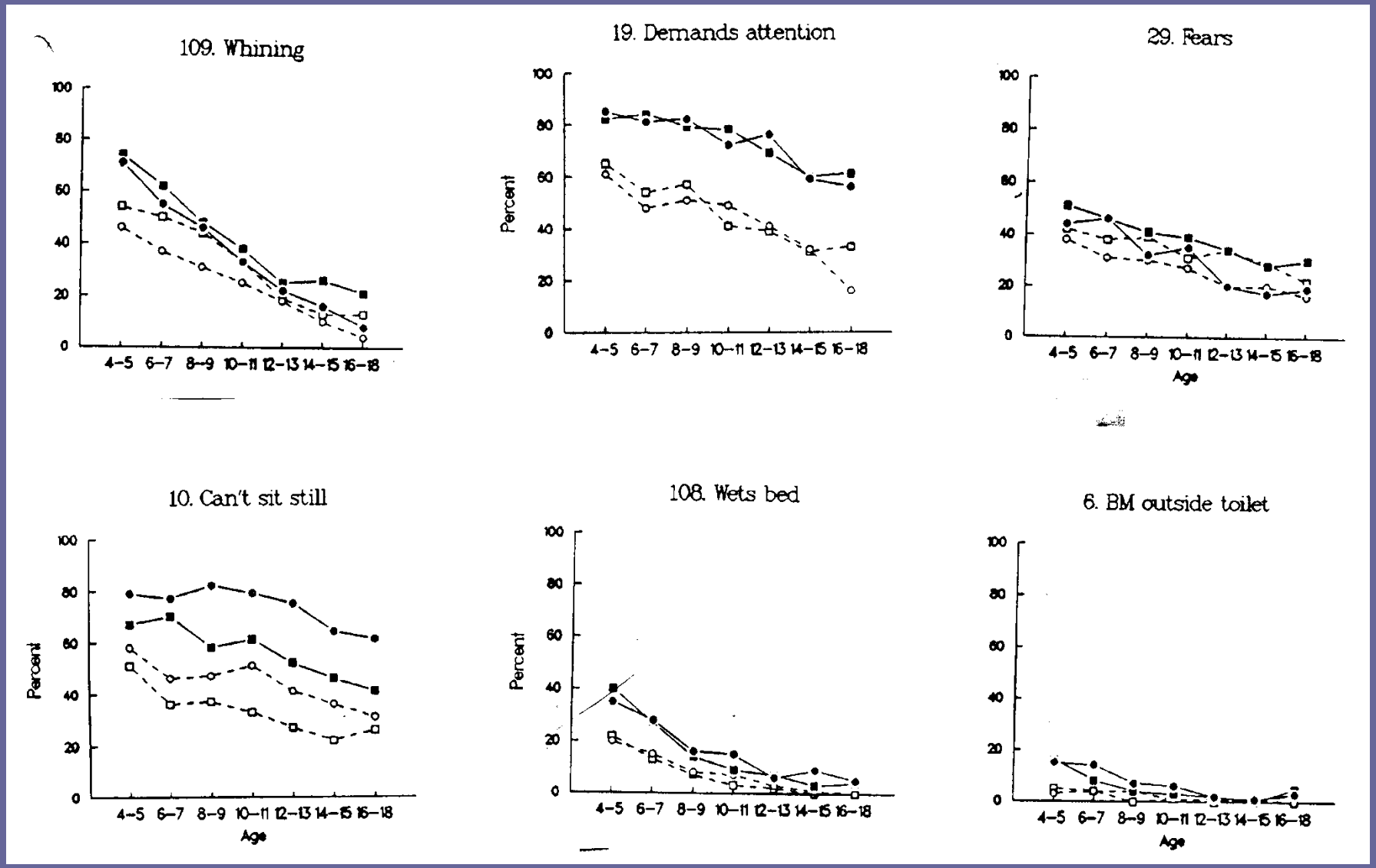
- Circles are Males ○
- Squares are Females □
- Open Squares and Circles Nonproblem Children ● ■
- Closed Squares and Circles Tough Kids Referred○ □
- From Ages 4 to 18

What Children Grow Out of and Do Not Grow Out Of



Source: Achenbach T. A. (1991) *Manual for the Child Behavior Checklist/4-18*. Burlington, VT: University of Vermont.

What Goes Away Naturally



- www.bedwettingstore.com/
- Alarms Clippo
- Malem ULTIMATE
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- Rodger Wireless
- Starter Kits Malem Starter Kit
- Malem ULTIMATE Kit
- Malem Wireless Kit
- Rodger Wireless Kit
- Bedding Underpads
- Mattress Pads
- Waterproof Covers
- Vinyl Covers

UCAN Poop Too: Encopresis

- http://www.ucanpooptoo.com/
- University Of West Virginia-Department of Pediatrics
- 12 Years of Research
- On-Line Treatment
- 20 On-Line Modules

Journal of Consulting and Clinical Psychology
2003, Vol. 71, No. 5, 910–917

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0022-006X/03/$12.00 DOI: 10.1037/0022-006X.71.5.910

An Internet Intervention as Adjunctive Therapy for Pediatric Encopresis

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Vanderbilt University Medical Center

Boris Kovatchev and Lela McKnight
University of Virginia Health System

Kushal Patel
Vanderbilt University Medical Center

Stephen Borowitz and James Sutphen
University of Virginia Health System

This study evaluated the benefits of enhanced toilet training delivered through the Internet for children with encopresis. Twenty-four children with encopresis were randomly assigned to the Internet intervention group (Web) or no Internet intervention group (No-Web). All participants continued to receive routine care from their primary care physician. The Web participants demonstrated greater improvements in terms of reduced fecal soiling, increased defecation in the toilet, and increased unprompted trips to the toilet ($ps < .02$). Both groups demonstrated similar improvements in knowledge and toileting behaviors. Internet interventions may be an effective way of delivering sophisticated behavioral interventions to a large and dispersed population in a convenient format.

Pediatric encopresis is a relatively common problem that is typically resistant to primary care intervention. Incidence estimates range from 1.5% to 7.5% of school children ages 6 to 12 years (Doleys, 1983). Encopresis accounts for 3% of general pediatric clinic visits (Loening-Baucke, 1993) and 25% of all pediatric gastroenterology clinic visits (Levine, 1975). There are many different ways of treating encopresis, including medical management, which typically involves the administration of enemas and laxatives (Levine & Bakow, 1976; Loening-Baucke, 2002); biofeedback, in which electromyographic monitoring is used to examine muscle strength and control, as well as reversing paradoxical constriction of the external anal sphincter (Cox, Sutphen, Borowitz, & Ling, 1999; Loening-Baucke, 1990); behavioral interventions, focusing on improving defecation dynamics through instruction and modeling, reinforcement of routine toileting behaviors, and promoting a positive problem-solving approach among patient and parents (Cox, Sutphen, Borowitz, Dickens, & Singles, 1994; Loening-Baucke, 1990; Van der Plas et al., 1996); and a combinations of these methods (Cox et al., 1999; Stark, Owens-Stively, Spirito, Lewis, & Guevremont, 1990).

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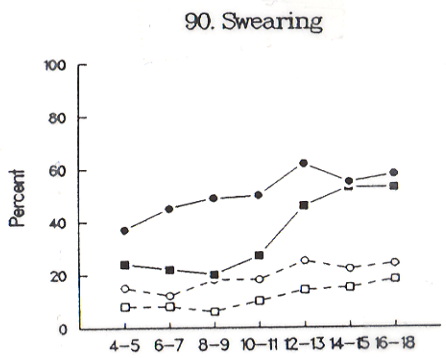
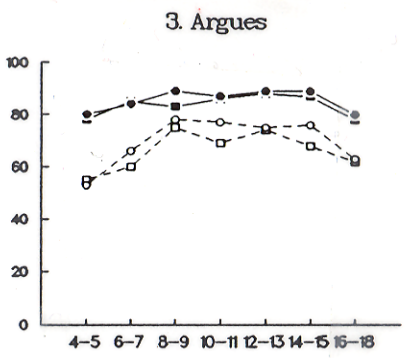
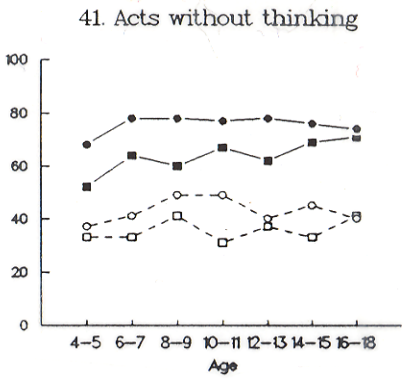
The outcomes associated with encopresis treatment programs vary considerably. In a recent review of the literature, McGrath, Mellon, and Murphy (2000) reported that medical intervention produced a 40% cure rate, which was defined as no accidents at postassessment. They further reported that for studies in which biofeedback was used with medical management (e.g., Cox et al., 1994; Loening-Baucke, 1990; Wald, Chandra, Gabel, & Chiponis, 1987), cure rates ranged from 55% to 79%. However, the addition of biofeedback does not necessarily enhance treatment outcome beyond that obtained with intensive medical management and behavioral intervention (Cox et al., 1999). Studies using positive reinforcement in combination with medical intervention reported cure rates ranging from 43% to 51% (Cox et al., 1994; Loening-Baucke, 1990; Van der Plas et al., 1996). The use of a group intervention combining medical treatment with behavioral techniques (enemas, education, bowel monitoring, goal setting, sitting regimen, reinforcement, and skill building) was found to produce an 89% cure rate in one study (Stark et al., 1990). In a replication of this study, 86% of the children had zero or one accident each week after treatment (Stark et al., 1997). In a review of randomized, controlled studies, Brooks et al. (2000) reported that standardized medical–behavioral treatments that combined enemas and/or laxatives with a toilet-sitting regimen, delivered by research clinicians, significantly reduced soiling in 16%–59% of children (Loening-Baucke, 1990; Van der Plas et al., 1996). The wide range of improvements across studies is likely due to variations in the definition of success as well as differences in treatment approach, study population, and study design.

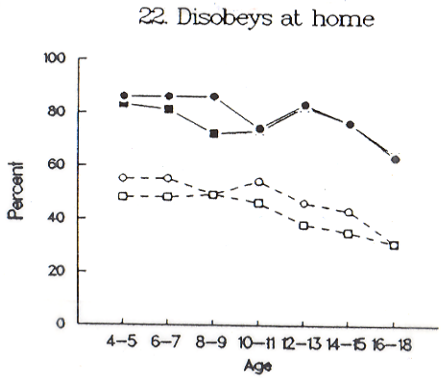
Enhanced toilet training (ETT) incorporates behavioral treatment (reinforcement for spontaneous use of the toilet and clean pants, instructions and modeling on how to strain and how to retain stool, education on anatomy and physiology) with the regimen of medical management. It is enhanced because it additionally in-

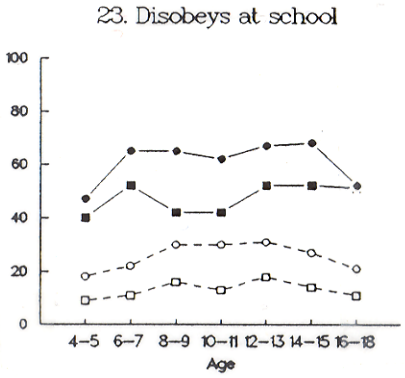
Behaviors That Do Not Go Away

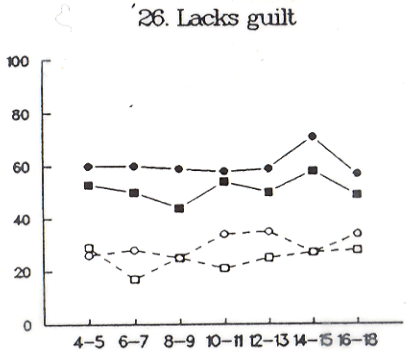




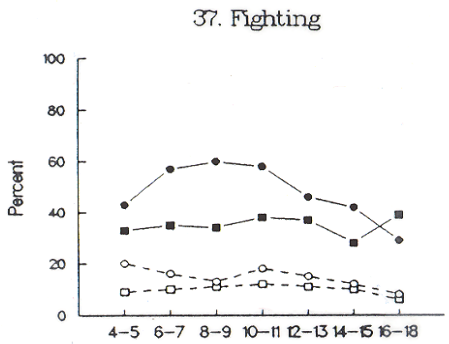


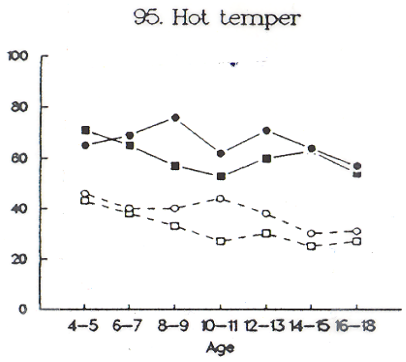


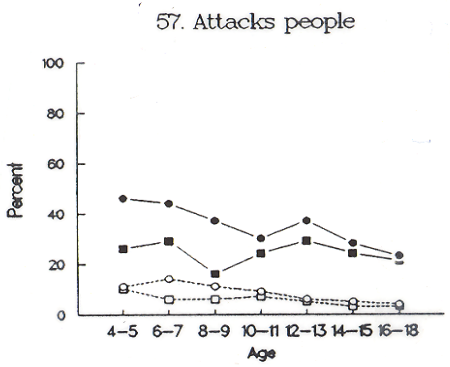


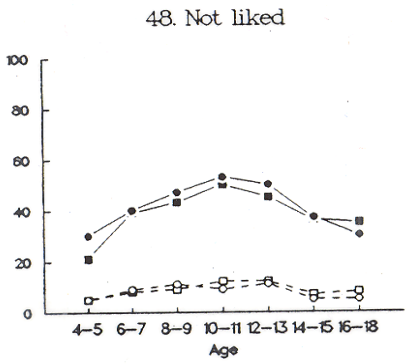


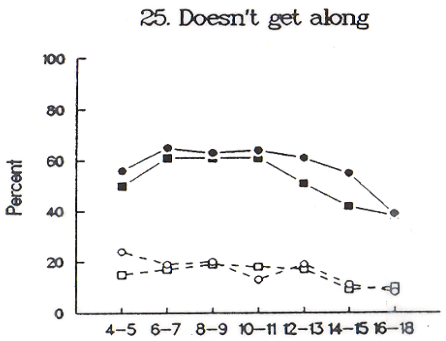
Stable and Social Behaviors

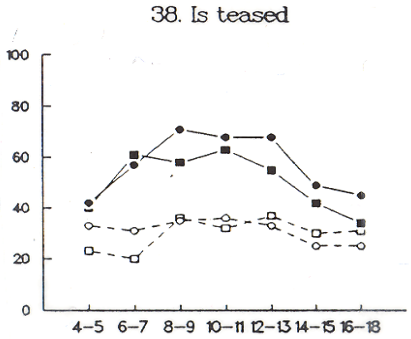
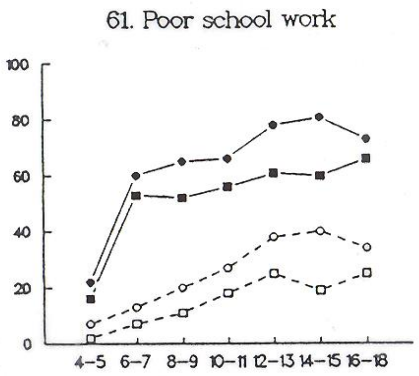
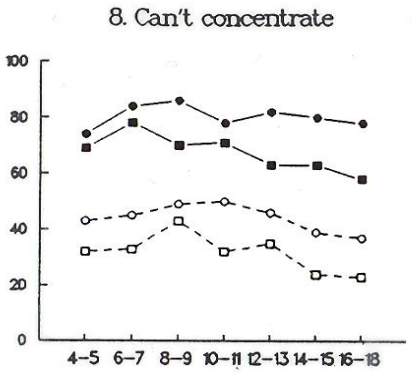
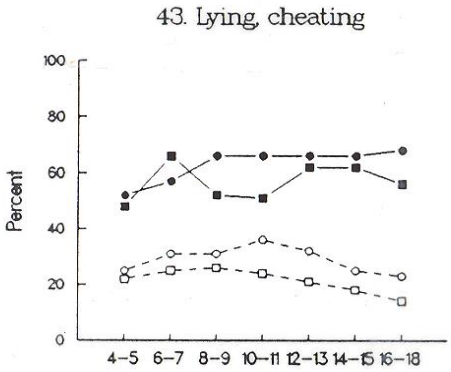
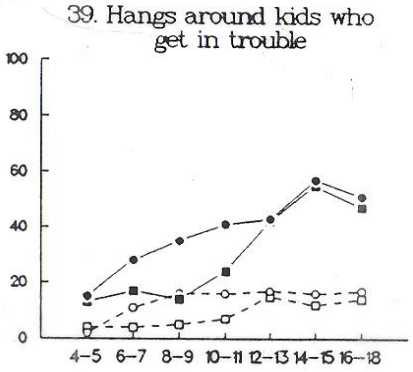
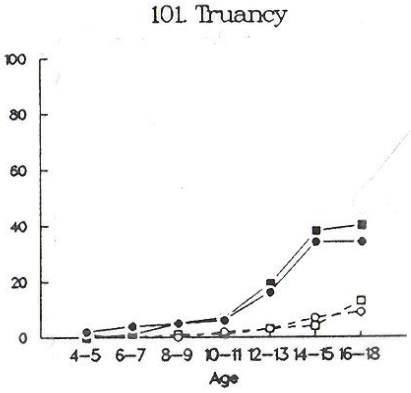
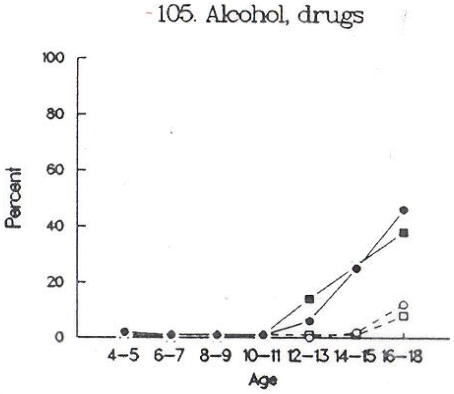












School and Age 10 Behaviors