# PEDIATRICIANS NEED TO KNOW MENTAL HEALTH!

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## Primary Care and Child Behavioral Health

- Most families seek help for mental health concerns initially in the primary care setting
- This is particularly so for families from culturally , economically, racially and ethnically diverse communities
- Some studies say that up to 70% of primary care medical appointments are for issues related to psychosocial concerns

## So: What's new or different ??

- DSM5 and ICD 10
- October 1st 2015 ICD 9 goes away and ICD takes over
- On this date DSM IV goes away and DSM5 takes over

## DSM 5

- We have 3 things to deal with:
- Changes in criteria for old diagnoses
- Loss of some previously frequently used diagnoses ( no more NOS )
- New Diagnoses

## DSM 5: Changes in diagnostic criteria ADHD

Still same 18 symptoms

Still divided into 2 symptom domains

1. Inattention
2. Hyperactivity /impulsivity

Still at least 6 symptoms are needed in one domain

## ADHD

Changes

1.Cross-situational requirement has been strengthened to " several " symptoms in each setting

2.Age of onset changed " several symptoms present prior to age 12 "

3. Comorbid diagnosis with Autism Spectrum now allowed

4. Subtypes changed to specifiers

5. Symptoms threshold change for adults

## Treatment: Stimulants

Advantages

- Can have some immediate onset of action
- Ability to use drug holidays
- Multiple options for drug delivery, peak actions, duration of action

## Treatmment: Stimulants

Disadvantages

- Patients may develop tolerance, psychological dependence
- May worsen motor and phonic tics
- Long-term use may suppress growth

## Treatment:Psychostimulants

- Effective for both motor and attention symptoms
  - Effects on motor activity may persist longer than effects on attention
  - Higher doses may be needed for attention symptoms than for motor symptoms
- Avoid dosing late in day because of risk of insomnia
- Children who are not growing or gaining weight should stop treatment, at least temporarily
- Theoretically, stimulatory actions would counter (and be countered by) therapeutic actions of antipsychotics and mood stabilizers
- Some patients respond to or tolerate methylphenidate better than amphetamine, and vice versa
- Half-life and duration of clinical action may be shorter in younger children
- Some patients may benefit from occasional 5-10 mg immediate release added to daily dose of sustained release
- Should not be used in individuals with structural cardiac abnormalities

## Atomoxetine:

- Dosing based on weight: 1.2 mg/kg/day
- Rare accounts of severe liver damage
- Metabolized by CYP450 2D6, so inhibitors/inducers of that enzyme can affect atomoxetine levels
- Individuals deficient in CYP450 2D6 (~7% of population) should receive half the usual dose
- Advantages
  - Once-daily dosing
  - No known abuse potential
  - No apparent effects on growth
  - Does not seem to exacerbate tics
- Disadvantages
  - Delayed onset of action
  - May not work as well as stimulants in some patients

## Selective Mutism

- No longer classified in the section " disorders Usually First Diagnosed in Infancy, Childhood or Adolescence"
- Now classified as an Anxiety Disorder
- Criteria largely remained unchanged

## Evidenced Based Treatment:

- Controlled Exposure Therapy
  including work in the office and homework
- Cognitive Behavioral Therapy ( CBT )
  manualized and a distinct treatment course
- Medications
  SSRIs

Fluoxetine and Fluvoxamine have both been studied and found to be helpful

## Separation Anxiety

- No longer classified in the section " disorders Usually First Diagnosed in Infancy, Childhood or Adolescence"
- Now classified as an Anxiety Disorder
- Criteria largely remained unchanged
- Criteria no longer says age of onset before age 18 years
- Duration for adults is " lasting more than 6 months or more"

## Intellectual Disability

- Severity is determined by adaptive functioning rather than IQ score
- Emphasis on the need for assessment of both cognitive capacity ( IQ) and adaptive functioning
- Federal Law has changed the term Mental Retardation to Intellectual Disability
- However deficits in cognitive capacity beginning in the developmental period with accompanying diagnostic criteria ) is still considered a mental disorder

## Autism Spectrum Disorders

- No more Autism
- No more Asperger's Disorder
- No more Childhood Disintegration Disorder
- No more Pervasive Developmental Disorder

## Autism Spectrum Disorders (ASD)

- Scientific Consensus was that the 4 previously separate disorders ( Autism , Asperger's, and Childhood Disintegrative Disorder and Pervasive Disorder NOS) are actually one single condition with different levels of symptom severity in 2 core domains
- 1. deficits in social communication and social interactions
- 2. Restricted repetitive behaviors, interests and activities

## Treatment:

- Keep in mind the word treatment is used in a very limited sense
- Each person is unique and each symptom of this complex spectrum disorder may need to be addressed
- Remember there is a lot of non scientifically proven "treatments" that are offered.

## Evidence Based Interventions

- Functional Behavioral Assessment (FBA)
- Antecedent Based Interventions (ABI)
- Differential Reinforcement of Alternative, Incompatible, or Other Behavior ( DRA/O)
- Discrete Trial Teaching (DTT)

## Evidence Based Interventions

- Response Interruption /Redirection (RIR)
- Reinforcement ( R+)
- Extinction (EXT)

## Evidence Based Interventions

- Social Narratives (SN)
- Social Skills Training (SST)
- Video Modeling (VM)

## Evidence Based Interventions

- Pharmacology of ASD
- Treating symptoms and Discomfort
- Hyperactivity there are some studies showing efficacy using psychostimulants
- There is no efficacy for psychostimulant usage for repetitive behaviors or irritability
- Side effect profile may be heightened
- Increase in repetitive behaviors , skin picking behaviors , insomnia , restricted eating

## Treatment:

- Pharmacology of ASD
- Atypical antipsychotic treatment
- FDA approved Risperidone and Aripiprazole
- Start low and Go Slow
- Side Effect Profile can be significant
- Glucose Metabolism difficulties
- Elevated Cholesterol and Triglycerides
- Prolactin elevations with Risperidone
- Dystonia,Occulogyratory Crisis
- Tardive Dyskinesia

## Social Communication Disorder

- This is a new Diagnosis
- Persistent difficulties in the social uses of verbal and non verbal communication .
- Deficits result in functional limitations in effective communication, social participation, social relationships, academic achievement
- It cannot be diagnosed in the presence of restricted repetitive behaviors , interests and activities
- Some previous PDD NOS kids may now be under this diagnosis

## GONE : But not forgotten

Mood Disorder NOS

## Disruptive Mood Dysregulation Disorder

- This is a totally new diagnosis
- The rationale for this new diagnosis was that there had been a huge increase in the diagnosis of Bipolar Disorder in Children and adolescents
- There was a concern that these children did not meet the criteria of Bipolar Disorder particularly in the duration of manic/hypomanic symptoms and in the lack of separateness of the manic/hypomanic symptoms.

## Disruptive Mood Dysregulation Disorder

- Lots and lots of studying went into deciding that the majority of these children given the diagnosis of Bipolar Disorder did not go on to make criteria for Bipolar Disorder as an adult
- Conclusion was that there was something occurring in childhood and adolescence that was a different illness and needed to have its own diagnosis
- Prognosis is still very poor but it is not the same as the prognosis for patients with Bipolar Disorder

## Disruptive Mood Dysregulation Disorder

- There is Childhood and Adolescent Onset Bipolar Disorder
- It is rare
- It meets FULL criteria for Bipolar Disorder
- Full criteria means that these patients have
- DISTINCT periods of abnormally and persistent elevated, expansive or irritable mood and persistently elevated goal directed activity or energy lasting at least one week and present most of day nearly every day

## Disruptive Mood Dysregulation Disorder

- **This diagnosis cannot coexist with**
- ODD
- Intermittent Explosive Disorder
- Bipolar Disorder
- **This diagnosis can exist with**
- Major Depressive Disorder
- ADHD
- Conduct Disorder
- Substance Use Disorders

## Disruptive Mood Dysregulation Disorder

- A. Several recurrent temper outbursts manifested verbally and /or behaviorally that are grossly out of proportion in intensity or duration to the situation or provocation
- B. The temper outbursts are consistent with developmental level
- C. The temper outbursts occur, on average, three or more times a week
- D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly everyday, and is observable by others

## Disruptive Mood Dysregulation Disorder

- Symptoms must have been present for 12 or more months
- Throughout the 12 months the patient has not had a period lasting 3 or more consecutive months without all the symptoms
- Symptoms must be present in at least 2 of 3 settings (home,school,peers) and severe in at least one of these
- There has never been a distinct period lasting more than one day during which complete symptom criteria for mania or hypomania is met

## Disruptive Mood Dysregulation Disorder

- The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition
- Always remember the developmentally appropriate mood elevation that occurs in the context of a highly positive event or its anticipation should not be considered mood instability or hypomania

## Outcomes:

- Patients with DMDD have lower rates of bipolar disorder
- Patients with DMDD have higher rates of depression and anxiety disorders as adults
- Patients with DMDD have increased risk for substance use
- Patients with DMDD have increased conduct issues and suicidal ideation
- Overall Functioning is greatly impaired with this diagnosis

## Treatment:

- You need to know what you're treating
- This is SO the case with this disorder
- MAKE SURE before even thinking of " treating " this disorder that the basics are covered
- The patient is getting appropriate SLEEP
- THAT THEY HAVE AN APPROPRIATE SLEEP HYGEINE
- THAT ANY ADHD has been treated

## Treatment:

- Probably needs Specialty Care
- Definitely needs multi pronged approach
- Family Involvement
- Environmental Involvement (school,home,peers)
- Pharmacological Involvement

## Treatment:

- Medications will not resolve:
- • Family stress/conflict
- • Poor parenting strategies
- • School stress/conflict
- • Strong willed temperament
- • Intellectual deficits
- • Developmental impairments

## Pharmacology of DMDD

- The 2 major components of this disorder are:

  Temper outbursts

  Irritable mood

## Treatment of Temper and Rage/Aggression :

- Psychostimulants
- There has been many published articles on the use of psychostimulants in aggression with adhd and the use of psychostimulants has been shown to be often efficacious for the aggression component

## Treatment of Temper and Rage /Aggression

- Atypical Antipsychotics
- Risperidone,Aripriprazole,Quetiapine,Olanzapine are FDA approved for the treatment of schizophrenia and acute management of mania in type 1 Bipolar in youth .
- Risperidone and Aripiprazole are FDA approved for the treatment of irritability ( including aggression, temper tantrums, self injurious behavior, and quickly changing moods ) in association with autism in children and adolescents

## Treatment of Temper and Rage/Aggression:

- Alpha 2 agonists
- Clonidine has been shown to reduce symptoms of disruptive disorders in children and adolescents particularly impulsive aggression
- Guanfacine has been shown to reduce aggressive behavior

## Treatment of Temper and Rage/Aggression:

- Anticonvulsants and Lithium
- Divalproex
- Lamotrigine
- Lithium

All have efficacy in the treatment of aggression

Side effect profile can seriously reduce the tolerability and there consistency of taking these medications

Need for blood levels can also hinder compliance and therefore efficacy

## Treatment Chronic Irritability:

- Irritability unlike aggression is not often a major outcome variable in medication treatment trials. Scales to measure irritability are also scarce and tend to capture the most severe manifestation which is aggression.
- However the Affective Reactivity Index (Stringaris 2012 ) may be a useful tool
- The 2 main classes of medications that have shown usefulness for irritability are
- Psychostimulants
- Atypical Antipsychotics

## PHEW!

# The END