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Childhood Rage: Diagnosis and Treatment Strategies for Severe Mood Dysregulation - Part 2: Diagnosis and Treatment


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AACC
2013 “Our Time is Now”
World Conference

Pre Conference Workshop 043:
Attachments and Neurobiology:
Helping Children with Anxiety Disorders
and Severe Mood Dysregulation*

* DSM-5: Developmental Mood Dysregulation Disorder

Gary Sibcy, Ph.D. and E. John Kuhnley, M.D.

Childhood Rage:

Diagnosis and Treatment Strategies for Severe Mood Dysregulation

Part 2: Diagnosis and Treatment

E. John Kuhnley, MD

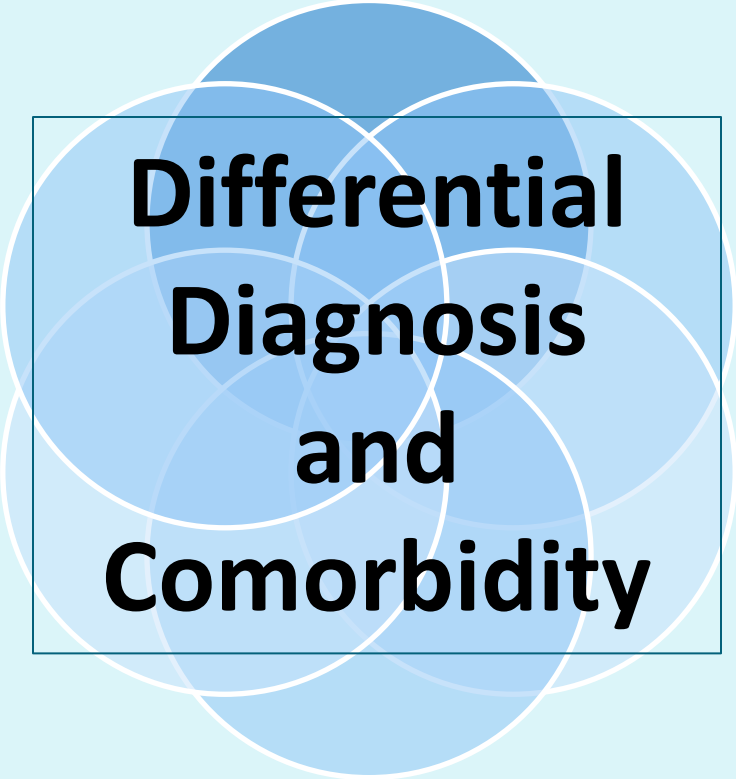
Child & Adolescent Psychiatrist

Lynchburg, Virginia

ODD

ANX

ADHD



Differential
Diagnosis
and
Comorbidity

MDD

BD

DMDD *
(SMD)

The most common diagnoses among patients with mood swings

FREQUENCY	DIAGNOSIS
39%	ADHD
15%	ODD with ADHD
15%	ANXIETY D/O (GAD)
12%	BIPOLAR DISORDER
10%	SECONDARY MOOD DISORDER (eg. Fetal Alcohol Spectrum Disorder)
3%	PDD, ASPERGER'S

Rages--what are they and who has them?

Conclusions:

- Psychiatrically hospitalized children with multiple rages have complex, chronic neuropsychiatric disorders and have failed prior conventional treatment.
- One third of children with rages had been given a bipolar diagnosis prior to admission. However, only 9% of children with rages were given that diagnosis after careful observation.



Gabrielle A. Carlson, MD

Bipolar Disorder Not a 'Quick and Dirty' Diagnosis

- Although some children are being misdiagnosed as having BD, the opposite is also true. There are many children, he said, who have BD but whose conditions are misdiagnosed and treated inappropriately.
- "This is something we need to be aware of because bipolar seriously affects the normal development of a child and increases their risk of suicide, substance abuse, and psychosocial problems. Early recognition and appropriate treatment are most important."



Boris Birmaher, MD

Disruptive Mood Dysregulation Disorder

DSM-5™ Diagnostic Criteria 296.99 (F34.8)

- A. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.
- B. The temper outbursts are inconsistent with developmental level.
- C. The temper outbursts occur, on average, three or more times per week.
- D. **The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others** (e.g., parents, teachers, peers).

Disruptive Mood Dysregulation Disorder

DSM-5™ Diagnostic Criteria 296.99 (F34.8)

E. Criteria A-D have been **present for 12 or more months**. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A-D.

F. Criteria A and D are present in at least two of three settings (i.e., at home, at school, with peers) and are severe in at least one of these.

G. The diagnosis **should not be made for the first time before age 6 years or after age 18 years**.

H. By history or observation, the **age at onset of Criteria A-E is before 10 years**.

I. There has **never been** a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a **manic or hypomanic episode** have been met. Note: Developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.

Disruptive Mood Dysregulation Disorder

DSM-5™ Diagnostic Criteria 296.99 (F34.8)

J. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder (e.g., autism spectrum disorder, posttraumatic stress disorder, separation anxiety disorder, persistent depressive disorder [dysthymia]).

Note: This diagnosis **cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder**, though it can coexist with others, including major depressive disorder, attention-deficit/hyperactivity disorder, conduct disorder, and substance use disorders.

Individuals whose symptoms meet criteria for both disruptive mood dysregulation disorder and oppositional defiant disorder should only be given the diagnosis of disruptive mood dysregulation disorder. If an individual has ever experienced a manic or hypomanic episode, the diagnosis of disruptive mood dysregulation disorder should not be assigned.

K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition.

Anxiety Disorders

- Excessive fear, worry, avoidance behavior
- Difficulty with transitions, unfamiliar circumstances
- **Mood swings/outbursts** during stressful periods when things don't proceed as they expect, tend to be short (5-10 minutes)
- Psychosomatic symptoms
- Restlessness is more likely practical, worrisome behavior, not the "driven," inquisitive, or overstimulated type
- Socially reticent, not disruptive, generally not impulsive or aggressive, often over inhibited
- **ADHD-like Symptoms** only during high anxiety state
- Difficulty sleeping common d/t excessive fear, worry, and psychosomatic symptoms
- Strong family history of anxiety disorders

Attention-Deficit/Hyperactivity Disorder

- Chronic symptoms of hyperactivity, distractibility, impulsivity, poor attentional skills, disorganization unrelated to mood; low frustration tolerance; present in 2 or more environments w/ onset before age 12 and strong family h/o ADHD
- **Mood swings/outbursts** are impulsive, reactive to frustration, brief, like hand-grenades
- Often difficulty falling asleep but then sleep well or sleepy/tired the next day; sometimes medication effect
- Busy minds, hyperactivity of thought
- Generally remorseful for negative behavior, including rage
- In ADHD, the aggression stems from an impulsive burst of anger when a goal is not achieved. Constant irritability is not a characteristic of ADHD.

Oppositional Defiant Disorder

- Daily (chronic) oppositionality, negativity, irritability & short (5-10 min.) mood swings or outbursts of anger (sometimes aggression) precipitated by 'not getting their way' or being asked to do something they do not want to do
- Resists initiating demands, whereas ADHD children may initiate but cannot stay on task
- Lacks impulsive, disinhibited behavior
- Defiance primarily directed towards mother initially; able to cooperate & complete tasks requested by others
- Often associated with parental child management deficits or family dysfunction

Bipolar Disorder

- Episodic mood shifts, alternating between manic (Euphoric/ elated/ expansive/ high energy)(unrelated to substance use), depressive, and normal; You often may feel the energy output of a manic individual
- Sudden catastrophic **“meltdowns” or “affective storms”**, like a hurricane, not a hand grenade; may go on for hours, and even days,
- Rages may involve destruction of property or aggression toward a sibling, parent, or pet.
- Grandiose, boastful, belligerent, and delinquent youngster is suspect for BD
- Family history – take carefully

Major Depression

- Depressed moods most days.
- Mad/cranky irritability found in depressive disorders; Depressed children had more severe irritability than depressed adolescents
- Impaired or excessive sleep
- Low energy and motivation
- Depression was the most common initial and most frequent episode for adolescents

Bipolar Disorder vs. ADHD

- Sleep (Decreased need vs. DFA then crash)
- Outbursts (hurricane vs. hand grenade)
- Elated or expansive mood in BD, not ADHD
- Mood energy vs. Motor activity
- Hypersexuality (BD>>ADHD)
- Racing vs. busy thoughts (BD>>ADHD)
- Episodic vs. Chronic/persistent

Medication

Individual Therapy
(CBT, Mindfulness)

Group Therapy
Skill Development

Family Therapy
Psychosocial
Psychoeducational



**Multimodal
(Integrative)
Treatment**

Attachment
Parenting
Behavioral
Modification

Spiritual
Counseling

Environmental Accommodations

Life style interventions (nutrition, exercise, sleep, etc.)

The treatment of a child with impulsive or affective aggression

- The treatment of a child with impulsive or affective aggression may be successful in one-on-one sessions or in group therapy.
- Principles include:
 - anxiety management
 - correction of cognitive distortions
 - assertiveness training
 - impulse control strategies
 - stress reduction
 - if applicable, therapy to address trauma.

Being Spiritual Protects People from Depression

- Those who rated their religious or spiritual beliefs as having high personal importance had one tenth of the risk of other participants for recurrence or new incidence of major depression over 10 years.
- Supporting religious or spiritual engagement by individuals with such inclinations may offer some protective value.

Miller L et al. Religiosity and major depression in adults at high risk: A ten-year prospective study. *Am J Psychiatry* 2011 Aug 24

Stop the Pop: Soda Linked to Aggression, Inattention in Kids

- Deborah Brauser - Aug 22, 2013 – www.medscape.com
- Consumption of even 1 soft drink per day may be associated with increased negative behavior in young children, new research suggests.
- A cohort study of almost 3000 5-year-olds showed that those who drank 1 to 4 servings of soda per day had significantly higher aggressive measurement scores than their peers who drank no soda.
- In addition, those who consumed 2 or more servings had higher withdrawn behavior scores, and those who consumed 4 or more servings had higher attention problem scores.

TRAY Recommendations

- Conduct a diagnostic interview.
- Assess current treatment effects.
- Begin with psychosocial and psychoeducational treatments.
- Treat the primary Axis I disorder with its first-line treatment.
- Use an atypical antipsychotic (not a typical antipsychotic) for the aggression.
- Use a conservative dosing strategy.
- Use crisis management techniques before emergency treatment of aggression.

TRAY Recommendations

- Avoid using PRN medications to control behavior.
- Assess adverse effects routinely.
- Ensure an adequate trial before switching medications.
- After a failed trial of one atypical antipsychotic, try a second one.
- For a partial response, consider adding a mood stabilizer to the atypical antipsychotic.
- If non-response to polypharmacy, consider tapering one medication.
- If remission of symptoms for > 6 months, consider tapering the antipsychotics.

CONDITIONS

- ODD
- ADHD
- Anxiety Disorder
- Depression
- Bipolar Disorder
- Disruptive Mood Dysregulation Disorder
- Psychosis

MEDICATIONS

- None
- Stimulants
- Antianxiety agents
- Antidepressants
- Mood Stabilizers
- α -2A agonists
- Antipsychotics

Any medication option, or combination of medications, may apply to many of the conditions, or combinations of conditions.

TABLE.

Evidence for Efficacy of Positive Trials Using Medication in Aggression in Child Psychiatric Disorders

Medication	ADHD +/- ODD/CD	ODD/CD	Autism	Bipolar Disorder
Stimulant	DBPC	DBPC		
Atomoxetine	DBPC			
Guanfacine XR	DBPC	DBPC		
Clonidine		OLT		
B-blockers		DBPC, OLT		
Lithium		DBAC, DBPC		DBAC
Valproic acid		DBPC		DBAC
Carbamazepine		DBPC		
Molindone		DBAC		
Haloperidol		DBAC		
Aripiprazole		OLT	DBPC, FDAA	DBPC
Risperidone	AT		DBPC, FDAA	DBPC
Olanzapine			OLT	DBPC
Quetiapine		OLT	OLT	DBPC
Ziprasidone			OLT	DBPC

ADHD=attention-deficit/hyperactivity disorder; ODD=oppositional defiant disorder; CD=conduct disorder; DBPC=double-blind, placebo-controlled trial; OLT=open label trial; AT=augmentation trial; DBAC=double-blind active comparator trial; FDAA=Food and Drug Administration approved for aggression

Evidence for Efficacy of Positive Trials Using Medications in Aggression in Child Psychiatric Disorders

Medication	ADHD +/- ODD/CD	ODD/CD	Autism	Bipolar Disorder
Stimulant (Ritalin, Concerta, Focalin, Metadate) (Adderall, Dexedrine, Vyvanse)	DBPC	DBPC		
Atomoxetine (Strattera)	DBPC			
Guanfacine XR (Intuniv)	DBPC	DBPC		
Clonidine (Kapvay)	(DBPC)	OLT		
B-Blockers (Inderal, Propranolol)		DBPC, OLT		
Lithium		DBAC, DBPC		DBAC
Valproic Acid (Depakote)		DBPC		DBAC
Carbamazepine (Tegretol)		DBPC		

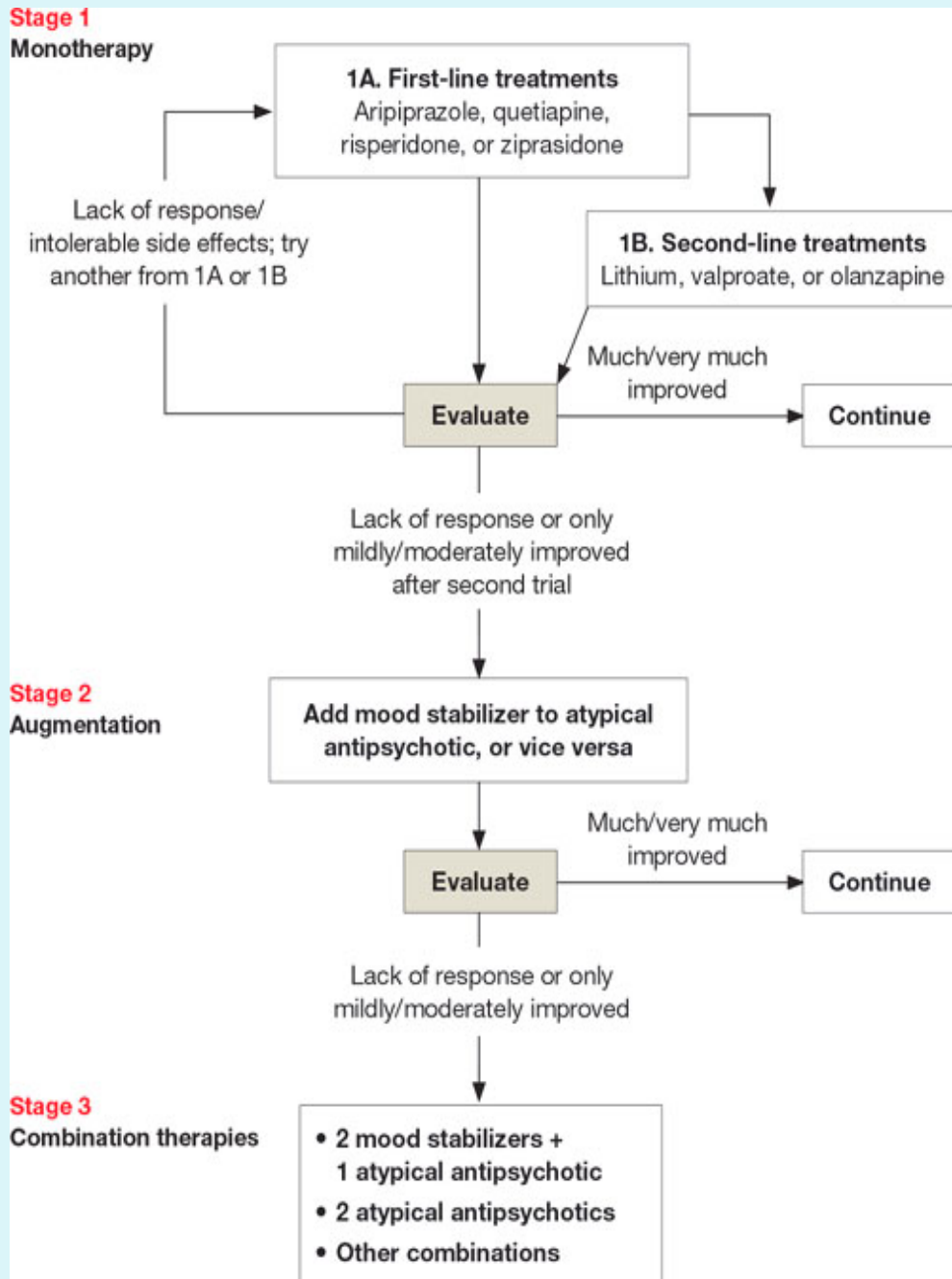
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Evidence for Efficacy of Positive Trials Using Medications in Aggression in Child Psychiatric Disorders

Medication	ADHD +/- ODD/CD	ODD/CD	Autism	Bipolar Disorder
Molindone (Moban)		DBAC		
Haloperidol (Haldol)		DBAC		
Aripiprazole (Abilify)		OLT	DBPC, FDAA	DBPC
Risperidone (Risperdal)	AT		DBPC, FDAA	DBPC
Olanzapine (Zyprexa)			OLT	DBPC
Quetiapine (Seroquel)		OLT	OLT	DBPC
Ziprasidone (Geodon)			OLT	DBPC

ADHD = attention-deficit/hyperactivity disorder; ODD = oppositional defiant disorder;
 DBPC = double-blind, placebo-controlled trial; OLT = open label trial; AT = augmentation trial;
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Child and Adolescent Bipolar Algorithm 2009



Diagnosis in Clinical Practice

- **Start by allowing the patient to express concerns; ask questions to facilitate expression**
- **Obtain the patients' (and collateral sources) accounts "In Their Own Words" rather than asking criteria they can endorse**
- **The clinical interview must elicit and elucidate the patient's experience and symptoms and thus lead us to diagnostic criteria; then the diagnostic criteria guide us to clarification/confirmation, rather than the diagnostic criteria guiding the interview**

Severe Mood Dysregulation

DSM-5: Disruptive Mood Dysregulation Disorder

- The distinction between severe mood dysregulation and bipolar disorder may have important treatment implications.
 - If severe mood dysregulation is a pediatric bipolar disorder phenotype, then first-line treatment would include mood stabilizers and atypical antipsychotics, with stimulants and selective serotonin reuptake inhibitors (SSRIs) being relatively contraindicated.
 - On the other hand, if severe mood dysregulation is more similar pathophysiologically to unipolar depressive and anxiety disorders, as well as to ADHD, then stimulants and SSRIs would be recommended.
- Given the relatively high side effect burden of atypical antipsychotics, coupled with the risks of using antidepressants or stimulants in bipolar disorder, this differentiation is important.

Ellen Leibenluft, M.D.



The anterior cingulate cortex and medial frontal gyrus—both hyperactivated in children with SMD (Severe Mood Dysregulation) following negative feedback—were the same areas activated in healthy control children following positive feedback.

“It makes you think about **cognitive training or therapies** that could perhaps train children with SMD to pay greater attention to positive feedback and less attention to negative feedback,” Liebenluft said.

Self-regulation refers to subject actions that indicate:

- Thinking: purposeful control of thoughts,
- Feeling: purposeful control of emotions,
- Doing: purposeful control of behaviors
 - Actions related to the completion of tasks
 - Academic
 - Occupational

Emotional self-regulation is normally implemented by a neural circuit comprising various prefrontal regions and subcortical limbic structures.

Beauregard et al suggest that **humans have the capacity to influence the electrochemical dynamics of their brains**, by voluntarily changing the nature of the mind processes unfolding in the psychological space.

Summary

- Obtain careful clinical information “in their own words” from multiple sources
- Mood swings and rage do not equate to Bipolar Disorder (BD) and more likely stem from ADHD, ODD, Anxiety, and/or psychosocial circumstances in the world of the child, BUT must consider BD
- Treat the patient, not the Diagnosis, though diagnosis guides the treatment, and
- A multimodal integrative treatment approach must target the causes/impairments and adjust over time as the clinical picture develops

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