EMOTION DYSREGULATION WITH EXPLOSIVE OUTBURSTS

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DISCLOSURE

I have no relevant financial relationships to disclose.

TODAY'S OUTLINE

Thank you for participating!

Thank you for all your efforts to help Maine youth and their families

- Target audience is PCP's and their offices; happy to have everyone here
- Description
- Impairment
- Biopsychosocial Causes
- Treatment Approach
  - Psychosocial
  - Approach to Medications
- Early Intervention: Where we all want to go

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Presidential Address: Emotion Dysregulation in Children and Adolescents

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Supplemental Material

References

Article Info

Related Articles

I am both excited and proud to become president of our Academy of Child and Adolescent Psychiatry for the next 2 years. In addition to working with an incredible organization, I have had the privilege and pleasure of serving and collaborating with our immediate past presidents including Drs. Drell, Joshi, Fritz, and Wagner. In thinking about how I wanted to focus my energy and some of AACAP's resources over the next couple of years, I've looked at the breadth of past initiatives. These have included prioritization within the organization and the field (Back to Project Future[1]), expanding our relationships with other countries and cultures (Partnering for the World's Children[2]),

GENERAL PICTURE

- Most children get frustrated by similar types of circumstance
  - Directed by adult (parent figure, teacher) to do something not inherently reinforcing. E.g., a chore. Please pick up your Legos.
  - Directed to stop a reinforcing activity. Please come inside; please turn off screen.
  - Given a limit. Told the word "no".
- Children vary in ability to modulate frustration
- What do children in top 5% of anger dyscontrol look like?
  - In addition to being loving, creative, funny, and delightful…

FREQUENT EXPLOSIVE OUTBURSTS ARE VERY IMPAIRING

- Childcare/Preschool Expulsion
- Impaired Family Relationships
- Impaired Peer Relationships
- Less community/family participation; more restrictive settings
  - Self-contained classroom
  - Day Treatment

IMPAIRMENT PART II

- Emergency Department (ED) visit
- Psychiatric Hospitalization.
- Residential Treatment
- Out of State Residential Treatment
- Extended Emergency Department Stays

IMPAIRMENT PART III

EXTENDED EMERGENCY DEPARTMENT STAYS

- We have, in Maine, decreased the number of youth we incarcerate by 90%
- Youth the hospitals and residential treatment programs can't serve
- The New Detention. If there is an immediate need for a locked door and security guard
- Long Creek takes youth outside
- The most restrictive level of placement we have ever had

GENERAL PRINCIPLES

- Multifactorial Etiology. There is almost never only one cause
- The Causes are Biopsychosocial; and the Treatment must also be Biopsychosocial
- Both/And thinking will be more effective than Either/Or thinking.
- Developmental Disabilities Often Play a Role.. Autism Spectrum; Speech/Language; Learning Disability; Fine/Gross Motor Delay; FASD. Not covered today.

PSYCHOSOCIAL TREATMENT FOR PREADOLESCENTS

- Specialized Parenting Skills
  - Parenting skills that may work for 90-95% of kids may not work for 5-10% of kids with most difficulty modulating emotions.
  - Parents may not have caused the problem; but they will need to be big part of the treatment
  - The Challenge: how to recommend Parenting Skills without making Parents feel blamed

SPECIALIZED PARENTING SKILLS PART II

- Individual therapy in preadolescents not as effective as working through parents
- Two approaches to Specialized Parenting Skills:
  - Teach parents in office; they practice at home. Positive Parenting Program (Triple P) and Incredible Years
  - Live parent coaching. Parent Child Interaction Therapy (PCIT).
  - These can be office based or in home. Often/usually need to be embedded in working on parent/family level problems.

BROADER ASPECTS OF BIOPSYCHOSOCIAL TREATMENT PART I

- Troubles run in families.
- Troubles are passed down environmentally and genetically; by nature AND nurture
- Parents may not have caused all of this problem, but they will have to be a big part of the treatment
  - Poverty is a risk factor for disruptive behavior
  - Parental mental health and/or SUD problems are common.
  - Both these can interfere with specialized parenting skills
  - Some Adverse Childhood Experiences can be alleviated; TCM/BHH necessary
- Blaming the parents is not, generally, clinically effective

BROADER ASPECTS OF PSYCHOSOCIAL TREATMENT: PART II

- Many/most youth will need a case manager
  - Targeted Case Management (TCM) or Behavioral Health Home (BHH)
  - If private insurance, office based care manager may need to help with Katie Beckett
  - TCM/BHH can submit application for intensive in-home treatment (Home and Community Based Tx, or HCT). For some families, office based tx won't work.
  - PCP office well served by close working relationship with a local TCM/BHH agency

PSYCHOSOCIAL TREATMENT FOR ADOLESCENTS

- Combination of family and individual therapy
- EBP's include Multisystemic Therapy (MST) and Functional Family Therapy (FFT)

THE ROLE OF TRAUMA

- Many youth with SED/EO have experienced Trauma; some have not.
- In Trauma Focused CBT (TF-CBT), the first phase is stabilization: specialized parenting skills, emotion regulation skills
- Stabilize; then Heal
- Youth with severe SED/EO will have great difficulty going directly to TF-CBT
- Please remember your Both/And thinking. It's often Nature Plus Nurture. Problems run in families for both environmental and genetic reasons.

IS REACTIVE ATTACHMENT DISORDER A CAUSE OF AGGRESSION?

- DSM-5 describes RAD as an internalizing disorder with depressive symptoms and withdrawn behavior (in introduction to Trauma and Stressor Related Disorders).
  - Doesn't seek comfort and/or isn't comforted
  - Unexplained irritability, sadness, or fearfulness in interactions with caregivers
  - "The disorder is seen relatively rarely in clinical settings."
  - "Less is known about the clinical presentation of RAD in older children, and the diagnosis should be made with caution in children older than 5."

- Is attachment important for all people? Yes! Have youth with SED often had relationship/attachment disruptions? Often
- Should RAD be considered the sole driver of aggression in a youth? No
- Anxious, avoidant, and disorganized attachment are significant risk factors
- Both/and, not either/or
- Best way to help youth improve attachment is to prevent further relationship disruptions; i.e., treat and reduce SED/EO

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THE MOST COMMON "BIO" DRIVER: ADHD

- Dr. Carlson states that, in her data, 75% of youth with SED/EO have ADHD as a component
- Dr. Russel Barkley's Clinical Handbook of ADHD (4th ed): Chapter 3 is entitled "Emotion Dysregulation is a Core Component of ADHD"
- Reviews of studies of stimulant medication for aggression in the context of ADHD show significant effect sizes.

ISN'T SED/EO ALWAYS A SIGN OF BIPOLAR?

- Several years ago, some felt non-episodic severe anger dyscontrol was a symptom of Bipolar Disorder. Research disproved this.
- Bipolar Disorder is an episodic illness; it has episodes. It can cause episodic SED/EO.
- Disruptive Mood Dysregulation Disorder (DMDD) was put into DSM-V to prevent the overdiagnosis of childhood Bipolar Disorder
  - Criteria wrong though: most with SED/EO are happy, not irritable, if events going their way
  - Most youth with DMDD have ADHD as one of their problems.

OTHER COMMON "BIO" DRIVERS OF SED/EO

- Depression. Check for DSM-5 Criteria
- Anxiety: when urge to avoid is blocked. Not generally a cause of SED/EO at home.
- In sum: "Bio" drivers can include (if other criteria are present) ADHD, PTSD, Depression, Anxiety, Bipolar Disorder, and Developmental Disability
- The most common situation is a combination. Please remember Both/And, not Either/Or
- The medication aspect of Biopsychosocial Treatment involves treating the underlying disorder.

SOME CHALLENGES IN TREATING ADHD WITH EXPLOSIVE OUTBURSTS

- Will meds only work? No!
- Can effective meds support emotion regulation and enable an effective psychosocial program (including TF-CBT)? Yes

- "Stimulants"
  - Unfortunate name
  - Dopamine Reuptake Blockers
  - Could say they stimulate self-control center in the brain
  - Significnt effect size on aggression in the context of ADHD
  - Missing a stimulant response leads to bad outcomes

A RESEARCH STORY

- Leading med researchers wanted to see which meds—Risperidone vs Divalproex—would be more effective in stimulant/parenting skills resistant ADHD aggression
- They only let in kids who were on stimulants—to increase proportion of stimulant resistance
- First phase: give everyone Specialized Parenting Skills and optimize stimulants
- The majority responded! It took years to get enough parenting skills/stimulant resistant youth to do the study.
- Never got enough study subjects to find a difference
- They were careful and methodical in how they tailored the stimulant treatment

PDF

P Published an "Inconclusive" Trial: Optimize, sychostimulant Treatment

• Douglas K. Novins, MD

tps://doi.org/10.1016/j.jaac.2020.03.009 • Check for updates

, Blader *et al.*[1] report the results of a double-blind randomized controlled trial (RCT) aimed at e efficacy and tolerability of adjunctive risperidone (RISP), valproex sodium (DVPX), or placebo fo ildren (aged 6−12 years) with attention-deficit/hyperactivity disorder (ADHD) and comorbid er (ODD) or conduct disorder (CD), as well as a prior history of psychostimulant treatment. e symptoms persisting after an open-label optimization of psychostimulant medication entered ase. Weekly sessions of family-based behavioral treatment were offered during both the mized phases. Among the 151 participants who completed the optimization phase (175 were ected 63.6% met the study criteria for remission, that is, 3 consecutive weeks with subthreshold e−Modified Overt Aggression Scale (R-MOAS). Therefore, only 45 participants were eligible for SP: n = 17; DVPX: n = 14; placebo: n = 9) were included in the primary analysis. Why did clusive trial? Because, in our view, the lessons that can be learned from this RCT (in particular,) are highly relevant for both clinicians and trialists in the field. We are confident that the Blader

STUDY TITRATION METHOD

- Boys and girls 6-12 years old
- Recent or current treatment with stimulant medication at a minimum daily total dose equivalent of 30 mg of methylphenidate (MPH) (eg, 15 mg of mixed amphetamine salts (MAS) or dexmethylphenidate, 40 mg of lisdexamfetamine) for at least 30 days but still aggressive.
- Began with MPH ER (OROS; formerly Concerta). Raise 18mg/week up to 72 based on Conners CGI, Retrospective Modified Overt Aggression Scale (R-MOAS), side effect scale
- If insomnia or appetite problems, could switch to biphasic MPH (Ritalin LA) up to 60mg
- Insufficient or adverse response: MAS-XR (formerly Adderall XR), 5mg per week, up to 35mg
- 64% responded and could not go to next step of study

ASSESSING THE EFFECTS OF STIMULANTS

- Pay close attention to time response.
  - On a non school day: what was your child like before he took meds
  - You did or did not notice a change an hour or so afterwards. If yes, please describe the change
  - If you noticed a change, you did or did not notice the change wear off? If yes, that was or was not a problem?
  - And of course the input of school is crucial. Big problem in assessment is teacher does not come to the appointment. Vanderbilts are most common tool.

ASSESSING THE EFFECTS OF STIMULANTS: PART II

- Determining whether stimulant increased irritability
  - We always start low; low dose probably won't be enough to treat SED/EO; so, low dose stimulant associated with ongoing SED/EO.
  - "EO has got better, worse, or stayed the same on this dose?" If not sure, take the next step
  - If EO a problem, is it when meds are in system or out?
  - Please remember: stimulants far more likely to treat irritability (in context of ADHD) than to cause it
  - Review article on stimulants and irritability in References. MPH vs AMP
- Stimulants, on average, decrease anxiety (see reference)

NON-STIMULANTS

- Alpha 2 Agonists FDA approved on own or combo with stimulants
  - Guanfacine ER. FDA approved up to 7mg in adolescents
  - Clonidine ER.
  - Effects on aggression not well studied; at AACAP meeting, experts do lean on this
- Personal opinion: I have found bupropion helpful for SED and irritability, especially in teens
- Second generation antipsychotics (aripiprazole; risperidone) only if all else fails.
  - Many youth on ARI will need metformin
  - Short term gain vs long term risk
  - It can definitely help; it's better than losing your placement
  - Please try everything else first. If you miss stimulant responses, you will over rely on antipsychotics.

ADDRESSING SED/EO IN PRESCHOOLERS

- With such a serious public health problem, we want to maximize Early Intervention
- The most aggressive two year olds are, on average, the most aggressive when older
- American Academy of Pediatrics ADHD Guidelines state meds are 2nd line before age 6.
- We need to find a way to make PCIT, Triple P, or other Specialized Parenting Skills EBP's available to parents of 2-5 year olds with SED/EO
- Some families will need in-home
- Early Childhood Consultation Partnership. All the relevant adults will need to skill up.
- These are wonderful children. Let's get ahead of this problem and help them thrive!

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