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# The Angry Child or Why Your Pediatric Patient Doesn't Have Bipolar

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# Objectives

- To develop a broader differential for irritability in children.
- To learn where to find additional information about a patient's developmental assessments
- To prescribe nonpharmacologic interventions for common behavioral and neurodevelopmental disorders



No Disclosures

# Why Your Patient Doesn't Have Bipolar

- Modern medical training teaches us to look for “disease.”
- Anger and irritability are symptoms of many problems. Only a few of these are medical illnesses with a “broken part.”
- Physicians are under pressure to diagnose a treatable illness, preferably one that can be easily/quickly solved.
- Symptom vs Syndrome thinking.

# Why Your Patient Doesn't Have Bipolar

In the absence of a syndromal manic episode,

- Several days of elated mood, very increased energy, and positive changes in self attitude that are a marked deviation from the baseline

do NOT diagnose Bipolar Disorder.

# If it's not a disease, what is it?

- Logical/normal (narrative)
- An outcome of behavior
- A result of psychological vulnerability

# Case 1

- An 8 year old boy is brought in by his parents due to irritability. The onset of his anger outbursts was 2 months ago when he started 3<sup>rd</sup> grade. He is happy and calm at home. He gets angry and fearful in the mornings when it's time to get on the bus. He is also irritable when he returns home. He tearfully recounts that older peers on the bus have called him names, threatened to beat him up, and told him that they would kill his parents if he said anything.

# Normal Moodiness

- Normal sadness is a response to loss
- Normal fear is a response to trauma
- Normal demoralization is a response to negative life circumstances

# Normal Moodiness

- “Treat” by
- Comforting and guiding.
- Teaching how to avoid similar encounters in the future.
- Rescripting/Reinterpreting the narrative in a way that provides more optimism and a sense of control.

# Caveat

- People experiencing a major depressive episode will often explain their symptoms as a natural extension of their narrative.
- Symptom vs. Syndrome
- Low self-attitude may help to distinguish between situational sadness and Major Depression.

## Case 2

- An 8 year old boy is brought to clinic for evaluation of irritability. He is angry at all times of day and in all settings, including at school and at home. He is short-tempered with his parents. He hits his siblings. He has difficulty paying attention in school. He argues about doing his homework. He picks at his scalp and has pulled his hair out in a circular patch at the crown of his head.
- When asked about his hobbies, he proudly states that he spends all of his time playing video games. He stays up as late as 11 pm on weeknights and wakes up at 7 am to go to school. On weekends, he is sometimes up all night.

# Socially Learned Behaviors

- Behaviors of this sort are not diseases, they are disorders of choice.
- The role of the physician is to “treat” by fostering change and helping the patient (and parents) to make better choices.
- As physicians, we exert significant influence on the choices that our patients make.

# Sleep and Exercise

- Please assess, educate, and guide your patients about their sleep and activity habits.
- Behavioral insomnia (of childhood) mimics many psychiatric disorders.
  - I recommend:
    - 11 hours of sleep per night for children ages 6-12.
    - 10 hours of sleep per night for children over age 12.
- Lack of physical activity exacerbates mood and behavior problems.
  - Aim for at least 1 hour per day of vigorous physical exercise.

# Screen Time

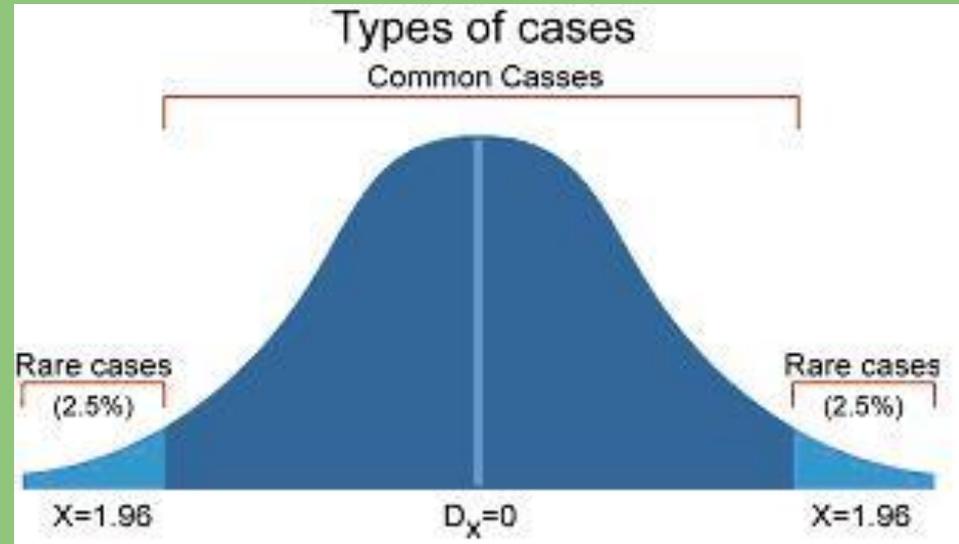
- Some guidelines state 1 hour or less before age 6, then give vague recommendations about limiting time.
- Screen time competes with time spent sleeping, exercising, doing homework, with family, etc.
- Parents should limit screen time to less than 2 hours per day. Zero is best!
- Parental time spent with screens correlates with time spent by children. Encourage parents to model better behaviors.

## Case 3

- An 8 year old boy presents for evaluation of anger outbursts that occur primarily at school. They began when he was in 1<sup>st</sup> grade. He says that he doesn't like school although he likes playing with his friends at recess. He refuses to participate in class activities and will tantrum when his teacher tries to enforce class rules. At home he is well-behaved and affectionate with parents. His father says that he had similar difficulties in school. His parents mention that he has an IEP but do not know why.

# Psychological Vulnerability

- All people can be measured on a spectrum of variables:
- Height
- Weight
- Intelligence
- Emotional Reactivity
- Expressive Language Ability
- Etc.



# Psychological Vulnerability

- “Some patients are vulnerable to distress because of their position on human psychological dimensions of variation . . . . Their distresses are those of any troubled person, just more easily provoked by challenges others can manage.”

-McHugh and Slavney

- We “treat” by strengthening and guiding the child to help them be more successful in their efforts.

# Disruptive Mood Dysregulation Disorder

- This diagnosis was invented to address the increased rates of diagnosis of bipolar disorder in children.
- Chronic, severe, persistent irritability and severe temper outbursts.
- No implication about etiology. “Rates of comorbidity in [DMDD] are extremely high.”

# Parent-Child Relational Problem

- Temperamental mismatch between parent and child.
- Inadequate parental involvement or supervision.
- Parental overprotection.

# Oppositional Defiant Disorder

- A pattern of irritability and anger accompanied by argumentative and defiant behaviors.
- No implied etiology. “Why?” is not answered when making this diagnosis.
- Children (and adults) tend to externalize the problem and blame their behaviors on others.
- “Hostile parenting” may play a role.
- Treatment includes a form of psychotherapy called Parent Management Training (PMT).

# Parent Management Training

- Behavioral therapy that changes parenting behaviors and encourages positive reinforcement strategies.
- Highly evidence-based treatment for disruptive behaviors in children.
- Available in multiple forms including
  - Self Help Books (123-Magic, Your Defiant Child, Parenting with Love and Logic)
  - Parenting Groups
  - Individual/Family Psychotherapy (Parent Child Interaction Therapy, Incredible Years, Oregon Model, etc.)

# Parent Management Training

- All programs have at least these two elements in common:
  - 1) Child-focused time
  - 2) Positive Reinforcement Strategies

# Neurodevelopmental Disorders

- A group of wide-ranging deficits in development that have onset in early childhood.
- They vary from specific deficits in learning to global intellectual impairment. The deficits are such that ability is significantly lower than expected for a child's age.
- They represent a point or range on a continuum of ability that also includes "normal" and above average functioning.
- For example, intellectual disability can be defined as encompassing individuals in the lowest (1<sup>st</sup>) percentile of intelligence in a population.

# Neurodevelopmental Disorders

- Commonly co-occur with other developmental and neurodevelopmental disorders.
- The presence of a developmental delay, premature birth, in utero exposure, genetic disorder, severe congenital malformation, or a family history of developmental disorders should prompt increased monitoring and screening.

# Mild Intellectual Disability

- Global deficit in cognitive ability.
  - Reasoning
  - Problem Solving
  - Academic Learning
  - Planning/Organization
  - Abstraction
- Onset during the early developmental period.
- For MILD intellectual disability, differences in ability may not become apparent until school age when the child begins to lag behind peers in academic ability.
- The child tends to have immature/concrete language and problem-solving ability.

# Mild Intellectual Disability

- Interventions include providing academic supports in school.
- Social support, especially during developmental transitions.
- Guidance about appropriate expectations in adulthood.
- Prescribe physical therapy, occupational therapy, and speech/language therapy as needed.

# Communication Disorders

- Speech = Expression of sound
- Language = Use of symbols (sounds/word, letters, gestures) for communication
- Communication = verbal and nonverbal behavior used to convey information

# Language Disorders

- A deficit in the acquisition and use of language across modalities (spoken, written, etc).
- Can be
  - Expressive: Affecting the production of language
  - Receptive: Affecting the process of receiving/comprehending language
  - Or Mixed Receptive and Expressive

# Language Disorders

- Presentation includes reduced vocabulary, difficulty with sentence structure, and difficulty with conversation.
- Parents often learn to “speak for” or “interpret” for the child.
- Clues include frequent responses of “I don’t know” or “I don’t remember.” Long pauses before a response is formulated.

# Language Disorders

- Diagnosed through assessment by a Speech Language Pathologist or similarly trained specialist.
- Treatment includes Speech and Language Therapy.
- Encourage parents to allow the child to speak for themselves. Parents can pause after asking a question. Children can learn to use socially-appropriate strategies to gain time to formulate sentences.

# Social/Pragmatic Communication Disorders

- Deficit in the social use of language.
  - Deficits in use of language for social purposes.
  - Difficulty following rules of conversation (taking turns, using and understanding nonverbal cues).
  - Difficulty understanding humor, nonliteral meaning of language.
- Differentiated from Autism Spectrum Disorder by a lack of restricted/repetitive interests and behaviors.
- Can be secondary to other disorders such as ADHD.

# Social/Pragmatic Communication Disorders

- Diagnosed by a psychologist/psychiatrist or through assessment by a Speech Language Pathologist or similarly trained specialist.
- Treatment includes both individual and group social skills therapy. This is often provided by a Speech Language Pathologist or by an Occupational Therapist.

# Specific Learning Disorder

- A deficit in the ability to process information that is expressed as a difficulty in learning specific academic skills.
- Is specified as a learning disorder
  - With impairment in reading
  - With impairment in written expression
  - With impairment in mathematics
- However, each one of these specifiers actually includes a multitude of neurologic deficits.

# Specific Learning Disorder

- Diagnosed by educational testing.
- Compare an IQ score to a linked educational achievement test.
- If there is a 20-point difference (2 standard deviations) between the Full Scale IQ and a specific educational achievement score, this is usually sufficient to make a diagnosis (i.e. IQ of 100 and Written Expression Score of 80).
- Treatment includes academic support and PRACTICE.

# Attention Deficit Hyperactivity Disorder

- A deficit in executive function (planning, strategizing, priority setting, and flexibility) that is expressed as difficulty with attention and impulsivity and often associated with hyperactivity.
- Treated with medications and to a lesser degree with behavioral interventions.

# Assessment/Testing

- You can refer patients to psychological testing that will often include an IQ test, educational achievement testing, and may include language testing or behavioral/emotional assessments.
- Schools will usually include these sorts of assessments as part of an evaluation for an Individualized Education Plan (IEP).

# IEP

- If there is concern for a possible neurodevelopmental disorder that is affecting academic function, parents can request that the school assess their child for an IEP.
- If an IEP is already in place, it will be a useful source of clinical information.
- Ask for the “IEP Evaluation Report”
  - An extremely high-yield document that will give detailed results of educational testing.

## Case 4

- An 8 year old boy is brought to clinic for evaluation of anger outbursts. He is short tempered with family, arguing and giving orders to parents and siblings. In school he is quiet and a model citizen. His parents say that he refuses to sleep in his own room. When his parents attempt to discipline him he tantrums, screams, and says that he wishes that he was dead.
- His mother was once 5 minutes late to pick him up from school and when she arrived he was furious and in tears.

# Anxiety Disorders

- Anger and irritability is a frequent chief complaint for children with anxiety disorders.
- Children below age 10-11 who have not yet developed abstract thinking will often deny anxiety symptoms despite being clearly anxious. Parents should be able to provide examples of anxiety/worrying in those cases.

# Anxiety Disorders

- Treatment is based on severity.
- Mild Anxiety = Mild distress. Little to no functional impairment.
  - Observation or therapy
- Moderate Anxiety = Some to a lot of distress. Functional impairment (home, school, friends).
  - Therapy, medication, or both
- Severe Anxiety = Overwhelming distress and inability to function in one or more domain.
  - Medication and therapy

# Cognitive Behavioral Therapy

- Emphasizes the relationship between thoughts, feelings, and behaviors.
- The patient is educated and coached on how to change his/her thoughts and assumptions or engage in behavioral “experiments” in order to change how he/she feels in a situation.
- Time limited. Problem oriented.

# Summary

- When presented with an irritable child try conceptualize the child's problem as one of:
  1. Narrative
  2. Behavior
  3. Vulnerability
  4. Disease
- Medications should only be prescribed when there is a clear diagnosis for which medications are an evidence-based intervention.
- There are many other forms of treatment to prescribe. Patients/parents will often accept these options when they are presented in a logical manner.

# Additional Resources

- [The Perspectives of Psychiatry](#) by Paul McHugh and Philip Slavney.
- [DSM-5](#) chapter on Neurodevelopmental Disorders.
- [1-2-3 Magic](#) by Thomas Phelan
- [Parenting with Love and Logic](#) by Foster Cline
- [Your Defiant Child](#) by Russell Barkley
- Understood.org – A great online resource to learn about IEPs and special education in schools.

# Questions?

- Thank you!