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Psychiatry and Addictions Case Conference
UW Medicine | Psychiatry and Behavioral Sciences

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WELCOME!

Today's Topic:

Child and Adolescent Mood Disorders:
How can I diagnose a mood disorder in my child and adolescent patients, and at what age would I consider both medications and therapy for the treatment of the mood disorder?

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PANELISTS:

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IRRITABILITY: ASSESSMENT AND MANAGEMENT

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GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

- ✓ Any conflicts of interest?
- ✓ Private consultant; Cecilia Margret MD PLLC and Seattle Psychology LLC.

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OBJECTIVES

- At the end of the session providers will be able to list and discuss the following

1. Definition and prevalence of irritability: what are we looking for ?
2. Clinical assessment : differential diagnoses to consider
3. Bipolar disorder: a primer
4. Management: therapy and medications

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CASE REPORT

- 16 yr F with previous history of learning disabilities, ADHD in attentive subtype, tics presenting with increased irritability since winter break. Self harm reports (cutting), interpersonal stress among peers and family with poor academic performances are present. No substance use.
- Neurovegetative symptoms: poor sleep, variable appetite, and energy.
- Dev. history remarkable for learning disabilities, but otherwise normal development. Familial history remarkable for mood disorder in paternal aunt. ADHD in sibling. Parents with depression and anxiety history, stabilized on treatment.
- Medications: Vyvanse 30mg, fluoxetine 20mg started by PCP.
- Consult question: sleep is poor overlapping with treatment. When should I be concerned for Bipolar?

WHAT IS IRRITABILITY?

- Irritability : Increased proneness to anger
- It is a NORMATIVE behavior / feeling in preschool and adolescence.
- CLINICALLY SIGNIFICANT based on
    - **CONTEXT,**

      MODULATION AND

      PERVASIVENESS

Leibenflut 2017

IRRITABILITY – A TRANSDIAGNOSTIC SYMPTOM

- Bipolar disorder
- ADHD with emotional lability
- Depression
- Trauma
- Anxiety and Obsessive compulsive disorder
- Conduct disorder
- Substance use disorder
- Autism
- Attachment disorder
- Borderline personality traits
- Disruptive Mood Dysregulation Disorder (DMDD)

Irritability is not DIMENSIONALLY DEVELOPMENTALLY defined in DSM

French, W PAL conference 2018, Leibenflut 2018

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DISSECTION

DISORDER	ADHD	ODD	DMDD	DEPRESSION	BIPOLAR
Definition	ADHD with mood problems	Angry/irritable/defiant	Recurrent outbursts and persistent irritable mood	Depressed mood, lack of interest, poor sleep	Mania, Mania and depression and cyclothymic
Mood quality	Easily irritated and excitable	Irritable and resentful	Persistently irritable	Irritable and sadness	Irritable and elated mood
Age	Preschool and school age	Bimodal : early and adolescence	>6 and < 10	Early to late adolescence	Mid to late adolescence
Associated	Distractibility	Difficult temperament, substance use	ADHD and depression	Psychosis /anxiety	Manic symptoms
Prevalence	38 – 75%	2- 16%	1-3%	10%	1-6%
Exclusions	Cannot occur during psychosis	Concurrent DMDD	ODD and BPD	No mania	Substance use or medical condition

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DISORDER	ADHD	ODD	DMDD	DEPRESSION	BIPOLAR
Definition	ADHD with mood problems	Angry/irritable/defiant	Recurrent outbursts and persistent irritable mood	Depressed mood, lack of interest, poor sleep	Mania, Mania and depression and cyclothymic
TARGET symptoms	Inattention, irritability, aggression	Irritable and resentful	Aggression and irritable mood	Irritable and sadness	Irritable and elated mood
TREATMENT Therapy	Parent management/ social skills/ Educational support/ Individual therapy	PMT	Family and individual therapy	CBT /DBT /Family therapy	CBT, Social Rhythms, Family therapy and support
Medications	Stimulants, Alpha agonists, Atomoxetine		Stimulants and SSRI	SSRI	Mood stabilizers, lithium, anticonvulsants

WHY BIPOLAR IS CONTROVERSIAL ?

- Lack of diagnostic clarity as in adults
- Comorbidities with irritability
- Current diagnostic prevalence does not translate into adult prevalence (<2%)
- Needing long term monitoring as it is a developmental diagnosis to consider, that persists as a life long disorder
- Pop culture / media
- Overlap with developmental phase of reactivity that may mimic symptoms of Mood disorder
- Limited insight into condition
- Environmental influences

French, PAL 2018

NO SCREENs available as they are misleading for diagnosis

SCREENS

- parent diagnosed with Bipolar disorder
- Experienced elation and or grandiosity
- symptoms of mania (BE SPECIFIC)
- psychotic symptoms (earlier age onset)
- depressive episode , anxiety *** (profound symptoms in prepubertal age)
- suicidal attempts
- Activation /poor tolerance /irritability with SSRI H/O

Leibenflut et al 2006, *** increased risk in 20 year follow-up for depression and anxiety

WHEN IS IT NOT BIPOLAR? WHAT TO DO ?

- **Mania symptoms and mood elation** are needed than baseline irritability
- Irritable mood tends to most often manifest as **risks for depression and or anxiety disorders**
- These are **SICK children** who are @ high risk, needing close follow up , parent support and mental health support ; **earlier the better and get a team**
- Supportive role for medication is there; but **non specific** targets

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IF BIPOLAR THEN WHAT TO DO?

- If yes, then refer to Child and Adolescent Psychiatrist as RISKS are as follows
  - Suicidality (15% of completed suicide)
  - Substance use (60%)
  - Anxiety (60%)
  - Psychotic SX (50%)
  - Relationship disruptions
  - Work disruptions
  - Hospitalizations (non compliance and recurrences despite medication compliance)

Stern and Herman 2004, Brent at al 1998, 1993; French W - PAL 2018

IF BIPOLAR THEN WHAT TO DO?

If no psychiatrist is available

- Obtain COLLATERAL information; separate session for family
- Seek Consultation (Partnership Access line PAL)
- Pause before diagnoses
- Advocate for multimodal care
- Safety planning, Acute and Maintenance medication plans, Individual support (coping and lifestyle coaching) and Family support

https://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/

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PSYCHOSOCIAL APPROACHES

- Individual /Parent management
- CBT for Depression and anxiety
- Social skills group
- Social rhythms
- Interpersonal therapy
- Case management
- Integrated Team approach for Bipolar disorder

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MEDICATIONS

❖ MANIA

- Lithium +/- Neuroleptic
- Risperdal, Aripiprazole, quetiapine, Olanzapine *, Asenapine, Ziprasidone

❖ ANXIETY

- SSRI/ Benzodiazepine or anxiolytics

❖ DEPRESSION

- Lamictal, Lurasidone

❖ RAPID CYCLING

- Depakote

❖ SLEEP AIDES

- Trazodone, Melatonin, Antihistamines

FDA approval for Lithium (>12 yr) and SGA mentioned above (>10 yrs and * > 13 yr) for Bipolar disorder management

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SGA/MOOD STABILIZERS – MONITORED USE

• Monitoring recommendation Frequency Suggestion	• At baseline and at each follow-up (at least every 6 months)
• Height and weight	• At least every 6 months
• Fasting blood sugar	• At least every 6 months
• Fasting triglyceride/cholesterol	• At least every 6 months
• Screen for movement disorder or tardive dyskinesia	• Once to catch if any suppression, a few months after initiation
• CBC with Diff	• At least once after starting medication
• BP/Pulse	• At baseline, get EKG if in doubt about risk from a mild QT increase
• Cardiac history	• Repeat disorder specific rating scale(s) until remission is achieved
• Determine if treatment response	

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CLINICAL PEARLS

1. Mood swings and irritability can be caused by a wide variety of disorders
2. Reflect on the choice to label impulsive, difficult kids as “bipolar” and consider epidemiology, nature of mood disorder and familial history
3. Parents who are struggling with disruptive and irritable children who do not have bipolar disorder still benefit from help
4. Getting help with diagnostic and treatment questions as often as necessary
5. Children with severe, chronic irritability and “hyperarousal” are at high risk for major depression or anxiety disorders, not necessarily bipolar disorder. “

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CASE REPORT

- Assessment – Depression? Worsening anxiety ? Emerging Bipolar?
  - Coordinate with school, therapist and parents
  - Increase support at school and self harm related coping (DBT candidate?)
  - Mood monitoring, screening for subclinical symptoms emergence or SSRI related activation/ induced mania
- Monitoring for mood and associated symptoms with SSRI and over natural course
- Consider wide differential with irritability as target symptoms
- Use rating scales to track symptoms and monitor treatment (PHQ 9, GAD 7 and Vanderbilt's)
- Safety planning and crisis prevention plan

- Consider therapy and medications, for common mental health conditions with monitoring for Bipolar in background.