Common Psychiatric Conditions in Children

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(Child) Psychiatry is different

- Phenomenological diagnoses verses pathologic diagnoses
- Third party histories
- Lack of tests
- Conditions and impairments versus diseases and disorders
- Evidence-based practices
What I treat

• Disorders of behavior
• Disorders of self regulation
• Disorders of development
• Classic psychiatric “disease”
Behavior disorders

• ODD and Conduct disorder
• Not medical conditions and not treated by medicines
  – Treat underlying medical/psychiatric conditions
• Occur at the confluence of psychiatric disorders, ineffective family structure and past emotional damage
• Medications support therapy, not the reverse
Treating behavior disorders

• Always be alert to abuse and/or neglect in behavior issues
• Holding medications hostage for therapy / using medications to build rapport for therapy
  – Risperidone as WMD of child psychiatry
• All families with a behavior disordered child need family therapy!!!
Therapy

• Therapy is about change – who wants change? Who wants to change?
• Therapy is not done to a patient, but by a patient – it is an active process and requires effort to change
• Does therapy work?
Types of therapy

• Therapist as friend and teacher
  – Most of therapy techniques
    • CBT, DBT, interpersonal, behavioral, etc
  – Early phases of therapy, often short term only
  – Changes thinking, and therefore (hopefully) feelings and behaviors
  – Requires participation by patient, and therefore insight. Mostly effective in older teens and parents who want to change
Types of therapy

• Therapist as parent
  – Corrective emotional experiences
    • To be a good child therapist, you only have to be a better parent than the one(s) they have. This goes for the parents as well as the child
  – Middle and late therapy
    • Doesn’t really even begin until a relationship is built, often 3-6 months into therapy
  – About the relationship, not the technique
  – Passive, does not require active buy-in by patient
Types of therapy

- Long term therapy
  - Seldom used anymore – psychoanalysis
- Family therapy, multisystem therapy
  - Treat the environment the “patient” lives in
  - Intensive, time consuming
  - Usually only through CMH or a residential program
Disorders of self regulation

- Anxiety control and self-soothing
- Attention control
- Impulse control
- Emotional control
- Sleep control
Anxiety and anxiety disorders

• Anxiety, like pain, is natural and necessary – it signals a need to do something protective
• Anxiety sources: “out there”, “in here” and “back then”
• Anxiety is not a disorder, but anxiety that serves no purpose, causes distress and can’t be alleviated by a natural, protective behavior IS a disorder
• Therapy is first line of treatment for anxiety, treat “out there”, “in here” and “back then”
Medical treatment of anxiety

• Anxiety disorders, like pain disorders, are difficult to treat
  – Minimally effective meds
  – Effective but addictive meds
  – Abuse of meds

• SSRIs are primary (FDA approved – none!)
  – Should be used in almost everyone with anxiety
  – SNRIs also can work in those intolerant of SSRIs
Medical treatment of anxiety

• Stimulants do NOT reduce anxiety, they induce a pleasure response
• Direct, effective treatment – benzos
  – Librium and valium FDA approved (age 6)
• Non addictive treatments
  – Vistaril & buspar FDA approved (age 6)
    • Marginally effective
  – Neurontin and Lyrica
    • More effective (at least in teens), not FDA approved, and better subjective benefit (and more abuse)
Medical treatment of anxiety

• Practical approach
  – Start SSRI in all, pick a favorite titrate to mid dose
    • If no benefit or side effect, pick another and repeat
    • If still nothing, go to SNRI
  – Other medications
    • In older kids, consider a symptomatic adjunct such as vistaril, buspar or neurontin
    • Rescue medicine for panic attacks – xanax or ativan
    • Benzo is last resort except acute, short use
  – Always look at therapy
Marijuana for anxiety

• Perhaps the biggest threat of chronic anxiety in youth is MJ
• Relieves anxiety for short periods while providing a “good” feeling youth may not find anywhere else in their lives, but rebound anxiety leads to increased use
• Kills motivation, ambition, can cause psychosis
• Parents and peers often tacitly approve “natural” medication
Attention control disorders

- Impairment in ability to regulate focus
  - Can’t keep focus on non-stimulating tasks
  - Easily distracted

- Associated issues
  - Impulsivity – inability to think before acting
  - Hyperactivity – driven by internal motor
  - Poor organization, messy, bad handwriting
  - Antisocial tendencies – inability to give current valance to future consequences
Attention control disorders

• Attention is like vision -- a continuum. How much do you need
  – When are we treating an impairment, and when are we performance enhancing?
• Meds work, therapy doesn’t.
  – Multiple studies show that supportive treatments can improve function in school and home but don’t treat attention
Attention control disorders

• Meds that work – almost always
  – Amphetamine FDA approved (age 3)
  – Methylphenidate FDA approved (age 6)

• Meds that usual help
  – Tenex, intuniv and clonidine (age 6)

• Meds that sometimes work
  – Wellbutrin, strattera (age 6), tricyclics and provigil
Attention control disorders

- Practical approach
  - Get a Connors or Vanderbilt
  - Start AMP or MTP (dMTP if tics, anxiety, weight issues, etc)
    - MTP start at 1/3mg per pound (60 pound = 20mg) as a single LA or 2 short acting doses
    - AMP (or dMTP) start at 1/3mg per kg as single XR or 2 short acting doses
    - Titrate up to double to control attention, or down if overfocused
Attention control disorders

- If no benefit – rethink diagnosis, switch med
- Titrate for attention, consider after school meds
- If still hyper – augment with guanfacine, start low and increase slow
- Other meds mostly for stimulant intolerance or abuse
- Treat sleep cycle with melatonin
- Always be suspicious of abuse, and if treatment not working, be suspicious of diversion
Impulse control disorders

• “I want it and I want it now!”
  – Drugs, sex, gambling, rage
  – Pleasure driven more than distress driven
• Related to ADHD but not a core symptom. Exists without ADHD
• Stimulants may improve, but high abuse risk
• Therapy, consequences, controlled access
• Not great psychiatric treatment options, more forensic treatments
Emotional control disorder

- DMDD – disruptive mood dysregulation disorder
- What it is not – depression or bipolar
- What it becomes – cluster B personality disorder
- Treatment
  - SSRI can be helpful, or induce activated emotions
  - Abilify at low dose (2 – 5 mg) can be first choice
  - Almost always behavior issues so always look at family therapy
  - Treat comorbid ADHD
Sleep control disorders

• Insomnia
  – Psychologists say these are mostly non medical and best treated behaviorally – and point to good studies
  – Sleep medicine specialists say these are mostly unresponsive to behavioral approaches and need medicine – and point to good studies
  – Bottom line, they are challenging to have and challenging to treat
Sleep control disorders

• Non medical treatment should always be attempted

• Medical treatment
  – FDA approved – antihistamines, can cause impaired learning
  – Insurance recommends chlorate hydrate???, benzos???
  – No good long term data on any meds
Sleep control disorders

• Practical approach to meds
  – Melatonin, considered safe, effective
    • 3-6 mg for insomnia, (5-10 mg in ADHD)
  – Clonidine in young children
    • 0.05 to 0.2 mg
  – Short term only – antihistamines in younger kids, GABA agonists (e.g. ambien) in older kids
  – Trazodone, remeron, seroquel – often used, seem generally safe, no good supporting data
Developmental disorders

- Autistic spectrum disorders
- Other cognitive impairments
- Elimination disorders
- ? Personality disorders
Autistic spectrum disorders

• Impairment in reciprocal communications – possibly impaired mirroring
• Diagnose early – treat early, screen in all babies and children
• Treatment is aggressive educational, occupational, speech, behavioral and possibly physical therapy
• Medications usually unnecessary
Autistic spectrum disorders

• Medication for severe symptoms
  – Risperidone for behaviors, aggression
  – Stimulants for attention
  – SSRI for obsessions or anxiety
  – Guanfacine for aggression, hyperactivity
  – Lower doses for all of these than in other conditions and more side effects

• Autistic kids can also have pain, anxiety, depression, etc
Cognitive impairments

• True CI is a lot like ASD in how it can present and how it is treated, regardless of the cause

• Borderline CI is one of the most challenging issues in kids
  – Borderline IQ around 80 – often no SPED
  – Slow processors – cope too slowly
  – Act to fit in – often taken advantage of
  – Especially challenging in early adolescence
Elimination disorders

• Primary disorders are often variants of normal and best not treated and not punished
• DDAVP, tricyclics and bell/pad all fairly effective at symptom control, but don’t correct the problem
• Secondary urinary issues often medical
• Secondary fecal issue usually behavioral in onset, can become medical
“Psychiatric disease”

- Mood disorders
- OCD and tics
- Psychotic disorders
- Personality disorders
Mood disorders

• Depression and bipolar disorder
  – What is a mood, and what makes it disordered
  – About 90% of “bipolar” is not bipolar
  – Most “depression” is not MDD
  – True mood disorders are strongly genetic – suspect family histories.

• Common “mood disorders” are probably more anxiety based, behavior based and DMDD based and need therapy first and meds second — focused on anxiety and environment stability
Mood disorders

• True bipolar and MDD probably need meds first, and therapy second

• Mood elevators
  – FDA approved: Prozac (8), lexapro (12), trazodone (6) and tricyclics (varies)
  – SSRI – first line. Treat mood and anxiety
  – SNRI, wellbutrin, second line
  – Antidepressant soup, remeron, viibryd, tricyclics, abilify and stimulants
Mood disorders

• Practical approach to depression
  – Start with favorite SSRI, titrate to medium dose
  – Therapy and wait, increase dose
  – Switch to second SSRI if no benefit
  – Either augment with abilify or buspar, or switch to SNRI or wellbutrin if SSRI not helpful
  – Remeron, viibryd, stimulants all off label and sometimes used
Mood disorders

• Mood stabilizers
  – Lithium, antipsychotics and antiepileptics
  – FDA approved in kids
    • Lithium (any age)
    • Zyprexa (13), Risperidone, seroquel and abilify (10)
  – Most psychiatrists (except east coast) usually start an antipsychotic acutely and consider change to antiepileptic later
  – Depakote, trileptal and lamictal all used, no good data
Mood disorders

• Practical approach to mania
  – Antipsychotic acutely
    • Risperidone – I like a 1:2 approach, eg .25 am and .5 hs, or .5 am and 1mg hs
    • If you need more aggressive meds than risperidone, call me
  – Most true bipolar kids have a history to lean on to make med choices, and like adults, most recurrences are due to non-adherence to plan
OCD and tics

• Similar in many ways
• OCD sometimes responds to high dose SSRIs
• Tics sometimes respond to strong D2 blocking antipsychotics and alpha agonists. They are common and don’t usually need treatment
• Both can be mild and managed, or totally debilitating and nearly impossible to manage or live with
OCD and tics

• Practical approach to OCD
  – Reduce offending agents if possible
  – Pick an SSRI and dial it up slowly
  – FDA approved: paxil (7), prozac (7), luvox (8), zoloft (6), anafranil (10)
  – Prozac or paxil, target 60 – 80mg
  – Zoloft or luvox target 200mg
  – Wait forever, can take up to 6 months to respond
  – Therapy is often helpful
OCD and tics

• Practical approach to tics
  – Reduce offending agents if possible
  – Does it bother the kid?
  – Alpha agonist, especially clonidine
  – Antipsychotic, risperidone, haldol, ORAP

• For both these disorders, if you aren’t getting a response, get help
Psychosis

• Hallucinations are not always psychotic. They can be normal or abnormal ego defenses based on age and degree of anxiety.

• Psychosis is not always schizophrenia. Mood disorders and anxiety disorders, especially PTSD, can cause psychosis. So can medical disorders and intoxication.

• If you diagnose schizophrenia in a boy under 16 or any girl, you are wrong (almost always)!
Psychosis

• In non-psychotic hallucinations, the first goal is to not overreact, then treat the other symptoms to the degree needed and usually ignore the hallucinations.

• In psychosis, treat any medical or mood causes. In most cases you will also want to start an antipsychotic. Use higher doses than for mood stabilizing but expect to have and treat side effects.
Psychosis

• Acute care of psychosis
  – Risperidone, 2-3 times a day. Young kids about a mg, preteens, 1-2mg, teens about 3mg (total daily dose).
  – Zyprexa 2-3 times a day. Young kids about 5mg, preteens 10mg, teens 15mg (total daily dose).
  – Add cogentin 0.5mg or 1mg twice a day
  – Treat anxiety with benzos. Psychosis, especially first episode, is terrifying. Do not use benzo alone.
Psychosis

• New psychosis in a child or adolescent almost always should be hospitalized

• Don’t forget a complete medical evaluation including exam and basic labs. EKG because of higher dose antipsychotics. Consider MRI

• Therapy very important, even though it may not address the cause, treating the family has big dividends for patient outcomes
Personality disorders

• By definition, these are altered ability to see oneself and relationships rooted in abnormal personality structure with onset in youth.
• Seldom diagnosed in kids but many childhood disorders progress to PDs such as RAD/PTSD to borderline PD or ODD/CD to antisocial PDs
• Treatment is usually anxiety control, long-term therapy and safety plans
Emotional Impairments

• Common theme through all of discussion.
• ODD, DMDD, anxiety disorders, impaired regulation, RAD, PTSD, Victims of abuse
• Often have irritable temperament
• Evolve into Personality disorders
• Often diagnosed as “bipolar” or “depression”
• Most kids (and adults) with suicidality fall into this group
Questions?