2019 UNE COM Alumni Reunion & CME Event

Pediatric ADHD when comorbid with other mental health disorders: Assessment & Treatment

Disclosures:

I have no actual or potential conflict of interest in relation to this program/presentation.

2019 UNE COM Alumni Reunion & CME Event
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Pediatric ADHD when comorbid with other mental health disorders: Assessment & Treatment

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Pediatric ADHD when comorbid with other mental health disorders: Assessment & Treatment

Objectives

1. Able to identify the most common comorbid mental health conditions in children and adolescents with ADHD

2. Able to identify the most common clinical presentations of mental health conditions that co-occur with ADHD

3. Able to identify appropriate treatment steps when identifying children & adolescents with ADHD and a comorbid mental health condition

ADHD

Overview

ADHD

Epidemiology

- Prevalence
  - 6% for children
  - 3% for adolescents
- Male>Female

ADHD

Etiology & Risk Factors

- Strong genetic component (76%)
- Perinatal factors – some evidence
- Neurobiological deficits – growing evidence
- Deprivation and family factors – important for course and outcome

ADHD

Why is it important to recognize?

ADHD:

- Is common
- Can be serious
- Can persist
- Is stigmatizing
- Is treatable

ADHD

The Basics

- **Core symptoms**
  - Inattention, hyperactivity, impulsivity
  - Present in more than one context
  - Leading to functional impairment
- **Subtypes**
  - combined, predominantly hyperactive, predominantly inattentive

ADHD

Differences According to Age

- **Pre-school:** play < 3mins, not listening, no sense of danger
- **Primary school:** activities < 10 mins, forgetful, distracted, restless, intrusive, disruptive
- **Adolescence**: attention< 30 mins, no focus/planning, fidgety, reckless
- **Adult:** incomplete details, restless, forgetful, impatient, accidents

ADHD

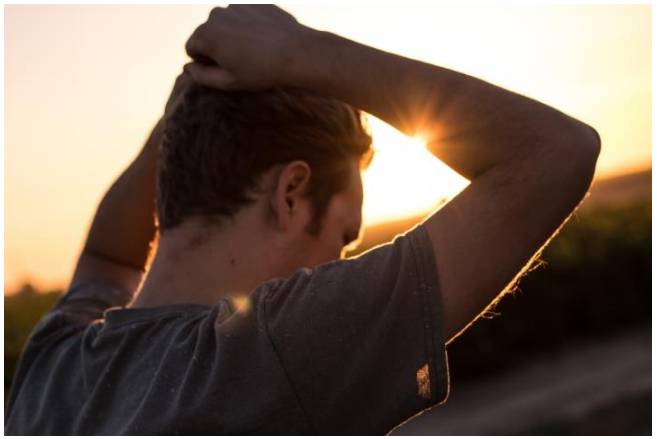
Course

- Some chronic
- Unclear persistence (Faraone 2006)
  - 15% full persistence
  - 40-60% partial remission
- Severe cases more persistent

ADHD

Associations with Durability of Symptoms

- Lower academic achievement
- Marital problems and dissatisfaction
- Divorce
- Difficulties dealing with offspring
- Lower job performance
- Unemployment
- Employment below potential
- Traffic accidents
- Other psychiatric disorders



ADHD

Clinical Assessment & Diagnosis

Information from **at least two** contexts

- Teachers are key
- Use of scales:

i.e. Vanderbilts

NICHQ Vanderbilt Assessment Scale – PARENT Informant*

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

	Symptoms	Never	Occasionally	Often	Very Often
1.	Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2.	Has difficulty keeping attention to what needs to be done	0	1	2	3
3.	Does not seem to listen when spoken to directly	0	1	2	3
4.	Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5.	Has difficulty organizing tasks and activities	0	1	2	3
6.	Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7.	Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8.	Is easily distracted by noises or other stimuli	0	1	2	3
9.	Is forgetful in daily activities	0	1	2	3
10.	Fidgets with hands or feet or squirms in seat	0	1	2	3
11.	Leaves seat when remaining seated is expected	0	1	2	3
12.	Runs about or climbs too much when remaining seated is expected	0	1	2	3
13.	Has difficulty playing or beginning quiet play activities	0	1	2	3
14.	Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15.	Talks too much	0	1	2	3
16.	Blurts out answers before questions have been completed	0	1	2	3
17.	Has difficulty waiting his or her turn	0	1	2	3
18.	Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19.	Argues with adults	0	1	2	3
20.	Loses temper	0	1	2	3
21.	Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22.	Deliberately annoys people	0	1	2	3
23.	Blames others for his or her mistakes or misbehaviors	0	1	2	3
24.	Is touchy or easily annoyed by others	0	1	2	3
25.	Is angry or resentful	0	1	2	3
26.	Is spiteful and wants to get even	0	1	2	3
27.	Bullies, threatens, or intimidates others	0	1	2	3
28.	Starts physical fights	0	1	2	3
29.	Lies to get out of trouble or to avoid obligations (i.e., "cons" others)	0	1	2	3
30.	Is truant from school (skips school) without permission	0	1	2	3
31.	Is physically cruel to people	0	1	2	3
32.	Has stolen things that have value	0	1	2	3
33.	Deliberately destroys others' property	0	1	2	3
34.	Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35.	Is physically cruel to animals	0	1	2	3
36.	Has deliberately set fires to cause damage	0	1	2	3

DSM-5 criteria for ADHD

≥5 symptoms per category **in adults**, ≥6 months; age of onset ≤12 years; noticeable in ≥2 settings; impact on social, academic or occupational functioning; not better accounted for by another mental disorder

Inattention

(a) Lack of attention to details / careless mistakes

(b) Difficulty sustaining attention

(c) Does not seem to listen

(d) Does not follow through on instructions (easily side-tracked)

(e) Difficulty organising tasks and activities

(f) Avoids sustained mental effort

(g) Loses and misplaces objects

(h) Easily distracted

(i) Forgetful in daily activities

Hyperactivity / Impulsivity

(a) Fidgetiness (hand or feet) / squirms in seat

(b) Leaves seat frequently

(c) Running about / feeling restless

(d) Excessively loud or noisy

(e) Always "on the go"

(f) Talks excessively

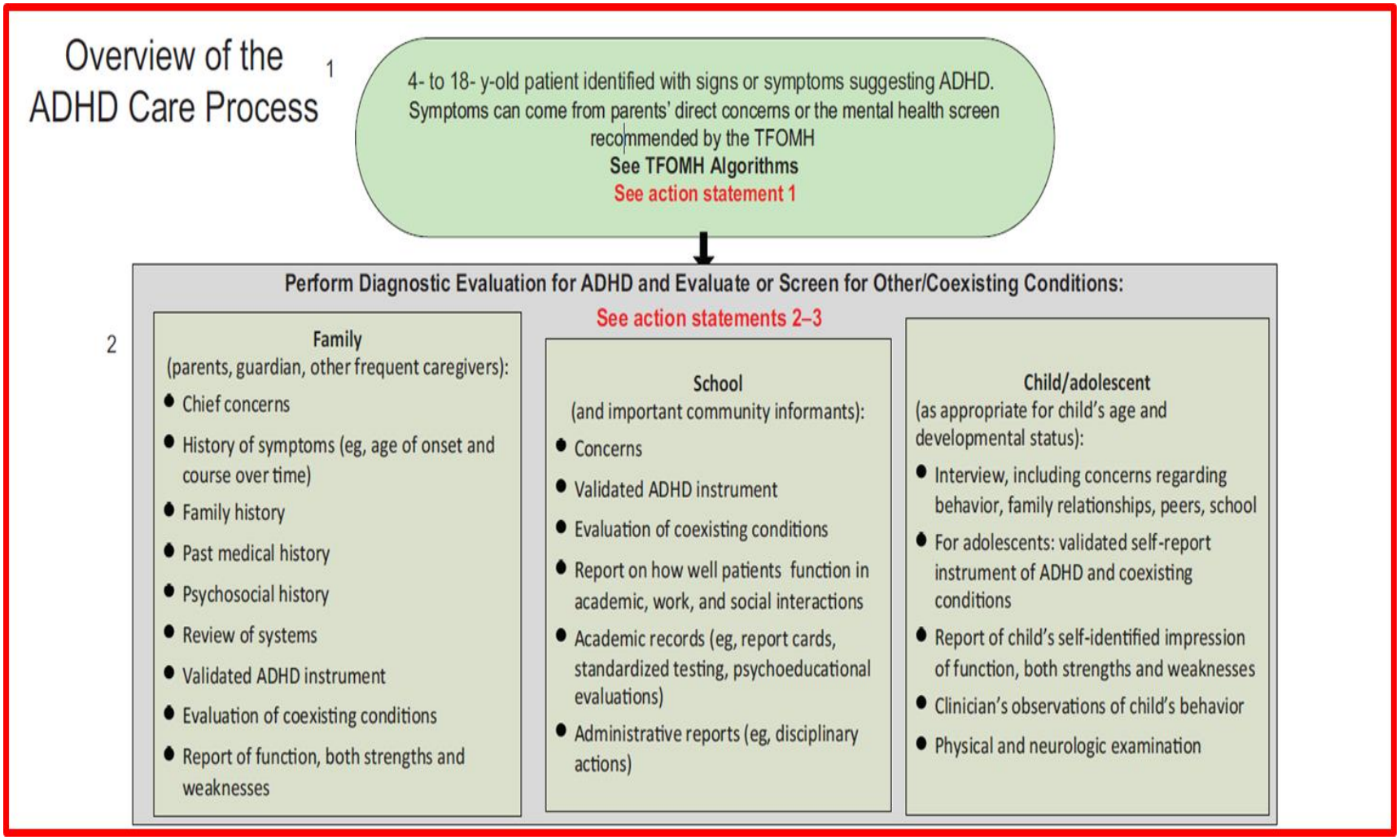
(g) Blurts out answers

(h) Difficulty waiting his or her turn

(i) Tends to act without thinking

ADHD

Clinical Assessment & Diagnosis



Review of Assessment Algorithm

- Does the child have problems with **inattention** and **over-activity**?
- Are symptoms **persistent**, severe and causing **impairment** in the child's functioning?

YES

YES

Consider ADHD if the answer to both is 'yes'

- Explore the impact of **environmental stressors** (e.g., family)

Explore ways to address environmental stressor as part of management plan

- **Rule out** medical or other conditions

Manage or refer

ADHD

Treatment

Evidence Based Treatments:

- Best evidence for stimulant medication
- Behaviour treatments also effective in mild to moderate cases
- Psycho-education for parents and school

ADHD

Stimulant Medication

Methylphenidate or Amphetamines

- Efficacy and safety well established
- ES 0.8-1.1; clinical response in 70%
- Dose: titrate for optimum response
- Short/long acting (sustained release) available

- Common side effects: nausea, weight loss, insomnia, agitation
- More serious side effects: tics, psychotic symptoms, raised blood pressure, growth retardation

ADHD

Non-Stimulant Medication

- Atomoxetine
- Clonidine
- Guanfacine
- Wellbutrin

ADHD

Psychosocial Treatments

- Behavior therapy
  - Individual
  - Parent management training: particularly useful in younger children and for associated behavior problems
  - School based: child in front of class, short tasks etc.

- Generally effective, but smaller effect size than medication

- First line treatment in younger children or milder cases

ADHD

Summary of Recommendations for Treatment

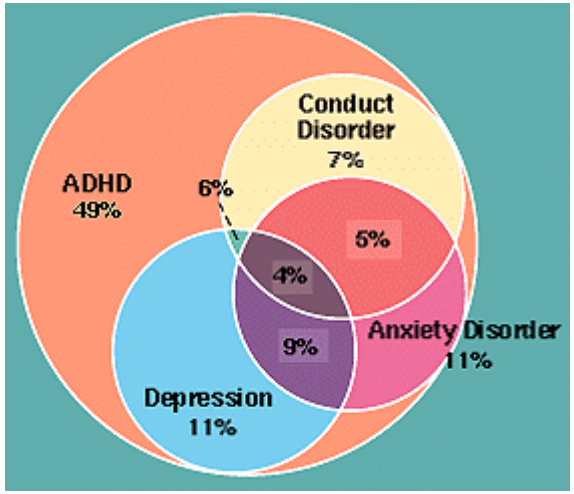
Table D.1.5 Summary of recommendations for treatment

Severity	4–5 years of age	6–11 years of age	12–18 years of age
Mild to moderate	• Psychoeducation • Parent training programs • Teacher-administered behavior therapy • If no improvement and symptoms are severe, consider methylphenidate.	• Parent training programs and CBT • If no access to CBT and in severe cases with uncomplicated ADHD: stimulants or atomoxetine • If no response: add stimulants or atomoxetine (first line medications) • If no adequate response or significant side effects: switch to another first line medication (e.g., from methylphenidate to dexamphetamine or to atomoxetine) • If no response and significant comorbidity: try second line medications	• Stimulants or atomoxetine • If no response: add CBT • If no adequate response or significant side effects: switch to another first line medication (e.g., from methylphenidate to dexamphetamine or to atomoxetine) • If no response and significant comorbidity: try second line medications
Severe		• Stimulants or atomoxetine, if possible combined with CBT • If no adequate response or significant side effects: switch to another first line medication (e.g., from methylphenidate to dexamphetamine or to atomoxetine) • If no response and significant comorbidity: try second line medications	• Stimulants or atomoxetine, if possible combined with CBT • If no adequate response or significant side effects: switch to another first line medication (e.g., from methylphenidate to dexamphetamine or to atomoxetine) • If no response and significant comorbidity: try second line medications

First line medications: stimulants, atomoxetine
Second line medications: extended release guanfacine,
Third line medications: extended release clonidine, tricyclic antidepressants, brupopion

When Assessment Suggests ADHD and "Something Else"…

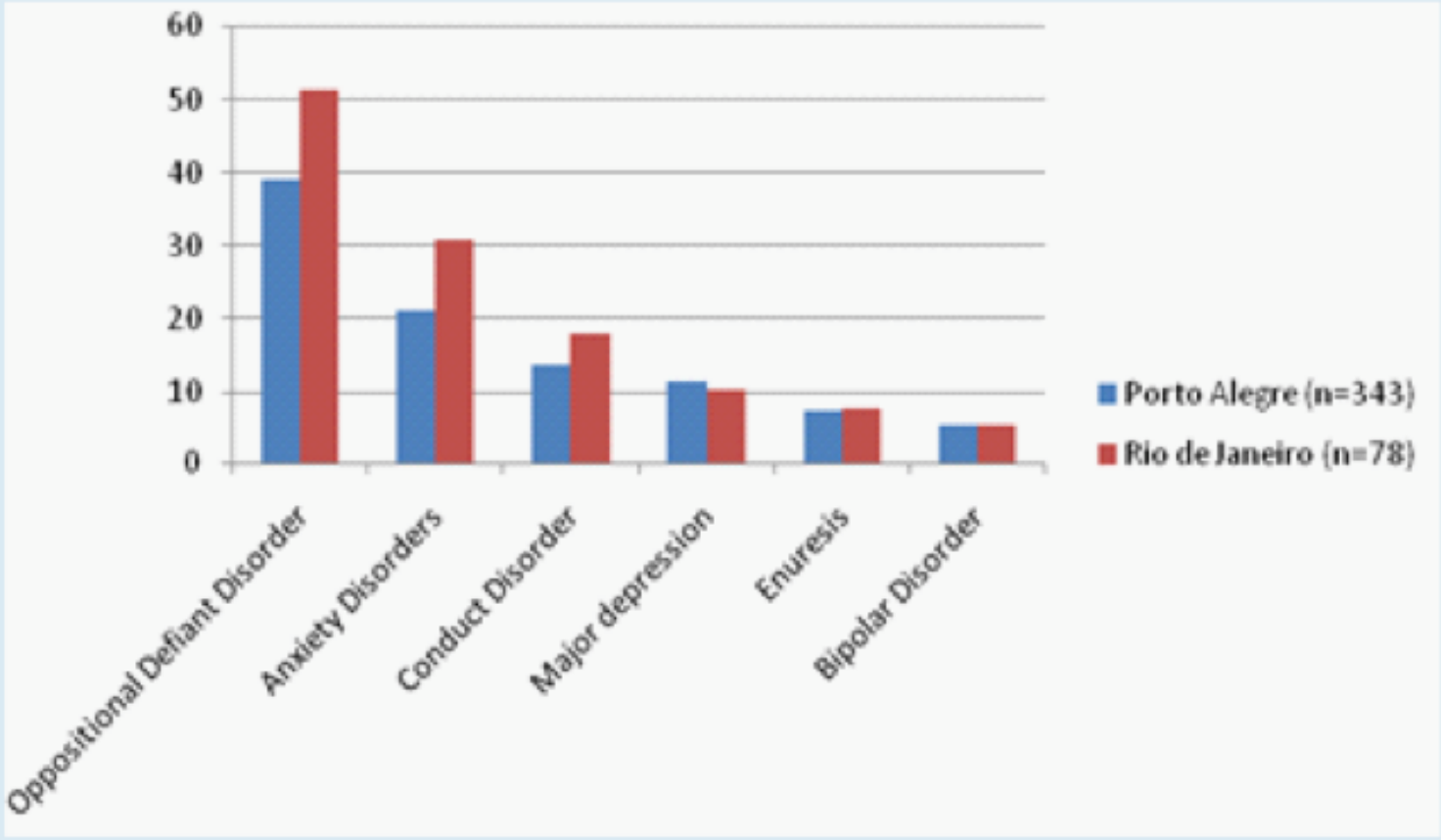
- If ADHD suspected, but assessment suggests another comorbid condition:
  - Rule out any underlying medical conditions
  - Determine Co-morbid psychiatric conditions; most common to be discussed:
    - ODD
    - Anxiety Disorders
    - Conduct Disorders
    - Depression



ADHD

Comorbid Disorders in Brazilian Community Samples

Figure D.1.4 Comorbid disorders in community samples of individuals with ADHD in two Brazilian cities



Adapted with permission from Souza et al (2004), "Attention-deficit/hyperactivity disorder and comorbidity in Brazil." European Child & Adolescent Psychiatry, 13:245.

When Assessment Suggests ADHD and "Something Else"…

PTSD

.Severe PTSD can present very similar to ADHD and can co-occur.

.In cases when both are co-occurring; trauma informed therapy interventions important.

.Can treat ADHD symptoms w/ stimulants; alpha agonist also often helpful

DMDD

.New diagnosis in DSMV

. **Chronic (non-episodic)** and **severe irritability** and **hyperarousal without** *euphoria and grandiosity* of bipolar disorder

. Cannot co-occur with ODD; DMDD dx nullifies ODD

ADHD

Comorbid Oppositional Defiant Disorder

Oppositional Defiant Disorder

Epidemiology

- Prevalence: 2-10%
- Boys>girls
- Symptoms decline after age 10
- Rarely diagnosed in older children
- Estimates vary across countries
- Majority do not develop conduct disorder
- High rates of comorbidities

Oppositional Defiant Disorder

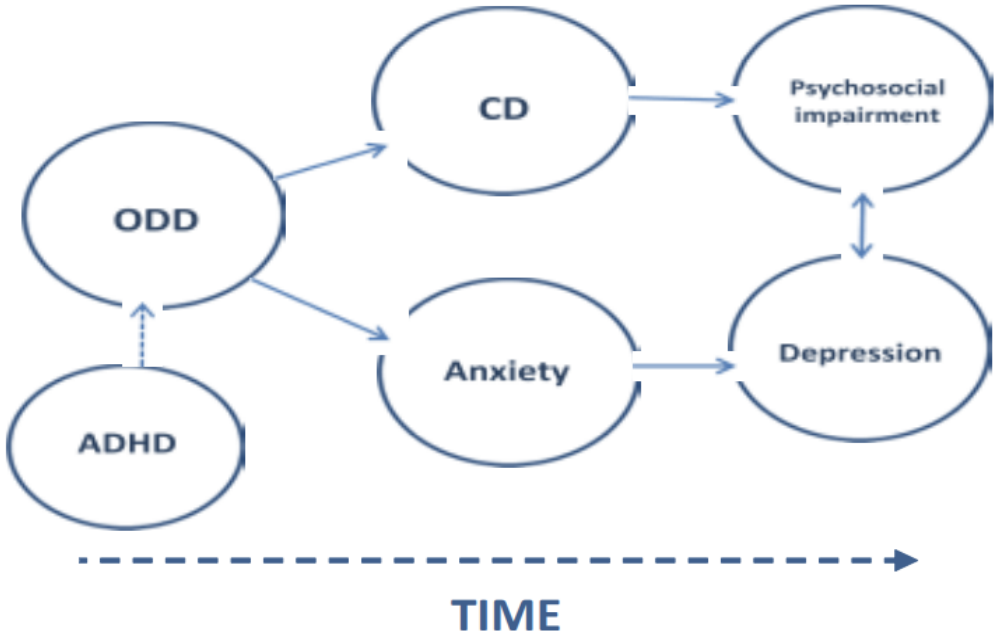
Etiology & Risk Factors

- Genetics
- Gene-environment interplay
- Different temperamental routes
- Rejection by non-deviant peers
- Social and economic disadvantage
- Neighborhood violence
- Negative parenting
- “Coercive family processes”

Oppositional Defiant Disorder

Comorbidity

Figure D.2.2: The relationship between ODD and other disorders (modified from Burke et al, 2005)



ODD: oppositional defiant disorder; CD: conduct disorder; ADHD: attention deficit/hyperactivity disorder (common precursor to ODD)

Oppositional Defiant Disorder

The Basics

- "A persistent pattern of defiant, disobedient, and antagonistic behavior toward adults"
- No antisocial or aggressive acts like the ones found in conduct disorder
- Common
- Substantial impairment
- Poorer adjustment outcomes
- Increased cost to society

Oppositional Defiant Disorder

Diagnosis

- DSM-5: 4 or more of the following, not just with siblings, lasting greater than 6 months
  - Often loses temper
  - Often touchy or easily annoyed
  - Often angry and resentful
  - Often argumentative with adults/authority figures
  - Often defies or doesn't follow rules
  - Often deliberately annoys others
  - Often blames others
  - Spiteful or vindictive 2 x in 6 months

Oppositional Defiant Disorder

Treatment

- Identify and treat comorbidities i.e. ADHD
- Address modifiable risks i.e. bullying
- Parent management training
  - The Incredible Years
  - Triple P (Positive Parenting Program)
- Alternative approaches
- School-based interventions
- Individual therapy (anger management)
- Medication- no evidence for ODD

Oppositional Defiant Disorder

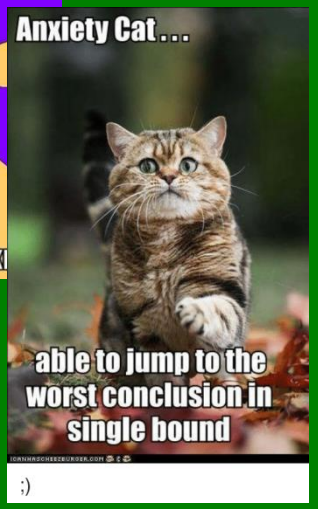
Treatment: Medication

- No evidence for medication in ODD alone
- Stimulants improve conduct and oppositional symptoms in ADHD
- Evidence lacking for use of SSRI's for anger in children
- Mood stabilizing agents such as 2nd gen antipsychotics: use short-term on a case by case basis only in setting of other conditions and not for ODD only

Oppositional Defiant Disorder

Summary

- ODD highly likely to be comorbid with other disorders, especially ADHD
- Individual therapy to develop anger management skills
- Parent management training
- Treat co-morbid ADHD in tandem with ODD interventions, but remember there is no medication for ODD alone



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ADHD

Comorbid Anxiety Disorders

Anxiety Disorders in Children and Adolescents

Epidemiology: Prevalence

- Variable across countries and studies
- ~5% in Western populations
- Prevalence:
  - Highest rates for specific phobias
  - Moderate for separation anxiety, generalized anxiety, social phobia
  - Lower for obsessive compulsive disorder
  - Lowest for post traumatic stress disorder

Anxiety Disorders in Children and Adolescents

Epidemiology: Gender distribution

- General Population:
  - females>males
  - As much as 1.5-2 x F>M
- Difference appears as young as 5 years of age
- In treatment seeking populations in Western societies M=F

Anxiety Disorders in Children and Adolescents

Risk and Maintaining Factors

Family transmission:

- Anxiety and inhibited temperament runs in families
- 1st degree relatives at risk for anxiety and mood disorders
- Transmission of specific disorders have some specificity
- Genetic and environmental influences

Anxiety Disorders in Children and Adolescents

Risk and Maintaining Factors

Genetic Factors:

- ~40% variance mediated by genetics
- Twin studies show 30-40% variance by heritability
- Especially high with general neuroticism
- Most studied is 5HTTLPR gene
- 2 short alleles on 5HTT gene increase environmental responsiveness

Anxiety Disorders in Children and Adolescents

Risk and Maintaining Factors

Temperamental Factors:

- Best studied and most clearly established risk factor–>**inhibition**
  - Withdrawal in face of novelty
  - Lack of smiling
  - Lack of talk
  - Limited eye contact
  - Close proximity to attachment figure
  - Slowness to warm up to strangers or peers
  - Unwillingness to explore new situations
- Inhibited preschool kids 2-4x more likely to have anxiety by middle childhood

Risk and Maintaining Factors

Parent and family factors:

- Evidence difficult to obtain
- Data not consistent
- Parenting characteristics:
  - Overprotection
  - Intrusiveness
  - Negativity
- Parental modeling and communication of fear
- Sexual abuse, physical abuse, family violence

Anxiety Disorders in Children and Adolescents

Risk and Maintaining Factors

Life Events:

- Increased negative life events
- Greatest difference on dependent events
- Bullying and teasing
- Neglect and rejection by peers

Anxiety Disorders in Children and Adolescents

Risk and Maintaining Factors

Cognitive Biases:

- Heightened threat beliefs and expectations
- Specific to disorder type
- Decrease with successful treatment
- Bias in attention toward threat
- Bias to interpret ambiguous info as threat

Anxiety Disorders in Children and Adolescents

Age of Onset

- Some of the earliest disorders to appear
- Begin by mid childhood to mid adolescence
- Association with temperamental inhibition and fearfulness
- Average ages of onset:
  - Animal phobias ~ 6-7 yrs
  - Separation anxiety ~7-8 yrs
  - GAD ~ 10-12 yrs
  - Social anxiety ~ 11-13 yrs
  - OCD ~13-15 yrs
  - Panic d/o ~ 22-24 yrs

Course

- Among the most stable
- Little spontaneous remission
- Increased risk in adolescence:
  - Anxiety and mood disorders
- Increased risk in adulthood:
  - Anxiety and mood disorders
  - Substance use
  - Suicide
- No association with family size, parental marital status, educational attainment, intelligence

Assessment: General

- 3 Parts: Questionnaires, diagnostic interview, behavioral observation
- Use clinical judgment to combine information from various sources
  - Separate interview with children > 8yrs old
  - Anxious kids “fake good”
  - Anxious parents may exaggerate symptoms
- Identify motivation behind behaviors
- Determine primary disorder and treat first*

Anxiety Disorders in Children and Adolescents

Assessment: Questionnaires

- Spence Children's Anxiety Scale (SCAS)
- Screen for Child Anxiety Related Disorders (SCARED)
- Multidimensional Anxiety Scale for Children (MASC 2)
- Preschool Anxiety Scale Revised (PASR)
- Revised Children's Manifest Anxiety Scale (RCMAS)
- State Trait Anxiety Inventory for Children (STAIC)
- Beck Anxiety Inventory for Youth
- Children's Moods, Fears and Worries
- Fear Survey Schedule for Children Revised (FSSC-R)
- Social Phobia and Anxiety Inventory for Children (SPAIC)
- Social Anxiety Scale for Children-Revised (SASC-R)
- Children's Anxiety Sensitivity Index (CASI)
- Children's Automatic Thoughts Scale (CATS)
- School Anxiety Scale-Teacher Report (SAS-TR)
- Children's Anxiety Life Interference Scale (CALIS)

Treatment

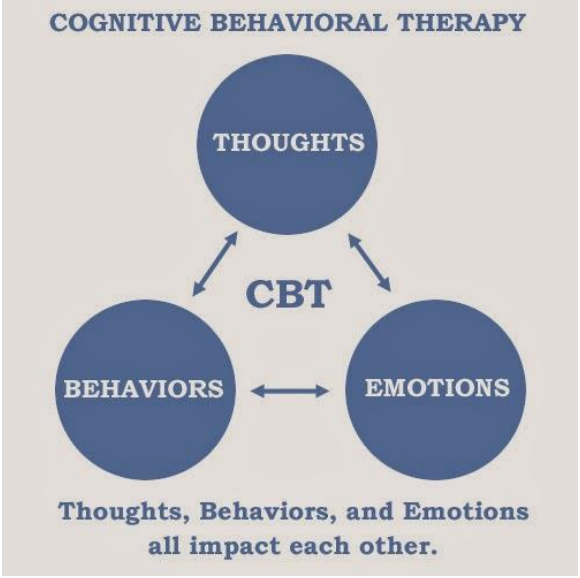
Psychopharmacology:

- Selective Serotonin Reuptake Inhibitors (SSRIs)
- Treatment generally 10-15 weeks
- 50-60% children respond vs 30% placebo
- Medication effects may level off after 8 weeks
- 7% anxious kids discontinue due to adverse side effects
- Monitor for suicidality

Anxiety Disorders in Children and Adolescents

Treatment

Vitamin CBT!!- aka Cognitive Behavioral Therapies



Skills-based programs:

- Psychoeducation
- Relaxation
- Exposure
- Contingency management
- Parent training
- Cognitive restructuring
- Social skills and assertiveness training

Generally 8-15 weeks
1-2 hours/session
Group or individual

Summary

.Anxiety Disorders often co-morbid with one another

.SSRIs and CBT together 1st line

.When comorbid w/ ADHD:

-Atomoxetine to treat both anxiety/ADHD

-or treat ADHD w/ stimulant and add SSRI/CBT/or both for anxiety

ADHD
Comorbid Conduct Disorder

Conduct Disorder

Epidemiology

- Occurs between 2%-8% of children & adolescents
- M>F
- **Childhood onset type** and **Adolescent onset type**
  - **Childhood onset** more likely to **persist** into adulthood, have **lower IQ**, more **attentional and impulsivity** problems, **more psychosocial difficulties**
  - **Adolescent onset** more related to association with **other delinquent youths**, seeking **social status**, and more likely to be time limited

Conduct Disorder

Etiology & Risk Factors

- Genetics Perinatal complications-may attribute some vulnerability
- Inconsistent parenting
- Smoking during pregnancy
- More likely to have deficits in language skills
- Low IQ
- Low socioeconomic status
- Executive dysfunction i.e. ADHD
- Exposure to domestic violence/conflict
- Abuse

Conduct Disorder

Factors Predicting Poor Outcome

- **Onset** Early onset of severe problems, before age 8
- **Phenomenology** Antisocial acts which are severe, frequent, and varied
- **Comorbidity** Hyperactivity and attention problems
- **Intelligence** Lower IQ
- **Family History** Parental criminality; parental alcoholism
- **Parenting** Harsh, inconsistent parenting with high criticism, low warmth, low involvement and low
- supervision.
- **Wider environment** Low income family in poor neighborhood with ineffective schools.

Diagnostic Criteria for Conduct Disorder

TABLE 9.2 | Diagnostic Criteria for Conduct Disorder

DSM-5

(A) A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least three of the following 15 criteria in the past 12 months from any of the categories below, with at least one criterion present in the past 6 months:

Aggression to People and Animals

(1) Often bullies, threatens, or intimidates others.

(2) Often initiates physical fights.

(3) Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun).

(4) Has been physically cruel to people.

(5) Has been physically cruel to animals.

(6) Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery).

(7) Has forced someone into sexual activity.

Destruction of Property

(8) Has deliberately engaged in fire setting, with the intention of causing serious damage.

(9) Has deliberately destroyed others' property (other than by fire setting).

Deceitfulness or Theft

(10) Has broken into someone else's house, building, or car.

(11) Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)

(12) Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery).

Serious Violations of Rules

(13) Often stays out at night despite parental prohibitions, beginning before age 13 years.

(14) Has run away from home overnight at least twice while living in parental or parental surrogate home, or once without returning for a lengthy period.

(15) Is often truant from school, beginning before age 13 years

(B) The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

(C) If the individual is 18 years or older, criteria are not met for Antisocial Personality Disorder.

Conduct Disorder

Diagnosis

. **Repetitive** & **Persistent** pattern of behaviors last >12 months

.Need **3 out of 15 criteria** occurring in past **12 months**

.Need at **least one** of the criterion present in **past 6 months**

.Must **impact functioning** in some way

.If >18 y.o. would be considered Antisocial Personality D/O

.Criterion categories**: Aggression to people and animals**, **Destruction of Property**, **Deceitfulness/Theft**, & **Serious Violation of Rules**

Conduct Disorder

Treatment

Principles of Treatment:

- Engage the family
- Develop strengths
- Treat comorbid conditions
  - -ADHD
  - -Screen for Substance Use
  - -Mood and Anxiety Disorders
- Promote social and scholastic learning
- Each Intervention should address each context specifically

Conduct Disorder

Treatment

Specific Interventions with Strong Evidence of Support:

Family based-i.e. FFT

Multiple Component Interventions- i.e. MST

Treatments that DON'T work:

-Harsh, military style incarceration, "boot camp"

- "Scared Straight" programming; worse outcomes

-Medications; none that directly treat CD*

ADHD

Comorbid Depression

Depression in Children and Adolescents

Epidemiology

- Pre-pubertal children: 1-2%
- Adolescents: 5%
- Cumulative prevalence
  - Girls: 12%
  - Boys: 7%

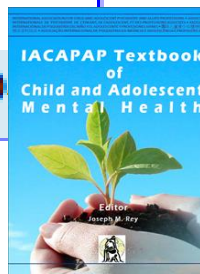
Depression in Children and Adolescents

Differences According to Age

Table E.1.1 Differences in the presentation of depression according to age. These symptoms can all be present at any age but are more common in the age group specified.

Pre-pubertal children	Adolescents	Adults
• Irritability (temper tantrums, non-compliance) • Affect is reactive* • Frequently comorbid with anxiety, behavior problems, and ADHD • Somatic complaints	• Irritability (grumpy, hostile, easily frustrated, angry outbursts) • Affect is reactive* • Hypersomnia • Increased appetite and weight gain • Somatic complaints • Extreme sensitivity to rejection (e.g., falsely perceived putdown or criticism) resulting, for example, in difficulties maintaining relationships.	• Anhedonia • Lack of affective reactivity • Psychomotor agitation or retardation • Diurnal variation of mood (worse in the morning) • Early morning waking

*Ability to be momentarily cheered up in response to positive events (e.g., visit by peers).



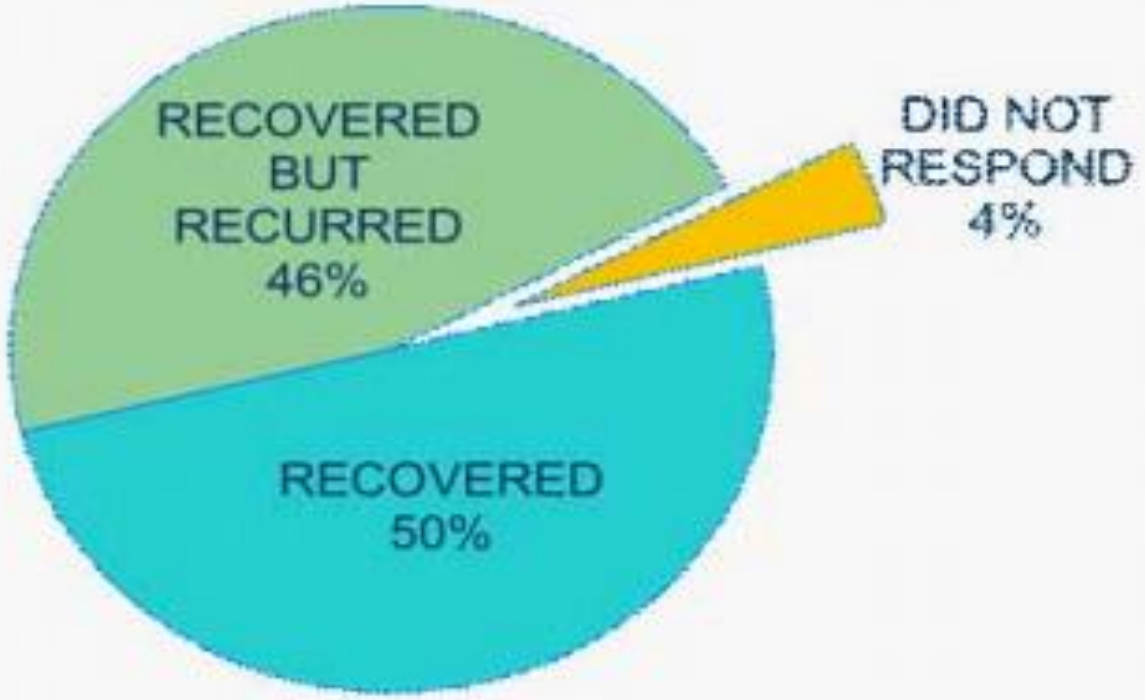
Depression in Children and Adolescents

Course

- Recurring, spontaneously remitting
- Average episode: 7-9 months
- 40% probability of recurrence in 2 years
- 60% likelihood in adulthood
- Predictors of recurrence:
  - poorer response, greater severity, chronicity, previous episodes, comorbidity, hopelessness, negative cognitive style, family problems, low SES, abuse or family conflict

Course

Figure E.2.2 Recovery and recurrence: TADS participants after five years (Curry J et al. 2010).



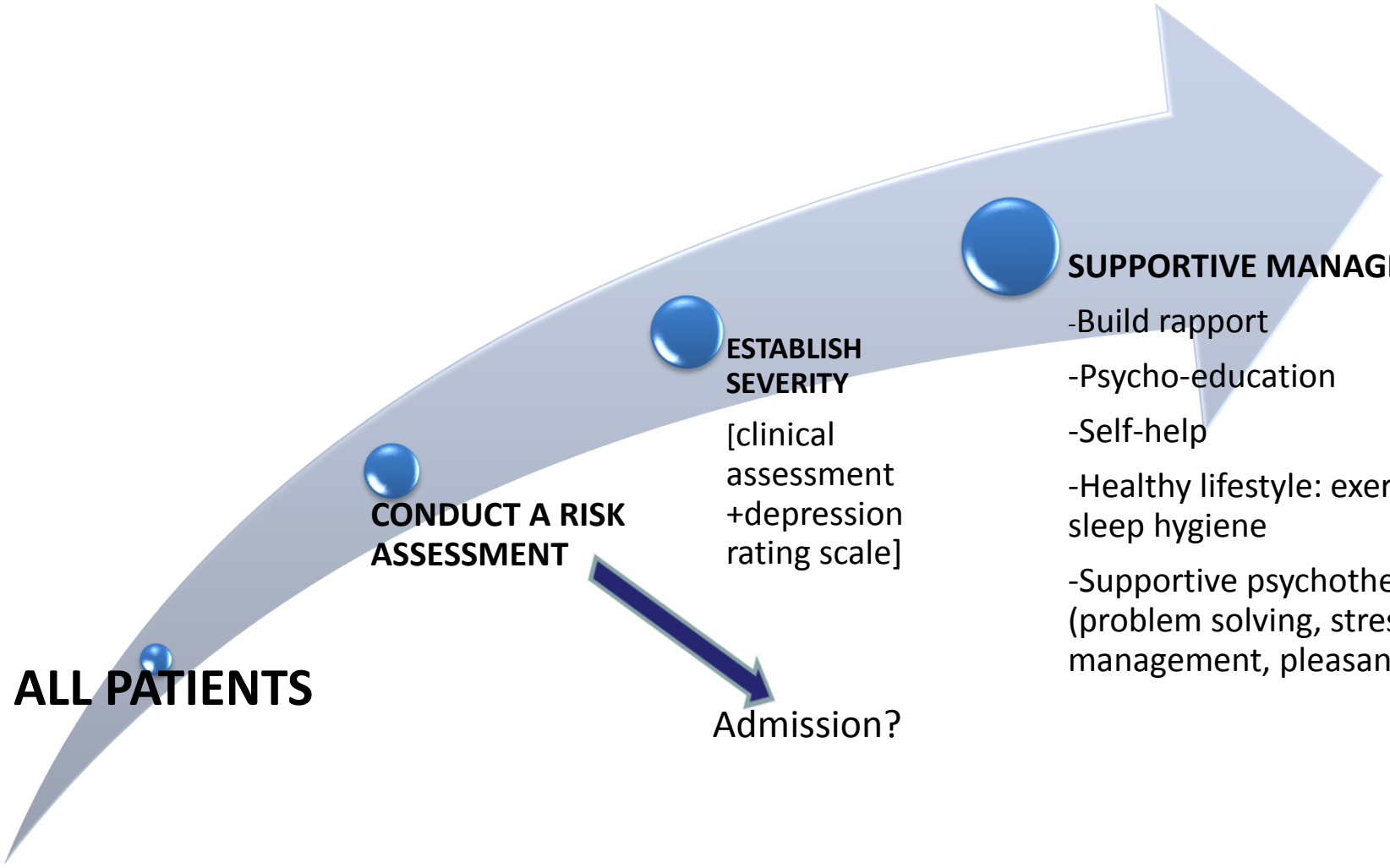
What Works?

Robust evidence of effectiveness for:

- Medication (moderate and severe depression)
- Psychotherapy (milder depression)
  - Cognitive behaviour therapy (CBT)
  - Interpersonal psychotherapy (ITP)

Depression in Children and Adolescents

Principles of Management for All Cases



Depression in Children and Adolescents

Treatment Options

Depending on severity:

- Watchful waiting
- Supportive management
- Psychosocial interventions
  - Cognitive Behavioral Therapy (CBT)
  - Interpersonal Psychotherapy (IPT)
- Medication

Depression in Children and Adolescents

Management of Acute Unipolar Depressive Episode

- **Mild:** supportive management, CBT, or IPT→no response→CBT, IPT, or antidepressant medication
- **Moderate:** supportive management, CBT, IPT or medication→ no response–add medication
- **Severe:** CBT/IPT and medication
- **Psychotic depression:** CBT/IPT and medication and second generation antipsychotic drug

Depression in Children and Adolescents

Summary

- Assess severity of depressive symptoms

- .When comorbid with ADHD:
- -Start by treating whichever disorder is more severe
- - Then add treatment for the second disorder if monotherapy does not result in remission of both disorder

Pediatric ADHD when comorbid with other mental health disorders:
Summary

. ADHD is common, and comorbidity is common

.ODD, Anxiety, Conduct Disorder, Depression most common comorbidities

. Evaluate ADHD in any child or adolescent who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity; *information needed from two different sources*

Aims of treatment: *Individually tailored, Reduce symptoms, Improved educational outcomes, Reduce family and school-based problems*

Pediatric ADHD when comorbid with other mental health disorders: Summary

. Stimulants still considered first line in treatment of ADHD

.When comorbid with other conditions, often it is still recommended to treat ADHD in tandem with other conditions; i.e. ODD and Conduct Disorder

. In the setting of comorbid depression and/or anxiety disorder, if overtly severe, often times need to start by treating these disorders followed by ADHD

Pediatric ADHD when comorbid with other mental health disorders

When to Refer?

- If no response and severe impairment after pharmacological treatment combined with behavioral approaches
  - Re-evaluate diagnosis and co-morbidity
  - Check for undetected social adversity or abuse
- If still no response after 6 months consult with specialist

Pediatric ADHD when comorbid with other mental health disorders:

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Pediatric ADHD when comorbid with other mental health disorders:

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The “IACAPAP Textbook of Child and Adolescent Mental Health” is available at the IACAPAP website http://iacapap.org/iacapap-textbook-of-child-and-adolescent-mental-health

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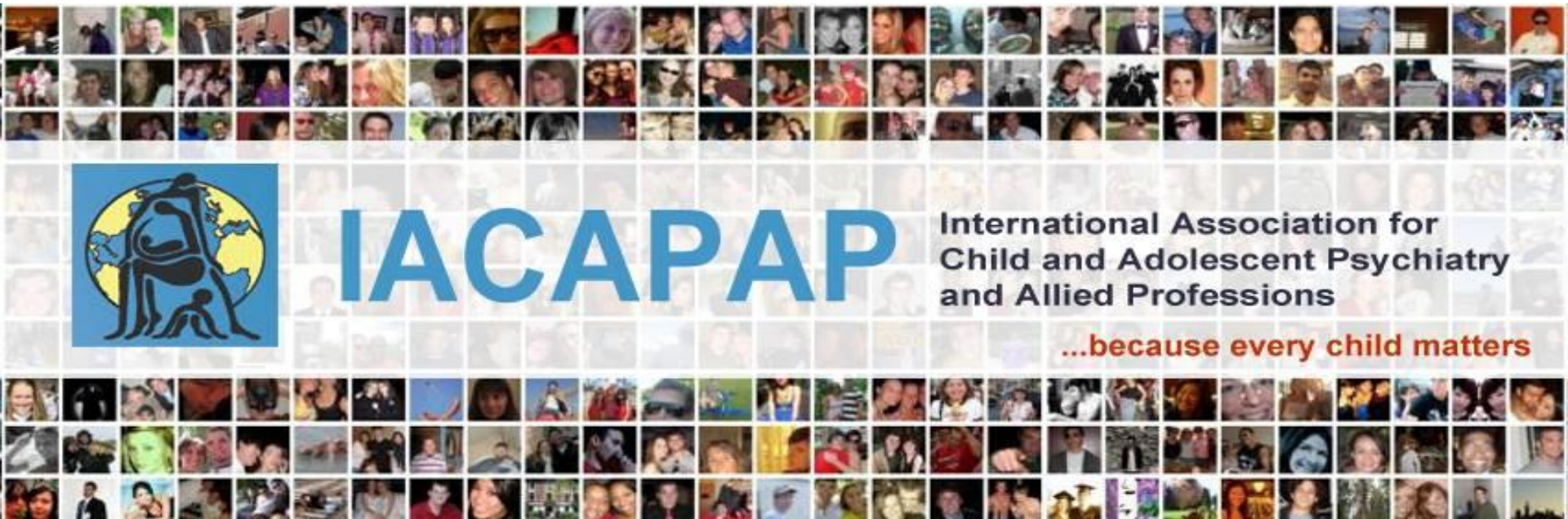

Thank you!