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IN THIS ISSUE

The Explosive Child

Managing Aggression in Children

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Dr. Fisher has disclosed that she has no relevant relationship or financial interest in any commercial company pertaining to this educational activity.

Once you have tried the various non-pharmacological approaches to aggression (see this month's interviews with Dr. Connor and Dr. Greene for suggestions), you will have to turn to what is generally the second choice—using medications. In this article, I'll discuss a practical approach to choosing and prescribing medications for childhood aggression. See the accompanying table on page 3 for details about dosing and side effects.

Before discussing specific agents, it is important to note that conduct disorder and oppositional defiant disorder respond infrequently to medication alone—generally it can only augment environmental and behavioral interventions. Also, I find that often the most difficult to treat patients have unrecognized long-standing anxiety or learning disabilities. So when you are having trouble achieving a response, you may want to start the diagnostic process over again with this in mind. In patients with autism, developmental disabilities or traumatic brain injury, slow all medication changes down substantially. This population may become aggressive merely in response to rapid dose changes irrespective of the underlying disorder. The dictum for using medications in children, "start low, go slow," applies particularly to this group.

Adrenergic Agents. I generally start with alpha adrenergic agents when I'm unsure about the cause of aggression, because these drugs work quickly and are fairly safe. These medications, originally developed for the treatment of hypertension, work by interrupting the fight or flight sensation in the body, and are similar in this regard to the beta blocker propranolol—used off-label for aggression in adults. The theory is that if you can prevent the somatic feeling of agitation, you can reduce the cognitive component of aggression as well. Alpha adrenergic agents seem to work by giving the child an extra couple of seconds to think about a situation before reacting.

I will usually start with guanfacine (Tenex) because its longer half-life (15 hours) allows for once a day dosing, usually at night. However, Dr. Jess Shatkin of the NYU Child Study Center tells us that in his experience Tenex works better when dosed twice a day: "I generally start with a late afternoon dose and then add a morning dose once the evening dose has proven tolerable." Guanfacine XR (Intuniv) was recently introduced by Shire and is the only alpha adrenergic agent approved for ADHD. We await more experience with it, but the extended release mechanism may make it a good once-a-day option for treating aggression.

With regard to clonidine (Catapres), because children metabolize it very quickly, this medication requires dosing throughout the day, which can be hard for families. It comes in a patch form, however, which eliminates the need for multiple daily doses.

Antidepressants. I find antidepressants helpful for treating aggression in sev-

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Learning objectives for this issue: **1.** Prescribe appropriate medications to children with aggression. **2.** Describe proposed changes to diagnostic criteria in DSM-5. **3.** Implement different non-pharmacologic approaches to assessing and treating aggressive children. **4.** Understand the most current findings in the literature regarding psychiatric treatment. This CME/CE activity is intended for psychiatrists, psychiatric nurses, psychologists and other health care professionals with an interest in the diagnosis and treatment of psychiatric disorders.

Managing Aggression in Children: A Practical Approach

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eral ways. Tricyclics, such as desipramine, can be used to target the impulsivity and conduct disorder aspects of ADHD. SSRIs, on the other hand, do not work for ADHD symptoms, but they *are* remarkably effective treatments for anxiety disorders in children. A significant cause of aggression in children is anxiety—a fact that is often missed, in part because aggressive kids will often not admit to being anxious.

How does anxiety lead to aggression? The emotional logic varies from child to child. For example, a child with obsessive compulsive disorder might have the intrusive thought that if he puts his shoes on his family will die. If someone says, "Go put your shoes on," he will resist it with the same intensity that you or I would fight against something that would hurt our families, including becoming aggressive. Another example is the child with generalized anxiety disorder, who may be immobilized by worries. He may avoid homework because of worries like, "Can I get it done? Can I do it right? Will I lose it? Will I get yelled at by my teacher?" If he is told to do his homework by his parents, it may feel like he is being asked to jump into a shark tank, and he may fight against it, becoming aggressive. I find that SSRIs can often prevent aggression in such children by treating the underlying anxiety that drives it.

Stimulant and Non-Stimulant Treatments for ADHD. Again, these work by treating the underlying disorder. In the case of ADHD, impulsivity seems to drive the aggression, as well as the oppositional/defiant characteristics of some children with this diagnosis. Both symptoms seem to remit with effective treatment of ADHD. Many kids have comorbid anxiety, however, that may worsen with stimulants. Remember that atomoxetine (Strattera) is serotonergic, so be careful of drug interactions if you combine Strattera with SSRIs for treating anxiety and ADHD. Check for learning disabilities as well—not only are they commonly comorbid, they are also a common source of agitation and defiance around homework.

Antipsychotics. Most child psychiatrists will not use antipsychotics for aggression until less risky measures have failed. For instance, when you have tried psychotherapy, family interventions, more benign medications such as alpha adrenergics and SSRIs, and yet the aggression persists, antipsychotics are an option. I may use antipsychotics earlier in children who are physically dangerous and at imminent risk of serious harm, or in children who are about to be kicked out of the home or other living situation because of their behavior. In such situations, I take advantage of the best features of antipsychotics—they work very quickly, and very well.

My antipsychotic of first choice is usually aripiprazole (Abilify), because it generally has fewer side effects, especially in terms of weight gain and lipids. In addition, the fact that it is a partial D2 agonist, rather than a full D2 antagonist, may theoretically give it some long term side effect advantages. For example, while the data is sparse, Abilify may be less likely to cause tardive dyskinesia than other atypical antipschotics.

After Abilify, I will turn to Risperdal, partly because it, like Abilify, has FDA approval for the treatment of irritability in autism, and partly because my experience is that it seems to work particularly well for aggression. Zyprexa is my third choice, because it appears to have better mood stabilizing effects than other antipsychotics. However, it can cause tremendous weight gain and sometimes hypotension, so it requires careful monitoring.

Mood Stabilizers. My mood stabilizer of first choice is Lamictal (lamotrigine) because it has few side effects and works fairly well for the common clinical profile of the child with irritable depression who may or may not have bipolar disorder. In fact, I tend to use Lamictal before an atypical antipsychotic in such children. Lithium, Depakote, and Trileptal are my aggression treatments of last resort because of a combination of severe side effects and the need for blood monitoring. Lithium can cause cognitive dulling, hypothyroidism, and renal problems. Depakote commonly causes weight gain, sedation, and nausea, and possibly polycystic ovarian syndrome. Trileptal is well tolerated but requires blood monitoring because of the small risk of hyponatremia and lowered white blood count. On the other hand, lithium and Depakote can be remarkably effective for aggression, and Depakote has a long track record of pediatric use in the treatment of epilepsy.

Benzodiazepines. While benzodiazepines can be helpful for pediatric anxiety, they are usually avoided in aggressive children because they can be disinhibiting. For this reason, benzodiazepines are not included in the medication chart.

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Proposed DSM-5 Changes for Child Psychiatry

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The DSM-5 proposed diagnostic criteria have been put out for public view, in advance of field testing, on www.DSM5.org. While the proposed changes are many, those most pertinent to child psychiatry are described below.

Temper Dysregulation Syndrome with Dysphoria. One big controversy is the possible inclusion of temper dysregulation syndrome with dysphoria (TDSD), an attempt to provide a more precise diagnostic home for kids who now are often classified as having bipolar disorder. Proposed diagnostic criteria for TDSD include out of proportion reactions to normal stressors, including violence or rage, occurring at least three times a week; a baseline mood of unhappiness for 12 months or more; and the *absence* of episodes of mania or hypomania.

The controversy over TDSD reflects a longstanding debate in the field between those who argue that chronic irritability is a pediatric bipolar marker—so-called "broad criteria" or "broad spectrum" view—versus those who argue that childhood mania is defined by classic symptoms, such as euphoria and grandiosity (so called "narrow criteria"). (For more on this topic, see this

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Medications Commonly Used to Treat Aggression in Children

Medication	Dose	Side Effects	Evidence
Adrenergic Agents			
Clonidine (Catapres)	0.05 mg QID for younger kids, BID to TID for adolescents. Can be administered via skin patch: 0.1 mg–0.3 mg daily delivery. Each patch lasts 5–7 days.	Sedation, hypotension, can cause irritability especially in younger children. Catapres skin patch adhesive can cause localized reaction. This can often be managed by applying hydrocortisone cream to area before putting on patch.	- Two randomized controlled trials of Catapres showed effectiveness for aggression when combined with stimulants for ADHD (*J Clin Psych* 2006;67(5):808–820). - One retrospective open label study of Catapres in autism showed effect on aggression and impulsivity (*Brain Dev* 2008;30(7):454–460). - Anecdotal evidence only for Tenex and aggression. - Intuniv XR is FDA approved for ADHD. Minimal data for aggression.
Guanfacine (Tenex)	1 mg–2 mg at bedtime or 1 mg BID		
Guanfacine XR (Intuniv)	1 mg–4 mg QAM		
Antipsychotics			
Aripiprazole (Abilify)	1 mg–30 mg QD	Side effects of all antipsychotics can include sedation, dry mouth, constipation, extrapyramidal side effects, akathisia, tardive dyskinesia, metabolic syndrome, hypotension, mood disturbance. Weight gain least likely with Abilify and Geodon. Cardiac arrhythmias can occur, especially with older antipsychotics—get EKG.	- Abilify and Risperdal are FDA approved for irritability in autism. - Open label study of Abilify and Geodon in aggression showed benefit (*Community Ment Health J* 2009; 45(1):73-77). - Zyprexa showed benefit in several small open label trials of aggression concurrent with other diagnoses (see for example *J Child Adolesc Psychopharm* 1998;8(2):107–113). - Seroquel showed benefit in open label trials of aggression in ADHD (*J Child Adolesc Psychopharmacol* 2007;17(3):334–347) and in conduct disorder (*J Child Adolesc Psychopharmacol* 2007;17(1):1–9). - One pilot RCT and one larger RCT demonstrated benefit of Haldol in aggression (*Arch Gen Psychiatry* 1984;41(7):650–656; *Psychopharm Bulletin* 1984;20(1):93–97). - Haldol and Thorazine are FDA approved for psychotic disorders in children over 3, Tourette's disorder in children over 3, in severe behavioral disturbance in children, and for emergency sedation of severely agitated (adult) patients.
Olanzapine (Zyprexa)	2.5 mg–20 mg QD		
Quetiapine (Seroquel)	25 mg–800 mg QD		
Risperidone (Risperdal)	0.5 mg–3 mg QD		
Ziprasidone (Geodon)	20 mg–160 mg QD		
Haloperidal (Haldol)	0.25-6 mg QD, or maximum 0.15 mg/kg/day		
Chlorpromazine (Thorazine)	0.5 mg–1 mg/kg/dose Q 4–5 hours to maximum of • 40 mg children <5 yrs • 75 mg children 5–12 • 200 mg or more in older children (up to 800 in adults)		
Mood Stabilizers			
Divalproate (Depakote, Depakote ER)	125 mg–2500 mg QD or 15 mg/kg/day based on blood level	Sedation, weight gain, polycystic ovary disease, rare liver failure. Must monitor liver function and therapeutic level via blood test. Teratogen.	- Depakote appears effective in conduct disorder (*J Clin Psych* 2006;67(5):808–820). - Pilot studies of Depakote in pervasive developmental disorder found no difference from placebo (*J Clin Psychiatry* 2001;62(7):530–534), but larger study showed benefit (*Neuropsychopharmacology* 2010;35(4):990–998). - Lamictal is FDA approved for maintenance in adult bipolar disorder and adjunctive therapy for pediatric seizure disorders. No data for use in aggression alone. - Lithium is possibly effective in conduct disorder, studies are mixed (*CNS Drugs* 2009;23(1):59–69; *Psychopharm Bulletin* 1995;31(1):93–102). - No data on Trileptal in aggression in children. Some positive findings in adults with aggression, including RCT (*J Clin Psychopharmacol* 2005; 25(6):575-579).
Lamotrigine (Lamictal, Lamictal XR, Lamictal ODT)	Weeks 1–2: 0.3 mg/kg/day, divided Week 3–4: 0.6 mg/kg/day, divided Subsequently, increase every week or two by 0.6 mg/kg/day, dosed BID, maximum 300 mg (400 mg for kids over 12)	Stevens-Johnson Syndrome, especially when dose titrated too quickly or when given simultaneously with Depakote (0.8% pediatric patients will develop serious rash). Restart at initial dose if >3 doses missed.	
Lithium (Eskalith, Lithonate, Lithotabs, Eskalith CR, Lithobid)	From 300 mg–1500 mg in divided doses; titrate to therapeutic blood level	Sedation, cognitive dulling, enuresis, hypothyroidism, kidney failure. Get baseline labs before starting. Must monitor therapeutic level via blood test.	
Oxcarbazepine (Trileptal)	300 mg–1800 mg divided BID, or 8–10 mg/kg/day, divided	Cognitive dulling, rash, hyponatremia, Stevens Johnson syndrome, toxic epidermal necrolysis, angioedema and multiorgan sensitivity. Monitor sodium.	

Although antidepressants and stimulants are commonly used to treat the underlying disorders that lead to aggression, they are not included in this table because they are not studied in primary aggression.
RCT=randomized controlled trial

Q&A With the Expert

Expert Interview

Aggression in Children and Adolescents

Daniel Connor, MD

Lockean Distinguished Professor of Psychiatry, Chief, Division of Child & Adolescent Psychiatry
University of Connecticut Medical School and Health Center

Dr. Connor has received grant/research support, and served as a consultant and on the speakers' bureau for Shire Pharmaceuticals in relation to their ADHD medications. Dr. Fisher has found no commercial bias in this educational activity.

CCPR: Dr. Connor, you have spent many years working with and studying aggressive children. Why don't you give us a little background on your interest in these kids?

Dr. Connor: About 50 to 80 percent of all children and adolescents who are referred to child psychiatry clinics or inpatient sites have problems with disruptive behavior disorders, conduct disorder, oppositional behavior and aggression. When I was first running a child psychiatry clinic, I became interested in trying to make more sense of this because I was very dissatisfied with the way DSM handled the problem of externalizing behavior disorders.

CCPR: And what did you learn?

Dr. Connor: What I found were several things. One is that aggression *per se* is not associated with specific DSM diagnoses; instead, aggression is a good measure of overall symptom severity. Tom McLaughlin and I published a study of aggressiveness in children and we found that the highest aggression ratings actually occurred in kids with anxiety disorders. And aggression did not identify a specific diagnostic category such as bipolar disorder (Connor DF et al., *Child Psychiatry and Human Development* 2006;37:1–14). It appears that like pain in surgery or a fever in medicine, aggression in psychiatry is a marker of illness severity, not specificity.

CCPR: So if we have a patient come into the office with a complaint of aggression, what approach should we take?

Dr. Connor: First, you should explore the history of the aggression. Chronic disruptive behavior with an onset before 10 years old is more difficult to treat than new onset or acute disruptive behavior. The earlier the disruptive behavior begins, the worse the prognosis.

CCPR: What else do you look at?

Dr. Connor: You have to assess the child's contextual relationships—what are the antecedents and what are the consequences of aggressive behavior? It's important to find out if child has learned to use aggression "contingently"—that is, to get out of something that he or she doesn't want to do or to obtain something desired.

CCPR: So you should be thinking about what purpose the aggression serves?

Dr. Connor: Yes, and that leads to looking at parenting practices. Things like failure to monitor the child's whereabouts and who he or she is hanging around with after school, and harsh or inconsistent discipline, meaning that the child's antisocial aggressive behavior is ignored at some times and then is responded to harshly at others.

CCPR: What does this evaluation teach you about a child's aggressive behavior?

Dr. Connor: There are two types of aggression: First, there is *reactive* aggression, which is highly emotional, defensive, and impulsive, and is generally a response to some sort of threat or frustration. Second, there is predatory or *proactive* aggression, which is generally planned and premeditated. We can help in many ways with reactive aggression, but we are less successful with proactive aggression. Fortunately, most kids fall into the first group.

CCPR: What is the role of trauma in aggression?

Dr. Connor: Physical abuse is highly associated with reactive forms of aggression. Sexual abuse appears to be more associated with internalizing symptoms such as anxiety and depression.

CCPR: What's the best treatment for aggression?

Dr. Connor: Well, treatment rests on a careful evaluation, and I think this is where the way we pay for mental health care seriously impacts the clinician's ability to do a thorough evaluation. These kids are time-consuming to treat with methods such as behavioral therapy, family therapy, etc., and those things have a lower reimbursement rate than prescribing meds. That said, there are some medications that are quite effective at treating aggressive behavior.

CCPR: Such as?

Dr. Connor: When aggression occurs in the context of ADHD, stimulants and adrenergic agents, such as atomoxetine and guanfacine appear to have a large anti-aggressive effect. This is true even for kids who have comorbid oppositional defiant disorder, in that the defiant behavior often responds to ADHD treatment.

CCPR: And what about other types of aggression?

Dr. Connor: For other kids, atypical antipsychotics and the first generation neuroleptics also have anti-aggression properties that seem independent of sedation. There is also some evidence from Steve Donovan at Columbia and Hans Steiner at Stanford that mood stabilizers such as Depakote are helpful for conduct disorder (Donovan SJ et al., *Am J Psychiatry* 2000;157:818–820; Steiner A et al., *J Clin Psychiatry* 2003:64:1183–1191). Interestingly, SSRIs have not been shown to be helpful for aggression in children,

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Q&A With the Expert

Expert Interview
Collaborative Problem Solving
Ross Greene, PhD

Associate Clinical Professor, Department of Psychiatry, Harvard Medical School
Author, The Explosive Child and Lost at School
Founder, Lives in the Balance (www.livesinthebalance.org)

Dr. Greene has disclosed that he derives income from books and speaking engagements concerning parenting techniques. Dr. Fisher has found no commercial bias in this educational activity.

CCPR: Child psychiatrists have a lot of kids come into our office with problems related to temper tantrums, explosive episodes, etc. You have developed a process for working with these kids. Tell us about it.
Dr. Greene: Collaborative Problem Solving views challenging behavior, like temper tantrums, as the result of lagging skills, not necessarily a symptom of a disease. It involves working with a child to get to the root of the problem behavior.
CCPR: What do you mean by "lagging skills"?
Dr. Greene: What I mean is that the child doesn't have the skills needed to respond to a situation appropriately—skills like problem-solving, tolerance for frustration, and flexibility and adaptability.
CCPR: So what can we do for these children?
Dr. Greene: Well, when we collaboratively solve the problems that are setting challenging behavior in motion, then we simultaneously teach the child the skills he or she is lacking that set the stage for the problem in the first place. The key to this is working together with the child—collaborating—to solve the problem, not making assumptions about what the problem is and forcing a solution.
CCPR: Tell us more about this.
Dr. Greene: Well, adults often resort to what I call "Plan A," which is unilateral problem solving. In *The Explosive Child,* I encourage "Plan B," which entails collaborative problem solving.
CCPR: Can you give an example?
Dr. Greene: Sure. One example from the book is a family leaving Disney World after spending a day there. Casey, the son, who is prone to explosive behavior, says, "I want cotton candy." A Plan A response would be simply, "No, you can't have cotton candy, we're about to have dinner." But Casey is a boy who has shown that he will respond to this approach with violent temper tantrums. So the family tried "Plan B." The father crouched down next to his son, and did some problem solving. "So let's think about this for a second," he said. "You really wanted cotton candy, and you're hungry for a snack before dinner. You've already had a lot of sugar today. Can you think of any ideas for a snack that isn't so sugary?" Eventually, Casey settled down and agreed to getting some french fries at McDonalds on the way back, and then had a reasonably healthy dinner at the hotel.
CCPR: So it's important to involve the child in determining the problem and its solution.
Dr. Greene: Yes, and Plan B is more than just talking. Plan B involves three ingredients. The first is getting the kid's concerns or perspective on the table on a particular unsolved problem. The second is getting the adult's concerns or perspective on the same unsolved problem. The third is brainstorming solutions that are realistic and address the concerns of both parties.
CCPR: Where can we learn more about this approach?
Dr. Greene: People can visit the website of my non-profit organization, Lives in the Balance, at www.livesinthebalance.org. There are a lot of resources there, including information on trainings and seminars and handouts for families.
CCPR: Thank you, Dr. Greene.

Expert Interview, Daniel Connor, MD, Aggression in Children and Adolescents *Continued from Page 4*

whereas they are effective for adults. But that may be a function of the fact that few studies have been done in children.
CCPR: I assume you would use an SSRI for an anxiety disorder?
Dr. Connor: Actually, I think first about skill-building treatments such as cognitive behavioral therapies and relaxation training. Furthermore, in my experience, when you have an anxious child you usually have an anxious parent, and I look carefully to see if the child is being reinforced for his or her anxiety by an anxious parent. So first I try cognitive behavioral therapy with a family component and then, if needed, I would add an SSRI targeting the anxiety. But you are treating anxiety here; you are not treating aggression.
CCPR: Do you think that antipsychotics are overused in children?
Dr. Connor: Yes. There are rising rates of antipsychotic use in the pediatric population over the past decade, including in very young children—three, four and five-year-old kids. And we know that the younger the children, the more dependent they are on the family environment for emotional homeostasis, so they require an extensive family and parenting evaluation before being medicated. But the reimbursement rates are higher for prescribing medications, and so this tends to be what happens.
CCPR: Thank you, Dr. Connor.

Research Updates IN PSYCHIATRY

Section Editor, Glen Spielmans, PhD

Glen Spielmans, PhD, has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

MOOD DISORDERS

Pediatric bipolar disorder vs. "severe mood dysregulation:" Are they the same or different?

There has been debate over whether nonepisodic irritability is a symptom of bipolar disorder in children and adolescent (Biederman J, *Biol Psychiatry* 2006;60:901–902). Recently, a new study examined whether children with severe nonepisodic irritability had the same risk of manic episodes as those diagnosed with more narrowly defined bipolar disorder.

Researchers enrolled 93 children with narrowly defined bipolar disorder (BD) (mean age 12.9) and 84 children with "severe mood dysregulation" (mean age 11.6). Severe mood dysregulation (SMD) was a category created specifically to study these patients. Criteria for SMD included nonepisodic irritability (defined as frequent and impairing anger outbursts), and at least three of the following: pressured speech, agitation, insomnia, flight of ideas/racing thoughts, or distractibility.

Both groups of children were evaluated by researchers at six month intervals over a median follow up period of about 2.5 years to see if they developed hypomanic, manic, or mixed episodes. Evaluators used the structured interview instrument Kiddie Schedule for Affective Disorders—Present and Lifetime Version (KSADS-PL) for all assessments.

Only one of the SMD patients (1.2%) had a hypomanic, manic, or mixed episode, versus 58 of the BD patients (62.4%) at the median follow-up of 28.7 months (Stringaris A et al., *J Am Acad Child Adolesc Psychiatry* 2010;49(4):397–405).

CCPR's Take: The evaluators were not blinded to the initial diagnosis, which could have theoretically biased the results. Nonetheless, this study provides fairly strong evidence that children presenting with severe nonepisodic anger outbursts (termed SMD in the study) are unlikely to go on to develop bipolar disorder. The authors reviewed prior research showing that children with SMD are at increased risk for developing both major depression and generalized anxiety disorders. The treatment implications are that children with SMD should be considered candidates for treatment with antidepressants and stimulants rather than mood stabilizers and atypical antipschotics.

Proposed DSM-5 Changes for Child Psychiatry

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month's research update "Pediatric BD vs. SMD") The DSM-5 committee's proposed diagnostic change is more in line with the view that irritability alone is not a bipolar disorder marker. This diagnosis will be somewhat difficult to differentiate from oppositional defiant disorder as it is proposed for the DSM-5, the wording of which is: "angry and irritable mood along with defiant and vindictive behavior."

Attention Deficit and Disruptive Disorders. The specifiers "predominantly inattentive" and "predominantly hyperactive/impulsive" may be discontinued with new scales used to describe the nature of the behavior. Alternatively, a new diagnosis, "attention deficit disorder" (as opposed to ADHD), may be created. Minimum age of onset would be broadened from seven to 12, and the number of criteria required to make the diagnosis in adults would be decreased from six to three.

Autistic Spectrum Disorder. A new disorder, autistic spectrum disorder, would replace Asperger's disorder, childhood disintegrative disorder, pervasive developmental disorder NOS and autistic disorder; Rett's disorder would be eliminated. The rationale is that while it is fairly easy to differentiate patients *on* the spectrum from those *not on* the spectrum, the individual disorders differentiate poorly and create more confusion than clarity.

See DSM-IV vs. DSM-5 chart on page 8

Eating Disorders. The eating disorders section would be renamed to eating and feeding disorders, to account for the addition of pica, rumination, and feeding disorder of infancy and childhood. Binge eating disorder would be moved from the appendix to this section as well, meaning that it is now a bona fide DSM-5 disorder. The diagnostic criteria for anorexia nervosa would allow for B criteria to include persistent weight loss behavior in lieu of the stated fear of gaining weight. The amenorrhea criterion for anorexia nervosa would be discontinued and stated fear of gaining weight would not be required. Bulimia nervosa criteria would be loosened to require only weekly binges and purges rather than twice weekly.

Non-Suicidal Self Injury. This proposed diagnosis, non-suicidal self injury, is an attempt by the DSM-5 study group to differentiate frequent cutters (and scratchers and burners) from patients with suicidal intent or borderline personality disorder. The rationale for this category is that most patients who cut do not meet criteria for borderline personality disorder but instead have a variety of different diagnoses.

Other Proposed New Disorders. There are about a dozen disorders proposed by groups outside of the APA that are under consideration, including sensory processing disorder, fetal alcohol syndrome, parent alienation syndrome, and developmental trauma disorder. Whether these diagnoses will be incorporated or not remains to be seen, as does the specific diagnostic criteria. They look to be in the "probably not" category, but are not entirely ruled out either.

CME Post-Test

To earn CME or CE credit, you must read the articles and log on to www.TheCarlatChildReport.com to take the post-test. Please see the pre-test listed below to prepare for this month's post–test. Learning objectives are noted on page 1. You must answer at least four questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be taken by May 14, 2011.

As a subscriber to *CCPR*, you already have a username and password to log on www.TheCarlatChildReport.com. To obtain your username and password, please email CME@thecarlatreport.com or call 978-499-0583.

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Below are the questions for this issue's CME post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatChildReport.com. Note: Learning objectives are listed on page 1.

1. When you're unsure of the cause of a child's aggression, which medications are a good first step, both because they work quickly and because they are fairly safe (L.O. #1)?
   - [ ] a. Stimulants
   - [ ] b. Adrenergic agents
   - [ ] c. Antidepressants
   - [ ] d. Benzodiazepines

2. In the proposed changes to DSM-5, the possible inclusion of temper dysregulation syndrome with dysphoria might provide a new diagnosis for some children thought to have bipolar disorder (L.O. #2):
   - [ ] a. True
   - [ ] b. False

3. In the Stringaris study, how many children classified with severe mood dysregulation subsequently had a hypomanic, manic, or mixed episode (L.O. #4)?
   - [ ] a. 0 of 84 (0%)
   - [ ] b. 1 of 84 (1.2%)
   - [ ] c. 44 of 84 (52.4%)
   - [ ] d. 52 of 84 (61.9%)

4. According to Dr. Daniel Connor's research, aggression can be used to identify a specific diagnostic category (L.O. #3):
   - [ ] a. True
   - [ ] b. False

5. What is Dr. Ross Greene's "Plan B" (L.O. #3)?
   - [ ] a. Unilateral problem solving
   - [ ] b. Punitive discipline
   - [ ] c. Collaborative problem solving
   - [ ] d. A system of rewards and punishment

PLEASE NOTE: WE CAN AWARD CME CREDIT ONLY TO PAID SUBSCRIBERS

First Name _____ Last Name _____ Degree (MD, PhD, NP, etc.) _____

Street Address _____

City _____ State _____ Zip _____

E-mail (REQUIRED FOR CME CERTIFICATES) _____

Your evaluation of this CME/CE activity (i.e., this issue) will help guide future planning. Please respond to the following questions:

1. Did the content of this activity meet the stated learning objectives? L.O.#1: [ ] Yes [ ] No L.O.#2: [ ] Yes [ ] No L.O.#3: [ ] Yes [ ] No L.O.#4: [ ] Yes [ ] No
2. On a scale of 1 to 5, with 5 being the highest, how do you rank the overall quality of this educational activity? [ ] 5 [ ] 4 [ ] 3 [ ] 2 [ ] 1
3. As a result of meeting the learning objectives of this educational activity, will you be changing your practice performance in a manner that improves your patient care? Please explain. [ ] Yes [ ] No

_____

4. Did you perceive any evidence of bias for or against any commercial products? Please explain. [ ] Yes [ ] No

_____

5. How long did it take you to complete this CME/CE activity? ___ hour(s) ___ minutes
6. **Important for our planning:** Please state one or two topics that you would like to see addressed in future issues.

_____

Comparing DSM-IV to Proposed Changes in DSM-5

DSM-IV	DSM-5
Bipolar disorder	Bipolar disorder remains, but new "temper dysregulation syndrome with dysphoria" may describe some children formerly diagnosed with bipolar disorder.
Major depression; borderline personality disorder	Both disorders remain, but new "non-suicidal self injury" may more accurately describe some of these patients.
Attention deficit hyperactivity disorder (ADHD)	Eliminate inattentive vs. hyperactive subtypes. Required age at onset broadened to 12 or older.
Pervasive developmental disorders	Renamed "autistic spectrum disorder." Rett's to be eliminated.
Eating disorders	Binge eating disorder now a bona fide disorder. Anorexia no longer requires amenorrhea or stated fear of gaining weight. Bulimic behaviors required frequency decreased to weekly (from twice weekly).
Mental retardation	Renamed "intellectual disability," diagnosis based on function rather than IQ.
Learning disorders	Reading disorder renamed dyslexia. Mathematics disorder renamed dyscalculia. Learning disabilities diagnosis addresses all others.

For more details, see article on page 2

Next Time in *The Carlat Child Psychiatry Report*: Treating Children and Families, with articles on family treatment and on discussing medication risks with parents.

This Issue's Focus:
The Explosive Child

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