Emotional Dysregulation in Adolescence

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Disclosures

- None of the planners or speakers for this activity have relevant financial relationships to disclose.

Objectives

- understand factors that contribute to emotional dysregulation in adolescence
- review current treatment options
- identify strategies to help with individual students
- recognize need to educate all team members

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Presidential Address: Emotion Dysregulation in Children and Adolescents

Gabrielle A. Carlson, MD

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Supplemental Material

References

Article Info

Related Articles

I am both excited and proud to become president of our Academy of Child and Adolescent Psychiatry for the next 2 years. In addition to working with an incredible organization, I have had the privilege and pleasure of serving and collaborating with our immediate past presidents including Drs. Drell, Joshi, Fritz, and Wagner. In thinking about how I wanted to focus my energy and some of AACAP's resources over the next couple of years, I've looked at the breadth of past initiatives. These have included prioritization within the organization and the field (Back to Project Future[1]), expanding our relationships with other countries and cultures (Partnering for the World's Children[2]),

Emotional dysregulation is normal!

- For purposes of this talk we will use the term severe emotional dysregulation
- SED

Etiologies of sed in adolescence

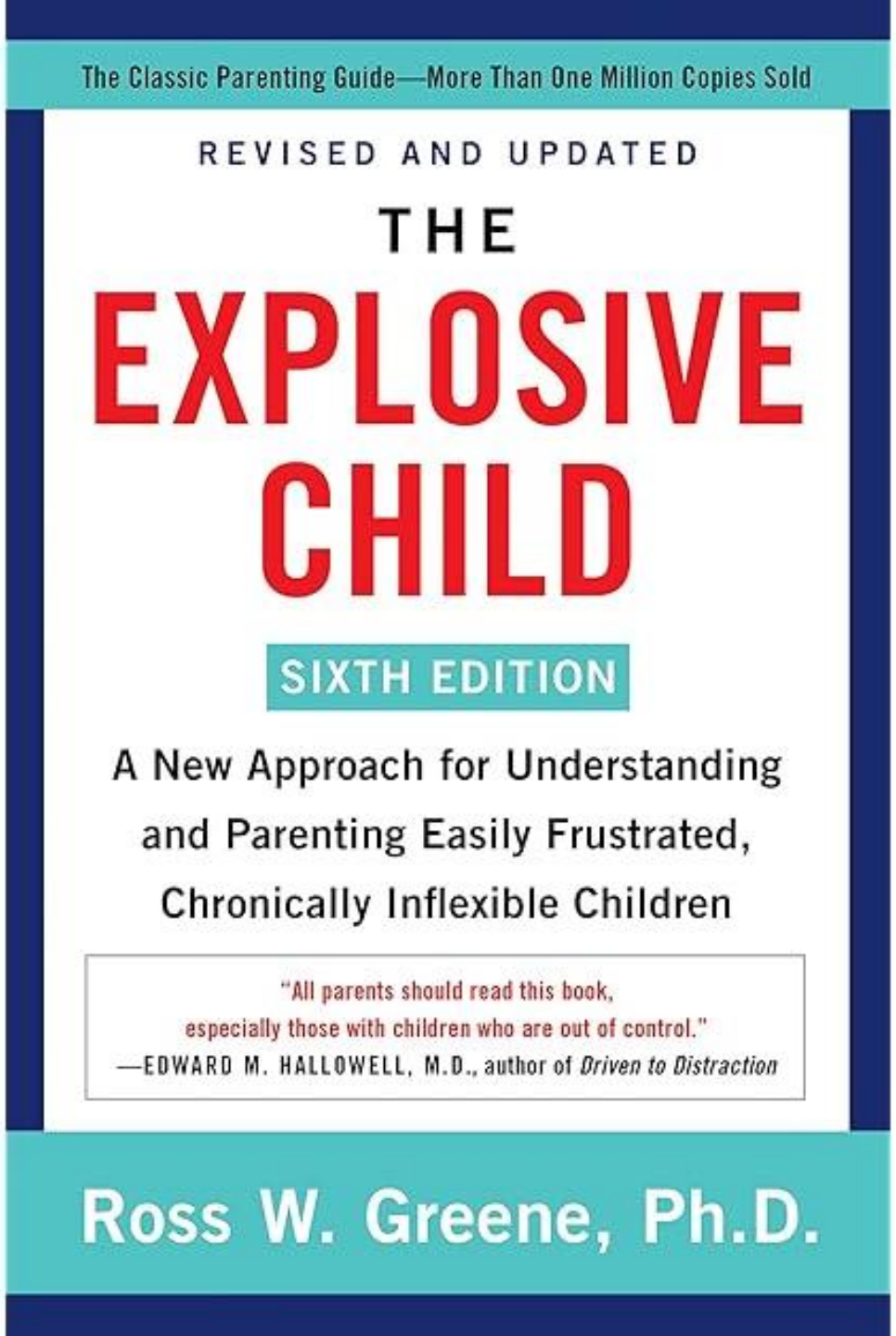
- Dr. Carlson likened outbursts, and the sequence of events that culminate in one, to a bomb.
- Triggers light the fuse
  - low frustration tolerance
  - abnormal threat sensitivity
  - cognitive inflexibility
- The length of the fuse is what some have called “tonic” irritability.
- The impairing part is what one does or “phasic irritability.”
- Often due to anger and/or distress

Etiologies of sed in adolescence

- ADHD
- DMDD
- ASD
- PTSD
- BPD
- ODD
- Bipolar Disorder
- Substance use

Lagging skills Collaborate & Proactive Solutions

- The CPS model is based on the premise that challenging behavior occurs when the demands and expectations being placed on a kid exceed the kid's capacity to respond adaptively



ADHD

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

- SED will present in settings where demands are out of proportion to skills
- ADHD patients get corrective feedback 10:1 compared to peers
- Home
  - During times of transition morning/evening routine
  - Doing homework
  - Non preferred activities or unexpected changes
- School
  - When expected to sit still quietly for long periods of time
  - When executive functioning skills are expected
  - When symptoms interfere with social relationships

DMDD

- Severe recurrent temper outbursts manifested verbally and/or behaviorally that are grossly out of proportion in intensity or duration to the situation or provocation
- The temper outbursts are inconsistent with developmental level,
- The temper outbursts occur, on average, three or more times per week, and
- The mood between temper outbursts is **persistently irritable** or angry most of the day, nearly every day, and is observable by others

DMDD

- SED will present in settings where demands are out of proportion to skills
- Pervasive low frustration tolerance with grown ups peers at home and in school

ASD

1. Deficits in social-emotional reciprocity
2. Deficits in nonverbal communicative behaviors used for social interaction
3. Deficits in developing, maintaining, and understanding relationships
4. Stereotyped or repetitive motor movements, use of objects, or speech
5. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., **extreme distress** at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).
6. Highly restricted, fixated interests that are abnormal in intensity or focus
7. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment

ASD

- SED will present in settings where demands are out of proportion to skills
- Home and school
  - During times of transitions or unexpected changes
  - Misunderstanding social cues with grown ups and siblings/peers
  - When overstimulated

PTSD

Criterion A (1 required): The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence

- Unwanted upsetting memories
- Nightmares
- Flashbacks
- **Emotional distress after exposure to traumatic reminders**
- **Physical reactivity after exposure to traumatic reminders**
- Trauma-related thoughts or feelings
- Trauma-related reminders
- Inability to recall key features of the trauma
- Overly negative thoughts and assumptions about oneself or the world

•Exaggerated blame of self or others for causing the trauma
•**Negative affect**
•Decreased interest in activities
•Feeling isolated
•Difficulty experiencing positive affect
•**Irritability or aggression**
•**Risky or destructive behavior**
•Hypervigilance
•**Heightened startle reaction**
•Difficulty concentrating
•Difficulty sleeping

PTSD

- SED will present in settings where demands are out of proportion to skills
- Home
  - If continuing to be exposed to trauma
  - If grown ups/siblings remind them of trauma
  - Due to hypervigilance
- School
  - Feeling out of control
  - Difficulty concentrating
  - Feeling negative about oneself and the world

Borderline Personality Disorder (BPD)

- Fear of abandonment
- Unstable relationships
- **Impulsivity**
- Identity disturbance
- Suicidal behavior
- Affective instability
- Feelings of emptiness
- **Difficulty controlling anger**
- Paranoia/dissociation

Borderline Personality Disorder (BPD)

- SED will present in settings where demands are out of proportion to skills
- Home
  - Conflict with grown ups/siblings due to ineffective communication
  - Constant contact with peers through social media
  - Boredom/emptiness needing to "feel something"
- School
  - Hypersensitivity to rejection from grown ups and peers
  - Symptoms interfering with academic success
  - Projection identification or self-fulfilling prophecy

ODD

- Often loses temper
- Is often touchy or easily annoyed
- Is often angry and resentful
- Often argues with authority figures
- Often actively defies or refuses to comply with requests from authority figures or with rules
- Often deliberately annoys others
- Often blames others for his or her mistakes or misbehavior,
- Has been spiteful or vindictive at least twice within the past 6 months

- **The behaviors do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also, the criteria are not met for disruptive mood dysregulation disorder. Please note that there is also an effort to include trauma history in this list of exclusionary criteria**

ODD

- SED will present in settings where demands are out of proportion to skills
- By nature of this diagnosis, it should present pervasively in all setting with grown ups and peers and not be better explained by another diagnosis

Bipolar Disorder

- grandiosity
- decreased need for sleep
- more talkative than usual
- racing thoughts
- distractibility
- increase in goal-directed activity or purposeless non-goal-directed activity
- reckless behavior

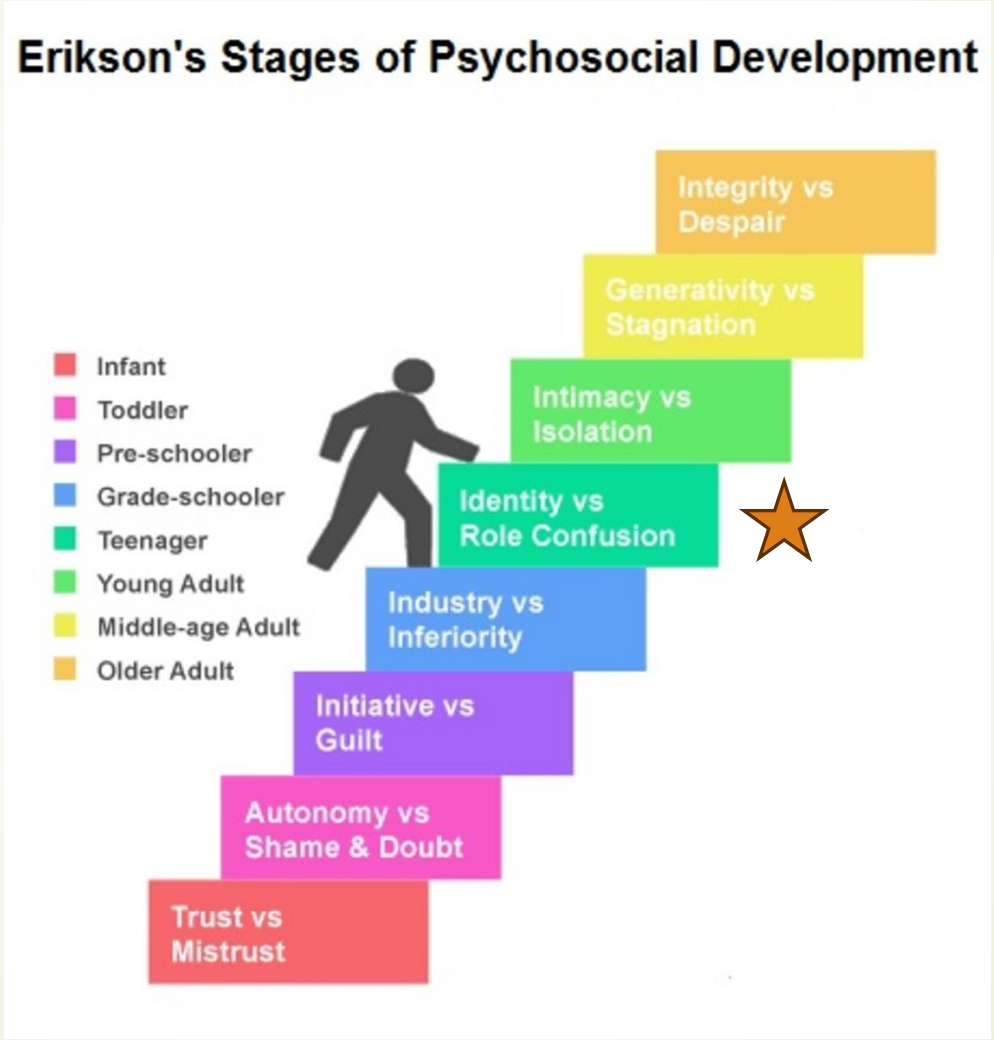
Bipolar Disorder

- Irritability with depressive and especially mixed manic episodes

Substance use

- Intoxication
  - Stimulants, methamphetamine, cocaine
- Withdrawal
  - Alcohol, opioids, cannabis
- Shame/guilt when “in trouble”
  - Consequences at home and at school

Developmental Considerations

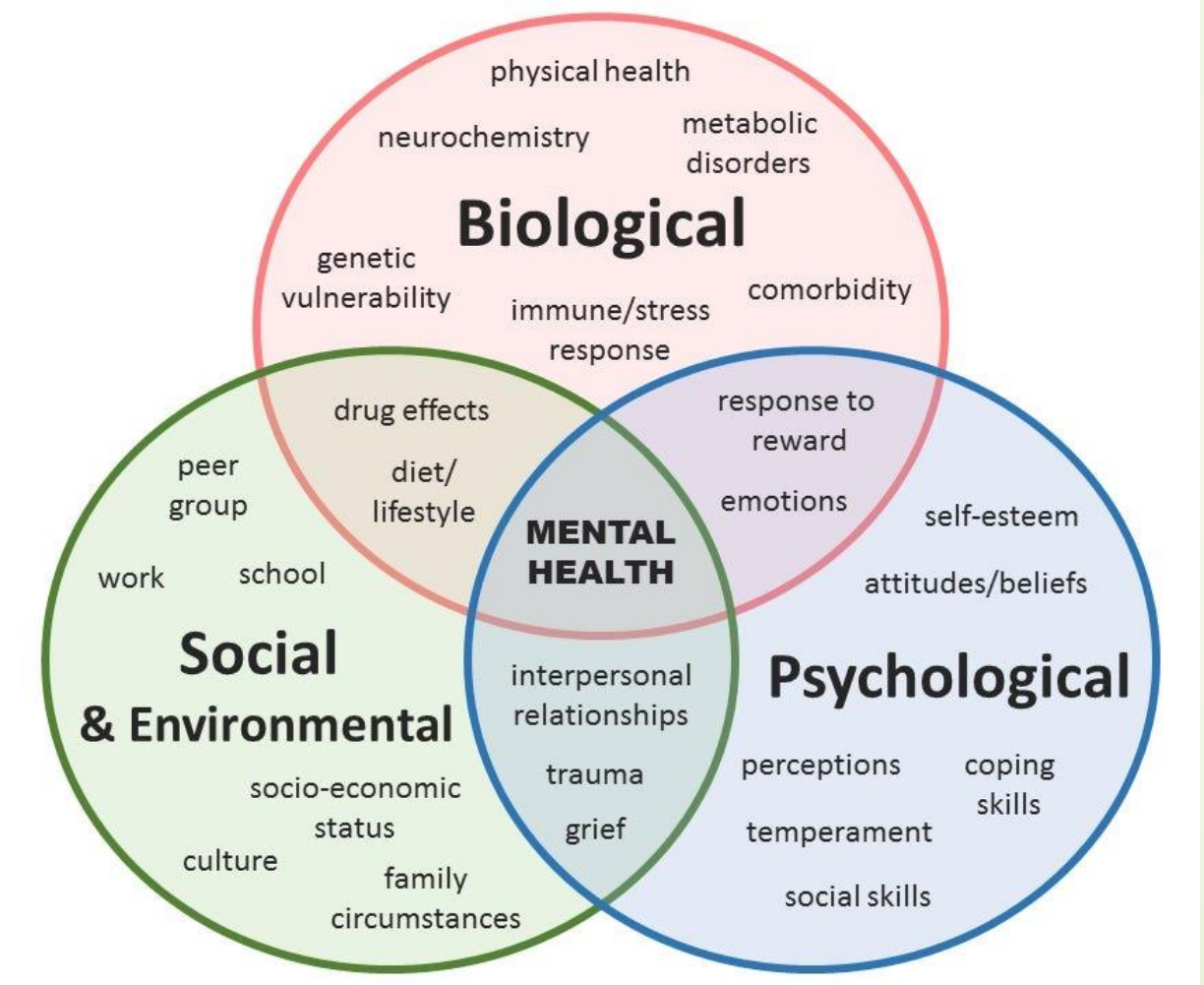


- **Psychosocial conflict**: Identity vs. role confusion
- **Major question**: "Who am I?"
- **Basic virtue**: Fidelity
- **Important event(s)**: Social relationships

Developmental Considerations

- Role confusion can have lasting consequences on a person's life, including:
  - **Difficulties with commitment**: A stable personal identity allows individuals to have better relationships with others.
  - **Worse mental health and well-being**: Research has linked a strong sense of identity to better emotional and psychological well-being in adolescents.
  - **Weak sense of self**: Role confusion has been found to lead to a weak sense of self.
  - **Lack of confidence**: A lack of self-identity can make it difficult for people to have confidence in themselves and their abilities.

Biopsychosocial Treatment

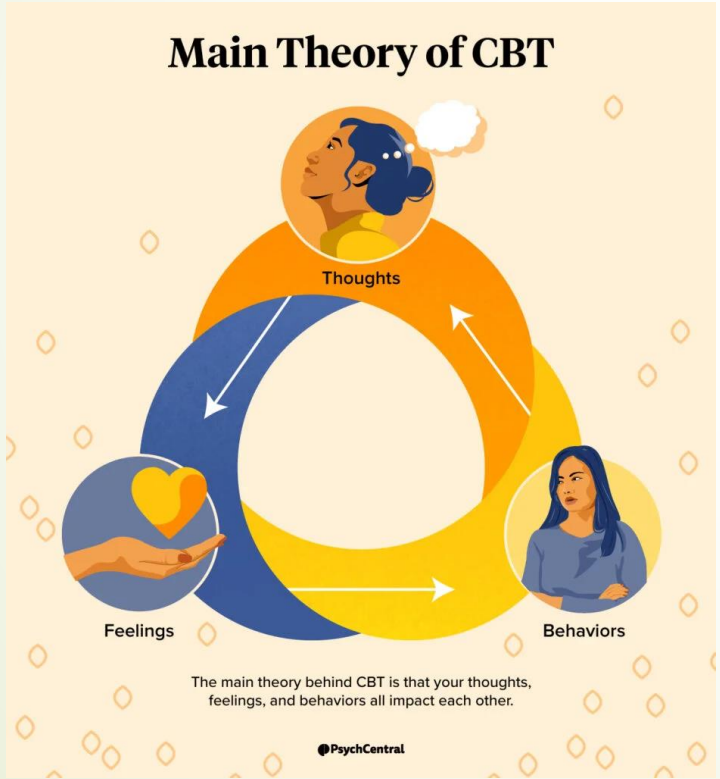


Bio depends on etiology

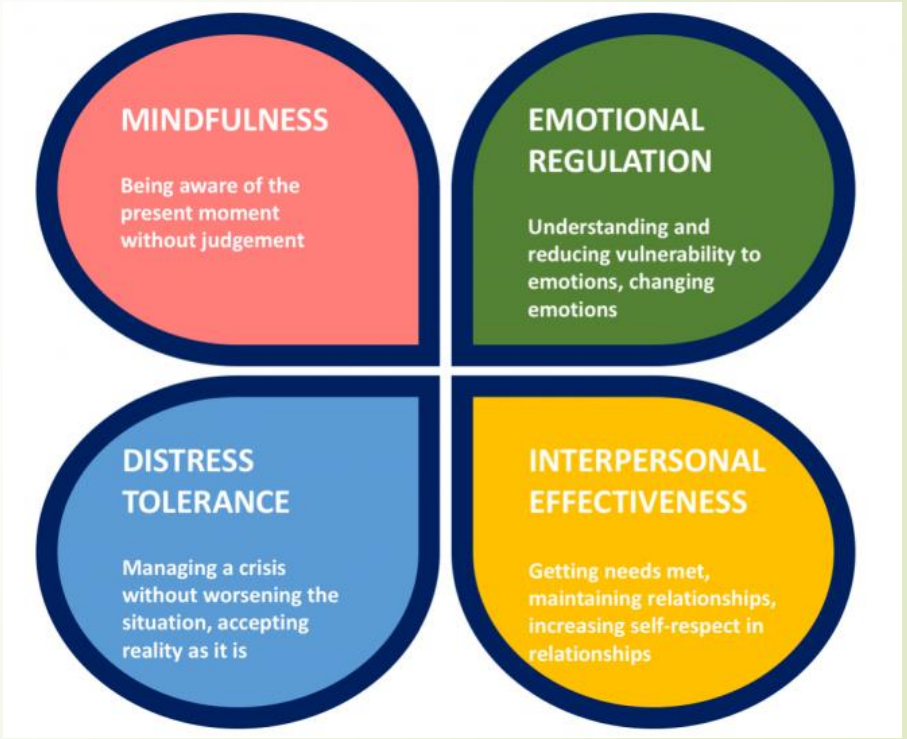
- ADHD
  - Stimulants and alpha agonists
- DMDD*
  - SSRI alpha agonists avoid atypical antipsychotics
- ASD
  - FDA approved for agitation associated with ASD risperidone and aripiprazole
  - Comorbid anxiety or depression SSRI ADHD stimulants alpha agonists
- PTSD
  - Alpha agonists SSRI
- BPD
  - More medications worsen clinical outcomes
- Substance use disorder
  - MOUD
- ODD treat comorbidities
- Bipolar Disorder
  - Mood stabilizers

Psychological

- Therapy
  - Cognitive behavioral therapy (CBT)



Dialectical behavioral therapy (DBT)



Psychological

- Fostering and enhancing a sense of competence
  - Vocational support
  - Volunteering
  - Extra curriculars

Social

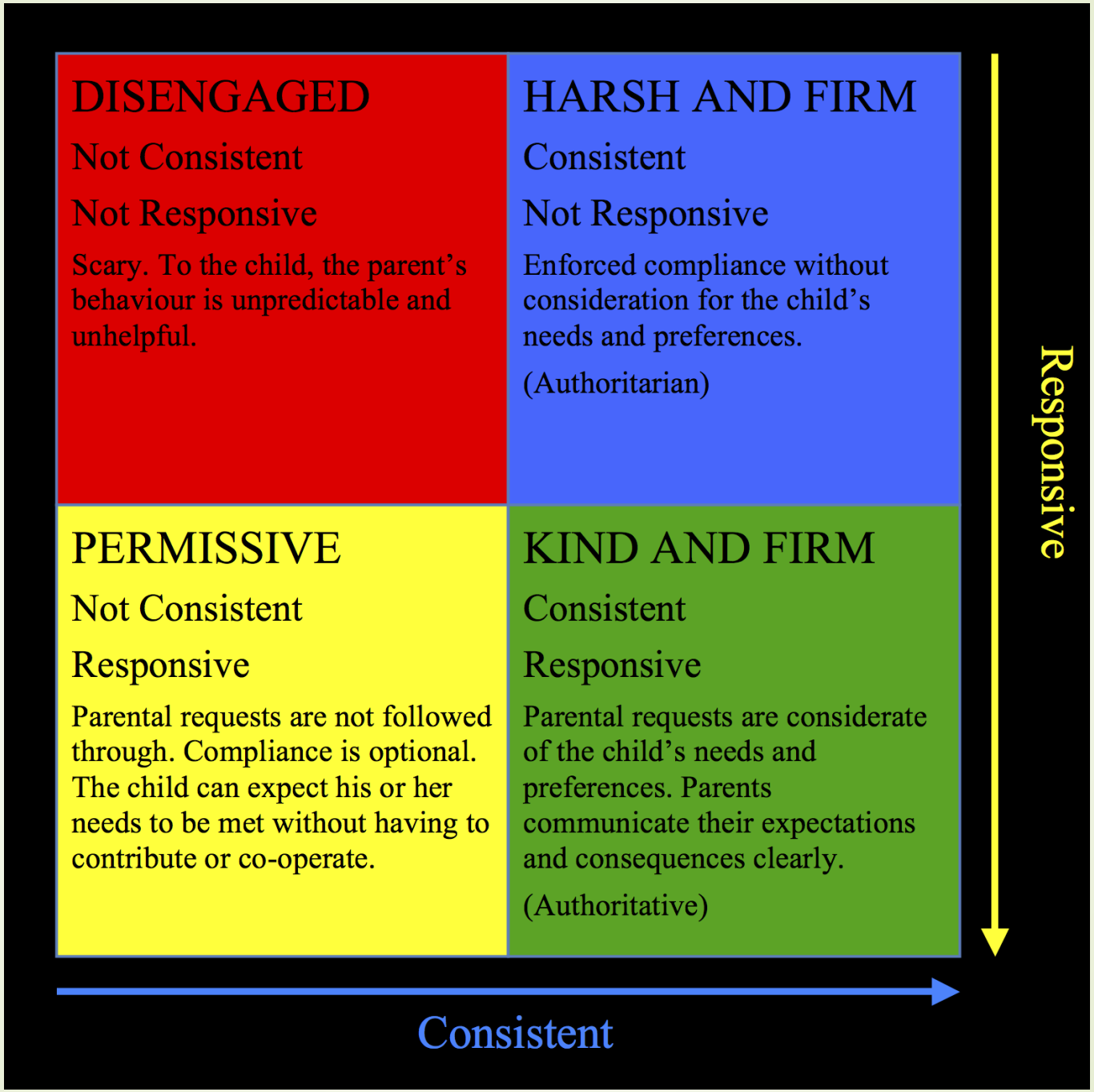
- Family work
  - Specific family therapy modalities
    - Family focused therapy (FFT) community based
    - Multisystemic therapy (MST) community based
    - Parent management training (PMT)
    - Collaborative & proactive solutions (CPS)
  - Anyone can treat the family!
    - Psycho education alone is helpful

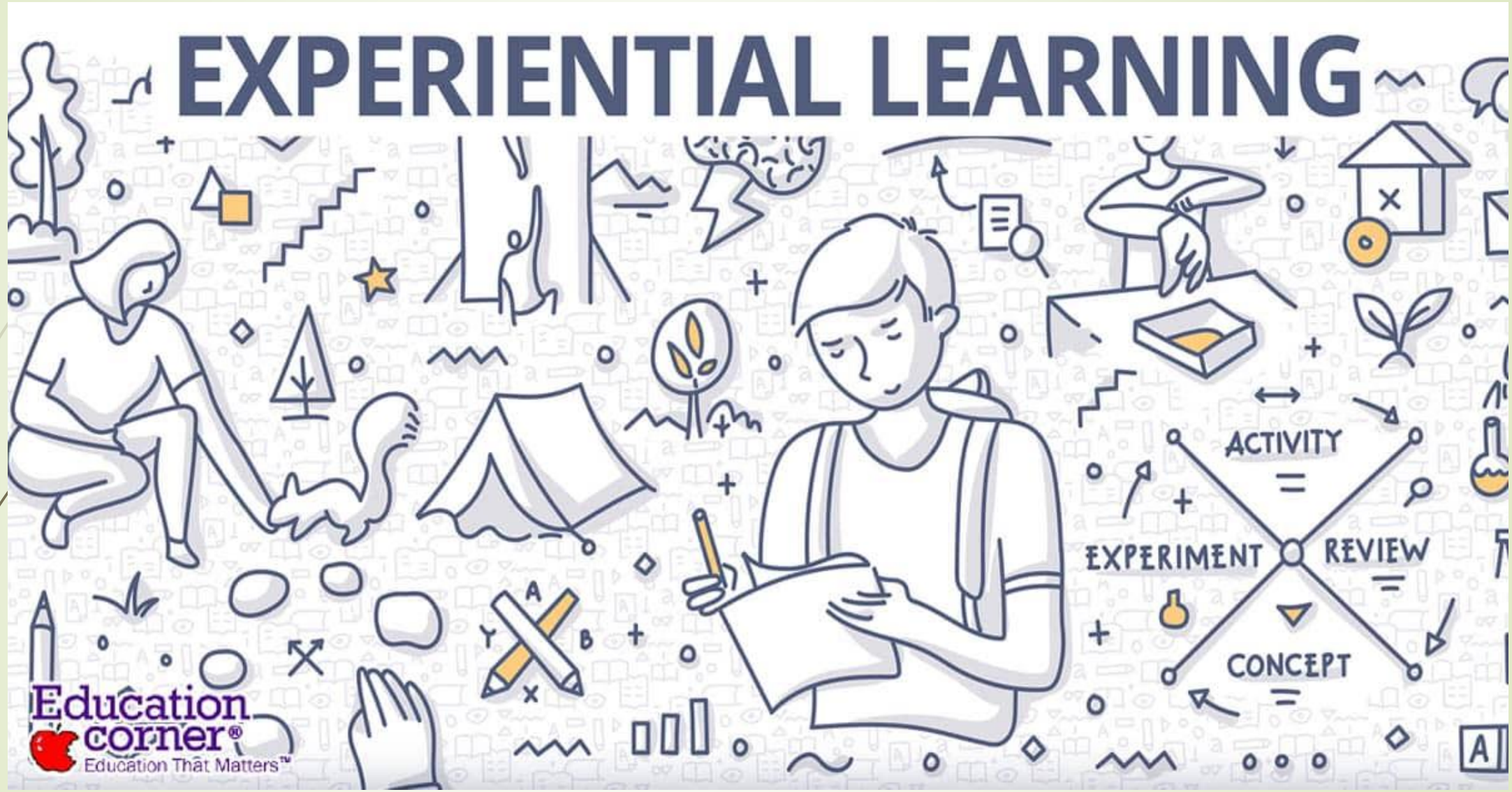
Social

- School support
  - Psycho education about patient's symptoms and most effective approach
  - Modeling strengths-based language
  - Validating their need to maintain safety
  - Advocating for social skills groups
  - Having care team members participate in IEP meetings when able

Social

- Peers
  - Friends are more important to adolescents than their family and that is normal!
  - Friends can also be a source of conflict/difficulty for adolescents
  - Goal is to promote healthy supportive relationships


DISENGAGED
Not Consistent
Not Responsive
Scary. To the child, the parent's behaviour is unpredictable and unhelpful.
HARSH AND FIRM
Consistent
Not Responsive
Enforced compliance without consideration for the child's needs and preferences.
(Authoritarian)
PERMISSIVE
Not Consistent
Responsive
Parental requests are not followed through. Compliance is optional. The child can expect his or her needs to be met without having to contribute or co-operate.
KIND AND FIRM
Consistent
Responsive
Parental requests are considerate of the child's needs and preferences. Parents communicate their expectations and consequences clearly.
(Authoritative)
Responsive
Consistent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What if we treated adolescents like toddlers?

- Similarities
  - Egocentric
  - Desire autonomy
  - Seeking differentiation
  - Emotionally dysregulated

What if we treated adolescents like toddlers?

What if we treated adolescents like toddlers?

Questions