
Provider Questions 2009

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Volume I

James R. Allen, M.D. - Bipolar Disorder With and Without Hyperactivity

1. **Question:** I am a home-based therapist and often have to work with my environment. I have noticed with some of the boys I work with, that I have a more productive session when they are allowed to continue playing their video games (it's also a very good narrative to work with cause and effect and consequences). Are there any studies that you know of correlating concentration & hyperactivity with playing computer or video games? It's amazing how long those games help them stay still and focused.

Answer: Children with ADHD/ADD typically have less trouble with concentration and attention when they are doing something they enjoy. The motivation systems, which are subserved with different neurophysiological circuits (and with dopamine), can “override” or support the usual attention/concentration circuits. Problems arise when the child is expected to sit still, and pay attention to something he/she does not find rewarding – such as math. Similarly, children with ADHD do better in a 1 to 1 situation than in a group such as a classroom.

If this doesn't seem to hold true, then one needs to question the diagnosis of ADHD.

There is considerable research with young children on the effects of increasing “circles of communication” – and the effects of this on developing attention and concentration. The work of Stanley Greenspan and associates is especially important. You will find helpful references on the 0-3 or ICDL (Interdisciplinary Council on Developmental and Learning Disorders) Web sites.

There is also a literature on increased aggression and shortened attention span associated with constant rapid reward and with violent computer games. So, the effect of computer games seems to depend

on an interaction of the particular child, his developmental level, dynamics and genetics, the particular game, and what else he is doing.

Parents need to monitor and limit the use of computer games – perhaps 1 hour a day – so the child has other experiences. Children with ADHD often have poor social skills, are not liked by other children, and so prefer to withdraw into computer games when, in reality, they need coaching in and experience in social activities. It is especially important the child doesn't use a game, board or computer, to avoid you.

You might be interested in a very fine article “The Use of Board Games in Child Psychotherapy” by Ayala Oren, in the Journal of Child Psychotherapy (2008), Vol. 34, No. 3, 364-383. It includes a useful bibliography.

2. **Question:** You mentioned that the generics for Wellbutrin are NOT as effective.
- a. Is that true for adults?
 - b. Is that true for diagnoses other than ADD/ADHD?
 - c. Which of the generics is most effective?

Answer: These are excellent questions, but we probably will never be able to answer them. Once a drug becomes generic, drug companies are no longer interested in funding studies on it.

The studies on the effectiveness of various generics of Wellbutrin have, to the best of my knowledge, been done only with adults, and for depression.

The problem with generics is that although they have the same basic chemical, they do not necessarily lead to the same blood level. Reportedly, there can be as much as a 40% difference in blood level between two generics. In the case of generic Wellbutrin, there are differences in the timing of drug release. While some studies were done on generic Wellbutrin 150 XL, none at all were done on generic Wellbutrin 300 XL because it was “grandfathered” in.

It should be noted that Wellbutrin is not a first-line medication choice for ADHD, as recommended by the Academy of Child and Adolescent Psychiatry, at all. As with other antidepressants, there is a black box warning about suicidality.

Each of us has his or her own individual metabolism. (This is true of all meds, not just generics.) Some people are fast metabolizers of a given

drug, some slow metabolizers. As we learn more about variance in the individual genes underlying specific metabolic pathways, we will one day be able to say which drug at which dose would be most/least useful for this particular patient.

At present, the best clinical course is usually:

- (1) Try a generic and watch to see what happens clinically over the next 6-8 weeks.
 - (2) Ask patients who are getting generic Wellbutrin to be aware whether they get the same one next time; e.g., does the tablet look the same?
3. **Question:** What is the best medication for a 6 year old male recently diagnosed with generalized anxiety disorder? (He has been prescribed Lexapro 10 mg for 1 month which has decreased his anxiety; although, he is now more hyperactive and impulsive. Still has observable motor tics=breathing and hand movements.

Answer: A 6 year old with generalized anxiety disorder probably should not be given any medication until a very careful workup and biopsychosocial formulation have been done. For example, how have the parenting people attempted to soothe him or have they made the condition worse? Usually, it is best to do parent education and coaching in containment, safety, protection, nurturance, some sort of environmental manipulation, and cognitive interventions.

Lexapro certainly can lead to activation in this age child as well as induce hypomania or mania in a child with the right genetic predisposition. However, if he had the observable motor tics and hand movements before taking the Lexapro, as I gather he did from your question, I would question the diagnosis of generalized anxiety disorder. They should not occur with this diagnosis. This points out need for a re-evaluation. You could be dealing with something else, such as pervasive developmental disorder or Tourette's syndrome which can have an obsessive-compulsive feature.

4. **Question:** What are your suggestions to improve school behavioral health service delivery?

Answer: I do not know exactly what you mean by "school behavioral health service." There are many models and their usefulness depends

on the ages of the children, their problems, the context, and what the parents and principal will permit.

In addition to a well-trained nurse, counselor, and people who can offer good psychological testing and provide appropriate OT, speech/language, PT, and prescription-based teaching and interventions, it is important to have strong links to the local CMHC and systems of care, and outside mental-health consultation to help teachers dealing with the more difficult problems. All this I would see as BASIC – but it is expensive (on the surface and in the short-run).

It is not too difficult also to provide school-based universal prevention programs such as effective classroom management techniques. Examples are: managing transitions without undue disorder; contingent rewards; establishing clear classroom rules and procedures; information about mental-health needs across developmental stages; “warning signs;” enhancing collaboration between school and parents; and parent coaching in addressing school related concerns with their children.

After this is done, one might target selective prevention efforts such as focusing on self-regulation, interpersonal problem-solving and the like.

The next level would be activities directed at specific problems. The largest body of evidence pertains to school-based violence prevention programs and programs helping students deal with trauma.

Articles you might find useful are:

Mytton, J.A., DiGuseppi, C., Gough, D.A., Taylor, R.S., & Logan, S. (2002). School-based violence prevention programs: Systematic review of secondary prevention trials. *Archives of Pediatrics & Adolescent Medicine*, 156(8):752-762.

Rathvon, N. (1999). *Effective school interventions: Strategies for enhancing academic achievement and social competence*. New York: Guilford Press.

Walter, H.J. (2001). School-based prevention of problem behaviors. *Child and Adolescent Psychiatric Clinics of North America*, 10 (1):117-127.

5. **Question:** Are there studies on decreasing symptoms of ADHD with meditation and hypnotherapy?

Answer: Studies on the use of meditation and hypnotherapy in decreasing the symptoms of ADHD have been disappointing, as you will see in the practice parameters of the American Academy of Child and Adolescent Psychiatry that I handed out.

However, for individual children, they may have some use, especially as adjunctive interventions. The problem is that there are many types of meditation, many types of hypnotherapy and hypnotherapists, and ADHD is not a single condition.

If you are comfortable in teaching mindfulness meditation, the child is willing/able to use it on a regular basis and it is acceptable to the parents, it can be a useful adjunctive therapy.

I have just returned from studying trance in Bali with a group of Ericksonian hypnotherapists. It would be way down my list of interventions for children with ADHD.

At this point, the single most effective intervention is a stimulant medication.

6. **Question:** Following Dr. Aman's studies: He suggests a hierarchy of treatment options, beginning with diet and behavioral modification before medication. Do you see diet and behavioral modification to be effective and do you have any specific suggestions for either?

Answer: As outlined in the practice parameters of the American Academy of Child and Adolescent Psychiatry, studies on diet have been very disappointing. Nevertheless, you will find a variety of different ones, each having a small number of believers. It may be that for a particular child a particular one may be useful – provided it does not cause vitamin deficiency or some other problem.

For many years, I ran children's inpatient units where we could control diet. This gave us the opportunity to see if mother or grandmother's belief that a certain food or dye made Johnny worse. Actually, it did in a few children – perhaps 1 or 2 out of 80 or so.

Behavioral interventions for younger children are of some help for ADHD and ADD. Notable and obvious are home and classroom structure, clear direction, decreased sensory distraction and overload, and peer-group influence. However, they are most helpful for co-

morbid oppositional defiant disorder. Sometimes, the most useful intervention by far is parent coaching in reducing chaos in the home, establishing an appropriate power hierarchy and clear limits, and use of a reward system. Prescription-teaching, occupational therapy, sensory integration therapy, speech/language therapy, and physical therapy are important for co-morbid learning problems which are very common and may be confused with ADHD. Unfortunately, they are often not easily obtainable.

Brent Bell, D.O. - Bipolar Disorder in Children and Adolescents

1. **Question:** What is the name of the book you referenced in your presentation?

Answer: “Clinical Manual for Management of Bipolar Disorder in Children and Adolescents”
Authors: Robert A. Kowatch, M.D.; Mary A Fristad, Ph.D., ABPP; Robert L. Findling, M.D.; and Robert M. Post, M.D.

The book may be found and ordered on the American Psychiatric Publishing, Inc. Web site at www.appi.org