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Proceedings of the 4th International Conference on Child & Family Behavioral Health-2016

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In its 4th iteration the International Child & Family Behavioral Health Conference, organized by the Child Psychiatry Service at Sheikh Khalifa Medical City, SKMC, was convened in Abu Dhabi, UAE, 28-30 January 2016. The conference boasted the contribution of local partners from public and private sectors, regional parties, The Gulf Child Mental & Behavioral Health Society (www.gcmbhs) and renowned institutes namely the American Academy of Child & Adolescent Psychiatry (AACAP), University of Chicago, USA & South London & Maudsley NHS Trust, UK.

In this paper we will summarize the main themes, recent advances in some topical areas and the recommendations of the conference. It is now considered the largest child & adolescent mental health event in the region with over 600 attendees, more than 100 lectures, 13 workshops, 30 new research posters and 83 speakers.

The event was held this year under the patronage of H.E. Sheikh Nahyan Bin Mubarak Al Nahyan, Minister of Culture, Youth and Community Development whose keynote lecture stressed the high hopes that the conference would positively impact child and adolescent mental health care and ignite research throughout the UAE and the region.

The opening ceremony was graced by a key note address from Dr. Paramjit Joshi, immediate past president of AACAP titled "Integrated care: why is it important".

A new set of workshops focused on the newly formed Arab Board certification in Child and Adolescent Psychiatry during the conference. This board will play a leading role in graduating future generations of qualified Child and Adolescent Psychiatrists.

Speakers and attendees came from UAE, Oman, Saudi Arabia, Kuwait, Qatar, Bahrain, Australia, Canada, UK and the USA. Speakers represented a variety of disciplines including general physicians, therapists, nurses, psychiatrists, psychologists, counselors, teachers and more. The main focus of the conference was multidisciplinary treatment

THEME 1: AUTISM SPECTRUM DISORDER

This was presented in a context of global mental health perspective and a new area of research and practice that place priority on improving and achieving equity in health for all people worldwide in the domain of mental health. Embracing this would improve access to mental health services, improve treatments and reduce human rights abuses of people experiencing mental health disorders. The global impact of autism affecting 70 million people was highlighted.

Evolving diagnostic criteria of autism were reviewed, global epidemiology was described, cultural differences in the presentation and risk factors in diverse settings were listed. As one would expect Leo kanner's (infantile Autism) and Asperger's (Autistic psychopathy) coincidental publication in 1943 and 1944 respectively were the usual starting points of the presentations. Of interest also was the history of the diagnoses appearing in 1968 in DSM11 as "schizophrenic reaction childhood type", then in 1980 in DSMIII as "infantile autism and pervasive developmental disorders". In 1981 Lorna king introduced Asperger's syndrome and DSM 1V and DSM IV-TR expanded the definition of both Autism and Asperger's syndrome. Finally, the current DSM-5 settled with "pervasive developmental disorders". Next on the agenda were the pertinent questions: is PDD increasing? And If so why? The range of current prevalence rates were from 1:150 in 2000 to the current 1:68 children in 2010. The issue is a hot topic and titles like the age of autism and the autism epidemic have been used to describe it. The following have also been listed as causes of contributing to the prevalence: Lower age at diagnosis, changes in diagnostic criteria, improved case identification and ascertainment methods, changes in diagnostic practices, diagnostic substitution or switching, rise in public awareness, research methodology environmental components, and cultural factors.

Finally, the AAP recommendation of screening of children at 18 and 24 months were stressed if: a sibling has ASD, there is Parental or other care giver or a Pediatrician concern. Also of note, were the "red flags" of The American academy of neurology and child neurology society practice guidelines on ASD screening indicating further evaluation if: no babbling or pointing or gesturing by age 12 months, no single words by 16 months, no 2-word spontaneous phrased speech by 24 months or loss of language or social skills at any age (Yolton et al., 2014).

THEME 2: ATTENTION DEFICIT HYPERKINETIC DISORDER, ADHD

The conference presentations reviewed etiology, clinical manifestations, evidence and practice based interventions and outcome of the diagnosis. The core symptoms of the disorder are: impulsivity, inattention & hyperactivity.

The major change in DSM-5 criteria for the diagnosis is mainly raising the cut off age from 7 to 12 years and the implications of that on prevalence, if any, were considered.

The estimated current prevalence is accepted to be 6-8 % (range of 3-11%) of children worldwide & 4% of adults, the latter commonly overlooked. In the Middle East although solid data is not available studies yield a range of 0.5-5.3%. ADHD is considered the most common behavioral disorder of childhood. There are more males than females with girls showing typically less hyperactivity fewer conduct problems and less externalizing behavior.

Impairment in ADHD include psychiatric morbidity, school/work failure, poor peer relationships, legal issues, tobacco and substance use, accidents and injuries, parental stress, family conflict, economical burden family and society.

Symptoms may change over time as a child may struggle with

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hyperactivity at first then over time becomes impulsive and ends up with inattention.

Life time course of ADHD symptoms in the inattention domain involve difficulty sustaining attention, the child doesn't listen, does not follow through tasks, can't organize and loses important items. In adulthood difficulty in sustaining attention shows in (meetings reading paperwork and paralyzing procrastination, slow and inefficient, poor time management and disorganization.

Hyperactivity - Impulsivity domain adults can't sit through meetings can't wait in line, drives too fast can't tolerate frustration, talks excessively, interrupts others, and makes inappropriate comments.

Psychiatric Comorbidity also involve disruptive behavior, learning disability, substance abuse, mood and anxiety disorders, earlier onset of depression, oppositional defiant disorder and conduct disorder. (McGough et al., 2005).

Etiological theories list prenatal and post natal causes. Multiple candidate genes (DBH, MAOA, SLC6A2, TPH-2, SLC6A4, CHRNA4, and GRIN2A) so far studied show small effects. There is enough evidence implicating several genes in the etiology of ADHD, with a role of the genes coding for DRD4, DRD5, SLC6A3, SNAP-25, and HTR1B. Estimated heritability is more than Type 2 diabetes, IQ, panic disorder up to autistic spectrum. In conclusion, although twin studies demonstrate that ADHD is a highly heritable condition, molecular genetic studies suggest that the genetic architecture of ADHD is complex and more studies are needed.

Environmental factors like serum lead level, artificial food additives also show a small effect. Important negative findings replicated are smoking during pregnancy, dietary sugar or vitamin / micronutrient deficits all show no effect. Psychosocial stressors are not causative but exacerbate the symptoms. (Faraone, Stephen & Mick, 2010). Delay in maturation of the cortex has also been implicated.

Pharmacotherapy and psychosocial interventions are the cornerstones of treatment. The effect size of stimulants remains one of the most impressive in all of medicine. Improvements are in all domains (impulsivity, hyperactivity and inattention. They also reduce impulsive aggression; improve social interaction and academic efficiency and accuracy. They are found to be protective in comorbidity (MDD, Anxiety, ODD) and lower the risk of repeating the grade. (Biederman et al., 2009). Stimulants also reduce criminality and drug offences. (Lichtenstein et al., 2012).

The outcome studies show. 1/3 becomes well, another third lives with subclinical symptoms and the last third continues to struggle with ADHD.

THEME 3: BIPOLAR DISORDER

It is possible for children and adolescents to be diagnosed as Bipolar disorder. Most often the diagnosis is made in older children and teenagers, but bipolar disorder can occur in children of any age. Children can present with mood swings from the highs of hyperactivity or euphoria (mania) to the lows of serious depression.

The sessions discussed definitions of cycles of bipolarity ultradian (daily) and ultra-rapid cycling. This is crucial in differentiating the episodes from the cycles to determine the overall duration of the episodes in both groups. An interesting view was Tillman& Geller's proposition to (1) *Episodes* will be defined by (a) the duration from onset to offset of a period of at least 2 weeks in length during which only one mood state persists or (b) the duration from onset to offset of a period of ultra-rapid or ultradian cycling for at least 2 weeks. (2) *Cycles* will be defined by mood switches occurring daily or every few days during an episode. Further research will be needed to elucidate potential differences between child and adult cycling patterns. (Tillman & Geller, 2014).

Also the question of what is considered Bipolar and what is not was an interesting discussion. What is not considered as Bipolar includes: Severe chronic irritability and mood labiality without clear episodicity. Also sources of diagnostic confusion include the variable developmental expression of mania and its symptomatic overlap with attention-deficit hyperactivity disorder (ADHD). (Wozniak et al.,1995).

Severe mood dysregulation SMD or Disruptive Mood Dysregulation syndrome (DMDD) are also not Bipolar disorder. (Leibenluft, 2011).

OTHER THEMES AND CONCLUSION

The conference covered many grounds and we tried to give a flavor of the proceedings and the caliber of the talks. Almost every aspect of child, adolescent and family behavioral health issue was included. Examples are substance misuse among adolescents in the region, internet addiction and gaming disorder, Schizophrenia in childhood, understanding and supporting grieving children, enhancing outcome through animal therapy (Penguins example) to name a few.

Interventions were dedicated special workshops like managing challenging behavior at home and classroom, family therapy, applied behavior analysis and CBT.

The conference's special signature was the dedication of a workshop for candidates wishing to specialize in Child and Adolescent Psychiatry, a much needed specialty in the region. The Arab Assessment and Management Board Examination is taking registrations soon for the first board examination and candidates had the chance to meet some examiners who provided mentoring sessions and supervision on how to prepare for the exam.

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