experience tantrums when they experience frustration. The question of whether irritability is typical or atypical is still not fully answered. Although symptoms of irritability have been present in children for a long time, research into the evaluation, etiopathology and treatment of these children has been ongoing [4]. Some studies have shown that these symptoms are present in very young children, may be permanent and are associated with impairment when they are permanent [5]. The relationship between neurodevelopmental disorders and irritability is considered important by many researchers. In a review on irritability, it was stated that irritability was a stable dimension and that it was associated with psychological disorders in the later period [6]. Researchers' interest in ADHD is increasingly directed towards irritability, irritable mood and irritable behavior in individuals with ADHD [7]. In one study, a neurobiologically different and stable ADHD subtype characterized by extreme negative emotion levels was defined. In another study, it was shown that irritability was mediated by ADHD and alcohol use problems in adolescents with ADHD [8].The explanation of the mechanisms by which these symptoms persist in childhood and how to change these trajectories is a critical goal for new research. In this presentation, we wanted to discuss irritability symptom in children by the help of current debates.

References

[1] Brotman MA, Kircanski K, Stringaris A, Pine DS, Leibenluft E. Irritability in youths: a translational model. American Journal of Psychiatry. 2017;174 (6):520–532.

[2] Peterson BS, Zhang H, Santa Lucia R, King RA, Lewis M. Risk factors for presenting problems in child psychiatric emergencies. Journal of the American Academy of Child & Adolescent Psychiatry. 1996;35 (9):1162–1173.

[3] AmericanPsychiatricAssociation. Diagnostic and statistical manual of mental disorders (DSM-5®). American Psychiatric Pub; 2013.

[4] Althoff RR. Pediatric Irritability Comes of Age. Elsevier; 2018.

[5] Wiggins JL, Briggs-Gowan MJ, Estabrook R, Brotman MA, Pine DS, Leibenluft E, et al. Identifying clinically significant irritability in early childhood. Journal of the American Academy of Child & Adolescent Psychiatry. 2018;57(3):191–199. e2.

[6] Vidal-Ribas P, Brotman MA, Valdivieso I, Leibenluft E, Stringaris A. The status of irritability in psychiatry: a conceptual and quantitative review. Journal of the American Academy of Child & Adolescent Psychiatry. 2016;55(7):556–570.

[7] Karalunas SL, Fair D, Musser ED, Aykes K, Iyer SP, Nigg JT. Subtyping attention-deficit/hyperactivity disorder using temperament dimensions: toward biologically based nosologic criteria. JAMA psychiatry. 2014;71(9):1015–1024.

[8] Harty SC, Gnagy EM, Pelham Jr WE, Molina BS. Anger-irritability as a mediator of Attention-deficit/ hyperactivity disorder risk for adolescent alcohol use and the contribution of coping skills. Journal of child psychology and psychiatry. 2017;58(5):555–563.

[Abstract: 0645] [Others]

An endophenotype in children and adolescents: irritability and current approachesIrritability: as a symptom in adolescence

Şafak Eray

Department of Child and Adolescent Psychiatry, Uludag University, Bursa, Turkey

E-mail address: drsafakeray@gmail.com

ABSTRACT

Irritability can be defined as an elevated proneness to anger relative to peers. Clinically impairing irritability in adolescents began to gain more attention as interest grew in the diagnosis of pediatric bipolar disorder (BPD). Beginning in the 1990s, child psychiatry researchers suggested that while pediatric BPD can present with distinct episodes of mania or hypomania as in adults, the more typical pediatric presentation was chronic, severe irritability and hyperarousal symptoms. Indeed, more recent evidence indicates that the pathophysiological correlates of the trait of irritability itself differ between BPD and Disruptive Mood Dysregulation Disorder (DMDD). The Youths with DMDD exhibit severe and recurrent temper outbursts that are more easily elicited, longer lasting, and contextually atypical relative to those of their peers. Outbursts are characterized by motor activity, prominent displays of anger and other negative emotions, and verbal as well as sometimes physical displays of reactive aggression. Between temper outbursts, severely irritable adolescents also have a persistent angry mood, involving hostile nonverbal behaviors and reports of being annoyed over many days. Thus, DMDD includes affective and behavioral. Adolescents generally come to child and adolescent psychiatry clinic with the symptom of irritability and clinicians have to make the differentiation from DMDD and other psychiatric diseases. When we differentiate DMDD from the BD, DMDD is characterized by chronic irritability, whereas, irritability in BD is episodic, representing a change from the person's

KEYWORDS

Irritability; adolescence; mood disorders

usual state. Thus, the typical mood of DMDD is consistently irritable or angry, while that of BD varies across euthymic, depression, and mania. Intermittent explosive disorder (IED): the two disorders differ in frequency of outbursts (2/week for IED for 3 months versus 3/week for DMDD). Critically, there is no requirement of persistent irritability in IED although it may be present. Since criteria may be met for both disorders, DSM-5 stipulates that DMDD takes precedence over IED. However, IED is appropriate when the duration is below one year. Oppositional Defiant Disorder (ODD): Both DMDD and ODD criteria include irritability and temper outbursts. The two disorders differ in (1) severity: in DMDD, outbursts must occur 3 times/week, but only once a week in ODD; (2) duration: 12 months for DMDD, and 6 months for ODD; and (3) pervasiveness and impairment: DMDD must impair function in two of three settings and be severe in one setting; there is no such requirement for ODD. Thus, more children with DMDD will meet criteria for ODD, than the reverse. Youths with chronic irritability (including when it occurs in the context of oppositional defiant disorder) are at elevated risk for later depression and anxiety, but not manic episodes. Early manifestation of chronic irritability during childhood, especially when combined with depressive/anxious mood, may be associated with an elevated risk for adolescent suicidality. Also high levels of childhood irritability also predict increased risk for suicidality and functional impairment in adulthood. The type of irritability and episodic nature of irritability may help us to understand this symptom. In this panel we wanted to discuss irritability symptom in youth by the help of our studies and current debates.

[Abstract: 0766] [Psychotherapy]

Self-harming behavior: definition, prevalence and psychosocial risk factorsa

Burcu Serim Demirgören

Department of Child and Adolescent Psychiatry, Dokuz Eylul University, Izmir, Turke

E-mail address: burcuserim@hotmail.com

ABSTRACT

Self-harm behavior includes behaviors such as self-cutting, scratching, and burning, done without the conscious intent to take one's life. Some studies have revealed adolescents who engage in self-harm behavior is to get relief from distress; to escape from a situation; and to show how desperate they are feeling. Some epidemiologic studies have demonstrated high rates of self-harm behavior in adolescents. In recent years, rates of self-harm behavior are quite high in contemporary populations of youth. Approximately 5–13% of school students reported self-harm behavior in United Kingdom and Australia. Over half of adolescents who have self-harmed report engaging in more than one episode in their lifetime, showing the repetitious nature of this behavior. Moreover, a previous history of self-harm is a key risk factor for suicide and so self-harm has become a growing public health concern. A high association between self-harming behavior and different psychiatric disorders, such as depression, anxiety, bipolar disorder, and borderline personality disorder, has been shown. Self-harm behavior is also associated with eating disorders, a history of abuse or trauma, awareness of self-harm in peers, family members who self-harm, drug misuse, and low self-esteem. Suicide ideation and attempts are more likely to be reported among those with repeated non-suicidal self-harm. Early interventions and prevention programs may reduce the number of serious physical injuries resulting from self-harm behavior and lower the risk of future suicide in young people. This presentation will include the definition, prevalence of self-harm behavior. And discuss about the psychosocial risk factors of self-harm behavior.

KEYWORDS

Self-harm behavior; deliberate self-harm; self-cutting; self-mutilation; para-suicidal behaviors; psychosocial risk factors

References

[1] Gratz KL. Risk factors for and functions of deliberate self-harm: an empirical and conceptual review. Clin Psychol Sci Pract. 2003;10:192–205.

[2] Klonsky ED. The functions of deliberate self-injury: a review of the evidence. Clin Psychol Rev. 2007;27:226–239.

[3] Madge N, Hewitt A, Hawton K, et al. Deliberate self-harm within an international community sample of young people: comparative findings from the Child & Adolescent Self-harm in Europe (CASE) Study. Journal of Child Psychology and Psychiatry. 2008;49:667–677.

[4] Owens D, Horrocks J, House A. Fatal and non-fatal repetition of selfharm – Systematic review. British Journal of Psychiatry. 2002;181:193–199.

[5] Tuisku V, Pelkonen M, Karlsson L et al. Suicidal ideation, deliberate self-harm behavior and suicide attempts among adolescent outpatients with depressive mood disorders and comorbid axis I disorders. Eur Child Adolesc Psychiatry. 2006;15:199–206.

[6] Nixon MK, Cloutier P, Jansson SM. Nonsuicidal self-harm in youth: a population-based survey. CMAJ. 2008;178:306–312.