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Childhood Psychiatric Disorders

The all-important context of environment:
Children and adolescents exist not solitarily, but in a great framework of school, peer, parents, sibling, and the influence of society in general. As they mature the influence of family dwindles, and those of society grow.

Goals of Assessment

Nature and context of presentation:
... Precipitating stressors?
... impact on functioning?
... To what do the parents attribute this problem?

HISTORY TAKING: ….children rarely present themselves; usually it's the family bringing them in

- from family as they are the ones who are presenting with the problem; i.e they view it as a problem

APPROACHES:
Children younger than 8:
Interactive play is the best way to engage; drawings can be used to gauge their feelings.
- **Draw the family**
- **Draw a person**
- **Draw a dream**
- **Draw an imaginary TV show**

The over-8s can be interviewed directly.
- **ask them: why were they brought here?**
- **What makes them happy, worried, angry or sad?**
- **Formal and informal projective techniques, eg→**
  - **asking the kid what they would spend their three wishes on**
  - **asking whom they would take to a deserted island**
  - **asking what animal they would prefer to be**

PREGNANCY: maternal health, smoking etc...
EARLY INFANCY:
quality of attachment between child and mother
developmental milestones
history of childhood illnesses
EARLY CHILDHOOD:
Transition experiences, eg. fro pre-school to primary
Cognitive and school performance
Peer and family relationships
Physical development
Temperamental traits
FAMILY FUNCTIONING:
Relationship of parents
Quality of sibling relationships
Influence of extended family
History of psychiatric illness in the family

Physical examination does nothing to disrupt the building of a therapeutic relationship.

ADDITIONALLY, FOR ADOLESCENTS:

Assessment does not differ much from that of an adult.
!! arrange to see the adolescent alone first-
- then bring the family in. IMPORTANT: do not attempt to relate to them, especially in the first interview. Youre old and therefore lame. Their culture is different and they are acutely sensitive to insincerity. Still, its unwise to be too authoritarian and clinical, so err on the side of lameness.

ALWAYS USE CORROBORATING SOURCES:

- from school councilor why build new rapport when someone has already done the hard work?
- from school records of achievement objective evidence of "not coping"
- from previous psychiatric assessments sheds light on past mental health state
- from the child themselves

PHYSICAL EXAMINATION:

Focus on syndromic features, abuse and neglect.
- skinny? Skin folds, thin hair, delayed development?
- Bruises on inside of arms, on face, finger bruises
- Look for signs of fetal alcohol syndrome, autism, Downs, Turners, and any multitude of other "funny-looking kid" syndromes.
-

SPECIAL INVESTIGATIONS:

To investigate potentially organic problems...
- CT scan
- EEG to rule out a seizure (rule in pseudosezure)
- Bloods to look for metabolic weirdness
  - Especially if delirious, decreased LOC, or you suspect an endocrine abnormality eg. Cushings or phenylketonuria.

DISORDERS OF EARLY INFANCY: from birth, to the FIFTH year.

GENERAL RULES OF THUMB:

Problems in the first five years of life are usually due to

- a DISTURBANCE IN THE PARENT-CHILD RELATIONSHIP, like a mis-match between parents and childs personality.
- ORGANIC BRAIN DISEASE eg. some sort of brain dysfunction
- DEVELOPMENTAL PROBLEMS eg. low intelligence.

ATTACHMENT TO CAREGIVERS:

- by 8 weeks the baby responds to any faces with smiles and eye contact.
- By 6 months this response is specific for attachment figures; this is where the child looks for comfort when illness strikes, or in times of stress and worry.
- Separation can result in over-attachment (clinging) or under-attachment (lack of response
- TEMPERAMENT: is the baby easy, placid, regular in its habits? Or is it difficult, demanding?
  - VERY IMPORTANT as difficult demanding babies may not have their demands met by their parents, especially if the mother is depressed, anxious, or otherwise unwell

FAILURE TO THRIVE **(non-organic, i.e not due to some sort of gut malformation or heart weirdness)**

- Not meting weight, height, head circumference milestones
- Delayed motor and language development
- Periods of indiscriminate clinging and withdrawn detachment

! this is a response to grossly distorted care or neglect!

The parents are at fault; treat THEM as a matter of urgency:

Counseling, teaching parenting skills, social work stuff.

THE CHILD:

Requires hospitalisation. FEED IT BACK UP TO NORMAL WEIGHT.

AUTISM: onset of symptoms is before age of 3

ABNORMAL SOCIAL INTERACTION:

- Inability to appreciate feelings of others
- Lack of empathy
- Inability to engage in imaginative play

PROBLEMS WITH COMMUNICATION:

- Rudimentary hard-to-understand speech
- Repetition of words and sentences

NARROWING OF ACTIVITIES AND INTERESTS:

- Rocking backwards and forwards
- Intolerance of change
- Repetitive mannerisms and ritual behaviours
- Fascination with moving objects
- Hand flapping or twisting

LACK OF RESPONSIVENESS is the first thing the parents notice: its almost as if the kid is deaf!

- MALES affected 3 times as often as females
- 1 in 1000 children is affected
- Aetiology is uncertain
- Course is lifelong
- "High-functioning" ones stand a good chance of improving those skills they lack.
- one in 3 achieve partial independence in life (eg. sheltered work, group home living)

COGNITIVE ABILITIES are low or average("high-functioning autism"); HOWEVER some abilities (eg.musical, maths, drawing) can be unusually overdeveloped. A pair of autistic twins in Oliver Sacks' book play games where the goal is to come up with the next highest eight-digit prime number.

EARLY DIAGNOSIS IS CRUCIAL: it allows multi-modal intensive treatment to begin, eg education, behavioural training and social skills training, plus behaviour management training for the parents. Pharmacotherapy is rarely needed, its mainly reserved for psychiatric comorbidities like depression, psychosis, ADHD, tics and epilepsy.

ASPERGER'S DISORDER:" Autism Lite", or "I cant belive is not Autism"

THIS IS ALSO MORE COMMON IN MALES

ABNORMAL SOCIAL INTERACTION: just like autism
- Inability to appreciate feelings of others
- Lack of empathy
- Inability to engage in imaginative play

NO PROBLEMS WITH VERBAL COMMUNICATION!

Its mainly non-verbal stuff;
- -no eye contact in conversation
- -lack of facial expression while talking
- -no understanding of social norms

NARROWING OF ACTIVITIES AND INTERESTS:
- Rocking backwards and forwards
- Intolerance of change
- Repetitive mannerisms and ritual behaviours
- Infatuation with concrete topics like timetables or maps
- Hand flapping or twisting

IQ is NORMAL and so diagnosis is usually later in childhood.

SOMETIMES ASSOCIATED WITH:
- Tourette's syndrome
- Anxiety
- depression

AS THE CHILD AGES, Characteristics will persist into adulthood with some kids developing the schizoid personality trait . Often these people are successful professionally, but not socially. There is an increased risk of psychotic episodes.

MANAGEMENT is same as for autism but with less emphasis on language skills.

MENTAL RETARDATION= IQ below 75

IQ testing is required for diagnosis; don't just guess!

MILD: 55 to 75
MODERATE: 40 to 55
SEVERE: 25 to 40
PROFOUND: below 25

Usually detected earlier because development is markedly delayed

One in a hundred are at least mildly retarded.
No specific aetiology, but numerous things could cause it eg. antenatal weirdness, genetic disorders etc. IT CAN ALSO BE CAUSED in a previously normal child by extreme emotional, social or physical deprivation.

The mildly affected can achieve vocational abilities that allow them to fill unkilled positions. They can live alone or in supervised accommodation.

Course of the illness is determined by environmental circumstances, like parental resources (can everyone afford expensive therapy?), maternal coping resources, community supports and community barriers (eg. swine).

Family members often in need of therapy as much as the child is. Depression, anger, guilt…

Higher rates of psychiatric disturbance in the mentally retarded; watch out for a second diagnosis (about 50% will go on to develop one; like ADHD, depression, conduct problems)

Higher vulnerability to stress and thus greater potential for involvement in delinquent activities

AGGRESSION is all too common: about one in four will suffer intense, frequent or prolonged episodes of aggressive or self-harming behaviour. This is usually a reaction to an inadequate environment. ANTIPSYCHOTICS are sometimes useful in the short term, but actually HARMFUL in the long term setting.

ELIMINATION PROBLEMS

Not everybody "grows out of it"

Functional Enuresis is WITHOUT A PHYSIOLOGICAL REASON.

Daytime or nighttime, doesn't matter.

HAS TO BE AT LEAST TWICE WEEKLY FOR ONE MONTH AFTER THE AGE OF 5.

Mainly in boys. Mainly childhood, though sometimes continues into adulthood.

PRIMARY ENURESIS: never been dry since early childhood

SECONDARY ENURESIS: follows 12 month of good urinary control

Recurrence is often due to family stress; often accompanied by other problems.

MANAGEMENT: it's a disorder of autonomic discipline; so treat it in a Pavlovian manner.

Eg. behavioural treatment using an incontinence pad sensor and alarm.

- parents train the child to use the toilet when the alarm rings, reset it after cleaning the bed.
- Treatment should continue for at least one month after the symptoms have resolved.

PHARMACOTHERAPY can be equally effective, but has a higher relapse rate.

...DESMOPRESSIN

...TRICYCLICS

Functional Encopresis is also divorced from organic functional problems.

..usually NOT INTENTIONAL.... Again, more frequent in boys....

THINK: could this bethe result of a sugary, fibreless diet? Could chronic constipation be the issue? It can result in overflow incontinence.

PARENTAL PRE-OCCUPATION with toilet training, and a punitive parent-child relationship- this will reduce the child's desire to cooperate and will increase fear of defecation.

OFTEN ASSOCIATED WITH:

- functional enuresis
- ADHD
- Family dysfunction
- Oppositional behaviour.

Sometimes also associated with

- Anxiety
- Poor self-esteem
- Poor social skills
- Peer rejection and embarrassment (understandably!)

MANAGEMENT

MAINLY BEHAVIOURAL; rewards for sitting on the toilet at the apprproiate time, improvement of diet, laxatives, parental training (mainly to address negative attitudes)

MENTAL HEALTH PROBLEMS IN PRIMARY SCHOOL CHILDREN

... most will tolerate separation from attachment figure by the age of 5; this allows us to endure school.

LEARNING DISORDERS: eg. Dyslexia

- developmental delays in acquiring language and motor skills
- delays in developing reading, writing and number skills
- diagnosis is via reading, writing, and arithmetic assessments
- diagnosed when the child performs 2 or more years below their peers
- Disruptive behavior disorders co-exist

! MUST DISTINGUISH FROM UNDER-ACHIEVEMENT!

Underachievers usually have a normal IQ. The problem is something else, eg. truancy, poor concentration, depression etc.

MANAGEMENT - initially speech therapy, motor skills training, and modified education

- Think alternative methods of learning and communicating, eg. keyboard instead of pen

DISRUPTIVE BEHAVIOUR DISORDERS:

- Conduct not socially acceptable; failure in recognizing responsibility.
- Its normal to have such conduct (its one of the ways we learn our boundaries):
  BUT we usually learn that something is wrong when we are chastised or punished.
  DISORDERED INDIVIDUALS DO NOT LEARN.
  This is the marker distinguishing an asshole child from a poor unfortunate with disruptive behaviour disorder.
- delays in developing reading, writing and number skills

ATTENTION DEFICIT HYPERACTIVITY DISORDER:

Cardinal features:

- Distractibility
- Cannot attend to instructions
- Difficulty in establishing routines
- Fidgety
- Excessively running about, climbing things (n the very young)
- Symptoms occur in most settings
- The younger the child, the less reliable the diagnosis
- 3 times more likely to be a boy.
- Prevalence is around 4%
- Some association with early attachment problems

5-fold increase in incidence since 1985

3 distinct flavours:
- Combined type
- Inattentive type (old ADD)
- Hyperactive-Impulsive type

CAN CONTINUE INTO ADULTHOOD:
But symptoms MUST have been present since before 7 years of age

Assessment:

- Behaviour rating scale for parents: helps compare to age peers
- Hearing, visual, neurological tests (to exclude other reasons for learning disability)

Management:

- Counsel the parents regarding behaviour management techniques.
  (these rarely address the core problems, but help the parents cope.)
- Engage the school:
  - Present schoolwork in 10 minute modules
  - Interrupt lessons with brief periods of exercise
  - Permit non-disruptive movement
  - Clearly articulate expectations of behaviour
- Pharmacotherapy:

PSYCHOSTIMULANTS: 90% show marked response

Render unto the child the ability to participate meaningfully in cognitive retraining

- ? Mechanism of action: excitation of sleepy dormant inhibitory pathways?
- Well-established safety in the long term
- Contraindicated if psychotic, or ridden by tics and movement disorders
- Avoid changing medications at critical transition periods.

PSYCHOSTIMULANTS IN DETAIL

DEXTROAMPHETAMINE: the d-isomer of amphetamine

- centrally acting sympathomimetic drug, causes release of noradrenalin from neuron. Also inhibits monoamine oxidase

METHYLPHENIDATE: a close chemical relative of amphetamine

- mechanism same as above

PEMOLINE: a non-amphetamine related mysterious psychostimulant

- mechanism of action unknown
- metabolized in the liver: DO LFTs as part of pre-Pemoline workup
- monitor LFTs: especially ALT: if it doubles, discontinue Pemoline

ATOMOXETINE: not really considered as a psychostimulant

- mechanism : presynaptic inhibition of noradrenalin reuptake
- causes headache, tremor, irritability, sometimes psychosis
- loss of appetite and insomnia are transient
- practically no cardiac side-effects

PROBLEMS with PSYCHOSTIMULANTS:

- Loss of appetite, weight loss; initial insomnia…reversible
- Tics vs Tourette's
- Moodiness, grumpiness, psychosis (rare)
- Supervision at school time (better to go with long acting med)
- Compliance, resistance
- Abuse, misuse
- Monitoring response and side effects
- Potential psychological impact on child of long term medication (unknown!)

ADHD THERAPIES OF QUESTIONABLE EFFICACY

- Amitryptyline (ECG first)…tricyclic
- Clonidine/ Catapres - helps with sleep
- SSRIs
- Moclobemide (Aurorix): a reversible monoamine oxidase inhibitor anti-depressant
- Risperidone, other antipsychotics (atypicals)
- Atomoxetine

OUTCOME OF ADHD

Approx. one third outgrow symptoms… **'developmental delay'**
Approx. one third continue to have functionally impairing symptoms into adult life… **'continual display'**
Approx one third '**developmental decay'** … continual core of symptoms, plus more serious psychopathology such as alcoholism, other substance abuse, antisocial personality disorder (esp. if comorbid conduct disorder)
Many, especially with unrecognised ADHD, go onto adult disorders such as anxiety disorders, mood disorders (Wender, 1994)

OPOSITIONAL DEFIANT DISORDER

Argumentative, annoying, touchy, frequent intense temper tantrums...??

Is this behaviour ABNORMAL AMONG PEERS? Compare the child to others of similar age and intelligence.

Symptoms must be "Maladaptive and inconsistent with developmental level"

Cardinal features and influencing factors:

1. has unusually frequent or severe temper tantrums for his or her developmental level;
2. often argues with adults;
3. often actively refuses adults' requests or defies rules;
4. often, apparently deliberately, does things that annoy other people;
5. often blames others for his or her own mistakes or misbehaviour;
6. is often 'touchy' or easily annoyed by others; more likely to perceive neutral acts by others as hostile, and more likely to believe conflicts can be satisfactorily resolved by aggression.
7. is often angry or resentful;
8. is often spiteful or vindictive.

- more likely to have IQ about 10 pts below peer average
- 4 times more likely in boys
- 3 times more likely to be from a low socioeconomic background
- clusters in families, 70% monozygotic twin concordance
- strongly associated with harsh erratic discipline, hostility directed at the child, lack of warmth, and poor supervision
- depression of the mother and criminality of the father are most accurate family predictors
- physical and sexual abuse
- poorly organized, unfriendly school

THE KEY IS: this behaviour only occurs n some situations, eg. when the child is frustrated.

There are periods of normal behaviour.

CONDUCT DISORDER:

"A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. - Manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:"

Aggression to people and animals

(1) often bullies, threatens, or intimidates others
(2) often initiates physical fights
(3) has used a weapon that can cause serious physical harm to others (e.g., abat, brick, broken bottle, knife, gun)
(4) has been physically cruel to people
(5) has been physically cruel to animals
(6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
(7) has forced someone into sexual activity

Destruction of property

(8) has deliberately engaged in fire setting with the intention of causing serious damage
(9) has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft

(10) has broken into someone else's house, building, or car
(11) often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
(12) has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, forgery)

Serious violations of rules

(13) often stays out at night despite parental prohibitions, beginning before age 13 years
(14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
(15) is often truant from school, beginning before age 13 years

- prevalence increases with social disadvantage
- 6% adolescent boys, 2% adolescent girls fit the criteria
- is this just medicalising the condition of being a little asshole? Good question. High correlation of features suggests that this is a legitimate syndrome and not an aggregation of various types of deviance. Plus there appears to be a genetic component (although crappy parenting, sexual abuse, harsh discipline, inadequate supervision and delinquent peers all play a more important role in aetiology)

EXTREMELY DIFFICULT TO TREAT: short-term improvement wanes quickly.

Parental training, family therapy, problems-solving therapy… Established antisocial behaviours are resistant to change.

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Practical Advice on Conduct Disorder from the Oxford Textbook

Parenting skills

Parent management training aims to improve parenting skills. There are scores of randomized controlled trials showing that it is effective for children up to about 10 years old. They address the parenting practices identified in research as contributing to conduct problems.

Typically, they include five elements.

1. Promoting play and a positive relationship
   In order to cut into the cycle of defiant behaviour and recriminations, it is important to instil some positive experiences for both sides and begin to mend the relationship. Teaching parents the techniques of how to play in a constructive and non-hostile way with their children helps them recognize the child's needs and to respond sensitively. The children in turn begin to like and respect their parents more, and become more secure in the relationship.
2. Praise and rewards for sociable behaviour
   Parents are helped to reformulate difficult behaviour in terms of the positive behaviour they wish to see, so that they encourage wanted behaviour rather than criticize unwanted behaviour. For example, instead of shouting at the child not to run, they would praise him whenever he walks quietly; then he will do it more often. Through hundreds of such prosaic daily interactions, child behaviour can be substantially modified. Yet some parents find it hard to praise, and fail to recognize positive behaviour when it happens, with the result that it becomes less frequent.
3. Clear rules and clear commands
   Rules need to be explicit and constant; commands need to be firm and brief. Thus shouting at a child to stop being naughty does not tell him what he should do, whereas telling him to play quietly, for example, gives a clear instruction which makes compliance easier.
4. Consistent and calm consequences for unwanted behaviour
   Disobedience and aggression need to be responded to firmly and calmly by, for example,putting the child in a room for a few minutes. This method of 'time out from positive reinforcement' sounds simple, but requires considerable skill to administer effectively. More minor annoying behaviours such as whining and shouting often respond to being ignored, but again parents often find this hard to achieve in practice.
5. Reorganizing the child's day to prevent trouble
   There are often trouble spots in the day which will respond to fairly simple measures, such as putting siblings in different rooms to prevent fights on getting home from school, banning television in the morning until the child is dressed, and so on.