Common Child and Adolescent Psychiatric Problems

Synopsis

- Childhood psychiatric problems that require treatment affect about 7% to 10% of young people at some time.
- Assessment involves talking with the child as well as the parents, supplemented by information from teachers.
- Emotional disorders (anxiety/depression) seriously impair learning and development. Suicide-risk assessment to ensure safety is an essential first step in treatment. Psychological treatments and parent training are usually effective, but antidepressant drugs (tricyclic antidepressants and selective serotonin reuptake inhibitors) may be necessary with specialist consultation.
- Behavioral disorders seriously disrupt social development and can cause long term mental health problems. Early intervention, with a focus on solving family conflict and parenting problems, helps prevent adverse outcomes.
- Stimulant medication is of value in treating attention deficit/hyperactivity disorder.
- Measures that improve individual self-esteem and family functioning facilitate recovery.

Introduction

Worldwide, the prevalence of clinically significant psychiatric disorder in children is at least 7%. This rate rises in socially disadvantaged and densely populated urban areas. It also increases by 3%-4% after puberty. Childhood psychopathology presents as:

- disturbed or antisocial behavior (externalising disorders) -- prevalence 3%-5%
- troubled emotions and feelings (internalising disorders) -- prevalence 2%-5%
- a mixture of psychological problems and physical illness (somatoform disorders) -- prevalence 1%-3%
- more rarely as childhood psychosis or pervasive developmental (autism spectrum) disorders -- prevalence about 0.1%.

Boys are two or three times more likely than girls to be affected by disturbed and antisocial behavior. The ratio is more equal for emotional disturbances. There are more girls than boys affected by depression and anorexia nervosa. Children with intellectual disability and those with chronic physical illness that involves the brain have a significantly increased risk of developing a range of emotional and behavioral problems.

Assessment

Assessment and diagnosis takes a biopsychosocial approach, with consideration of the contribution made by biological development and medical illness, cognitive and personality characteristics and the family, school and social environment. The components of assessment are:
- Family interview
  - Define the problem(s), developmental and family history (genogram), parental mental and physical health, family interactions

- Interview with the child
  - **Mental state:** Do they have a problem? School experiences, friendship, play and teasing. Worries, fears, mood (including tears and suicidal ideas), expression of anger, sleep and appetite, habits and obsessions, and (when indicated) enquire about sexual/physical abuse, auditory hallucinations and delusional ideas.
  - Supplement the interview by play and drawing (ask the child to draw a person/family/dream)
  - **Physical examination:** including assessment of handedness, motor coordination or clumsiness

- Structured questionnaire rating scales
  - Parent and teacher checklists (e.g., Child Behavior Checklist for children of normal intelligence and the Developmental Behavior Checklist for children with intellectual disability) which provide an overall psychopathology score and problem domain subscale scores

- Other investigations
  - Psychological tests (e.g., IQ profile) -- indicated when there are learning problems, delayed or uneven development, cognitive or perceptual disturbances.
  - Laboratory tests (e.g., chromosome analysis) -- indicated when there is the possibility of an associated biological problem, such as fragile X syndrome or thyroid disease
  - Neuroimaging and electroencephalogram -- indicated when there may be associated neurological disorder such as epilepsy

The use and interpretation of play and drawing in the psychological treatment of children requires special training, but in general clinical practice children should be encouraged to play and draw to assist them to communicate. This may confirm information already gained or generate possibilities that need to be confirmed in further discussion with the child, parents or others, such as teachers. For example, recurring play themes arising from real life experiences may occur in free play with toys. The child may communicate emotional or relationship problems when drawing a picture of a person, the family, or a dream. This process is facilitated when the child experiences the clinician as non-judgmental and has heard the parents explain their concerns to the clinician and why help is being sought.

Motor clumsiness, problems with handedness and fine motor difficulties (e.g., gripping a pencil) might indicate neurodevelopmental problems. These are often associated with attention deficit hyperactivity disorder (ADHD), learning problems and low self-esteem and therefore require further neurological assessment.

Psychopathology checklists completed by parents, such as the *Child behavior checklist* or the *Developmental behavior checklist*, take 10 to 15 minutes to complete and are an effective and efficient means of providing the clinician with a broad survey of emotional and behavioral problems.
problems, some of which may be missed in a clinical interview. Selected questions or the entire questionnaire can also be used to follow response to treatment. At a more detailed level, answers on the Child behavior checklist can be scored in reference to the manual, to give a measure of the child's psychopathology relative to a general population of children of the same age and sex. There are also two broad subscales rating disturbance with emotional (internalising) problems and behavioral (externalising) problems and more detailed problem domains, such as anxiety and aggression.

Childhood psychopathology

The four most common psychiatric disorders in childhood presenting in the community are anxiety, depression, oppositional defiant disorder & conduct disorder, and ADHD. These will each be described to highlight the general approach to the treatment of psychiatric disorder in children.

1. Anxiety disorders

The most common manifestation of anxiety in children is fear to be separated from parents and home and refusal to attend school. The prevalence of anxiety is highest at times of transition: moving from preschool to primary school, and from primary to secondary school. Children who refuse to attend school are usually capable but self-critical students, and mostly have separation anxiety, being frightened to leave home. The prognosis is good with treatment, but persistent anxiety disorder predicts the development of panic disorder in adulthood.

**Symptoms**

- Distress and agitation when separated from parent and home
- School refusal
- Pervasive worry and fearfulness
- Restlessness and irritability
- Timidity, shyness, social withdrawal
- Terror of an object (e.g., dog)
- Associated headache, stomach pains
- Restless sleep and nightmares
- Poor concentration, distractibility and learning problems
- Reliving stressful event in repetitive play

**Family factors**

- Parental anxiety, overprotection, separation difficulties
- Parental (maternal) depression and agoraphobia
- Family stress: marital conflict, parental illness, child abuse
- Family history of anxiety

**Management**
- Cognitive-behavioral therapy
- Family therapy for overprotection
- Treat parental anxiety/depression
- Psychotherapy (interpersonal therapy)
- Teacher support
- Drug therapy (tricyclic antidepressant or selective serotonin reuptake inhibitor) as adjunct to psychological interventions

2. Depression

Contrary to earlier beliefs, persistent depression occurs in children and becomes progressively more common after puberty. Up to 24% of adolescents will have had a major depression by the age of 18. It seriously affects social, emotional and educational development, and is the most important predictor of suicidal behavior in young people aged 15-24 years.

Symptoms

- Persistent depressed mood, unhappiness and irritability
- Loss of interest in play and friends
- Loss of energy and concentration
- Deterioration in schoolwork
- Loss of appetite and no weight gain
- Disturbed sleep
- Thoughts of worthlessness and suicide (suicide attempts are rare before age 10, then increasing)
- Somatic complaints (headache, abdominal pain)
- Comorbid anxiety, conduct disorder, attention deficit hyperactivity disorder, eating disorders or substance abuse

Family factors

- Family stress (ill or deceased parent, family conflict, parental separation)
- Repeated experience of failure or criticism
- Family history of depression

Management

- Cognitive-behavioral therapy
- Family therapy for grief and conflict
- Psychotherapy (interpersonal therapy)
- Success achievement school programs
- Antidepressant drugs: role still to be established in children; more useful in adolescents
Although the symptoms of depression in children are similar to those seen in adults, they also usually have irritable mood, may fail to make expected weight gain, and tend to keep secret their depressive thoughts and crying. Depression can also occur in combination with another disorder such as anxiety, conduct disorder or ADHD, which require assessment and consideration in planning treatment. The prognosis is good when the depression is secondary to a life stress and responds to psychological treatment. A positive family history of mood disorder and a good response to antidepressant medication indicate an increased risk of further depressive or bipolar disorder in adult life. The National Health and Medical Research Council has released a comprehensive clinical practice guidelines booklet on Depression in young people, with accompanying booklets for general practitioners and their patients.

3. **Oppositional Defiant Disorder and Conduct disorder**

Oppositional Defiant Disorder is a psychiatric disorder, characterized by two sets of problems, aggressiveness and a tendency to purposefully bother and irritate others. This is the reason that people seek treatment. When ODD is present with ADHD, depression, Tourette's, anxiety disorders, or other neuropsychiatric disorders, it makes life with that child far more difficult.

The clinical definition is a pattern of negative, hostile, and defiant behavior lasting at least six months during which four or more of the following are often present:

1. blaming others for mistakes or misbehavior  
2. spiteful and vindictive  
3. losing his/her temper  
4. arguing with adults  
5. actively defying or refusing to comply with adult requests or rules  
6. "touchy" or easily annoyed by others  
7. angry and resentful  
8. deliberately annoying people

The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning. Serious and persistent patterns of disturbed conduct and antisocial behavior predominantly affect boys and comprise the largest group of childhood psychiatric disorders.
Conduct Disorder
In some ways, conduct disorder is just a worse version of ODD. However recent research suggests that there are differences. Children with ODD seem to have worse social skills than those with CD. Children with ODD seem to do better in school. (1). Conduct disorder is the most serious childhood psychiatric disorder. Approximately 6-10% of boys and 2-9% of girls has this disorder. Here is the definition.

Conduct disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major society rules are violated. At least three of the following criteria must be present in the last 12 months, and at least one criterion must have been present in the last 6 months.

Aggression to people and animals
- bullies, threatens, or intimidates others
- initiates physical fights
- has used a weapon that can cause serious physical harm to others (a bat, brick, broken bottle, knife, gun)
- physically cruel to animals
- physically cruel to people
- stolen while confronting a victim (mugging, purse snatching, extortion, armed robbery)

Destruction of property
- deliberately engaged in fire setting with the intention of causing serious damage
- deliberately destroyed other's property other than by fire setting

Deceitfulness or theft
- broken into someone else's house, building or car
- lies to obtain goods or favors or to avoid work
- stolen items of nontrivial value without confronting a victim (shoplifting, forgery)

Serious violations of rules
- stays out at night despite parental prohibitions, beginning before 13 years of age
- has run away from home overnight at least twice without returning home for a lengthy period
- skips school before age 13

Conduct disorder causes significant impairment in social, academic, and occupational functioning.

Conduct disturbance may begin early in childhood, manifesting as oppositional, aggressive and defiant behavior becoming established during the primary school years and amplifying after puberty. The presence of other psychological disorders is common in these children, with about 30% showing ADHD and learning problems. Clinical depression is also found in about 20% of young people with conduct disorder, and, although controversial, a prospective study suggests that this emotional disturbance is secondary to the conduct disorder. This group of childhood disorders requires vigorous early intervention, assessment and management because, although about a third make a reasonable adjustment, there is evidence
that at least half of the young people with serious conduct disorder will continue to experience mental health and psychosocial problems in adult life, such as personality disorder, criminality and alcoholism, and about 5% develop schizophrenia.

Are ODD and CD Related?
Current research shows that in many respects, CD is a more severe form of ODD. Severe ODD can lead to CD; milder ODD usually does not. The common thread that separates CD and ODD is safety. If a child has CD there are safety concerns. Sometimes it is the personal safety of others in the school, family, or community. Sometimes it is the safety of the possessions of other people in the school, family or community. Often the safety of the child with CD is a great concern.

Children with ODD are an annoyance, but not especially dangerous. If there is a child with CD disorder in the home, parents most likely do not feel entirely safe. Or, do not feel that their things are entirely safe. It is the hardest pediatric neuropsychiatric disorder to live with as a family. Nothing else even comes close. It is worse than any medical disorder in pediatrics. Some parents have indicated that at times it is worse than having your child die.

4. Attention deficit hyperactivity disorder (ADHD)

There is usually a history of difficult and uneven development from infancy. It is likely that the disorder has a neurobiological basis that is complicated by family interactions and the progressive consequences of associated learning problems. The clinical features are:

**Symptoms**

- Inattention
- Carelessness
- Does not listen
- Does not follow through
- Interrupts and cannot wait turn, talks excessively
- Avoids difficult tasks
- Fidgets, unable to sit still
- Forgetful, distractible, disorganised
- Impulsive
- Anxiety/depression (in about 20%)

**Associated factors**

- Difficult temperament
- Learning disabilities
- Pregnancy and perinatal complications with soft neurological signs (brain impairment) (e.g., clumsiness)
- Family conflict and parenting problems (may be a reaction)
Management

- Parenting-skills training and home help
- Educational program for learning disabilities
- Environment modification to reduce distraction
- Tasks in small steps to channel energy
- Behavioral management of antisocial behavior
- Family therapy for conflict
- Pharmacotherapy: stimulants (dextroamphetamine, methylphenidate), clonidine, imipramine, and thioridazine in consultation with a specialist

More recent evidence indicates that the young person does not necessarily grow out of the problem. Symptoms tend to persist, although adolescents usually become more goal-directed and less impulsive, channeling activity into sport or work if the opportunity is available. The outcome is less favorable for those who have an associated conduct disorder. In these cases, there is a significantly increased risk of continuing to have mental health, personality and social adjustment problems.

Principles of management

The key to effective management of childhood psychopathology is a comprehensive assessment and diagnosis upon which to base the treatment plan. This process can of itself provide families with an understanding of the problem and generate possible solutions. Even if the child receives an individually focused treatment, involving the parents helps to improve outcome and facilitates treatment compliance.

Psychological treatments are the most effective, with drugs having a limited role in childhood but an increasingly important role during adolescence as more adult psychiatric conditions occur. The first consideration is to ensure that the child is safe. In depressed young people, suicide risk is assessed by determining a past history of suicide attempts and risk-taking behavior, the experience of a sense of hopelessness, helplessness and having no future, and current suicidal ideas, plan and means. Referral to specialist services is required when the young person is suicidal.

Children and adolescents need to know that what they tell you in private is confidential, unless they are a risk to themselves or others, or if they are being abused. Most children, provided they were present when information was gathered from the parents, are relieved to consent to the clinician sharing their concerns with parents. The young person usually wants to be present when feedback is given to parents and this process is often therapeutic.
Psychological treatments:

- **Cognitive-behavioral therapy**

  Each treatment program is modified according to the symptoms, but involves:
  
  - relaxation training, with progressive muscle relaxation and breathing exercises which can then be used to cope with greater exposure to anxiety-provoking or stressful situations
  - modeling and reinforcement of confident behaviors to help reduce anxiety and improve self-esteem
  - formulating more positive thoughts (cognitions) and self-attributions to alter maladaptive beliefs and self-appraisal, and to relieve anxiety, depression and angry antisocial thoughts
  - the experience of rewarding structured tasks, and activities using operant conditioning to develop pro-social behavior and improve social skills, particularly in delinquent youths.

  The evidence for the effectiveness of cognitive-behavioral treatment approaches is now so substantial that these should be used as the first option.

- **Play and psychodynamic psychotherapy**

  These approaches rely on using play, discussion and the relationship with the therapist to help children develop insight into their problems and learn to understand and cope with their emotional distress. There is growing evidence that these approaches do work, but they are generally not as efficient and effective as cognitive-behavioral therapy. The more recent structured approach referred to as "interpersonal psychotherapy" is providing results that are more equivalent to cognitive-behavioral therapy when applied to the treatment of internalising conditions.

- **Family therapy**

  There are a variety of different approaches to working with families, but most are based on working with the family as a group, improving communication and problem-solving skills, developing more effective methods of discipline of behavioral control and the expression of emotion, and encouraging new patterns of interaction. Studies of family therapy have shown it to be useful in treating a range of child psychiatric problems including conduct disorder and delinquency, anxiety and depression and bereavement.

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**Pharmacotherapy**

Drugs have a limited role in managing psychopathology in children. Even in cases where they have a clear therapeutic benefit, they should be used as an adjunct to a more broadly based management plan which involves the parents and, when appropriate, the school.
Internalising disorders

The role of drug treatment for anxiety and depression in childhood has still to be firmly established by controlled trials. There is limited evidence that imipramine may reduce symptoms of anxiety in separation anxiety disorder and school refusal. Some case reports indicate a positive response to tricyclic antidepressants in the treatment of depression in children and adolescents, but systematic controlled studies have failed to demonstrate significant efficacy compared with placebo.

A recent placebo-controlled outpatient study of young people (aged 7-17 years) with non-psychotic major depression found significant improvement in depression rating scale scores and clinical assessment in a group treated with the selective serotonin reuptake inhibitor fluoxetine (20 mg morning dose for eight weeks). This finding requires replication. The judicious use of antidepressants as a secondary treatment is justified with regular review and monitoring for side effects and compliance.

There is no evidence that benzodiazepines have any role in the treatment of anxiety or depression in children, and they might even produce paradoxical responses. Due to potentially serious side effects, neuroleptic drugs such as thioridazine should only be used in consultation with a specialist.

Externalising disorders

Conduct disorder: There is virtually no indication for the use of drugs in the treatment of conduct disorder unless the child also suffers from ADHD or a depressive disorder.

Attention deficit hyperactivity disorder: There is a large body of evidence that, for school-aged children with ADHD, psychostimulants such as dextroamphetamine and methylphenidate reduce motor activity, enhance attention in cognitive performance and improve social behavior. The effective daily dose of methylphenidate is usually 0.3-0.5 mg per kg. Preschool children have a more unpredictable response and respond better to parent training and behavioral management programs. Although psychostimulants are generally safe, they can have a number of troublesome side effects, including anorexia and weight loss, sleep disturbance, abdominal pains and headaches, irritability and depressed mood. Growth can also be inhibited, but this is reversible on drug discontinuation. Drug dependence has not been demonstrated.

Clonidine is an alpha-adrenergic agonist used primarily in the treatment of hypertension. It has also been shown to be effective in the treatment of ADHD (25-50 mg one to three times a day; monitor blood pressure), although sedation may be a troublesome side effect. Imipramine (25-50 mg in a single evening or divided dose; history of heart disease is a contraindication; check pulse) has also been shown to be effective, but whether this is more specifically in a group of children with ADHD who also have concurrent anxiety has not yet been determined.

Consulting teachers and providing structured educational programs that address specific learning disabilities and facilitate and reward success are also an important adjunct to the treatment of childhood emotional and behavioral disorders.