433 Teams

PSYCHIATRY

Lecture (8)

Child Psychiatry

For the Diseases in gray , Dr.ALturki Said it is same is adult disorders and not that important for us to know .

Any way it is short so go through them for the exam cause Prof. Mohammed will write the MCQs.

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Child psychiatry:

is concerned with the assessment and treatment of children's emotional, behavioral and relationship problems. Children are not small adults, but immature and developing individuals. Childhood is a period of life characterized by change and the necessity for adaptation.

During childhood the child undergoes a remarkable transformation from a helpless dependent infant to an independent self-sufficient individual with his own views and outlook capable of living separately from his family. In order to judge whether any observed emotional, social or intellectual functioning is abnormal, it has to be compared with the corresponding normal range for the age group.

The practice of child psychiatry differs from that of adult psychiatry in several important aspects:

1. Children are generally **less able to express themselves in words**. Therefore, evidence of disturbance is based more on observations of behavior made by parents, teachers and others.
2. Greater attention must be paid to the stage of development of the patient and the duration of the disorder in order to decide what is normal and what is abnormal.
3. The treatment of children makes less use of medication or other methods of individual treatment. Instead the main emphasis is on changing the attitudes of parents, reassuring and retraining children, working with the family and coordinating the efforts of others who can help children, especially at school.

The family is a most powerful force for the promotion of health as well as for the production of disturbance in the child's life. Assessment of parenting qualities, the marital relationship and the quality of the family interaction are essential components of child psychiatric practice. It is a frequent observation that it is the parents who are disturbed and not the child.

Children development has many aspects: intellectual, emotional, social, and psychodynamic.

❖ Assessment:

Child assessment follows the usual steps in the adult assessment with the following important considerations:

- **Flexibility** is **essential**.
- Both parents should be asked to attend the assessment interview, and it is often helpful to have other siblings present.
- The interview room should be large enough to seat the family comfortably and also allow the children to use play material in a relaxed manner.
- Detailed personal history is required.
- Obtaining detailed family interaction is essential:
- Quality of parenting.
- Parent - child relationship.
- Pattern of family relationships.
- Separation from caretaker for more than a week.
- General health: eating, elimination, sleeping and physical complaints.
- School: attendance, achievement, and relationship with schoolmates and teachers.
- Attention span, concentration and activity.

Observation of the child should include:

- ✓ Degree of attachment to parents and ease of separation.
- ✓ Abnormal movements e.g. tics.
- ✓ Nutritional status.
- ✓ Evidence of neglect or physical abuse

❖ Childhood Psychiatric Disorders:

Neurodevelopment Disorders :

- Intellectual Disabilities
- Autism Spectrum Disorder
- Attention-Deficit/Hyperactivity Disorder
- Communication Disorders
- Specific Learning Disorder
- Motor Disorders

Other Neurodevelopmental Disorders

Feeding and Eating Disorders :

- Pica
- Rumination Disorder
- Avoidant/Restrictive Food Intake Disorder

Elimination Disorders :

- Enuresis
- Encopresis

❖ Intellectual Disabilities (Mental Retardation)

Diagnostic Criteria :

A. Significantly subaverage intellectual functioning: **an IQ of approximately 70 or below on an individually administered IQ test.**

B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) in **at least two of the following areas**: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.

C. The onset is **before age 18 years.**

Causes:

- Congenital defects.
- Intrauterine infections.
- Perinatal: anoxia, cerebral hemorrhage
- Postnatal: encephalitis, meningitis…
- Psychosocial causes; chronic lack of intellectual stimulation.

Comorbidity:

Psychiatric disorders are common in intellectually disabled individuals due to:possible common genetic etiology, organic brain disease, reaction to the stigma of subnormality, family reactions e.g. overprotection, punishment, and

 consequences of abnormalities associated with handicap e.g. lack of social skills. Diagnosis of psychiatric disorders is sometimes difficult because symptoms may be modified by low intelligence and poor verbal fluency.
 Depression is common but less likely to be expressed verbally.
 Adjustment disorders are frequently encountered in mildly retarded people.
 Hyperactivity occurs **commonly**.
 Schizophrenia may occur. The main features include further deterioration of mental functions with disturbed behavior and social adjustment. Delusions and hallucinations are less likely to be expressed clearly.

Types:

Mild	(IQ:**50–70**)	**about75**% of cases; **Educable**.
Moderate	(IQ:**35– 49**)	**about 15**% of cases; **Trainable**.
Severe	(IQ: **20-34**)	about 8% of cases.
Profound	(IQ: **below 20**)	about 2% of cases.

Degree of Mental Retardation	Preschool Age (0 to 5 yrs) Maturation and Development	School Age (6 to 20 yrs) Training and Education
Mild	Can develop social and communication skills; minimal retardation in sensorimotor areas; often not distinguished from normal until later age	Can learn academic skills up to approximately 6th grade level by late teens; can be guided toward social conformity
Moderate	Can talk or learn to communicate; poor social awareness; fair motor development; profits from training in self-help; can be managed with moderate supervision	Can profit from training in social and occupational skills; unlikely to progress beyond second-grade level in academic subjects; may learn to travel alone in familiar places
Severe	Poor motor development; speech minimal; generally unable to profit from training in self-help; little or no communication skills	Can talk or learn to communicate; can be trained in elemental health habits; profits from systematic habit training; unable to profit from vocational training
Profound	Gross retardation; minimal capacity for functioning in sensorimotor areas; needs nursing care; constant aid and supervision required	Some motor development present; may respond to minimal or limited training in self-help

Assessment:

Detailed history including: family history of inherited diseases. Prenatal, perinatal and neonatal history. Development and milestones.

- Physical examination.
- Behavioral assessment.
- IQ test.

Management:

- **Special education and training.**
- **Family support and education.**
- **Residential care for severe cases.**
- **Regular reassessmen and follow up.**

❖ Pervasive developmental disorders (PDD):

- ✓ PDDs: affect multiple areas of development (social, language, emotional, & behavioral).They emerge **before the age of 3 years** and cause persistent dysfunction.

- ✓ PDDs **includes five disorders**:

1.autistic disorder,
2.Asperger's disorder
3.Rett's disorder,
4.childhood disintegrative disorder,
5.pervasive developmental disorder not otherwise specified.

1-Autistic Disorder (AD)

AD is a severe pervasive disorder of emotions, speech and behavior starting in early childhood after a brief period of normal development (before 30 months of age). It occurs at a rate of 4 – 8 / 10,000 , affecting boys more than girls.

Features:

 Impaired reciprocal social interactions (even with parents). **Gaze avoidance is a characteristics feature.**

 Impaired emotional responses (emotions toward parents, strangers and inanimate objects are almost the same).

 Impaired language development (interpersonal verbal communication is markedly affected).

 Restricted behavioral repertoire.

Other features:
Resistant to change the routine and transition (e.g. having breakfast before a bath when the reverse was, may evoke temper tantrums).
Preoccupation with certain objects and rituals with resistance to change (e.g. the same dress, food,).
Labile mood and non-specific anger and fear.
Stereotypies, mannerisms, and grimacing.
Disturbed sleep.
Varying degrees of mental retardation are present in 75 % of cases. Epilepsy may develop in adolescence in 20 – 25 % of severe cases. Enuresis and encopresis may occur.

- **Causes:**

unknown organic brain insult is suggested.

- **Treatment:**

no specific medication, **special school**: programs to promote behavioral skills and to reduce undesirable behavior.

Family **education** and **support**.

- **Prognosis:**

varies depending on several factors such as **IQ**, language development, and early treatment. About 15 % can lead independent life. About 50 % can acquire some useful speech but continue to have disturbed behavior and cold emotions

2-Childhood Disintegrative Disorder(CDD)- Heller's syndrome-:

marked **regression** in several areas of functioning after at least 2 years of normal development. **Deterioration** over several months of intellectual, social, and language function occurring in 3- and 4-year-olds with previously normal functions. After the deterioration, the children closely resembled children with autistic disorder.

3- Asperger's Disorder

although it is a PDD, no significant delays in language, cognitive development, or self-help skills.

Features: impairment in social or emotional reciprocity interaction (eye contact, facial expression).

4- Rett's disorder

is a progressive PDD. Prevalence of 6 / 100,000 girls. It has its onset after some months of normal development.

Features :impaired speech, communicative and social skills. The head circumference growth decelerates and produces **microcephaly**. Poor muscle coordination and gait disturbances.

❖ Attention-Deficit Hyperactivity Disorder (ADHD)

The prevalence is about 4 %. M > F (4:1).

Features:

- **Diminished attention** and concentration.
- **Overactivity** in more than one situation; constant movement with inability to settle.
- Interfering and intruding on others.
- Impulsivity.
- **Recklessness**, prone to accidents.
- Disobedience and aggression.
- Learning difficulties.

Etiology:

The causes are unknown. Several factors have been suggested to play some role :

- ✓ Prenatal toxic exposures & prematurity.
- ✓ Perinatal trauma and early malnutrition.
- ✓ Non specific subtle CNS disease.
- ✓ Specific learning disabilities.

Treatment:

- **Medications***:* stimulant medications have been found to reduce hyperactivity and improve attention span in 75 % of cases, the exact mechanism of action is not yet known, however, stimulation of cortical inhibition is suggested.

  - ✓ **Dextroamphetamine**(Dexedrine);for children > 3years
  - ✓ **methylphenidate** (Ritalin,Concerta); for children > 6 years in the morning and afternoon,
  - ✓ doses are adjusted according to the response.
  - ✓ Possible side effects include restlessness, tremor, sleep disturbances, growth inhibition (growth chart is needed) and dependence.

- **Psychological treatment**: individual and family therapy, Special education.

Prognosis:

hyperactivity improves with age in most cases. Some cases may continue in adult life; mainly those with low intelligence and major learning problems.

- Oppositional Defiant Disorder (ODD):

Negativistic, hostile behavior; refusal to comply with adults, argument and annoyance of others, loss of temper, anger outburst,; spiteful / vindictive behavior. ODD may coexist with ADHD, conduct and many other disorders. It's occurrence increases in families with rigid parents, and intense moody children. Treatment: psychological (individual / family).Behavior modification.
Carbamazepine or lithium.

- Conduct Disorder (CD

Fatures: severe and prolonged antisocial behavior in older children and teenagers; aggressive or destructive behavior, rebellion against parents, lying, stealing, vandalism, fire setting, & truancy
Etiology:Adverse psychosocial situations play major roles e.g. broken family, unstable relationships, and poverty.
Treatment:Explore the environmental settings, social & family situations. Family and individual therapies.Haloperidol, lithium and carbamazepine have been found effective in controlling aggression and impulsivity.
Prognosis:Some teenagers continue to have antisocial behavior after the age of 18 years (antisocial personality disorder).

- Elimination Disorders

A. Functional Enuresis:
 Repeated involuntary voiding of urine after the age at which continence is usual (5 years) in the absence of any identified physical disorder.
 Nocturnal = bed wetting (at night).
 Diurnal = during waking hours.
 Primary enuresis:

If there has been no preceding period of urinary continence for at least 12 months.
 Secondary enuresis:

If there has been period of urinary continence for 12 months.
 It is likely to coexist with other psychological distress (e.g. sibling birth, parental discord…).
 No specific etiology:? delay in maturation of some brain centers.
 Psychological sequel of enuresis: conflicts with parents, low self-esteem, social ostracism

Treatment:
 Search for and treat any possible physical disease e.g. repeated urinary tract infections (UTIs), diabetes, epilepsy…..
 Treat any associated emotional problem.
 Advice to parents (to avoid criticism…).
 Fluid restrictions before bedtime.
 Going to toilet before sleep.
 Behavior therapy:
 Record dry nights on a calendar and reward dry nights with a star and 7 consecutive dry nights with a gift (star chart technique).
 A bell and pad apparatus is helpful.
 Bladder training.
 Medications:
 Imipramine (a tricyclic antidepressant) 10 – 50 mg at night can reduce bed wetting significantly, but relapse rate after discontinuing treatment is high.
 Desmopressin (an analogue of vasopressin) can be helpful but there is a risk of fluid overload.

B.Functional Encopresis:
 Repeated passing of feces into inappropriate places after the age at which bowel control is usual (4 years).
 Physical causes should be ruled out:

e.g. chronic constipation with overflow incontinence.
 Stressful events at home may precipitate the condition.
 Assessment should include parental attitudes, emotional factors in the child, and the child's concern about the problem.
 Behavior therapy (rewarding success and ignoring failure) often is helpful.
 Parental guidance and family therapy is required.

- Separation Anxiety Disorder

Excessive anxiety concerning separation from home or from major attachment figure for at least 4 weeks.
Features:
 Excessive distress when separation is anticipated.
 Excessive worry about possible harm befalling or losing attachment figures.
 Reluctance to go to school because of fear of separation.
 Excessive fear when left alone
 Reluctance to sleep away from attachment figure.

The disorder may be initiated by a frightening experience or insecurity in the family, and is often maintained by overprotective attitude of the parents.
Treatment: Psychological (individual / family) therapy.
Behavior therapy. Tricyclic antidepressants (e.g. imipramine 25mg/day).

❖ Phobias in Children

Phobias are common, and usually normal in children. Common feared objects and situations include: animals, strangers, darkness, loud noisy voices. Most childhood phobias improve without specific treatment measures. However, parents should adopt a reasonable reassuring approach. Behavior treatment is required if phobia persists.

School Phobia:

 Irrational fear of going to school associated with unexplained physical complaints such as headache, diarrhea, abdominal pain or feeling sick. Boys and girls are equally affected.
 Complaints occur on school days not in weekends.
 It occurs most commonly at the commencement of schooling, change of school or beginning of intermediate or secondary school.
 Academic achievement is good or superior.
 Possible precipitating factors:
 Separation anxiety (mainly in younger children) child wants to stay with a major attachment figure. Mothers are frequently overprotective.
 Minor physical illness.
 Upsetting event either at home (e.g. parental discord), or at school (e.g. criticism).
 General psychiatric problems e.g. low self - esteem and depression (in older children).

Treatment:

 Identify and treat possible causes.
 Early graded return to school (most helpful).
 Both parents should participate.
 School and teachers should be involved.
 Drugs have some role in reducing anxiety / or depressive features.

School Refusal: a pattern of behavior that can have many psychosocial causes and may not be a disorder (e.g. a form of rebellion).

❖ Depression in Children

Depressive disorder in children is not uncommon. Child may not express his low mood verbally. Therefore, thorough assessment is required. Depression may be distinguished from normal lowered mood by associated features:

 Significant loss of pleasure (anhedonia) in all areas of interest.
 Withdrawal from social activities.
 Deterioration in school performance (poor concentration and motivation).
 Irritability

Childhood depression is usually self-limiting, but may become chronic or recurrent. Masked depression may present as a behavior disorder. Depression in children may present mainly with somatic symptoms (depressive equivalents). Treatment may include a variety of measures discussed earlier in chapter 9. Antidepressants may be started with low doses. Psychosocial treatment approaches are important.

Done By:

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