

Common child and adolescent psychiatric problems and their management in the community

by Bruce Tonge

Solving the psychological problems of children is often a matter of family medicine

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.
 - Behavioural 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.
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Worldwide, the prevalence of clinically significant psychiatric disorder in children is at least 7%.¹ 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 behaviour (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 behaviour. 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 behavioural problems.²

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 a child psychiatric 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)³
- Physical examination: including assessment of handedness, motor coordination or clumsiness

Structured questionnaire rating scales

- Parent and teacher checklists (e.g., Child Behaviour Checklist⁴ for children of normal intelligence and the Developmental Behaviour Checklist⁵ 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

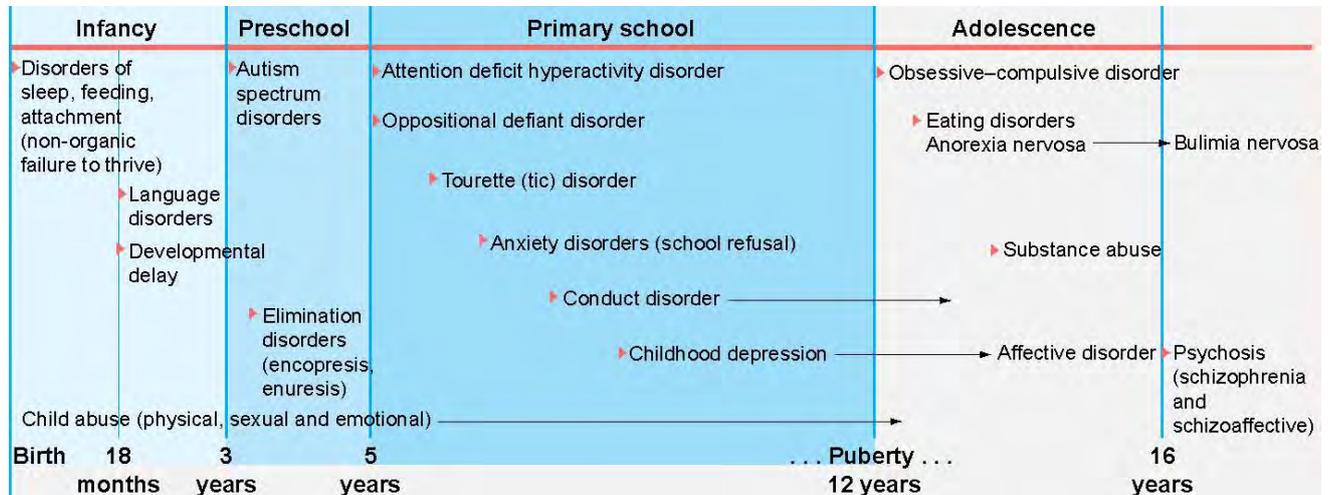
The use and interpretation of play and drawing in the psychological treatment of children requires special training, but in general clinical practice children should be encouraged to play and draw to assist them to communicate. This may confirm information already gained or generate possibilities that 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.³ This process is facilitated when the child experiences the clinician as non-judgemental 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 behaviour checklist⁴ or the Developmental behaviour checklist,⁵ 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 behavioural 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 behaviour checklist can be scored in reference to the manual,⁴ 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 behavioural (externalising) problems and more detailed problem domains, such as anxiety and aggression.

Childhood psychopathology

Several psychopathological conditions mainly occur, or have their onset, during childhood. These are specifically recognised in the major classification systems of the DSM-IV6 and ICD-10.7 The peak ages of onset for various childhood psychiatric disorders are shown in this diagram:



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

Anxiety disorders

The most common manifestation of anxiety in children is fear to be separated from parents and home and refusal to attend school.⁹ The common symptoms of anxiety are:

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-behavioural 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

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.⁹

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 18.¹¹ It seriously affects social, emotional and educational development, and is the most important predictor of suicidal behaviour in young people aged 15-24 years.¹¹

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.^{3,12}

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-behavioural 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

Depression can also occur in combination with another disorder such as anxiety, conduct disorder or ADHD, which require assessment and consideration in planning treatment.^{10,12} 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.¹¹

Conduct disorder

Serious and persistent patterns of disturbed conduct and antisocial behaviour predominantly affect boys and comprise the largest group of childhood psychiatric disorders.¹³ Conduct disturbance may begin early in childhood, manifesting as oppositional, aggressive and defiant behaviour 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.¹³ 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.¹³ The clinical features are:

Symptoms

- Persistent disruptive and antisocial behaviour
- Hostile, defiant, spiteful, vindictive behaviour
- Aggression towards people and animals
- Vandalism, fire lighting
- Truancy, lying, stealing
- Acting alone (about 20%)
- Acting with group (about 80%)
- Hyperactive (about 30%) and with learning problems (about 50%)
- Depression, low self-esteem (about 20%)
- Running away from home

Family factors

- Social disadvantage
- Large family size
- Inconsistent, hostile parenting (father's role)
- Parental conflict
- Foster home/institutional care
- Parental mental illness and criminality
- Child abuse and family violence
- Antisocial peer groups

Management

- Early intervention: parenting-skills training
- Creating opportunities for success in sport and recreation
- Success achievement in educational programs
- Behaviour treatment (social skills)
- Family therapy for conflict and criticism

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.¹³

Attention deficit hyperactivity disorder (ADHD)

Controversy exists regarding the prevalence of this condition, which is now being more frequently diagnosed in Australia. Using international diagnostic criteria, the prevalence is probably about 1%, being three times more common in boys than girls.¹⁴ 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.¹⁴ 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
- Behavioural management of antisocial behaviour

- 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, channelling activity into sport or work if the opportunity is available. The outcome is less favourable 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.¹⁴

Somatiform disorders

Of particular importance for general practitioners are those disorders in which there is an interaction between physical illness and psychological factors. In some children with a chronic illness (e.g., asthma, diabetes or ulcerative colitis), emotional distress, anxiety or anger can combine with family interactions (e.g., overprotection, enmeshment and unresolved conflict) to lead to poor compliance with treatment and deterioration in the illness (*see Case history 4, below*).^{15,16}

Clear and open education of parents and children about the illness and its treatment and working with the parents to communicate more effectively and resolve conflicts helps to reduce over-protectiveness and secondary emotional problems. If these measures fail, referral for more intensive family and individual psychological treatment is indicated to prevent worsening illness.

General practitioners have an important role in the prevention and early intervention of eating disorders. At any time, anorexia nervosa now affects up to 1% of otherwise healthy young 15-18-year-old young women. Girls who are having difficulty with peer group and family relationships (including sexual abuse) are vulnerable to the disorder, which is initiated through peer group and media pressure regarding the desirability of a thin pre-pubertal body and pressure to diet and exercise. Girls with anorexia nervosa develop an intense preoccupation with dieting, a fear and perceptual disturbance regarding fatness, and bodily changes caused by starvation.¹⁷ Their expression of emerging independence and self-control becomes focused on food intake.¹⁷

Early intervention is vital to prevent a chronic psychiatric disorder, which is associated with ill-health and a mortality from inanition and suicide of about 5%. Both parents and the child need education on healthy eating and normal adolescent development. Other mental health problems, such as the treatment of depression in the mother, need attention. These measures, together with frequent review, can be effective in preventing the development of anorexia nervosa. Once established, anorexia nervosa requires specialist referral for individual psychological and family therapy, hospitalisation for re-feeding, and pharmacotherapy.

The potential adverse consequences of obesity (body weight exceeding ideal weight for height by 20%) justify early intervention. Obesity is based on constitutional and early feeding practices, but is usually aggravated by a sedentary lifestyle, watching television, low self-esteem and self-comforting eating. Early intervention leading to reduced calorie intake and increased activity levels requires peer and family support and is necessary by puberty, because about 80% of obese adolescents will become obese adults.

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.^{9,13}

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 behaviour, the experience of a sense of hopelessness, helplessness and having no future, and current suicidal ideas, plan and means.¹¹ 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-behavioural 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
- modelling and reinforcement of confident behaviours 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 behaviour and improve social skills, particularly in delinquent youths.¹²

The evidence for the effectiveness of cognitive-behavioural treatment approaches is now so substantial that these should be used as the first option.⁹

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-behavioural therapy.¹⁸ The more recent structured approach referred to as “interpersonal psychotherapy” is providing results that are more equivalent to cognitive-behavioural therapy when applied to the treatment of internalising conditions.¹⁹

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 behavioural control and the expression of emotion, and encouraging new patterns of interaction.²⁰ Studies of family therapy often have methodological problems, but, overall, it has been shown to be useful in treating a range of child psychiatric problems including conduct disorder and delinquency, anxiety and depression and bereavement.¹⁹

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.²¹ 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.²²

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 (20mg morning dose for eight weeks).²³ 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.²⁴ 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.¹³

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 behaviour.^{14,25} The effective daily dose of methylphenidate is usually 0.3-0.5mg per kg. Preschool children have a more unpredictable response and respond better to parent training and behavioural 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 α -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.^{14,24} 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.²⁴

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 behavioural disorders.

The role of the general practitioner

Most childhood psychiatric disorders can be effectively managed in a general practice and community setting. Brief cognitive-behavioural therapy, family therapy and parenting-skills training can be provided in 15-20-minute consultations if the general practitioner has received introductory skills training in these techniques. The necessary regular monitoring of drug therapy for compliance, side effects and therapeutic response is also appropriate for the general practitioner.

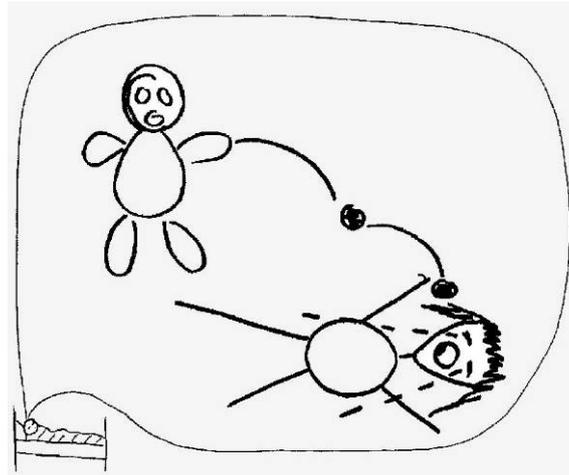
When to refer

Referral to a specialist paediatrician with an interest in behavioural paediatrics or a child psychiatrist should occur if the prescription of psychoactive drugs is contemplated, when simple behavioural and family support interventions fail, when symptoms persist, when there is suicidal risk, or when there is evidence of psychosis. A clinical child psychologist can also provide cognitive and psychopathology assessment and psychological treatments. If child abuse is suspected, reporting to the relevant community services agency is necessary (if not mandatory according to local laws).

Early and timely intervention produces the best chance of a favourable outcome and improves the prognosis for all childhood emotional and behavioural problems.

Case history 1: Separation anxiety presenting as school refusal⁸

A 9-year-old girl, "Anne", presented with a 16-month history of increasing fearfulness, refusal to go to school, stomach pains before school and social withdrawal. She would not let her mother out of her sight, which complicated the care of her 2-year-old sister. The father was increasingly angry with Anne and to avoid the situation withdrew to his workshop when home. There were no problems with the 7-year-old brother.



Anne rated herself at the maximum of 100 on the drawing of a "fear thermometer"¹⁰ which indicated how afraid she was to leave home and go to school. Anne also drew a picture of a bad dream³ in which an "angry baby monster" made the crying mother "take poison pills and die". Family assessment revealed that the mother was suffering a persistent depressive illness that had commenced in the postnatal period following the birth of her youngest daughter and that she had taken an unreported overdose of sleeping tablets about 20 months ago "to escape for a while into sleep". The father felt confused and powerless and had withdrawn into his work and hobbies. Therefore, Anne was anxious about her mother's mental health and was staying home to keep her safe.

Treating Anne's condition involved addressing the problems of the whole family. Her mother received antidepressant drug therapy (selective serotonin reuptake inhibitor) and some home help. Both parents were given guidance on consistent child management and education about postnatal depression. The father was involved in parental duties, taking responsibility for getting Anne to school. Anne was taught relaxation techniques to apply when anxious (including the use of an audio tape). Her school teacher was enlisted to help provide successful school experiences and support for school return.

In the improved home environment that followed these interventions and with new skills to manage anxiety, Anne recovered from her fears and returned happily to school.

Case history 2: Planning positive events and cognitive restructuring in the treatment of childhood depression

“Ben” was a 10-year-old boy with a six-month history of increasingly unstable and depressed mood and loss of interest in play and school. His father had died in a work accident when Ben was three years old. His mother had recently remarried and the stepfather was having problems coping with Ben’s provocative and irritable behaviour. Successful treatment involved parental guidance on consistent child care, organisation by the stepfather of planned positive events with Ben such as a ride in his truck to pick up building supplies, playing football and playing a favourite board game, several individual sessions to talk about Ben’s memories of his father and his death and his reaction to his new stepfather (interpersonal therapy) and two sessions of cognitive therapy during which Ben gave spontaneous depressive statements in response to questions about his life, such as “What do you think about school?”. He was then asked to construct Spontaneous depressive statements alternative positive statements, which he read aloud and alternative positive statements to his mother and stepfather twice a day.

I done like schol because I never get anything riht right	Mr E can help me I can read to the preps
I done want to wake up and be alife	When I awake I can play football and have a sluppee and visit gran

Spontaneous depressive statements and alternative positive statements elicited in therapy

Case history 3: Family violence presenting as conduct disorder in a boy with ADHD

An 8-year-old boy was suspended from school for attacking his teacher with scissors after being reprimanded for hitting some classmates. He had a history of disobedience and running away from home, aggression to other children and stealing sweets and toys from shops. He was also impulsive, overactive and had poor concentration; these symptoms were treated with dexamphetamine by a paediatrician, with a resulting improvement in his concentration and activity level.

During assessment a recurring theme was evident in his free play: a toy cow and her calf were attacked and “eaten up” by a “wild lion”, a “wild racing car” crashed into a toy car and “killed the mother and children”, and the doll’s house mother was “thrown around the room down the stairs and out the window” by a “wild robber”.

This gave the clue, apprehensively confirmed by the mother, that she and her son were the victims of domestic violence from her de facto partner. She had earlier separated from the boy's father because of his violence and drunkenness.

After informing her of how to contact the local family refuge, the mother elected to work on this problem with her partner in conjoint therapy. A behavioural program for her son was also initiated at home and school using rewards (e.g., football cards) for an absence of aggressive behaviour and a voluntary "time out" area if the boy felt he needed to calm down.

The boy rapidly lost his antisocial behaviour when the parental relationship improved, although he continued to require stimulant medication.

Case history 4: Asthma and an overprotective family

A family had a 10-year-old daughter with severe chronic asthma. She spent about four to seven days each month in hospital, where her condition would settle rapidly and respond to treatment, but once home her symptoms would return and be unresponsive to nebuliser and corticosteroid treatment.

The parents, the patient and her two younger brothers came for an assessment. The father closed the office window in case their daughter might "be in a draught" (overprotection). All questions directed at any of the children about school or interests were answered by the parents, usually the mother (enmeshment). The father repeatedly involved himself in correcting and adding to the free drawings his sons were quietly engaged in. On several occasions minor disagreements occurred between the parents – for example, when and where they might go on holiday. Attempts by the therapist to get the parents to elaborate and solve these disagreements led to the "patient" asking for her puffer, with a move in focus on to her and the suggestion that she might need to go back to the ward (detouring of conflict).

Throughout the meeting the girl sat attentively on the edge of a swivel chair that she had raised to maximum height between her parents.

Subsequent family, then parent, therapy revealed a longstanding marital conflict between the parents regarding their sexual relationship and desire for children, with both parents having anxiety and low self-esteem. At follow-up two years later the girl's asthma had stabilised on regular prophylactic inhaled medication and she had had only one hospital admission (for an episode of bronchitis).

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