Symposium:
How to manage children and adolescents with mental health problems (2)

Sue Hawkridge: Behavioural problems
Bernice Castle: Struggling academically
Lee Theron: Substance abuse

Management of behavioural problems

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Meaning what, exactly?

- Infants: Excessive crying, irregular sleep patterns, fussy feeding, hard to soothe, "colicky"
- Toddlers & preschoolers: Oppositionality, tantrums, power struggles, separation issues
- Prepubertal: Dissatisfied, disobedient, always in conflict, unpopular, dishonest, "cheeky"
- Adolescence: Rebellious, sex & substances, neglecting school work, moody, aggressive, risk-taking behaviour

- BEHAVIOUR MEANS SOMETHING…

Causes?

- Normal developmental stage
- Temperament/temperamental mismatch
- Reaction to external stressors
- General medical condition
- Inappropriate parenting
- Parental psychopathology
- Psychiatric disorder in the child

Developmental stage

- Infancy: Adaptation to child's routine by parent, reduction of anxiety in parent(s)
- Toddler: Basic job description – autonomy
- Preschooler: Separation issues, sibling rivalry
- Prepubertal: Negotiating success/failure/status
- Adolescence: Peer group primacy, separation from parents, individuality, romantic relationships, future plans

Sibling rivalry

- Aggression towards sibling(s)
- Feelings of displacement
- Perceptions of favouritism
- Need of any child to feel "special" & "best-beloved"
- Formulation and acceptance of underlying feelings, reassurance, establishment of "fair" rules, alternative methods of communication

Temperament

- Biological regularity – sleeping/eating/etc.
- Activity level
- Approach/withdrawal
- Adaptability
- Threshold and intensity of response
- Mood quality
- Distractibility, attention span and perseverance

External stressors

- Unmet basic needs: food, shelter, contact
- Under-/over-stimulated/uncontained
- Loss of attachment figures/parental conflict
- Chaotic household/inconsistent discipline
- Abuse (physical, sexual or emotional)
- Inappropriate/inadequate educational system
- Community instability/violence

General medical conditions

- Intrinsic to disorder/treatment/reaction
- Chronic hunger/illness with fatigue & irritability
- Anxiety-provoking illnesses: cardiac, respiratory
- "Disfiguring" conditions: fear & anger
- Endocrine disorders
- CNS disorders: e.g., ***delirium***, seizure disorders
- Substance/medication-induced

Parental pathology

- Ignorance/cognitive impairment: inappropriate expectations
- Personality pathology: especially cluster B
- Substance abuse
- Mood disorders
- Anxiety disorders
- Psychosis

Psychiatric disorders in the child

- Reactive attachment disorder
- Developmental disorders: global, specific and pervasive
- Disruptive behaviour disorders
- Anxiety/mood disorders
- Eating disorders
- Psychotic disorders

Reactive attachment disorder

- Pathological care causing inability to attach
- Inhibited type: “ignore” others, failure to mix with peer group, unable to establish trusting relationships
- Disinhibited type: indiscriminate attachment, inappropriate degree of intimacy, clinging to adult figures
- “Insecure attachment”: ambivalent behaviour

Mental retardation

- Delayed development
- Passage through normal stages at later age
- Takes longer to learn appropriate behaviour
- Intense emotions may be expressed physically
- Self-stimulating/soothing behaviour
- Difficult to manage because child is larger
- Parents may be unable to accept diagnosis

Specific developmental disorders

- May affect child's ability to understand adults
- Affect child's ability to comply
- School system may increase stress
- Targeting by peers/teachers/parents
- Poor self esteem leading to depression/anxiety
- Poor verbal skills lead to acting out of distress

Pervasive developmental disorders

- Autistic disorder : unable to attach in any mutual way, resistant to change, outbursts
- Autistic spectrum disorders:
  - Fluctuating, intense anxiety
  - Aggressive outbursts
  - Irrational, unpredictable behaviour
- Undiagnosed Asperger's disorder in older children: lack of social skills

Attention deficit / hyperactivity disorder

- Impaired attention and concentration
- Excessive motor activity level
- Difficulties at home and school
- Disciplinary conflicts
- Negative spiral
- Self esteem damage in child and parents
- Appropriate treatment may improve all facets

Oppositional defiant disorder

- Argumentative, resentful and unhappy
- Often provoke conflict
- Unpopular and feel unloved
- Disobedient "on principle"
- Frequently dysthymic/depressed
- Family approach usually helpful; may need individual treatment for comorbid disorders

Isolated antisocial symptoms

- Stealing: "comfort" stealing, "buying" friends, feelings of deprivation
- Truanting: learning disorders, anxiety disorders, school-related stressors, etc.
- Arson: curiosity, mental retardation, conduct disorder
- Vandalism: peer group pressure, anger, envy

Conduct disorder

- Violation of major societal norms
- Vulnerable to depressive disorders and substance abuse
- Often comorbid learning disorders
- Usually severe family pathology present
- Early psychosocial intervention is crucial
- Management of comorbidity

Personality pathology

- Not diagnosed as disorder under 18 years or in presence of major psychiatric illness
- Borderline traits: recurrent self-destructive behaviour, promiscuity, substance abuse, mood swings
- Antisocial personality traits: 1/3 of children with conduct disorder

Anxiety disorders

- Separation anxiety disorder, OCD, panic disorder, GAD, PTSD, social or specific phobia
- Symptoms may cause family conflict
- Younger children may express anxiety through disruptive behaviour/tantrums/clinging
- Vulnerable to later substance abuse
- Effective treatment & psychoeducation

Depressive disorders

- Irritable mood; oppositional, self destructive and clinging behaviour
- Poor performance at school
- Social isolation
- In adolescents may resemble conduct disorder or borderline personality pathology
- Effective treatment, including family intervention

“Paediatric Bipolar disorder”

- Very difficult diagnosis to make in prepubertal children
- Use of second generation antipsychotics and mood stabilisers widespread in USA – limited efficacy and significant adverse effect profiles
- Danger of overlooking other pathology or family issues
- Bipolar disorder does occur in a small number of children and a larger number of adolescents and requires psychiatric assessment and management

Eating disorders

- Major battle ground in the toddler wars
- Recurrence in pre-puberty/adolescence
- Anorexia nervosa/bulimia
- May be related to drive for autonomy
- Peer group and cultural influence – need for acceptance
- Usually require specialist intervention

Psychotic disorders

- Symptoms usually of recent onset
- Aberrant behaviour causes family friction
- Unexplained poor academic performance
- Social withdrawal in schizophrenia
- Manic episodes may embarrass family or cause legal complications
- Effective treatment and family psychoeducation

General principles

- Thorough medical and developmental history
- Ascertain onset, extent and course of symptoms
- Identify medical or psychiatric conditions and manage/refer appropriately
- Identify parental psychopathology and manage/refer appropriately
- Identify family process problems and refer

Medication in behavioural disorders

- Not as first line treatment except for methylphenidate in children with clear AD/HD
- Specialists may use antipsychotic medications and/or mood stabilisers as a last resort in behavioural disorders
- Prescription of an antipsychotic medication as a first line treatment for a disruptive child is not good practice
- Significant adverse effects require strong clinical grounds for use, an acceptable evidence base in that specific disorder in that specific age group, and a favourable risk:benefit ratio
- After accurate assessment and diagnosis, first line of treatment is referral to good parenting skills resource unless medication is strongly indicated

Stimulant treatment of AD/HD

- Methylphenidate regarded as a first line treatment (MTA study) but…
- MUST be part of multimodal management if at all possible
- Assistance of clinical psychologist, education professionals, occupational therapist, parenting skills counsellors, other mental health professionals for parents if needed
- Cardiovascular concerns: increased risk of sudden death in younger patients as well as older
- Substance abuse: risk mediated by conduct disorder
- Growth retardation: remains a concern – monitoring
- Long acting formulations usually preferred

Non-stimulant treatment of AD/HD

- Atomoxetine
- Other adrenergic agonists: clonidine etc
- Efficacy in AD/HD symptom reduction, longer onset time, also has cardiovascular side effects
- Alternative/"natural" medications – evidence base is still scanty

Use of antipsychotic medications in behavioural disorders

- Not the first line treatment in any accepted protocol
- Most evidence is in children with developmental disorders
- Some evidence for reduction of impulsive aggression, not premeditated aggressive behaviour
- Serious concerns around rapid-onset metabolic side effects:
  - lipograms, glucose metabolism, weight increase
- Hyperprolactinaemia/neuroleptic malignant syndrome
- Cognitive effects
- If regarded as necessary, should be used in consultation with child psychiatrist if possible