



**433 Teams**

# PSYCHIATRY

## Child Psychiatry

Manual of Basic Psychiatry

Doctor's notes

Important

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## What is child psychiatry?

- A branch of Psychiatry.
- The central focuses of the subject are behavioral and emotional disorders of childhood, but many would include physical symptoms such as non-organic headache and stomach pain in which stress or other environmental factors appear to play an important causative role. Delays and deviations in development, as well as general and specific learning problems lie within the practice of child psychiatry. Childhood period extends averagely up to age of 18 years
- **REMEMBER! Children are not miniature adults, they're immature developing individuals**
- Children development has many aspects: intellectual, emotional, social, and psychodynamic.

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

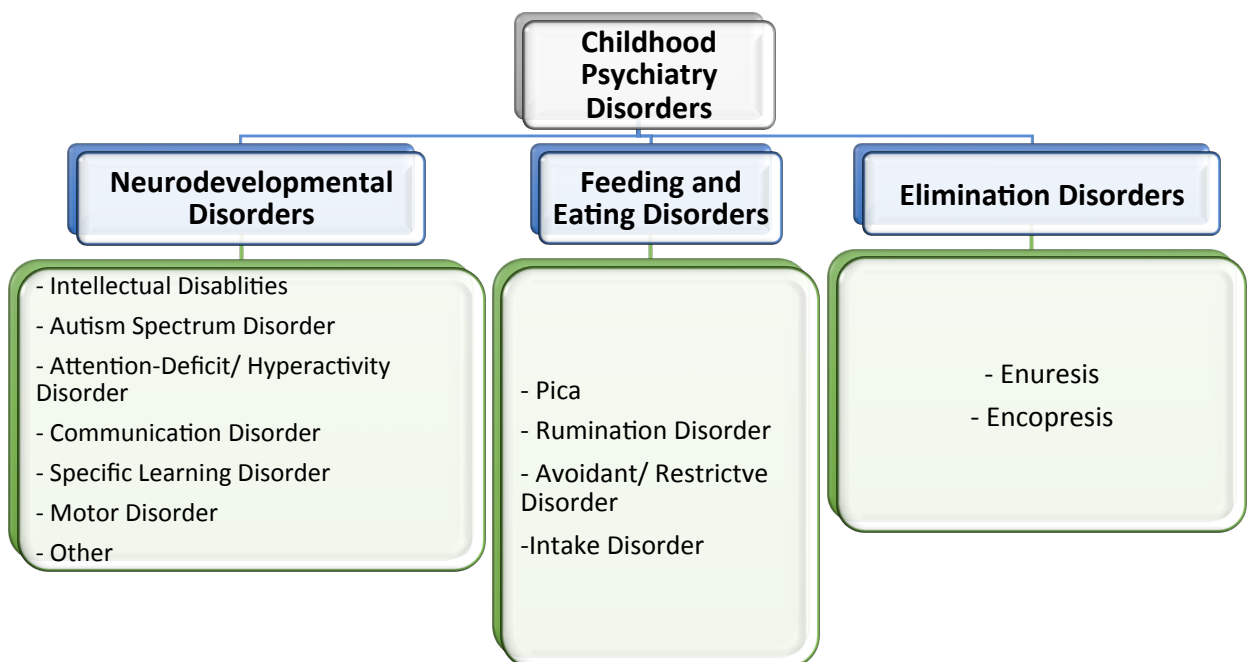
- Initiation of the consultation with the clinician.
- The stage of the development of the patient is very important.
- Psychological problems in a child may be a manifestation of disturbance in other members of the family. **You must understand the family.**
- Evidence of disturbance is based more on observation of behavior made by parents, teachers and others. **The mental status examination starts from the moment the child and the family step in the clinic even without doing any tests, by knowing who came with the child, who is the dominating figure and who controls the situation, the kid is more close to which member of the family and so on. And make sure you don't start something you can't finish. The family is a most powerful force for the promotion of health as well as to produce 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.**
- Treatment of children makes less use of medication and other methods of individual therapies. **Primarily you work with the family, behavioral intervention and counseling, with teenagers we mainly go with behavioral psychotherapy, cognitive behavioral therapy (CBT)**

## Etiology:

- The determinants of childhood disturbance are usually multiple.
- Developmental aspects are important (their disorders reflect psychological & social maturation).
- Four interacting group of factors are important: genetic factors, temperament & individual differences, physical problem especially brain damage, chronic physical diseases and environmental, family, social and cultural causes like chronic adversities and physical, & emotional maltreatment.

## Child Psychiatry Evaluation:

- 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.
- **Identifying data:**
  - Identify patient and family members
  - Source of referral
  - Informants
  - Reliability
- **History:**
  - Chief complaint
  - History of present illness
  - Developmental history and milestones
  - Psychiatric history
  - Medical history, including immunizations
  - Family social history and parents' marital status
  - Educational history and current school functioning
  - Peer relationship history
  - Current family functioning
  - Family psychiatric and medical histories
  - Current physical examination
- **Mental status examination**
- **Neuropsychiatric examination** (when applicable)
- **Developmental, psychological, and educational testing**
- **Formulation and summary**
- **DSM-5 diagnosis.**



## Intellectual Disabilities (Mental retardation):

### Diagnostic criteria:

- A. Significantly sub-average 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 sub normality
  - Family reactions e.g. overprotection, punishment
  - Consequences of abnormalities associated with handicap.
- 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) about **75% 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.

### 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.
- Regular reassessment and follow up.

## Pervasive developmental disorders (PDD):

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. Autism Spectrum Disorder:

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.



#### ASD is characterized by:

- Deficits in social communication and social interaction **it's the most important feature, if it's not present it's not autism, if all the criteria apply but emotionally fine we don't call it autism.** (لب التوحد)
- Restricted repetitive behaviors, interests, and activities, restrain to change to the routine and transition. **Autistic children don't put themselves in the role of similar people, emotionally they don't know how to play the role.**
- Impaired language developmental. Verbal and nonverbal communication is markedly affected. **Their problem is in the language itself, they either remain silent or produce weird sounds, or they talk without using pronouns.** يعني يصير يشير لنفسه بضمائر الغائب او الأسماء. Or they use telegraphic way of communication.
- **The better the language the better the prognosis of the disorder, and the high IQ indicates a gifted kid.**

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

The cause is unknown, but brain insult is suggested.

**Tx:**

- No specific medications, special schools: 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 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).
- Hyperactivity and inability to settle, impulsivity and diminished attention. If you have these three things over 6 months' course before the age of 12, you have ADHD.
- Inattention is interfering and intruding with others and academic achievements. Hyperactivity and impulsivity is affecting the kid's safety.

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

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

**Tx:**

**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, and however, stimulation of cortical inhibition is suggested.

- Dextroamphetamine(Dexedrine); for children > 3years
- Methylphenidate (Ritalin (short acting), Concerta (long acting)); for children > 6 years in the morning and afternoon. It's the best medication to treat ADHD because it improves attention and reduce hyperactivity. Methylphenidate does not cause addiction, studies had proven that using Methylphenidate at early ages it prevents abusing later on.

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.

## Anxiety Disorders in Children:

- Children are anxious by nature, part of their normal development they believe that all the surroundings are alive. (e.g. when they fall from the chair and you hit the chair as a revenge they think it has feelings)
- **Types:**
  - Normal anxiety in childhood.
  - Separation anxiety disorder → mainly it's because of an over protective mother, or the house situation isn't stable
  - Generalized anxiety disorders → Similar to the adult type but with childish features.
  - Phobic disorders. → usually they develop specific phobias because of the others' reaction to a certain situation.
  - Selective Mutism → similar to Social phobia but they attend the situation quietly.
  - Social Anxiety Disorder (Social Phobia)
  - Panic Disorder
  - Agoraphobia

## • Depression in Children:

- Symptoms are similar to the adult type, but usually when the child is complaining of low mood he is copying someone else's words.
- Depression in children is very rare; if you suspect depression in a child always look for adjustment disorder because they reflect the family's situation.
- **Bipolar affective disorder** is rare before the age of 12, if you suspect it look for organic cause.

## • Trauma- and Stressor-Related Disorders:

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Adjustment Disorders.
- Causes:
  - Abuse
  - Divorce
  - Death of a parent
  - Birth of a sibling
  - Acquired physical disease or injury
  - School issues
  - Temperament

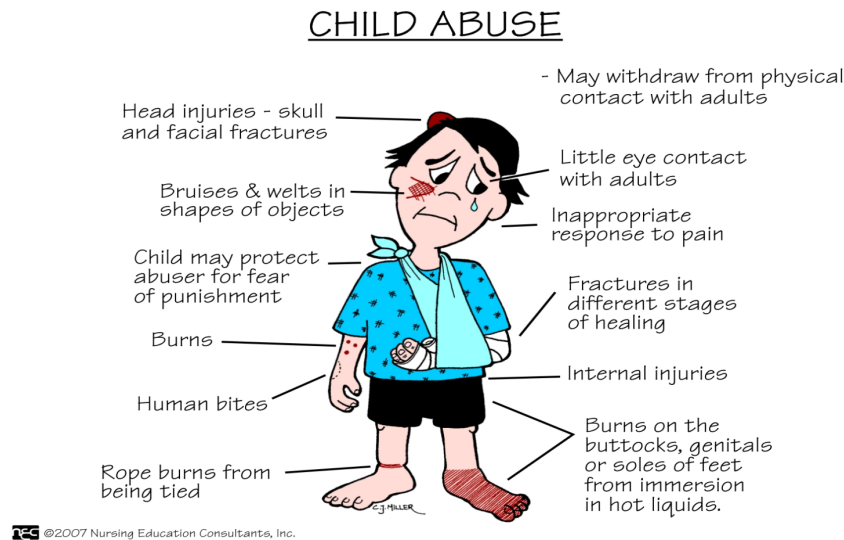
## • School Refusal:

- It is not a psychiatric disorder.
- A pattern of behavior that can have many causes.
- Repeated absence from school.
  - Physical illness
  - Deliberately kept at home by parents to help with domestic work or for company
  - School refusal:
    - separation anxiety disorder
    - school phobia
    - failure to do well in the class
    - depression
    - truancy



## • Child Abuse:

- Including physical and emotional maltreatment, sexual abuse and neglect.



## • 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 only.
  - 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), mothers are usually overprotective.
  - Minor physical illness.
  - Upsetting event either at home or school.
  - General psychiatric problem.
- Tx:
  - Identify the cause and treat it.
  - Both parents, school and teachers should be involved.



- **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 witting (at night).
- Diurnal = during waking hours.
- **Primary:** if there has been no preceding period of urinary continence for at least 12 months.
- **Secondary:** if there has been period of urinary continence for 12 months.
- It is likely to coexist with other physiological distress
- No specific etiology, delay of maturation of some brain centers.
- **Psychological sequel of enuresis:** conflicts with parents, low self-esteem, social ostracism.
- **Tx:** - Search for and treat the possible physical disease.
- Treat any associated emotional problem
- Advice parents.
- Fluid restriction and going to toilet before bedtime.
- **Behavioral therapy:** - Reward system and bladder training.
- **Medication:** - **Imipramine** (Tricyclic antidepressants) can reduce bed witting effectively but relapse rate is high after discontinuation.
- **Desmopressin** (vasopressin analogue) risk of fluid overload.

- B. Functional Encopresis:**

- Repeated passing of feces in inappropriate places after the age of 4.
- Physical causes should be ruled out.
- Stressful events at home.
- Assessment should include parental attitude, emotional factors and child's concerns.
- Behavioral therapy and parental guidance.

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