

Child and Adolescent Mental Health



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Introduction on Child Mental Health Disorders

People often wonder about child mental health, asking: can children really have mental health problems? What could go wrong at such an early stage in children's lives? In fact, childhood and adolescent mental health problems are actually extremely common. Various epidemiologic studies have examined the prevalence of mental disorders in the general population of children and adolescents, finding on average that around 15 to 20% of those under 18 years of age experience a mental disorder some time during their childhood or adolescence. The types of disorders we'll describe in this paper all can impact children's lives in more ways than one: they affect normal development, they impair the ability to learn in school, they interfere with the child's ability to have friendships and relationships, and they can lead to dangerous consequences if not treated, such as suicide and severe acts of violence. Needless to say, these disorders also impact families caring for affected children, and parents often feel at a loss to explain the child's behavior, nor do they know what to do, until a proper diagnosis is made.

A Developmental Perspective (which disorders present when)

Children and adolescents go through normal stages of development that occur sequentially in multiple domains such as development of language, motor skills, cognition (the ability to think), emotions, social relatedness, empathy,

identity, sexuality and morality. Each developmental period can end up with significant deviations from expected milestones that children are expected to gain, with resulting disorders that show up preferentially depending on the age of the child. For example, in children 1-5 years of age, conditions such as Autism Spectrum Disorders, Speech and Language Disorders, Motor Skills Disorders and Intellectual Disability (previously known as Mental Retardation) manifest and are detected in this age group. The earlier such conditions are detected and diagnosed, the greater the opportunity for early intervention. In school aged children between the ages of 6-12 years, the most commonly encountered conditions are Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), Separation Anxiety Disorder (SAD) and Learning Disorders (LD) such Reading, Writing and Math Disorders. Tic Disorders (such as Tourette's Disorder) and Obsessive Compulsive Disorder (OCD) often start in this age group as well. During their adolescence, teenagers show greater risk of developing Major Depressive Disorder (MDD), Bipolar Disorder, Substance Use Disorders, Panic Disorder, Generalized Anxiety Disorder, Conduct Disorder and Psychotic Disorders (like Schizophrenia). While Mood and Psychotic Disorders significantly rise in prevalence after puberty, they can still have an onset before puberty.

A Few Words on Causes

It is a common misperception that mental disorders in children and adolescents are the results of bad parenting. Parents are often blamed, by doctors, teachers, or their relatives for children's behavioral or psychological problems. The fact is that most mental disorders have complex poly-genic etiologies with evidence for Gene-Environment interactions. For example, there are clear genetic risk factors for Major Depressive Disorder (being homozygous for the short allele of the serotonin transporter gene), but this risk is amplified by exposure to multiple stressful events. Stressful or traumatic events do not cause Depression or Anxiety by themselves, but they may add to the risk of Depression in a child or adolescent



who has a certain genetic vulnerability. Actually many children get exposed to stressors and adversities but do not develop mental disorders afterwards. Other commonly encountered conditions such as Autism Spectrum Disorders or ADHD also have strong genetic contributions to their etiology. Sometimes external factors (such as smoking during pregnancy) can contribute to the appearance of developmental, behavioral and learning disorders by directly impacting brain development which is not yet completed in the fetus.

The Evaluation and Testing Process

The importance of getting an accurate diagnosis is paramount. Like in all areas of medicine, there are basic principles in evaluating and testing children and adolescents that need to be followed in order to arrive at a complete picture of all existing conditions, ruling out certain disorders and clarifying comorbid (co-existing) conditions. There are specialists in Child and Adolescent Psychiatry who have the expertise to do so. Unfortunately, sometimes non-psychiatric physicians in other specialties

take it upon themselves to diagnose and treat psychiatric disorders in children and adolescents, often with poor results due to not capturing the complexity of these disorders.

There are specific steps to take when evaluating a child or a teen who is presenting with behavioral or emotional changes or lags in one or more areas of development. Information is often collected from multiple sources of information as children often behave and act differently in different settings. There are specific standardized and validated psychological tests that may be conducted and Rating Scales that may be collected in order to examine the cognitive profile of the child and to measure the degree of symptoms present respectively.

Some Common Disorders

We will describe below a few of the most frequently encountered disorders, their salient presentations and their treatment. Due to space considerations, other disorders will not be included here.

Autism Spectrum Disorders (ASD)

ASD used to be known as Pervasive Developmental Disorders in previous classifications of Mental Disorders. The new terminology was coined to acknowledge the fact that Autism does exist on a spectrum with varying levels of symptoms present. It is encountered in almost 1% of all children. Children with ASD often start showing changes or absence of development of social and verbal communication in the first two years of life. They present with delayed (or absent) speech that is not compensated by non-verbal communication means such as pointing or gesturing. There is a lack of social and emotional reciprocity such as not making eye contact and not responding to emotional cues of parents. There are often associated repetitive stereotyped movements and restricted interests. Play objects and toys that are usually of interest to toddlers and pre-school children do not interest children with ASD. Pediatricians have a major vital role in early screening, discovery and referral of children presenting with these constellation of symptoms. The Pediatrician is often the only health professional who screens that toddler, and a golden window of opportunity is lost if the parents of this toddler with speech delays are dismissed with “don’t worry he or she will speak later”. Pediatricians need to ask a couple more simple questions (eg about eye contact and pointing) before deciding that this is simple speech delay. Indeed there is clear evidence that implementing multi-disciplinary intervention as early as possible can vastly improve prognosis in ASD. This intervention consists of a team of professionals delivering intensive behavioral modification techniques, parent training, speech therapy, special education and psychomotor therapy.

Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is present in around 5% of children and adolescents, and is more common in boys than girls. This is a worldwide prevalence and is not influenced by cultural factors. While the term “hyperactivity” is part of the name of this condition, the core problems in ADHD have to do with the capacity to sustain attention and concentration and with impulsivity. Children with ADHD have difficulty completing required tasks, are easily distracted, and often make silly mistakes, rushing to finish their homework. ADHD symptoms are most evident in the school setting or while doing homework, ie situations in which sustained attention is required. They occur month after month and

year after year. Children and teenagers with ADHD are often seen as “under-achieving”; ie working below their true potential. Some children with ADHD are truly restless and fidgety and have difficulty sitting still. The treatment of ADHD is also multi-disciplinary and may involve treatment with medications (eg stimulants, noradrenergic potentiators) in combination with behavioral modification and parent training. Once properly diagnosed and treated, ADHD symptoms are totally reversible and treated children are able to demonstrate their full capacities.

ADHD is often comorbid with other Learning Disorders (eg problems specifically in reading, writing or maths), and testing by specialized Child and Adolescent Psychologists is often required to determine the full cognitive profile of the child. It is also often useful to have some classroom-based accommodations within the school setting, particularly during tests and examinations when such disorders exist.

Separation Anxiety Disorder (SAD)

While normal during toddlerhood and the early preschool years, Separation Anxiety becomes problematic as children get older yet are plagued by fears that something will happen to separate them from their families. It is present in around 2% of children, and manifests by fear and distress upon separation from key attachment figures such as mothers and fathers. For example, children with SAD avoid being in a room by themselves, avoid sleeping alone in their beds or bedrooms, have nightmares involving themes of separation from family, keep calling parents if they go out at night and may have various physical symptoms (eg headaches and abdominal pain) on school mornings. Other fears and phobias may be present at the same time. If untreated, severity may increase with time as the child and family get into a vicious cycle of avoidance of separation, thus re-enforcing the child’s fears. Anxiety can become so severe as to manifest as panic attacks. The treatment of SAD (and other Anxiety Disorders) involves a particular kind of psychotherapy called Cognitive Behavioral Therapy (CBT) which is conducted by trained Child and Adolescent Psychologists. Medications such as SSRIs may sometimes be used for severe cases.

Mood Disorders

These disorders include Major Depressive Disorder (MDD) and Bipolar Disorder (BD). While they may

occur in children before puberty, their prevalence rises sharply during the adolescent years. The prevalence of MDD in adolescent girls may reach 16% in some studies whereas that in adolescent boys is around 8%. The same criteria used to diagnose MDD and BD in adults are also used for adolescents. It is a myth that Depression is a normal part of adolescence and that all adolescents go through an “adolescent crisis”. When teenagers become sad, depressed, and irritable, avoiding contact with family and friends, losing interest in things they liked to do, experience a drop in their school performance and start expressing wishes they were dead, then MDD has to be considered. In BD there are mood and energy shifts that occur, cycling between periods of depression and periods of elevated or “high” mood with increased energy. Unlike ADHD where the symptoms are constant day in and day out, in BD there is a clear pattern of cycling which gives a clear clue that there’s a mood disorder emerging. Teenagers with Mood Disorders often engage in self-injurious behaviors (eg self-cutting) and may attempt suicide. Indeed, suicide among youth (15-24 years) is the third leading cause of death worldwide. MDD and BD are both treatable with medications and psychotherapy combined. If untreated, they may continue to cycle and recur, causing severe impairment over time.

When to refer to Child and Adolescent Psychiatrists?

Just like parents do not hesitate to contact a pediatrician for physical symptoms, they must not hesitate to contact a Child and Adolescent Psychiatrist when they have concerns over their child’s development, behaviors or emotions. Any delay in development in the early years should trigger referral and consultation in order to start treatment early. Any poor academic performance (chronic or acute) requires evaluation as the student may not be showing his/her full capacity due to LD or ADHD. Any change in a child’s or a teen’s wellbeing and emotional state should not be taken for granted and merits consultation,



particularly when the child or teen has voiced death wishes or has made suicide threats. Any violent behavior towards others or property should be evaluated. Any obsessions, compulsions, tics, and unusual preoccupations are reasons for psychiatric consultation.

Conclusion

Mental Disorders in childhood and adolescents are quite common, and if unrecognized often have debilitating or tragic consequences for the child and family. It requires specialized skills and expertise to diagnose and treat these conditions. The examples of disorders given above (ASD, ADHD, SAD and Mood Disorders) are ones that are commonly encountered, but they are merely a fraction of other conditions that children and adolescents may experience as they grow. As they will become adults and will shape the working and family forces of the future, it is essential that children grow with a sense of wellbeing, a positive image of themselves and a high level of creativity and productivity, all of which can be destroyed by mental disorders. Targeted and specific treatments exist for these conditions and are best started early in the course of the disorder.