



Child and Adolescent Mental Disorders For MO



ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

ADHD is a neurodevelopmental disorder, is characterized by inattention and hyperactivity/impulsivity.

Boys are four times more often affected than girls.

Hyperactivity/ impulsivity is commoner in boys, whereas girls commonly report daydreaming and over-talkativeness. In 50-60% of cases features persist into adulthood.





Clinical features of ADHD:

- Hyperactivity manifesting as fidgetiness, motoric restlessness, running as though driven by a motor
- Inattention is characterized by easy distractibility, careless mistakes, 'daydreaming'
- Impulsivity manifesting in the form of blurting out answers, interrupting, and acting rashly without thinking through



NAME OF MEDICATION	DOSE		SIDE EFFECTS
	Starting dose	Maintenance dose	
Methylphenidate	5-10 mg/day in divided doses. Last dose to be given preferably before 5 pm.	20-30 mg/day (Max-60 mg/day)	Appetite reduction, sleep disturbances, increased blood pressure and heart rate (relatively contraindicated in structural cardiac defects)
Atomoxetine	0.5 mg/kg/day. Can be given as a single dose in the morning.	1-1.2 mg/kg/day	Headache, somnolence, GI disturbances like nausea, vomiting, appetite loss.
Clonidine	25-50 microgm/day	0.3-0.7 microgm/kg/day in divided doses	Drowsiness, hypotension. To avoid sudden cessation as this may lead to rebound hypertension

Follow-up- Medication and psychotherapeutic interventions need to be reviewed in follow-up. Regular monitoring should include: symptom status (using rating scales), school performance (teacher report), growth (height, weight), heart rate and blood pressure, and other side effects.

OPPOSITIONAL DEFIANT DISORDER

Clinical features of ODD

These are called 'disruptive' because the behavioural disturbances seen in children affected by them creates disruption in their environment, including home, school and with peers. The prevalence of this disorder is recorded at around 2-10%.

- **Excessive argumentativeness with adults**
- **Refusal to comply with adult requests/ instructions by adults**
- **Questioning rules at school and home**
- **Refusal to follow rules**
- **Behaviour intended to annoy or upset others**
- **Blaming others for their misbehaviours or mistakes**
- **Becoming easily annoyed with others**
- **Frequently seen to be angry or upset**
- **Speaking harshly or unkindly to others**
- **Behaviour to seek revenge when upset by others**

Disruptive Behaviour Disorders (DBDs) include Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD).





QUESTIONS TO DETECT ODD DURING CLINICAL EVALUATION

- Does your child actively defy or refuse to comply with requests and rules?
- Does your child say cruel, mean, or hateful things when upset?
- Does your child argue excessively with adults and other authority figures?
- Do you find that your child just doesn't take rules seriously?
- Is your child touchy, prickly, or easily offended?



- **Management:** If you suspect ODD in a child, it is preferable to refer to a psychiatrist or child psychologist.
- **Pharmacotherapy:** There is little evidence for the use of medication unless there are comorbid disorders that stand to benefit from them, e.g. mood disorders.
- **Psychotherapeutic interventions with the child:** Children with ODD have significant difficulties with social and emotional skills. They benefit from new skills for identifying and managing feelings, managing anger, problem-solving, interacting with other people more effectively, and strategies for making good decisions that are based on thinking rather than feeling.

PARENT-MEDIATED INTERVENTIONS

- “Catch the child being good”. Use abundant social rewards – attention, praise, affection, physical proximity
- Positive, quality family time where no ‘problems’ are discussed
- Ignore mild unwanted behaviours and pay attention to alternate positive behaviours
- Clear, direct communication by looking into child’s eyes. Avoid repeating commands
- Give choices – foster a sense of control and responsibility





- Setting limits on unacceptable behavior with consistent consequences for non-compliance
- Increase “Do” instructions, Decrease “Don’t” instructions
- School-home contract: Daily behavior report card from a teacher with a home-based reward system
- Engage child in multiple co- and extra-curricular activities
- Know who your child’s friends are and how your child is spending time in and outside home. Protect from association with deviant peer groups.



CONDUCT DISORDER

Conduct disorder is a serious clinical condition, in terms of the extent and nature of behavioral concerns. It can involve intentional cruelty to people and animals, violent behaviors, and criminal activity.

Children and adolescents with the disorder have significant difficulty in following rules and behaving in a socially acceptable way.

There may be aggressive, destructive, and display deceitful behavior that violates the rights of others

CLINICAL FEATURES OF CONDUCT DISORDER





QUESTIONS TO DETECT CONDUCT DISORDER

- Does your child say cruel, mean, or hateful things when upset?
- Do you find that your child just doesn't take rules seriously?
- Does your child bait classmates and pick fights with them by purposely doing things that annoy them?
- Has your child ever tried to intentionally harm/hit/intimidate younger children or tried to harm animals?
- Does your child frequently lie to you/ steal money or other objects without showing any remorse for actions?
- Has your child threatened to damage objects or indulged in such behaviour in case his demands are not met?

- **Management:** If you suspect CD in a child, it is preferable to refer to a psychiatrist or child psychologist.
- **Pharmacotherapy:** There is little evidence for the use of medication unless there are comorbid disorders that stand to benefit from them, e.g. mood disorders and ADHD. Prescribing antipsychotics for relatively short periods in low doses can help families cope. Any antipsychotic for children with CD will be prescribed by a Psychiatrist. During this time, it is crucial to introduce more effective psychological management. However, antipsychotics are not recommended in anything other than unusual circumstances.





Psychotherapeutic Interventions with the Child

- Identifying the strengths of the young person is crucial. This helps engagement and increases the chances of effective treatment.
- Encouragement of abilities helps the child spend more time behaving constructively rather than destructively – e.g., more time spent playing football is less time spent hanging round the streets looking for trouble.
- Encouragement of prosocial activities – for example to complete a good drawing or to play a musical instrument well – also increases achievements and self-esteem and hope for the future.





Psychotherapeutic Work with the Family

- The role of parents is very important in management. Explicit attempts are made to reduce negative spirals in family interactions by interrupting and diverting the flow of negative, blaming speeches.
- Parent training techniques are similar to those found in standard approaches and include praise, rewards (e.g., if you come home by 6pm each night, I will take you to the cinema on Saturday), limit setting, consequences and response-cost (e.g., losing TV time for swearing).

DISORDER OF INTELLECTUAL DEVELOPMENT (DID) & INTELLECTUAL DISABILITY (ID)

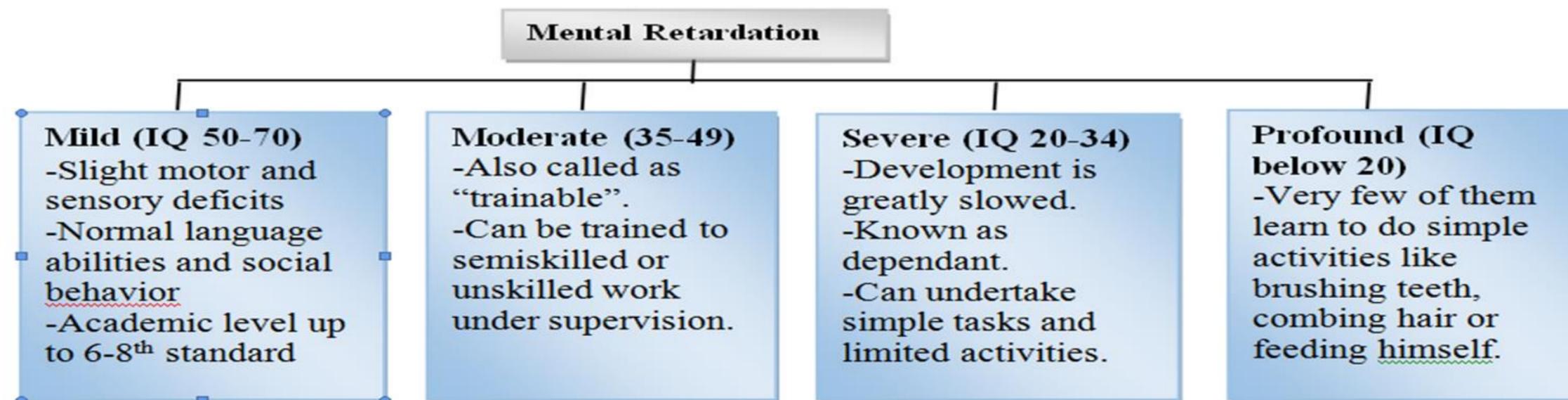
- Disorder of intellectual development (DID) is common permanent developmental condition, in which 6 years or above individuals will have limitations in their intellectual and adaptive functioning.
- It is difficult to accurately diagnose DID in children who are 5 years or below (between 3 months to 5 years), who have delays in 2 or more developmental domains, viz; gross/fine motor, speech/language, social, cognition, and activities of daily living are diagnosed to have Global Developmental Delay (GDD).
- Across the world, the prevalence of DID is around 2.5%. However, Indian studies on DID have used varied definitions and methodology and reported a prevalence range of 1/1000 to 32/1000.
- Children with DID and their families need multi-disciplinary care and services across the lifespan.





CLASSIFICATION OF IDD

a) Based on testing of intellectual ability on intelligence quotient test, DID is classified into four clinical subgroups. In absence of testing facility, based on the clinical assessment of developmental behaviours, the subgroup can be diagnosed.



b) Among DID subtypes, mild DID subtype is most common amounting to 70% to 80% of DID's.



Risk Factors

- **Before birth of a child:** Infections, placental dysfunction, hormonal disturbances, exposure to certain drugs, radiation or nutritional deficiencies during pregnancy.
- **During delivery:** Prolonged labour or obstructed labour, prematurity, lack of respiration immediately after birth, instrumental delivery, low birth weight.
- **After delivery:** Injury, malnutrition, infection, etc.
- **Other factors:** Chromosomal abnormalities (Down's syndrome), metabolic disorders, etc.
- **Other co-morbidities:** Epilepsy, hyperactivity, mood disorders, personality disorders, autism, and sensory problems like difficulty in hearing or vision.

It is important to know that medical conditions like hypothyroidism, iodine deficiency and phenylketonuria can be treated and development of DID can be prevented.





Clinical Features

DID children present to clinics with following complaints: Slow in development / delayed milestones of development, Poor speech, Poor in self-care, Poor learning and memory, less intelligent compared to other children and Poor in reading and writing.

Assessment

GDD/Subtype of DID:

- Assess the important milestones attainment and look for delay
- Assess that, the delay is single domain of development or in 2 or more domains
- Ask parents regarding their estimation of child's mental age





Cause of IDD

- Do a physical examination and look for major and minor congenital anomalies
- Check for family history of DID, GDD, non-progressive and progressive neurological disorder
- Check for history of regression (loss of attained milestones) in child

Family/Parents

- Assess the parents' knowledge about of the child's problems, caring practices, treatment seeking, and coping (Look for stress/depression in parents)





Management and Referral

Psycho-education of parents – points to communicate are

Insult to developing brain (prenatal/perinatal/postnatal) is the cause

Child can learn new skills with repeated, graded training inputs.

The child will learn at a slower pace; (what a typical child learns in one year, the child with DID may take 1.5 years to 2.5 years to learn the same)



- As the child grows older, with training he/she will become more independent in his/her day to day activities and may be able to do unskilled and semi-skilled jobs under the supervision
- No medications are available to cure the condition
- Usually the parents will give up on training thinking the child can't learn, or they will do all the work for child instead of training the child. So they should be counselled and trained regarding the same.
- Parents need to plan and implement a daily routine according to the child's mental abilities.



Early intervention / sensory-motor stimulation for young children –under 3 to 4 years

- Spend more time interacting with the child
- Make different types of sounds, and rhymes, draw the child's attention, and imitate the child's sounds (Parallel vocalization). Using touch sensation (e.g., tickling, stroking, gentle massaging) stimulates the child. Attempt to improve hand functions (taking, holding, giving, pushing, pulling) by using safe and easily available play materials. Show different colored objects, play peek-a-boo, show different facial expressions, and try to improve the eye-to-eye contact while stimulating.
- Teach simple imitation, pointing, body parts, colors, shapes
- Teach simple verbs, common nouns for family members, day to day food items and utensils, teach opposite words like big /small, in/out with visual cues.
- Teach self helps skills step by step





Home-based parent mediated skills training – teach and train parents what and how to teach their children at home itself

- Find the current level of mental age and adaptive abilities and ask the parents to teach self-help, communication, conceptual and practical skills for that age for next one and half year to two years. (10-year old child with mental abilities of a 5 year old should be taught a 5 years old's learning activities)
- The child will learn at a slower pace; (what normal child learns in one year, the child with DID may take 1.5 years to 2 years to learn the same)
- Teach household chores, basic academic skills, vocational skills, agro-based activities under adult supervision. Also teach concept of safety and self – protection.





Education

a) Liaise with Anganawadi/ schools /special schools

b) Advocate for reduction of academic pressure and involvement in extra-curricular activities

Social welfare/liaison measures

a) Disability certification for social welfare benefits

b) Encourage parents to consult other agencies or services such as parent support groups and associations

c) Give information on the National trust act and welfare schemes





Referral

There is need for referral if:

- Child has severe developmental problems
- Cause for DID is not clear or/ and parents are thinking of family expansion indicating the need for genetic counseling
- History of regression (loss of acquired skills)
- Definite family history of developmental problems such as the history of similar problems in the sibling
- Co-morbid severe behavioral or emotional problems, uncontrolled seizures
- Very poor social responsiveness – autism
- Difficulty in diagnosing mild DID vs learning disorder





Thank You

