CHILD AND ADOLESCENT MENTAL HEALTH TRAINING MODULE FOR SPECIALISTS

THIS TRAINING MODULE IS RECOMMENDED TO BE USED WIDELY BY GENERAL PSYCHIATRISTS, PAEDIATRICIANS AND FAMILY MEDICINE SPECIALISTS

Prepared by the technical working group Child and Adolescent Psychiatrists, Psychiatrists, Paediatricians, Family Medicine Specialists, and Public Health Specialists

2nd Edition • 2009
Children of the world face many threats; among others are infectious diseases, malnutrition and emotional deprivation. Having good physical and mental health can help children navigate the complex world they face. Around the globe up to 20% of children and adolescents suffer from a disabling mental illness with 3-4% requiring treatment. The mental health of children and adolescents is influenced by stresses on families, parenting styles of parents, economic adversity, access to education and health and displacement through war and catastrophe.

In Malaysia according to the 2nd National Health and Morbidity Survey in 1996 showed 13% of children and adolescents experience mental health morbidity. Evidence shows there is a strong relationship between long-term consequences of childhood disorders and their continuity with psychiatric disorders. The financial cost to society from the consequences of untreated disorders is tremendous. The burden of child and adolescent emotional disorders, mostly extensively felt by families and friends of those affected, also impacts many systems that support a society, including health, education, welfare and the juvenile justice system.

Taking cognizance of the global effort to decentralise and enhance treatment for children and adolescents with emotional and behavioural disorders and to address the increasing emotional and behavioural problems faced by Malaysian children and adolescents, an initiative to develop a training module of Management of Child and Adolescent Mental Health was carried out in November 2001.

This module aims to facilitate the training of psychiatrists, paediatricians and family medicine specialists in Child and Adolescent Mental Health and Psychiatry at the national, state, hospital and clinic level. It consists of two units, that is Unit One on Mental Health Promotion and Unit Two on Emotional and Behavioural Disorders in Children and Adolescents.

I would like to congratulate the collaborative effort shown by the technical working group from the Psychiatric Departments and Family Health Development Division of the Ministry of Health, University of Malaya and Universiti Kebangsaan Malaysia in the development of this module.

It is hoped that this module will be fully utilised as a training and reference material for doctors and specialists in the hospital and health clinics in managing their patients.

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by Director General of Health 3

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We would like also to extend our appreciation to Dr. Nor Bizura Abd. Hamid, Dr. A. L. Liza bt. Abd. Latip, Hj. Razali Mohd. for their hard work in typing, proof reading, editing, formatting and printing of the manual. Editing was done by Dr. Toh Chin Lee.
INTRODUCTION TO THE MODULE

This Child and Adolescent Mental Health Training Module for Specialists is initiated by the Child and Adolescent Psychiatrists and the Family Health Development Division of the Ministry Of Health to facilitate the training of specialists, namely general psychiatrists, paediatricians and family medicine specialists at national, state and local hospital level.

The Training Module is aimed at updating their knowledge in early detection and management of child and adolescents with emotional and behavioural disorders as well as to enable them to carry out mental health promotion in children and adolescents.

This module was developed by a working group consisting of Child and Adolescent Psychiatrists, Paediatricians, Family Medicine Specialists and Public Health Specialists from the Ministry Of Health, University of Malaya Medical Centre and Universiti Kebangsaan Malaysia Hospital.

Objectives

Through the training module, it is hoped the following will be achieved:
1. To provide standard material for training of core trainers in Child and Adolescent Mental Health.
2. To facilitate echo training programme at state and local level.
3. To assist in the integration of mental health into primary, secondary, and tertiary health care.

Users of the Module

The module is intended for National, state and local trainers in the Ministry of Health who have been identified to conduct the training for specialists who will be implementing Child and Adolescent Health services.

How to use the Module

1. THE CONTENT: The module consists of two sections:
   i. Mental Health Promotion
   ii. Emotional and Behavioral Disorders

   Section 1: Mental Health Promotion of Children and Adolescents
   Unit 1: Normal Child, Adolescent and Family development
   Unit 2: Mental Health Needs of Children and Adolescents
   Unit 3: Parenting skills
   Unit 4: Stress and Anger Management
   Unit 5: Counseling
Section 2 : Emotional and Behavioural Disorders of Children and Adolescents
Unit 1 : Attention Deficit Hyperactive Disorder
Unit 2 : Depression
Unit 3 : Eating Disorders
Unit 4 : Learning Disabilities
Unit 5 : Substance Abuse and Dependence
Unit 6 : Tics
Unit 7 : Separation Anxiety Disorder
Unit 8 : Stress Related Disorders
Unit 9 : Post-Traumatic Stress Disorder
Unit 10 : Conduct Disorder
Unit 11 : Oppositional Defiant Disorder
Unit 12 : Elimination Disorders
  12.1 : Enuresis
  12.2 : Encopresis
Unit 13 : Mental Retardation
Unit 14 : Schizophrenia
Unit 15 : Bipolar Disorder
Unit 16 : The Child with Chronic Illness
Unit 17 : Unexplained Somatic Complaints
Unit 18 : Conversion / Dissociative Disorders
Unit 19 : Motor Skills Disorder
Unit 20 : Autism
Unit 21 : Special Mental Health Problems of Children and Adolescents
  21.1 : Bullying
  21.2 : Teenage Pregnancy
  21.3 : Emotional Abuse and Neglect
  21.4 : Child Sexual Abuse
  21.5 : Physical Abuse
  21.6 : Children and the Law

2. THE METHODOLOGY OF TRAINING
   Training is by lectures, discussions and group work. Skill acquisition is emphasized. Active participation from the target audience is vital to keep training sessions lively and effective.

3. EVALUATION
   A pretest questionnaire (Appendix 1) can be utilised to evaluate the knowledge of the participants prior to the training. An evaluation of the training session is also attached in this module to facilitate the trainers to evaluate their training programme.
MENTAL HEALTH PROMOTION OF CHILDREN AND ADOLESCENTS
UNIT 1 : NORMAL CHILD, ADOLESCENT AND FAMILY DEVELOPMENT

1.1 DIFFERENT STAGES OF HUMAN DEVELOPMENT

Human development is a pattern of change that begins at conception and continues throughout the lifespan. There are discrete, qualitatively distinct stages of development.

Every human undergoes the different stages of development beginning from infancy, to old age as in Figure 1.

There are several theories of human development. Eriksson (1965) described the ‘Eight Stages of Man’, a model for socio-emotional development. The stages relevant to childhood are:

1.1.1 BASIC TRUST VS. MISTRUST (FIRST YEAR OF LIFE)
The child will develop trust in the world if his / her needs are predictably met. Otherwise, the child may develop a perception of the world as a hostile and unpredictable place. Gross deprivation at this stage may lead to emotional detachment in childhood and towards life. He may have difficulties forming deep and lasting relationships in adulthood.

1.1.2 AUTONOMY VS. SHAME AND DOUBT (1 - 3 YEARS)
The child acquires confidence in his own ability as opposed to self-doubt. The child begins to recognise his own will and ability to be independent; and may feel guilt if he does not conform to expected behaviour. This stage is about balancing one’s own wishes against those of others. Failing to exert oneself may lead to reduced confidence and initiative, but failure to take into account others’ wishes may make it difficult to integrate into society fully.

1.1.3 INITIATIVE VS. GUILT (3 - 5 YEARS)
The child acquires more social skills and assumes greater responsibility for himself. A sense of time begins to develop. The child builds on the tasks accomplished in the previous stage. Successful resolution at this stage results in a confident and outgoing child. Others may develop fears or problems with nightmares as they struggle to resolve the conflict.
1.1.4 INDUSTRY VS. INFERIORITY (5 - 11 YEARS)
The challenge here is to achieve and to overcome feelings of failure. The child will be industrious in schoolwork, sport and social relationships. If these are not achieved, the child may feel a sense of failure and inferiority. He may also become isolated from the peer group.

1.1.5 IDENTITY VS. CONFUSION (11+ YEARS)
In this stage the child acquires a firm sense of who he is, what he wants from life and where he is going.

The three remaining stages for completeness are: intimacy vs. isolation (young adulthood), generativity vs. stagnation (middle adulthood), and integrity vs. despair (old age).

1.2 MENTAL HEALTH NEEDS
Every individual has his or her own needs. If these needs are not met, it will result in uneasiness, unhappiness and a feeling of frustration and dissatisfaction. Therefore, in order to attain positive mental health, it is essential for the individual to meet the needs during different stages.
2.1 MENTAL HEALTH NEEDS OF CHILDREN

2.1.1 INTRODUCTION
It is easy for parents to identify their child's physical needs: nutritious food, clothing, and shelter. However, a child's mental and emotional needs may not be as obvious. The psychological and emotional needs of a child are as important as the physical needs. Good mental health practices allow a child to think clearly, to develop socially, and to learn new skills.

Play is important for the development of children. Suitable playmates, encouraging words and praises, and proper guidance are important in helping your child to develop self-confidence, high self-esteem, and a healthy emotional outlook on life.

2.1.2 MENTAL HEALTH NEEDS OF A CHILD
• Unconditional love from the family.
• Self-confidence and self-esteem.
• Time for play.
• Appropriate guidance and instructive discipline.
• Safe and secure surroundings.

2.1.2.1 Unconditional love
Love, security, and acceptance should be at the heart of family life. A child needs to know that love does not depend on his accomplishments or wrongdoings. Mistakes and failure should be expected and accepted. Confidence grows in a home that is full of unconditional love and affection.

2.1.2.2 Self-Confidence and Self-Esteem.
Nurture the child's confidence and self-esteem through:

- Praise and Encouragement
Praise and encouragement will help children to develop a desire to explore and learn about their surroundings as well as reinforce their achievements. Praise shows them what behaviours are good, shows them you care, and increases their self worth.

Negative statements are not helpful and often damage the child's self-esteem. He does not learn how to improve himself. Instead, he develops a fear of making mistakes as well as of authoritarian adults.

- Setting Realistic Goals
Parents need to set realistic goals to match their children's ambitions and abilities. Children need help in choosing activities suitable with their abilities. Success in achieving their goals will increase their self-confidence.

- Being Honest
Parents need to be honest with their children. It is important for children to know that adults also make mistakes.

- Avoiding Sarcastic Remarks
If a child loses a game or fails a test, try to find out how he feels about the situation. Avoid passing sarcastic or hurtful remarks. Encourage the child not only to strive to do his best, but also to enjoy the process. Trying new activities teaches children about teamwork, self-esteem, and new skills.
2.1.2.3 Time for play

- **Encourage children to play**
  Parents should allow their children time to play. Playtime is as important to the child's development as food and basic care. Playtime helps children to be creative, learn problem-solving skills, and learn self-control. Running and yelling during playtime is not only fun but also helps children to be physically and mentally healthy. Play will help children to make friends and learn social skills. Having friends allows children to acquire social/peer support.

- **Children need playmates**
  It is important for a child to feel like 'one of the gang'. By playing with friends, a child discovers his strengths and weaknesses and develops a sense of belonging.

- **Parents can be great playmates**
  Playing with their child gives parents an opportunity to share ideas and spend time together in a relaxed setting.

- **Television viewing and playing video games should be monitored**
  Do not use TV as a “baby-sitter.” Limit the number of hours for TV and be selective when choosing television programmes and video games. Children may learn aggressive behaviour from TV and video games.

  Some shows and video games however can be educational as well as entertaining.

2.1.2.4 Appropriate guidance and instructive discipline

Parental guidance and discipline should be fair and consistent.

- **Appropriate guidance**
  Children need the opportunity to explore and develop new skills and independence. At the same time, children need to learn that certain behaviours are unacceptable and that they are responsible for the consequences of their actions. Parents, minders, and teachers should tell children very clearly, what behaviours are expected of them.

  As members of a family, children need to learn the rules of the family. They will adopt these social skills and rules of conduct to school and eventually to the workplace and society.

- **Discipline and Punishment**
  Physical punishment may lead to resentment and more disobedience. It is extremely important for parents to learn and develop disciplinary skills, other than spanking or hitting e.g. time-out techniques.

**Suggestions on guidance and discipline:**
- Explain to the child why he is being punished before any disciplinary action.
- Be firm, but kind and realistic with your expectation.
- Set a good example.
- Criticise the behaviour, not the child.
- Avoid nagging, threats and bribery.
- Talk about your feelings with your child.

Remember, the goal is not to control your child, but for your child to learn self-control.
2.1.2.5 Safe and secure surroundings
A child needs to feel protected and loved by his parents. He needs a physical and emotional environment which is safe and encouraging.

Parental conflicts can lead to misinterpretation of parents’ behaviours. When children see and hear parents fight they feel anxious and blame themselves for their parents’ problems.

When the intonation of the parents’ voices after a verbal fight is maintained, even when speaking to the child, he may become timid and feel too scared to speak-up. The child will then tend to be passive and this could lead to unassertiveness. The child may also tend to suppress his feelings.

Verbal and physical fights between parents may lead to child physical abuse. This could be due to the parent's anger and dissatisfaction being taken out on the child.

When parental conflicts arise from disagreement over their respective lifestyles, this may lead to conflict within the child in choosing a lifestyle and a set of behaviour patterns to copy.

2.1.3 SOME CONSEQUENCES OF UNMET MENTAL HEALTH NEEDS IN CHILDREN
- Decline in school performance.
- Regular worry or anxiety.
- Refusal to go to school or to take part in normal children's activities.
- Hyperactivity or fidgeting.
- Nightmares.
- Disobedience or aggression.
- Frequent temper tantrums.
- Sadness, irritability, or depression.

2.2 MENTAL HEALTH NEEDS OF AN ADOLESCENT

2.2.1 INTRODUCTION
Adolescence is the transition period between childhood and adulthood - the period during which the child achieves physical ‘maturity’ but has not yet taken on the roles and responsibilities that accompany full adult status. Due to the physiological and psychological changes, the adolescent has other additional mental health needs.

2.2.2 MENTAL HEALTH NEEDS OF AN ADOLESCENT
- Emotional independence from parents.
- Peer group acceptance.
- Self-identify.
- Freedom.
- Realisation of individual potential.
- Preparation for adulthood.

2.2.2.1 Emotional independence from parents
Adolescents seek to become free from dependence on parents and to develop affection for parents without dependence upon them.

2.2.2.2 Peer group acceptance
Adolescents need to be associated with a group and comply with the group norms in order to be accepted. They need to learn to work with others for a common purpose, disregarding personal feelings and to lead without dominating.
2.2.2.3 **Self-identify**
Adolescents are often uncertain of their own self-identify. They need to learn and accept a socially approved adult masculine or feminine social role.

2.2.2.4 **Freedom**
Adolescents often have the urge to do things in their own way. Their need for freedom has to be balanced with their awareness to take into account of the values that society places on one's personal behaviour.

2.2.2.5 **Realisation of individual potential**
Adolescents by nature are very curious and like to try out new experiences. They should be allowed to explore and at the same time be given proper guidance. They are also imaginative and creative. These potentials should be fully encouraged and directed towards healthy activities, which are of interest to them.

2.2.2.6 **Preparation for adulthood**
Adolescents need to learn to organise their plans and energies to begin a career or make a living. They also need to develop a positive attitude toward starting family life.

2.2.3 **SOME CONSEQUENCES OF UNMET MENTAL HEALTH NEEDS IN AN ADOLESCENT**

An adolescent whose mental health needs are not met will sometimes manifest these following symptoms:-

- Disturbance of appetite and sleep.
- Isolation from others.
- Excessive worry / anxiety / fears.
- Loss of interest and enjoyment in usual activities.
- Problems at school.
- Persistent disobedience / aggressive and antisocial behaviours (Truancy, lying, stealing, vandalism).
- Rebellion against parents and authority figures.
- Disapproved sexual behaviour.
- Substance abuse.
- Lack of self-control.
- Lack of self-confidence.
- Feelings of sadness and irritability.
UNIT 3 : PARENTING SKILLS

3.1 TYPES OF PARENTING

There are several types of parenting styles commonly used. These are authoritative, authoritarian, neglecting and indulgent parenting.

- **Authoritative:**
  This type of parenting is the most useful parenting style. Parents are strict and in control, yet they are willing to listen to their children's point of view. When necessary, a compromise is reached. Children are brought up with warmth and they are expected to behave at their intellectual and social age.

- **Authoritarian:**
  Parents are strict and uncompromising. They exert lots of demands on their children. Warmth and two way communication is rare.

- **Neglecting:**
  Parents are not aware of their children’s whereabouts, activities, friends, or school assignments and performance. Parents are too busy with their own lives and careers.

- **Indulgent:**
  Parents are very responsive with their children, placing few demands on them (pampering).

Authoritative parenting is often referred to as **Positive Parenting**. The rest of the styles are less healthy parenting styles.

‘**Positive Parenting**’ parents are sensitive to the child's behaviour and give encouragement. They use non-violent disciplinary techniques. The child carries out tasks under the guidance of their parents. In addition, through encouragement and setting of rules, they learn self-control.

3.2 DISADVANTAGES OF LESS HEALTHY PARENTING STYLES

The children:

- Have lower self esteem.
- Are not assertive.
- Are less responsible or mature.
- Have a poor child-parent relationship.
- Are rebellious.

3.3 BENEFITS OF POSITIVE PARENTING

- Improved parent-child relationships.
- Increased self-worth of the child.
- Promotes self-discipline in children.
- Teaches children to think for themselves.
- Opportunity for parents to teach the child.
- Development of self-control in children.
3.4 WAYS TOWARDS POSITIVE PARENTING

There are many ways to encourage positive parenting. The guidelines listed below are based on psychological research that shows that much of children's behaviours are learnt through observation of their parents and thus can be unlearnt through appropriate parenting.

Listed below are some of the ways:

- Spending time with the child.
- Using praise.
- Having rules.
- Ignoring bad behaviour resulting from attention-seeking.
- Encouraging children to make decisions.

3.4.1 SPENDING TIME WITH THE CHILD

Spending time with the child improves interactions between parents and their children and acts as an opportunity to parents to understand and teach.

3.4.2 USING PRAISE

Praising children is important. It shows them what behaviours are good, shows them you care and increases their self-worth. Negative statements on the other hand, are not helpful and often damages the child's self-esteem. They do not learn how to improve themselves.

3.4.3 HAVING RULES

In every family there are “do’s” and “don’ts”. Children need to know what is expected of them and it is important that parents tell the child very clearly what behaviours are expected.

3.4.4 IGNORING BAD BEHAVIOUR

There will be times when parents tell their children what behaviour is appropriate and the children continue to act up. The child is usually seeking attention. By not reacting to the bad behaviour, the child stops. This technique is called ignoring.

3.4.5 ENCOURAGING CHILDREN TO MAKE DECISIONS

An important aspect of parenting is teaching children to think for themselves. To achieve this, parents need to guide their children through the decision-making process rather than just simply giving them the correct answer.

3.5 ADDITIONAL SKILLS

The following are a list of the most common additional skills that parents have found useful for dealing with their children's behaviours.

- Give your child choices to encourage decision making e.g. 'Do you want to eat now or later?'
- Inform ahead of time. e.g. 'Bedtime in 30 minutes.' 'We will leave in 15 minutes.'
- If you expect your child to comply, give 'do' commands, i.e. commands with a verb at the beginning. e.g. 'Put away the toys, please.', 'Walk slowly.' or 'Speak softly.'
- Use 'when ... then' commands to tell your child consequences of their actions. e.g. 'When you have finished washing the dishes, you can play with your friends.'
- Have realistic expectations of what your child can and cannot do.
UNIT 4 : MANAGEMENT OF STRESS AND ANGER

4.1 STRESS MANAGEMENT

4.1.1 DEFINITION OF STRESS:
• A physical, emotional or mental response to change, whether positive or negative.
• The extreme physiological and emotional arousal a person experiences when confronted with a threatening situation; the body’s reaction to a noxious stimulus (Vecchio 1991).
Some amount of stress is necessary to motivate us. If not perceived or handled well, stress can be harmful.

4.1.2 SOURCES OF STRESS
Stressors may be personal, from the home, school or community.

Personal
• Ambitions, hopes and values.
• Fear of failure.
• Changes in the body or diseases.
• Comparison between siblings or friends.

Home
• Conflict between parents.
• Separation of parents.
• Divorce.
• Loss or separation due to death.
• Not being able to fulfil the demands from parents.
• Conflict between parents and siblings.
• Illness in the family.
• Admission to ward.
• Birth of younger sibling.
• Moving to new home or death of a pet.
• Change of workplace of parents which require them to leave home for a long duration.
• Abuse.
• Neglect.

School
• Starting school.
• Change of school.
• Punishment or being made fun-of at school.
• Fight between friends.
• Bullying.
• Participation in too many activities.
• High expectations.
• Loss of friends.

Community
• Minimal socio-economic necessities such as no playground, sewage disposal, water and electricity.
• Crowded housing.
• Unsafe living environment (alcohol abuse, substance abuse, and prostitution).
4.1.3 REACTION TO STRESS VARIES. IT DEPENDS ON:
• Developmental age of the child.
• Ability to handle stress.
• Duration of stress.
• Intensity of the stress.
• Support which is given.

4.1.4 REACTION TO STRESS IN CHILDREN VARIES WITH THEIR AGES:

Early childhood
• Feeling unloved.
• Dependency.
• Not following rules.

Middle childhood
• Fear of the future.
• Headaches.
• Insomnia.
• Loss of appetite.
• Inability to concentrate at school.
• Enuresis.

Adolescence
• Anger.
• Disappointment.
• Low self-esteem.
• Loss of faith in adults.

In the extreme, adolescents might indulge in health risk behaviours such as:
• Behaviour contributing to unintentional injuries and violence.
• Tobacco use.
• Alcohol and other drug use.
• Sexual behaviour.
• Unhealthy dietary behaviour.
• Physical inactivity.

4.1.5 STRESS PATTERNS IN ADOLESCENT
Girls and boys experience distinctly different patterns of stress. However, the levels of stress are similar.

4.1.6 SOURCES OF STRESS
Girls : Relationships with parents, friends and teachers
Boys : Trouble in school and other non-relationship factors (e.g. move to a new house)

4.1.7 MANAGEMENT OF STRESS
• Information.
• Practical knowledge and coping skills.
• Effective parenting.
• Resources and outreach.

4.1.7.1 Information
Information for adolescents on:
• Good health habits.
• Risk reduction.
• Responsible sexual behaviour.
Advice for adolescents on coping with stress:
- Identify situations that stress them and how they react to the stress.
- Work out how they could behave differently in these situations.
- Imagine how other people might behave if they acted differently.
- Rehearse some of the different ways to react to the situation.
- Be prepared to fail the first time.
- List all the things they can think of that would make things easier or less stressful.
- Write them down.

Advice to adolescents to get help:
- Stress is affecting their health.
- They have thoughts of stopping school, running away, or self-harm.
- They feel low, sad, tearful, that life is not worth living.
- There is loss of appetite and insomnia.
- They have worries, feelings and thoughts that are hard to talk about because others won't understand.

4.1.7.2 Practical knowledge and coping skills
- Problem solving.
- Conflict management.
- Positive thinking.
- Time management.
- Relaxation techniques.

4.1.7.3 Effective parenting
- Targeted at parents of adolescents.
- They must know the needs of adolescents.
- Provide needs within reason.
- Talk and listen.
- Allow responsibility and self control.
- Practice limits and boundaries.

4.1.7.4 Resources and outreach for adolescents
- School.
- Medical/health clinics.
- Non-governmental organisations.
- Ministry of Youth and Sport.

4.1.8 PREVENTING STRESS FROM OVERWHELMING THE ADOLESCENT
- Healthy lifestyle - nutrition, exercise, self care.
- Pets, hobbies and other interests.
- Adequate sleep.
- Specific practices; e.g. praying, yoga and relaxation techniques.
4.2 ANGER MANAGEMENT

4.2.1 DEFINITION:
Anger is a state, which arises out of strong emotion due to frustration, disappointment, threat or losses. It can affect mood and influence our actions.

4.2.2 ANGER CAN GIVE RISE TO PROBLEMS IF IT:
• Occurs too often.
• Is severe in intensity.
• Is prolonged.
• Occurs in unfavourable situations.
• Leads to aggressiveness.

4.2.3 ANGER RESPONSES:

4.2.3.1 Physical responses to anger:
• Increased heart rate.
• Tightness of chest.
• Difficulty in breathing.
• Sweating palms.
• Trembling.
• Tightness of neck or back.
• Headaches.
• Clenching of teeth and fists.
• Flushing of face.

4.2.3.2 Emotional responses to anger:
• Cynicism and sarcasm.
• Lack of concentration and attention.
• Suspiciousness.
• Depression.
• Unforgiving.
• Apathy.
• Decreased creativity, inability to enjoy.
• Irritability and outbursts.

4.2.3.3 Behavioural responses to anger:
• Procrastination, inability to complete one's responsibility.
• Sleep disturbances.
• Appetite disturbance.
• Increase in smoking or drinking.
• Accident proneness.
• Social withdrawal.
• Restlessness, disturbed concentration.
• Physical aggression / violence.
• Refusing advice.
• Rash decisions.
• Verbally abusive.
4.2.4 MANAGEMENT OF ANGER:

- By the child.
- With the help of adults.

4.2.4.1 By the child:

- Positive thinking.
- Hobbies.
- To divide time for play and study.
- Not to exaggerate or belittle an issue.
- Get somebody / mentor to discuss problems with.
- Practice healthy lifestyle.

4.2.4.2 With the help of adults:

- Spend time with the child and encourage them to discuss their problems and difficulties.
- Help them to develop self esteem.
- Help them to be assertive.
- Teach them to overcome anger positively: maintain calmness, control anger and do problem solving.
- Make them think of the consequences of their action and help them to develop problem solving skills using the IDEAL concept.

  I - Identify the problem
  D - Describe possible options
  E - Evaluate consequences of each action (the pros and cons)
  A - Act
  L - Learn

- Anticipate stressful situations and help them to be prepared.
- Do not burden them with too many responsibilities and activities.
- Use gentle humour.
- Encourage children to seek social support e.g.: friends, grandparents and relatives.
- Encourage them to do physical activities and develop other interests e.g. exercise, outdoor activities and hobbies.
- If the adult is still not able to resolve the problem, referral for professional help is advised.
UNIT 5 : COUNSELING

5.1 DEFINITION

- Providing help, support and understanding for someone who is in need; creating a non-defensive climate and building a trusting relationship, helping the client to gain clearer insight into himself and his situation so that he is more able to help himself and draw on his resources.

- A process of helping someone to be more confident of himself and uplifting his esteem so as to enable him to solve his problems. This is to ensure his well-being and a more meaningful life for him.

5.2 PRINCIPLES OF COUNSELING

- Human beings are very complex and unique individuals; therefore in counseling they should be managed as such.

- The presenting problems are not necessarily their actual problems.

- Different persons require different lengths of time to trust and disclose their real problems to others.

- Individuals have the right to either disclose or not to disclose any information about themselves.

- A personal relationship is necessary to create rapport and trust towards the counselor.

- Clients are in the best position to solve or cope with their own problems and make the right decisions.

5.2.1 PRINCIPLES OF COUNSELING THE ADOLESCENT

- Adolescence is a period of transition. Adolescents are able to take control of their own life and make decisions for themselves. Therefore the counselor is to assist the adolescent to make informed choices.

- The counselor should have the skills necessary to demonstrate to the client respect and a willingness to listen.

- It is important that the counselor accepts the client as an individual even if their behaviour is seen as inappropriate.

- The counselor can help clients feel more in control of their own lives, to feel successful and confident. Initially, this will be done by the client making small changes.

- Rewards from feeling more confident have a far greater effect on the healthy development and behavioural changes of adolescents then do punishments and it is more durable than external reward.

- Internal rewards will help the adolescent try to make greater changes in the way he lives his life and to wait longer for the rewards.
5.3 ETHICAL ISSUES IN COUNSELING

- **Confidentiality**
  The knowledge that what is discussed with the counselor will not be revealed to anyone else gives people permission to disclose their innermost fears and feelings.

- **Transference**
  This is an unconscious process whereby clients project onto their counselor past feelings or attitudes that they had towards significant people in their lives. A client will then view the counselor with a mixture of positive and negative feelings. At different times the same client may express love and hatred towards the counselor.

- **Counter transference**
  This is the opposite of transference, whereby the counselor develops certain feelings and emotions towards the particular client. It may facilitate or become a hindrance to the progress of counseling. If it causes hindrances, the counselor should terminate the session and refer the client to another counselor.

- **Termination of counseling**
  It is best that termination of counseling is by mutual agreement between counselor and client. Counseling should not end abruptly; it would be more helpful if it were to be discussed in advance. However, if the counselor feels that the counseling should end, but the client does not feel the same, this would indicate that the client has become overly dependent upon the counselor and efforts should be made to deal with that issue before ending the counseling.
UNIT 1 : ATTENTION DEFICIT HYPERACTIVITY DISORDER

1.1 INTRODUCTION / DEFINITION

In the 2nd National Health and Morbidity Survey conducted by the Ministry of Health, it was found that 4.3% of children and teenagers between 5-15 years of age had symptoms of attention deficit hyperactivity disorder (ADHD). Males are affected more than females.

ADHD has the core symptoms of developmentally inappropriate attention deficit, high activity level and impulsivity. The deficits in ADHD are evident in multiple settings of home, school and clinic (when they present for assessment and management).

1.2 PRESENTING COMPLAINTS

Patient is very active:
- Unable to sit still for more than a short time.
- Always on the move.
- Cannot wait for turn.
- Will not listen to what others say.
- Has poor concentration.
Younger ones may be disruptive in school.

1.3 DIAGNOSTIC CRITERIA

DSM IV criteria for diagnosing Attention Deficit / Hyperactivity Disorder are as follows:

A:- EITHER (1) OR (2):

(1) Six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention:
 a) Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
 b) Often has difficulty sustaining attention in tasks or play activities.
 c) Often does not seem to listen when spoken to directly.
 d) Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behaviour or failure to understand instructions).
 e) Often has difficulty organising tasks and activities.
 f) Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).
 g) Often loses things necessary for tasks or activities (e.g. toys, school assignments, pencils, books, or tools).
 h) Is often easily distracted by extraneous stimuli.
 i) Is often forgetful in daily activities.

(2) Six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity:
 a) Often fidgets with hands or feet or squirms in seat.
 b) Often leaves seat in classroom or in other situations in which remaining seated is expected.
c) Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness).

d) Often has difficulty playing or engaging in leisure activities quietly.

e) Is often “on the go” or often acts as if “driven by a motor”.

f) Often talks excessively.

**Impulsivity:**

g) Often blurts out answers before questions have been completed

h) Often has difficulty awaiting turn

i) Often interrupts or intrudes on others (e.g. butts into conversations or games)

**B:** Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

**C:** Some impairment from the symptoms is present in two or more settings (e.g. at school [or work] and at home).

**D:** There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

**E:** The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder)

**Code based on type:**

**314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type:**
If both Criteria A1 and A2 are met for the past 6 months.

**314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type:**
If Criterion A1 is met but Criterion A2 is not met for the past 6 months.

**314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type:**
If Criterion A2 is met but Criterion A1 is not met for the past 6 months.

**1.4 DIFFERENTIAL DIAGNOSIS**

- Conduct Disorder
  (patient exhibits disruptive behaviour without inattentiveness)

- Oppositional Defiant Disorder
  (patient’s behaviour is seen only in the home or school but not in both settings)

- Learning Disorder or Mild Mental Retardation
  (patient loses concentration because of inability to follow the lessons in class)

- Autism / Pervasive developmental disorder
  (social language impairment and stereotyped behaviours are present)

- Parent-child problems
  (patient shows variation in behavioural difficulties in selected situations e.g. at home but not in class)

- A specific physical disorder
  (e.g. epilepsy, fetal alcohol syndrome, thyroid disease)
1.5 CO-MORBIDITIES

Up to 40-60% of children with ADHD have at least one other major disorder. The following disorders can co-exist in a patient with ADHD. Careful eliciting of the history and psychiatric examination will enable the additional diagnoses to be made.

- Learning Disorder: up to 60%.
- Conduct Disorder: 25% of children, 45-50% of adolescents.
- Oppositional Defiant Disorder: 40%.
- Anxiety Disorders: 30%.
- Depression: 10-30%.
- Bipolar Disorder: 20%.
- Tourette's Disorder, Chronic Tic Disorder: 7%.
  (60% of patients with Tourette's Disorder have ADHD).
- Substance abuse.

ADHD youth have increased risk of early cigarette use, followed by alcohol and then drug abuse.

Many children who have Autism or Mental Retardation have features of hyperactivity.

1.6 ESSENTIAL INFORMATION FOR PATIENT AND FAMILY

- Hyperactive behaviour is not the fault of the child. It is caused by an impairment of attention and self-control that is often inborn.
- Hyperactive children need extra help to remain calm and attentive at home and school.
- Some hyperactive children continue to have difficulties into adulthood, but most make a satisfactory adjustment especially with treatment.
- Patients may behave better if parents can be calm and accepting.

1.7 COUNSELING OF PATIENT AND FAMILY

- Combined approaches to the management of the child/teenager with ADHD are probably the most useful and realistic. This should include psychosocial interventions, pharmacotherapy and educating the child and his parents about ADHD and what they can do to cope and eventually overcome the effects.
- Encourage parents to give positive feedback or recognition when the child is able to pay attention.
- Disciplinary control must be immediate (within seconds) to be effective. Physical punishment should be avoided as it may encourage the child to use aggression himself.
- Parents should be advised to discuss the problem with the child's schoolteacher. This is to explain the need for learning in short bursts, immediate rewards to encourage attention, and giving the child periods of individual attention.
- Distractions need to be minimised (e.g. have child sit in the front row in class)
- Encourage sports, games and other physical activities to help release energy.

1.8 MEDICATION

Stimulants are the most commonly used group of medications of which methylphenidate is the most studied. Beneficial effects have been seen on the defining symptoms of ADHD as long as the medication is taken. However stimulants do not normalise the entire range of behaviour problems.
Children under treatment may still display more behaviour problems than normal children.

Dosage range of Methylphenidate: 0.1 mg - 1.0 mg/kg/day. Commonly, 10-30 mg / day in divided doses. Usually starting with a low single dose per day, increasing to higher doses and up to twice a day.

Practical pointers:
- Methylphenidate should be given after food, as it tends to cause appetite loss.
- Multivitamins may be added to help the child maintain his appetite.
- Do not give Methylphenidate in the evenings (i.e. not later than 4 pm) as it may cause insomnia.
- Regular monitoring of height and weight is necessary to detect any adverse effects on growth especially in those children with poor appetite. Parents should be advised to discontinue Methylphenidate in their children if the height and weight do not increase or if there is continued weight loss.

Side-effects of Methylphenidate:
- Loss of appetite
- Abdominal pains
- Insomnia
- Behavioural toxicity (become more hyperactive, aggressive, crying for no apparent reason).
- The dose should be decreased or the medication discontinued if no improvement of the side effects occurs.

Contraindication:
- Do not give Methylphenidate to patients with tics or Tourette's disorder.

Other useful medications include:
- Neuroleptics
  (To reduce the activity level without increasing concentration) e.g. Haloperidol, Risperidone.
- Antidepressants
  (For its empirical effect on inattention and not for antidepressant effect) e.g. Fluvoxamine, Fluoxetine.

1.9 **REFERRAL TO OCCUPATIONAL THERAPIST, EDUCATIONAL PSYCHOLOGIST, CLINICAL PSYCHOLOGIST WHERE APPROPRIATE.**

1.10 **SPECIALIST CONSULTATION**
Consider child psychiatry consultation if symptoms are severe or measures above are not successful.
REFERENCES

1. Diagnostic and Statistical Manual of Mental Disorders IV. American Psychiatric Association.


6. CHADD Factsheet 5. ADHD and co-existing disorders. CHADD 2000

7. Ministry of Health, Malaysia. Diagnostic and Management Guidelines for Mental Disorders in Primary Health Care.
UNIT 2: DEPRESSION

2.1 INTRODUCTION

About 5% of children at any given time suffer from clinical depression. It can interfere with the normal developmental process of childhood.

Sadness is a common normal experience characterised by lowered mood and a loss of interest or pleasure in activities that are normally enjoyable. Depression can be distinguished from sadness by its severity, persistence, duration and the presence of characteristic symptoms.

Untreated depression can affect school performance, social interactions and development of peer relationships. It also affects self-esteem, life skills acquisition and parent-child bonding. It can lead to substance abuse, disruptive behaviour, violence, aggression, trouble with the law and even suicide.

2.2 PRESENTING COMPLAINTS

Depression is a disorder that is defined by certain behaviours and thought patterns. Although the core troubles are the same for children as they are for adults, often the specific behaviours are different and vary according to the age and developmental level of the child.

<table>
<thead>
<tr>
<th>ADULT SYMPTOMS</th>
<th>CHILD EXAMPLE</th>
<th>ADOLESCENT EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diminished interest / pleasure, inability to feel pleasure.</td>
<td>Not as motivated or playful, not as curious and explorative, school work drops off, boredom. Lack of interest in playing with friends.</td>
<td>Isolate themselves, quits activities, shows no initiative, grades drop, boredom.</td>
</tr>
<tr>
<td>Unintentional weight changes.</td>
<td>Fails to gain weight normally.</td>
<td>Weight changes.</td>
</tr>
<tr>
<td>Sleep changes.</td>
<td>Difficulty falling asleep or staying asleep and sleeping most times.</td>
<td>Difficulty falling asleep or staying asleep, stays up all night, hypersomnia.</td>
</tr>
<tr>
<td>Being slowed down or speed up.</td>
<td>Difficulty concentrating or sitting still, impulsivity, less active or interactive, hyperactive, disorganised.</td>
<td>Difficulty concentrating or sitting still, impulsivity, less active or interactive, disorganised.</td>
</tr>
<tr>
<td>Fatigue.</td>
<td>Needs rests, naps, complains when pushed to do things, plays ‘sick’. Frequent vague, non specific physical complaints such as head-aches, muscle-aches, stomach-aches or tiredness. Frequent absences from school or poor performance in school.</td>
<td>Refuses to participate, lazes around a lot, sleeps during day, acts ‘sick’ a lot. Frequent vague, non specific physical complaints such as headaches, muscleaches, stomach-aches or tiredness. Frequent absences from school or poor performance in school.</td>
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</table>
The way symptoms are expressed varies with the developmental stage of the child. In addition, children and adolescents with depression may have difficulty in properly identifying and describing their internal emotional or mood states. For example, instead of communicating how bad they feel, they may act out and be irritable toward others, which may be interpreted simply as misbehaviour or disobedient. An easier way to identify symptoms of depression by using the mnemonics below:

**“SIGECAPS” - for Depression**

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<td>Worthlessness and guilt.</td>
<td>Makes negative self comments such as ‘You hate me’ and ‘I’m stupid’</td>
<td>Makes negative self comments such as ‘I’m fat’, ‘I’m ugly’, ‘Everybody hates me’.</td>
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<td>Poor concentration, can’t make decisions.</td>
<td>Poor attention and concentration, easily distracted, disorganised</td>
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<tr>
<td>Reckless behaviour.</td>
<td></td>
<td>Frequent absences from school or poor performance in school. Talk of efforts to run away from home.</td>
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<td></td>
<td>Alcohol or substance abuse.</td>
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<tr>
<td>Thoughts of death or suicide.</td>
<td>Talks about death, states ‘I wish I was never born’ or ‘I wish I was dead’.</td>
<td>Obsesses on death and morbid topics, voices wishes to be dead or thinks about / attempts suicide.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Susiciousness, paranoia, seeing fearful images or hearing their name called.</td>
</tr>
<tr>
<td>Psychosis; hearing things, seeing things, or paranoia.</td>
<td>Extreme fears for safety, seeing scary images, hearing monsters.</td>
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**2.3 DIFFERENTIAL DIAGNOSIS**

1. **Dysthymic disorder**
   The presence of depressed or irritable mood for most of the day, nearly every day, as indicated either subjective account or observation by others for at least two years. It includes the presence of two of the following symptoms (DSM IV):
   - Poor appetite / overeating
   - Insomnia / hypersomnia
   - Low energy or fatigue
   - Poor concentration / difficulty.
   - Making decisions.
   - Feelings of hopelessness.

In children and adolescents, mood can be irritable and duration must be at least 1 year.
(2) Major depressive disorder
Significant distress or impairment manifested in five to nine of the criteria listed below (DSM IV):

- Occurring almost daily for two weeks.
- A depressed, diminished or irritable mood.
- Lost of interest and or pleasure must be among these criteria.
- And must represent a change from previous functioning:
  - Depressed / irritable.
  - Recurrent thoughts of death and suicidal ideation.
  - Diminished interest or pleasure.
  - Weight loss / gain.
  - Psychomotor agitation / retardation.
  - Fatigue or energy loss.
  - Feelings of worthlessness.
  - Diminished ability to think / concentrate.

2.3.3 BEREAVEMENT
It is sadness related to a major loss that typically persists for less than two months after a loss. The symptoms are transient and may have a mild impact on functioning.

2.3.4 ADJUSTMENT DISORDER
Refer to section on Stress Related Disorders.

2.3.5 BIPOLAR AFFECTIVE DISORDER
Refer to section on Bipolar Disorders.

2.4 DIAGNOSTIC CRITERIA (DSM IV)

CRITERIA FOR MAJOR DEPRESSIVE EPISODE

A: Five (or more) of the following symptoms have been present during the same 2-week periods and represent a change from previous functioning. At least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g., appears tearful).
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feeling of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B: The symptoms do not meet criteria for a Mixed Episode.

C: The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D: The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
E: The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms or psychomotor retardation.

2.5 ASSOCIATED CONDITIONS

a. Infections
   • Human immunodeficiency virus infection.

b. Neurological disorders
   • Epilepsy.
   • Post concussion syndrome.

c. Endocrine
   • Hyperthyroidism.
   • Hypothyroidism.
   • Addison's disease.

d. Autoimmune conditions
   • SLE.

e. Effects of Medications
   • Barbiturates.
   • Benzodiazepines.
   • Corticosteroids.
   • Cimetidine.
   • Aminophylline.
   • Anticonvulsants.

f. Others
   • Alcohol abuse.
   • Depression in the family.
   • Psychotic illness.
   • Presence of a chronic illness e.g. diabetes.
   • History of abuse.

Sometimes medical conditions may produce symptoms of lethargy, listlessness that could be mistaken for depression. These include:
   • Anaemia.
   • Viral Hepatitis.
   • Chronic Renal Failure.

2.6 EVALUATION

When a child is suspected to be depressed, a comprehensive mental health evaluation is warranted. Interview the child, parents and when possible other informants e.g. school teachers.

Investigations that can be done to rule out organic causes:
• Complete blood cell count - to exclude anaemia or infection.
• Serum electrolytes and creatinine - to screen for electrolyte disorders or renal disease.
• Liver function studies - to exclude hepatitis and drug effects.
• Thyroid function tests - to detect thyroid disorders.
• Electroencephalogram - to assist in ruling out a seizure disorder.
2.7 MANAGEMENT

The management of depressed children depends greatly on the nature of the problems identified. This involves short-term psychotherapy, medication or a combination plus targeted intervention in the school, home etc.

a) Psychoeducation
Involves educating the patient and his family to enhance the understanding of the disorder and help improve patient compliance with therapy. This education should occur within the patient’s community as well, especially the school.

b) Antidepressants
The development of newer antidepressant medications and mood stabilisers in the last 20 years has revolutionised the treatment of depression.

There are several types of antidepressants:

- **Selective Serotonin Reuptake Inhibitors (SSRI)**
  - Fluoxetine, Sertraline, Fluoxamine, and Citalopram

- **Reversible Monoamine Oxidase Inhibitors (RIMAs)**
  - Moclobemide

- **Others:**
  - Venlafaxine,
  - Mirtazapine

2.8 INFORMATION TO FAMILY

- Proper explanation about the illness, its treatment and complications.
- Acute treatment with medications helps to relieve symptoms until the patient feels well. Once the symptoms are relieved, maintenance therapy typically continues for 6 to 12 months to prevent a relapse.
- Untreated depression can lead to suicide. Suicide is the third leading cause of death for 15 to 24 year-olds and the sixth leading cause of death for 5 to 14 year-olds.

2.9 SPECIALIST CONSULTATION

Consider referral to a Child Psychiatrist if the child fails to respond to the recommended treatment.
UNIT 3 : EATING DISORDERS

3.1 INTRODUCTION

Eating disorders are illnesses that occur when eating, or the lack of it, leads to psychiatric problems. It includes anorexia nervosa and bulimia nervosa, both of which involve serious psychiatric and physical disturbances. They are more common in girls than boys (ratio of 8 -12: 1). They are most common in post-pubertal age, but may also occur in pre-pubertal boys and girls.

Anorexia nervosa is predominantly a disorder of adolescent girls. Its essential feature is the profound aversion of eating leading to serious weight loss. Despite losing weight, their body image is distorted and thus they deny being unduly thin even when they appear cachexic.

There are 2 types of anorexia nervosa:
* Restricting type (poor intake)
* Binge eating / purging type with self-induced vomiting or the misuse of laxatives, diuretics or enemas.

Patients with restrictive type of Anorexia Nervosa will commonly go on to develop the bulimic type. Most bulimic anorectic patients retain their bulimia.

Bulimia Nervosa patients have recurrent episodes of binge-eating (i.e. excessive eating in a discrete period of time) usually followed by self-induced vomiting, misuse of laxatives, diuretics and enemas.

3.2 PRESENTING COMPLAINTS

a) Anorexia Nervosa - characterised by these features:
• Deliberate loss of weight
  Achieved by strict dieting and the avoidance of food perceived to be fattening. Fasting continues despite excessive hunger and cravings for food. Other tactics employed are self-induced vomiting and purging, excessive exercise, and use of appetite suppressants or diuretics / laxatives.

• Excessive fear of obesity and weight gain
  Preoccupation with body weight and shape. Individuals have self-exaggerated influence on self-image. They will set very low and unrealistic target weights for themselves and do not acknowledge that they have a problem.

• Associated endocrine dysfunction
  Females develop amenorrhea (cessation of menstruation for at least 3 months), while in men the endocrine disorder is associated with a loss of sexual desire and potency. In pre-pubertal children, anorexia nervosa may be evidenced by failure of growth spurts and delayed puberty.

b) Bulimia Nervosa - may have some features of Anorexia Nervosa but other distinguishing factors include:
• Morbid fear of becoming fat.
• Irresistible urge to overeat.
• Self- induced vomiting or purging.
3.3 SIGNS AND SYMPTOMS

a) Anorexia Nervosa:
- Low pulse.
- Low blood pressure.
- Emaciation.
- Drowsiness.
- Dry cold skin.
- Unhealthy dry hair.
- Lanugo hair.
- Irritability.
- Obsessional thinking.
- Increased perfectionism.
- Social withdrawal so as to avoid situations involving eating.
- Low self-esteem.

b) Bulimia Nervosa:
- Swollen salivary glands from recurrent vomiting often confused with mumps.
- Irregular menstruation caused by energy deficiency during periods of starvation.
- Dental decay caused by the high acid content of vomitus.
- Abdominal pain due to acute stretching or dilatation of the stomach due to overeating.
- Irritable bowel, dark mucus in colon (melanosis coli), disturbed bowel motion from chronic laxative abuse.
- Insomnia.
- Chronic hoarseness of voice.

3.4 DIAGNOSTIC CRITERIA ANOREXIA NERVOSA (DSM IV):

(307.1) Criteria for Anorexia Nervosa
A. Refusal to maintain body weight at or above a minimally normal weight for age and height.
B. Intense fear of gaining weight or becoming fat, even though underweight.
C. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation or denial of the seriousness of the current low body weight.
D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles.

Specify type:

Restricting Type:
During the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics or enemas)

Binge-Eating / Purging Type:
During the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives diuretics or enemas)

(307.2) Criteria for Bulimia Nervosa
A. Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
   1. Eating in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
   2. A sense of lack of control over eating during the episode (e.g., a feeling that one can’t stop eating or control what or how much one is eating).
SECTION 2: EMOTIONAL AND BEHAVIOURAL DISORDERS OF CHILDREN AND ADOLESCENTS

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, enemas or other medications, fasting or excessive exercise.

C. The binge-eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specify type:

Purging Type:
During the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas.

Nonpurging Type:
During the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas.

(307.2) Criteria for Eating Disorder Not Otherwise Specified
The Eating Disorder not otherwise specified category is for disorder of eating that do not meet the criteria for any specific eating disorder. Examples include

1. For females, all of the criteria for Anorexia Nervosa are met except that the individual has regular menses.
2. All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual's current weight is in the normal range.
3. All of the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or of duration of less than 3 months.
4. The regular use of inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food (e.g., self-induced vomiting after the consumption of two cookies).
5. Repeatedly chewing and spitting out, but not swallowing large amounts of food.
6. Binge-eating disorder: recurrent episodes of binge-eating in the absence of the regular use of inappropriate compensatory behaviors characteristics of Bulimia Nervosa (see appendix B in DSM IV for suggested research criteria).

3.5 DIFFERENTIAL DIAGNOSIS

a) Anorexia Nervosa
- Organic causes - Crohn's Disease, brain tumour, chronic debilitating disease, malabsorption syndrome.
- Depression.
- Obsessional symptoms.
- Psychosis.
- Bulimia nervosa.

b) Bulimia Nervosa
- Chronic diarrhoea.
- Klein Lewin syndrome.
- Personality disorders.
- Depression.
3.6 MANAGEMENT

Management should be multi-modal. Milder cases may be treated as out-patient, but severe ones should be admitted to hospital.

a) Restoration of weight and normal eating pattern

For adolescents the objective is to achieve steady weight gain or weight stability so that the individual is physically healthy and continues to grow at a normal rate. The target Body Mass Index (BMI) is 18.5 - 25 although premorbid weight may also be used as a guide.
(Note: BMI is the weight in kg divided by the square of the height in metres)

b) Psychological intervention includes:

- Fostering healthy beliefs about body weight and shape
- Psychotherapy - includes family therapy and individual psychotherapy. It enhances the psychological well being of the individual.
  - Family therapy allows the patient and family to work on the various family issues that contributed to the disorder. Examples of family therapy models used include systemic, strategic and structural family therapy.
  - Individual psychotherapy allows the patient to develop more adaptive responses to stress and to use more effective coping mechanisms so that mastery of the self can be achieved without resorting to maladaptive eating patterns.
  - Behavioural therapy is essential in the process of encouraging the patient to gain weight and to eat normally.

c) Pharmacological treatment

Research evidence has shown that antipsychotics are generally of no clinical value in the treatment of Anorexia Nervosa.

Antidepressants are indicated in the anorexic patient with accompanying depression. It can also be effectively used to control binge eating. Examples of antidepressants that can be used is the SSRI's.

Liaison with a dietician is strongly recommended.

3.7 SPECIALIST CONSULTATION

Consider consultation if symptoms are severe or if there are medical complications.
UNIT 4 : LEARNING DISABILITIES

Other name: Specific Developmental Disorders of Scholastic Skills (SDDSS)-ICD-10; Learning Disorders - DSM-IV

4.1 INTRODUCTION

Learning Disorders (LD) are defined as disorders in which the normal patterns of skill acquisition are disturbed from the early stages of development. This results in which one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or to do mathematical calculations, including conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia and developmental aphasia.

The term does not include learning problems that are primarily the result of visual, hearing, or motor disabilities, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantages.

4.2 PREVALENCE

Boys are more commonly affected compared to girls and this disorder may persist into adulthood.

The exact etiology of SDDSS is not known. However there is an assumption that the biological factors interacting with non-biological factors (such as opportunity for learning and quality of teaching) produce the manifestations.

4.3 DIFFICULTIES IN DIAGNOSIS

a) There is a need to differentiate these disorders from normal variations in scholastic achievement.

b) There is a need to take the developmental course of the child into account namely:

   â€¢ Severity (e.g. the significance of one year’s retardation in reading at age 7 is quite different from that of one year’s retardation at 14 years),

   â€¢ Change in pattern (e.g. Speech delay in a preschooler may resolve but is followed by reading problems in school and severe spelling problems in adulthood. The condition is the same through out but the pattern alters with increasing age)

   c) Scholastic skills have to be taught and learned. They are not simply a function of biological maturation. A child’s level of skills will depend on family circumstances and schooling as well as his/ her own individual characteristics.

   d) There is no easy way to differentiate a child who has reading difficulty due to cognitive abnormalities from one who has difficulty due to environmental deprivation.

   e) There are continuing uncertainties over the best way of subdividing the learning disorders.

4.4 PRESENTING COMPLAINTS

LD frequently occur in conjunction with other clinical syndromes namely ADHD, conduct disorder or other developmental disorders such as specific developmental disorder of motor function or specific developmental disorders of speech and language.
4.5 TYPES OF LEARNING DISORDERS (ICD-10)

1. Specific Reading Disorder.
2. Specific Spelling Disorder.
3. Specific Disorder Of Arithmetical Skills.

4.6 DIAGNOSTIC FEATURES

- Clinically significant degree of impairment in the specified scholastic skill. The individual’s achievement in reading, arithmetic or written expression is substantially below that expected for age, schooling and level of intelligence. (Substantially below is defined as a discrepancy of more than 2 standard deviations between achievement and IQ)
- The learning problems significantly interfere with academic achievement or activities of daily living that require reading, mathematical or writing skills.
- The impairment must be specific, not solely explained by mental retardation.
- The impairment must be developmental i.e. it must have been present during the early years of schooling and not acquired later in the educational process. The child’s school progress should provide evidence on this point.
- There must be no external factors that could provide a sufficient reason for scholastic difficulties.
- Uncorrected visual or hearing impairments have been ruled out.

4.7 ASSOCIATED FEATURES AND DISORDERS

- Feeling demoralised.
- Low self-esteem.
- Deficit in social skills.
- Increased school drop-out rate.
- Difficulties in employment or social adjustment in adulthood.

Many individuals (10 - 25%) with Conduct Disorder, Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Major Depression or Dysthymic Disorder also have learning disorders.

There is evidence that developmental delays in language may occur in association with LD especially reading disorder although these delays may not be sufficiently severe to warrant the separate diagnosis of a Communication Disorder.

4.8 CULTURE-SENSITIVE TESTING

Care should be taken to ensure that intelligence testing procedures reflect adequate attention to the individual’s ethnic or cultural background. This is usually accomplished by using tests in which the individual’s relevant characteristics are represented in the standardization sample of the test or by employing an examiner who is familiar with aspects of the individual’s ethnic or cultural background. Individualized testing is always required to make the diagnosis of a Learning disorder.
4.9 DIFFERENTIAL DIAGNOSIS

- Normal variation in academic attainment.
- Scholastic difficulties resulting from lack of opportunity, poor teaching, cultural factors.
- Impaired vision or hearing.
- Mental Retardation.
- Pervasive Developmental Disorder.
- Communication Disorders.
- Neurological conditions (e.g. epilepsy).
- General medical conditions (e.g. Lead poisoning, Fetal alcohol syndrome, Fragile X- syndrome).

TYPES OF LEARNING DISORDER

1: Specific Reading Disorder (Dyslexia)
Diagnostic Features:
- Reading achievement (reading accuracy, speed or comprehension) falls substantially below that expected of age, education and intelligence.
- The disturbance significantly interferes with academic achievement or activities of daily living that require reading skills.
- If a sensory deficit is present, the reading difficulties are in excess of those usually associated with it.
- Oral reading is characterized by distortions, substitutions or omissions.
- Both oral and silent reading is characterized by slowness and errors in comprehension.

2: Specific Spelling Disorder
Diagnostic features:
- Specific and significant impairment in the development of spelling skills. This is clearly shown by below average spelling performance for his/her age, general intelligence and school placement.
- Absence of history of specific reading disorder.
- Disability is not due to low mental age, visual acuity, hearing problems, neurological dysfunction or inadequate schooling.
- Psychiatric and other disorders have been ruled out.
- The ability to spell orally and to write out words correctly is both affected.

3: Specific Arithmetic Disorder
Diagnostic features:
- Mathematical ability is substantially below that expected of age, education and intelligence.
- The impairment significantly interferes with academic achievement or activities of daily living that require mathematical ability.
- If a neurological or other general medical condition or sensory deficit is present, the difficulties in mathematical ability are in excess of those usually associated with it.
- Skills that may be impaired in mathematical disorder include ‘linguistic’ (understanding or naming mathematical term, operation, or concepts, decoding written problems.
- Option: involves recognising number, symbols, memorising facts, aligning numbers, and understanding concepts like place values and fractions.
4: Mixed Disorder of Scholastic Skills

LEARNING DIFFICULTIES

Adequate stimulation?

Global intellectual dev. delay

MENTAL RETARDATION

Speech & language problems

Specific areas of difficulties

Impaired social development

ENVIRONMENTAL UNDER STIMULATION

READING DISORDER

MATHEMATICS DISORDER

DISORDER OF WRITTEN EXPRESSION

SPECIFIC SPEECH & LANGUAGE DISORDER

PERVASIVE DEVELOPMENT DISORDER
4.10 MANAGEMENT

Steps to be taken to evaluate a child who is not performing well at school:

- Assess global intellectual functioning. Is the child’s learning difficulty part of an overall pattern of delayed development of speech, cognition and social functioning? If so, consider mental retardation.
- Exclude common physical impairments that affect learning. Check vision and hearing.
- Has the problem been noticed since very young or is recent? If it is present from the very start, it is more likely to be due to developmental factors. If it is recent, look for any precipitating factors either at school or at home.
- Is there any problem in engaging the child? Is there difficulty in getting his attention? Does he show abnormalities in social interaction? If so, consider autism or ADHD.
- Has the problem been noticed since very young or is it recent? If it is present from the very start, it is more likely to be due to developmental factors. If it is recent, look for any precipitating factors either at school or at home.
- Is there any specific learning under-achievement? Is the child under-performing over a whole range of subjects or just in some areas? Special educational achievement tests need to be done to evaluate this to pick up areas for remedial coaching.
- Engage the parents and teachers to help diagnose and jointly manage the situation. The child would need remedial help from special needs education.

4.11 COUNSELING FOR PATIENT AND FAMILY

Option:

- Parents need to educate themselves about the child’s condition.
- Visit the child’s class often, taking notes of any difficulties in class.
- Plan activities with the child e.g. off days, reading aloud to the child as often as possible, communicating with the child and learn to be patient. Understand that learning is difficult and challenging for the child - they need patience, support and laughter.

A. How can teachers and parents help?

Remedial teaching can be a slow process, but early intervention increases the likelihood of a better outcome. In multilingual communities, parents and teachers need to be especially vigilant because specific impairment in language is much harder to detect.

- They need to understand that LD may lead to emotional distress to the child and their family. Emotional difficulties may magnify the problems further.
- Teachers must provide learning opportunities for the children to be involved and to be able to demonstrate their competence.
- The child can be involved in play, sports art or other forms of learning.
- The child’s adaptive skills can by built further by improving their social skills and self-esteem.

Practical parenting tips to encourage reading

1. Obtain audio versions of books or make audio recordings of children's books. This is to enable the child to attempt to read while listening to the book being read. Get the child to match their books with their corresponding tapes using coloured stickers.
2. Buy a book for each child for each holiday occasion as a family tradition. Read the book together with your child.
3. Keep your child actively involved while you read aloud. E.g. acting out the story, mimicking animal sounds etc. Make reading interesting by using gestures, different facial expressions and tones. You may ask your child to bring a favourite toy along to “listen” to the story.
4. Play audio recordings of your child’s favourite stories to listen to when the child is too tired to read. A tired child may listen to the tapes and just follow along. Remember to say beep or ring a bell when you turn each page just as the commercial books and tapes do!
5. Schedule a daily reading time. Make it a relaxed and fun time, not a chore.
6. Reward older children with extra reading time alone in bed for a few minutes after the usual lights-out time.
7. Parents should set a good example by practicing the reading habit.
8. Use a lot of encouragement and praise.

B. Specialist consultation
Refer to the Paediatrician for assessment, diagnosis, exclusion of medical conditions and further management.

A Clinical Psychologist is needed to perform formal psychological and educational assessment. Refer to a Child Psychiatrist for assistance in the assessment and for management of associated emotional and behavioural problems.
UNIT 5 : SUBSTANCE ABUSE AND DEPENDENCE

5.1 INTRODUCTION

Substance abuse and dependence amongst adolescents has become a major health problem. Adolescents are experimenting with alcohol and tobacco at an earlier age which increases the risk of using other drugs later. There tends to be a stepwise progression in substance abuse. It is usually starts with the use of tobacco progressing to marijuana (ganja) and heroin.

Adolescents maybe involved with legal or illegal drugs in various ways:

- **Mainly experimental**
  Most adolescents experiment, at least with alcohol, cigarettes, marijuana (ganja), at some stage.

- **Situational or recreational**
  A smaller number may use drugs at parties and in stressful situations e.g. facing examinations and family disharmony.

- **Compulsive**
  A smaller number become dependent on one or more drugs.

5.2 REASONS FOR SUBSTANCE ABUSE

It is important to understand why the individual is engaging in this kind of behaviour. Some of the possible reasons are:
- Social/peer pressures.
- Emotional stability and personality of the person.
- Psychiatric conditions such as depression and conduct disorder
- Genetic predisposition.
- Social isolation.
- Poor parental relationship.
- Low self-esteem.
- Unconventional beliefs regarding drugs and their use.

5.3 WHO IS AT RISK?

Teenagers at risk for developing serious alcohol and drug problems include those:
- With a family history of substances abuse.
- Who are depressed.
- Who have low self-esteem.
- Who feel like they don’t fit in or are out of the mainstream.
WARING SIGNS OF TEEN SUBSTANCE ABUSE

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
</tr>
<tr>
<td>Fatigue, repeated health complaints, red and glazed eyes, and a lasting cough.</td>
</tr>
<tr>
<td>Emotional</td>
</tr>
<tr>
<td>Personality change, sudden mood changes, irritability, irresponsible behaviour, low self-esteem, poor judgement, depression and a general lack of interest.</td>
</tr>
<tr>
<td>Family</td>
</tr>
<tr>
<td>Starting arguments, breaking rules or withdrawing from the family.</td>
</tr>
<tr>
<td>School</td>
</tr>
<tr>
<td>Decreased interest, negative attitude, drop in grades, many absences, truancy and discipline problems.</td>
</tr>
<tr>
<td>Social problem</td>
</tr>
<tr>
<td>New friends who are less interested in standard homes and school activities, problems with law and changes to less conventional styles in dress and music.</td>
</tr>
</tbody>
</table>

Some of the warning signs listed above can also be signs of other problems.

5.4 COMMONLY ABUSED SUBSTANCES

<table>
<thead>
<tr>
<th>DRUG</th>
<th>HOW USED</th>
<th>MAIN CHARACTERISTIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>Smoked</td>
<td>Powerfully addictive, widely advertised and readily available to young people.</td>
</tr>
<tr>
<td></td>
<td>Chewed</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>Drunk as toddy, beer and wine</td>
<td>Causes physical dependence and widely abused, introduced to children in some families.</td>
</tr>
<tr>
<td>Cannabis Product</td>
<td>Smoked in cigarettes (joints) and pipes</td>
<td>Intoxicant and euphoric, causes psychological dependence, relatively cheap, readily available.</td>
</tr>
<tr>
<td>- Hashish</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Marijuana/Ganja</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stimulants</td>
<td>Oral Intronous</td>
<td>Euphoric, causes feelings of well being and increased energy. May cause psychosis. Dependence common, mainly psychological dependence.</td>
</tr>
<tr>
<td>- Amphetamines</td>
<td></td>
<td></td>
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<tr>
<td>(speed and ice)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- MDMA (ecstasy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inhalants</td>
<td>Inhaled, often from plastic bag</td>
<td>Brief euphoria and confusion. Psychological dependence may occur. May cause brain damage.</td>
</tr>
<tr>
<td>- Petrol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Solvents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Glue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Narcotics</td>
<td>Intravenous</td>
<td>Feeling of well being, pleasant drowsiness, contentment. Physical dependence may occur.</td>
</tr>
<tr>
<td>- Heroin</td>
<td>Oral</td>
<td></td>
</tr>
<tr>
<td>- Morphine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Codeine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tranquillizers</td>
<td>Oral Intronous (rarely)</td>
<td>Light headedness; relief of tension. Used for calming down after using stimulants. Physical and psychological dependence may occur.</td>
</tr>
<tr>
<td>- Benzodiazepines</td>
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</tbody>
</table>
5.5 **DIAGNOSTIC CRITERIA FOR SUBSTANCE ABUSE (DSM IV)**

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12 month period.

1. Recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use, substance-related absences, suspensions, or expulsions from school; neglect of children or household).
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

5.6 **COURSE AND PROGNOSIS**

Drug use is associated with a variety of negative consequences, including increased risk of serious drug use later in life, school failure, and poor judgement which may put teens at risk for accidents, violence, criminal activity, unplanned and unsafe sex and self-harm.

Generally, levels of substance abuse peak in late adolescence or early adulthood. Life events such as educational achievement, career attainment, marriage, and parenthood tend to decrease or stop substance abuse.

5.7 **MANAGEMENT**

Evaluation of the patient should include:

- Medical assessment.
- Psychosocial assessment.

No single treatment is appropriate for all teenagers. It is important to match treatment settings, interventions, and services to each individual's particular problems and needs. This is critical to his or her ultimate success in returning to healthy functioning in the family, school and society.

Treatment should include:

a) Establishment of rapport.
b) Good empathic working relationship.
c) Clarification of goals of treatment.
d) Detoxification when necessary.
e) Psycho education - family involvement where possible.
f) Support for family.

Parents can help through early education about drugs, open communication, good role modelling, and early recognition if problems are developing. If there is any suspicion that there is a problem, parents must find the most appropriate intervention for their child.

The decision to get treatment for a child or adolescent is serious and often delayed. Parents are encouraged to seek consultation from a psychiatrist or mental health professional when making decisions about substance abuse treatment for children and adolescents.
UNIT 6 : TICS

6.1 INTRODUCTION

Tic disorders are the most common movement disorders diagnosed in children. 5-20% of school children experience simple or complex motor or vocal tics during their lifetime. Although tics are involuntary, they can be suppressed for a period of time. They are more likely to appear when under stress or concentrating on a task e.g. reading or writing. Most tics seem to nearly disappear during sleep.

Tic disorders are highly co-morbid with psychiatric and behavioural disorders. They can be devastating, producing embarrassing behaviours. This may limit a child's participation in school, social and recreational activities.

Transient Tic disorder is characterized by motor or vocal tics that are not permanent and appear before the age of 18. The Tics occur many times a day for at least four weeks, but go away after no more than 12 consecutive months.

Chronic Tic disorder features tics that persist for more than 12 consecutive months. Only one type of Tic - motor or vocal, not both, is present.

Tourette's Disorder is a chronic tic disorder presenting with both motor and vocal symptoms.

6.2 PRESENTING SYMPTOMS

Two basic types of Tics presentation - simple and complex.

<table>
<thead>
<tr>
<th></th>
<th>SIMPLE</th>
<th>COMPLEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor tics</td>
<td>Eye blinking</td>
<td>Facial gestures</td>
</tr>
<tr>
<td></td>
<td>Neck jerking</td>
<td>Grooming behaviours</td>
</tr>
<tr>
<td></td>
<td>Shoulder shrugging</td>
<td>Jumping</td>
</tr>
<tr>
<td></td>
<td>Facial grimacing</td>
<td>Touching</td>
</tr>
<tr>
<td></td>
<td>Repeated coughing</td>
<td>stamping</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sniffing an object, echokinesis, i.e. imitation of someone else's movements.</td>
</tr>
<tr>
<td>Vocal tics</td>
<td>Throat clearing</td>
<td>Repeating words or phrases out of context</td>
</tr>
<tr>
<td></td>
<td>Grunting</td>
<td>(Coprolalia, i.e. use of socially unacceptable words, usually obscene)</td>
</tr>
<tr>
<td></td>
<td>Sniffing</td>
<td>(Palilalia, i.e. repeating one's own sounds or words)</td>
</tr>
<tr>
<td></td>
<td>Snorting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Barking</td>
<td></td>
</tr>
</tbody>
</table>

6.3 DIAGNOSTIC CRITERIA: TIC DISORDER (DSM IV)

Besides tics, there are several types of behaviour often associated with Tourette's Disorder. At least half the persons affected with Tourette's Disorder show symptoms of obsessive-compulsive disorder (OCD), ADHD, impulse control disorder and sleep disorders.

(307.23) Criteria for Tourette's Disorder
A. Both multiple motor and one or more vocal Tics have been present at some time during the illness, although not necessarily concurrently. (A Tic is sudden, rapid, recurrent, nonrhythmic, stereotyped motor movement or vocalisation.)
B. The Tics occur many times a day (usually in bouts) nearly every day or intermittently throughout a period of more than 1 year and during this period there was never a Tic-free period of more than 3 consecutive months.

C. The disturbance causes marked distress or significant impairment in social, occupational or other important areas of functioning.

D. The onset is before age 18 years.

E. The disturbance is not due to the direct physiological effects of a substance (e.g., stimulants) or a general medical condition (e.g., Huntington’s disease or postviral encephalitis).

### (307.22) Chronic Motor or Vocal Tic Disorder

A. Single or multiple motor or vocal Tics (i.e., sudden, rapid recurrent, nonrhythmic, stereotyped motor movements or vocalisations), but not both, have been present at some time during the illness.

B. The Tics occur many times a day nearly every day or intermittently throughout a period of more than 1 year and during this period there was never a Tic-free period of more than 3 consecutive months.

C. The disturbance causes marked distress or significant impairment in social, occupational or other important areas of functioning.

D. The onset is before 18 years.

E. The disturbance is not due to the direct physiological effects of a substance (e.g., stimulants) or a general medical condition (e.g., Huntington’s disease or postviral encephalitis).

F. Criteria have never been met for Tourette’s Disorder.

### (307.21) Transient Tic Disorder

A. Single or multiple motor and/or vocal Tics (i.e., sudden rapid, recurrent, nonrhythmic, stereotyped motor movements or vocalisations).

B. The Tics occur many times a day, nearly everyday for at least 4 weeks, but for no longer than 12 consecutive months.

C. The disturbance causes marked distress or significant impairment in social, occupational or other important areas of functioning.

D. The onset is before 18 years.

E. The disturbance is not due to the direct physiological effects of a substance (e.g., stimulants) or a general medical condition (e.g., Huntington’s disease or postviral encephalitis).

F. Criteria have never been met for Tourette’s Disorder or Chronic Motor or Vocal Tic Disorder.

Specify if: Single Episode or Recurrent

### (307.20) Tic Disorder Not Otherwise Specified

This category is for disorder characterised by Tics that do not meet criteria for a specific Tic Disorder. Examples include Tic lasting less than 4 weeks or tics with an onset after age 18 years.

### 6.4 DIFFERENTIAL DIAGNOSIS

The differential diagnosis of simple motor Tics includes:

- Myoclonus.
- Simple partial seizures.
- Tremors.
- Chorea.
- Athetosis.

Complex motor tics can be confused by other complex behaviours e.g. stereotyping and compulsive rituals. Tics may be associated with head injury, carbon monoxide poisoning, stroke, drug use, and mental retardation.
6.5 MANAGEMENT

Transient Tic Disorders – advice parents to ignore and not to punish.
Chronic Tic Disorders are frequently life long. When treating chronic Tics ensure continuity of care.

Types of treatment available are:

6.5.1 PHARMACOLOGICAL

- Neuroleptics: Risperidone, Haloperidol.
- Antidepressants: Adjuvant treatment for behaviour associated with Tourette's Disorder e.g. Fluoxetine (Prozac) for Obsessive Compulsive Disorder.
- Mood stabilisers: Lithium Carbonate. These drugs can be used to treat uncontrolled aggression associated with Tourette's Disorder.
- Anticonvulsants: Tegretol, Epilim.

NB:
Neuroleptics can cause memory impairment, reduce concentration, weight gain and drowsiness.

6.5.2 PSYCHOLOGICAL INTERVENTIONS

- Psychotherapy - may be beneficial in helping a patient cope.
- Behaviour therapy - can teach the substitution of one Tic for another which is more acceptable.
- Relaxation techniques - can alleviate stress reactions that cause tics to increase.

6.5.3 PHYSICAL ACTIVITY

Is also an excellent way for children with Tourette's Disorder to reduce tension and work off their extra energy.

6.5.4 PSYCHOEDUCATION

It positive effects by reshaping family expectations and relationships. Educating the teachers can contribute towards securing a positive and supportive environment in school.

6.6 ESSENTIAL INFORMATION

Forty percent of children with tic disorder have attention problems, and 30 to 40% have academic difficulties, which require intervention. The academic problems are generally secondary to attention problems. Another problem area in as many as 80% is with obsessions and compulsions. 25 to 30% may experience difficulties in controlling their aggression, which can lead to social problems.

6.7 PROGNOSIS

The prognosis is generally good for Tourette's Disorder with most experiencing their worst symptoms from 9 to 15 years of age. The course in adulthood varies. Poorer prognoses are associated with co-morbid developmental and mental disorders, chronic physical illness and an unsupportive family environment.

6.8 SPECIALIST CONSULTATION

Most of the children would need to see a neurologist as well as a psychiatrist to help them manage with their difficulties.
UNIT 7 : SEPARATION ANXIETY DISORDER

7.1 INTRODUCTION AND DEFINITION

Separation anxiety disorder is diagnosed when children develop intense anxiety, even to the point of panic, as a result of being separated from a parent or other loved one. It often appears suddenly in a child who has shown no previous signs of a problem.

7.2 PRESENTING COMPLAINTS

Complaints include:

- Extreme shyness.
- Refusal to go to school.
- Aches and pains e.g. stomach-aches, headache.
- Nausea and vomiting.
- Palpitations.
- Dizziness and feeling faint.
- Sleep problems e.g. trouble falling asleep, nightmares.

- It is a worry about being away from parents which is way out of line for that child's age, culture and life. Fear centres around being lost or of something terrible happening to them or their parents. This anxiety is so intense that it interferes with children's normal activities and being afraid to go to places without parents.
- They refuse to leave the house alone to go to school, visit or sleep at a friend's house, go out or go on errands.
- At home, they may cling to their parents or “shadow” them by following closely on their heels, get nervous if the parent is going to leave, worrying that something bad is going to happen to their parent. Nightmares about being separated may be experienced and when severe they can’t sleep alone.

7.3 DIAGNOSTIC CRITERIA (DSM IV)

A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:
   1. Recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated.
   2. Persistent and excessive worry about losing, or about possible harm befalling, major attachment figures.
   3. Persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped).
   4. Persistent reluctance or refusal to go to school or elsewhere because of fear of separation.
   5. Persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings overly clingy.
   6. Persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home.
   7. Repeated nightmares involving the theme of separation.
   8. Repeated complaints of physical symptoms (such as headaches, stomach-aches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated.

B. The duration of the disturbance is at least 4 weeks.

C. The onset is before age 18 years.
D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.

E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder With Agoraphobia.

7.4 DIFFERENTIAL DIAGNOSIS

- Normal separation anxiety seen between eighteen months and three years of age,
- Stranger anxiety, which is typically seen at seven to eleven months of age.
- School refusal due to bullying.

The disturbance does not occur exclusively during the course of:

- Pervasive Developmental Disorder,
- Schizophrenia, or other Psychotic Disorder,
- Panic Disorder With Agoraphobia.

7.5 ESSENTIAL INFORMATION FOR PATIENT AND FAMILY

- Feeling anxious about separating from a caregiver is to be expected when a child is 9 months to a year old, but after that, a child should gradually become more comfortable with a parent leaving.
- Separation anxiety may give rise to what is known as school refusal. Children refuse to attend school because they fear separation from a parent, not because they fear the school environment.
- Proper management of SAD reduces a child's risk of developing psychiatric problems in adulthood, including depression, panic attacks, anxiety, eating disorders, and even agoraphobia.

7.6 MANAGEMENT

Therapies may include counseling, medication, or a combination of the two, depending on the nature and severity of the problem.

- Behavioural therapy targets the child's behaviour and emphasizes treatment in the context of family and school.
- Cognitive-behavioural therapy helps to restructure their thoughts into a more positive framework, resulting in more assertive and adaptive behaviours.

In school refusal secondary to separation anxiety disorder, the goal of treatment is to facilitate successful separation of parent and child and a rapid return to school.

Working with the family system is the key way to decrease the anxiety symptoms experienced by the child. The aim of therapy with the family is to improve the family interactional patterns.

7.7 MEDICATIONS

Pharmacotherapy is used as an adjunct to behavioural or psychotherapeutic interventions. SSRIs have been used for children with anxiety disorders. Advantages of SSRIs include the low side effect profile and relative safety in overdose.

7.8 SPECIALIST CONSULTATION

Consider referral to a child psychiatrist if children do not respond to the suggested management.
UNIT 8 : STRESS RELATED DISORDERS

8.1 INTRODUCTION AND DEFINITION

Stress is a physical, emotional and mental response to change, whether or not the change is positive or negative. Some amount of stress is normal and even healthy. However, children today seem to encounter many stressful life events and at earlier ages. If stress is not managed appropriately, it can lead to serious problems.

Stressors can be physical or emotional, either internally or externally generated. Stressors can be events, situations, people or demands that the individual perceives to be the source of stress.

8.2 PRESENTING COMPLAINTS

Stress has a great deal of influence upon our body and its proper functioning. Problems begin when ordinary stress becomes too much stress or distress. Multiple stressors worsen the stress level and duration of the stress.

Reaction to stress vary with the child's stage of development, ability to cope, the length of time the stressor continues, intensity of the stressor, and the degree of support from family, friends, and community.

Children under stress change their behaviour and react by doing things that are not in keeping with their usual style. The two most frequent indicators that children are stressed are:

1. Change in behaviour and,
2. Regression of behaviour i.e. behaviours seen in earlier phases of development, such as thumb sucking and regression in toileting, may reappear.

| 1. Emotionally          | • Appear more fearful, sensitive, tense, angry, anxious, restless and/or irritable.  
|                         | • Shock, fear, grief, anger, resentment, guilt, shame, helplessness, hopelessness, emotional numbness.  
|                         | • They can also present as school refusal.  
| 2. Behaviourally        | • They may appear with aggression such as school bullying, lying, stealing, truancy or vandalism.  
|                         | • Inability to concentrate, fearfulness, clingingness or separation anxiety.  
|                         | • Bed-wetting and thumb sucking can reappear.  
|                         | • Other symptoms include insomnia, nightmares and preoccupation with thoughts and memories of the stressful event.  
| 3. Academically         | • Deterioration in academic performance  
| 4. Cognitive Reactions  | • Easily distracted or restless.  
|                         | • Difficulty concentrating, shortened attention span or making decisions.  
|                         | • Their expression may seem dull or vacant.  
|                         | • They may be preoccupied with images of monsters or other threats and/or daydream more than usual.  
|                         | • They have feelings of confusion, disorientation, indecisiveness, worry, memory loss, unwanted memories, self-blame.  

8.3 DIFFERENT TYPES OF STRESS

8.3.1 ACUTE STRESS
This is the most common form. It usually comes from a one-time incident that usually comes and goes quickly. Its effect on us can last from minutes or hours to days or weeks. Examples of acute stress include being involved in an incident at school, motor vehicle accident.

It can be thrilling and exciting in small doses, but too much is exhausting. Acute stress can occur in anyone’s life, and it is highly treatable and manageable.

8.3.2 EPISODIC ACUTE STRESS
- Episodic Acute Stress is the feeling of being in an almost constant state of chaos or crisis. Children who have high expectations of themselves or when placed upon them by the environment are more prone. These include children who worry excessively.
- They are over aroused, short tempered, irritable, anxious and tense.
- They are always in a hurry, tend to be abrupt, and sometimes their irritability comes across as hostility. Interpersonal relationships deteriorate rapidly when others respond with hostility.

8.3.3 CHRONIC STRESS
Chronic stress occurs as a result of facing difficult experiences and situations for more than 6 months. This is the kind of stress that wears people away and is detrimental to their health.

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<tr>
<td></td>
<td>May be more prone to accidents, illness and/or aches and pains.</td>
<td>Distrust, irritability, quarrelsome, feeling rejected or abandoned, reactions judgmental, sensitive or over-controlling in relationship</td>
<td>Exacerbation of asthma, migraine headache or gastrointestinal illnesses.</td>
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<td>They may have lower energy levels, trouble with constipation or diarrhoea.</td>
<td></td>
<td>Muscular symptoms including tension headache, back pain and the muscular tensions that lead to pulled muscles, tendon and ligament problems;</td>
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<td>They may bite their fingernails.</td>
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<td>Gastrointestinal tract symptoms such as heartburn, flatulence, diarrhoea, constipation and irritable bowel syndrome;</td>
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<td>Feeling tensed, fatigue or edgy.</td>
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<td>Transient over-arousal leads to elevation in blood pressure, tachycardia, sweaty palms, palpitations, dizziness, headaches, cold hands or feet, shortness of breath and chest pain.</td>
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<td>They may also have difficulty sleeping, being startled easily.</td>
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Some sources of stress include:
- School demands and frustrations.
- Negative thoughts and feelings about themselves.
- Changes associated with growth and puberty.
- Problems with friends and / or peers at school.
- Unsafe living environment / neighbourhood.
- Separation or divorce of parents.
- Chronic illness in oneself or in the family.
- Death of a loved one.
- Moving or changing schools.
- Taking on too many activities.
- Having too high expectations.
- Family financial problems.
- Family violence including child abuse.

8.4 LONG-TERM CONSEQUENCES OF STRESS IN CHILDHOOD

- The greater the number of stressors a child has to endure, the less control the child has over the stressor, and the higher the involvement of a loved one in inflicting the stress, the more severe the long term consequences.
- Children who experience mild, short-term stress have the best chance of having no long-term problems.
- When they become overloaded with stress and are inadequately managed:
  - Stress can lead to anxiety and depression,
  - Withdrawal or aggression,
  - And with poor coping skills they are at higher risk of impulsive behaviour and involvement in drug and / or alcohol use.
  - Poor coping skills such as drug and / or alcohol use.
- Reactions to stress on the very severe end include depression, psychosis or self-harm

8.5 DIAGNOSTIC CRITERIA

8.5.1 ACUTE STRESS REACTION

Acute Stress reaction is a transient disorder of significant severity, which develops in an individual without any past history of apparent mental disorder, in response to exceptional physical and / or mental stress. The disturbances usually subside within a few hours or days.

The stressor may be an overwhelming traumatic experience involving serious threats to the security or physical integrity of the individual or of a loved person (rape, assault, death) or an unusual threatening change in social position and / or networking of the individual.

They can present with:
- Depressed mood
- Tearfulness
- Irritability
- Restlessness or jitteriness
- Insomnia
- Mild cognitive impairment: poor concentration, exaggerated startle response and hyperalertness.
- Anxiety symptoms
8.5.2 ADJUSTMENT DISORDER WITH ANXIETY (WITH OR WITHOUT DEPRESSED MOOD).
The development of emotional and/or behavioural symptoms occur within 3 months in response to an identifiable stressor. These symptoms and behaviours cause marked distress in excess of that which could be expected and results in significant occupational, social, or academic performance. Once the initiating stressor has ceased, the disturbance does not last longer than 6 months.

It can present with:
- With depressed mood.
- With anxiety.
- With mixed anxiety and depressed mood.
- With disturbance of conduct.
- With mixed disturbance of emotions and conduct.

8.5.3 POST-TRAUMATIC STRESS DISORDER (PTSD).
When a child or adolescent experiences a catastrophic event, they may develop ongoing difficulties known as posttraumatic stress disorder (PTSD).

Refer to section on PTSD (unit 9)

8.6 DIFFERENTIAL DIAGNOSIS
- Depression
- Psychosis
- Substance Abuse
- Personality Disorder

8.7 MANAGEMENT
- A careful history of the traumatic event must be taken with particular care especially about what had happened, what was seen, how long, to whom and its significance to the patient.
- A thorough psychiatric history including a family and social history must be taken to look for pre-existing psychiatric disorders or vulnerabilities in the patient.
- The child should be encouraged to speak (ventilate) about the trauma, when they are ready, to family members or close friends.
- A full physical examination including a neurological examination is mandatory especially if the traumatic event resulted in any form of injury. This is followed by a mental state examination to look for clinical symptoms of psychiatric disturbances.
- Laboratory investigations should be carried out particularly to look out for substances and general medical conditions that mimic or aggravate symptoms of stress and anxiety.
- During the early stage of acute stress reaction, we would need to allay the patients’ anxieties either by allowing them to ventilate or teaching them simple methods to relax or to cope. At times, the interview may need to be withheld if the child’s emotional state does not allow for us to continue with the history taking and/or examination.
- Always reassure the child of their safety as well as that the reaction is acute and help is possible.
- Encourage the child to gradually confront situations by progressive desensitisation, gradual exposure to the situation along with relaxation methods.
- Social support is crucial thus it is necessary to identify potential sources of support from others (families and friends).
- The child may need to be moved away from the danger of the traumatic event. Hospitalisation may be required especially when the safety of the child is suspect. The child may need to be placed in a safe environment and at times, protection may be necessary.
- Ensure that the child receives follow-up consultations.
8.8 MEDICATIONS

Symptoms of severe anxiety may be treated with benzodiazepines, for example lorazepam or diazepam. Insomnia may benefit from treatment with benzodiazepines on a short-term basis as well.

Depression of moderate to severe nature may require anti-depressant medications.

8.9 SPECIALIST CONSULTATIONS (REFERRAL TO A CHILD PSYCHIATRIST)

This is recommended when a child’s feelings and behaviour appears to be getting worse i.e.
- They are unable to enjoy their usual interests or are unable to concentrate at school;
- Increasingly low or irritable mood;
- When the signs of extreme stress last for longer than one month or,
- When worries prevent the child or their family from getting on with normal everyday life.

8.10 ESSENTIAL INFORMATION FOR PATIENT AND FAMILY

Our bodies need relief from stress to re-establish balance. Acute signs of stress normally fade away after a few weeks with help and support from people who are close to us.

Parents can help their children in these ways:
- Practice open communication and early recognition if problems are developing.
- Monitor if stress is affecting their child’s health, behaviour, thoughts or feelings.
- Allowing the child to talk and the parents to listen carefully.
- Learn stress management skills.
- Support involvement in recreational sports and social activities.

Children can decrease stress by the following:
- Healthy eating.
- Regular exercise.
- Avoid illegal drugs, alcohol and tobacco.
- Learn relaxation exercises (abdominal breathing and muscle relaxation techniques).
- Learn to be assertive.
- Decrease negative self talk.
- Rehearse and practice dealing with difficult situations which cause stress.
- Learn practical coping skills i.e. Break a large task into smaller, or attainable tasks.
- Learn to feel good about doing a competent or good enough task rather than demanding perfection.
- Take a break from stressful situations.
- Build a network of supportive and helpful friends who can help the child cope in a positive manner.
UNIT 9 : POST-TRAUMATIC STRESS DISORDER (PTSD).

9.1 INTRODUCTION AND DEFINITION

A child or adolescent who experiences a catastrophic event may develop ongoing difficulties known as posttraumatic stress disorder (PTSD). The stressful or traumatic event involves a situation where someone's life has been threatened or severe injury has occurred (e.g. they may be the victim or a witness of physical abuse, sexual abuse, violence in the home or in the community, automobile accidents, natural disasters such as flood, fire, earthquakes, and being diagnosed with a life threatening illness).

9.2 PRESENTING COMPLAINTS

A child’s risk of developing PTSD may be related to:
- Severity of the trauma,
- Whether the trauma is repeated,
- The child's proximity to the trauma,
- His / her relationship to the victim(s).

Following the trauma, children may initially show:
- Agitated or confused behaviour.
- Intense fear, helplessness, anger, sadness, horror or denial.
- Repeated trauma might develop a kind of emotional numbing.

Children with PTSD avoid situations or places that remind them of the trauma. They may also become less responsive emotionally, depressed, withdrawn, and more detached from their feelings.

A child with PTSD may also re-experience the traumatic event by:
- Having memories of the event, or in young children, play in which some or all of the trauma is repeated over and over.
- Having upsetting and frightening dreams.
- Acting or feeling like the experience is happening again.
- Developing repeated physical or emotional symptoms when the child is reminded of the event.
- Worry about dying.
- Lost interest in activities.
- Have physical symptoms e.g. headaches or stomach aches.
- Difficulty falling asleep or staying asleep.
- Irritability and anger outbursts.
- Problems concentrating.
- Acting younger than his age.

PTSD may last from several months to many years.

9.3 DIAGNOSTIC CRITERIA (DSM IV KEY POINTS)

9.3.1 SYMPTOMS

PTSD usually appears within 3 months of the trauma, but sometimes the disorder appears later.

PTSD’s symptoms fall into three categories:
- Intrusion
- Avoidance
- Hyper arousal
9.3.1.1 Intrusion
In people with PTSD, memories of the trauma reoccur unexpectedly, and episodes called “flashbacks” intrude into their current lives. This happens in sudden, vivid memories that are accompanied by painful emotions that take over the victim’s attention. This re-experience, or “flashback,” of the trauma is a recollection. It may be so strong that individuals almost feel like they are actually experiencing the trauma again or seeing it unfold before their eyes and in nightmares.

9.3.1.2 Avoidance
Avoidance symptoms affect relationships with others. The person often avoids close emotional ties with family, colleagues, and friends. At first, the person feels numb, has diminished emotions, and can complete only routine, mechanical activities. Later, when re-experiencing the event, the individual may alternate between the flood of emotions caused by re-experiencing and the inability to feel or express emotions at all. The person with PTSD avoids situations or activities that are reminders of the original traumatic event because such exposure may cause symptoms to worsen.

The inability of people with PTSD to work out grief and anger over injury or loss during the traumatic event means the trauma can continue to affect their behaviour without their being aware of it. Depression is a common product of this inability to resolve painful feelings. Some people also feel guilty because they survived a disaster while others - particularly friends or family did not.

9.3.1.3 Hyper Arousal
PTSD can cause those who have it to act as if they are constantly threatened by the trauma that caused their illness. They can become suddenly irritable or explosive, even when they are not provoked. They may have trouble concentrating or remembering current information, and, because of their terrifying nightmares, they may develop insomnia. This constant feeling that danger is near causes exaggerated startle reactions.

Finally, many people with PTSD also attempt to rid themselves of their painful re-experiences, loneliness, and panic attacks by abusing alcohol or other drugs as a “self medication” that helps them to blunt their pain and forget the trauma temporarily. A person with PTSD may show poor control over his or her impulses and may be at risk for suicide.

9.4 Differential Diagnosis

- Head injury
- Epilepsy
- Substance-related disorders, including alcohol
- Anxiety disorders
- Pain disorders
- Personality disorders (especially borderline personality)
- Factitious disorder
9.5 MANAGEMENT

Treatment
PTSD is a severe disorder that is difficult to treat and needs multi modal therapy.

Behaviour therapy
Focuses on correcting the painful and intrusive patterns of behaviour and thoughts by teaching people with PTSD relaxation techniques and examining (and challenging) the mental processes that are causing the problem.

Psychodynamic psychotherapy
Focuses on helping the individual examine personal values and how behaviour and experience during the traumatic event affected them.

Family therapy
May also be recommended because the behaviour of spouse and children may result from and affect the individual with PTSD.

Group therapy
Encourages survivors of similar traumatic events to share their experiences and reactions to them. Group members help one another realize that many people would have done the same thing and felt the same emotions.

Medication can help to control the symptoms of PTSD.

9.6 MEDICATIONS

Antidepressants - SSRI's are recommended.

Insomnia may benefit from treatment with benzodiazepines as well.

Symptoms of severe anxiety may be treated with benzodiazepines, for example lorazepam or diazepam for not more than 2 weeks.

9.7 SPECIALIST CONSULTATIONS

It is recommended that patients be referred to a psychiatrist.

9.8 ESSENTIAL INFORMATION FOR PATIENT AND FAMILY

The symptoms of PTSD may last from several months to many years. Symptoms may recur in response to reminders of the traumatic event or to ordinary life stressors or to a new traumatic event. The child may have limited control over his symptoms.

There may be complications such as an increased risk of suicide.

There may be impairment in school performance. There may be distress to others in the family or school. Some young patients abuse drugs or alcohol as a self-medication.

Early intervention and support from parents, school and peers are important.
UNIT 10 : CONDUCT DISORDER

10.1 INTRODUCTION

Conduct Disorder (CD) is a repetitive and persistent pattern of behaviour in children and adolescents in which the rights of others or basic social rules are violated.

These behaviour patterns are seen in a variety of settings i.e. at home, at school and in social situations, causing significant impairment in social, academic and family functioning.

Conduct Disorder is more common among boys than girls. Conduct Disorder can have an early onset before the age of 10, or in adolescence. Children who display early-onset Conduct Disorder are at greater risk for persistent difficulties, troubled peer relationships and academic problems.

10.2 PRESENTING COMPLAINTS

- Aggressive behaviour that causes or threatens harm to other people or animals, such as bullying or intimidating others, often initiating physical fights, or being physically cruel to animals.
- Non-aggressive conduct that causes property loss or damage, such as fire setting or the deliberate destruction of others’ properties.
- Deceitfulness or theft, such as breaking into someone’s house or car, lying or “conning” others.
- Serious rule violations, such as staying out at night when prohibited, running away from home overnight, or often being truant from school.

Many youths with conduct disorder may have trouble feeling and expressing empathy or remorse and reading social cues. Conduct disorder may also be associated with other difficulties such as substance use, risk-taking behaviour, school problems, and physical injury from accidents or fights.

Many factors may contribute to a child developing conduct disorder, including brain damage, genetic vulnerability, child abuse, school failure, and traumatic life experiences.

10.3 DIAGNOSTIC CRITERIA (DSM IV)

A. A repetitive and persistent pattern of behaviour in which the basic rights of others or major age appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

Aggression to people and animals:
1. Often bullies, threatens, or intimidates others.
2. Often initiates physical fights.
3. Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun).
4. Has been physically cruel to people.
5. Has been physically cruel to animals.
6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery).
7. Has forced someone into sexual activity.

Destruction of property:
8. Has deliberately engaged in fire setting with the intention of causing serious damage.
9. Has deliberately destroyed others’ property (other than by fire setting).
Deceitfulness or theft:
10. Has broken into someone else’s house, building, or car.
11. Often lies to obtain goods or favours or to avoid obligations (i.e., “cons” others).
12. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery).

Serious violations of rules:
13. Often stays out at night despite parental prohibitions, beginning before age 13 years.
14. Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period).
15. Is often truant from school, beginning before age 13 years.

B: The disturbance in behaviour causes clinically significant impairment in social, academic, or occupational functioning.

C: If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

SPECIFY TYPE BASED ON AGE AT ONSET:

Childhood-Onset Type:
Onset of at least one criterion characteristic of Conduct Disorder prior to age 10 years.

Adolescent-Onset Type:
Absence of any criteria characteristic of Conduct Disorder prior to age 10 years.

SPECIFY SEVERITY:

Mild:
Few if any conduct problems in excess of those required making the diagnosis and conducting problems cause only minor harm to others.

Moderate:
Number of conduct problems and effect on others intermediate between "mild" and "severe".

Severe:
Many conduct problems in excess of those required to make the diagnosis or conduct problems cause considerable harm to others.

10.4 Differential Diagnosis

- Oppositional Defiant Disorder:
  - Displays disobedient behaviour at home but do not violate laws.

- Attention-Deficit Hyperactivity Disorder:
  - Displays symptoms of attention deficit and hyperactivity.

- Manic Episode:
  - Displays prominent mood symptoms.

- Adjustment Disorder:
  - There is an identifiable stressor(s) preceding the behaviour.

- Antisocial Personality Disorder:
  - The individual is at least 18 years of age.
10.5 CO-MORBIDITY

Many children with conduct disorder may have coexisting conditions such as mood disorders, anxiety, PTSD, substance abuse, ADHD and learning problems.

10.6 MANAGEMENT

Children who exhibit these behaviours should receive a comprehensive evaluation.

Research shows that youngsters with conduct disorder are likely to have ongoing problems if they and their families do not receive early and comprehensive treatment. Without treatment, many youngsters with conduct disorder are unable to adapt to the demands of adulthood and continue to have problems with relationships and holding a job. They often break laws or behave in an antisocial manner. Early intervention programmes will reduce the socio-economic burden on the individual, family and society.

Treatment of children with conduct disorder can be complex and challenging.

See Treatment of ODD/CD.
UNIT 11 : OPPOSITIONAL DEFIANT DISORDER (ODD)

11.1 INTRODUCTION

All children are oppositional from time to time, particularly when they are tired, hungry, stressed or upset. They may argue, talk back, disobey or defy parents, teachers, and other adults. Oppositional behaviour is often a normal part of development for two to three year olds and early adolescents. Openly uncooperative and hostile behaviour becomes a serious concern when it is so frequent and consistent that it stands out when compared with other children of the same age and developmental level.

The causes of Oppositional Defiant Disorder (ODD) are unknown, but many parents report that their child was more rigid and demanding than their siblings from an early age. Biological and environmental factors may have a role.

11.2 PRESENTING COMPLAINTS

In children with ODD, there is an ongoing pattern of uncooperative, defiant, and hostile behaviour towards authority figures that seriously interferes with the youngster's day-to-day functioning.

Symptoms of ODD may include:

- Frequent temper tantrums
- Excessive arguing with adults
- Active defiance and refusal to comply with adult requests and rules
- Deliberate attempts to annoy or upset people
- Blaming others for his or her mistakes or misbehaviour
- Often being touchy or easily annoyed by others
- Frequent anger and resentment
- Talking in a mean and hateful way when upset
- Seeking revenge

The symptoms are usually seen in multiple settings, but may be more noticeable at home or at school.

11.3 DIAGNOSTIC CRITERIA (DSM IV)

A. A pattern of negativistic, hostile, and defiant behaviour lasting at least 6 months, during which four (or more) of the following are present:
   1. Often loses temper.
   2. Often argues with adults.
   3. Often actively defies and refuses to comply with adults’ requests or rules.
   4. Often deliberatelyannoys people.
   5. Often blames others for his or her mistakes or misbehaviour.
   6. Is often touchy or easily annoyed by others.
   7. Is often angry or resentful.
   8. Is often spiteful or vindictive.

   Note: Consider a criterion met only if the behaviour occurs more frequently than is typically observed in individuals of comparable age and developmental level.

B. The disturbance in behaviour causes clinically significant impairment in social, academic, or occupational functioning.
 SECTION 2 : EMOTIONAL AND BEHAVIOURAL DISORDERS OF CHILDREN AND ADOLESCENTS

C. The behaviours do not occur exclusively during the course of a Psychotic or Mood Disorder.

D. Criteria are not met for Conduct Disorder and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

11.4 DIFFERENTIAL DIAGNOSIS

- Conduct Disorder.
- Attention Deficit Hyperactivity Disorder.
- Manic Episode.
- Adjustment Disorder.
- Antisocial Personality Disorder.

11.5 MANAGEMENT

A child presenting with ODD symptoms should have a comprehensive evaluation. It is important to look for other disorders which may be present; such as, Attention Deficit Hyperactivity Disorder (ADHD), learning disabilities, mood disorders (depression, bipolar disorder) and anxiety disorders. It may be difficult to improve the symptoms of ODD without treating the coexisting disorder. Some children with ODD may go on to develop conduct disorder.

11.6 TREATMENT OF ODD/CD

The treatment of both conduct disorder and oppositional defiant disorder requires a multi dimensional approach:

11.6.1 PSYCHOLOGICAL THERAPY

- Counsel parents to help them understand and manage the child's behaviour.
- Prepare a behaviour modification plan
- Target problem behaviours e.g. hitting others.
- Give clear-cut alternatives to problem behaviour e.g. sit down and read a comic.
- All caregivers must be consistent.
- Rewards should be based on the child's age and interest.
- There should be a combination of positive and negative reinforcers i.e. reward for good behaviour e.g. later bedtime on the weekend, and withdrawal of privileges for bad behaviour.
- Rules should be made simple and straightforward so that the child understands.
- Help the child to develop more effective anger management.
- Help the family to improve communication.
- Assist problem-solving and decrease negativity.
- Increase flexibility and improve frustration tolerance with peers by social skills training.
- Focus on the child's strengths and interests.
- Promote positive change and improve socialization skills through group therapy.
- Parents and carers must set good examples and be positive role models.

11.6.2 PHARMACOTHERAPY

The use of medication depends on concomitant psychiatric problems:

- Those with depression or mood component may benefit from antidepressants or mood stabilisers.
- Severely impulsive aggression may benefit from mood stabilisers.
- Children with irritability and abnormal EEG may improve with anticonvulsants e.g. carbamazepine.
• Children with concomitant ADHD may benefit from methylphenidate.
• Antipsychotics, both conventional and atypical have been shown to have some efficacy in severely aggressive children when other methods have failed.

11.6.3 OTHER INTERVENTIONS
• Special education may be needed for children and adolescents with learning disabilities.
• Vocational training may also be useful for some adolescents.
• In severe cases legal sanctions may be needed and the child sent to a residential facility especially in cases of Conduct Disorder (CD). (Refer to the section on Children and the Law).

Treatment is rarely brief since establishing new attitudes and behaviour patterns take time. However, early treatment offers the child a better chance for considerable improvement and hope for a more successful future.

11.7 SPECIALIST CONSULTATION

Refer to a child psychiatrist if there associated psychiatric problems.

11.8 ESSENTIAL INFORMATION FOR PATIENT AND FAMILY

A child with CD or ODD can be very difficult for parents. These parents need support and understanding.

Parents can help their child in the following ways:

- Always build on the positives. Give the child praise and positive reinforcement when he shows flexibility or cooperation.
- Take time-out or have a break if you are feeling angry or are about to make the conflict with your child worse.
- Pick your battles. Since the child has trouble avoiding power struggles, ignore trivial issues.
- Set up reasonable, age-appropriate limits with consequences that can be enforced consistently.
- Maintain your own interests, so that managing your child doesn’t take all your time and energy. Try to work with and obtain support from the other adults i.e. spouse, other family members and teachers.
- Manage your own stress with exercise and relaxation. Get another person to care for the child for a short period so that you can have a break.
- Avoid threats and physical punishment. The child may learn that using force is acceptable.
- Try to do the things that the child likes doing (within limits) rather than what you want them to do.
- Do not neglect your other children.

Many children will respond to the positive parenting techniques listed above.
UNIT 12 : ELIMINATION DISORDERS

12.1 ELIMINATION DISORDERS: ENURESIS

12.1.1 INTRODUCTION

- Enuresis can be defined as involuntary emptying of the bladder in the absence of an organic cause in a child over the age of 5 years.
- Enuresis may be nocturnal, diurnal (by day) or both.

12.1.2 PRESENTING COMPLAINTS

- Wetting may have been present from birth (primary or continuous), or may occur after months or years of becoming dry (secondary enuresis).
- The wetting may be regular or intermittent.
- Nocturnal enuresis occurs in -10% of children at 5 years old and -1% at 15 years old (Isle of Wight study).
- Male more than female.
- After the age of 7, secondary enuresis is commoner than primary.
- 70% of enurectic children have a family history of enuresis in at least 1 first degree relative.
- Enuresis is associated with urinary tract infections, especially in girls.
- Stressful life events at age of 3-4 are associated with twice the risk of enuresis.
- Enuresis is associated with lower socioeconomic status, overcrowded home and institutional care.
- Other developmental problems are twice as common.

12.1.3 DIAGNOSTIC CRITERIA (DSM-IV)

A. Repeated voiding of urine into bed or clothes (whether involuntary or intentional).
B. Frequency of twice a week for at least 3 consecutive months or presence of significant distress or impairment in social, academic, or other important areas of functioning.
C. Chronological age of at least 5 years.
D. Not due to diuretic or a general medical condition.

12.1.4 DIFFERENTIAL DIAGNOSIS

- Urinary tract infections (particularly in girls).
- Nocturnal Epilepsy - (differentiate by a detailed history).
- Diabetes Mellitus.
- Diabetes Insipidus.
- Chronic Renal Failure or other Renal Tubular Disorders.
- Neurogenic Bladder.

12.1.5 MANAGEMENT

a) Look out for associated emotional or behavioural disturbances.
b) Bladder ‘training’: parental supervision of gradually lengthening intervals of passing of urine in the daytime (1/2 → 3-4 hourly intervals over a week).
c) Enuresis alarms: treatment of choice for children aged 6 & above. (Not widely available locally).
d) Use of desmopressin may be helpful especially among primary enuretics.
e) Counseling of Patient & Family.

- Find out what the parents have already tried
- Keep a diary of wetting
- Rewards: use of star charts, which emphasize achievements (dry nights) rather than failures.
- 90% of children wetting at age 7 would be dry by 14 years.
12.1.6 SPECIALIST CONSULTATION

- Problem persists despite basic interventions above
- Presence of other accompanying difficulties e.g. family relationship difficulties

REFERENCES


12.2 ELIMINATION DISORDER: ENCOPRESIS

12.2.1 INTRODUCTION
Encopresis occurs in 1 - 3% of children, with higher rates in boys than in girls. Most children present as a problem at school age. Three main groups of children with soiling can be identified.

12.2.2.1 CHILDREN WITH CONSTIPATION AND OVERFLOW INCONTINENCE
These children are constipated. Their rectum is usually dilated with impacted faeces around which liquid stool may leak out, manifesting as soiling. Stretching of the rectum due to faeces causes the muscle to be inefficient and unable to expel its contents. Stool retention may have started following a painful perianal lesion such as a fissure. These children may present with alternating hard infrequent stools and intermittent soiling.

Constipation may be identified by palpation of hard stools per abdomen or per rectum, or by a plain abdominal radiograph demonstrating multiple faecal masses.

12.2.2.2 SOILING WITH NO CONSTIPATION
These are children who have not been adequately toilet trained for various reasons. Some may be generally inadequate in self-care. Others may not wish to give up the attention they get from parents through soiling.

12.2.2.3 ENCOPRESIS
Stools are passed in inappropriate places, e.g. in drawers or under settee. The encopresis here may be a manifestation of an underlying emotional problem. It may go undetected unless health professionals directly inquire into toileting habits.

12.2.3 DIAGNOSTIC CRITERIA (DSM-IV)
A. Repeated passing of faeces into inappropriate places (e.g. clothing or floor) whether involuntary or intentional.
B. At least one such event a month for at least 3 months.
C. Chronological age is at least 4 years.
D. Not due to laxatives or a general medical condition (except constipation).

12.2.4 DIFFERENTIAL DIAGNOSIS

12.2.4.1 CONSTIPATION AND OVERFLOW
a) Functional constipation (95%).
b) Child sexual abuse.
c) Organic.
i) Neurogenic causes (Hirschsprung’s disease patient does not typically pass large bowel movement and rarely soil).
ii) Anal causes e.g. fissures, trauma, anterior displacement of anus.

12.2.4.2 SOILING WITH NO CONSTIPATION
a) Child may not be developmentally ready to be toilet trained.
b) As part of a conduct or disruptive behavioural problem.

12.2.5 ESSENTIAL INFORMATION FOR PATIENTS & FAMILY
☞ By the age of 4 most children can control their bowels and are toilet trained.
☞ Problems controlling bowel movements can cause soiling which leads to frustration and anger on the part of the child, parents, teachers and other people important in the child’s life.
☞ Social difficulties with this problem can be severe - the child is often made fun of by friends and avoided by adults. These problems can cause children to feel badly about themselves.
12.2.6 SOME OF THE REASONS FOR SOILING ARE:

- Problems during toilet training.
- Physical disabilities, which make it hard for the child to clean him/herself,
- Physical conditions, for example chronic constipation, Hirschprung’s Disease,
- Family or emotional problems.

Soiling which is not caused by an illness or disability is called encopresis.
Children with encopresis may have other problems, such as short attention span, low frustration
tolerance, hyperactivity and poor coordination. Occasionally, this problem with soiling starts with
a stressful change in the child’s life, such as the birth of a sibling, separation/divorce of parents,
family problems, or a move to a new home or school.

Encopresis is more common in boys than in girls.
Although most children with soiling do not have a physical condition, they should have a
complete physical evaluation by a family physician or paediatrician.

If no physical causes are found, or if problems continue, the next step is an evaluation by a child
and adolescent psychiatrist.

Most children with encopresis can be helped, but progress can be slow and extended treatment
maybe necessary.

Early treatment of a soiling or bowel control problem can help prevent and reduce social and
emotional suffering and pain for the child and family

12.2.7 MANAGEMENT

a) Ensure soft, well-formed stools by:
   i) Dietary changes e.g. add fiber drinks.
   ii) Stool softener or laxatives.

b) Develop a standard clean-up procedure:
   i) Carried out in an emotionally neutral and supportive manner.
   ii) Parents to use a neutral tone of voice while directing child through (developmentally
       appropriate) clean-up activities.
   iii) Avoid blaming, criticising or name-calling.

c) Keep a toileting/soiling diary:
   To monitor patterns of soiling and to reward success.

d) Address toilet refusal behaviour:
   i) By positive toilet sit strategy
      1. Scheduled sits 3 - 5 times daily at family's convenience.
      2. Begin with very short sits (e.g. 30 seconds).
      3. Gradually increase to maximum of 5 minutes each sit.
      4. Child can sit with pants/diapers on because not expected to produce bowel
         movement.
      5. Provide enjoyable, relaxing activities and individual parental attention during
         sit.
      6. Elimination of factors leading to a fear of using the toilet.
   ii) Adopting a firmer approach - for more resistant children

e) Schedule prompted toilet sits:
   i) Choose times when the child is likely to defecate; the best time is 5 - 20 mins. after
each meal (to take advantage of gastro colic reflex).
   ii) Can be scheduled up to 5 times daily (3 - 5 mins. each)
f) Provide incentives for appropriate bowel movements and self-initiation:
   i) Incentives can be linked to passing of stool in toilet.
   ii) Effective incentives should be age-appropriate, given immediately after the desired
       behaviour is displayed.
   iii) The child can be rewarded for using the toilet on his own initiative and for showing
       personal responsibility

12.2.8 SPECIALIST CONSULTATION

Consider referral to child psychiatrist if:
1. Problem persists despite basic interventions being carried out as listed above.
2. Presence of other accompanying difficulties such as family relationship difficulties, other
   accompanying behavioural problems or associated child sexual abuse

REFERENCES:

1. Kuhn BR, Marcus BA, Pitner SL. Treatment Guidelines for Primary Non retentive Encopresis and Stool
   Toileting Refusal. American Family Physician April 15, 1999
13.1 INTRODUCTION

- Mental Retardation (MR) is characterised by the global impairment of intellectual skills and significant limitations in adaptive skills. This involves a person's ability to learn, think, solve problems and cope, and to have the skills needed to live independently. Thus children with MR would have difficulties in activities of daily living (e.g. toilet training, feeding and dressing) and are slow to learn and to develop.
- Antenatal and postnatal screening would pick up some cases of MR.
- Early diagnosis of MR would facilitate prompt referral to early intervention programmes.

13.2 PRESENTING COMPLAINTS

The usual presentation of a child with MR is impairment of adaptive functioning. A child with MR may have difficulties performing activities of daily living which is expected for their age e.g. dressing, feeding, communicating or self care.

Ways in which they present:
- Moderate or more severe MR often presents with delayed gross motor milestones in the first year of life.
- Mild or moderate MR usually presents with speech and language delay or behavioural abnormalities with normal development.
- Mild MR may not be detected until school entry age. The child may present with difficulties in speaking, remembering things, understanding rules, problem solving, thinking logically, seeing the consequences of their actions or poor academic achievement.

13.3 DIAGNOSTIC CRITERIA (DSM-IV)

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 2 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

13.4 SPECTRUM OF SEVERITY:

Four degrees of severity can be specified, reflecting the level of intellectual impairment:

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>IQ LEVEL</th>
<th>ABILITY AT SCHOOL GOING AGE</th>
<th>ABILITY AT ADOLESCENT TEARS</th>
</tr>
</thead>
</table>
| Mild MR | 50 to 70 | Can learn up to Standard 6 levels; educable.    | • Can achieve enough social and vocational skills for self-support.  
|          |          |                                                 | • Can live independently within the community with social support.  
|          |          |                                                 | • Needs assistance during times of stress e.g. Financial difficulties |

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SECTION 2 : EMOTIONAL AND BEHAVIOURAL DISORDERS OF CHILDREN AND ADOLESCENTS

13.5 DIFFERENTIAL DIAGNOSIS

- Pervasive Developmental Disorders.
- Learning Disabilities.
- Attention Deficit Hyperactivity Disorder.
- Hearing Deficits.
- Visual Impairment.
- Chronic illness and failure to thrive.
- Language Disabilities.
- Emotional abuse and neglect.

13.6 COUNSELING OF PATIENT & FAMILY

Issues that need to be discussed with the family include:

- Diagnosis and prognosis.
- Support services and Early Intervention Programmes available. These are mainly available at Community Based Rehabilitation Centres (PDKs) and NGOs.
- Registration with the Social Welfare Department.
- Schooling - as these children progress in age, they cannot cope with the normal school curriculum. They require special schools or integrated / special classes in the public schools. For these, they need referrals using forms available at the Social Welfare Department and Specialist Clinics.
- Job training - these facilities are scarce and mainly run by the Social Welfare Department & NGOs.
- Associated medical problems e.g. epilepsy, Down's syndrome with cardiac abnormalities.
- Associated psychological problems e.g. depression, psychosis.
- Sexuality issues e.g. masturbation, menarche.
13.7 MANAGEMENT

Four components to be assessed:

1. Investigation of the cause of the MR (chromosomal studies, metabolic screening, CT brain, EEG) and management of associated medical problems. There are often co-existing medical problems e.g. hearing or visual impairment, epilepsy.
2. Determination of the level and profile of cognitive functioning. Where available, the children would need to be referred to a clinical/educational psychologist for formal IQ assessment.
3. Support for parents and siblings who may be profoundly affected psychologically.
4. Assessment of family functioning, care, expectations, and coping capacity.
5. Counseling of Patient & Family

Important components of management:

I. Breaking the news: the diagnosis of MR should be explained to the family in a sensitive manner.
II. Counseling on promotion of development in the child e.g. speech, stimulation activities for gross motor development, visual aids, and activities of daily living.
III. Dealing with associated disabilities and behaviour problems. We would need to determine if the child is being neglected or inadequately stimulated.
IV. Advice on appropriate education.
V. Genetic counseling, where appropriate.
VI. Providing social and emotional support.
VII. An multidisciplinary approach where available e.g. child with cerebral palsy and spasticity will need referral to physiotherapy and occupational therapy.
VIII. Every child with this disability should be registered with the Department of Social Welfare

13.8 PREVENTION

Acquired causes of MR may be prevented, for example:

I. Antenatal folic acid for pregnant mothers, to reduce the incidence of neural tube defects.
II. Neonatal screening of congenital hypothyroidism.
III. Immunisation against measles, Haemophilus influenza type b, etc.
IV. Treatment of severe neonatal jaundice to prevent kernicterus.
V. Prevention of brain injuries e.g. use of seat belts, bicycle helmets, prevention of non-accidental injuries.

13.9 SPECIALIST CONSULTATION (REFERRAL TO CHILD PSYCHIATRIST)

A child may need to be referred to a psychiatrist when there are behavioural difficulties, or suspected psychoses or depression.

In the above cases a child may need to be put on medication:

a) Behavioural: anticonvulsants, antidepressants.
b) Psychosis: anti psychotics (haloperidol, risperidone), anticonvulsants (Carbamazepine, Sodium valproate) and benzodiazepines (diazepam, lorazepam).
c) Depression: SSRI (selective serotonin reuptake inhibitors).

* The newer medications have less side effects e.g. antipsychotics (risperidone), antidepressants (Prozac, Cipram).
13.10 ESSENTIAL INFORMATION FOR PATIENTS & FAMILY

I. Parents would need to gather as much information about the child's condition, how to help the child as well as to help themselves.

II. Mild MR rarely has an identifiable cause.

III. Moderate to profound MR more often has an identifiable physical cause.

IV. Associated sensory disorders, especially hearing and visual defects are very common in children with MR. Regular checks are needed and correction of the deficits may improve their quality of life.

V. Epilepsy is common and the child may need to be investigated and put on an anticonvulsant.

VI. Children with mental handicap are at risk of developing emotional and behavioural problems.

VII. MR persists throughout adulthood.

VIII. Encourage independence in the child e.g. Daily care skills such as grooming skills, using the bathroom.

IX. Children should be encouraged to take part in home living activities e.g. household chores and participate in family recreational activities. Tasks may need to be broken into smaller steps, to be demonstrated and to be shown repeatedly and patiently. Positive feedback and praise should to be given.

X. Talk to other parents with a child with MR, to get advice and support.

XI. Meet with the school teachers to find out how the child is coping and if there are issues to be addressed.
UNIT 14 : SCHIZOPHRENIA

14.1 INTRODUCTION

Schizophrenia is a serious and complex illness that causes disturbances in thinking, feeling, experiences and behaviour. Social functioning is disrupted.

Schizophrenia is uncommon in children. It may be difficult to recognize in its early phases. It is often difficult to elicit the presence of hallucinations and delusions directly from the child or adolescent.

14.2 PRESENTING COMPLAINTS

- Disorganised speech - irrelevant or incoherent.
- Hallucinations - seeing things or hearing voices that are not present.
- Delusions - strong beliefs that people are against them, “out to get them” or talking about them.
- Odd and eccentric behaviour and/or speech.
- Unusual or bizarre thoughts and ideas resulting in:
  - Confused thinking.
  - Extreme moodiness.
  - Regression in behaviour.
  - Severe anxiety and fearfulness.
- Social withdrawal from friends and family.
- Negative symptoms - reduced facial expression (affective flattening), poverty of speech (a logia), lack of purposeful action (avolition), and lack of pleasurable experience (anhedonia).
- Increased isolation.
- Decline in personal functioning and hygiene.

14.3 DIAGNOSTIC CRITERIA (DSM IV)

14.3.1 CRITERIA FOR SCHIZOPHRENIA

A. Characteristics Symptoms:
Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less is successfully treated):
(1) Delusions
(2) Hallucinations
(3) Disorganised speech (e.g., frequent derailment or incoherence)
(4) Grossly disorganised or catatonic behaviour
(5) Negative symptoms, i.e., affective flattening, alogia or avolition.

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person’s behaviour or thoughts, or two or more voices conversing with each other.

B. Social / Occupational Dysfunction:
For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic or occupational achievement).
C. Duration:
Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms.

During these prodromal or residual periods, the signs of disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective and Mood Disorder exclusion:
Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic or Mixed Episodes have been occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. Substance / General Medical Condition exclusion:
The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of a abuse, a medication) or a general medical condition.

F. Relationship to a Pervasive Development Disorder:
If there is a history of Autistic Disorder or another Pervasive Development Disorder, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

14.3.2 CRITERIA FOR SCHIZOPHRENIA SUBTYPES
The subtypes of Schizophrenia are defined by the predominant symptomatology at the time of evaluation.

(295.30) Paranoid Type
A type schizophrenia in which the following criteria are met:
A. Preoccupation with one or more delusions or frequent auditory hallucinations.
B. None of the following is prominent: disorganized speech, disorganized or catatonic behaviour or flat or inappropriate affect.

(295.10) Disorganised Type
A type of Schizophrenia in which the following criteria are met.
A. All of the following are prominent:
   (1) Disorganised speech
   (2) Disorganised behaviour
   (3) Flat or inappropriate affect
B. The criteria are not met for Catatonic Type

(295.20) Catatonic Type
A type of Schizophrenia in which the clinical picture is dominated by at least two of the following:
(1) Motoric immobility as evidenced by catalepsy (including waxy flexibility) or stupor.
(2) Excessive motor activity (that is apparently purposeless and not influenced by external stimuli).
(3) Extreme negativism (an apparently motiveless resistance to all instructions or maintenance of a rigid posture against attempts to be moved) or mutism.
(4) Peculiarities of voluntary movement as evidenced by posturing (voluntary assumption of inappropriate or bizarre posture), stereotyped movements, prominent mannerisms or prominent grimacing.
(5) Echolalia or echopraxia.
(295.90) Undifferentiated Type

A type of schizophrenia in which symptoms that meet Criterion A are present, but the criteria are not met for the Paranoid, Disorganized or Catatonic type.

(295.60) Residual Type

A type of schizophrenia in which the following criteria are met:
A. Absence of prominent delusions, hallucinations, disorganized speech and grossly disorganized or catatonic behaviour.
B. There is continuing evidence of the disturbance, as indicated by the presence of negative symptoms or two or more symptoms listed in Criterion A for Schizophrenia, present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

14.3.3 CLASSIFICATION OF LONGITUDINAL COURSE FOR SCHIZOPHRENIA

These specifiers can be applied only after at least 1 year has elapsed since the initial onset of active-phase symptoms:

Episodic With Interepisode Residual Symptoms:
When the course is characterized by episodes in which Criterion A for Schizophrenia is met and there are clinically significant residual symptoms between the episodes. With Prominent Negative Symptoms can be added if prominent negative symptoms are present during these residual periods.

Episodic With No Interepisode Residual Symptoms:
When the course is characterized by episodes in which Criterion A for Schizophrenia is met and there are no clinically significant residual symptoms between the episodes.

Continuous:
When characteristic symptoms of Criterion A are met throughout all (or most) of the course. With Prominent Negative Symptoms can be added if prominent negative symptoms are also present.

Single Episode In Full Remission:
When there has been a single episode in which Criterion A for Schizophrenia has been met and no clinically significant residual symptoms remain.

Other or Unspecified Pattern:
If another or an unspecified course pattern has been present.

14.4 DIFFERENTIAL DIAGNOSIS

- Organic conditions e.g. CNS lesions, tumours or infections; metabolic disorders; seizure disorders.
- Pervasive developmental disorders e.g. autism.
- Mood Disorders e.g. Bipolar Disorder.
- Non-psychotic emotional and behavioural disturbances (including post-traumatic stress disorder).
14.5 ESSENTIAL INFORMATION

Schizophrenia is a serious psychiatric disorder.
- The cause of schizophrenia is not known but current research suggests that brain changes, biochemical, genetic and environmental factors may play a role.
- Agitation and strange behaviour are symptoms of a mental illness and not due to possession by evil spirits.
- Early diagnosis and medical treatment are important.
- Schizophrenia is a lifelong disease that can be controlled.
- Onset in children below the age of 13 is rare.
- Children and adolescents suspected to have schizophrenia must undergo evaluation.

14.6 MANAGEMENT

Children and adolescents with schizophrenia require comprehensive treatment plans that involve multiple modes of management. A combination of medication and psychosocial intervention (e.g. individual therapy, specialised rehabilitation programs, school programs) is necessary.

14.6.1 PSYCHO-EDUCATION

- Ensure the safety of the patient and those caring for him/her.
- Stress and stimulation should be minimised.
- Do not argue with psychotic thinking.
- Avoid confronting or criticising unless it is necessary to prevent harmful behaviour.
- Emphasise the importance of compliance and supervision of medication

14.6.2 PSYCHOLOGICAL INTERVENTION

- Counseling
- Family therapy
- Individual psychotherapy

14.7 MEDICATION

14.7.1 ANTIPSYCHOTICS

are the mainstay of treatment of schizophrenia. The choice of antipsychotics should be made on the basis of the agent's relative potency, potential side effects and the patient's history of medication response. First line agents include conventional (typical) antipsychotics and atypical agents. Clozapine should be reserved for treatment-resistant schizophrenia.

Examples of common dosages:
- Risperidone 1.0 - 2.0 mg twice daily
- Olanzapine 5.0 - 10.0 mg once daily
- Haloperidol 1.5 - 3.0 mg twice daily

Depot antipsychotics should be considered only in adolescents with documented chronic symptoms and a history of poor medication compliance.

Anxiolytics may be used in conjunction with antipsychotics to control acute agitation e.g. Lorazepam 0.5 - 1.0 mg up to 4 times a day.

Continue antipsychotics for at least 3 months after symptoms resolve.
Monitor for side effects of medication.

* Acute dystonias or spasms may be managed with injectable antiparkinsonian drugs (e.g. 1M Kemadrin 5 - 10 mg).
* Akathisia (severe motor restlessness) may be managed by dosage reduction or benzodiazepines.
* Parkinsonian symptoms (tremor, akinesia) may be managed with oral antiparkinsonian drugs (e.g. benzhexol 1-2 mg three times a day)

For patients who get a relapse of their illness, medication will need to be continued longer.

14.7.2 ELECTROCONVULSIVE THERAPY (ECT)

May be used in children and adolescents, who either are medication non-responders, cannot tolerate medication or have catatonia. Informed consent must be taken from the patient and family after a detailed discussion that includes the relative risks and benefits of ECT.

14.8 SPECIALIST CONSULTATION

If possible consider consultation for all new cases of schizophrenia in children and adolescents.

REFERENCES:


5. Ministry of Health Malaysia. Diagnostic and Management Guidelines for Mental Disorders in Primary Health Care.
UNIT 15 : BIPOLAR DISORDER

15.1 INTRODUCTION / DEFINITION

Bipolar Disorder is a mood disorder that is characterised by cyclical disturbances in mood, cognition and behaviour. The diagnosis requires a history of mania for at least 1 week.

Patients with Bipolar Disorder have elevated mood, increased energy and activity (mania or hypomania) or on other occasions with depression (lowering of mood).

Bipolar Disorder is rarely seen in young children, though it does occur in adolescents but is most common in adults.

15.2 PRESENTING COMPLAINTS

15.2.1 MANIA
- Unusually happy or silly; or very irritable, angry, agitated or aggressive.
- Unrealistic highs in self esteem (grandiosity).
- Great increase in energy.
- Need little or no sleep for days without feeling tired.
- Increase in talking (too much, too fast, topic changes too quickly).
- Distractibility.
- Repeated high risk-taking behaviour e.g. abuse of alcohol and drugs, reckless driving, increase in sexual activity.

15.2.2 DEPRESSIVE SYMPTOMS
- Depressed mood, or irritability.
- Frequent crying.
- Loss of enjoyment in favourite activities.
- Thoughts of death or suicide.
- Frequent complaints of headaches, stomachaches (somatising symptoms).
- Low energy level, fatigue.
- Poor concentration.
- Appetite change (loss or gain in appetite).
- Sleep changes (reduced or increased sleep).

Either mania or depression may predominate.

Episodes may be frequent or may be separated by periods of normal mood. In severe cases, patients may have hallucinations or delusions during periods of mania or depression.

15.3 DIAGNOSTIC CRITERIA (DSM IV)

CRITERIA FOR BIPOLAR DISORDER

(269.0x) Bipolar I Disorder, Single Manic Episode
A. Presence of only one Manic Episode and no past Major Depressive Episodes.
   Note: Recurrence is defined as either a change in polarity from depression or an interval of at least 2 months without manic symptoms.

B. The Manic Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder or Psychotic Disorder Not Otherwise Specified.
Specify If:
Mixed: If symptoms meet criteria for a Mixed Episode

Specify (for current or most recent episode):
Severity / Psychotic / Remission Specifiers.
With Catatonic Features.
With Postpartum Onset.

(269.40) Bipolar I Disorder, Most Recent Episode Hypomanic
A. Currently (or most recently) in a Hypomanic Episode.
B. There has previously been at least one Manic Episode or Mixed Episode.
C. The mood symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
D. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder or Psychotic Disorder Not Otherwise Specified.

Specify:
Longitudinal Course Specifiers (With and Without Interepisode Recovery).
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes).
With Rapid Cycling.

(269.4x) Bipolar I Disorder, Most Recent Episode Manic
A. Currently (or most recently) in a Manic Episode.
B. There has previously been at least one Major Depressive Episode, Manic Episode or Mixed Episode.
C. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder or Psychotic Disorder Not Otherwise Specified.

Specify (for current or most recent episode):
Severity / Psychotic / Remission Specifiers
With Catatonic Features
With Postpartum Onset

Specify:
Longitudinal Course Specifiers (With and Without Interepisode Recovery).
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes).
With Rapid Cycling.

(269.6x) Bipolar I Disorder, Most Recent Episode Mixed
A. Currently (or most recently) in a Manic Episode.
B. There has previously been at least one Major Depressive Episode, Manic Episode or Mixed Episode.
C. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder or Psychotic Disorder Not Otherwise Specified.

Specify (for current or most recent episode):
Severity / Psychotic / Remission Specifiers
With Catatonic Features
With Postpartum Onset

Specify:
Longitudinal Course Specifiers (With and Without Interepisode Recovery).
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes).
With Rapid Cycling.
SECTION 2 : EMOTIONAL AND BEHAVIOURAL DISORDERS OF CHILDREN AND ADOLESCENTS

(269.5x) Bipolar I Disorder, Most Recent Episode Depressed
A. Currently (or most recently) in a Manic Episodes
B. There has previously been at least one Major Depressive Episode, Manic Episode or Mixed Episode.
C. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder or Psychotic Disorder Not Otherwise Specified.

Specify (for current or most recent episode):
Severity / Psychotic / Remission Specifiers
Chronic
With Catatonic Features
With Melancholic Features
With Atypical Features
With Postpartum Onset

Specify:
Longitudinal Course Specifiers (With and Without Interepisode Recovery)
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes)
With Rapid Cycling

(269.7) Bipolar I Disorder, Most Recent Episode Unspecified
A. Criteria, except for duration, are currently (or most recently) met for a manic, a Hypomanic, a Mixed or Major Depressive Episode.
B. There has previously been at least one Manic Episode or Mixed Episode.
C. The mood symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
D. The mood symptoms in Criteria A and B are not Better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder or Psychotic Disorder Not Otherwise Specified.
E. The Symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Specify:
Longitudinal Course Specifiers (With and Without Interepisode Recovery).
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes).
With Rapid Cycling.

(269.89) Bipolar II Disorder (Recurrent Major Depressive Episodes With Hypomanic Episode)
A. Presence (or history) of one or more Major Depressive Episodes.
B. Presence (or history) of at least one Hypomanic Episode.
C. There has never been a Manic Episode or Mixed Episode.
D. The mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder or Psychotic Disorder Not Otherwise Specified.
E. The Symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Specify (for current or most recent episode):
Hypomanic: if currently (or most recently) in a Hypomanic Episode.
Depressed: if currently (or most recently) in a Major Depressive Episode.
Specify: (for current or most recent Major Depressive Episode only if it is the most recent type of mood episode)

**Severity or Psychotic or Remission Specifiers.**

*Note:* fifth-digit codes specified cannot be used here because the codes specified cannot be used here because the code for Bipolar II Disorder already uses the fifth digit.

**Chronic.**
- With Catatonic Features.
- With Melancholic Features.
- With Atypical Features.
- With Postpartum Onset.

Specify:
- **Longitudinal Course Specifiers** (With and Without Interepisode Recovery).
- **With Seasonal Pattern** (applies only to the pattern of Major Depressive Episodes).
- **With Rapid Cycling.**

### 15.4 Differential Diagnosis

* Drug abuse
* Conduct disorder
* Attention Deficit Hyperactivity Disorder
* Schizophrenia
* Organic diseases e.g. epilepsy, thyroid disorders, electrolyte abnormalities.

### 15.5 Essential Information for Patient and Family

* Unexplained changes in mood and behaviour are symptoms of illness.
* Careful observation over an extended period of time is needed to make the diagnosis.
* A thorough evaluation is helpful.
* Effective treatment is available.
* Long term treatment can prevent future episodes.
* Mania, if left untreated, may be dangerous or disruptive.

### 15.6 Management

Bipolar disorder can be effectively treated with medication and psychosocial intervention.

* **Psychoeducation**
  To enable patient and family to manage the illness.
* **Psychotherapy**
  Helps the patient understand himself, adapt to stresses, rebuild self esteem and improve relationships.
* **Counseling to patient and family.**

During manic episodes:

* Avoid confrontation unless necessary to prevent harmful or dangerous acts
* Advise caution about impulsive or dangerous behaviour.
* Close observation by family members
* Consider hospitalization if behaviour is disruptive or agitated
15.7 MEDICATIONS

15.7.1 MOOD STABILISERS

- These reduce the severity and number of manic episodes and also help to prevent depression.
  - Examples: Lithium carbonate, Sodium valproate, Carbamazepine

15.7.2 ANTIPSYCHOTIC MEDICATION

- To control psychotic behaviour associated with mania or depression.
  - Examples: Haloperidol, Risperidone, Olanzapine

15.8 SPECIALIST CONSULTATION

Consider consultation for acute manic phase or depressive phase.
UNIT 16 : THE CHILD WITH A CHRONIC ILLNESS

16.1 INTRODUCTION

About 10 to 20% of children in a population may suffer from a long-term illness, e.g. diabetes mellitus, bronchial asthma, juvenile chronic arthritis. Such an illness may affect not only the child's life, but also that of his family. Conversely, the stage of development at which an illness occurs and the family situation at the time can affect the individual's and family's response to the illness. Other factors, which may have an influence, include the nature and effects of the specific disease as well as the cultural, social and economic background of the family.

Aspects of a chronic illness, which may affect the child's development and disrupt family life, include the following:

16.1.1 FACTORS RELATING TO TREATMENT:

• Numerous clinic visits and the need for repeated or prolonged hospital stay.
• The need to travel to a distant facility for specialty or sub-specialty care.
• The need to consult the expertise of professionals in different disciplines.
• The need to adhere to a specific treatment regimen, which may include medication required at specific times, restrictions to diet and activity.
• Requirement for specialised care or equipment which prevent the child from leaving the hospital.

16.1.2 FACTORS DIRECTLY AFFECTING THE CHILD AND FAMILY

• Experiencing repeated painful and/or invasive treatments and investigative procedures.
• Tolerating unpleasant side effects of treatment.
• Interference with normal growth and development.
• Disfigurement or alteration of one's appearance due to the disease itself or effects of treatment.
• Physical limitations and limitations to mobility.
• Gradual deterioration and mortality associated with certain diseases.
• Unpredictability of exacerbations.
• The risk or presence of more than one affected child in genetic diseases.

16.2 PROBLEMS AT SPECIFIC STAGES

A child's perception and response varies with his age and stage of development.

The stage in a child's life when illness occurs may modify his development and shape his personality.

16.2.1 INFANCY

Normal developmental process:

• Child begins to explore once he finds the environment reliable and predictable.
• He develops a sense of his own individuality and gradually becomes able to tolerate separation from his caregiver.

Effect of chronic illness:

• Repeated pain, separation from home and family and physical restrictions make the environment hostile and frightening.
• Parents may go through a period of mourning and grief when their expectation of a normal child is not fulfilled.
• Parental reactions of anger, depression or guilt can affect the care of their child.
• The above situation can foster fear, distrust and dependency in a child.
Effect on parents:
- Interference with bonding and interaction between parent and child.
- Failure to develop self-confidence and competence as parents.
- This occurs for the following reasons.
  - Irritability and lethargy of the child due to illness
  - Feeding difficulties
  - Lack of social responsiveness due to sensory and neurologic deficits
  - The need to depend on medical advice and services
  - Parents are tired and worn out

16.2.2 TODDLERS

Normal developmental process:
- Improved motor and communication skills from 18 months to 3 years.
- Child becomes more confident, wants to explore and do things for himself.
- Child begins to acquire a limited independence and learns to make simple choices.
- Learning of self-control through rules and limits set by parents.
- Child forms mental pictures and remembers people and things he has encountered before.
- Child thinks imaginatively, but cannot understand through reason and logic.

Effect of chronic illness:
- Restrictions to movement and activity may prevent a child from learning new skills, e.g. riding a tricycle.
- Child may miss out on new experiences important for cognitive stimulation e.g. visiting the zoo, going to the supermarket.
- Failure to learn or delay in learning of simple self-care skills like feeding, dressing, and toileting which parents continue to do for the child.
- Parents may fail to set limits and control impulsive behaviour out of reluctance to punish or discipline a sick child. The resulting poor impulse control may make it more difficult to introduce discipline later on.
- Some toddlers may feel defeated from restrictions, becoming passive, apathetic and clinging.
- Some toddlers may enjoy the care and attention they get at the expense of learning skills and independence important for building self-esteem.

16.2.3 PRESCHOOLERS

Normal developmental process:
- Child takes more initiative in planning and carrying out tasks, setting goals.
- Child seeks approval for accomplishments.
- The understanding of cause and effect is based more on correlation (i.e. linking people and things at the same place and time) than on reasoning and understanding how things work.

Effect of chronic illness:
- Restrictions may be imposed by nature of illness itself or by parents.
- Limits activities and opportunities for interaction with friends, e.g. attending play school and kindergarten.
- Limits child’s enthusiasm and ability to gain self-confidence through new accomplishments.
- Limited opportunities to develop social skills learnt through interaction e.g. sharing, taking turns.
- Child may associate falling ill with certain actions, e.g. he may connect falling sick with certain actions like “playing in the rain” or getting well with certain actions like “drinking herbal soup”.
- Child may think he has fallen sick because he did something bad.
16.2.4 THE SCHOOL-AGED CHILD

**Normal developmental process:**
- Child spends more time away from home and more in school.
- Child has a need to be accepted by friends and peers.
- Achievements in school are important for a child to feel successful and capable.

**Effect of chronic illness:**
- Irregular attendance in school and limited participation in physical and other school activities, e.g. sports, camping, excursions.
- Illness may emphasise difference between child and his friends. Child may be labelled and identified through his illness rather than his personality. It may be more difficult for him to fit in and be accepted by his peers.
- Difficulties with schoolwork and limited opportunities to achieve both academically and in other fields.
- Child may have low self-esteem if he sees himself as a failure and underachiever and friends share this view.
- A more sophisticated understanding of how the body works and mechanisms of illness gives rise to many more questions about his illness.
- The sense of powerlessness and helplessness produced by the illness can give rise to frustration.

16.2.5 THE ADOLESCENT

**Normal developmental process:**
- Struggle of individual to achieve own identity and independence.
- Development of more complex and abstract thought.
- Physical changes of puberty accompanied by new emotions, appearance of sexual urges and the need to look and feel attractive.
- Individual has to face multiple pressures simultaneously,
  - Burden of school work.
  - New types of peer relationships and the beginning of the dating game.
  - The need to make decisions and formulate goals in life.
- More time spent away from home, especially with friends and peers who may sometimes have a greater influence on the individual than his own family.
- Period of experimentation and seeking adventure with new fashions, new activities - sometimes this could involve risk-taking and unhealthy activities e.g. smoking, drinking alcohol, speeding, sexual activity.
- Normal for individual to have anxiety, confusion, tendency to self-criticism and go through a range of behaviours and emotions during this transition period.

**Effect of chronic illness:**
- Illness and/or treatment may be disfiguring or cause poor growth and delayed puberty. Some illnesses may be associated with embarrassing symptoms like incontinence, frequent diarrhoea or some form of disability. Looking and feeling physically unattractive because of his illness can sometimes cause great emotional and psychological distress.
- Anxiety about the capacity to function sexually or have children which may not be spoken aloud.
- Disruption of education and opportunity to follow career of choice.
- The adolescent patient may try to seek more information about his illness. Some may depend more on less reliable sources such as their own friends and the popular or alternative media.
SECTION 2: EMOTIONAL AND BEHAVIOURAL DISORDERS OF CHILDREN AND ADOLESCENTS

Special problems associated with chronic illness in adolescents:

- Greater struggle for independence versus parental over-protectiveness. This can hinder the process of taking over more responsibility for health care and treatment in preparation for adult life.
- Preoccupation with body image and restrictions to social activities. Less emphasis on issues affecting health.
- Non-compliance with therapeutic regime and restrictions (e.g. diet) if this interferes with social activities such as eating out, staying out late, driving.
- Involvement with risk-taking behaviour can be dangerous and disastrous in the presence of other illnesses e.g. smoking and drinking alcohol in a diabetic.
- Some girls may be at higher risk of early sexual activity because of the need to prove that they are normal and attractive.
- Some adolescents may manipulate their illness / treatment to fulfil a desired body image e.g. not taking hyperthyroid medication to lose weight.
- Behavioural problems can arise when adolescents become manipulative and use compliance to bargain with parents.
- Adolescents with disabilities, especially cognitive impairment are particularly vulnerable to exploitation e.g. sexual exploitation.

16.3 INTERACTION BETWEEN CHILD AND FAMILY

Functioning in the presence of a chronic illness:

- Health care practitioners should have an understanding of the relationship between:
  1. How a family functions.
  2. The functioning and development of an individual child.
  3. How functioning patterns can change in the presence of a chronic illness in a child.
- The adaptation of a family to any crisis situation depends on the balance between the various demands placed on the family versus its capability to cope.
- Demands include factors like the illness itself, job stresses experienced by parents, marital conflict, financial problems and day to day problems e.g. car breakdown, burst kitchen pipe.
- Capabilities that can be an asset include a sense of humour, practical skills, education, good parenting and conflict resolution skills, as well as easy access to community resources like health care services, helpful neighbours etc.
- Demands and capabilities for a particular family can change with time and tip the balance until the family learns to cope.
- How the family adapts to the crisis of an illness can affect the development of the child - poor adaptation and coping by the family can negatively affect the child.

16.4 ROLE OF PRIMARY HEALTH CARE SERVICES

(general paediatricians and family physicians) in care of children with chronic illness

- Primary health care providers i.e. general paediatricians and family physicians who know the family better and are more accessible should work in partnership with sub specialists.
  - to provide comprehensive care.
  - to try to reduce the inconvenience of medical consultation and treatment.
  - to educate the family about the child's illness and treatment.
  - to help the family develop the ability to care for their child.
- Monitoring of overall growth and development and provision of advice to facilitate normal development and adaptation to illness.
- Positive encouragement for the child to build up self-esteem.
- Advice to parents regarding discipline and setting limits.
- Encourage the child and family to lead as normal a life as possible with a balance of work, leisure and participation in the community.
Facilitate family’s access to community resources, e.g. special education and rehabilitation facilities, support services and support groups.

Advocate for the child and address school problems, e.g. communicate with school authorities regarding a child’s special needs.

Provide anticipatory guidance and early recognition of psychosocial problems and mal-adaptation to illness.

Focus on the needs of the family as a whole, i.e. recognising illness / problems in other family members and providing necessary care and advice or facilitation of referral to other support services e.g. depression in parent, behavioural problems in siblings who may have been neglected due to attention focused on the ill child, needs of main caregiver to have respite care.

Work with families to help them recognise and reinforce their own strengths and abilities which are helpful in handling their situation.

**Care of the adolescent patient**

- Include adolescents in discussions about their illness and decision-making processes and obtain their input.
- Create opportunities to talk to them alone.
- Acknowledge and address their anxieties and concerns and do not dismiss them as trivial matters.
- Ensure that they become involved in their own health care, especially in the presence of overprotective or domineering parents. Help them to acquire the necessary skills towards independent care as adults as far as possible.
- Be open-minded and non-judgmental.
- Be honest and prepared to explain. Encourage parents to do the same rather than to hide information.
- Be clear and consistent about ground rules and emphasise mutual respect.
- Be flexible and tolerate short periods of non-compliance if necessary to ensure better long-term cooperation from the adolescent patient.

**16.4 INDICATIONS FOR REFERRAL TO A CHILD PSYCHIATRIST OR PSYCHIATRIST DEALING WITH FAMILY PROBLEMS**

- Behavioural problems that do not respond to counseling or simple behaviour modification techniques.
- Presence of severe psychosocial disturbance, e.g. depression, suicidal ideation or self-harming behaviour that may require pharmacological and other specialised intervention.
- Presence of severe mental health problems in either parent that may require specialised intervention.
- Severe disruption in family relationships or ability to cope e.g. marital problems that affect the care of a child.
REFERENCES:


UNIT 17 : UNEXPLAINED SOMATIC COMPLAINTS

17.1 INTRODUCTION / DEFINITION

Unexplained somatic complaints are symptoms for which a physical or medical condition is not found after a full history, physical examination and tests. These symptoms may be single or multiple and may change over time. They may vary widely across different cultures and are commonly seen in children and adolescents.

These unexplained symptoms are often a product of psychological/emotional stress in the child or adolescent. They may allow the patient to avoid stressful situations or be exempted from certain responsibilities e.g. being allowed to stay home from school.

17.2 PRESENTING COMPLAINTS:

- Headache.
- Chest pain.
- Difficulty in breathing.
- Difficulty in swallowing.
- Nausea.
- Vomiting, including “haematemesis”.
- Diarrhoea.
- Frequent micturition.
- Abdominal pain.
- Low back pain.
- Skin problems.
- Muscle discomfort.
- Symptoms of anxiety and depression are common.
- Frequent medical visits in spite of negative investigation results.
- Some patients may be concerned with obtaining relief from physical symptoms.

17.3 DIAGNOSTIC CRITERIA (DSM IV)

17.3.1 CRITERIA FOR PAIN DISORDER:

A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.

B. The pain causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

C. Psychological factors are judged to have an important role in the onset, severity, exacerbation or maintenance of the pain.

D. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).

E. The pain is not better accounted for by a Mood, Anxiety or Psychotic Disorder and does not meet criteria for Dyspareunia.
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Code as follows:

(307.80) Pain Disorder Associated With Psychological Factors:
Psychological factors are judged to have the major role in the onset, severity, exacerbation or maintenance of the pain. (If a general medical condition is present, it does not have a major role in the onset, severity, exacerbation or maintenance of the pain). This type of Pain Disorder is not diagnosed if criteria are also met for Somatisation Disorder.

Specify if:
- **Acute**: Duration of less than 6 month.
- **Chronic**: Duration of 6 months or longer.

(307.89) Pain Disorder Associated With Both Psychological Factors and a General Medical Condition:
Both psychological factors and general medical condition are judged to have important roles in the onset, severity, exacerbation or maintenance of the pain. The associated general medical condition or anatomical site of the pain is coded on Axis III.

Specify if:
- **Acute**: Duration of less than 6 month
- **Chronic**: Duration of 6 months or longer

17.4 DIFFERENTIAL DIAGNOSIS
1. Depression - if low mood or sad mood is prominent.
2. Generalised Anxiety Disorder - if anxiety symptoms are prominent.
3. Acute Psychotic Disorder - if strange beliefs about symptoms are prominent.
4. Sexual Abuse.

17.5 ESSENTIAL INFORMATION FOR PATIENT AND FAMILY
1. Stress often produces physical symptoms.
2. Focus on managing the symptoms.
3. Try to discover the possible causes of the stress e.g. being bullied, being physically or sexually abused.
4. Having school related pressure.

17.6 COUNSELING FOR PATIENT AND FAMILY
1. Acknowledge that the patient's symptoms are real. They are not lies or inventions.
2. Ask about the patient's beliefs regarding what is causing the symptoms and fears.
3. Offer appropriate reassurances. Advise patients not to focus on medical worries.
4. Discuss emotional stresses that were present when the symptoms started.
5. Help the patient and family handle the stresses e.g. speak to the headmaster to deal with school bullies who have been victimising the patient.
6. Teach the patient relaxation techniques (e.g. Jacobson’s progressive muscle relaxation).
7. Encourage exercise, enjoyable activities, religious or spiritual practices and meditation in moderation.
8. Encourage early return to normal activities even before all symptoms have resolved.
9. For patients with more chronic complaints, scheduled regular time-limited appointments. This helps prevent frequent visits to the emergency department.
10. Maintain a consistent, stable, non-judgmental attitude. This helps patients to feel understood, encourages continuation of treatment and reduces “doctor shopping.”
17.7 MEDICATION

1. Short-term low dose anxiolytics (not more than 1 month) or anti-depressant medication (for its anxiolytic action) may be helpful. Avoid anxiolytic medication in children below 6 years of age.
2. Avoid unnecessary diagnostic testing or prescription of new medication for each new symptom.

17.8 SPECIALIST CONSULTATION

Primary care settings are the best for patients with unexplained somatic symptoms. A complete physical examination and appropriate tests should be done to exclude a medical condition.

If symptoms persist after 6 weeks or progress rapidly, refer to a paediatrician or a child psychiatrist.
UNIT 18 : CONVERSION / DISSOCIATIVE DISORDERS

18.1 INTRODUCTION / DEFINITION

Conversion disorder presents with apparent deficits of the voluntary motor or sensory neurologic system without corresponding neurological signs. It often mimics recognised neurologic or other medical conditions. The symptoms are not intentionally produced but are due to underlying psychological factors expressed in physical symptoms. They do not conform to recognised anatomic pathways. Patients often do not appear upset. The disorder may reflect symbolically, past or current stressors.

18.2 PRESENTING COMPLAINTS

1. Paralysis.
2. Seizures.
3. Loss of sensation.
4. Visual disturbances e.g. double vision, blindness.
5. Difficulty in swallowing.
6. Aphonía.
7. Amnesia.
8. Trance.
10. “Possession” states.

Examples: loss of sensation in a “glove” distribution; paralysis of a hand but not of the arm.

Onset is often sudden and related to psychological stress or difficult personal circumstances. In acute cases, symptoms may be dramatic and unusual, change from time to time and be related to getting attention from others.

Mass/Epidemic hysteria” occurs in a large number of persons at the same time precipitated by environmental and personal stressors.

18.3 DIAGNOSTIC CRITERIA (DSM IV)

(300.11) CRITERIA FOR CONVERSION DISORDER

A. One or more symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition.
B. Psychological factors are judged to be associated with the symptom or deficit because the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors.
C. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).
D. The symptom or deficit causes clinically significant distress or impairment in social, occupational or other important areas of functioning or warrants medical evaluation.
E. The symptom or deficit is not limited to pain or sexual dysfunction, does not occur exclusively during the course of Somatization Disorder, and is not better accounted for by another mental disorder.

Specify type of symptom or deficit:
With Motor Symptom or Deficit
(e.g., impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or “lump in throat,” aphonía and urinary retention).
**With Sensory Symptom or Deficit**  
(e.g., loss of touch or pain sensation, double vision, blindness, deafness and hallucinations).

**With Seizure or Convulsions**  
Includes seizures or convulsions with voluntary motor or sensory components.

**With Mixed Presentation**  
If symptoms of more than one category are evident.

### 18.4 DIFFERENTIAL DIAGNOSIS

- Physical disorders need to be carefully excluded. Early symptoms of neurological disorders may resemble conversion symptoms. E.g. complex partial seizures, periodic hypocalcaemic paralysis, Guillain-Barre syndrome.
- Factitious disorders may be difficult to distinguish from conversion disorder in children.
- Consider the possibility of sexual abuse especially in those who present with trance like or possession states.

### 18.5 ESSENTIAL INFORMATION FOR PATIENT AND FAMILY

- Physical and neurological symptoms often have no clear physical cause.
- Symptoms can be brought about or worsened by stress.
- The patient is not pretending or lying.
- Symptoms usually resolve leaving no permanent damage.

### 18.6 COUNSELING OF PATIENT AND FAMILY

- The patient should be encouraged to acknowledge recent stresses or difficulties.
- All effort must be made to determine the underlying stressors.
- Give positive reinforcement for improvement in symptoms.
- Avoid confrontation i.e. telling the patient that the symptoms are not real. Do not attribute the symptoms to psychological conflicts.
- Try not to reinforce the symptoms e.g. by giving the child excessive attention for being sick, allowing absence from school, etc.
- Encourage the patient to overcome the symptoms e.g. if the patient is “paralysed” he should be encouraged to walk in the absence of relatives.
- Get the patient to gradually return to normal activities, often with the help of physiotherapy where appropriate.
- Advise against prolonged rest or withdrawal from activities.
- Encourage family and friends to help the patient to return to normal function rather than overprotect or pamper him.

### 18.7 MANAGEMENT

#### 18.7.1 PSYCHOLOGICAL THERAPY

- Relaxation Technique.
- Cognitive behaviour therapy.
- Family therapy.
- Improve the child and family coping skills.
18.7.2 MEDICATION

- Avoid anxiolytics or sedatives.
- Antidepressant medication may be helpful for its anxiolytic action or in cases with depressive symptoms.

18.8 SPECIALIST CONSULTATION

Consider consultation to child psychiatrist:
- If symptoms persist longer than 2 weeks.
- If symptoms progress rapidly.
- To prevent or treat physical complications of conversion symptoms.
UNIT 19 : MOTOR SKILLS DISORDER

DEVELOPMENTAL COORDINATION DISORDER

19.1 INTRODUCTION

Children with this disorder manifest a marked impairment in the development of motor coordination. Their performance in daily activities requiring motor coordination is markedly below the level expected for their chronological age and measured intelligence.

These children may also present with emotional and psychosocial disturbances resulting from their disability, such as aggressive or oppositional behaviour, depression, withdrawal, low self-esteem. These manifestations may arise from frustration as well as being subject to criticism, ridicule and being ostracised as a result of their disability.

19.2 PRESENTING COMPLAINTS

- Delayed motor milestones e.g. achieving sitting balance, standing, walking
- Clumsiness
- Poor performance in sports and games
- Poor handwriting
- Difficulty in tying shoelaces, fastening buttons

19.3 DIAGNOSTIC CRITERIA (DSM-IV)

A. Performance in daily activities that require motor coordination is substantially below that expected given the person's chronological age and measured intelligence. This may be manifested by marked delays in achieving motor milestones (e.g. walking, crawling, and sitting), dropping things, 'clumsiness,' poor performance in sports, or poor handwriting.

B. The disturbance in Criterion A significantly interferes with academic achievement or activities of daily living.

C. The disturbance is not due to a general medical condition (e.g. cerebral palsy, hemiplegia, or muscular dystrophy) and does not meet criteria for a Pervasive Developmental Disorder.

19.4 DIFFERENTIAL DIAGNOSIS

- Specific neuromuscular disorders e.g. cerebral palsy, muscle diseases and disorders of cerebellar coordination.
- Severe mental retardation.

19.5 MANAGEMENT

- Explanation to parents and child that symptoms are due to disability, which is no one's fault.
- Counseling to parent and child to help them to accept the disability.
- Referral to an occupational therapist at the hospital or Community Polyclinic to improve functional ability with training or use of appropriate aids for specific tasks.
- Liaison with school authorities to help improve overall function.
- Recommendation to school and relevant bodies for extra time to sit for written examination if indicated.
- Referral to Welfare Department and Education Department for registration of disability.
19.6 ESSENTIAL INFORMATION FOR PATIENTS & FAMILY

- The child is not responsible for his disability and should not be punished and criticised for problems and poor performance due to his disability.
- The child requires a great deal of patience and encouragement.
- Create opportunities for the child to participate and develop skills in activities, which give him a sense of achievement and build up his self-esteem.

19.7 SPECIALIST CONSULTATION

- Referral to Paediatric Neurologist or Developmental Paediatrician in cases where a specific neuro muscular disorder cannot be ruled out.
- Referral to Child Psychiatrist in children who manifest severe emotional or behavioural disturbances.
UNIT 20 : AUTISM

20.1 INTRODUCTION

Autism is a life long, pervasive neuro-developmental disorder, which begins in the first 36 months of life. It is 3-4 times more common in males than females.

The outcome of children with autism is determined by IQ and language ability at age of 5 years. Good or fair outcomes are almost always associated with IQ's of more than 60 and the acquisition of useful speech by 5 years of age. Follow-up studies into adulthood show approximately two thirds remain seriously disabled and unable to care for themselves; 5 - 17 % is able to work with minimal support while most of them have abnormal social relationships.

20.2 CLINICAL PRESENTATIONS

The core clinical features of autism include:
- Impairment in social interaction
- Impairment in verbal and non-verbal communication
- Restricted, repetitive and stereotyped patterns of behaviour, interests and activities

The common manifestations in persons with autism may differ with age:
- Early childhood - hyperactivity, stereotyped behaviours, irritability and temper tantrums may be prominent.
- Late childhood - Tic-like behaviours, aggressiveness and self-injurious behaviour.
- Adolescence and adulthood - particularly in higher functioning individuals, depression or obsessivecompulsive phenomena may develop. In lower functioning individuals about a third may develop epilepsy.

Associated conditions include:
- Attention Deficit Hyperactivity Disorder.
- Mental retardation (in 75% of individuals).
- Epilepsy (in 33% of individuals with onset during adolescence).
- Unusual responses to sensory stimuli.
- Sleep problems.
- Food fads.

20.3 DIAGNOSIS

The diagnosis of autism is made by gathering information about the child's developmental history and behavioural presentation. Information is obtained from parents, teachers and carers. Some useful rating scales e.g. Childhood Autism for Toddlers (CHAT), Childhood Autism Rating Scale (CARS).

The DSM-IV diagnostic criteria for Autistic Disorder are as follows:

A) A total of 6 (or more) items from the following:
  1) Impairment of social interaction manifested by:
     - Absent eye-gaze and facial expressions, and gestures to regulate social interaction.
     - Failure to develop appropriate peer relationships.
     - Lack of spontaneous seeking to share with others.
2) **Impairment in communication as manifested by:**
   - Delay or total lack of the development of spoken language.
   - Inability to initiate or sustain a conversation.
   - Stereotyped and repetitive use of language or idiosyncratic language.
   - Lack of spontaneous imaginative play.

3) **Restricted repetitive and stereotyped patterns of behaviour, interests and activities as manifested by:**
   - Preoccupied with one or more stereotyped patterns of interest.
   - Inflexible adherence to specific, non-functioning routines or rituals.
   - Stereotyped and repetitive motor mannerisms e.g. flapping hands, twisting or whole body movements.
   - Persistent preoccupation with part objects.

B) **Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3:**
   - Social interaction
   - Language as used in social communication
   - Symbolic or imaginative play

C) **The disorder is not better accounted for by Rett’s disorder or childhood disintegrative disorder.**

**20.4 DIFFERENT DIAGNOSIS**

- Developmental language disorder
- Hearing impairment
- Mental retardation
- Psychosocial deprivation
- Landau Kleffner Syndrome
- Fragile-X syndrome

**20.5 MANAGEMENT**

20.5.1 **INVESTIGATIONS**

- Audiological examination
  - to exclude hearing impairment.
- Medical investigations
  - to exclude associated organic conditions e.g. Fragile-X Syndrome and Tuberous Sclerosis.
- Psychological assessment
  - IQ or developmental assessment.
- Speech and language assessment
  - to assess the level of receptive and expressive language.

20.5.2 **TREATMENT**

Autistic individuals have multiple specialised needs. Thus treatment requires a multi-disciplinary approach. This involves paediatricians, psychiatrists, psychologists, educators, speech and language therapists, occupational therapists and social workers.

**The goals of treatment are:**

- To increase social skills.
- To increase socially acceptable behaviours.
- To facilitate the development of verbal and non-verbal communication.
- To assist families in coping with autism.
The management approaches include:

1) Speech and language therapy.
2) Occupational therapy.
   • Social skills training - eye-contact, attention, turn-taking, compliance.
   • Training in activities of daily living.
3) Behavioural interventions.
   e.g. Applied Behaviour Analysis (ABA), Applied Verbal Behaviour (AVB).
4) Special needs education can be obtained in special centres and government-run integrated classes
   a) In government schools:
      - Children would need to be registered with the Department of Special Education, Ministry of Education.
      - The forms can be obtained from the nearest education department or hospital.
   b) In special centres:
      - National Autistic Society Of Malaysia (NASOM)
      - Institut Masalah Pembelajaran Dan Autisme (IMPIAN)
      - Malaysian Care
      - Kiwanis, etc
5) Disability registration
   • This is done with the Social Welfare Department.
   • The forms can be obtained from the nearest welfare department or hospital.
6) Pharmacotherapy
   There is no medication to cure autism but they can be used to treat co-morbid conditions.
   • Risperidone, Haloperidol.
     - diminish aggressiveness, hyperactivity and self-injurious behaviours.
   • Methylphenidate.
     - reduces hyperactivity and improves concentration.
7) Counseling
   • To help the family cope with the diagnosis of Autism.
   • To educate the family and carers about the disorder and management of behaviours.
   • To provide information about educational and diagnostic medical facilities available.
8) Other forms of therapy
   a) Diet therapy
      In a small proportion of autistic children modifications in diet may improve some symptoms e.g.:
      - Elimination diet - track down food allergies and exclude from food items.
      - Gluten and casein free diet.
      - Feingold diet - exclude artificial ingredients and salicylates from food.
   b) Megavitamins are not helpful in autism.
   c) Music therapy:
      Music may be used as a medium to promote learning, interaction and communication.

20.6 ADDITIONAL INFORMATION

- Residual social impairment persists into adulthood, even among those with high functioning autism.
- Autistic individuals are not at increased risk of developing schizophrenia.
- Early intervention programmes (EIP) should be implemented as soon as diagnosis is made.
SECTION 2 : EMOTIONAL AND BEHAVIOURAL DISORDERS OF CHILDREN AND ADOLESCENTS

20.7 REFERRAL TO SPECIALIST

- Refer to a Child Psychiatrist for:
  1) Diagnosis
  2) Management of associated psychiatric co-morbidities
  3) Family counseling

- Refer to Paediatrician for:
  1) Diagnosis
  2) Investigation and management of medical conditions

REFERENCES:


UNIT 21 : SPECIAL MENTAL HEALTH PROBLEMS OF CHILDREN AND ADOLESCENTS

21.1 BULLYING

21.1.1 INTRODUCTION

A large number of children and adolescents are known to be targets of various kinds of harassment, abuse and violence. Peer harassment or bullying is a form of violence to which close attention has been paid only during the last two decades.

It is a common problem affecting 1 in 5 children. The prevalence of bullying appears to peak at age 7 and ages 10 to 12. In general boys are more likely than girls to be victims and perpetrators. Bullying often occurs without the knowledge of parents and teachers.

21.1.2 DEFINITION

Bullying can be defined as repeated and systematic harassment and attacks on others. Bullying can be perpetrated by individuals or groups. It can include much different behaviour such as:

- Physical violence and attacks.
- Verbal taunts, name calling and put-downs.
- Threats and intimidation.
- Extortion or stealing of money and possessions.
- Exclusion from the peer group.

21.1.3 PRESENTING COMPLAINTS

A. VICTIMS

Children who become repeated victims of aggression and bullying tend to be quiet and shy. They typically lack friends and social support at school. They do not wish to tell their parents and teachers due to embarrassment or fear of retaliation.

Thus they may present as:

- Fear of going to school.
- Lack of friends.
- Missing belongings.
- Torn clothing.
- Increased fearfulness and anxiety.
- Declining academic performance.

Doctors should be aware that these children might present with recurrent symptoms of:

- Sore throat.
- Colds.
- Breathing problems.
- Nausea.
- Abdominal pains.
- Poor appetite.
- Headaches.
- School worries.
SECTION 2 : EMOTIONAL AND BEHAVIOURAL DISORDERS OF CHILDREN AND ADOLESCENTS

The typical victim is one who: 
- Is more insecure than most children.
- Reacts passively and anxiously to situations.
- Tends to be physically smaller and weaker.
- Is often cautious, sensitive and quiet.
- Is characterised as having low self esteem and feelings of being stupid, ashamed and unattractive.

B. BULLIES

They tend to come from homes where there is poor supervision, modelling of and tolerance for aggressive behaviour.

They may present with: 
- Learning difficulties.
- Behavioural problems.
- Truancy.
- Delinquency.

The typical bully is one who: 
- May be equally aggressive towards teachers, parents, siblings and peers.
- Usually dislikes and has not adjusted to school.
- Has poor impulse control.
- Wishes to dominate.
- Is physically strong.
- Craves social prestige.
- Is insensitive to the feelings of others.
- May project high self-esteem and reports ease in making friends.

Factors, which contribute to bullying:
- Family factors (Parenting styles associated with bullying):
  - A lack of attention and warmth towards the child.
  - Modelling aggressive behaviour at home.
  - Poor supervision of the child.
  - Harsh disciplining methods.
- Individual factors
  - Children with difficult temperament.
  - Children who are overly active and impulsive.
- School factors
  - Insufficient supervision.
  - Lack of appropriate intervention for bullying incidents.
  - Negative school environment e.g. poor control over students, low morale amongst teachers

21.1.4 MANAGEMENT

Role of the physician: 
- Identifying the problem.
- Screening for psychiatric morbidities such as:
  - Separation anxiety and generalised anxiety disorder.
  - Dysthymia.
  - Depression.
  - Conduct Disorder.
- Counseling the families.
- Advocating violence prevention.
Role of counseling:

- To raise the self esteem of the child.
- To encourage parents to find an extra-curricular activity in which the child excels or expresses an interest.
- To teach the victim to:
  ✓ Walk away from the bully (do not run).
  ✓ Talk to the bully (look him in the eye).
  ✓ Talk to the teacher (don’t bottle it up).

VIOLENCE PREVENTION:

Strategies for parents and schools:

- Zero tolerance for behavioural disturbances such as bullying, victimisation and standing by during bullying.
- A discipline plan for modelling appropriate behaviour.
- An integrated programme to teach self control skills.
- A mentoring programme for adults and children to help children avoid assuming the role of victim, bully or observer.

21.1.5 SPECIALIST CONSULTATIONS

When counseling and simple behavioural therapy fails, the victim or the bully should be referred to the child psychiatrist. This is to prevent and treat the long-term consequences for bullies and victims such as poor self-esteem, poor academic achievement, poor social-emotional development, aggression, depression and suicide.

21.1.6 ESSENTIAL INFORMATION FOR PATIENT AND FAMILY

What To Do If Your Child Is Being Bullied

- Ask the child directly and look for signs such as fear of going to school, lack of friends or missing belongings.
- Work with the school to make sure your child is safe, that effective measures are taken towards the bully and monitoring in school is adequate.
- Advocate for involvement of the bully’s parents.
- If the bullying is happening on the way to and from school, arrange for the child to be accompanied en-route until other interventions can take place.
- Suggest that the school implement a comprehensive anti-bullying programme.

What to Do If Your Child Is Aggressive Or Bullies Others

- Take the problem seriously.
- Talk to your child and to his or her teachers.
- Keep in mind that the bully will try to deny or minimise his wrongdoing.
- Make it clear to your child that you will not tolerate this kind of behaviour.
- Discuss with your child the negative impact bullying has on the victims.
- Arrange for effective non-violent discipline which is proportional with the severity of the child’s actions and his age and stage of development (refer to appendix - parenting).
- Increase your supervision of your child’s activities and whom he / her are associating with.
- Co-operate with the school in modifying your child’s aggressive behaviour.
- Communicate with teachers to find out how your child is doing in changing his behaviour.
- Praise the efforts your child makes to follow home and school rules, and responsible behaviour.
- Viewing violent television shows and playing violent video games will increase violent and aggressive behaviour. Ensure children do not view violent programmes.
- Witnessing violence at home influences children toward aggressive behaviour. Make sure violence does not happen at home.
- Work together with the school counsellor and family doctor to gain support for the child.
REFERENCES / READING MATERIAL FOR CHILDREN

1. Trouble with the bully- Berenstain Bears Series (Kindergarten and primary school age).

2. Don’t Pick on Me (Intermediate age groups).

3. The Health Impact Of Bullying: Weir; CMAJ Canadian medical association Journal vol; 165 (9) 30 Oct 2001 page 1249

4. Centre For children and families In the Justice System - Bullying: Information for parents and teachers: http://www.ifcc.on.ca/bully.htm
21.2 TEENAGE PREGNANCY

21.2.1 INTRODUCTION

Pregnant teenagers face more challenges while trying to achieve their own developmental milestones, finish their education and care for their unborn child. Many teenage pregnancies are the result of incest, rape or sexual abuse. In many cases, these teenagers must deal with and overcome the social stigma, disadvantages and the sequelae.

Clinicians can do much to improve the lives of these teenagers by increasing the likelihood of receiving adequate health care. The health care facility should serve as a source of information about appropriate social services, education about child rearing and advocacy. All health care providers should offer service and support in a non-judgemental manner.

21.2.2 PRESENTING COMPLAINTS

Consider the possibility of pregnancy when an adolescent presents with any of the following somatic complaints:

Symptoms:
- Irregular / missed menses
- Nausea or vomiting
- Unusual vaginal bleeding
- Acute or chronic abdominal distension
- Fatigue / light headedness/actual fainting
- Urinary tract infection
- Breast enlargement and tenderness

A high index of suspicion is necessary because many teenagers may hide or are ignorant of their pregnancy. The adolescent mayor may not admit to have had sex.

Signs and investigation findings:
- Weight changes.
- Increased abdominal girth and the uterine fundus may be palpable.
- A pregnancy test / serum HCG is usually positive.
- Abdominal ultrasound may be done to confirm and date the pregnancy.

21.1.3 FACTORS ASSOCIATED WITH RISK TO INFANTS

- Poor prenatal care e.g. reluctance to seek care.
- Poor nutrition, leading to intrauterine growth retardation.
- Use of illicit drugs, and or alcohol.
- Associated sexually transmitted diseases (STD).
- Smoking.
- Poor parenting skills.
- Poor social support, education, financial status.
- Presence of psychiatric disorders e.g. depression.

Teenagers who do not receive medical care are at greater risk for:
- Intra uterine growth retardation.
- Fetal death.
- Anaemia.
- High blood pressure.
- Labour and delivery complications.
21.2.4 MANAGEMENT

1) MEDICAL CARE:
At the first antenatal visit a full physical examination and appropriate investigations, including blood, urine test, Pap smear, screening for STD and exposure to mumps, measles and rubella should be carried out.

Issues to be discussed:
- Confidentiality.
  - Regarding the need to inform their parents.
- Frequency of antenatal visits.
- Physical and emotional changes.
- Dealing with common uncomfortable features of pregnancy like nausea and vomiting.
- Referral to social services.
Cases should be informed to the nearest health centre for postnatal home visit.

2) COUNSELING:
Issues to be addressed during counseling:

Lifestyle changes
- Eat right
  - Pregnancy is not the time to go on a diet. Encourage them to maintain a well balanced diet. Avoid fast food, soft drinks, and sweets. Drink plenty of water.
- Get enough rest.
- Exercise regularly. Low-impact exercises such as walking and swimming are the best.
- Avoid risky sexual behaviours e.g. multiple partners, unprotected sex.
- Avoid excess caffeine.
- Avoid non-prescribed medication.
- No smoking.
- No alcohol, illicit drugs.

Feelings
They may be happy or scared that they are pregnant. They may find it hard to believe or feel they are too young. They may feel that their life is out of control.

Choices
Pregnant teenagers have some choices. If they decide to have the baby, they can have choices about what to do after the baby is born. They can keep the baby or place the baby for adoption. If a therapeutic termination of the pregnancy has been decided, the earlier it is done, the better.

Planning for the future
Arrange for postpartum visit four to six weeks after delivery to make sure both mother and child are healthy. Also discuss their future health needs including contraception.

Contraceptives
Abstinence is a sure way to avoid becoming pregnant again or getting an STD. Sexually active teenagers should be encouraged to use contraception if permitted by religion. Discuss the various methods of contraception.

Family support
It is important to involve the father of the baby and other family members. The clinician should ask the partner for his medical history. Encourage him to participate in the discussion about his relationship with the teenage mother and to support her. Support of the extended family is very important.
21.2.5 REFERRALS TO SPECIALIST

If presence of:

- Domestic violence - refer OSCC.
- Sexual abuse - refer SCAN team/OSCC.
- Psychiatric morbidities e.g. damaged self esteem, Post Traumatic Stress Disorder, Depression refer psychiatrist.

REFERENCES:


2. The American College of Obstetricians and Gynaecologists' Patient Education Pamphlet.

21.3 EMOTIONAL ABUSE AND NEGLECT

21.3.1 INTRODUCTION

Emotional abuse refers to the hurting of a child by non physical means. It includes repeated criticism, scolding, and withdrawal of affection, rejection, threat, ridicule and discriminatory treatment.

Neglect encompasses the lack of attention to the basic physical needs such as food, shelter, clothing, education and proper health care. It also includes absent or inadequate supervision, failure to engage a child in cognitive stimulation and failure to express love to fulfil his developmental and emotional needs.

Young children who are raised in an environment of severe emotional deprivation and under-stimulation may manifest disturbances in physical growth in the absence of any organic illness in what is known as the syndrome of ‘non-organic failure to thrive’.

Emotional abuse may occur in isolation or together with other forms of abuse and neglect. However all children who experience various forms of abuse or maltreatment always suffer concomitant emotional abuse.

21.3.2 PRESENTING COMPLAINTS

The diagnosis is usually suggested by its consequences in the child: “the severe adverse effect on the behaviour and emotional development of a child caused by persistent or severe emotional ill-treatment or rejection.”

The insidious nature of emotional abuse and neglect and the lack of specific positive physical signs make their identification difficult. However, it is still possible to recognize characteristic groups of features that demand further investigation.

Key features in infants:

Physical
- Failure to thrive.
- Recurrent and persistent minor infections.
- Frequent attendances at casualty department or admission to hospital.
- Unexplained bruising.
- Severe nappy rash.

Development
- General delay.

Behaviour
- Attachment disorders.
- Lack of social responsiveness.

Key features in preschool children:

Physical
- Short stature.
- Microcephaly.
- Unkempt and dirty.

Development
- Language delay.
- Attention span limited.
- Social and emotional immaturity.

Behaviour
- Overactive.
- Aggressive and impulsive.
- Indiscriminate friendliness.
- Seeks physical contact with strangers.
Key features in school children:

**Physical**
- Short stature.
- Poor hygiene.
- Unkempt appearance.

**Development**
- Learning difficulties.
- Lack of self-esteem.
- Poor coping skills.
- Social and emotional immaturity.

**Behaviour**
- Dysfunctional relationship.
- Self-stimulating behaviour e.g. head banging.
- Self-injurious behaviour.
- Enuresis, encopresis, or both.

21.3.3 MANAGEMENT

- Children who are being emotionally abused or neglected may not be in immediate physical or moral danger, but their need for protection must be emphasised.
- Suspected cases should be referred to SCAN team.
- Detailed evaluation of the child's family and social background and circumstances surrounding abuse in consultation with medical social worker and other members of the SCAN team.
- Mandatory reporting of suspected abuse to Child Protector (This is a gazetted officer under the Social Welfare Department).
- Decision on placement of child and arrangement for subsequent monitoring to be made in consultation with Social Welfare Department.
- Referral of other family members or parents to appropriate medical or social support services.
- Follow-up to monitor for evidence of disability, problems in school, emotional disturbances, adjustment problems (especially in children who are placed with an alternative carer).
- Rehabilitation and arrangements for special education for children with resulting disability.
- Child psychiatry referral for children with severe emotional disturbances.

21.3.4 ESSENTIAL INFORMATION FOR FAMILY

1. Improving parenting skills.
2. Discussion of possible outcome to the emotionally abused and neglected child.
   a) Indiscriminate overfriendliness, over-activity, and aggression
   b) Problems in making and sustaining close personal relationships
   c) Disturbed feeding behaviour, wetting, and soiling
   d) Poor social adjustment
   e) Antisocial behaviour

REFERENCES:

1. ABC of Child Abuse. Edited by Roy Meadow. BMJ
21.4 CHILD SEXUAL ABUSE

21.4.1 INTRODUCTION

The majority of children who are sexually abused are made so by a family member or person known to the child in the home or familiar surroundings. Most cases of child sexual abuse do not involve physical violence.

The abuse may begin with simple touching and gradually progress to penetrative intercourse. The abuser may use trickery, persuasion or emotional blackmail to coerce the child to co-operate and keep the abuse silent. The child's silence is often "bought" with bribes or threats.

Disclosure of the abuse is often delayed or occurs by accident.

21.4.2 DEFINITION

Child sexual abuse is the involvement of dependent, developmentally immature children and adolescents in sexual activities, which they do not fully comprehend, are unable to give informed consent to and violate social taboos and family roles.

21.4.3 SPECTRUM

Sexual abuse entails all types of sexual activity such as exposure to indecent acts, pornography, or external genital contact in the form of being fondled, masturbating an adult and all forms of penetrative intercourse, including oral, vaginal and anal penetration.

21.4.4 PRESENTING COMPLAINTS

1. Statements of the child e.g. X touched my 'bottom'.
2. Symptoms due to local trauma or infection e.g. perineal soreness, vaginal discharge, and anal pain or bleeding.
3. Presence of a sexually transmitted disease in a child.
4. Unexplained somatic symptoms e.g. recurrent headache, abdominal pain.
5. Eating disorders e.g. anorexia nervosa, bulimia.
6. A significant change in behaviour e.g. child becoming anxious, fearful or depressed.
7. Symptoms attributable to emotional effect e.g. loss of concentration, enuresis, encopresis, anorexia and parasuicide/self inflicted injuries.
8. Sexualised conduct or inappropriate sexual knowledge for young children.
10. Substance abuse.
11. Conversion disorder.
12. Gender identity difficulties e.g. cross dressing.
13. Running away from home.

Important note

1. Some of the above behaviours are not specific for sexual abuse. However sexual abuse should be considered as a possible diagnosis in children/adolescents with any of the above symptoms. Such children need further evaluation for sexual abuse.
2. The majority of children who have been sexually abused have normal examination findings. Therefore a normal physical examination does not exclude the possibility of sexual abuse.

21.4.5 MANAGEMENT

If there is any reasonable suspicion of sexual abuse the child must be directly referred to a local SCAN team or One Stop Crisis Centre (OSCC) to avoid unnecessary and repeated examinations.
21.4.6 ACUTE SEXUAL ABUSE

When abuse is thought to have occurred within 72 hours, examination should be conducted with the collection of forensic evidence. The child’s clothing should not be removed or any attempt made to clean or bathe him/her, before the examination. Junior medical staff should not examine suspected victim unless the child urgently needs medical attention e.g. there are serious genital injuries.

21.4.7 ESSENTIAL INFORMATION FOR FAMILY

1. Do not blame the child for the abuse.
2. Encourage the child to report any further abuse.
3. Abused children may develop problems which require treatment e.g. sexualised behaviour, sleep disturbances, school refusal, eating disorders, anxiety, depression, etc.
4. Children who receive support from their family do better.
5. It is not safe to allow the abuser to come into further contact with the child.
6. Parents should seek help for the children and for themselves.

REFERENCES:

1. ABC of Child Abuse. Edited by Roy Meadow. BMJ

21.5 PHYSICAL ABUSE

21.5.1 DEFINITION

Any child who receives non-accidental physical injury as a result of acts, or omissions on the part of his parents, guardians or others.

21.5.2 BACKGROUND INFORMATION

- The abuse is rarely an isolated incident, but often repeated over a period of time before it is identified.
- It is usually accompanied by emotional abuse.
- There is often associated abnormal interaction between the child and his parents or caregivers e.g. domineering parents.
- Physical abuse may co-exist with other problems within the family e.g. domestic violence, parental marital conflict, substance abuse by parent.

21.5.3 PRESENTATION

Physical abuse may present and be suspected in one or more of the following situations:

- Multiple injuries of different ages in a child, often brought in for an unrelated complaint.
- History of abuse reported by the child or witnesses with compatible injuries.
- Characteristic patterns of injury diagnostic of abuse.
- Account of the accident is not compatible with the pattern of injuries seen.
- Significant injury in a child with no history of trauma.
- History of trauma not compatible with a child’s development.
- Younger child blamed for the injury.
- History of injury changes with time and varies from person to person.
- Delay in seeking medical treatment for trauma without a reasonable explanation.
- Parents' affect and reaction to the child's trauma is abnormal e.g. preoccupation with their own problems rather than with the child’s condition.
- Abnormal interaction of the child with parents.
- Injuries in a child who shows evidence of physical neglect, e.g. dirty and unkempt, and has associated failure to thrive.

21.5.4 SPECTRUM

- Superficial injuries: bruises, laceration, burns.
- Skeletal injuries.
- Visceral injuries: e.g. ruptured bowel, liver lacerations.
- Intracranial injuries.

Severe physical abuse can result in physical disfigurement, permanent disability and even death.

21.5.5 PSYCHOSOCIAL DISTURBANCES SEEN IN PHYSICALLY ABUSED CHILDREN

- Depression.
- Anxiety / phobias.
- Low self-esteem.
- Aggressive or oppositional behaviour.
- Withdrawal.
- Poor concentration.
- Poor school performance.
- Disturbances in appetite and sleep.
- Post-traumatic stress disorder.
- Multiple personality states.
21.5.6 MANAGEMENT

- Admit the child to hospital.
- Specific treatment for physical injuries.
- Detailed evaluation of child's family and social background and circumstances surrounding abuse. This may be done in consultation with the medical social worker and other members of the SCAN (Suspected Child Abuse and Neglect) team if available.
- Mandatory reporting of suspected abuse to Child Protector (This is a gazetted officer under the Social Welfare Department).
- Decision on placement of child and arrangement for subsequent monitoring to be made in consultation with Social Welfare Department.
- Referral of other family members / parents to appropriate medical/social support services.
- Follow-up visits to monitor for evidence of disability, problems in school, emotional disturbances, adjustment problems (especially in children who are placed with an alternative carer).
- Rehabilitation and arrangements for special education for children with resulting disability.
- Child psychiatry referral for children with severe emotional disturbances.
21.6 CHILDREN AND THE LAW

(Some Legal Aspects Relevant to Child & Adolescent Health Care)

1. CONSENT.
2. CONFIDENTIALITY.

21.6.1 CONSENT - ISSUE OF CONSENT IN MANAGEMENT OF CHILDREN AND ADOLESCENTS

A) GUIDELINES FOR GOOD PRACTICE ON CONSENT

⇒ Parents and young people need to be informed and involved as much as possible in treatment decisions.
⇒ Treatment can proceed with the consent of a parent/guardian and the young person’s agreement.
⇒ If either the parent or young person refuses, treatment should be delayed for more discussion, modification of the treatment plan or to obtain the opinion of another specialist.
⇒ Treatment may proceed with the consent of one parent. If any dispute occurs, attempts should be made to negotiate and if that fails, the local welfare authority may be consulted.
⇒ If there is no parent or guardian willing to consent to a necessary action or treatment programme for a child who is not competent, consult the local welfare authority.
⇒ If neither parent is competent to give consent, consult the local welfare authority.
⇒ Overruling the refusal of any young person should be considered only if:
   a) Attempts to discuss and modify the treatment have failed,
   b) The parents are in favour, or consent from the relevant authorities (court, social welfare) is obtained;
   c) The young person is more likely than not to suffer significant harm without treatment.
⇒ Before treating a young person against his or her will:
   a) The reasons for the decision should be recorded in the notes.
   b) Record the consent from the parent, guardian or relevant authorities.
⇒ Parents or the young person can withdraw consent at any time.

B) POINTS TO CONSIDER IN TAKING CONSENT

⇒ The need for consensus / agreement
   • Do the parents and child understand the illness and the treatment options available?
   • Does more explanation or information need to be provided for consent?
   • Is more time needed for consideration?
   • Is a second opinion required?
⇒ The risks and benefits of the treatment
   • What are the risks of treatment versus no treatment?
⇒ The nature of the illness
   • How disabling, chronic or life threatening?

REFERENCE:


3. Child Act, 2001, Malaysia
21.6.2 CONFIDENTIALITY

(A guide for cases where confidentiality is an issue)

1. Issues regarding confidentiality need to be explained to a child in a way that he can understand.
2. A child should be informed in situations where his right to confidentiality may be limited and the reasons for this should be explained. Potential areas where the confidentiality of the interview may be broken (e.g. disclosure of abuse) should be explained to the child at the outset.
3. In other situations, a decision to breach confidentiality can be guided by answers given to the following questions:
   • Is there a significant risk of physical harm to either the child or others if disclosure to the relevant authorities is not made?
   • Is there a legal requirement to report to the authorities?
   • What is the accepted practice among the professionals in this area?
4. Consult a more experienced colleague when unsure of what to do.

REFERENCE:

1. Qualidata Legal and Ethical Issues in Interviewing Children. Internet Source.
21.6.3 CHILD ACT 2001 - RELEVANT HIGHLIGHTS

The Child Act 2001 is an Act to consolidate and amend the laws relating to the care, protection and rehabilitation of children. It has come into force in Malaysia since 1 August 2002.

Interpretation of terms:
- "Child": a person under the age of 18 years.
- "Hospital": any Government hospital or any teaching hospital of a University.
- "Medical officer": a registered medical practitioner in the service of the Government, including a registered medical practitioner in the teaching hospital of any University.
- "Registered medical practitioner": a practitioner registered under the Medical Act 1971.
- "Protector": the Director-General, Deputy Director-General, Division or State Director of Social Welfare or any Social Welfare officer appointed by notification in the Gazette to exercise the powers or perform the duties of a Protector under the Act.

CHILDREN IN NEED OF CARE & PROTECTION (SEC 17)

Categories of children in need of care and protection under this Act include the following:

a. A child who has been physically or emotionally injured or sexually abused by his parent or guardian or member or his extended family, or a child at risk of such abuse or injury. This includes a child who has suffered emotional injury resulting from conflict between himself and his parent or guardian.

b. A child at risk of injury or abuse described under (a) whose parent or guardian has failed to protect or is unlikely to protect him from such injury or abuse.

c. A child whose parent or guardian is unfit, has neglected to or is unable to exercise proper supervision and control over the child.

d. A child whose parent or guardian has neglected to or is unwilling to provide adequate care, food, clothing, or shelter.

e. A child who has been abandoned or who has no parent or guardian.

f. A child whose parent or guardian refuses medical examination, investigation or treatment which a child needs to restore or preserve his health.

g. A child who behaves in a way that may harm himself or others whose parent or guardian is unable to or unwilling to take remedial action.

h. A child who is used for begging or any illegal activity (e.g. gambling, hawking), which is detrimental to his health and welfare.

PROVISIONS FOR THE MEDICAL EXAMINATION AND TREATMENT OF A CHILD IN NEED OF CARE AND PROTECTION*
(SECTION 20 TO 26)

a. The Act provides for a Protector or police officer to bring such a child, if appropriate, to a medical officer and leave him in hospital for medical examination and treatment.

b. The Protector or police officer may also direct the person having care of such a child to bring him to hospital for medical examination and treatment.

c. The Act also provides for a medical officer to take into temporary custody in the hospital any child suspected to be a victim of physical, emotional or sexual abuse until custody is handed over to a Protector or police officer.

d. The medical officer may with the authorization of the Protector / police officer conduct a medical examination and necessary tests or procedures for diagnosis, as well as provides treatment for any minor illness or injury.

e. If the child has a serious illness or injury, which requires surgery or psychiatric treatment, the medical officer should inform the Protector or police officer to contact the parent or guardian for authorisation of treatment.
f. If there is immediate risk to the health of the child, the medical officer should certify this in writing. The Protector may then authorise treatment only under any of the following circumstances:
   * The parent or guardian unreasonably refuses or withholding consent.
   * The parent or guardian is unavailable or cannot be found in time.
   * The Protector believes on reasonable grounds that the parent or guardian has abused or neglected the child.

g. The medical officer who examines or treats the child is exempted from any liability for doing this under the above provisions (Section 21 to 24).

h. The medical officer is however not exempt from other forms of liability which he would be subject to under normal circumstances when parental consent is available (e.g. relating to duty of due diligence and care).

**DUTIES OF A MEDICAL OFFICER OR MEDICAL PRACTITIONER**

**Mandatory reporting**

a. A medical officer or registered medical practitioner is required to inform the Protector of any child that he examines or treats whom he suspects to be a victim of abuse.

b. The penalties for failure to comply include a fine of up to RM 5 000 and / or a prison sentence of up to two years.

**CHILDREN BEYOND CONTROL (SEC 46)**

There may be occasions where a parent seeks assistance or advice regarding a child over whom he is unable to exercise proper control.

This section of the Act provides for such a child to be detained in an approved place under the authority of the Court for Children if the parent or guardian makes a request for this in writing.

The parent or guardian should refer to the district Social Welfare department for advice and assistance with the relevant procedures.

**REFERENCE**

APPENDIX 1

PRE - TEST AND POST - TEST QUESTIONNAIRE
ANSWER ALL QUESTIONS. INDICATE “T” FOR TRUE OR “F” FOR FALSE FOR EACH STATEMENT.

1. Normal development according to Erikson’s theory of psychosocial development.
   A. A child will develop trust if his needs are predictably met. ✓
   B. Children learn to balance their own wishes against those of others. ✓
   C. Children build on the tasks accomplished in previous stages. ✓
   D. The stage of identity vs confusion occurs from age 3-5 years ✓

2. Mental health needs of a child
   A. Unmet needs result in unhappiness, frustration and dissatisfaction. ✓
   B. Unconditional love leads to a spoiled child. ✓
   C. Children should set goals to match parents’ expectations. ✓
   D. Parents should focus on teaching children, rather than playing with them. ✓

3. Parenting skills
   A. Parents who give their children everything they ask for protect children from disappointment. ✓
   B. Parents should be flexible, yet strict and in control. ✓
   C. Overstrict parenting leads to well behaved children. ✓
   D. Parents need to praise their children. ✓

4. Stress
   A. Children cope well with stress, generally. ✓
   B. Adolescents under stress may turn to substance abuse. ✓
   C. Low self esteem is the consequence of stress. ✓
   D. Boys and girls experience different patterns of stress. ✓

5. Mental retardation
   A. Low IQ is the only requisite for diagnosis of Mental Retardation. ✓
   B. The lower the IQ, the easier it is to detect clinically. ✓
   C. Activities of daily living need to be taught to moderately retarded children. ✓
   D. Mentally retarded children are at higher risk of developing mental illness. ✓
6. **Attention Deficit Hyperactivity Disorder**
   A. Children with ADHD show their symptoms in most situations.
   B. ADHD leads to problems in learning.
   C. Stimulant medications are the best treatment for ADHD.
   D. Behavioural techniques used include extinction.

7. **Depression**
   A. Childhood depression is often overlooked.
   B. Depression in children is diagnosed using different criteria from adults.
   C. Depressed adolescents may be argumentative and aggressive.
   D. Antidepressants are efficacious for depressed children.

8. **Post-traumatic Stress Disorder**
   A. Results from extreme fear of being separated from parents.
   B. Characterized by avoiding reminders of trauma.
   C. In adolescents, predisposes to high risk behaviours.
   D. Antipsychotic medication is required.

9. **Substance Dependence**
   A. Drug rehabilitation in Malaysia is effective.
   B. Marijuana abuse leads to dependence on more dangerous drugs e.g. heroin.
   C. Many adolescents experiment with at least tobacco or alcohol.
   D. There is increased risk of HIV infection.

10. **Tics**
    A. Commonly seen in children and require intervention.
    B. Chronic tics last more than 12 months.
    C. Tourette's Syndrome can be treated with antipsychotics.
    D. Neurological referral is necessary.
APPENDIX 2

CASE STUDIES
CASE STUDY 1

MD is a 14-year old Malay boy whose parents brought him to the clinic with presenting features of easily getting angry and had expressed wishes to either leave the family home or to die.

When MD and his family were seen they both expressed difficulties about each other.

As a boy, MD was constantly on the move and it was difficult to get him to settle down to do anything. When he entered school, he faced more problems - the teachers frequently complained that he was not able to pay attention for long; he never completed his homework and his examination results were never satisfactory. His parents were exasperated and disappointed. They were both teachers and expected some form of discipline from their five children, and MD being the eldest, they felt that he should be a good example to his younger siblings.

As he grew, he began to realise that he was different from his siblings and his friends at school. Despite attempting to improve on his academic performance, he found difficulty in concentrating for long and soon enough, he became disinterested in his studies. There was a similar group of friends equally disinterested in their studies and by the time they were in Standard Six, they were already playing truant from school and began smoking. Last year, the whole gang began experimenting with ganja.

How would you go about managing the above case?
CASE STUDY 2

SS is a 14-year old Malay boy who was previously on regular follow-up during his earlier childhood years in the neurology child unit for his epilepsy. He has been fits free since the age of 7 and has not been on medication since the last two years.

Since the past six months, he was brought in for three episodes of fits - he would not get up from bed in the mornings and later towards the day when the father insisted that he be sent to school, they would notice he had jerky movements of all four limbs and he would not respond to call. When he did go to school, his parents were called as his teacher had complained of seeing similar jerky movements of limbs while he was asked to lie down at the headmaster's office after complaining of not feeling well. When asked much later, he said that he had a headache. On one occasion, he was sent directly to the hospital by the school teachers. However, in the last two admissions, thorough physical examinations and investigations were carried out and an organic cause of “fits” had been ruled out.

When his mother was met to seek further history about SS, it was revealed that it was his first year in the secondary school and he was not very popular amongst the other students even though he is intelligent, he was rather obese. Father has been very upset at this latest development and has taken harsh measures to get him back to school. With the episodes of fits, the children are afraid of him and they have stopped calling him names. His only friend is a small sized boy who had frequent hospital admissions for his asthma.

How would you go about managing the above case?
CASE STUDY 3

AJ was an 8 year-old Malay boy who was admitted to hospital with sudden onset of being unable to walk. He had apparently been physically well prior to this illness, being an active boy who liked to ride his bicycle. There was no fever, pains or history of trauma or injury.

When he was examined, he was very cooperative. He did not seem too distressed over the fact that he could not stand or walk. He held on to his mother who had him in his lap, while father hovered anxiously.

His vital signs were stable. There was no fever. The paediatrician noticed unusual sensory levels on testing with a pin. His muscle powers were generally 4 or 5 in strength for the major muscle groups. There was no neck stiffness.

His parents had recently been separated. His mother had got to know that his musician father had taken up with a much younger woman for the past 3 months. This had been his 3rd affair in the 10 years that they had been married (at least as far as the mother knew about). Mother had issued please to father to end the affair and return to the family, but father had refused. He told her that this time it was true love. There were many emotional scenes at home including fights, quarrels and pleadings. Patient and his two younger siblings had been witnesses to all that.

One day after father moved out of the house, patient could not walk. Mother had frantically called father and they had both brought him to a GP’s clinic before being referred to hospital.

1. What is the likely diagnosis? What differentials would you consider?
2. What investigations would you do to confirm this diagnosis?
3. What other information would be helpful?
4. What would you tell the parents?
5. How would you manage this patient and his family?
6. The patient has confided in you that he wants his father and mother to be happily married and live together like before. He wants you to make it happen. What do you do?