

DISORDERS DIAGNOSED IN INFANCY, CHILDHOOD OR ADOLESCENCE

Aim

Identify disorders first prevalent under 18 years of age.

Before starting to look at childhood problems, we must first decide and describe what abnormal behaviour is and how it is classified. The following criteria can be used to determine whether a person's behaviour is abnormal or not:

- Deviation from statistical norms - the word abnormal means 'away from the norm'. Many population facts are measured such as height, weight and intelligence. Most of the people fall within the middle range of intelligence, but a few are abnormally stupid. But according to this definition, a person who is extremely intelligent would be classified as abnormal. Thus in defining abnormal behaviour we must consider more.
- Deviation from social norms; every culture has certain standards for acceptable behaviour - behaviour that deviates from that standard is considered to be abnormal behaviour. But those standards can change with time and vary from one society to another.
- Maladaptiveness of behaviour; this third part is how the behaviour affects the well-being of the individual and/or social group. Examples are a man who attempts suicide, an alcoholic who drinks so heavily that he or she cannot keep a job or a paranoid individual who tries to assassinate national leaders.
- Personal distress; the fourth part considers abnormality in terms of the individual's subjective feelings, personal distress, rather than his behaviour. Most people diagnosed as 'mentally ill' feel miserable, anxious, depressed and may suffer from insomnia. In the type of abnormality called neurosis, personal distress may be the only symptom, because the individual's behaviour seems normal.

Mental health professionals apply various criteria in making judgements on whether a client's behaviour is normal or not. They may use the above criteria or they may conduct their own criteria for the definition of the problem. They may also look at different elements such as biological or medical, behavioural, or cognitive. Cultural differences also need to be noted and looked as they can play a part in one's behaviour and the manifestation of that behaviour. What may be okay in one culture and seem normal – can be seen as something quite different in another culture.

Diagnostic and Statistical Manual of Mental Disorders (DSM)

The most commonly used tool for diagnosis of mental disorders is the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM is the standard classification of mental disorders used by mental health professionals in the United States. It is also used by many other countries as a basis for a common understanding in the language of abnormal behaviours. It is intended to be applicable in a wide array of contexts and used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioural, interpersonal, family/systems).

The manual has been designed for use across settings, inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care, and with community populations and by psychiatrists, psychologists, social workers, nurses, occupational and rehabilitation therapists, counsellors, and other health and mental health professionals. It is also a necessary tool for collecting and communicating accurate public health statistics to have a common thread globally. The DSM consists of three major components: the diagnostic classification, the diagnostic criteria sets, and the descriptive text.

The diagnostic classification is the list of the mental disorders that are officially part of the DSM system. "Making a DSM diagnosis" consists of selecting those disorders from the classification that best reflect the signs and symptoms that are afflicting the individual being evaluated. Associated with each diagnostic label is a diagnostic code, which is typically used by institutions and agencies for data collection and billing purposes.

For each disorder included in the DSM, a set of diagnostic criteria that indicate what symptoms must be present (and for how long) in order to qualify for a diagnosis (called inclusion criteria) as well as those symptoms that must not be present (called exclusion criteria) in order for an individual to qualify for a particular diagnosis. However, it is important to remember that these criteria are meant to be used as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion.

Finally, the third component of the DSM is the descriptive text that accompanies each disorder. The text of DSM systematically describes each disorder under the following headings: "Diagnostic Features"; "Subtypes and/or Specifiers"; "Recording Procedures"; "Associated Features and Disorders"; "Specific Culture, Age, and Gender Features"; "Prevalence"; "Course"; "Familial Pattern"; and "Differential Diagnosis."

DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision), published in June 2000 was the last major revision of the DSM. Much of the effort involved conducting a comprehensive review of the literature to establish a firm empirical basis for making modifications. Numerous changes were made to the classification (i.e., disorders were added, deleted, and reorganized), to the diagnostic criteria sets, and to the descriptive text based on a careful consideration of the available research about the various mental disorders.

Childhood Disorders

Childhood disorders differ from adult disorders in a very important way. Most adults identify themselves as having a problem, whilst children with problems are often identified by others. If an adult sees themselves as needing help, this has an effect on their desire to seek treatment, whereas with a child, someone is telling them that they need help or some form of treatment.

There are a number of ways in which diagnosing disorders in children differs from diagnosis in adults.

- Children rarely initiate the consultation themselves
- The child's developmental stage has to be taken into consideration
- Children tend to have more difficulty expressing things in words
- Medication is usually a last resort

A developmental approach is usually undertaken for the following reasons:

- The child's developmental stage determines whether the behaviour is normal or pathological
- The impact of life events alters as the child develops
- The child's psychopathology may alter as it gets older.

The causes of psychological disorders in children are similar to that for adults, i.e. there are genetic and environmental factors. In addition there are developmental factors, i.e. children mature psychologically and socially as they get older and their disorders reflect such maturation.

A child with a "major psychiatric disorder" has a very serious illness affecting several areas of the child's life. These areas may include emotions, social or intellectual ability, or the use of language.

When a child and adolescent psychiatrist examines a child to learn if he or she has a major psychiatric disorder, these are some of the signs they look for or ask parents about:

- failure to look or smile at parents or other care givers;
- very strange actions or appearance;
- lack of movement or facial expression;
- lack of interest in or awareness of other people;
- odd way of speaking, or private language that no one else can understand;
- strange conversations with him- or herself;
- odd or repetitive movements, such as spinning, hand-flapping, or head-banging; and
- panic in response to a change in surroundings.

There are many different kinds of major psychiatric disorders. The specific name given to a child's illness will depend upon the combination of symptoms listed above, and on how severe the illness is.

Two of the main groups of disorders for children include disorders of under controlled behaviour and disorders of over controlled behaviour. Disorders of under controlled behaviour are suggested when a child lacks, or has insufficient, control over their behaviour compared to that expected by a child of that age and in that setting. These types of disorder usually create problems for others. These types of disorders include:

- ADHD (attention deficit hyperactivity disorder) – more commonly known generally as hyperactivity.
- Conduct disorders – There is no single definition of conduct disorders, but it includes things such as aggression, lying, destructiveness, vandalism, truancy etc. The underlying thread being that they are a violation of societal norms and the basic rights of others. But the patterns and severity of the acts go beyond what is usually expected of children and adolescents.

Disorders of over controlled behaviour - these types of disorders usually create more problems for the child themselves than for others. Children with problems of over control will report feelings of shyness, unhappiness, feeling unloved, feeling inferior, depressed, socially withdrawn.

They can include things such as:

- School phobia
- Social withdrawal disorder

Other serious disorders that affect children are eating disorders. Anorexia Nervosa and Bulimia Nervosa commonly start during adolescence, typically with the onset of puberty, but it can start earlier or later. These will be discussed further in lesson 9.

Major psychiatric disorders often last a long time, and may be life long. However, when children with these disorders begin treatment early, their health and ability to perform everyday tasks may improve.

Attention-Deficit/Hyperactivity Disorder (ADHD)

Hyperactivity is a common term, often used by parents and teachers. "He's hyper today." This does not mean that a child is suffering from ADHD, just that they may be full of energy for that day. For a child to be diagnosed with ADHD, they have to have suffered from problems for at least six months.

DSM-IV TR has criteria for ADHD. Either A or B must be present for a child to have ADHD.

- A. The child must show six or more manifestations of inattention for at least months to such a degree that is maladaptive and greater than would be expected for the person's developmental level. For example, careless mistakes, not listening well, not following instructions, forgetful in daily activities, easily distracted.

Or

- B. Six or more manifestations of hyperactivity-impulsivity present for at least months to a maladaptive degree, greater than expected for the child's developmental level. For example, running around inappropriately, squirming in their seat, acting as if "driven by a motor" and incessant talking. Some of this should be present before the age of 7, present in two or more settings (for example, home and school). There should be significant impairment in academic, occupational functioning or social functioning. It should not also be part of any other disorder such as schizophrenia, anxiety disorders and mood disorders.

A child with ADHD will be constantly in motion, tapping their fingers, fidgeting, difficulty concentrating and so on. They may appear disorganised, erratic, bossy and tactless. They may also wear out clothes and shoes quickly, smash toys and exhaust their family and teachers.

Children with ADHD may also have problems getting on with their peers and establishing and maintaining friendships. This may be because their behaviour can be intrusive and annoying to others. About 15 – 30% of children with ADHD (Barkley et al, 1990) also have a learning disorder and about half will have difficulty adjusting to the typical classroom environment.

The symptoms of ADHD are varied, so DSM-IV-TR also included three subcategories

- Predominantly inattentive type – where the child has the main problem of poor attention.
- Predominantly hyperactive-impulsive type, where the child shows primarily hyperactive and impulsive behaviour.
- Combined type, where the child has both types of problems.

The majority of children with ADHD have the combined type. They are more likely to develop conduct problems and be placed in special education classes.

Conduct Disorder

The difference between ADHD and a conduct disorder is hard to define. DSM-IV-TR defines a conduct disorder as that with behaviours that violate the basic rights of others and the societal norms. Also, nearly all such behaviour is illegal. The types of behaviour may include lying, stealing, cheat, aggression, cruelty to people or animals, damaging property etc, they go beyond the mischief and pranks shown usually among children and adolescents, in their frequency and severity. The behaviour is often marked with a lack of remorse, callousness and viciousness. A conduct disorder is also one of the historical criteria for an adult antisocial personality disorder. ODD (Oppositional Defiant Disorder) is related to conduct disorder, but there is debate as to whether it is a distinct disorder to conduct disorder, or whether it is an earlier or milder manifestation of a conduct disorder.

Therefore, DSM-IV-TR categorises conduct disorder as:

Repetitive and persistent behaviour patterns that violate the basic rights of others or conventional social norms as manifested by the presence of three or more of the following over the previous 12 months and at least one of them in the last six months:

- A. Aggression to people and animals, such as bullying, physically cruel, forcing someone into sexual activity.
- B. Destruction of property, for example, fire setting, vandalism.
- C. Deceitfulness or theft, such as breaking into another's house or car, conning, shoplifting.
- D. Serious violation of the rules, such as staying out at night before age of 13, truancy before 13.

Significant impairment in social, occupational and academic functioning.

If the person is older than 18, the criteria is not met by an antisocial personality disorder.

ODD can be diagnosed if the child does not meet the criteria for a conduct disorder, especially physical aggressiveness, but will exhibit behaviour such as losing their temper, arguing with adults, refusing to comply with requests from adults, deliberately doing things to annoy others, being angry, spiteful and touchy.

Mental Retardation

DSM-IV-TR has the following criteria for mental retardation :

- Significantly below average intellectual functioning, IQ below 70.
- Deficits in adaptive social functioning in at least two of the following – communication, home living, self-care, interpersonal skills, functional academic skills, leisure, work, health and safety.
- Onset before age 18.

Around 3% of the population will have an IQ below 70. The IQ test should be delivered by a competent professional and take account of any other difficulties, for example, if the child has physical disabilities, speaks a language other than English as a first language and so on.

Adaptive Functioning refers to the ability to master childhood skills, such as toileting, dressing, understanding time and money, travel by public transport, being socially responsive etc.

Age of onset – mental retardation should occur before the age of 18. This is to rule out any deficits in intelligence or adaptive behaviour that occurs due to illness or injury.

Hyperactivity is a common term, often used by parents and teachers. “He’s hyper today.” This does not mean that a child is suffering from ADHD, just that they may be full of energy for that day. For a child to be diagnosed with ADHD, they have to have suffered from problems for at least six months.

Asperger’s Disorder

This is believed to be a milder form of autism in which social relationships are poor. There is also intense, rigid, stereotyped behaviour, but with the person’s language and intelligence intact. The child will show:

- Difficulty with reciprocal social interactions – that is, they may have no desire to interact, whilst others will not have the skills to. They may not understand the give and take nature of social interactions. They may not understand the verbal and non-verbal cues of our typical social interactions, such as turn-taking, matching conversational and non-verbal responses.
- Impairments in Language skills – they may see language as a way to share facts and information, not feelings, thoughts and emotions. They may have difficulties processing verbal information, initiation, maintenance and so on. Their prosody (pitch, rhythm or melody of speech) may also be impaired.
- They may have a narrow range of interests and insistence on set routines. They may have their interactions ruled by rigidity, obsession and repetition.
- Motor Clumsiness – many people with Asperger’s syndrome will have problems with their fine and gross motor skills.
- Cognitive Skills – Mindblindness is the inability to make inferences about what another person is thinking. This is a core problem for those with Asperger’s Syndrome. The person will therefore have difficulty empathising with others and assume they are thinking the same thing. The world will exist in black and white, rather than shades of grey. This rigidity in touch interferes with problem solving, impulse control and their ability to engage in imaginative play.
- Sensory Sensitivities – Many children with Asperger’s syndrome will have sensory issues. This can be in taste, touch, sight, sound or smell. The degree of difficulty varies from one individual to another. They may experience ordinary sensations as very intense or under-react to a sensation. This can be very challenging, as it is a sensory reaction, not a learned behaviour.

Stereotypic Movement Disorder

This is a condition where the person engages in repetitive, rhythmic and purposeless movements. These movements can sometimes result in self-harm. For the behaviour to be considered a disorder, the repetitive movements must continue for at least four weeks and interfere with the person’s normal functioning. This disorder most commonly affects children with developmental and mental retardation.

The symptoms most commonly include – rocking, head banging, nail biting, self-biting, self-hitting, picking at skin, handshaking or waving, mouthing of objects.

It is not known what causes SMD, but the movements tend to increase if the person is frustrated, bored or stressed. Certain physical conditions can cause the disorder, such as head injury and some drugs, such as cocaine. The condition most often affects children with neurological (brain and nerve) disorders and/or mental retardation. It can occur at any age and is more common in boys than girls. If the symptoms are present, a doctor will perform various tests to rule out a physical illness or side effects of any medication. There is no actual test to diagnose SMD. The diagnosis of SMD usually occurs when the symptoms persist for four weeks or longer and interfere with normal functioning.

Normal Functioning

You may have read some of these and realised that you or your child has some of these symptoms. You may, for example, bite your nails, find conversation difficult at times and so on. For this to happen occasionally, does not mean that you or the child is suffering from a disorder. For the child to have these disorders, they must be occurring over a period of time, be intense and be above that expected at the child's developmental level. For example, if you bite your nails when you are stressed, that's fine. But a child with stereotypic movement disorder may bite their nails continually, over and over, all day, removing their nails.

Depression in Childhood

There is often the image of happy-go-lucky children, but this may not always be the case. However, children can experience depression. There are some similarities and some differences in depression in adults and children. Children aged seven to seventeen may resemble adults in terms of their depressed mood, inability to experience pleasure, fatigue, concentration problems and thoughts of suicide. They differ because the rates of suicide attempts are higher, they may experience more guilt, more frequent early waking, more weight loss, loss of appetite and early morning depression than adults. Depression in children is also recurrent. Children who have had a major depression are likely to continue to show significant depressive symptoms four to eight years later. Estimates of the amount of children experiencing depression depend on the country, sample used and age of children.

Depression can also be inferred from some behaviours, such as acting aggressively and misbehaving, which would not be used in adults as showing an underlying depression. Depression has been found to occur in less than 1% of pre-school age children, 2 – 3% of school age children, but 7 – 13% of adolescents. In adolescence, females outweigh males by a ratio of 2:1 in experiencing depression, but prior to the age of 12, boys are more likely to experience depression.

There is a problem with diagnosing depression due to the presence of other factors. Up to 70% of children with depression will also have an anxiety disorder or significant anxiety symptoms. Depression is also common with children with conduct disorders or attention deficit disorders.

Anxiety Disorders

Children may suffer from anxiety disorders, such as phobias, panic disorders, obsessive-compulsive disorders, school phobias, post-traumatic stress disorder and so on. Anxiety disorders are where irrational and overblown fears are the central disturbance.

Anxiety is a sense of apprehension, worry, fear and distress. Usually symptoms of anxiety are physical, such as feeling sick, headaches, or emotional, such as fear and nervousness. Symptoms can be severe and affect a child's decision-making, perception, learning and concentration. It can raise their blood pressure, heart rate, lead to vomiting, diarrhoea, tingling and so on.

All children will experience some anxiety, this is normal. For example, if they go to school for the first time, are left alone for the first time etc. This is only a problem when it starts to affect their normal activities, such as making friends, sleep, attending school.

Types of anxiety disorder may include:

Generalised Anxiety Disorder – where a child has recurring fears or worries that they find difficult to control. They may worry about almost anything, school, sport, being on time etc. They can be restless, irritable, tense, easily tired, or may have problems sleeping or concentrating. Children with GAD are usually “perfectionists” who are eager to please others and may be dissatisfied with their performance if they view it as less than perfect.

Social Phobia – This often emerges in the mid-teens where young people have a constant fear of social situation, performing in class, eating in public and so on. The fear can also be accompanied by blushing, palpitations, shortness of breath, sweating and tension. Children with social phobia may be overly sensitive to criticism, have trouble being assertive and have low self-esteem. A child may have social phobia in some situations, such as speaking in class, but not in others, such as attending parties.

Separation Anxiety Disorder – A child with SAD may have intense anxiety about being away from home or from their caregivers, which affects their ability to function at school and socially. They may have a great need to stay at home or be close to parents. They may worry excessively about their parents when they are not together. This can lead to them fearing sleeping alone, recurrent nightmares, stomach aches, headaches and so on.

Obsessive Compulsive Disorder – OCD typically begins in early childhood or adolescence. It is estimated that between 1 and 3% of adolescents experience symptoms of OCD. Children as young as five or six can show this obsessions (frequent and uncontrollable thoughts) and may perform routines or rituals, called compulsions to eliminate the thoughts. They may often repeat behaviours over and over to avoid imagined consequences, for example, excessive handwashing to avoid germs. Other compulsions may include repeating words silently, rechecking tasks, counting. Sometimes these compulsions can interfere with their daily life and cause anxiety for the child.

Tourette's Syndrome is another type of OCD. It is more likely to be present in boys and children who develop OCD at a younger age. Children and adolescents with OCD are also more likely to have ADHD, learning disorders, oppositional behaviour and other anxiety disorders.

Types of Therapy

There are many different forms of therapy that support people who are experiencing emotional difficulties. Below is a brief summary of some of the better known therapies.

Adlerian Therapy

Adlerian therapy is a growth model, which stresses a positive view of human nature. We are in control of our own fate, not a victim to it. At an early age, we begin to create a unique style of living and that style remains fairly constant during our lives. The idea is that we are motivated by our goal setting, dealing with tasks we face in life and our social interest. The therapist will gain information on our family history and use this information to set goals for the client and to get an idea of the person's past performance. This will help to determine that a goal is not too high or too low, so that the client has the means to reach it. The goal of the therapy is to encourage and challenge the client's goals and premises. The therapist will encourage goals that are socially useful and make them feel equal. They may include ending substance abuse, parenting skills and so on. The therapist will look at the client's lifestyle and try to form a relationship of mutual trust and respect with the client. They will mutually set goals and the therapist will provide encouragement for the person to reach those goals. The therapist may provide homework and set up contracts, as well as making suggestions on how the person can achieve their goals.

Behaviour Therapy

Behaviour therapy uses learning to overcome specific behavioural problems. In behaviour therapy, it is believed that behaviours are learned and that we are a product of our environment. The therapy focuses on our present and overt behaviour. Behaviour is thought to be a direct result of learning, so abnormal behaviour is thought to be due to defective learning. Therapy is based on learning theory and the treatment will include a treatment plan with goals for the treatment laid out and the outcome expected. To eliminate unwanted behaviours, the client is expected to learn new behaviours, such as assertion, coaching, cognitive restructuring, social skills and so on. The client and therapist take an active role in learning the more desired behaviour. Behaviour therapy is well suited to supporting people with depression, children's phobias, sexual disorders and stuttering.

Existential Therapy

Existential therapy focuses on freedom of choice to shape your own life. It teaches people that they are responsible for shaping their own lives and the need for self-determination and self-awareness. Each individual is unique and has a unique personality, starting in infancy. Existential therapy focuses on the present and future. The therapist tries to help the client to see that they are free to shape their future possibilities. They will challenge the client to recognise that they are responsible for the events in their lives. This is well suited to helping clients make choices or dealing with life.

Gestalt Therapy

Gestalt therapy tries to integrate the mind and body, stressing the integration of behaviour, thinking and feelings. Clients are thought to have the ability to recognize that their earlier life influences may have changed their life. The client is made aware of how to avoid problems, finish unfinished matters, be aware of personal responsibility and be positive. The therapist helps lead the client to accept responsibility for themselves, rather than expecting others to take care of them. They will use dream analysis, role playing etc. Their treatment may cover marital/family therapy, problems with children's behaviours, psychosomatic disorders.

Person-Centred Therapy

Person-centred therapy views humans in a positive manner and gives more responsibility to the client for their own treatment. Carl Rogers founded the therapy in the 1940s and had faith that we could and would work out our own problems. The therapist will move the client to self-awareness, helping them to experience denied feelings, teaching them to trust themselves and use this trust to find their way in life. The person centred therapist makes the client aware of their problems and guides them to a means to resolving them.

The therapist and client must have faith that the client can and will find self-direction. The therapist focuses on the here and now, motivating the client to experience and express feelings. The therapist believes good mental health is a balance between the real and ideal self. The problem lies when there is a difference between what we are and what we want to be, causing maladaptive behaviour.

Psychoanalysis

Psychotherapists believe that a person is driven by aggressive and sexual impulses that are unconscious and influence our behaviour. The first six years of a person's life are thought to be responsible for determining their later personality. Repressed childhood conflicts can lead to personality problems later in life, which can lead to anxiety. Unconscious motives lead to maladaptive behaviour. They argue that to develop a normal personality, a person needs to develop successfully through five psychosexual stages – oral, anal, phallic, latency and genital.

If we do not resolve these stages, this can lead to flawed personality. The therapist helps the client to make repressed conflicts conscious, making unconscious conscious helps them work towards awareness. Psychotherapy is not useful if clients are self centred, impulsive or severely psychotic. Therapists require extensive training. Treatment is usually long term.

Rational-Emotive and Cognitive-Behavioural Therapy

Rational-emotive therapy is action oriented and deals with the cognitive and moral state of the client. It stresses the ability of the client to think on their own and change. The therapist believes that we are born with rational thinking, but people may become irrational thinkers. Clients should be able to think, make good judgements and take action. Rational emotive and cognitive behavioural therapists use directed therapy and believe neurosis is a result of irrational behaviour and irrational thinking. The therapist believes client's problems are rooted in childhood, with their belief system formed in childhood. Therapy includes solving and dealing with emotional problems. Therapists help client eliminate self-defeating outlooks and help them view life in a rational way. The therapist thinks of the client as a student and them as a teacher.

Reality Therapy

Reality therapists teach clients ways to control the world around them and meet their personal needs. They believe clients can and will change their life for the better.


They focus on the “what” and “why” of client’s actions, pointing out what the client is doing and getting them to evaluate it. A behavioural or emotional problem is a direct result of what the client believes and feels about themselves. The therapist will help clients evaluate their behaviours and feelings, challenging them to become more effective at meeting their needs.


Transactional Analysis

TA focuses on the client’s cognitive and behavioural functioning. The therapist helps the client evaluate past decisions and how they affect their present life. Self – defeating behaviours and feelings can be overcome by awareness of them. The therapist believes the client’s personality is made up of the parent, adult and child. They argue that it is important for the client to examine past decisions to enable them to make new and better decisions.

SET TASK

Carry out a library or internet search on depression and anxiety in children and make notes.

	SELF ASSESSMENT Perform the self assessment test titled ‘Test 1.1’ If you answer incorrectly, review the notes and try the test again.
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	ASSIGNMENT Download and do the assignment called ‘Lesson 1 Assignment’.
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