Health and Mental Health Issues in Children

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Course Overview

- The course will provide an overview of common health and mental health issues in children, the common treatments of these illnesses, and their effects on family functioning.
- Workers will be able to provide understanding, collaboration, support, and connection to resources for families.
- In addition, you will:
  - Identify red flags for common mental health problems in children and adolescents
  - Learn more about health conditions that impact children and family's coping mechanisms

Topics

- The developing brain, health and mental health
- Common mental disorders in children
- Chronic illness in children and the impact on families
- Childhood obesity and health

Relevance of Health and Mental Health for Child Welfare

- Nearly 90 percent of children entering child welfare have physical health problems, and more than half have two or more chronic conditions
- One-quarter of children entering foster care have three or more chronic conditions
- Nearly half of children entering foster care have significant emotional and behavioral health conditions

Health conditions in Child Welfare

- Chronic health conditions included asthma, autism, AIDS, Down syndrome, diabetes, ADHD, heart problems, hypertension, depression, anxiety, and migraines, among others. Depending on the measurement researchers used, 30.6 to 49 percent of children investigated were found to have a chronic condition.
- On all measures, male children aged six or older were more likely to have a condition.

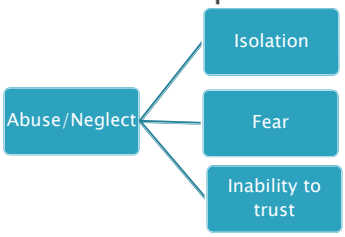
Table Talk: Mental Health Disorders in Children

- **What makes it difficult to understand mental health disorders in children?**

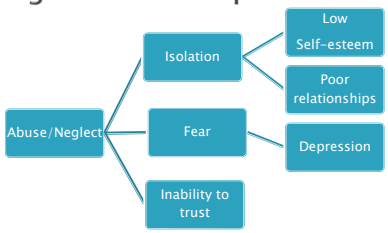
Basics for child's good mental health

- Unconditional love from family
- Self-confidence and high self-esteem
- The opportunity to play with other children
- Encouraging teachers and supportive caretakers
- Safe and secure surroundings
- Appropriate guidance and discipline

Abuse and Neglect: Immediate Consequences



Abuse and Neglect: Long-term Consequences



Good News: Protective Factors

- Some children with high risk factors avoid long-term consequences.
- Common factors underlying resiliency
  - Sense of being loved by their parent(s)
  - Interest in school
  - Help from outside the family to improve environment
- Some interventions promote resiliency

Culture and Mental Health

Differences between cultures

- Symptom expression
- Tolerance
- Nuances of verbal and non-verbal language
- Causes
  - Religious
  - Spiritual
  - Supernatural

Confronting Myths

- Table Talk
- What myths have you heard about mental illness in children and teenagers?

Counteracting Stigma

- Definition: Shame or disgrace attached to something regarded as socially unacceptable
- Children in child welfare systems can have labels that follow them for years.
- Parents with mental illness are vulnerable to losing custody of their children.
- CWS workers can counteract stigma.

The Developing Brain

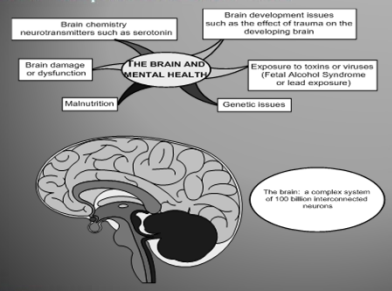
The Brain 101

- Robust period of brain development in first 3 years of life
- By age 2 to 3 brain growth slows
- Adult brain size by age 5

The Developing Brain

- "Pruning" of synapses occurs during adolescence
- Mean age of presentation of mental issue age is between 5 to 8 years old

Brain Development and MH



Relevant Mental Health Diagnoses in Child Welfare

- Autism spectrum
- ADHD
- Depressive disorders
- Anxiety disorders
- Trauma and stressor related disorders
- Conduct and ODD

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DSM 5

- Diagnostic and Statistical Manual of Mental disorders-5
- Three new groups
  - Gender
  - Geriatrics
  - Infants and young children

DSM 5 Highlights

- Improved focus on children
  - Developmental
  - Psychosocial / historical assessment
- Risk factors and vulnerabilities
- Better description of "rule outs"
- Emphasis towards diagnostic validity

DSM 5
What was Eliminated?

- Multi-axis system
- Aspergers
- GAF --> Now severity scales
- The grief exclusion for Major depression has been eliminated
- "Disorders of Infancy, Childhood and Adolescence" category

DSM 5 Definition of a "Mental Disorder"

- A syndrome characterized by clinically significant disturbance in an individuals cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning
- Causing clinically significant disturbance in a number of domains

Autistic Spectrum Disorders

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Autism Prevalence

- Roughly 1 in 110 American children born today will fall somewhere on the Autistic Spectrum (double the rate from 10 years ago and 10 times the incidence a generation ago) *Source: Centers for Disease Control (CDC)*
- ASDs occur in all racial, ethnic and socioeconomic groups, but are four times more likely to occur in boys than in girls

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Why the Increase?

- Public awareness and public health campaigns
- Earlier diagnosis and recognition
- Environmental triggers or causes
- New subtypes identified (syndromes with G.I symptoms, seizures, immune disorders)-- each could have different causes

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Causes and Risk Factors

- We do not know all of the causes of ASD.
- There are likely many causes for multiple types of ASD.
- Different factors that make a child more likely to have an ASD include environmental, biologic and genetic factors.

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Causes and Risk Factors

- Most scientists agree that genes are one of the risk factors that can make a person more likely to develop an ASD.
- Children who have a sibling or parent with an ASD are at a higher risk of also having an ASD.
- ASDs tend to occur more often in people who have certain other medical conditions. About 10% of children with an ASD have an identifiable genetic disorder, such as Fragile X syndrome, tuberous sclerosis, Down syndrome and other chromosomal disorders.

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DSM 5 Criteria

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

DSM 5 Criteria

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g, strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).
4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Neurodevelopmental Disorders

Attention-Deficit/Hyperactivity Disorder

- Specify whether
  - Combined
  - Predominantly inattentive
  - Predominantly hyperactive / impulsive
    - ✓ In partial remission
    - ✓ Severity: Mild, Mod, Severe
- Other
- Unspecified

- Persistent pattern of inattention and/or hyperactivity/impulsivity that interferes with functioning or development.
- 6 or more symptoms for at least 6 months

Inattention in ADHD

- Note: Not solely due to oppositional, defiance or hostility.
- Older adolescents require only 5 symptoms
- Fails to give close attention
- Difficulty sustaining attention
- Does not seem to listen
- Does not follow through on instructions
- Difficulty organizing tasks and activities
- Avoids tasks that require sustained mental effort
- Often loses things
- Easily distracted by extraneous stimuli
- Often forgetful in daily activities

Hyperactivity and Impulsivity in ADHD

- 6 or more of the following symptoms
- Note: Not solely due to oppositional, defiance or hostility.
- Older adolescents require only 5 symptoms
- Often fidgets, taps hand or feet or squirms
- Often leaves seat when at work or in classroom
- Often runs about or climbs in inappropriate settings
- Often unable to play quietly
- Acts as if "driven by a motor"
- Often talks excessively
- Often blurts out answers
- Has difficulty waiting his or her turn
- Interrupts or intrudes on others

AD/HD treatment (non-pharmacotherapy options)

- Voucher, Token or Point System
  - Helps children with ADD/ADHD & oppositional behaviors
  - Kids work at correcting behavior because they know the choices they make will determine their rewards and consequences
  - Control over actions and accountability increases dramatically
  - With the structure they learn to be more creative, overcome obstacles, attain goals and improve behaviors

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ADHD Pharmacotherapy

- Stimulant Drugs (first line treatment)
  - Adderall (d and l amphetamine)
  - Dexedrine (d amphetamine)
  - Ritalin, Concerta (methlyphenidate)
- Norepinephrine reuptake inhibitor
  - Strattera (atomoxetine)
    - FDA approved for children and adults with ADHD
    - Along with stimulants Strattera is considered a first-line drug for the treatment of ADHD
  - Effexor XR (Venlafaxine)

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AD/HD treatment

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ADHD: Treatment

- Voucher, Token or Point System
  - Hard to manipulate and does not provoke anger as many other methods of discipline can
  - Because nothing is taken away from the child, power struggles and retaliation can be prevented
  - Tailored to fit each child individually
  - Even the compliant child can benefit (use with sibs also)
  - Parents often comment that sibling rivalry and fighting between siblings is greatly reduced or eliminated as children learn to control angry outbursts and other unacceptable behaviors

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Depressive Disorders

- DMDD
  Major Depressive Disorder

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Disruptive Mood Dysregulation Disorder (DMDD)

- New diagnosis in DSM 5

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DMDD – DSM 5 Criteria

- The onset of symptoms must be before age 10, and a DMDD diagnosis should not be made for the first time before age 6 or after age 18
- Abnormal mood is present at least half of the day on most days and is noticeable to people around the child
- The symptoms should impair at least one setting in the child's life

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DMDD Criteria

1. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.
2. The temper outbursts are inconsistent with developmental level (e.g., the child is older than you would expect to be having a temper tantrum).
3. The temper outbursts occur, on average, three or more times per week.
4. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, friends).
5. The above criteria have been present for 1 year or more, without a relief period of longer than 3 months. The above criteria must also be present in two or more settings (e.g., at home and school), and are severe in at least one of these settings.
6. The diagnosis should not be made for the first time before age 6 years or after age 18. Age of onset of these symptoms must be before 10 years old

DSM 5 Criteria: Major Depressive Disorder

- The core criteria of major depressive disorder are unchanged in the new DSM 5 . However, the specifier "with mixed features" can be affixed to a diagnosis of major depressive disorder to indicate symptoms of mania without meeting the full criteria for a manic or hypomanic episode.
- Symptoms: five or more symptoms in the same two-week period and represent a change from previous functioning; at least one is either depressed mood or loss of interest/pleasure

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DSM 5 Criteria

1. Depressed mood most of the day, almost every day, indicated by your own subjective report or by the report of others. This mood might be characterized by sadness, emptiness, or hopelessness.
2. Markedly diminished interest or pleasure in all or almost all activities most of the day nearly every day.
3. Significant weight loss when not dieting or weight gain.
4. Inability to sleep or oversleeping nearly every day.

DSM 5 Criteria

5. Psychomotor agitation or retardation nearly every day.
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day.
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
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.

Developmental Features in Depression

- **Age 1-2**
  - Delay in development, nightmares and night terrors, self-stimulating behaviors, clinginess, excessive fears, and decrease in play behaviors
- **Age 3-5**
  - Sadness, tiredness, anger, apathy, illness, irritability, social withdrawal, weight loss
- **Age 6-12**
  - Symptoms more closely resemble that of an adult with depression: Anhedonia, apathy, and low self-esteem, moodiness, lack of motivation, suicidal ideation, and decline in school performance, anger, delinquency, and somatization.
- **Age 12-18**
  - Volatile mood, rage, low self-esteem, sexual acting out, substance abuse, oversleeping, overeating, social withdrawal, suicidal ideation

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Treatment of Depression in Children

- For mild depression, CBT or interpersonal psychotherapy is recommended first
- For pharmacologic therapy, SSRIs are the first-line choice
- If there is no response to the SSRI, switch to a second SSRI or SNRI

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Anxiety Disorders

- Separation Anxiety Disorder
- Panic Disorder
- Panic Attack

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Anxiety Disorders

- Definition

  Anxiety can result when a combination of increased internal and external stresses overwhelm one's normal coping abilities or when one's ability to cope normally is lessened for some reason.

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Anxiety Disorders in the DSM 5

- Generalized Anxiety Disorder
- Substance/Medication-Induced Anxiety Disorder
- Anxiety Disorder Due to Another Medical Condition
- Other Specified Anxiety Disorder
- Unspecified Anxiety Disorder
- Separation Anxiety Disorder
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder (Social Phobia)
- Panic Disorder
- Panic Attack (Specifier)
- Agoraphobia

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Prevalence

- Lifetime prevalence for anxiety disorders as a whole in adults is about 25%.
  - The prevalence in children is unknown.
- Anxiety disorders in children often are overlooked or misjudged.
- There is a consensus that many "adult" psychiatric disorders likely have their first (although perhaps subtle or ignored) manifestations in childhood.
- If left untreated, these anxiety disorders in children likely progress to adult versions.

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Components

- Physiological: "fight/flight" response, experience of bodily tension
- Cognitive: beliefs, thoughts, interpretations of the negative feeling
- Behavioral: trying to physically avoid or escape the feeling or situation

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Anxiety Disorders

- Etiology
  - Genetic
    - Studies show 50% of patients with Panic Disorder have at least one relative affected with an anxiety disorder. There is a higher chance of an anxiety disorder in the parents, children and siblings of a person with an anxiety disorder than in the relatives of someone without an anxiety disorder. Twin studies demonstrate varying but important degrees of genetic contribution to the development of anxiety disorders
  - Physiological
    - Evidence exists that supports the involvement of norepinephrine, serotonin and GABA. In some cases there appears to be a dysregulation of the noradrenergic and serotonergic neural systems--two systems that are complexly interrelated in the brain

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Symptoms of Anxiety

- Symptoms of Anxiety
  - Many worries about things before they happen
  - Constant worries or concern about school performance, friends or sports
  - Repetitive thoughts or actions (obsessions)
  - Fears of embarrassment or making mistakes
  - Low self esteem
- Phobias
  - Afraid of specific things such as dogs, insects or needles and these fears cause significant distress
  - Afraid to meet or talk to new people
  - May have few friends outside the family

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Anxiety Symptoms

- Anxious children may be overly tense or uptight.
- Some may seek a lot of reassurance, and their worries may interfere with activities.
- Some children may be quiet, compliant and eager to please, so their difficulties may be missed.
- Educate parents about the signs of severe anxiety so they can intervene early to prevent complications.
- It is important not to discount a child's fears.

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Focus of Fears

Age	Focus of Fear or Anxiety
0-6 months	Loss of primary caregiver Loud noises, intense stimuli
6-9 months	Strangers or unexpected stimuli
1 year	Separation from caretaker, injury, toilet, strangers
2 years	Animals, dark, separation from caretakers, loud noises such as thunder
3 years	Animals, masks, being alone, separation from caretaker
4 years	Darkness, animals, noises
5 years	Animals, bad people, darkness, separation from caretaker
6 years	Sleeping alone, going to school (separation from caretaker), monsters, ghosts, bodily injury
7-8 years	Monsters, ghosts, extraordinary traumatic events (9/11), injury, staying alone
9-12 years	Tests, oral reports, school performance, bullying, teasing or rejection by peers
13-18 years	Social alienation, embarrassment, failure in school, death, natural or manmade disasters

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Treatment of Anxiety disorders

- Family therapy
- Cognitive behavioral therapy
  - Exposure, desensitization, flooding and relaxation
- Behavior modification
- Play therapy
- Psychodynamic psychotherapy
- Parent education

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Separation Anxiety Disorder DSM 5 Criteria

- The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning
- The disturbance is not better explained by another mental disorder such as Autism spectrum disorder, psychotic disorders, agoraphobia, generalized anxiety or illness anxiety disorder
- Developmentally inappropriate and excessive anxiety concerning separation as evidenced by three (or more) symptoms
- The duration of the disturbance is at least 4 weeks in children and adolescents and 6 months or more in adults

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Separation Anxiety Disorder: Treatment

- The most common treatments for Separation Anxiety Disorder are often used in combination with each other:
  - Play therapy
  - Cognitive Behavioral Therapy
  - Systematic Desensitization (gradual introduction of the separation, measured by time and distance)

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Separation Anxiety Disorder: Treatment

- Continued
  - Relaxation techniques
  - Bibliotherapy (using books and stories to model healthy separation behavior)
  - Family therapy (including the parents and even siblings) – this reduces the sense of "it's your problem," addresses the reality that one child's problems affect everyone else in the family and also accounts for the probability that something in the parents' lives or parenting style may be contributing to the problem in the first place

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Panic disorder

- Panic disorder sometimes runs in families, but no one knows for sure why some people have it while others don't
- Several parts of the brain are involved in fear and anxiety
- Researchers are also looking for ways in which stress and environmental factors may play a role

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Panic Attacks in Children

- Up to 12% of ninth graders have had a panic attack. About 1–2% of all adults have multiple panic attacks. If you look at adults with panic disorder, 20% had their first panic attack before the age of 10. *(AACPP, 2000)*
- In children and teenagers, panic attacks can take on many different disguises.
  - SOB, Chest Pain, Red Face, Palpitations
  - Nausea
  - Anger
  - Somatization

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Panic Disorder in Children

- Panic disorder in children is not common but can be a very disabling condition.
- It will often
  - affect school performance
  - impair them socially
- Approx 10% of children will have a panic attack.
- Approx 1-2% will develop Panic disorder.
- Of those that do develop Panic disorder
  - 10-35% will recover and remain well the rest of their lives
  - At least 50% will be mildly affected years later
  - The rest will have chronic Panic disorder for years

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Panic Disorder: DSM 5 Criteria

An abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time, 4 or more of the following symptoms occur:

- Palpitations
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feelings of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, lightheaded or faint
- Chills or heat sensations
- Numbness or tingling
- Feelings of unreality or being detached from oneself
- Fear of losing control or "going crazy"
- Fear of dying

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Panic & Co-Occurring Disorders

- Many children with panic disorder also had agoraphobia.
- The children with panic or agoraphobia had a high rate of co-morbid depression and other anxiety disorders
- They also had a high incidence of disruptive behavior disorders such as Conduct Disorder and ADHD.
- The course of the panic disorder and agoraphobia appeared to be chronic.

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Long Term Outcomes

- If you follow-up children with panic disorder, about 25% will still have it years later.
- Of those who continue to have Panic disorder as they go into adulthood, many will develop other psychiatric difficulties.
  - About 50% will develop agoraphobia
  - 20% will make suicide attempts
  - 27% will develop alcohol abuse
  - 60% will develop depression
  - 35% will believe they are unhealthy
  - 27% will not be financially independent
  - 28% will make frequent outpatients visits
  - 50% will be show significant social impairment.

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Treatment of Panic Disorders in Children

- Regular meals, adequate sleep, regular exercise and a supportive environment
- Deep abdominal breathing and other relaxation techniques
- CBT: Exposure, desensitization, flooding and relaxation
- If agoraphobia is present, the child should make up a hierarchy of fear-inducing situations. Assist the child to move up the hierarchy of feared situations .
- If therapy is only partially effective, medication may be added.
- In children with severe anxiety or with co-morbid disorders, one might start therapy and medications simultaneously.

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Trauma- and Stressor-Related Disorders

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Posttraumatic Stress Disorder
- Adjustment Disorders

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Reactive Attachment Disorder DSM 5 Criteria

- Consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers manifested by both:
  - Rarely seeks comfort when distressed
  - Rarely responds to comfort when distressed
- Persistent social and emotional disturbance characterized by at least 2 of the following:
  - Minimal social and emotional responsiveness to others
  - Limited positive affect
  - Episodes of unexplained irritability, sadness or fearfulness even during nonthreatening interactions with caregivers

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Reactive Attachment Disorder DSM 5 Criteria (continued)

- Child has experienced extremes of insufficient care as evidenced by at least 1 of the following:
  - Social neglect or deprivation in the form of lack of comfort, stimulation, affection by caregivers
  - Repeated changes in primary caregivers
  - Rearing in unusual settings that limit selective attachments (institutions)
- Begins before age 5
- Rule out Autistic Spectrum disorder

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Disinhibited Social Engagement Disorder: DSM 5 Criteria

- A pattern of behavior in which a child approaches and interacts with adults exhibiting at least 2 of the following criteria:
  - Reduced or absent reticence in approaching unfamiliar adults
  - Overly familiar verbal or physical behaviors (with culture in mind)
  - Diminished or absent checking back with adult caregiver
  - Willingness to go off with unfamiliar adult
- Not due to impulsivity as in ADHD

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Disinhibited Social Engagement Disorder: DSM-5 Criteria (cont.)

- Child must have developmental level of at least 9 months
- Child has experienced extremes of insufficient care as evidenced by at least 1 of the following:
  - Social neglect or deprivation in the form of lack of comfort, stimulation, affection by caregivers
  - Repeated changes in primary caregivers
  - Rearing in unusual settings that limit selective attachments (institutions)

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Interventions

- Medical evaluation/hospitalization
- Behavioral interventions
- Parent-child Interaction therapy
- "Theraplay"

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Attachment Disorder: Long Term Goals

- Child
  - Learn to function mutually in relationships
  - Understand and take responsibility
  - Learn productive means of identifying and dealing with emotions and stress
  - Welcome emotional intimacy
  - Develop the ability to love and enjoy life, themselves and others
- Parents
  - Learn healthy parenting skills and coping skills
  - Establish specific, well-enforced structure
  - Learn to hope again as they acquire new skills for helping the child with his/her behavior

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Post Traumatic Stress Disorder

- **New subtype of PTSD in DSM 5 for children ages 6 and younger**

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PTSD Prevalence

- 15-43% of girls and 14-43% of boys have experienced at least one traumatic event in their lifetime.
- Of those children and adolescents who have experienced a trauma
  - 3 to 15% of girls and 1 to 6% of boys could be diagnosed with PTSD.
- Research findings regarding development of PTSD
  - 100% of children who witness a parental homicide or sexual assault develop PTSD
  - 90% of sexually abused children
  - 77% of children exposed to a school shooting
  - 35% of urban youth exposed to community violence

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Post Traumatic Stress Disorder

- Predictors of likelihood of PTSD
  - Severity of the traumatic event
  - Parental reaction to the traumatic event
  - Physical proximity to the traumatic event
  - In general, most studies find that children and adolescents who report experiencing the most severe traumas also report the highest levels of PTSD symptoms.

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Trauma vs. Neglect and Brain Development

- Neglect means that there was an absence of appropriate stimulation at the right time of development.
- Trauma means that there was an over stimulation at the wrong time and perhaps for a prolonged period of time.

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Trauma

- Trauma results from the over-activation of the stress network.
- Repeated activation of traumatic experiences increases the severity of traumatic effects and makes them less amenable to treatment.

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Stress Response & Brain Development

- Threat results in total-body mobilization.
- Survival strategies involve more primitive brain functions.
- Fight, flight, or surrender (dissociate)
- Primary adaptive responses in the brain to threat exist on two continuums:
  - **Hyperarousal**
  - **Dissociative**
- Different people may have different responses to the same trauma.

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PTSD for Children 6 Years and Younger: DSM 5 Criteria

- Exposure to actual or threatened death, serious injury or sexual violence by one (or more) of the following
  - Directly experiencing the traumatic event(s)
  - Witnessing, in person, the event(s)
  - Learning that the traumatic event(s) occurred to a parent or caregiving figure

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PTSD for Children 6 Years and Younger: DSM 5 Criteria (cont.)

- Presence of one (or more) symptoms in four primary major symptom clusters:
  - Re-experiencing
  - Arousal
  - Avoidance
  - Persistent negative alterations in cognitions and mood

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Assessment of preschool PTSD

- Standardized screening and assessment instruments have been developed for caregivers of this age group, with both self-administered checklists and diagnostic interviews

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Adjustment Disorders

- Adjustment disorder is very common in the United States.
- More than five percent (5%) of all persons seen in clinical, outpatient mental health settings have some type of adjustment disorder.

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Children's Reactions to Grief and Loss

- Bodily Distress
  Somatic bodily symptoms such as tightness in throat, can't breath, nightmares, can't go to school
- Hostile Reactions
  Resentment projected outward in order to relieve guilt by making someone else responsible for the death
- Idealization
  In an attempt to fight off unhappy thoughts, becomes obsessed with deceased person's good qualities

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Adjustment Disorder – Prevalence

- Adjustment disorder is very common in the United States.
- More than five percent (5%) of all persons seen in clinical, outpatient mental health settings have some type of adjustment disorder.

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Adjustment Disorder – DSM-5 Criteria

- The development of emotional or behavioral symptoms in response to an identifiable stressor occurring within 3 months of the onset of the stressor(s)
  - marked distress that is in excess of what would be expected from exposure to the stressor (note culture and external context)
  - significant impairment in social or occupational (academic) functioning
- Rule out other mental disorders
- Not due to normal bereavement
- Symptoms do not persist for more than an additional 6 months if the stressor is terminated.

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Conduct and Oppositional Defiant Disorders

Prevalence of Conduct Disorder

- In the United States, prevalence rates for conduct disorder (CD) are estimated at 2–9% and are complicated by relatively high rates of co-occurrence or comorbidity with other disorders.

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Etiology: BioPsychoSocial Factors

Psychological Factors

- A poor relationship with one or more parent
- A neglectful or absent parent
- A difficulty or inability to form social relationships or process social cues

Social Factors

- Poverty
- Chaotic environment
- Abuse
- Neglect
- Lack of supervision
- Uninvolved parents
- Inconsistent discipline
- Family instability (such as divorce or frequent moves)

Biological Factors

- A parent with a history of attention-deficit/ hyperactivity disorder (ADHD), ODD or CD
- A parent with a mood disorder (such as depression or bipolar disorder)
- A parent who has a problem with drinking or substance abuse
- Impairment in the part of the brain responsible for reasoning, judgment and impulse control
- A brain-chemical imbalance
- A mother who smoked during pregnancy
- Exposure to toxins
- Poor nutrition

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ODD / CD

- Children with either may experience. . .
  - Higher rates of depression, suicidal thoughts, suicide attempts and suicide
  - Academic difficulties
  - Poor relationships with peers or adults
  - Sexually transmitted diseases
  - Difficulty staying in adoptive, foster or group homes
  - Higher rates of injuries, school expulsions and problems with the law

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Oppositional Defiant Disorder (ODD): DSM 5 Criteria

- A pattern of angry/irritable mood, argumentative/defiant behavior or vindictiveness lasting at least 6 months with at least 4 symptoms from any of the categories outlined. (Behavior must be exhibited with at least one non-sibling).
- **Angry/Irritable Mood**
  - Loses temper
  - Touchy or easily annoyed
  - Angry and resentful
- **Argumentative/Defiant**
  - Argues with adults and authorities
  - Defies or refuses to comply with rules
  - Blames others for own mistakes
  - Annoys people on purpose
- **Vindictiveness**
  - Spiteful and vindictive

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Conduct Disorder (CD) DSM 5 Criteria (cont.)

- Symptoms include a repetitive and persistent pattern of violating the basic rights of others for the past 12 months. At least one of the following symptoms must occur in the past six months:
  - Aggression to people and animals
  - Destruction of property
  - Deceitfulness or theft
  - Serious violation of rules
- Specifiers

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ODD / CD Treatment

- Parent training programs to help manage the child's behavior
- Individual psychotherapy to develop more effective anger management
- Family therapy to improve communication
- Cognitive-Behavioral therapy to assist problem solving and decrease negativity
- Social skills training to increase flexibility and improve frustration tolerance with peers
- Residential care

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Treatment (continued)

- Conduct disorder is one of the most difficult disorders to treat.
- The earlier the conduct disorder is identified and treated, the better the chance for success.
- It's never too late to start a Voucher, Token or Point System.
  - Teaches teens the skills they will need to function in the real world (money management, cooperation, time management and responsible behavior)
  - Enhances self-discipline and responsibility while building self-esteem, self respect and respect of others
  - Relationships and overall communication with parents improves as the system creates more time for positive interactions.

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Substance Use and Self Harm

Children and Adolescents

- The use of illegal drugs is increasing, especially among young teens.
- The average age of first marijuana use is 14, and alcohol use can start before age 12.
- The use of marijuana and alcohol in high school has become common.
- Drug use is associated with a variety of negative consequences including increased risk of serious drug use later in life, school failure and poor judgment putting teens at risk for accidents, violence, unplanned and unsafe sex, and suicide.

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Teens: Signs of Drug/Alcohol Use/Abuse

- Secretive behaviors
- Change in personality or baseline mood
- Drop in grades
- Dropping old friends and getting "new" friends whom they often do not introduce to parents
- Change in participation in extracurricular activities
  Paraphernalia found, even if child claims it belongs "to a friend"

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What to do if someone talks about suicide

1. Take it seriously.
2. Treat it as an emergency until an assessment can be completed.
3. Allow the person to express his/her thoughts.
4. Realize you won't make it worse by letting them talk about it.
5. Don't think it is to gain sympathy.

Self Harm and Self Mutilation

Why do people self harm?

- Relief from feelings
- A method of coping
- Stopping, inducing or preventing dissociation
- Euphoric feelings
- Physically expressing pain
- Communication
- Self-nurturing
- Self-punishment
- Re-enacting previous abuse
- Establishing control

Health Conditions in Children and Teens

Topics

- Chronic health conditions
- Advocacy
- Empowering families
- Treatment planning

Common Experiences of Children with Physical or Mental Disorders

- Describe what might be common to children with physical vs. mental disorders?
- What might be different?

"A Partnership for Healing"

- Values and respects the family
- Empowers, supports and nurtures parents
- Uses a strength-based model
- Child with a disability not a disabled child
- Child with diabetes, not a diabetic
- Baby with Down syndrome, not a Down's baby
- Questions one's beliefs about children who are "different"

Emotional Impact of Diagnosis

- Fear
- Isolation
- Grief reactions

Prematurity

- A baby born before 37 weeks of pregnancy is considered premature.
- Neurological or brain disorders may occur in newborn babies.

Neurological Risks

- **Intraventricular Hemorrhage** – Bleeding inside or around the ventricles, the spaces in the brain containing the cerebrospinal fluid
- **Periventricular Leukomalacia** – Damage and softening of the white matter

Prematurity

- Premature infants are at risk for developmental delays, learning problems, and cerebral palsy.
- Additional risks: Apnea of Prematurity

Congenital disorder

- About 3 or 4 out of every 100 babies have some type of anomaly at birth.
- Can be mild or severe

Spina Bifida

- Spina bifida is a type of neural tube defect. Neural tube defects, including spina bifida (open spine) and anencephaly (open skull), are seen in 1 to 2 out of 1,000 live births.
- Approximately 85% of defects are found in the lower back area. The remaining 15% of the defects are located in the back of the neck or upper back areas

Fetal Alcohol Syndrome

- Fetal Alcohol Syndrome (FAS) is a group of abnormalities in babies born to mothers who consume alcohol during pregnancy. It is the most common known non-genetic cause of mental retardation in the United States.

Fetal Alcohol Syndrome

- **Symptoms**
  - Small head, small jaw, and small, flat cheeks
  - Malformed ears
  - Small eyes, poor development of optic nerve, crossed-eyes
  - Upturned nose, low bridge
  - Small upper mouth structure and teeth
  - Caved-in chest wall
  - Umbilical or diaphragmatic hernia

Fetal Alcohol Syndrome

- **Symptoms**
  - Limited movement of fingers and elbows
  - Extra fingers, abnormal palm creases
  - Excessive hair
  - Under-grown nails
  - Incomplete or lack of development of brain structures
  - Heart murmurs, heart defects, abnormalities of large vessels
  - Incomplete development of genitalia
  - Growth, motor, and mental retardation
  - Irritability in infancy and hyperactivity in childhood
  - Poor coordination

Fetal Alcohol Syndrome

- Cause: Mother uses 5-6 alcoholic drinks per day during pregnancy. The baby becomes addicted to alcohol in utero. At birth, the baby's dependence on alcohol continues but withdrawal symptoms occur. Alcohol withdrawal may begin within a few hours after birth, and symptoms may last up to 18 months.

Craniofacial Anomalies

- **Cleft lip and/or cleft palate** – A separation that occurs in the lip or the palate (roof of the mouth), or both. Cleft lip and cleft palate are the most common congenital craniofacial anomalies seen at birth.
- **Cleft lip –** An abnormality in which the lip does not completely form. The degree of the cleft lip can vary greatly, from mild (notching of the lip) to severe (large opening from the lip up through the nose).
- **Cleft palate –** Occurs when the roof of the mouth does not completely close, leaving an opening that can extend into the nasal cavity. The cleft may involve either side of the palate. It can extend from the front of the mouth (hard palate) to the throat (soft palate). The cleft may also include the lip.
- **Cause**
  - No single factor causes Craniofacial Abnormalities; however, likely causes include: combination of genes, environmental factors, and folic acid deficiency.

Chromosomal Abnormalities

- **Trisomy 21 (Down Syndrome)**
  - Down syndrome (DS) is the most common genetic cause of developmental disability currently known. DS is caused by an extra copy of chromosome 21 (Trisomy 21), and is manifested by microcephaly (reduced brain size) and varying degrees of mental retardation. Compared with IQ-matched controls without DS, individuals with DS have particular problems with language, short-term memory, and with changing tasks.
- **Cystic Fibrosis (CF)**
  - Cystic fibrosis is one of the most common inherited single gene disorders in Caucasians. About 1 in 2500 Caucasian babies is born with CF and about 1 in 25 Caucasians of northern European descent carries the gene for CF. People with CF secrete abnormal body fluids, including unusual sweat and thick mucus which prevents the body from properly cleansing the lungs. The mucus interrupts the function of vital organs and leads to chronic infections.

Chromosomal Abnormalities

- **Sickle Cell Anemia (SC)**
  - Sickle cell anemia is one of the most common, inherited single gene disorders in African-Americans.
  - About 1 in 600 African-American babies is born with SC, and about 1 in 12 African-American people carries the gene for SC.
  - Sickle cell disease involves the red blood cells, or hemoglobin, and their ability to carry oxygen.

Asthma

- Asthma is a chronic, inflammatory disease in which the airways become sensitive to allergens (any substance that triggers an allergic reaction).
- Asthma is the leading chronic illness among children in the US. Approximately 26.3 million people in the US have been diagnosed with asthma, with at least 8.6 million of them children under the age of 18.

Juvenile Rheumatoid Arthritis

Other Rheumatoid conditions:

- Systemic Lupus Erythematosus (SLE)
- Lupus is a Rheumatoid condition in which the body's immune system attacks its own healthy cells and tissues.
- Lupus is characterized by periodic episodes of inflammation of and damage to the joints, tendons, other connective tissues, and organs, including the heart, lungs, blood vessels, brain, kidneys, and skin.
- Fibromyalgia

Type I Diabetes and Other Endocrine Disorders

- Other endocrine conditions:
  - Disorders of Sexual development
  - Growth problems
  - Adrenal and thyroid gland problems

Childhood Obesity

Prevalence of Childhood Obesity

- Childhood overweight and obesity are highly prevalent in the United States, affecting one-third of children and adolescents.
- Since 1980, the rates of obesity have tripled for children aged 2 to 19 years.
- The risk of obesity is higher among minority and low-income populations.

Health Consequences of Childhood Obesity

- Overweight children and adolescents are at greater risk for health problems when compared with their normal-weight peers and are more likely to become obese adults.
- Obese children and adolescents are more likely to have serious illnesses such as type 2 diabetes, hypertension, high cholesterol, stroke, heart disease, nonalcoholic fatty liver disease, certain types of cancer, and arthritis.
- Other reported health consequences of childhood obesity include eating disorders and mental health issues such as depression and low self-esteem

Factors Contributing to Childhood Obesity

- Many factors interact to contribute to obesogenic environments and affect children's weight. These include:
  - Genetic and individual factors
  - Home influences
  - The school environment
  - Factors in the local community
  - Policies implemented at the regional and national levels

Wang Y, Wu Y, Wilson RF, et al. AHRQ Comparative Effectiveness Review No. 115. Available at www.effectivehealthcare.ahrq.gov/child-obesity-prevention.cfm.

Risk factors for Obesity

- Diet
- High-calorie foods
- High-fat foods dense in calories
- Soft drinks, candy, desserts high in sugar / calories

Inactivity
- Sedentary kids more likely to gain weight
- Inactive leisure activities

Risk factor for Obesity: Genetics

- Overweight family and child may be genetically predisposed to gain excess weight
- environment of high-calorie foods
- physical activity may not be encouraged

Heredity/Genes

- 80%
  of children with two overweight parents will become overweight
- 40%
  of children with one overweight parent will become overweight
- 7-9%
  of children with no overweight parents will become overweight

Genetics/Environment

- Overweight family and child may be genetically predisposed to gain excess weight
- environment of high-calorie foods
- Physical activity may not be encouraged

Psychological Risk Factors for Obesity

- Some eat to cope with problems or deal with emotions; stress or boredom
- Parents may have similar tendencies

Media Influences

- Chips, cookies, and other less healthy food choices are marketed to children via media.
- Temptation is everywhere

Behavioral/Socio-cultural

- Sedentary lifestyles
- Calorie-dense foods
- Large portion sizes
- Excessive television viewing / video games means low energy expenditure
- Parent modeling - eating and exercise behaviors

Health Consequences: Adult Premature Death

- 500,000 deaths per year – surpassing tobacco
- Risk increases with increased weight

Other Health Consequences in Children

- Endocrine disorders
  - Type 2 Diabetes
  - Polycystic Ovary Syndrome
  - Early sexual maturation
- Orthopedic disorders
- Skin conditions
  - AN – seen in:
  - 10% of obese white children
  - 50% of obese black children
  - Skin fungal infections

Other Health Consequences in Children

- Gastrointestinal
  - fatty liver disease
  - elevated liver enzymes
  - gallstones and cholecystitis
  - gastroesophageal reflux
  - constipation
- Sleep apnea
- Asthma
- Risk for Kidney problems

Psychosocial Health Consequences in Children

- Depression/Anxiety
- Quality of Life
- Negative self-esteem/Poor body image
- Feelings of chronic rejection / Withdrawal from interaction with peers/Behavioral problems
- Decreased endurance / involvement
- Social, academic and job discrimination (Deckelbaum and Williams, 2001)

Preventing Childhood Obesity

- Obesity is difficult to treat, and prevention of childhood obesity has been identified as a key to fight the growing obesity epidemic.
- Leading health organizations, including the World Health Organization and an Institute of Medicine expert panel, have recommended comprehensive interventions to fight obesity.
- The main goal of most childhood obesity prevention interventions is to prevent children who are not overweight from becoming overweight or obese.
- Interventions designed for obesity prevention may also help overweight or obese children lose excess weight or stabilize their weight.

Childhood Cancers

- Bone Cancers: Sarcoma
- Hodgkin's Lymphoma
- Neuroblastoma: arises in the adrenal glands near the kidneys, attacks very young children, and spreads very quickly.
- Brain tumors: brain tumors originate in the cells of the brain and are the most common solid tumors in children. Approximately 1,500 children in the US are diagnosed with a brain tumor each year.
- A benign brain tumor does not contain cancer cells.
- Malignant brain tumors do contain cancer cells. Malignant brain tumors are usually fast growing and invade surrounding tissue.

Childhood Cancers

- **Survival rates**
  - In the last 40 years, the overall survival rate for children's cancer has increased from 10% to nearly 90% today, but for many more rare childhood cancers, the survival rate is much less.
  - 12% of children who are diagnosed with cancer do not survive.
  - 60% of children who survive suffer devastating late effects such as secondary cancers, muscular difficulties and infertility.
  - There are approximately 375,000 adult survivors of children's cancer in the United States.

Childhood Leukemia

- Leukemia is cancer of the blood and develops in the bone marrow.
- **Acute Lymphocytic Leukemia (ALL)**
  - Accounts for about 75 to 80% of the childhood leukemias. High rate of survival at 73%
- **Acute Myelogenous Leukemia (AML)**
  - Accounts for about 20% of the childhood leukemias.
  - Children with certain genetic syndromes, such as Down syndrome, are at a higher risk of developing AML than other children.
- **Chronic Myelogenous Leukemia (CML)**
  - Uncommon in children

Childhood Cancers

Treatment:

The types of treatment used most often to treat cancer are surgery, chemotherapy, radiation therapy, immunotherapy, and bone marrow or peripheral blood stem cell transplantation.

Seizure Disorders and Other Neurological Conditions

Other Neurological Conditions:

Muscular Dystrophy (MD)

- Genetic (inherited) disorder of the muscles.
- Muscular dystrophy causes the muscles in the body to become very weak. The muscles break down and are replaced with fatty deposits over time.
- Other health problems commonly associated with muscular dystrophy include the following:
- Heart problems, Scoliosis, and Obesity

Coping with Chronic and Life Threatening Illness

Empowerment approach

- Families feel empowered when they are able to make choices, be involved in decisions, and work as a team with the child's caregivers.

Support Groups, Summer camps and Self help groups

- **Types of camps**
  - Children with Cancer
  - Siblings of Children with Cancer
  - Diabetic Camp
  - Family Camp for Diabetes
  - Camps for specific disabilities

Support groups

- **Web based support**
  - Numerous sites are available on-line for information, bulletin boards, and support for both children and parents.
- **Parent support groups**
  - Many local and national organizations sponsor support groups for parents coping with all illnesses and disabilities. Parents need encouragement to seek out and attend these meetings when the timing is right for them.

School advocacy

- The three main federal laws that may apply:
  - Individuals With Disabilities Education Act (IDEA)
  - Section 504 of the Rehabilitation Act of 1973 (Section 504)
  - Americans with Disabilities Act (ADA) passed in 1990

Co-Existing Conditions

- Most children cope relatively well with their health-related conditions but are at higher risk for emotional issues, such as:
  - Depression
  - Anxiety
  - Post traumatic stress disorder
  - Adjustment disorders

Video: Medicating Kids

- http://www.pbs.org/wgbh/pages/frontline/video/flv/generic.html?s=frol02s3f0q55&continuous=1

Websites

National Cancer Institute
- www.cancer.gov

Childhood Brain Tumor Foundation
- http://www.cbtf.org/

- Type I Diabetes
  - http://www.childrenwithdiabetes.com/
  - www.jdrf.org
- Grief and loss
  - http://www.dougy.org/

Websites

- Juvenile Arthritis
  - http://www.kidsgetarthritistoo.org/living-with-ja/daily-life/
  - www.arthritis.org

Bay Area Lupus Foundation
- www.balf.org

- All health and mental health conditions
  - http://www.stanfordchildrens.org/en/service/index
- End-of-life care, palliative medicine, and hospice care
  - http://www.growthhouse.org/

Websites

- Parenting at a Challenging time (parent with illness)
  - http://www.mghpact.org/
- Brain and Development
  - http://www.childtraumaacademy.com/amazing_brain/
- Facts for Families: American Academy of Child Adolescent Psychiatry
  - http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/The-Child-With-A-Long-Term-Illness-019.aspx

Websites

- Trauma-FocusedCognitive Behavioral Therapy
  - https://tfcbt.musc.edu/
- Obesity
  - http://www.who.int/dietphysicalactivity/childhood_what_can_be_done/en/