The difficult child

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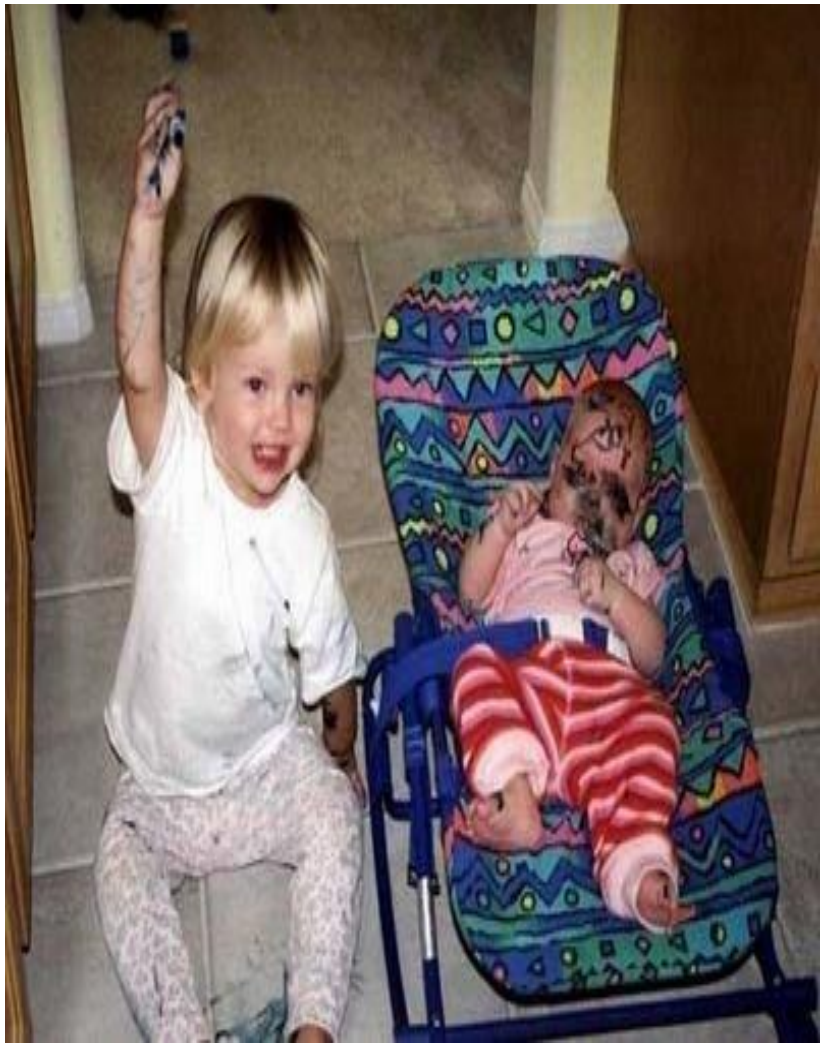
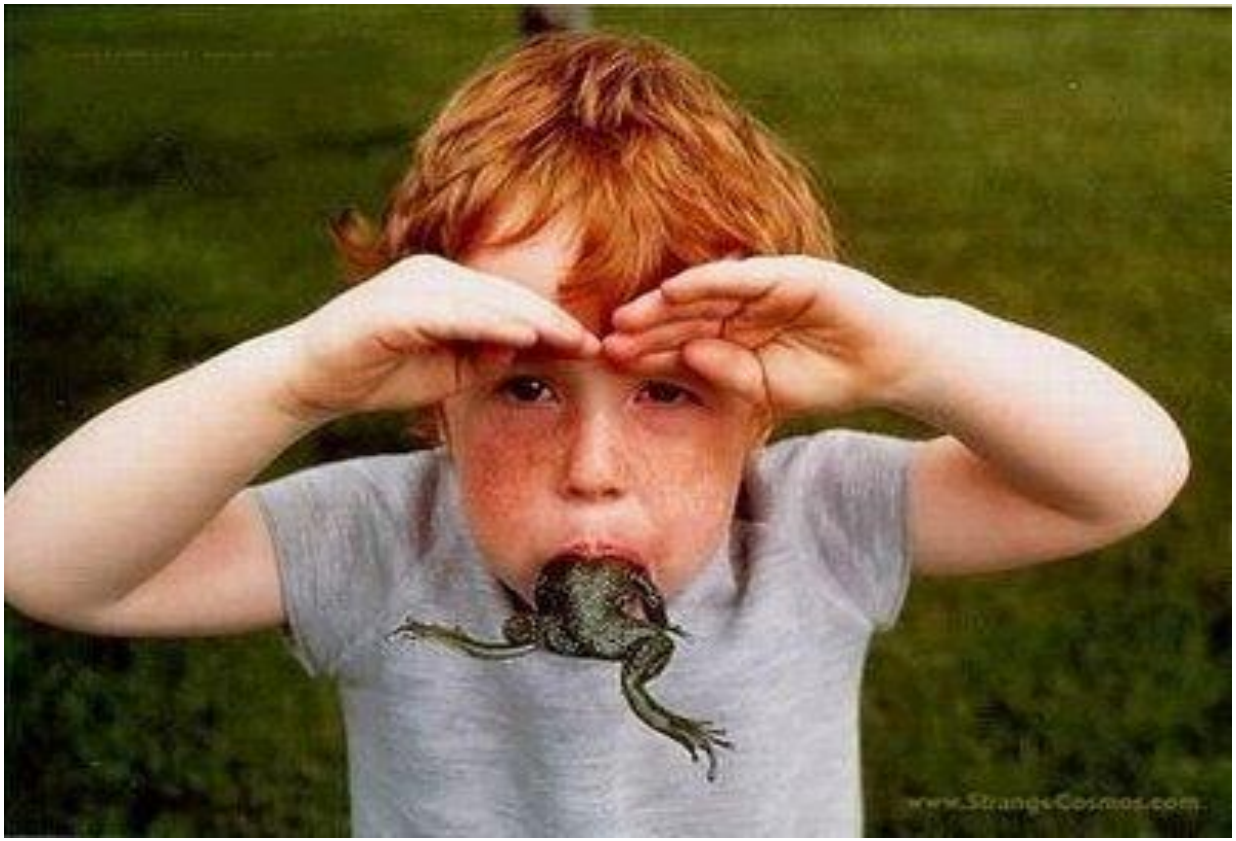


- What does a difficult child mean to you?

Could you be thinking of this?

Or this?

Or this?



The difficult child: possible reasons

- Normal, age-appropriate behaviour
- Difficult temperament
- Parental attributes e.g. Parent-child fit, the good enough parent, immature parent, insensitive to the child's physical and emotional needs

The difficult child

- Intellectual impairment e.g. Mental retardation
- Social impairment e.g. Autism
- Mood disorders e.g. Depression, Bipolar spectrum
- Anxiety disorders e.g. Separation anxiety disorder, PTSD

The difficult child

- Behavioural disorders e.g. ADHD, Conduct Disorder, Oppositional Defiant Disorder
- Psychotic Disorders e.g. Childhood Onset Schizophrenia
- Feeding and eating disorders e.g. Anorexia nervosa
- Bladder and bowel control e.g. Enuresis/ encopresis

Enuresis

Michael Angelo of Poop Paintin

not only did she go by herself but she made a pretty picture

Mixed messages?

Child and adolescent assessment :

- 1) Firstly collect demographic data e.g. age, school, with child and caregiver present. Observe interactions. This allows one to formulate a mental idea of the child's physical details and how those present relate to each other

Child and adolescent assessment

- 2. Next explore the presenting complaint with the caregivers and the child. Explore in detail with regards to onset, duration, perpetuating factors etc. Consider separating the child from the caregiver to get more accurate information

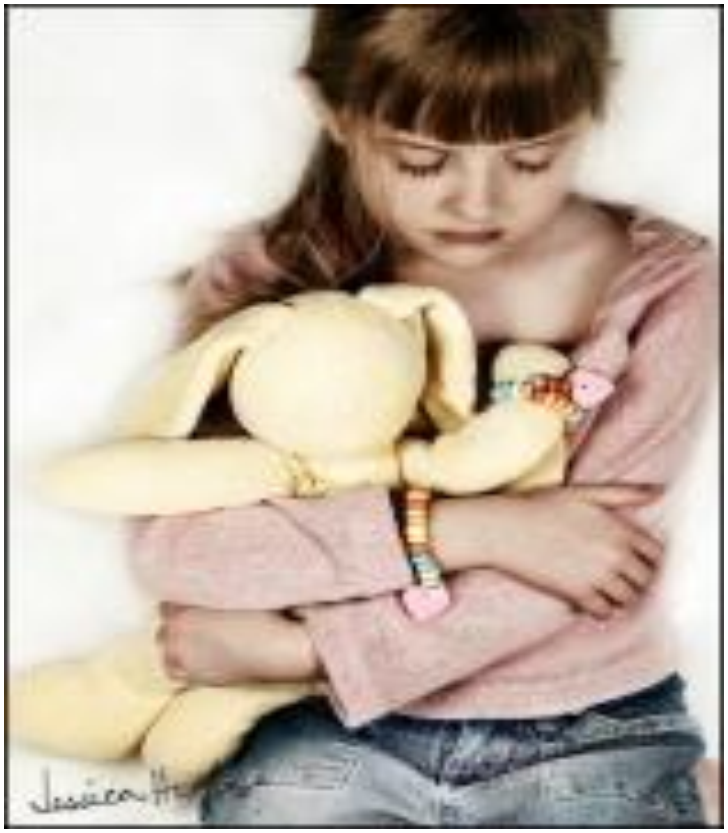
Assessment continued:

- 3. Find out what effect the problem/s have on current level of functioning e.g. interpersonal, academic, extra-murals.

Assessment continued:

- 4. Explore the family situation e.g. psychiatric history, substance usage, education level, relationships

Assessment continued:



- 5. Enquire about psychiatric symptoms e.g. mood, anxiety, psychotic, vegetative features

Assessment continued:

- 6. Developmental history e.g. details regarding pregnancy, early development

Assessment continued

- 7. School history e.g. academics, peers authority figures, changes, failed grades

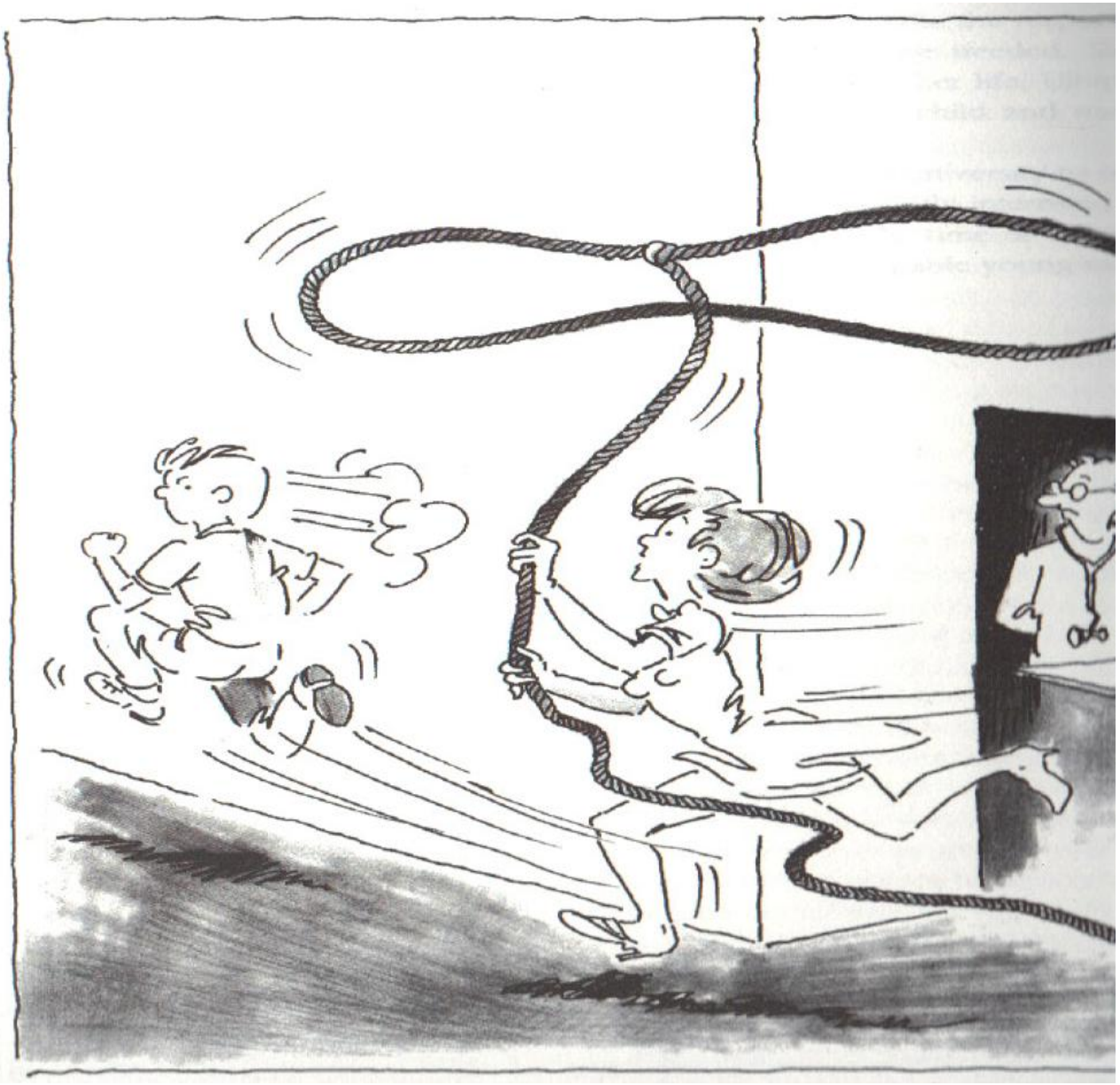
Assessment continued:

- 8. Interview child alone. One can use projective tests e.g. DAP (draw a person). Opens a window into how the child perceives their world in a nonintrusive manner..

Assessment continued:

- One can also assess crude level of intellectual functioning with good-enough DAP. Watch the child play-themes and perceptions emerge during play

ATTENTION DEFICIT HYPERACTIVITY DISORDER



Diagnosis DSMTR4:

- 6 or more symptoms of inattention:
  - careless mistakes, can't sustain attention, doesn't listen, can't organize tasks, avoids schoolwork, loses things, easily distracted, forgetful.
- 6 or more symptoms of hyperactivity- impulsivity:
  - Fidgeting or squirming, leaves seat, runs or climbs excessively, cannot play quietly, on the go, talks excessively, blurts out answers, cannot await turn, often interrupts.

Diagnosis:

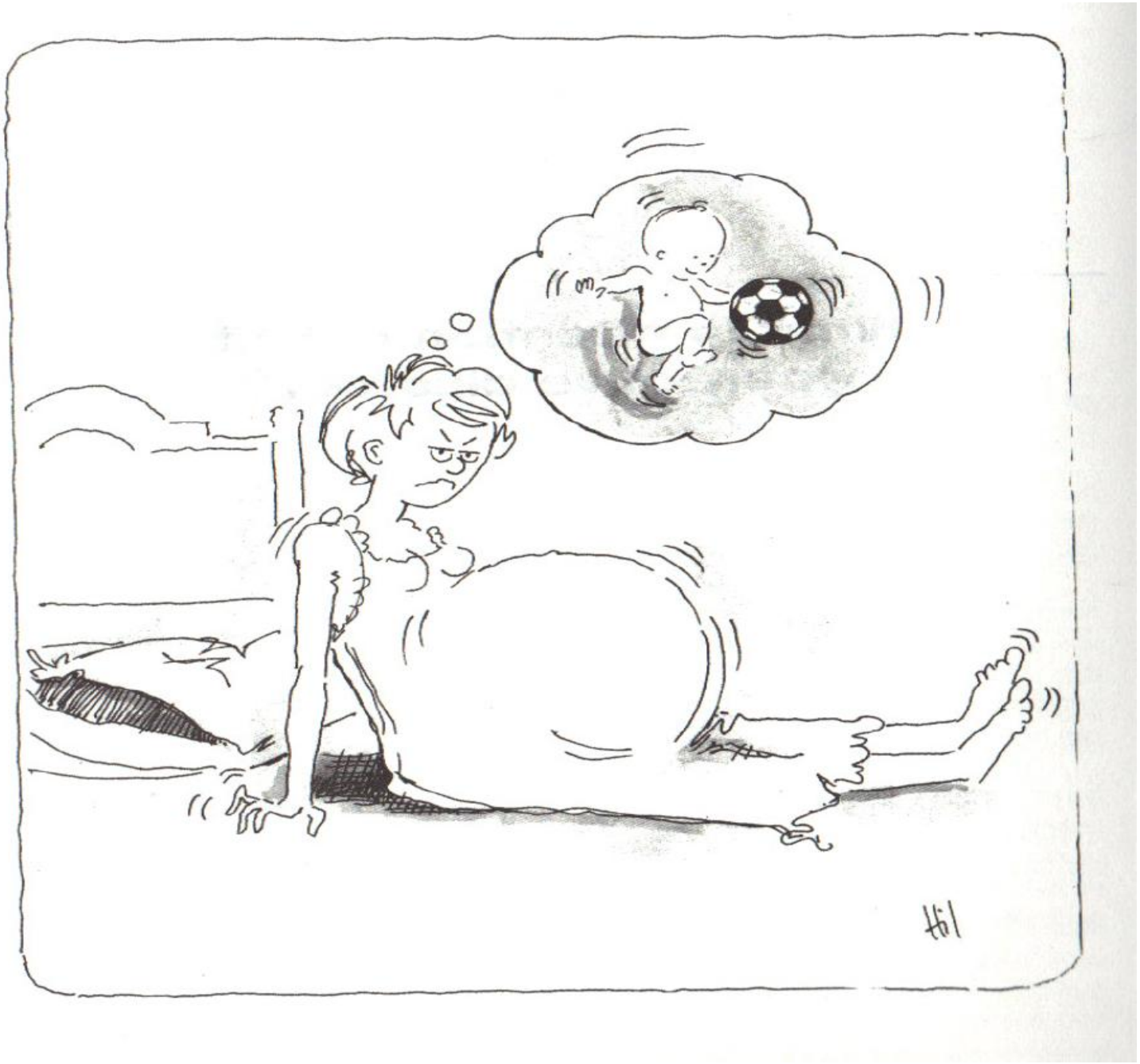
- Some symptoms have been present before age 7.
- Symptoms present for at least 6 months
- Symptoms present in at least 2 settings.
- Impairment of academic and / or social functioning.
- Not due to another Axis 1 disorder.
- Subtype: -combined type, predominantly inattentive or hyperactive-impulsive type

Clinical features

- Often keeps company with other disorders e.g. learning disorders, co-ordination problems, sensory integration issues, irritable mood, anxiety, behavioural problems
- Need to exclude medical problems that can present like ADHD e.g. abscence seizures

Aetiology

- Genetic factors:
  - Greater concordance in monozygotic twins.
  - Siblings have twice the risk to develop ADHD.
  - Biological parents have higher risk for ADHD.
  - 75% heritability



Aetiology

- Environmental factors e.g. Smoking, cocaine and alcohol during pregnancy
- Neurotransmitters : noradrenaline and dopamine involved

Course and prognosis

- The course of ADHD is very variable.
  - Symptoms may continue into adolescence (60%) and adulthood (30-60%).
  - Symptoms may fully remit.
  - Hyperactivity may disappear while attention problems persist.

Management

- Holistic approach includes bio-pscho-social interventions
- Scientific evidence: stimulants and behavioural techniques
- Stimulants include methylphenidate and amphetamines
- Non-stimulants include atomoxetine, bupropion, clonidine

Management

- Behavioural techniques include positive reinforcement e.g. star chart
- Social skills training including problem solving training
- Address co-morbidities e.g. learning disorders need remedial schooling, sensory integration issues need O.T.
- Family therapy
- Psycho-education

BEHAVIOURAL DISORDERS

Behaviour disorders

- This category in DSM-IVTR includes:
- Oppositional Defiant Disorder
- Conduct Disorder
  - Disruptive behavior disorder NOS

Oppositional Defiant Disorder

- This disorder is characterised by a consistent pattern of negativity, disobedience, hostile & defiant behaviour towards authority figures.
- The hostility does not normally go as far as physical aggression or significant destruction of property.

ODD diagnosis

- A pattern of negativistic, hostile, defiant behavior for 6 months during which 4 or more of following are present:
  - Loses temper, argues with adults, defies or refuses to comply with rules, annoys people, blames others, touchy, angry, spiteful.
- Clinically significant impairment in academic and social functioning.

ODD

- The behaviour is invariably present at home, but may be absent in other settings.
- The children usually do not see their behaviour as oppositional, but as a reaction to unfair circumstances

Course and prognosis

- 25% of children do not continue to meet the criteria for the disorder over a period of several years.
- The group with more severe aggression and / or a co-morbid diagnosis of ADHD are more likely to later develop conduct disorder.
- In an intact family the prognosis is better.

Treatment

- Family intervention:
  - Direct training of parents in child management skills and careful assessment of family interactions.
- Behavior therapy:
  - parent's should alter their behavior to discourage oppositional behavior (by ignoring not reinforcing) and encourage & reinforce appropriate behavior.
- Individual psychotherapy:
- Patterns of harsh and punitive parenting evoke aggression and can promote the development of Conduct Disorder.

CONDUCT DISORDER

Diagnosis DSM4TR:

- Repetitive and persistent pattern of behavior in which basic rights of others or major age-appropriate societal norms and rules are violated.
- 3 (or more) of the following must be present in the past 12 months and at least 1 in the past 6 months:

Conduct disorder

- Aggression to people and animals: bullies, fights, has used a weapon that can cause harm, cruel to people/animals, robbery, rape.

Diagnosis CD

- Destruction of property by fire-setting or other means.
- Deceitfulness/theft: house-breaking, often telling lies or shoplifting.
- Serious violations of rules: stays out against rules, has run away or often truant.

- Clinically significant impairment in school and social functioning.

Aetiology

- Child abuse and maltreatment:
  - Children chronically exposed to violence often behave aggressively.
  - Children with a pattern of hypervigilance and aggressive responses are more likely to violate the rights of others.
- Other factors:
  - CNS dysfunction or damage; and
  - Early extremes of temperament can predispose children to the development of CD.

Management

- No treatment is curative, but helps to contain symptoms and promote pro-social behaviour.
- Best result: Multimodal programs that use family and community resources.
- Structured environment with consistent rules and expected consequences.
- Evaluate family; if abusive and chaotic, remove child.
- Structured school setting to promote socially accepted behaviour toward peers.

THANK YOU FOR LISTENING