

## *Child and Adolescent Mental Health Issues*

Statistics compiled by the National Mental Health Association (NMHA)

- One in five children meets the criteria for a DSM-IV diagnosis.
- Attention deficit hyperactivity disorder (ADHD) is one of the most commonly diagnosed mental disorders in children, 3 to 5 percent of school-age children.
- As many as one in every 33 children and one in eight adolescents may meet the criteria for depression.
- Once a child experiences an episode of depression, he or she is at risk of having another episode within the next five years.
- Teenage girls are more likely to develop depression than teenage boys.
- Children and teens who have a chronic illness, endure abuse or neglect, or experience other trauma have an increased risk of depression.
- Suicide is the third leading cause of death for 15- to 24-year-olds and the sixth leading cause of death for 5- to 14-year-olds. The number of attempted suicides is even higher.

### Recommended Web Sites

NYC Department of Mental Health and Hygiene, Office of Child and Adolescent Services  
<http://www.nyc.gov/html/doh/html/dmh/cas.shtml>

US Department of Health and Human Services, Surgeon General's Report on Children's Mental Health <http://www.surgeongeneral.gov/topics/cmh/>

US Department of Health and Human Services, Surgeon General's Report on Youth Violence  
[http://hc.bbprod.cuny.edu/webapps/portal/frameset.jsp?tab=courses&url=%2Fbin%2Fcommon%2Fcourse.pl%3Fcourse\\_id%3D\\_20562\\_1](http://hc.bbprod.cuny.edu/webapps/portal/frameset.jsp?tab=courses&url=%2Fbin%2Fcommon%2Fcourse.pl%3Fcourse_id%3D_20562_1)

National Institute of Mental Health (NIMH), Autism Spectrum Disorders (listed in DSM-IV as Pervasive Developmental Disorders) <http://www.nimh.nih.gov/publicat/autism.cfm>

National Institutes of Health Consensus Development Program, Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder  
<http://consensus.nih.gov/1998/1998AttentionDeficitHyperactivityDisorder110html.htm>

National Institute of Mental Health (NIMH), Helping Children and Adolescents Cope with Violence and Disasters <http://www.nimh.nih.gov/publicat/violence.cfm>

Gender Identity Reform Advocates, DSM-IV-TR: Gender Identity Disorder in Children  
<http://www.transgender.org/gidr/gid3026.html>

Children's Global Assessment of Functioning Scale  
[http://www.health.nsw.gov.au/policy/cmh/mhoat/outcome\\_measures/CGASv1.pdf](http://www.health.nsw.gov.au/policy/cmh/mhoat/outcome_measures/CGASv1.pdf)

## Attention Deficit Hyperactivity Disorder (ADHD)

The principal characteristics of ADHD are inattention, hyperactivity, and impulsivity.

### IMPORTANT CAUTION:

When diagnosing ADHD it is important to gather information that will rule out other possible reasons for the child's behavior. Among possible causes of ADHD-like behavior are the following:

- A sudden change in the child's life—the death of a parent or grandparent; parents' divorce; a parent's job loss
- Undetected seizures, such as in petit mal or temporal lobe seizures
- A middle ear infection that causes intermittent hearing problems
- Medical disorders that may affect brain functioning
- Underachievement caused by learning disability
- Anxiety or depression.

## Conduct Disorder

Children diagnosed with conduct disorder repeatedly violate the personal or property rights of others and the basic expectations of society. A diagnosis of conduct disorder is likely when symptoms continue for 6 months or longer. Conduct disorder is known as a "disruptive behavior disorder" because of its impact on children and their families, neighbors, and schools.

Another disruptive behavior disorder, called oppositional defiant disorder, may be a precursor of conduct disorder. A child is diagnosed with oppositional defiant disorder when he or she shows signs of being hostile and defiant for at least 6 months. Oppositional defiant disorder may start as early as the preschool years, while conduct disorder generally appears when children are older. Oppositional defiant disorder and conduct disorder are not co-occurring conditions.

Symptoms which suggest consideration of the diagnostic category conduct disorder include:

- Aggressive behavior that harms or threatens other people or animals;
- Destructive behavior that damages or destroys property;
- Lying or theft;
- Truancy or other serious violations of rules;
- Early tobacco, alcohol, and substance use and abuse; and
- Precocious sexual activity.

From <http://mentalhealth.samhsa.gov/publications/allpubs/CA-0010/default.asp>

### IMPORTANT CAUTION:

Excerpt from Kirk, S.A. & Hsieh, D.K. (2004). Diagnostic consistency in assessing conduct disorder: An experiment on the effect of social context. *American Journal of Orthopsychiatry*, 74(1), 43-55.

In the case of adolescent antisocial behavior, we found that the likelihood of experienced clinicians reaching a particular *DSM* diagnosis is significantly altered when the social context of the behavior changes. Specifically, when the antisocial behavior is presented in the symptoms-only context, clinicians were more likely to consider the diagnoses of ODD and disruptive behavior disorders NOS/ADHD. When presented in a context that suggests an adaptive or expectable reaction to environmental circumstances, clinicians were less likely to diagnose CD but more likely to use adjustment disorders, no disorder/V-Codes, and adjustment reaction to adolescence. When the context suggested likely internal dysfunction, clinicians were more likely to indicate impulse-control disorders and mood disorders. One possible explanation of this pattern is that our context variations inadvertently contain elements that could suggest alternative diagnoses. For example, although all cases met the *DSM-IV* (American Psychiatric Association, 1994) diagnostic criteria of CD, in the internal dysfunction context the youth is described as having an explosive temper and as highly irritable, which could suggest impulse-control disorders (e.g., intermittent explosive disorder) or mood disorders. The environmental reaction context describes the youth's behavior to be a response to a threatening gang-filled environment, an identifiable psychosocial stressor, which could lead some clinicians to consider adjustment disorders. Nevertheless, this potential confound probably resembles the ambiguity encountered in the actual clinical situation. Furthermore, the fundamental point is that information about social context affects judgments about whether a disorder is present and which diagnosis is used. It is worth noting that this pattern mirrors a phenomenon commonly encountered in clinical practice: What initially appear to be disruptive behavior disorders on the basis of behavioral features may turn out to be mood disorders or adjustment disorders, as additional information about the youth's affective and social history becomes available. This underscores the critical importance of obtaining more complete information about the child's affective state and environmental circumstances, in addition to behavioral symptoms, in arriving at a valid diagnosis. It also shatters the illusion that diagnostic judgment can simply be a matter of matching presenting symptoms with *DSM* criteria, without the need to account for the social context.

## Trauma

The following information on trauma and its effects on children and adolescents and additional information on the topic can be found at: <http://www.nimh.nih.gov/publicat/violence.cfm>

"Trauma" has both a medical and a psychiatric definition. Medically, "trauma" refers to a serious or critical bodily injury, wound, or shock. This definition is often associated with trauma medicine practiced in emergency rooms and represents a popular view of the term. Psychiatrically, "trauma" has assumed a different meaning and refers to an experience that is emotionally painful, distressful, or shocking, which often results in lasting mental and physical effects.

Psychiatric trauma, or emotional harm, is essentially a normal response to an extreme event. It involves the creation of emotional memories about the distressful event that are stored in structures deep within the brain. In general, it is believed that the more direct the exposure to the traumatic event, the higher the risk for emotional harm. Thus in a school shooting, for example, the student who is injured probably will be most severely affected emotionally; and the student who sees a classmate shot, even killed, is likely to be more emotionally affected than the student who was in another part of the school when the violence occurred. But even second-hand exposure to violence can be traumatic. For this reason, all children and adolescents exposed to violence or a disaster, even if only through graphic media reports, should be watched for signs of emotional distress.

Reactions to trauma may appear immediately after the traumatic event or days and even weeks later. Loss of trust in adults and fear of the event occurring again are responses seen in many children and adolescents who have been exposed to traumatic events. Other reactions vary according to age:

For children 5 years of age and younger, typical reactions can include a fear of being separated from the parent, crying, whimpering, screaming, immobility and/or aimless motion, trembling, frightened facial expressions and excessive clinging. Parents may also notice children returning to behaviors exhibited at earlier ages (these are called regressive behaviors), such as thumb-sucking, bedwetting, and fear of darkness. Children in this age bracket tend to be strongly affected by the parents' reactions to the traumatic event.

Children 6 to 11 years old may show extreme withdrawal, disruptive behavior, and/or inability to pay attention. Regressive behaviors, nightmares, sleep problems, irrational fears, irritability, refusal to attend school, outbursts of anger and fighting are also common in traumatized children of this age. Also the child may complain of stomachaches or other bodily symptoms that have no medical basis. Schoolwork often suffers. Depression, anxiety, feelings of guilt and emotional numbing or "flatness" are often present as well.

Adolescents 12 to 17 years old may exhibit responses similar to those of adults, including flashbacks, nightmares, emotional numbing, avoidance of any reminders of the traumatic event, depression, substance abuse, problems with peers, and anti-social behavior. Also common are withdrawal and isolation, physical complaints, suicidal thoughts, school avoidance, academic decline, sleep disturbances, and confusion. The adolescent may feel extreme guilt over his or her failure to prevent injury or loss of life, and may harbor revenge fantasies that interfere with recovery from the trauma.

Some youngsters are more vulnerable to trauma than others, for reasons scientists don't fully understand. It has been shown that the impact of a traumatic event is likely to be greatest in the child or adolescent who previously has been the victim of child abuse or some other form of trauma, or who already had a mental health problem. And the youngster who lacks family support is more at risk for a poor recovery.

## Mental Retardation

Mental retardation is characterized both by a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life, such as communication, self-care, and getting along in social situations and school activities. Mental retardation is sometimes referred to as a cognitive or intellectual disability.

Children with mental retardation can and do learn new skills, but they develop more slowly than children with average intelligence and adaptive skills. There are different degrees of mental retardation, ranging from mild to profound. A person's level of mental retardation can be defined by their intelligence quotient (IQ), or by the types and amount of support they need.

From Department of Health and Human Services <http://www.cdc.gov/ncbddd/dd/ddmr.htm>

## Autism Spectrum Disorders

The autism spectrum disorders are more common in the pediatric population than are some better known disorders such as diabetes, spinal bifida, or Down syndrome.<sup>2</sup> Prevalence studies have been done in several states and also in the United Kingdom, Europe, and Asia. A recent study of a U.S. metropolitan area estimated that 3.4 of every 1,000 children 3-10 years old had autism.<sup>3</sup> This wide range of prevalence points to a need for earlier and more accurate screening for the symptoms of ASD. The earlier the disorder is diagnosed, the sooner the child can be helped through treatment interventions. Pediatricians, family physicians, daycare providers, teachers, and parents may initially dismiss signs of ASD, optimistically thinking the child is just a little slow and will "catch up." Although early intervention has a dramatic impact on reducing symptoms and increasing a child's ability to grow and learn new skills, it is estimated that *only 50 percent of children are diagnosed before kindergarten.*

All children with ASD demonstrate deficits in 1) social interaction, 2) verbal and nonverbal communication, and 3) repetitive behaviors or interests. In addition, they will often have unusual responses to sensory experiences, such as certain sounds or the way objects look. Each of these symptoms runs the gamut from mild to severe. They will present in each individual child differently. For instance, a child may have little trouble learning to read but exhibit extremely poor social interaction. Each child will display communication, social, and behavioral patterns that are individual but fit into the overall diagnosis of ASD.

Children with ASD do not follow the typical patterns of child development. In some children, hints of future problems may be apparent from birth. In most cases, the problems in communication and social skills become more noticeable as the child lags further behind other children the same age. Some other children start off well enough. Oftentimes between 12 and 36 months old, the differences in the way they react to people and other unusual behaviors become apparent. Some parents report the change as being sudden, and that their children start to reject people, act strangely, and lose language and social skills they had previously acquired. In other cases, there is a plateau, or leveling, of progress so that the difference between the child with autism and other children the same age becomes more noticeable.

ASD is defined by a certain set of behaviors that can range from the very mild to the severe. The following possible indicators of ASD were identified on the Public Health Training Network Webcast, *Autism Among Us*.<sup>4</sup>

#### Possible Indicators of Autism Spectrum Disorders

- Does not babble, point, or make meaningful gestures by 1 year of age
- Does not speak one word by 16 months
- Does not combine two words by 2 years
- Does not respond to name
- Loses language or social skills
- Some Other Indicators
- Poor eye contact
- Doesn't seem to know how to play with toys
- Excessively lines up toys or other objects
- Is attached to one particular toy or object
- Doesn't smile
- At times seems to be hearing impaired

From National Institute of Mental Health <http://www.nimh.nih.gov/publicat/autism.cfm#4>