



Interventions with Children and Adolescents

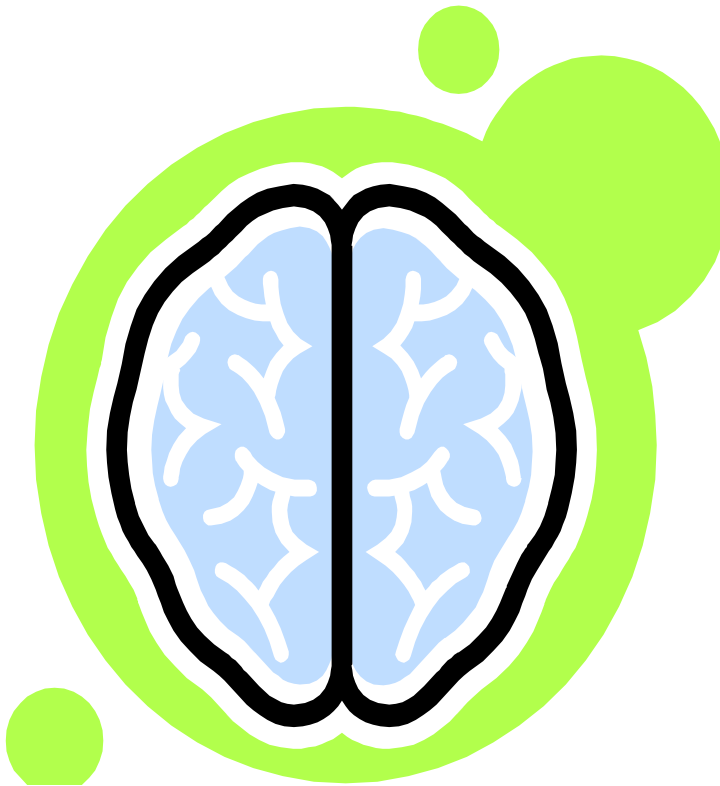
State of Georgia
Crisis Intervention Team
Training Program




Objectives

- Assessments of children and adolescents
- Most common diagnoses
- Treatment modalities
- Community resources
- Practical applications

Assessment



- Components of a complete diagnostic assessment include
 - Clinical history
 - Physical examination & laboratory tests
 - Mental status examination




Assessment – clinical history

- Interview both the child & parent / primary caregiver as well as other family members, teachers, daycare providers, juvenile court officials, DFCS staff
- Goal is to understand the factors contributing to the distress
 - explore current psychiatric symptoms, past psychiatric history, recent stressors, medical history, substance use, home environment, school, peer relationships, abuse / neglect, history of mental illness in relatives

Assessment – clinical history

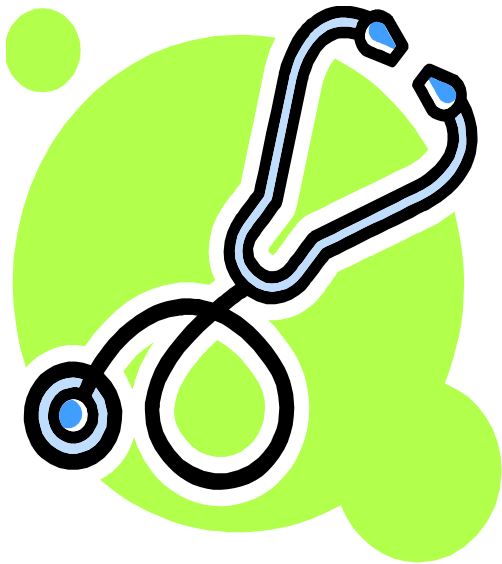
- Keep in mind
 - chronological (true age) & developmental age of the child
 - For younger children, you may want to physically be on their level to facilitate rapport
 - It often helps to begin with non-threatening topics first
 - With adolescents, it is important to assess risk
 - harm to self or others, self injurious behavior, substance use, high risk sexual behavior, abuse / neglect, legal issues



Assessment – clinical history

- Review records from previous mental health treatment, pediatrician, schools, agencies (DFCS, DJJ), psychological testing
- Can use standardized evaluation instruments such as behavior checklists to be completed by children, parents, and teachers

Assessment – physical examination



- Many diseases, both medical & psychiatric, can present with psychiatric symptoms
- It is imperative that children presenting with psychiatric symptoms have a physical exam (and laboratory tests depending on results of the physical exam) to rule out medical causes such as seizure disorder, genetic diseases, & neurodevelopmental disorders

Assessment – mental status examination

- A complete mental status examination includes
 - Appearance
 - Attitude / behavior
 - Psychomotor activity
 - Mood and affect
 - Speech
 - Thought processing
 - Thought content – suicidal & homicidal ideation, hallucinations, delusions
 - Insight & judgment
 - Cognitive / sensorium

Assessment – biopsychosocial model

- Biopsychosocial model
 - Biological system = family / genetic history, development, intelligence
 - Psychological system = emotional development, personality style, primary defenses
 - Social system = peers, community, economic status, race / ethnicity / culture, spirituality



Assessment of the family

- It is important to assess the family to understand the child
- Techniques such as the genogram (family tree) can be used but you can often learn about the family by asking caregivers questions and by observing the family (seating arrangement, attitudes, power)
- Be mindful of existing cultural factors to facilitate engaging the family in this process & better understand the child & the identified problem within a cultural framework

The power of observation



- Do not underestimate the power of observation
- Observe the child & others while they interact as this is very important regardless of the setting
- The old adage, actions speak louder than words, often rings true when working with youth

Assessment – putting it all together

- Once all the information has been collected, make a diagnosis based on DSM-IV
- Many people are not aware that youth may suffer from the same mental illnesses as adults but many times the symptoms are manifested differently
- Youth tend to be diagnosed more frequently with disruptive behavior disorders but more youth are also being diagnosed with depressive & anxiety disorders
- Often times, youth will have multiple diagnoses

Common diagnoses



- Disruptive behavior disorders
 - Attention Deficit Hyperactivity Disorder (ADHD)
 - Oppositional defiant disorder (ODD)
 - Conduct disorder (CD)
- Depressive disorders
- Anxiety disorders
- Substance use disorders

Attention Deficit Hyperactivity Disorder

- Inattention, hyperactivity, & impulsivity are the core symptoms of ADHD
- Impairment relative to expected developmental level in learning & following rules & difficulty in inhibiting impulsive responses to their own needs or external factors
- Great difficulty with motivation, sustained attention, organization, & completion of tasks when they are long, complex, difficult, or boring
- Prone to seek immediate gratification
- School problems include delayed learning, poor study skills, incomplete homework & tests with careless mistakes, & disruptive behavior

Attention Deficit Hyperactivity Disorder

- Peers often perceive children with ADHD as immature & irritating & often avoid them because of their low frustration tolerance, difficulty following rules, & intrusive, bossy behavior
- Children with ADHD may behave differently in different settings
 - When a child is in a highly structured environment or novel setting, is engaged in a stimulating activity, or is alone with an interested adult, symptoms may not be apparent at all
 - Symptoms typically worsen in situations that are unstructured, boring, & minimally supervised or that required sustained attention or mental effort

Oppositional Defiant Disorder

- Argumentative, disobedient, defiant behavior without serious violation of rights
- Anger-related symptoms directed at authority figures such as parents, teachers, & police officers
- Critical feature is self-defeating stance that youth take in arguments – may be willing to lose something they want rather than lose the battle or lose face

Conduct disorder



- Youth who repeatedly violate societal rules or personal rights of others
- Consequences of truancy & school suspensions combined with attention problems & learning disorders can lead to loss of interest in school, school failure & drop out, & eventual unemployment
- Youth with CD are at increased risk for early pregnancy, STDs, & physical injury from fights

Depressive disorders



- A depressed youth may look agitated & irritable rather than lethargic & may fail to make expected weight gains (particularly younger children)
- Childhood-onset depression is more likely to evolve into bipolar disorder
- A child who is depressed & suicidal may show more impulsive behavior like jumping in front of cars

Anxiety disorders



- An anxious child may be generally socially appropriate but quite clingy to his parents
- Generalized anxiety disorder (GAD)
 - shy, self-doubting, self-deprecating
 - pessimistic
 - may have somatic complaints
 - may be excessively compliant with authority
 - habits such as thumb sucking, nail biting, & hair pulling are common

Anxiety disorders



- Post-traumatic stress disorder (PTSD)
 - Occurs in youth who have experienced traumatic events such as physical / sexual abuse, rape, victim of violence or witness to family violence
 - Hallmark symptoms include re-experiencing trauma (nightmares, flashbacks), avoidance & numbing, hypervigilance
 - Can include fear of separation from parents or fear of death, may withdraw from new experiences, perceptual distortions, sleep disturbances, somatic symptoms, regression (irritability)



Substance use disorders

- The continuum of adolescent drug users ranges from nonusers, through experimental and casual users, to abuse & dependence
- The line between use & abuse is crossed more easily by young people than by adults
- Almost all adolescents referred for treatment of substance use have additional disorders such as ADHD, ODD, CD, depression, & anxiety disorders
 - Psychiatric disorders may predate substance use or be secondary to the substance use itself such as in substance-induced mood & psychotic disorders



Substance use disorders

- Risk factors for adolescent substance use include family history, peer influence (avoidance, initiation, & maintenance), low self-esteem, impulsivity, aggression, history of physical & sexual abuse, family dysfunction
- Substance use interferes with developing cognitive, social, & physical abilities
- Potential morbidity & mortality from substance use are substantial – increased suicidal ideation & behavior, risk of death from intentional or accidental overdose & dangerous behavior while intoxicated, indiscriminate sexual activity

Treatment



- Think biopsychosocial model
- Biological system – medications, hospitalization
- Psychological system – psychotherapy
- Social system – case management, residential treatment

Treatment – biological system



- Medications

- Psychiatric symptoms have been shown to improve with medications
- Sometimes youth are unable to benefit from other forms of treatment until they are assisted with medication
- BUT psychotropic medications in children are controversial!
- There are different classes of medication – stimulants, antidepressants, anxiolytics, mood stabilizers, antipsychotics

Treatment – biological system



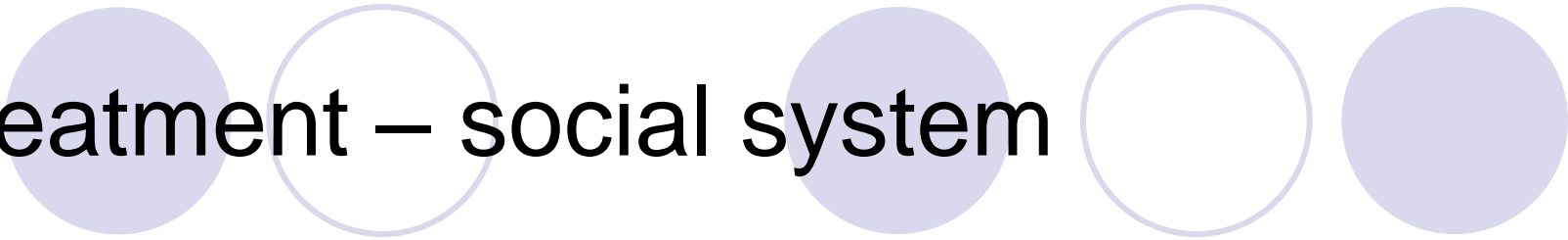
- Hospitalization

- If a child is an imminent danger to himself or others, hospitalization is appropriate for safety & stabilization

Treatment – psychological system

- There are many types of psychotherapy
 - Individual
 - Cognitive behavioral therapy
 - Psychodynamic psychotherapy & psychoanalysis
 - Play therapy which in young children is useful as they express themselves through play rather than words
 - Family
 - With family therapy you meet with family members to discuss how the youth's issues are impacting them but also to observe how the youth's behavior is impacted by the family
 - Many times the central issue for parents is loss of (or given up) power & the need to help parents regain that power
 - Group

Treatment – social system



- Case management – many schools & community mental health agencies have case managers to assist youth & families in getting connected with a variety of helpful resources
- Residential treatment
 - residential treatment facilities provide a safe environment for children & have treatment staff especially trained to deal with extreme behaviors
 - Psychiatrists, psychologists, licensed therapists, & case managers are often on staff to see youth multiple times a week
- Wrap around services



Community resources

- Youth are provided resources from multiple agencies - outpatient clinics, hospitals, schools, DFCS, recreational facilities, & other agencies
- These services include:
 - individual & family therapy
 - psychiatric monitoring
 - assistance with a child who has been abused / neglected
 - behavioral aide services
 - respite care
 - parenting education
 - mentoring
 - psychoeducational programs,
 - substance abuse treatment

Community Resources



- Due to the increasing numbers of single-parent families, these resources are very important
- Overall goal of many agencies is to keep children in their family although there are still a few residential treatment facilities accepting youth who cannot be managed in their family

So what does this mean for you?



Practical Applications

- Crisis
 - families call because they are in acute distress and in need of an intervention
 - the intervention usually involves a hospital assessment or further interaction with the legal system
- Red flags – suicidal & homicidal ideation, psychosis, substance intoxication
- Safety - assess the child's risk of harming himself or others
 - self-injurious behaviors, suicide attempts
 - level of aggression
- Psychosis - look for evidence of psychotic symptoms
 - does the child seem confused or out of it
 - are his or her words & actions making sense to you

Practical Applications



- Substance intoxication - look for evidence of substance use
 - does the child look high or intoxicated – pupil size, speech, belligerent or aggressive behavior
- Remember the developmental as well as the chronological age of the child as this colors your perception of the acuity of the situation and thus affects the disposition
- Problematic behaviors
 - truancy, runaway, destruction of property, assault
 - Legal involvement often the intervention of choice

Questions



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