

# CHILD AND ADOLESCENT INTERVENTION

## Overview

This lesson will focus on commonly encountered childhood disorders and ways in which young people with brain disorders are different from their adult counterparts. Disorders of childhood are most often marked by disturbances in behavior as opposed to thinking. Children suffer from some of the same brain disorders as adults but these sometimes present quite differently. Most of the behavioral disorders listed below are specifically excluded as diagnoses for adults. Adult ADHD is an exception.

### I. Common Childhood Disorders:

- A. Attention Deficit Hyperactivity Disorder (ADHD)** –Inattention, hyperactivity, and impulsivity are the core symptoms of ADHD. There is impairment relative to the expected developmental level in learning and following rules. There is also difficulty in inhibiting impulsive responses to their own needs or external factors. There is great difficulty with motivation, sustained attention, organization, and completing of tasks when they are long, complex, difficult, or boring. Children with ADHD are prone to seeking immediate gratification. Possible problems involving school include delayed learning, poor study skills, incomplete homework, tests with careless mistakes, and disruptive behavior. Peers often perceive children with ADHD as immature, irritating, and often avoid them because of their low frustration tolerance, difficulty following rules, and intrusive, bossy behavior.
- B. Oppositional Defiant Disorder (ODD)** –Children with ODD display behavior that is argumentative, disobedient, and defiant without the serious violation of rights. They have anger-related symptoms that are directed at authority figures such as parents, teachers, and/or police officers. The critical feature is a self-defeating stance that youth take in arguments; in other words, they may be willing to lose something they want rather than lose the battle or lose face.
- C. Conduct Disorder (CD)** –Youth with CD are children who repeatedly violate societal rules or the personal rights of others. Consequences include truancy and school suspensions combined with attention problems and learning disorders, which can lead to a loss of interest in school, school failure and drop out, and eventual unemployment. Youth with CD are at increased risk for early pregnancy, STDs, and physical injury from fights.

- D. Depression/Mood Disorders** –Differential diagnosis can be very difficult with young people. Irritability can be a sign of depression but could also be confused with one of the more behavioral disorders listed above. A depressed youth may look agitated and irritable rather than lethargic and may fail to make expected weight gains. Childhood-onset of depression is more likely to evolve into bipolar disorder later in life. A child who is depressed and suicidal may show more impulsive behavior like jumping in front of cars.
- E. Anxiety Disorders** –An anxious child may be generally socially appropriate but quite clingy to his or her parents. Generalized anxiety disorder (GAD) causes a child to be shy, self-doubting, self-deprecating, and pessimistic. He or she may have somatic complaints and may be excessively compliant with authority. Habits such as thumb sucking, nail biting, and hair pulling are common. Posttraumatic stress disorder (PTSD) is a specific type of anxiety disorder that occurs in youth who have experienced traumatic events such as physical or sexual abuse, rape, victimization, or witness to family violence. Hallmark symptoms include re-experiencing the trauma through nightmares and flashbacks, as well as avoidance, numbing, and hyper vigilance. It can include fear of separation from parents or fear of death so they may withdraw from new experiences. They may also have perceptual distortions, sleep disturbances, somatic symptoms, or regression.
- F. Substance Use Disorders** – The continuum of adolescent drug users ranges from nonusers through experimental and casual users to abuse and dependence. The line between use and 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, and/or anxiety disorders. Risk factors for adolescent substance use include family history, peer influence, low self-esteem, impulsivity, aggression, history of physical/sexual abuse, and family dysfunction. Substance use interferes with developing cognitive, social, and physical abilities. Potential morbidity and mortality from substance use are substantial. There is increased suicidal ideation, risk of death from intentional or accidental overdoses, dangerous behavior while intoxicated, and indiscriminate sexual activity.

## **II. Assessment and Treatment Strategies**

- A.** The assessment of the younger person takes many factors into account. It is often the case that children are not cognitively or emotionally mature enough to recognize and discuss issues regarding their inner experience.
- B.** Behavioral observation will often reveal what the young person is experiencing or struggling with. It can be their way of “telling you” what is wrong. Observations can be made in a variety of contexts and will often include family and other significant people in the children’s lives (i.e., teachers, other health care professionals.)

- C. Parents and other family members can have a profound impact on the mental state of a young person. Often the issue with the child is a manifestation of some conflict occurring within the family. Children will often “act out” what is going on with them instead of talking about it. The significance of the acting out in the family context will often provide clues to the issue that needs to be addressed. The child and a parent or primary caregiver should be interviewed as well as other family members, teachers, daycare providers, juvenile court officials, and DFCS staff.
- D. Significant events, either within the family or in some other context, can have a significant impact on the emotional well-being of a young person. It is important to review records from previous mental health treatment, pediatrician, schools, agencies, and psychological testing. Standardized evaluation instruments can be used such as the behavior checklists to be complete by children parents, and teachers.
- E. It is important to do a physical examination in order to confirm or rule out the presence of medical causes of the psychiatric symptoms. A complete mental status examination should also be performed and it includes appearance, attitude/behavior, psychomotor activity, mood and affect, speech, thought processing, thought content, insight and judgment, and cognitive function.
- F. Treatment is based on the biopsychosocial model. It involves a biological component such as medication and/or hospitalization. It also involves a psychological component like psychotherapy. There is also a social component that involves case management and residential treatment.

**1. Biological System:**

- a) Psychiatric symptoms have been shown to improve with medications
- b) BUT psychotropic medications in children are controversial!
- c) There are different classes of medication including stimulants, antidepressants, anxiolytics, mood stabilizers, and antipsychotics.
- d) If a child is an imminent danger to himself or others, hospitalization is appropriate for safety and stabilization.

**2. Psychological System:**

- e) Individual therapy including cognitive behavioral therapy, psychodynamic psychotherapy and psychoanalysis, and play therapy, which in young children is useful as they express themselves through play rather than words.
- f) Family therapy where 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.
- g) Group therapy is also utilized where the individual meets with groups of fellow youth.

### **3. Social System:**

- h)** Case management- many schools and community mental health agencies have case managers to assist youth and families in getting connected with a variety of helpful resources.
- i)** Residential treatment facilities provide a safe environment for children and have treatment staff especially trained to deal with extreme behaviors. They also have psychiatrists, psychologists, licensed therapists, and case managers.
- j)** Wrap around services are also available.

### **Wrap Up and Review**

As a result of your participation in this lesson you should now be able to recognize the signs and symptoms of commonly encountered childhood disorders, understand the ways in which young people suffering from brain disorders are different from similarly suffering adults, describe assessment and treatment strategies for children and adolescents and identify the types of services available for children and adolescents. Ultimately, when faced with a child or adolescent who is mentally ill and in crisis, you should be able to apply knowledge acquired from this lesson to assure a safe resolution for all concerned parties.