Child and Adolescent Psychiatry Overview

INSTRUCTOR:

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OUTLINE:

1. Introduction
    a. Key Components of Mental Health Assessment
    b. Interviewing children and adolescents
2. Specific Psychiatric Disorders
    a. Mood disorders
    b. Anxiety Disorders
    c. Obsessive and Compulsive Related Disorders
    d. Trauma and Stressor Related Disorders
    e. Disruptive, Impulse-Control, and Conduct Disorders
    f. Substance Use Disorders
    g. Psychosis
    h. Neurodevelopmental Disorders
    i. Elimination Disorders
3. Safety Planning (imbedded in discussion of mood disorders)

OBJECTIVES: After studying this unit you should be able to:

1. Differentiate between similar but unique diagnoses seen in child and adolescent psychiatry.

2. Understand that co-morbidity is common.

3. Understand key components of safety assessment and planning in youth.

READING REFERENCE:

1. JM Rey's IACAPAP e-Textbook of Child and Adolescent Mental Health (https://iacapap.org/english/)
2. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (accessed through psychiatryonline.org https://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596)

Child and Adolescent Psychiatry: An Overview, Part I

Focusing on Diagnoses Encountered in Pediatric Psychiatry

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Slides adapted from previous lecture sets from Drs. Koval and Gwynette

Learning Objectives

- Become familiar with psychiatric diagnoses in children and adolescents
- Differentiate between similar but unique diagnoses
- Understand co-morbidity is common
- Understand key components of safety assessment / planning in youth

Why is this important?

- Psychiatric disorders in children and adolescents are common
- They can have a huge cost to the child, family, and society
- Identification and treatment in childhood can lead to a long-term improvement in quality of life and decrease in impairment in functioning over the child's lifespan
- Primary care physicians are often treating childhood psychiatric disorders

Key Components of Mental Health Assessment

Mood	Interest, motivation, leisure functioning	Energy, activity	Concentration
Learning	Socialization	Sleep	Appetite / weight changes
Functioning at home, school, work	Thought content / process	Safety	Stressors

Interviewing Children

- Parents / guardians will be giving most of the history
- Creativity and enthusiasm are important
- Younger kids may have difficulty separating from parents for an individual interview and this is expected --- especially below the age of 8 --- but for kids 8-10 and over it is important to have at least a little time with just the child in an assessment
- Utilizing tools like art (having them draw a picture of something they love to do or of their family, for example) can be a useful exercise
- Appropriate / strategic toys (soft-covered blocks, dry erase or chalkboard, etc.) can be helpful in developing rapport or making kids feel comfortable and may also be useful in assessment of certain skills

Interviewing Adolescents

- Often they will not be the ones seeking help / prompting assessment (similar to younger children)
- Their goals for appointments may be different from their guardians or the ones bringing them for assessment / treatment
- Changes in mood, motivation, thought process, and thought content are best reported by the adolescent
- Changes in behavior, socialization, attention, and performance are best reported by others (parents, teachers, coaches, peers)
- Confidentiality (and limits to confidentiality) is important to discuss up front with teen and family
- For teens as opposed to younger children, often more time is spent directly with teen (for younger children, most of the history is gathered from family)

Specific Psychiatric Disorders *Diagnostic Criteria directly from DSM 5*

Mood Disorders

- Disruptive Mood Dysregulation Disorder (DMDD)
- Major Depressive Disorder
- Persistent Depressive Disorder (dysthymia)
- Premenstrual Dysphoric Disorder
- Substance/medication-induced Depressive Disorder
- Unspecified Depressive Disorder
- Bipolar disorder

Depression (DSM-5 Criteria Details with Specifications for Kids)

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)

- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain.)

Depression (Facts)

- High prevalence and significant consequences make it an important topic / something to be able to identify and treat
- More common in girls compared to boys after puberty (prior to puberty boys and girls have more similar prevalence rates)
- The earlier the onset, the worse the prognosis
- Higher risk for recurrence
- First identified episode of bipolar disorder is often a depressive episode

Depression in kids

- More likely to deny depressed mood than adults with depression
- Often present with irritable mood
- Complaints about school, friends, family
- Complaints of boredom
- Declining grades
- Decrease in pleasurable activities (quit band, sports, hobbies)
- Somatic complaints

Persistent Depressive Disorder (Dysthymia)
(DSM-5 Criteria Details with Specifications for Kids)

- Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years.
- **Note:** In children and adolescents, mood can be irritable and duration must be at least 1 year.

Disruptive Mood Dysregulation Disorder

- Diagnosis first seen in DSM-5 (2013)
- Placed in grouping with depressive disorders in DSM-5 to highlights kids with this pattern of symptoms are more likely to have depression as opposed to bipolar disorder in adulthood (per DSM)
- Diagnosis formulated in order to decrease potential for overdiagnosis of and treatment of bipolar disorder in kids
- For children up to age 12
- Core feature is chronic, persistent, severe irritability
- Co-morbidity extremely common

DMDD Criteria

A. Severe recurrent temper outbursts manifested verbally and/or behaviorally that are out of proportion to the situation
B. The outbursts are inconsistent with developmental level
C. The outbursts occur, on average, 3 or more times per week
D. The mood between outbursts is persistently irritable
E. Symptoms present in at least 2 settings
F. Diagnosis should not be made prior to age 6 or after age 18
G. Onset of symptoms is before age 10

Bipolar Disorder

- Common onset is late adolescence
- Lifetime prevalence ~ 1%
- Boys = girls
- 65% concordance in monozygotic twins
- Often doesn’t present with euphoric mood; irritable mood is much more common
- Substance use / abuse, promiscuous sexual activity, antisocial or criminal behavior can be presenting concerns

Suicide

- Suicide is the 2nd leading cause in youth aged 12-18
- Girls more likely to attempt but boys more likely to die by suicide
- LGBTQ+ population at elevated risk
- Risk Factors (from www.aacap.org, facts for families):
  - depression
  - family history of suicide attempts
  - exposure to violence
  - impulsivity
  - aggressive or disruptive behavior
  - access to firearms
  - bullying
  - feelings of hopelessness or helplessness
  - acute loss or rejection
  - Substance use / abuse (not on the facts for families page but an important risk factor)

Safety Planning for Suicide

Inquire directly about suicidal thoughts

Assess for ideation, plan, intent, means, preparation

Identify risk factors and protective factors

If access to guns, remove access. Access to potentially dangerous objects (medications, specify over the counter medications, and sharp objects)

Increased observation / direct monitoring is key

Hospitalization may be necessary

As opposed to adults, often safety planning can be easier given role of guardians

Anxiety Disorders

- Generalized Anxiety Disorder
- **Separation Anxiety Disorders**
- **Selective Mutism**
- Social Anxiety Disorder
- Panic Disorder
- Agoraphobia
- Specific Phobia
- Anxiety Disorder due to a General Medical Condition

Anxiety Disorders

- 10% of children have anxiety symptoms that interfere with their day-to-day functioning
- “Shy” children at higher risk for developing anxiety disorders
- Anxiety disorders can include hyperactivity and inattention as symptoms
  - Good evaluation for ADHD rules out anxiety
  - Anxiety and ADHD are also common co-morbidities
- Anxiety can interfere with learning / school, with relationships

Obsessive-Compulsive and Related Disorders

- Obsessive-Compulsive Disorder (OCD)
- Body Dysmorphic Disorder
- Hoarding Disorder
- Trichotillomania
- Excoriation (Skin-Picking) Disorder

Trauma and Stressor Related Disorders

- Adjustment Disorders
- Reactive Attachment Disorder, Disinhibited social engagement disorder
- Posttraumatic Stress Disorder

Reactive Attachment Disorder

- A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:
  - The child rarely or minimally seeks comfort when distressed.
  - The child rarely or minimally responds to comfort when distressed.
- A persistent social and emotional disturbance characterized by at least two of the following:
  - Minimal social and emotional responsiveness to others.
  - Limited positive affect.
  - Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.
- The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:
  - Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
  - Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
  - Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).
- The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the lack of adequate care in Criterion C).
- The criteria are not met for autism spectrum disorder.
- The disturbance is evident before age 5 years.

Disinhibited Social Engagement Disorder

- A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits at least two of the following:
  - Reduced or absent reticence in approaching and interacting with unfamiliar adults.
  - Overly familiar verbal or physical behavior (that is not consistent with culturally sanctioned and with age-appropriate social boundaries).
  - Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.
  - Willingness to go off with an unfamiliar adult with minimal or no hesitation.
- The behaviors in Criterion A are not limited to impulsivity (as in attention-deficit/hyperactivity disorder) but include socially disinhibited behavior.
- The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:
  - Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
  - Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
  - Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).
- The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).
- The child has a developmental age of at least 9 months.

PTSD

- Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
    - **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
- Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
    - **Note:** In children, there may be frightening dreams without recognizable content.
- Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
    - **Note:** In children, trauma-specific reenactment may occur in play.

Adverse Childhood Experiences (ACE) Study

- Higher numbers of adverse childhood experiences linked to higher rate of mental AND PHYSICAL consequences in adulthood.
- Adverse Childhood Experiences include psychological, physical, or sexual abuse, living with parents who had substance use disorders, depression/mental illness/suicide attempts, or were imprisoned, and parental separation.
- Most adults had at least one ACE.
- There was a graded relationship (the more ACEs the more negative consequences). People with greater than 4 categories of exposure are most at risk.
- Correlations include increased risk of obesity, smoking, alcoholism or substance use disorders, depression, suicide attempt, ischemic heart disease.
- Protective factors impact outcomes as well

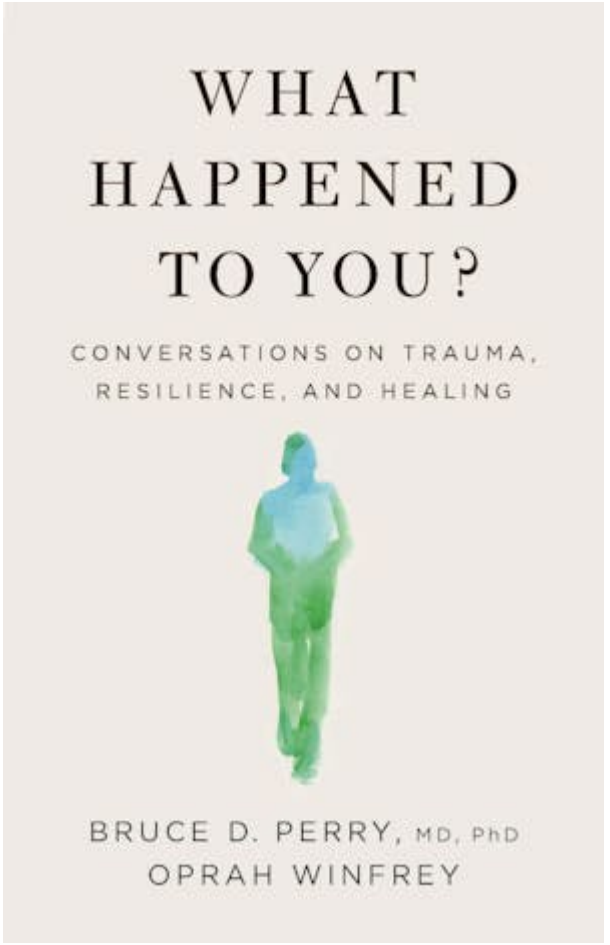
Vincent J Felitti, Robert F Anda, Dale Nordenberg, David F Williamson, Alison M Spitz, Valerie Edwards, Mary P Koss, James S Marks, Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study, American Journal of Preventive Medicine, Volume 14, Issue 4, 1998, Pages 245-258

Highly Recommended Read!!

What Happened to You?: Conversations on Trauma, Resilience, and Healing

published April 27, 2021

by Oprah Winfrey (Author), Bruce D. Perry (Author)



Adjustment Disorders

- The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
- These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:
  - Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.
  - Significant impairment in social, occupational, or other important areas of functioning.
- The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.
- The symptoms do not represent normal bereavement.
- Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.
- *Specify* whether: **with depressed mood, anxiety, mixed anxiety and depressed mood, disturbance of conduct, mixed disturbance of emotions and conduct**

Disruptive, Impulse-Control, and Conduct Disorders

Oppositional Defiant Disorder

Conduct Disorder

Oppositional Defiant Disorder (ODD)

- Important to look at biopsychosocial factors with all disorders of course, but very important to assess / treat ODD within context of interactions with caregivers (the treatment involves family therapy / behavior management)
- Behavior must be developmentally inappropriate to make the diagnosis (tantrums at age 2 do not mean ODD)
- Oppositional behavior often in two environments (home and school) but no longer has to be to meet criteria

ODD Criteria (DSM-5)

- A pattern of angry / irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months, during which 4 or more of the following are present:
  - Angry/irritable mood
  - Often looses temper
  - Is often touchy or easily annoyed
  - Is often angry or resentful
  - Often argues with authority figures
  - Often actively defies or refuses to comply with authority figures or rules
  - Often deliberately annoys others
  - Often blames others for his or her mistakes
  - Has been spiteful or vindictive at least twice during the past 6 months

ODD (Treatment)

- Assess for abuse (aggression)
- Behavior management support
- Consequences are important but reinforcement is more effective and should be a part of behavioral plan
- Point system, structure, supervision all important components
- Some evidence that medications can be helpful for ODD but primary treatment is family therapy
- Evaluate for co-morbidities and treat those and that can also indirectly help with ODD symptoms

Conduct Disorder (DSM-5 Criteria)

- A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least three of the following 15 criteria in the past 12 months from any of the categories below, with at least one criterion present in the past 6 months:
- **Aggression to People and Animals**
  - Often bullies, threatens, or intimidates others.
  - Often initiates physical fights.
  - Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun).
  - Has been physically cruel to people.
  - Has been physically cruel to animals.
  - Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery).
  - Has forced someone into sexual activity.
- **Destruction of Property**
  - Has deliberately engaged in fire setting with the intention of causing serious damage.
  - Has deliberately destroyed others' property (other than by fire setting).
- **Deceitfulness or Theft**
  - Has broken into someone else's house, building, or car.
  - Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others).
  - Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery).
- **Serious Violations of Rules**
  - Often stays out at night despite parental prohibitions, beginning before age 13 years.
  - Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period.
  - Is often truant from school, beginning before age 13 years.

Other Disorders

Substance Use Disorders

Psychosis

Substance Use Disorders

- Difficult to identify younger age limit; do not assume young child has never used
- 12% of high school seniors have engaged in binge drinking within the past 2 weeks*
- 27% of students have used an illicit drug (combination of 8th, 10th, and 12th graders)*
  - Hovered between 32-34% since 2006 other than in 2021
  - Most of this accounted for is marijuana use (23.1% in 2021 data)
- Cigarette use usually initiated in adolescence
- Most kids who experiment with substances do NOT go on to develop serious problems but for those that do the the consequences can be grave (acute consequences like MVA, increased risk for substance use disorders later in life)
- Perceived harmfulness indirectly correlated to prevalence of use

*data from Monitoring the Future Study published 2021 (there was a sharp decline in substance use among teens in according to this study between 2020 and 2021 possibly due to pandemic)

Substance Use Screening

- All youth should be routinely screened for substance use
- All use is problematic / concerning in youth
- CAGE does not have as much validity as in adults
- CRAFFT is useful tool

CRAFFT

www.ceasar.org, Dr. Knight

- Screening tool for teens age 12-21

During the past 12 months, on how many days did you:

1. Drink more than a few sips of beer, wine, or any drink containing alcohol?

2. Use marijuana (pot, weed, hash, or in foods) or “synthetic marijuana” (like K2, spice) or “vaping” THC oil?

3. Use anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff or “huff”)?

If you put 1 or higher in ANY box, the following questions are asked:

- Have you ever ridden in a **C**AR driving by someone (including yourself) who was “high” or had been using alcohol or drugs?
- Do you ever use alcohol or drugs to **R**ELAX, feel better about yourself, or fit in?
- Do you ever use alcohol or drugs while you are by yourself, or **A**LONE?
- Do you ever **F**ORGET things you did while using alcohol or drugs?
- Do your **F**AMILY or **F**RIENDS ever tell you that you should cut down on your drinking or drug use?
- Have you ever got in **T**ROUBLE while you were using alcohol or drugs?

Psychosis

- “hearing voices” is much more common in youth than psychotic disorders themselves
  - A child reporting ‘hearing voices’ does not automatically mean a psychotic disorder
    - Young children can have trouble distinguishing between their own thoughts and voices
    - ‘Imaginary friend’ developmentally normal in younger kids
    - Reports of hearing voices in teens do not mean elevated risk for psychotic disorders but are correlated with diagnosis of some sort in adulthood
- Schizophrenia in males does have common onset in late teens / early adulthood
- Psychosis in children involves thorough medical work-up (labs, MRI, EEG)

Child and Adolescent Psychiatry: An Overview, Part II

Focusing on Diagnoses Encountered in Pediatric Psychiatry

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Neurodevelopmental Disorders

- Intellectual Disabilities
- Communication Disorders
- ASD
- ADHD
- Tic Disorders
- Learning Disorders

Intellectual Disabilities

- Intellectual disability (intellectual developmental disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following three criteria must be met:
- Deficits in **intellectual functions**, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.
- Deficits in **adaptive functioning** that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.
- Onset of intellectual and adaptive deficits during the developmental period.

Severity

- Mild
- Moderate
- Severe
- Profound

In DSM 5, severity is based on adaptive functioning, not on specific IQ number.

Individuals with intellectual disability typically have scores two standard deviations or more below the mean on intellectual functioning tests.

Prevalence is about 1%.

Communication Disorders

- Language Disorder
  - Reduced vocabulary
  - Limited sentence structure
  - Impairments in conversation
- Speech Sound Disorder
  - Difficulty with speech sound production
- Childhood-Onset Fluency Disorder (Stuttering)
- Social Communication Disorder

Social Communication Disorder

- Persistent difficulties in the social use of verbal and nonverbal communication as manifested by all of the following:
  - Deficits in using communication for social purposes, such as greeting and sharing information, in a manner that is appropriate for the social context.
  - Impairment of the ability to change communication to match context or the needs of the listener, such as speaking differently in a classroom than on a playground, talking differently to a child than to an adult, and avoiding use of overly formal language.
  - Difficulties following rules for conversation and storytelling, such as taking turns in conversation, rephrasing when misunderstood, and knowing how to use verbal and nonverbal signals to regulate interaction.
  - Difficulties understanding what is not explicitly stated (e.g., making inferences) and nonliteral or ambiguous meanings of language (e.g., idioms, humor, metaphors, multiple meanings that depend on the context for interpretation).

Autism Spectrum Disorders

Prevalence of 1 in 44 children (2018 data from CDC)

4x more common in boys

Reported to occur in all racial, ethnic, and socioeconomic groups

Autism Spectrum Disorders

- Persistent deficits in social communication and social interaction across multiple contexts, as manifested by all of the following, currently or by history (examples are illustrative, not exhaustive; see text):
  - **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.
  - **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.
  - **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.

Autism Spectrum Disorders (continued)

- **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):
  - **Stereotyped or repetitive motor movements**, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
  - Insistence on sameness**, inflexible adherence to routines**, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
  - **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 interests).
  - **Hyper- or hyporeactivity to sensory input** or unusual interest 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).

ASD Specifiers

- With or without accompanying intellectual impairment
  - Remember, not all people with ASD have intellectual impairment and some are extremely intelligent
  - Asperger's Syndrome is NOT in DSM 5
- With or without accompanying language impairment
- Associated with a known medical or genetic condition or environmental factor
- Associated with another neurodevelopmental, mental, or behavioral disorder

ASD evaluations

- American Academy of Pediatrics recommends *screening* for ASD at 18 and 24-month check-ups.
  - M-Chat is a common screening tool used in pediatrics offices for children ages 16 months to 30 months
- Screening indicates need for comprehensive developmental evaluation
  - Structured tests include Autism Diagnostic Interview (ADI), Autism Diagnostic Observation Scale (ADOS), and Childhood Autism Rating Scale (CARS)

Attention-Deficit/Hyperactivity Disorder

- A persistent pattern of **inattention and/or hyperactivity-impulsivity** that interferes with functioning or development
- Symptoms are INCONSISTENT WITH DEVELOPMENTAL LEVEL
- Symptoms persist at least 6 months (i.e. it is a chronic disorder)
- At least some symptoms are present in two or more settings
- Symptoms present before the age of 12 (ADHD begins in childhood)
- Prevalence 5% of children (although some variation depending on source)
- Symptoms interfere with social, academic, and occupational functioning

Inattention Symptoms (need at least 6)

- Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
- Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
- Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
- Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).
- Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).
- Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).
- Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
- Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
- Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

Hyperactivity and impulsivity symptoms (at least 6)

- Often fidgets with or taps hands or feet or squirms in seat.
- Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).
- Often runs about or climbs in situations where it is inappropriate. (**Note:** In adolescents or adults, may be limited to feeling restless.)
- Often unable to play or engage in leisure activities quietly.
- Is often “on the go,” acting as if “driven by a motor” (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
- Often talks excessively.
- Often blurts out an answer before a question has been completed (e.g., completes people’s sentences; cannot wait for turn in conversation).
- Often has difficulty waiting his or her turn (e.g., while waiting in line).
- Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people’s things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

Specific Learning Disorder

READING

WRITING

MATH

Tic Disorders

Tourette's Disorder

- Both multiple motor and one or more vocal tics have been present at some time during the illness, although not necessarily concurrently.
- The tics may wax and wane in frequency but have persisted for more than 1 year since first tic onset.
- Onset is before age 18 years.

Persistent (chronic) motor or verbal tic disorder

- Single or multiple motor or vocal tics have been present during the illness, but not both motor and vocal.
- The tics may wax and wane in frequency but have persisted for more than 1 year since first tic onset.
- Onset is before age 18 years.

Provisional Tic Disorder

- Single or multiple motor and/or vocal tics.
- The tics have been present for less than 1 year since first tic onset.

Tics

Generally start between age 4-6, peak age 10-12, then decline

Tourette videos

https://tourette.org/about-tourette/stories-that-inspire/

https://www.youtube.com/watch?v=OXx-VeDB9-g

Elimination Disorders

Incontinence

Encopresis

Enuresis

- Repeated voiding of urine into bed or clothes, whether involuntary or intentional.
- The behavior is clinically significant as manifested by either a frequency of at least twice a week for at least 3 consecutive months or the presence of clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
- Chronological age is at least 5 years (or equivalent developmental level).
- The behavior is not attributable to the physiological effects of a substance (e.g., a diuretic, an antipsychotic medication) or another medical condition (e.g., diabetes, spina bifida, a seizure disorder).

Enuresis (continued)

- Prevalence
  - 5-10% in 5-year-olds
  - 3-5% in 10-year-olds
  - ~1% in those aged 15 or older
- Primary or secondary

Encopresis

- Repeated passage of feces into inappropriate places (e.g., clothing, floor), whether involuntary or intentional.
- At least one such event occurs each month for at least 3 months.
- Chronological age is at least 4 years (or equivalent developmental level).
- The behavior is not attributable to the physiological effects of a substance (e.g., laxatives) or another medical condition except through a mechanism involving constipation.
- Prevalence is about 1% in 5-year-olds
- *Specify* whether:
  - **With constipation and overflow incontinence:** There is evidence of constipation on physical examination or by history.
  - **Without constipation and overflow incontinence:** There is no evidence of constipation on physical examination or by history.

Practice Questions

1. Which is not true about ADHD?

   A. Symptoms need to be present before age 7
   B. Core features are impulsivity, hyperactivity, and inattention
   C. Its prevalence ranges from 5-12 % in school aged children
   D. Stimulants are most effective treatment
   E. Co-morbidities are common

2. How do we diagnose ADHD?

   A. Computerized test
   B. Paper and pencil test
   C. Lab test
   D. Clinical interview involving collateral information

Practice Questions

3. Which symptom is more likely to be present in adolescents with depression compared to adults with depression?

   A. Change in appetite

   B. Irritable mood

   C. Inattention

   D. Impaired sleep

   E. Anhedonia

4. Which of the following are criteria for Autism?

   A. Deficits in social communication and interaction

   B. Restricted and/or repetitive behaviors, interests, or activities

   C. Intellectual impairment

   D. A and B

   E. A, B, and C