Child Psychiatry

- Childhood disorders of psychological development and behavioural and emotional disorders with onset usually occuring in childhood and adolescence .

classification

- Specific deveolpmental disorders
- Perversive developmental disorders
- Hyperkinetic disorders
- Conduct disorders
- Tic disorders
- Enuresis and encopresis
- Speech disorders
- Habit disoders

Child and Adolescent Psychiatry

Differences of Child psychiatry from adult psychiatry:

- The child’s existence and emotional development depends on the family or care givers - cooperation with family members; sometimes written consent
- The developmental stages are very important assessment of the diagnosis
- Use of psychopharmacotherapy is less common in comparison to adult psychiatry
- Children are less able to express themselves in words
- The child who suffers by psychiatric problems in childhood can be an emotionally stable person in adulthood, but some of the psychic disturbances can change a whole life of the child and his family

Disorders of Psychological Development

1. Specific developmental disorders of speech and language
2. Specific developmental disorders of scholastic skills
3. Specific developmental disorder of motor function
4. Mixed specific developmental disorders
5. Pervasive developmental disorders
6. Other disorders of psychological development
7. Unspecified disorder of psychological development

Specific Developmental Disorders of Speech and Language

1. Specific speech articulation disorder
2. Expressive language disorder
3. Receptive language disorder
4. Acquired aphasia with epilepsy (Landau-Kleffner)
5. Other developmental disorders of speech and language
6. Developmental disorder of speech and language, unspecified

Specific Speech Articulation Disorder

- A specific developmental disorder in which the child's use of speech sounds is below the appropriate level for its mental age, but in which there is a normal level of language skills.
- The articulation abnormalities are not caused by a neurological abnormality and nonverbal intelligence is within normal range.
- Developmental:
  - phonological disorder
  - speech articulation disorder
- Dyslalia
- Functional speech articulation disorder

Expressive Language Disorder

- A specific developmental disorder in which the child's ability to use expressive spoken language is markedly below the appropriate level for its mental age, but in which language comprehension is within normal limits.
- There may or may not be abnormalities in articulation.

- Developmental dysphasia or aphasia, expressive type

Receptive Language Disorder

- A specific developmental disorder in which the child's understanding of language is below the appropriate level for its mental age, particularly in more subtle aspects of language - grammatical structures, tone of voice.
- The social reciprocity and make- believe play is normal and severe hearing disturbances are not present.

- Developmental:
  - dysphasia or aphasia, receptive type
  - Wernicke's aphasia
- Word deafness

Acquired Aphasia with Epilepsy (Landau-Kleffner)

- The child loses receptive and expressive language skills after previous period of normal language development. The paroxysmal abnormalities on the EEG are present and in the majority of cases epileptic seizures occur as well.
- Some children become mute in a period of few months.
- Usually the onset is between the ages of three and seven years, with skills being lost over days or weeks.
- An inflammatory encephalitic process has been suggested as a possible cause of this disorder.
- About two-thirds of patients are left with a more or less severe receptive language deficit.

Treatment

- Cooperation of neurologist and speech therapist is very important.
- Psychiatric treatment is necessary if the child has secondary psychic problems, for example in relationship with other children or family.
- Nootropic drugs, psychotherapy and special education are useful.

Specific Developmental Disorders of Scholastic Skills

- Disorders in which the normal patterns of skill acquisition are disturbed from the early stages of development.

1. Specific reading disorder
2. Specific spelling disorder
3. Specific disorder of arithmetical skills
4. Mixed disorder of scholastic skills
5. Other developmental disorders of scholastic skills
6. Developmental disorder of scholastic skills, unspecified

Specific Reading Disorder

- The child’s reading performance is below his level of mental age. Poor schooling, mental or visual impairment is not the cause of the delay.
- The child has difficulties in reciting the alphabet, there are omissions of words, distortions of the content of the facts from material read and rate of reading is very slow.
- Associated emotional and behavioural disturbances are common during the school age period.

  - "Backward reading"
  - Developmental dyslexia
  - Specific reading retardation

Specific Spelling Disorder

- Specific and significant impairment in the development of spelling skills in the absence of a history of specific reading disorder, which is not solely accounted for by low mental age, visual acuity problems, or inadequate schooling.
- The ability to spell orally and to write out words correctly are both affected.

  - Specific spelling retardation (without reading disorder)

Specific Disorder of Arithmetical Skills

- The arithmetical performance is significantly below the level of the general intelligence, reading and spelling skills are within normal rage.
- The deficit concerns mastery of basic computational skills of addition, subtraction, multiplication, and division rather than of the more abstract mathematical skills involved in algebra, trigonometry, geometry, or calculus.

Developmental:

- acalculia
- arithmetical disorder
- Gerstmann's syndrome

Mixed Disorder of Scholastic Skills

- The child can suffer from all previously described specific developmental disorder of scholastic skills (both arithmetical and reading or spelling skills are significantly impaired)
- Disorder is not solely explicable in terms of general mental retardation or of inadequate schooling

Specific Developmental Disorder of Motor Function

- Serious impairment in the development of motor coordination that is not solely explicable in terms of general intellectual retardation or of any specific congenital or acquired neurological disorder
- The child is generally clumsy in fine and gross movements; there are difficulties in learning to tie shoe laces, to run, to throw the balls. Drawing skills are usually also poor
- In most cases - marked neurodevelopmental immaturities
  - Clumsy child syndrome
  - Developmental:
    - coordination disorder
    - dyspraxia

Treatment

- The family and the school have to be properly informed about the child’s disorder.
- Special educational training is necessary, nootropic drugs are useful.
- For children with coordination difficulties special physical education programs may be help to enhance the child’s self-esteem and ability to interact with peers.

Pervasive Developmental Disorders

- Disorders characterized by qualitative abnormalities in reciprocal social interactions and in patterns of communication, and by a restricted, stereotyped, repetitive repertoire of interests and activities.

1. Childhood autism
2. Atypical autism
3. Rett's syndrome
4. Other childhood disintegrative disorder
5. Overactive disorder associated with mental retardation and stereotyped movements
6. Asperger's syndrome
7. Other pervasive developmental disorders
8. Pervasive developmental disorder, unspecified
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AUTISM

AUTISM

- Is a disorder characterized by impairment in communication skills, or the presence of stereotyped behavior, interests and activities with associated impairment in social interactions
- More common among boys
- Usually diagnosed at age 2
- It is treatable but not curable
- Impaired interpersonal functioning

MOST ACCEPTABLE CAUSE OF AUTISM

- Biological Factors
  - Brain anoxia
  - Intake of drugs

MOST COMMON SIGNS AND SYMPTOMS OF AUTISM

- Resist normal teaching method
- Silly laughing or giggling
- Echolalia
- Acts as deaf
- No fear of danger
- Insensitive to pain
- Crying tantrums
- Loves to spin objects

MOST COMMON SIGNS AND SYMPTOMS OF AUTISM

- Resists change in the routine
- Sustained odd play
- Difficulty interacting with others
- No eye contact
- Wants blocks and not balls
- Points to anything
- Attachment to inanimate objects

COMMON PROBLEMS AND APPROPRIATE MANAGEMENT

- Tantrums-Risk for injury
  - Involves head-banging
  - Place a helmet on the head

- Communication
  - All vowels
  - Use of short sentences when talking to the child

- Routines
  - Provide consistency

- **Behavioural therapy** :
- Development of regular routine with a few changes as possible
- Structured classroom training
- Positive reinforcements to teach self-care skills
- Speech therapy
- Behavioural techniques to encourage interpersonal interactions

- **Psychotherapy:**
- Parental counselling and supportive psychotherapy
- Usefull in allaying parental anxiety and quilt and helping their active involvement in therapy
- Overstimulation of child should be avoided during treatment.

- **Pharmacology :**
- Haloperidol decreases dopamine hence decreasing hyperactivity and behavioural symptoms
- Risperidone atypical antipsychotic may be used
- Anticonvulsant used for rx of generalized or other seizures if present

Childhood Autism

- Described by Kanner 1943 as infantile autisms
- Autisms are severe impairment of developmental disorder which presents before age of 3 years.
- The abnormal functioning manifest in the area of social interaction, communication and repetitive behaviour
- There are typical features of clinical picture:
  - Inability to relate
  - Disorders in development of speech
  - Cognitive abnormalities
  - Stereotyped behaviour

Childhood Autism

- The cause of childhood autism is unknown, studies of twins suggest genetic etiology
- The deficits continue through whole life; great impact on his abilities to socialize and communicate with other people
- 60-80% of autistic children are unable to lead independent life
- IQ level can be normal
- 30-40 cases per 100 000 children; more common in boys than in girls

  - Autistic disorder
    - Infantile:
    - autism
    - psychosis
  - Kanner's syndrome

Treatment

- Specific treatment is unknown.
- Autistic children usually require special schooling or residential schooling although attempts of integrations are also started.
- Special techniques for teaching autistic children and special psychotherapeutic approaches were developed.
- Sometimes antipsychotic drugs and antidepressants are used to cope with aggressive behaviour and depression.

Atypical Autism

- A type of pervasive developmental disorder that differs from childhood autism either in age of onset or in failing to fulfill all diagnostic criteria
- Abnormal and impaired development manifests after age 3 years or there are impairments in communication and stereotyped behaviour is present, but emotional response to caregivers is not affected.
- Atypical autism is diagnosed often in profoundly retarded individuals.

  – Atypical childhood psychosis
  – Mental retardation with autistic features

Rett's Syndrome (Described by Rett 1964)

- The syndrome was described only in girls
- Normal early development is followed by partial or complete loss of speech and of skills in locomotion and use of hands, together with deceleration in head growth
- In most cases onset is between 7 and 24 months of age.
- Loss of purposive hand movements, hand-wringing stereotypies, and hyperventilation
- Social interaction is poor in early childhood, but can develop later
- Motor functioning is more affected in middle childhood, muscles are hypotonic, kyphoscoliosis and rigid spasticity in the lower limbs occurs in majority of cases
- Aggressive behaviour and self injury are rather rare, the antipsychotic drugs for the control of challenging behaviour is not often needed.

Asperger's Syndrome

- Described by Asperger as autistic psychopathy in 1944.
- Characterized by the same kind of impairment of social activities and stereotyped features of behaviour as is described in autistic children. There is no delay of speech and cognitive development. The condition occurs predominantly in boys (8:1)
- Often associated with marked clumsiness.
- There is a strong tendency for the abnormalities to persist into adolescence and adult life.
- Psychotic episodes occasionally occur in early adult life.

  - Autistic psychopathy
  - Schizoid disorder of childhood

Other Childhood Disintegrative Disorder

- These are very rare developmental disorders with a short period of normal development before onset. The child looses his acquired skills within few months.
- General loss of interest in the environment, stereotyped, repetitive motor mannerisms, and autistic-like abnormalities in social interaction and communication.
- These children usually remain without speech and unable to lead independent lives.

  - Dementia infantilis
  - Disintegrative psychosis
  - Heller's syndrome
  - Symbiotic psychosis

Behavioural and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence

1. Hyperkinetic disorders
2. Conduct disorders
3. Mixed disorders of conduct and emotions
4. Emotional disorders with onset specific to childhood
5. Disorders of social functioning with onset specific to childhood and adolescence
6. Tic disorders
7. Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence

Hyperkinetic Disorders

1. Hyperkinetic disorders
2. Disturbance of activity and attention
3. Hyperkinetic conduct disorder
4. Other hyperkinetic disorders
5. Hyperkinetic disorder, unspecified

Hyperkinetic Disorders

- **Hyperkinetic disorders** occur mostly in first five years of life, and they are several times more frequent in boys than in girls
- The main marks of the syndrome are:
  - inattention
  - impulsivity
  - hyperactivity
- ADHD: Attention-Deficit Hyperactivity Disorder (formerly MBD: minimal brain dysfunction)
- Prevalence is from 3% to 10% of elementary-school children

Hyperkinetic Disorders

- Etiology: genetic predisposition, maternal deprivation, environmental toxins or intrauterine or postnatal brain damage
- About 50% of children with hyperkinetic syndrome have so called „soft signs” and minor abnormalities in EEG
- IQ: from subnormal to high intelligence
- Specific learning disabilities often coexist with hyperkinetic syndrome
- Types of hyperactivity syndrome:
  - disturbance of activity and attention
  - hyperkinetic conduct disorder

Treatment

- Parents and teachers have to be advised how to cope with hyperactive children
- Nootropic drugs and mild doses of antipsychotics are sometimes prescribed.
- Stimulant drugs as methylphenidate sometimes have the paradoxical effect, according to theory, that stimulants act by reducing the excessive, poorly synchronized variability in the various dimensions of arousal and reactivity seen in ADHD.
- Stimulants are the drugs of first choice

Conduct Disorders

- Conduct disorders are diagnosed when the child is showing persistent and serious dissocial or aggressive behaviour patterns, such as excessive fighting or bullying, cruelty to animals or other people, destructiveness to property, stealing, lying, and truancy from school and running away from home.

1. Conduct disorders
2. Conduct disorder confined to the family context
3. Unsocialized conduct disorder
4. Socialized conduct disorder
5. Oppositional defiant disorder
6. Other conduct disorders
7. Conduct disorder, unspecified

Conduct Disorder Confined to the Family Context

- The dissocial or aggressive behaviour is intent on family members and occurs mostly at home or immediate household. Stealing from home and destruction of beloved property of particular family members is typical. Social relationships outside the family are within the normal range.

Unsocialized Conduct Disorder

- Aggressive and dissocial behaviour is connected with the child’s poor relationships with other children and peers groups.
- There is a lack of close friends, rejection by other children, unpopularity in the school and hostile feelings toward adults.

Socialized Conduct Disorder

- The diagnosis is applied when the child is showing aggressive and dissocial behaviour, but relationship with children of the same age is adequate.

Oppositional Defiant Disorder

- Children under age of 9 to 10 years, showing persistently negativistic, provocative and disruptive behaviour.
- The more aggressive conduct disorders are not present, general law and rights of other people are respected.
- This type of behaviour is often directed towards a new member of the family - i.e. step father.

Treatment

- Family situation should be consider and its relation to the child’s disorder. The family therapy is necessary to enhance emotional support and understanding.
- In the cases of dysfunctional families, abused or neglected children, an adoptive homes, foster care or supervised residence is recommended.
- Court intervention is required for the placement.

Mixed Disorders of Conduct and Emotions

- A group of disorders characterized by the combination of persistently aggressive, dissocial or defiant behaviour with overt and marked symptoms of depression, anxiety or other emotional upsets
- Mood disorders in children are often expressed by a challenging behaviour or somatic symptoms

1. Mixed disorders of conduct and emotions
2. Depressive conduct disorder
3. Other mixed disorders of conduct and emotions
4. Mixed disorder of conduct and emotions, unspecified

Emotional Disorders with Onset Specific to Childhood

1. Emotional disorders with onset specific to childhood
2. Separation anxiety disorder of childhood
3. Phobic anxiety disorder of childhood
4. Social anxiety disorder of childhood
5. Sibling rivalry disorder
6. Other childhood emotional disorders
7. Childhood emotional disorder, unspecified

Separation Anxiety Disorder of Childhood

- The child is showing anxiety when being separated from persons who are for him emotionally important - parents, family members. Developmental stage should be considered
- School refusal is often a symptom of separation anxiety disorders
- Treatment:
  - in the case of school refusal the child should be returned to school immediately and strict limits should be established
  - the treatment is focused on family structure and recommendation in the ways of upbringing.
  - in severe cases use of antidepressants is necessary

Phobic Anxiety Disorder of Childhood

- The phobic states most commonly encountered in children involve fear of animals, insects, dark and school. Animal and insect phobias usually start at the age of 5 years and almost none start in adult life. Some phobias start in the late adolescence - i.e. agoraphobia

- Treatment:
  - psychotherapy and a sensible parental handling is recommended
  - the anxiety reducing techniques are useful, i.e. desensitization

Social Anxiety Disorder of Childhood

- There is a wariness of strangers and social apprehension or anxiety when encountering new, strange, or socially threatening situations. This category should be used only where such fears arise during the early years, and are both unusual in degree and accompanied by problems in social functioning.
- A fear of social encounters is associated with avoidance behaviour, which produces problems in functioning in a peers group and in the school performance as well.
- The social acceptance of the child can be very difficult and can have impact on his or hers further personal development.
- Treatment:
  - psychotherapy
  - anxiolytic drugs

Sibling Rivalry Disorder

- Some degree of emotional disturbance usually following the birth of an immediately younger sibling is shown by a majority of young children.
- Sibling rivalry disorder should be diagnosed only if the degree or persistence of the disturbance is both statistically unusual and associated with abnormalities of social interaction.
- The children with sibling rivalry disorder are acting with serious hatred to the new born, in severe cases they are showing physical harming behaviour and persistent competition to gain parents attention.
- Treatment:
  - psychotherapy dealing with family structure
  - prevention

Disorders of Social Functioning with Onset Specific to Childhood and Adolescence

- This group of disorders is characterized by abnormalities in social functioning which are not associated with severe deficit and social incapacity found in pervasive developmental disorders.

1. Disorders of social functioning with onset specific to childhood and adolescence
2. Elective mutism
3. Reactive attachment disorder of childhood
4. Disinhibited attachment disorder of childhood
5. Other childhood disorders of social functioning
6. Childhood disorder of social functioning, unspecified

Elective Mutism

- Characterized by a marked, emotionally determined selectivity in speaking, such that the child demonstrates a language competence in some situations but fails to speak in other (definable) situations
- These children show specific personality features as social anxiety and oversensitivity.

- Treatment:
  - psychotherapy
  - in severe cases anxiolytic drugs

Reactive Attachment Disorder of Childhood

- Characterized by abnormal social responses of the child to the care givers that develop before age of 5 years.
- The disorder is often an outcome of a parental neglect, abuse or mishandling and deprivation in institutional care.
- The child shows fearfulness, poor social interaction with peers, aggressive responses and self injurious behaviour.
- The language development could also be delayed and impaired physical growth can occur.
- Treatment:
  - avoidance of mishandling in institutional care
  - good foster homes and adoption policy
  - social vigilance to inept parenting

Disinhibited Attachment Disorder of Childhood

- Abnormal social functioning develops during first 5 years in children who have no opportunity of emotionally stable relationship with care givers.
- The disturbance can be recognized in children growing from infancy in institutions or experiencing extremely frequent changes in care givers.
- To avoid this developmental disturbance good adoption policy is necessary.
- Non - attachment institutional care should be excluded from praxis.

Tic Disorders

- A tic is an involuntary, rapid, recurrent, nonrhythmic motor movement (usually involving circumscribed muscle groups) or vocal production that is of sudden onset and that serves no apparent purpose
- Tics are experienced as irresistible, but can be suppressed for shorter periods of time

- Conditions of diagnosis are also a lack of neurological disorder, repetitiveness, disappearance during sleep, lack of rhythmicity, and lack of purpose

Tic Disorders(cont)

- Simple motor tics: eye-blinking, neck-jerking, shoulder-shrugging, facial grimacing
- Simple vocal tics: throat clearing, barking, sniffing, hissing
- Complex motor tics: jumping and hopping
- Complex vocal tics: repetition of particular words or sentences, and sometimes the use of socially unacceptable (often obscene) words (coprolalia), and the repetition of one's own sounds or words (palilalia)

Classification of Tic Disorders

1. Tic disorders
2. Transient tic disorder
3. Combined vocal and multiple motor tic disorder (de la Tourette)
4. Other tic disorders
5. Tic disorder, unspecified

Treatment

- Sleep therapy
- Hypnotherapy
- Hydrotherapy
- Neurosurgery
- Shock therapy
- Antipsychotic drugs
- Antidepressants
- Nootropic drugs
- Behavioural and cognitive therapy
- Cooperation with the family is important.

Other Behavioural and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence

1. Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence
2. Nonorganic enuresis
3. Nonorganic encopresis
4. Feeding disorder of infancy and childhood
5. Pica of infancy and childhood
6. Stereotyped movement disorders
7. Stuttering (stammering)
8. Cluttering
9. Other specified behavioural and emotional disorders with onset usually occurring in
10. Unspecified behavioural and emotional disorders with onset usually occurring in childhood and adolescence

Nonorganic Enuresis

- The child is not able of voluntary bladder control during the day (enuresis diurnal) or during the night (enuresis nocturnal)
- The enuresis may be present from birth (enuresis primaria), or it may occur after a period of time of acquired bladder control (enuresis secundaria)
- There is no neurological disorder or structural abnormality of urinary system, or lack of bladder control is not due to epileptic attacks or cystitis or diabetic polyuria
- Enuresis is not diagnosed in a child less than 4 years of mental age
- Emotional problems may arise as a secondary consequence of enuresis

Treatment

- Mild restriction of fluids before bedtime
- Waking for the toilet during the night
- Rewarding success and not to focus attention on failure
- Antidepressants

Nonorganic Encopresis

- The diagnosis involves repeated intended or unintended passage of faeces in places not appropriate for that purpose.
- The etiology:
  a) result of inappropriate toilet training
  b) the child is able of bowel control, but because of different reasons is refusing to defecate in appropriate places
  c) physiological problems or emotional problems
- Encopresis can be accompanied by smearing of faeces over the body or environment or is a part of anal masturbation. It occurs in children with emotional or behavioural disturbances or mentally retarded persons.

Treatment

- Psychotherapy
  - to reward success
  - the child is taught to establish more normal bowel habit, for example by sitting on the toilet regularly after the meals
- Anxiolytics or antidepressants

Feeding Disorder of Infancy and Childhood

- Feeding disorder generally involves food refusal and extreme faddiness in the presence of an adequate food supply, a reasonably competent caregiver, and the absence of organic disease.
- Can be associated with rumination (repeated regurgitation without nausea)
- Occurs often in children in institutional care or mentally retarded

Pica of Infancy and Childhood

- Persistent eating of non - nutritive substances (soil, wall paint)
- Common in mentally retarded children or very young children with normal intelligence level

Stereotyped Movement Disorders

- Voluntary, repetitive, stereotyped, nonfunctional (and often rhythmic) movements that do not form part of any recognized psychiatric or neurological condition.
- The non self-injurious movements:
  - body-rocking
  - head-rocking
  - hair-plucking
  - hair-twisting
  - finger-flicking mannerisms
  - hand-flapping
- Stereotyped self-injurious behaviour:
  - repetitive head-banging
  - face-slapping
  - eye-poking
  - biting of hands, lips or other body parts
- In mentally retarded children, or in some children with visual impairment.

Stuttering (Stammering)

- Frequent repetition of prolongation of sounds or syllables or words
- Could be transient phase in early childhood or persistent speech failure until adult life

Cluttering

- A rapid rate of speech with breakdown in fluency, but no repetitions or hesitations, of a severity to give rise to diminished speech intelligibility.
- Speech is erratic and dysrhythmic, with rapid jerky spurts that usually involve faulty phrasing patterns

Other Specified Behavioural and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence

- Attention deficit disorder without hyperactivity
- Excessive masturbation
- Nail — biting
- Nose — picking
- Thumb — sucking

Psychic Disorders that Usually Occur in Adulthood but Can Have Early Onset in Childhood or Adolescence

- Schizophrenic disorders with early onset in childhood occur, but they are very rare and the prognosis is poor, because of influence on psychic development. Treatment quite often includes antipsychotic drugs and residential care
- Manic-depressive disorder is rare before puberty, but increases in incidence during adolescence
- Treatment resembles that of adults, only electroconvulsive therapy is not applied before adolescence

Child Abuse

- The term child abuse is used to indicate physical abuse, sexual abuse, or emotional abuse and child neglect.
- Child care after divorce:
  - some parents are not able to reach consent about child care after divorce period, so child psychiatrist is asked by the court to give an advice on the best solution for the children
  - after divorce disagreements are traumatic for the children and the child psychiatrist's statements should be very carefully expressed, to protect the well being and future development of the child
  - the parental rights of both parents - mother and father should be respected and protected
  - cooperation with child psychologist and social workers is necessary

MENTAL RETARDATION

- It is not a mental illness
- Main problem is inadequate mental functioning
- Essential feature of MR is below-average functioning (IQ less than 70) accompanied by significant limitations in areas of adaptive functioning.

LEVELS OF MENTAL RETARDATION

LEVEL OF MENTAL RETARDATION	INTELLIGENCE QUOTIENT (IQ)	WHAT CAN BE DONE
MILD / MORON	50 / 55 TO 70	EDUCABLE
MODERATE / IMBECILE	35 / 40 TO 50 / 55	TRAINABLE
SEVERE / IDIOT	20 / 25 TO 35 / 40	NEEDS CLOSE SUPERVISION
PROFOUND	BELOW 20 / 25	NEEDS CUSTODIAL CARE

BASIS OF DIAGNOSIS OF MENTAL RETARDATION

- The Intelligence Quotient should not be the only criterion used in making a diagnosis of Mental Retardation.

- It should serve only to help in making a clinical judgment of the patient's adaptive behavioral capacity

- This judgment should also be based on an evaluation of the patient's developmental history and present functioning, social and emotional maturity

CAUSES OF MENTAL RETARDATION

- Congenital numerical deficiency or abnormal arrangement of brain cells
- Birth injuries due to pelvic disproportion, premature births or forceps delivery
- Rh blood-factor incompatibility between mother and child
- Infectious diseases, such as German measles of the mother during the first three months of pregnancy
- Infectious diseases during childhood, such as meningitis and encephalitis

CAUSES OF MENTAL RETARDATION

- Brain injuries occurring during childhood
- Endocrine deficiencies, such as thyroid deficiency, known to be the cause of cretinism
- Exposure to environmental deprivation, with poor housing and poor economic and social conditions.
- Familial or hereditary causes
- Inborn errors of metabolism, such as the inability to metabolize proteins, carbohydrates or fats.
- Genetic defects, such as abnormalities in genes and chromosomes

PREVENTION OF MENTAL RETARDATION

- Adequate medical care during the prenatal period and birth
- Early detection of various disorders
- Immunization against communicable diseases
- Educating parents to understand the important concepts of growth and development
- Educating family members and society to accept the mentally retarded
- Better housing and living conditions
- Improved nutrition through dietary requirement instruction and meal planning

NURSING CARE FOR MENTALLY RETARDED PATIENTS

- Help parents accept a diagnosis of mental retardation

- Consider the developmental or functional age and not the chronological age

NURSING CARE FOR MENTALLY RETARDED PATIENTS

- Teach parents that they should:
  - Protect the child from danger
  - Make the child as independent as his condition will permit
  - Teach the child small social graces and manners which are a tremendous factor in helping to be accepted by others

NURSING CARE FOR MENTALLY RETARDED PATIENTS

- Teach parents that they should:
  - Teach the child to refrain from holding their mouths open as this gives them a dull appearance
  - Select attractive, well-fitted clothing, hair style and good hygiene practices
  - Eliminate the child's undesirable social traits, such as touching their noses and ears, scratching, etc.

NURSING CARE FOR MENTALLY RETARDED PATIENTS

- Teach parents that they should:
  - Teach the child only one thing at a time
  - Demonstrate what they teach, whenever possible
  - Use pictures, since these are valuable visual aids

NURSING CARE FOR MENTALLY RETARDED PATIENTS

- Teach parents that they should:
  - Start teaching the child simple things, gradually progressing to more complex learning experiences
  - Remember that patience and repetition are necessary virtues
  - Avoid prolonged teaching sessions since retarded individuals easily become fatigued

NURSING CARE FOR MENTALLY RETARDED PATIENTS

- Teach parents that they should:
  - Refrain from scolding because it blocks learning and instills fear
  - Give compliments as a motivating force
  - Not show fear themselves as this emotion will be transferred to the child
  - Protect the child from teasing and taunting

NURSING CARE FOR MENTALLY RETARDED PATIENTS

- Teach parents that they should:
  - Recognize a temper tantrum as a child's attempt to meet some underlying emotional need such as attention, affection and security or as the expression of the child's dislike for activity
  - Recognize that these children have a tendency to express jealousy
  - Know that play activities are enjoyed and may be a teaching experience.

PRINCIPLES OF NURSING CARE FOR MENTALLY RETARDED PATIENTS

- Repetition
- Role Modeling
- Restructuring the Environment

FOCUS OF EDUCATION FOR MENTALLY RETARDED PATIENTS

- Reading
- Writing
- Basic Arithmetic

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

- A disorder characterized by:
  - Inattentiveness
  - Over-activity
  - Impulsiveness
- A common disorder among boys
- Occurs before the age of 7

MAIN PROBLEMS IN ADHD

- Inattention
- Hyperactivity
- Impulsivity

COMMON ETIOLOGICAL FACTORS

- Neurologic impairment
- Pre-natal trauma
- Early malnutrition
- Frontal lobe hypoperfusion
- Use of drugs by the mother during pregnancy

SIGNS AND SYMPTOMS OF ADHD

- Subdivided into:
  - Inattentive behaviors
  - Hyperactive and Impulsive behaviors

SIGNS AND SYMPTOMS OF ADHD - INATTENTIVE BEHAVIORS

- Misses details
- Makes careless mistakes
- Has difficulty sustaining attention
- Does not seem to listen
- Does not follow-through on chores or homework
- Has difficulty with organization
- Avoids tasks requiring mental effort
- Often loses necessary things
- Is easily distracted by other stimuli
- Is often forgetful in daily activities

SIGNS AND SYMPTOMS OF ADHD - HYPERACTIVE / IMPULSIVE BEHAVIOURS

- Fidgets
- Often leaves a seat, (e.g., during a meal)
- Runs or climbs excessively
- Can not play quietly
- Is always on the go; driven
- Talks excessively
- Blurts out answers
- Interrupts
- Can’t wait for turn
- Is intrusive with siblings and playmates

- ✓ Excessive or exaggerated muscular activity such as aimless or haphazard running or fidgeting.
- ✓ Difficulty in sustaining attention.
- ✓ Being highly distractible.
- ✓ Failure to follow instructions or respond to demands made on them.
- ✓ Having impulsive behaviour as well as low tolerance to frustration.
- ✓ They tend to be of low intelligence due to hyperactivity, with an IQ of 7-15 below the average.
- ✓ They are socially intrusive and immature.
- ✓ They have a high rate of driving offences when they attain adolescence

PSYCHOPHARMACOLOGY FOR ADHD

- Stimulant Drugs
  - Methylphenidate (Ritalin) – drug of choice
  - Dextroamphetamine (Dexedrine)
  - Amphetamine (Adderall)

NURSING CARE FOR ADHD

- Ensuring the client's safety and that of others
  - Stop unsafe behavior (priority nursing diagnosis is RISK FOR INJURY)
  - Provide close supervision
  - Give clear directions about acceptable and unacceptable behavior

NURSING CARE FOR ADHD

- Improved role performance
  - Give positive feedback for meeting expectations
  - Manage the environment (e.g., provide a quiet place free of distractions for task completion)

NURSING CARE FOR ADHD

- Simplifying instructions and directions
  - Get the child's full attention
  - Break complex tasks into small steps
  - Allow breaks

NURSING CARE FOR ADHD

- Structured daily routine
  - Establish a daily schedule
  - Minimize changes

NURSING CARE FOR ADHD

- Client / Family education and support
  - Listen to parents' feelings and frustrations