Basics of Mental Health & Clinical Psychiatry
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Lecture 32
Child Psychiatry – II

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Hello, everyone. Let us start lecture number 32. That is Child Psychiatry part two. So, the concepts that we will be reading today, discussing today is reactive attachment disorder and disinhibited social engagement disorder, sibling rivalry, academic problems, school refusal, attention deficit hyperactivity disorder, conduct disorder, oppositional defiant disorder, childhood depression, childhood schizophrenia, childhood bipolar disorders and lastly Tic and Tourettes.

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So, what is this reactive attachment and disinhibited social engagement disorder? They basically evolved from pathological caregiving issues which evolved when the child is developing and evolving from infant to toddler or to adolescent, teenage age groups. So, what happens there is those attachment problems which actually culminates, or there might be issues, where the, there can be various issues where the child faces at home or at the school.

So, these are all issues they ultimately culminate into a problem of reactive attachment and disinhibited social engagements disorders. There are various etiological factors. So, what is this? It is a clinical disorder characterised by aberrant social behaviour in a young child that reflectively, that reflects grossly negligent parenting and maltreatment, that is the child is not being properly treated at home. They disrupt the kind of developmental or the normal attachment process and they lead to this two important entities.

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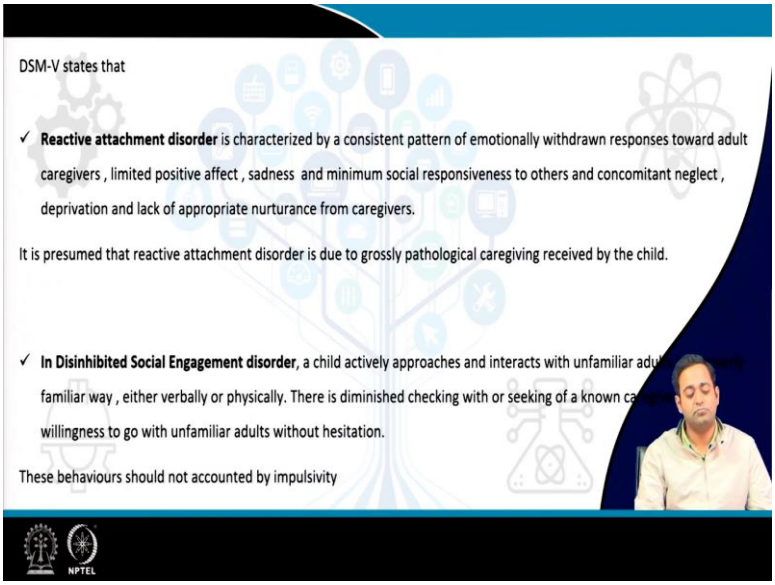

So, reactive attachment disorder, they are characterised by a consistent pattern of emotionally withdrawn responses, towards the adult, that is, who are taking care of the child. Limited positive effect, sadness, minimum social responsiveness, whenever there is a communication problem, and concomitant neglect on the part of the parents or the caregiver, and lack of appropriate nurturance from the caregivers.

So, it is presumed that, this reactive attachment disorder is grossly due to pathological caretaking received by the child. And so, what is disinhibited social engagement disorder? So, as the name suggests, disinhibited, so there is no inhibition as such. So, as you see, normally when we talk with someone who is not part of our family, or for whom we are not known to, there is some strange kind of anxiety, which keeps ourselves inhibited, restricted, from having an open discussion, loud discussion. So, for this kind of children, they do not have those kinds of inhibitions, they are, they become disinhibited and the kind of behaviour, they portray and exhibit is what is present in disinhibited social engagement disorder.

So, these all they happen due to pathological caretaking, the neglect, the maltreatment the child receives, as the child is progressing, evolving, those kinds of issues they result into disinhibited social engagement disorder. So, there is, the child interacts with unfamiliar adults in a overly familiar way, either verbally, or physically. There is diminished checking with seeking of a known caregiver, and willingness to go with the unfamiliar person. So, child altogether goes and talks to, talks to him or her or sometimes accompanies him or her without any hesitation or inhibition.

So, this has to be checked at this particular problem should not be present in, because there can be some personality issues involved, impulsive declusters, cluster B traits, that is your personality issues, temperamental issues in the early age group, where this kind of behaviour should not be present, in order to delineate the, disinhibited social engagement disorder from other developing disorders.

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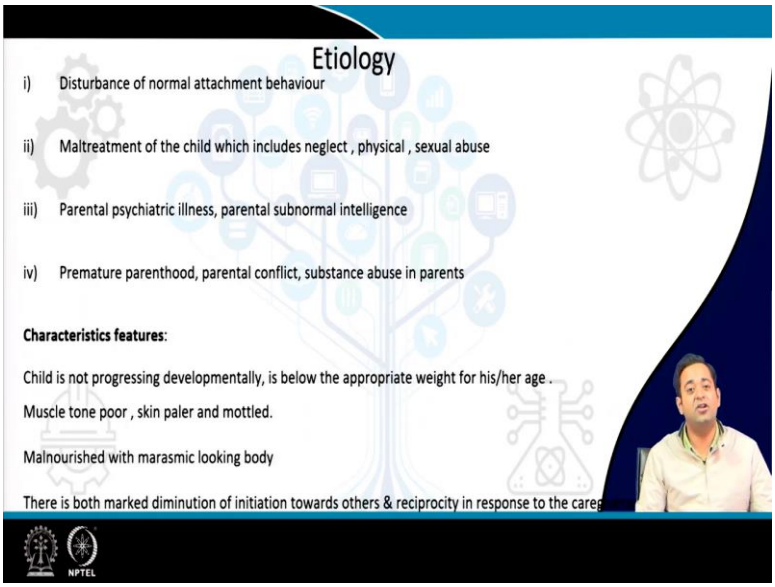

So, what are the etiological factors? There can be disturbance of normal attachment behaviour, most important and important contribution in progressing into a reactive attachment, or a disinhibited social engagement disorder. Second is maltreatment of the child, when the child suffers neglect, physical abuse, sexual abuse, or your the child is being thoughted, or taunted, on various other activities, you are not supposed to do this, you are not supposed to do that, you are worthless. So, these kind of taunts, they also ultimately affects the child's developmental process.

So, there can be parented psychiatric illnesses, where the parents, they are suffering from psychiatric issues, depression, schizophrenia, bipolar, or personality disorders. Or, the parents might be suffering from some kind of, substance abuse disorders, they are detected, addicted to alcohol, nicotine, cigarettes smoking, cannabis addiction, or the parents might not be well educated, or they, might be suffering from subnormal intelligence. They are suffering from ID, that is intellectual disability, that is mental retardation, that also has a fair role in these kind of issues, because the attachment of the child towards the parents that gets affected.

Then you have premature parenthood, adulthood, where the child is born, when the parents are in a very young age, early or late part of the adolescence, 17 to 19 years of age, they do not have the proper rules, and conduct to guide their children. And yes, there can be conflict between the parents itself. These all factors, they eventually leads to this kind of this disruptive behavioural disorders.

So, what are the characteristic features that the child can develop? Child is not progressing developmentally, is below the appropriate weight, height, among their, with respect to their peers, there might be decreased weight gain leading to poor muscle tone, skin is listless, dry. So, proper nutrition is not given to the child, because the neglect and maltreatment. And thereby having a miasmic body, where the carbohydrate container of the body, the fat, is very less. There is both, marked diminution of initiation towards others. And reciprocity, the child is not able to reciprocate, communicate properly due to this pathological caregiving model.

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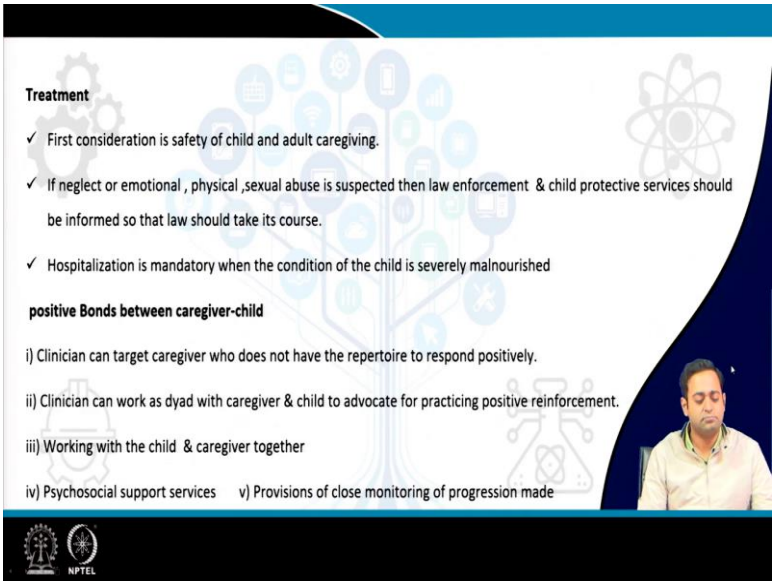

So, how do you treat this child? So, treatment is, first and foremost is, is to consider the safety of the child and the caregiving modes, what are the ways for which it should not be done? So, that needs to be encounter, that needs to be assessed. So, if there is a neglect of the child leading to maybe various issues, physical, sexual, or emotional neglect, the if, that is being suspected, so child protection services and the law enforcement agencies that should be brought into consideration or notified, so that the law should take its course. And hospitalisation, if found that the child is really suffering or is malnourished, then the hospitalisation is actually required for the sake of child.

So, what are the psychosocial issues, that should be assessed and looked for? There has to be a positive bond between the caregiver, and the child. Now, how it should be reiterated and seen that that is functioning properly? The clinician can take, the can target caregiver who is responsible for this, and clinician can work as a dyad, that is the child and as well as caregiver, they both should be brought into the session and actively take participation, psychosocial support services and there is a, there should be close monitoring of what is being actually acquired, what is being gained in the due process of those sessions, that has to be monitored by the physician or the psychiatrists or the mental health professionals.

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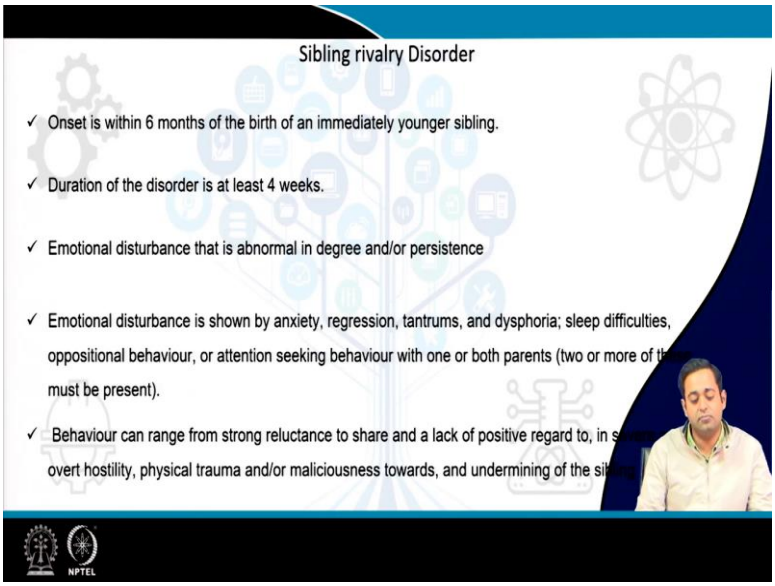

So, what is sibling rivalry disorder? Sibling rivalry disorder is present when the, it is brought into effect is when the, there is a birth of a younger sibling. It is most commonly seen within the birth of six months. So, what are the areas or the problems with a child faces, is there is abnormal in degree and persistence that, there is emotional disturbance.

And this emotional disturbance is shown by anxiety, regressive behaviour, child vocalises in a, behaviour of age 1 or 2, when if the child is having the sibling rivalry, when the problem is evolving at the age of 6 or 7 years, but the child is behaving as if he or she is of 3 years, so, that is a regressive attitude.

So, there can be temper tantrums, child should cry or agitated the caregiver around the family members, there can be difficulties in sleep or they can be defiance behaviour is not listening to their parents neither their caregivers, or the elders. So, all those kinds of behaviours are actively looked out for. So, they have strong reluctance to share with the new child born and

lack of positive regard. Sometimes the hostility is also present, maliciousness towards the new born child.

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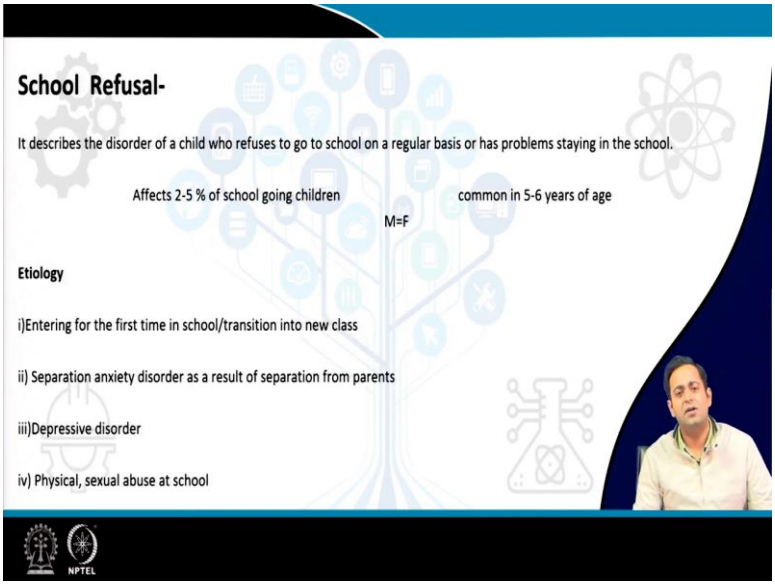

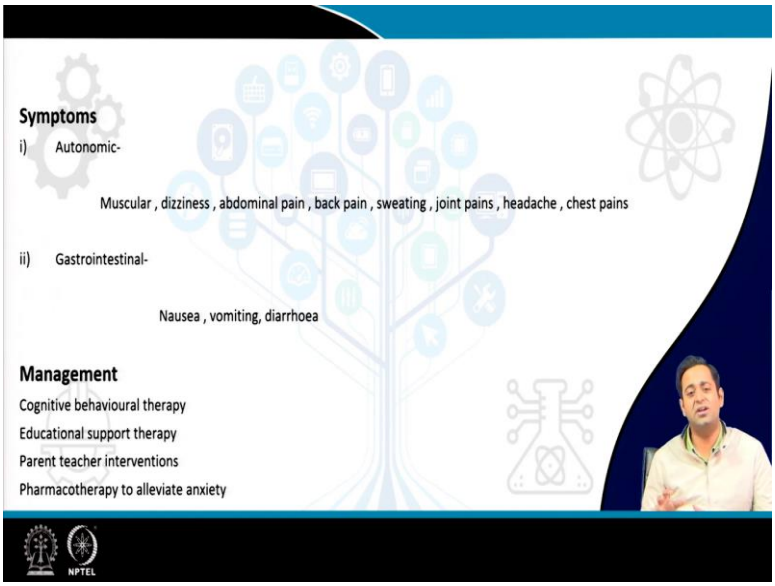

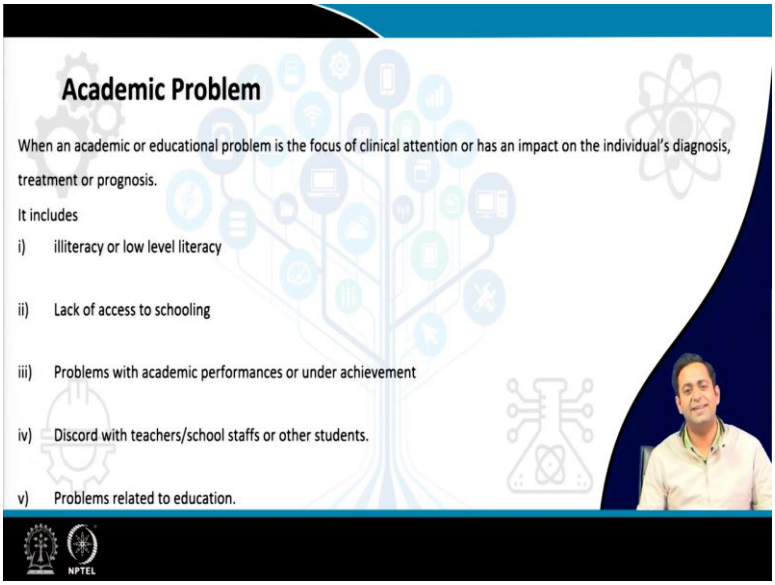

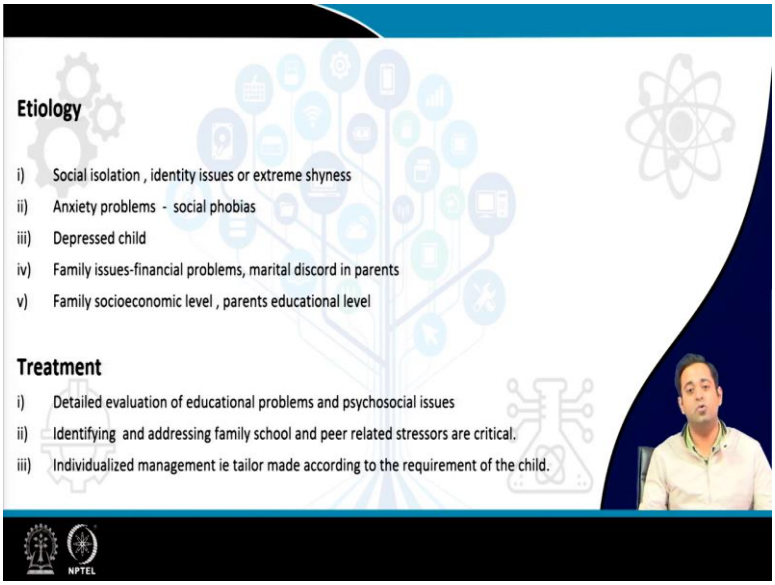

Now, what is school refusal? School refusal is a disorder where the child refuses to go to school on a regular basis, and it is seen most commonly in the age group of 5 to 6 years. What are the various factors? Various factors can be social phobia, he is not able to talk or communicate whenever there is a public domain or at school where, or whenever there is a more than some 10 to 15 people, there is a crowd.

So, the if at all there are some attachment issues where separation anxiety disorders might be there for the child, child might also develop some depression that can also lead to school refusal, or most important when the child is being neglected or maltreated at home. There can be physical, sexual or emotional abuse.

Symptoms are in the form of muscular pain, dizziness, abdominal pain, nausea, vomiting, headache, chest pains, these are the complaints the child actually comes up with whenever the child is having school refusal. So how are we going to manage this, with the help of cognitive behavioural therapy, education support, parent teacher management training programs, and sometimes pharmacotherapy if there is those social phobias. So SSRIs are given in order to alleviate the anxiety.

Academic problems. So academic problems is when really the patient the child is having issues with pertaining to education per say. And they are in the form of literacy, or low level literacy, the there is a lack of access to schooling for the child, problems with academic performances or underachievement, he is not able to get those good grades in the class, there can be discord with the teachers, problem with teachers or at parents at times, or there might be difficulty with students peers at school. And there can be the problems related to communication disorders or language disorders, that is expressive deficits, receptive deficits, problems in reading, writing, all those issues can have academic problems.

Treatment is with detailed evaluation of the education problems, and various psychosocial issues both at home and at the school, whatever the whenever the child is facing that, identifying, addressing those areas with those family intervention programs and school intervention programs and have tailor made or individualised management programs for the child per se, for who for he or she is suffering from.

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Etiology

i) Social isolation , identity issues or extreme shyness
ii) Anxiety problems - social phobias
iii) Depressed child
iv) Family issues-financial problems, marital discord in parents
v) Family socioeconomic level , parents educational level

Treatment

i) Detailed evaluation of educational problems and psychosocial issues
ii) Identifying and addressing family school and peer related stressors are critical.
iii) Individualized management ie tailor made according to the requirement of the child.

Attention Deficit Hyperactivity Disorder(ADHD)

The cardinal features of ADHD are excessive and impairing levels of

They are pervasive over time.

These features must be evident in more than one setting, cause serious impairment and be excessive in relation to the person's mental age and development, and must not be due to other causes such as anxiety, schizophrenia or autism.

Diagnostic criteria: The hyperkinetic disorder is the **ADHD** equivalent in ICD 10.

Minimum age – 12 years **Prevalence – 1-2 %** **M:F – 3:1**

To confirm a diagnosis of ADHD, impairment from inattention and/or hyperactivity-impulsivity must be observable in at least 2 settings and interfere with developmentally appropriate functioning in extracurricular activities and should persist for at least six months.

Hyperactivity-impulsivity symptoms include: fidgeting, being 'always on the go', talking excessively; unable to play quietly; continually interrupting.

Inattention symptoms include: being easily distracted, being unable to sustain attention, difficulties completing tasks, difficulties organizing, avoiding tasks requiring mental effort; appearing not to listen, being forgetful, and losing things.

Hyperactivity is more impairing and more noticeable in **pre-school children.**

In school inattention is more noticeable.

Inattention and Impulsivity is noticeable in both adolescent and adult populations, especially in social situ

✓ Impulsive- hyperactive type ADHD → Conduct → Substance abuse
ODD

Assessment:

Connors questionnaire Vanderbilt Questionnaire

Both will assess parent and Teachers observation regarding child's overall behaviour.

Behavioural disorders, you have attention deficit hyperactivity disorder. This particular disorder is having three cardinal symptoms, where you have difficulty in hyperactivity, in attentiveness, and impulsivity. So, these features, they must be present for two setting, that is at school and as at, as well at home. And the child age should be of minimum 12 years to have this diagnosis. And they should interfere in their social academic life and extracurricular activities and should persist for all these problems should persist for six months, to have a diagnosis of attention deficit hyperactivity disorder.

So, what are these three basically domains in which a child is having problems? Among hyperactivity type, when the child is having hyperactivity, kind of symptoms, there can be a fidgeting kind of behaviour, child can run from one place to another, it is difficult to sit at one place, they are talking out of their terms excessively, they are unable to play quietly, they are constantly running.

So, these are the hyperactive behaviours where the child can present with. Inattentiveness, child is having easy distraction. So at times parents complaint that child is, my child is not able to do the various kinds of activities playing, walking, or playing, swimming, or doing their homework continuously.

So, every 10 to 15 minutes child gets distracted, gets up and walks, walks around. So these are the most common things which are present when the child can have problems in inattention. They are not able to listening for being forgetful losing things. And hyperactivity is more impairing and more noticeable in preschool age groups in school, inattention is more noticeable, and this inattention impulsivity they are both noticeable in adolescence and adult populations.

Now, there are various schools of thought where it has been found and there are some studies available where it is propagated that impulsive and hyperactive type of ADHD, they progresses to become conduct or ODD, and later on becomes go and procure substances, becomes substance dependence, and ultimately leading to an antisocial personality disorders.

So the assessment of ADHD is by various questionnaires Vanderbilt and Connors, they both assess the parent teacher component the scales, the questionnaires which is given to both the teachers and as well as to the parents to assess the overall problems present for the child.

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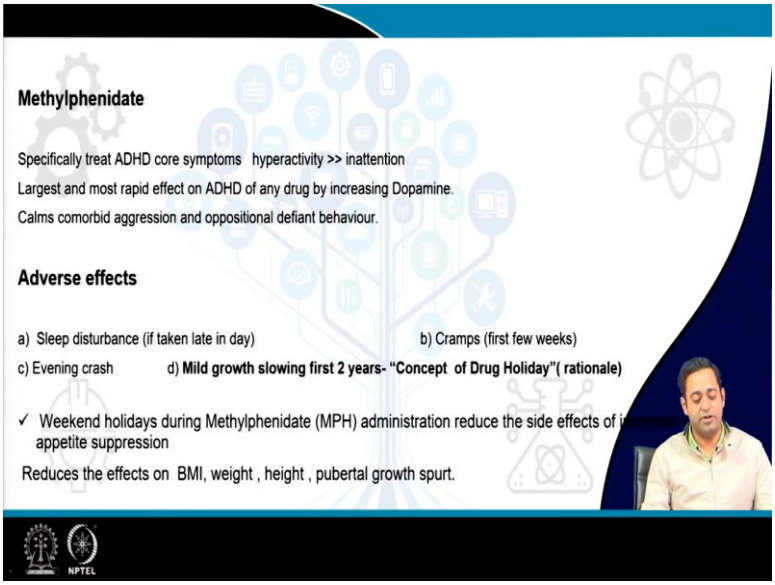

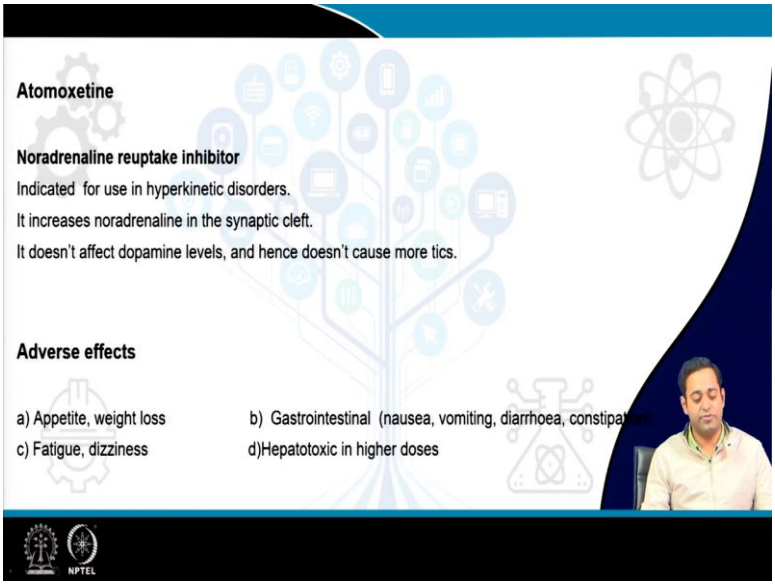

How can you treat it, the treatment is with pharmacological and non pharmacological management. Firstly, the there is psycho education for the condition to the parent and to teacher, sometimes to the child also that this is a problem the child is suffering from. So, parent training programs for child management skills, it is based on social learning model that is positive reinforcement operant conditioning and behavioural interventions, CBT methods, and social skill training.

Social skills training is you have those social perception skills, those receptive skills and expressive skills. So, you need to understand what the people around you are talking about you, you need to process those information, those you have to understand those nonverbal gestures, those are the things which have been taught.

And lastly, the expressive skills, how do you reciprocate? How do you talk to them, with them, those are the skills, social perception skills which have been taught in social skill training. Among pharmacological treatment, you have stimulants. Stimulants, methylphenidate, and next is you have atomoxetine.

So, what are the etiological factors for ADHD? First can be genetic factor that is increased risk of child having ADHD, those who are having ADHD, their parents and their siblings can have ADHD to this particular child. So neurochemical factors you have dopamine and noradrenaline responsible. The neurotransmitter responsible for this is dopamine, and noradrenaline.

Among developmental factors if the child is premature, prematurely born or the mothers if they might have mental infection during the first trimester or perinatal insult, during time of delivery, when the child is getting delivered. Some injuries can also result into developing into ADHD.

Psychosocial factors, the chronic abuse and neglect maltreatment. So, all these issues can lead to ADHD in the child. What is the anatomical localisation where the disease the disease is seen? It is the prefrontal region, the prefrontal area of the brain cortex of the brain where the which is responsible for attention deficit hyperactivity disorder.

So among stimulants pharmacological therapy, methylphenidate is given it is commonly indicated. So, it is basically given to treat the hyperactivity and inattentive symptoms. It is having the most largest and the most rapid effect. What are the side effects for methylphenidate? Sleep disturbances because since it is a stimulant, it should not, it should be avoided given in the later part of the day, and they have effect on the growing spot of the child.

So that is why the rationale is to give drug holidays for methylphenidate whenever the child is being given. So, this methylphenidate when, whenever there is a weekend holiday, this the active side effect of the methylphenidate is reduced and that is why it reduces the pubertal growth spurt, which is being decreased initially when the child is was on continuous treatment of methylphenidate.

Next is atomoxetine, it is an noradrenaline reuptake inhibitor and it increases noradrenaline in the synaptic cleft. So, it does not affect the dopamine levels as methylphenidate. And so, that

is why they can be given in case of tics, because they are also the dopamine levels are affected.

Adverse effects of atomoxetine is appetite, weight loss, fatigue, dizziness, gastrointestinal issues nausea, vomiting, and it is hypertoxic at high doses that is why the regular or reparative six monthly screening of liver function tests should be done. So what are the order, other order alternatives given in cases of ADHD, the pharmacological treatment. Alpha 2 agonists, clonidine and guanfacine, they both can control hyperactive and those inattentive features present.

So adverse effects is sedation, and there can be rebound hypertension. So, that is why they are wherever the drug is being given, the drug leads to postural hypotension whenever there is stoppage of the drug. So, repetitive or regular blood pressure recordings has to be done, whenever the codeine is being given to the child.

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Conduct Disorder

Diagnostic criteria:

Children with conduct disorder are likely to demonstrate behaviours in the following four categories

- Physical aggression or threats of harm to people, cruelty to people and animals
- Destruction of their own property or that of others
- Theft or acts of deceit
- Frequent and serious violation of age appropriate rules like truanting or running away

ICD-10 requires at least one behaviour to be present for at least six months.

Prevalence - 5-7 % M:F - 4:1

DSM-5 criteria, **atleast 3 out of a list of 15 behaviours should begin before the age of 13, for a period of 12 mon**

Conduct disorder occurs with greater frequency in the children of parents with antisocial personality disor dependence than in the general population.

NPTEL

ODD is characterized by an enduring pattern of negative, hostile, disobedient and defiant behaviour, without serious violations of societal norms or the rights of others.

Symptoms must be persistent and evident for at least 6 months.

Age of onset of ODD is generally earlier than that for CD.

1. The child"s temper outbursts, active refusal to comply with rules, tendency to blame others, spiteful and annoying behaviour exceed expectations for these behaviours for children of the same age.
2. Manifestations of the disorder are almost invariably present in the home, but they may not be present at school or with other adults or peers.
3. Features of the disorder from the beginning of the disturbance are displayed outside the home; in other cases, the behaviour starts in the home, but is later displayed outside.
4. Typically, symptoms of the disorder are most evident in interactions with adults or peers whom the child knows well.
5. ODD can begin as early as 3 years of age, it typically is noted by 8 years of age and usually not later than

NPTEL

Etiology **Prevalence 2-5%** **Boys> Girls**

Temperamental factors like sick or traumatized child and power struggle between parents & child.

Longitudinal studies suggest that

ADHD in early life is a predictor of oppositional defiant disorder and conduct disorder later in life.

Chronic oppositional defiant disorder almost always interferes with interpersonal relationships and school performance

Secondary to these difficulties can be low self-esteem, poor frustration tolerance, depressed mood, and tempe

Adolescents may abuse alcohol and illegal substances.

The disturbance may evolve into a conduct disorder or a mood disorder.

NPTEL

Next is disorders of childhood conduct. So among disorders of childhood conduct, you have two disorders that is oppositional defiant disorder and conduct disorder. So, oppositional defiant disorder is characterised by enduring pattern of negativistic hostility and defined behaviour, disoriented behaviour without serious violations of the societal norms.

Whereas in cases of conduct disorder, this demonstrate serious violation of age appropriate rules, like taunting or running away. So, there is difference between conduct disorder and oppositional defiant disorder. So, the age of ODD is generally earlier than CD that is the oppositional defiant disorder is diagnosed earlier than conduct disorders.

What are the features, the child's temper outburst active refusal to comply with the rules they will not obey the rules as told by their parents or the caregivers, they are very annoying, this child almost invariably present in home the act, the kinds of behaviours which is being portrayed at home will not be shown outside or in the public places where the child is not known to anyone.

So these kind of behaviours they are being expressed out to the persons who the child knows. Typically, the disorder is most interactions with adults or peers with a child knows and it begins early as three years of age, and noted by most commonly in eight years of age. Commonly seen by boys, and ADHD in early life is a predictor of ODD and conduct disorders later in life. So, there are various studies.

What are the features that the child can present with, they are having low esteem, poor frustration tolerance, depressed mood, temper outbursts. And in order to come out of this problem, they actually sometimes self medicate themselves by abusing substances nicotine or alcohol. And this disturbance if it is not intervened properly, they went on to progress into a conduct disorder.

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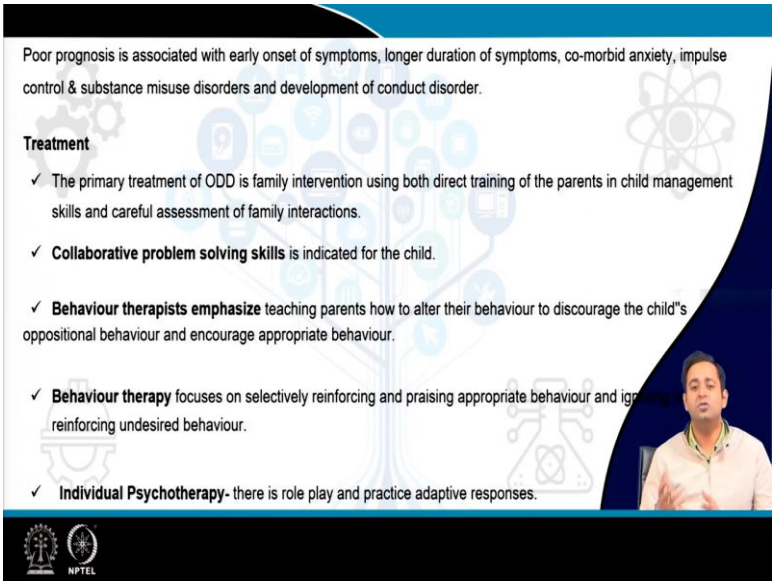

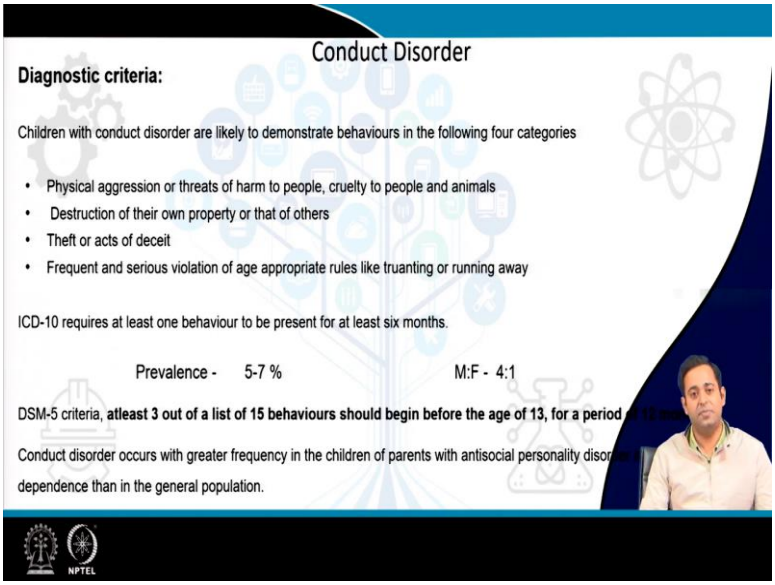

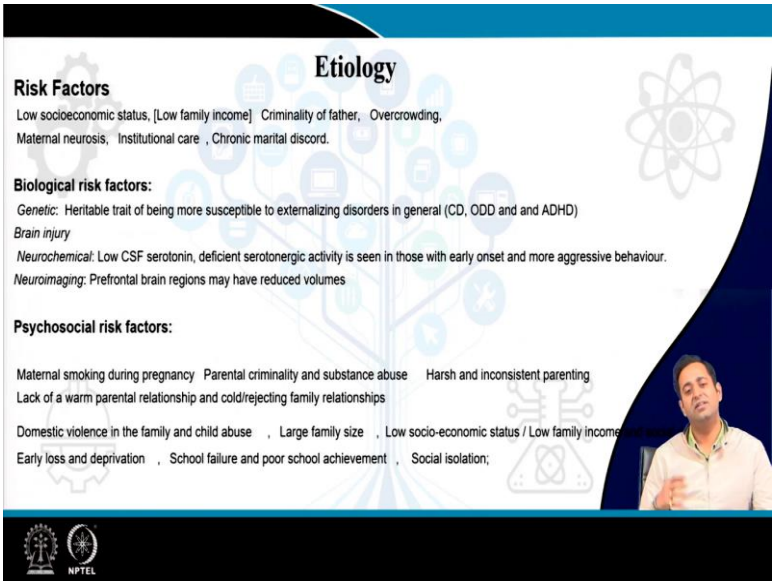

So the treatment is basically by collaborating problem solving skills, behaviour therapists, they emphasise will be the selected reinforcing and praising appropriate behaviour and ignoring what is not. So you have positive reinforcement, where the reward has been given for the activities and the behaviours that the child is supposed to do. And you punish or accurate does not allow the behaviours for which the child should not be doing it.

Among conduct disorders, there are basically four categories in which the child displays their behaviour, that is physical aggression or threats, or harm to people or cruelty to people and animals. There is destruction of their own as well as others property, theft or acts of deceit and there is frequent or serious violation of age appropriate rules like truanting or running away.

So ODD and is and conduct there is a difference between this important point that is frequent and serious violation of age appropriate rules, were in ODD there is no serious violation. So males are most commonly seen with this, and conduct disorders with greater frequency in the children of patients with antisocial personality disorder and alcohol dependence than the general population.

Risk factors, you have various risk factors low socioeconomic status, low family income, criminality, in the case of father, there can be financial issues, parental neglect, parental conflict, or the parents are not well educated. Among biological risk factors, you have genetical issue, genetical factors like patient can be seen those who are most susceptible to develop ADHD, they later on become ODD, or conduct disorder.

New imaging findings showed that it is a peripheral area of the brain, which is most commonly affected to have this kind of problems. Psychosocial issues, you have maternal smoking during the early ages, first trimester. Criminality in the parents substance abuse in the parent, harsh punitive parenting, that is punishment giving severe punishment to the child, whenever this kind of behaviours are being expressed or portrayed. So domestic violence in the family, child abuse, large family sizes, all factors they bring about, or they culminate into a conduct disorder.

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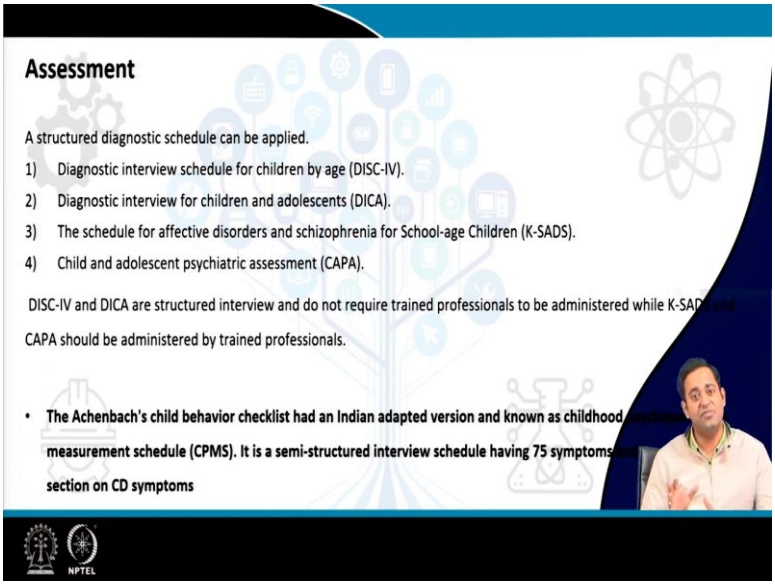

So, what is the, how the child is being assessed for this conduct and ODD. So there are various diagnostic schedules. Most important is diagnostic interview schedule for children by age, and interview for children at adolescence. So, this child and adolescent psychiatric assessment and schedule for affective disorders and schizophrenia for school aged children They are used by trained professionals, whereas the DISC and DIC are basically given by non trained individuals. So, Achenbach's child behaviour checklist is one that has been having an Indian adapted version. And this is a semi structured interview schedule which is having 75 symptoms and other designated section of conduct disorders.

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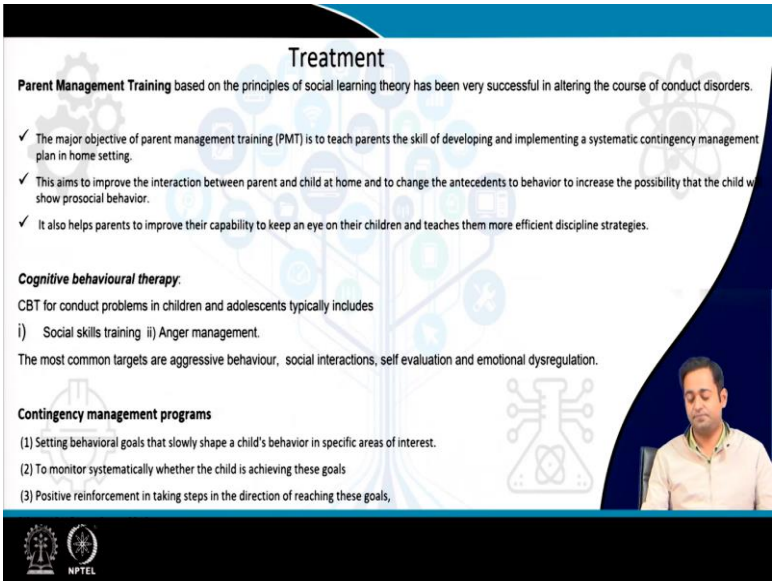

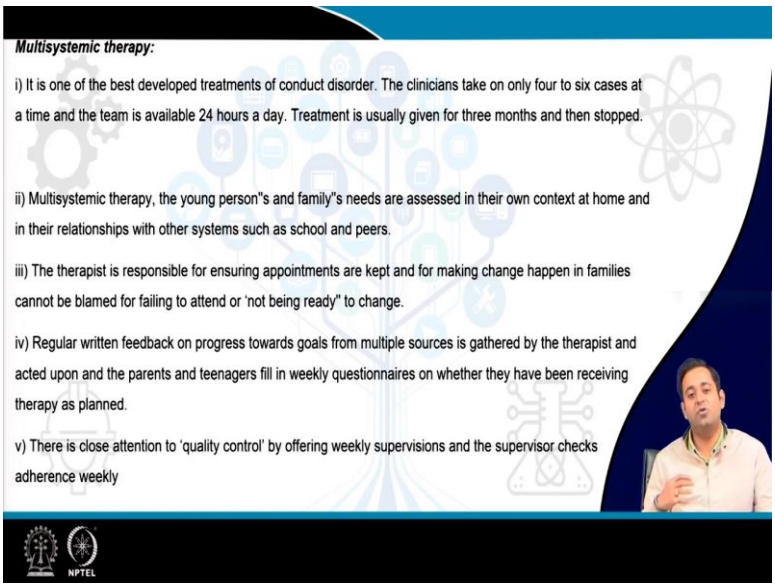

So, how do you treat it? With the help of parent management training, cognitive behavioural therapy, and contingency management programs. So, what is parent management training? Here the major objective is that the parents are taught the skills of developing and implementing a contingency management programs at home.

So, here in contingency management you have setting up goals, shaping up the child's behaviour to monitor the child with whether the child is progressing towards the goals which was set before the session was started. And positive reinforcement in taking steps in the direction of the schools are taken. Among cognitive behavioural therapy, you have social skill training and anger management techniques.

So, multisystemic therapy was the treatment strategy employed for this kind of children treatment is given 24 hours a day, and usually three months are taken and then stopped. So, multisystemic therapy is when a young person family needs are assessed in their own context at home, and the relationships with other system, that is at schools and peers.

So, therapists are responsible for ensuring that the session is being progressed, if there is a delay or there is a stoppage of a session because due to some problems at home in the family, it is the duty of the therapists to have the active collaboration of the parents and the child itself, there should be progression of the notes, there should be supervision on the part of therapists, they should be the ones who should be actively seen and sought after for this kind of therapies.

And there should be a quality control which is being offered weekly by the therapist, and they should be the ones who should be seeing that the therapy, the sessions of the multisystem therapy is being progressed in a smooth and functioning way.

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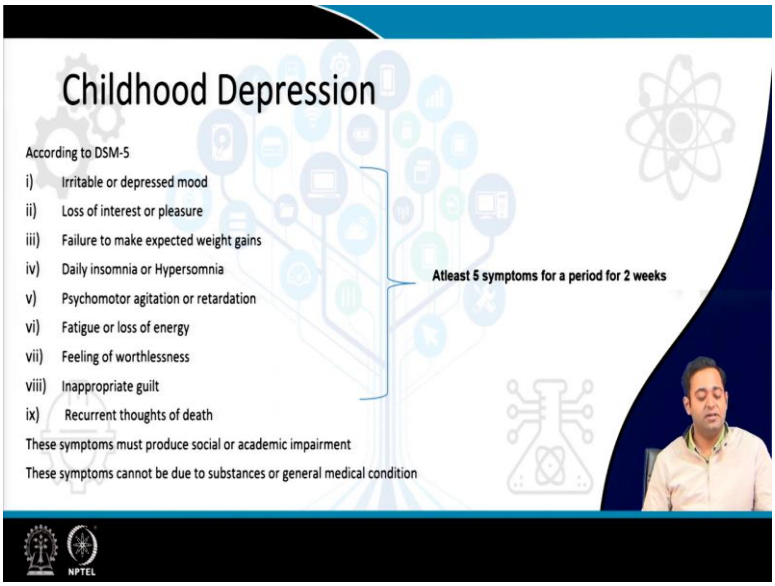

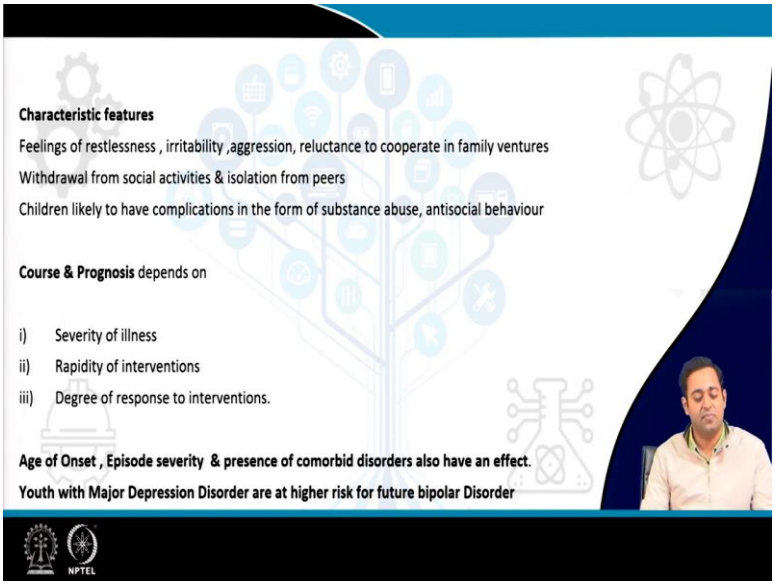

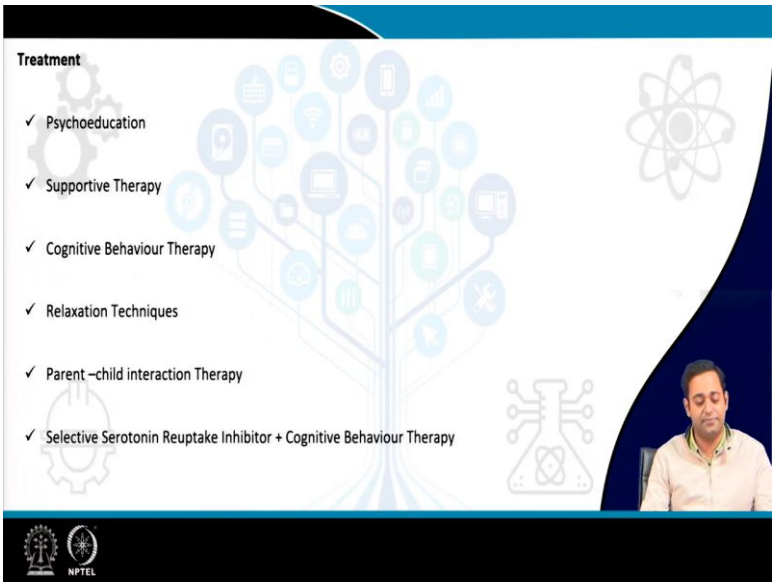

Next is childhood depression. So, childhood depression, have the similar kind of symptoms as does it found in early depression, with irritable and depressed mood or angry irritable mood changed by depressed mood which is seen in adult depression. So, what are the criterias, the criterias are at least 5 of the symptoms which can be irritable or depressed mood, loss of interest, fatigue ability, those psychomotor agitation, feeling of worthlessness, guilt, all those things should be present for at least two weeks. And these symptoms should bring about impairment in social and academic life, spheres of life, and this should not be due to any kind of general medical condition or psychiatric illnesses.

Other psychiatric illness, substances that is due to any substances with the person, with the child or might be taking it, what are the characteristic features? Feeling of restlessness, irritability, aggression, reluctance to cooperate with family members, withdrawal from the

social activities, and these all have leading to isolation from their friends and families. So, the course and prognosis of this illness should depend upon the severity, the intensity of the present episode or the disease per se.

How the, when the child has responded with the treatment he or she has received all those things should be assessed properly. Age of onset has a very important role in assessing the depressive phase of the illness. So, if the child has this particular episode in the early part of their life, then give, this gives a indication of bipolarity, and because the child might suffer from bipolar episodes later on in their life. Treatment is by psychoeducation, supportive therapy, CBTs, relaxation techniques, parent child interaction therapy, and with the SSRIs and CBT both if individually they are not able to suffice.

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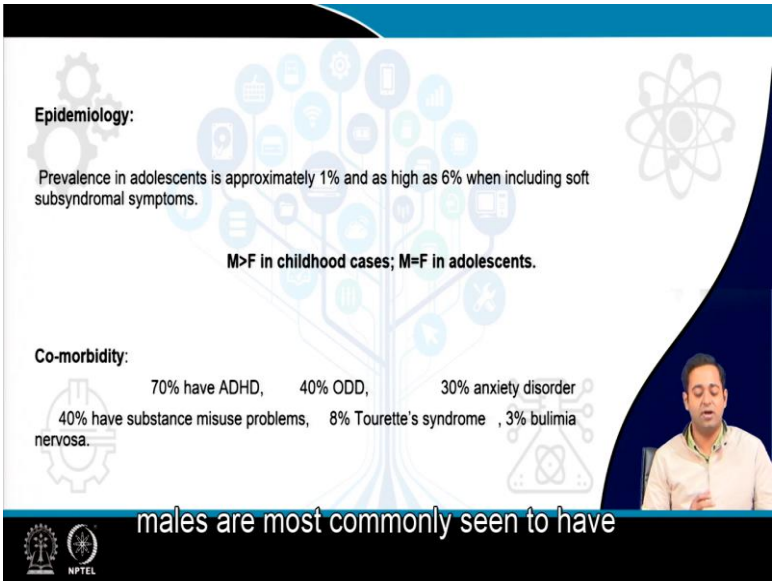

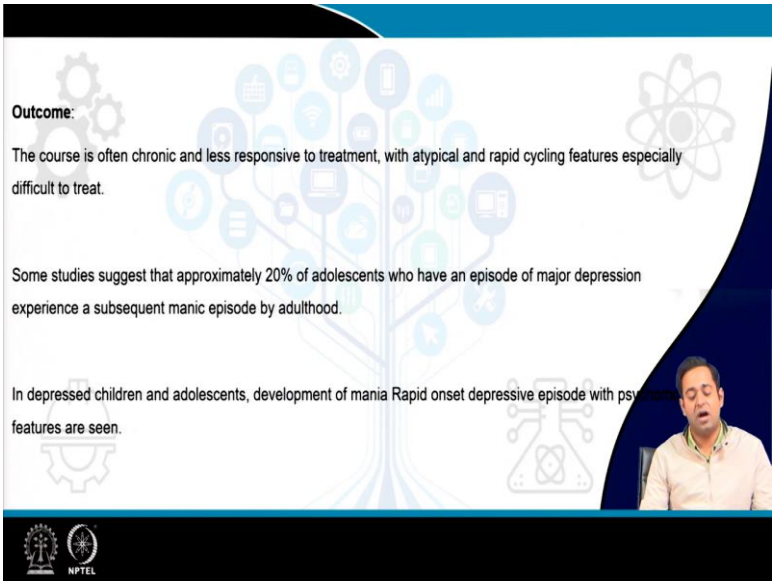

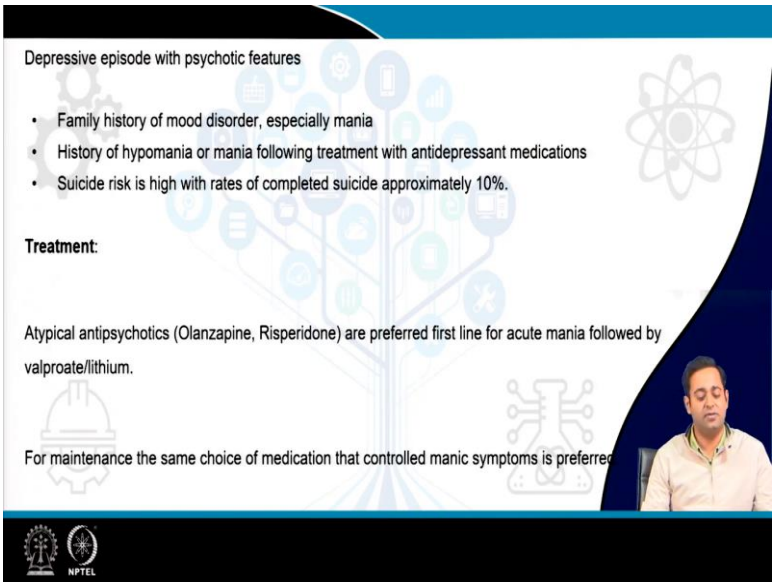

Among bipolar disorders, you have the same kind of manic and depressive phases the child can present with. So, male has more common statistical evaluation where the child in cases of child and adolescent cases the males are most commonly seen to have involved. And in the comorbidities, the ADHD and ODDs are most commonly seen in cases of bipolar. Outcome is the course is often chronic and it is less responsive to treatment. However, antipsychotics and mood stabilisers are in given in cases of treatment of these kinds of problems.

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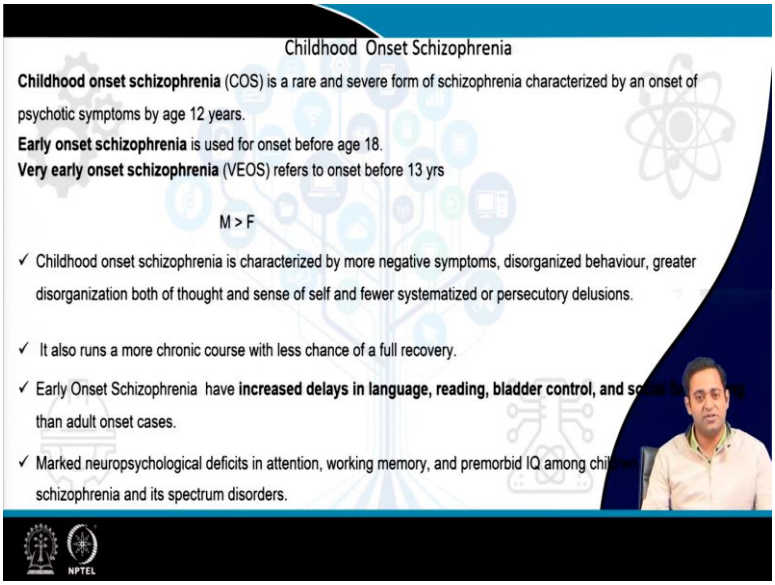

So, next is childhood onset schizophrenia. Child onset schizophrenia is a rare and severe form of schizophrenia, where it is characterized by onset of psychotic symptoms by the age of 12 years. Now, very early onset is where the onset is before 13 years and early onset is when the onset is before 18 years.

There are some these are some technical terms which needs to be remembered, childhood onset schizophrenia, most, they are mostly characterised by negative symptoms, disorganised behaviour, greater disorganisation of both thought, and sense of self, and fewer or systematised persecutory delusions.

So, there will be disturbance in the language development, bladder bowel control, reading and social functioning then the adult counterparts. There can be marked neuropsychological deficits in the form of attention, concentration, premorbid IQ. Those who develop schizophrenia spectrum disorders.

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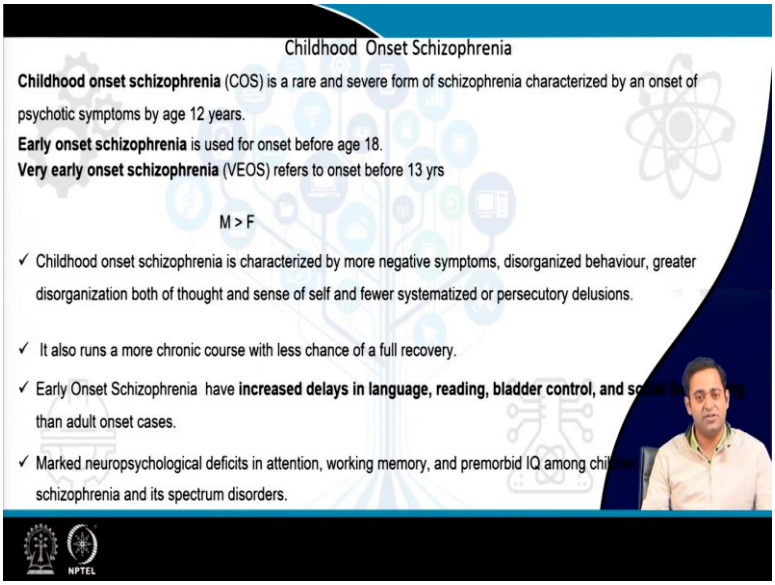

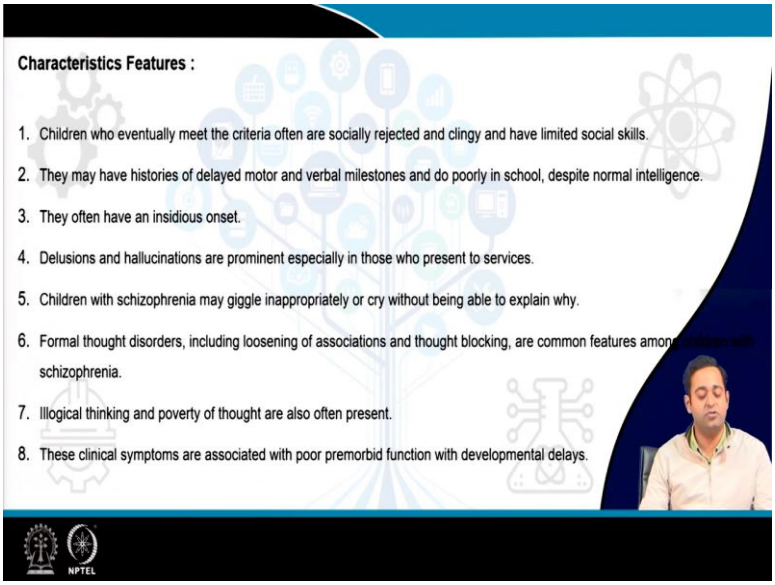

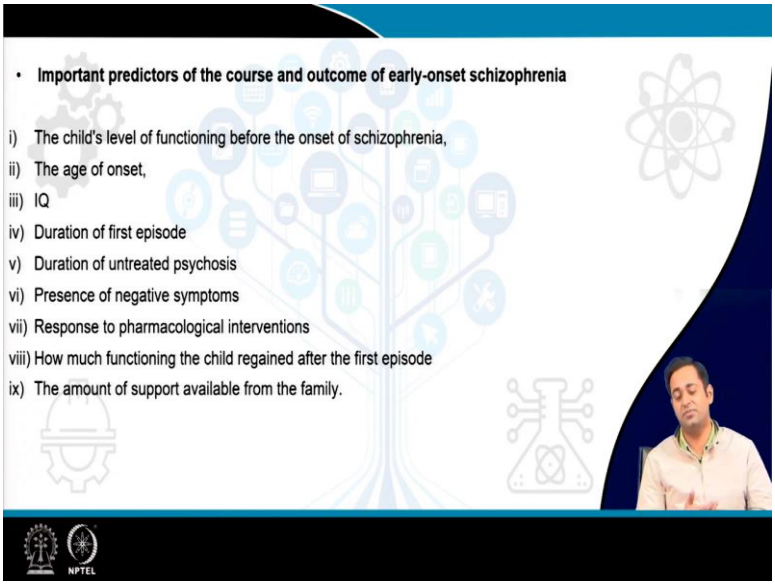

The characteristic features are, they are mostly socially rejected. Once from the society they have histories of delayed motor and verbal milestones. Delusions, hallucinations are mostly prominent in those who come to the services, that is those who are brought into attention and getting admitted in the tertiary care centres.

Formal thought disorders including loosening of associations thought blocking are the common found features in childhood schizophrenia. They are important predictors of early onset schizophrenia, these are age at which the schizophrenia start, what is the IQ level which the child attains, because before the development of schizophrenia, what are the psychosocial factors the support the family support, friends and families present for the child at the time of developing schizophrenia,

Then some negative symptoms, presence the positive symptoms, what is the duration untreated psychosis, that is the duration for which the child does not receive symptom. So those are the things that needs to be assessed.

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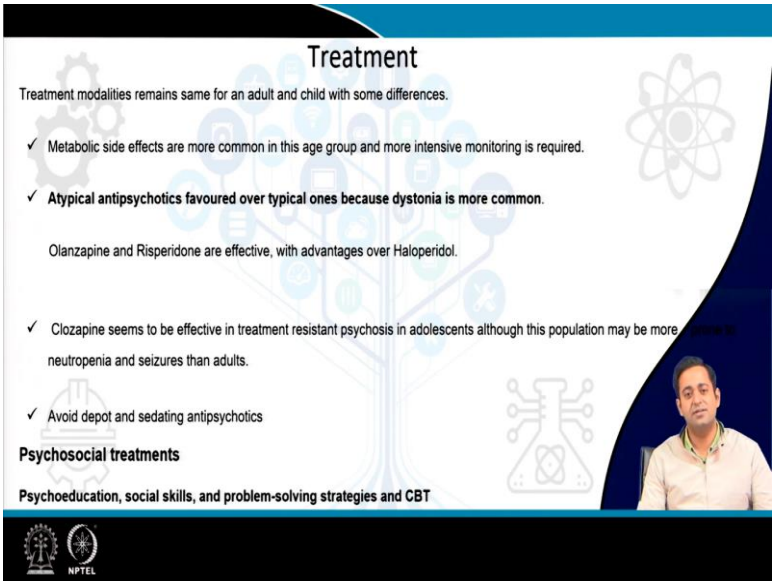

Treatment is with atypical antipsychotics, because typically once they are noted as to cause extra parameters side effects. Olanzapine seems to be effective in treatment resistant schizophrenia, which is actually same as that of adult cases. Psychosocial treatment, you have psychoeducation, social skills, problem solving strategies, and CBT.

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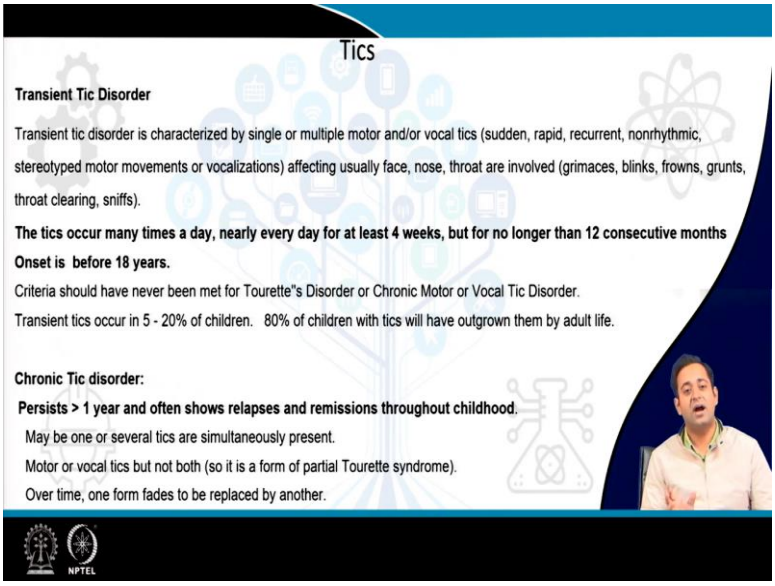

So what are tics, there can be two types, transient tics and chronic tins. Transient tics, they occur many times a day for at least four weeks, but no longer than 12 consecutive, that is less than one year and this reparative multiple behaviours act should not be present. After that, it should be present before 18 years.

So transient tic is characterised by singular multiple vocal tics, and they are sudden rapid, recurrent, non rhythmic stereotypic in nature, whereas chronic tic, they are persisting for more than 1 year. So ticks should be present, simple tick should be present for less than 1 year, and this chronic tick should be present for more than 1 year. And they show relapses and remissions throughout their childhood. So maybe one or several tics are present simultaneously. And over time, this fades and replaced by another.

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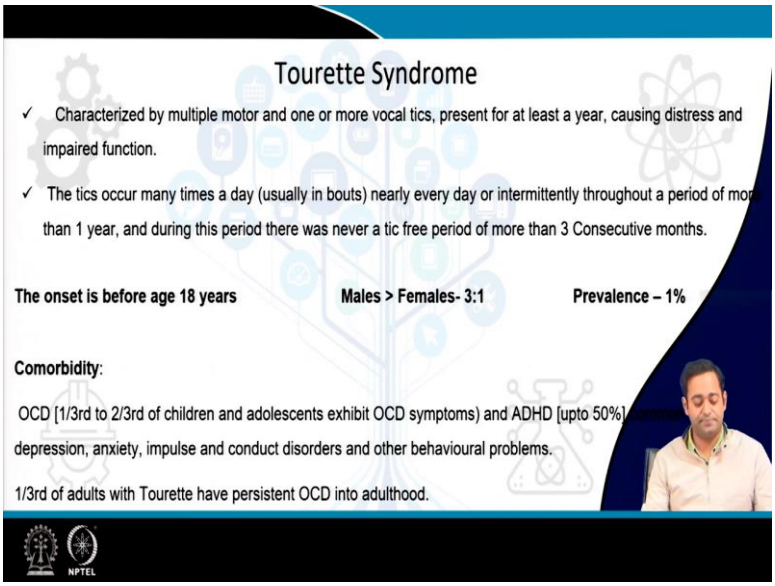

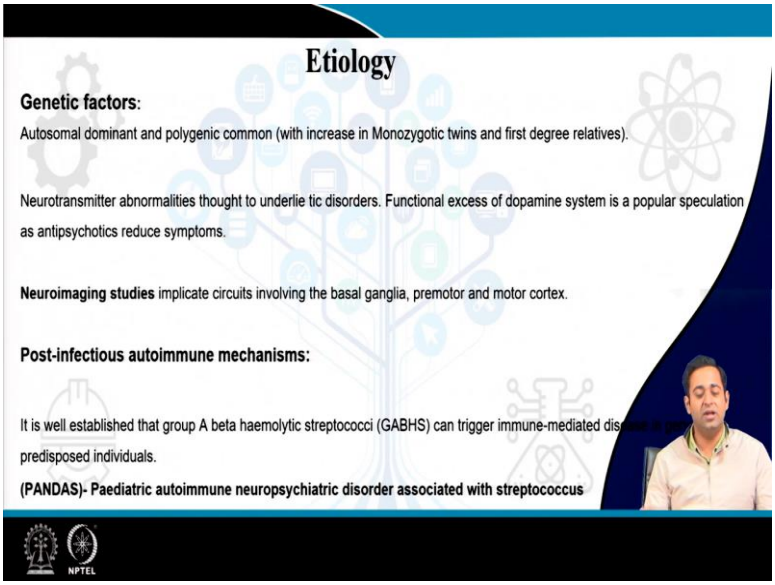

Tourette Syndrome. So Tourette syndrome is basically characterised by multiple motor and vocal tics, which is present for at least 1 year causing distress and impairment in functioning of the life of the child. They are seen to occur everyday intermittently through a period of more than 1 year. And during this period, there should the patient the child should not be

symptom free for a minimum of 3 months. So onset is before 18 years of age, the most common comorbidity associated with Tourettes is OCD and ADHD.

Etiological factors, you have genetic factors, autosomal dominant and polygenic conditions are associated where the Monozygotic twins are the ones where the conditions are seen. Neurotransmitters affected are dopamine or adrenaline and sertraline, there is functional access of dopamine in the basal ganglia which is responsible for this condition.

So, there is one immunological role where you have group A beta haemolytic streptococci which is supposedly involved, and there is an entity called as PANDAS, that is paediatric autoimmune neuropsychiatric disorders associated with streptococcus bacteria. This is entity or condition which the child gets affected with, if at all, he or she is infected with group A, group beta haemolytic streptococcal.

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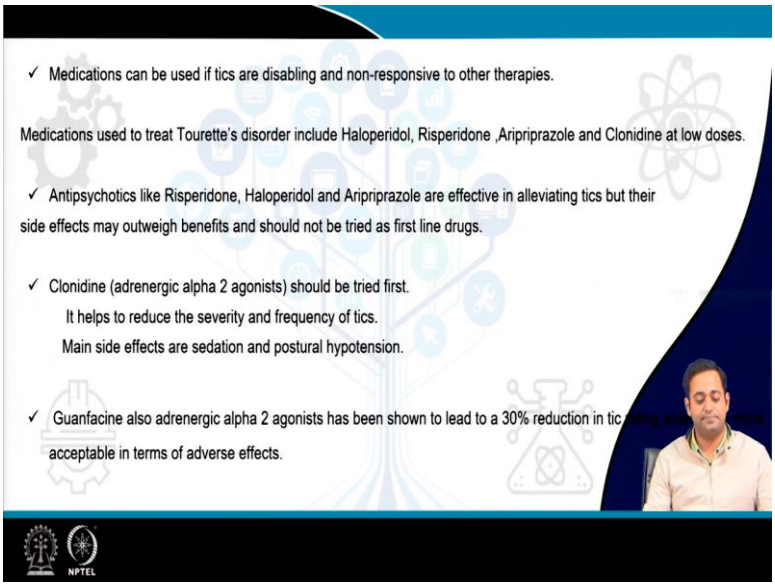

✓ Medications can be used if tics are disabling and non-responsive to other therapies.

Medications used to treat Tourette's disorder include Haloperidol, Risperidone ,Aripriprazole and Clonidine at low doses.

✓ Antipsychotics like Risperidone, Haloperidol and Aripriprazole are effective in alleviating tics but their side effects may outweigh benefits and should not be tried as first line drugs.

✓ Clonidine (adrenergic alpha 2 agonists) should be tried first.
It helps to reduce the severity and frequency of tics.
Main side effects are sedation and postural hypotension.

✓ Guanfacine also adrenergic alpha 2 agonists has been shown to lead to a 30% reduction in tic [illegible] more acceptable in terms of adverse effects.

CONCLUSIONS

➢ -In this lecture we have discussed regarding concepts Reactive Attachment disorder & disinhibited social engagement disorder ,Sibling rivalry ,School refusal ,Academic problem Attention Deficit Hyperactivity Disorder, conduct disorder, oppositional defiant disorder Childhood depression ,childhood schizophrenia & bipolar disorder, Tic & Tourette disorder along with its management.

REFERENCES

1 Oxford Test book Of Psychiatry
2 Comprehensive Text book Of Psychiatry (Kaplan & Sadock)
3 Text book Of psychiatry (Tasman & Leibermann)
4. Stephan stahl's psychopharmacology

So there are basically of two types in Tourette syndrome, simple tics and motor tics. So, this motor and vocal tics can be manifested in the form of simple and complex. So the simple ones are due to repetitive contractions of similar muscle groups. That is eye blinking, shoulder shrugging, in simple vocal text you have throat clearing, grunting or snorting. Among complex motor you have multiple purposeful ritualistic than simple tics for grooming behaviours, echopraxia. So, this individual tics may increase or decrease or persist or may be replaced by new ones. They are comorbidity associated with ADHD and OCDs.

Medications they treat, Tourette are FDA approved are haloperidol pimozide. However, atypical antipsychotics are commonly integrated because of the less side effect profile which is associated with typical ones than the atypical ones. So, the other drugs which can be used in case of Tourette is alpha 2 agonist, that is clonidine and guanfacine. It reduces the severity and frequency of tics, main side effects are sedation and postural hypotension.

So, in this lecture, we have discussed regarding the concepts of reactive attachment, disinhibited social engagement disorders, sibling rivalry, school refusal, childhood depression, schizophrenia, bipolar disorder and Tourette disorder. These are my references. Thank you.