Common Pediatric Behavioral Health Problems

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Disclosures

- No conflicts to report
- Parent
- Child and Adolescent Trained
I DON'T WANT TO GO TO SCHOOL! I HATE SCHOOL!
I'D RATHER DO ANYTHING THAN GO TO SCHOOL!
Defined

- Refusing to attend school or remain in class for an entire school day
  - As a pattern of behavior
Large diversity of causes
Mental Health

- Separation anxiety
- Fear of parents dying
- Social anxiety
- Fear of panic attacks
- Depression......hopeless, fatigued
- Paranoid.....people talking about, conspiring
- ADHD
- Learning disability
Bullying
Not fitting in, exclusion
Perception of no friends
Different academics (above or below)
Unknown event
Personal

- Uncontrollable hygiene problem
  - Incontinence
  - Menses
  - Bad breath

- Appearance:
  - Disability
  - Obesity
  - Dentition
  - Skin
Many others

- Lack of supervision
- Peer group behavior, peer pressure
- Substance abuse
- Non-traditional learner
- Sleep, teens

- Parents and kids may have very different opinions as to the reason.
- May be in open conflict about this.
May be active
May be passive
May be “pactive”
Occurrence

- Lifetime 5-28%
- Males = Females
- Can occur at all ages
  - An important question is “why now”
- Peak age of occurrence
  - 5-7 years old
  - 11-14 years old
Behavioral Spectrum

- **Substantial distress while attending school with pleas to parents for future nonattendance**
- **Severe misbehaviors in the morning in an attempt to miss school**
- **Chronic tardiness to school**
- **Skipping certain classes or periods of school during the school day**
- **Lengthy absences from school**
Short Term Consequences

- Distress
- Academic Decline
- Peer alienation
- Family conflict
- Financial
- Legal problems
  - Neglect?
Long Term Consequences

- Dropout
- Delinquency
  - vs. perseverance
- Social isolation
  - Importance of social learning
- Employment Problems/Economic
Symptoms

- **Internalizing**
  - Depression
  - Fatigue/Insomnia
  - Fear/Panic
  - Social anxiety
  - Self-Consciousness
  - Somatization

- **Externalizing**
  - Aggression
  - Clinginess
  - Dependence/Reassurance
  - Non-compliance/Defiance
  - Running away
  - Tantrums
  - Slow moving
Psychiatric Disorders

- No Diagnosis: 32.9%
- Separation Anxiety: 22.4%
- Generalized Anxiety: 10.5%
- Oppositional Defiant: 8.4%
- Major Depression: 4.9%
- Specific Phobia: 3.5%
- Conduct Disorder: 2.8%
- ADHD: 1.4%
- Panic Disorder: 1.4%
- Enuresis: 0.7%
- PTSD: 0.7%
Complaints and Conditions

**Somatic Complaints**
- Diarrhea/Irritable Bowel
- Fatigue
- Headache/stomach ache
- Nausea/Vomiting
- Palpitations/Perspiration
- Abdominal Pain
- Shaky/tremulous
- Sleep Problems

**Medical Conditions**
- Allergic rhinitis
- Asthma/Respirations
- Chronic Pain
- Diabetes
- Dysmenorrhea
- Lice
- Incontinence
- Dental Disease

“Is there something about your health or appearance that makes it hard to go to school?”
Assessment I

- Understand what has been tried already
- They have likely used up their ideas
- Observe parent/child interaction
  - Do they still listen to each other?
- Hear both sides, apart if needed
- Plug for Rating Scales
- Assess safety (mostly for teens)
  - Self harm or injuries (including fights at home)
  - Unaccounted for time, out overnight
  - Family advocacy?
Assessment II

- Medical work-up: conservative, but appropriate to age, history, objective findings
  - Timing of symptoms......Fridays good, Mondays bad?
    - It won’t always be so clean

- Functional:
  - Avoid (anxiety, panic attacks)
  - Escape (bullying, shame)
  - Pursue attention (new sibling)
  - Pursue Reinforcers (new peer group)

- Mental Health:
  - Given that two-thirds of children with school refusal meet criteria for a mental health Dx., a referral is always appropriate
Attempting to help I

- Identify the subjective cause
  - Empathize, form a non-judgmental alliance
  - Normalize, after all 5-28%
  - Reassure: This is a problem that usually has a solution.

- Provide resources
  - Encourage School Engagement

- Make suggestions consistent with your comfort and experience
RMOP’s are waiting for your calls
Temper Tantrums
Occur

- Peak ages 2-5 years
- Diminish as children gain language skills
- Can still occur in older kids
  - Which is when we are more likely to see it

- Fortunately never afflicts adults
Causes

- Can’t have something
- Can’t accomplish something
- Isn’t allowed to do something
- Asked to do something they don’t want
- Tired, hungry, uncomfortable
- Attention
- Learned
- Kids aren’t consciously choosing this behavior
Assessing

- What is the frequency, duration, length?
- What triggers?
- What have you tried for responses?
- What are you saying “No” to.
- Parents on same page? Nanny?
- More severe behaviors
  - Breath holding
  - Head banging
  - Destruction
- Who, What, When, Where, Why
Guidance - Basics

- Calm
- Ignore, but keep safe
- Don’t give in
  - Extinction Reaction
- Process
- Normalize
- Unity
Guidance II

- Get a video
- Give any plan time
- Written behavior plan
  - Write out the causes and responses
    - Both positive and negative
  - Include school (schools have lots of expertise)
  - Identify the positive opposite behavior
  - Consider a token or sticker economy
  - Provide resources
    - they should leave with something
Beyond Normal

- Other diagnoses
- Other help
Non-Suicidal Self Injury
What is NSSI?

- Includes cutting, scratching, burning, picking scabs or interfering with wound healing, punching self or objects, infecting oneself, and bruising
  - And many other creative attempts

- It’s important to ask extensively
  - Almost never the reason for the visit

- Extend appointment or make a quick follow-up
13%–45% of adolescents report having engaged in self-harm at some point in their lifetime (Nock, 2010).

Women are more common than men, but not by the extent one might believe. To put into perspective, NSSI exceeds the rates of other important clinical problems:

- Anorexia/Bulimia <2%
- OCD <3%
- ADHD 7–8% (most common diagnosis of childhood)

Good prognosis

In a way, it’s not scary

but common and treatable
The Role of NSSI

- Individual escape, manage, or regulate emotions.
- Self-punishment
- Anti-dissociation
  - stay real
- Resisting suicidal urges (stay alive; prevent suicide)
✓ Sudden and recurrent intrusive impulses to hurt oneself.

✓ A sense of being “trapped.”

✓ An increasing sense of agitation, anxiety, and anger.

✓ A constricted ability to “problem solve” or to think of reasonable alternatives for action.

✓ A sense of relief after the act of self-harm.

✓ A depressive or agitated-depressive mood, although suicidal ideation is not typically present.

(Pattison & Kahan, 1983)
Nearly 50% of self-harming individuals report physical and/or sexual abuse during childhood.
  - 50% don’t

As high as 90% report they were discouraged from expressing emotions, particularly anger and sadness.

Typically, self-harming individuals have a low self-esteem and a lack of healthy coping mechanisms.

Self harm reduces emotional pain

Serves as a coping mechanism
Microsystem
Family Dynamics

- Parent-Child Interactions
  - Invalidating family environment
  - Rejecting of child’s emotionality
  - Reinforcement of extreme emotions
    - Anger
    - Silent suffering
- How do parents cope with distress?
- How do parents show emotion?
- Attachments
Family Dynamics

- NSSI can arise as a learned response to insecure attachments (relationships)
  - A tool of control
- Parents would benefit from support as they struggle with their own intense emotions around NSSI.
  - Patients 1B & 1C
Family cont.

- Parents also need direction to SLOW DOWN and NOT OVERREACT.
- Similar response to tantrums if appropriate
  - Limit emotional response
  - Normalize and validate
  - Keep safe.......may restrict matches, razors
  - Show concern at other times.....check arms/legs
  - Process when everyone is calm
  - Unity between parents
  - Enlist school
  - Emphasize other ways to praise and validate
Peer Dynamics

- Contagion effect

- Peer influence processes
  - peer conformity
  - shared stressors
  - peer selection effects

- Possible treatment approaches:
  - Psychoeducational and support groups
  - School psychoeducation
  - The Embassy
  - Parent resources (don’t forget patients 1B & 1C)
**NSSI and Suicide**

- NSSI is a risk factor for subsequent suicidal attempts and completed suicide.
- NSSI can be mistaken for suicide attempts.
- Self-injury is most often NOT suicidal.
  - But about managing negative emotions.
- Some individuals report both NSSI and suicide attempts.
  - Important to screen for suicide.
- Rating scales and symptom questionnaires.
NSSI and Suicide

• NSSI is associated with higher risk for a suicide attempt when the following are present:
  – Higher levels of suicidal ideation
  – Severity of depression
  – Diagnosis of Borderline Personality Disorder
  – Impulsivity
  – Greater levels of negative affect
  – Apathy & hopelessness
  – Self-derogation/lack of self-acceptance

Brausch & Gutierrez (2009); Muehlenkamp (2010)
NSSI and Suicide

• Risk Factors
  – Severity and duration of NSSI (increased suffering)
  – NSSI becoming less effective in reducing emotional distress
  – Worsening mental health symptoms
    – Trend?

• Protective Factors
  – Hope
  – Family connectedness, support
  – Peer social support

_Brausch & Gutierrez (2009); Muehlenkamp (2010)_
Don’t forget to screen for..

These make everything better. What makes everything worse?

Substance Abuse
Treatment Approaches

- Individual Therapies
  - CBT, DBT, EMDR, Psychodynamic
- Family Therapy
- Group Therapy
- No evidence-based pharmacological treatments for self-harm
- But
- Treat underlying diagnoses
  - Depression being the most common
Your response with the child

- Make eye contact and speak in calm tones.
- Emphasize privacy
  - I’ll do everything I can to protect your privacy
- Normalize the behavior.
- Focus on the internal experience not the injury.
- Make the time
- Let the child teach you about his/her experience
- Remain neutral
  - self-injury isn’t “wrong”, it’s a symptom of suffering
- Be direct and specific about your concerns
  - “I’m worried you might cut an artery by mistake”
- Empower: “What do you think would help?”
Response DON’Ts

- React with horror or discomfort
- Immediately call a parent/guardian
- Ask abrupt and rapid questions
- Threaten or get angry
- Demand they stop
- Mandate therapy/hospitalization
- Accuse them of attention seeking
- Get frustrated if behavior continues
  - This is a long term problem that slowly improves
- Ignore other warning signs (i.e., family issues, suicidality, substance abuse, trend)
Your response with parents

- Realize how stressed they may feel
- Make time........let them talk in private
- Educate them about self-harm
  - No quick fix......it’s a family fix
  - Good prognosis
- Describe appropriate responses to their child
  - Avoid anger and strong emotional responses
  - Emphasize healthy communication
  - Safety, without affect
  - Strengthen parent-child bond
  - Learn their child’s triggers
  - Boundaries
- Try to do this non-judgmentally
About Contacting Parents

- A teen’s trust in you is paramount
- Do not break unless it is mandatory
  - Mandatory reporting?
- Ask permission first
  - Explain the reason
  - Describe what you will disclose
  - Ask what should not be disclosed
- Politely protect privacy if parents request more.
  - “It’s important that Paul has a private place to talk about some things”
Understand Triggers

– Trauma related events
  • Flashbacks/memories
  • Seeing the perpetrator
  • A smell, a song
– Being touched
– Family contact
– Peer interactions

– Reaching out (no follow through)
– Anxiety/Nerves
– Unregulated emotions
– Guilt
– Shame
– Sadness
– Anger
Support Plans

- Understand and limit triggers
- Know the details of self-harm
  - frequency, methods, history, peers, trend, plans
- Map out support system.
  - Understanding who is good support and who is not.
- Assess suicide, but in a caring and non-reactive way.
- Follow up soon and try to involve others
  - RMOP
What helps?

- Journaling (usually most helpful)
- Expanding support system
- Plans, contracts (if done correctly)
- Harm reduction
- Breathing/grounding techniques
- Learning to set boundaries
- Working through trauma(s)
- Being direct and modeling emotional expression.
- Physical exercise
- Support groups
- Being with people who genuinely care
You made it!
Enuresis

- Objectives:
  - Identify types of Enuresis
  - Discuss a physical work up
  - Discuss treatment options
Enuresis defined

- Discrete periods of nighttime urinary incontinence (while asleep) in children aged 5 and over.
Normal Development

- Toddler Phase (18 months - 3 years)
- Bowel Continence
- Bladder Continence
Enuresis

- Nocturnal Enuresis
  - Monosymptomatic
  - Polysymptomatic
- Diurnal Enuresis
- Primary Enuresis
- Secondary Enuresis
Types of Enuresis

- Regressive Enuresis
- Monosymptomatic Nocturnal Enuresis
- Polysymptomatic Nocturnal Enuresis
- Functional Enuresis
- Nonfunctional Enuresis
- Revenge Enuresis
- Enuresis due to lack of training
- Detrusor Dependent Enuresis
- Volume-Dependent Enuresis
Prevalence

- 30% of US children achieve continence by age 2
- 5-10% of 5 year olds meet criteria for nocturnal enuresis
- 15% of enuretic children have spontaneous resolution of symptoms each year
- 2-3% of 12 year olds meet criteria for nocturnal enuresis
- 1% of 18 year olds still have enuretic symptoms

Normalizing

- “when you wet the bed, first it’s warm and then it’s cold”
  - James Joyce, *A Portrait of the Artist as a Young Man*
Diagnostic Workup

- Child’s Age
- Onset of Symptoms (Primary/Secondary)
- Timing (Nocturnal/Diurnal/Both)
- Straining
- Frequency
- Family History/Genetics
- Developmental History
Physical Exam

- Neurological Exam
- Throat and Neck Exam
- Skin Exam
- Abdominal Exam
- Routine Blood Draw
- UA
Hints to spinal malformation

- Hair/pigment/tags/masses

- Expectant mom’s friend folic acid
Wait and See or Consult

- Pediatric Urology
- Ultrasound of Genitourinary system
- Voiding Cystourethrogram
- Renal Ultrasound
- Pediatric Neurology
- Sleep Study

![Graph showing percentage of wetting over age]

- Orange line: Wet occasionally
- Green line: Wet every night
RMO(P)’s & MP’s are waiting for your calls
Treatment

- Treat any medical issues
- Education
- Watchful Waiting
- Non-pharmacological Management
- Pharmacological Management
- Other therapies
Non-Pharmacological Interventions

- Education
- Advice
- Bell and Pad
Non-Pharmacological Interventions

- Bladder-Volume Alarm
- Star Chart System
- Nightlifting*
- Timed Night Awakening
- Bladder Training Exercises/Overlearning
Pharmacological Interventions

- Desmopressin
- Imipramine
- Oxybutynin
- TCAs, SSRIs & Psychostimulants
- NSAIDs
Additional Treatments

- Psychotherapy
  - Parents are patients 1b & 1c

- Acupuncture

- Biofeedback
My Current Patient

A 15yo girl, almost straight A’s, plays guitar well, naturally pretty but wears no make-up, self-desc introvert

- **Causes:**
  - Teacher embarrassed her
  - Test anxiety
  - Only girl in crossfit- “didn’t want to look weak”
  - Headaches
  - Pelvic pain
  - Nausea
  - Sprained thumb in softball (parents enabled)

- **Her Dx:**
  - Major depressive disorder
  - Social Anxiety D/O
  - OCD Traits
  - Hx of Self-harm
Attempting to help II
Keys to relationship

- Trust
- Listening
- Empathy
- Non-judgment
- Knowledge
- Privacy
- Follow-through
- Self-actualization