Child Psychiatry

By Leen Baqaeen
Saif barham

What is *Child Psychiatry ?*

Definition:

Child psychiatry focuses on the diagnosis and treatment of emotional, behavioral, and developmental disorders in individuals aged (0–18)years.

- **Presentations differ from adults, as children express symptoms according to their developmental stage.**
- **Requires a developmentally appropriate approach to assessment and treatment.**
- **Early identification and intervention are crucial to improve long-term outcomes.**

Sources of Clinical Info & Methods of Assessment

- **Sources of Clinical Information**

Primary caregivers Teachers & school staff
Pediatricians & health professionals
Child welfare/social services (if relevant)

- **Methods of Assessment**

Play therapy: Emotional expression through play, drawing, storytelling
Classroom observation: Evaluates real-world behavior & functioning
Neuropsychological testing: IQ, memory, attention, executive functioning
K-ABC (ages 2–12): Problem-solving vs acquired knowledge
WISC-R (ages 6–16): Verbal, performance & full-scale IQ

Safety Screening &Importance of Early Detection

- **Always assess for:**

~Suicidal ideation/self-harm

~Homicidal thoughts

~Command hallucinations

- **Suicide = 2nd leading cause of death (ages 10–34 in U.S.)**
- **In 2024, Jordan recorded 166 suicides, up slightly from 160 in 2023; 16 were minors under 18**
- **Suicide > 2× more common than homicide in youth**

Mood Disorders
Major Depressive Disorder (MDD)

- **Definition: A mood disorder characterized by persistent feelings of sadness or irritability, loss of interest or pleasure (anhedonia), and associated cognitive and somatic symptoms that impair daily functioning. In children and adolescents, irritability may predominate instead of sadness.**
- **15% of adolescents (12–17 years of age) report major depression in the past 12 months. (NIMH)**
- **Pre-puberty, there is a slightly higher incidence of depressionin boys than girls. After puberty, the incidence is higher in girls.**
- **Psychiatric comorbidities are common, e.g.:**

1. **Conduct disorder or oppositional defiant disorder**
2. **Anxiety**
3. **Attention deficit hyperactivity dis**

Major depressive disorder

- ***Diagnosis and DSM-5-TR Criteria***

A diagnosis of MDD requires the presence of ≥5 symptoms for ≥2 weeks, representing a change from baseline functioning. At least one symptom must be either depressed mood or anhedonia:

1.Depressed or irritable mood most of the day, nearly every

2.Diminished interest or pleasure in all or most activities

3.Significant weight loss or gain, or failure to gain expected weight in children.

4. Insomnia or hypersomnia nearly every day

5.Psychomotor agitation or retardation observable by others

6. Fatigue or loss of energy

7. Feelings of worthlessness or excessive guilt

8. Diminished ability to concentrate or indecisiveness

9.Recurrent thoughts of death, suicidal ideation, or suicide attempt

Major Depressive Disorder (MDD)

Diagnosis

- Diagnostic criteria for MDD are the same as two exceptions: Irritability can be noted in the assessment of mood.
Failure to gain weight can be noted in the assessment of appetite.
- Some symptoms may resemble those of attention deficit hyperactivity disorder(ADHD) , e.g.:

1. Irritability
2. Difficulty concentrating or worsening performance at school

Major Depressive Disorder

***Etiology*:**

Genetic factors: Increased risk if family history of mood disorders

Neurobiological: Monoamine dysregulation, HPA axis abnormalities

Psychosocial: Family conflict, loss, trauma, bullying

Cognitive vulnerabilities: Negative attributional style, low self-esteem

Major Depressive Disorder

Treatment:

- Psychotherapy: Cognitive Behavioral Therapy (CBT) is first-line
- Pharmacotherapy:

Fluoxetine (FDA-approved ≥8 years)

Escitalopram (≥12 years) as second-line

- Combination therapy (CBT + SSRI) shows superior outcomes
- Monitor for **suicidality, especially during early SSRI treatment**
- Involve family and school supports in treatment planning

Bipolar Disorder

- **Definition**: A chronic mood disorder characterized by alternating episodes of **mania/hypomania and depression**. In pediatric populations, it often presents with rapid cycling, irritability, and mixed episodes.
- A sudden change in a child or adolescent's mood or activity that differs significantly from their usual behavior may indicate bipolar disorder. Mood swings are normal during puberty, so symptoms should be differentiated from them.
- Prevalence: 1-3% in adolescents; rare in prepubertal children.
- Onset: late childhood to adolescence.
- Equal sex distribution pre-puberty; post-pubertal males more likely to develop BD I.
- Comorbid ADHD: up to 60%, conduct disorder: 25%

Bipolar Disorder

Diagnosis and DSM-5-TR Criteria

Manic Episode :

- **distinct period of abnormally and persistently elevated, expansive, or irritable mood, and increased goal-directed activity or energy, lasting ≥1 week (or any duration if hospitalization is required), with ≥3 (≥4 if mood is irritable only) of:**

1. Inflated self-esteem or grandiosity
2. Decreased need for sleep
3. More talkative than usual (pressured speech)
4. Flight of ideas or racing thoughts
5. Distractibility
6. Increase in goal-directed activity or psychomotor agitation
7. Excessive involvement in risky activities (e.g., unprotected sex, spending sprees):
-Causes marked impairment, hospitalization, or psychosis
-Not due to a substance or medical condition

Bipolar Disorder

Diagnosis and DSM-5-TR Criteria

Hypomanic Episode:

- **Similar to mania but duration is ≥4 consecutive days, and does not cause marked impairment or require hospitalization**

Major Depressive Episode:

- **Same criteria as outlined in MDD**

More specific changes:

Changes during manic episode may include:

-Sleeping only for a few hours but not feeling tired

-Difficulty staying focused in school

-Increased interest in risky activities (e.g., dangerous sports without proper training)

Changes during depressive episode may include:

-Sleeping more than usual (e.g., more than 12 hours several days in a row)

-Lack of interest in activities that were previously enjoyed

-Feelings of doing everything wrong

Bipolar Disorder

Etiology:

- Genetic loading: High heritability (up to 85% in twin studies)
- Neurobiological: Fronto-limbic dysfunction, circadian rhythm dysregulation
- Environmental: Childhood trauma, parental mood disorders, stressors

Bipolar Disorder

Treatment:

- **Pharmacotherapy:**

Lithium (FDA-approved for children ≥12 years)

Atypical antipsychotics: Risperidone, Aripiprazole, Quetiapine

Mood stabilizers: Valproate (off-label), Carbamazepine

- **Psychotherapy: Family-focused therapy, CBT, interpersonal and social rhythm therapy**
- **Psychoeducation and school-based accommodations are vital**
- **Monitor thyroid, renal, hepatic function and serum levels where appropriate**

Disruptive Mood Dysregulation Disorder

- ***Definition*** : A mood disorder characterized by extreme irritability and severe recurrent outbursts of anger (verbal or physical). Outbursts are inappropriate for developmental age and occur **> 3** times per week for **> 12** months. Diagnosed between 6 and 18 years of age in individuals who do not meet the criteria for bipolar disorder.
- **Gender**: More common in males than females
- **Prevalence**: Chronic severe irritability is estimated to affect 2–5% of children (6–12-month prevalence)
- **Common comorbidities**:

Oppositional Defiant Disorder (ODD)
Major Depressive Disorder (MDD)
Attention-Deficit/Hyperactivity Disorder (ADHD)
Anxiety and substance use disorders (in adolescents)

Disruptive Mood Dysregulation Disorder

DSM-5 diagnostic criteria for DMDD :

- **Severe recurrent verbal and/or physical outbursts out of proportion to situation.**
- **Outbursts ≥3 per week and inconsistent with developmental level.**
- **Mood between outbursts is persistently angry/irritable most of the day nearly every day, and is observed by others.**
- **Symptoms for at least 1 year, and no more than 3 months without symptoms.**
- **Symptoms in at least two settings (e.g., home, school, peers).**
- **Symptoms must have started before age 10, but diagnosis can be made from ages 6 to 18.**
- **No episodes meeting full criteria for manic/hypomanic episode lasting longer than 1 day.**
- **Behaviours do not occur during MDD and not better disorder (this disorder cannot coexist with oppositional explained by another mental defiant disorder, intermittent explosive disorder, or bipolar disorder).**
- **Symptoms not due to a substance (medication or drug) or another medical condition**

Disruptive Mood Dysregulation Disorder

Etiology: (Causes currently being investigated include)

- **Brain function differences, especially in areas like the amygdala and prefrontal cortex**
- **Family history of mood disorders (genetics)**
- **Temperament: children who are highly reactive or irritable**
- **Environmental stressors (parental conflict, trauma, inconsistent caregiving)**

Prognosis:

Individuals with DMDD are at increased risk of major depressive disorder and anxiety disorders in adulthood.

Treatment

- **Given the newer nature of this diagnosis, there are no consensus evidenced-based**
- **treatments. Psychotherapy (such as parent management training) for the patient and family is generally first line.**
- **Medications should be used to treat comorbid disorders.**
- **Stimulants, SSRIs, mood stabilizers, and second-generation been used to treat the primary symptoms of DMDD.**

Anxiety Disorders in Children & Adolescents

- **Definition**: A group of internalizing disorders characterized by excessive fear, anxiety, and related behavioral disturbances, often manifesting in avoidance behaviors, school refusal, irritability, and somatic symptoms in children. These disorders often emerge early and can cause significant developmental and social impairments if left untreated.
- **Diagnosis and DSM-5-TR Core Criteria (General)**

Developmentally inappropriate, excessive fear or anxiety
Persistent, typically ≥6 months
Causes clinically significant distress or functional impairment
Not attributable to substances or another mental disorde

subtypes

Separation Anxiety Disorder (SAD)

Generalized Anxiety Disorder (GAD

Social Anxiety Disorder (Social Phobia)

Selective Mutism

Specific Phobia

1. Separation Anxiety Disorder (SAD)

Excessive anxiety about being separated from home or attachment figures, beyond what is developmentally appropriate.

DSM-5-TR Criteria (≥3 of the following for ≥4 weeks in children):

- ***Recurrent distress when anticipating or experiencing separation***
- ***Excessive worry about losing or harm befalling attachment figures***
- ***Reluctance or refusal to go to school or other places***
- ***Fear of being alone or without attachment figures***
- ***Refusal to sleep away from home or without major attachment figures***
- ***Nightmares involving separation***
- ***Physical symptoms (e.g., headaches, nausea) during or in anticipation of separation***

***Age of onset:* ~7–9 years**

***Course*: May lead to school refusal, withdrawal, and academic failure if untreated**

2. Generalized Anxiety Disorder (GAD)

Excessive, uncontrollable worry about multiple life domains (school, family, health), not limited to a specific situation.

DSM-5-TR Criteria:

- **Excessive worry occurring most days and for ≥6 months, about various domains**
- **Difficulty controlling the worry**
- **≥1 of the following in children:**
- **Restlessness or feeling on edge**
- **Difficulty concentrating.**
- **Muscle tension.**
- **Fatigue**
- **Irritability**
- **Sleep disturbances**

Features in children:

- **Perfectionism.**
- **Constant reassurance seeking**
- **Physical complaints (e.g., stomachaches, headaches)**
- **Academic underperformance due to fear of failure**

3. Social Anxiety Disorder (Social Phobia)

Persistent fear of social or performance situations where the child is exposed to unfamiliar people or possible scrutiny.

DSM-5-TR Criteria:

- Marked fear/anxiety about one or more social situations involving possible scrutiny
- Fear of acting in a way that will be negatively evaluated
- Avoidance of feared social situations
- Fear is out of proportion to actual threat
- Lasts ≥6 months

Common manifestations:

- Avoiding answering questions in class
- Fear of eating in public or using public restrooms
- Avoiding peer interaction
- May lead to selective mutism or school refusal

4. Selective Mutism

Consistent failure to speak in specific social situations (e.g., school) despite speaking in other settings (e.g., home).

DSM-5-TR Criteria:

- **Failure to speak in specific social settings where there is an expectation for speaking**
- **Interferes with educational or social communication**
- **Duration ≥1 month (not limited to the first month of school)**
- **Not due to language knowledge or communication disorder**

Features:

- **Usually begins before age 5**
- **Often coexists with social anxiety disorder**
- **Speech and language abilities are normal in comfortable environments**

5. Specific Phobia

Persistent, irrational fear of a specific object or situation (e.g., animals, heights, blood), leading to avoidance.

DSM-5-TR Criteria:

- **Marked fear or anxiety about a specific object/situation**
- **The object/situation is avoided or endured with intense fear**
- **Fear is out of proportion to actual danger**
- **Lasts ≥6 months**

Common types in children:

- **Animals/insects (dogs, spiders)**
- **Natural environments (storms, darkness)**
- **Blood/injections**
- **Situational (elevators, planes)**

Features:

- **May manifest as tantrums, crying, clinging, or freezing**
- **Impairment depends on the frequency of exposure to the phobic stimulus**

Anxiety Disorders in Children & Adolescents

Epidemiology

- Lifetime prevalence: ~10–30%
- GAD and specific phobia are **most common**
- Females > males (ratio varies by subtype)
- Onset often in early to middle childhood
- High comorbidity with MDD, ADHD, learning disorders

Etiology

- Genetic vulnerability (heritability ~30–40%)
- Neurobiological: Dysregulation of amygdala and limbic circuits; serotonin/GABA dysfunction
- Cognitive: Catastrophic thinking, attentional bias toward threat
- Environmental:
- Parental modeling of fear/anxiety • Traumatic experiences • Overprotective parenting
- School transition stressors

Treatment

Psychotherapy

- CBT (Gold Standard)
- Relaxation techniques
- Exposure therapy
- Cognitive restructuring
- Play-based CBT for younger children

Pharmacotherapy

- SSRIs:
- Fluoxetine and Sertraline most studied
- Used when severe impairment or lack of CBT response
- Dosing: Start low, go slow; monitor for behavioral activation and suicidality

Other Supports

- Parental involvement in therapy enhances outcomes
- School collaboration to address avoidance and reinforce adaptive behavior
- Avoid reinforcement of avoidance behaviors (e.g., excessive reassurance

Early-Onset Schizophrenia

Definition

A rare, severe neurodevelopmental disorder with onset of schizophrenia symptoms before age 18.

EOS presents with hallucinations, delusions, disorganized thinking, and cognitive/social decline.

Epidemiology

- Extremely rare: ~1 in 10,000 before age 13
- More common in males and lower SES
- Earlier onset = worse prognosis
- Commonly comorbid with ASD, ADHD, and learning disabilitie

Early-Onset Schizophrenia

Diagnosis and DSM-5-TR Criteria:

Presence of ≥2 of the following, each present for a significant portion of time during a 1-month period (at least one must be 1, 2, or 3):

1. Delusions
2. Hallucinations
3. Disorganized speech
4. Grossly disorganized or catatonic behavior
5. Negative symptoms (e.g., flat affect, alogia, avolition)

AND:

- Social/occupational dysfunction
- Continuous signs of disturbance persist for ≥6 months
- Schizoaffective and mood disorders ruled out
- Not due to substance or general medical condition
- For children: hallucinations must be persistent and impairing

Early-Onset Schizophrenia

Etiology

- Genetic factors: Strong family history of schizophrenia or psychotic disorders
- Neurodevelopmental: Early brain insult, obstetric complications
- Neurobiological: Enlarged ventricles, gray matter reduction, dopamine dysregulation
- Psychosocial stressors may precipitate exacerbations

Treatment

- **Antipsychotics**:
- Risperidone, Aripiprazole, Olanzapine (second-generation agents preferred)
- Clozapine for treatment-resistant cases (requires WBC monitoring)
- **Psychosocial interventions:**
- Psychoeducation for families
- Cognitive remediation therapy
- Individualized Education Plans (IEPs) for school performance
- Lifelong treatment often required
- Best outcomes seen with early diagnosis, adherence, and integrated care

Oppositional Defiant Disorder

Definition

a maladaptive pattern of irritability/anger, defiance, or vindictiveness that causes dysfunction or distress in the individual or in those affected by their behavior. These interpersonal difficulties must involve at least one non-sibling (typically an authority figure).

Epidemiology

- Prevalence: ≈ 3%
- Onset: Usually occurs during preschool years
- Gender: More common in boys prior to adolescence
- Frequently comorbid with ADHD and substance use disorders
- Although ODD can precede Conduct Disorder (CD), the majority of children with ODD do not go on to develop CD

Oppositional Defiant Disorder

Diagnosis and DSM-5 Criteria

ODD is characterized by at least four symptoms lasting for **≥6 months**, with at least one directed toward an individual who is not a sibling.

Symptoms fall into the following categories:

-**Angry/Irritable Mood:**

- Frequently loses temper.
- Is often angry and resentful

-**Argumentative/Defiant Behavior:**

- Often argues with authority figures
- Actively defies or refuses to comply with rules or requests
- Deliberately annoys others
- Blames others for his or her own mistakes or misbehavior

-**Vindictiveness:**

- Has been spiteful or vindictive at least twice within the past six months

Additional diagnostic requirements:

• The behaviors must be associated with distress in the individual or others in their immediate social context, or must negatively impact functioning in social, educational, or occupational settings.

• The behaviors cannot be explained exclusively by another mental disorder (e.g., depression, anxiety, psychosis)

Oppositional Defiant Disorder

- **Etiological Factors**

- Genetic predisposition
- Neurobiological anomalies: e.g., dysregulation in cortisol levels, executive function deficits
- Environmental stressors: inconsistent or harsh parenting, family conflict, abuse, and neglect

- **Treatment**

• Behavior modification strategies, including positive reinforcement and consistent limit-setting
• Conflict management and problem-solving skills training
• Parent Management Training (PMT): Helps caregivers implement structure, consistency, and effective discipline
• Pharmacologic treatment is reserved for managing comorbid conditions (e.g., stimulant medications for ADHD)

THANK YOU