HEADS UP ON
MENTAL HEALTH CONCERNS
IN CHILDREN WITH
DEVELOPMENTAL DISABILITIES

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Psychiatrist
MENTAL HEALTH

• WHO: Health is more than the absence of illness

• Emotional well being is as important as physical health

• Good mental health allows children to develop resilience, cope with life and grow into well rounded healthy adults
MENTAL HEALTH PROBLEMS

- Affects 1 in 10 children and adolescents
- WHO global estimate: 10-20%
- 80% have not had appropriate interventions at a sufficiently young age
CHILDREN WITH DEVELOPMENTAL DISABILITIES

- Face all of the challenges faced by children with typical development
- Manifest the same range of psychiatric illness

Presence of a developmental disability often alters the symptomatic presentation of psychiatric disorders and makes accurate diagnosis more difficult.
Children With Developmental Disorders “A Highly Vulnerable Population”

• Burdened with disabilities not shared by typically developing children
• Need special interventions and accommodations
• Many are aware of their disabilities and special interventions
• Susceptible to psychiatric comorbidities
• Parents show high levels of distress
• **Recognition is crucial** for caregivers and those who interact with the child.

• When unrecognized or untreated → fail in educational and social settings, be unmanageable at home and show aggression and self injury.

• **Distinct challenge for parents and individuals:**
  - To work with children with disabilities
  - Be alert to the possible presence of a psychiatric disorder and obtain early diagnosis and treatment
UNDERSTAND the signs and symptoms
IDENTIFY early
INTERVENΕ promptly
Causes of Psychiatric Disorders Among Children with Developmental Disabilities

- Biological
- Environmental
- Psychosocial
MENTAL HEALTH ISSUES

1. Anxiety disorders
2. Obsessive compulsive disorders
3. Post-traumatic stress disorder
4. Mood disorders – depression
5. Suicidal ideations/ tendencies/ actions
ANXIETY and MOOD DISORDERS
ANXIETY AND MOOD DISORDERS

• Among the most common disorders in children

• Antecedent for many emotional and behavioral difficulties

• Cause a great deal of distress and dysfunction

• Sometimes... it is NOT JUST A PHASE
Anxiety and Mood Disorders

• Epidemiology: 5 – 15% of children and adolescents
• Depression: ? Rare in young children
  10-15% in adolescents
• Anxiety affects boys and girls equally
• Girls are more vulnerable to depression than boys
  (2 of 3 depressed teens are female)
• Suicidal thoughts present in about 15% of adolescents with mood and anxiety disorders
Anxiety and Mood Disorders in ASD

• Children diagnosed high functioning ASD/Asperger’s Syndrome at age 4 – 6
• Followed up for 6 years

• Demonstrated higher levels of psychiatric problems than the general population (17%)
• High levels of anxiety and depression correlated with higher levels of aggression
RISK FACTORS

- Anxiety and depression represent gene-environment interaction

<table>
<thead>
<tr>
<th>Family</th>
<th>Environment</th>
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<tbody>
<tr>
<td>Parental anxiety/depression</td>
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<tr>
<td>Family stressors: poverty, marital conflicts, persistent parent child conflict</td>
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<tr>
<td>Family history of suicide</td>
<td>Home/ School/ Therapy/stress</td>
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<tr>
<td>Relationships problems</td>
<td>Social media (Facebook, Twitter, Instagram)</td>
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<table>
<thead>
<tr>
<th>Individual</th>
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<tr>
<td>Cognitive distortions</td>
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<td>Personal/global attribution styles</td>
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<td>Pessimism/negative thoughts</td>
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What Are The Signs?
ANXIETY

Presence of uncertainty and danger in normal situations

↑ Heart rate
↑ Alertness
↑ Perception
↑ Tension
ANXIETY AND MOOD DISORDERS

Shared symptoms: feeling edgy, restless, muscle tension, irritability, sleep disturbances

- Separation anxiety
- Social anxiety
- Generalized anxiety disorder
- Obsessive compulsive disorder
- Panic disorder
- Phobias
Anxiety Disorders

• Separation Anxiety
  • Most common in middle childhood (7-9 yrs)
  • 4% - 5% prevalence rate
  • Excessive anxiety at points of separation from parent
  • School phobia

• Generalized anxiety disorder
  • Older children and teens (12-19)
  • Excessive anticipatory worries about common events and activities

• Social anxiety disorder
  • Social and performance anxiety
  • Fear of being humiliated/embarrassed
  • Red flags: school refusal, test anxiety, excessive shyness, poor peer relationships, diminishing social circle
Anxiety Disorders

Specific Phobias
- Excessive fear of specific objects (mouse, spider) or situation (elevator)
- Avoidance behavior can interfere in functioning

Panic Disorder
- Intense fear with somatic symptoms (palpitations, excessive sweating, headache, shortness of breath)
- Triggered by certain situations (open spaces, crowded places)
Obsessions, Compulsions AND RITUALS
Obsessive-Compulsive Disorder

• Obsessions and compulsions causing severe distress/anxiety

• Obsessions: usually hostile, unacceptable (e.g., thoughts of house burning, cursing God in one’s mind, counting numbers)

• Compulsions: hand washing, checking doors

• R/o PANDAS (pediatric autoimmune neuropsychiatric disorder associated with streptococcal infection)
Can it happen to children?

Can it happen to Omran?
Post- Traumatic Stress Disorder

• Childhood trauma commonly seen in pediatric clinic

• Acute or chronic conditions:
  • Child abuse (sexual, physical, emotional)
  • Natural disasters surviving (typhoons, fires)
  • Witnessing violent events

• Symptoms
  • Exaggerated startle response
  • Always anticipating danger
  • Recurrent frightening dreams
  • Intrusive recall of traumatic events
  • Irritability
  • Social withdrawal
  • Sleep problems
  • Outburst of violent behavior
DEPRESSION: The Signs
• Forty years ago, physicians doubted existence of depressive disorders in children - Belief that children lacked mature psychological and cognitive structure necessary to experience the problem.

• Current evidence confirms that children and adolescents experience the whole spectrum and suffer significant morbidity and mortality
How common is depression in neurotypical children?

Does it exist in the special needs population?

Can children in the low-functioning or with severe developmental disabilities have depression too?
DEPRESSION IN CHILDREN

3% of the population

<table>
<thead>
<tr>
<th>YOUNGER CHILDREN</th>
<th>OLDER CHILDREN</th>
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<tbody>
<tr>
<td>• Anxiety</td>
<td>• Sad mood with negative self statements (<em>I can’t do anything right</em>)</td>
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<tr>
<td>• Irritability</td>
<td>• Decreased involvement in activities and relationships</td>
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<tr>
<td>• Weepiness</td>
<td>• Frequent bodily complaints</td>
</tr>
<tr>
<td>• Temper tantrums</td>
<td>• Sensitive to rejections, criticisms</td>
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<tr>
<td>• Somatic symptoms</td>
<td>• Irritability</td>
</tr>
<tr>
<td></td>
<td>• Thoughts of death (<em>I wish I’m dead</em>)</td>
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</table>
Who are the most vulnerable children among those with developmental disabilities?
DEPRESSION IN ADOLESCENTS

6-8% of the population

MAJOR SYMPTOMS

- Irritability, anxiety
- Deep sadness (dark clothes, poems and drawings with morbid themes)
- Social withdrawal
- Lack of motivation
- Sleep disturbance
- Change in appetite (anorexia, bulimia)

Dear Mom and Dad don't bother to give me dinner I'm not that hungry

Love From The saddest person in the world

This world is so cruel
And I don't wanna see it anymore
DEPRESSION IN ADOLESCENTS

MAJOR SYMPTOMS

- Risky behaviors (alcoholic binge, drug use, cutting—may be subtle, in parts covered by clothes)
- Guilt feelings
- Hopelessness and helplessness
- Preoccupation with death

Can lead to NSSI
Seen self-harm content on the internet in the last year:

- 13 – 14 year olds: 1 in 6
- 15 – 16 year olds: 1 in 4

Non-Suicidal Self Injury
EARLY RECOGNITION IS IMPORTANT!
Avoid minimizing! - e.g. Nag-iinarte ka na naman

Hopelessness
Suicidal ideations

More likely to commit suicide
Higher rates of completed suicide
Bipolar Disorder

• About 40% of depressed teenager switch to bipolar disorder

Signs & Symptoms

✓ Sad feelings quickly switch to anger
✓ Restlessness
✓ Unhappy mood
✓ Decreased need for sleep
✓ Racing thoughts/flight of ideas
✓ Over talkativeness/pressured speech
✓ Grandiosity and expansive mood
Conduct Disorder

- Physical aggression against people or animals
- Destruction of property
- Theft and deceitfulness
- Violation of age appropriate rules or norms
Oppositional Defiant Disorder

- Pattern of anger and irritable mood
  - Temper outburst
  - Touchy, easily annoyed
  - Angry and resentful
- Argumentative and defiant behavior
  - Argues with adults/authority figures
  - Defiant/refuses to comply with rules
  - Deliberately annoys others
  - Blames others for his mistakes/misbehavior
- Vindictiveness
  - Spiteful and vindictive
HOW CAN WE HELP?
We have an important role
We have a responsibility
We can help
UNDERSTAND the signs and symptoms
IDENTIFY them early
INTERVENE promptly inform pediatrician/dev pediatrician
REFER to Psychiatry
Parents ← Relative/caregiver
Teachers, therapists
What Can Be Done Before Referring to Psychiatrist

Primary Goals: Reduce the stress
   Reduce symptoms
   Identify and practice coping strategies

Interventions: Inform parents
   Identify family and environmental stressors
   (family conflict, school pressure, etc)
   Monitor and support return to normal
   (be attentive, be supportive)
   Assess suicidal risk -> develop safety plan

Refer to a MENTAL HEALTH PROFESSIONAL
COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version with Triage Points

SUICIDE IDEATION DEFINITIONS AND PROMPTS:  

<table>
<thead>
<tr>
<th>Ask questions that are bolded and underlined.</th>
<th>Past month</th>
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<tbody>
<tr>
<td>Ask Questions 1 and 2</td>
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<tr>
<td>(1) Wish to be Dead:</td>
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<tr>
<td>Person endorses thoughts about a wish to be dead or not live anymore, or wish to fall asleep and not wake up.</td>
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<tr>
<td><em>Have you wished you were dead or wished you could go to sleep and not wake up?</em></td>
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<tr>
<td>(2) Suicidal Thoughts:</td>
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<tr>
<td>General non-specific thoughts of wanting to end one's life/commit suicide, &quot;I've thought about killing myself&quot; without general thoughts of ways to kill oneself/associated methods, intent, or plan.</td>
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<tr>
<td><em>Have you actually had any thoughts of killing yourself?</em></td>
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<td>If YES to 2, ask questions 3,4,5, and 6. If NO to 2, go directly to question 6.</td>
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<tr>
<td>(3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):</td>
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<tr>
<td>Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. &quot;I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it...and I would never go through with it. &quot; <em>Have you been thinking about how you might kill yourself?&quot;</em></td>
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<tr>
<td>(4) Suicidal Intent (without Specific Plan):</td>
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<td>Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to &quot;I have the thoughts but I definitely will not do anything about them.&quot; <em>Have you had these thoughts and had some intention of acting on them?</em></td>
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<tr>
<td>(5) Suicide Intent with Specific Plan:</td>
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<tr>
<td>Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. <em>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</em></td>
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<tr>
<td>(6) Suicide Behavior Question:</td>
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<tr>
<td><em>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</em></td>
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<tr>
<td>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.</td>
<td></td>
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<tr>
<td>If YES, ask: <em>How long ago did you do any of these?</em></td>
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<tr>
<td><em>Over a year ago?</em></td>
<td><em>Between three months and a year ago?</em></td>
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Suicide Intervention

- **Psychosocial Support**
  - Demonstrate a non-judgmental, caring and accepting approach
  - Encourage a support network
  - Psychoeducation of parents and patient

- **Formulation of Safety Plan**
  - Collaborative
  - Warning signs, internal coping strategies, socialization strategies for support and distraction, social and professional contacts for assistance during crisis, means restriction

- **Referral to child and adolescent psychiatrist**
- **Hospitalization if necessary**
Together We Can!
WE CAN'T HELP EVERYONE BUT EVERYONE CAN HELP SOMEONE.

-- RONALD REAGAN