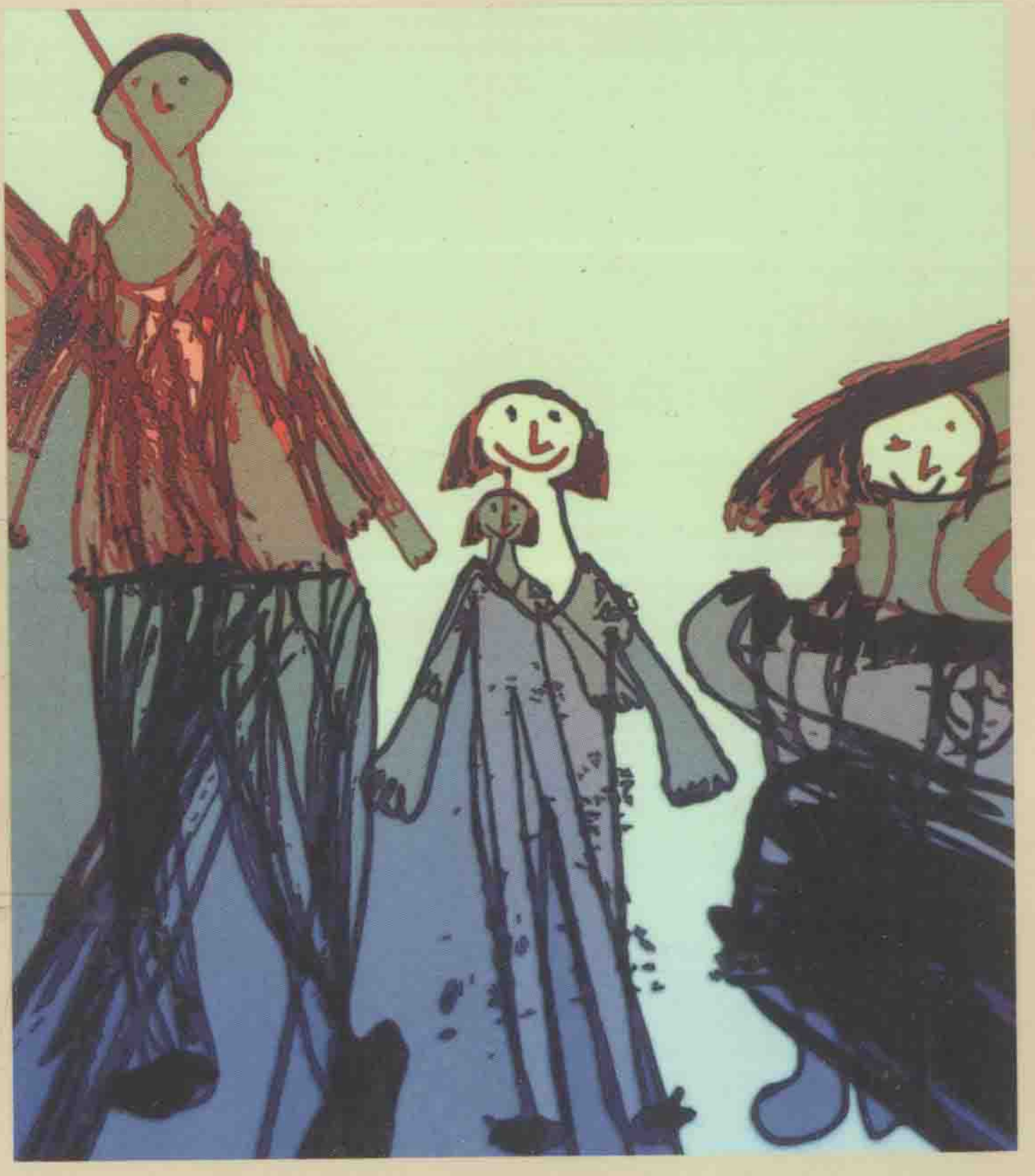
CORE HANDBOOKS IN PEDIATRICS

CHILD AND ADOLESCENT MENTAL HEALTH

David L. Kaye
Maureen E. Montgomery
Stephen W. Munson



LIPPINCOTT WILLIAMS & WILKINS

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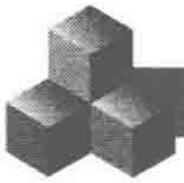

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CHILD AND ADOLESCENT MENTAL HEALTH

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Preface

I (D. K.) had completely forgotten the name Hale Shirley, M.D. But there was his book in the same place on my bookshelf. I had not looked at it for years since it was given to me by an old friend whose father had been a pediatrician. In 1948, Dr. Shirley wrote *Psychiatry for the Pediatrician.* As I prepared to write I marveled at how we've once again gone "back to the future." At that time he wrote:

The time, perhaps, is past when the pediatrician needs to be urged to consider the mental as well as the physical health of his patient. Organized pediatrics has increasingly recognized its strategic position in the prevention and treatment of children's behavior and personality disorders. Because of their early and repeated contacts with children and their parents, the pediatrician and general practitioner have an unequaled opportunity to discover situations which may interfere with the normal personality development of the child, to detect early evidences of maladjustment in the child, and to provide opportunity for proper therapeutic measures at an age when treatment can be expected to be most effective. They can also play a vital role in the mental health of their communities by translating to parents, nurses, and teachers the insight, concepts, and attitudes needed in the daily care of children and by giving parents guidance and reassurance in the management of the everyday problems of the everyday child.

Over the past 50 years there has been slow and incremental movement of the two fields towards each other, often punctuated by stutters and stops. In the last ten years this slow progress seems to have improved. In this recent past, within the medical brother- and sisterhood there has been an increasing appreciation for the unity of mind/body/spirit. This has promoted a greater valuation of the doctor-patient relationship by primary care physicians (PCPs) as well as a greater appreciation of the brain by psychiatrists. At the same time that these philosophical orientations within medicine have shifted, the gale winds of managed care have both promoted this collaboration (e.g., by limiting the indications for the "million dollar workup" which fosters a mind-body split; by capitation which fosters prudent use of resources and due consideration of psychiatric and developmental considerations) and also undermined the doctor-patient relationship (e.g., arbitrary and rapid changes in "provider" panels, disregard of the critical need for patient confidentiality, and in many situations promoting a serious conflict of interest for doctors, for example the doctor's financial well being versus the patient's welfare). In spite of these conflicting forces, the reality is that anyone serious about promoting the health care needs of children must address psychiatric and developmental issues.

Child and adolescent psychiatry is a young specialty, developing 25 to 50 years behind pediatrics. The first widely known textbook in the U.S., *Child Psychiatry* (Kanner), was published in

1935. Child psychiatry was not fully recognized as a medical specialty by the American Board of Psychiatry and Neurology until 1957. The major journal in child and adolescent psychiatry, the *Journal of the American Academy of Child and Adolescent Psychiatry,* was established in 1962. Although still quite young, the field has matured; and as it has developed, its fruits have become available to primary care. This is the way of much of medical progress. The evolution of primary care often occurs as a result of a subspecialty problem, which becomes more clearly defined as consensus develops around treatment. At that point, it begins to be incorporated into primary care medicine. For example, some years ago asthma was treated by pulmonologists, but now is routinely handled by PCPs. The same happened with enuresis which was a common problem seen by child and adolescent psychiatrists (CAPs) in the 1960s and 1970s. Now this is a routine pediatric problem that is only seen by a CAP when it is an incidental problem of a child with more severe difficulties. This evolution has now also included attention-deficit/hyperactivity disorder, which is being managed increasingly by PCPs. We think this trend will continue and will accelerate in the future. As pediatricians spend less time on acute illness, they will spend more time on prevention and attention to psychosocial and psychiatric issues. These changes will require that pediatricians and family physicians caring for children be well versed in child and family development, the institutional systems involved in children's lives, and common psychosocial issues and psychiatric conditions. A working knowledge of psychopharmacology will also become essential. We write this book in the hope that it will help to address these issues. While not intended to be exhaustive, it is meant to be current, informed by advances in knowledge, and practical. We hope that, in this way, it will be useful to, and used by, primary care physicians.

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Acknowledgments

Every creative effort has its context. An important context for this book has been the terrorist attacks of September 11, 2001, which has cast its shadow over, as well as inspired, our efforts. One of our chapter authors was directly impacted by these events, and all of us indirectly. These events have served to strengthen our commitments to those personal and professional values we hold dear. This project has involved a lot of work, but was also a joy as we have gotten to know each other better, shared ideas, and enriched ourselves. In doing so, we aspire to add hope and light to the world of children and families.

In completing this book, we first thank our chapter authors, who graciously wrote and rewrote as we evolved the structure and format for the chapters. We are very pleased with their efforts and proud of their final products. We are also grateful to Timothy Y. Hiscock, acquisitions editor at Lippincott Williams & Wilkins, for believing in the concept and the importance of this book. Michael Standen's steady, behind-the-scenes editing should also not go unmentioned. Emily Lerman cheerfully marshalled the book to publication. Emily Ets-Hokin, Ph.D., and Jeff Bostic, M.D., went above and beyond the call with numerous discussions that led to fruitful changes in the book. We also thank the following individuals who read earlier versions of chapters and helped us develop our thoughts: Don Crawford, Ph.D., Henry Cretella, M.D., Michael Cummings, M.D., Kim Dobson, M.D., Eric Glazer, J.D., Dasha Lekic, M.D., Anne Lockwood, Ph.D., David Munson, M.D., David Nathanson, Ph.D., Diana Sanderson, M.D., Patrick Stein, M.D., and Peter Tanguay M.D.

The Yoruba say we sit on the shoulders of those who come before us. And none of this would have occurred without our parents, teachers, and mentors. The inspiration of Muriel and Carl A. Whitaker, M.D., comes through in their belief in families. David V. Keith, M.D., a true artist, has extended these teachings. Gary N. Cohen, M.D., provided fertile ground in the conversations that were the seminal beginnings of this book.

Lastly, we thank and dedicate this book to our families for their persistent encouragement and support: Emily, Madeline and Eliza, Theo, and Paul. They gave up many weekends and evenings, allowing us the time to complete this project. As Eliza said towards the end of the project: "Da—ad, when are you going to be finished *with that book*??" They believed in it as much as, and at times more than, we did. Thank you.

David L. Kaye, M.D.
Maureen E. Montgomery, M.D.
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Contents

I

Understanding Child and Adolescent Mental Health Problems

1 Orientation and Organization of this Book

David L. Kaye

One of the chief priorities in the Office of the Surgeon General and Assistant Secretary for Health has been to work to ensure that every child has an optimal chance for a healthy start in life. When we think about a healthy start, we often limit our focus to physical health. But, as clearly articulated in the Surgeon General's Report on Mental Health, mental health is fundamental to overall health and well-being. And that is why we must ensure that our health system responds as readily to the needs of children's mental health as it does to their physical well-being.

—*David Satcher, M.D., Ph.D.*
Surgeon General, U.S.A.
December 2000

Many children experience mental health problems that interfere with normal development and functioning. The Surgeon General has stated that our nation is facing a public health crisis in this regard. Problems of detection and recognition, access to services, stigma, and discriminatory insurance reimbursement patterns all contribute to this crisis. Primary care physicians (PCPs) are ideally situated to have a significant impact on these issues and improve the health and well-being of children. To address these issues, a PCP needs to be armed with adequate information. We hope this book begins to fill this need.

First, it is important to review the epidemiology of mental health disorders to understand the scope of the problem. Information about epidemiology in child and adolescent psychiatry has grown dramatically in the past 25 years. The optimal method for getting a true picture of prevalence rates is by randomly surveying a population in the community and using standardized approaches to diagnosis (the most widely used of such is the *Diagnostic and Statistical Manual of Mental Disorders* [DSM]). A number of such studies have now been done. Although much work remains, an emerging consensus finds that overall prevalence rates for any DSM-based diagnosis run at **15% to 20%** of children between the ages of 5 and 18 years. Of these children, 33% to 50% are experiencing severe functional impairments (for a detailed review, see Roberts et al. 1998). If one multiplies these percentages by the actual number of children, one comes up with huge numbers of children in the United States with very serious disturbances. Physicians, teachers, and others working with children know this intuitively. The prevalence rates for specific disorders are given in Table 1.1. To put this into perspective, we have also included prevalence rates for selected other pediatric problems.

The next question might be: How many of the children with diagnosable mental health problems receive any kind of help?

Table 1.1. Prevalence of pediatric disorders

Disorder	Percent
Total DSM disorders	15–20
Anorexia nervosa	0.5–1.0 adolescents
Anxiety disorder (any)	6
AD/HD	2–5
Autistic-spectrum	0.2
Major depression	2 children/5 adolescents
Substance abuse	
Daily alcohol	5 adolescents
Daily marijuana	3
Suicide attempt	5–10 adolescents
Other pediatric disorders	
Cerebral palsy	0.2
Cystic fibrosis	0.03 (whites)
Diabetes mellitus, type I	0.2
Epilepsy	0.3
Traumatic brain injury	0.2

AD/HD, attention-deficit/hyperactivity disorder; DSM, *Diagnostic and Statistical Manual of Mental Disorders.*

Again, although much work remains, the best data we have suggest that **relatively few receive treatment.** In the best study to date, Burns et al. (1995) found in a community survey that less than 20% of the more troubled youth had received any mental health treatment within the past 3 months. Of those who seek treatment, a large percentage leaves treatment prematurely and abruptly. Although many of these children had seen their pediatrician, only 10% addressed the problem with their PCP. The moral is that PCPs are in a unique position to monitor, evaluate or triage, manage a range of problems, and make certain that youth receive appropriate mental health treatment. This has the potential to make an enormous difference in the lives of individual children and families, the pediatric public health, and society as a whole.

The central importance of the family. Throughout this book we convey a particular point of view about children and families and how PCPs can be most effective in promoting their optimal development. At its core, this perspective holds that the **family is at the center** of growth, development, and health for children (and adults as well, we might add). Helping children requires empathy and appreciation for parents and an ability to form a working relationship with them or other responsible adults. It is through active collaboration with families that PCPs are optimally able to help their pediatric patients. PCPs can have a powerful influence