Child Psychiatry In Primary Care+

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Summary

This article aims to give a brief summary of child psychiatric practice in a primary care setting. Five types of common childhood psychopathology are described, these include anxiety disorders, antisocial behaviour, enuresis, hyperactivity, and child abuse. The emphasis is on the recognition of the disturbance and practical advice on early treatment strategies. The epidemiological aspects of child psychiatric disturbances in primary care setting and referral practices reported in the West are summarised. Throughout the article, references to data relevant to the local context are made. (HK Pract 1997; 19: 245-254)

摘 要

本文闡述基礎診治中的兒童精神病變，其中五類常見病變包括焦慮症，不愛交際行為、遺尿，多動症及虐兒。重點指出確認問題及提出早期治療方法，對西方國家有關兒童精神病變的流行病學資料做總結，全文中本地相關資料亦加入論述。

Child psychiatric morbidity in primary care

Epidemiological studies in the West have consistently reported that a substantial minority of children had psychiatric disturbances and only a fraction of them were under psychiatric care.[1,2] A large proportion of these disturbed children were seen at primary care setting. Systematic studies using validated interview schedules reported that 22-28% of children attending primary care clinics in the U.K. and U.S. have psychiatric disorders.[3,4] A WHO study on children attending primary care facilities at 4 developing countries reported the prevalence rates of mental disorders are between 12-29%.[5] Thus it appears fair to say about one in every five children attending primary care facilities has one type of psychiatric disorder or other.

Little is known about the psychiatric morbidity of children attending the primary care services in Hong Kong. Two local studies gave partial insight into the extent of the problems. Chung *et al.*[6] reported that parent- and doctor-referrals to child psychiatric clinic were similar in demography, nature and severity of illness. My colleagues and I conducted a prospective comparison study on children attending a community mental health clinic and a hospital clinic using questionnaires and standardised interviews. Across the two settings, there were no

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difference in demographic profile, degree of social adversity, number of preceding life-events, previous help-seeking behaviours, duration of chief complaints, maternal psychopathology, parental explanatory model of the child's problems, and expectation in treatment.[7] Given the similarity of the two samples, parents' complaints of child mental disturbance at community-based clinics could be as problematic as those found in psychiatric clinics.

The types of psychiatric disorders seen in primary care setting, in descending order of frequency, are anxiety disorders, antisocial behaviour, enuresis, and childhood hyperactivity.[3] Though a substantial number of children attending primary care services has diagnosable psychiatric disorders, only 2-5% of them have psychiatric disturbances as their chief complaints.[8] It means the identification of psychiatric morbidity is not straight forward and requires diagnostic skills.

The recognition and management of common child psychiatric problems

Anxiety disorders

Anxiety is perhaps the commonest emotion experienced by children and it can be a part of normal development. Pathological anxiety is characterised by its severity, persistence, functional impairment, subjective distress, and inflexibility like avoidance. It is noteworthy that the content of anxiety changes with the cognitive ability of the child. For example, in an ascending order with age, the content of fears may include strangers, separation, darkness, imaginary monsters, animals, social gatherings etc.[9]

An anxious child may present with a plethora of disturbances. School age children may report feelings of tension, constant worries, and irritability. Fearfulness related to a specific situation are common. Many anxious children had sleep disturbances in the form of difficulty in falling asleep, nightmares, night terror, somnabulism, and refusal to sleep alone. They may complain of aches of non-identifiable origin. Regression to immature behaviour, undue dependence, secondary enuresis, and tics can be found. Some may develop rituals. Presentations with psychosomatic complaints can be difficult to recognise as the following case may illustrate.

A.F. is an 11-year-old schoolboy who presented with a 2 months' history of recurrent abdominal pain. The pain changed in its location and nature, was accompanied by nausea but no vomiting and no diarrhoea. Despite numerous medical consultations, repeated examinations and investigations (blood tests, x-ray, ultrasonogram, and CT scan), no abnormality was found. The pain disappeared quickly after seeing doctors with or without analgesics. Because of the recurrent negative findings and prompt recovery, A.F.'s mother started to accuse the child of pretending. Finding that the mother had refused to turn up even when the child was in pain and the pain had persisted, the school requested a medical certificate to prove the child's suitability to attend school. One month prior to the psychiatric referral, A.F. had been absent from school and was staying at home. The pain was assessed to be a somatic expression of underlying school problems because of the following:

(1) regular occurrence at 9 o'clock in the morning, more severe if there were English lessons, and occurred less frequently when there were P.E. lessons or on Saturdays;

(2) the onset was 1 month after he was promoted to the present school where he failed to meet the academic demands. He and one other kid were the only two previous classmates promoted to the new school, and he was often bullied by other classmates;

(3) consistent relief of the pain not by analgesic but by returning or staying at home; and

(4) complete recovery of the pain after the underlying issues were brought to attention and addressed.

Anxious children often become a source of great distress to parents. Many parents, because of their own anxiety or understandable desire to help, often extensively discuss and question the anxiety symptoms, and some may become over-accommodating. Thus, advice to the parents on ways to help the child to overcome sources of fear and to

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avoid the reinforcement trap is often beneficial. The irrational nature of anxiety-provoking fantasies that many anxious children have should be gently pointed out to the child. Kendall[10] described cognitive-behavioural techniques to help anxious children and these included recognition of anxiety, clarification of anxious cognitions, developing coping strategies, and evaluation of performance. Randomised trials in comparison with wait list controls reported substantial improvement. The long term use of benzodiazepine in anxiety disorders in childhood should be discouraged. A recent trial of the tricyclic antidepressant, imipramine, failed to replicate previous positive therapeutic effect.[11] It is interesting to note that the drug trial selected cases resistant to vigorous behavioural treatment and yet over half of those on placebo improved spontaneously. The finding seems to suggest that many anxious children respond quite non-specifically to intervention and the effective treatment component has yet to be identified.

Antisocial behaviours

Antisocial behaviours refer to a broad range of activities that contravenes social norms like aggression, lying, vandalism, theft, truancy, fire setting, running away etc. Nearly all children at some time show some forms of antisocial behaviour. When a child has multiple and persistent antisocial behaviours which significantly impair his/her everyday function and/or considered unmanageable by adults, it is called conduct disorder. The significance of conduct disorder lies in the fact that it is a very stable and enduring behavioural trait. It is highly predictive of a wide range of future maladjustment, which is costly to the society, and constitutes a common problem at psychiatric clinics.[12-14]

Symptoms of conduct disorder vary systematically with age. Conduct disorder is seldom diagnosed prior to school age, but parents often notice arguments, stubbornness, tantrums, and oppositional behaviours in the preschool years. The latter pattern of behaviours is referred to as the oppositional defiant disorder, a suspected developmental precursor of conduct disorder.

Recognition of conduct disorder is not difficult, but a comprehensive understanding of the case is a more demanding job. Obtaining information from the child especially on these socially less desirable activities can be a difficult job. Time will be well spent in building up a problem solving relationship. The frequency, range and severity of antisocial behaviours have to be obtained in detail. Presence of emotional disturbances, substance abuse, educational difficulties, and relationship problems need to be examined. It is important to understand the context in which these antisocial behaviours take place. These include the family function, parental mental state, their disciplinary methods, motivation and attitude. The diverse and secret nature of antisocial behaviours make it necessary to obtain information from parents and teachers.

Conduct disorder is a chronic condition and any brief treatment that focus on the child without attention to the contextual influences is bound to have limited therapeutic impact. The most extensively evaluated treatment with clear therapeutic gain including long term sustained improvement is parent management training.[15-17] It refers to the systematic retraining of parenting techniques so that prosocial rather than coercive behaviours are maintained in the family.[18] General practitioners may not be interested in the details of the treatment package but a brief description of the handling of children's aggression and tantrums may be in place. First, the problematic behaviour, it's antecedents and consequences have to be described in full details, preferably by anchoring at the most recent incident. Second, any maladaptive patterns of interchanges noticed in the above description have to be brought up for discussion. For example, recurrent precipitants of aggression may be removed by environmental manipulation. Severe, erratic and frequent physical punishment may aggravate the child's aggression. Inappropriate yielding to, and /or excessive reasoning with, the child's tantrum may inadvertently reinforce the child's non-compliance. Third, non-violent disciplinary procedures such as time-out and response cost are helpful. Fourth, and more importantly, parents should be advised to give extra attention and rewards to compliant and appropriate behaviours so as to help the child to build up prosocial skills.

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Enuresis

Enuresis refers to the repeated involuntary passage of urine in the absence of organic cause in a child over the age of 5 years. Secondary enuresis refers to those children who start to wet after a period of continence. Psychiatric disturbance is 2-6 times more common among enuretics than non-enuretics and the association is strongest among girls, diurnal and secondary enuretics.[19] Enuretics do not have a specific pattern of psychiatric disturbances.

An essential history for enuretic children usually includes the following: onset, frequency of enuresis, precipitating stressors, parental handling on discovery of enuresis, previous treatment and their responses, previous toilet training, sleep arrangement, developmental history, the attitudes of the child and the family.[20] The associated emotional and behavioural disturbances should be clarified. Possible organic causes include urinary tract infection or abnormalities, nocturnal seizures and diabetes. Usually a good history, physical examination, and simple investigations are good enough to exclude them.

Management of monosymptomatic nocturnal enuresis begins with reassurance about the nature and prevalence of the problem. It is helpful to advise parents to deal with wet nights in a non-emotional manner and to shift attention to the child's successes by keeping records on those dry nights only. Many parents try nocturnal fluid restriction, night-lifting, and retention control training (deferring micturition at gradually lengthening period). None of these practices have empirical support. Over 30 studies involving more than 1500 children over 50 years consistently reported the usefulness of the enuretic alarm.[21] Two groups of drugs have clear anti-enuretic effects. Low dose tricyclic antidepressants have been used for more than 30 years, though one needs to be cautious of potential cardiac toxicity. The more recently advocated medication, desmopressin, is equally effective and is believed to correct the hypothetical deficiency in vasopressin among enuretics.[19,22,23]

Enuretic children with associated psychiatric disturbances may also respond to treatment outlined above. However, when the mental disturbance is severe and persistent, it may merit separate treatment. It has to be reminded that enuresis can be a cause of psychiatric disturbances (because of stress arising from harsh parental handling and associated stigma) as well as a symptom of the underlying psychiatric disturbances (e.g. a clinical feature of anxiety disorder).

Childhood hyperactivity

Overactivity is a very common childhood complaint. In a questionnaire study of a large representative sample of schoolboys in Hong Kong, over twice as many Chinese as English boys were rated hyperactive.[24] Yet diagnostic study reported a prevalence rate of childhood hyperactivity lower than the U.K. or U.S.[25] Not only is the complaint common, it is non-specific. Complaints of overactivity may arise in the following circumstances: inexperienced parents, movement disorder, overanxious child, side effects of medication (e.g. long acting barbiturates), thyrotoxicosis, lead poisoning, and of course, attention deficit hyperactivity disorder.

A rational approach to the complaint begins with a detail description of the symptoms. Given the findings reported above, history taking should try to elicit specific examples rather than impressionistic statements. Variations of the symptoms across settings may provide important clues to the extent of the problem and environmental contributions. A typical picture of attention deficit hyperactivity disorder may be illustrated by the following case.

C.H. is a 8-year-old boy coming from a working class family. His mother said C.H.'s problems were becoming obvious since promoting to Primary One but it could be traced back to kindergarten days. Since the age of 3 or 4, kindergarten teachers started to complain that the child could not sit still, was always on the run, and unable to settle in group games. Consequently, C.H. had to change kindergarten but it didn't improve the situation. His primary school teacher found C.H. noisy, constantly fidgeting, talkative, and often left things unfinished including examination papers. At home, the child left his seat several times before he finished his meal. His mother added that C.H. was not able to watch TV quietly and it seemed as

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if his hands must play with something. After promoting to Primary One, doing homework became a nightmare both for the child and the mother. C.H. took exceedingly long hours to finish small pieces of work. Minor noises or stationary on the table would distract him. At times, he appeared to be day dreaming. His performance could be worse without one-to-one supervision. Finding that repeated warnings were useless, C.H.'s mother resorted to the rattan stick recently. C.H. was found to be running around in the corridor before the interview. As soon as he jumped into the interview room, he started to explore around, picking up toys and played noisily. He soon got bored with the toys and began to open drawers in the office. While he was talking to the doctor, he started to play with stationary and papers on the table and asked questions about the pictures on the wall. He was constantly fidgeting at the seat. After about 10 minutes of conversation, the child found an excuse, left the interview room and again wandered noisily in the corridor.

Hyperactive children have wide range of co-morbid psychiatric disturbances which merit detailed assessment. These include conduct disorder, perceptual-motor delay, specific learning disorder, emotional disturbances, self-esteem deficit, and social relationship problems. Many parents mistake hyperactivity for simple naughtiness and disobedience. Explanations on the nature of childhood hyperactivity will help parents to see the problem in perspective. Many parents welcome simple advice on handling of hyperactive behaviours like provision of structured activities, removal of distractable cues, shortened periods of sustained attention, and contingent rewards to attentive behaviours etc. The enthusiasm of applying cognitive-behavioural approach to reduce overactivity in children in the 1980s have somewhat receded because of their limited therapeutic impact.[26] The most powerful treatment available is the use of psychostimulant like methylphenidate.[27] It should be borne in mind that many hyperactive children have co-morbid psychiatric disturbances and these (e.g. antisocial behaviours, low self-esteem) would not disappear with medication. Thus, drug treatment of childhood hyperactivity should be seen as a component of multimodal therapy which aims to foster normal development.

Child Abuse

Recognition of child abuse in general practice may not be straight forward. Abusers often avoid telling the facts, they may deny or play down what has happened. There may be delay in seeking medical advice, inconsistent and unconvincing explanation of injuries, and past history of suspicious injuries. Where physical injuries are present, the number, severity, sites, ages, and possible modes of inducing such injuries should be recorded in detail. A good record, or sometimes clinical photo, is essential because of the potential forensic nature of the cases. The commonest form of injuries is multiple bruises, but cuts, burns, bone fractures, and internal haemorrhage can also happen. Physically abused children may experience gross neglect as well. Thus, the physical appearance, clothing, tidiness, and nourishment have to be noted. Some children may be so severely beaten that they become very quiet, watchful, and sometimes fearful in front of the abuser.

Perhaps the more difficult type of abuse to recognise is sexual abuse of children. Because of fear, anxiety, lack of understanding, and some may believe what happened is universal, many sexually abused children do not report the abuse incidents. In a review of sexually abused children presented to professionals in Hong Kong, Ho & Lieh-Mak found that a significant proportion of cases, especially intrafamilial ones, were discovered accidentally.[28] It has to be cautioned that in case of father-daughter incest, maternal denial is common and thus, by itself, cannot disprove the presence of abuse.

Similar to that reported in the West, sexual abuse of children in Hong Kong, especially pre-pubertal children, often involve fondling, inappropriate exposure, and sometimes oral sex.[28] These do not leave any physical marks. In fact as low as 25% of sexually abused victims have any positive physical findings and many are non-specific.[29] Thus a high index of suspicion is required. Children rarely lie about being sexually abused and their allegations should be taken seriously.[30] Children presenting with unexplained recurrent urinary

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tract infection, genital injuries or bruises, and sexually transmitted diseases should be regarded as high risk indicators. Because of physiological arousal and lack of understanding, many abused victims re-enact the abuse scenario or have inappropriate sexual behaviour like excessive masturbation, sexual exploitation of other children, and hypersensitivity to heterosexual matters. Many emotional and behavioural problems, though non-specific, should raise suspicion. They include suicide attempts, running away, marked decline of academic performance, eating disorder, psychosomatic complaints, secondary enuresis etc.[31]

In the course of collecting further information from the suspected sexual abuse victim, it is important to note the child's account in his/her own words, how the child describes the genitalia, and the associated emotion. Try to ask open question, use the child's vocabulary, and avoid teaching the child to use adults' words. These simple techniques will help to avoid contaminating the child's evidence. The doctor's expression of disgust, embarrassment and disbelief could easily inhibit the child to unfold his/her unfortunate encounter. Acknowledgement of the child's anxiety and difficulties are often better than vigorous questioning. Diagnostic interview of suspected sexually abused children is a demanding job which requires specific techniques, adjunctive aids like anatomically correct dolls, and possibly videotaping.[32]

Suspected abused children and their families require physical, psychiatric and social assessment and therefore a multi-disciplinary team to deal with. Further management often requires a legal mandate especially in view of recent law changes and uncooperative parents.[33] Thus the job of a general practitioner is to reach reasonable grounds of suspicion and refer the child to a place of safety, which often means the hospital. In case of doubt, it will be good practice to consult the social service.

Help-seeking Behaviours and Referral Practices

Studies in both developed and developing countries consistently demonstrated that primary health care workers have low sensitivity in detection of child psychiatric disorders.[5,34] Only one child out of six with psychiatric diagnosis is identified by physicians in the primary care setting.[5,35] Even if identified, only a fraction of disturbed children are referred.[36,37] The critical barriers for making a referral include: little discussion of parents' concern,[38] unsatisfactory communication skill,[39] perceived adequate treatment provisions at the primary care setting,[36] and families' reluctance to accept referrals.[37] Similar to that described in the West, disturbed children in Hong Kong have to go through several filters before they reach the child psychiatric service. Study on 100 consecutive referrals to the child psychiatric clinic in Queen Mary Hospital found that the help-seeking processes of referred children were characterised by a sequential pattern of lay consultations, detour through a number of school-based professionals and medical personnels.[40] The more professionals the child had seen prior to the referral to child psychiatric clinic, the longer it took to reach the specialist service. The mean time to reach the clinic was 2.2 years (note that the average waiting time to the clinic was about 2 months) and more than 10% of cases took more than 5 years ! Moreover, the longer the delay is, the worse is the symptom scores for these disturbed children.

Several disquieting implications could be drawn from these findings. The underdiagnosis of psychiatric disturbance in primary care practice has not received adequate attention. Improving the diagnostic skills and interviewing techniques in the area of childhood mental illness should be an important area in the training of future generations of primary care doctors. Of course, one has to be contended with the fact that some parents may be upset by discussion of referral for a psychiatric evaluation. This issue of stigmatisation has to be dealt with in a much wider context and long-term perspectives in terms of public health education. On the other hand, there are disturbed children who go through multiple professionals in a tortuous path, denied of the referral and only manage to reach the specialist service years later, and unfortunately with worsening psychopathology. The mismatch of service and needs warrants serious thinking. There are more compelling forces other than childhood psychopathology in

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Key messages

1. About one in every five children attending primary care facilities has one type of psychiatric disorder or other.
2. The common types of childhood psychiatric disturbances in primary care setting include anxiety disorders, antisocial behaviour, enuresis, and hyperactivity.
3. Childhood psychiatric disturbances are often not recognised in primary care setting and are rarely referred to the child psychiatric service.
4. Identification of childhood psychopathology in primary care setting requires a high level of sensitivity, interview techniques, and diagnostic skills.

bringing disturbed children into psychiatric treatment. The society has to determine whether this is a reasonable way to allocate scarce mental health resources. These results speak clearly of the need to have a good network with general practitioners and the need to provide easy access in order to avoid unnecessary delay and hopefully early and more effective interventions for these unfortunate children. ■

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