

TREATMENT OF CHILDREN AND ADOLESCENTS

Acknowledgements: Most of the information included in this chapter was obtained from the Handbook of Psychiatry, 2005, Mental Health Information Centre of SA, Department of Psychiatry, University of Stellenbosch.

Chapter by Professor Susan Hawkrige, Dr Linda Keyter and Dr Bennie Steyn

A. TREATMENT: PSYCHOPHARMACOLOGY

Please note: Medication should NEVER be the only treatment modality. Additional modalities, for example, counselling, support, behavioural programmes, other types of psychotherapy, social interventions, etcetera, are essential in order to establish a holistic approach to the child's problems. Often the other treatments are adequate in themselves, and it is unnecessary to use medication at all. If circumstances and the diagnosis allow it, non-pharmacological treatments should be tried first.

Ideally only one drug should be used. In complex cases or multiple comorbidity, more than one may be necessary. Except in the case of the short-term use of short-acting benzodiazepines in anxiety disorders, complex cases should first be discussed at specialist level. Many children who need psychotropic medication are also receiving medication for general medical conditions. Drug-drug interactions can be fatal, and the practitioner must always check possible interactions in a good, up-to-date resource.

The duration of pharmacological treatment depends on the nature of the disorder, the response to treatment and the safety and acceptability of the drug used. Young patients often do not like to take medication, and may stop the treatment themselves. In children with depressive and anxiety disorders, treatment should continue for at least six months after complete recovery. Withdrawal of the drug must always be done gradually. Transient anxiety symptoms that resemble the original disorder may sometimes occur. It is usually worth waiting for a week or two before deciding to restart the medication. Consultation at specialist level can help with these difficult decisions. In disorders

such as schizophrenia the need for continued treatment is important, and medication should not be stopped or adjusted without consultation with the treating psychiatrist.

Stimulants

Indications

In child psychiatry these drugs are only used for AD/HD. The diagnosis must be definitively confirmed, and all possible differential diagnoses must be excluded. The use of stimulants for AD/HD has been shown to be effective and safe in a large number of clinical trials, in children with normal as well as lower IQ. Motor hyperactivity is reduced and concentration is improved. The children who respond best to stimulants are those with the least comorbidity and those who present with more hyperactivity and impulsivity. These drugs are less successful in children who present with only attention deficit.

Methylphenidate (Ritalin ®)

This is a CNS stimulant, similar to the amphetamines. It causes concern amongst clinicians and parents because of the possibility of addiction.

Adrenergic drugs

Clonidine, an α -adrenergic agent that is usually prescribed for hypertension or migraine, is also used for the treatment of AD/HD. The desired effect is often only seen after up to 3 months and tolerance tends to develop with a decreased effect after several months.

The new noradrenergic drug, atomoxetine, is promising as it appears to combine good efficacy with minimal side-effects and once daily administration.

SSRI's

Indications

SSRI's are currently prescribed for children and adolescents with anxiety disorders, but data with respect to the long-term safety and efficacy is still scarce. They certainly appear to be safer than the tricyclic antidepressants, but their use must still be clinically well motivated. Long-term safety is still being investigated. Efficacy in the treatment of OCD has been confirmed in many studies, and preliminary data on use in separation anxiety disorder, generalised anxiety disorder, panic disorder, social phobia/selective mutism and posttraumatic stress disorder, is promising.

Tricyclic antidepressants

Indications

These drugs, particularly imipramine, have been prescribed for children for decades. Data concerns predominantly desipramine/imipramine and clomipramine. Imipramine is used in the treatment of enuresis, depressive disorders (without good evidence of efficacy), anxiety disorders, AD/HD and tic disorders. Clomipramine is used in the management of OCD and efficacy has been shown beyond doubt. There are no controlled studies of the use of amitriptyline and other tricyclics in children.

Other anxiolytics

Benzodiazepines

The use of these drugs in children and adolescents is preferably avoided because of problems with dependence, behavioural disinhibition and cognitive dulling. Clonazepam appears to be an exception in terms of dependence, and has been successfully used in anxiety disorders as well as epilepsy. Disinhibited behaviour has been described in a few children taking this drug, and in these cases should be stopped. Alprazolam and lorazepam (high potency and short-acting) are sometimes used as short-term (not more than two weeks) adjuvant treatment in anxiety disorders, but should be reduced as soon as the effect of the antidepressant takes effect. The short-acting, high potency benzodiazepines are even more addictive than the long-acting ones.

Beta-blockers

These drugs are used in the treatment of specific social phobia, for example, before examinations or concerts. According to an open study beta-blockers may also be useful in the treatment of young children with PTSD. There are no controlled studies as yet. The use of beta-blockers is contraindicated in children with asthma or cardiovascular problems.

Buspirone

This drug is a serotonin antagonist that can be used in the treatment of children and adolescents with generalised anxiety disorder. Adverse effects of aggressive behaviour, mania and even psychosis have been described in a few children. The child must thus be carefully monitored for such symptoms.

Antipsychotics

The treatment of children and adolescents with any antipsychotic may only occur if the diagnosis warrants it. Owing to the fact that the older drugs are all associated with possible long-term extrapyramidal adverse effects (viz. tardive dyskinesia), and that the newer drugs have not been in use long enough to determine that there is no similar risk, informed consent should be obtained from the child's parents or guardian.

Indications

There are three groups of disorders in children and adolescents that may be treated with antipsychotics:

- Psychotic disorders are the most common indication, and include schizophrenia, bipolar disorder and other psychotic disorders.

- Tic disorders that require medical management can be treated with pimozide, haloperidol or risperidone. Studies involving other antipsychotic drugs are under way, but there is currently no good evidence that any other type of antipsychotic is effective.
- Antipsychotics are sometimes used in the treatment of conduct disorder, borderline personality disorder and mental retardation. This decision should be taken at specialist level or at least in consultation with a specialist.

Mood stabilisers

These include lithium and sodium valproate. Sodium valproate is preferred where compliance is in doubt and in rapid-cycling bipolar mood disorder. There is at present little information concerning the use of the newer anticonvulsants for the treatment of psychiatric disorders in children and adolescents. The use of olanzapine as a mood stabiliser is currently being studied, but there is as yet insufficient evidence to recommend such use in children and adolescents.

Indications

These drugs are used in the treatment of bipolar disorder, schizoaffective disorder and sometimes for mood swings in borderline personality disorder or aggressive outbursts in behavioural disorders. The anticonvulsants are naturally also used for the treatment of epilepsy.

B. TREATMENT: PSYCHOSOCIAL

Many children who present with “psychiatric” symptoms are not suffering from a psychiatric disorder, but still need help. Most of our patients are not treated with individual therapy; a great deal of attention is rather paid to the child’s environment, including the school and the family.

The following methods of treatment are used:⁹

- Family therapy
- Parent counselling
- Marital counselling for parents
- Changes to the environment
- Group therapy for the patient
- Group therapy for the parents
- Individual therapy for the child (play therapy for younger children)
- Behavioural therapy
- Admission
- Referral to a special school or unit
- Medication (see above, Section A).

Referral

When specific problems are identified, children may be referred for specialised therapy, for example speech therapy and occupational therapy.

A few special units exist, for example for autistic children and children under 12 years with severe emotional problems. Referral to some special schools may now only be done by the relevant school clinic. Others require motivation from a specialist. In South Africa there is a great lack of schools or classes for children with special needs. It is currently the national policy that such children should be accommodated in mainstream classes and schools. In the absence of adequate staffing of schools and training of teachers, children who are placed in an inappropriate educational environment may develop serious psychiatric disorders.

References

1. Maloney M, Schwam J. Clonidine and sudden death (letter). *Pediatrics* 1995;96(1176): 1177.
2. Spencer T, Biederman J, Wilens T. Growth deficits in children with attention deficit hyperactivity disorder. *Pediatrics* 1998;02(2 Pt 3):501-506.

3. Berkovitch M, Pope E, Phillips J, Koren G. Pemoline-associated fulminant liver failure: testing the evidence for causation. *Clin Pharmacol Ther* 1995;57(696).
4. Ten Eick AP, Nakamura H, Reed MD. Drug-drug interactions in pediatric psychopharmacology. *Pediatr Clin North Am* 1998;45(5):1233-12xi.
5. Riddle MA, Nelson JC, Kleinman CS, Rasmusson A, Leckman JF, King RA, et al. Sudden death in children receiving Norpramin: a review of three reported cases and commentary. *J Am Acad Child Adolesc Psychiatry* 1991;30(1):104-108.
6. Watson A. Tricyclic antidepressants and sudden death [letter; comment]. *J Am Acad Child Adolesc Psychiatry* 1998;37(7):683-684.
7. Wilens TE, Biederman J, Baldessarini RJ, Geller B, Schleifer D, Spencer TJ, et al. Cardiovascular effects of therapeutic doses of tricyclic antidepressants in children and adolescents. *J Am Acad Child Adolesc Psychiatry* 1996;35(11):1491-1501.
8. Fijnheer R, van de Ven P, Erkelens D. Psychiatrische medicatie als risicofactor voor fatale hittecollaps. *Ned Tijdschr Geneesk* 1995;139:1391-1393.
9. Kaplan HI, Sadock BJ, eds. *Synopsis of psychiatry* (8th Edition). Baltimore, Lippincott: Williams & Wilkins, 1998:885-931; 1266-1276; 1282-1285.