

01 - Chapter 10 Psychiatric Disorders in Children

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Psychiatric Examination of a Child **SOURCES OF INFORMATION** Gather and integrate collateral information from multiple sources to obtain as accurate a clinical picture as possible: primary caregivers, teachers, pediatricians, and the child welfare system (if relevant). **METHODS OF GATHERING INFORMATION** Determine the child's developmental stage and tailor the interview appropriately. ■ Play therapy: Utilizes the child's symbolic play, storytelling, or drawing as a forum for expression of emotions and experiences. ■ Classroom observation: A window into the child's functioning in school. ■ Formal neuropsychological testing: Quantitatively assesses a child's strengths and weaknesses by examination of their cognitive profile: intelligence quotient (IQ); language and visual-motor skills; memory, attention, and organizational abilities. ■ Kaufman Assessment Battery for Children (K-ABC): Intelligence test comparing intellectual capacity with acquired knowledge of patients between 2 and 12 years old. ■ Wechsler Intelligence Scale for Children-Revised (WISC-R): Assesses verbal, performance, and full-scale IQ of patients between 6 and 16 years old. **SAFETY ASSESSMENT** ■ Always screen for safety issues including self-injurious behavior, suicidal ideation, homicidal ideation, and command auditory hallucinations in a developmentally appropriate manner. ■ In the United States, suicide rates have increased significantly and are currently the second leading cause of death in individuals 10–34 years old. In the United States, 2½ times as many suicides occurred as homicides. Collectively, deaths due to suicide and homicide have remained a major cause of premature death for victims between 10 and 24 years old. **Intellectual Disability** Intellectual disability (ID), or intellectual developmental disorder, is characterized by impaired cognitive and adaptive/social functioning. Severity level is currently based on adaptive functioning, indicating the degree of support required. A single IQ score does not adequately capture this and is no longer used solely to determine ID severity. **DIAGNOSIS AND DSM-5 CRITERIA** ■ Deficits in intellectual functioning include learning, reasoning, judgment, planning, abstract thinking, and problem solving. ■ Deficits in adaptive functioning

include communication, social participation, and independent living. **PSYCHIATRIC DISORDERS IN CHILDREN** **WARDS QUESTION Q:** Should you screen a new patient for suicidal ideation? **A:** Yes. Asking a patient directly about suicidal thoughts may help save their life and does not cause suicidal tendencies.

122 PSYCHIATRIC DISORDERS IN CHILDREN WARDS TIP Characteristic physical features of genetic syndromes: • Down syndrome: Epicanthic folds, flat nasal bridge, and palmar crease. • Fragile X syndrome: long, narrow face, joint hyperlaxity, and macroorchidism in postpubertal males. • Prader-Willi syndrome: Obese, small stature, and almond-shaped eyes. **EPIDEMIOLOGY** ■ Overall: 1% of population. ■ Severe ID: 6/1000. **ETIOLOGY KEY FACT** Fragile X Syndrome Facts and Stats • Most common inherited form of ID. • Second most common cause of ID. • Due to FMR-1 gene mutation. • Males > females. **KEY FACT TABLE 10-1.** Causes of Intellectual Disability Cause Examples Down Syndrome Facts and Stats • 1/700 live births. • Most common chromosomal disorder. • Trisomy 21 = 3 copies of chromosome 21. Prenatal Infection and toxins (TORCH): ■ Deficits affect multiple domains including conceptual, practical, and social. ■ Onset occurs during the developmental period. ■ Intellectual deficits are confirmed by clinical assessment and standardized intelligence testing (scores at least two standard deviations below the population mean). ■ Adaptive functioning deficits require ongoing support for activities of daily life. ■ Severity levels: Mild, moderate, severe, and profound. ■ Causes include genetic, prenatal, perinatal, and postnatal conditions (see Table 10-1). ■ Fifty percent of ID cases have no identifiable cause. Global Developmental Delay ■ Failure to meet expected developmental milestones in several areas of intellectual functioning. ■ Diagnosis reserved for patients less than 5 years old when severity level cannot be reliably assessed via standardized testing. Patients will need to be reevaluated when older to clarify the diagnosis. Specific Learning Disorder (LD) Characterized by delayed cognitive development in a particular academic domain. Genetic ■ Down syndrome: Trisomy 21 (1/700 live births) ■ Fragile X syndrome: Involves mutation of X chromosome, 2nd most common cause of intellectual disability, males > females ■ Other causes: Phenylketonuria, familial mental retardation, Prader-Willi syndrome, Williams syndrome, Angelman syndrome, tuberous sclerosis ■ Toxoplasmosis ■ Other (syphilis, AIDS, alcohol/illicit drugs) ■ Rubella (German measles) ■ Cytomegalovirus (CMV) ■ Herpes simplex Perinatal Anoxia, prematurity, birth trauma, meningitis, hyperbilirubinemia Postnatal Hypothyroidism, malnutrition, toxin exposure, trauma

DIAGNOSIS AND DSM-5 CRITERIA ■ Significantly impaired academic skills which are below expectation for chronological age and interfere with academics, occupation, or activities of daily living (ADLs). ■ Begins during school but may become more impairing as demands increase. ■ Affected areas: Reading (e.g., dyslexia), writing (e.g., dysgraphia), or arithmetic (e.g., dyscalculia). ■ Not better accounted for by intellectual disabilities, visual/auditory deficits, language barriers, or subpar education. **EPIDEMIOLOGY** ■ Prevalence in school age children: 5–15%. ■ Males > females affected. **ETIOLOGY** ■ Environmental factors: Increased risk with prematurity, very low birth weight, and prenatal nicotine exposure. ■ Genetic factors: Increased risk in first-degree relatives of affected individuals. **COMORBIDITY** ■ Commonly co-occurs with other neurodevelopmental disorders, such as attention deficit/hyperactivity disorder (ADHD), communication disorders, developmental coordination disorder, and autism spectrum disorder (ASD). ■ Comorbid with other mental disorders, including anxiety, depressive, and bipolar disorders. **TREATMENT** ■ Systematic, individualized education tailored to child's specific needs. ■ Behavioral techniques may be used to

improve learning skills. Communication Disorders Communication disorder includes impaired speech, language or social communication that are below expectation for chronological age. Symptoms begin in the early developmental period and lead to academic or adaptive issues. ■ Language disorder—Difficulty acquiring and using language due to expressive and/or receptive impairment (e.g., reduced vocabulary, limited sentence structure, impairments in discourse). Increased risk in families of affected individuals. ■ Speech sound disorder (phonological disorder)—Difficulty producing articulate, intelligible speech. ■ Childhood-onset fluency disorder (stuttering)—Dysfluency and speech motor production issues. Increased risk of stuttering in first-degree relatives of affected individuals. PSYCHIATRIC DISORDERS IN CHILDREN KEY FACT Fetal Alcohol Exposure Facts Fetal alcohol syndrome (FAS) = Leading preventable cause of birth defects and ID. Three features of FAS:

1. Growth retardation
 2. CNS involvement (structural, neurologic, functional)
 3. Facial dysmorphism (smooth philtrum, short palpebral fissures, thin vermilion border)
- Fetal alcohol spectrum disorders: Fetal alcohol exposure of any amount may cause a range of developmental disabilities, which are often underrecognized. WARDS TIP Always rule out sensory deficits before diagnosing a specific learning disorder.

124 PSYCHIATRIC DISORDERS IN CHILDREN TREATMENT What treatment is indicated? DIAGNOSIS AND DSM-5 CRITERIA ■ At least six inattentive symptoms: ■ Social (pragmatic) communication disorder—Challenges with the social use of verbal and nonverbal communication. If restricted/repetitive behaviors, activities, or interests are also present, consider diagnosis of ASD. Increased risk with family history of communication disorders, ASD, or specific LD. ■ Speech and language therapy, family counseling. ■ Tailor educational supports to meet the individual's needs. A 10-year-old girl is referred for psychiatric evaluation because of academic and behavioral issues over the last year. The student has an above average IQ and seems to comprehend class material. Her teachers share concerns that she makes careless mistakes on homework and rushes through tests, leading to lower than predicted grades. She also blurts out answers without waiting for her turn. During the interview, she has difficulty staying focused and asks the examiner to repeat the question several times. Her mother complains that she does not clean her room or complete assigned chores. What is the most likely diagnosis? The patient has classic symptoms of attention deficit/hyperactivity disorder (ADHD) occurring in two different settings (home and school). If the child does not have any contraindications, stimulant medications are usually the first-line treatment for ADHD. Attention Deficit/Hyperactivity Disorder (ADHD) ADHD is characterized by persistent inattention, hyperactivity, and impulsivity inconsistent with the patient's developmental stage. There are three subcategories of ADHD: predominantly inattentive type, predominantly hyperactive/impulsive type, and combined type. ■ Two symptom domains: Inattentiveness and hyperactivity/impulsivity. •• Does not pay attention to details or makes careless mistakes. •• Has difficulty sustaining attention. • Difficulty listening. • Struggles to follow instructions. • Is unorganized. • Avoids tasks requiring high cognitive demands. • Misplaces/loses objects frequently. • Is easily distracted. • Is forgetful. And/or ■ At least six hyperactivity/impulsivity symptoms: •• Fidgets with hands/feet or squirms in seat. • Has difficulty remaining still.

• Runs/climbs excessively in childhood (extreme restlessness in adults). • Has difficulty engaging in activities quietly. • Acts as if driven by a motor (an internal sensation in adults). • Talks

excessively. • Blurts out answers before questions have been completed. • Has difficulty waiting or taking turns. • Interrupts or intrudes upon others. ■ Symptoms more than 6 months and present in two or more settings (e.g., home, school, work). ■ Symptoms interfere with or reduce quality of social, academic, and/or occupational functioning. ■ Onset prior to age 12, but can be diagnosed retrospectively in adulthood. ■ Not due to the physiological effects of a substance, another medical or neurological condition (e.g., traumatic brain injury), or another mental disorder.

EPIDEMIOLOGY ■ Prevalence: 10% of children and 4.5% of adults. ■ Males > females with 2:1 ratio. ■ Females present more often with inattentive symptoms.

ETIOLOGY The etiology of ADHD is multifactorial and may include: ■ Genetic factors: Increased rate in first-degree relatives of affected individuals. ■ Environmental factors: Potentially in utero exposure to neurotoxin, low birth weight, or childhood abuse or neglect.

COURSE/PROGNOSIS ■ Stable through adolescence. ■ Many continue to have symptoms as adults (inattentive > hyperactive). ■ High incidence of comorbid oppositional defiant disorder, conduct disorder, and specific LD.

TREATMENT Multimodal treatment plan: Medications are the most effective treatment for decreasing core symptoms, but should be used in conjunction with educational and behavioral interventions. ■ Pharmacological treatments: •• First-line: Stimulants (e.g., methylphenidate compounds, dextroamphetamine, mixed amphetamine salts). • Second-line: Alpha-2 agonists (e.g., clonidine, guanfacine) can be used instead or as adjunctive therapy to stimulants. May be used in children who respond poorly to other medications, experience side effects, or have coexisting conditions such as tics.

PSYCHIATRIC DISORDERS IN CHILDREN WARDS QUESTION Q: What are first-line treatments in ADHD? **A:** Stimulants.

126 PSYCHIATRIC DISORDERS IN CHILDREN ■ Nonpharmacological treatments: **WARDS TIP**

DIAGNOSIS AND DSM-5 CRITERIA Consider ASD as the diagnosis if there is a rapid deterioration of social and/or language skills during the first 2 years of life. Complete an appropriate workup, such as auditory testing, prior to diagnosing ASD. An extensive medical workup needs to be initiated if skills are lost after age 2, or more expansive losses occur (e.g., self-care, motor skills).

WARDS TIP Assess for a potential cause of pain/discomfort if a nonverbal child with ASD presents with new onset aggression or self-injurious behavior.

EPIDEMIOLOGY ■ Ratio in males to females is 4:1.

ETIOLOGY Etiology of ASD is multifactorial: • Second-line: Atomoxetine, a norepinephrine reuptake inhibitor. May be more appropriate when a history or family history of illicit substance use is present. •• Parental psychoeducation, parent management training. • Executive function coaching, behavior modification techniques and social skills training. • Educational accommodations such as classroom modifications.

Autism Spectrum Disorder (ASD) ASD is characterized by impairments in social communication/interaction and restrictive, repetitive behaviors/interests. This disorder encompasses the spectrum of symptomatology formerly diagnosed as autism, Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder. ■ Problems with social interaction and communication: •• Impaired social/emotional reciprocity (e.g., inability to hold conversations). • Deficits in nonverbal communication skills (e.g., decreased eye contact). • Interpersonal/relational challenges (e.g., lack of interest in peers). ■ Restricted, repetitive patterns of behavior, interests, and activities: •• Intense, peculiar interests (e.g., preoccupation with unusual objects). • Inflexible adherence to rituals (e.g., rigid thought patterns). • Stereotyped, repetitive motor mannerisms (e.g., hand flapping). • Hyper/hyporeactivity to sensory input (e.g., hypersensitive to particular textures). ■ Abnormalities in functioning begin in the early developmental period. ■ Not better accounted for by ID or global developmental delay. When ID and ASD co-occur, social communication is below expectation based on developmental level. ■

Causes significant social or occupational impairment. ■ Recent increase in prevalence to 1% of population. May be related to expansion of diagnostic classification and/or increased awareness/recognition. ■ Symptoms typically recognized between 12 and 24 months old but varies based on severity. ■ Prenatal neurological insults (e.g., infections, drugs), advanced paternal age, and low birth weight.

■ Fifteen percent of ASD cases are associated with a known genetic mutation. ■ Fragile X syndrome = most common known single gene cause of ASD. ■ Other genetic causes of ASD: Down syndrome, Rett syndrome, and tuberous sclerosis. ■ High comorbidity with ID. ■ Association with epilepsy. **PROGNOSIS AND TREATMENT** ASD is a chronic condition. The prognosis is variable, but the two most important predictors of adult outcome are level of intellectual functioning and language impairment. Only a minority of patients can live and work independently in adulthood. Treatment targets associated symptoms in order to improve basic social, communicative, and cognitive skills: ■ Alpha-2 agonists (e.g., clonidine, guanfacine) and low-dose atypical antipsychotic medications (e.g., risperidone, aripiprazole) may help reduce disruptive behavior, aggression, and irritability. ■ Early intervention. ■ Remedial education. ■ Behavioral therapy. ■ Psychoeducation. **Tic Disorders** **TOURETTE'S DISORDER** Tics are defined as sudden, rapid, repetitive, stereotyped movements or vocalizations. Although experienced as involuntary, patients can learn to temporarily suppress tics. Prior to the tic, patients may feel a premonitory urge (somatic sensation), with subsequent tension release after the tic. Anxiety, excitement, and fatigue can be aggravating factors for tics. Tics may present as simple or complex, depending on length of time, purpose, and orchestration. Tourette's disorder is the most severe of the tic disorders. It is characterized by multiple motor tics and at least one vocal tic lasting for at least 1 year. Vocal tics may appear many years after the motor tics, and they may wax and wane in frequency. The most common motor tics involve the face and head, such as eye blinking and throat clearing. Examples of vocal tics: ■ Coprolalia—Utterance of obscene, taboo words as a bark or grunt. ■ Echolalia—Repeating others' words. **Diagnosis and DSM-5 Criteria** ■ Multiple motor and at least one vocal tic present (not required to occur concurrently) for more than 1 year since onset of first tic. ■ Onset prior to age 18 years. ■ Not caused by a substance (e.g., cocaine) or another medical condition (e.g., Huntington disease). **PSYCHIATRIC DISORDERS IN CHILDREN** **WARDS TIP** Tic disorders are one of the few psychiatric disorders in which diagnostic criteria do not require symptoms to cause significant distress.

128 PSYCHIATRIC DISORDERS IN CHILDREN **Epidemiology** ■ Prevalence: Boys > girls. **Etiology** **Course/Prognosis** ■ Tics wax and wane and change in type. **Treatment** ■ Psychoeducation. **WARDS TIP** A child may have oppositional defiant disorder if they no difficulty getting along with peers but will not comply with rules from parents or teachers. Other tic disorders include: **OPPOSITIONAL DEFIANT DISORDER (ODD)** **KEY FACT** Unlike conduct disorder, ODD does not involve physical aggression or violating the basic rights of others. ■ **Transient tic behaviors:** Common in children. ■ **Tourette's disorder:** 3 per 1000 school-age children. ■ **Genetic factors:** > 55% concordance rate in monozygotic twins. ■ **Prenatal/perinatal factors:** Older paternal age, obstetrical complications, maternal smoking, and low birth weight. ■ **Psychological factors:** Symptom exacerbations with stressful life events. ■ **Onset** typically occurs between 4 and 6 years, with the peak severity between ages 10 and 12. ■ **Symptoms** tend to decrease in adolescence and significantly diminish in adulthood. ■ **High comorbidity** with ADHD, OCD, and LD. ■ **Behavioral interventions**—Habit reversal therapy. ■ **Medications**—Utilize only if tics become severely impairing or also treating

comorbidities. Due to the fluctuating course of the disorder, it can be difficult to determine medication efficacy. •• Alpha-2 agonists: guanfacine (usually first choice), clonidine. • In severe cases, can consider treatment with atypical (e.g., risperidone) or typical antipsychotics (e.g., pimozide). ■ Persistent (chronic) motor or vocal tic disorder: Single or multiple motor or vocal tics (but not both) that have never met criteria for Tourette's. ■ Provisional tic disorder: Single or multiple motor and/or vocal tics less than 1 year that have never met criteria for Tourette's. Disruptive and Conduct Disorders These disorders involve problematic interactions with or inflicting harm on others. While disruptive behaviors may appear within the scope of normal development, they become pathologic when the frequency, pervasiveness, and severity impair functioning of the individual or others. A maladaptive pattern of irritability/anger, defiance, or vindictiveness, which causes dysfunction or distress in the patient or those affected. These interpersonal difficulties involve at least one non-sibling (usually an authority figure). Diagnosis and DSM-5 Criteria Characterized by at least four symptoms present for more than or equal to 6 months (with at least one individual who is not a sibling):

■ Anger/Irritable mood—Loses temper frequently; often angry and resentful. ■ Argumentative/Defiant behavior—Breaks rules, blames others, argues with authority figures, and deliberately aggravates others. ■ Vindictiveness—Is spiteful/vindictive at least two times in the past 6 months. ■ Behaviors are associated with distress in the individual or others, or negatively impact functioning. ■ Behaviors cannot be explained exclusively by the diagnosis of another mental disorder. Epidemiology ■ Prevalence: Approximately 3%. ■ Onset usually during preschool years: Seen more often in boys before adolescence. ■ Increased incidence of comorbid substance use and ADHD. ■ Although ODD often precedes CD, most do not develop CD. Treatment ■ Behavior modification, conflict management training, and problem-solving skills. ■ Parent management training (PMT) can help with setting limits and enforcing consistent rules. ■ Medications are used to treat comorbid conditions, such as ADHD. CONDUCT DISORDER (CD) CD includes the most serious disruptive behaviors, which violate the rights of other humans and animals. These individuals inflict cruelty and harm through physical and sexual violence. They may lack remorse for committing crimes or lack empathy for their victims. Diagnosis and DSM-5 Criteria A pattern of recurrently violating the basic rights of others or societal norms. The individual has displayed at least three of the following behaviors exhibited over the last year and at least one occurring within the past 6 months: ■ Aggression to people and animals: Bullies/threatens/intimidates others; initiation of physical aggression, including use of a weapon; robbery; rape; cruelty to animals. ■ Destruction of property (e.g., fire setting). ■ Deceitfulness or theft: Burglary; lying to obtain goods/favors. ■ Serious violations of rules: Runs away from home, stays out late at night, and often truant from school before age 13 years old. Epidemiology ■ Lifetime prevalence: 9%. ■ More common in males. ■ High incidence of comorbid ADHD and ODD. ■ Associated with antisocial personality disorder. PSYCHIATRIC DISORDERS IN CHILDREN KEY FACT Cruelty to animals may be indicative of Conduct disorder. KEY FACT Males: Higher risk of fighting, stealing, fire setting, and vandalism. Females: Higher risk of lying, running away, sex-work, and substance use.

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TIP The majority of enuresis cases spontaneously remit (5–10% per year) by adolescence.

ETIOLOGY ■ A multimodal treatment approach with behavior modification, family, and community involvement. ■ PMT can help parents with limit setting and enforcing consistent rules. ■ Medications can be used to target comorbid symptoms and aggression (e.g., SSRIs, guanfacine, propranolol, mood stabilizers, antipsychotics). Characterized by developmentally inappropriate elimination of urine or feces. Though typically involuntary, this may be intentional. The course may be primary (never established continence) or secondary (continence achieved for a period and then lost). Incontinence can cause significant distress or impair social or other areas of functioning. ■ Recurrent voiding of urine onto clothes or bed. ■ Occurs two times per week for at least 3 consecutive months or results in clinical distress or marked impairment. ■ Can occur during sleep (nocturnal), waking hours (diurnal), or both. ■ Not due to a substance (e.g., diuretic) or another medical condition (e.g., urinary tract infection, neurogenic bladder, diabetes). **Encopresis:** ■ Recurrent defecation into inappropriate places (e.g., clothes, floor), which may be voluntary or involuntary. ■ Occurs at least one time per month for at least 3 months. ■ Not due to the physiological effects of a substance (e.g., laxatives) or another medical condition (e.g., hypothyroidism, anal fissure, spina bifida), except via a constipation-related mechanism. • • 5–10% of 5 year olds; 3–5% of 10 year olds; 1% of >15 year olds. • Nocturnal enuresis more common in boys; diurnal enuresis more common in girls. ■ Prevalence of encopresis: 1% of 5-year-old children; boys >girls. ■ Genetic predisposition for nocturnal enuresis: • • Approximately 4 times increased risk if history of maternal urinary incontinence. • Approximately 10 times increased risk if history of paternal urinary incontinence. ■ Psychosocial stressors may contribute to secondary incontinence.

■ Encopresis: Often related to constipation/impaction with overflow incontinence. **TREATMENT** ■ Psychoeducation is key for children and their primary caregivers; provide information about high spontaneous remission rates. ■ Treat if symptoms are distressing and impairing. Engage the patient as an active participant in the treatment plan. Encourage investment in a waterproof mattress. ■ PMT for managing intentional elimination. ■ Enuresis treatment: • • Limit fluid intake and caffeine at night. • Behavioral program with monitoring and reward system, “bladder training” exercises, or urine alarm (upgrade from the “bell and pad” method). • Pharmacology can be used if the above methods are ineffective or for diurnal enuresis.

- First line: Desmopressin (DDAVP), an antidiuretic hormone analogue.
- Second line: Imipramine, a tricyclic antidepressant, can be used at low doses for refractory cases but has less tolerable side effects. ■ Encopresis without constipation: Comprehensive behavioral program (“bowel retraining”) for appropriate elimination. ■ Encopresis due to constipation: Initial bowel cleaning followed by stool softeners, high-fiber diet, and toileting routine in conjunction with a behavioral program. **PANS/PANDAS** Pediatric acute-onset neuropsychiatric syndrome (PANS aka childhood acute neuropsychiatric symptoms or CANS) refers to a group of disorders characterized by the presence of obsessive compulsive disorder or severely restricted food intake. As suggested by the name, the onset is typically rapid, often described by parents as “appearing overnight.” The presence of severe symptoms from two or more of the following categories are necessary to meet the diagnostic criteria: ■ Anxiety. ■ Emotional lability and/or depression. ■ Irritability, aggression, and/or oppositional behaviors. ■ Behavioral/developmental regression. ■ Sudden deterioration in school performance. ■

Motor or sensory abnormalities. ■ Somatic symptoms and signs, including sleep disturbances, enuresis, or urinary frequency. Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) is a subtype of PANS. Diagnosis requires OCD and/or a tic disorder. The initial onset and/or periodic exacerbations are temporally associated with group A streptococcal infections. Motoric hyperactivity and/or adventitious movements are commonly present. While both PANS and PSYCHIATRIC DISORDERS IN CHILDREN

132 PSYCHIATRIC DISORDERS IN CHILDREN Child Abuse WARDS TIP • Red flags for physical abuse: Delayed medical care for injury, inconsistent explanation of injury, multiple injuries in various stages of healing, head injuries, cigarette burns, spiral bone fractures, bruising patterns consistent with hand or belt. • Red flags for sexual abuse: Sexually transmitted diseases, recurrent urinary tract infections, prepubertal vaginal bleeding, pregnancy, or trauma/bruising/ inflammation of genitals/anus. PHYSICAL ABUSE SEXUAL ABUSE WARDS TIP If a child reports sexual abuse, it should be taken seriously as it is rarely unfounded. PSYCHOLOGICAL ABUSE NEGLECT PANDAS have been topics of debate in regards to their etiologies, evaluation, and treatment, PANDAS is listed in the DSM-5, as an Obsessive Compulsive and Related Disorder due to Another Medical Condition. Child abuse encompasses physical abuse, sexual abuse, emotional abuse, and neglect. Toxic stress may result when children endure prolonged, severe trauma and adversity without the buffer of supportive caregivers. This can disrupt a child's development and lead to a spectrum of pathologic sequelae. ■ About 1 million cases of child maltreatment in the United States. ■ Up to 2500 deaths per year caused by abuse in the United States. These numbers may be an underestimation as many cases go undetected and unreported. ■ Any act that results in non-accidental injury and may be the result of severe corporal punishment committed by an individual responsible for the child. ■ Physical exam and x-rays may demonstrate multiple injuries not consistent with child's developmental age. ■ Most common perpetrator is a first-degree male caregiver (e.g., parent, guardian, mother's partner). ■ Any sexual act involving a child intended to provide sexual gratification to an individual responsible for the child. ■ Sexual abuse is the most invasive form of abuse and results in detrimental lifetime effects on the victim. ■ Data indicates approximately 25% of girls and 9% of boys are exposed to sexual abuse. Abuse is generally underreported, and males are less likely than females to report it. ■ Children are most at risk of sexual abuse during preadolescence. Non-accidental verbal or symbolic acts that result in psychological damage. ■ Failure to provide a child with adequate food, shelter, supervision, medical care, education, and/or affection. ■ Victims of neglect may exhibit poor hygiene, malnutrition, stunted growth, developmental delays, and failure to thrive. ■ Severe deprivation can result in death, particularly in infants. ■ Neglect accounts for the majority of cases reported to child protection services.

TREATMENT Early intervention can potentially mitigate the negative sequelae and facilitate recovery. SEQUELAE ■ Increased risk of developing posttraumatic stress disorder, anxiety disorders, depressive disorders, dissociative disorders, self-destructive behaviors, and substance use disorders. ■ Increased risk of continuing intergenerational abuse cycle with partners and children. PSYCHIATRIC DISORDERS IN CHILDREN WARDS TIP Doctors are mandated reporters, thus legally required to report all cases of suspected child abuse to the appropriate social service agencies.

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