Asian Journal of Psychiatry 44 (2019) 97–98

Contents lists available at ScienceDirect

Asian Journal of Psychiatry

journal homepage: www.elsevier.com/locate/ajp

Letter to the Editor

Child psychiatry - The twists and turns!

Child psychiatry is a delicate, yet difficult subspecialty. Major psychopathology (e.g. early-onset schizophrenia) starting that early generally portend poor prognostication (Costello et al., 2003). Hits to developing brain in this critical period drastically take its toll on cognitive reserve with subsequent functional decline. Duration of untreated illness is notoriously longer in this population (e.g. denial by parents) and hence presenting pretty late for treatment. Prodromata are ubiquitously non-specific (e.g. anxiety). Diagnostic challenges abound. To start with, diagnostic criteria in the current classificatory systems (DSM-5 and ICD-11) are sorely developmentally insensitive (Levy, 2014). Presentations in this population tend to be atypical and severe (bipolar runs a chronic psychotic mixed course rather than typical adulthood episodicity). Comorbidities are the rule rather than the exception. Syndromic shifts and diagnostic instability (e.g. first-episode psychosis) are commonplace. Homo/heterotypic syndromic projections into adulthood are typically seen (ADHD trajectory of adult ADHD or as bipolar mood disorder) (Leon et al., 2000). Skewed views confound the practice. Some posit children do not have the cognitive capacity to endorse depressive syndromes whilst others tend to label/overdiagnose juvenile bipolar or ADHD for any child with disruptive behaviour. Medical or environmental influences might colour the presentation. Iron or zinc deficiency, thyroid dysfunction, vitamin D deficiency, sleep apnoea and so forth might masquerade as ADHD. Major role transitions, parenting styles, abuse, pernicious neighbourhood, trauma exposure all outwardly frame the clinical picture. These should be factored in whilst formulating a working diagnosis or differential. Dysfunctional criterion capitalizes on academic and social capacity contrasted with occupational impairment in adults.

In the same vein, children with neurodevelopmental disorders are commonly referred to child psychiatrists for behavioural decompensation. These special populations (intellectual disability, autism spectrum disorder, epilepsy) have the popular problem of diagnostic overshadowing, although psychopathology tends to be 3–6 fold overrepresented in these children (Hansen et al., 2018). Besides, it is difficult to conduct a routine MSE with these children. Diagnostic challenges in these populations include intellectual distortion, cognitive disintegration, baseline exaggerations and psychosocial masking.

Turning to treatment, parents are more often than not aversive to put their kids on meds. Children, by virtue of larger hepatic parenchyma and higher renal blood flow require higher and multiple dosing per day. This is balanced against first episode patients that usually respond to lower doses than multi-episode patients. By virtue of age, children are more vulnerable to side effects (neurohormonal and metabolic syndromes of antipsychotics). The risk is even inflated in children with neurodevelopmental disorders being susceptible by virtue of neurodisability (e.g. tardive dyskinesias). Of related interest is the FDA blackbox warning of activation of suicidal ideation and behaviours in those younger than 25 on antidepressants (Naguy, 2016). Double-blind randomized controlled trials in children are scant and are met with ethical dilemmas. Placebo effects in children are typically large. Many psychotropic agents are sorely prescribed off-label as a down-extension from adult studies. This is at peril as it does not take into account the ontogeny of pharmacokinetics and dynamics. For instance, noradrenergic antidepressants (e.g. SNRIs) did not separate from placebo in paediatric population whilst RCTs in adults attest to a positive efficacy signal. CYP 450 hepatic microsomal systems mature in early years of life (e.g. 1A2), exceed adult levels then normalize after puberty. Moreover, psychotherapeutic interventions need special training and should be developmentally appropriate.

Equally important is functional recovery and strategies aiming at neuroprotection and treatment adherence is a high priority in this population compared to end-point of symptomatic remission in multi-episode adults.

Another challenge pertinent to this region is chiefly logistic. Shortage of child psychiatrists, limitation of training programs in medical schools, accessibility to service and finances, regional military disputes, stigmatization and lack of database for conducting research are just few to name. There is no reason to believe that child psychiatric disorders are any different in this region despite transcultural influences. For instance, data from Iran (Talepasand et al., 2019) speaks to the idea that CAP disorders are on the rise with anxiety disorders being the commonest to encounter. Another study from Indonesia demonstrated boys in post-conflict areas were sorely more exposed to community violence that took its toll on their mental health whilst girls were reported to endorse more internalizing disorders (Fausiah et al., 2019)

Financial disclosure

Authors declare no financial affiliations or sponsorship.

Acknowledgement

Authors extend their deepest gratitude to Dr Naif El-Harby, Director General of KCMH for his unfaltering support.

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https://doi.org/10.1016/j.ajp.2019.07.023
Received 28 June 2019

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