teacher and parent form) and an ADHD rating form may also be helpful. A class or recess observation is recommended. Interview the child and ask about abuse, neglect, psychotic symptoms, mood symptoms, anxiety symptoms, and safety issues. Ask about smoking or drugs. Ask the child to draw his family doing something together. Ask about the child's three wishes. Inquire about issues of guilt and remorse. Does the child have insight into how his behavior affects others? In this case, PTSD (neglect and sexual abuse by an older cousin when the child was 4), ADHD, and a reading disability were diagnosed. The conduct issues were assessed to emanate from these other disorders, and a separate CD diagnosis was not made at this time. However, treatment planning included interventions to address the severe behavioral issues.

PART C

Other Disorders of Infancy, Childhood, or Adolescence

8 Separation Anxiety Disorder

Essential Concepts

- Separation anxiety disorder (SAD) commonly presents with somatic symptoms such as stomachaches or headaches to avoid leaving home.
- About three-fourths of children with SAD exhibit school avoidance.
- Children with SAD experience unrealistic fears that they or their parents will be injured, kidnapped, or killed.
- Children with SAD are disabled by their inability to sleep alone, attend school, visit friends, or stay at camp.

Separation anxiety disorder (SAD) is a common disorder of children, and is characterized by extreme anxiety and worry concerning separation from home or from those to whom the individual is attached. It is often first diagnosed in preschool or kindergarten, when the child experiences a separation from home and the "attachment object." Although some anxiety symptoms may persist, separation anxiety disorder is generally a disorder of childhood, and remits with advancing age.

CLINICAL DESCRIPTION

Table 8.1 provides criteria for a diagnosis of SAD.

TABLE 8.1. Diagnosis of Separation Anxiety Disorder

When the child is frightened of being separated he or she will **PUSH** or **NAGS**. This is a mnemonic to recall the eight criteria for Separation Anxiety Disorder (three of eight required).
Physical symptoms and complaints with anticipated separation
Untoward event anxiety
Sleep difficulties
Harm to attachment figures a concern
Nightmares
Alone is a big fear
Going to school or out of home difficult
Separation fears
The onset of symptoms must be in childhood, occur for at least 4 weeks, and cause clinically significant impairment.

Adapted from American Psychiatric Association (2000), Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Text revision. Washington, DC. American Psychiatric Association.

KEY POINT

In SAD, somatic symptoms such as headache, stomachache, nausea, and vomiting are common, and medical assessment should be done to rule out a primary medical etiology. However, in SAD the somatic symptoms are typically absent on weekends, holidays, and when there are no separations. The symptoms occur on evenings and mornings before school or before an anticipated separation.

TIP

Children with separation anxiety will typically have a great deal of difficulty at the start of each school year. I recommend to families that the child have a structured out-of- home summer plan (usually a day camp) to decrease the regression that is typical when a child stays home with the attachment figure most of the summer. Additionally, I typically recommend supportive and anxiety management psychotherapy beginning several weeks prior to the start of school. Working with the school system to have a support system in place is also crucial. I suggest that the school social worker or psychologist form a strong relationship with the child, and meet the child at the beginning of the school day to help with the school transition. SAD is a disorder that needs strong collaboration between the therapist, school personnel, parents, and child to help decrease distress and disability.

Epidemiology

The prevalence of SAD is estimated to be 2.4 to 4.7% of the population of children. Males seem to be affected about equally to females.

Etiology

Anxiety disorders tend to aggregate in families. SAD is likely precipitated by the interaction of genetic, temperament, family dynamics, and other environmental factors. The temperamental construct of "behavioral inhibition to the unfamiliar" describes the shy, cautious, and introverted child. Children with this temperamental disposition may be at increased risk for SAD, as well as other anxiety disorders. Parents with anxiety disorders may provide genetic vulnerability, as well as unwittingly convey their own fearfulness, to which the child reacts with fearfulness as well.

Assessment

The assessment includes a standard complete psychiatric evaluation. Multiple informants (the primary care physician, school or preschool personnel, parents, etc.) are key. The assessment should focus on symptoms of anxiety and/or mood disorders in both the child and parents. A parent may need to be present for the entire interview of the child if he or she is unable to separate. The information gleaned from attempting a separation must be weighed against the trust and comfort of the child in the therapeutic relationship and his or her need for the parent to be present. Typically, history is sufficient for the diagnosis. The differential diagnosis includes other anxiety disorders, depressive disorders, as well as pervasive developmental disorders or psychosis.

Treatment

Treatment of SAD is multimodal, and includes psychosocial and school interventions. Additionally, medications may be indicated when the symptoms are severe and disabling.

The psychosocial interventions include cognitive-behavioral, individual educational/supportive, and/or psychodynamic psychotherapy combined with parent guidance, behavior modification, family therapy, and school consultation.

The child will benefit from learning relaxation skills. Sleep disturbance or resistance to sleeping alone typically responds positively to systematic monitoring of bedtime behavior, gradual weaning of parental presence (including sitting outside of the open door for a period of time), and relaxation skills. Psychodynamic psychotherapy may help children with SAD resolve conflicts and achieve mastery over separation and autonomy. Transference and working through separations with the therapist are key.

Parents must be involved in the therapy to reassure the child as he or she achieves more independence and autonomy. School interventions include working with the school personnel to support the child's school attendance, providing added support to the child in dealing with anxiety, and using relaxation and other techniques to help the child feel more comfortable at school. Appropriate limits around requested phone calls home and a plan for somatic symptoms and nurse visits should be anticipated. A behavioral plan with reinforcements for appropriate school behavior is recommended. At times, children may require a partial hospital program or modified school program to allow a transition to school reentry. Home-bound education is contraindicated.

Medication treatment is typically with the selective serotonin reuptake inhibitors (SSRIs) for treatment of anxiety with or without depression. Tricyclic antidepressants may also be considered. Benzodiazepines may be indicated for the acute treatment of school refusal—but treatment should be brief and focused, with monitoring for behavioral disinhibition.

KEY POINT

School refusal may be considered a psychiatric urgency (not quite an emergency, but requiring prompt and intensive intervention). The longer the child is out of school, the greater the treatment resistance, chronicity, and school failure. If a child with SAD is refusing to go to school, an intensive treatment plan needs to be formulated quickly and collaboratively—to include family, school, and child components. Medication to help decrease the level of anxiety may be quite helpful. The temporary use of benzodiazepines may be indicated in this urgent clinical crisis.

9 Selective Mutism

Essential Concepts

- Selective mutism is a fairly rare disorder of childhood characterized by the ability to understand language and speak, but to do so only in certain situations.
- This disorder is often very frustrating to teachers and parents, who are at a loss as to how to get the child to speak.
- Children with selective mutism may have academic underachievement and impaired peer relationships due to their lack of speaking.

Selective mutism is a fascinating disorder of children who are able to speak, but refuse to do so in public situations. Child and adolescent psychiatrists are often consulted when the disorder has become more chronic and is interfering with educational and social adjustment. It is typically first diagnosed in preschool or kindergarten, when the child is first expected to interact in a broader social environment. There may be a link between selective mutism in children and social phobia in adults.

CLINICAL DESCRIPTION

A child with selective mutism consistently does not speak in specific social situations in which there is an expectation for speaking, such as school. The child is able to speak in other situations. The symptoms must persist for at least 1 month and be severe enough to negatively impact educational and interpersonal functioning.

Epidemiology

Selective mutism has a prevalence of less than 1% of school-age children in mental health settings (about 0.7% prevalence overall). Girls are thought to be affected twice as often as boys.

TIP

Children with selective mutism are typically extremely aware of the frustration they are causing to the adults and peers in the environment. They are also usually hypervigilant about covert attempts to "get them to talk." A referral to "get the child to talk" in school needs to be quickly reframed, as this type of control struggle rarely is effective and frequently exacerbates the disorder. Helping the child to feel comfortable, to participate, to make friends, and to be academically successful are more appropriate goals. The other children in the class need to be educated to minimize their concern about the selectively mute child speaking and not to overly react if the child does speak. I have seen children who are beginning to speak shut down again if their peers or teachers are too joyful about the utterances.

Etiology

Selective mutism is thought to be an anxiety disorder, possibly an early form of developing social phobia. Parents of selectively mute children have a higher incidence of anxiety disorders, such as panic, social and performance anxiety, and others. Biological factors such as genetic predisposition to anxiety disorders and temperament are thought to be contributory.

Selectively mute children often also have experienced developmental delays in speech and language. About half of these children have speech immaturities or a speech disorder. Nonspecific neurodevelopmental disorders are also more common.

Some children with selective mutism have a history of trauma. Abuse, early hospitalization, family instability, and frequent moves may also contribute to the development of symptoms in some children.

Assessment

The assessment includes a standard complete psychiatric evaluation. Neurological and hearing assessment, physical examination for oral-facial abnormalities, cognitive testing for mental retardation, and speech and language evaluation are generally indicated. Frequently, parents will need to describe speech patterns and developmental history in considerable detail, as the

child rarely will speak to the examiner. Nonverbal tests of intelligence (such as the Leiter scale or TONI [Test of Nonverbal Intelligence]) may be required. Family patterns of communication should be investigated. Family history of anxiety disorder should be elicited. Although the child will likely not speak, assessment of drawings, play, and relatedness are important. Differential diagnosis includes communication and cognitive disorders, hearing loss, pervasive developmental disorders, psychotic disorders, and conversion disorder.

Therapy

Therapy of selective mutism is based on the assumption that the child will speak again if he or she feels safe and comfortable. Any form of communication is encouraged through behavioral plans that shape progressive communication, interventions to decrease anxiety, and the formation of trusting relationships. The overall philosophy is a nonconfrontational collaborative approach to helping the child gain more adaptive functioning. Behavior therapy and parent counseling tend to be more effective than individual psychotherapy. The identification and focus on secondary reinforcement and family patterns that maintain symptoms are crucial. Clear and nonconfrontational articulation by the parents, school personnel, and therapist of the expectation that the child communicate is important. It is not helpful to have a sibling or other routinely talk for the patient. Medications to treat the anxiety disorder are typically the SSRIs.

CLINICAL VIGNETTE

Jenny is a 6-year-old first-grade student about whom you are consulted because of concerns that she has never spoken at school, despite parental reassurance that she speaks at home. Jenny is a fraternal twin, and has been the shyer of the two. Her twin sister, a popular and social child, often speaks for Jenny.

Jenny has never spoken in school, although she will sometimes mouth the words without vocalization. Jenny does speak at home, and if children are visiting her home, she will speak with them. This may have secondary gain for Jenny, as many of the girls in her class ask to be invited over to hear her speak. When in school, however, she does not talk.

Jenny's father is a successful businessman who travels a great deal, much to Jenny's disappointment. Her mother has

had intermittent difficulties with anxiety and panic, and successfully takes an SSRI for this.

The treatment of Jenny involved decreasing secondary gain for not talking (education of her classmates and a preset schedule for play dates), requesting her sister not to speak for her, and family involvement in making expectations clear (especially from both her mother and her father). Paternal attention seemed particularly helpful in reinforcing expectations and helping Jenny get attention from her father in an adaptive manner. Additionally, an SSRI was initiated for treatment of anxiety. The combination of treatments was effective in allowing Jenny to begin to speak in school and in public.

PART D
Tic Disorders

Tourette Disorder and Other Tic Disorders

Essential Concepts

- Motor tics are repetitive, involuntary movements of discrete muscle groups.
- Phonic (or vocal) tics are involuntary sounds.
- The tics of Tourette disorder are temporarily suppressible and preceded by a premonitory urge.
- The tics associated with Tourette disorder characteristically wax and wane.
- High emotions typically exacerbate tics.

CLINICAL DESCRIPTION

There are four tic disorders described in the Diagnostic and Statistical Manual (DSM-IV-TR): 1) Tourette disorder (also known as Tourette syndrome or TS); 2) chronic motor or vocal tic disorder; 3) transient tic disorder; and 4) tic disorder not otherwise specified. Tourette disorder (which will be referred to as TS) is an inherited neurological disorder with onset in childhood, characterized by the presence of multiple motor tics and at least one phonic (vocal) tic. The tics characteristically wax and wane. TS was once considered a rare and bizarre syndrome, with a psychogenic cause. The eponym for the disorder was bestowed by Jean-Martin Charcot on behalf of his resident, Georges Gilles de la Tourette, a French neurologist who published an account of nine patients with the unusual movement disorder in 1885.

For chronic motor or vocal tic disorder, there are single or multiple motor or vocal tics, but not both. Transient tic disorder is single or multiple motor and/or vocal tics for no