IDRAAC

Institute for Development, Research, Advocacy and Applied Care.
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IN THIS ISSUE

The IDRAAC newsletter is the result of a joint effort by all IDRAAC team members.
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Editor: Caroline Cordahi Tabet | caroline.tabet@idraac.org

EDITORIAL

Mental Health in Children and Teenagers

I am often asked by people who meet me the first time after they find out that I'm a Child and Adolescent Psychiatrist: "Is it possible that children have real psychiatric problems?" After answer that indeed children and adolescents do, the next two questions I get are: "Isn't it all because of stress and war? Isn't it because of how parents raise them?".

Misperceptions about child mental health are actually very common. However the truth about why children develop such conditions like Autism, Attention Deficit Hyperactivity Disorder (ADHD), Learning Disorders (such as Dyslexia), Conduct Disorder, Separation Anxiety Disorder or Depression is still elusive. The answers are far from simple, and involve highly complex interactions between genetics, biologic factors, temperament and the environment within which children grow.

From the moment babies are conceived until their birth and all through their later growth into childhood and adolescence, normal development follows many pathways simultaneously. This development proceeds along cognitive (thinking), emotional, social, motor (movement), and speech pathways, and each progressing step by step, achieving one milestone after another, intertwining with each other. This intricate process is coordinated by the brain.

Problems in mental health begin to occur when there are major deviations from these normal pathways, and disorders occur when these deviations are extreme. There are genetic and environmental factors that interact together to result in a particular child having a mental disorder.

These disorders are not unique to one culture or to the Western World. They have been documented in all populations all over the world, and Lebanon is no exception. Nor are these disorders rare; far from it, they range from around 0.5% in the case of Autism Spectrum Disorders (more common than diabetes in children) to 5% in the case of ADHD (as common as asthma). These disorders not only affect a child's internal world, but also impact the ability to learn, to get along with family, to make friends and to play. Many disorders are chronic, going on for years and continuing into adulthood, taking their toll on the most productive years in life.

The LEBANON study of psychiatric disorders conducted by IDRAAC on a nationally representative sample of adults found that the onset of these disorders took place in childhood or adolescence in 50% of the cases.

Needless to say, parents who raise a child with developmental delays or a psychiatric disorder know the degree of suffering and pain they and their child go through along with all members of the family. It is therefore crucial to recognize and diagnose these disorders in children and adolescents as soon as they occur in order to provide interventions early on and to prevent secondary complications.

Child and Adolescent Psychiatrists and Psychologists are specialists with expertise in diagnosing these disorders and treating them. Treatment is usually multidisciplinary in nature, involving a combination of interventions ranging from individual therapy, parent training and family therapy to medication and hospitalization.

As parents do not usually hesitate to ask their pediatrician about any health concern, they may have about their child, they similarly must not hesitate to ask a mental health specialist.

Dr. John Fayyad

ABOUT IDRAAC

IDRAAC is a non-profit, non-governmental organization that was officially founded by experts in the field of mental health in 1997. IDRAAC members have been conducting research since 1982. At that time, the founding members of IDRAAC were faced with a grim reality: there was no data on mental health disorders in Lebanon, nor any available assessment tools to assess the prevalence of these disorders (on a large scale). Above all, the Lebanese wars had been ravaging the country for seven years and there was little knowledge about their effect on the mental health of the population. IDRAAC's main mission is to promote research in mental health, to increase public awareness, and to participate in the improvement of training and educational programs in mental health. IDRAAC has a sister institution, the Medical Institute for Neuropsychological Disorders (M.I.N.D.), which focuses on providing clinical services to the public. The majority of the psychiatrists and psychologists working at M.I.N.D. are also actively involved in the research conducted at IDRAAC. Additionally, most IDRAAC and MIND members are part of the Department of Psychiatry and Clinical Psychology at the St. George Hospital University Medical Center and Balamand University Faculty of Medicine.

Visit IDRAAC's Website!

Our website www.idraac.org, offers a wealth of information on mental health in Lebanon and the Arab World for both professionals and the public.

- Visit the Research section where you can read about the various studies undertaken by IDRAAC over the last two decades.
- Visit the **Training Activities** section to discover the various training opportunities available at IDRAAC.
- Learn specifically about what we found on the effects of **War and Mental Health.**
- Discover the various **Services** that IDRAAC has offered and continues to offer to the community.

• Our website also provides you with many links to various international organizations and academic centers specialized in mental health as well as links to other resources for patient centered information on commonly encountered problems.

• Click on the "**Mental Health Research in the Arab World**" section and find the wealth of information that this database offers. You can search studies relevant to mental health in all Arab countries from 1966 to the present.

• Finally, you can visit **Get Involved** to become a friend of IDRAAC, to support IDRAAC or to know more about IDRAAC's fundraising activities.

MOST COMMON ISSUES OF CHILDHOOD AND ADOLESCENCE

Numerous prevalence surveys have now been conducted across the world, and they show that psychopathology in young people is common. Most studies estimate the prevalence of childhood and adolescence mental health disorders to be somewhere between 10% and 20%. Emotional disturbances and disorders of disruptive behavior are more or less equally common (with rates of 6 to 8%). *Yet community studies have shown that only a small proportion (typically between 10 and 30%) of children and adolescents with a mental health disorder have had contact with specialized mental health services.* Early detection of mental health problems among children and adolescents is a crucial step for the future of the individual, permitting a better prognosis.

Misperceptions about children and adolescents' mental health are very common in Lebanon, however the truth about why children develop mental health problems is far from simple and involve highly complex interactions between genetics, biological factors, temperament and the environment within which children grow up. Multiple risk factors are now solidly established for specific childhood and adolescence disorders. These findings have led to the development and systematic testing of treatment interventions targeting these risk factors and consolidation of evidence-based practices.

For example, the relationship found between parenting problems, lack of maternal warmth, harsh discipline, marital discord, and the onset of symptoms of conduct disorder in children has led to better targeted parent-child interventions.

For many disorders, risk factors have been identified within the *child*: prenatal exposure to substances that affect brain development (e.g.: smoking, alcohol, etc…) low birth weight, developmental delays, medical and brain disorders, and IQ and cognitive strengths and weaknesses were found to have a powerful role in determining the child's mental health. Other factors were identified in the *family*: parental psychopathology, marital discord, and maternal sensitivity and warmth were also found to be strong contributors to the child's mental health. In *school*, classroom size, peer relationships, discipline practices, and teaching styles were identified to affect the child's psychological state and level of academic performance. In the *community*, poverty, crime rates, access to drugs, and broader societal factors such as media viewing, body ideals, etc... were also found to have a significant impact.

The research findings also clearly indicate that *psychosocial risk factors* operate differently in individuals according to their *genetic background.*

There is a wealth of information on our MIND website about some child mental health disorder such as Attention Deficit Hyperactivity Disorder (ADHD), Obsessive Compulsive Disorder (OCD), TIC Disorders, Depression, Anxiety Disorders, Autism, etc… To view these resources, please visit www.mindclinics.org.
We have also adapted material about each clinical information specifically for the public.

IDRAAC has played a leading role in Lebanon and the region in researching and promoting child and adolescent mental health. Starting with the pioneering studies of children and war in South Lebanon after the 1996 war leading to school-based and community interventions, IDRAAC continues in its efforts to raise awareness in Lebanon among families, schools, organizations, health professionals and policy makers to advocate for the importance of mental health.

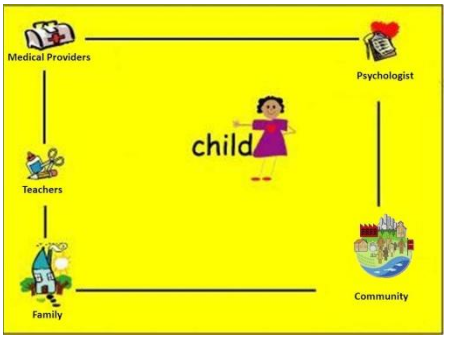
In 2003, IDRAAC conducted the Lebanese Evaluation of the Burden of Ailments and Needs of the Nation (L.E.B.A.N.O.N) a study on a nationally representative sample of psychiatric and psychological problems among adults.

The results of this study showed that the onset of these disorders took place in childhood or adolescence in 50% of the cases. The IDRAAC L.E.B.A.N.O.N. study was part of the worldwide mental health surveys, conducted with Harvard University and the World Health Organization, Geneva.

One of the important points of interest in the L.E.B.A.N.O.N. studies was to look at childhood adversities and how they affect adult psychopathology. It was found indeed that childhood adversities have a strong relationship with adult mental health outcome. The study looked at four types of childhood adversities: interpersonal loss (parental death, parental divorce, and other early separations from parents), parental maladjustment (substance misuse, criminality, and violence), maltreatment (physical abuse, sexual abuse, and neglect), life-threatening physical illness and family economic adversity. To examine joint associations of 12 childhood adversities, national or regional surveys of 51,945 adults from 21 countries (including Lebanon) assessed childhood adversities and lifetime psychiatric disorders.

The results indicated that childhood adversities and psychiatric disorders were highly prevalent and interrelated. Childhood adversities associated with maladaptive family functioning (parental mental illness, child abuse, neglect) were the strongest predictors of psychiatric disorders. Childhood adversities generally account for about 30% of all disorders across countries. Childhood adversities were also associated with an increased risk of suicide attempt and ideation. The risk increased with the number of adversities experienced. Sexual and physical abuse in particular was consistently the strongest risk factors for both the onset and persistence of suicidal behavior, especially during adolescence.

The L.E.B.A.N.O.N. studies also investigated ADHD. Childhood history of ADHD and adult ADHD were assessed in 10 countries (including Lebanon), in the World Health Organization World Mental Health Surveys (Fayyad et al, 2009). A substantial proportion (33 % to 84% across countries) of children with ADHD continues to meet full criteria for ADHD as adults. Highest persistence was associated with attentional plus impulsive-hyperactive type, symptom severity, comorbid major depressive disorder, high comorbidity, paternal, anxiety mood disorder and paternal antisocial personality disorder. (Carmen Lara, et.al 2009). Persistence was strongly related to childhood ADHD symptom profile.



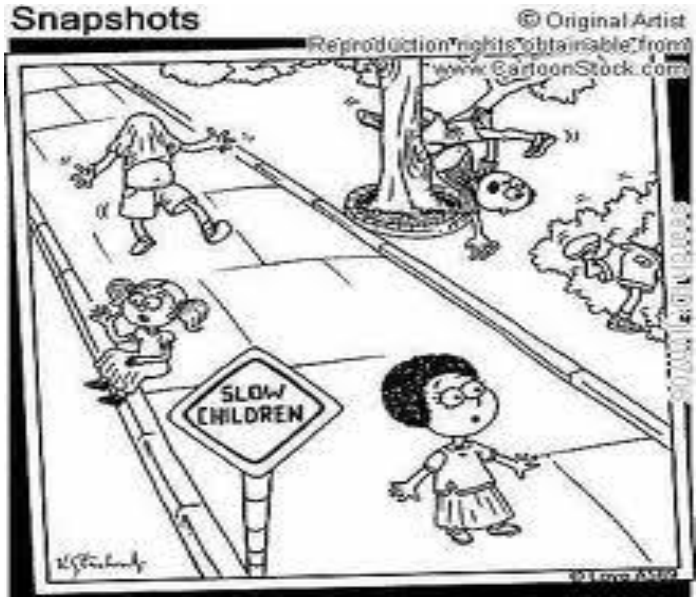
Child and adolescent mental health problems are prevalent and require adequate interventions. Despite several evidence-based interventions for these problems described in the literature, in developing countries, few studies addressed strategies to diffuse efficacious interventions for child mental disorders. In 2008 (Graeff-Martins, et.al 2008), an extensive review of the literature related to developing countries was performed in a joint effort by several mental health workers around the world including ones from IDRAAC, aiming to identify evidence-based interventions for children and adolescents with mental disorders, and the professionals to target in disseminating these interventions, as well as the available strategies to diffuse information.

In 1996, IDRAAC conducted a study to examine the effectiveness and specificity of a classroom-based psychosocial intervention after war. 2,500 students of six villages in southern Lebanon designated as most heavily exposed to war received a classroom-based intervention delivered by teachers, consisting of cognitive-behavioural and stress inoculation training strategies. A random sample of non-treated students and a matched control group were assessed for the prevalence of major depressive disorder (MDD), separation anxiety disorder (SAD) and posttraumatic stress disorder (PTSD) pre-war, one month post-war (pre-intervention), and one-year post-war. The results indicated that the rates of disorders peaked one month post-war and decreased over one year. Post-war MDD, SAD and PTSD were associated with pre-war SAD and PTSD, family violence parameters, financial problems and witnessing war events.

One year later, in 1997, IDRAAC started a long-term multidisciplinary group treatment that was conceptualized on the basis of empirical data for a specific subgroup of children and adolescents who became orphans of the 1996 in south Lebanon.

These empirical data were obtained through yearly phases of clinical evaluation and re-evaluations, in order to adjust yearly the group treatment interventions according to the assessed needs. Results indicated that even one year after the trauma, the prevalence of "any disorder" was 62.5% and decreased five years later to 23.2%.

While emotional disorders improved significantly with time, behavioral problems remained unchanged and sometimes increased, possibly related to the lack of parental mental and emotional availability to follow-up their kids with the right amount of authority and discipline, as it appeared in the qualitative observations.



In the years 2007-2008 (Fayyad JA, et.al 2010) IDRAAC conducted the "Parenting Skills Treatment Program for Mothers of Children with Behavioral Problems". Eight sessions given by lay social workers trained by IDRAAC in social development centers and dispensaries affiliated with the Lebanese Ministry of Health and ministry of Social Affairs. Each social and health worker trained mothers of children with behavioral problems under supervision utilizing an Arabic adaptation of the treatment manual for externalizing disorders ''Helping Challenging Children'' developed by the Integrated Services Taskforce of the World Psychiatric Association Child Mental Health Presidential Programme. A total of 20 workers and 87 mothers participated in the training.

The proportion of children who obtained a "total difficulties" score in the abnormal range decreased from 54.4% to 19.7% after the training. Whereas 40.2% of mothers used severe corporal punishment with their children before the intervention, this decreased to 6.1% post intervention. Three-fourths of mothers related that the program helped them develop new parenting skills.

As a result of this project, there was a significant improvement in the children's behavioral problems and also with the relationship between parents and their children.

After the July 2006 war in Lebanon, IDRAAC was commissioned by the Lebanese Higher Council for Children, Ministry of Social Affairs, with support from Handicap International and the European Union ECHO program to conduct the "Assessment Study of Psychosocial Status of Children and Adolescents in the south of Lebanon and southern suburbs of Beirut"- the SSS Study. There were two main objectives: First, to map available community psychosocial resources, and second, to conduct a psychosocial needs assessment of children and adolescents in Lebanon, in the areas mostly affected by the recent July 06 war events (south Lebanon and Beirut southern suburbs).

One of the main findings from this study was that 14.5% of adolescents were likely to have a mental disorder after the July 2006 war. This study tested several variables some of which were not related to war. The results have shown that some variables predicting disorders and not related to war included having pre-war disorders and family violence, financial problems, a family member suffering from chronic illness, and violence at school. Based on the data from this study, IDRAAC staged a set of workshops for professionals, national and international organizations as well as governmental officials. A set of recommendations was handed to the Ministry of Education, the Ministry of Public Health, the Ministry of Social Affairs, the Ministry of Interior and the Ministry of Information.

We are proud that IDRAAC has pioneered the dissemination of evidence-based interventions into communities that do not have access to health care.

We are also excited to report on a new project by IDRAAC being conducting in seventeen schools in Lebanon. With support from the European Union, we conducted a classroom-based intervention that builds resilience and coping strategies among children in Grades 4, 5, 6 and 7, to help their students develop mechanisms and life skills to resist the negative effects of various types of stressors they face in their lives. For more follow-up on information on the results of this experiment, please visit our website (www.idraac.org) regularly in the near future.

Video games for children improve visual attention skills

FALSE! Children's excessive video games are correlated with poor academic performance. When video games are analyzed for violent content, additional risk factors are observed such as increased aggressive behaviors and desensitization to violence. However, playing video games does increase reaction time and visual cognition. Parents should recognize that video games can have powerful effects on children, and should therefore set limits on the amount and content of games their children play. In this way, we can realize the potential benefits while minimizing the potential harms.

Parents should be firm and hit their children when they misbehave

FALSE! Parents should be firm by setting clear limits and rules. Hitting children does not teach them how to behave in an appropriate way. In the long run, physical violence will affect children's self-esteem and may every predispose them to become more violent themselves by thinking that when they are angry, it is acceptable to hit others.

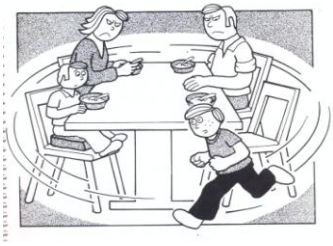
When parents have highly conflictual relationships, it is better to stay together for the sake of the child.

FALSE! Many parents considering divorce wonder whether they should stay together for the child's sake. Studies here found that when divorce ends a highly conflictual marriage, children's psychological adjustment typically benefits in the long run. High levels of marital conflict and interesting of parental fights and violence can cause children to feel "caught in the middle" in the battle between their parents and may even be highly traumatizing. Children living with married but contentious parents have poorer school achievement, lower self-esteem and more behavior problems than children from divorced families.

Jealousy between siblings is inevitable.

TRUE! Feelings of jealousy in young children are very common. It can be managed well if the parents spend quality time with every child. Parents should never compare their child to another because every child has his/her own character and potential. They should instead emphasize the strengths and weaknesses of each one of them.

Poor parenting causes hyperactivity and attention problems



FALSE! Parents end up blaming themselves for having a child with Attention Deficit Hyperactivity Disorder (ADHD) but there is no scientific evidence to support that. ADHD is a highly genetic disorder. However, poor parenting can aggravate ADHD symptoms. It is important to provide a structured environment at home, coupled with clearly set expectations, guidance and a positive parental attitude.

War trauma does not affect children.

FALSE! Our research studies in Lebanon and several other studies from around the world demonstrate that exposure to highly traumatic war events can lead to fear, anxiety, depression and violent behavior.

Parents are not to blame for their child's Autism

TRUE! In the past, mothers used to be blamed for Autism in their child, thinking if it was mother's lack of demonstrating affection that caused Autism. This cannot be further from the truth, as scientific evidence in the last few decades has clearly demonstrated the Autism is a disease of the Brain.

Children and Adolescents are too young for suicide.

FALSE! Global data on patterns of death from countries all over the world reveal that suicide is the second leading cause of death in the 15-19 years age group, and the tenth leading cause of death in the 10-14 years age group. Suicide in children and adolescent is almost always associated with the presence of an unidentified or untreated psychiatric disorder. Our data from the L.E.B.A.N.O.N. study on adults conducted by IDRAAC indicated that suicide rates increase following periods of war. The onset of suicide ideation, plan, and attempt was associated with female gender, younger age, post-war period, major depression, impulse-control disorders, and social phobia. In our national sample, nearly half (45%) of adult females who reported ever seriously thinking of suicide had an onset of this ideation before age 18 years compared to only 7.8% of males.

- ***Attachment Disorder*** is characterized by inappropriate social relatedness of the child before the age of 5. The child may show signs of severe colic and/or feeding difficulties, failure to gain weight, detached and unresponsive behavior, difficulty being comforted, inhibition or hesitancy in social interactions, disinhibition or inappropriate familiarity or closeness with strangers. Most children with Attachment Disorder may have experienced disregard to their basic emotional and/or physical needs or repeated changes of primary caregiver.

- Infants with ***Feeding Disorder*** have persistent failure to eat adequately that is not explained by any gastrointestinal or other medical condition. Feeding Disorder can be reflected in significant weight loss or failure to gain weight. Its onset is at the first year of life.

- ***Autism Spectrum Disorders*** are characterized by a markedly abnormal or impaired development in social interaction and/or communication and a markedly restricted repertoire of activity or interest.

(Below the grid: This figure shows the ages at which common mental health disorders present during childhood and adolescence. Sections with the darkest colors represent the ages during which children and adolescents' disorders most typically present.)

A child with Autism is generally withdrawn, aloof, and fails to respond to other people. He/she may have difficulties to respond to his name and often fails to develop peer relationship. He/she may speak in rhyme or have echolalia. Some parents may report that the child had normal development for the first year or even 2 years after which the signs appear. Early detection and intervention are essential.

- ***Motor Skills / Communication Disorders*** are characterized by a lower level of performance than expected given the person's chronological age and measured intelligence. The disturbance interferes with academic achievement or activities of daily living.

A child may manifest marked delays in achieving motor milestones: crawling, sitting, walking, or difficulties in recalling words, understanding words, verbal expression, and limited vocabulary. Interventions with specialized therapists are needed.

- ***Elimination Disorders*** are characterized by a repeated passage of feces (encopresis) or passage of urine (enuresis) into bed, clothes or other inappropriate places during the day or at night (during sleep). These behaviors are clinically significant if they occur after the age of 4 and are not due to any physiological or general medical condition. Behavioral Therapy and certain medications are helpful.

- Students with ***Learning Disorders*** may have difficulties in reading, mathematical ability or writing skills. Some of these disorders are also known as "Dyslexia".

These deficits are measured by standardized tests which show below average level on these cognitive functions than expected given the person's chronological age, measured intelligence and age appropriate education.

Classroom interventions and help from special educators may be needed.

- Any child may show inattention, distractibility, impulsivity, or hyperactivity some of the time, but the child with ***Attention Deficit Hyperactivity Disorder (ADHD)*** shows these symptoms and behaviors more frequently and severely than other children of the same age or developmental level. To be diagnosed with ADHD, a child must show symptoms in at least two settings, such as home and school, and the symptoms must interfere with the child's ability to function at home or school. ADHD can be treated with either medication, behavioral therapy or a combination of both.

- All children are oppositional from time to time, particularly when tired, hungry, stressed or upset. They may argue, talk back, disobey, and defy parents, teachers, and other adults. Oppositional behavior is often a normal part of development for two to three year olds and early adolescents. In children with ***Oppositional Defiant Disorder (ODD)***, there is an ongoing pattern of uncooperative, defiant, and hostile behavior toward authority figures that seriously interferes with the youngster's day to day functioning. Behavioral and Family Therapy is needed to target ODD.

- ***Conduct Disorder*** refers to a group of behavioral and emotional problems in youngsters. Children and adolescents with this disorder have great difficulty following rules and behaving in a socially acceptable way. They are often viewed by other children, adults and social agencies as "bad" or delinquent, rather than mentally ill. They may exhibit some of the following behaviors: aggression to people or animals, destruction of property, fire setting, staying out at night despite parental objections,

and running away from home. Many factors may contribute to a child developing conduct disorder, including brain damage, child abuse, genetic vulnerability, school failure, and traumatic life experiences. Family interventions involving very strict limit setting are required.

- A ***Tic*** is a problem in which a part of the body moves repeatedly, quickly, suddenly and uncontrollably. Tics can occur in any body part, such as the face, shoulders, hands or legs. Sounds that are made involuntarily (such as throat clearing) are called vocal tics. Most tics are mild and hardly noticeable. They can be stopped voluntarily for brief periods. Tics are often transient and go away by themselves. Some may get worse with anxiety, fatigue, and some medications. Children with ***Tourette's Disorder*** have both body and vocal tics (throat clearing). Medical treatment is needed when Tics are severe.

- All children experience anxiety. ***Anxiety*** in children is expected and normal at specific times in development. Anxious children are often overly tense or uptight. Some may seek a lot of reassurance, and their worries may interfere with activities. Anxious children may also be quiet, compliant and eager to please. Parents should be alert to the signs of severe anxiety so they can intervene early to prevent complications. There are different types of anxiety in children. ***Separation Anxiety*** includes constant thoughts and intense fears about the safety of parents and caretakers, refusing to go to school, frequent stomachaches and other physical complaints, extreme worries about sleeping away from home, trouble sleeping or nightmares.

Generalized Anxiety includes many worries about things before they happen, constant worries or concerns about family, school, friends and activities.

Social Phobia involves extreme shyness, intense fear of certain social situations, especially the ones that are unfamiliar or in which the child will be watched or evaluated by others. Severe anxiety problems in children can be treated.

Early treatment can prevent future difficulties, such as loss of friendship, failure to reach social and academic potential, and feelings of low self-esteem.

- ***Obsessive Compulsive Disorder (OCD)*** is characterized by recurrent intense obsessions and/or compulsions that cause severe discomfort and interfere with day-to-day functioning, academic functioning, social activities, or relationships. Obsessions are recurrent and persistent thoughts, impulses, or images that are unwanted and cause marked anxiety or distress. Frequently, they are unrealistic or irrational.

Compulsions are repetitive behaviors or rituals (like hand washing, hoarding, keeping things in order, checking something over and over) or mental acts (like counting, repeating words silently, avoiding).

The obsessive thoughts may vary with the age of the child and may change over time. A younger child with OCD may have persistent thoughts that harm will occur to himself or a family member, for example an intruder entering an unlocked door or window. The child may compulsively check all the doors and windows of his home after his parents are asleep in an attempt to relieve anxiety.

The child may then fear that he may have accidentally unlocked a door or window while last checking and locking, and then must compulsively check over and over again. OCD can be treated both medically and with a specific form of psychotherapy called Cognitive Behavior Therapy (CBT).

- Children and adolescents may experience ***Mood Disorders***. Signs and symptoms of ***Depression*** in children include continuous feelings of sadness, irritability or anger, hopelessness, social withdrawal, changes in appetite, changes in sleep, difficulty concentrating, fatigue, physical complaints (such as stomachaches, headaches), guilt feeling and thoughts of death or suicide.

Children may also have mood swings with extreme ups and downs, known as ***Bipolar Disorder***. These intense moods quickly change from one extreme to another without a clear reason. Some children and adolescents may briefly return to a normal mood between extremes. Sometimes they have symptoms of both mania and depression at the same time.

During a time of mania, children and adolescents may feel irritable or "super-happy" and throw violent temper tantrums, use sexual language, are often belligerent and may experience a loss of need for sleep with high levels of energy. Both Depression and Bipolar Disorder can be treated medically and psychologically.

- ***Eating disorders***, including ***Anorexia Nervosa*** and ***Bulimia Nervosa*** are psychological disorders that involve extreme disturbances in eating behavior.

A teen with Anorexia refuses to maintain a normal body weight. Someone with Bulimia has repeated episodes of binge eating followed by compulsive behaviors such as vomiting or the use of laxatives to remove the food. Symptoms of eating disorders may include the following: a distorted body image, unusual eating habits (such as eating thousands of calories at one meal or skipping meals), frequent weighing, extreme weight change and high interest in exercise. Teens with eating disorders are often in denial. Medical care and psychological individual and family therapy are often needed.

- Most teenagers will have some experience with Alcohol and other Drugs. Some will experiment and stop, or continue to use casually without significant problems.

Some will use regularly, with varying degrees of physical, emotional, and social problems. Some will develop a dependency and be destructive to themselves and others for many years. Teenagers using substances need to be fully evaluated for the presence of other psychiatric disorders. Specialized psychological and medical treatment is needed.

- ***Schizophrenia*** is a psychiatric illness that causes strange thinking, strange feelings, and unusual behavior. It is uncommon in children before puberty and is hard to recognize in its early phases but it begins to appear during mid to late adolescence. The symptoms and behavior of children and adolescents with schizophrenia may differ from that of adults with this illness. The behavior of children with schizophrenia may change slowly over time. For example, children who used to enjoy relationships with others may start to become more shy or withdrawn and seem to be in their own world. Sometimes youngsters will begin talking about strange fears and ideas.

They may start to cling to parents or say things which do not make sense. The following symptoms and behaviors can occur in children or adolescents with schizophrenia: seeing things and hearing voices which are not real (hallucinations), unusual or bizarre thoughts and ideas, confusing television and dreams from reality, ideas that people are out to get them or talking about them, withdrawn and increased isolation, decline in personal hygiene.

Psychiatric medication can be helpful for many of the symptoms and problems identified.

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