

## Tantrums: When to worry

Temper tantrums are a common childhood event, particularly in the preschool years. They can be difficult for parents to manage, and also can lead to fears that a child is suffering from difficulties that require treatment. Belden, Thomson and Luby (2008) conducted a study of temper tantrums, comparing features seen in children both with and without psychological difficulties. They point to several features that help parents and professionals determine when tantrums are a normal part of childhood, and when parents should seek assistance in managing their child's emotions and behavior.

Belden and colleagues showed that children exhibiting other disruptive behaviors (e.g. defiance, aggression, deliberate rule breaking) had more tantrums. Normal and depressed children tended to have on average about one tantrum per week, whereas children with other significant disruptive behaviors had tantrums daily or every other day. These children were also much more likely to have tantrums in school or other out of home settings, which was relatively uncommon in normal or depressed children. Children with disruptive behaviors were also more likely to have tantrums that were deemed aggressive (including kicking, hitting, or throwing objects) or excessive (intense shouting, crying, flailing of arms and legs).

Differences in tantrums were more subtle for children who were depressed. These children had similar levels of tantrums compared to normal children, but were more likely to use self injurious behaviors (hitting self, banging head, holding breath or biting self) during tantrums. They also tended to have longer tantrums (greater than 15 minutes) and have more difficulty recovering once a tantrum was over, particularly if they had signs of both depression and behavior problems.

Belden, A. C., Thomson, N. R. & Luby, J. L. (2008). Temper tantrums in healthy versus depressed and disruptive preschoolers: Defining tantrum behaviors associated with clinical problems. *Journal of Pediatrics*, 152, 117-122.

## Child behavior impacts parenting

Parents know that how they respond to child misbehavior is important in shaping future behaviors. However, child misbehaviors also have been shown to influence how parents act towards children. Burke, Pardini and Loeber (2008) conducted a study to examine which childhood problems tend to create ineffective parenting, leading to increasing difficulties at home and in school. They found that in particular, defiant argumentative child behaviors tend to influence parents to be more timid in their discipline. For example, parents might hesitate to discipline for fear of provoking a tantrum or violence. Child defiant behaviors also lead to parents communicating less well with children and being less involved with their children. All of these parent behaviors, particularly the hesitancy to discipline, led to increased levels of child behavior problems. Pardini and colleagues point out that parents need to be aware of this reciprocal relationship, so that they are better able to avoid falling into the trap of responding hesitantly to child defiance.

Burke, J. D., Pardini, D. A. & Loeber, R. (2008) Reciprocal Relationships between parenting behavior and disruptive psychopathology from childhood through adolescence. *Journal of Abnormal Child Psychology*, 36, 679-692.

## International trends in psychological medication use

The use of medications to treat mental health concerns has increased in children and teens in the past decade. This is due to many factors, such as availability of a greater number of medications, more awareness of mental health concerns, and demand for fast and effective treatments. To better understand prescribing trends, Zito and colleagues (2008) conducted a study of medication use across 3 different countries: Germany, the Netherlands, and the USA. They found that children in the USA were 2-3 times more likely to be receiving psychological medications, with 6.66% of US children having at least one prescription. Usages were similar across countries for a few classes of medications, including anxiety and antipsychotic medications. The US sample had much higher use of stimulant medications (3-4 times higher, used primarily to treat ADHD), antidepressant medications (5-10 times higher) and lithium (15 or more times higher, used to treat bipolar disorder). Children in the USA were also more likely to be taking more than one psychological medication, with 19.2% of the children taking any medication having more than one (as compared to 8.5% of Dutch children and 5.8% of German children). Authors make no conclusions about the value of these trends.

Zito, J. M., Safer, D. J., de Jong-van den Berg, L. T., Janhsen, K., Fegert, J. M., Gardener, J. F. et al (2008). A three-country comparison of psychotropic medication prevalence in youth. *Child and Adolescent Psychiatry and Mental Health*, 2, article 26. Retrieved Sept 26, 2008 from <http://www.capmh.com/content/2/1/26>

## Are newer antipsychotics better?

Since the release of 2<sup>nd</sup> generation antipsychotic medications, their usage with children in the USA has increased and now surpasses that of the first generation antipsychotics (Zito et al, 2008). Antipsychotics must be used with caution in children due to concerns about side effects for the developing brain, as several neurological side effects are found to be more common for youths than adults. Sikich and colleagues (in press) conducted a study to determine if these newer drugs are more effective and safer in youth populations. They examined two 2<sup>nd</sup> generation medications, Olanzapine and Risperdone, and one first generation medication, Molindone. Their results showed that all 3 medications were equal in alleviating psychotic symptoms, with only moderate success rates (approx 50% of youths improved significantly). Olanzapine was discontinued before the conclusion of the study as it was associated with high rates of weight gain without evidence of better efficacy. By the end of the study, youths taking Risperdone had also showed significant weight gain, while those taking the first generation medication, Molindone, showed no significant weight changes. Few neurological symptoms were observed in any group, with slightly more seen in children taking Molindone. Authors state that the long term health risks of the second generation medications were shown to be greater, and urged caution in their use.

Sikich, L., Frazier, J. A., McClellan, J., Findling, R. L., Vitiello, B., Ritz, L et al (in press). Double-blind comparison of first- and second-generation antipsychotics in early-onset schizophrenia and schizoaffective disorder: Findings from the Treatment of Early-Onset Schizophrenia Spectrum Disorders (TEOSS) study. *American Journal of Psychiatry*.

## Borderline personality in teens

The diagnosis of personality difficulties has been restricted to adults, as teens and children have not fully developed their personality. However, clinicians working with troubled teens often observe personality styles in teens that meet criteria for these diagnoses. Miller, Muehlenkamp and Jacobson (2008) conducted a review of literature on one such disorder, borderline personality disorder to explore if this diagnosis can be accurately applied to teens. Borderline personality disorder (BPD) is a style of interactions marked by extreme shifts in mood, relationships, and self-concept.

Miller and his colleagues found a great deal of evidence that the diagnosis of BPD can accurately be applied to teens. First, they found that personality patterns in general are relatively stable starting in middle childhood (although not as stable as in adults). Teens do meet criteria for BPD as written, with rates higher than those found in adults, and some evidence of stability over time. In one study, 6 years after initial assessment, 25% of teens still met diagnostic criteria. In another, 84% met criteria 2 years after the initial diagnosis. These rates, while low, are similar to those found in adult studies. In both adults and teens, the diagnosis leads to effective treatment of symptoms. Miller and colleagues concluded that the diagnosis has enough validity in adolescence that clinicians should routinely assess for it, but with caution not to over-diagnose. They suggested using a dimensional approach that describes not only the symptoms, but how severely they are affecting the teen's social and emotional functioning.

Miller, A. L., Muehlenkamp, J. J. & Jacobson, C. M. (2008). Fact or fiction: Diagnosing borderline personality disorder in adolescents. *Clinical Psychology Review, 28*, 969-981.

## Mirror exposure and obesity

Childhood obesity is a growing concern. It is primarily treated through behavior change, but even when successful, anxiety over body image often leads children to resume old, comforting behaviors and avoid exercise. Jansen and colleagues (2008) describe a successful technique for reducing this anxiety, thus improving both self esteem and treatment adherence. With a clinician present, they asked youths to stand in front of a mirror dressed in a bathing suit, and used a structured interview to encourage them to describe their body in neutral or realistically positive terms, out loud, for 50 minutes. Youths who participated were much less anxious and more positive over their appearance than those in a control group. Authors conclude that the technique is promising, and advocate for further research to determine if the benefits last beyond initial treatment.

Jansen, A., Bollen, D., Tuschen-Caffier, B., Roefs, A., Tanghe, A. & Braet, C. (2008). Mirror exposure reduces body dissatisfaction and anxiety in obese adolescents: A pilot study. *Appetite, 51*, 214-217.



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## Why children struggle in school

School failure is a major concern for both parents and the community. 15% of Santa Clara county students drop out before completing high school ([www.kidsdata.org](http://www.kidsdata.org)). Most kids struggle for years before reaching this point, with parents and educators at a loss for how to help. They show a mixed array of problems including failing grades, poor attention and classroom behavior, poor relationships with peers, and negative mood. Given this wide range of difficulties, it is hard to know what will help any given youngster overcome their difficulties and get the most out of an educational program.

The first step to helping a child who is struggling in school is understanding what is causing their difficulties. School puts demands on all aspects of children's functioning. In order to succeed, they must pay attention, sit still and control their impulses, process visual, auditory, verbal and numerical information, encode and retrieve information from memory, establish satisfactory peer relationships to a degree that they feel safe and comfortable in the classroom, and learn to manage a full range of emotions including anger, worry and disappointment. Problems starting in any one of these areas can lead to symptoms of difficulty in all areas - school performance, behavior, relationships and emotions.

Accurate diagnosis of children can be difficult as they are still learning to understand themselves and frequently cannot put difficulties in words. Often parents reach a solution by trial and error, trying out solutions based on several causes until they find one that works. Unfortunately years can be lost in this process. Educational and psychological testing provide a much faster way to pinpoint the problem. Unlike school evaluations, a psychologist specializing in diagnostic testing can assess all areas of a child's functioning, from academic processing and attention through social skills and emotional control. Once the core problem is identified, solutions are chosen to target the specific area of need, and a speedy recovery is far more within reach.

Advancing Minds specializes in assessing all areas of children's functioning. If your child or a child you work with is struggling in school, a thorough and accurate assessment may be the key to the success you have been seeking. Call us at (408) 294-9905 to find out if this service is right for you.

## Caffeine use, sleep and depression

Caffeine is widely used in our culture, with rates in youth nearly as high as those in adults. Given its possible impact on sleep and mental health, Whalen and colleagues conducted a study to determine how caffeine use in youth relates to both sleep difficulties and depression. They found that overall, depressed youth consumed more caffeine than non depressed youth, and also had poorer sleep. However, caffeine use was not correlated with sleep problems and did not appear to be causing them. They found that as depressed youth in treatment began to show improvements, they would (without therapist suggestion) use less caffeine, leading researchers to conclude that the youths were using caffeine as a self-medication of depression, to boost attention and energy levels. However, depressed youth also reported greater levels of anxiety while consuming caffeine, indicating that this self treatment has significant negative consequences. Authors speculate that caffeine use in depressed teens may lead to a cycle of increasing negative and anxious affect, as it improves some symptoms while worsening others. Authors also noted that while depression and caffeine use improved with treatment, sleep did not. As poor sleep can often create depression like symptoms, youth recovering from depression may require additional help achieving healthy amounts of sleep.

Whalen, D., Silk, J., Semel, M., Forbes, E., Ryan, N., Axelson, D. et al (2008). Caffeine consumption, sleep, and affect in the natural environments of depressed youth and healthy controls. *Journal of Pediatric Psychology, 33*, 358-367.