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Adolescent Psychiatry as a Separate Specialty of Psychiatry – A Clinical and Conceptual Consideration

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ABSTRACT

Adolescent psychological problems are unique in their mode of onset and presentation. They differ from child psychiatric problems in severity and heterogeneity of symptoms. Certain adolescent psychiatric problems like antisocial behaviours and substance abuse are uncommon in children. There is often a need that arises leading to an inpatient treatment of adolescents with psychiatric problems. This paper argues for the need of adolescent psychiatry as a separate subspecialty unlike child and adolescent psychiatry where both are clubbed together. The paper present some clinical and theoretical arguments towards this viewpoint while emphasizing the need to focus on adolescent psychiatric units and adolescent mental health as a whole.

KEYWORDS : adolescence, adolescent psychiatry, mental health.

INTRODUCTION

Adolescence is known to be a period of storm and stress. Clinicians, psychologists and teachers dealing with both children and adolescents thoroughly understand that adolescent is a period that is distinct from childhood. Most textbooks to be precise mention adolescent as a period that starts at 12 to 13 years of age and extends upto 18 years when adulthood starts. Some also prefer to further divide adolescence into early adolescence (12-15 years) and late adolescence (15-18 years). This is however for theoretical purposes as adolescence in essence, starts at 12 years with the onset of psychological and physiological changes that ensue with puberty [1].

Child and adolescent psychiatry has always been a separate speciality within psychiatry. This was so as child and adolescent problems were always considered distinct from adult psychiatric problems. More so the approaches to the psychiatric interview and the treatment as well as therapy differed markedly when we were dealing with adult or child and adolescent populations. In a modern era today we are seeing a surge of psychological problems in adolescents highly distinct from children [2]. The general psychology of childhood and adolescence too is different. With recent advances in neurobiology and brain development studies we have also been able to ascertain a distinct neurobiology of childhood and adolescence. Keeping these factors in mind in this chapter, I propose to provide a case for us as clinicians to consider the development of adolescent psychiatry as a separate speciality.

NEED FOR ADOLESCENT PSYCHIATRY AS A SEPARATE SPECIALTY

The arguments in putting forth the need for a separate speciality of adolescent psychiatry shall be divided by me into 4 groups, viz. general considerations, neurobiological considerations, disorder based considerations and treatment based considerations.

General considerations

- It is well known that there is a vast difference between child psychiatric and adolescent psychiatric problems right from the factors leading to causation, symptoms at the time of presentation, methods of treatment and intervention as well as diagnostic considerations. Problems presenting for the first time in adolescence may often have different development trajectories compared to child psychiatric problems. They also have a more prolonged course and follow different pathways into adult life [3].
- Today with the advances in neurosciences, we have a better understanding of the neurobiology of human development. We have also understood how hormonal factors influence and affect brain development. Itis well known that testosterone and estrogen have receptor profiles that they target in the human brain and have differential effects on mood, behaviour and cognition. The adolescent brain is at a critical period in development where it is neither fully complete in development and yet complete in many ways. A large number of neuroimaging studies have focused on this issue and thus the study of the neurobiology of adolescent brain development is a specialized field on its own [4].
- A large amount of personality development is complete towards the end of adolescence and the advent of adulthood. In fact the effects of childhood influences and mentors one comes across in childhood fully blossoms in adolescence giving rise to personality development which is said to completely form by the age of 18 years. Thus adolescence is an intermediate phase of personality development where adult goals and childhood influences along with peer groups and adolescent exposures coalesce leading to the full blown development of a complete personality in adulthood [5].
- Adolescence unlike childhood is also a period that heralds the onset of sexual development with puberty setting in. The focus of the adolescent shifts to sexuality with the need to like others, fall in and out of relationships as well the opportunity for sexual exposures. It is also a period where sex education is a must to help the adolescent deal with these changes. It is a special task that entails helping and educating adolescents about love and relationships as well as teaching them to deal with changes in their body while helping them handle sexual feelings and sexual needs [6].
- Many hospitals have adolescent medicine as a separate specialty. There are specific needs of adolescents like menstrual problems, hormone related skin conditions, polycystic ovary syndrome and disorders like juvenile rheumatoid arthritis as well as juvenile diabetes. It is very essential that a team of doctors that understand adolescent hormonal changes along adolescent physiology and pathophysiology function as a specialized adolescent medicine unit. It goes without saying that such an adolescent medicine will have patients that present with psychological difficulties that shall entail the need for a special adolescent psychiatrist on their team as well. Thus adolescent psychiatry as a separate subspecialty shall have to work with adolescent medicine to ensure holistic management of an adolescent patient. This would also then lead to an adolescent inpatient unit which would be separate from the adult unit which would be coupled with an adolescent social worker as well as psychologist [7].

Disorder based considerations

- The symptom presentations of many psychiatric disorders differ in childhood and adolescence. There are marked differences between conduct disorder that presents in childhood and in adolescence. Early conduct disorder has less aggression and hostility as well as violence compared to late onset conduct disorder that starts after 10 years of age. It is also noted that late onset conduct disorder has more comorbidity and a longer course with lower recovery rates than early onset conduct disorder [8].
- Bipolar disorder is more common in adolescents than in children. While children may show more mood symptoms in childhood onset bipolar disorder, adolescent onset bipolar disorder presents with more irritability, decreased sleep and aggressiveness. The use of stronger treatment measures is also implicated in adolescents with admission rates being higher for adolescent bipolar disorder. Hormonal considerations are also known to affect the course, duration and prognosis of bipolar disorder in adolescence

[9].

- Symptom profiles markedly differ between childhood and adolescent depression. The severity of depressive symptoms is greater in adolescent depression with longer durations in case of both non treatment as well as routine treatment approaches. Suicidal thoughts and feelings too are more common in adolescent depression. There are a variety of environmental factors specific to adolescence that may trigger depression. It is also well known that depressions with a genetic basis may present first in the adolescent period. Adolescents with depression are also better equipped to express their mood symptoms in a clinical interview compared to children where one may have to use indirect methods of assessment [10].
- There have been differences noted in the presentation and epidemiology or childhood and adolescent anxiety disorders as well. Social anxiety and generalized anxiety disorder are more common in adolescence. Panic attacks and their triggers along with pathogenesis also vary between childhood and adolescence. Factors involved in the causation of basic anxiety too differ between children and adolescents [11].
- Disorders related to menstrual cycle usually are only seen after the age of 12. The presentation of premenstrual syndrome, premenstrual anxiety, irritability, menstrual related mood swings and depression related to the menstrual cycle are all features of adolescence. Some adolescent girls have a repugnance towards the menstrual cycle and those issues need to be addressed and handled in adolescence itself. Thus menstrual disorders are a sole feature of adolescence rather than child psychological problems [12].
- School refusal seen in childhood usually transits into adolescence as well. School refusal in children while may be due to multiple causes usually rebounds into truancy and conduct based factors in adolescence. Thus the handling of a school refusal problem in both childhood and adolescence differs markedly in both assessment and management [13].
- Attention deficit hyperactivity disorder (ADHD) is one of the most common disorders diagnosed in children. It is well known that ADHD does not wear off in childhood and rather moves into adolescence and adulthood as well. The disorder as well as it comorbidities usually lead to impairment in academics in an adolescent child in a manner that has far reaching implications than in a younger child. The hyperactivity component may reduce in adolescence but there is a marked increase in aggression, mood swings and conduct issues in adolescence. There is often a need to dissect adolescent ADHD into whether it would progress into an adult ADHD or whether it would move into a bipolar disorder. Substance abuse and dependence as a comorbidity may announce its presence in the adolescent phase as well [14].
- It is well known that substance abuse starts in adolescence as this is the period of experimentation and novelty seeking. Adolescents with alcohol or other substance dependence may often quit a substance if brought to treatment early. Thus the diagnosis and long term management as well as relapse prevention strategies for an adolescent differ largely from that of an adult with substance abuse. Even among the substance abuse disorders, inhalant abuse is commoner in adolescents than adult patients [15].
- There are certain behavioural addictions which are in vogue today and usually are seen in teenagers alone. These include online gambling like poker, video game addiction as well internet and pornography addiction. This thus involves special education and intervention at both a school and clinic level. These problems usually start in childhood but come to stage where they warrant intervention only in adolescence [16].
- Schizophrenia though rare in childhood has made its presence felt while it is documented research based evidence that schizophrenia may first present in adolescence. Many patients may have their first episode of psychosis in late adolescence. Early detection of first episode psychosis as well treatment methods aimed at preventing recurrences if planned in adolescence may lead to a lower incidence of the disorder resurging in adulthood [17].
- In case of developmental disabilities like mental retardation and autism, there are a large number of psychological problems related to aggression, obsessiveness and sexuality that usually present for the first time in adolescence. Thus handling adolescents with developmental disabilities both at home and in the special school setting entails a detailed understanding of how adolescent brain and hormonal development may affect these children along with specific behavioural intervention methods that may differ from those used in childhood [18].
- Childhood suicide is rare while suicidal behaviour peaks in adolescence. Suicide in adolescence is a divergent phenomenon. On one hand it could be a direct rebound of depression while it could also indicate the development of a borderline personality disorder in the making. Thus any suicidal attempt in adolescence warrant a detailed teasing of psychopathology to ascertain the causative factor to enable treatment measures as well prevention of future attempts [19].
- Child sexual abuse has long term aftereffects on personality development. Many victims of child sexual abuse present with psychopathology in adolescence. This is in keeping with the fact that a realization of the nature and significance of the trauma they gone through dawns on them along with an understanding of sexual feelings and sexuality. Counselling adolescents regarding the trauma, guilt and various other emotions is a must to prevent the spilling of this trauma into adulthood which may in turn result in psychopathology that may last lifelong [20].
- Many a times adolescents may be brought to the clinic with sexuality related worries or problems along with failures in love and relationships. Handling relationships, the first crush and various other issues like masturbation myths, masturbation guilt and sex education all need support and intervention that is a purely adolescent age domain [21].

Treatment and Intervention based considerations

- For a large number of psychiatric disorders, the treatment measures differ in adolescence compared to childhood. Psychotherapeutic treatments used in adolescence are structured unlike childhood where eclectic and symptom based unstructured psychotherapy is preferred. Various forms of psychotherapy like cognitive behaviour therapy (CBT) have been developed structurally for adolescents as is the case Rational Emotive Behaviour Therapy (REBT). In children specific psychotherapies are rarely used keeping in mind the child's inability to comprehend the basic essence of psychotherapy. Any therapist involved in psychotherapy with adolescents needs to be aware of the sensitive nature of adolescents along with the choice of words and ethical issues in adolescent psychotherapy [22].
- Confidentiality is an area that one must judiciously tread in adolescent psychotherapy. With children, the confidentiality principle rarely applies as parents are often active members in therapy compared to adolescents where certain issues may need to be confidential and then disclosed at a later date to the parents or in some cases the parents may be perpetrators where confidentiality will then have to be maintained [23].
- Worldwide there has been a felt need for separate adolescent inpatient units. This is in keeping with the view that adolescents at a sensitive development period and tender age need to handled carefully and in separate units compared to chronic psychiatrically ill patients. Adolescents with substance abuse particularly need to be admitted separately as if admitted with a group of chronic substance abuse patients, they might gain further inspiration and have relapses. They need to be admitted with young and early substance abuse cases like themselves where they will learn the road to recovery faster [24].
- There are also marked differences in behaviour therapy interventions used between children and adolescents. Reinforcement may not be effective in adolescents as in children and token economies and contingency contracting works better. Even parent training in handling children and adolescents differs as methods used to discipline and convey values to children and adolescents differ. Even at a school level academic support and help may differ in the manner provided to adolescents versus children [25].
- Adolescent psychopharmacology is an upcoming area with a lot of controversies. While one is very cautious in prescribing psychotropic medications in a child age group, there are serious concerns with psychotropic use in adolescence as well. Antidepressants and suicidal ideation has been an area of debate and though resolved to a large extent, some reservations exist. The use of atypical antipsychotics in adolescence with the risk of has-

tening hyperglycemia, hyperlipidemia and metabolic syndrome as well as weight gain is an area of worry. Stimulant use in ADHD with the risk of stimulant abuse is troublesome as well. FDA approvals for just a few medications exist while most of the medications used are as off label indications with no clear guidelines in place [26].

- Psychological testing has now been specialized or adolescents with specific norms for their age group and specialized tests as well. There are various rating scales with different scoring norms designed for the adolescent. A detailed description of the same does not come under the purview of this chapter [27].
- Religion and spiritual issues is another area of concern along with morality and ethical dilemmas that confront the adolescent. There is a need that these areas be explored in therapy and directions in these areas be handed down to the adolescent. Adolescence is a stage where these beliefs start to form in a manner aimed at a firm footing in adulthood. Clearing the cobwebs at this stage will help in a clear belief system in adulthood [28].

Conclusions

Adolescent medicine is a separate specialty worldwide and today we have reached an era of specialization and super specialization in all fields of medicine. There is a need for specialization within psychiatry as well. Adolescent psychiatry has been always clubbed with child psychiatry. Today with increasing populations, divergent medical conditions and changes in worldviews there are enough general, neurobiological, diagnostic and treatment based arguments to warrant the need for a specialized branch of adolescent psychiatry. Adolescents are the adults of tomorrow and need our attention. It is time we give adolescent psychiatry the attention it deserves.

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