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Research Article

Neuroses in Children

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Abstract

Purpose of the work: to analyze the characteristics of neuroses in children, identify their main symptoms and study the factors influencing their occurrence

Neurosis is a psychogenic (usually conflictogenic) neuropsychiatric disorder that occurs as a result of disruption of particularly significant life relationships of a person and manifests itself in specific clinical phenomena in the absence of psychotic phenomena.

Neurosis is characterized by: reversibility of pathological disorders, regardless of its duration; psychogenic nature of the disease, which is determined by the existence of a meaningful connection between the clinical picture of neurosis, the characteristics of the relationship system and the pathogenic conflict situation of the patient; specificity of clinical manifestations, consisting in the dominance of emotional-affective and somatovegetative disorders.

Keywords: neurosis; psychotic phenomena; emotional-affective; somatovegetative disorders

Introduction

What is neurosis?

Neurosis is a psychogenic (usually conflictogenic) neuropsychiatric disorder that occurs as a result of disruption of particularly significant life relationships of a person and manifests itself in specific clinical phenomena in the absence of psychotic phenomena.

Neurosis is characterized by: reversibility of pathological disorders, regardless of its duration; • psychogenic nature of the disease, which is determined by the existence of a meaningful connection between the clinical picture of neurosis, the characteristics of the relationship system and the pathogenic conflict situation of the patient; • specificity of clinical manifestations, consisting in the dominance of emotional-affective and somatovegetative disorders.

Currently, the concepts of polyfactorial etiology of neuroses are most widely used in world literature. The unity of biological, psychological and social mechanisms is recognized. When assessing the role of a particular etiological factor in neuroses, significant difficulties arise.

Psychotraumatization is the leading cause of neurosis, but its pathogenic significance is determined by the most complex relationships with many other predisposing conditions (genetically determined "soil" and "acquired predisposition"), which are the result of a person's entire life, the history of the formation of his body and personality. It is difficult to take into account all the congenital and lifetime circumstances, to obtain valid data, because for this it is necessary to compare with similar characteristics in healthy people. In addition, in the origin of neurosis in a particular patient, the ratio of etiological factors has a unique peculiarity, and averaging etiological indicators often leads to the opposite result. Neuroses can occur in people who do not suffer from psychopathies, as well as without psychopathic character traits. One of the main etiological factors of a social nature is improper upbringing in the family. Patients with hysterical neurosis were characterized by an atmosphere of pampering, fawning upbringing, unprincipled compliance with the patient, unjustified emphasis on existing and non-existent virtues, positive qualities, which leads to to an inadequate overestimation of the level of aspirations. Character traits inherent in hysteria can be formed, on the other hand, with an indifferent attitude of the "rejection" type, as well as in an environment of crudely despotic suppressive education. The formation of personality traits predisposing to the development of obsessive-compulsive neurosis is facilitated by improper education in an environment of excessive care, protection, intimidation, suppression of independence and deprivation of one's own initiative. Of particular importance is the presentation of contradictory demands. In the genesis of

psychogenic disorders, a special place is occupied by psychological conflict (external or internal), the pathogenicity of which is due to the patient's inability to resolve it. External conflict is determined by the clash of disturbed relationships of the individual with the demands of the environment. Internal (intrapersonal) conflict is determined by the existence of contradictory desires, tendencies, motives and positions of the individual.Hysterical conflict is determined primarily by excessively inflated claims of the individual, combined with underestimation or complete disregard for objective real conditions or demands of others. It is distinguished by an excess of demands on others over demands on oneself and a lack of critical attitude to one's behavior. Due to improper upbringing, such individuals have a weakened ability to inhibit their desires that contradict social demands and norms. The obsessive-psychasthenic type of neurotic conflict is caused primarily by contradictory internal tendencies and needs, the struggle between desire and duty, between moral principles and personal attachments. At the same time, even if one of them becomes dominant, but continues to meet resistance from the other, favorable opportunities are created for a sharp increase in neuropsychic tension and the emergence of obsessive-compulsive neurosis.

Of particular importance is the presentation of contradictory demands on the individual, which contributes to the formation of a sense of inferiority, contradictory life relationships and leads to a break from life, the emergence of unrealistic, unrealistic attitudes

The neurasthenic type of conflict is a contradiction between the capabilities of the individual, on the one hand, his aspirations and inflated demands on himself, on the other. The specified types of neurotic conflicts to a certain extent correspond to three main forms - hysteria, obsessive- compulsive disorder and neurasthenia. Patients with neuroses are characterized by such personality traits as weakness, indecisiveness, a tendency to reflection, dependence on the environment, the search for approval, the desire for normativity.

A patient with neurosis is characterized not by the presence of one or two leading, most significant conflicts, but by the existence of a wide range of them, caused by disturbances in the system of relationships, among which an emotionally unfavorable, inadequate attitude towards oneself acts as the most pathogenic, causing many subjectively unresolvable contradictions. It is possible to identify personality disorders common to patients with neuroses, among which infantile and egocentric traits are the main ones and determine the emotional, behavioral and social deficits of the personality of a patient with neurosis. The relationship between a doctor and a patient with neurosis has certain characteristics depending on the methods of treatment used.

Types of neuroses:

Neurasthenia.

The word "asthenia" in Greek means "impotence, weakness". Asthenia is understood as pathological fatigue after normal activity, accompanied by a decrease in energy, which is necessary to ensure normal life and attention, a sharp decrease in performance. Asthenia is usually accompanied by lethargy, drowsiness, irritability; a feeling of fatigue and exhaustion prevails.

The main symptom of neurasthenia is irritable weakness, i.e., increased excitability and easy exhaustion. Asthenic complaints proper (general weakness, fatigue, exhaustion, lethargy, daytime sleepiness) are combined with headaches, attention and memory impairment. These complaints do not go away after rest. In addition, children often suffer from various sleep disorders: difficulty falling asleep, superficial and restless sleep with an abundance of dreams, easy awakening under the influence of minor external stimuli.

Anxiety-phobic disorders.

Anxiety is an emotional state characterized by strong negative affect, symptoms of muscle tension, and a premonition of danger or failure in the future. This definition includes two main signs of anxiety: strong negative emotions and an element of fear. Neurotic phobias are an obsessive experience of fear with a clear plot in the presence of sufficient criticism. They are exacerbated in certain situations and are vivid, figurative, and sensory in nature.

In preschool and primary school age, anxiety disorder associated with separation anxiety in childhood is common. It manifests itself in excessive anxiety that is inappropriate for development, associated with being outside the home or with the fear of separation from parents and other people to whom the child is attached, as well as in a constant reluctance (refusal) to go to school or go anywhere from home for fear of being separated from loved ones. The child experiences persistent and excessive anxiety about the possible loss of people to whom he or she is strongly attached, or about an expected accident with them, and does not want to go to bed if they are not nearby. The reason for visiting a doctor is often complaints of malaise (headache, stomach ache, etc.), as well as the appearance of nausea or vomiting when separation from loved ones occurs or is expected. If the child refuses to go to school or leaves lessons, then later the child often develops “test anxiety” - strong experiences in situations where knowledge is tested (tests, exams).

Children with generalized anxiety disorder experience chronic or excessive anxiety and emotional tension, which are often accompanied by somatic symptoms.

Children with specific phobias are characterized by strong fear associated with certain objects or situations (fear of heights, vaccinations, spiders, etc.). Anxiety can be expressed in crying, whims, freezing in place, seeking protection from adults. Specific phobias can develop at any age, but most often occur in children aged 10-13. Phobias associated with animals, darkness, insects, blood, and injuries usually appear between the ages of 7 and 9, making them similar to fears characteristic of normal development. Like normal fears, clinical phobias weaken over time, but, unlike fears, phobias tend to persist for a much longer period of time. Symptoms of social phobia include fear of speaking in public, blushing, excessive anxiety about actions and deeds, and extreme shyness.

Obsessive-compulsive disorder

Obsessive-compulsive disorder is characterized by the appearance of obsessive thoughts and ritualistic behavior. Obsessions are persistent, intrusive, and irrational thoughts, ideas, impulses, or images. The most common obsessions in children are fear of contamination and fear of harming themselves or others.

Research on children's mental health problems

Studies of Child Mental Health Problems There is growing interest in child and adolescent mental health problems [1]. Mental disorders affect a significantly higher proportion of children and adolescents in the child welfare system than in the general population. A pooled prevalence of 49% for any mental disorder has been estimated using meta-analysis [2]. In the United States, 43,283 parents of children aged 3 to 17 years responded to a national survey that found that 7.4% of the children had current conduct problems, 7.1% had current anxiety problems, and 3.2% had current depression [3]. The survey, which relied on parent reports, estimated that the prevalence of anxiety or depression among children aged 6 to 17 years increased from 5.4% in 2003 to 8.4% in 2011–12 [4].

Based on a meta-analysis report summarizing the prevalence of common mental disorders among adolescents aged 10 to 19 years, the global prevalence of common mental disorders measured by the 12-item General Health Questionnaire with cut-off points of 4 and 3 were 25% and 31%, respectively [5]. The Seoul Child and Adolescent Mental Health Survey reported the estimated prevalence of full syndrome and subthreshold Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) disorders as 16.2% and 28.1%, respectively [6]. Interestingly, the prevalence rate of mental disorders estimated through epidemiological studies and the diagnostic prevalence rate observed in clinical practice may differ. The prevalence rate of mental disorder diagnosis was found to be 1.95–2.38% based on sample data from the Korea Health Insurance Review and Evaluation (HIRA) for children aged 0– 18 years during 2010–2015 [7]. These gaps can also be identified within individual disorders.

While attention deficit hyperactivity disorder (ADHD) is reported to be present in 5–8% of children worldwide, the average annual prevalence of ADHD diagnosis in Korean children is 0.357%.

Similarly, while the prevalence of disruptive mood dysregulation disorder is estimated to be 2–5% in DSM-5 [8], the weighted average prevalence was found to be 0.3–0.76% in Taiwanese children as reported in a national epidemiological survey [9]. These differences may also be explained by variables such as comorbid mental disorders or preference for psychotropic medications [10].

Interest in mental disorders among children and adolescents has increased; However, there is a lack of data based on recent clinical practice. Several studies have reported limited year- and condition-specific data on clinical aspects of first-time pediatric patients, but few have identified changes and long-term trends for the overall population. The aim of the present study was to fill this gap in existing research by analyzing trends in clinical diagnoses in a university hospital outpatient child psychiatry clinic compared with the general population and longitudinally following new patients for eight years.

Materials and Methods Participants

This study included patients in grades 1–12 who presented for the first time to the outpatient child psychiatry clinic, Kyung Hee University Hospital, Seoul, Korea, over an eight-year period from January 2009 to December 2016. Kyung Hee University Hospital is a general hospital with approximately 800 beds and one of more than 30 university hospitals in the Seoul metropolitan area. Three child psychiatrists and a clinical psychologist are responsible for the outpatient care of youth. Infants and preschoolers aged 0–6 years were excluded from this study because they needed to be observed for a certain period to obtain an accurate diagnosis and were therefore difficult to diagnose unambiguously [7]. Data collection was set for 2009–2016 because thehospital's electronic medical record system was changed before and after the data collection period. However, during this period there were no changes in the composition of psychiatrists and clinical psychologists, which ensured consistency between the medical record system and the medical staff.

Methods

During the study period, gender, grade, and diagnosis were retrospectively analyzed using the medical records of first-time patients by year. To analyze the factors affecting treatment continuity, participants with fewer than three outpatient visits were classified as the early dropout group, while participants with three or more outpatient visits were considered as the treatment continuity group; this was based on a study on early dropout factors [11]. Patients were diagnosed by child psychiatrists and a clinical psychologist using the Korean Standard Classification of Diseases (KCD) [12], which is based on the International Classification of Diseases [13].

Age groups were analyzed using three-year intervals (grades 1–3, 4–6, 7–9, 10–12) based on a previous study reporting the prevalence of mental disorder diagnoses in the 0–18-year-old age group [7].

To compensate for the limitations of individual hospital data, the diagnostic rates for the entire population were calculated by reflecting the total population at mid-year [14]. In other words, the clinical diagnosis of mental disorders was analyzed based on the total population aged 6–18 years per year.

The KCD codes for diagnosis were limited to mental disorders, symptoms and signs, abnormal clinical and laboratory findings not elsewhere classified, and factors affecting health status and contact with health services. For mental disorders, six higher diagnostic groups were established in order of frequency based on sample data from the HIRA study [9] and a preliminary analysis of these data. Hyperkinetic disorders (F90) and tic disorders (F95) were assigned to the same diagnostic group. The remaining four diagnosis groups were classified together with related disorders: neurotic disorders (F40–48), depressive disorders (F32, 33), disruptive behaviour disorders (F91–94), and mental retardation (F70–79). Disorders that affect a small number of patients were classified as 'other', which included the following diagnoses: psychotic disorders (F20–29), bipolar disorders (F30, 31), eating and sleep disorders (F50, 51), personality disorders (F60–65), learning and developmental disorders (F80–84), and unspecified mental disorder (F99). The per-person diagnosis analysis allowed for redundancy.

Statistical analysis

Changes in the prevalence of mental disorders from 2009 to 2016 by gender, grade, and year were examined according to the rate of increase or decrease in the average annual rate, and the significance of trends was assessed using a trend test. The prevalence rate was converted to the percentage of F codes diagnosed by psychiatrists per 100,000 population included in each group, as indicated by the general population at mid-year.

To examine factors affecting continuity of care, patients were divided into groups based on the number of outpatient visits, and the best-fit logistic regression model was selected using a stepwise method based on gender, grade, implied diagnosis, and number of excess diagnoses. A generalized linear model with an interaction term for year and grade was estimated to compare the annual growth rate of each class by gender.

Statistical significance was set at 0.05 for all analyses and data were analyzed using R 4.0.2 in SAS 9.4 (Statistical Analysis System version 9.4, SAS Institute, Cary, NC, USA).

Results

Of the 1467 participants, 931 (63.5%) were male and 536 (36.5%) were female. Between 2009 and 2016, the overall number of cases per 100,000 population by age group (6–18 years) significantly decreased from 3.24 to 1.88, and the number of male patients significantly decreased from 4.14 to 2.03. The number of female patients decreased from 2.24 to 1.72, which was not statistically significant. The overall ratio of male to female patients decreased from 1.87 to 1.29 during the study period, which was not statistically significant. In the overall distribution of participants by class, the highest proportion of patients was in classes 1–3. In terms of annual changes, the changes in classes 1–3 were higher than in other classes in 2009, 2011, and 2013, and the changes in classes 10–12 were higher than in other classes in 2010, 2012, and 2014– 2016. The number of males decreased significantly in classes 1–3, 7–9, and 10–12. The

number of females showed a significant decrease in classes 4–6 and 7–9. Using a generalized linear model with year and grade as interaction terms, the number of female participants in grades 10–12 showed a significant increase compared to participants in grades 1–3. In terms of the distribution of diagnostic codes in male participants, hyperkinetic disorders (F90) were the highest, followed by neurotic disorders (F40–48), tic disorders (F95), psychotic disorders (F20–29), bipolar disorders (F30, 31), eating and sleep disorders (F50, 51), personality disorders (F60–69), specific developmental disorders of speech and language (F80), specific developmental disorders of scholastic skills (F81), pervasive developmental disorders (F84), unspecified mental disorder (F99), intellectual disability (F70–79), depressive disorders (F32, 33), and disorders disruptive behavior (F91–94). F90 had the highest diagnostic rate during the data collection period, but this has been declining. F91–94 diagnoses have decreased significantly with each passing year. In women, the diagnostic distribution was F40–48, F90, F32, F33, other, F70–79, F95, and F91–94. The most common single diagnosis in women was other anxiety disorders (F41), followed by depressive episodes (F32), somatoform disorders (F45), and F90. F70–79 diagnoses have decreased significantly with each passing year.

Discussion

In this study, a significant decrease in the total number of newly diagnosed patients and male patients was observed even when the statistics were adjusted for the declining birth rate in the Republic of Korea. These results are consistent with the decreasing prevalence of mental disorder diagnosis in children and adolescents aged 0–19 years reflected in the HIRA statistics [7]. These trends are in contrast to the increasing prevalence of mental disorders in children and adolescents in screening-oriented epidemiological studies [15]. This suggests that there may be differences in the estimated prevalence and diagnosis rates in clinical practice depending on the epidemiological study methods or national health systems. Two factors may have influenced this trend: first, the Adolescent Personality and Mental Health Problems Screening Questionnaire, which has been administered to 1st, 4th, 7th, and 10th grade students nationwide in the Republic of Korea annually since 2012 and the increased number of treatment-related cases; Secondly, the awareness of parents about mental disorders in young people through mass media or public education [1]. The gender ratio of mental disorders changes during the transition from childhood to adulthood due to biological and environmental factors. According to the 2011 HIRA data, in a population study of under 19 years old, the ratio of males to females with mental disorders was

1.68:1 [16]. This study also showed that the percentage of male patients was higher than the percentage of female patients. The HIRA sample data of 1,375,842 individuals in 2011 showed that the ratio of males to females in 19–30 years old was 48.1 to 51.9 [17]. A cross-national meta- analysis of mental disorders in the World Health Organization World Mental Health Surveys also showed that the prevalence of mental disorders was 1.1 times higher in females than in males [18]. The reason for this change in gender ratio should be noted here. One of the reasons for such a significant narrowing of the gender difference was related to depressive disorders and changing traditionalism of gender roles [18].

In this study, the number of male patients from grades 1 to 12 and female patients from grades 1 to 9 decreased. Interestingly, the increase in the number of female patients in grades 10–12 was statistically significant compared to other grades when the number of patients in grades 1–3 was the reference, although the increase in the number of female patients in grades 10–12 per year was not statistically significant. One of the factors contributing to the trend observed in this study was the different distribution of mental disorders in female patients compared to males. The most common diagnosis in female patients in this study was F41, followed by F32, F45, and F90. The lifetime diagnosis of anxiety or depression among children aged 6 to 17 years has increased based on a survey of parents in the United States [4]. While current anxiety increased significantly, current depression did not change. In a study on the prevalence of childhood mental disorders in Taiwan, anxiety disorder had the highest lifetime prevalence, followed by ADHD, sleep disorder, and tic disorders [19]. Comorbidity and homotypic and heterotypic continuity from ages 9 to 16 were more pronounced in girls than in boys, and girls had a higher incidence of depressive disorders as they grew older [20]. In Kim's study [21], the number of patients in grades 1–3 was higher than in any other grade from 2004 to 2009, and in grades 10–12 was higher than in any other grade from 2010 to 2013. During this period, the incidence of depressive disorders increased among grades 7–12.

The most common diagnosis in male patients in this study was F90. One of the reasons why the class 1–3 group is larger than other classes in the psychiatric outpatient clinic may be that this group has a higher diagnosis and treatment rate of patients with ADHD [7]. From three population cohorts and a meta-analysis, it is evident that children and adolescents who are relatively younger than their classmates have a higher risk of being diagnosed with ADHD [22]. According to the Centers for Disease Control and Prevention in the United States, ADHD was the most common mental disorder among children under 18 years of age [23]. ADHD was the most common mental disorder among the population under 19 years of age based on the HIRA sample data, followed by other anxiety disorders (F41), depressive episodes (F32), somatoform disorders (F45), reaction to severe stress, and adjustment disorders (F43) [16]. A longitudinal comparison over a 26-year period (1980–2005) in a tertiary care centre for child and adolescent psychiatric services in India found an increase in the reporting of affective illnesses at ages 10–15 years, reflecting the global trend towards earlier onset and increasing prevalence of affective illnesses [24]. In a study of the prevalence of common mental disorders among adolescents over three consecutive years in Taiwan, rates of ADHD and phobias decreased, while rates of major depression and substance use disorders increased [25]. Conduct disorder and ADHD were more common among boys, while major depression and phobias were higher among girls.

A significant decrease in F91–94 was observed among male patients over the years, while F70–79 showed a decreasing trend in female patients in this study. A comparison of clinical profiles of patients in child psychiatry in Bahrain between 1981–82 and 2011–12 showed that the prevalence of conduct disorder and anxiety disorders was lower [26]. The reason for this decrease in prevalence is most likely due to reasons other than a real decrease, such as those diagnosed with ADHD or learning disorders instead of conduct disorder. In this study, if conduct disorder and ADHD coexisted in the same patient, they could be diagnosed with ADHD. The prevalence of conduct disorder also decreased between 1998 and 2013–14 among young men, according to a study in Australia, primarily due to a decrease in prevalence among men living in two-parent families [27]. The significant decrease in F70–79 may be due to earlier identification and intervention among individuals with intellectual disabilities in the preschool years compared to the past, resulting in improved adaptability [16]. However, the reason for the significant decrease only among women in this study should be investigated in future studies. In this study, significant factors for treatment continuity were female, higher grades, one or more clinical diagnoses, and disorders such as depressive disorders, hyperkinetic disorders, and tic disorders. One of the reasons influencing treatment continuity among those in higher grades and among women may be the increased anxiety and depressive disorders in the respective gender and age group [9]. A study based on inpatient adolescents showed that being female predicted change in global

functioning [28]. Pelkonen et al. [11] also reported that the absence of a mood disorder and non- use of psychotropic medications were associated with early dropout from outpatient psychiatric treatment in adolescents. The younger the patients, the more likely they were to drop out of the study early without starting pharmacotherapy for ADHD [29]. Young children are at higher risk of receiving suboptimal care with psychotropic medications [30], and their treatment adherence may be reduced by their parents' adherence [31]. These findings suggest that factors in treatment adherence may differ depending on target disorders, culture, age and gender of subjects, or study design.

This study has several limitations. First, as a descriptive study, the results and conclusions are limited to this sample. The participants in this study are outpatients of a single university hospital, and caution should be exercised in applying the results of this study to the entire general population. However, since it is based on the medical records of the same medical staff at a single institution, consistency in care may be an advantage.

Second, this study is a retrospective review of medical records and does not administer planned diagnostic instruments as in prospective studies. Therefore, it has limitations in application and difficulty in determining the causes of the results. In the future, it may be better to conduct a prospective study to estimate prevalence. Although this study adopted a retrospective perspective, the fact that the same child psychiatrists and the same clinical psychologist performed the diagnostic procedures also provides the advantage of increasing diagnostic accuracy and consistency.

Third, the results may reflect some bias. It is possible that patients referred to a university hospital psychiatric clinic have more severe symptoms or other associated characteristics than those who do not require a university hospital clinic. Moreover, such patients may be more likely to have pre-existing psychiatric disorders due to referral bias.

Despite these limitations, this is the first study in Korea in which trends among outpatients were verified by reflecting changes in the general population. Identifying predictors of treatment continuity in first-time patients is also a strength of this study. The study is meaningful because patients with treatment continuity were followed for approximately eight years in the same outpatient clinic.

To overcome these limitations and apply the results of this study to extrapolate mental health problems to the general child and adolescent population, follow-up studies involving other university hospitals and private clinics are needed.

Treatment of neuroses

Sedatives and tranquilizers are used to treat neuroses in children. The former include herbal preparations based on valerian, lemon balm, St. John's wort: Dormiplant, Gelarium Hypericum, etc. The group of tranquilizers (anxiolytics) includes psychopharmacological agents that reduce manifestations of anxiety, emotional tension, and fears. In addition, tranquilizers are characterized

by hypnotic, anticonvulsant, and muscle relaxant effects. In the treatment of neuroses in children, it is advisable to use non-benzodiazepine tranquilizers (Phenibut, Tenoten, Atarax), since they have fewer side effects. One of such drugs is Adaptol. Adaptol can have a metabolic effect, normalizing metabolic processes disrupted by stress, and also affect the functioning of neurotransmitter systems. According to the literature, Adaptol exhibits antagonistic activity in relation to the excitatory adrenergic and glutamatergic systems and enhances the functioning of the inhibitory serotonin- and GABA-ergic mechanisms of the brain. It has moderate anxiolytic activity, eliminates or reduces anxiety, anxiety, fear, internal emotional stress and irritability. The tranquilizing effect of the drug is not accompanied by muscle relaxation and impaired coordination of movements. Adaptol does not cause emotional dullness, deterioration of attention and memory, inhibition, muscle relaxation, drowsiness, etc. The drug has a dopamine-positive effect, clinically manifested in its activating component of action, which is very important in the treatment of neurasthenia. Based on this, it is classified as a daytime tranquilizer. In addition, Adaptol is characterized by a nootropic effect. The drug is prescribed to children aged 5–7 years at a dose of 0.5 g/day, 7–10 years — 0.75 g/day, 10–14 years — 1.0 g/day, 14 years and older — 1–1.5 g/day in 2–3 doses. The course of treatment is 1–2 months, but improvement can be observed already in the 1st week of therapy.

Recommendations for the prevention of neuroses in children

Do not focus on the child's weaknesses and help him develop those good and respectable qualities. The girl is not a beauty? So what, but what a smile she has, how sociable, kind and smart she is. You cannot get by with general phrases like "this is not the main thing" when talking about a child's shortcomings, be sure to provide some of his real positive qualities as an alternative.

Try to be objective about the child and form a healthy attitude towards himself. Do not attribute non-existent qualities to him, do not praise him for what the parent wants to see and certainly do not scold him for "not wanting" to do what the parents think he is capable of. But do not keep silent about the merits - any talent of the child is valuable and only life will show which of them was the most important.

Develop social behavior skills in the child. It is necessary to teach the child the rituals of greeting, farewell, and introduction accepted in society, not to allow the child to be ignored or alienated, to ensure that the child is sufficiently informed - in order to communicate with others, it is necessary to have common topics for discussion with them.

Do not allow manifestations of overprotection. Only if you give the child the opportunity for independence - within reasonable limits, of course - will he take advantage of this opportunity.

To sum up, we can say with confidence that neurosis does not occur in self-confident people, in those prepared for real life, in those who are able to adapt to life normally and with dignity, and most importantly, in people who are devoid of egocentrism. A child should love himself, some egoism is natural in him, but he should also love his environment - mom, dad, friends, city, nature, his daily activities,

References:

1. Kim H., Jung S., Jung C. (2015). The distributional changes in the first-visit psychiatric child and adolescent outpatients at a university hospital over a ten-year period. J. Korean Acad. Child Adolesc. Psychiatry; 26:165-175.
2. Caye A., Petresco S., de Barros A.J.D., Bressan R.A., Gagelha A., Gonçalves H., Manfro A.G., Matijasevich A., Menezes A.M.B., Miguel E.C., et al. (2020). Relative age and attention-deficit/ hyperactivity disorder: Data from three epidemiological cohorts and a meta-analysis. J. Am. Acad. Child Adolesc. Psychiatry.;59:990-997.
3. Perou R., Bitsko R.H., Blumberg S.J., Pastor P., Ghandour R.M., Gfroerer J.C., Hedden S.L., Crosby A.E., Visser S.N., Schieve L.A., et al. (2013). Centers for Disease Control and Prevention (CDC) Mental health surveillance among children-United States, MMWR; 62:1-35.
4. Malhotra S., Biswas P., Sharan P., Grover S. (2007). Characteristics of patients visiting the child & adolescent psychiatric clinic: A 26-year study from north India. J. Indian

Assoc. Child Adolesc. Ment. Health; 3:53-60.

5. Gau S.S., Chong M.Y., Chen T.H.H., Cheng A.T.A. (2005). A 3-year panel study of mental disorders among adolescents in Taiwan. Am. J. Psychiatry; 162:1344–1350.
6. Al-Ansari A.M. (2015). Characteristics of child and adolescent populations visiting a public child and adolescent psychiatric clinic in Bahrain: A 30-year comparative analysis. Arab. J. Psychiatry; 25:32-38.
7. Sawyer M.G., Reece C.E., Sawyer A.C.P., Johnson S.E., Lawrence D. (2018). Has the prevalence of child and adolescent mental disorders in Australia changed between 1998 and 2013 to 2014? J. Am. Acad. Child Adolesc. Psychiatry; 57:343-350.
8. Kennedy J., Hembry P., Green D., Skuse D., Lewis S. (2020). Predictors of change in global psychiatric functioning at an inpatient adolescent psychiatric unit: A decade of experience. Clin. Child Psychol. Psychiatry.;25:471-482.
9. Hong M., Lee W.H., Moon D.S., Lee S.M., Chung U., Bahn G.H. (2014). A 36-month naturalistic retrospective study of clinic-treated youth with attention-deficit/hyperactivity disorder. J. Child Adolesc. Psychopharmacol;24: 341-346.
10. Dinnissen M., Dietrich A., van der Molen J.H., Verhallen A.M., Buiteveld Y., Jongejan S., Troost P.W., Buitelaar J.K., Hoekstra P.J., van den Hoofdakker B.J. (2020). Prescribing antipsychotics in child and adolescent psychiatry: Guideline adherence. Eur. Child Adolesc. Psychiatry;29: 1717- 1727
11. Nagae M., Nakane H., Honda S., Ozawa H., Hanada H. (2015). Factors affecting medication adherence in children receiving outpatient pharmacotherapy and parental adherence. J. Child Adolesc. Psychiatr. Nurs;28: 109-117.

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