

# Mini Child Psychiatry Topics: Tips and Tricks in Evaluating and Treating

ADHD  
Mood Disorders  
Trauma/PTSD

5/5/23 8:45 -9:45

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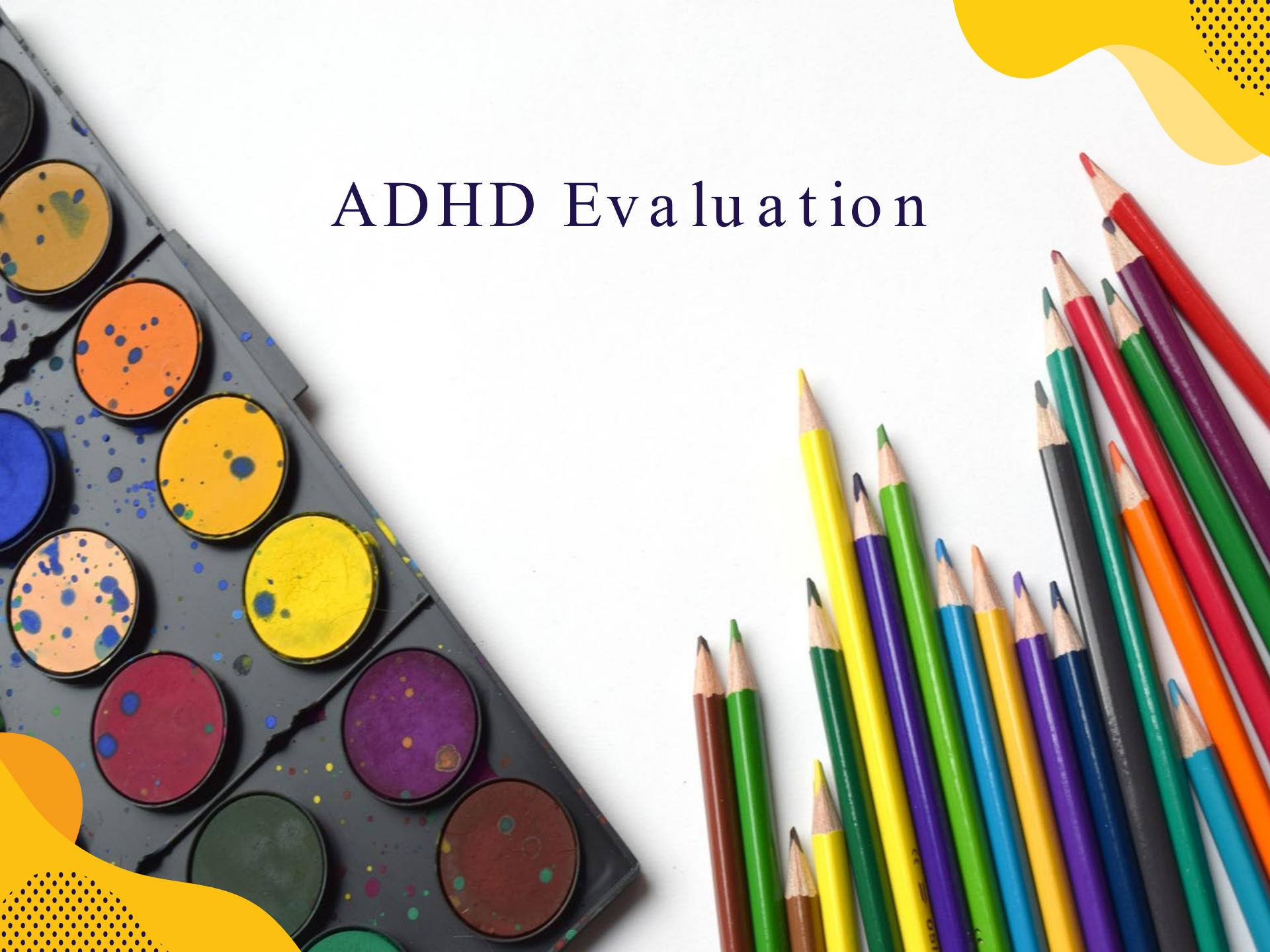


No  
Disclosures

# Objectives

Review high yield tips and tricks in evaluating and treating ADHD, mood disorders, and trauma/PTSD

# ADHD Evaluation



# ADHD and Context At Evaluation

- If symptoms are highly discrepant in different settings AKA lots of ADHD at home but not school, ask the parents what they think is going on. Approach with curiosity and non judgmentally. Often there is a good reason
  - examples: Maybe it's a new school, maybe it's a great teacher, maybe they were kept behind a grade, maybe they are on meds during the day but they wear off at home.
- Families often come in at different points of trying things. They need different approaches. For the family already doing everything - don't start with telling them to read basics out of the book. For the family that hasn't started anything - start with telling them the basics. Then for treatment do shared decision making. Keep in mind families often come in with guilt, shame.
- For young kids you need to take safety into account the younger they are. ADHD dx can be made at age 3. PATS study showed the severe ADHD kids benefitted from meds bc of treating safety concerns

# ADHD Subtypes

**ADD is the old terminology for ADHD inattentive subtype. If someone has reported add, you should put adhd inattentive type in the chart as the diagnosis.**

**Girls tend to get in trouble less and bc of this ADHD is more likely to be missed and more likely to be diagnosed later than boys .**

Mowlem, F.D., Rosenqvist, M.A., Martin, *et al.* Sex differences in predicting ADHD clinical diagnosis and pharmacological treatment. *Eur Child Adolesc Psychiatry*, 481–489 (2019). <https://doi.org/10.1007/s00787-018-1211-3>

**Hyperactivity tends to improve with age - but inattention stays stable.**

Döpfner, M., Hautmann, C., Görtz-Dorten, A. *et al.* Long-term course of ADHD symptoms from childhood to early adulthood in a community sample. *Eur Child Adolesc Psychiatry*, 665–673 (2015). <https://doi.org/10.1007/s00787-014-0634-8>

Easy reading on different types:  
<https://www.additudemag.com/category/adhd-add/adhd-essentials/types-of-adhd/>



# ADHD Treatment



# When do you treat?

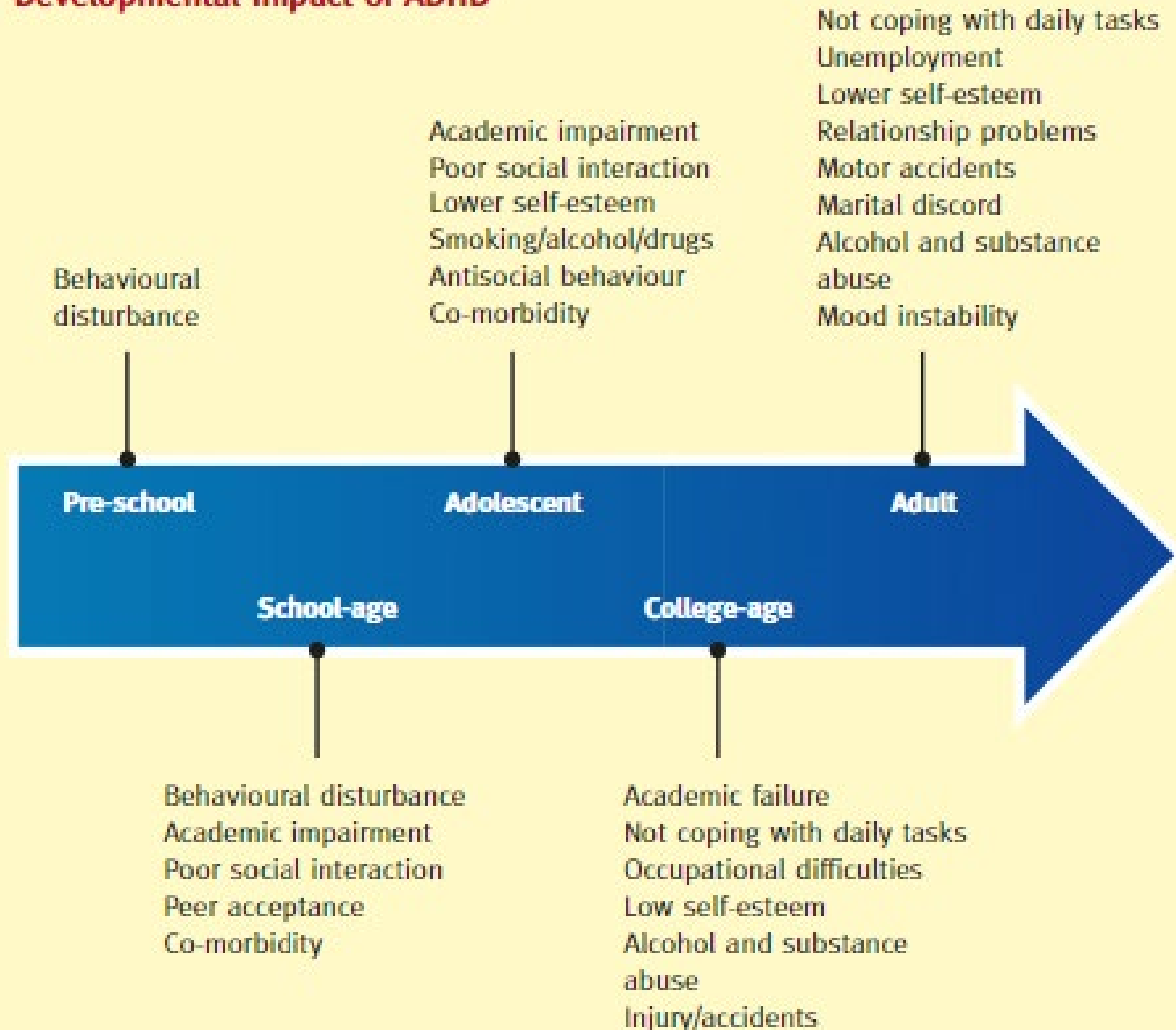
For diagnosing and treating, you need to see a significant impairment in the functioning from the standard expected age/development.

The younger the child, the more you need to weigh multiple other aspects and the safety concerns might push us more into treatment mode



# Why Bother Treating

## Developmental impact of ADHD



### Citations:

Asherson, Philip. (2012). ADHD across the lifespan. *Medicine*. 40. 623-627. 10.1016/j.mpmed.2012.08.007.

# The Role of Therapy in ADHD Treatment

- Therapy is largely indicated for ADHD and the type depends upon the age and treatment that is needed.
- The only time research has shown that therapy is not outright beneficial is for older kids who just have straight up, mild or moderate ADHD without any other comorbidities.

# Treating Young Children - Tips

For preschool children with moderately impairing ADHD, alpha agonists such as guanfacine have some evidence in addition to behavioral modifications.

[https://www.contemporarypediatrics.com/view/study\\_-\\_examines-alternatives-for-preschool-adhd-medications](https://www.contemporarypediatrics.com/view/study_-_examines-alternatives-for-preschool-adhd-medications)

Stimulants when there are safety concerns

[https://chadd.org/attention\\_-\\_article/the\\_-\\_preschool-adhd-treatment\\_-\\_study-in-summary/](https://chadd.org/attention_-_article/the_-_preschool-adhd-treatment_-_study-in-summary/)

One important question you need to ask while evaluating these kids can they swallow pills?

Insurance often expects for under 6 that you start with adderall/dexedrine which is FDA indicated. PATS study shows Ritalin is safe in age 4.

Brand Name	Generic Name (Description)	Duration of Effect	Age Approval
Adderall	d, l-amphetamine (immediate release)	5 hrs	3–12 years
Adderall XR	d, l-amphetamine (extended release)	7 hrs	6–17 years
Concerta	d, l-methylphenidate	12 hrs	6–17 years
Daytrana	Methylphenidate (transdermal patch)	12 hrs	6–12 years
Dexedrine	d-amphetamine (immediate release)	3–6 hrs	3–16 years
Dexedrine Spansules	d-amphetamine (sustained release)	6–9 hrs	3–16 years
Focalin XR	SODAS microbeads d-methylphenidate	12–16 hrs	6–17 years
Metadate-CD	d, l-methylphenidate (timed release)	8 hrs	6–15 years
Provigil	Modafinil	15 hrs	Off Label
Rtialin LA	SODAS microbeads d, l-methylphenidate	8–12 hrs	6–12 years
Ritalin, Methylin	d, l-methylphenidate (immediate release)	2–4 hrs	6–12 years
Ritalin SR, Methlyn SR	d, l-methylphenidate (sustained release)	4 hrs	6–15 years
Vyvanse	Lisdexamfetamine dimesylate	10–12 hrs	6–12 years

Ryan, Joseph & Katsiyannis, Antonis & Hughes, Elizabeth. (2011). Medication Treatment for Attention Deficit Hyperactivity Disorder. Theory Into Practice. 50. 52-60. 10.1080/00405841.2010.534939.

# Treatment Dosing

## Stimulant dosing

- For anyone stimulant naive, I still usually start on about the lowest dose of any stimulant to see how they respond
- Amphetamine based products are dosed with a target of 0.5-1mg/kg
- Methylphenidate based products are dosed with a target of 1-2mg/kg
- Exceptions are focalin and vyvanse. Focalin is 0.5mg/kg and vyvanse is 1-2mg/kg
- The target doses for the whole daily dose so if a kid is 20 kilos and they are on Concerta 27 mg and then have a booster of 10 mg in the afternoon that will be a total of 37 mg which would equal around the max of 2 mg per kilogram
- when possible, go with the lowest possible dose
- On average it seems like kids do better with methylphenidate (ritalin) and teens/adults do better with amphetamine (adderall) products. Adderall products on average are twice as potent.

## Guanfacine Dosing

- For guanfacine I learned the 20/30/40 rule. 20kg - max 1mg BID. 30kg - max 1.5mg BID, 40kg - max of 2mg BID. Can get up to 6mg total in divided doses if indicated.
- Often guanfacine and stimulants end up both being helpful together.
- Intuniv (extended release guanfacine) is not a 1:1 equivalent to guanfacine. Intuniv 1mg = guanfacine 0.66mg. To go from immediate release to extended release - you might need a higher dose than immediate release for this reason
- Have kids drink more water with it ESPECIALLY in the summer. It's a little dehydrating.

## Atomoxetine Dosing

- Max 1.3mg/kg generally speaking.

One thing to remember - we have a lot of medications out there. A child shouldn't be maintained on a drug that sedates them/zombifies them/makes them agitated/causes them to become a skeleton UNLESS the cons really are worth the pros

# Research says you can use stimulants safely in kids with seizures

Stimulants have not been shown on average to raise the seizure threshold or cause seizures in individuals with epilepsy. Multiple studies have come out as of late that say if a kid has ADHD and epilepsy it's still worth while just trialing the stimulant

Fun fact: I learned this asking a neurologist multiple times about different cases and to make a point of the fact that it's ok, he continues to send me studies when they come out about how stimulants are fine in epilepsy.

Thank you Dr. Ciliberto for putting up with me asking this roughly a million times on different patients and always having the patience to give me the same answer with more evidence.

**Stimulants Do Not Increase the Risk of Seizure-Related Hospitalizations in Children with Epilepsy**

*Xinyue Liu, Paul R. Carney, Regina Bussing, Richard Segal, Linda B. Cottler, and Almut G. Winterstein*

*Journal of Child and Adolescent Psychopharmacology* 2018 28:2, 111-116

**Effectiveness and Side Effect Profile of Stimulant Medication for the Treatment of Attention Deficit/Hyperactivity Disorder in Youth with Epilepsy**

*Mary C. Kral, Michelle D. Lally, and Andrea D. Boan*

*Journal of Child and Adolescent Psychopharmacology* 2017 27:8, 735-740



# There are some good charts out there that can be helpful too

- The ADHD Medication Guide<sup>©</sup> was developed by Dr. Andrew Adesman, Chief of Developmental and Behavioral Pediatrics at the Steven and Alexandra Cohen Children's Medical Center of New York, part of Northwell Health. - This is a common one to have in offices
- This is only partially the guide in the picture - the full one is two pages. You can access at the link below

<http://www.adhdmedicationguide.com/>

**ADHD Medication Guide\*** Revised: October 1, 2022

Methylphenidate Formulations – Long Acting** (Capsules and tablets in this section are shown at actual size)															
Concerta®†	6-12 Yrs: 18-54mg; SD: 18mg 13-17 Yrs: 18-72mg; SD: 18mg ≥18 Yrs: 18-72mg; SD: 18mg or 36mg	G		G		G		G		G		Methylphenidate ER 72mg (bioequivalent to 2 x 36 mg Concerta tablets)			
Aptensio® XR‡	6 Yrs-Adult: 10-60mg; SD: 10mg (biphasic – 40/60)	G		G		G		G		G		G		G	
Cotempla XR-ODT®§ (grape flavor)	6-17 Yrs: 8.6-51.8mg; SD: 17.3mg	G		G		G		G		G		G		G	
Focalin® XR‡ (dexmethylphenidate)	6-17 Yrs: 5-30mg; SD: 5mg 18 Yrs-Adult: 5-30mg; SD: 5mg (biphasic – 50/50)	G		G		G		G		G		G		G	
Quilivant XR® (5mg/5mL) (barbana flavor)	6 Yrs-Adult: 20-60mg; SD: 20mg	G		G		G		G		G		G		G	
Quillichew ER®§ (cherry flavor)	6 Yrs-Adult: 20-60mg; SD: 20mg	G		G		G		G		G		G		G	
Ritalin® LA‡	6-12 Yrs: 10-60mg; SD: 20mg (biphasic – 50/50)	G		G		G		G		G		G		G	
Metadate® CD‡	6-17 Yrs: 10-60mg; SD: 20mg (biphasic – 30/70)	G		G		G		G		G		G		G	
Metadate® ER†	6 Yrs-Adult: 20-60mg; SD: 20mg	G		G		G		G		G		G		G	
Daytrana® (patch)	6-17 Yrs: 10-30mg; SD: 10mg (The color border around each patch reflects the packaging color, not the patch itself.)	G		G		G		G		G		G		G	

Methylphenidate Pro-Drug Formulations - Long Acting** (Medications in this section are shown at actual size)					
Azstarys®† (lisdexamfetidine + dextroamphetamine)	6-12 Yrs: 26.1/5.2 – 52.3/10.4; SD: 39.2/7.8 mg Adult: 39.2/7.8 – 52.3/10.4; SD: 39.2/7.8mg	G		G	
		G		G	

Methylphenidate Formulations – Long Acting/Delayed Onset** (Medications in this section are shown at actual size)											
Jornay PM®‡	6 Yrs-Adults: 20-100mg (dosed in the evening); SD: 20mg	G		G		G		G		G	

Methylphenidate Formulations – Short Acting** (Medications in this section are shown at actual size)							
Focalin® (dexmethylphenidate)	6-17 Yrs: Daily: 5-20mg, divided BID; SD: 2.5mg BID	G		G		G	
Ritalin®	6-12 Yrs: Daily: 10-60mg, divided BID or TID; SD: 5mg BID Adults: Daily: 10-60mg, divided BID or TID	G		G		G	
Methylphenidate Chewable® (grape flavor)	6-12 Yrs: Daily: 10-60mg, divided BID or TID; SD: 5mg BID Adults: Daily: 10-60mg, divided BID or TID	G		G		G	
Methylin® Solution (grape flavor)	6-12 Yrs: Daily: 10-60mg, divided BID or TID; SD: 5mg BID Adults: Daily: 10-60mg, divided BID or TID	G		G		G	

**Administration Key:**  
 † Orally disintegrating tablet  
 ‡ Must be swallowed whole  
 § Chewable  
 ¶ Can be mixed with yogurt, orange juice, or water  
 † Can open capsule and sprinkle medication on apple sauce  
 ‡ Can open capsule and sprinkle medication into water or onto apple sauce  
 ‡ Can open capsule and mix with apple sauce or yogurt  
 G Indicates a generic formulation is also available; generic products are not shown  
 G Indicates a generic (but NOT a branded) formulation is available

• Updated versions of the ADHD Medication Guide can be viewed at: [www.ADHDMedicationGuide.com](http://www.ADHDMedicationGuide.com)  
 • Laminated copies of the ADHD Medication Guide can be ordered on-line from the ADD Warehouse  
 • Contact Dr. Andrew Adesman with any comments or suggestions: [ADHDMedGuide@Northwell.edu](mailto:ADHDMedGuide@Northwell.edu)

**\*\*Important Information:** The age-specific dosing information listed for each medication reflects the FDA-approved prescribing information. "SD" refers to the FDA-recommended starting dose, which sometimes varies by age. Practitioners should refer to the full prescribing information for each medication. **Please note:** medications have been arranged on the ADHD Medication Guide for ease of display and visual comparison; dosing comparability cannot be assumed.

**\*Discontinued ADHD Medications:** The following FDA-approved proprietary formulations are no longer available (though, in some cases, branded or generic equivalents are still available): Adhansia XR; Ritalin LA capsule (60mg); Metadate CD capsules (40mg, 60mg); Metadate ER tablet (10mg); Ritalin SR tablets (20mg); Methylin Chewable tablets (2.5mg, 5mg, 10mg); Dextroline Spansules (5mg, 10mg); Dextroline tablets (5mg, 10mg); Dextrostat tablets (5mg, 10mg); LiguADD solution (5mg/5mL); and Cylert (pemoline).

# Mood Disorder Evaluation



# DSM terminology

“The DSM-IV section on Mood Disorders has been replaced in DSM-5 with separate sections for the Bipolar Disorders and the Depressive Disorders.

The section on Bipolar Disorders is placed between the Psychotic Disorders and the Depressive Disorders in DSM-5, “in recognition of their place as a bridge between the two diagnostic classes in terms of symptomatology, family history and genetics”

Three new depressive disorders are included in DSM-5: disruptive mood dysregulation disorder, persistent depressive disorder, and premenstrual dysphoric disorder;

The number of bipolar disorders is unchanged; they consist of bipolar I, bipolar II, and cyclothymic disorders, as well as bipolar disorder due to medications, drugs, or a medical condition. The criteria for episodes of disorders is unchanged; they consist of bipolar I, bipolar II, and cyclothymic disorders, as well as bipolar disorder due to medications, drugs, or a medical condition. The criteria for episodes of mania, hypomania, and major depression are generally unchanged from DSM-IV, with a few important exceptions.

Missing from DSM-5 is the DSM-IV entity of mood disorder NOS, which has been replaced with unspecified bipolar disorder and unspecified depressive disorder; people who present with an unclear pattern will have to be designated as one or the other.”

Unspecified Mood Disorder is in the ICD 10

DSM-5 and Psychotic and Mood Disorders

George F. Parker

Journal of the American Academy of Psychiatry and the Law Online Jun 2014, 42 (2) 182-190

<https://jaapl.org/content/42/2/182>

# DSM terminology

When a professional would refer for a “mood disorder” they would sometimes be trying to say there is emotional intensity, or bipolar, or borderline.

Whenever anyone tells me mood disorder for a referral I almost always have to follow up with asking what they mean.

It’s kind of like putting in a referral for someone being “neurotic.” Yes that was a real term we used previously but not really now in common psychiatric evaluation.

Terms that could be used instead - concerns for: bipolar disorder, depressive disorder, mood instability, emotional lability, emotionality, mood swings, risky behavior etc.





# Depression Screening

A very common question: When is this depression vs an angsty teenager going through puberty and other stuff?

Answer: You have to know the developmental stuff to some degree. But beyond that, it's when there is an extreme that seems "not normal" compared to the other kids you see.

Example:

14 year old who doesn't want to get out of bed in the morning and wants to stay on the phone at night, has a boyfriend, is sneaking inappropriate but funny youtube videos by itself is pretty standard.

14 year old girl who never comes out of her room, wants to sleep all day, refuses to go to school or sleeps in school, is snapping at everyone and losing friends, and is looking at how to kill yourself on youtube should make your professional spidey sense go off.

Unless there is concern for safety, you can work with parents on meds/therapy/life style changes. But if you're really concerned then you need to start highly recommending stuff more.



# Developmental Aspects Make a Difference

Symptom	Preschool–	School Age	Adolescent	Adult
Dysphoria	+++ but more time/activity variability, can be challenging to elicit	+++ more persistent than in younger children, but still variable	+++ can present as isolation	+++
Anhedonia	+++ but varies in time—seems to not have much fun	+++ varies but less so over time—seems to lack or reports lack of fun	+++ may also present as boredom	+++
Irritability	+++	+++	+++	++
Acting Out	+++	+++	+++	+
Decreased Energy	+	++	+++	+++
Sleep Disturbance	+/-	+/-	+++	+++
Weight Loss/Appetite Change	+	+	++	+++
Other Somatic Complaints	+++	+++	++	+
Delusions	Very rare	Very rare	+	++ but increases with age

+++ common, ++ less frequent, + infrequent, +/- variably present

Irritability is common in kids with depression (and anxiety) and less likely in adults

## Child and Adolescent Depression, An Issue of Child and Adolescent Psychiatric Clinics of North America

1st Edition - April 28, 2012

**Authors:** Stuart Goldman, Frances Wren

Hardback ISBN: 9781455738403

9 7 8 - 1 - 4 5 5 7 - 3 8 4 0 - 3

eBook ISBN: 9781455743933

# Mood Disorder Treatment



# Applying the QPR method: A suicide prevention intervention (not therapy) that anyone can do for teens and older

Q - question. Example: are you thinking about killing yourself?

P - persuade. Example: Would you let me get you help?

R - Refer. Example: Find someone who might be able to help. Connect them to professionals. Directly if possible. Ask the person who else might help. Family? Friends? Brothers? Sisters? Teachers? Bishop? Physician?

Suicidal young people often believe they cannot be helped. By trying to help them, you are instilling hope. Getting the words right isn't the key here, it's the trying and showing you care.

*“Since almost all efforts to persuade someone to live instead of attempt suicide will be met with agreement and relief, don't hesitate to get involved or take the lead.” Try saying: “I want you to live,” or “I'm on your side...we'll get through this.”*

All information on this taken directly from <https://qprinstitute.com/> with occasional wording modifications

# Treatment

## We have three landmark studies in child psychiatry about depression:

*TORDIA* Treatment of Resistant Depression in Adolescence

*TADS* Treatment for Adolescents with Depression Study

*ADAPT*-Adolescent Depression Antidepressant and Psychotherapy Trial

## Research strongly shows that moderate to severe depression benefits the most by meds and therapy in combination

- Evidence from the TADS study: Taking both benefit and risk into account, the benefit to risk ratio is 17 to 1 for the combination of fluoxetine and cognitive-behavioral psychotherapy and 5 to 1 for fluoxetine alone. The more robust benefit to risk ratio for combination treatment stems from its greater impact on symptoms of MDD and on a reduction in harm-related adverse events relative to patients treated with fluoxetine alone.

Walkup JT. Treatment of depressed adolescents *Am J Psychiatry*;2010;167(7):734-737. doi:10.1176/appi.ajp.2010.10040566

<https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2010.10040566>

[https://www.aacap.org/aacap/families\\_and\\_youth/Resources/Psychiatric\\_Medication/The\\_Treatment\\_for\\_Adolescents\\_with\\_DepressionStudy\\_TADS.aspx](https://www.aacap.org/aacap/families_and_youth/Resources/Psychiatric_Medication/The_Treatment_for_Adolescents_with_DepressionStudy_TADS.aspx)

**For mild depression, therapy without medications can be considered.**

# Big Therapy Points From Landmark Child Psychiatry Studies

“What is the role of psychotherapy in the treatment of teen depression?”

- In the TADS acute phase, CBT alone was not significantly more effective than medication management with placebo, except in those who had milder symptoms and shorter duration of illness and in those whose family had higher incomes.
- CBT and medication was better than medication alone on some outcomes but not for the more severely affected, where the addition of CBT to medication did not offer additional benefit.
- TADS did identify that the addition of CBT to medication may have a protective effect on the risk for suicidality observed in the medication alone group.
- In the ADAPT trial, the addition of CBT to medication did not significantly improve outcome and did not identify either a risk for increased suicidality in those on medication or a protective effect of CBT on suicidality.
- In the TORDIA acute phase, the groups getting combined treatment had an approximately 10% greater response rate, but this between-group difference did not persist to week 24.
- TORDIA, like ADAPT, did not find a signal for SSRI-associated suicidality or for the protective effects of CBT.
- There is probably a role for CBT alone for milder and shorter duration depressive illness and in those who might be considered ideal candidates for psychotherapy.
- However, it is very difficult to argue that CBT is not helpful at all for those with more severe depression, but the data do not support either the use of CBT as first-line treatment or the utility of CBT as an adjunct to medication for severely ill patients. The data from the ADAPT trial is particularly clear on this point.”

Walkup JT. Treatment of depressed adolescents. *Am J Psychiatry*. 2010;167(7):734-737.

doi:10.1176/appi.ajp.2010.10040566 <https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2010.10040566>



# Big Medication Points From the Studies

“What should we expect from medication treatment?”

- There is a group of depressed patients who have not been exposed to antidepressant medication who respond rapidly to treatment.
- Even among those who have failed one antidepressant, there is a group of patients who respond quickly to a switch in medication, even as early as week 6.
- there is probably little reason why these teens should not routinely be identified and successfully treated to remission and recovery.
- In all of these clinical trials, the clinic visits were frequent and dose adjustments brisk. Maybe kids need more aggressive treatment rather than the normal “start low and go slow” approach.
- For those who are more complex and who may take longer to remit, it is probably more important to adjust dosing quickly and to use adequate doses to either establish the capacity to respond or to take the next step, a switch in antidepressant treatment.
- How long to wait before switching antidepressants is not fully established, but remitters usually demonstrate improvement by 8–10 weeks.
- Minimal response or failure to respond by 8–10 weeks does not preclude later improvement, but clinicians and patients should not let grass grow under their feet and should be prepared for the management of resistant depression, a la TORDIA, early in treatment.”

Walkup JT. Treatment of depressed adolescents. *Am J Psychiatry*. 2010;167(7):734-737.

doi:10.1176/appi.ajp.2010.10040566 <https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2010.10040566>

# SSRIS Aren't killing kids. In general they are saving lives.

The black box warning - SSRIs can increase suicidal ideation in kids.

Previous studies are old - showed suicidal ideation went up by 1-2% in the population. No increase in suicide just thoughts

SSRIs are thought to be protective against suicide once maintenance dose achieved

If there are NEW or CONCERNING suicidal thoughts, the medication can be stopped and parent should follow up with doctor. It should be approached with the same amount of anxiety as amoxicillin causing a drug rash.

When the FDA came out with the black box warning there was a major spike in suicide in young people because of everyone getting afraid of SSRIS. There has been a lot of debate about if this warning should stay on.

Christopher Noel; Antidepressants and suicidality: History, the black-box warning, consequences, and current evidence. *Mental Health Clinician* 1 September 2015; 5 (5): 202–211. doi: <https://doi.org/10.9740/mhc.2015.09.202>

Friedman RA. Antidepressants' black-box warning--10 years later. *N Engl J Med*. 2014;371(18):1666-8. DOI: <https://doi.org/10.1056/NEJMp1408480>. PubMed PMID: 25354101.

# SSRIS ARE NOT BLACK MAGIC.

“Few PCPs (25% for moderate, 32% for severe) recommended an antidepressant. Compared with treatment recommendations for moderate depression, severe depression was associated with a greater likelihood of child psychiatry referral (OR 5.50[95% CI 2.47-12.2]  $p < .001$ ). Depression severity did not affect the likelihood of antidepressant recommendation (OR 1.58[95% CI 0.80-3.11]  $p = .19$ ). Antidepressants were more likely to be recommended by PCPs with greater depression knowledge (OR 1.72[95% CI 1.14-2.59]  $p = .009$ ) and access to an on-site mental health provider (OR 5.13[95% CI 1.24-21.2]  $p = .02$ ) and less likely to be recommended by PCPs who reported higher provider burden when addressing psychosocial concerns (OR 0.85[95% CI 0.75-0.98]  $p = .02$ ).

PCPs infrequently recommended antidepressants for adolescents, regardless of depression severity. Continued PCP support through experiential training, accounting for provider burden when addressing psychosocial concerns, and co-management with mental health providers may increase PCPs’ antidepressant prescribing.”

“Perhaps the most important step in improving outcomes for teen depression is to make sure that teens get to the clinic and get there early in their course of illness. There has been a lot of public chatter about how antidepressants are not effective or are harmful for teens that may be keeping teens and their families away from treatment. Investigator-initiated studies such as TADS, ADAPT, and TORDIA are unequivocally clear that treatment for teen depression that includes medication is effective and can be implemented safely.

Hopefully, broadly disseminating the results of TORDIA, TADS, and ADAPT can improve outcomes for depressed teens.”

Dwyer, J.B., Stringaris, A., Brent, D.A. and Bloch, M.H. (2020), Annual Research Review: Defining and treating pediatric treatment-resistant depression. *J Child Psychol Psychiatr*, 61: 312-332.

<https://doi.org/10.1111/jcpp.13202>

<https://acamh.onlinelibrary.wiley.com/doi/abs/10.1111/jcpp.13202>



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*J Dev Behav Pediatr*. 2014 January ; 35(1): 28–37. doi:10.1097/DBP.0000000000000008.

## Primary Care Providers' Initial Treatment Decisions and Antidepressant Prescribing for Adolescent Depression

Ana Radovic, MD, MSc<sup>1,2</sup>, Coreen Farris, PhD<sup>3</sup>, Kerry Reynolds, PhD<sup>3</sup>, Evelyn C. Reis, MD<sup>1,2,4</sup>, Elizabeth Miller, MD, PhD<sup>1,2</sup>, and Bradley D. Stein, MD, PhD<sup>3,5</sup>

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**Except paroxetine. Don't start  
paroxetine in kids.**

## **Paroxetine/Paxil**

Only indicated if child comes to you and is doing well on this. Otherwise it is the only medication which has evidence that it increases suicidal gestures in children/adolescents



# DMDD

This diagnosis was created and first seen in the DSM edition. Part of the reason it was created was because we realized in child psychiatry we are not good at picking out which kids truly have bipolar disorder. However there is a subset of kids who are so extremely moody that they did not quite fit into any other category. Therefore DMDD was created.

“While similar behaviors may overlap between bipolar disorder and DMDD, the symptoms of BD are contained within episodes. The symptoms of DMDD are ongoing. Additionally, bipolar is less common in children and adolescents. BD is usually a lifelong condition, whereas DMDD is more likely to “change” into major depressive disorder or generalized anxiety disorder later in life. Before DMDD became an official diagnosis in 2013, most children with DMDD were misdiagnosed with bipolar disorder. “

As of now - if you diagnose DMDD you cannot also diagnose ODD. Studies have shown that almost all kids with the DMDD also have ODD And therefore DMDD is seen as sort of a trump card diagnosis at this time.

## Points:

Ages 6-18, sx usually by age 10

Unlike ODD, sc must be present in two settings. Often one worse than the other.

<https://my.clevelandclinic.org/health/diseases/24394-disruptive-mood-dysregulation-disorder-dmdd>

## Disruptive Mood Dysregulation disorder (DMDD)

**DMDD symptoms usually begin before the age of 10. A child with DMDD experiences:**



**An irritable or angry mood most of the day, almost every day.**



**Severe temper outbursts (verbal or behavioral) that are out of proportion to the situation. These usually happen three or more times per week.**



**Issues with daily functioning due to irritability in more than one environment, such as at home, at school or with their peers.**



# Pediatric Bipolar Disorders

“Bipolar disorder is very rare in childhood and rare in adolescence. PBD as a diagnostic construct fails to correlate with adult bipolar disorder and the term should be abandoned. Hypomanic syndromes in adolescence may not always progress to adult bipolar disorder. Early diagnosis of bipolar disorder is important, but over-diagnosis risks adverse iatrogenic consequences.”

Parry, P., Allison, S. & Bastiampillai, T. 'Pediatric Bipolar Disorder' rates are still lower than claimed: a re-examination of eight epidemiological surveys used by an updated meta-analysis. *Int J Bipolar Disord*, 21 (2021). <https://doi.org/10.1186/s40345-021-00225-5>

Takeaway: we are really not good at picking out which kids have and will have bipolar disorder. The community is still mixed on how young bipolar disorder can be diagnosed.

Honestly for bipolar disorder, I would usually defer to an outpatient child psychiatrist who knows the patient well, or inpatient child psychiatrist who has seen the patient flagrantly manic. Are they running around naked chanting in jibberish wearing plastic cups on their hands to cast a spell on you while they dance to loud music? Ok then maybe.

I have seen probably 10-20 cases of what I feel comfortable diagnosing as bipolar disorder in young people (18 and under) over my time in residency, fellowship and as an attending. If you think someone looks “bipolar” and want to refer to child psychiatry - I would not use those terms with the family at least. Say stuff like.. mood instability, emotional lability, roller coaster emotions, etc.

You know how some people say they have the flu and it can kind of mean any bad illness? But if they say influenza A- that's the flu for sure. If you're evaluating or see someone sick who has “flu” symptoms you wouldn't diagnose them with influenza A unless you knew it was influenza A. Same with bipolar. Say they have up and down moods but don't throw around the term bipolar loosely if you can, even if families do.

As a professional would you use the term sociopath for a baby who throws rattles all the time? Probably not. Maybe a parent would. We want to get away from “medicalizing” language when it's not developmentally appropriate or diagnosed. So if a parent says “I think my kid is bipolar” you might say “what do you mean by that?” or you might reframe “so their emotions change quickly throughout the day?”

# Kids with extreme emotional lability

Likely to have DMDD or maybe a combination of disorders (ADHD, depression, learning disabilities)..

## Refer for Therapy

As for meds...

DMDD - data is still coming out. Right now the best thought of action is to treat comorbid ADHD aggressively with stimulants. But can also use any med that might help with the symptom (ie, often gets really down - consider SSRI)

Kids that 'look bipolar' and you've already tried other meds (something for depression - something for ADHD) - sure then try the mood stabilizers. I hardly ever start a mood stabilizer as the first line treatment on a kid. But if I do, I usually consider risperidone, aripiprazole, lamotrigine...

Point being if someone comes looking "bipolar" you need to do a really good job investigating what it most likely is. Depression in kids? very common and treatable. Bipolar in kids? extremely rare, still controversial, treatable to some degree with more intense meds.

# A Note about Supplements

There is some evidence for some supplements being helpful. Generally not as robust as prescription medication and/or therapy.

I am not a fan of recommending most supplements because they are not well regulated. Studies come out at least every few years showing that what we think is in supplements often isn't. They aren't routinely checking, but when they do finally check, usually the results come back shocking.

Most recently: <https://www.nytimes.com/2023/04/25/well/live/melatonin-gummies-mislabeled-sleep.html>

I do recommend melatonin for sleep, N Acetyl Cysteine for trichotillomania. Other medications I do not bring up but will discuss if parents ask. There is good evidence for omega 3 fatty acids helping everything a little. Evidence for saffron helping ADHD.

I usually recommend to parents if possible, try and find a reputable company who you can trust and usually does their own internal evaluations as well.

For myself as an adult, I will take supplements. For my own kids, I will give supplements if there isn't another good alternative. But as a child psychiatrist I stick with being conservative in my recommendations because of quality control.

# The New 988 code

## The National Suicide Prevention Lifeline is now: 988 Suicide and Crisis Lifeline



988 has been designated as the new three-digit dialing code that will route callers to the National Suicide Prevention Lifeline. While some areas may be currently able to connect to the Lifeline by dialing 988, this dialing code will be available to everyone across the United States starting on July 16, 2022.

# Trauma and PTSD Evaluation



# The DSM Perspective

There is an explosion of interest and of understanding trauma right now and the DSM is sort of still in its infancy regarding the topic. In the DSM IV PTSD was listed under anxiety disorders. In the DSM V now there is a separate diagnostic category for it called, “Trauma and Stressor-related Disorders.”

Disorders listed in this category are: post traumatic stress disorder, acute stress disorder, reactive attachment disorder, disinhibited social engagement disorder, unspecified trauma and stressor related disorder and adjustment disorder.

Understanding of trauma and correlation to mental health disorders is still evolving.

Pai A, Suris AM, North CS. Posttraumatic Stress Disorder in the DSM-5: Controversy, Change, and Conceptual Considerations. Behav Sci (Basel). 2017 Feb 13;7(1):7. doi: 10.3390/bs7010007. PMID: 28208816; PMCID: PMC5371751. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5371751/>

Additional, semi-controversial related diagnoses NOT in the DSM but have been discussed and considered and have some evidence: complex ptsd (exists in ICD-11) and developmental trauma disorder

<https://www.ptsd.va.gov/PTSD/professional/articles/article-pdf/id87751.pdf>



# Trauma does not equal PTSD

Trauma is common. PTSD is not.

“Studies show that about 15% to 43% of girls and 14% to 43% of boys go through at least one trauma. Of those children and teens who have had a trauma, 3% to 15% of girls and 1% to 6% of boys develop PTSD. Rates of PTSD are higher for certain types of trauma survivors.”

[https://www.ptsd.va.gov/understand/common/common\\_children\\_teens.asp](https://www.ptsd.va.gov/understand/common/common_children_teens.asp)

I often explain to families that trauma can have an effect on a child in ways we will never know or in ways that there isn't a specific diagnosis for. Just because they don't fit criteria for PTSD, doesn't mean there hasn't been an impact from the trauma. Whenever a parent believes there is a diagnosis of PTSD or an attachment disorder - I tell them that I don't think the child formally meets criteria, but it doesn't mean that

# Abuse is common

**Approximately one in four children experience child abuse or neglect in their lifetime.**


Of maltreated children, 18 percent are abused physically, 78 percent are neglected, and 9 percent are abused sexually.

**The fatality rate for child maltreatment is 2.2 per 1000 children annually, making homicide the second leading cause of death in children younger than age one. When you consider the first cause is accidents - it's possible we may be missing even more homicides.**


Brown CL, Yilanli M, Rabbitt AL. Child Physical Abuse And Neglect. [Updated 2022 Jun 14]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK470337/>

These stats are sad. But it can still be good to know them because it can be normalizing for kids and for parents to know that a lot of children have experienced trauma and can still grow up and live their lives. They aren't alone and there is hope.

The number of adverse childhood events a child has the bigger potential for problems they have.



**There is hope. Children can and do recover from traumatic events, and you can play an important role in their recovery.**



**A critical part of children's recovery is having a supportive caregiving system, access to effective treatments, and service systems that are trauma informed.**

<https://www.samhsa.gov/child-trauma/understanding-child-trauma>



# With Trauma it's not just what you evaluate - but how you evaluate

- **Trauma-Informed Pediatric Care** does include acts that help reduce PTSD. [Beaulieu Jones, 2022]
  - **Minimize Potentially Traumatic Aspects of Medical Care and Procedures**
  - **Provide Children/Families with Basic Support and Information**
  - **Addressing Immediate Child Distress**(ex, Pain, Fear, Loss)
  - **Promote Emotional Support**
  - **Identifying Family Needs**
  - **Screening**
  - **Anticipatory Guidance about Adaptive Coping Skills**

<https://pedemmorsels.com/pause-to-prevent-pediatric-ptsd/>





# Retraumatization

## WHAT HURTS?



### SYSTEM

*(Policies, Procedures, Structural and Institutional Racism and Oppression)*

### RELATIONSHIP

*(Power, Control, Subversiveness, Interpersonal Racism and Oppression)*



HAVING TO CONTINUALLY RETELL THEIR STORY



BEING TREATED AS A NUMBER



BEING SEEN AS A LABEL (I.E. ADDICT, SCHIZOPHRENIC)



NO CHOICE IN SERVICE OR TREATMENT



NOT BEING SEEN/HEARD



NON-TRANSPARENCY AND VEILED TRUTHS



DOES THINGS FOR RATHER THAN WITH



USE OF PUNITIVE TREATMENT, COERCIVE PRACTICES AND OPPRESSIVE LANGUAGE

<https://www.pacesconnection.com/blog/new-re-traumatization-chart>

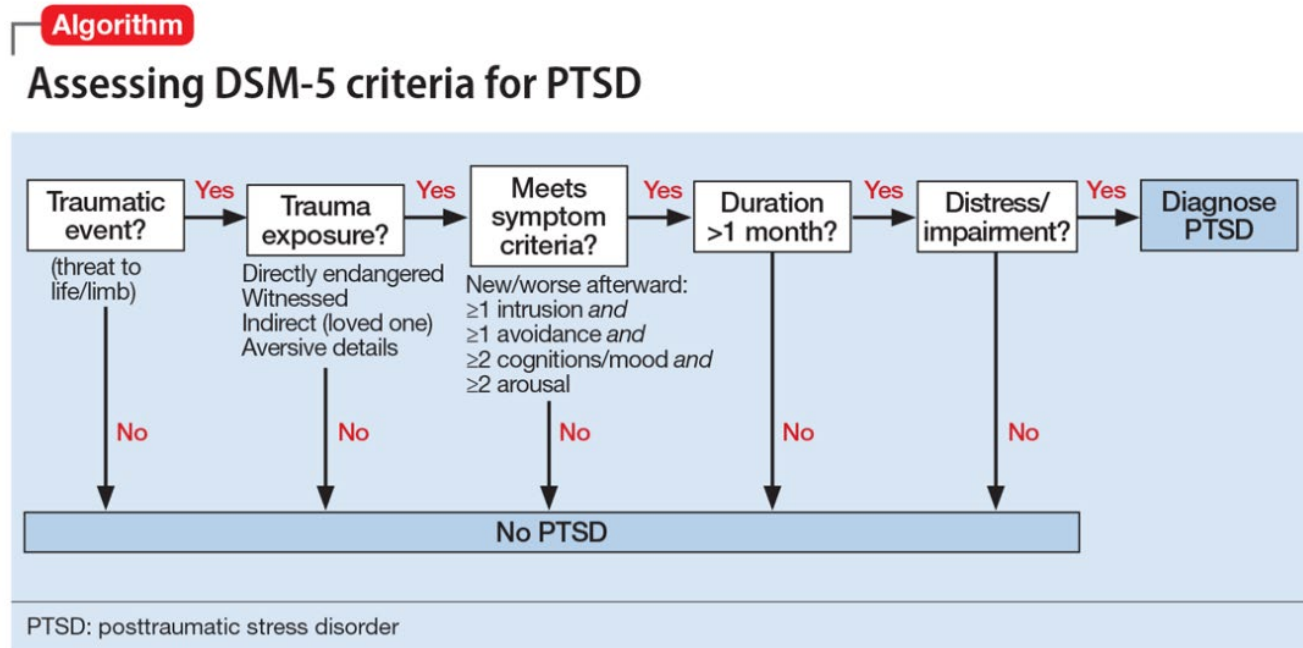
\*I think most of think we don't do much of this. When in reality we may do way more than we realize. How often are you giving families choices?

# P T S D

Trauma is common. PTSD is not.

“Studies show that about 15% to 43% of girls and 14% to 43% of boys go through at least one trauma. Of those children and teens who have had a trauma, 3% to 15% of girls and 1% to 6% of boys develop PTSD. Rates of PTSD are higher for certain types of trauma survivors.”

[https://www.ptsd.va.gov/understand/common/common\\_children\\_teens.asp](https://www.ptsd.va.gov/understand/common/common_children_teens.asp)





# P TSD

DSM-IV: PTSD	DSM-5: PTSD
Disorder Class: Anxiety Disorders	Disorder Class: Trauma- and Stressor-Related Disorders
<p>A. The person has been exposed to a traumatic event in which both of the following were present:</p> <ol style="list-style-type: none"> <li>1. The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.</li> <li>2. The person's response involved intense fear, helplessness, or horror.</li> </ol>	<p>A. Exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways:</p> <ol style="list-style-type: none"> <li>1. Directly experiencing the traumatic event(s).</li> <li>2. Witnessing, in person, the event(s) as it occurred to others.</li> <li>3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of family member or friend, the event(s) must have been violent or accidental.</li> <li>4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).</li> </ol> <p>Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.</p>

Substance Abuse and Mental Health Services Administration. Impact of the DSM-IV to DSM-5 Changes on the National Survey on Drug Use and Health [Internet]. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2016 Jun. Table 3.14, DSM-IV to DSM-5 Posttraumatic Stress Disorder Comparison. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK519704/table/ch3.t14/>

# Trauma and PTSD Treatment



# Trauma Informed Care: Addressing Family Needs



## How to Assess: Family

TRAUMATIC STRESS IN ILL OR INJURED CHILDREN

### Assess distress of parents/family members. Ask:

- How is your family coping right now?
- Who is having an especially difficult time?

### Gauge family stressors and resources. Ask:

- Are you eating, getting sleep, and taking breaks?
- Do you have friends who can help out at home?

### Address other needs (beyond medical). Ask:

- Are there other stressors going on (such as money, job, transportation) that make it particularly difficult right now?

F

Let's say James is a patient who was recently diagnosed with Diabetes when he was hospitalized for diabetic ketoacidosis.

To address **Family needs**, you might:

- Listen to James' dad's concerns and frustrations and address what you can. After he has had a chance to voice his frustrations, say that often a new diagnosis can be almost as hard on the family as on the patient and ask what concerns him most right now.
- Remember to check in with James' mom about how she is doing in this challenging situation. Even when a parent seems calm and 'together', checking in with them is important.
- If James has siblings, ask how they are dealing with James being in the hospital, and talk about visits and staying in touch.

# Pediatric Providers Play a Big Role

- Pediatric providers are trusted adults who are seeing children often for routine, and non judgemental reasons. They are uniquely positioned to ask children what they have experienced and respond calmly. By having this unique position, and by taking time to ask and talk to a child about what is going on, in many ways they are providing some intervention.
- Pediatric providers may not be able to “solve” the trauma or PTSD. However they can improve a child’s clinical trauma picture by trusting what the child is saying, and being willing to to treat other aspects that make a difference. For instance a child who is frequently somatic goes through a traumatic situation and the symptoms get worse. A provider may recognize that the somatic symptoms are a component of the trauma but still listen and do due diligence investigating. Maybe they will trial something for GERD, send to GI, treat headaches, refer to PT, etc.

Cohen JA, Kelleher KJ, Mannarino AP. Identifying, Treating, and Referring Traumatized Children: The Role of Pediatric Providers. *Arch Pediatr Adolesc Med.* 2008;162(5):447–452. doi:10.1001/archpedi.162.5.447

# All the other recommendations

- Therapy is recommended- especially trauma informed therapies. Right now TF-CBT is the most widely known and utilized form of CBT for therapy.
- Many therapies can be helpful- but often are dependent on the age, development, status and type of trauma of the child. For example a 4 year old would likely benefit more from parent-child psychotherapy
- EMDR has good evidence in adults. There is some evidence it is helpful for children as well but this is still being researched more.
- There is no FDA indicated medication for PTSD in children. In adults there are FDA medications with good data. Evidence does show that likely children with PTSD would benefit from an SSRI.
- Treating comorbid conditions can be extremely beneficial to treating the PTSD as well. For example, a child with PTSD and moderate to severe depression would benefit from medication and therapy.

J.A. Cohen, O. Bukstein, H. Walter, S.R. Benson, A. Chrisman, T.R. Farchione, J. Hamilton, H. Keable, J. Kinlan, U. Schoettle, M. Siegel, S. Stock, J. Medicus

**Practice parameter for the assessment and treatment of children and adolescents with posttraumatic stress disorder**

Journal of the American Academy of Child & Adolescent Psychiatry, 49 (4) (2010), pp. 414-430

# Resilience

- Don't lose hope and remind families not to lose hope. Just because something bad happened to them does not mean it has to ruin their future or make it so that they cannot lead a contented life.
- Treat the PTSD with meds and therapy as indicated, but remember to look at all other factors which make contribute and could help. Fortify supports that are already existing
- Joining with families, collaborating in teams, partnering with schools can boost the resilience of the child. "Adaptation of children in disasters depends on the resilience of interconnected systems, including families, schools, communities and policy sectors."  
Masten, A.S. (2021), Resilience of children in disasters: A multisystem perspective. *Int J Psychol*, 56: 1-11.  
<https://doi.org/10.1002/ijop.12737>
- Correlates of resilience included multisystem factors, such as **social, cultural, family and individual aspects, which is in line with the multisystem approach as described by recent resilience theories ."**  
Mesman E, Vreeker A, Hillegers M. Resilience and mental health in children and adolescents: an update of the recent literature and future directions. *Curr Opin Psychiatry*. 2021 Nov 1;34(6):586-592. doi: 10.1097/YCO.0000000000000741. PMID: 34433193; PMCID: PMC8500371.
- Most of the articles coming out about trauma and PTSD for covid say the same stuff as above. We need to take a family centered systemic approach. Stark, A. M., White, A. E., Rotter, N. S., & Basu, A. (2020). Shifting from survival to supporting resilience in children and families in the COVID-19 pandemic: Lessons for informing U.S. mental health priorities. *Psychological Trauma: Theory, Research, Practice, and Policy*, 12(3), S123–S135.  
<https://doi.org/10.1037/tra0000781>



# Thank you

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