

# Psychiatric Evaluation and Management of Children and Adolescents

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# Objectives:

- Identify ways to address the unique needs of children, adolescents and their families in an initial evaluation
- Describe appropriate assessment and management strategies for children and adolescents experiencing a psychiatric problem
- Identify risk and protective factors for self-injurious behavior, suicide, and aggression in children and adolescents
- Describe decision making strategies regarding the use of medications and/or therapies in children and adolescents with a psychiatric problem

# Disclosures:

- I have no financial disclosures to make nor conflicts of interest to report.
- This presentation includes discussion of suicide, self-injurious behavior, weapons, threats and acts of violence.

# Assessment Goals

- Accurate assessment
- Appropriate intervention
- Disposition

## 3 things to achieve:

- A therapeutic connection/intervention
- Understanding of the psychiatric and social/systemic factors that contribute to this crisis
- Safety

# Connection

- Not an interrogation
- An attempt to understand
- Be empathic
- Be honest and trustworthy
- Share what you know
- Consider confidentiality and ramifications
- An offer of help

# Remember

- Kids don't want to get in trouble
  - Kids don't want to be considered crazy
  - Kids don't want to come in the hospital
  - Kids will lie
  - Kids don't always understand what we're asking about
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- I don't want kids to get in trouble, think they're crazy or come into the hospital. I need to think like they do, and talk to them at their level. I want them to be honest. I want to help.

# Environment

- Calm
- Quiet
- Private (patient and parent)
- Leisurely(not rushed)
  
- Not always easy to arrange-you need time and space



# Necessary information

- Prior history
- MSE
- Collateral history
- Engagement with supports
- Response to interview and intervention

# Screening Tools (free)

- DSM Cross-Cutting Scale (initial screen-symptoms)
  - Child Self Rating (ages 11-17) 25 items and/or
  - Parent Rating (ages 6-17) 25 items
- WHODAS 2.0 (initial screen-functioning)-36 items
- Vanderbilt Scale (ADHD/ODD/Anxiety)-35 items
- Screen for Child Anxiety Related Disorders-41 items
- CSSR (Columbia Suicide Severity rating Scale)-12 items
- ASQ (Ask Suicide Screening Questions)-7 items
  - If positive, BSSA (Brief Suicide Safety Assessment)

# Necessary information

- Prior history
- MSE
- Collateral history
- Engagement with supports
- Response to interview and intervention

# Prior history-risk factors

- Recent, high lethality attempt
- Escalating aggressive, suicidal or SIB
- Researching death or violent means
- Believed behavior would be fatal
- Access to means
- Longstanding or escalating SIB
- Substance use

# Prior history-protective factors

- Impulsive, low risk attempt
- Called for help or stopped self
- Threats in the presence of others
- Minor aggression or property destruction without intent to harm others
- High supervision
- No access to lethal or dangerous means
- Child has coped successfully in the past with stressors

# MSE-risk factors

- Currently homicidal or suicidal
- Agitation, insomnia, paranoia or anhedonia
- Refusal to speak
- Unwilling to discuss stressors
- Guilt or shame about recent disclosure (of family or sexual abuse)
- Positive regard for death (relief of burden or suffering, being with deceased )

# MSE-protective factors

- Future oriented
- Emotionally appropriate but maintains composure
- Broad, congruent affect
- No S/II or plan
- Contingently suicidal (if/then)

# Collateral info-risk factors

- None
- Significant safety concerns
- Parental lack of concern despite serious attempt/symptoms
- FH of suicide
- Recent suicide in peer group



# Collateral info-protective factors

- Parent/guardian knows child well, understands symptoms and does not have acute safety concerns

# Engagement with supports-risk factors

- No outpatient treatment
- Refusal to attend treatment
- Poor social supports
- Limited interest in friends/family/school

# Engagement with supports-protective factors

- Good alliance with outpatient providers
- Connected to peers and school
- Supportive family

# Response to interview-risk factors

- Not responsive to interventions-remains agitated/paranoid/suicidal
- Refuses to engage

# Response to interview-protective factors

- Responds to therapeutic support
- Responds to medications (for psychosis/agitation)

# Safety

- Ask safety question “Do you think you need help to keep yourself safe?”
- Safe place to be
  - Supportive people
  - No access to weapons
  - No access to substances
  - Time to process and heal
  - Healthier alternatives/coping strategies

# Case examples:

- 15 year old female presents to office with multiple superficial cuts on her left arm.
- 16 year old male brought to ED from home with 2nd degree burns on both arms from setting a fire in his backyard with gasoline today.
- 11 year old nonverbal female with ID and ASD sent to ED from school with aggression, hitting and kicking peers and staff in school, and hitting herself repeatedly in the head.
- 13 year old male brought to office by mother, at the insistence of the school, having posted threats to “shoot up” his school during an Instagram chat with a friend.

# Case 1

- 15 year old female
- No previous psychiatric history
- “Superficial” cuts



# Necessary information

- Prior history-no hx of depression or SI/SIB
- MSE-upset, embarrassed, denied SI
- Collateral history-break up with bf, “a lot of my friends are doing it”
- Engagement with supports-parents supportive, has PCP but no connection with BH
- Response to interview and intervention- open and talkative when seen individually, cooperative with parents and referral

# Necessary information

- Prior history-hx of depression and SIB-pt admits, parent unaware
- MSE-tearful, angry, hopeless, vague re: SI
- Collateral history-break up with bf, “friends are doing it”
- Engagement with supports-parent dismissive and contemptuous, no PCP or BH
- Response to interview and intervention- sullen, irritable and terse when seen individually, conflicted with parent and both parent and patient uninterested in referral

## Case 2

- 16 year old male
- Second degree burns on arms
- Firesetting with gasoline

# Necessary information

- Prior history-ADHD since 7, OCD since 10, no previous fire behavior
- MSE-upset, embarrassed, denied SI/HI
- Collateral history-doing well in school, no stressors, but socially isolated
- Engagement with supports-parents supportive, in psych OP tx for medication and therapy
- Response to interview and intervention- open and talkative when seen individually, cooperative with parents

# Necessary information

- Prior history-ADHD since 7, OCD since 10, has been “fascinated and obsessed” with fire
- MSE-negativistic, dysphoric, angry and anxious. Denied intent to harm self “it was an accident.” No psychotic sx.
- Collateral history-grades dropped, conflicts with father and new stepmother, has been depressed, irritable, and isolative for two months
- Engagement with supports-parents at odds-father minimizing, stepmother alarmed; in psych OP tx for medication but not taking rx recently, not in therapy
- Response to interview and intervention- sullen initially, then angry and blaming of others when seen individually, uncooperative with parents

# Case 3

- 11 year old female
- ID and ASD, nonverbal
- Aggressive with staff and peers at school
- Hitting self in head

# Necessary information

- Prior history-ASD and ID since early childhood, nonverbal, some head slapping when anxious, rarely aggressive, generally happy
- MSE-pleasant and calm, rocking gently and clutching a well-worn stuffed animal
- Collateral history-substitute teacher in special ed classroom, routine disrupted, no stressors at home
- Engagement with supports-parents supportive, special ed school staff concerned about sudden change in behavior and safety, in OP BH tx
- Response to interview and intervention-parents want her to come home, school wants her to return tomorrow

# Necessary information

- Prior history-ASD and ID since early childhood, nonverbal, frequently engages in SIB or aggression when upset, anxious or in pain
- MSE-restless, pacing, rocking, hooting at times and frequently slapping head
- Collateral history-no stressors or changes in routine at school or at home, sick with cold in past few days
- Engagement with supports-parents concerned, school alarmed by increase in aggressive behavior, engaged in OP BH tx
- Response to interview and intervention-patient remains agitated, not calming down, continues to hit self at times, but not aggressive to others



## Case 4

- 13 year old male
- No previous history
- Police were notified of “concerning” messages on social media, went to home and insisted he be evaluated at psych ED

# Necessary information

- Prior history-no psych history, no history of threats, being bullied, or bullying others.
- MSE-scared, crying, initially denied sending any messages, later admitted he made a comment out of frustration while chatting to a friend “I hope someone would blow up school so we don’t have to go”
- Collateral history-struggling academically, “doesn’t like going to school” and has had two incidents in last two years at school-upset and broke a peer’s glasses, and talking out in class. No access to weapons.
- Engagement with supports-mother concerned, doesn’t think her son “would do anything like this.” No BH.
- Response to interview and intervention-remorseful, embarrassed and afraid of being expelled, mother supportive, open to referral

# Necessary information

- Prior history-isolated, victim of bullying for several years
- MSE-quiet, guarded, flat in affect, depressed in appearance, admits to thoughts of wanting to get back at bullies and anger that “nothing has been done”  
“Someone should blow up the school”
- Collateral history-more isolated, withdrawn, internally preoccupied and “miserable” No access to weapons.
- Engagement with supports-mother concerned, but patient dismissive of her. No BH treatment
- Response to interview and intervention-patient uninterested in help, mother stated “I can’t get him to see anyone.”

# What should we do?

- Identify the problem(s)
- Instill hope-in child, parent, and everyone else!
- Identify and reinforce the strengths
- Pick an option and do one thing at a time
- Assess and measure a response
- Explain everything and set expectations regarding time and effect (and what isn't going to happen)

# Treatment precepts

- Parents want help for their child
- Children don't want to have a problem
- Everyone is trying their best
- Time and development are on our side
- There are other things that can be done besides the use of medications
- Medications won't work (and they will also cause new problems)

# Stimulant Medications

- One of the most robust treatments in psychiatry
- 70% of children with ADHD will respond to any one of the stimulants, all generally of equal efficacy
- An additional 20% will respond to the next stimulant attempted
- Two primary stimulants: amphetamine (1937) and methylphenidate (1957)

# Stimulants are effective- why look any further?

- Decreased appetite
- Delayed sleep onset
- Time-action profile
- Comorbid disorders (tics, anxiety, mood)
- Schedule II drugs
- Diversion/abuse potential
- No refills, can't call in prescriptions, can't provide samples
- Stimulants don't work for everyone
- Patient and parent preference

# Alternatives to stimulants

- Atomoxetine (Strattera®)
- Tricyclic antidepressants: imipramine, desipramine, nortriptyline
- Bupropion (Wellbutrin®)
- Venlafaxine (Effexor®)
- Alpha agonists: clonidine and guanfacine (Tenex®)
- Caffeine/nicotine
- Behavioral and environmental interventions



# Treatment for depression and anxiety disorders

- CBT only for mild depression and/or anxiety
- CBT and medications for severe OCD and other moderate to severe depressive and/or anxiety disorders.
- Follow up carefully and see patient regularly (q1 week/2 weeks/4 weeks).
- Remember that antidepressants will take 4-6 weeks to reach full effect.

# Medications

- SSRIs (Prozac, Paxil, Zoloft, Celexa, Lexapro, Luvox)
- Benzodiazepines (Valium, Librium, Ativan, Xanax, Klonopin)
- Other antidepressants (Wellbutrin, Effexor, Cymbalta, TCAs)
- Other agents (Inderal, Clonidine, Guanfacine, Lamictal, Neurontin)

# Treatment of Children and Adolescents with PTSD

- First-step management
- Psychotherapy
- Medications

# First-step: Identification and Management of Symptoms

- When a child or adolescent has been exposed to a traumatic incident healthcare professionals should inform the parents about the risk for PTSD (i.e. in an emergency room or a disaster relief situation). This should be accompanied by a brief description of the most likely symptoms and an information sheet about what to expect
- The “Facts for Families”, “Helping Your Child After a Disaster” and “Post-Traumatic Stress Disorder” prepared by the American Academy of Child and Adolescent Psychiatry offer this information and can be disseminated. (Available in several languages – used worldwide)

# Psychotherapy

- Trauma-focused Cognitive Behavioral Therapy, which includes:
  - Psychoeducation
  - Stress management
  - Affect expression and modulation
  - Cognitive coping
  - Creating trauma narrative
  - Cognitive processing
  - Behavior management training

# Medications

- No medications have been specifically designed to treat the symptoms of PTSD, although some medications commonly used to treat anxiety disorders and depression have been found to be effective in helping people manage their symptoms.
- SSRI's and other meds such as Prazosin and Tenex have limited data and effectiveness

# Summary

- Establish a therapeutic alliance with both child and parent(s)
- Ask the patient about SI and HI
- Get collateral history
- Past suicidal behavior is the strongest risk factor for future attempts
- Ask safety question “Do you think you need help to keep yourself safe?”
- Discuss means restriction (securing or removing lethal means)
- Consider therapy and medication options
- Recognize our limitations and do the best we can

# References

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