

TOPICAL WEBINAR FOR APA MEMBERS

An Educational Resource from Newport Healthcare

Childhood Psychiatric Disorders: Presentations, Screening, and Treatment

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ATTENDANCE

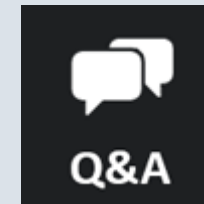
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- A recording of this presentation will be emailed to everyone in 2 weeks' time.
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HAVE A QUESTION?

- You are on mute. Communicate using the **Q&A box** in the webinar screen. Attendees can view and upvote on submitted questions in the Q&A box to help presenters identify popular topics.
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Dr. Mirela Loftus

PRESENTER

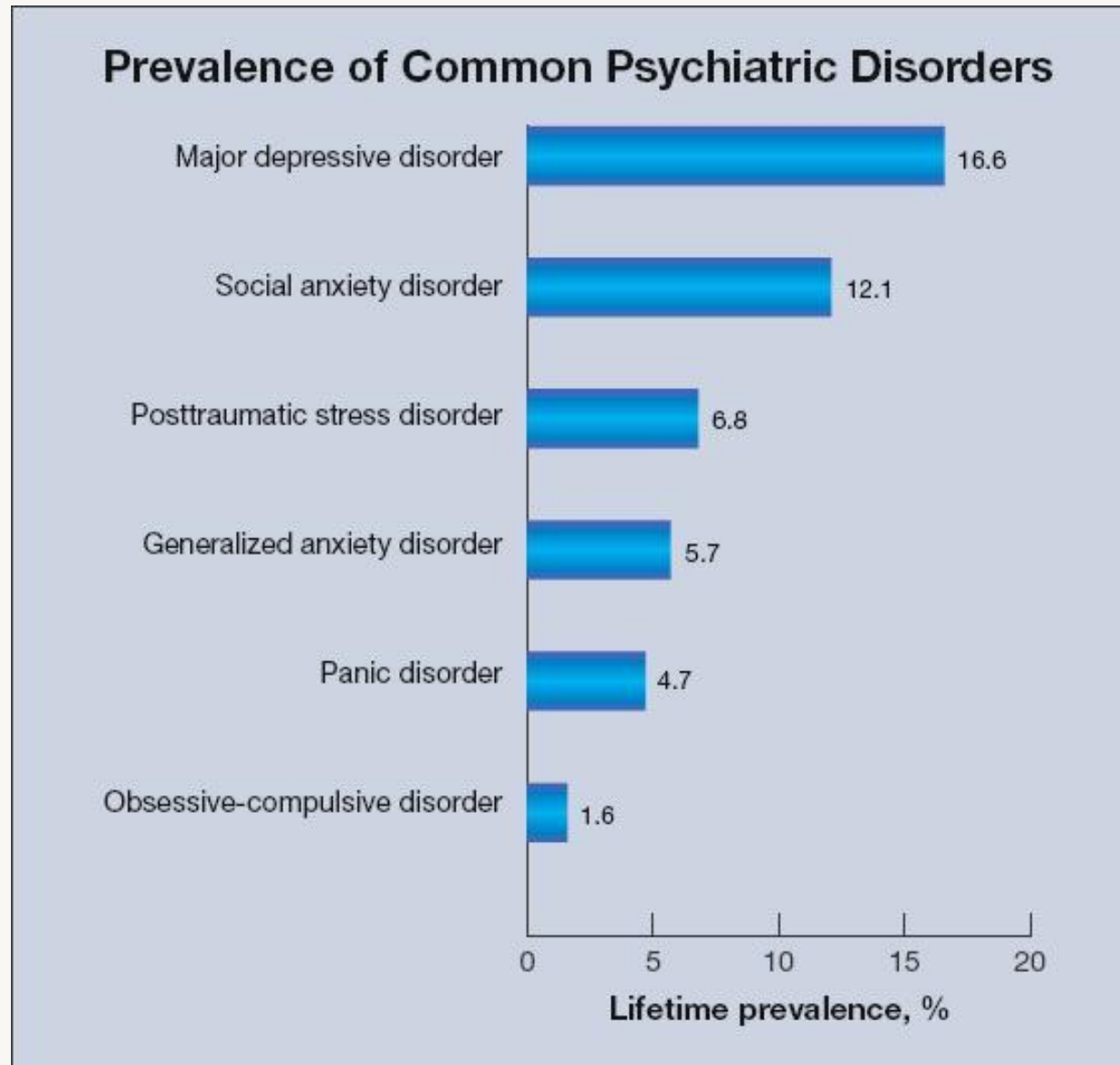
- Dr. Mirela Loftus, MD, PhD
 - *Medical Director, Connecticut, Newport Healthcare*

Objectives

- Learners will become familiar with the steps in [detecting and diagnosing](#) pediatric depression and anxiety
- Learners will become familiar with different [levels of care](#)
- Learners will become familiar with the guidelines regarding the [pharmacologic treatment](#) of pediatric depression and anxiety and the possible role for [genomic guidance](#) in selecting antidepressants
- Learners will become familiar with [suicide screening and prevention](#)

Levels of Care

- **Outpatient:**
 - *weekly individual therapy with a LCSW, PsyD and/or psychiatrist (meds); and or family therapy; School Counseling*
- **Intensive Outpatient Program (IOP):**
 - *3 X/week group therapy*
- **Partial Hospital Program (PHP):**
 - *up to 20 hours/week group therapy*
- **Inpatient Psychiatric Hospital:**
 - *locked facility (safety concerns)*
- **Residential Treatment Center (RTC):**
 - *30-90 days live in (various types)*
- **In Home services:** IICAPS, MST, MDFT
- **Therapeutic Boarding School:** some schools pay for the school portion
- **Emergency:** mobile crisis team (211) or ER (911)
- **Payment:** In vs Out of Network; DCF voluntary service



Depression as seen in Primary Care

Depression can be:

- *The cause of headaches, abdominal pain, somatic symptoms*
- *Can arise from ADHD, other LD*
- *Can arise from substance abuse and can fuel further substance use*
- *Missed because children and adolescents do not seek help readily*
- *Detected when talking to parents, as PCP have a longstanding relationship*
- *Extremely painful*
- *If untreated leads to recurrence more so than if treated*
- ***A contributor to attempted or completed suicide***

First Step: Detection

- Use of waiting room checklists
 - (*PSC-#17, PHQ-9*)
- Use of clinical questions
- Bottom line: Monitor for the child who has “**fallen off their growth curve**” and is not functioning in some area as they had before
- Ex: No longer spending time with friends, grades have dropped, energy seems different, sleeping more or less, eating more or less

Second Step: History then Mental Status Exam

- Usual state of good health until....
- Ask symptoms more directly both to the parent and to the child or adolescent
- Guide: NAMI Family Guide
- Ask about *family history*
- *Social history* with regard to trauma, losses, separations, (and sex, drugs, rock and roll....)
- Then speak to *patient alone*

Highlights of a Mental Status Exam

- Developmental issues present? (intellectual, social cognition vulnerabilities-bottom line: does the child/adolescent seem his or her age?)--If not, why not?
- Assess for type of depression symptoms (irritability versus neurovegetative SIGECAPS)
- Assess for current trauma/abuse (reporting laws)
- Assess for substance use (consider the CRAFFT)

Depression Mnemonic

[**SIG - E - CAPS**]

- **S**leep changes [insomnia, hypersomnia]
- **I**nterest loss 'anhedonia'
- **G**uilt or low self-esteem
- **E**nergy level [loss of energy, low energy, or fatigue]
- **C**oncentration [poor concentration, forgetfulness]
- **A**ppetite changes [loss of appetite or increased appetite]
- **P**syomotor changes [agitation/slow physical & emotional reactions]
- **S**uicidal ideations [active or passive thoughts?]



The CRAFFT Questionnaire (version 2.1)

To be completed by patient

Please answer all questions **honestly**; your answers will be kept **confidential**.

During the **PAST 12 MONTHS**, on how many days did you:

1. Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none. # of days
2. Use any **marijuana** (weed, oil, or hash, by smoking, vaping, or in food) or **synthetic marijuana** (like "K2," "Spice") or "vaping" **THC oil**? Put "0" if none. # of days
3. Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put "0" if none. # of days

READ THESE INSTRUCTIONS BEFORE CONTINUING:

- If you put "0" in **ALL** of the boxes above, **ANSWER QUESTION 4, THEN STOP.**
- If you put "1" or higher in **ANY** of the boxes above, **ANSWER QUESTIONS 4-9.**

- | | No | Yes |
|---|--------------------------|--------------------------|
| 4. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs? | ☐ | ☐ |
| 5. Do you ever use alcohol or drugs to RELAX , feel better about yourself, or fit in? | ☐ | ☐ |
| 6. Do you ever use alcohol or drugs while you are by yourself, or ALONE ? | ☐ | ☐ |
| 7. Do you ever FORGET things you did while using alcohol or drugs? | ☐ | ☐ |
| 8. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use? | ☐ | ☐ |
| 9. Have you ever gotten into TROUBLE while you were using alcohol or drugs? | ☐ | ☐ |

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Suicide Screening – **A** **MUST**

- The myth
- The Ask Suicide-Screening Questions (ASQ) tool is a set of four brief suicide screening questions that takes 20 seconds to administer.



Ask Suicide-Screening Questions

NIMH TOOLKIT

Suicide Risk Screening Tool

Ask the patient:

- In the past few weeks, have you wished you were dead? ☐ Yes ☐ No
- In the past few weeks, have you felt that you or your family would be better off if you were dead? ☐ Yes ☐ No
- In the past week, have you been having thoughts about killing yourself? ☐ Yes ☐ No
- Have you ever tried to kill yourself? ☐ Yes ☐ No

If yes, how? _____

When? _____

If the patient answers **Yes** to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now? ☐ Yes ☐ No

If yes, please describe: _____

Next steps:

- If patient answers “No” to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- If patient answers “Yes” to any of questions 1 through 4, or refuses to answer, they are considered a **positive screen**. Ask question #5 to assess acuity:
 - ☐ “Yes” to question #5 = **acute positive screen** (imminent risk identified)
 - Patient requires a **STAT** safety/full mental health evaluation.
 - Patient cannot leave until evaluated for safety.
 - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient’s care.
 - ☐ “No” to question #5 = **non-acute positive screen** (potential risk identified)
 - Patient requires a **brief** suicide safety assessment to determine if a **full** mental health evaluation is needed. Patient cannot leave until evaluated for safety.
 - Alert physician or clinician responsible for patient’s care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text “HOME” to 741-741

asQ Suicide Risk Screening Toolkit

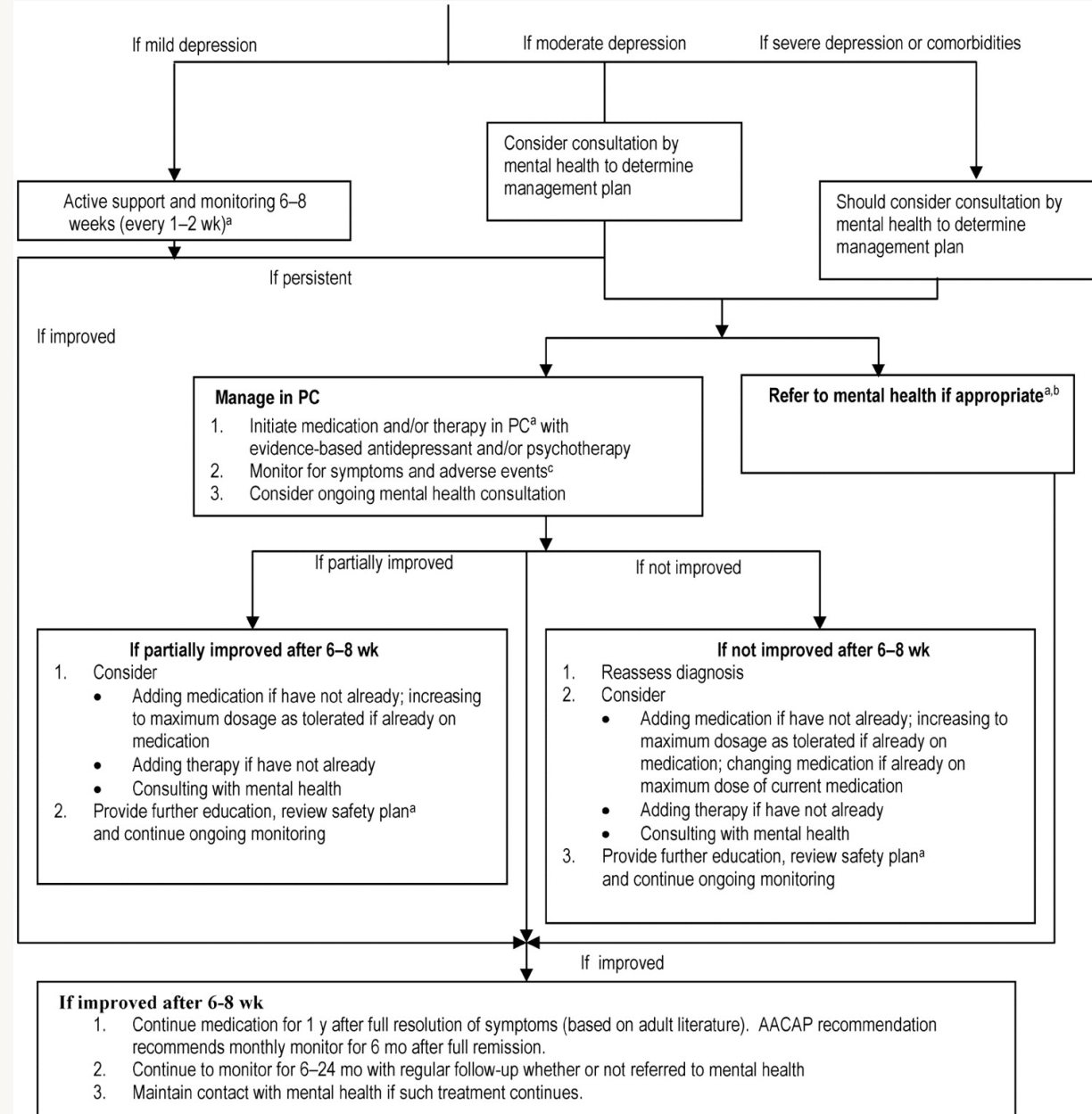
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 7/1/2020

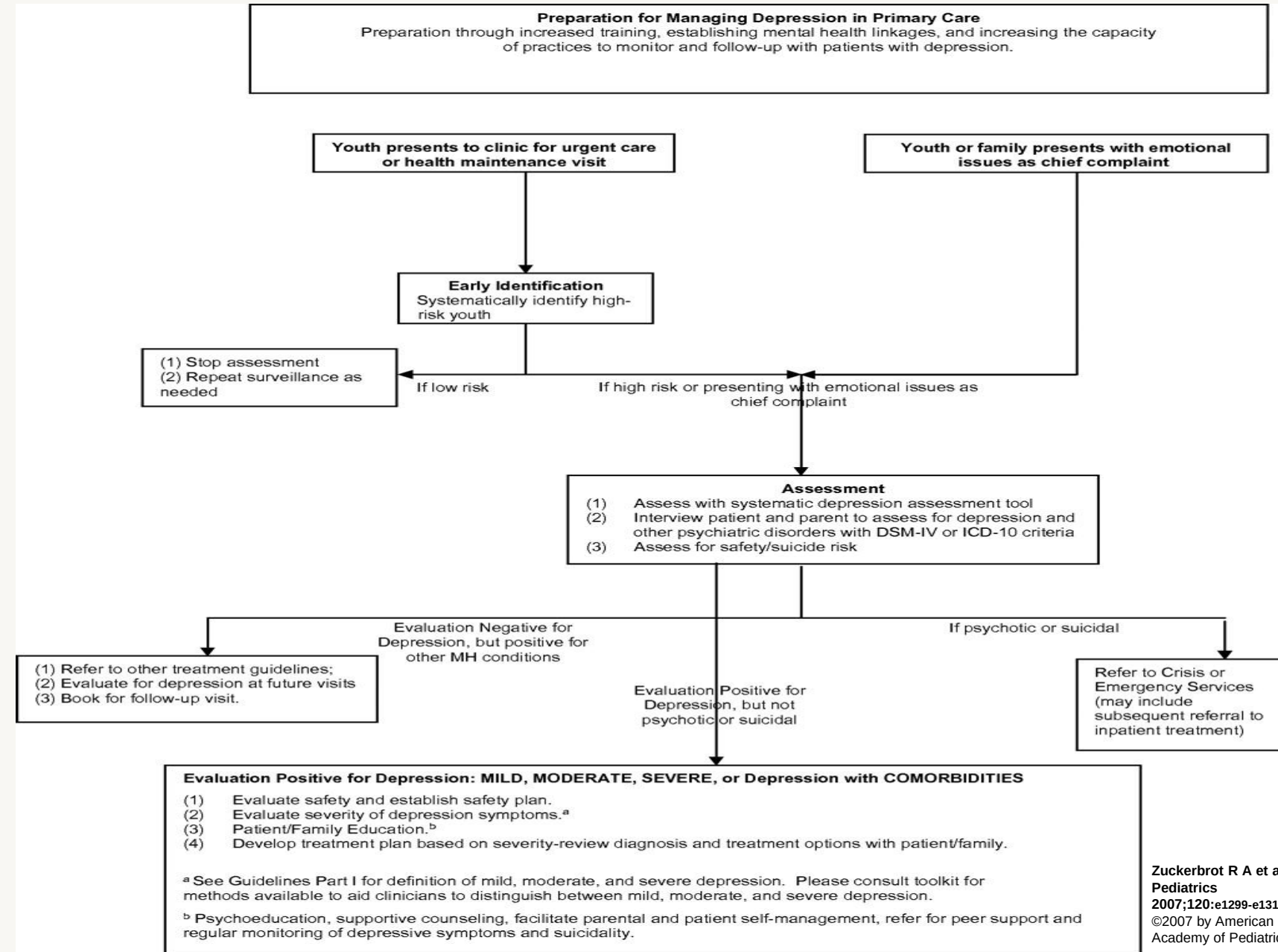
Young People **at Risk**

- Serious adverse childhood events:
 - *Trauma, abuse*
- Being bullied: Gay, lesbian, bisexual, transgender, etc, at greater risk
- Family history of suicide
- Sleep disturbance
- Chronic medical conditions
- Access to lethal means: CALM (<https://www.sprc.org/resources-programs/calm-counseling-access-lethal-means>)

Clinical Management Flowchart



Clinical Assessment Flowchart



Third Step: Diagnosis and Determining Treatment Needs

- Level of care: outpatient, partial hospitalization, inpatient, mobile crisis team (211) or ED (911)
- If outpatient, then determine psychotherapy (CBT, IPT, supportive) or psychotherapy with medication
- If medication seems indicated, do you treat within primary care? (In CT AccessMH)

Considerations in Initiating Psychopharm in Pediatric Primary Care

- Level of severity (mild-moderate)
- Organization of family system
- Availability to do follow-up
- Therapist to co-manage depression
- Determination of low-risk (no suicidal ideation)
- A must: safety planning (all meds, sharps, guns, safely locked and monitored)=Lethal Means Restriction (LMR)

Pediatric Psychopharmacology: Clinical Guidelines

- **When?** Marked change or inability to function at age/developmental levels. Just having symptoms is not enough.
- **What?** Clear list of target symptoms (poor sleep, irritability, lack of pleasure/motivation) before initiating any antidepressant trial and a clear understanding of how the efficacy of the trial will be determined. (i.e., checklists, teacher report, child report, parent report, psychologist report, etc.)
- **Who?** As much as is developmentally appropriate, engage the child or adolescent in understanding the reasons for the medication trial and what target symptoms you are hoping to control and how they can let you know if the meds are helpful, or not.
- **Start low, go slow.** These symptoms have been around for a while.
- If you see symptoms worsen, consider discontinuing rather than increasing the medication because it may be a side effect rather than the disorder itself.
- Alternatively, after an appropriate duration (i.e., 2-3 weeks for SSRI's), if there are no side effects and the symptoms are the same or only a bit better, increase the dose, then wait and reassess.

Pediatric Psychopharmacology: Clinical Guidelines (cont)



Suicide and Youth with Depression

- Obtain **informed consent**. Review “black box warning” and other pertinent side effects, risks, benefits and how the medication trial will be monitored.
- Ensure the patient and the family that the medication will be continued only if it has been helpful.
- Above all, do no harm.

Youth with depression are at increased risk for suicide attempts and suicide. It is important to ask your child whether they are having thoughts about hurting themselves. If your child expresses suicidal thoughts, this is an opportunity to discuss taking precautions to make the child's environment safe. Talking with your child about suicide does not cause suicide, but it does let your child know that you are concerned and that you want to know whether they have any thoughts about it.

How common are suicidal thoughts, behaviors, and death by suicide in youth?

Among students in grades 9–12 in the United States in 2015, 18% reported seriously considering attempting suicide in the previous 12 months, whereas 15% actually made a suicide plan. Nine percent of students attempted suicide one or more times, and 3% made an attempt that resulted in an injury, poisoning, or an overdose that required medical attention.

In 2015, suicide was the third leading cause of death among youth between the ages of 10 and 14 years and the second leading cause of death among individuals between the ages of 15 and 34 years. Suicide claims more lives than many

diseases in children and adolescents. More adolescents and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined.

What factors other than depression may increase suicide risk?

Additional risk factors for suicide include having a family member who died by suicide or knowing someone else who died by suicide. Other factors include family conflict, sleep problems, substance use, school problems, impulsivity, other mental illnesses, not feeling connected to others, and easy access to lethal means of self-harm.

Do antidepressant medications increase the risk of suicide?

Determining whether antidepressant medications increase the risk for suicide is quite hard, particularly because children and adolescents with depression are more likely to think about suicide and attempt it than other children. With this concern, the FDA (US Food and Drug Administration) reviewed all published and unpublished clinical trials of antidepressants in children and adolescents, and in 2004, it issued a black box warning about an increased risk

of suicidal thoughts and/or behaviors in youth who take antidepressants. There was no record of completed suicides in their review of over 2,000 youth who were treated with antidepressant medications, but the rate of suicidal thinking/behavior (including actual suicide attempts) was twice as high in youth taking medications (4%) than those taking placebo or sugar pills (2%).

Treating underlying depression in youth who are thinking about suicide is an important strategy, because antidepressant medications improve depressive symptoms, which is the best way to treat suicidal thoughts and behavior. Antidepressant medication may increase the risk for suicidal thoughts and/or behaviors in a small percentage of youth. If a doctor determines that medication is appropriate for your child, it is important to weigh the pros and cons of antidepressants. If your child has moderate to severe depression, the benefit of reducing depressive symptoms may outweigh the risks of medication side effects. Maintaining regular follow-ups and monitoring throughout treatment helps manage any uncertainty. It is important that your child be monitored closely for all side effects, including suicidal thinking and behavior, particularly in the first few weeks after beginning treatment with an antidepressant and after adjusting the antidepressant dose.

Pharmacogenomics: Should a pediatrician order it?

- Depends in part with your comfort on the interpretation of the results
- As we learned in med school, only order tests if you know how to interpret the results
- Remember: it is **NOT** standard of care to order this testing
- Our research has taught us that the testing seems most relevant if a patient has a history of significant or unusual side effects and you are trying to understand why standard therapies are not working
- Know what panels include which genes
- Remember that **pharmacokinetic genes** are most likely to determine tolerance whereas **pharmacodynamic genes** have the potential to confer response/efficacy
- Even though the results might be conveyed in terms of which medications are green, yellow, or red, consider **looking at each gene result individually**

GeneSight® ADHD
COMBINATORIAL PHARMACOGENOMIC TEST

Report Date: _____
Clinician: _____
Reference: _____

Questions? Call 855.891.9415 or email medinfo@assurexhealth.com

PATIENT GENOTYPES AND PHENOTYPES

PHARMACODYNAMIC GENES

COMT
VAL/VAL
This patient is homozygous for the Val allele of the Val158Met polymorphism in the catechol-O-methyltransferase gene. Carriers of this genotype are more likely to have a typical response to stimulant medications.

ADRA2A
G/G
This patient is homozygous for the G allele of the -1291G>C polymorphism in the adrenergic alpha-2A receptor gene. This genotype suggests a typical response to certain ADHD medications.

PHARMACOKINETIC GENES

CYP2D6
*4/*17
CYP2D6*4 allele enzyme activity: None
CYP2D6*17 allele enzyme activity: Reduced
This genotype is most consistent with the poor metabolizer phenotype. This patient may have reduced enzyme activity as compared to individuals with the normal phenotype.

GeneSight® ADHD COMBINATORIAL PHARMACOGENOMIC TEST

Report Date: _____
Clinician: _____
Reference: _____

USE AS DIRECTED	MODERATE GENE-DRUG INTERACTION	SIGNIFICANT GENE-DRUG INTERACTION
dexamethylphenidate (Focalin®) guanfacine (Intuniv®) methylphenidate (Ritalin®, Concerta®, Metadate®, Daytrana®)	amphetamine salts (Adderall®) 1 dextroamphetamine (Dexedrine®) 1 lisdexamfetamine (Vyvanse®) 1	clonidine (Kapvay®) 1 atomoxetine (Strattera®) 1,5

GeneSight® Psychotropic COMBINATORIAL PHARMACOGENOMIC TEST

DOB: _____
Order Number: _____
Report Date: _____
Clinician: _____
Reference: _____

Questions? Call 855.891.9415 or email medinfo@assurexhealth.com

PATIENT GENOTYPES AND PHENOTYPES

PHARMACOKINETIC GENES

CYP1A2
-163C>A - C/A, 5347C>T - C/T
This genotype is most consistent with the extensive (normal) metabolizer phenotype.

CYP2B6
*1/*6
CYP2B6*1 allele enzyme activity: Normal
CYP2B6*6 allele enzyme activity: Reduced
This genotype is most consistent with the intermediate metabolizer phenotype. This patient may have reduced enzyme activity as compared to individuals with the normal phenotype.

CYP2C19
*1/*1
CYP2C19*1 allele enzyme activity: Normal
CYP2C19*1 allele enzyme activity: Normal
This genotype is most consistent with the extensive (normal) metabolizer phenotype.

CYP2C9
*1/*2
CYP2C9*1 allele enzyme activity: Normal
CYP2C9*2 allele enzyme activity: Reduced
This genotype is most consistent with the intermediate metabolizer phenotype. This patient may have reduced enzyme activity as compared to individuals with the normal phenotype.

CYP3A4
*1/*1
CYP3A4*1 allele enzyme activity: Normal
CYP3A4*1 allele enzyme activity: Normal
This genotype is most consistent with the extensive (normal) metabolizer phenotype.

CYP2D6
*2A/*9
CYP2D6*2A allele enzyme activity: Increased
CYP2D6*9 allele enzyme activity: Reduced
This genotype is most consistent with the extensive (normal) metabolizer phenotype.

UGT1A4
*1/*1
UGT1A4*1 allele enzyme activity: Normal
UGT1A4*1 allele enzyme activity: Normal
This genotype is most consistent with the extensive (normal) metabolizer phenotype. The patient is expected to have normal enzyme activity.

UGT2B15
*1/*1
UGT2B15*1 allele enzyme activity: Normal
UGT2B15*1 allele enzyme activity: Normal
This genotype is most consistent with the extensive (normal) metabolizer phenotype. The patient is expected to have normal enzyme activity.

Common Questions

Q: Will this medication adversely affect my child's brain?

A: No, but they will change its **chemistry**. In fact, we believe that the disorders we treat with medications are caused by chemical imbalances of the brain. Using medications, we hope to correct these imbalances.

Q: Will this medication cause future substance use/abuse?

A: In fact, long term prospective studies show the **opposite**. Medical treatment of psychiatric disorders (especially ADHD and depression) decreases future substance use.

Q: Will this medication change the personality of my child (i.e., create a “zombie”)?

A: No, but if you see any changes after we start medication that you are not comfortable with, report them, and we will consider decreasing the dose, or stopping the medication altogether. A medication is only continued if it is helpful, and the benefits outweigh any risks.

Q: Is there any blood test or brain scan that will help you with my child's diagnosis?

A: Unfortunately **no**. It certainly would make things easier. However, the evaluation process is not unlike that for most medical disorders. It is a clinical diagnosis based on history and a description of signs (observations of behavioral changes) and symptoms. Remember the **medical school rule**: history suggests 80% of diagnoses.

Common Questions

- **Q: Has this medication been studied on children?**
- **A:** Yes, but that does not necessarily imply FDA approval (as with many other medications used for children). The FDA-approved psychiatric medications for children include all ADHD medications, Luvox and Zoloft for OCD and Prozac, Lexapro for depression.

SELECTIVE SEROTONIN REUPTAKE INHIBITORS		
Medication	Formulations	Daily Dose Range
Citalopram (Celexa)	Tablet: 10/20/40 mg Suspension: 10 mg/5 ml	10–40 mg
Escitalopram (Lexapro)*	Tablet: 5/10/20 mg Suspension: 1 mg/1 ml	10–20 mg (initial dose may be 2.5–5 mg)
Fluoxetine (Prozac)**	Tablet and capsule: 10/20/40/60 mg Suspension: 20 mg/5 ml	20–60 mg (initial dose may be 10 mg)
Fluvoxamine (Luvox)	Tablet: 25/50/100 mg	50–200 mg (initial dose may be 25 mg)
Paroxetine (Paxil)	Tablet: 10/20/30/40 mg Tablet CR: 12.5/25/37.5 mg Suspension: 10 mg/5 ml	10–50 mg
Sertraline (Zoloft)	Tablet: 25/50/100 mg Suspension: 20 mg/ml	50–200 mg (initial dose may be 12.5–25 mg)

Non-SSRI

- Never a first choice. Consider referring to a specialist

NON-SSRI ANTIDEPRESSANTS		
Medication	Formulations	Daily Dose Range
Bupropion, Bupropion SR (Wellbutrin)	Tablet: 75/100 mg Tablet ER 12 hour: 100/150/200 mg	150–300 mg (first dose may be 37.5–75 mg)
Bupropion XL (Wellbutrin)	Tablet ER 24 hour: 150/300/450 mg	150–450 mg
Desvenlafaxine (Pristiq)	Tablet ER 24 hour: 25/50/100 mg	50–100 mg (first dose may be 25–50 mg)
Duloxetine (Cymbalta)	Tablet: 20/30/40/60 mg	40–60 mg (first dose may be 20 mg)
Levomilnacipran (Fetzima)	Capsule ER 24 hour: 20/40/80/120 mg	40–120 mg (first dose may be 20 mg)
Mirtazapine (Remeron)	Tablet: 7.5/15/30/45 mg Tablet disintegrating: 15/30/45 mg	15–45 mg (first dose may be 7.5–15 mg)
Trazodone (Desyrel)	Tablet: 50/100/150/300 mg	100–150 mg (first dose may be 25–50 mg)
Venlafaxine XR (Effexor)	Tablet: 25/37.5/50/75/100 mg Capsule and Tablet ER 24 hour: 37.5/75/150/225 mg	150–300 mg (first dose may be 37.5 mg)
Vilazodone (Viibryd)	Tablet: 10/20/40 mg	15–40 mg (first dose may be 10 mg)
Vortioxetine (Trintellix)	Tablet: 5/10/20 mg	20 mg (first dose may be 10 mg)

Placebo Controlled Pediatric Depression Studies

	Emslie ¹	Keller ²	Wagner ³	Wagner ⁴
Drug	Fluoxetine	Paroxetine/ Imipramine	Citalopram	Sertraline
N	180	275	174	376
Age	8-17	12-18	7-17	6-17
Dose Mg/day	20 (fixed)	PXT up to 40 IM up to 300	Up to 40	50-200
Time	8 weeks	8 weeks	8 weeks	10 weeks
Measure	CGI/CDRS	CGI/HAM-D	CGI/CDRS	CGI/CDRS
• Emslie GJ et al. J Am Acad Child Adolesc Psychiatry, 2002, 41 (10):1205-15 (Emslie, 1997) • 2. Keller MB et al. J Am Acad Child Adolesc Psychiatry, 2001: 40 (7):762-72 • 3. Wagner KD et al. Am J Psychiatry, 2004: 161 (6) 1079-83 • 4. Wagner KD et al., JAMA, 2003, 290 (8):1033-41				

Placebo Controlled Pediatric Depression Studies (cont)

	Wagner ⁵	March ⁶	Emslie ⁷
Drug	Escitalopram	Fluoxetine/ CBT	Venlafaxine XR
N	131	439	137 / 197
Age	6-17	12-17	6-11 / 12-17
Dose Mg/day	10-20	Up to 40	37.5-225
Time	8 weeks	12	8 weeks
Measure	CGI/CDRS	CGI/CDRS	CGI/CDRS
5. Wagner KD et al. AACAP, Washington, DC 2004 (Scientific Proceedings)) 6. March J et al. JAMA, 2004: 292 (7) 807-20 7. Emslie GJ et al. AACAP, Washington, DC 2004 (Scientific Proceedings)			

Placebo Controlled Pediatric Depression Studies (cont)

	Emslie ⁵	March ⁶	Wagner ⁷
Drug	Venlafaxine XR	Fluoxetine/ CBT	Escitalopram
N	137 / 197	439	131
Age	6-11 / 12-17	12-17	6-17
Dose Mg/day	37.5-225	Up to 40	10-20
Time	8 weeks	12 weeks	8 weeks
Measure	CGI/CDRS	CGI/CDRS	CGI/CDRS
5. Emslie GJ et al. AACAP, Washington, DC 2004 (Scientific Proceedings) 6. March J et al. JAMA, 2004: 292 (7) 807-20 7. Wagner KD et al. AACAP, Washington, DC 2004 (Scientific Proceedings)			

Treatment of Adolescent Depression Study TADS (March et al., 2004, 2005, funded by NIMH)

- First phase: Initial 12 weeks
- Children and adolescents (N=439)
- 4 treatment arms
 - *Placebo (30%),*
 - *fluoxetine (61%),*
 - *fluoxetine/CBT (71%),*
 - *CBT alone (44%)*

TADS: Suicide-Related Adverse Effects

- Defined as increased suicidal ideation, suicide attempt or both
- 4 treatment arms:
 - *placebo* (5.4%);
 - *Fluoxetine* **(11%);**
 - *fluoxetine/CBT* (8%)
 - *CBT* (4%)
- Sufficient to be seen as a risk?

NIMH Responds...

Question: Do the pros outweigh the cons for adolescents using an antidepressant?

Answer: The data from TADS indicate that there is a **favorable balance** between risk and benefits for the use of **fluoxetine** in the treatment of adolescents with depression, especially when this medication is used in conjunction with cognitive-behavioral therapy. However, decisions about treatment for adolescents with depression must be made on a case-by-case basis involving their parents and their doctors.

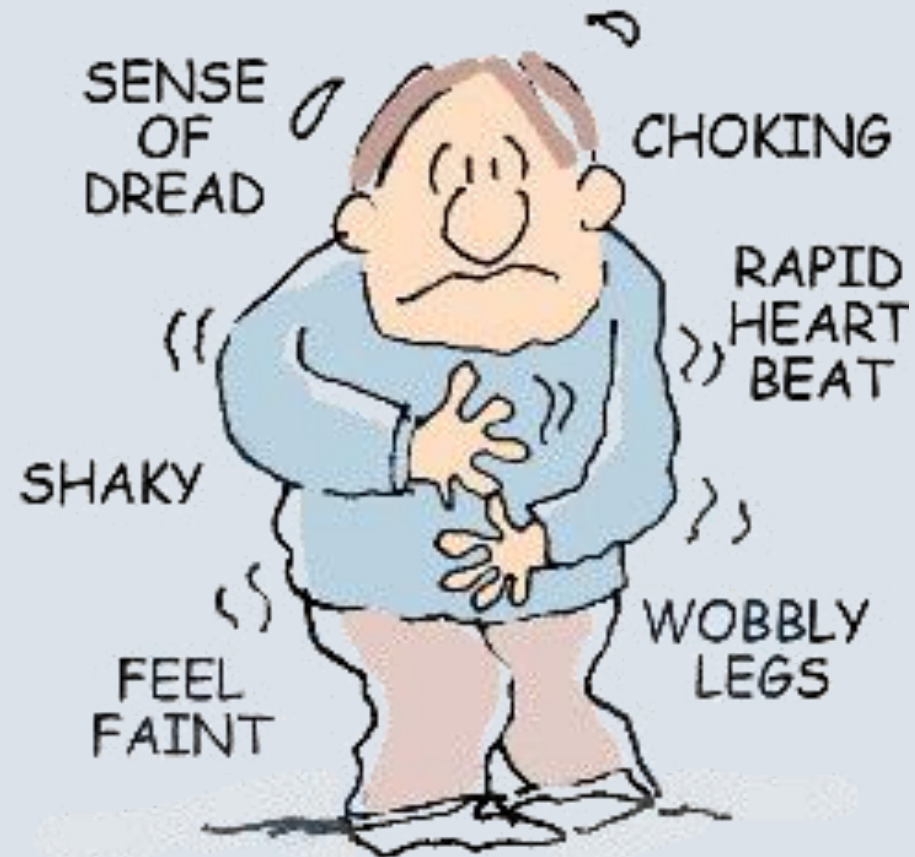
Before starting treatment, each child should be carefully and thoroughly evaluated by a physician to determine if medication is appropriate. Those who are prescribed an SSRI should receive ongoing monitoring by a health care professional, especially during the first few days.

Anxiety: A Normal Physiological Response

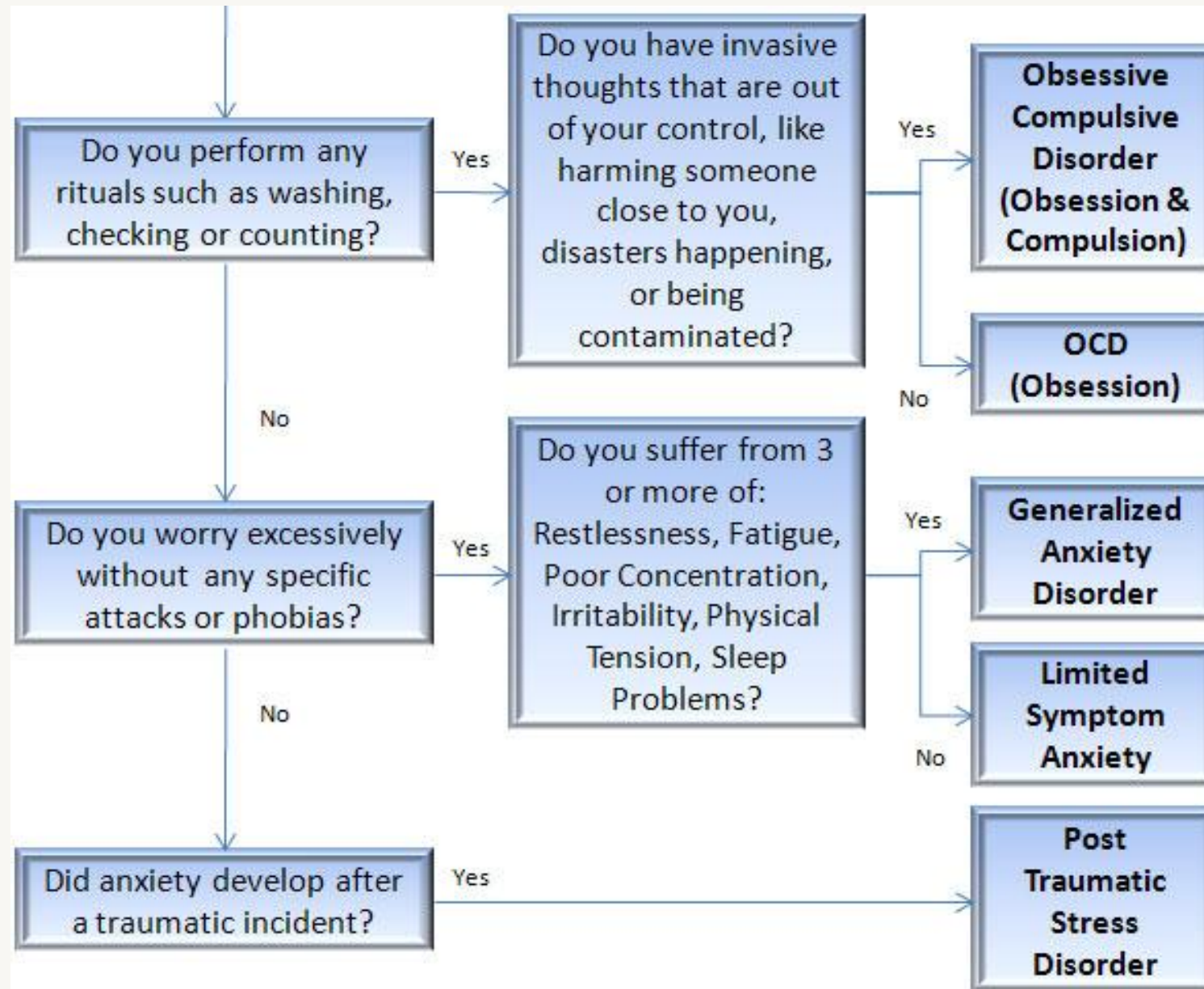


First Step: Detection (PSC 17)

- Complains of aches and pains
- Is afraid of new situations
- Visits the doctor with doctor finding nothing wrong
- Worries a lot
- Wants to be with you more than before
- Has trouble sleeping







Generalized Anxiety Disorder

- Excessive anxiety and worries, restlessness, and one or more:
 - *Easily fatigues*
 - *Concentration difficulties (mind goes blank)*
 - *Irritability*
 - *Muscle Tension*
 - *Sleep Problems*



Post-Traumatic Stress Disorder

- *Exposure to a traumatic event in which (both):*
 - *Event involved actual or threatened death, physical integrity of self or others*
 - *The response was intense fear, helplessness*
- *Re-experiencing the event:*
 - *Distressing recollections (repetitive play), dreams, flashbacks*



Obsessive Compulsive Disorder

(either obsessions or compulsions)

- Obsessions: recurrent, persistent thoughts, impulses, images perceived as intrusive, inappropriate and that cause distress.
- Compulsions: repetitive behaviors (handwashing, ordering, checking) or mental acts (praying, counting, repeating words silently) performed in response to an obsession, or according to rules, and aimed at reducing distress.
- Y-BOCS

PATIENT
NAME

DATE

22.

YALE-BROWN OBSESSIVE COMPULSIVE SCALE (Y-BOCS)*

Questions 1 to 5 are about your obsessive thoughts

Obsessions are unwanted ideas, images or impulses that intrude on thinking against your wishes and efforts to resist them. They usually involve themes of harm, risk and danger. Common obsessions are excessive fears of contamination; recurring doubts about danger, extreme concern with order, symmetry, or exactness; fear of losing important things.

Please answer each question by circling the appropriate number.

1. TIME OCCUPIED BY OBSESSIVE THOUGHTS SCORE _____
How much of your time is occupied by obsessive thoughts?

0	=	None
1	=	Less than 1 hr/day or occasional occurrence
2	=	1 to 3 hrs/day or frequent
3	=	Greater than 3 and up to 8 hrs/day or very frequent occurrence
4	=	Greater than 8 hrs/day or nearly constant occurrence
2. INTERFERENCE DUE TO OBSESSIVE THOUGHTS SCORE _____
How much do your obsessive thoughts interfere with your work, school, social, or other important role functioning? Is there anything that you don't do because of them?

0	=	None
1	=	Slight interference with social or other activities, but overall performance not impaired
2	=	Definite interference with social or occupational performance, but still manageable
3	=	Causes substantial impairment in social or occupational performance
4	=	Incapacitating
3. DISTRESS ASSOCIATED WITH OBSESSIVE THOUGHTS SCORE _____
How much distress do your obsessive thoughts cause you?

0	=	None
1	=	Not too disturbing
2	=	Disturbing, but still manageable
3	=	Very disturbing
4	=	Near constant and disabling distress
4. RESISTANCE AGAINST OBSESSIONS SCORE _____
How much of an effort do you make to resist the obsessive thoughts? How often do you try to disregard or turn your attention away from these thoughts as they enter your mind?

0	=	Try to resist all the time
1	=	Try to resist most of the time
2	=	Make some effort to resist
3	=	Yield to all obsessions without attempting to control them, but with some reluctance
4	=	Completely and willingly yield to all obsessions

Social Anxiety Disorder

- A persistent fear of social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others, and fears embarrassment or humiliation.
- The feared situations are avoided or else are endured with intense anxiety and distress.
- Can lead to School Refusal (Psychiatric Emergency): COVID impact



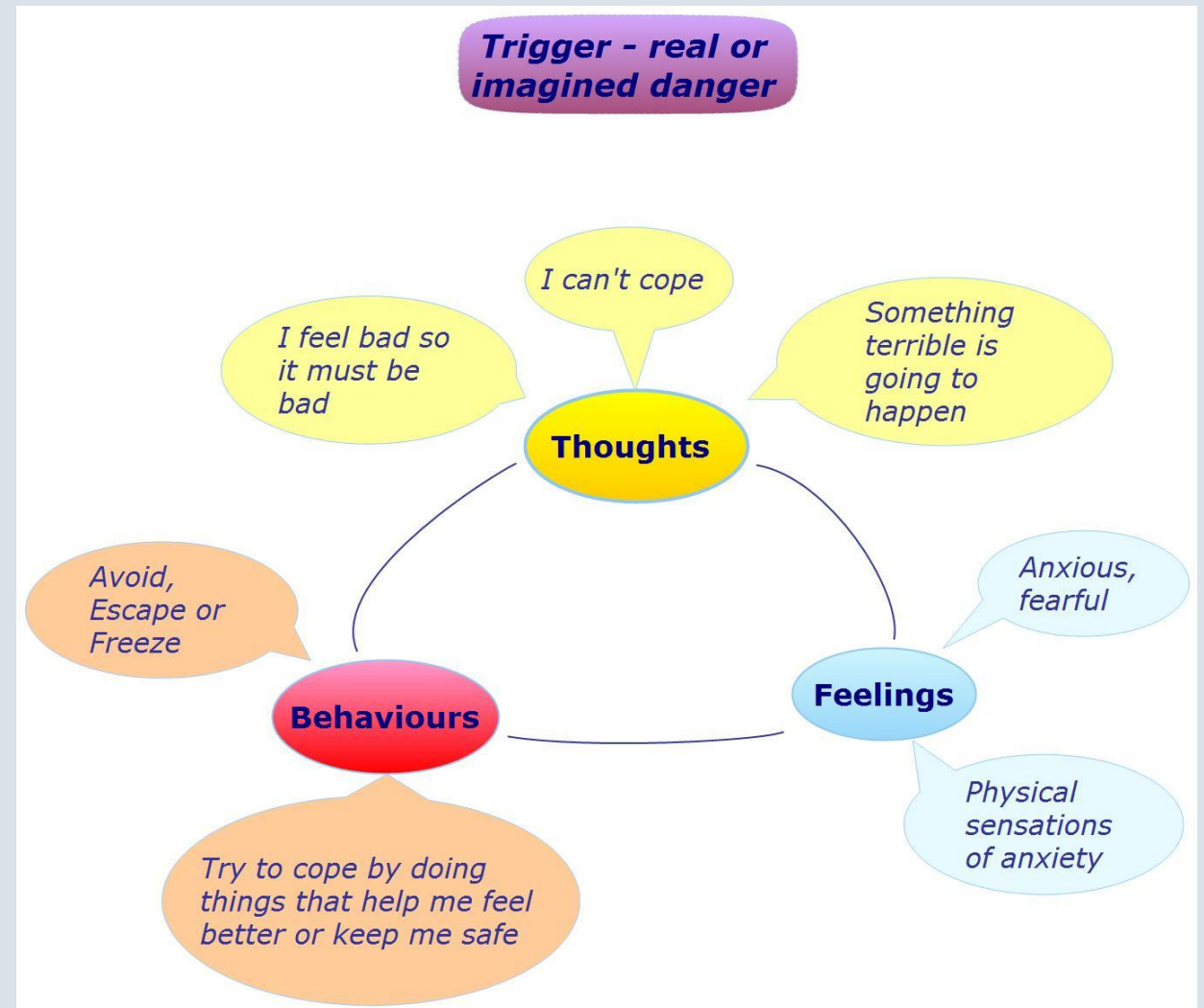
Treatment Guidelines

Therapy

- Always start with **therapy first** (6 months) before considering medications (if no safety concerns)
 - Holistic approach: mind and body connection
 - Always start with the lowest level of care that function allows
- Use EBM:
 - *OCD: CBT*
 - *PTSD: EMDR, TF-CBT*
 - *Family therapy: Attachment-Based Family Therapy*

CBT

- A method of addressing cognitions that drive anxiety
- Techniques include exposure, compare and contrast
- Involves assignments
- Many books and self guided treatment programs
- It works!



Treatment Guidelines: Medications

- Medications:
 - *POTS (Pediatric OCD Treatment study); CAMS (Child Anxiety Multimodal Study)*
 - *Placebo, CBT, Sertraline, CBT + Sertraline*
 - *Most efficacious: CBT + Sertraline*
- FDA Labeling:
 - *OCD/GAD: Sertraline, Fluvoxamine, Fluoxetine, Clomipramine*
 - *Panic Disorder: Sertraline*
- SSRI first trial
- Benzos used only for short term relief
- Alpha agonists (Clonidine, Guanfacine, Prazosin) for PTSD
- Start low (very low) and go slow
- Informed consent, black box warning



School Refusal Approach

- Mild/first step:
 - *Therapy/LOC: outpatient (CBT); family therapy; medications not yet*
 - *School: emergency meeting*
- Moderate/ongoing:
 - *Therapy: Increase LOC: IOP/PHP, School refusal Program, consider medications*
 - *School: 504, IEP, Neuropsych testing (comorbidities)*
- Severe (post-COVID):
 - *Therapy: RTC; medications*
 - *School: support out of district placement*

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AUDIENCE Q&A

FINAL THOUGHTS

- A recording will be emailed to you in 2 weeks. It will include the presentation slides.
- Take our survey immediately after the webinar has concluded.

THANK YOU!

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