

Webinar Title: Childhood Psychiatric Disorders: Presentations, Screening, and Treatment

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Moderator: Hello, and welcome to today's webinar, Childhood Psychiatric Disorders: Presentations, Screening, and Treatment. This topical webinar is paid for by Newport Healthcare, a national leader in teen and young adult behavioral health treatment, providing sustainable healing for mental health and co-occurring disorders. Some important points before we get started. Dr. Mirela Loftus, the presenter for today's webinar, has a working relationship with Newport Healthcare.

As such, she has both a financial and an intellectual interest in the webinar content. The purpose of this presentation is to provide a balanced view on how to recognize, diagnose, and treat childhood psychiatric disorders. APA does not endorse any products or services. The content was created by Newport Healthcare and does not reflect the views of APA or its editorial staff. Email advertising@apa.org to learn more.

Next, this program does not offer CE. However, we will email everyone watching live today a certificate of attendance. Certificates will only be issued to those who watch for a minimum of 45 minutes. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides. During our time together, you will be on mute.

You can communicate with us using the Q&A box located on your webinar screen. The Q&A is enabled for attendee interaction with submitted questions. Attendees can view all submitted questions and upvote those they find important. This helps the presenter identify questions that many attendees want answered. A link to the presentation slides will be posted in the chat box of your webinar screen. If you miss them, don't worry.

We will email them to you with a recording. Now, let me introduce our presenter, Dr. Mirela Loftus. Dr. Loftus earned her medical degree at one of the oldest and most acclaimed medical schools in Romania, and received her PhD from the University of California, Davis. Her career has included stints as a researcher and attending and consulting psychiatrist at Hartford HealthCare's Institute of Living, and medical director of the institute's clinical trials unit, researching experimental depression and suicidal ideation treatments.

Dr. Loftus has spoken at the state capitol on numerous occasions in her role as president of the Connecticut Council of Child and Adolescent Psychiatrists. Welcome, Dr. Loftus.

Dr. Mirela Loftus: Thank you so much, Jen, and welcome, everybody, for this opportunity. James, I can't-- doesn't seem to move down, the slide. Okay, again, hello, everybody. Thank you for joining. Thank you for your interest in childhood psychiatric disorder. I know this is a hot topic, especially in the last few years, following a lot of stressors for young kids, with COVID and everything.

What we're going to overview today is how to quickly detect and diagnose, specifically depression and anxiety, as those are the most prevalent disorders in childhood. I'm going to give a brief introduction to the different levels of care. I'm going to touch shortly on genomic guidance as part of the pharmacologic treatment for depression and anxiety. I'm also going to review the suicide screening and prevention, specifically to children and adolescents.

As a general overview for levels of care, while you're, I'm sure, familiar with all of this, there are some specific to the pediatric population. The lowest level of care, outpatient, your typical individual therapy, monthly, with a psychiatrist and/or a family therapy. If the needs are somewhat higher, you can look for a IOP program three times a week, group therapy setting. Believe it or not, adolescents actually do like the partial hospital and the group settings.

They do bond more with those of their own age. They're more likely to listen to peers than to us, old adults. If you need more hours, then you move up to PHP, that's up to 20 hours a week. When safety concerns arise, that's when we look at inpatient level of care, locked facility. During this time, it's deemed that the child is not able to be safe in the community. Those are usually short-term hospitalizations, the maximum is about 10 to 14 days. Really just to-- stabilization, but a lot of issues require a longer-term treatment.

That's where the residential treatment level of care comes in. It is very commonly used for adolescents and you can have a wide range of specialties, substance use, specifically at Newport, we use attachment-based family therapy to strengthen the relationship with the parents. When that is not an option and you need even a longer term, there are services for in-home therapy.

They're usually block grants, federal block grants who offer that. Some state insurances offer in-home services, multisystemic therapy, multidimensional family therapy. There's evidence-based behind how effective these are in substance use and conduct disorder kids. There's the therapeutic boarding schools. With good advocacy, and definitely when schools cannot meet the needs for the children from an academic point of view, some schools will pay for the school portion of the therapeutic boarding school.

There are such thing as emergency mobile crisis team, depending on the state you are. For all of this, you have to look at who's paying for it. There's only two ways, in and out of network. In Connecticut, we do have programs that offer DCF voluntary services to people who do have insurance, but their insurance does not cover any of these levels of care that I was talking about. As I mentioned before, I'm going to focus on depression and anxiety because these are the most prevalent.

Pre-seminar, I did get some questions about some other disorders, which, if there's time in the question and answer portion at the end, we can address. Jumping right in depression, and the reason I choose the primary care is because that's the first level of where someone is seen. For you as well, as a therapist in your office, if somebody has not seen a psychiatrist yet for medication management, this is the first interface.

What do you do? You start peering your ears, at an intake. Let's say it's the first time you meet a child or an adolescent, and you hear, "Oh, they complain about

headaches, pain, somatic symptoms, problems in school, maybe using substances," and no one paid attention, it got missed. Sometimes they say, "Well, they're just kids, they're just adolescents, it's a phase."

You're going to start digging more information from the parents, of course, but also, don't forget the pediatrician, they are the biggest source of information, they know families, they know the families through multiple siblings, if there are, they know them from birth, they saw them grow together, it's your biggest resource of collateral information. Yes, it can be extremely painful, and the sooner we treat it, the less likely it is to reoccur, and most importantly, it can contribute to suicide.

How do we do detection? There's definitely the screening part, where you can start using checklists. We also have links to all these tools that I'm referencing today, for you to have at the end, if you're interested. The checklists are not a diagnostic tool, but since we all have just a one-hour intake allotted, and you don't have time to go through your whole DSM, you want to focus on what the screening tools offer you. That's when you move to clinical questions.

The first question I ask, as they are in my office and I don't know why they are referred, is, "When did everything change?" When has this child or adolescent fallen off their growth curve? That's not just physical, but emotional, academic, psychological. When did it all start? They might say, "Well, they stopped spending time with their friends. Their grades have dropped. They look different. They sleep more. They sleep less. They eat more. They eat less."

That's the starting point, your anchor. Your anchor is, when did it all change? No wonder, we say, "Oh, patient was in their usual state of good health until-- and then." Then you go into more specific symptoms, which-- don't be worried to ask them directly of the child or adolescent. They actually want to talk about how they feel. Most of them, it takes time to get to an appointment, for various reasons, lack of recognition of the need, finding someone, connecting with someone, fitting into the schedule.

When that finally happens, just the mere fact that they're in the office is helpful. You'll see how that actually comes back to haunt us because of the placebo effect of no treatment in our treatment trials, because just being in the office is helpful. NAMI has a family guide, a guide for families to help out with questions and engagement of the family. Family history is a must. All of these are genetic disorders, and social history is a must.

Find out, again, what was happening around the time of the change? Did they break up with someone? Did their best friend move out of state? Never forget to talk to the patient alone. Then we move to mental status. You're saying, okay, well, do they look their age, and if they don't, why do they not look? Are they too anxious? They don't open their mouth. They are jumping around in your office. What sets them apart? Are there any red flags?

Then you can move on specifically for depression at your DSM criteria, the SIG-E-CAPS. Yes, children and adolescents present with depression very different than adults. However, some things are still the same, like sleep, appetite, concentration, level of interest. Those are all the same. However, they're not going to be able to tell

you how their mood is, how they feel, especially an adolescent, sultry boy is not going to admit they've been depressed.

You're going to see more irritability. That's a major differentiating symptom in depression between adolescents and adults. They're moody, and your job is to determine if that moodiness is just part of normal adolescent development when the body goes through such tremendous transformation, right? Not just size, but hormones, becoming adults. Of course, their mood is going to be affected.

Yes, there is a normal level of moodiness in adolescents, then you're saying, "Well, how am I going to know which one's normal and which one's not?" Simple. Not really, but simple. Again, falling off the curve. It's okay if they're moody, but still go to school, still are able to-- It's okay if sometimes they drop their grades, but pull back up together. It's okay to have a fight with a friend, but not be without friends. It's falling off the curve.

That's the level of the impact, what differentiates normal from diagnosable condition. Of course, we cannot forget about trauma and abuse, and yes, PTSD is a different topic than this today, but they might not show in your office with a big sign saying "I had trauma, I have PTSD." That should be in your differential diagnosis. Definitely the substance use screening, and the CRAFT Questionnaire, again, all available to you, is a very short and simple tool to screen for substance use.

However, the biggest topic that we can never talk too much about is the suicide screening, which is a must. Now, those that are over a certain age, like my age, will know that when we were in training, there was the myth of, if you ask about suicide, you're going to make them think about suicide. That's what that is, it's a myth. Anyone who suffers with such painful thoughts, they actually want to share them. It's just not easy to come up with the words.

With a very clinical-minded approach, these questions, they're begged to be asked. Now, how often do you ask? Do you ask at every single appointment? Do you ask in depth? Do you do a Columbia rating scale? Depends on the circumstance. At a screening, like this would be in a pediatrician office, who has to evaluate all the systems, including mental health, maybe this five-question tool is sufficient, just to rule it out.

In a more in-depth, in a therapy session, if you have someone who's at high risk, the way I do it is, I said from the beginning, I set up a common language of how I assess for risk for suicide. It's my own tool, I developed-- not developed, it's just a way of how I decided to ask. It is 0 to 10, but not by intensity, severity, or anything. Zero to five is passive, just-- thoughts haven't moved out from where I'm sitting, it's just in my head. The more formed those thoughts are, it gets closer to a five.

I can get into detail if there's ever a talk about suicide, specifically. Then over five, let's say, five, six, it's Googling stuff, journaling. Seven, eight is collecting things about that, like pills, or walking by a bridge, and then nine, 10 is attempt. Once I establish that language, it's much easier each time, instead of asking, back to all the Columbia questions, being redundant and becoming immune to those questions, is just to refer to what our mutual language has been.

Where are you? Are you past five or under five? Rather than using passive and active thoughts, after a certain time, they seem sort of stale. Oh, okay. That's the suicide screening slide. Who's more at risk for suicide? Trauma and abuse, bullying, family history, huge. That's why I was saying, just in general, for diagnosis, to get the family history, and especially at the ages that the family or the relative had committed suicide.

Chronic medical conditions, we have kids with cystic fibrosis, with cancer, and also, the most important thing to not forget, that I do almost every session, every time I meet with them, depending on where they're on that scale that we agreed upon, is to see what they have access to, pills. The link you have here is about counseling for access on lethal means. I explained to them, you might think that an adolescent would feel it's being intruded upon to say you can't have access to your pills, your mom has to have them in a lockbox.

Then I explained to them that, really, I can't tell the future, I don't have a crystal ball to know whether they're going to act on their thoughts or not. What I do have, the only thing that I do have is to limit the access that they are going to be acting upon those thoughts. That most people who have acted on those thoughts and live to tell, they do tell us that it was an impulsive, in a second decision, that they regretted later.

My only tool as a psychiatrist that I have is to delay that, those few seconds in which they're impulsive. I do that by locking up pills, and they actually get it, they understand where I'm coming from. This is not for me to go over, it's just to share with you that for those who are more interested in a more structured approach of how to diagnose and then treat depression, there are charts, the pediatric journal, I have the reference here, takes you step-by-step of how one would do that, and how to move forward.

This is just as a reference for you guys. Okay, first time in your office, you spend an hour, you're like, "Okay, yes, yes, I think that, definitely, they have depression, anxiety," what am I going to do? Safety will determine if you send them home or not, and how, by 211-- Oh, sorry, I don't know if 211 is in every state. It's like emergency mobile crisis, like someone who comes but it's not the 911 call.

I just send them with some references and say, "Here are some names for therapists," or I tell parents to call the local hospital which offers PHP level of care. If it is outpatient, there are different kinds, somebody asked here, like, "What other kinds other than CBT?" CBT is huge evidence for children and adolescents, for depression and anxiety. Definitely, it's a number one tool, but we do have the advantage, because of their age, to use also play therapy, art therapy.

There's a lot of experiential therapies that we use, and there is evidence behind them, absolutely. Where I work currently, at this residential treatment center, we use, for example, equine therapy, adventure therapy. I'll give you a real quick example of how rock climbing through adventure therapy has really turned a girl around, who had a comorbid eating disorder and was a cancer survivor at age 15.

The reason she had developed eating disorder is because she felt her body turned against her, and didn't want her to live. Through rock climbing and other adventure therapies where she conquered that hurdle, physical hurdle, she realized that her

body is much stronger and it just gave her a completely 180 view of how she saw her physical abilities and her body. We use a lot of experiential therapy. Then you're like, okay, meds, should we do meds or not? Who should be doing the meds?

Depending on your state and your resources, sometimes pediatricians do them, and sometimes they have to be referred to a specialist. To decide that, it goes by, well, how severe are they depressed, let's say. Again, that goes back to the level of function. How much is their function impaired? Have they stopped going to school for the last six months versus just sporadically? Have they had many ER visits for suicide attempts versus none? All of that goes into determination of level of severity and level of care.

How organized is the family system? Are they able to do follow-ups? We always need a therapist to co-manage. It's a team approach. For eating disorders, for example, part of that team is definitely the pediatrician in addition to the therapist, the psychiatrist, and a dietician. I don't take on any eating disorder in outpatient unless I have a team of four. Safety planning, we already talked about the access to lethal means.

Some very brief and superficial guidelines. When should we start meds? I say, mark change. Just having symptoms is not enough. I have a lot of kids says, "I don't feel good. I want meds. I don't feel good." I'm like, "I don't treat feelings with medications, okay? That's not enough. I need to see what is it that I'm treating." Then I pick target symptoms. If they say, "Well, I don't feel good. Because of that, I don't sleep well. It takes me two hours, three hours to fall asleep."

I'm like, "Okay, that I can help with." I don't have energy. I stay in bed all day and I don't feel like going to school. I don't feel like going with my friends. Yes. I can help with that as well. Not just feelings. Before I start a medication, I get the target symptoms that we all agree on, that that's what we're going to be tracking as opposed to feeling better. I do it by either checklists, or-- my favorite is, I have them do a calendar, like a monthly calendar.

Every day, we pick two or three things, let's say sleep and seeing friends. Let's say I pick those two. Then, every day, under S, for sleep, they tell me good or bad, plus or minus. Then for seeing friends, yes or no, let's say. Then I get a one month view and I see if there are any changes. How do we talk to them? Definitely, we need consent from parents. Depending on the age of the child, definitely their assent.

We have a discussion of how that particular medication would be helpful. The start low, go slow, is a must. It's a rule. The reason is that, you'd be surprised, you'd think, "Oh, lower bodies, lower doses." No, actually, it's the opposite. Lower bodies actually need higher doses because they have a higher metabolism. If they metabolize more, then it gets less available to their receptors. They actually might need higher doses.

Sometimes they even need twice a day doses, because they metabolize so fast, but that's the target goal, not how we're starting. The reason we still start low and go slow is because potential side effects. If they do have side effects, they're in the realm of physical, not emotional. Most of the time, 95% of the time. They can cause headaches, GI stuff. If I am going higher, as they actually would need, then those side effects are more likely to appear.

It's already hard as a parent to have your 10-year-old take medications, let alone if they have side effects. Then, if symptoms worsen, you definitely discontinue rather than go up, because it might be a side effect. I had someone who was seen by GI, gastrointestinal, for tummy aches, which was actually anxiety. They started her on an adult dose of an SSRI. Her tummy aches got worse and the dose was increased, because that's what the medication was for. We don't do that. That's when you go to a specialist.

As I said, informed consent, everybody knows about the black box warning, right? Increased suicidal ideation. I am old enough to have seen it, how it progressed from not existing, when in 2004, there were anecdotal reports, which were then taken in Great Britain, in UK, which then were taken at their highest level of organization, where they had parents say that kids that were put on Prozac, they experienced suicidal ideation.

Then the FDA followed, they did a big study in a review, to see what's the difference between those treated with a SSRI versus a placebo. They found that, whenever they looked at individual medications, there was no difference. Then if they pull together all antidepressants, again, compared to all controls, then there was a difference. I had here, something highlighted yellow.

I don't know if you see my screen, but the third column, higher first paragraph at the bottom, it says that the suicidal thinking was twice as high in youth taking medications than those taking placebo. The difference is 4% to 2%. While there is a potential increase in suicidal thoughts, it is minimal. It is only during the first two weeks of either starting a medication or increasing the dose.

That is why our follow-ups are frequent when we start a med or increase the doses, but it is not a side effect after maintenance, let's say, six months on the same dose, they come with suicidal ideation, it is not from the medication. However, what I do tell parents when I go over this black box warning is that, listen, anything you see different in your child, it's not worth it. We're going to stop the med. These are not like dialysis medication that you have to take.

These symptoms have been there for a long time. We're going to manage them. We're going to find other ways. If you feel that your child is doing worse when we start a med, we stop the med. Switching gears to pharmacogenomics. Not sure how much you've heard, but it's been the talk of the town the last 10, 15 years, in that the pharmaceutical industry moved ahead of clinical, and they were able to come up with tests that, through just a cheek swab, you're able to analyze that person's ability to metabolize meds.

In simple words, what that means is that we all metabolize different, right? Some of us need three times the dose of Tylenol. Others take just a crumb, and that's fine for them. The same with alcohol. We all metabolize alcohol differently. There is a way to then differentiate what type of metabolizers we are. Then you take the information of each medication. How are they metabolized, and would that be impacted?

That's where they came up with this green, yellow, and red column. If I am a slow metabolizer of a certain enzyme, and that happens to also be the enzyme that metabolizes, let's say, Prozac, then I must not be able to metabolize Prozac

correctly. Then that gets put in the red column, let's say. That's all that they did, all that these tests did. That was it. Then, unfortunately, people who don't know all the details or it was too at the beginning of this research, initially, they ran with it.

If that was the case, they wouldn't prescribe Prozac. Later, we realized that, actually, that is just a guide. It's just a guide. It's not that you can't use it. It's just an informational guide, that now I should know that I am not metabolizing Prozac. That means that maybe it's building up and I should use much lower doses because it might be the perfect medication for me.

It doesn't mean I shouldn't use it. It just means that I might need to use it in a different dose. For example, in that same column, would be put the medication if you metabolize too fast or too slow. Now, if I metabolize too fast, means I need a higher dose. Lo and behold, you'll get the same information if they're in the red column, but you would have completely different approaches how to use that information.

Bottom line is, they're good tests, but the number one rule in medical school is do not order a test if you don't know what it's going to tell you or you don't know how to interpret it, and definitely use it if you have a background of how that medication that you're interested in is affected by. I hope that covers the five minute overview of pharmacogenetic testing. Common questions that we get. Will this medication adversely affect my child's brain? What we answer is no, but it will change.

It's chemistry, and in fact, we believe that the disorders we treat are caused by chemical imbalances of the brain. There has been a controversial, well talked out review two years ago, of there being no link between serotonin changes and depression, and those were very specific to measurements of serotonin in the brain, in the spinal cord, post-mortem, and therefore, it raised the question whether these medications should be used for depression.

However, where the fallacy of the argument comes in, is that no one has claimed that we know that there's a change in serotonin in depression, because we don't have the tools yet, to visualize at such level in live people. What we do claim is that these medications who happen to change the serotonin levels are effective. It was an indirect correlation, not a direct correlation. I have the reference, it's missing here in this slide.

I do have it, if anyone is interested in, as well as how many lives antidepressants have saved since they've been around. Will this medication cause future substance use or abuse? It's the opposite. Especially ADHD and depression does lead to substance abuse because you do need to self-medicate, and we all know how available all these self-medicating drugs are around. If we take care of it in a controlled way, it's actually going to prevent future substance use.

Will it change the personality of my child, like create a zombie? We say no, in fact, you don't even notice. I tell people you're not supposed to notice anything. It's like taking a vitamin. Do you know that a vitamin it's making you healthier? You don't know that, the same with this. Do you think it's going to make you a happy person? No, it's not supposed to do that, but if anything changes, then you let us know, and we stop it. Is there any blood test or brain scan that will help you with my child's diagnosis?

This is a slide that I had changed and I would like to make it available for anyone interested, because from the last time I wrote this talk, the answer now is unfortunately not yet, but there is a article in *Nature Medicine*, that is amazing, differentiating six different brain circuits types correlated to particular depression symptoms and response to treatment. I can definitely make that available, because that's going to be a landmark study.

While it's not for individual people, it's group of people, nevertheless, to see that correlation between brain circuitry symptoms and treatment, it's a first, so hopefully someday. However, still in our office, all our diagnosis are clinical. When people say you don't have a test, I'm like, yes, neuropsych testing definitely is the gold standard, the most that we have, to get a x-ray of the mind, right? Neuropsych testing, but short of that, everything else is clinical interview.

Has this medication been studied on children? Yes, but that does not necessarily imply FDA approval. The difference between FDA approval and just studies are that pharmaceutical companies go for FDA approval. FDA only has studies that have been done by pharmaceutical companies. Only in, I think, 2004, the FDA started requiring all pharmaceutical companies to have also trials in under 18, in order to get FDA approval. Anything that came out before 2004 does not have required studies to be done in kids.

That doesn't mean that we don't have studies done by academics in various institutions. I'll get to that, but anyway, these are the non-SSRIs, never a first choice. This would be a specialized psychiatrist's doing. Here are, again, not to go over, but just to show you that when we do prescribe a non-FDA medication, it does come from studies. While it is called off-label, it's not based on no data. Here are all the placebo-controlled pediatric-- not all, some, giving you some ideas.

They're in high numbers, 130, 439 compared Prozac and CBT, and their effects. They go on and on. This is the last one that I'm going to go over. I'm circling back when I said what it means for someone to just be in the office. This is also a seminal study. It's the gold standard of how we look at a study when we want to see effectiveness. You would do-- it's called the TADS, the Treatment of Adolescent and Depression Study. It's only 12 weeks. A lot of studies are very short.

There are no long-term studies for years. When parents ask me, "What's the long-term effect? Will this affect their brain and development after using it so many years during development?" My answer is there are no clear studies about that. However, the untreated depression itself has an impact on brain development. That also doesn't mean that if you don't treat it, then you're not going to have an impact later. Yes, that's the long-term treatment.

Anyway, the four treatment arms. The gold standard is, you have placebo, you have medication plus therapy, and then therapy alone. As you see, the effectiveness was best with both medication and therapy, 71%. Placebo had 30%. They did not receive therapy or medication, but they were coming to the office. They were coming to the office because they didn't know if they were taking a sugar pill or not, or they were-- treatment in the community, given by a pediatrician.

They still were getting something. That's 30%. That's a lot, 30%, one in three, respond to just attention. Side effects. This is a good one. For suicidal ideation, placebo had 5%. Fluoxetine did have more, 11%. Then the rest, and then the question was asked, does it justify the risk? NIMH responded, do the pros outweigh the cons? They say, yes, there is a favorable balance between risk and benefits for the use of fluoxetine in the treatment of adolescents with depression, especially when used with CBT.

As always, everything is on an individualized approach. I'm going to stop here, just being mindful of the time, and really wanting to hear some of your questions.

Moderator: Thank you so much, Dr. Loftus. We had some great questions come in that were pre-submitted, and we have some really wonderful questions that came in during this live session. We will try to get through as many as we can. Thank you to those who have been asking these questions. The first question is, from what age do you recommend asking children about suicidal ideations?

Dr. Mirela Loftus: Oh, yes, that's a good question. I assume you're saying like, how young? Should I ask a three-year-old? Should I ask a five-year-old, a 10-year-old? They're so different, right? Two years difference between three and five is like a lifetime, right? Versus from 30 to 32 years old, an adult. It's completely different language and connection. I think it depends what brought them in, and I go by what it was reported to me. Let's say mom says, "My six-year-old is sad, she wants to jump from the balcony."

Then it's in the context of being upset, irritable, depressed. Then I do ask about that specific incident. I make my way depending on what was brought to me. It's almost like being a detective. Actually, I use Detective Colombo's approach a lot. I say, "Tell me more, I don't understand." I say, "Well, if you wanted to die, then how come you had three pills? Did you think three pills would kill you?" I play a lot of-- not play, but I need them to talk more, to tell me more, so I can understand. The same I would do with a younger child.

It's not a certain age, it's more what brought them to me. Some of them can say, "Yes, I wanted to fly. Yes, I wanted to-- I think I'd die and be with grandma." I try to elicit from them what they're telling me. I wouldn't do with them my 0 to 10 scale that I talked about.

Moderator: Got you, thank you for that. Is it ever appropriate for a paraprofessional to administer a suicide screening before the clinical interview, or should this always be done by the clinician during the session?

Dr. Mirela Loftus: I'm not familiar with the role of the paraprofessional before, and I don't know if it means just helping fill out the scale, a scale, a screening tool, or actually a clinical interview. If it's clinical interview, definitely not, definitely not. The reason why is because what if they open something, they uncover something, then they don't know what to do with it. It's not just about asking the question, it's what do you do with the answer?

If it's just a simple screen where they put, I think that would be fine, because they would do that on their own regardless, since it's a self-questionnaire, right? I would say that part is fine, but clinical interview, no.

Moderator: There's a question here. How do we navigate treatment when there's a mismatch between the child's self-report and the parent's observations or concerns?

Dr. Mirela Loftus: I love that one because that's my daily problem, okay? Daily. It's not just different perceptions, but also, they're not going to tell you everything, or they might tell you more. It could go both ways. It could be amplifying the parent because they're anxious and worried, and the kid is minimizing, or the other way, the kid might tell me, "Yes, I really want to die," and the parent minimize it. There's a oftenness, which is why, always, all my sessions are alone and together with the parent.

I ask both sides, how much are they willing to share with the other party? Let's say the kid says, "Yes, I want to die. Mom doesn't know. I don't want her to know." I say, "Well, that's the line, right? That's the line I draw. Anything else, we can keep private, but anything that's safety--" I say, "I'm sure you understand my position, right? I can't let you go home to kill yourself." I do have to share some with the parent.

The other way, let's say they're like, "Oh, they're out of control. They're punching walls," and they come and say, "It's been fine. Nothing's happening at home." Then I bring the parent and say, "Let's talk more about the last time there was an incident in the house." Then it turns a little bit into a family session, right? Yes, you bring them at the table.

Moderator: Staying in that same realm of the parent-child relationship, how should we support a child at risk of developing psychological issues due to a parent's mental illness, especially when that parent also shapes the child's environment?

Dr. Mirela Loftus: Yes, that's a tough one, because we don't have a lot of community preventative. Pediatrician is your best bet. Best bet is the pediatrician. Let's say I have an adult, and I know they have kids, and they're-- My patient is an adult, and I know they have kids. How can I help that kid? It's good that you're mindful and aware of that, of the impact of the adult's psychiatric illness on the rest of the household. It's not just the kids, right? It could be the partner. It could be anyone else as well.

I would just do periodic check-ins about their well-being. "How's your six-year-old? They're going to school? What's the teacher saying? Do they like school? Do they miss school?" Then if you start getting worried, if there are red flags, I would see who I would bring in the picture. You said, how can we prevent? You are probably the best person to act as someone who can prevent it, because there are no other community programs, let's say, or so. Yes.

Moderator: Then another family question. How do you navigate conversations with the parents or the caregiver who's naive or reluctant to accept the children's mental health disorder?

Dr. Mirela Loftus: Yes, and something funny is that I don't give diagnosis lightly, or frequent, I should say. Even labeling someone, let's say bipolar or something, I don't

think I ever have done that under a handful, in my almost 30 years career. That's because treating children and adolescents-- they're constantly evolving, right? If I put something at age 12, I don't know how they're going to turn out in five years, 15 years. All I can do is to describe what's here in front of me.

Even someone that I have a suspicion of bipolar, let's say, at age 12, I'm going to still put unspecified mood disorder, unless it really, really, really meets criteria. I'm not in a specialized clinic, like Gabrielle Carson, who-- that's all she sees, and then she can make that diagnosis. In the more general population-- because again, I can't predict of what they're going to be developing. With that in mind, if I have a kid that I am worried, they definitely have something that's treatable and the parents are in denial, let's say.

First of all, I empathize, because which parent wants to hear that their 12-year-old has a serious mental health and needs treatment for that? I'm not there to sell a diagnosis, as I just told you, I am there to sell-- What you brought to me, how can I help you with that? I go by function, back to, "What is it that worries you about your child not going to school, dropping grades, staying in bed all day, and how can I help with that complaint?"

I don't know if it's satisfactory to you guys, but as much as I do go by DSM as a guide, if I have to, and when I fill out forms for insurance, absolutely, I have to follow that, but relational in the office, that is not what I'm there for. I'm there to help the family and the child to be in a better place.

Moderator: We probably have time for maybe a couple more. This was a preregistered question. How to tell the difference between a strong imagination and a genuine hallucination in a preteen?

Dr. Mirela Loftus: Yes, oh yes, I saw this one. I like this one a lot because psychosis is actually why I went to become a psychiatrist, as I really didn't like any other specialty, like broken bones or hearts that don't click appropriately. Psychosis, to see what the brain can do, change our perception and make things-- think that they're there when they're not there. That's fascinating.

We all have that as part of our development, through imagination, and some have a more vivid imagination than others, which probably might serve them well when they become writers or artists. Then it's the fine line of how does, let's say, an imaginary friend for a lonely person become a constant imaginary friend for someone on the spectrum, who also lives in their own world and those are their only friends, then to an outright intrusive hallucinations.

It's a continuum, right? Exactly as I just described it. How do you draw the line of where it's normal and where it's not? Depending on the age, would be how able is the child to acknowledge that that's imaginary and not real? A five-year-old, it's going to feel real. Just verbally, they're not going to be able to verbalize, to say, "Yes, it's my imagination." They don't know yet what that is.

Now you're going into very specialized, like childhood schizophrenia, which is very, very rare. Let's say a little older, 10-year-old, then they should be able to distinguish imagination from reality. The other way is the impact. Are they running in the street

talking to the air, thinking they talk to people? That is not anymore just imagination. The impact of what they're hearing or seeing has on the surrounding.

Moderator: Thank you so much for that, Dr. Loftus. Thank you again for joining us. Thank you to all of you for listening, and for your participation. We'd also like to thank Newport Healthcare for making this webinar possible. A recording of this presentation will be emailed to everyone in two weeks time. The recording will include the presentation slides. As soon as the webinar has ended, a short survey will appear on your screen.

Please, take the survey and give us your feedback. We thank you for your attention and hope you all have a great day. Thank you.

[00:59:49] [END OF AUDIO]