Endorsements of the Book

Pediatricians and other primary care providers are increasingly being asked to deal with psychological and behavioral problems in their patients. For many of us, our training in these areas was simply not adequate. Along comes a book, Practical Child and Adolescent Psychiatry for Pediatrics and Primary Care that helps the primary care physician effectively handle these concerns. The authors clearly know the psychiatric issues facing physicians in primary care pediatrics. Their case examples are excellent. As I read many of them, I thought, “I talked to a parent about this just last week!” As the book’s title claims, it is very practical. Included are helpful algorithms and diagnostic criteria for many common psychiatric issues facing primary care physicians. Brief summaries of psychotropic medications are just what a primary care physician needs to determine the uses of different medications, as well as their risks and side effects. Their “Clinical Pearls” for many of the medications will be especially helpful. Good information is also available for those medications not commonly prescribed by primary care physicians. This up-to-date handbook will be a valuable resource for pediatricians and other primary care practitioners to effectively diagnose and manage their patients’ behavioral problems, and to decide when to refer to a child and adolescent psychiatrist.

Rickey L. Williams, MD, MPH, President of Tanque Verde Pediatrics, Tucson, AZ

This is a terrific book, surpassing its promise of providing pediatricians and PCPs with a guide to assessing and treating children and adolescents with mental health problems. Using a remarkably innovative format including descriptions, tables, algorithms and clinical pearls, this format guides clinicians through the challenges of clinical diagnosis, clinical decision-making and treatment. Borrowing from advances in Information Technology and Continuous Quality Improvement processes, the book channels the clinician to pertinent standardized evaluations, symptom and severity checklists, diagnostic criteria and medication recommendations located elsewhere in the book with an ease that approaches a drop down menu and a point and click experience. Practical Child and Adolescent Psychiatry for Pediatrics and Primary Care is an exceedingly valuable contribution to the mental health treatment of children and families and the pediatricians and PCPs who will bear much of the responsibility for addressing their needs because of the severe limitations in access to care in the current health care marketplace.

Robert K. Schreter, MD, Associate Professor of Psychiatry, University of Maryland School of Medicine, Baltimore, MD

I would predict that the pages of this important book will become worn with daily use by pediatric primary care clinicians in their efforts to care for children with mental health needs. Drs. Trivedi, Kershner, and their colleagues are to be commended for this excellent contribution to the growing field of collaborative child and adolescent psychiatry.

Barry Sarvet, MD, Massachusetts Child Psychiatry Access Project, Springfield, MA

Drs. Trivedi and Kershner have given clinicians providing primary care for children and adolescents a valuable tool for approaching the behavioral and psychosocial problems that make up fully one fifth of our practices. Their Practical Child and Adolescent Psychiatry for Pediatrics and Primary Care contains resources for diagnosis and management presented in a manner highly relevant to primary care practice. They offer algorithms to approach a child’s or adolescent’s presenting problem that are clinically relevant and consistent with current practice. Treatment options discussed are relevant to the primary care setting, recognizing that referral to a mental health professional might not always be timely or even available. This text is likely to become part of the essential library for the primary care office.

Joseph F. Hagan, Jr., MD, FAAP, Clinical Professor in Pediatrics, University of Vermont College of Medicine, Primary Care Pediatrics, Burlington, VT

It is increasingly clear that the majority of psychiatric problems will be treated in primary care or pediatric practice. This marvelous volume by a distinguished child psychiatrist and a distinguished pediatrician addresses the growing need to have straightforward practical, user-focused actions that pediatricians and others in primary care practice with children can adopt to deal effectively with common mental health problems in children. The organization of the volume is thoughtful and designed to be quickly and effectively utilized when mental health problems present. The first section describes common chief complaints that typically present in primary care or pediatric practice such as excessive worries or out of control behavior. The second discusses common psychiatric diagnoses and the third, perhaps most importantly, describes what kind of practical actions can be taken for each of these conditions. In fact, intervention toolboxes are provided for each the major conditions and diagnoses. This is an eminently readable, carefully constructed volume and I highly recommend it.

William R. Beardslee, MD, Academic Chair, Department of Psychiatry, Children’s Hospital Boston, MA

Doctors Trivedi and Kershner have put together an innovative volume that goes well beyond simply providing practical pointers for managing common child and adolescent mental health presentations in primary care settings. Their book is in fact an overarching algorithm that will help non-specialists move out of their erstwhile comfort zones and squarely into the psychiatric domain. With Trivedi and Kershner’s guidance, practitioners should expect real results: their clinics will run more smoothly, their consultation requests be fewer and better targeted, and most importantly, the mental health of youths under their care will be addressed in time, on site, and by the very clinicians who know them best.

Andrés Martin, MD, MPH, Professor of Child Psychiatry and Psychiatry, Director of Medical Studies, Yale Child Study Center and Medical Director of Children’s Psychiatric Inpatient Service, Yale-New Haven Children’s Hospital, New Haven, CT

This is a terrific book and resource to both primary care and mental health clinicians. One of the major and common challenges consultants to primary care face is their ability to communicate effectively. Drs. Trivedi and Kershner were very successful in using language that is user-friendly and well known to primary care clinicians. The use of algorithms throughout the book makes it efficient and fun. Truly great work.

Lourival Baptista Neto, MD, Director of Clinical Services, Morgan Stanley Children’s Hospital of NY Presbyterian/Columbia

Challenges to mental health are common in children, yet child mental health specialists are scarce. Primary care pediatricians are often the first to face these problems, and must provide much of the treatment even when they feel their training has not fully prepared them to do so. This easy-to-use volume offers practical approaches to screening, assessing and treating the wide range of childhood behavioral and emotional challenges that are carefully adapted to the everyday realities of busy pediatricians. Clear and compassionate, this impressive guide is bound to become a favorite for child mental health specialists as well.

Joshua Sparrow, MD, Harvard Medical School, Children’s Hospital Boston, MA
Notice

Child and adolescent psychiatry, like all of medicine, is constantly in flux as new research is published and advancements are made in the field. The authors and the publisher have made every effort to ensure that all information contained in this text is accurate and consistent with current recommendations and generally accepted practice at the time of publication. However, due to changing government regulations, continuing research, and changing information concerning drug therapy and reactions, the reader is urged to check the package insert for any change in indications and dosage, or other added precautions. The authors and publisher disclaim any responsibility for any consequences which may follow from the use of information presented in this book.

It is important to note that there are sections of this book for which evidence-based data are not available or where treatments are recommended which are considered “off-label.” The authors have attempted to take a conservative perspective when recommending an approach to evaluation and treatment in order to allow for safe and judicious patient care based upon the knowledge base at the time of publication. Application of this material to patient care and ascertainment of current Food and Drug Administration (FDA) status when planning interventions remains the professional responsibility of the practicing physician.

Although the format of the text is algorithmic in nature, it is important to note that this text is not a substitute for a medical examination or consultation with a physician. Please note that due to the individual needs of specific patients, or due to certain clinical situations, appropriate clinical care may require assessment, treatment, and monitoring different from what is covered in this text. Consultation with a physician specialist, such as a child and adolescent psychiatrist, should be considered for recommendations regarding specific patients that you are treating. Readers are encouraged to verify the information presented in this text with current information in other sources.

Nonphysicians, lay readers, regulators, courts, or legislative bodies should note that significant portions of information for the safe evaluation and management of patients are not presented in this text as they are an integral part of medical training for physicians. The algorithms in this text are not a substitute for sound medical judgment. They should not be applied by practitioners without a medical degree, appropriate Accreditation Council for Graduate Medical Education (ACGME) certified residency or fellowship training, and current active medical licensure. All questions about treatments or therapies should be directed to a physician.

Conflict of Interest Statement / Disclosures

Dr. Trivedi and Dr. Kershner have made all efforts to ensure that the information presented in this text is free of bias. They do not have any conflicts of interest to disclose. They do not receive any compensation nor do they have any other such relationships with pharmaceutical companies or medical device manufacturers.
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Practical Child and Adolescent Psychiatry for Pediatrics and Primary Care

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Dedication

To those who taught me compassion, humanity, and work ethic –  
Balashankar P. Trivedi, Markand G. Rawal, & Ramesh J. Trivedi

To those who sustain me and propel me to strive onward –  
Kirit, Pratima, Maulik, Mala, Dylan, Sonya, family, & friends

To those who allow me into their lives to help them –  
the youth, parents, and families I work with daily

And to the one who means everything to me –  
my wife, Urmi

HKT

To my husband Robert,  
who continues to open doors and has encouraged me to follow my dreams

To my two daughters, Shaina and Emily,  
who have taught me that parenting is a great challenge,  
a humbling experience, and the most rewarding job in the world

To the families  
who have allowed me the privilege of being a part of their lives

JDK
In the realm of child mental health services, pediatricians and primary care providers are often unsung heroes. When there is limited access to mental health professionals, when stigma associated with psychiatrists or psychologists makes parents hesitant to use them, or when the vagaries of managed care preclude referrals to specific mental health professionals, you are the ones being asked to fill the void. Most often this is done, though, with varying degrees of enthusiasm.

Our medical system certainly doesn’t make it easy for primary care physicians to be mental health providers. Reimbursement is a significant problem, as arcane rules make it difficult, for example, for a pediatrician to get paid when billing for “depression” as opposed to a “urinary tract infection.” Too often it seems that society’s expectation is for a primary care physician to provide psychiatric services in less time than it takes me to do the job – even though I have had more training and many years of experience treating psychiatric problems.

In my experience, however, the financial hardship is not the main factor behind primary care physicians’ hesitancy – when it occurs – to deal with children’s mental health issues. Much more salient is the concern about their expertise in the mental health arena. I’ve frequently heard variations on the following:

“There are so many controversies in child psychiatry and the field is changing so fast that it seems like a minefield – so much to know.”

“My residency training was light in the behavioral realm – I don’t feel competent.”

or

“Child psychiatry isn’t my main interest – I’m afraid I don’t read enough to be up-to-date.”

I certainly resonate with those sentiments: truth be told, I’m not that enthusiastic about evaluating a 6-year-old’s earache or a teenager’s belly pain when it’s my turn to be the weekend attending on our inpatient psychiatric units. The difference is that I have immediate access to pediatric consultation and can refer the patient at will. Rarely do primary care physicians have the same options when it comes to their patients’ psychiatric problems. Hence, the heroism.

This book represents a big step forward as it provides high-quality, practical psychiatric information in an accessible form for busy pediatricians and primary care providers. Dr. Trivedi, Dr. Kershner, and their collaborators have combined their extensive knowledge of child and adolescent psychiatry with an awareness of the realities of primary care to produce a gem of a resource book. It is extremely up-to-date, without getting mired in the latest debates about forms of bipolar disorder or how one should prescribe antipsychotics to 2-year-olds. The book is – as it should be – balanced between psychosocial and biological approaches. It is appropriately without influence from the pharmaceutical industry.

My sense is that with a reference like this at your fingertips you will be more competent, confident, and comfortable in your role as a child mental health provider. When that happens, children will be the true beneficiaries.

Gregory K. Fritz, MD
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Preface

If you have picked up this book, you are likely all too aware of the staggering problems that exist both in the prevalence of child and adolescent mental illnesses as well as in finding trained specialists to care for them.

The Problem

The US Surgeon General estimates that one out of five children and adolescents between the ages of nine and seventeen has a diagnosable mental or addictive disorder causing functional impairment. Within the United States alone, this equates to over 10 million youths that require mental health treatment. It is estimated that it would take 30,000 child and adolescent psychiatrists to meet this need. Unfortunately, less than one fourth of that number, only about 7,000, are currently in practice.

As Dr. Thomas F. Anders, a past president of the American Academy of Child and Adolescent Psychiatry, put it “There is a serious crisis in the child and adolescent psychiatry workforce. There are far too few of us, and large parts of the country – especially rural and inner city areas – have few, if any, child and adolescent psychiatrists… Fewer than half of the children in need of care are evaluated, and even fewer are treated effectively.” Due to the severe shortage of child and adolescent psychiatrists, the vast majority of these patients are seen by pediatricians and other primary care providers (PCPs) for the diagnosis and treatment of their mental health problems.

Two Paths: One Goal

It isn’t completely random that of all the people who might write a book on this topic, Jeryl Kershner and I were the ones who felt compelled to make it happen. We first met during our child and adolescent psychiatry fellowship at Children’s Hospital Boston. She was a seasoned pediatrician with over twenty years of experience. In her pediatric practice, she had been treating kids with mental health problems for years now; so much so that she was commonly referred patients from her pediatric colleagues. She had a growing frustration about how these patients got (or didn’t get) the help they needed. She decided to go back for additional training and joined the Developmental Behavioral Pediatrics Fellowship at Children’s Hospital Boston. Wanting to know more, she boldly decided to do what would most help her patients. She left her pediatric comfort zone in order to pursue child and adolescent psychiatry fellowship training.

I had quite a different professional path to arrive at the same training program. I had fallen in love with pediatrics during medical school at Mount Sinai. I had seriously considered joining their “Triple Board Program” (combined 5 year training in pediatrics, psychiatry, and child and adolescent psychiatry), but in the end knew that my true calling was to go where I was most needed (child and adolescent psychiatry). After completing my general psychiatry training, I was selected as a congressional fellow and was placed in the Washington, DC office of Senator Jack Reed (D-RI). I had the fortune of helping to develop language for one of the few pieces of mental health legislation that got enacted during that time. The Garrett Lee Smith Memorial Act provided funding (over $80 million over 3 years) for developing suicide prevention programs and improving college mental health services nationally. I quickly learned about the difference I could make by working for larger systemic changes. Indeed my work as a congressional fellow allowed me to accomplish more with the stroke of a pen and help far more people than I can ever hope to treat as a physician diligently working with my patients over a thirty-plus year career. As I was entering the child and adolescent psychiatry fellowship at Children’s Hospital Boston, I had a renewed sense of direction – to not only hone my clinical skills, but to also keep my eyes open for the next opportunity to improve the lives of children and families affected by mental illness.
Despite our very different professional paths, Dr. Kershner and I share one thing: At the heart of our professional passion is an earnest desire to fundamentally improve the lives those we treat daily.

**A Common Understanding**

We both recognized that most pediatricians and PCPs have little exposure to the routine assessment and treatment of mental or addictive disorders during training. Despite a lack of appropriate training or clinical expertise, they are routinely confronted with the difficult task of having to triage, differentially diagnose, and treat many of these issues.

Imagine going through your entire residency training and never really being taught about how to listen for lung sounds, about how to diagnose and treat respiratory ailments, or about the appropriate management of RSV or asthma. Now imagine starting your first job in the dead of winter, during flu season, and 20% of the patients walking through your door are complaining of difficulty breathing, shortness of breath, or wheezing. You would likely get a gnawing feeling in your stomach that you were inadequately prepared to help a large number of your patients.

Unfortunately, a similar event already occurs daily when that same patient walks through the door with a mental health problem. Without really being taught about how to diagnose and treat basic psychiatric conditions, 20% of the patients in your practice may need help for mental health conditions as common and as basic as RSV or asthma. Now you may really have that gnawing feeling recur, but this time it is with good reason.

**So Many Obstacles**

As if all of this wasn’t enough, the recent Food and Drug Administration black box warning for stimulants and antidepressants has only created further anxiety amongst providers in helping to care for this population. Add to that the recent announcement and retraction from the American Heart Association that all kids starting stimulants need an electrocardiogram. When combining all of these pressures with the fact that most pediatricians and PCPs see 40–60 patients per day, the obvious question is: How can you take care of the most common psychiatric presentations that walk through your door every day? How can you do it while ensuring quality mental health care? Not to mention, how can you do this, while continuing to meet the needs of all the other patients that you see daily?

For the physicians reading this preface, there is some part of you that resonates with this frustration. You have patients who certainly are having problems, but you aren’t sure what they are. Even if you do remember from your medical school rotation that you are seeing the signs of depression, what is the current standard of care? How do you evaluate the severity of the symptoms? How do you determine what type of treatment the patient needs? And just as important, how do you manage to take care of this patient in the midst of a busy practice without falling two hours behind?

You do not have the time to read reference texts or to extensively research the current literature between patients. What you need is a book that is easily accessible, practical, and useful, and that places clinically relevant information at your fingertips.

**The Solution**

Combining our knowledge and professional experience, we quickly realized that we were in a unique situation to understand both the needs of pediatricians and PCPs, while also understanding the needs of the patients who present to a child and adolescent psychiatrist for the treatment of their mental health problems. We spoke to many colleagues and families about what would be most helpful – and how we could help the most kids get needed access to quality competent care. We heard from many people who passionately spoke about the need for this book, a different kind of handbook, one that gave only the information that would be most helpful to you: A book that is written specifically for a pediatric and PCP audience,
not getting bogged down with too much psychiatry, and having clear algorithmic steps of what to do.

As opposed to chapters on psychiatric diagnoses (which aren’t so helpful if you don’t know what the diagnosis is), we start with the chief complaints that you are likely to encounter. We provide algorithms to guide you through the assessment and treatment of children and adolescents with mental health problems. Our hope is that this structure will help you to develop a framework in your own mind to think about these issues. We then allow you to input your clinical judgment to determine what the next steps are and subsequently lead you through progressive parts of the book to the key information that you need:

- Did you ever wonder whether your patient should get a trial of therapy before starting medications? We help you figure that out.
- Did you ever wonder which medicine to start, at what dose, how to titrate, what to tell parents, and how to manage it? We help you with that as well.
- Did you ever ask yourself which rating scale would be helpful in monitoring a child’s progress?

Done.

The Goal

We want you to feel just as comfortable treating a child with ADHD, depression, or separation anxiety disorder as you would treating a child with an ear infection, the flu, or asthma. We know that you want to provide conscientious and competent care. We know that you want tips on how to structure your practice so that it can function smoothly even when a psychiatrically urgent or emergent patient is seen.

In creating this book, we have made every effort to best address your needs. As you read through it yourself, we also need your help. We welcome your feedback so that we can make future editions even more useful. Most importantly, we sincerely hope that the book will provide you with the tools to better help your patients. Thank you.

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References


Contributors

The following contributors aided in the research and writing of this text. In creating the innovative format for this book, we acknowledge and thank them for agreeing to have their “traditional” chapters broken down and reconstructed to mesh into the algorithmic format presented. This has required much flexibility on their part and an earnest willingness to allow for significant rewriting of their work. Indeed, most chapters are an amalgam of multiple contributors. The contributors are listed below based upon the chief complaint or topic area that they worked on. Please note that they have also contributed to subsequent diagnosis and treatment sections based upon where their chief complaint or topic areas mapped onto the algorithms. This has allowed for the creation of a clearly written, well designed, practical, and useful text. It is our hope that this book will help many youths get needed access to quality care.

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# Table of Contents

Dedication ........................................ vi
Foreword ......................................... vii
Preface ........................................... ix
Contributors ..................................... xiii
Acknowledgements ................................ xiv

**Section I: Getting Ready** ........................................ 1
Chapter 1: How to Use This Book ....................................... 3
Chapter 2: Setting Up Your Office ....................................... 6

**Section II: Approach To Common Chief Complaints** .................. 11
Chapter 3: Irritable or Out-of-Control Behavior ........................ 13
Chapter 4: Fatigue or Changes in Appetite ............................. 19
Chapter 5: School Refusal ............................................ 25
Chapter 6: Recurrent Mild Medical Complaints ....................... 32
Chapter 7: Speech Problems or Refusing to Speak .................... 38
Chapter 8: Sudden Personality Change or Confusion .................. 45
Chapter 9: Excessive Worries ......................................... 50

**Section III: Psychiatric Diagnoses** .................................. 55
Chapter 10: Adjustment Disorder ....................................... 57
Chapter 11: Anxiety Disorders ........................................ 61
Chapter 12: Attention Deficit Hyperactivity Disorder ............... 73
Chapter 13: Autism and Pervasive Development Disorders ........ 76
Chapter 14: Delirium ................................................ 82
Chapter 15: Disruptive Behavior Disorders ............................ 85
Chapter 16: Eating Disorders .......................................... 91
Chapter 17: Learning Disorders ....................................... 96
Chapter 18: Mental Retardation ....................................... 99
Chapter 19: Mood Disorders .......................................... 101
Chapter 20: Psychotic Disorders ..................................... 109
Chapter 21: Somatoform and Factitious Disorders ................... 116
Chapter 22: Substance Use Disorders ............................... 121

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From H. K. Trivedi, J. D. Kershner: Practical Child and Adolescent Psychiatry for Pediatrics and Primary Care © 2009 Hogrefe Publishing
Section IV: Toolbox of Interventions ................................................................. 127

Pharmacological Interventions ................................................................. 129
Chapter 23: Alpha Adrenergic Agonists ................................................... 131
Chapter 24: Antidepressants .................................................................... 136
Chapter 25: Atypical Antipsychotics ....................................................... 142
Chapter 26: Benzodiazepines ................................................................. 151
Chapter 27: Mood Stabilizers ................................................................. 155
Chapter 28: Stimulants and Related ADHD Medications ..................... 162

Psychotherapeutic And Psychosocial Interventions .............................. 173
Chapter 29: Planning for Psychotherapeutic Interventions .................... 175
Chapter 30: Planning for Psychosocial Interventions ............................. 181

Appendices
Appendix A – Comprehensive Psychiatric Evaluation ............................. A1
Appendix B – Suicide and Risk Assessment ............................................. B1
Appendix C – Concise Overview of Pertinent DSM-IV-TR Diagnoses ........ C1
Appendix D – Commonly Used DSM-IV-TR Diagnostic Codes ............... D1
Appendix E – Suggested Rating Scales .................................................. E1
Appendix F – References and Sources for Additional Information .......... F1
List of Algorithms

Assessment Algorithms for Chief Complaints:
Assessment Algorithm for Irritable or Out-of-Control Behavior ........................................... 16
Assessment Algorithm for Fatigue or Changes in Appetite ..................................................... 22
Assessment Algorithm for School Refusal ................................................................. 28
Assessment Algorithm for Recurrent Mild Medical Complaints ........................................ 35
Assessment Algorithm for Speech Problems or Refusing to Speak ..................................... 42
Assessment Algorithm for Sudden Personality Change or Confusion ............................... 48
Assessment Algorithm for Excessive Worries ................................................................. 53

Algorithms for Psychiatric Diagnoses:
Severity Assessment and Treatment Algorithm for Adjustment Disorders ......................... 59
Assessment Algorithm for Anxiety Disorders .................................................................. 63
Severity Assessment and Treatment Algorithm for Anxiety Disorders ................................ 71
Severity Assessment and Treatment Algorithm for Attention Deficit Hyperactivity Disorder .................................................... 75
Assessment Algorithm for Autism and Pervasive Development Disorders ........................ 77
Severity Assessment and Treatment Algorithm for Autism and Pervasive Development Disorders .............................................. 81
Assessment Algorithm for Disruptive Behavior Disorders ............................................. 86
Severity Assessment and Treatment Algorithm for Disruptive Behavior Disorders ............ 89
Assessment Algorithm for Eating Disorders ...................................................................... 92
Severity Assessment and Treatment Algorithm for Eating Disorders ............................ 94
Assessment Algorithm for Learning Disorders .............................................................. 97
Assessment Algorithm for Mood Disorders ...................................................................... 102
Severity Assessment and Treatment Algorithm for Mood Disorders ............................ 108
Assessment Algorithm for Psychotic Disorders ................................................................. 110
Severity Assessment and Treatment Algorithm for Psychotic Disorders ........................ 115
Assessment Algorithm for Somatoform Disorders .......................................................... 117
Section I

Getting Ready

This section presents information related to planning for the evaluation and treatment of youth with mental illness.

It will cover the following topics:

• How to Use This Book
• Setting Up Your Office
1 How to Use This Book

Not too many medical texts you purchase will come with instructions. Then again, not many medical texts have devoted as much thought and energy to creating an educational aide as we have for this one. Our goal is to not only provide you with a fund of knowledge about child and adolescent psychiatry, but hopefully, to also help you in developing a thought process to think like a child and adolescent psychiatrist. When evaluating children and adolescents with mental health issues in your office, we want you to not only pick the best course of action but to also truly understand the method by which that clinical decision was made. This in itself is a large task, one that usually requires a 2-year fellowship, after 3 or 4 years of general psychiatry training, plus at least another handful of years in practice to get it right. Although we may not make you into a child and adolescent psychiatrist, we do want to help you understand the rationale behind thoughtful assessment and treatment.

Each section is designed to help you in developing this framework. We introduce a step-by-step methodology so that you can learn a safe and comprehensive approach to differential diagnosis, assessment, and treatment. This is written as a programmed text in that it leads you through each successive step of the evaluation by allowing for your clinical input and medical judgment to determine the direction in which to take the case. As you work through this format and start understanding the thought process, you will find that you will need to reference earlier parts of this book less and less. By allowing your own clinical impressions to guide you through this text, we help you to engrain certain automatic responses. For example, if a patient states that he has had recent fleeting suicidal thoughts, we refer you to the Appendix to learn how to conduct a comprehensive safety and risk assessment. As you learn the appropriate questions to ask, over time, you may find yourself no longer needing to look at that appendix for the “right” questions to ask. By having algorithms that lead you to appropriate portions of the book, we help you to develop your thought process while getting familiar with the knowledge base as well.

As marvelous as this sounds, it is important to note that this format does not allow for the appropriate management of all cases nor all severities of illness. Every effort has been made to address routine presentations of common illnesses. The best analogy would be a generalist and specialist model. If a patient presented to you with malaise, fever, and recent weight loss, you would know how to work up and treat the most common illnesses. As you went down your differential, if you determined that it may be a case of acute lymphoblastic leukemia, you would likely refer out to a specialist.

Similarly for child and adolescent psychiatry, we believe that there is a core of diagnosis and treatment that can be safely assessed and appropriately treated in the primary care office. If there are more complicated cases or cases refractory to your treatment, they should be referred to the specialist. We have thought about the situations where the algorithm goes beyond what most pediatricians and primary care physicians (PCPs) can safely and routinely treat in their office. In these instances, we clearly delineate when to refer to a child and adolescent psychiatrist. We acknowledge that for some advanced practitioners, you may feel that our arbitrary line in the sand for when to refer occurs too soon. Our experience in discussing the referral points with more novice practitioners is that their sentiment was quite the opposite – wanting to consult the specialist sooner. In trying to strike this balance, we have decided upon rational points in treatment where consulting a specialist may be quite helpful. Your decision of when to refer
should be guided by your own comfort level and level of expertise.

As such, we understand that there is a wide spectrum of exposure and comfort in dealing with children and adolescent psychiatric issues among pediatricians and primary care physicians (PCPs). In attempting to meet you at your current level of expertise, the book is divided into four sections. For those who are pre-contemplative about whether this can be done in the primary care setting or for those who already do it but want to become more efficient, we offer Section I in the book entitled “Getting Ready.” It addresses the main concerns about getting more involved in the assessment and treatment of these common disorders. We walk you through the practicalities of setting up your office, scheduling appointments, optimally using support staff, incorporating the use of rating scales, and more. Once you have reviewed this section, you will likely refer to it only minimally in the course of evaluating patients.

The second section is “Approach to Common Chief Complaints.” As opposed to other texts which have “traditional” chapters divided by psychiatric diagnoses, this text starts one step back with chief complaints. Most likely, parents will not come to you and say “I think my child has major depressive disorder, recurrent, severe, with psychotic features. Can you help me?” Based upon Dr. Kershner’s years of experience dealing with patients and parents in a pediatric primary care office, we have developed a list of the most common chief complaints that you are likely to encounter. We realize that this is not an exhaustive list of complaints. These particular ones have been chosen because they map onto the main categories of psychiatric disorders and treatments. While working up these chief complaints, you will become facile at thinking through other chief complaints in the process as well.

Another difference from more traditional medical texts is that chapters are usually written by different authors and then edited for content and format. This can lead to books that vary in tone, length, language, and quality from chapter to chapter. We acknowledge the contributors of this text for agreeing to have their traditional chapters broken down and reconstructed to mesh into the algorithmic format presented. This has required much flexibility on their part and an earnest willingness to allow for significant rewriting of their work. Indeed, most chapters are an amalgam of multiple contributors. This has allowed for the creation of a clearly written, well designed, practical, and useful text that is consistent from chapter to chapter.

The feature that you will notice most about the chapters from Section II onwards is that they have limited text and present multiple figures and tables. During the midst of a busy day, we want this to be a ready reference. Indeed, most of the key information that you will likely use over and over again is presented in graphical form as a figure or table. Each chapter is meant to be easily accessible and reviewable within 3–5 minutes. Any longer and this book would likely join the other books on your shelf that you would love to read when you have more time.

In trying to create this balance, there are two important points to keep in mind. The first is that we know that you are a pediatrician or PCP. For this reason, we do not belabor the medical work-up or cover issues that you already know. For example, we do not cover child abuse as a freestanding chapter nor do we tell you to look for fractures at different stages of healing. We know that any appropriately trained pediatrician or PCP is well aware of this. To keep this handbook from becoming unwieldy, we only focus on the information that you may be less familiar with.

Secondly, it is important to keep in mind that we are also limiting the psychiatric information that we present. By limiting ourselves to the key clinical information that applies to most patients and is most relevant to what you can assess and treat in a primary care office, we are able to present information that you can review quickly. For example, we do not walk you through the assessment algorithm for learning disorders or mental retardation. Although they may be present, you will not be the one conducting educational, cognitive, psychological, or neurological testing. We would expect that you would refer to a specialist if a concern arose. Please remember that this is not an authoritative textbook; it is meant to be a practical handbook. Our focus is on helping you to provide
care. If you need more in-depth information, we have suggested references at the back of the book to guide the user to other well-trusted sources.

Each chief complaint provides Clinical Snapshots of likely presentations, Key Points describing take home messages for the physician, a Psychiatric Differential Diagnosis with an Assessment Algorithm, and Take Home Messages for the patient, parent, and family. Your clinical input will help lead you through the algorithm to relevant portions of the book regarding diagnosis and treatment in subsequent sections. As you become more familiar with the work-up of these chief complaints, you may find yourself referring only to the assessment algorithm or going directly to the diagnosis and treatment sections. As this occurs, you will likely become more efficient and more comfortable with the material.

Section III then presents information related to accurately diagnosing psychiatric illnesses and determining severity of symptoms. Each chapter provides an Assessment Algorithm based upon DSM-IV-TR and a Severity Assessment and Treatment Algorithm to determine the level of intervention required. Levels of severity are divided into routine, urgent, and emergent. Your clinical input will help lead you through the algorithm to relevant portions of the book regarding the treatment options in subsequent sections. As you become more familiar with these diagnoses, you may find yourself referring only to the diagnostic algorithm or going directly to the treatment section.

Section IV presents information related to treatment options for psychiatric illnesses. The treatments are subdivided into biological interventions, psychotherapeutic interventions, and psychosocial interventions. Each chapter provides a Treatment Description and Clinical Pearls to maximize treatment efficacy while limiting potential side effects. As you become more familiar with these treatments, you may find yourself significantly impacting the lives of the children and adolescents you treat. Hence, as we first asserted: This is not your average medical text.

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1 DSM-IV-TR® is a trademark of the American Psychiatric Association.
In talking to pediatricians and PCPs about their greatest concerns with providing mental health assessment and treatment in their practices, a number of practical issues recurrently came up, such as optimizing practice structure, utilizing support staff, and managing kids and families in crisis. This chapter was written to address many of those concerns, which are likely similar to the concerns that you have as well.

We understand that pediatric and primary care practices have significant variation in regards to location of the practice, number of providers, patient population served, support staff present, availability of child and adolescent mental health service providers, and a multitude of other characteristics. In attempting to distill the most important suggestions for setting up your office, the following general suggestions were selected as those that would be effective in a majority of practice settings with minimal need to drastically change office functions. Further specification of these recommendations to meet your practice’s individual needs is suggested as the applicability and implementation of these steps will vary from practice to practice.

2 Setting Up Your Office

Start with What You’ve Got

Before trying to figure out everything that you need to change, take two steps back and conduct a needs assessment. It is important to first figure out what things you already do well and what areas require further attention. Ask your staff as well as your patients and their parents about how you could improve things. Let them know that you are considering some changes to better improve mental health care in the office and get their thoughts about what they would like to see. This will help you to prioritize where you should devote initial energies. As a part of this discussion, let them know to expect that some hiccups may occur and that you want them to tell you when they happen. Reassure them you are committed to helping them and that you will be responsive to the concerns that are raised.

Comprehensive Solutions Require a Team

Your office is probably a busy place filled with kids ranging in age from newborns to college-bound young adults. You probably rush from patient to patient, taking care of runny noses, sprained ankles, belly pains, and a host of other chief complaints. You likely field urgent phone calls from concerned parents as well as respond to calls from other providers and consultants. You probably have some days when you go about doing one thing after the other, not even realizing where the time went. Somewhere in the midst of this controlled chaos exists the glue that keeps many practices going. As we paint this all too familiar picture, the truth is that having great support staff can make all the difference with how well your practice functions on a day to day basis.

In order to appropriately assess, treat, and manage youth mental health issues in your practice, you will need to have support staff who are well trained, who know how to respond, and are aware of their role in this process. Just as you may have concerns about how this will practically occur in the midst of your practice, they too will have their concerns. Before enacting the changes that we recommend below, we ask you to gauge your staff’s level of anxiety as well as their willingness or buy-in to caring for youth with mental health problems in the office.
Make sure that staff members have an avenue for voicing their questions and concerns to you or the practice administrator. As you start implementing changes to optimize your practice procedures, there needs to be an on-going opportunity for receiving their feedback and for adjusting office processes to better fit your practice structure. Indeed, they may often catch on to issues long before you become aware of them.

**Setting the Tone for Practice Functions**

As much as there is an avenue for open communication, it is important that you set the tone for patient care in the practice. As both you and your staff enter new unfamiliar waters in addressing mental health concerns, it is important that you dictate the level of service and tone for treatment that staff will adopt. There needs to be an expectation, coming from you, that all staff members are ready and willing to support patients and families with mental health issues. It should not be perceived as one more burden in their day, especially by the patient or family.

That being said, the clearer your expectations are, the easier it will be for everyone. In particular, thought should be given about what you can *and cannot* handle in your office. As previously mentioned, each practice and each practitioner may be at different places in their level of comfort with assessing and treating different psychiatric diagnoses. Your staff should understand your level of comfort as well as have an understanding of their own internal barometer. If there are multiple physicians in your practice, it may be easier for your staff if the providers have developed a consistent message of what can and cannot be handled in the office.

A key point to discuss from the beginning is that as your level of comfort increases, the types of cases that you treat may also change. In the best case scenario, your staff will also be progressing in their level of comfort in dealing with mental health issues as well.

**Nothing Decreases Anxiety Like Knowledge and Reassurance**

There are probably some staff members that you can already identify in your office who tend to do well with patients and parents in crisis. They may be the ones who are most excited and looking forward to your willingness to start more comprehensive assessment and treatment of mental health problems. Utilize these people as your resources and allow them to get other staff members on the same page. Identify ways that they can be helpful and use their positive energy to create traction in the office. In short, think about all of the ways that you can utilize them more efficiently.

The next main obstacle for most people is lack of knowledge. People tend to be apprehensive of things they are unfamiliar with. Try to figure out how you can schedule an in-service or lunch training with staff to help ease their anxiety. Also, don’t assume that you need to cover everything in one session. Just as you don’t want to overload parents with too much information, break things down to more manageable pieces and provide the trainings over the course of weeks to months. At the outset, however, if you plan on doing additional sessions in the future, let them know about it.

Another great resource comes in the form of pamphlets created by the professional associations. Both the American Academy of Child and Adolescent Psychiatry’s *Facts for Families* (www.aacap.org) and the American Academy of Pediatrics *Guidelines for Parents* (www.aap.org) are valuable handouts to have in your office. Leave copies of these in your lunchroom or break area so staff members can familiarize themselves with the information. They will be learning the information themselves and will then be able to handout appropriate pamphlets to patients and parents. Encourage your staff to review these handouts and to use the information to support and guide patients and families.

Also think of other important pieces of information that would be helpful for them to learn. For example, have an in-service with staff regarding the mental status exam. It will help your staff to monitor for important signs and to better commu-
nicate their observations to you. A sample format for the mental status exam is reviewed in Appendix A. Have them practice filling out a sample mental status exam on selected patients and then compare it to your findings.

**Decreasing the Element of Surprise Through Routine Assessment**

We have had providers tell us that they don’t use routine assessments or try not to ask too many probing questions because they aren’t sure what they would do if they did find something. Others have expressed a fear about the level of uncertainty that mental health problems create in their daily schedules and how the rest of their patient care hours take a toll when a psychiatrically urgent or emergent patient must be seen.

Although this may seem counter-intuitive, if you start routinely assessing for mental health issues, you will actually have fewer surprises when a patient is in a crisis. Additionally, as you get better at assessment and treatment, you will also help to avert many of these situations from ever occurring. We recommend that you incorporate the use of a standard general screening questionnaire for all patients at routine intervals. These can be handed out by your receptionist and should be completed in the waiting room. Consider using the Pediatric Symptom Checklist or the Child Behavior Checklist (see Appendix E). Once completed, get your support staff to review and score these assessments for you. Have them flag the ones that are of concern for your review.

In addition to the use of a general screening tool, adopt a method of incorporating the use of specific rating scales depending on the chief complaint. If a patient or parent brings up concerning issues regarding depression in the general screening or comes in with a chief complaint of depression, have support staff already trained to give out a depression rating scale. If you are already treating an adolescent for depression, have the patient and parent fill out a depression rating scale at successive visits to monitor progress. Adding these additional steps will add structure to your practice and provide you with valuable information.

If you get a core group of rating scales together that you and your staff are familiar with, keep them in a central location near your check-in area and get everyone into the habit of utilizing them. An often overlooked point is to also incorporate a uniform location in your chart to file completed scales for future reference and to track scores over time to monitor progress. Rating scales are reviewed in Appendix E. When you get a positive screening, review it with your staff to reinforce not only the importance of the rating scale, but also their role in this process.

**Realistic Scheduling and Improved Triage Can Help to Improve Your Mental Health**

Nothing is harder to do during the course of a busy day than to catch up with your schedule. At the outset, let us be clear in stating that patients with mental health problems can not be scheduled the same as every other patient that walks through the door. Expect that you will need to spend more time with them, especially in the beginning. It is best to keep dedicated time for scheduling patients with mental health issues. For example, for routine follow-ups (nonurgent and nonemergent cases) have one afternoon a week set aside for such kids. If you can’t schedule out a block of time, try to schedule these appointments with built in buffers. For example, schedule them later in the day or before a charting or lunch break, so that you can spend a little extra time with them if needed, and so that it doesn’t throw off the rest of your patient schedule. For those who can incorporate evening hours into your practice, this is also a good time to schedule appointments for mental health concerns. How much time you set aside will be based on how many such patients you regularly see. Expect to schedule at least 30 minutes for an initial visit and approximately 15 minutes for a follow-up appointment.

One of the mistakes that we sometimes see is that the receptionist books patients with mental
health issues in the middle of same day urgent appointments. Although they may be urgent, they will definitely take more time than a regular urgent patient. A word to the wise would be to avoid situations that are set up to fail. Help to train your staff about how to figure out with the parent whether the patient falls into the urgent or emergent categories. Any parent who is concerned about the immediate safety of their child or of other family members, hence an emergent case, should be referred to an emergency room. All psychiatric emergencies should be referred to your local emergency room for an emergency psychiatric evaluation. Urgent cases, those that do not need to be seen immediately but do require your attention, should be scheduled to see you within 24–72 hours depending on the presentation. Routine evaluations or follow-up appointments can be scheduled within 3–7 days.

By following these tips, we hope that you will find both you and your staff feeling more comfortable with addressing the mental health concerns of the patients and families that you are caring for. Being open to making adjustments and tailoring our suggestions to fit your practice will lead to the best outcomes. Also, if there are important things that you learn along the way, please let us know so that we can let others know (see contact information in the Preface).
Section II

Approach to Common Chief Complaints

This section presents information related to the clinical approach for evaluating common chief complaints. Each chief complaint provides Clinical Snapshots of likely presentations, Key Points describing take home messages for the physician, a Psychiatric Differential Diagnosis with an Assessment Algorithm, and Take Home Messages for the patient, parent, and family. Your clinical input will help lead you through the algorithm to relevant portions of the book regarding diagnosis and treatment in subsequent sections. As you become more familiar with the work-up of these chief complaints, you may find yourself referring only to the algorithm or going directly to the diagnosis and treatment sections.

It covers the following chief complaints:

• Irritable or Out-of-Control Behavior
• Fatigue or Changes in Appetite
• School Refusal
• Recurrent Mild Medical Complaints
• Speech Problems or Refusing to Speak
• Sudden Personality Change or Confusion
• Excessive Worries