

## Overview

### Understanding the Issues of Children's Mental Health

This section of the Toolkit aims to provide you with some useful information regarding the basics of children's mental health. Resources included in this section are targeted toward basic information related to specific diagnoses including the effect on the person experiencing the mental health issue and the symptomatic expressions associated with particular mental health diagnoses. Additionally, this section provides information that frames childhood mental illness from an advocate's perspective. The goal is to provide general information to inform and provide direction to your advocacy work.

# CLC Information Sheet

## Children's Mental Health: Understanding the Issues

### Children's Mental Health Disorders Are Not Uncommon

- ◆ According to the [National Alliance on Mental Illness](#), one in five children ages 13 to 18 currently or at some point in the future will experience a serious mental illness.

### Mental Health Symptoms Often Mistaken For "Normal Childhood Behavior"

- ◆ The National Alliance on Mental Illness and [National Institute of Mental Health](#) provide lists of warning signs for mental illness in children. These warning signs are often mistaken for "normal childhood behavior" delaying professional intervention. Some common warnings signs are:
  - Repeated use of drugs or alcohol
  - Drastic changes in behavior, personality or sleeping habits, such as waking up early and acting agitated
  - Extreme difficulty in concentrating or staying still that can lead to failure in school
  - Not eating, throwing up, or using laxatives to lose weight; significant weight loss or gain
  - Out-of-control, risk-taking behaviors that can cause harm to self or others
  - Severe mood swings that cause problems in relationships
  - Social withdrawal
  - Returning to behaviors more common in younger children, such as bedwetting
  - Repeated thoughts of death

### Parents and Advocates Are Not Helpless to Intervene

- ◆ The National Institute of Mental Health has compiled a helpful guide to frequently asked questions about the treatment of mental illness in children. It can be found [here](#). Some of the action steps it recommends are:
  - Communicate with your child's school regarding appropriate evaluations for your child.
  - Talk to your child's doctor or health care provider; know that your child's pediatrician or family physician may refer your child to a specialist for evaluation
  - Consult with specialists such as psychiatrists, psychologists, social workers, psychiatric nurses, and behavioral therapists.

# CLC Information Sheet

## Understanding Mental Health Diagnoses in Children

### How Children Are Diagnosed With a Mental Illness

- ◆ Children are diagnosed with a mental health condition in the same way an adult would be. A doctor or other licensed mental health professional will observe your client's symptoms. Using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), the professional will decide what, if any, mental health condition aligns with the signs and symptoms displayed. The mental health professional will then provide a diagnosis.

### Understanding the DSM-5

- ◆ Understanding the DSM-5 will assist you in being an effective advocate for your client. By understanding what a mental health professional will be using to diagnose your client, you will be in a better position to advocate for an appropriate diagnosis for your client.
- ◆ [The National Juvenile Defender Center](#) has produced a resource brief for juvenile defenders to help them understand the DSM-5. Although the resource is targeted toward advocates representing clients in the juvenile justice system, it provides valuable information about the DSM-5 that is transferable to advocates practicing in the realm of child abuse and neglect. The resource brief is called "What Juvenile Defenders Should Know about the DSM-5" and can be found [here](#).

### Common Mental Health Conditions and Their Treatments

- ◆ The DSM-5 will help you understand the reasons your client has been diagnosed with a specific mental health disorder. Now, it is time to understand what a mental health diagnosis means and the treatment available for the condition with which your client has been diagnosed. The Children's Law Center has developed a guide entitled The Child Advocate's Guide to Psychiatric Diagnoses & Psychotropic Medications. It is included in this section immediately following this Information Sheet.
- ◆ Additionally, there are several therapeutic modalities that may be employed to treat your client's diagnosed mental health condition. The [American Academy of Child and Adolescent Psychiatry](#) provides a listing of the different types of psychotherapy available. A list of common modalities is provided below; the complete list is available [here](#):
  - **Cognitive Behavioral Therapy (CBT):** During CBT, a child learns to identify harmful thought patterns. The therapist then helps the child replace this thinking with thoughts that result in more appropriate feelings and behaviors.
  - **Dialectical Behavioral Therapy (DBT):** DBT emphasizes taking responsibility for one's problems and helps the person examine how they deal with conflict and intense negative emotions. This often involves a combination of group and individual sessions.
  - **Family Therapy:** Family Therapy focuses on helping the family function in more positive and constructive ways by exploring patterns of communication and providing support and education. Family therapy sessions can include the child or adolescent along with parents, siblings, and grandparents.
  - **Play Therapy:** Play Therapy involves the use of toys, blocks, dolls, puppets, drawings, and games to help the child recognize, identify, and verbalize feelings. The psychotherapist observes how the child uses play materials and identifies themes or patterns to understand the child's problems.

## The Child Advocate's Guide to Psychiatric Diagnoses & Psychotropic Medications



Cartoon from Google Images, courtesy of <http://contemplative-activist.blogspot.com/>

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## Purpose and Disclaimer

The overarching aim of this guide is to better equip advocates of children to nurture the mental health needs of their clients. The guide is organized in chapters by mental health condition. Each chapter offers a brief description of the condition (as laid out in the current Diagnostic and Statistical Manual of Mental Disorders, DSM-5) and the most common treatments for the condition. Each chapter contains a section on commonly asked questions and important things to know about the conditions and treatments. Each chapter concludes with a section entitled “Reputable Resources Regarding,” which provides URL links to websites that can be trusted as reliable sources for information. At the end of the guide are two appendices, one which lists each medication (alphabetically by brand name and by generic name) and directs the reader to the chapter in which information can be found about that medication, and one which lists common medical abbreviations that an advocate might encounter when reviewing medical records or files. Throughout the guide, important points are highlighted with various colors so that the guide may be scanned quickly for take-home points, but all highlights are transparent enough that if the guide is printed in black-and-white ink, the highlighted text will still be readable. In order to keep limit the length of the guide, only the most commonly encountered mental health conditions and medications have been included. Conditions not covered include: conduct disorder, oppositional defiant disorder, learning disorders, reactive attachment disorder, gender dysphoria, and eating disorders. These conditions, while important and prevalent in the communities with which child advocates work, are often treated with non-medication interventions and may be covered in other educational series available to child advocates. This guide primarily aims to increase knowledge and awareness about medication interventions (through pertinent psychotherapies are mentioned). Additionally, pediatric schizophrenia is not covered for the sake of space, and because this condition is more rare than those that have been included.

This guide is intended to serve as a reference for professionals working in the field of child advocacy. It is meant to provide a general overview of common mental health conditions and treatments, and to help advocates form questions to ask mental health providers on behalf of their clients. It is not intended to offer medical advice or to be used in place of seeking professional medical care. All questions pertinent to a particular client or situation should be directed to the medical provider who is caring for the patient. Additionally, any personal opinion contained within this guide represents that of the author, and not of the general psychiatry community or of Children’s National Medical Center in particular.

With gratitude for all who tend to children,

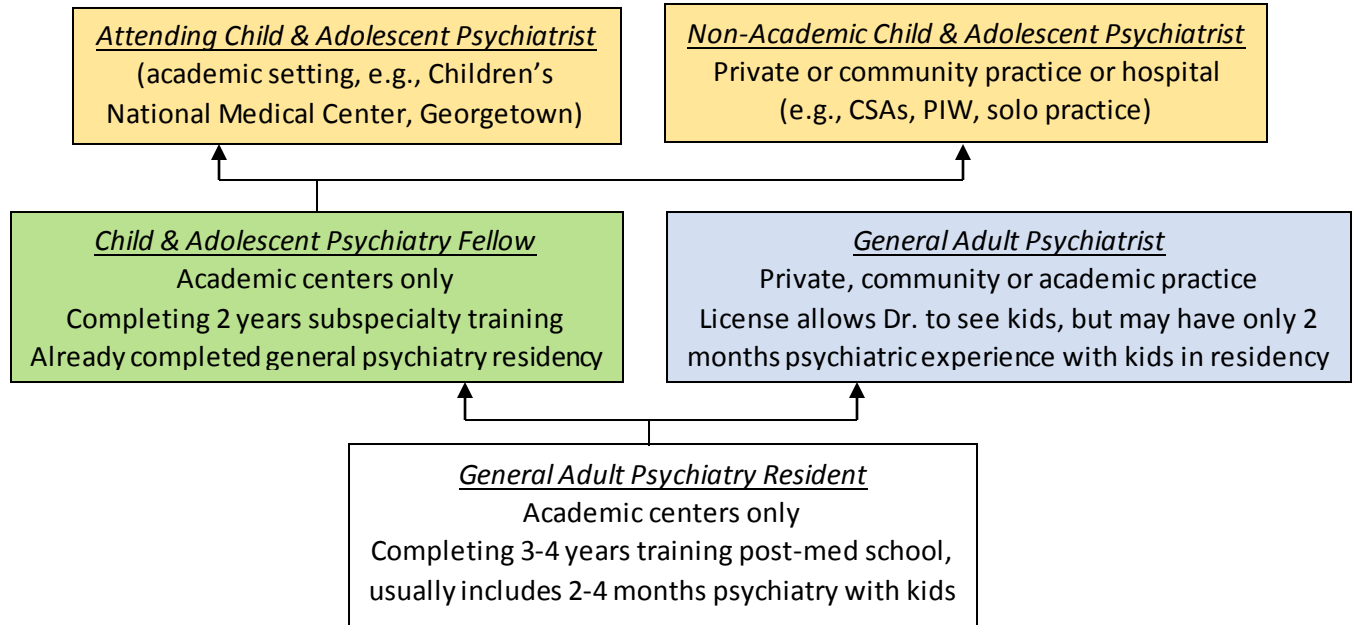
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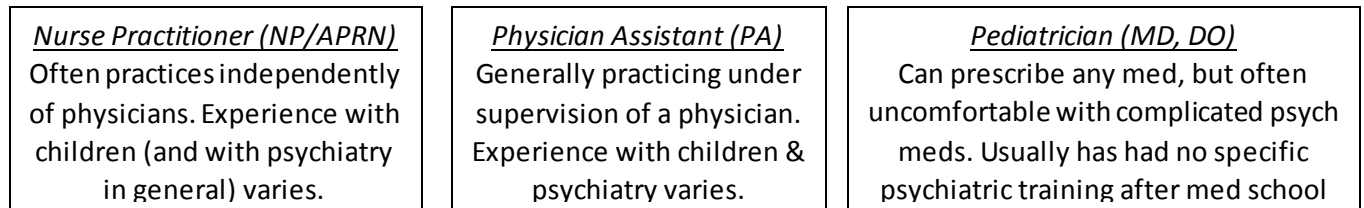
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## Who Is Treating My Client?

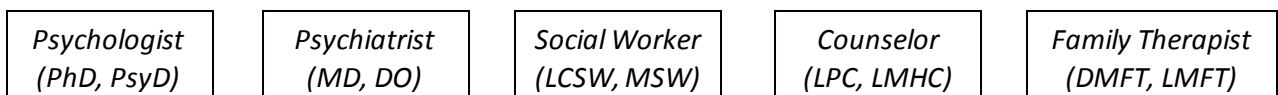
### Psychiatrists (MDs or DOs) Hierarchy



### Other Prescribers



### Providers of Psychotherapy



In general, it is best for children and adolescents to be seen by prescribers who have specialized psychiatric training in the pediatric age group (orange or green boxes above), especially for an initial evaluation. It is important to note, however, that many child & adolescent psychiatric practices (including Children's National Medical Center) cannot treat children after they turn 18, even though other pediatric departments will often see patients through age 24 years. Thus, it is important to anticipate the child's 18<sup>th</sup> birthday in order to ensure smooth transitioning to an adult practitioner (blue box). Additionally, because there is such a shortage of child-trained psychiatrists, it is helpful for children with uncomplicated conditions (such as well-controlled ADHD or simple depression improving on a stable dose of medication) to be managed by their pediatricians, who can then consult with child a psychiatrist as needed.

## The FDA and Psychotropic Meds for Kids

Advocates often raise concerns about whether or not medications prescribed to their clients are approved by the FDA for use in children. In truth, this is probably not the *right* question to ask.

The FDA “approves” medications for use in specific populations with specific conditions (e.g., adults over 65 with chest pain; pregnant women with diabetes; children with cystic fibrosis; etc.). When a drug company submits a new medication to the FDA for approval, it must provide data from research studies demonstrating that the medication is safe and effective for use. Drug companies can’t study all possible uses in all age groups—the trials would be prohibitively large and expensive and drugs would rarely be approved for anything or anyone. Thus, assuming that the data is compelling enough, the FDA will approve the medication for only the certain conditions and populations studied in the drug trials that have been submitted. This doesn’t mean, however, that doctors can’t prescribe the medication to—or that it wouldn’t be beneficial for—other “unapproved” patient groups.

When a medication is prescribed to a type of patient or for a reason that is not specified in the original FDA approval, it is being used in an “off-label” manner. This term is often misconstrued to mean “inappropriate.” In reality, when a doctor prescribes off-label, he or she is making the decision to do so based on clinical knowledge and experience, and on data from other ongoing trials (not necessarily being conducted by the drug company itself) that have been published in peer-reviewed (scientifically reputable) medical journals. This sort of practice is referred to as **evidence-based medicine (EBM)**. There are many off-label uses that most doctors and researchers agree are safe and beneficial, based on study data; some of these uses, however, never become approved by the FDA. One reason for this is that once a medication has been approved for one purpose, there is little incentive for the manufacturing pharmaceutical company to put in the time and expense to get it approved again.

To illustrate, several medications used to treat depression in adults are not approved by the FDA to treat depression in children, even though they may be approved to treat other conditions in that age group (Zoloft, for example, is approved for obsessive compulsive disorder in children but not depression). These meds are regularly prescribed off-label for depression with positive effect. Another (perhaps surprising) example is ADHD. Because this condition is traditionally identified and treated in childhood, many of the medications used for ADHD have not been FDA-approved for use in adults. Because ADHD affects some people into adulthood, providers often prescribe these meds off-label.

Fortunately for prescribers (and for patients), there are national organizations of medical specialists who come together to decide what is the best evidence-based practice in a given field. The American Academy of Child and Adolescent Psychiatry (AACAP) releases **practice parameters** for providers to reference when they are making clinical decisions. These are only guidelines; each individual provider must offer treatment according to his/her own judgment regarding the unique patient sitting before him/her. A better question, then, for parents and advocates of children is this: **Is the med being prescribed based on scientific evidence and the consensus of the specialty?**



## Reputable Resources Regarding the FDA and Prescribing

National Institute of Mental Health section on mental health medications:

<http://www.nimh.nih.gov/health/publications/mental-health-medications/index.shtml>

FDA section on drug research in children:

<http://www.fda.gov/Drugs/ResourcesForYou/Consumers/ucm143565.htm>

National Institutes of Health *Eunice Kennedy Shriver* National Institute of Child Health and Human Development section on the Best Pharmaceuticals for Children Act (BPCA):

<http://bpca.nichd.nih.gov/about/Pages/Index.aspx>

American Academy of Child & Adolescent Psychiatry section on Practice Parameters:

[http://www.aacap.org/AACAP/Resources\\_for\\_Primary\\_Care/Practice\\_Parameters\\_and\\_Resource\\_Centers/Practice\\_Parameters1.aspx](http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters1.aspx)

# Chapter I: Attention Deficit Hyperactivity Disorder (ADHD)

## Three types:

- Predominantly inattentive type
- Predominantly hyperactive/impulsive type
- Combined type (inattentive and hyperactive/impulsive) – *most common*

## Common symptoms:

- Trouble staying focused, difficulty paying attention to details, easily distracted
- Fidgety, wanders classroom, calls out in class, talks constantly, intrusive
- Poorly organized, forgets homework, loses things easily

## Important criteria for making the diagnosis:

- Symptoms must appear before age 12 years & last at least 6 months
- Symptoms must occur in at least two settings (home, school, sports, church, etc.)
- Symptoms must cause distress/impairment - poor performance in school; negatively affected social relationships; kicked off sports teams; problems at work

## Treatment:

- Large study conducted by the National Institute of Mental Health (NIMH), the Multimodal Treatment Study of Children with ADHD (the MTA), found that **medication is more effective than behavioral therapy alone for the treatment of ADHD.**
- Combining medication with behavioral treatment helps parents, children, and teachers modify problematic behaviors. In the MTA study, some children receiving behavioral therapies were able to take lower doses of medication with good outcomes.
- There are two major categories of medications for ADHD: Stimulants & Non-Stimulants

**Stimulant Medications:** Generally the first-line choice for treatment, very effective

- **Methylphenidate Derivatives:**
  - Short-acting (immediate release): Ritalin, Focalin, Methylin (chewable and solution forms). These meds are sometimes dosed more than once daily.
  - Long-acting (extended release): Ritalin LA, Concerta, Focalin XR, Metadate CD, Metadate ER, Daytrana (patch), Quilivant (liquid). Meds usually given once daily.
- **Amphetamine Derivatives:**
  - Short-acting (immediate release): Adderall, ProCentra (liquid). Meds are sometimes dosed more than once daily.
  - Long-acting (extended release): Adderall XR, Vyvanse, Dexedrine Spansule. Meds are usually dosed once daily.

**Non-Stimulant Medications:** Generally second-line, if stimulants are ineffective or contraindicated

- **Atomoxetine (Strattera):** Takes longer to see effect (2-4 weeks), lower efficacy than stimulants. Positive: not a controlled substance—low abuse potential/little street value.
- **Guanfacine:** Short-acting (Tenex) and long-acting (Intuniv) forms. Sometimes given in combination with stimulants. Not controlled, low abuse potential.
- **Clonidine:** Short-acting and long-acting (Kapvay) forms. Sometimes given in combination with stimulants. Not controlled, low abuse potential.
- **Bupropion (Wellbutrin):** Antidepressant, takes weeks for effect.

## Common Questions & Important Things to Know About ADHD

- **What are possible side effects of medications for ADHD?**

- Stimulants:
  - More common: decreased appetite, trouble falling asleep, headache, nausea
  - More rare: irritability, tics, hallucinations, heart racing, dullness/"Zombie"-ism
- Atomoxetine (Strattera):
  - Nausea, stomach pain, mood swings. Carries Black Box Warning for suicidal thoughts (see section on Black Box Warning for details)
- Guanfacine & Clonidine:
  - Most important: low blood pressure, dizziness, fainting
  - Sedation, daytime sleepiness

- **What if my client suddenly stops his medication?**

The prescriber should always be consulted before stopping medication, as some medications need to be slowly tapered down to prevent adverse effects. If your client misses his medication, especially for multiple days, it is important to contact the provider. In general, for ADHD meds:

- Stimulants: Usually no/mild adverse effects from sudden stoppage. May get headache, irritability, or fatigue. Some parents don't give stimulants over weekends & holidays to "give the child a break." Most doctors advise against this practice; if the medication is needed for daily function, then it should be given *daily*.
- Atomoxetine (Strattera): Usually no serious withdrawal upon sudden stoppage, but depends on dose and duration of treatment. May have dizziness, headache, anxiety.
- Guanfacine & Clonidine: **DANGEROUS TO STOP SUDDENLY!** May have serious and rapid elevations in blood pressure. Less serious but bothersome: agitation, tremor, anxiety.

- **Do children become addicted to stimulants? Does taking stimulants lead to other illicit drug use?**

According to the National Institute on Drug Abuse (NIDA), research suggests that people diagnosed with ADHD have a higher risk of abusing drugs/alcohol than people without ADHD. Retrospective studies of adult substance users indicate that a high percentage of users had ADHD that was undiagnosed & untreated in childhood. In fact, NIDA found that children who were medicated for ADHD were less likely to become substance abusers than un-medicated children with ADHD. Additionally, treatment with medication delays the age of onset of substance use. Though it is uncommon for children with ADHD to abuse their own meds, they are at risk for sharing or selling their meds, or for parents to divert them. Also of note, teenage drivers with ADHD are more likely to have traffic accidents, more likely to have traffic injuries, and more likely to be at fault in traffic issues than teens without ADHD. Studies suggest that stimulants improve performance and safety on the road. *References at end of chapter.*

- **Why does my client have to see the doctor every month for a prescription?**

Stimulants are classified as Schedule II Controlled Substances by the DEA. This means that doctors can only write prescriptions for a one-month supply and cannot write for refills. Additionally, faxed and phoned-in prescriptions are not allowed.

- **What should schools be doing for my clients who have ADHD?**

The MTA study demonstrated that medications are superior to behavioral intervention alone in treating ADHD, but concluded that medication *plus* behavioral intervention is ideal. Children with ADHD should be given support in school to help with organization skills, behavior modification, social interaction, and academic performance. Most children benefit from having a 504 plan, if not a full individualized education plan (IEP), to ensure that they receive appropriate accommodations at school. Doctors *should* check in with teachers and school counselors, whether by telephone or through scales and written feedback, to provide a well-rounded picture of how the child is doing (i.e., prescribing and increasing medication without understanding how the child is doing in school, where he spends most of his waking hours, is not best practice). Reciprocally, schools should follow recommendations of providers when diagnoses are made or special accommodations are needed (e.g., a child needs to take his medication at school or needs to be allowed an afternoon snack because of decreased lunchtime appetite due to medication).

- **What about special diets to treat ADHD?**

The best advice is for families to consult with their doctor about diet and herbal/alternative treatments for ADHD. In general, most dietary treatments lack supporting evidence for effect, and some can be dangerous if implemented incorrectly. Like every child, kids with ADHD should eat a balanced diet and engage in regular exercise.

- **Why does it seem like every child is diagnosed with ADHD?**

ADHD and the medicating of children is a hot topic and parents and child advocates often wonder how it is possible that “so many kids” have ADHD. The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, updated in 2013) indicates that ADHD occurs in ~5% of children—one child in a classroom of twenty. The CDC notes that community studies yield higher rates than this, and that rates vary significantly by state. The NIMH indicates that ADHD affects ~9% of children between the ages of 13 and 18 years, and that boys are 4 times at risk compared to girls. (Of note, girls are more likely to have the inattentive type, and are sometimes missed until they are much older because they are not acting out with behavior problems.) Studies show that the number of children being diagnosed with ADHD is increasing, but it is as yet unclear why—are we diagnosing it better and picking up kids who in the past have been missed? Are we over-diagnosing? Is there a true increase in prevalence? It’s hard to say. An important take-home point is that not every child who is inattentive or hyperactive has ADHD—many other conditions can cause these symptoms (anxiety, depression, stressful circumstances, etc.). Providers must do their best to take an all-encompassing picture of the child (through child interview, parent interview, family history, rating scales, teacher feedback, etc.) to come to a diagnosis. Similarly, it is important for families and child advocates to understand that sometimes providers get it wrong, and sometimes diagnoses change over time (in fact, many people “grow out” of ADHD symptoms as they age, especially hyperactive symptoms). In the absence of a crystal ball, providers and families must work together to come to the best diagnosis and treatment plan possible for a child, to ensure that vital time is not lost for academic progress, participation in formative activities, and the development of peer relationships and social skills. Undertreating is problematic, too, and can lead to long-lasting drops in self-esteem and happiness.

## Reputable Resources Regarding ADHD

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD). Includes reference regarding ADHD and teenage driving: <http://www.chadd.org/>

National Institute of Mental Health section on ADHD:  
<http://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd/index.shtml#part4>

Center for Disease Control and Prevention section on ADHD:  
<http://www.cdc.gov/ncbddd/adhd/index.html>

National Institute on Drug Abuse article on substance abuse in ADHD:  
[http://archives.drugabuse.gov/NIDA\\_Notes/NNVol14N4/ADHD.html](http://archives.drugabuse.gov/NIDA_Notes/NNVol14N4/ADHD.html)

American Academy of Child & Adolescent Psychiatry: Parents Medication Guide for ADHD  
[http://parentsmedguide.org/parentguide\\_english.pdf](http://parentsmedguide.org/parentguide_english.pdf)

## Chapter II: Anxiety and Depression

### Anxiety Disorders:

There are many different kinds of anxiety disorders, but in general, they share a few common features: patients suffer from excessive fear or worry about imminent threats, future threats, or perceived threats; patients often engage in avoidance behaviors (refusing to go to school, for example); patients often hold negative cognitions about themselves that can seem like paranoia (e.g., “everyone is always talking about me”); and patients are debilitated by their worry. In children, it is important to **distinguish anxiety disorders from developmentally normative fear or anxiety and transient fears or anxieties (often related to stressful situations)**. Anxiety disorders are persistent. Many anxiety disorders of adulthood first develop in childhood and early intervention can be instrumental.

- Types of anxiety disorders: Separation Anxiety Disorder; Generalized Anxiety Disorder; Selective Mutism; Specific Phobia; Social Anxiety Disorder; Panic Disorder; Agoraphobia
- Obsessive Compulsive Disorder (OCD) used to be grouped with anxiety. In the DSM-5 it has its own section, “Obsessive-Compulsive and Related Disorders,” which includes other conditions like Body Dysmorphic Disorder, Hoarding, and Trichotillomania (Hair-pulling). Treatment for OCD is similar to anxiety, so it is included here.

### Depressive Disorders:

Many people are familiar with the classic condition called Major Depressive Disorder (MDD), which can be a single episode of clear changes in mood, cognition, sleep, appetite, energy and feelings of self-worth, or can be a recurrence of episodes separated by remissions of feeling good or “normal.” Children and adolescents can be deeply affected by their own depression or that of their caretakers. Identifying and treating depression in children and teens is **crucial because depression can lead to checking out from school work and afterschool activities, turning to substances to alleviate low mood, and feeling so down as to want to engage in self-harming behaviors or even commit suicide.**

- Types of depressive disorders: Major Depressive Disorder (MDD); Persistent Depressive Disorder (Dysthymia); Premenstrual Dysphoric Disorder; Substance-Induced Depression
- New in the DSM-5: Disruptive Mood Dysregulation Disorder (DMDD). This will be discussed in its own chapter later in this guide.
- Depression accompanies Bipolar Disorder (also discussed later in this guide), and in fact people with bipolar disorder generally spend more time feeling depressed than manic. It is important to screen for accompanying mania when diagnosing depression.

### Symptoms and Presentation:

- In kids, anxiety and depression often look different than they do in adults. Irritability and anger can be seen more often than sad mood.
- Anhedonia is especially common in teens (lack of interest/ability to find pleasure in activities that used to be pleasurable—quits clubs, sports teams, sits in room all day)
- Academic decline is very common—sudden problems completing assignments in 10<sup>th</sup> grade is likely not new-onset ADHD at 15...should be concerned about depression!

### **Symptoms and Presentation, continued:**

- Somatic symptoms or complaints are very common—especially stomach aches and headaches without a physical explanation. Missing school for physical symptoms is a red flag for anxiety or depression
- Bullying is a huge culprit as a precipitating and/or perpetuating factor, and the online nature of children’s social lives makes it easy to anonymously bully in a public venue

### **Treatment:**

In general, severe depression is treated with a two-pronged attack: medication plus psychotherapy. The Treatment of Adolescents with Depression Study (termed TADS and published in JAMA in 2004- *see resources page*) found that teens improved more quickly and with better lasting effect when they were given a medication *and* participated in cognitive behavioral therapy. It’s important to note that teens on medication for depression will likely not be on medication forever; it is normal practice to pull children off medication once they have had a substantial period of remission from symptoms. Additionally, most forms of anxiety are treated with *the same* first-line medications as depression, though the doses needed to adequately treat the varying conditions may differ.

- **First-line Medications:** Selective serotonin reuptake inhibitors (SSRIs)
  - Fluoxetine (Prozac), Sertraline (Zoloft), Citalopram (Celexa), Escitalopram (Lexapro)
  - These medications **take 4-6 weeks to take effect**, so a “true trial” requires sticking with the medication before declaring it ineffective.
  - These medications **need to be taken every day**, and not an as-needed basis
  - If a true trial of one medication is ineffective (or if side effects necessitate early discontinuation), the general practice is to try another medication in this class. If that fails, generally providers will try *a third* medication in this class
- **Second-line Medications (for depression):**
  - Switch to: Venlafaxine (Effexor), Duloxetine (Cymbalta), Bupropion (Wellbutrin)
  - Give SSRI plus adjuvant med: low-dose lithium; aripiprazole (Abilify); T3 (synthetic thyroid hormone)
- **Second-line or Adjuvant Medications (for anxiety):**
  - Benzodiazepines: usually added to antidepressants, rarely given alone
    - Long-acting: Clonazepam (Klonopin)
    - Short-acting “rescue”: Lorazepam (Ativan), often used in inpatient setting for severe agitation or panic attack
    - Very short-acting: Alprazolam (Xanax), ALMOST NEVER USED IN KIDS/TEENS!! Can be very habit-forming & has street value
  - Other forms: usually added to antidepressants rather than given alone
    - Gabapentin (Neurontin), Buspirone (Buspar), Clonidine, Propranolol (beta-blocker); Fluvoxamine (Luvox) is an SSRI used for OCD, given alone
- **Psychotherapy:** Very helpful and important for almost anyone with anxiety/depression
  - Cognitive Behavioral Therapy (CBT) with an individual therapist weekly
  - Family therapy, especially when social/economic stressors are a significant problem

## Common Questions & Important Things to Know About Anxiety & Depression

- **What are possible side effects of Selective Serotonin Reuptake Inhibitors (SSRIs)?**

In general, SSRIs are well tolerated by most people. While it can take up to 6 weeks to see positive effects on mood, adverse effects (side effects) usually appear soon after initiating the medication and many of them resolve after the first week. Patients may experience upset stomach, nausea, diarrhea, headache, sleep changes, weight gain, night sweats, decreased libido, decreased ability to have or sustain erection. For teenagers especially, the sexual side effects may cause them to stop taking the medication without telling their parents why. If side effects occur, it is very important to talk with the provider who prescribed the medication.

- **What is the deal with the Black Box Warning about suicidal thoughts?**

In 2004 the FDA reviewed the available literature and issued a public warning about increased suicidal thinking in children and adolescents taking SSRIs to treat depression. In 2006 the FDA expanded the black box warning to include persons up to age 25. As summarized on the NIMH website: “In the FDA review, no completed suicides occurred among nearly 2,200 children treated with SSRI medications. However, about 4 percent of those taking SSRI medications experienced suicidal thinking or behavior, including actual suicide attempts—twice the rate of those taking placebo, or sugar pills.” There are many theories about why there was an apparent increase in reported suicidal thinking, and it is best for families who have questions about the black box warning to talk about this with their providers. The NIMH website also notes that there was a subsequent comprehensive review of pediatric trials, published in JAMA in 2007 (*see resources page*), which found that the benefits of antidepressant medications outweigh the risk. It should be remembered that depression itself seriously increases the risk of suicidal thoughts and that untreated depression seriously increases the risk of *suicide attempts*. The take-home point for all of this for providers has been that **children and teens should be closely monitored for suicidal thinking upon initiating antidepressant treatment.**

- **Is it dangerous to take *too much* of an SSRI?**

YES! Overdosing on SSRIs can be very dangerous. Additionally, taking an SSRI with other medications that cause increases in serotonin levels can be very dangerous. Other medications that increase serotonin levels include: antidepressants in other classes [TCAs (amitriptyline), SNRIs like venlafaxine (Effexor) or duloxetine (Cymbalta), MAOIs ]; some anti-migraine medications, like triptans (e.g., Imitrex, Imigran, Maxalt); and herbal medications like St. John’s Wart. In general (as in most cases), be sure that your client talks with the provider before adding new medications, and **be sure that *all* providers know about *all* medications being taken.** In the event of overdose, call the provider right away and/or go to the ED. Build up of too much serotonin in the body can lead to Serotonin Syndrome, which is marked by anxiety, sweating, significantly increased heart rate, high blood pressure, overactive reflexes, and hallucinations. **This is an emergency and should be treated in an ED/hospital setting.**



- **What if my client suddenly stops taking his SSRI?**

The prescriber should always be consulted before stopping medication, as some medications need to be slowly tapered down to prevent adverse effects. If your client misses his medication, especially for multiple days, it is important to contact the provider. In general, for SSRIs, there may be a discontinuation or withdrawal syndrome, marked by a “flu-like reaction” (headache, nausea, vomiting, dizziness, blurred vision, dizziness). Usually this is not serious or life-threatening. In general, the higher the dose at the time of the sudden stop, the greater the chance of experiencing a withdrawal reaction. Additionally, short-acting (and short-lived) medications pose a greater risk for withdrawal—fluoxetine (Prozac) has a long half-life and generally “self-tapers” upon cessation, making withdrawal less likely but requiring much more time for the medication to fully leave the system; paroxetine (Paxil), on the other hand, has a very short half-life and may be more likely to produce withdrawal symptoms if it is stopped abruptly. Withdrawal symptoms are treated with supportive care (i.e., no specific medication needed, as with alcohol withdrawal). **Always consult the provider before stopping medications, or after it is discovered that your client has stopped his medication.**

- **Is there any special monitoring that is needed for people who are taking SSRIs?**

SSRIs do not require monitoring of blood levels or of specific physical exam findings. Given the black box warning, however, when starting children or teens on SSRIs, there should be frequent contact with the provider to assess for safety.

## Reputable Resources Regarding Anxiety & Depression

National Institute on Mental Health section on depression in children & adolescents:

<http://www.nimh.nih.gov/health/topics/depression/depression-in-children-and-adolescents.shtml>

National Institute on Mental Health section on anxiety in children & adolescents:

<http://www.nimh.nih.gov/health/publications/anxiety-disorders-in-children-and-adolescents/index.shtml>

Treatment for Adolescents with Depression Study (TADS). Available for free:

<http://jama.jamanetwork.com/article.aspx?articleid=199274>

Article in the Journal of American Medical Association (JAMA, 2007) regarding suicide risk and antidepressants, as mentioned in the text of this chapter. Available for free:

<http://jama.jamanetwork.com/article.aspx?articleid=206656>

## Chapter III: Autism Spectrum Disorder (ASD)

### Features:

- Persistent deficits in social communication & social interaction across multiple contexts
  - Poor back-and-forth conversation, reduced sharing of interests, difficulty with nonverbal cues, trouble understanding relationships, poor eye contact
  - Must occur in more than just one setting (school, home, community, etc.)
- Restricted, repetitive patterns of behavior or interests
  - Stereotyped movements, lining up toys, echolalia (repeating what is heard), insistence on sameness, fixed interests abnormal in intensity (e.g., cannot stop talking about trains and memorizes train routes and schedules), hypo- or hyper-reactivity to sensory input
- Symptoms must be present in early development
- Symptoms must cause significant impairment
- Can have autism *with* or *without* intellectual impairment
- Can have autism *with* or *without* language impairment

### Treatment:

Early intervention with supports for the child and family is key. Treatment depends on level of functioning (or level of impairment).

- **Therapy:**
  - Applied Behavioral Analysis therapy (ABA) – shapes and reinforces new behaviors and reduces undesirable ones. Interventions are focused on functional and socially appropriate goals. Based on the principle of positive reinforcement.
  - School services are imperative – IEP, sometimes specialized schools
  - Occupational therapy, especially for patients with sensory issues (some specialized schools have “sensory rooms” that can be very helpful)
  - In-home services for therapy and/or nursing assistance for family
  - Support groups and networks for family and patient (*see resources page*).
- **Medication:**
  - There are no medications to treat the primary symptoms of autism
  - FDA has approved aripiprazole (Abilify) and risperidone (Risperdal) for treatment of aggression, self-harming acts, dangerous outbursts in this population
  - DSM-5 indicates that ~70% of individuals with autism have another mental disorder, and 40% may have two or more. It is important to treat these conditions (especially anxiety, depression, ADHD)—with the institution of DSM-5, patients may now be diagnosed with *both* ASD and ADHD if they meet criteria for both, whereas under DSM-IV the diagnosis of autism excluded ADHD).

## Common Questions & Important Things to Know About ASD

- **What if I suspect that my client has autism but he hasn't been diagnosed?**

Any doctor can diagnose autism, but often the symptoms aren't straight-forward and the diagnosis is not clear-cut. In such instances, more formalized evaluation can be helpful. Child psychiatrists and psychologists are the best trained to make the diagnosis; more specifically, specialized autism centers offer the most in-depth option for evaluation. In this area, Children's National Medical Center has the Center for Autism Spectrum Disorders (CASD) in Rockville, MD. Unfortunately, DC Medicaid does not pay for evaluation at that site. The Kennedy Krieger Institute (KKI) at Johns Hopkins in Baltimore also has a full diagnostic center. There is no blood test or single scale to assess for autism. The Autism Diagnostic Interview (ADI) and the Autism Diagnostic Observation Schedule (ADOS) are helpful and specific assessment tools, but they must be administered by an evaluator who receives specialized certification to give them. Other important assessments to pursue are neuropsychological testing (done by a PhD in psychology — this is sometimes confused with a *neurology* assessment by an MD, which is not generally a needed piece in an autism evaluation unless there are specific concerns regarding neurological complaints), speech and language evaluation (by a speech pathologist), and occupational therapy assessment (OT). At the very least, referral to a child psychiatrist, who can then orchestrate all these other pieces, should be pursued when autism is suspected (but not confirmed) by the family, child advocate or pediatrician.

- **If my client already has an IEP but has now been diagnosed with autism, is it necessary to add the autism diagnosis to the IEP?**

The answer to this is a resounding YES. Children with the autism diagnosis are entitled to resources and accommodations that are sometimes hard to get without the diagnosis. Additionally, there are certain specific interventions and curricula that are specific for children with autism. Even if the child's particular school is not implementing these interventions for other students, they may be compelled to do so if the advocacy team of a child with autism pushes for them. If the school is not equipped, it is important that the autism diagnosis be formalized in the IEP so that the child can be transferred to a school that might better fit his needs.

## Reputable Resources Regarding ASD

CNMC Autism Family Resources PDF:

[http://childrensnational.org/~media/cnhs-site/files/departments/casd/casdbook\\_june27\\_final.ashx?la=en](http://childrensnational.org/~media/cnhs-site/files/departments/casd/casdbook_june27_final.ashx?la=en)

Children's National Medical Center – Center for Autism Spectrum Disorders

[http://childrensnational.org/departments/center-for-autism-spectrum-disorderscasd?sc\\_lang=en](http://childrensnational.org/departments/center-for-autism-spectrum-disorderscasd?sc_lang=en)

Autism Speaks:

<https://www.autismspeaks.org/>

National Institute of Mental Health section on autism:

<http://www.nimh.nih.gov/health/topics/autism-spectrum-disorders-asd/index.shtml>

## Chapter IV: Mood Disorder NOS, Bipolar Disorder, and Disruptive Mood Dysregulation Disorder (DMDD)

All children and teenagers have mood swings and emotional outbursts—this is part of normal development. For some youth, however, regulating mood and emotion can be overwhelming and incapacitating, and in some cases out of their volitional control. In the DSM-IV, Mood Disorders (also called affective disorders) were classified into two main categories: Depressive Disorders and Bipolar Disorder. Depressive Disorders have been covered in another chapter (but to refresh, include Major Depressive Disorder, Persistent Depressive Disorder or Dysthymia, and Substance-Induced Depression, among others). Bipolar Disorder will be covered in more detail in this chapter, but in general is a condition of cycling mood, consisting of discrete periods of expansive and abnormally elevated mood (mania) and longer periods of low mood (depression). For people with debilitating impairments in mood that do not quite meet the specific criteria for a depressive or bipolar disorder diagnosis, the diagnosis of Mood Disorder Not Otherwise Specified (NOS) has historically been given. Advocates for children often see this diagnosis and feel confused about what exactly it means—to be frank, this is how many providers feel when they see this diagnosis as well. To further muddle the waters, the diagnosis of Bipolar Disorder in pediatric populations has been contentious at best within the psychiatric community and in the realm of mass media. In the DSM-5, Mood Disorder NOS does not specifically exist. There is a new diagnosis called Disruptive Mood Dysregulation Disorder (DMDD), which appears in the “Depressive Disorders” section of the DSM-5, which may help to capture some of the mood/affective problems seen in children. There is a section called “Bipolar and Related Disorders” that includes the classical Bipolar I and Bipolar II disorders, and also “Unspecified Bipolar and Related Disorder.” Advocates for children may see these diagnoses with increasing frequency in the future. This chapter will discuss DMDD and Bipolar Disorder and the treatments children might receive.

- **Disruptive Mood Dysregulation Disorder (DMDD)**
  - Created in part to address concerns about the over-diagnosis of bipolar diagnosis in children and adolescents.
    - Characterized by severe recurrent temper outbursts (verbal or physical) that are out of proportion to the intensity of the situations provoking them, occurring 3+ times/week
    - Mood between temper outbursts is persistently irritable or angry most of the day, nearly every day
    - These symptoms have been present for 12 months, with no more than 3 consecutive months without symptoms
    - Must be at least 6yrs old to be diagnosed, with symptoms having begun by age 10
  - Estimated prevalence of 2-5%
  - Research has demonstrated that children with DMDD usually do not go on to have bipolar disorder in adulthood. They are more likely to develop problems with depression or anxiety.
  - **IMPORTANT FOR TREATMENT DECISIONS: Classified in DSM-5 as a Depressive Disorder**
    - Specific treatments may vary by provider and by the individual patient, but it may not be unusual to see this diagnosis treated with antidepressants, or with mood stabilizers (covered in this chapter). Recommend talking with the provider for clarification of how the particular child’s condition has been conceptualized in creating the treatment plan.

- **Bipolar Disorder**

- Severe, non-episodic irritability has been considered as characteristic of bipolar disorder in children, but DSM-IV and DSM-5 require that both children and adults have distinct episodes of mania or hypomania to qualify for the diagnosis (thus, DMDD was created)
  - Manic episode: distinct period of persistently elevated, expansive or irritable mood and increased energy or goal-directed activity lasting at least 1 week and present most of the day
  - Common symptoms: grandiosity, decreased need for sleep (sometimes staying awake for days at a time without fatigue), pressured speech, flight of ideas/racing thoughts
  - The mood disturbance is severe enough to cause impairment in social functioning or to warrant hospitalization to prevent harm to self or others
  - Hypomania is similar to mania but must last only 4 consecutive days and persist most of the day, nearly every day, and is not severe enough to cause marked impairment in functioning or to necessitate hospitalization
  - The manic episode may be preceded and/or followed by hypomanic episodes or depressive episodes
- Cyclothymic Disorder (classified in the DSM-5 under the “Bipolar and Related Disorders” chapter) is given to children who have had at least one full year (2 yrs for adults) of both hypomanic and depressive periods without having fulfilled the criteria for a single episode of mania, hypomania or major depression
- DSM-5 estimates that the prevalence ranges from 0.0– 0.6% worldwide
- Family history is one of the strongest risk factors for the condition, with risk increasing by about 10-fold for people with a first-degree relative with the condition
- Suicide risk is very high in Bipolar Disorder. DSM-5 estimates that the risk of suicide is 15 times that of the general population, and that bipolar disorder may account for 25% of all completed suicides. This makes screening of adolescents, and provision of appropriate treatment, exceedingly important for children and teens with this diagnosis.

- **Common Treatments**

- Mood Stabilizers:
  - Lithium:
    - Classic medication that works well.
    - Need to monitor kidney function regularly via blood draw
    - Need to check thyroid function before starting and periodically thereafter (blood test to measure TSH)
    - Must monitor levels of drug in the blood
    - Can cause significant weight gain, so measure cholesterol and blood sugar before starting and periodically thereafter
    - Should taper off—don't discontinue rapidly.
  - Valproic Acid (Depakote, Depakene):
    - Originally an anti-seizure medication & still used regularly for that purpose, but shows positive effects for mood stabilization
    - Need to check liver function (blood test) before starting and periodically thereafter

- Can cause significant weight gain, good idea to monitor blood sugar and cholesterol
    - Can cause pancreatitis (generally requires hospitalization) and changes to platelet counts
    - Must monitor levels of drug in the blood
    - Teratogenic (girls should be on birth control)
    - Should taper off — don't discontinue rapidly.
  - Lamotrigine (Lamictal):
    - Can be very helpful for mood, and generally has less weight gain than lithium and valproic acid, and antipsychotics
    - **LIFE-THREATENING SIDE EFFECT:** Stevens Johnson Syndrome (SJS)
      - Begins as rash. ANY sign of rash should be reported to the doctor IMMEDIATELY and the medication should be stopped
      - Generally occurs in response to high doses started too precipitously— providers should start low and go slow with dosing (increased every two weeks in small increments)
      - There is no withdrawal/sudden discontinuation syndrome
      - If a few doses are missed, notify the provider because the patient will likely need to go back to a lower dose to restart it
  - Other Mood Stabilizers: Sometimes these are used in mood disorders; they are also all used to treat patients with seizure disorders, and sometimes for migraines
    - Carbamazepine (Tegretol), Oxcarbazepine (Trileptal), Topiramate (Topamax)
- Antipsychotics:
  - True schizophrenia and other psychotic disorders (marked by hallucinations, delusions, and paranoia) are unusual in children. Sometimes, however, psychotic symptoms accompany mood disorders (as in depression with psychotic features or mania with psychosis).
  - When antipsychotic medications are prescribed in kids, it is often for mood stabilization, aggression/self-harm (as discussed in the autism chapter), or as adjuvants to antidepressants (as in Abilify + SSRI, discussed in the depression chapter), rather than to treat psychotic symptoms.
  - Significant controversy exists about the use of antipsychotics in children, particularly children in the foster care system (where they have been shown to be prescribed with greater frequency), and there is little known about long-term effects of these medications in children.
  - Antipsychotics are generally classified into first and second generation meds:
    - First Generation (AKA Typical) Antipsychotics:
      - Haloperidol (Haldol), Chlorpromazine (Thorazine), Perphenazine (Trilafon), and Fluphenazine (Prolixin)
      - These are not used often in children, except for Haldol, which is sometimes used for acute management on inpatient units or on an outpatient basis for children who have not responded to other meds
      - **Adverse effects:** Extrapyramidal Symptoms (EPS): muscle spasms, restlessness, rigid muscles, Parkinsonism (tremor, slowed movements);



Tardive Dyskinesia: long-term effect, jerky movements, often seen in tongue/mouth

- Second Generation (AKA Atypical) Antipsychotics:
  - Aripiprazole (Abilify), Olanzapine (Zyprexa), Quetiapine (Seroquel), Risperidone (Risperdal), Ziprasidone (Geodon), Clozapine (Clozaril)
  - Preferred over first generation because the risk of EPS is lower
  - **Adverse effects:** Weight gain (esp with Zyprexa, Seroquel, Risperidone), diabetes/metabolic problems; Gynecomastia, or enlarged breast tissue, even in boys (especially with Risperdal)
- Very rare but serious side effect of antipsychotics: **Acute Dystonia**
  - Sudden & severe rigidity, twisting, sustained contractions of limbs, face, or whole body
  - This is an emergency and requires hospital-level intervention
  - More likely with first generation (typical) antipsychotics
- If the antipsychotic medication works very well to stabilize mood or control aggression but there are some unwanted (but not severe) side effects, providers sometimes use additional medication to ameliorate the side effect:
  - Benztropine (Cogentin)
  - Diphenhydramine (Benadryl)
- **Combination Treatment:**
  - Sometimes, and especially in the midst of an acute manic episode, providers use a mood stabilizer plus an antipsychotic.
  - It is unusual, however, to have a child on more than one antipsychotic, except in the case of cross-tapering from one to another (at the end of which the child will be on only one antipsychotic)

## Common Questions & Important Things to Know About Mood Stabilizers & Antipsychotics for Mood Disorders

- **What sort of monitoring needs to be done if my client is on one of these medications?**

For any of the medications that can cause weight gain or metabolic problems (lithium, valproic acid, atypical antipsychotics), the patient should have blood sugar, electrolytes and a lipid panel (cholesterol) drawn prior to initiating the therapy. Continued monitoring depends on the particular medication. It is important to note that **blood sugar and lipid panels should be drawn after the patient has fasted (at least 6 hrs), so it is best to schedule this first thing in the morning.** Lithium requires monitoring of thyroid hormone levels and kidney function (via creatinine). Valproic acid requires monitoring of liver function tests and blood cells (especially platelets). Lithium and Valproic acid also require that the level of drug in the blood be monitored periodically. In general, **blood drug levels should be drawn just before the AM dose is given;** a blood level taken shortly after the patient has received the medication is less helpful. Clozapine (Clozaril) is not used very often, despite the fact that it works very well for treating psychosis, because it carries a risk of agranulocytosis (dangerously low levels of a particular kind of white blood cell), which leaves the patient at risk for serious infection. **Patients on clozapine must have a complete blood count (CBC) drawn regularly** and they must be listed on a national registry if they are taking this medication.

- **What sort of medication should kids with DMDD be prescribed?**

Because DMDD is a relatively new diagnosis, it is unclear as of yet what will be the most common treatments for the disorder. Because the diagnosis was conceived of partly in order to keep children with chronic irritability from being labeled as having bipolar disorder, it may be that providers will still reach for mood stabilizers to help to level off the irritable/labile mood. This may be exactly the right approach for some children. On the other hand, because studies have shown that children who meet criteria for DMDD are more likely to go on to develop depressive disorders than bipolar disorder, it may make more sense to treat with antidepressants to address irritability and emotional lability (as these symptoms may be stemming from underlying dysphoria or depression). This may be exactly the right approach for some children. Complicating matters further is the well-established fact that using antidepressants, particularly SSRIs, in people with underlying bipolar disorder can precipitate a switch into mania, which can be dangerous (and children are reportedly especially vulnerable to a “manic switch” from SSRIs). Taken together, **the best advice is to talk with the provider about the diagnosis, and about why the particular treatment plan is being chosen for that particular child**—there may be other factors, like family history, co-morbid conditions, or past medication trials that are playing a role in the treatment planning.

- **What is the deal with the use of antipsychotics and the foster care system?**

This question is the subject of entire books and is too large for a guide like this one. The American Academy of Child & Adolescent Psychiatry (AACAP) has written a Practice Parameters document about the use of antipsychotics in children and it addresses this issue. It can be accessed for free here: [http://www.aacap.org/App\\_Themes/AACAP/docs/practice\\_parameters/Atypical\\_Antipsychotic\\_Medications\\_Web.pdf](http://www.aacap.org/App_Themes/AACAP/docs/practice_parameters/Atypical_Antipsychotic_Medications_Web.pdf). AACAP is in the process of creating another Practice Parameters document that is solely dedicated to the mental health of children in foster care.

## **Reputable Resources Regarding Mood Disorders, Mood Stabilizers & Antipsychotics**

National Institute of Mental Health (NIMH) section on Bipolar Disorder in Children & Adolescents:

<http://www.nimh.nih.gov/health/publications/bipolar-disorder-in-children-and-adolescents/index.shtml>

NIMH section: Most Children with Rapidly Shifting Moods Don't Have Bipolar Disorder:

<http://www.nimh.nih.gov/news/science-news/2010/most-children-with-rapidly-shifting-moods-dont-have-bipolar-disorder.shtml>

American Academy of Child & Adolescent Psychiatry:

<http://www.aacap.org>

## Chapter V: Post-Traumatic Stress Disorder

- **Description:**
  - **For adults, teens, and children > 6yrs old:**
    - Exposure to actual or threatened death, serious injury, or sexual violence by direct experiencing, witnessing, or learning that event happened to close family member
    - Presence of intrusive symptoms associated with event – memories, flashbacks, nightmares
    - Persistent avoidance of stimuli associated with traumatic event
    - Hyper-reactivity/hyper-arousal associated with triggers
  - **For children < 6yrs:**
    - Sexually violent events may include developmentally inappropriate sexual experiences without violence/injury
- **Treatment:**
  - **Therapy:**
    - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
      - Should be given by an experienced therapist
      - Continuity of therapist is very important! If the child will be inconsistent with therapy or may not be able to complete and will have to start over, or if the therapist will be leaving the agency, consider postponing the therapy until the child can work with *one* therapist consistently through completion of therapy
  - **Medication:**
    - Some studies indicate that SSRIs can be helpful
    - Clonidine (quiets the fight-or-flight system) can be helpful
    - Prazosin (similar to clonidine) is used on the west coast and in military vets to treat nightmares associated with PTSD; not wide usage in children, especially on east coast
- **Is it PTSD?**
  - **Not every child who experiences trauma will develop PTSD:**
    - There is growing literature on resiliency in children – who suffers through trauma but does not go on to develop PTSD, and why not?
    - Some studies show that over-therapizing or forcing therapy directly after a traumatic event can actually make coping worse (fine line)
  - **Look for co-morbid conditions:**
    - Children with PTSD can still have anxiety and depression, and often do
    - Sometimes children with symptoms of PTSD are mis-diagnosed as having ADHD; it is important to inform providers of known trauma. It should be noted, however, that children with PTSD can *also* have ADHD. Sometimes treating symptoms in the service of daily functioning can be more helpful than focusing on diagnosis

## Reputable Resources Regarding PTSD

National Child Traumatic Stress Network:

<http://www.nctsn.org>

National Institute of Mental Health section on PTSD:

<http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>

U.S. Department of Veterans Affairs National Center for PTSD, section on Children & Adolescents:

[http://www.ptsd.va.gov/professional/treatment/children/ptsd\\_in\\_children\\_and\\_adolescents\\_overview\\_for\\_professionals.asp](http://www.ptsd.va.gov/professional/treatment/children/ptsd_in_children_and_adolescents_overview_for_professionals.asp)

## Appendix I: Medications Index

**Alphabetical by Brand Name** (alphabetical by generic name on next page)

<b>Medication</b>	<b>Usual Uses</b>	<b>Chapter</b>
Abilify (aripiprazole)	Mood stabilization, adjuvant for depression, psychosis, aggression	IV, III
Adderall (mixed amphetamine salts)	ADHD	I
Ativan (lorazepam)	Anxiety, acute agitation	II
Buspar (buspirone)	Anxiety	II
Celexa (citalopram)	Depression, anxiety	II
Clonidine (clonidine)	ADHD	I
Clozaril (clozapine)	Mood stabilization, psychosis	IV
Concerta (methylphenidate ER)	ADHD	I
Cymbalta (duloxetine)	Depression	II
Daytrana (methylphenidate patch)	ADHD	I
Depakote, Depakene (valproic acid)	Mood stabilization, seizure control	IV
Effexor (venlafaxine)	Depression	II
Focalin (dexmethylphenidate)	ADHD	I
Geodon (ziprasidone)	Mood stabilization, psychosis	IV
Haldol (haloperidol)	Mood stabilization, psychosis, acute agitation	IV
Inderal (propranolol)	Performance anxiety, panic, restless leg	II
Intuniv (guanfacine ER)	ADHD	I
Kapvay (clonidine ER)	ADHD	I
Klonopin (clonazepam)	Anxiety	II
Lamictal (lamotrigine)	Mood stabilization	IV
Lexapro (escitalopram)	Depression, anxiety	II
Lithium	Mood stabilization, seizure control, adjuvant for depression	IV
Luvox (fluvoxamine)	Depression, anxiety, OCD	II
Metadate (methylphenidate CD)	ADHD	I
Neurontin (gabapentin)	Anxiety, neuropathic pain	II
Prolixin (fluphenazine)	Mood stabilization, psychosis	IV
Prozac (fluoxetine)	Depression, anxiety, bulimia	II
Quillivant (methylphenidate liquid)	ADHD	I
Risperdal (risperidone)	Mood stabilization, psychosis, aggression	IV, III
Ritalin (methylphenidate)	ADHD	I
Seroquel (quetiapine)	Mood stabilization, psychosis, sometimes sleep	IV
Strattera (atomoxetine)	ADHD, depression	I
Tegretol (carbamazepine)	Mood stabilization, seizure control	IV
Tenex (guanfacine)	ADHD	I
Topamax (topiramate)	Mood stabilization, seizure control, migraines	IV
Trilafon (perphenazine)	Mood stabilization, psychosis	IV
Trileptal (oxcarbazepine)	Mood stabilization, seizure control	IV
Vyvanse (lisdexafetamine)	ADHD	I
Wellbutrin (bupropion)	Depression, sometimes ADHD	II
Xanax (alprazolam)	Panic attacks	II
Zoloft (sertraline)	Depression, anxiety, OCD	II
Zyprexa (olanzapine)	Mood stabilization, psychosis	IV

## Appendix I: Medications Index

### Alphabetical by Generic Name

Medication+C6A45:C76	Usual Uses	Chapter
Alprazolam (Xanax)	Panic attacks	II
Aripiprazole (Abilify)	Mood stabilization, adjuvant for depression, psychosis, aggression	IV, III
Atomoxetine (Strattera)	ADHD, depression	I
Bupropion (Wellbutrin)	Depression, sometimes ADHD	II
Buspirone (Buspar)	Anxiety	II
Carbamazepine (Tegretol)	Mood stabilization, seizure control	IV
Citalopram (Celexa)	Depression, anxiety	II
Clonazepam (Klonopin)	Anxiety	II
Clonidine (clonidine)	ADHD	I
Clonidine ER (Kapvay)	ADHD	I
Clozapine (clozaril)	Mood stabilization, psychosis	IV
Dexmethylphenidate (Focalin)	ADHD	I
Duloxetine (Cymbalta)	Depression	II
Escitalopram (Lexapro)	Depression, anxiety	II
Fluoxetine (Prozac)	Depression, anxiety, bulimia	II
Fluphenazine (Prolixin)	Mood stabilization, psychosis	IV
Fluvoxamine (Luvox)	Depression, anxiety, OCD	II
Gabapentin (Neurontin)	Anxiety, neuropathic pain	II
Guanfacine (Tenex)	ADHD	I
Guanfacine ER (Intuniv)	ADHD	I
Haloperidol (Haldol)	Mood stabilization, psychosis, acute agitation	IV
Lamotrigine (Lamictal)	Mood stabilization	IV
Lisdexafetamine (Vyvanse)	ADHD	I
Lithium	Mood stabilization, seizure control, adjuvant for depression	IV
Lorazepam (Ativan)	Anxiety, acute agitation	II
Methylphenidate (Ritalin)	ADHD	I
Methylphenidate CD (Metadate)	ADHD	I
Methylphenidate ER (Concerta)	ADHD	I
Methylphenidate liquid (Quillivant)	ADHD	I
Methylphenidate patch (Daytrana)	ADHD	I
Mixed amphetamine salts (Adderall)	ADHD	I
Olanzapine (Zyprexa)	Mood stabilization, psychosis	IV
Oxcarbazepine (Trileptal)	Mood stabilization, seizure control	IV
Perphenazine (Trilafon)	Mood stabilization, psychosis	IV
Propranolol (Inderal)	Performance anxiety, panic, restless leg	II
Quetiapine (Seroquel)	Mood stabilization, psychosis, sometimes sleep	IV
Risperidone (Risperdal)	Mood stabilization, psychosis, aggression	IV, III
Sertraline (Zoloft)	Depression, anxiety, OCD	II
Topiramate (Topamax)	Mood stabilization, seizure control, migraines	IV
Valproic acid (Depakote, Depakene)	Mood stabilization, seizure control	IV
Venlafaxine (Effexor)	Depression	II
Ziprasidone (Geodon)	Mood stabilization, psychosis	IV

## Appendix II: Common Medical Abbreviations

A&O/AAO	alert and oriented
ADE/ADR	adverse drug effect/reaction
ADHD	attention deficit hyperactivity disorder
AED	anti-epileptic drug
AMS	altered mental state
ASD	autism spectrum disorder
AVH	auditory and visual hallucinations
BAL	blood alcohol level
BID	twice daily
BMP	basic metabolic panel
BPD	borderline personality disorder OR bipolar disorder (ambiguous)
c	*with straight line over top* "with"
CBC	complete blood count
CC	chief complaint
CICU	cardiac intensive care unit
CMP	complete metabolic panel
CNII-XII	cranial nerves II-XII
CNS	central nervous system
CPK	creatine phosphokinase (measure of muscle breakdown)
CSF	cerebrospinal fluid
CT	computerized tomography or chlamydia trachomatis (STI)
CTA	clear to auscultation
CVA	cardiovascular accident (stroke)
Cx	culture (for urine, blood, sputum, etc.)
CXR	chest x-ray
D/C	discharge or discontinue
DDx	differential diagnosis (list of conditions that might fit the symptoms)
DKA	diabetic ketoacidosis (life-threatening result of very high blood sugars)
DM	diabetes mellitus, specify type I (insulin resistant) and type II
DMDD	disruptive mood dysregulation disorder
DTR	deep tendon reflexes
DVT	deep vein thrombosis
Dx	diagnosis
ECT	electroconvulsive therapy
EDNOS	eating disorder not otherwise specified
EEG	electroencephalogram
EKG/ECG	electrocardiogram
EOM	extraocular muscles
EtOH	ethanol (used short-hand to indicate alcohol on breath, for example)



F/U	follow up
FMH	family medical history
FTT	failure to thrive
Fx	fracture
GAD	generalized anxiety disorder
GC	gonorrhea
GI	gastrointestinal or gastroenterology
GID	gender identity disorder
GSW	gunshot wound
gt/gtt	drops
GU	genitourinary
H/H	hemoglobin and hematocrit (often reported together)
HCG	human chorionic gonadotropin (measure of pregnancy & some tumors)
HCT	hematocrit (measure of anemia)
HEENT	head, eyes, ears, nose and throat
HgA1c	hemoglobin A1c (measure of long-term blood sugar control)
Hgb	hemoglobin (measure of anemia)
HI	homicidal ideation
HIV	human immunodeficiency virus
HPI	history of present illness
HPV	human papillomavirus
HSM	hepatosplenomegaly (enlarged liver or spleen)
HSV	herpes simplex virus
HTN	hypertension
Hx	history
I&O	input and output (fluid in and fluid out)
I/P	inpatient
ICU	intensive care unit
ID	infectious disease (department)
IED	intermittent explosive disorder
IM	intramuscular
IOP	intensive outpatient program
IT	intrathecal (delivered into the cerebrospinal fluid, usually chemotherapy)
IV	intravenous
JODM	juvenile onset diabetes mellitus
KUB	x-ray of kidneys, ureters, bladder
LFTs	liver function tests
LMP	last menstrual period
LOC	loss of consciousness or level of consciousness
LP	lumbar puncture (spinal tap, commonly)
LUQ/LLQ	left upper/lower quadrant (of abdomen)
M/R/G	murmurs, rubs or gallups
MDD	major depressive disorder

MMR	measles, mumps, rubella vaccine
MRA	magnetic resonance angiogram
MRI	magnetic resonance imaging
MRSA	methicillin-resistant staph aureus
MSE	mental status exam
MVA/MVC	motor vehicle accident/crash
NAD	no acute distress
NC	nasal cannula (as in oxygen delivered to nose)
NCAT	normo-cephalic, atraumatic (normal head, no injuries)
NES	non-epileptic seizure
NG	nasogastric (as in a feeding tube through the nose)
NICU	neonatal intensive care unit
NKDA	no known drug allergies
NOS	not otherwise specified
NPO	nothing by mouth (as in before surgery)
NSR	normal sinus rhythm (refers to cardiac exam)
O/P	outpatient
OCD	obsessive compulsive disorder
OCP	oral contraceptive pill
ODD	oppositional defiant disorder
OT	occupational therapy
PDDNOS	pervasive developmental disorder not otherwise specified
PE	physical exam or pulmonary embolism
PFTs	pulmonary function tests
PHP	partial hospitalization program
PICU	pediatric intensive care unit
PKU	phenylketonuria
PMH	past medical history
PNA	pneumonia
PO	by mouth
PPD	purified protein derivative (tuberculosis skin test)
PR	per rectum
PRN	as needed
Pt	patient
PT	physical therapy
q	every (q4h = every 4 hours)
QID	four times daily
QOD	every other day
QTc	corrected QT interval (EKG finding pertinent to some meds)
R/O	rule out
RIS	responding to internal stimuli
ROM	range of motion
ROS	review of symptoms

RPR	rapid plasma reagin (syphilis test)
RRR	regular rate and rhythm
RTC	residential treatment center OR return to clinic
RUQ/RLQ	right upper/lower quadrant (of abdomen)
Rx	prescription
s	*with straight line over top* "without"
S/NT/ND	soft, non-tender, non-distended
S/S	signs and symptoms
SAD	seasonal affective disorder OR schizoaffective disorder (ambiguous)
SGA	second-generation antipsychotic (atypical antipsychotic)
SI	suicidal ideation
SIB	self-injurious behavior
SL	sublingual (under the tongue)
SNRI	serotonin and norepinephrine reuptake inhibitor
SOB	shortness of breath
SQ	subcutaneous
SSRI	selective serotonin reuptake inhibitor
STD/STI	sexually transmitted disease/infection
SUD	substance use disorder
Sx	symptoms
TCA	tricyclic antidepressant
TFTs	thyroid function tests
THC	tetrahydrocannabinol (marijuana)
TIA	transient ischemic attack
TID	three times daily
TSH	thyroid stimulating hormone
Tx	treatment or therapy
U/S	ultrasound (also US)
UA	urinalysis
UDS	urine drug screen
UPT	urine pregnancy test
URI	upper respiratory infection
UTI	urinary tract infection
VDRL	Venereal Disease Research Laboratory (syphilis test)
VPA	valproic acid (Depakote/Depakene)
VRE	vancomycin-resistant enterococcus
W/U	workup
WBC	white blood cells
WNL	within normal limits
WWP	warm and well-perfused