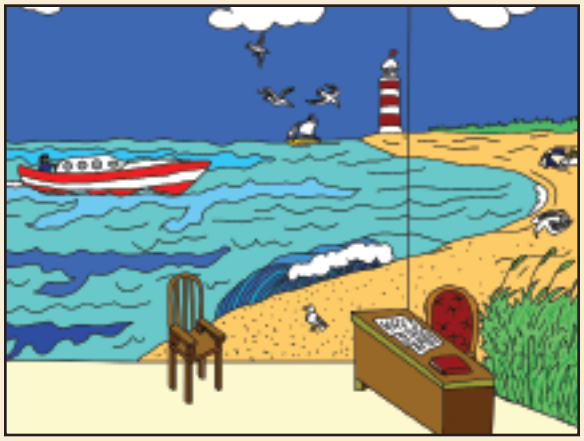
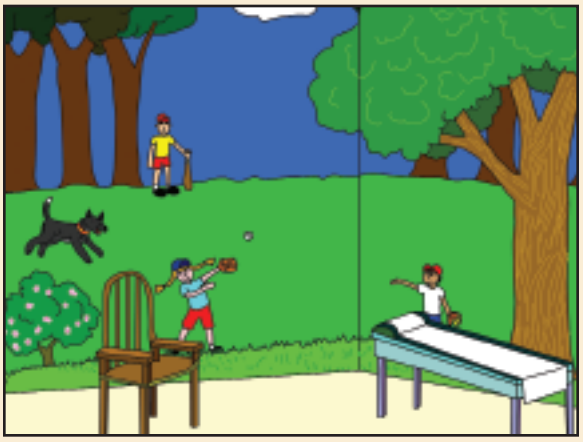




CASE SUMMARY


Siu

- Siu, an eight year old girl, lives in Chinatown with her family who speak predominantly Cantonese at home.
- During a regular check-up, Siu's mother reports that Siu is having difficulties in school and gets nervous about tests.
- Siu's mother also notes that Siu is very shy and does not spend much time with friends.
- During this visit, Siu appears distressed and hides when addressed directly by the pediatrician.
- To further assess these issues, the pediatrician schedules a follow-up appointment in one week and asks Siu's mother to bring in a report card and to complete the PSC-17, a shortened version of the PSC-35 with subscales for internalizing, attention, and externalizing problems.
- Siu has a positive score on the overall PSC-17, a positive score for internalizing problems, and a borderline score for attention problems.
- Due to the positive internalizing score and history, the pediatrician suspects an anxiety problem.
- While discussing the scores, the pediatrician learns that the family has experienced several recent stressors-on 9/11 Siu's family lost some friends and Siu's mother lost her job.
- The pediatrician also uses the PSC-17 scores to focus her assessment and administers the Vanderbilt Assessment Scale (Parent and Teacher versions) to further examine the borderline attention score.

KEY TEACHING POINTS

1. Siu's case may exemplify the experience of some children who have problems with learning, ADHD and/or anxiety disorders. Parents may experience shame if their child's academic work is poor and may not discuss the problem until it is at a more urgent level. This could occur, for example, after the school contacts the parent to discuss the child's academic progress. Parents may not volunteer this information unless asked specifically because they do not think school problems belong in the realm of a medical checkup. Scheduling a specific follow-up appointment to address psychosocial issues can convey the importance of these issues and help ensure timely follow-up.

2. Mental health problems, especially internalizing disorders like depression and anxiety, often go unrecognized. Families may believe that children are too young to have such problems and caregivers may not recognize that their own mental distress may transfer to their children. Parents may cope better with a concrete physical problem than with a mental health problem that needs prolonged counseling and/or may wax and wane with environmental changes. Parent-child-physician partnership in addressing these complex issues is critical.

3. Linguistic and cultural competencies are critical in any clinical encounter; this is particularly true when dealing with children's mental health issues. The vignette is presented in Chinese and English with the dialogue occurring directly between the parent or child and the clinician. In many clinical situations an interpreter may be needed, but it is vitally important that the interpreter not be the child. In addition, availability of screening tools in the parent and child's native language can also prove invaluable.

Case study derived with permission from the award-winning CD-ROM *Feelings Need Check Ups Too*

All children have some anxiety, fear, and worrying,
and this can be a normal response to a stressful situation.
Having an anxiety disorder is different from normal worry.

Children with anxiety problems have excessive fear and distress in response to "everyday" situations. This can be so severe that it causes significant distress to a child and interferes with a child's schoolwork, friendships, fun, or family relationships.

PREVALENCE

Anxiety disorders are the most common type of mental health disorder in childhood, affecting approximately 8% of all children and adolescents. There are many types of anxiety disorders that affect youth, the most common being Generalized Anxiety Disorder, Panic Disorder, Separation Anxiety Disorder, and Phobic Disorders.

SYMPTOMS

Symptoms of anxiety disorders can include:

- Recurring fears and worries about routine parts of every day life
- Physical complaints, like stomachache or headache
- Trouble concentrating
- Trouble sleeping
- Fear of social situations
- Fear of leaving home
- Fear of separation from a loved one
- Refusing to go to school

Co-morbid disorders, in particular ADHD and depression, are not uncommon.

DIAGNOSIS

A good diagnostic evaluation will include a complete history of symptoms to determine their severity and how long they have been present. Clinicians should assess for anxiety symptoms based on diagnostic criteria established in the DSM IV or ICD 10 and should use standardized anxiety tools to aid in the assessment.

TREATMENT

Anxiety disorders are treatable! Studies have shown that cognitive behavioral therapies (CBT) and medication treatments are both effective in treating anxiety disorders in youth. Parent involvement in treatment has also been shown to improve outcomes in some children. Early treatment can prevent future difficulties, such as academic or social difficulties and low self-esteem.

Remember...

- Review treatment options with the child and his/her family.
- Include the child and his/her family in the treatment plan.

Developed by *Reaching Children Initiative*, 2005 • Materials adapted by *RCI* faculty (American Red Cross grant, Mount Sinai School of Medicine) in collaboration with the Center for the Advancement of Children's Mental Health at Columbia University and from Bright Futures, MCHB

CASE SUMMARY


Doug

- Doug is an 11-year-old boy and an only child of a married couple living in suburban New Jersey.
- Doug has always been healthy, had many interests, and had been doing well in school.
- In March 2002, Doug and his mother attend his annual check-up with the pediatrician who has seen Doug since the age of five.
- During this visit, the pediatrician learns that Doug's grades have dropped due in part to more time being devoted to helping his mother with household chores.
- Upon further questioning by the pediatrician, Doug's mother discloses that her husband was killed in the attack on the World Trade Center.
- Neither mother nor son initially volunteered information about the death of Doug's father on September 11th.
- The pediatrician continues the interview by asking how Doug and his mother first learned about his father's death, their reactions to date, and how they have started to adjust.
- To rule out signs of PTSD, depression, or anxiety Doug is interviewed privately by his doctor who asks Doug to describe the events of that day.
- Doug tells him that his father left a message on their phone machine on the morning of September 11th to say that he was all right; but then he never came home.
- Doug wondered if his father might still be alive if he had not gone to school that day and had been home to speak to him.
- To better assess what is going on at home, the pediatrician also speaks to Doug's mother alone.
- She tells him that although she is close to falling apart and feels very sad and alone, she is getting great support from Doug.

KEY TEACHING POINTS

1. Eliciting what might have changed in a child/family's life since the last primary care visit is a critical step. Even with major life events, parents may ultimately be able to seek help or raise the issue with their physician, but many are reluctant or hesitant to do so. Openness to discussion can be communicated to families through active listening and open-ended questions that invite dialogue.

2. Loss of a parent is unfortunately experienced by about 5% of children by the age of 16. Primary care physicians should be prepared to counsel and support families through this difficult time. Concrete steps that can aid in this area are drawing upon the established relationship with the family, active listening, and providing guidance about the normal reactions to grief.

3. Grief and mourning are normative reactions to loss and by themselves do not require medication or traditional mental health services. However, a supportive environment in the primary care setting and availability of community resources can be exceedingly helpful for families struggling with a loss. Detecting more serious depression can be assisted by the use of a screening tool such as the PSC.

Case study derived with permission from the award-winning CD-ROM *Feelings Need Check Ups Too*

Experiencing the death of a family member or friend is one of the greatest stressors that children may face

PREVALENCE

The vast majority of children will experience the death of a family member or friend sometime during their childhood. Five percent of children will experience the death of a parent by age 16.

RISK FACTORS FOR COMPLICATED GRIEF

- Sudden and unanticipated death (especially if traumatic or violent, or the result of suicide or homicide) or death after a very long illness
- Perception of death as being preventable
- Death when the child is less than 5 or during adolescence
- Other losses in the child's life or ongoing stressors
- Angry, ambivalent, or dependent relationship between the child and deceased
- If parent remarries and there is an unsupportive relationship between the child and stepparent
- Pre-existing mental health problem in the child
- Inadequate support within the family or community for the child

HOW CAN PEDIATRICIANS PROVIDE ASSISTANCE?

Pediatricians can draw upon their established relationship with the child and family in order to:

- Actively listen to the child and be with the child/family while they express their grief
- Provide guidance on normal reactions to grief
- Identify and address guilt reactions and misconceptions
- Provide concrete advice on how to support children, such as relates to funeral attendance
- Identify and address somatization
- Screen for rare but more serious reactions, such as depression
- Provide referrals to community resources (e.g., children's bereavement support groups)
- Provide follow-up - contact children after time has passed to see how they are doing

EXAMPLES OF COMMENTS TO AVOID

- DO NOT try to cheer-up children who are actively grieving (e.g., "I know it hurts very much right now, but I know you will feel better within a short period of time"). Allow children to grieve.
- DO NOT encourage the child or parent to cover up their emotions (e.g., "You need to be strong for your mother/son. You don't want them to see you crying, do you?").
- DO express your own feelings and demonstrate empathy (e.g., "I realize this must be extremely difficult for you" or "I can only begin to imagine how painful this must be"), but AVOID statements such as:
    - "I know exactly what you are going through" (You cannot know this.)
    - "You must be angry" (Let the individual express his/her own feelings. Do not tell him/her how to feel.)
    - "Both my parents died when I was your age" (Do not "compete" with the survivor for sympathy.)

ADVICE TO GIVE TO PARENTS ON FUNERAL ATTENDANCE

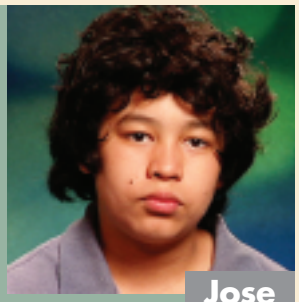
Children, just as adults, often benefit from participating in the funeral and other ceremonies. Explain to children concretely what to expect and invite them to participate to the level they feel comfortable. Do not coerce children to do something that makes them uncomfortable (e.g., kissing the deceased). Identify a "partner" to guide the child and monitor reactions throughout the event. He/She can answer the child's questions and allow the child to leave temporarily or permanently if the child so desires. He/She should be well known to the child, understand the child's developmental needs and preferably not be actively grieving so as to be able to attend to the child's needs.

Remember...

- Notify families that you are interested in learning about important events that may impact their child's life, such as the death of a family member or friend. Otherwise they may not contact you for support at such times.
- Help parents find support for themselves, so they are better able to support their children.
- Be sure to follow-up with families over time since grieving is a long-term process.

Developed by Reaching Children Initiative Faculty, 2006

CASE SUMMARY


Jose

- Jose is a 13-year old male who lives with his mother, father and 9-year old brother. The family is fluent in English and Spanish and lives in the Bronx. A counselor refers Jose to the neighborhood clinic because he is concerned about his weight.
- Jose is unclear why he was referred but offers three possibilities: his weight, his asthma, or his difficulty getting along with his schoolmates.
- Jose has a history of school-related problems. He does not raise his hand or participate in class activities, does not complete his schoolwork and often complains of being bored. He prefers to be home with his mother and does not have many friends.
- The pediatrician elicits a history that a year ago, Jose saw his grandmother murdered and since then has wanted to stay at home with his mother. He also knows students who lost parents in the events of 9/11 and seems to think about it a lot. Previous visits to a counselor were not successful.
- The pediatrician encourages them to meet again with a counselor, and also schedules a follow-up visit in two weeks.
- Jose and his parents miss the follow-up visit. Three months later, Jose's father calls the clinic to request a same day appointment for his son who is very upset and refuses to go to school. At the visit, the father reports that the other kids bully Jose, and that Jose has threatened to jump out of the first floor window.
- The use of the PSC-17 internalizing score followed by the PHQ-9 diagnostic aid may further elucidate Jose's mental health problems.

KEY TEACHING POINTS

1. Research shows that the use of open-ended questions (e.g., "why," "how," or "what do you feel about"), is more effective than a yes-no format in eliciting parents' and youth's concerns. In addition, even if the clinician thinks that she/he understands the chief reason for coming to care, it is often useful to re-ask the open-ended question of what else does the patient need or want to discuss. These questions only take a few minutes and may result in actually saving time over the long run.

2. Primary care clinicians are well placed to address physical health issues in tandem with mental health issues. In fact, as illustrated in this case, the two may be linked and easier to address together.

3. Emergency mental health referrals for a true suicide attempt, with a clear and unambivalent wish to die or a specific plan, are quite appropriate and necessary. However, most adolescents have thoughts of death or dying in any given year, so thoughts or threats in and of themselves may not warrant an emergency mental health referral. Instead, one should determine the extent to which the child or youth actually intends to hurt him/herself, whether he/she has specific plans to do so, and his/her degree of impulsivity. Forming a contract with the youth to notify you or the parent if she/he has recurrent thoughts to hurt him/herself can be helpful.

4. While not the primary concern for this family, in the post 9/11 world it is not unusual for children who have had previous traumatic exposures to be more vulnerable to depressive symptomatology as a result of the events of 9/11 or other traumatic incidents.

Case study derived with permission from the award-winning CD-ROM *Feelings Need Check Ups Too*

Depression is a serious mental disorder that negatively affects overall functioning and may potentially lead to suicide.

The main characteristics of depression are excessive sadness, loss of interest in activities, sleeping problems, lack of energy, preoccupation with death or dying, feelings of worthlessness or excessive guilt, and difficulty in thinking, concentrating, or making decisions.

PREVALENCE

In the United States, it is estimated that up to 3 percent of children and up to 8 percent of adolescents suffer from depression. Estimates of lifetime prevalence are significantly higher at 18-20%.

SYMPTOMS

- Sadness
- Irritability
- Change in appetite
- Change in sleeping patterns (too much or too little)
- Loss of interest in activities
- Loss of energy
- Fatigue
- Feeling slowed down or "burned out"
- Excessive feelings of guilt
- Inability to concentrate
- Indecisiveness
- Feelings of hopelessness and helplessness
- Recurring thoughts of death and suicide
- Physical complaints (Stomachaches, Headaches)
- Behavioral changes
    - Conflicts with family and friends
    - Decline in school performance
    - Inappropriate sexual activity
    - Use of alcohol or drugs

DIAGNOSIS

A good diagnostic evaluation will include the following:

- A complete history of symptoms to determine how long and how often they have been present
- Questions about thoughts of death or suicide
- Inquiry about any family history of depression and other mental illnesses

Primary care clinicians should evaluate for depression in high-risk adolescents as well as those who present with emotional problems as the chief complaint. Clinicians should assess for depressive symptoms based on diagnostic criteria established in the DSM-IV or ICD 10 and should use standardized depression tools to aid in the assessment.

TREATMENT

Both psychotherapies and antidepressant medications can be effective in treating childhood and adolescent depression:

Psychotherapies proven to treat depression effectively in youth:

- Cognitive behavioral therapy
- Interpersonal therapy

Both are time-limited, structured therapies that are typically administered in either individual or group sessions.

Psychopharmacology shown to treat depression effectively in youth:

- Selective Serotonin Reuptake Inhibitors (SSRIs) (The most well known is Fluoxetine)

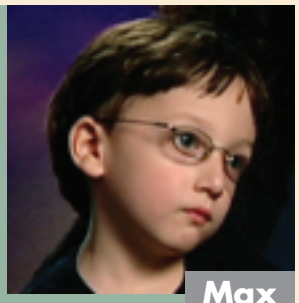
These medications target a chemical in the brain called serotonin, which is believed to play a major role in depression. Other therapies such as family therapy, play therapy, and other medication treatments are available but there is little evidence demonstrating their effectiveness.

Remember…

- Review these treatment options with the child and his/her family.
- Include the child and his/her family in the treatment plan.

Developed by *Reaching Children Initiative*, 2005. Materials adapted by *RCI* faculty (American Red Cross grant, Mount Sinai School of Medicine) in collaboration with the Center for the Advancement of Children's Mental Health at Columbia University and from Bright Futures, MCHB

CASE SUMMARY


Max

- Max is a boy nearly four years of age who lived with his family in Battery Park City, across the street from the World Trade Center.
- Prior to 9/11, he had already experienced numerous traumatic events including surgeries for a chronic condition and hospitalization for a minor burn.
- In December 2001, Max saw his pediatrician for the first time in several months and presented with vomiting and poor appetite.
- During this visit, the pediatrician learned that on 9/11 Max was exposed to various graphic images of seriously injured individuals and has shown symptoms consistent with acute stress reaction.
- To further assess his condition, the pediatrician asked Max's mother to complete the PSC-17, a shortened version of the PSC-35 with subscales for internalizing, attention, and externalizing problems.
- Max had an overall positive score on the PSC-17 and a positive score for internalizing problems.
- Since 9/11, Max has reverted to wearing diapers at night, wears his shoes all the time, has become increasingly introverted and stopped wanting to go to school, although he enjoyed going to school in the past.
- Over time, pediatric visits grew more frequent as Max continued to experience stomachaches and difficulty breathing despite normal physical exams.

KEY TEACHING POINTS

1. It is important to help families distinguish between normal reactions to traumatic events and those trauma-related symptoms that persist and may be in need of intervention.

2. Using a "sick visit" to identify what has been happening emotionally and behaviorally with a child might offer distinct opportunities to elicit key events in families' lives.

3. The need for a mental health referral can be a sensitive issue for a family. The literature indicates that about 50% of children referred to a mental health professional do not keep their appointments. Pediatricians play a central role in the well being of children and families in emotional distress by providing reassurance, securing the appointment, and arranging follow-up in primary care. In addition, primary care physicians are important sources of guidance and continuing support.

4. Parents can play a significant role in addressing symptoms of PTSD by reassuring a child that he/she is safe. Helping to reestablish routines and encouraging the child to hold onto toys may help allay some fears.

5. Parents should also be encouraged to speak with their child's teacher about ways to offer support and reassurance in the classroom.

6. While this case exemplifies a situation where there is a need for referral outside the primary care setting, eliciting the trauma history and the use of the PSC-17 as a screening tool did help guide the clinician's thinking. Identifying symptoms in the domains of internalizing (internal feelings of sadness, fear, distress), externalizing (outward behavior), and attention behaviors may be helpful in understanding how they relate to the clinical picture. Those findings may also be useful to the mental health specialist in his or her initial assessment.

Case study derived with permission from the award-winning CD-ROM *Feelings Need Check Ups Too*

Post-Traumatic Stress Disorder is an anxiety disorder that occurs following a traumatic event. Such events include physical or sexual abuse, rape, bullying, criminal assault, community violence, war, a natural disaster or other injurious events.

PREVALENCE

Among school-aged children, no published studies have addressed the overall prevalence of PTSD in primary care settings. However, specific studies have looked at the prevalence of PTSD related to specific traumas such as motor vehicle crashes (12.5%) and sexual abuse (range 43%-63.5%).

SYMPTOMS

While it is not unusual to have acute stress reactions occurring within 4 weeks of exposure to a trauma, persistence of symptoms beyond a month may signal PTSD. Symptoms of PTSD typically begin within 3 months after the traumatic event. However, it is also possible for the symptoms to appear years after the event, often in response to another life stressor. The symptoms in children often differ from those of adults.

Symptoms in children may include:

- Recurrent, distressing dreams or recollections of the traumatic event
- Generalized nightmares of monsters, of rescuing others, or of threats to self or others
- Difficulty sleeping alone
- Repetitive or disorganized play reliving the event
- Physical symptoms such as stomachaches and headaches
- Extra fears or aggressive behaviors in response to stress
- Separation anxiety

Co-occurring depression and substance abuse is not uncommon.

DIAGNOSIS

Primary care physicians should look to consistently identify a history of trauma and to link that trauma exposure to presenting symptoms. A brief trauma question derived from the UCLA PTSD Index (Pynoos, 1998) to be asked of children and adolescents is "Has anything ever happened to you that was really scary, dangerous or violent?" or " Have you ever seen something really scary, dangerous or violent happen to someone else?" If a trauma exposure is revealed, follow-up questions should elicit the full history, ask if the child thinks about the event, worries about the event, replays the event, has associated sleep disturbances, is withdrawn, or avoids activities and interactions with others. Child/Adolescent and parent should be involved in this dialogue. Mental health referral is indicated for symptomatic children.

TREATMENT

While there is minimal rigorous research supporting the effectiveness of current treatments for PTSD, treatment for traumatic stress appears to be better than no treatment. A recent research study has demonstrated that children with PTSD showed significant improvement in their symptoms after receiving cognitive-behavioral therapy, a time-limited form of "talk therapy."

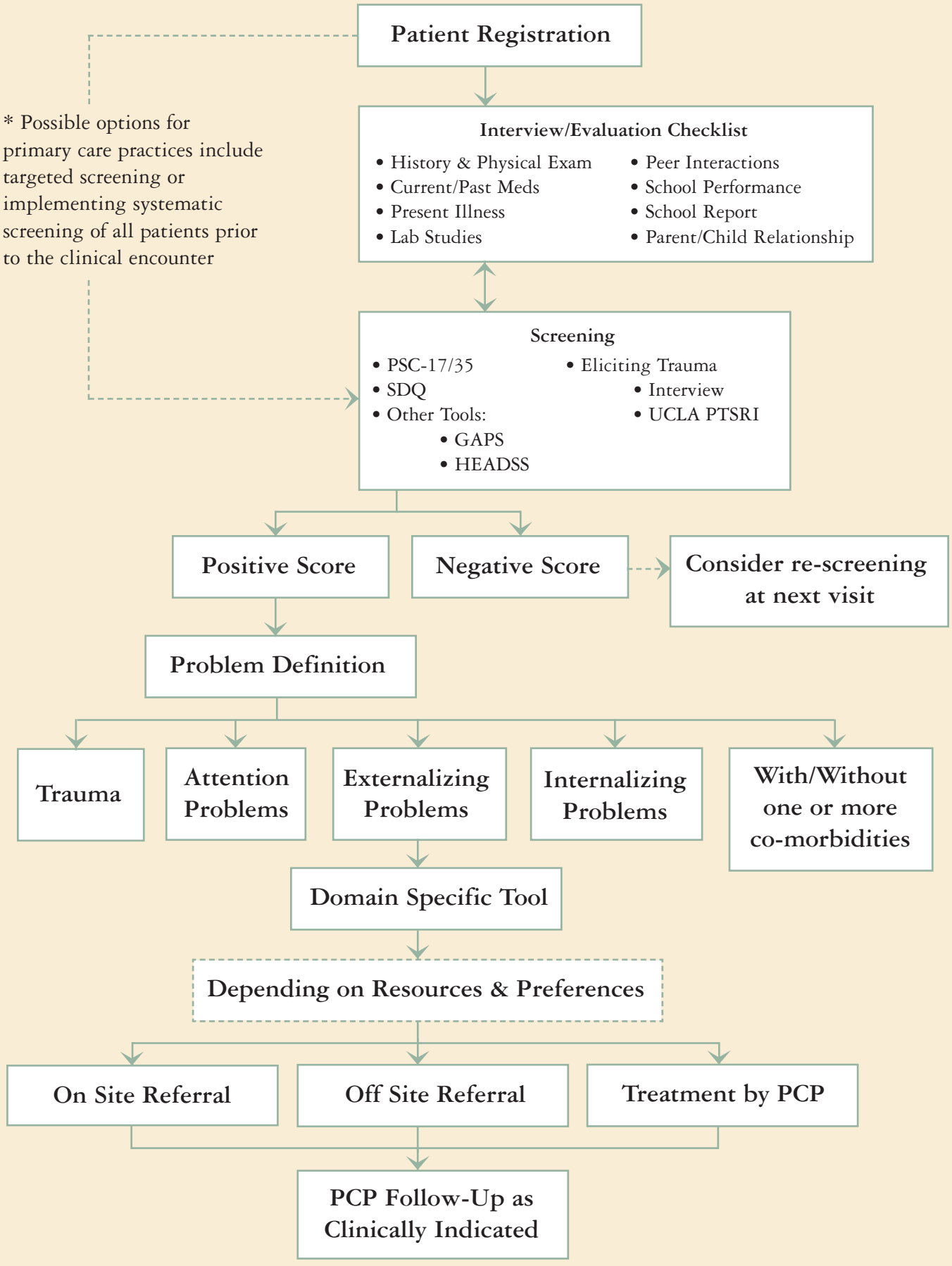
Other therapies such as family therapy, play therapy, and other medication treatments are available. However, there is little evidence demonstrating their effectiveness.

Remember…

- Review treatment options with the child and his/her family.
- Include the child and his/her family in the treatment plan.

Developed by *Reaching Children Initiative*, 2005. Materials adapted by *RCI* faculty (American Red Cross grant, Mount Sinai School of Medicine) in collaboration with the Center for the Advancementof Children's Mental Health at Columbia University and from Bright Futures, MCHB

SCREENING FOR PSYCHOSOCIAL IMPAIRMENT



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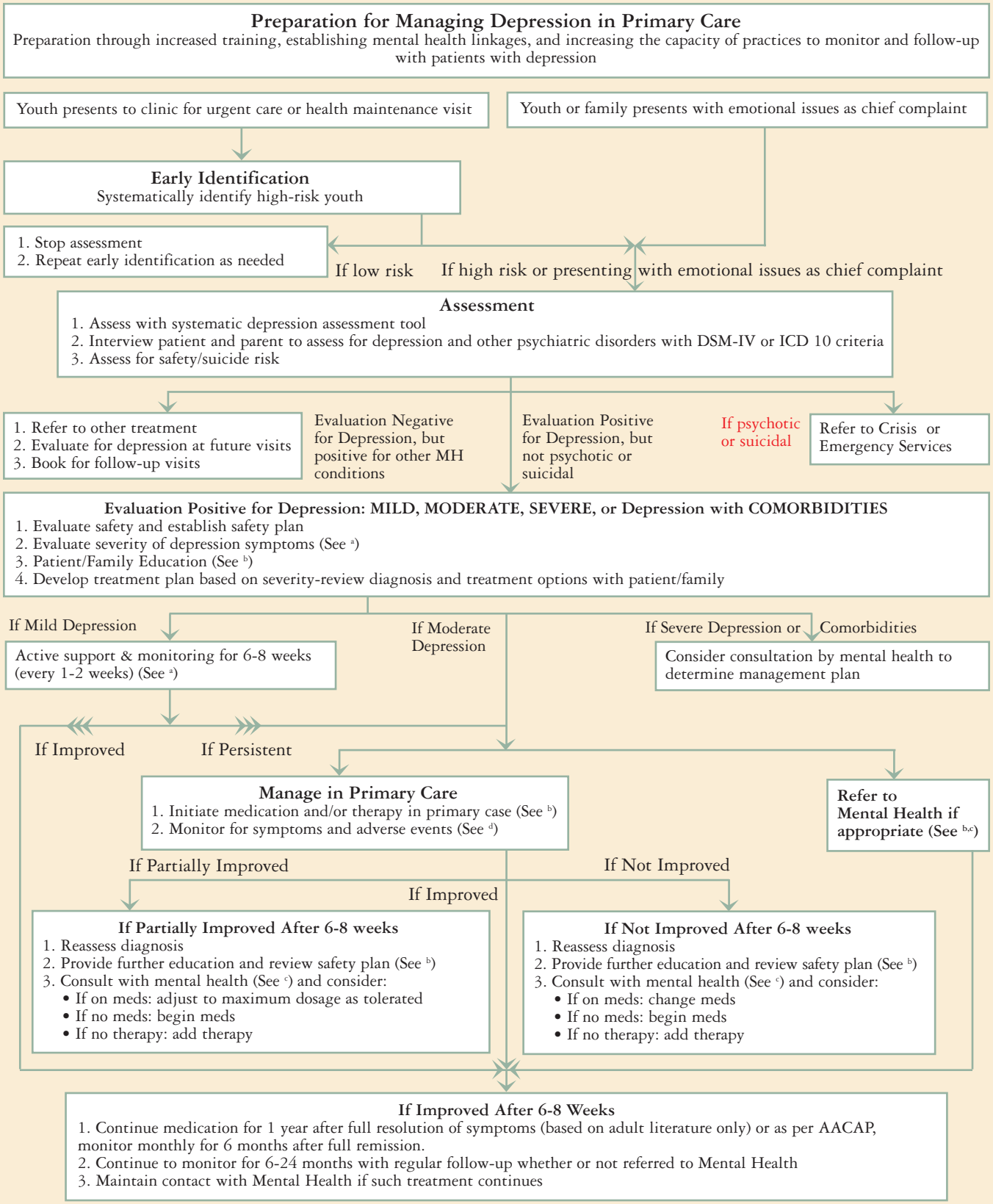
GLAD-PC CLINICAL ASSESSMENT FLOWCHART



[a] See guidelines for definition of mild, moderate, and severe depression. Please consult GLAD-PC toolkit for methods available to aid providers to distinguish between mild, moderate, and severe depression.
[b] Psychoeducation, supportive counseling, facilitate parental & patient self-management, refer for peer support and regular monitoring of depressive symptoms and suicidality.
[c] Negotiate roles/responsibilities between primary care and mental health, and designate case coordination responsibilities. Continue to monitor in primary care after referral. Maintain contact with MH.
[d] Professionals should monitor for changes in symptoms and emergence of adverse events such as increased suicidal ideation, agitation or induction of mania. For monitoring guidelines please refer to guidelines/toolkit.

Adapted with permission from the *Guidelines for Adolescent Depression in Primary Care, GLAD-PC* Toolkit developed by the Center for the Advancement of Children's Mental Health at Columbia University

PEDIATRIC SYMPTOM CHECKLIST-17 (PSC-17)

Filled out by: _____ Record #: _____

Child's DOB: _____ Today's Date: _____

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:		NEVER	SOMETIMES	OFTEN
◆	Fidgety, unable to sit still ◆	0	1	2
❊	Feels sad, unhappy ❊	0	1	2
◆	Daydreams too much ◆	0	1	2
❑	Refuses to share ❑	0	1	2
❑	Does not understand other people's feelings ❑	0	1	2
❊	Feels hopeless ❊	0	1	2
◆	Has trouble concentrating ◆	0	1	2
❑	Fights with other children ❑	0	1	2
❊	Is down on him or herself ❊	0	1	2
❑	Blames others for his or her trouble ❑	0	1	2
❊	Seems to be having less fun ❊	0	1	2
❑	Does not listen to rules ❑	0	1	2
◆	Acts as if driven by a motor ◆	0	1	2
❑	Teases others ❑	0	1	2
❊	Worries a lot ❊	0	1	2
❑	Takes things that do not belong to him or her ❑	0	1	2
◆	Distracted easily ◆	0	1	2

OFFICE USE ONLY

Total ◆ _____ Total ❑ _____ Total ❊ _____ Grand Total ◆+❑+❊ _____

Form adapted with permission for *Feelings Need Check Ups Too*, 2004

SCORING THE PEDIATRIC SYMPTOM CHECKLIST-17 (PSC-17)

(PARENT AND YOUTH VERSIONS)*

INSTRUCTIONS FOR SCORING

- The PSC-17 is a shortened version of the PSC-35 and consists of 17 items.
- Each item is rated as "NEVER," "SOMETIMES," or "OFTEN" present and scored 0, 1, and 2 respectively.
- The total score is calculated by adding together the score for each of the 17 items.

  Positive PSC-17 score ≥ 15

- Attention, externalizing and internalizing subscale scores are calculated by adding the score for each corresponding symbol:

  ◆ = Attention, *positive score ≥ 7*

  ❑ = Externalizing, *positive score ≥ 7*

  ❇ = Internalizing, *positive score ≥ 5*

HOW TO INTERPRET

- As with the PSC-35, the PSC-17 is *not* meant to be used as a diagnostic tool.

  A positive score on the PSC-17 or any of the subscales suggests the need for further evaluation by a qualified health (e.g., M.D., R.N.) or mental health (e.g., Ph.D., L.I.C.S.W.) professional.

PSC-17 VALIDATION (GARDNER ET AL. 1999)

- The PSC-17 subscales have obtained reasonable agreement with validated and accepted parent-report instruments for internalizing, externalizing, and attention problems.
- Cronbach's α was high for each subscale, i.e., the items in each subscale have similar meanings for a parent reporting his/her impressions of his/her child.
- Both false positives and false negatives occur, and only an experienced health professional should interpret a positive PSC health score as anything other than a suggestion that further evaluation may be helpful.

YOUTH PEDIATRIC SYMPTOM CHECKLIST-17 (Y PSC-17)

Name: _____ Record #: _____

Date of Birth: _____ Today's Date: _____

Please mark under the heading that best fits you:		NEVER	SOMETIMES	OFTEN
◆	Fidgety, unable to sit still ◆	0	1	2
❊	Feel sad, unhappy ❊	0	1	2
◆	Daydream too much ◆	0	1	2
❑	Refuse to share ❑	0	1	2
❑	Do not understand other people's feelings ❑	0	1	2
❊	Feel hopeless ❊	0	1	2
◆	Have trouble concentrating ◆	0	1	2
❑	Fight with other children ❑	0	1	2
❊	Down on yourself ❊	0	1	2
❑	Blame others for your troubles ❑	0	1	2
❊	Seem to be having less fun ❊	0	1	2
❑	Do not listen to rules ❑	0	1	2
◆	Act as if driven by a motor ◆	0	1	2
❑	Tease others ❑	0	1	2
❊	Worry a lot ❊	0	1	2
❑	Take things that do not belong to you ❑	0	1	2
◆	Distract easily ◆	0	1	2

OFFICE USE ONLY

Total ◆ _____ Total ❑ _____ Total ❊ _____ Grand Total ◆+❑+❊ _____

Form adapted with permission for *Feelings Need Check Ups Too*, 2004

SCORING THE PEDIATRIC SYMPTOM CHECKLIST-17 (PSC-17)

(PARENT AND YOUTH VERSIONS)*

INSTRUCTIONS FOR SCORING

- The PSC-17 is a shortened version of the PSC-35 and consists of 17 items.
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- The total score is calculated by adding together the score for each of the 17 items.

  Positive PSC-17 score ≥ 15

- Attention, externalizing and internalizing subscale scores are calculated by adding the score for each corresponding symbol:

  ◆ = Attention, *positive score ≥ 7*

  ❑ = Externalizing, *positive score ≥ 7*

  ❇ = Internalizing, *positive score ≥ 5*

HOW TO INTERPRET

- As with the PSC-35, the PSC-17 is *not* meant to be used as a diagnostic tool.

  A positive score on the PSC-17 or any of the subscales suggests the need for further evaluation by a qualified health (e.g., M.D., R.N.) or mental health (e.g., Ph.D., L.I.C.S.W.) professional.

PSC-17 VALIDATION (GARDNER ET AL. 1999)

- The PSC-17 subscales have obtained reasonable agreement with validated and accepted parent-report instruments for internalizing, externalizing, and attention problems.
- Cronbach's α was high for each subscale, i.e., the items in each subscale have similar meanings for a parent reporting his/her impressions of his/her child.
- Both false positives and false negatives occur, and only an experienced health professional should interpret a positive PSC health score as anything other than a suggestion that further evaluation may be helpful.

MODIFIED PATIENT HEALTH QUESTIONNAIRE-9

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

	Not At All (0)	Several Days (1)	More Than Half The Days (2)	Nearly Every Day (3)
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
[ ] Yes [ ] No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?
[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
[ ] Yes [ ] No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
[ ] Yes [ ] No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:**

SCORING THE MODIFIED PHQ-9

Only questions 1-9 count in the scoring, but the other questions must be looked at to assess dysthymia and suicidality.

Add up all "X"ed boxes on the PHQ-9.

FOR EVERY X:		
Not at all	=	0
Several days	=	1
More than half the days	=	2
Nearly every day	=	3

TOTAL SCORE	DEPRESSION SEVERITY
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Adapted with permission from the *Guidelines for Adolescent Depression in Primary care*, *GLAD-PC* Toolkit developed by the Center for the Advancement of Children's Mental Health at Columbia University

WARNING SIGNS FOR ACTION

Your behavioral health is an important part of your physical health. If you are experiencing any of these feelings, let your doctor know. You are not alone…not 1 in a 1000, but 1 in 10, because many kids have similar problems! Getting help is what counts. Help is available, and treatments work! Don't wait. Talk with a helpful adult, such as your parents, doctor, school nurse or counselor, or minister/rabbi.


Siu

- Feeling very sad or withdrawn for more than 2 weeks
- Seriously trying to harm or kill yourself, or making plans to do so
- Sudden overwhelming fear for no reason, sometimes with a racing heart or fast breathing
- Involved in many fights, using a weapon, or wanting to badly hurt others
- Severe out-of-control behavior that can hurt yourself or others
- Not eating, throwing up, or using laxatives to make yourself lose weight
- Intense worries or fears that get in the way of your daily activities
- Extreme difficulty in concentrating or staying still that puts you in physical danger or causes school failure
- Repeated use of drugs or alcohol
- Severe mood swings that cause problems in relationships
- Drastic changes in your behavior or personality


Jose

These warning signs were adapted from those developed under a grant from SAMHSA/HHS, number 520712. The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.
Jensen P, et al. *The Warning Signs Project*

INTRODUCTION

Cognitive Behavioral Therapy (CBT) is based on the principle that one's thoughts, feelings, and behaviors affect one another.

Problematic thoughts regarding self, experiences, and the future can result in psychopathology.

Examples:	PROBLEMATIC THOUGHTS	PSYCHOPATHOLOGY
	• Self-unworthy • Environment is disapproving • Future is uncertain	→ Depression
	• Self-inadequacy • Environment is dangerous • Future is hopeless	→ Anxiety

One of the key principles in CBT is Cognitive Restructuring which involves modifying unrealistic assumptions, beliefs, and thoughts that lead to disturbing emotions and impaired functioning.

STEPS IN COGNITIVE RESTRUCTURING

1. Identify a Situation	What happened that made me upset?
2. Feelings	4 Major Types of Upsetting Emotions: • Fear and Anxiety • Sadness and Depression • Guilt and Shame • Anger
3. Thought	What am I thinking that is making me feel this way? How is this thought a problem? • All-or-Nothing • Emotional Reasoning • Overgeneralizing • Overestimation of Risk • Must/Should/Never • Self-Blame • Catastrophizing
4. Challenge Your Thought	What evidence do I have for this thought? Is there an alternative way to look at this situation? How would someone else think about the situation?
5. Making a Decision	Do things mostly support my thought or do things mostly NOT support my thought?

Adapted from *Brief Intervention For Continuing Postdisaster Distress* (Hamblen J, et al.) developed by the National Center for PTSD

HOW TO IDENTIFY CBT PRACTITIONERS

Families should seek the following information when looking for a qualified cognitive behavior therapist:

- Valid license on state education department website (for all therapists)
- High volume of CBT cases in his or her practice
- Evidence of initial intensive training and supervision to learn CBT
- Evidence of ongoing professional education in CBT (recent workshops attended or reading of recent CBT publications/journals)
- Membership in professional organizations which promote CBT (e.g., AABT)
- Ability to clearly articulate examples about how CBT is used in his/her practice and to use CBT terminology in his/her discussion
- Evidence of specialty in CBT (e.g., CBT for phobias, ADHD)
- Authorship of professional or mass media publications on CBT

WHEN YOU SUSPECT ANXIETY IN A CHILD OR ADOLESCENT

- **Rule out** other causes of symptoms including learning disabilities, problems with attention, post-traumatic stress disorder, and depression
- **Psychoeducate** children and their families regarding anxiety—symptoms, duration, severity, impact on academic and social functioning, and the need for treatment
- **Educate** children and their families on treatment options such as cognitive behavioral treatment

SIGNS OF ANXIETY AND TECHNIQUES THAT CAN BE USED

SIGNS	TECHNIQUES
• Siu takes a long time to do her homework • Mom has to sit with her as she does homework	• **Coping skills** Examples: Deep breathing, muscle relaxation, positive "self-talk," thought stopping, and thinking of a safe place Teach the same **coping skills** to parents so they can "coach" Siu if needed
• Siu often has test anxiety *"I am going to fail"*	• **Cognitive coping** Explain to the family how the way we think about situations affects how we feel and then behave in that situation • **Positive "Self-Talk"** Encourage Siu to change her attitude about tests from "I am going to fail" to "This is really hard for me, but I studied and I should do ok"
• Siu is very shy • Siu has no after school activities or plans with friends	• **Exposure** Encourage parents to involve Siu in after school activities and help make plans with friends that will be fun for her Suggest to parents to involve the parents of Siu's friends in making these plans
• Parents do not speak about the events of 9/11 *"My husband and I are not used to talking about these things"*	• **Psychoeducation** Explain to parents that at times it is beneficial to talk to their kids about traumatic events like 9/11, and that this can ease possible negative effects

Developed by *Reaching Children Initiative* Faculty and Mount Sinai School of Medicine, 2005

WHEN YOU SUSPECT DEPRESSION IN A CHILD OR ADOLESCENT

- **Rule out** other causes of symptoms including general medical conditions and look for possible co-morbid conditions such as substance use and past trauma
- **Psychoeducate** children and their families regarding depression—symptoms, duration, severity, response to treatment, and warning signs including suicidal or self-injurious thoughts
- **Educate** children and their families on treatment options such as cognitive behavioral treatment and SSRIs

SIGNS OF DEPRESSION AND TECHNIQUES THAT CAN BE USED

SIGNS	TECHNIQUES
• Jose has several school-related problems: disinterest in school, inability to concentrate, attendance issues	• **Cognitive Restructuring** Teach Jose that he can learn to change his mood based on how he thinks about situations and that positive expectations often lead to positive outcomes Ask Jose to monitor his negative "self-talk" about school and to come up with arguments to dispute these automatic thoughts
• Jose does not want to engage in usual social activities • Jose reports being targeted by bullies	• **Role Playing and Modeling** Ask Jose what advice he would give a friend who wants to better manage the impressions that others have of him Have Jose share what his strengths are in social situations and explore with him the "small steps" he could take to increase his social status • **Positive "Self-Talk"** Have Jose come up with positive statements he can say to inoculate himself from the negative comments of others
• Jose exhibits suicidal ideation	• **Problem Solving Skills Training** Teach Jose alternative ways to express his frustration and distress, such as talking to his parents about the feelings he keeps bottled up inside Review the process of problem solving with Jose including ways to generate alternative solutions when he feels trapped • **Positive "Self-Talk"** Ask Jose to share his positive reasons for living, including his long-term goals for his life and his family
• Jose expresses emotional distress that exacerbates existing medical problems and weight gain	• **Feelings Identification** Help Jose understand the connection between his feelings, thoughts and their impact on the body Ask Jose to monitor what happens inside of him (e.g., thoughts of his grandmother's murder) before feeling compelled to eat or sensing that an asthma attack is coming

Developed by *Reaching Children Initiative* Faculty and Mount Sinai School of Medicine, 2005

WHEN YOU SUSPECT POST-TRAUMATIC STRESS IN A CHILD OR ADOLESCENT

- Obtain a comprehensive **trauma history**
- **Psychoeducate** children and their families regarding post-traumatic stress—symptoms, impact on functioning, and need for treatment
- **Educate** children and their families on options available for treatment (e.g., generic vs. trauma-focused treatment) and seeking appropriate service providers for ongoing and complete treatment

SIGNS OF PTSD AND TECHNIQUES THAT CAN BE USED

SIGNS	TECHNIQUES
• Max draws and plays out the events repetitively	• **Exposure** Encourage parents to allow Max to express feelings through repetition of the drawing Ask parents to introduce a reparative element by giving positive feedback to Max about safety
• Max exhibits separation anxiety and school aversion	• **Exposure** Explain to parents that Max needs to go to school even if he protests, and that the longer the child stays out of school, the harder it is to go back • **Psychoeducation** Reassure parents that once Max is in school, he will learn through experience that nothing bad will happen, and that after a traumatic event it is best to get children back to their regular routines as soon as possible
• Max refuses to take off his shoes even when sleeping	• **Psychoeducation** Encourage parents to allow Max wear his shoes Explain to parents that wearing the shoes helps Max to feel safe and that he will be able to take them off when a sense of safety is restored
• Max has regressed to wearing diapers at night	• **Psychoeducation** Explain to parents that regression is common among children after a traumatic event and that it usually remits with time and treatment
• Max is withdrawn and does not interact with other kids	• **Exposure** Ask parents to plan play dates and social activities for Max Encourage the family to get Max back to his old social routines
• Max has recurrent stomachaches	• **Psychoeducation** Explain to Max and his parents that the stomachaches are the body's way of giving children the signal that they are feeling anxious Encourage the family to view the stomachaches as a "message" from the body to address the anxiety • **Coping Skills** Teach Max **deep breathing** and/or progressive **muscle relaxation** exercises Teach the same coping skills to parents so they can "coach" Max if needed

Developed by *Reaching Children Initiative* Faculty and Mount Sinai School of Medicine, 2005

BOOKS FOR PARENTS

ANXIETY	• Chansky, T. 2004. *Freeing Your Child from Anxiety*. New York: Broadway Books. • DuPont Spencer, E., R. DuPont, and C. DuPont. 2003. *The Anxiety Cure for Kids: A Guide for Parents*. Hoboken: Wiley. • Spence, S.H., V. Cobham, and A. Wignall. 2000. *Helping Your Anxious Child: A Step-by-Step Guide for Parents*. Oakland: New Harbinger Publications.
ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER	• Koplewicz, MD, H.S. 1997. *It's Nobody's Fault: New Hope and Help for Difficult Children and Their Parents*. New York: Three Rivers Press. • Wender, P.H. 2001. *ADHD: Attention-Deficit Hyperactivity Disorder in Children and Adults*. New York: Oxford University Press. • Zeigler Dendy, C.A. 1995. *Teenagers with ADD: A Parent's Guide*. Bethesda: Woodbine House.
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PTSD	• Straus, M.A., R.J. Gelles and S.K. Steinmetz. 1981. *Behind Closed Doors: Violence in the American Family*. Two Harbors: Anchor Books. • Dumas, L.S. 1992. *Talking with Your Child about a Troubled World*. New York: Ballantine Books.
OTHER	• Wilens, T.E. 2004. *Straight Talk about Psychiatric Medication for Kids*. New York: Guilford Press. • Ellis, A., J.L. Wolfe, and S. Moseley. 1980. *How to Raise an Emotionally Healthy, Happy Child*. North Hollywood: Wilshire Book Company. • Clark, L. 1996. *SOS Help for Parents: A Practical Guide for Handling Complex Behavior Problems*. Bowling Green: Parents Press.

BOOKS FOR CHILDREN

ANXIETY	• Cain, B. and J.J. Smith-Moore. 2000. *I Don't Know Why…I Guess I'm Shy: A Story About Taming Imaginary Fears*. Washington, DC: Magination Press.
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DEPRESSION	• Garland, E.J. 1998. *Depression is the Pits, But I'm Getting Better: A Guide for Adolescents*. Washington, DC: Magination Press. • Leghorn, L. 1995. *Proud of Our Feelings*. Washington, DC: Magination Press.
POST-TRAUMATIC STRESS DISORDER	• Patel, A. 2002. *On That Day, A Book of Hope for Children*. Berkeley: Tricycle Press. • Trottier, M. and J. Friedman. 1997. *A Safe Place*. Morton Grove: Albert Whittman. • Aboff, M. & K. Gartner. 1996. *Uncle Willy's Tickles*. Washington, DC: Magination Press.
OTHER	• MacGregor, C. 2004. *The Divorce Helpbook for Teens.* Atascadero: Impact Publishers. • Stallard, P. 2002. *Think Good – Feel Good: A Cognitive Behaviour Therapy Workbook for Children and Young People.* Indianapolis: John Wiley & Sons Ltd.

WEBSITE FOR FAMILIES National Alliance on Mental Illness www.nami.org

Adapted from *Healthy Kids, Happy Futures: Healing Children in the Aftermath of Tragedy* developed by the NYU Child Study Center and funded by Project Liberty

SUGGESTED READINGS ON SCREENING AND DIAGNOSTIC AIDS

PEDIATRIC SYMPTOM CHECKLIST	• Duke N, Ireland M, Borowsky IW. Identifying psychosocial problems among youth: factors associated with youth agreement on a positive parent-completed PSC-17. *Child Care Health Development*. 2005 Sep;31(5):563-573. • Wren FJ, Bridge JA, Birmaher. B. Screening for childhood anxiety symptoms in primary care: integrating child and parent reports. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2004 Nov;43(11):1364-1371. • Jutte DP, Burgos A, Mendoza F, Ford CB, Huffman LC. Use of the Pediatric Symptom Checklist in a low-income, Mexican American population. *Archives of Pediatric and Adolescent Medicine*. 2003 Dec;157(12):1169-1176.
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WEBSITES

FINDING MENTAL HEALTH PROFESSIONALS

- Academy of Cognitive Therapy — www.academyofct.org
- Association for Advancement of Behavior Therapy — www.aabt.org
- Albert Ellis Institute — www.rebt.org

SCREENING AIDS

- Bright Futures in Practice Series: Mental Health—Volume II, Toolkit
  Visit www.brightfutures.org for PDFs of tools for health professionals

- Family Practice Network – Pediatrics Book, Neurology Chapter, Neurology Index
  Visit www.fpnotebook.com/PEDCh9.htm for information on different screening aids

- Massachusetts General Hospital, School Psychiatry Program and Madi Resource Center
  Visit www.massgeneral.org/madiresourcecenter/schoolpsychiatry/index.asp for information on different screening aids and links for tools available online

- Massachusetts General Hospital
  Visit www.mgh.harvard.edu/allpsych/PediatricSymptomChecklist/psc_home.htm for the PSC-35 and YPSC-35 downloadable forms in various languages

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FACULTY:
FEELINGS NEED CHECK UPS TOO
CD-ROM & TOOLKIT

Danielle Laraque, MD, FAAP
Chief, Division of General Pediatrics
Debra & Leon Black Professor of Pediatrics,
Jack & Lucy Clark Department of Pediatrics
Mount Sinai School of Medicine, NY

Peter Jensen, MD
Ruane Professor of Child Psychiatry
Director, Center for the Advancement
of Children's Mental Health
Columbia University/NY State
Psychiatric Institute, NY

David Schonfeld, MD, FAAP
Thelma and Jack Rubinstein Chair
Director, Division of Developmental Disabilities
Cincinnati Children's Hospital Medical Center, OH

CONTRIBUTING FACULTY

Loretta Y. Au, MD, FAAP
Chief, Pediatrics Section, Charles B. Wang
Community Health Center, NY

John Draper, PhD
Director, National Suicide Prevention Lifeline,
Mental Health Association of NYC, NY

Susan Levitzky, MD, FAAP
Medical Director, Jewish Child Care
Association of New York
Clinical Assistant Professor, Pediatrics,
NYU Medical Center, NY

James Rodriguez, PhD
Director, Parent Empowerment Programs
Instructor, Clinical Psychology, Psychiatry,
Columbia University, NY

ADDITIONAL AMERICAN ACADEMY
OF PEDIATRICS FACULTY

Errol Alden, MD, FAAP
Executive Director/CEO, American Academy
of Pediatrics

Eileen Ouellette, MD, JD, FAAP
President, American Academy of Pediatrics

Carden Johnston, MD, FAAP
Past President, American Academy of Pediatrics

RESEARCH ASSISTANT

Maan Dela Cruz, MPH
Mount Sinai School of Medicine, NY

PROJECT DIRECTORS

Lucy Bruell, MS
Marcel Dumont
John Edward Putnam, MS
L.A. Bruell, Inc., NY

Mary McGowan, MA
American Academy of Pediatrics

FACULTY: REACHING CHILDREN INITIATIVE

Minna Barrett, PhD
Director of Research & Training, WTC Family
Center, South Nassau Communities Hospital, NY

Joseph A. Boscarino, PhD, M.P.H.
Senior Investigator II, Center for Health Research,
Geisinger Health System
Adjunct Associate Professor, Pediatrics and Medicine,
Mount Sinai School of Medicine, NY

Claude M. Chemtob, PhD
Clinical Professor, Psychiatry and Pediatrics,
Mount Sinai School of Medicine, NY

Thomas Demaria, PhD
Assistant Vice President, Behavioral Sciences,
South Nassau Communities Hospital, NY

Annette Hernandez, PhD
Clinical Instructor, Psychiatry,
Mount Sinai School of Medicine, NY

Gerald McCleery, PhD
Associate Executive Director, Mental Health
Association of NYC, NY

Jeffrey H. Newcorn, MD
Associate Professor, Psychiatry and Pediatrics,
Mount Sinai School of Medicine, NY

Lori Rockmore, PsyD
Adjunct Faculty, Psychiatry, Rutgers University, NJ

MaryEllen Salamone, JD
Advisory Board Member, Families of September 11

Deborah P. Steinbaum, MD, FAAP
Assistant Professor, Pediatrics,
Mount Sinai School of Medicine, NY

Rachel A. Zuckerbrot, MD, FAAP
Assistant Professor, Psychiatry and Pediatrics,
Columbia University, NY

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