

WORKING WITH CHILDREN WITH A HISTORY OF TRAUMA



Karen Bos, MD, MPH
Assistant Professor, Child & Adolescent Psychiatry, OHSU
Medical Director, Lifeworks NW

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DISCLOSURES

- No financial disclosures or conflicts of interest

OBJECTIVES

- Review what is known about the impact of trauma and toxic stress on development and mental health
- Recognize some of the common clinical presentations of trauma in children and adolescents
- Increase awareness about the strategies and limitations of evidence based trauma specific interventions

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OUTLINE

- Definition and assessment of trauma
- Treatment of trauma
- Trauma-informed care
- Resources

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CASE 1: JAMES

- James is a 6 year old boy, currently in foster care in his fourth placement since being removed from biological parents about one year ago. Foster parents report that he has frequent "meltdowns" both at home and school when he will be physically aggressive including hitting and kicking. He has been suspended twice from school. They describe him as oppositional and impulsive.

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CASE 2: MARIA

- Maria is a 13 year old girl who lives with her mother. She comes in for a well child check and describes seeing a shadowy figure especially at night. She has frequent nightmares. She describes thoughts of wanting to hurt herself.

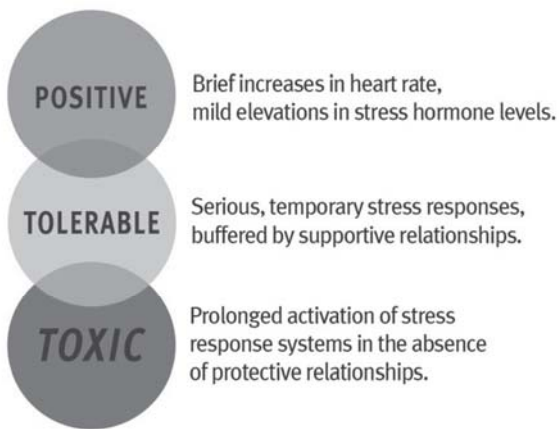
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“ Adverse childhood experiences are the single greatest unaddressed public health threat facing our nation today ”

Dr. Robert Block, the former President of the American Academy of Pediatrics



70:30 CAMPAIGN: EMPOWERING COMMUNITIES TO PROTECT OUR CHILDREN

Stress in Childhood

Stress is a natural & inevitable part of childhood, but the **TYPE** of stress can make a difference in the impact on a child's brain & body.

“ STRESS is a mental, physical or biochemical response to a perceived threat or demand ”

Positive Stress
Mild stress in the context of good attachment

Temporary, mild elevation in stress hormones & brief increase in heart rate

No buffering support necessary

Increased **RESILIENCE** and confidence
Development of coping skills

Tolerable Stress
Serious, temporary stress, buffered by supportive relationships

More severe, continuing cardiovascular and hormonal response

Presence of buffering caring adult

Adaptation and recovery with some possibility for physical/emotional damage

Toxic Stress
Prolonged activation of stress response system without protection

Prolonged activation of stress response system & disrupted development of brain and immune system

No adult buffers

Lifelong consequences:
- Heart disease
- Alcoholism
- Memory & learning difficulties
- Anxiety/depression
- Cancer

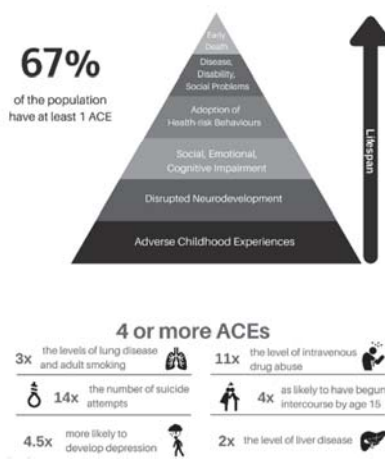
LEARN MORE 020 8688 3773 info@70-30.org.uk www.70-30.org.uk @7030Campaign

FIGURE 1. CATEGORIES OF ADVERSE CHILDHOOD EXPERIENCES (ACEs)

The three types of ACEs include

ABUSE	NEGLECT	HOUSEHOLD DYSFUNCTION	
Physical	Physical	Mental illness	Incarcerated Relative
Emotional	Emotional	Mother treated violently	Substance Abuse
Sexual		Divorce	

Source: Robert Wood Johnson Foundation, 2013



In adults, ACEs have been found to have a **strong, dose response association** with cardiovascular disease, chronic lung disease, headaches, autoimmune disease, sleep disturbances, early death, obesity, smoking, general poor health, depression, posttraumatic stress disorder, anxiety, substance abuse, and binge drinking

People with 6+ ACEs can die

20 yrs

earlier than those who have none

- Most children and adolescents will experience a traumatic event by the time they reach adulthood
- The reported numbers of trauma-exposed children who develop PTSD vary widely across studies of different populations and types of trauma.



Trauma vs. traumatic experience

RISK FACTORS FOR PTSD

- Trauma characteristics
 - Interpersonal violence: highest risk of PTSD onset
 - Exposure to war, history of displacement associated with high rates of PTSD
 - Higher number of traumatic events leads to greater risk than a single trauma
- Child and family characteristics
 - Girls 2-3 times more likely to develop PTSD than boys
 - Children with history of other mental disorders more likely to develop PTSD following trauma exposure
- Response to the traumatic event
 - Cognitive and emotional responses affect risk for PTSD (higher levels of anger or rumination about event, dissociation during and after traumatic event increase risk)

Table 1
DSM-5 criteria for PTSD

Trauma exposure	
Trauma	Actual or threatened violent death, serious injury or accident, or sexual violence
A. Exposure	Via any of the following: 1. Directly exposed to trauma 2. Eyewitness (in person) to others directly exposed to trauma 3. Learning of direct exposure to trauma of a close family member or close friend 4. Repeated or extreme exposure to aversive details of traumatic event (eg, trauma workers viewing human remains or repeatedly exposed to details of child abuse), in person or via work-related electronic media
Symptom groups B to E (symptoms beginning or worsening after the traumatic event)	
B. Intrusion	≥1 intrusion symptoms: 1. Recurrent, involuntary, distressing trauma memories 2. Recurrent, distressing trauma-related dreams 3. Dissociative reactions/flashbacks related to trauma 4. Intense or prolonged psychological distress to trauma reminders 5. Marked physiological reactions to trauma reminders
C. Avoidance	≥1 avoidance symptoms: 1. Avoidance/efforts to avoid distressing internal trauma reminders (memories, thoughts, feelings) 2. Avoidance or efforts to avoid distressing external trauma reminders (people, places, activities)
D. Negative cognition and mood	≥2 negative cognition/mood symptoms: 1. Amnesia for important parts of trauma exposure 2. Persistent, exaggerated negative beliefs about self, others, or the world 3. Persistent, distorted trauma-related cognitions leading to inappropriate blame of self/others 4. Persistent negative emotional state (eg, fear, horror, anger, guilt, shame) 5. Loss of interest or participation in significant activities 6. Detached/estranged feelings from others 7. Persistent loss of positive emotions (eg, happiness, satisfaction, love)
E. Hyperarousal	≥2 marked alterations in trauma-related arousal and reactivity: 1. Irritability and angry outbursts with little/no provocation (eg, verbal/physical aggression toward people/objects) 2. Reckless or self-destructive behavior 3. Hypervigilance 4. Exaggerated startle 5. Concentration problems 6. Sleep disturbance (eg, difficulty falling or staying asleep, restless sleep)

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C. Avoidance	>1 avoidance symptoms: 1. Avoidance of thoughts or feelings related to trauma 2. Avoidance of external reminders (people, places, activities) associated with the trauma

- D. Negative cognition and mood**
- >2 negative cognition/mood symptoms:
1. Amnesia for important parts of trauma exposure
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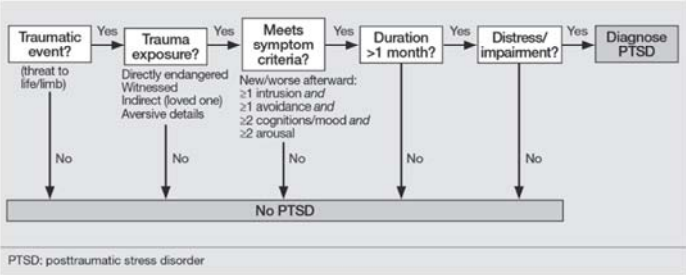
North, Hong, Downs, PTSD: A systematic approach to diagnosis and treatment. Current Psychiatry 2018 April;17(4):35-43.

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Algorithm
Assessing DSM-5 criteria for PTSD



North, Hong, Downs, PTSD: A systematic approach to diagnosis and treatment. Current Psychiatry 2018 April;17(4):35-43.

PEDIATRIC CONSIDERATIONS

- Age and developmental level at the time of the trauma
- Nature and duration of the trauma
- Social support following the trauma



PRESCHOOL PTSD SUBTYPE

- The DSM-5 introduced a new developmental subtype of PTSD for preschool children (6 years old and younger).
- This represents the first developmental subtype of an existing disorder in the DSM.
- Criteria are more behaviorally anchored and developmentally sensitive.
- Studies showed that when a developmentally sensitive set of criteria were used, approximately three to eight times more children qualified for the diagnosis of PTSD compared to the DSM-IV

DEVELOPMENTAL CONSIDERATIONS: PRE SCHOOL

- Clingy
- Disordered attachment
- Separation anxiety
- Hyperactive/impulsivity
- Tantrums/aggression
- Stubborn/oppositional
- Regression
- Somatic complaints
- Re-experiencing may manifest as repetitive play
- Difficulty with sleep or scary dreams

DEVELOPMENTAL CONSIDERATIONS: SCHOOL AGE

- Anger/irritability
- School refusal
- Poor attention
- Somatic complaints
- Separation anxiety
- Avoidance symptoms more closely related to event/trauma
- Trauma related play (becomes more complex and elaborate)
- Better able to understand concepts of future, past more realistically
- Nightmares (may change from event specific to generalized over time)

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DEVELOPMENTAL CONSIDERATIONS: ADOLESCENT

- Shame/blame
- Oppositional/aggressive behaviors to regain a sense of control
- School avoidance/refusal/truancy
- Drugs/alcohol
- Self-injurious urges and behavior
- Revenge fantasies (especially with developmental issues/social delays/victims of bullying)
- Detachment
- Aggression
- Sense of foreshortened future may take form of belief that they will not reach adulthood or don't need to play for the future

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What can pediatricians do?



Dr. Nadine Burke Harris, Center for Youth
Wellness, San Francisco, CA

Since the last time I saw you, has anything really scary or upsetting happened to you or your family?

Or for parents of children under age 8:

Since the last time I saw your child, has anything really scary or
upsetting happened to your child or anyone in your family?

Cohen, Kelleher, and Mannarino, 2008.

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TRAUMA HISTORY

- Victims may not be able to remember trauma
- Use the adults to get information
- Use multiple informants when possible
- Don't be a can opener with the child
- Multiple sessions commonly required

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RATING SCALES

- Aid in assessment (traumatized individuals avoid talking about trauma)
- Can be used as a baseline
- Can be used to monitor treatment response
- Many to pick from
- Semi-structured interviews vs Self-report measures

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SCREENING FOR ACES IN PRIMARY CARE

CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Child

To be completed by Parent/Caregiver

Today's Date: _____ Date of Birth: _____
 Child's Name: _____ Relationship to Child: _____
 Your Name: _____

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance. Please read the statements below. Count the number of statements that apply to your child and write the total number in the box provided.

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box.

Section 1. At any point since your child was born...

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide

<https://centerforyouthwellness.org/cyw-aceq/>

TABLE 6. PRIMARY CARE PROVIDER SAMPLE SCRIPTS

Screening Result

GENERAL INTRODUCTION TO THE CYW ACE-Q RESULTS

CYW ACE-Q SCORE OF 0

CYW ACE-Q SCORE 1-3 WITHOUT SYMPTOMATOLOGY

Sample Script

New research has shown that children's exposure to stressful or traumatic events can lead to increased risk of health and developmental problems, like asthma and learning difficulties. As a result, at this clinic we now screen all of our patients for Adverse Childhood Experiences. Once again, you don't have to tell us which ones your child experienced, only how many. I'd like to take a moment to review your responses.

Based on your responses, I don't see any cause for concern. We now understand that exposure to stressful or traumatic experiences like the ones listed here may increase the amount the stress hormones that a child's body makes and this can increase their risk for health and developmental problems. If, in the future, [Child's Name] experiences any of these issues, please let us know because early intervention can lead to better outcomes.

I see that [Child's Name] has experienced [CYW ACE-Q Score] of these items, is that correct? Based on your responses, I want to ask a few more questions about her/his health and development. Has [Child's

<https://centerforyouthwellness.org/cyw-aceq/>

Instrument	Acronym	Age Range (years)	Administration Time (minutes)	Cost
Child PTSD Symptom Scale	CPSS	8-18	15-20 min	Free
Child Stress Disorders Checklist - Short Form	CSDC-SF	6-17	<5min	Free
UCLA PTSD Reaction Index for DSM-5-Brief Form	RI-5-BF	7-18	2-8 min	\$2/administration https://www.reactionindex.com/

Additional information about screening and assessment measures:
 National Child Traumatic Stress Network
<https://www.nctsn.org/treatments-and-practices/screening-and-assessments/measure-reviews>

DIFFERENTIAL & CO-MORBID DIAGNOSES

- Another "The Great Imitator/Masquerader"
- Untreated often leads to other psychiatric disorders
- Therefore often co-morbid with other psychiatric disorders
- The majority of the genes that affect risk for PTSD also influence risk for other psychiatric disorders and vice versa

DEPRESSION

- Depressed Mood or Irritability
- Anhedonia
- Significant Weight Change
- Sleep Disturbance
- Psychomotor Agitation
- Fatigue
- Feeling Worthless
- Difficulty Concentrating
- Suicidal ideations or behaviors

GENERALIZED ANXIETY DISORDER

- Restless, keyed up, or on edge
- Easily Fatigued
- Difficultly Concentrating
- Irritability
- Muscle Tension
- Sleep disturbance

ADHD

- Squirmy or fidgety
- Can't sit still
- Running around
- Noisy
- Driven by motor
- Chatterbox
- Can't wait turn
- Interrupts often
- Blurts out answers
- Forgetful
- Distractible
- Poor Concentration
- Does not listen
- Poor follow-through
- Disorganized
- Avoids activities that require focus
- Often loses things
- Fails to attend

BRIEF REACTIVE PSYCHOSIS

- Delusions (altered sense of reality)
- Hallucinations (flashbacks)
- Disorganized speech—frequent derailment or incoherence
- Grossly disorganized or catatonic

OUTLINE

- Definition and assessment of trauma
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AFTER TRAUMA EXPOSURE

- Provide education about how common these events are and about common physical and emotional reactions
- Self-care as a way to regain control after trauma exposure
- Teaching children and parent simple relaxation techniques
- Monitoring over time for PTSD symptoms



Approach to selecting treatment for PTSD in children and adolescents



Brent, Cohen, Strawn, Approach to treating posttraumatic stress disorder in children and adolescents, UpToDate.

Approach to selecting treatment for PTSD in children and adolescents



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TRAUMA SPECIFIC PSYCHOTHERAPIES

- Multiple options
- Therapeutic relationship matters
- Systemically oriented
- Good treatment can support resilience and change biology



TRAUMA SPECIFIC PSYCHOTHERAPIES: CORE COMPONENTS

BEFORE INTERVENTION

1. Risk screening: identify high-risk clients
2. Triage: match clients to the interventions that will most likely benefit them
3. Systematic assessment and treatment planning: tailor intervention to the needs, strengths, circumstances, and wishes of individual clients
4. Engagement & address barriers: ensure clients receive an adequate dosage of treatment in order to make sufficient therapeutic gains

TRAUMA SPECIFIC PSYCHOTHERAPIES: CORE COMPONENTS

DURING INTERVENTION

1. Motivational interviewing: engage clients
2. Psychoeducation: trauma and loss reminders, posttraumatic stress reactions, and grief reactions
3. Teach and practice coping skills: emotional regulation skills, safety skills, relapse prevention skills
4. Exposure and response prevention: reduce posttraumatic stress reactions
5. Monitor client progress during treatment
6. Evaluate treatment effectiveness

TRAUMA SPECIFIC PSYCHOTHERAPIES: CORE COMPONENTS

DURING INTERVENTION

7. Parenting skills to improve caregiver-youth relationship
8. Maintaining adaptive routines at home and outside of home
9. Advocacy on behalf of the client to improve client support and functioning outside of the home

TRAUMA SPECIFIC PSYCHOTHERAPIES

- PCIT: Parent-Child Interaction Therapy
- CBT: Cognitive Behavior Therapy (TF-CBT, CBITS)
- CPS: Collaborative Problem Solving
- DBT: Dialectical Behavior Therapy
- CPP: Child-Parent Psychotherapy
- EMDR: Eye Movement Desensitization & Reprocessing

PCIT PARENT-CHILD INTERACTION THERAPY



- Age range: 2 – 12yr
- Conjoint child and caregiver sessions
- Average duration of treatment: 12 – 20 sessions
- Components:
 - Skill building: direct parent coaching, parent self-care
 - Relationship building: child directed interactions, parent directed interactions
- Theoretical basis: Attachment and Behavioral

PCIT



8 RULES of EFFECTIVE COMMANDS

- DIRECT – “Please hand me the block” instead of “Will you hand me the block?”
- DO THIS – positively stated, “Do this” instead of “Don’t do that!”
- ONE at a time – single actions
- SPECIFIC – “Please get off the table” instead of “Be careful!”
- AGE-APPROPRIATE
- POLITE & RESPECTFUL
- ONLY WHEN NECESSARY
- AFTER EXPLANATION – give concise explanation and then command. If forget to give explanation, explain only after command obeyed to avoid “whys?”

TF-CBT

TRAUMA FOCUSED COGNITIVE BEHAVIOR THERAPY



- Age range: 3- 21yr
- Individual and Conjoint Sessions
- Average duration of treatment: 12 – 25 sessions
- Components:
 - Skill building: relaxation, emotion regulation, cognitive reframing, parenting
 - Trauma processing: trauma narrative and in vivo exposure to triggers
- Theoretical basis: Cognitive-Behavioral and Family

CPS

COLLABORATIVE PROBLEM SOLVING



Kids do well if they can...
(vs. kids do well if they want to)

... and if they can't, adults need to figure out what's getting in the way, so we can help.

Approach to selecting treatment for PTSD in children and adolescents



Brent, Cohen, Strawn, Approach to treating posttraumatic stress disorder in children and adolescents, UpToDate.

MEDICATION

No FDA approved medications for PTSD in youth



ANTIDEPRESSANT MEDICATIONS

- SSRIs have been found to reduce PTSD symptoms in adults but do not appear to be efficacious in children with PTSD
- Clinical trial of 10-17 year olds receiving TF-CBT, randomly assigned to receive adjunctive sertraline. No difference in PTSD symptom reduction between the two groups at 12 weeks.
- No clinical trials of other antidepressants

ANTIADRENERGIC MEDICATIONS

- Clonidine and guanfacine: No randomized clinical trials of alpha-2 adrenergic agonists in children with PTSD
- Uncontrolled trial suggests that guanfacine may reduce intrusive and hyperarousal symptoms in children with PTSD symptoms
- Generally well tolerated, most common side effects are dry mouth and sedation
- Monitor blood pressure and pulse at baseline and during treatment

- Extended release clonidine (Kapvay): start at 0.1 mg at bedtime, can be increased by 0.1 mg per week to max of 0.4 mg/day. Administered twice daily, with dose divided equally or with higher dose at bedtime. Must be tapered to stop.
- Extended release guanfacine (Intuniv): start at 1 mg daily, can increase by 1 mg/week, target weight-based dose range is 0.05-0.12 mg/kg. Max dose generally 4 mg/day in children, some would go higher in adolescents (up to 7 mg) but should be done with caution. Administered once per day, can be either morning or bedtime. Must be tapered to stop.

- Prazosin- case reports and retrospective case series of youth suggest that prazosin may be effective and well tolerated in treating sleep disturbances in youth with PTSD
- Multiple clinical trials have found prazosin to be efficacious and well tolerated in adults with PTSD-associated sleep disturbances

- Start prazosin at 1 mg, given 30 minutes before bedtime. Dose can be increased by 1 mg every 3-4 days for the first two weeks, starting lower and titrating up more slowly in younger children or in children experiencing any side effects.
- No evidence of a dose-response relationship, but UpToDate recommends increasing the dose, as tolerated, to at least 5 mg over the course of 4-8 weeks before concluding that it is ineffective
- Monitor blood pressure and pulse at baseline and during treatment

ANTIPSYCHOTICS

- Limited, uncontrolled trials of second-generation antipsychotic medications in youth with PTSD symptoms have found mixed results and high rates of treatment-emergent adverse events
- Side effects: weight gain, insulin resistance, dyslipidemia, hyperprolactinemia, extrapyramidal symptoms
- Keep in mind that children exposed to childhood trauma are at risk for chronic health problems independent of medication use

OTHER MEDICATIONS

- No good data on use of other medications such as anticonvulsants for pediatric patients with PTSD

COURSE OF PTSD

- Highly variable course
- Most adolescents who develop PTSD recover from it, but one third experience a chronic course that can last many years
- Characteristics of adolescents who were least likely to recover included those:
 - Living in poverty
 - Having co-occurring bipolar disorder
 - Experienced additional traumatic events after the trauma that triggered the onset of PTSD

McLaughlin, K. Post traumatic stress disorder in children and adolescents: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis. UpToDate.

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CASE 1: JAMES

- James is a 6 year old boy, currently in foster care in his fourth placement since being removed from biological parents about one year ago. Foster parents report that he has frequent “meltdowns” both at home and school when he will be physically aggressive including hitting and kicking. He has been suspended twice from school. They describe him as oppositional and impulsive.
- James is currently prescribed risperidone 1 mg BID. His foster parents and school state that the risperidone might be helping him some with behavior and sleep, although he continues to have difficulty with oppositional and impulsive behaviors. He has gained about 10 pounds since starting the risperidone six months ago. He has never had any labwork done.

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CASE 1: JAMES

- Diagnosis:
 - Are there any comorbid psychiatric disorders that haven't been identified?
- Treatment:
 - Are James and his foster parents engaged in any therapy, specifically any trauma specific psychotherapy?
 - If medications are indicated, have other medications been tried that may have a better side effect profile?



CASE 2: MARIA

- Maria is a 13 year old girl who lives with her mother. She comes in for a well child check and describes seeing a shadowy figure especially at night. She has frequent nightmares. She describes thoughts of wanting to hurt herself.
- Maria and her mother tell you that they are worried she might be “crazy” because she is “seeing things.” When talking with Maria, she discloses that she was sexually assaulted by a peer about one year ago. She also describes ongoing bullying by peers.

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CASE 1: MARIA

- Diagnosis:
 - Are there any comorbid psychiatric disorders that haven't been identified?
- Treatment:
 - Is Maria engaged in any therapy, specifically any trauma specific psychotherapy?
 - If medications are indicated, what might be an appropriate first choice?

OUTLINE

- Definition and assessment of trauma
- Treatment of trauma
- **Trauma-informed care**
- Resources

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TRAUMA-INFORMED CARE



Promote active and creative coping
Offer supportive and safe relationships
Create access to resources for well-being
Contribute to a compassionate, inclusive,
and safe community
For self, colleagues, clients, peers

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Universal Precautions as a Core Trauma Informed Concept

Presume that every person in a treatment setting has been exposed to abuse, violence, neglect, or other traumatic experiences.

“What have you lived through?”

instead of
“What is wrong with you?”

OUTLINE

- Definition and assessment of trauma
- Treatment of trauma
- Trauma-informed care
- **Resources**

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LOCAL RESOURCES

- Collaborative Problem Solving (CPS) Program at OHSU
 - Margaret Johnson, LMSW, OHSU Instructor, Think:Kids Clinical Consultant and Trainer
 - Contact directly to be notified of upcoming CPS Trainings. Email: cps@ohsu.edu
 - Calendar of CPS Trainings and Events in Oregon: www.ohsu.edu/cps
- PCIT locations in Oregon:
 - https://www.ohsu.edu/sites/default/files/2019-06/Oregon-PCIT-locations-alphabetical-2018_o.pdf

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The 5-Minute Psychologist

Translating Evidence-Based Therapies to Primary Care

DATE: March 6, 2020 PRESENTED BY: Andrew R. Riley, PhD, Associate Prof, Pediatrics



Behavioral health concerns are very common

- 20-30% meet criteria for mental disorder¹
- Additional 40% with impairing or distressing symptoms²
- PCPs most likely source of professional help³
- Concerns raised in 50–80% of all child medical visits⁴
- Primary concern in 15-20% of cases⁵

¹Costello et al., 2003, *Arch Gen Psychiatry*
²Costello & Shugart, 1992, *Pediatrics*
³Embry & Biglan, 2008, *Clinical Child and Family Psych Rev*
⁴Fries et al., 1993, *N Engl J Med*
⁵Williams et al., 2004, *Pediatrics*

2



... yet poorly identified

- Under-identified
 - 14-54% sensitivity w/o screening¹
 - Little change in screening practices since 2004²

¹Sheldrick, Merchant, & Perrin, 2011, *Pediatrics*
²Stein, 2016, *Academic Pediatrics*

3



Something Doesn't Add Up

- Average well-child visit
 - 15-20 minutes
 - Behavior: $M < 30$ second, $Med = 0$ ¹
- Average behavioral consult
 - 20 minutes



¹Norlin, 2001, *Academic Pediatrics*

4

Refer?

- Nationwide shortage of child mental health providers
- Insufficient reimbursement models
- <50% referred MH services will access them¹⁻³
 - Most needy are the least likely to access services
 - Barriers: transportation, child care, leave from work
- Integrated behavioral health helps, but disparities remain
- Well-child care is likely the best opportunity to impact MH for many children and families

¹Chisolm, Klima, Gardner, & Kelleher, 2009, *Adm Policy Ment Health*
²Hacker et al., 2006, *Pediatrics*
³Rushton, Bruckman, & Kelleher, 2002, *Arch Pediatr Adolesc Med*

5



OK, but 5 minutes?

- Challenging, but reason for optimism
 - A few seconds of conversation can increase the likelihood of smoking cessation¹
 - Motivational techniques can be employed with minimal time disruption²
 - Evidence-based “kernels”³

¹Stead, Bergson, & Lancaster, 2008, *Cochrane Database of Sys Rev*
²Miller & Rollnick, 2002, *Motivational Interviewing: Preparing People for Change, 2nd ed.*
³Embry & Biglan, 2008, *Clinical Child and Family Psych Rev*

6



Finding Kernels

- Psychological interventions are usually multi-component packages targeting clusters of symptoms

- Differential attention
- Strategic ignoring
- Therapeutic play
- Limit-setting
- Rewards
- Problem-solving
- Time-out
- Instruction delivery
- Contingent praise
- Stress management

- Non-compliance
- Emotional lability
- Aggression
- Hyperactivity
- Impulsiveness
- Argumentativeness
- Defiance
- Whining
- Destruction
- Tantrums



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Finding Kernels

- In RCTs, these are collapsed into single variables
- This allows for evaluating efficacy the package, but not the individual components

- Differential attention
- Strategic ignoring
- Therapeutic play
- Limit-setting
- Rewards
- Problem-solving
- Time-out
- Instruction delivery
- Contingent praise
- Stress management

Parent management training

- Non-compliance
- Emotional lability
- Aggression
- Hyperactivity
- Impulsiveness
- Argumentativeness
- Defiance
- Whining
- Destruction
- Tantrums

Oppositional defiance



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Finding Kernels

- Best available evidence (empirical theory, meta-analyses, and study of individual components) can guide clinical decision making in time-limited circumstances

- Differential attention
- Strategic ignoring
- Therapeutic play
- Limit-setting
- Rewards
- Problem-solving
- Time-out
- Instruction delivery
- Contingent praise
- Stress management

- Non-compliance
- Emotional lability
- Aggression
- Hyperactivity
- Impulsiveness
- Argumentativeness
- Defiance
- Whining
- Destruction
- Tantrums



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Behavioral Care, Bite-Sized

- Target robust principles of behavior
- Utilize well-established mechanisms of change (*kernels*)
- Communicate digestibly and memorably



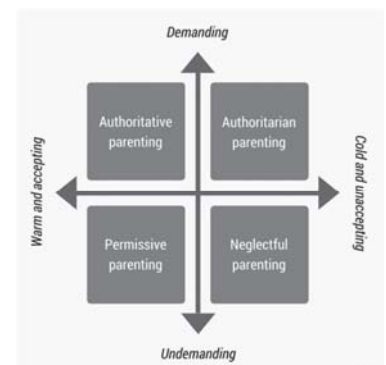
Scenario 1: *Terrible Tantrums*

- Presentation
 - Not dangerous, but disruptive behaviors (e.g., tantrums, yelling, whining, excessive crying)
- Critical issue
 - Inadvertent positive reinforcement via contingent attention – Parental attempts to persuade, soothe, threaten, cajole, etc, backfire.



Technique 1: *Kansas or Oz?*

- Goal: Promote parental attention consistent with authoritative parenting





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14



15



16



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Scenario #2: *Dangerous and Destructive*

- Scenario: Persistent problem behavior that cannot be ignored (aggression, destruction, dangerous)
- Critical issue: Many have tried “time-out” and found it doesn’t work.
 - 85% implement time-out sub-optimally

(Riley et al. 2016)

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Technique 1: *2 Kinds of Nothing*

- Goal: Refine time-out procedures to make them more effective.



Nothing going on.



Nothing going on.
Nothing they can do about it.



We tried that and it didn't work!

- Is there sufficient positive reinforcement (time-in) in place?
- Is there something going on?
- Is there something he/she can do about it?
 - Escape from TO is most likely reason for ineffectiveness
 - Consider *walking TO*

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Scenario 3: *The Avid Avoider*

- Scenario: Older/child adolescent struggling with anxiety (among other things)
- Critical issue: *Paradoxical avoidance* - the more feeling anxious is avoided, the more disabling it becomes.



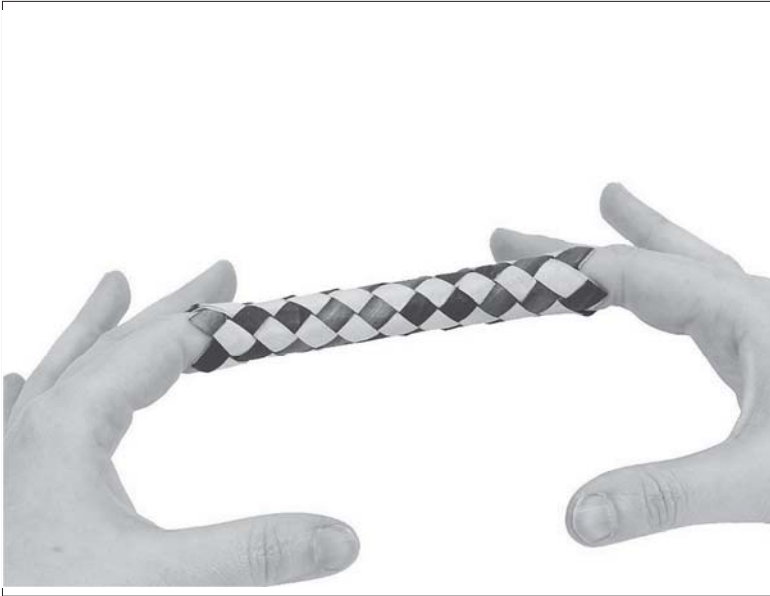
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Technique 4: *Finger Trap*

- Goal
 - Generate *acceptance* of uncomfortable thoughts and feelings in order to enable goal-directed action

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Scenario #4: *Chronic health behavior struggles*

- Scenario: Adolescent/family struggling with health behaviors/self-management
- Critical issue: The environment doesn't encourage healthy behavior, but this is interpreted as indifference or laziness.

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Technique 4: *Fill-Ups vs Oil Changes*

- Goal
 - Build *understanding* of the behavioral dynamics at play to reduce guilt, and generate empathy.



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Scenario #5: *Adolescent Ambivalence*

- Scenario: Adolescent/young adult recognize need for change but hesitant to commit... “I’d like to, but...”
- Critical issue: If not ready for change, a prescriptive approach may be iatrogenic

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“People are generally better persuaded by the reasons which they themselves discovered than by those which have come into the minds of others.”

—Blaise Pascal (ca. 1670)



Technique 5: *Row your OARS*

- **O**pen ended questions
- **A**ffirmations
- **R**eflective listening
- **S**ummarizing





Open ended ?



Affirmation

Reflection



Whoops!





Reflection



Summary



Final Thoughts

- Behavior change is hard
- Recognize limitations
- Find your style
- Do one thing well
- When in doubt, listen and empathize



Thank You

rileyand@ohsu.edu
@AndrewRileyPhD

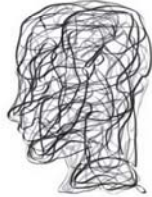


Pediatric Obsessive-Compulsive Disorder

ENTANGLED IN ONE'S OWN YOUNG BRAIN

PARIA ZARRINNEGAR, M.D.

MARCH 2020



Disclosure

I have no conflict of interest in relation to this presentation

Outline

- Background
- Diagnostic Criteria
- Clinical Features
- Epidemiology
- Etiology & Pathogenesis
- Comorbidities
- Course and prognosis
- Evaluation
- Treatment
- Book recommendation

Background

- 7th Century St. John Climacus's story of a monk
- Symptoms of OCD described as far back as 1467, evidence of possession by the devil
- Religious texts of 1600s described "scrupulosity", excessive devotion and extremes of religious doubting
- Studied by pioneers of psychiatry " Carl Westphal and Pierre Janet" as early as 1838
- OC symptoms were noted by Freud early on in his work, Anna Freud attributed to ego deficits and conflicting drives
- OCD was moved from "anxiety disorders" in DSM-IV TR to "Obsessive-Compulsive spectrum disorders" in DSM-5. Other diagnosis in this category include body dysmorphic disorder, hoarding disorder, trichotillomania and excoriation disorder

DSM-5 Diagnostic Criteria

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

- 1) Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress
- 2) The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion)

Compulsions are defined by (1) and (2):

- 1) Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
- 2) The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

DSM-5 Diagnostic Criteria

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder

Specifiers:

- **With good or fair insight:** The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may not be true
- **With poor insight:** The individual thinks obsessive-compulsive disorder beliefs are probably true
- **With absent insight/delusional beliefs:** The individual is completely convinced that obsessive-compulsive disorder beliefs are true.
- **Tic-related:** The individual has a current or past history of a tic disorder

Clinical Features

- Presenting problems are variable: temper tantrums, decline in school performance, poor school attendance, food refusal, dermatitis, clogged toilet, running out of cleaning supply
- Obsessions:
 - Most Common obsessions: contamination, safety of self and others, exactness or symmetry, religious scrupulousness
 - Sexual and aggressive preoccupations less common
 - One study found boys to be more likely to have sexual obsessions and girls to have hoarding symptoms
 - Obsessional slowness – motor slowness in severe OCD
- Compulsions:
 - Most Common compulsions in adolescents: cleaning, repeating actions until it feels “right”, checking rituals
 - Most children are unable to specify what their rituals are intended to avert, beyond a vague idea of something bad happening. There is commonly lack of well-developed obsessions

Clinical Features

- Children tend to have isolated and idiosyncratic functional deficits which may be severe but domain specific and variable.
- Parents are often involved in cleaning or checking, reassurance seeking “verbal checking”, covering deficits.
- Kids get angry with parents seeking help, parents want to believe it’s just a phase.
- Most cases have a gradual onset
- OCD symptoms wax and wane, and change over time

Epidemiology

- Pediatric OCD Prevalence: 1-2%
- Childhood OCD is Male predominant (3:2 M:F) with prepubertal age of onset 6-12.5 years. Adult: slight female preponderance seen in late adolescence
- Age of clinical presentation on average 2 years after onset
- No difference in prevalence based on race/ethnicity or geography
- Sex or age of onset do not predict severity of illness
- Pediatric OCD is more familial and generally has a better prognosis
- OCD is underrecognized and underdiagnosed in youth
- Childhood onset OCD occurs in at least 30-50% of cases with OCD
- 2 peaks of incidence for OCD across life span: preadolescence and early adult life ~21 yrs

Etiology/Pathogenesis

- Genetic component:
 - high concordance rate, higher rate in first-degree relatives
 - Young age of onset is associated with greater familiarity
 - Research has shown some genetic association trends., likely multiple genes of small effect
- Environmental factors:
 - higher rate of perinatal trauma (shoulder dystocia, breech, forceps, prolonged hypoxia) in males with earlier onset of OCD
 - Higher rates of mothers requiring medical care during pregnancy
 - Amongst children with OCD, those with adverse perinatal experiences have earlier age of onset, more severe symptoms, increased risk for comorbidity
- Precipitating Psychosocial events:
 - physical or sexual assault
 - Witnessing domestic violence
 - Being home alone during a forced breaking and entering

Etiology/Pathogenesis

- Auto-immune etiology:
 - In 1980s NIH notes a subset of children with OCD with abrupt-onset following infections
 - Led to development of Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PNDAS) in 1998 and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) in 2010
- Major brain structures central to OCD: Orbitofrontal cortex, ant. Cingulate cortex, caudate and thalamus
- Neurotransmitters known to be involved in OCD: glutamate, dopamine, serotonin
 - fMRI in 2000, elevated glutamate level in the caudate nuclei of 11 treatment-naïve children, normalized with treatment

PANDAS Criteria

- Presence of OCD and/or a tic disorder (diagnosed according to DSM – Diagnostic and Statistical Manual of Mental Disorders)
- Pediatric onset (between 3 years and the beginning of puberty)
- Episodic course of symptom severity with abrupt onset or dramatic exacerbations
- Symptoms exacerbations must be temporally related to GABHS (Group A streptococcal infection), i.e., associated with positive throat culture and/or elevated anti-GABHS antibody
- Association with neurological abnormalities (motoric hyperactivity and adventitious movements, including choreiform movements or tics)

PANS Criteria

- Abrupt, dramatic onset of obsessive-compulsive disorder or severely restricted food intake
- Concurrent presence of additional neuropsychiatric symptoms, (with similarly severe and acute onset), from at least two of the following seven categories:
 1. Anxiety
 2. Emotional lability and/or depression
 3. Irritability, aggression, and/or severely oppositional behaviors
 4. Behavioral (developmental) regression
 5. Deterioration in school performance (related to attention-deficit/hyperactivity disorder [ADHD]-like symptoms, memory deficits, cognitive changes)
 6. Sensory or motor abnormalities
 7. Somatic signs and symptoms, including sleep disturbances, enuresis, or urinary frequency
- Symptoms are not better explained by a known neurologic or medical disorder, such as SC

Comorbidities

- Very common, present in more than 50% of cases
- Most common comorbidities:
 - Tic disorders - increased risk with earlier age of onset of OCD, remits with age
 - Mood disorders
 - Anxiety disorders - increased risk with earlier age of onset of OCD
 - Disruptive behaviors
 - ADHD – increased risk with earlier age of onset of OCD
- Comorbidity increases risk of relapse of OCD with medication discontinuation

Course and Prognosis

- Most cases have a gradual onset without a history of precipitating stressor
- Trauma may lead to abrupt onset of OCD
- OCD symptoms wax and wane, and change over time
- Many children remit partially or entirely
- Predictors of persistence of symptoms: earlier age of onset, longer duration of illness, history of inpatient treatment, comorbidity, initial poor treatment response, positive first degree family history
- Lower likelihood of cohabitation and marriage, higher likelihood of living with parents as adults, higher level of peer/social problems, isolation and unemployment.
- No difference in average educational level

Evaluation

- Carefully assess current and past OC symptoms
- Distinguishing OC from childhood rituals, routines and anxious worries. what is “normal for age”?
 - OC are recurrent, time consuming, intrusive and distressing and interfere with function. Ask if the child performs the compulsive act to relieve obsession or prevent feared outcome
 - Ask what would happen if the child did not perform the compulsion
 - Ask how the child knows when it has been done enough
- Note that children are often secretive about their symptoms and you might hear concerns from parents only
- Screening questions:
 - Younger children: Do you have worries that just won't go away? Do you have habits that you can't stop?
 - Older children: Do you ever have unwanted thoughts that upset you and that you can't suppress? Do you ever have to do rituals over and over even though you know they don't make sense?

Evaluation

- Yale-Brown Obsessive Compulsive Scale (CY-BOCS)
 - Clinician administered, best when given to both children and their parents
 - Checklist for over 60 obsessions and compulsions. 8-15:mild, 15-23:moderate,=>24: severe
 - Rates the severity by scoring the 1) time occupied, 2)degree of life interference, 3)subjective distress, 4)internal resistance and 5)degree of control
 - 25-40% reduction is considered a clinically significant response
- Assess the degree of parental entanglement which impairs family life, interferes with tm and helps perpetuate child's symptoms
 - Family Accommodation Scale for OCD – Interviewer rated

Evaluation

- Assess for comorbid conditions, review medical, developmental and family history
 - Acute onset or exacerbation in the setting of recent URI or Strep infection
 - Labs to consider: ASO, Anti-dsDNA. A 0.2 log rise in either or absolute level more than twice upper limit normal suggest recent GABHS infection
- Obtain information from school/teachers
 - School performance: compulsive rereading or rewriting, pathological perfectionism, comorbid anxiety, attentional and impulse problems; or associated cognitive impairments
 - Consider Neuropsychological testing if there is academic struggles

Evaluation - Differential Diagnosis

- Developmentally normal ritualistic behaviors in toddlers and preschoolers
 - In children younger than 6, mild or transient symptoms are very common
 - One study found that 60% of 4th graders have preoccupation with guilt about lying, engage in checking behaviors, 50% contamination and germ fears
 - excessive rituals early in life may be a marker for later onset of OCD
- Anxiety disorders
 - recurrent thoughts in anxiety disorders are usually about real-life concerns and/or social situations, whereas the obsessions of OCD usually include content that is odd, irrational, or of a seemingly magical nature
 - compulsions are not present in anxiety disorders but avoidance is

Evaluation – Differential Diagnosis

- Major depressive Disorder
 - Rumination is mood-congruent and not experienced as intrusive or distressing
- Stereotypic, repetitive behaviors and restricted and narrow range of interests in ASD
 - OCD is ego-dystonic and associated with anxiety-driven obsessional fears. ASD behaviors are done with apparent gratification and only upsetting when these activities are interrupted.
- Primary psychotic illnesses
 - Over valued ideation and delusional thinking in OCD with poor insight
 - Assess insight when anxiety is minimum
 - Nature of obsessional ideation is not as atypical
 - OC symptoms sometimes herald a primary psychotic illness

Evaluation – Differential Diagnosis

- Tic Disorder
 - sometimes difficult to distinguish from complex tics as both may be preceded by premonitory urges that persists until the action is completed
 - Tics are less complex than rituals and not aimed at neutralizing obsessions
- Other OC related disorders: obsessions/compulsions are mostly focused on a specific area
- OCDP, perfectionism

Treatment Planning

- Individual features of the child have important implications for treatment planning
- Plan should target content and severity of core OCD symptoms but also comorbid difficulties in the context of developmental level, personality, adaptive functioning
- Involve family as much as possible in developing the treatment plan
- Help destigmatize and reframe child's symptoms
- Family therapy should be included when possible
- Collaboration with school is a key part of treatment interventions

Treatment Options

- Medications:
 - Serotonin Reuptake Inhibitors
 - Augmentation with neuroleptics, benzodiazepines
- Psychotherapy alone:
 - CBT: C part without E/RP is less effective
 - Other types of therapy such as ACT (Acceptance and Commitment Therapy) or ABM (Attention Bias Modification) have not been systematically studied as monotherapy in pediatric population
- Combined treatment:
 - Individual therapy: supportive, skills-building, create a sense of mastery
 - Family therapy: Family psychopathology is neither necessary nor sufficient for the onset of OCD symptoms but families affect and are affected by the disorder. High expressed emotions exacerbate sx, calm and supportive family may improve outcome. Help with entanglement.
 - Family support groups

Treatment Planning

- Mild OC symptoms and no impairment could be monitored. If related to stressors, can consider therapy
- Mild to moderate OCD in the absence of comorbidity, can be treated with CBT alone as the first line treatment
- When to start with medications: severe symptoms, time, expense, effort, anxiety associated with CBT, unavailability of therapist, child's lack of sufficient cognitive or emotional maturity or lack of family support, presence of comorbid depression, anxiety and disruptive behaviors
- Many clinicians prefer combined treatment as the first line treatment

Treatment - CBT

- Treatment of choice for mild to moderate OCD symptoms
- More durable effect as compared to medication
- CBT added to stable medication regimen enhances the response
- CBT reduce relapse rate when medication is discontinued
- Treatment is 13-20 sessions and include 3 elements:
 1. Information gathering
 2. Hierarchy-based therapist assisted graded exposure and response prevention (E/RP) :Exposure reduces phobic anxiety and RP reducing rituals
 3. Homework assignment
- Developmental considerations
- Child needs to be willing to participate
- “tool kit” : relaxation, cognitive therapy, use of systematic reinforcement to help with compliance

Treatment - CBT

Prognostic indicators of good response

- motivated patient
- presence of overt rituals and compulsions
- ability to monitor and report symptoms
- absence of complicating comorbid conditions

Prognostic indicators of partial or nonresponse

- extensive comorbidity
- family conflict integrating with CBT
- cognitive limitation as in extreme young age, intellectual disability, ASD
- less effective in kids with obsessions only

Add medication if no response after 2-4 weeks or partial response after 4-7 weeks
Research looking at augmenting CBT with D-Cycloserine (partial glutamate agonist)

Treatment – Serotonin Reuptake Inhibitors

- Clomipramine
 - significantly superior to placebo and other TCAs, moderate improvement in 75% by week 5
 - Dose: 3mg/kg per day for 3 months NTE 5mg/kg or 250 mg/day due to risk of toxicity, EKG changes, and seizures
 - Side effects: anticholinergic, antihistaminic
- SSRIs – first line treatment
 - Sertraline, fluvoxamine, fluoxetine are FDA-approved
 - No data to compare efficacy. Pick based on side effect profile and comorbidities
 - Fluoxetine: steady state is not reached for 2-3 weeks and not completely eliminated for up to 6 weeks – available in liquid form
 - Side effects: nausea, headache, tremor, GI complaints, drowsiness, insomnia, akathisia, disinhibition, agitation, hypomania, “frontal lobe syndrome”: apathy and/or disinhibition, occasionally worsen tics
 - Jitteriness syndrome may go away after 10 days

Treatment - SSRIs

- Start low, go slow
- Fair trial: adequate dose for 10-12 weeks. Many do not show response for 6-10 weeks. Most cases continue to improve during the first 3 months
 - Failure to respond to one SSRI does not predict respond to another SSRI
 - Switch after 10-12 weeks, switch again to another SSRI or Clomipramine
 - No data to compare switching with augmentation
 - Substantial number of patients do not respond or have residual symptoms
 - Predictors of response is largely unknown
 - Individuals with comorbid or family history of tic disorder may not respond as well to the SSRIs

Treatment - Augmentation

- Augmentation is reserved for treatment resistant cases
- Treatment resistant: failure to respond to at least 2 monotherapies as well as combined treatment with at least persistent moderate symptoms
- Augmentation options:
 - Clomipramine + SSRI: Check EKG, watch for drug-drug interactions (monitor clomipramine level)
 - Clonazepam was found to be superior to placebo in adults. Be mindful of the associated risk of withdrawal, dependency, and disinhibition
 - SSRIs+ Antipsychotics were found to be superior to placebo in adults. Carefully assess risks/benefits
 - OCD comorbid with bipolar disorder: focus on treating mood episodes first
 - OCD and ADHD: focus on treating OCD first. Consider alpha-2 agonists, atomoxetine, bupropion for ADHD
 - OCD and Tics: consider augmentation with antipsychotics, clonidine, clomipramine. Monitor QTc

Treatment - Maintenance

- No clear time (12-18 months following satisfactory response)
- Periodic discontinuation trials are advisable (decrease by 25% q2months), but many responders require ongoing maintenance treatment
 - Double blind discontinuation study, 89% of children and adolescent patients with drawn from long term clomipramine relapsed within 2 months, comparable rate observed in adults within 7-12 weeks from clomipramine or fluvoxamine
 - CBT may decrease the need for long term pharmacotherapy. Do booster sessions or introduce CBT if symptoms worsen with medication taper
 - Do not stop abruptly: GI disturbance, HA, dizziness, malaise, insomnia
 - Monitor both patient and parent report
 - Periodically monitor for comorbidities

Other treatments

- Potential pharmacological treatments include riluzole (anti-glutamatergic drug), D-cycloserine as an adjunct to CBT, ketamine and memantine.
- prophylactic antibiotics
- IVIG, plasmapheresis
- Studied in adults but not children:
 - IV Clomipramine
 - Psychosurgery: Deep Brain Stimulation
 - Transcranial magnetic stimulation

Pediatric OCD Treatment Study (POTS)

Goal: To evaluate the efficacy of CBT alone, sertraline alone, or CBT and sertraline combined, as initial treatment for children and adolescents with OCD.

Design, setting, and participants: The Pediatric OCD Treatment Study, a balanced, masked randomized controlled trial conducted in 3 academic centers in the United States and enrolling a volunteer outpatient sample of 112 patients aged 7 through 17 years with a primary Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition diagnosis of OCD and a Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS) score of 16 or higher. Patients were recruited between September 1997 and December 2002.

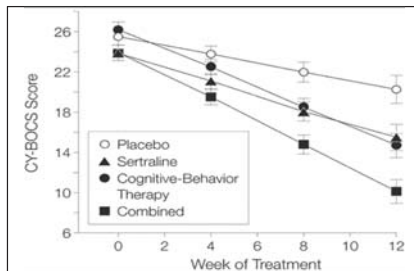
Interventions: Participants were randomly assigned to receive CBT alone, sertraline alone, combined CBT and sertraline, or pill placebo for 12 weeks.

Main outcome measures: Change in CY-BOCS score over 12 weeks as rated by an independent evaluator masked to treatment status; rate of clinical remission defined as a CY-BOCS score less than or equal to 10.

Results: Combined treatment proved superior to CBT alone and to sertraline alone, which did not differ from each other. Site differences emerged for CBT and sertraline but not for combined treatment, suggesting that combined treatment is less susceptible to setting-specific variations.

POTS

The rate of clinical remission for combined treatment was 53.6%; for CBT alone, 39.3%; for sertraline alone, 21.4%; and for placebo, 3.6%.



Pediatric OCD Treatment Study-Phase II

Objective: To examine the effects of augmenting SRIs with CBT or a brief form of CBT

Design, setting, and participants: A 12-week randomized controlled trial conducted at 3 academic medical centers between 2004 and 2009, involving 124 pediatric outpatients between the ages of 7 and 17 years with OCD as a primary diagnosis and a CY-BOCS score of 16 or higher despite an adequate SRI trial.

Interventions: Participants were randomly assigned to 1 of 3 treatment strategies: MM (7 sessions), MM+I-CBT (7 sessions), MM+CBT (7 sessions of MM plus 14 concurrent sessions of CBT). In contrast to CBT, I-CBT did not include: (1) therapist-assisted exposure; (2) imaginal exposure; and (3) didactic parent sessions.

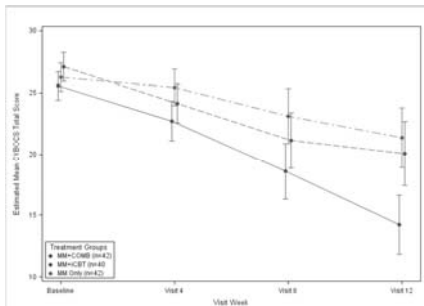
Main outcome measures: Responder status as defined as a post-treatment CY-BOCS reduction of 30% or greater compared to baseline; change in continuous CY-BOCS total score over 12 weeks.

Results: MM+CBT was superior to MM and to MM+I-CBT on all outcome measures.

- In the primary ITT analysis, 68.6% in MM+CBT were considered responders, which was significantly better than the 34.0% in MM+I-CBT, and 30.0% in MM.
- NNT with MM+CBT versus MM to see one additional RESPONSE at Week 12, on average, was estimated as 3; for MM+CBT versus MM+I-CBT the NNT was also estimated as 3; for MM+I-CBT versus MM the NNT was estimated as 25.

Conclusions: Among patients aged 7 to 17 years with OCD and partial response to SRI use, the addition of CBT to medication management compared with medication management alone resulted in a significantly greater response rate, whereas augmentation of medication management with the addition of instructions in CBT did not.

POTS-II



Book Recommendation

- Talking back to OCD – John March
- What to do when your brain gets stuck – Dawn Huebner
- Up and Down the worry hill – Aureen Pinto Wagner
- What to do when your child has Obsessive-Compulsive Disorder – Aureen Wagner
- Standing Up to OCD workbook for kids – Tyson Rueter
- The ACT workbook for Teens with OCD – Zurita Ona
- Freeing your child from OCD – Tamar Chansky
- Turtles all the way down – John Green
- Under Rose-Tainted Skies – Louise Gornall
- Everything is an Emergency – Jason Adam Katzenstein



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Individual Research article references available upon request



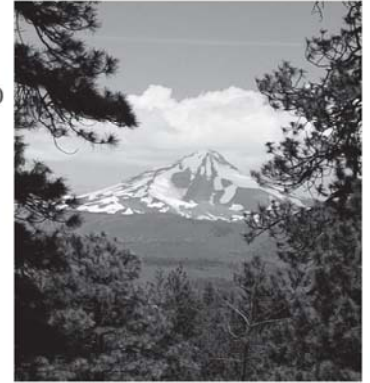
Bullying; Another ACE

3rd Annual Pediatric Mental Health
Update, March 2020

Ajit Jetmalani, M.D.
Professor and Director
Division of Child and Adolescent Psychiatry,
Oregon Health & Science University

Disclosures

I have no conflict of
interest disclosures to
make.



Mt. Jefferson

Main Points

What is bullying?

Who is at risk

Do zero tolerance policies and expulsion work?
(Hint....No)

Should victims be asked to "mediate" with
bullies (hint...No)

How do we help the targets, bystanders and
perpetrators of bullying

How can you identify victims in your office

What you can do to help

Information Sources:

- [Youth Voice Project](#) (Stan Davis and Charisse Nixon, Ph.D.)
- www.Stopbullying.gov
- www.violencepreventionworks.org (Dan Olweus, PhD)



What is bullying?

*Bullying is any **unwanted aggressive behavior(s)** by another youth or group of youths...that involves an **observed or perceived power imbalance** and is **repeated multiple times** or is **highly likely to be repeated**. Bullying may inflict harm or distress on the targeted youth including physical, psychological, social, or educational harm.*

www.cdc.gov/violenceprevention/pdf/bullying-definitions-final-a.pdf

stopbullying.gov

WE HAVE ALL



WATCHED
BULLYING
(BYSTANDER)



BEEN A
TARGET AND
OR



BEEN A
BULLY



Modes of Bullying



Direct:

Aggressive behavior that is face to face



Indirect:

Behind the scenes



Types:

- **Physical:** hitting kicking spitting pushing...
- **Verbal:** taunting, name calling, verbal threats of harm, sexual comments
- **Relational:** Social isolation, rumors, posting embarrassing information \ images.



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How many children and youth are bullied?

22% of students ages 12-18 were bullied at school during the 2012-2013 school year

20% of high school students were bullied on school property at least once in the past 12 months

U.S. Department of Education (2015)

Kann et al. (2014)

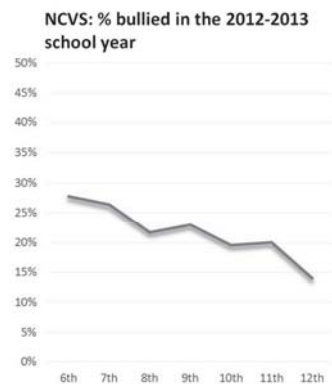
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Age Trends in the Frequency of Being Bullied

- Children are most likely to be bullied in elementary grades
- The likelihood decreases through middle school and high school



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Children and Youth At Higher Risk for Being Bullied

- Those who:
 - Have learning disabilities
 - Have attention-deficit/hyperactivity disorder (ADHD)
 - Have autism spectrum disorder (ASD)
 - Have special health care needs or chronic diseases
 - Are overweight or underweight
 - Are lesbian, gay, bisexual, or transgender; are questioning their sexual orientation; or do not conform to gender stereotypes
 - Speak another language at home
- However, even if a child has these risk factors, it doesn't mean that they will be bullied.*

stopbullying.gov

Students who are bullied may:

- Have damaged clothing
- Have unexpected cuts and bruises
- Have few friends
- Seem afraid to go to school
- Take the long way to school
- Lose interest or begin to do poorly in school
- Seem sad and moody
- Frequent headaches abdominal pain
- Bad dreams and trouble sleeping
- Loss of weight
- Seem anxious and have low self-esteem

www.violencepreventionworks.org



Students Who Bully May:

- Have positive attitude towards violence
- Strong need to dominate
- Impulsive, aggressive, reactive
- Lack empathy
- Defiance towards adults
- Involved in other antisocial behavior
- Tend to be stronger and larger
- Be more likely to report access to guns.

www.violencepreventionworks.org



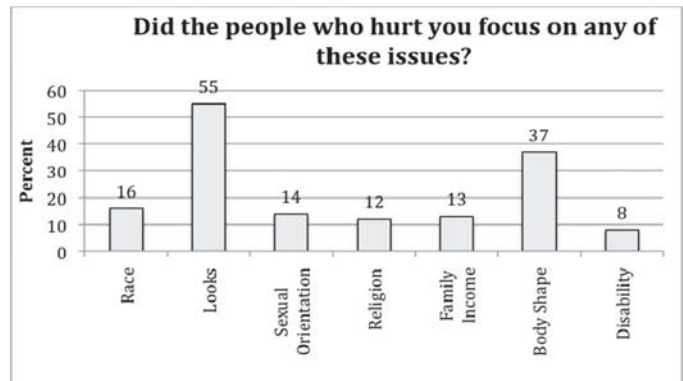
Stan Davis and Charisse Nixon, Ph.D.
Youth Voice Project 2007



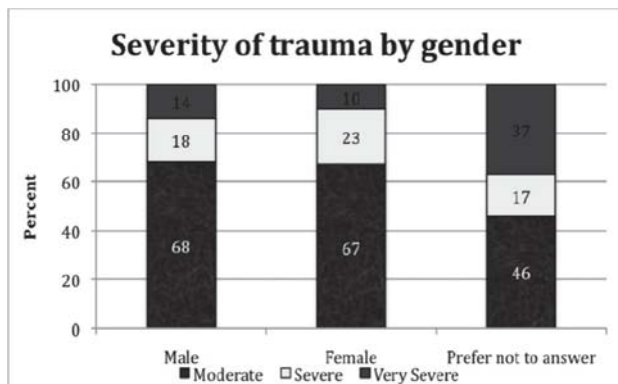
- 11,893 youth in 5th to 12th grade completed a survey.



Stan Davis and Charisse Nixon, Ph.D.
Youth Voice Project 2007



Stan Davis and Charisse Nixon, Ph.D.
Youth Voice Project 2007



GLSEN Survey 2017
www.glsen.org

The Experiences of Lesbian, Gay, Bisexual, Transgender, and Queer Youth in Our Nation's Schools

The final sample consisted of a total of 23,001 students between the ages of 13 and 21. Students were from all 50 states, the District of Columbia, and 5 U.S. territories.

- 87.3% experienced harassment or assault based on personal characteristics
- 70% verbal harassment
- 28.9% physical harassment
- 12.4% assaulted
- 48% electronic harassment

Likelihood of Reporting

Why are children and youth reluctant to report being bullied?

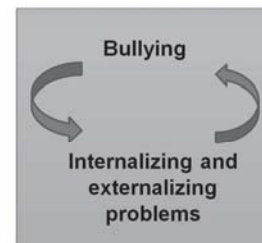
- Negative messages about “tattling” and “snitching”
- Concern about retaliation
- Gender stereotypes
- Lack of confidence in adults’ actions



EFFECTS OF BULLYING

Effects on Bullied Children and Youth

- Being bullied is associated with later:
 - Internalizing problems
 - Depression, anxiety, panic disorder, self-harm, suicidal thoughts and attempts
 - Psychosomatic problems
 - Headaches, stomach pain, sleeping problems, poor appetite
 - Academic problems
 - Externalizing behavior



How Much Are Students Effected by Bullying

(Stan Davis and Charisse Nixon, Ph.D. Youth Voice Project)

Mild: What they did bothered me only a little: 46%

Moderate: It bothered me quite a bit : 36%

Severe: I had or have trouble eating, sleeping, or enjoying myself: 11%.

Very severe: I felt or feel unsafe and threatened because of what happened to me : 7%



BULLYING IS VIOLENCE AND CAN BECOME AN ADVERSE CHILDHOOD EXPERIENCE FOR ALL INVOLVED

Exposure to toxic stress in the absence of supportive relationships can lead to ACE's and related sequelae



CDC. (2016). *Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9-12: Youth Risk Behavior Surveillance*. Atlanta, GA: U.S. Department of Health and Human Services

- Ideation is three times that of heterosexual youth..
- Attempts 5 times higher.
- Attempts are 5 times as likely to require TX.
- 40% of transgender have attempted.
- LGB youth from rejecting families are at 8.4 times the risk.
- Each episode of LGBT victimization, such as physical or verbal harassment or abuse, increases the likelihood of self-harming behavior by 2.5 times on average.

Concern for Children Who Bully:

- Children and youth who bully others are more likely than their peers to:
 - Exhibit antisocial or delinquent behaviors (such as fighting, stealing, vandalism)
 - Dislike school and drop out of school
 - Drink alcohol and smoke cigarettes
 - Carry a weapon
 - Think about and attempt suicide
 - Come from homes with intimate partner violence

stopbullying.gov



PROTECTIVE FACTORS

Protective Factors for Bullying

Individual and Family Factors

- Secure, caring and self-confident children
- Supportive parenting and the modeling of positive relationships
- Consistent and affectionate parent-child interactions

Peer and School Factors

- Close, positive friendships with peers
- Engaged and responsive teachers and school staff
- Inclusive, nurturing and safe schools

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Which Strategies made things

Better or Worse?

Stan Davis and Charisse Nixon, Ph.D.
Youth Voice Project

- Told an adult at home
- Told an adult at school
- Made a joke about it
- Told a friend(s)
- Hit them or fought them
- Made plans to get back at them
- Reminded myself that it's not my fault
- Walked away
- Told the person how I felt
- Told the person or people to stop
- Did nothing
- Pretended it didn't bother me



STRATEGIES IN THE SCHOOLS



#1: Focus on the Social Climate

- Bullying prevention requires changes in social climates of schools and organizations.
- Students feel connected to schools where they know, care about, and support one another, and have common goals.
- Changing social norms around bullying requires commitment, time, and effort but can have a positive effect on behavior.
- Increasing adult supervision is also important.

stopbullying.gov

The Olweus Bullying Prevention Program (OBPP)

- “OBPP was successful in reducing all forms of being bullied and bullying others—verbal, physical, indirect, sexual, and electronic/cyberbullying”.

• Olweus, D., Limber, S.P. & Breivik, K. Addressing Specific Forms of Bullying: A Large-Scale Evaluation of the Olweus Bullying Prevention Program. *Int Journal of Bullying Prevention* 1, 70-84 (2019).



Olweus Key Components

- School-Level
 - Committee, trainings, questionnaire, introduce rules, kickoff
- Classroom Level
 - Post rules, regular class meetings with students and parents
- Individual Level
 - Supervise students, intervene immediately, meet with students and parents, individual intervention plans
- Community level
 - Committee participation, spread messages and principles.



Olweus Bullying Prevention Program Results over 1 school year

- Olweus, D. (2005). A useful evaluation design, and effects of the Olweus Bullying Prevention Program. *Psychology, Crime & Law*, 11, 389-402
- Olweus, D. (2007).

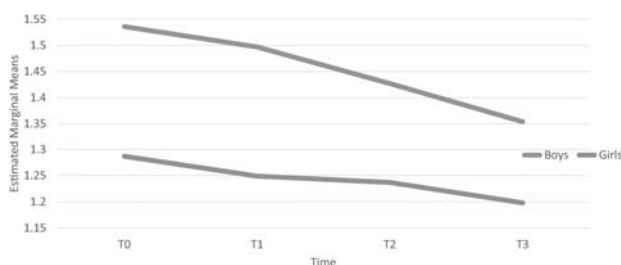
- Percent Victims: reduced by 42% (to 8.3%)
- Percent Bullies: reduced by 52% (to 3.1%)

www.violencepreventionworks.org



OBPP Reduction in Bullying Over 8 Months

Olweus, D., Limber, S.P. & Breivik, K. Addressing Specific Forms of Bullying: A Large-Scale Evaluation of the Olweus Bullying Prevention Program. *Int Journal of Bullying Prevention* 1, 70-84 (2019).



Summary: What Makes Things Better

accessing support from peers and adults was the most helpful strategy to make things better



Misdirection #1: Zero Tolerance for Bullying

- Also referred to as “student exclusion” policies. Concerns:
 - They potentially affect a large number of students.
 - Threats of severe punishments may actually discourage children and adults from reporting.
 - Bullying can be an early marker of other problem behaviors. Children who bully need positive, prosocial role models, including adults and students in their school.
- School safety may occasionally demand that a student be removed from a school environment, but these situations should be rare.

stopbullying.gov



This Photo by Unknown Author is licensed under CC BY

“SCHOOL TO PRISON PIPELINE”

Expelling youth leads to further risks of functional and emotional deterioration, community aggression /revenge fantasies and actions, completed suicide and imprisonment.



Misdirection #2: Conflict Resolution and Peer Mediation

- Are often used to address conflicts among students. Concerns:
 - Bullying is a form of victimization, not conflict.
 - Mediating a bullying incident may send inappropriate messages to the students who are involved.
 - Mediation may further victimize or traumatize a child who has been bullied.

stopbullying.gov

Misdirection #3: Group Therapeutic Treatment

- Group treatment with children who bully
 - May involve anger management, skill-building, empathy-building, self-esteem enhancement.
- Well-intentioned but often counter-productive. Why?
 - Group members can serve as poor role models and reinforce each others' antisocial and bullying behavior.

stopbullying.gov

Misdirection #5: Simple, Short-Term Solutions

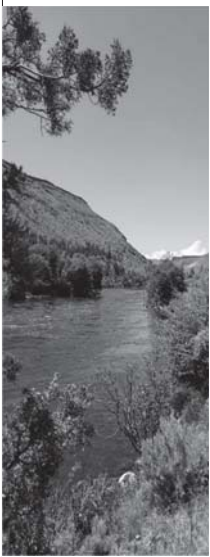
- Often administrators and staff adopt a short-term, piecemeal approach.
 - Bullying may be the topic of a staff in-service training, PTO meeting, school-wide assembly, lessons taught by individual teachers
 - These efforts may be good first steps, but are unlikely to reduce bullying on their own. Why?

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Additional Ways to Makes Things Worse

- **Youth in special education, youth of color (except for Asian American youth), and males reported that adults told them not to tattle more often than did youth not in special education, white or female students.**





In Your Office

Ask about Bullying When:

- Unexplained somatic concerns
- School Avoidance
- Symptoms of Depression
- Symptoms of Anxiety
- Suicidal Thinking



Interview strategies



Empathetic Listening



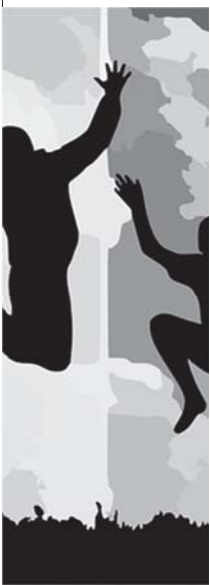
Praise



Adults Will Help



XX
Confrontation



Interview



Work on a plan with child and care giver.



Schedule return visit



Reach out to the school ? Policies and practices



Recommend Olweus antibullying program or other SEL



Advocacy?

- With your local school district
- Oregon Student Success Act



Resources from Screenagers for Youth and Parents

<https://www.screenagersmovie.com/antibullying-campaigns>

- Pacer.org
- socialmediahelpline.com
- Thetrevorproject.com
- itgetsbetter.org
- loveislouder.com



Thank you

Learning Disorders: What are they, when should you be concerned, and what can you recommend



Kristen Mackiewicz Seghete, PhD
Assistant Professor
Department of Psychiatry
OHSU



Disclosures

No financial disclosures or conflicts of interest

Learning Objectives

- 1) Understand the DSM-5 definition of a Specific Learning Disorder (SLD) and DSM-5 criteria for a SLD
- 2) Identify potential signs of a SLD in your patients at different ages and appropriate follow-up referrals
- 3) Understand different evaluation processes and identify what you as a provider and your patient (family) can expect to receive from an evaluation

Learning Objectives

- 1) Understand the DSM-5 definition of a Specific Learning Disorder (SLD) and DSM-5 criteria for a SLD

DSM-5



"Specific learning disorder, as the name implies, is diagnosed when there are specific deficits in an individual's ability to perceive or process information efficiently and accurately ... and is characterized by persistent and impairing difficulties with learning foundational academic skills in reading, writing, and/or math."

APA. (2013). *DSM-5*. pg. 32.

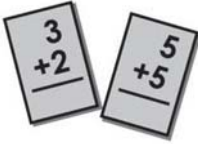
Diagnostic Criteria

- A) Persistent (> 6 months) difficulty acquiring keystone academic skills

Examples

Reading

- Delayed site word learning
- Effortful reading
- Omissions, guessing, transposing
- Blends
- Comprehension



Math

- Memorizing math facts
 - Number sense
 - Procedures
- Reasoning/story problems
- Functional academics

Writing

- Spelling
- Grammar
- Capitalization, spacing, alignment



Diagnostic Criteria

- A) Persistent (> 6 months) difficulty acquiring keystone academic skills
- B) Academic skills are substantially (and quantifiably) below expected levels
- C) Apparent in early school years
- D) Learning difficulties are specific (unexpected underachievement)

Root Cause

Core deficits may contribute to specific academic difficulties in multiple domains



Learning Objectives

- 2) Identify potential signs of a SLD in your patients at different ages and appropriate follow-up referrals

Developmental Course

Not formally diagnosable until some formal academic training

However, many children can show early warning signs



Preschool Warning Signs*

- Difficulty learning and/or following rhyming games
- Unable to learn the alphabet, names of letters, or sounds of letters
- Struggles to learn rote information (e.g., days of the week)
- Difficulty learning to count
- Frequently mispronounce words
- Poor graphomotor skills

**These are not predictive and can be present within normal development as well*

Developmental Course

Symptoms will emerge more prominently in kindergarten, which will result in extra supports, a “wait and see” response, or go unnoticed



Kindergarten Signs*

- Unable to learn site words
- Transposing letters *and* numbers
- Unable to learn to write words – even when copying directly
- Unable to sound out short words
- Continued struggles to learn growing rote information
- Resistance to reading and/or writing work
- Difficulty deciphering written work
- Not able to master numerical sense
- Poor math reasoning/comprehension

**These are not predictive and can be present within normal development as well*

Elementary Course

- Poor reading fluency
- Continued transposing
- Substitutions and omissions continue
- May comprehend with contextual cues
- Poor spelling
- Difficulty with memorizing multiplication tables and long division
- Rote memory difficulties
- Hard time defining vocabulary words
- Resistance to school work
- School refusal
- Inconsistent capitalization, punctuation, grammar, and spacing
- Hard time with conceptual and/or procedural math
- Misalignment of written math problems

Developmental Course

By middle school, many adolescents may have mastered the more basic/automatic processes but still struggle when they must be implemented quickly or under higher demands



What to do you do when you have concerns?



Learning Objectives

- 3) Understand different evaluation processes and identify what you as a provider and your patient (family) can expect to receive from an evaluation

Types of Evaluations: School Evaluations

- 1) School Evaluations
 - 60 school day rules
 - At schools discretion whether or not to proceed
 - School selects appropriate evaluations
 - Goal: determine whether or not child is eligible for one of 11 IEP categories (SLD is one) based on standardized criteria
 - IEP = additional services (pull-outs), specialized learning center, aide, etc. AND accommodations
 - 504 Plan = accommodations ONLY

Types of Evaluations: Private Evaluations

- 2) Psychoeducational Evaluation
 - Good fit when the primary question is related to school performance and/or SLD
 - Typically includes intellectual and achievement testing
 - Goal: describe cognitive and academic strengths and weaknesses
 - Provide helpful recommendations for the school setting

Types of Evaluations: Private Evaluations

- 3) Neuropsychological Evaluation
 - Good fit when differential diagnosis is needed (e.g., R/O ADHD) or presentation is more complex due to medical, psychiatric, and/or behavioral history
 - Comprehensive evaluation of cognitive functioning, not just achievement, including executive function
 - Goals: 1) describe cognitive strengths and weaknesses, 2) diagnostics, and 3) provide broader scope of recommendations

	School	Psychoeducational	Neuropsychological
Developmental History	Yes	Yes	Yes
Intellectual/General Cognitive	Yes*	Yes	Yes
Achievement Testing	Yes*	Yes	Yes
EF/Neuropsychological Functioning	No	No	Yes
Parental/Teacher Questionnaires	Yes	Yes	Yes
Classroom Observation	Yes	Maybe	Usually No
IEP Determination	Yes	Can be considered	Can be considered
Diagnosis	No	IQ/SLD	Multiple
Completion Time	~1 school year	Depends on WL	Depends on WL; longest
Cost	Free	\$	\$\$\$
Report	School	Family (maybe school)	Provider/Family
Insurance Coverage	N/A	Usually No	Depends

Learning Objectives

- 1) Understand the DSM-5 definition of a Specific Learning Disorder (SLD) and DSM-5 criteria for a SLD
- 2) Identify potential signs of a SLD in your patients at different ages and appropriate follow-up referrals
- 3) Understand different evaluation processes and identify what you as a provider and your patient (family) can expect to receive from an evaluation

Questions?



mackiewi@ohsu.edu



Adolescent Eating Disorders

Jessica Serrano, MD, MPH



Disclosures

I do not have any financial relationships with any commercial interest.

Objectives

1. Briefly review the following eating disorders: anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant/restrictive food intake disorder, and other specified feeding or eating disorder.
2. Identify and recognize key elements of the history, ROS, and physical exam when evaluating a patient for eating disorder.
3. Review diagnostic tests helpful in the evaluation of eating disorders.
4. Briefly review levels of care and review programs in the NW for treatment of eating disorders.

DSM-5 Criteria

Published May 2013

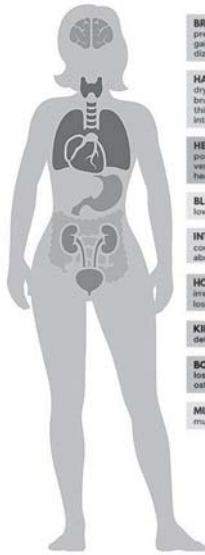
Anorexia Nervosa (AN)



- Restriction of energy intake relative to requirements, leading to a significantly low body weight- less than that minimally expected.
- Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.
- Disturbance in the way in which one's body weight or shape is experienced, or **persistent lack of recognition of the seriousness of the current low body weight.**

AN Type

- **Restricting type:**
 - Not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).
 - Weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.
- **Binge-eating/purging type:**
 - Engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).



- BRAIN**
preoccupation with food/calories, fear of gaining weight, headaches, fainting, dizziness, mood swings, anxiety, depression
- HAIR/SKIN**
dry skin and lips, brittle nails, thin hair, bruises easily, yellow complexion, growth of thin white hair over body (lanugo), intolerance to cold
- HEART**
poor circulation, irregular or slow heart beat, very low blood pressure, cardiac arrest, heart failure
- BLOOD**
low iron levels (anaemia)
- INTESTINES**
constipation, diarrhoea, bloating, abdominal pain
- HORMONES**
irregular or absent periods, loss of libido, infertility
- KIDNEYS**
dehydration, kidney failure
- BONES**
loss of bone calcium (osteopenia, osteoporosis)
- MUSCLES**
muscle loss, weakness, fatigue

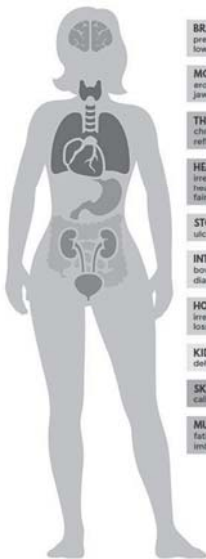


Bulimia Nervosa (BN)



- Recurrent episodes of binge eating:
 - Eating, in a discrete period of time, large amount of food than most individuals would eat in a similar period.
 - A sense of lack of control over eating during the episode.
- Recurrent compensatory behaviors to prevent weight gain, such as self-induced vomiting; use of laxatives, diuretics, or other medications; fasting; or excessive exercise.
- The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.

Diagnostic and Statistical Manual of Mental Disorder, 5th ed DSM-V, 2013 APA



- BRAIN**
preoccupation with food and weight, low self-esteem, anxiety, depression
- MOUTH**
erosion of dental enamel, swollen jaw, bad breath, gum disease, tooth decay
- THROAT/OESOPHAGUS**
chronic sore throat, indigestion, heartburn, reflux, inflamed or rupture of oesophagus
- HEART**
irregular or slow heart beat, cardiac arrest, heart failure, low blood pressure, fainting, dizziness
- STOMACH**
ulcers, pain, stomach rupture
- INTESTINES**
bowel problems, constipation, diarrhoea, cramps
- HORMONES**
irregular or absent periods, loss of libido, infertility
- KIDNEYS**
dehydration
- SKIN**
calluses on knuckles, dry skin
- MUSCLES**
fatigue, cramps caused by electrolyte imbalance, tiredness, lethargy



Binge Eating Disorder (BED)



- Recurrent episodes of binge eating:
- The binge-eating episodes are associated with three (or more) of the following:
 - Eating much more rapidly than normal.
 - Eating until feeling uncomfortably full.
 - Eating large amounts of food when not feeling physically hungry.
 - Eating alone because of feeling embarrassed by how much one is eating.
 - Feeling disgusted with oneself, depressed, or very guilty afterward.

Diagnostic and Statistical Manual of Mental Disorder, 5th ed DSM-V, 2013 APA

Avoidant/Restrictive Food Intake Disorder (ARFID)



- Lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating with failure to meet nutritional and/or energy needs associated with one (or more) of the following:
 - Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
 - Significant nutritional deficiency.
 - Dependence on enteral feeding or oral nutritional supplements.
 - Marked interference with psychosocial functioning.

Diagnostic and Statistical Manual of Mental Disorder, 5th ed DSM-V, 2013 APA

ARFID Continued

- The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.
- The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

Diagnostic and Statistical Manual of Mental Disorder, 5th ed DSM-V, 2013 APA

Other Specified Feeding or Eating Disorder (OSFED)

- **Atypical Anorexia Nervosa:** All criteria are met, except despite significant weight loss, the individual's weight is within or above the normal range.
- **Purging Disorder:** Recurrent purging behavior to influence weight or shape in the absence of binge eating
- **Night Eating Syndrome:** Recurrent episodes of night eating. Eating after awakening from sleep, or by excessive food consumption after the evening meal. The behavior is not better explained by environmental influences or social norms. The behavior causes significant distress/impairment. The behavior is not better explained by another mental health disorder (e.g. BED).

Diagnostic and Statistical Manual of Mental Disorder, 5th ed DSM-V, 2013 APA

Evaluation

History, physical and testing

Presenting concerns

- Physical symptoms
 - Dizziness, fatigue, headache, heartburn, constipation, amenorrhea, syncope, vomiting, abdominal pain.
- Weight loss picked up during routine visits.
- Coaches, teachers, & parents may become suspicious.

Example screening questions

- How has your nutrition been?
- How many meals do you eat a day?
- Skipping any meals?
- Any snacking?
- Do you or anyone else have concerns about your eating or exercising habits?

Eating habits & behaviors

- Current dietary practices
- Binging & purging (ask without parent in room).
- Misuse of diuretics, laxatives, diet pills, ipecac
- Fads or avoidance
- Reading labels
- Calorie cutoffs
- Tracking intake on apps

Eating habits & behaviors

- Preference for eating alone
- Extremely limited food choices
- Excessive fluid intake (water, caffeine)
- Ritualizing behavior (eating foods in a particular order, chewing 30 times before swallowing...)
- Excessive chewing of ice or gum
- Recent vegetarianism, vegan, or gluten-free diet
- Excessive interest in food (cooking shows & magazines, preparation)

History

- Weight history
 - Review growth charts and obtain from previous provider if new patient
 - Maximum & minimum weight
 - Goal weight
- Exercise history
 - Types, frequency, duration, intensity
 - Turning normal activities into exercise
- Menstrual History (if relevant)
 - Age at menarche
 - Frequency, duration, flow
 - If no menarche obtain pubertal history

Review of Systems

- Constitutional
 - Weight loss, weakness, fatigue, decreased energy
- Respiratory
 - Shortness of breath
- Cardiovascular
 - Poor peripheral perfusion, palpitations, chest pain
- Gastrointestinal
 - Vomiting, diarrhea, constipation, early satiety, abdominal pain, epigastric pain, hematemesis
- Integumentary
 - Hair loss, dry skin, fuzzy hair

Review of Systems

- Hematologic
 - Pallor, easy bruising/bleeding
- Endocrine
 - Menstrual irregularities or amenorrhea, cold intolerance
- Neurologic
 - Concentration issues or worsening school performance, slowed cognition, dizziness
- Psychiatric
 - Depression, anxiety, irritability

Rooming patient

- Have patient void and collect urine
 - Urine dip to assess SG
- Gowned blind weight
- Height
- Orthostatic BP and pulse
 - supine 5 minutes, standing 2 minutes
- Temperature

Physical Exam

- Vital signs
 - Bradycardia, hypothermia, orthostatic changes
- General appearance
 - AN: emaciated, sunken cheeks, flat affect
 - BN/BED/OSFED: may be normal or overweight
- Skin
 - Dry skin, lanugo, loss of shine or brittle hair, nail changes, hypercarotenemic, subconjunctival hemorrhage, callus on knuckles, bruising along bony prominences

Physical Exam

- HEENT
 - Sunken eyes, dry lips, gingivitis, loss of tooth enamel, caries, parotitis
- CV
 - Bradycardia, arrhythmias, delayed cap refill, hands and feet are cold
- Abdomen
 - Scaphoid, palpable stool, epigastric tenderness

Physical Exam

- Extremities:
 - Edema, calluses on dorsum of hand (Russell sign), acrocyanosis
- Neuro/Psych
 - Flat affect, slow to answer questions, slowed speech
 - Unconcerned until you suggest current weight is unhealthy

Initial testing

- CBC
 - Leukopenia, thrombocytopenia
- CMP
 - Hypokalemia, hypochloremia, metabolic alkalosis, hyper/hyponatremia; elevated creatinine or LFTs
- Magnesium and phosphorus
- TSH
- Pregnancy test if amenorrhea present
- EKG

Treatment

Starting the recovery process

Treatment goals

- Weight restore and stabilize weight
- Normalize activity
- Normalize thought process
 - Re-establish healthy relationship with food & exercise
- Normalize family involvement

Treatment options

- Medical hospitalization
- Residential treatment
- Partial hospitalization/day treatment (PHP)
- Intensive outpatient (IOP)
- Outpatient

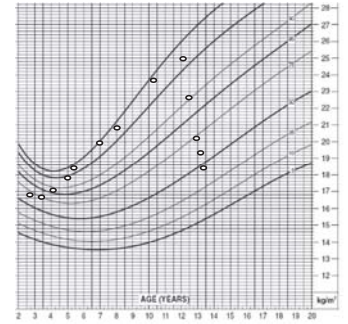
Hospital admission criteria

Bradycardia	Pulse < 50 beats/minute at daytime, < 45 beats/minute at night
Hypotension	BP < 90 / 45 mm Hg*
Hypothermia	T < 35.6 °C / 96 °F
Orthostasis (from supine to standing position)	<ul style="list-style-type: none">• Pulse increase > 20 beats/minute**• Systolic BP decrease > 20 mm Hg• Diastolic BP decrease > 10 mm Hg
Weight	< 75% median body mass index (mBMI) for age and sex
EKG abnormalities	e.g., prolonged QTc > 460 msec
Electrolyte abnormalities	<ul style="list-style-type: none">• Phosphorus < 3.0 mg/dL• Potassium < 3.5 mmol/L• Magnesium < 1.8 mg/dL
Other acute medical events	e.g., syncope, GI bleeding, severe dehydration, etc.

Patient Cases

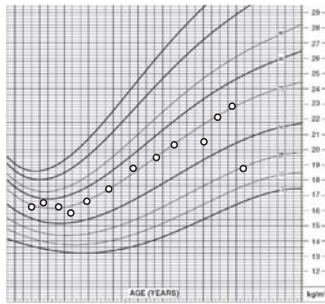
Edgar 13 y.o. M

- Presenting for yearly WCC.
- At his 12 year well child check was told by PCP "Looks like you are overweight and need to work on losing weight to prevent diabetes".
- Has been exercising and eating healthier.



Rebecca 15 y.o. F

- Presenting for amenorrhea
- Participating in cross country since 6th grade
- Wants to improve her time
- Makes sure she eats healthy and learned in Health class at school about sugars



Adolescent & Young Adult Clinic



Wayne Sells
M.D., MPH.

Professor of Pediatrics, Division of Adolescent Medicine, School of Medicine



Jessica Serrano
M.D., MPH.

Assistant Professor of Pediatrics, Division of Adolescent Medicine, School of Medicine



Megan Jacobs
M.D., M.S.C.S.

Assistant Professor of Pediatrics, Division of Adolescent Medicine, School of Medicine

Questions?

serranoj@ohsu.edu

The Nature of Eating Disorders: A Psychological Perspective

Rodney J. Reid MD, PhD
Providence St. Vincent Medical Center
Portland, Oregon

Providence St. Vincent Partial Hospital Eating Disorders Treatment Program

9450 SW Barnes Road, Suite 200
Portland, OR 97225

<https://oregon.providence.org/our-services/p/providence-adult-eating-disorders-treatment-program/contact-us/>

Screening Evaluation: (503) 216-2025

Eating Disorders

- Anorexia Nervosa
- Bulimia Nervosa
- Avoidant/Restrictive Food Intake Disorder
- Binge-Eating Disorder
- Rumination Disorder
- Pica

Eating Disorders

- Lifetime prevalence of AN is about 0.5%
- Lifetime prevalence of BN is about 1.5%
- About 60% of adolescent females express subjective unease with body weight/shape, but this is transient

Anorexia Nervosa

- Restriction of caloric intake leading to low body weight.
- Intense fear of gaining weight or of becoming fat
- Disturbance in how one's body weight or shape is experienced

Anorexia Nervosa

- A complex physiologic and psychological phenotype that is "understood" or interpreted via shifting cultural values
- The core characteristics of AN can be understood as adaptive traits that have evolved via natural selection
- Not simply a result of psychological conflict or a desire to be fashionably thin

Anorexia is poorly understood

- Characterized as a modern psychological illness resulting from a culture that idealizes thinness
- AN deviates from normal desire to lose weight/change shape

Anorexia is poorly understood

- Risks, costs, and dangers are undeniable
- Causal motivation is often opaque
- Stubbornly defended avoidance of even small weight gain
- Manifestly peculiar
- Recovery requires a long stretch of time
- Patient behaves as if avoiding their normative BMI offers some benefit, the nature of which is elusive even to themselves.

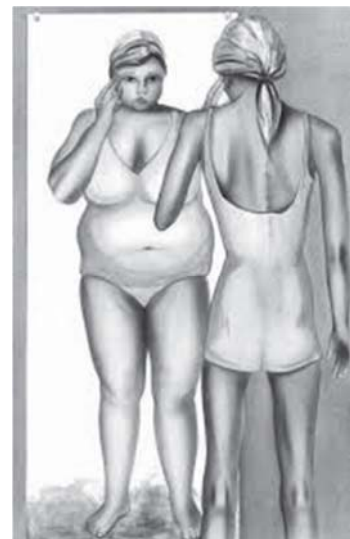


Anorexia is poorly understood

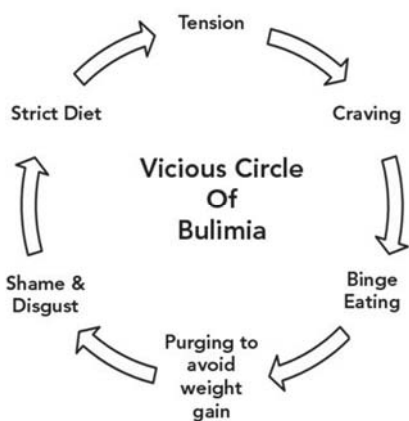
- Predictable Questions:
- What draws an adolescent so rapidly, so intractably, into a state of mind lacking common sense?
- Why is she suddenly blind to her actual appearance?
- Is this voluntary, or senselessly compelled?
- Why does she still think she needs this, even after the costs, and potential ramifications are begrudgingly acknowledged?

Bulimia Nervosa

- Recurrent episodes of binge eating.
- Recurrent compensatory behaviors to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
- Self-evaluation is unduly influenced by body shape and weight.



Bulimia Nervosa as Unhealthy Coping Strategy



Unhealthy Coping Strategies

- Alcohol/Drugs
- Self-Harming
- Screen Time
- Gambling
- Excessive Sleeping
- Spending/Shopping



Anorexia Nervosa as Unhealthy Coping Strategy

- Feels in control, safe, accomplished
- Malnutrition numbs anxiety, uncomfortable feelings, distress, etc.
- Pt feels he/she has found their identity
- Exercise has been seen “a hypomanic defense against a fear of depression, a form of masochistic self-punishment, a goal oriented pursuit of achievement serving narcissistic/ exhibitionistic concerns, or as a general mechanism for regulating such tension states as anxiety, anger, and the like” (Johnson, 1984, p. 24).

Anorexia Nervosa vs. Bulimia Nervosa

- Underweight vs. Normal Weight/Overweight
- Egosyntonic vs. Egodystonic
- Overcontrolled vs. Dysregulated
- Cluster C personality traits vs. Cluster B personality traits
- Introverted vs. Extroverted
- Deny family conflict vs. Exaggerate Family conflict

Anorexia Nervosa

- A complex physiologic and psychological phenotype that is “understood” or interpreted via shifting cultural values
- The core characteristics of AN can be understood as adaptive traits that have evolved via natural selection
- Not simply a result of psychological conflict or a desire to be fashionably thin

Presentation of Anorexia Nervosa

- Prior to weight loss, patient was uncommonly well-mannered, dutiful, self-disciplined, conscientious, uneasy with change, prone to anxious worry, and attentive to others
- Ill suited for the suddenness of pubertal change, both physically as well as the myriad of developmental challenges of adolescent life.

Presentation of Anorexia Nervosa

- Initial weight loss is often innocent;
 - eating “healthier” after taking nutrition course
 - illness caused unintended weight loss
- Prior to malnutrition, patient becomes consumed with calorie counting, weight checking, mirror gazing, and insistence that further weight loss is urgent need
- Very quickly, after a small amount of weight loss, the patient insists that her body is unacceptably large, gross, and she must lose weight ASAP

Sir William Gull (1816-1890)

- It seemed hardly possible that a body so wasted could undergo the exercise which seemed agreeable
- The inclination of the patient should in no way be consulted ... the tendency of the physician to indulge the patient’s caprice and the endless stream of rationalizations was dangerous and should be discouraged; and that parents are sometimes the worst attendants

Psychoanalytic Theories of AN

- Hilde Bruch (1904 – 1984) - proposed that food refusal represents a struggle for psychological autonomy and control
- She chastised the doctors and psychotherapists “who approach and evaluate anorexic patients in a critical manner, with a certain guardedness and prejudice, even an open dislike . . . Because of the therapist’s often unexamined suspicion that the patient’s denial of illness indicates dishonesty . . . as if patients could change it through an act of will.”

Psychoanalytic Theories of AN

- Hilde Bruch brought a compassionate stance to patients she saw as engaged in a desperate fight against feeling enslaved and exploited by their mothers.
- Her work provided the conceptual framework for psychodynamic and family systems work that followed.

Psychoanalytic Theories of AN

- Gerald Russell (1928 - 2018) became convinced that AN was the result of a “morbid fear” of fatness, a formulation that became part of the DSM–IV–TR criteria.
- Working from a developmental model, Arthur Hamilton Crisp (1980) proposed that self-starvation is an attempt to regress to a prepubertal state.
- Regina Casper (1983) noted an instability in self-concept among patients with AN as a defense against sexuality, as an ascetic repudiation of bodily urges, or in a drive for thinness.

Psychoanalytic Theories of AN

- Self psychologists thought that failures in empathic mirroring and idealization during childhood were responsible for AN (Geist, 1984).
- Family theorists saw a family as using an anorexic child to maintain pathological homeostasis within the family system (Minuchin, Rosman, & Baker, 1978; Palazzoli, 1974).

Psychoanalytic Theories of AN

- Researchers, frustrated in attempts to find consistent overt psychopathology in parents, hypothesized hidden dysfunction.
- Palazzoli (1974) wrote that parents concealed disillusionment with themselves and their marriage behind a facade of respectability and good works.
- Bruch (1973) described the anorectic's parents as controlling, experience denying, and competitive about who was making the most sacrifices for their families.

Psychoanalytic Theories of AN

- There is, in fact, no relationship between patients' disturbances in hunger and satiety and other areas of perceptual confusion or denial (Halimi, Sunday, Puglisi, & Marchi, 1989).
- Halimi (1992) concluded, "Disturbed eating in eating disordered patients cannot be dismissed as merely reflecting an underlying psychodynamic turmoil."

Theories of AN

- Biomedical Theories
- Social Theories

Recent Genetic Studies

- AN is polygenic
- AN associated with OCD, MDD, Anxiety/Neuroticism, Schizophrenia, educational attainment



Ancestral past sheds light on AN

- "Nothing in biology makes sense except in the light of evolution."
- Theodosius Dobzhansky
- Psychological symptoms, though painful and even detrimental, are also defenses/adaptations

Anorexia Mirabilis

- Miraculous absence of appetite; "holy anorexia"
- Piety
- Asceticism
- Compliant and driven
- No fear of being fat



Ancestral Adaptations

- Adapted to Flee Famine – (Shan Guisinger 2003)
- Food Restriction, Denial of Starvation, Hyperactivity evolved mechanisms that enabled nomadic foragers leave depleted environments
- Weight loss triggers these archaic adaptations

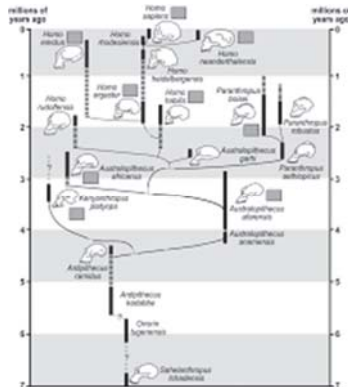


On the Origin of Species...(Darwin 1859)

- “All the organic beings which have ever lived on this earth have descended from some one primordial form, into which life was breathed.”
- Last Universal Common Ancestor (LUCA) ~ 3.5 billion years ago
- All life forms store genetic information via the same DNA and RNA codes
- All modern animals share 6331 genes that trace to a common ancestor over 650 million years ago

Ancestral Adaptations

- “Recent” cognitive developments allow us to make sense and non-sense of our adaptations
- “Man is not a rational animal; he is a rationalizing animal.” — **Robert A. Heinlein**



Ancestral Adaptations



Ancestral Adaptations

- Low body mass selected in birds for take off, speed, agility
- Subordinate fish self-impose food restriction so dominate fish are not threatened. Social hierarchy is maintained reducing risk of being unprotected.
- Small size can be a defensive morphology where large predators favor large prey with high energy gain

Post-traumatic Stress Disorder

- True stressful event – life threatening
- Re-experiencing the event
- Avoidance and numbing
- Increased arousal
- Negative thoughts, feelings, and moods
- Risks for enduring symptoms
 - Pre-existing or genetic risk for mental disorder
 - Proximity
 - Post-traumatic environment
 - Stuck in unhelpful narrative about trauma

Treatment of Eating Disorders

- Structured Meal Plan
- Family-Based Treatment (The Maudsley Model)
- Cognitive Behavioral Therapy
- Exposure and Response Prevention Therapy
- Dialectical Behavior Therapy
- Individual and Group Psychotherapy
- Medications

Carl Whitaker MD



“There are no individuals in the world, only fragments of families.”

Treatment of AN

- Olanzapine vs Placebo
- 16 weeks
- Olanzapine increased BMI by 0.259
- Placebo increased BMI by 0.095
- No change in obsessive thoughts/behaviors

Attia et al (2019). Olanzapine versus placebo in adult outpatients with anorexia nervosa: A randomized clinical trial. *American Journal of Psychiatry*, 176(6), 449-456.

Serotonin Reuptake Inhibitors FDA Approvals

- Approved for OCD
 - Clomipramine \geq 10 years
 - Fluvoxamine \geq 8 years
 - Sertraline \geq 6 years
 - Fluoxetine \geq 7 years
- Approved for Depression
 - Fluoxetine \geq 7 years
 - Escitalopram \geq 12 years
- Approved for Non-OCD Anxiety
 - Duloxetine \geq 7 years (GAD)



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