🧒 Child & Adolescent Psychiatry Quick Reference Guide

📋 Developmental Considerations in Assessment

🔍 Age-Specific Presentation of Common Disorders

Age Group	Depression	Anxiety	ADHD	Trauma
Preschool (3-5)	Irritability, somatic complaints, regression	Separation anxiety, specific fears, selective mutism	Extreme hyperactivity, defiance, poor impulse control	Regression, nightmares, traumatic play
School-Age (6-12)	Irritability, somatic complaints, social withdrawal	Specific phobias, social anxiety, school refusal	Inattention, hyperactivity, academic difficulties	Avoidance, nightmares, somatic complaints
Adolescent (13-17)	Anhedonia, isolation, substance use, suicidality	Social anxiety, panic, generalized worry	Inattention, poor organization, risk-taking	Risk-taking, substance use, self-harm

🧠 Neurodevelopmental Considerations

Development Stage	
📈 **Cognitive**	Concrete vs. abstract thinking capabilities
Language	processing abilities 🧩
Executive function	development

Social-Emotional Development

- Attachment patterns
- Peer relationships
- Identity formation (especially in adolescence)

🏫 **Academic Context**

- Learning disabilities co-occurrence
- School performance and adjustment
- Need for educational accommodations

🔍 Assessment Strategies

📝 Multi-Informant Assessment

Source	Benefits	Limitations
👶 **Child/ Adolescent**	Direct symptom experience, internal states	Limited insight, developmental constraints
👪 **Parents/ Caregivers**	Behavioral observations, developmental history	Potential bias, limited observation of all settings
🏫 **Teachers/ School**	Academic performance, peer interactions	Limited to school context
👥 **Other Providers**	Previous treatment response, medical history	May have incomplete information

📊 Validated Assessment Tools

🧒 Broad Screening Instruments

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- Child Behavior Checklist (CBCL)
- Strengths and Difficulties Questionnaire (SDQ)
- Pediatric Symptom Checklist (PSC)
- Youth Self Report (YSR) (ages 11+)

Disorder-Specific Assessments

- Children's Depression Inventory (CDI)
- Screen for Child Anxiety Related Disorders (SCARED)
- ADHD Rating Scale-5
- Child PTSD Symptom Scale (CPSS)
- Autism Spectrum Screening Questionnaire (ASSQ)

Functional Assessments

- Children's Global Assessment Scale (CGAS)
- Columbia Impairment Scale (CIS)
- Behavior Assessment System for Children (BASC-3)

Developmental History Elements

Prenatal/Perinatal Factors

- Maternal health during pregnancy
- Substance exposure
- Birth complications
- Prematurity

Early Development

- Motor milestones
- Language acquisition

Social engagement

- Temperament
- **Medical History**

Chronic illnesses
- Head injuries
- Hospitalizations
- Seizures
- Sleep patterns
- disabilities
- Substance use disorders
- **Family History**
- Family functioning
- Psychiatric disorders
- Learning

Common Disorders: Clinical Pearls

Neurodevelopmental Disorders

Autism Spectrum Disorder

- Often presents differently in females (better social camouflaging)
- High co-occurrence with anxiety, ADHD, and intellectual disability
- Sensory sensitivities may underlie many behavioral challenges
- Assess for strengths and special interests, not just deficits
- Screen for medical comorbidities (GI issues, sleep

disorders) **ADHD**

- Presentation changes with development (hyperactivity often decreases)
- Executive function deficits may persist despite symptom improvement
- Higher rates of oppositional behavior, learning disorders, and anxiety
- Consider sleep disorders in differential diagnosis
- Academic accommodations often as important as medication

Learning Disorders

- Often co-occur with ADHD, anxiety
- Comprehensive psychoeducational testing essential
- Specific interventions based on deficit pattern
- Emotional impact (frustration, low self-esteem) requires attention
- May present as behavioral problems or school refusal

Mood Disorders

Depression

- Often presents as irritability rather than sadness in youth
- Increased risk in adolescence, especially for females
- Screen carefully for suicidality and self-harm
- Family-based approaches often more effective than individual therapy alone
- Consider seasonal pattern, especially in adolescents

Bipolar Disorder

- Rare before puberty, increasing incidence in adolescence
- Often initially misdiagnosed as ADHD or conduct disorder
- Look for distinct mood episodes, not just mood lability
- highly relevant Family history
- Caution with antidepressant monotherapy

Anxiety Disorders

Separation Anxiety

- Developmentally normal in early childhood
- Assess for family factors (parental anxiety, overprotection)
- School refusal common presentation
- Gradual exposure most effective intervention
- Parent coaching essential component of treatment

Social Anxiety

- Increases in adolescence
- Differentiate from autism spectrum disorder
- Academic impact often significant
- Digital/social media may exacerbate symptoms
- CBT with exposure therapy most evidence-based approach

Generalized Anxiety

- Excessive worry across multiple domains
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Physical symptoms (stomachaches, headaches) common

- Perfectionism and reassurance-seeking behaviors •
Sleep disturbance common
- Mindfulness approaches increasingly supported

Trauma-Related Disorders

PTSD/Acute Stress Disorder

- Presentation varies by developmental stage
- May present as behavioral problems rather than classic PTSD symptoms •
Trauma-focused CBT is first-line treatment
- Caregiver involvement critical
- Consider systemic interventions if ongoing trauma exposure

Attachment Disorders

- Requires history of severe neglect or institutional care •
Differentiate from autism spectrum disorder
- Focus on caregiver-child relationship
- Avoid coercive "attachment therapies"
- Long-term supportive interventions often needed

Feeding and Eating Disorders

Anorexia Nervosa

- Increasing incidence in younger children
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Medical stabilization priority

- Family-based treatment (Maudsley approach) first-line
- Monitor growth and development impacts
- Long-term monitoring essential due to relapse risk

ARFID (Avoidant/Restrictive Food Intake Disorder)

- Not driven by body image concerns
- Often sensory-based or fear-based
- High co-occurrence with anxiety and autism spectrum disorders
- Multidisciplinary approach including feeding therapy
- Nutritional supplementation often necessary

Psychopharmacology Considerations

Risk-Benefit Assessment

- **Evidence Base**
- Pediatric-specific studies vs. extrapolation from adult data
- FDA approval status for age group
- Off-label considerations
- **Developmental Factors**
- Metabolic differences (often require weight-based dosing)
- Developing brain sensitivity
- Long-term neurodevelopmental impacts

- **Monitoring Requirements**

• Vital signs	• Growth parameters
• Laboratory monitoring	• Behavioral activation/disinhibition

Medication Classes: Special Considerations

Stimulants

- First-line for ADHD
- Monitor growth, appetite, sleep
- Consider timing for school performance
- Extended-release formulations improve adherence
- Potential for misuse/diversion in adolescents

Antidepressants

- Black box warning for suicidality in youth
- SSRIs first-line for anxiety and depression
- Start low, go slow approach
- Weekly monitoring during initiation phase
- Fluoxetine has strongest evidence base for depression

Antipsychotics

- Significant metabolic and neurological risks
- Reserve for specific indications (bipolar disorder, psychosis, severe aggression)

Baseline and regular metabolic monitoring essential

- Consider lowest effective dose
- Regular reassessment of risk-benefit ratio

Mood Stabilizers

- Limited evidence in prepubertal children
- Lithium: requires close monitoring of levels, thyroid, renal function •
  Lamotrigine: slow titration to minimize rash risk
- Valproate: teratogenic risk in adolescent females •
  Consider specialist consultation

Monitoring Protocols

Medication Class	Baseline	Follow-up Monitoring

Stimulants

Medication Class	Baseline	Follow-up Monitoring
	Height, weight, BP, HR, cardiac history	Height/weight (q3-6mo), BP/HR (each visit), sleep/appetite assessment
Antidepressants	Baseline mood, suicidality assessment	Weekly first month, then monthly; suicidality monitoring
Antipsychotics	BMI, BP, HR, fasting glucose, lipids, LFTs, EPS exam	BMI/vitals (monthly), metabolic labs (q3mo initially, then q6mo), EPS (each visit)
Mood Stabilizers	Depends on agent; generally includes CBC, renal, thyroid, LFTs	Agent-specific protocols; lithium levels, CBC, thyroid, renal function

Family-Based Interventions

Parent Management Training

Core Components

- Positive reinforcement strategies
- Effective command-giving
- Consistent consequences
- Special time/relationship building

Best For

- Disruptive behavior disorders
- Behavior tracking
- ADHD
- Oppositional defiant disorder
- Younger children

Clinical Pearls

- Parental consistency critical for success
- Address parental mental health issues
- Cultural adaptations may be necessary
- Regular practice between sessions essential

Family Therapy Approaches

Structural Family Therapy

- Focuses on boundaries, hierarchies, and subsystems

- Useful for family conflict, adolescent behavioral issues

- **Strategic Family Therapy**

- Problem-focused, directive interventions

- Useful for specific behavioral problems

- **Cognitive-Behavioral Family Therapy**

- Addresses family cognitions and interaction patterns

- Useful for anxiety, OCD, depression

- **Attachment-Based Family Therapy**

- Focuses on repairing attachment bonds
- Particularly useful for adolescent depression and suicidality

School-Based Interventions

- **IEP (Individualized Education Plan)**

- For students requiring special education services •
  Legally mandated accommodations and goals •
  Annual review required

- **504 Plan**

- For students with disabilities not requiring special

education •
Provides accommodations but not specialized instruction
•
Regular review recommended
•
Common Accommodations
•
Extended time for assignments/tests
•
Preferential seating
•
Break opportunities
•
Modified assignments
• • plans
Behavioral **Clinical Pearls**
intervention
Attend school meetings when possible
•
Specific recommendations more helpful than general ones
•
Regular communication with school
essential •
Consider classroom observations

Crisis Management

Suicide Risk Assessment

•
Risk Factors
•
Previous attempts (strongest
predictor) •
Family history of suicide
•
LGBTQ+ identity

- Substance use
- Access to lethal means
- History of self-harm
- Social isolation/bullying

Protective Factors

- Strong family support
- itual beliefs
- Future orientation
- Problem-solving skills
- Connection to school/activities

Assessment Components

- Direct questioning about ideation, plan, intent
- Differentiate passive from active ideation
- Assess access to means
- rationale
- Evaluate support system
- Document risk level and

Hospitalization Criteria

- Active suicidal intent with plan/means
- Inadequate supervision/support
- Severe symptoms impairing judgment

Inability to maintain safety

- Failed outpatient management

Aggression Management

Triggers

- Limit-setting

Common

- Transitions
- Sensory overload
- Perceived threats
- Medication effects/withdrawal

De-escalation Strategies

- Calm, non-threatening approach
- Clear, simple communication
- Offer choices when possible
- Remove triggers/audience
- Provide physical space

Emergency Interventions

- Crisis team involvement
- Consider mobile crisis services
- Emergency medication (if prescribed)
- Safe physical management (last resort)
- Emergency department

evaluation

Post-Crisis Planning

- Identify patterns and triggers
- Develop prevention strategies
- Adjust treatment plan
- Consider level of care needs
- Safety planning with family

Special Populations

Intellectual Disability

- **Assessment Considerations**
  - Adapt communication to cognitive level
  - Behavioral equivalents of psychiatric symptoms
  - Higher rates of psychiatric comorbidity
  - Medical conditions may present as behavioral issues
- **Treatment Adaptations**
  - Simplified psychoeducation materials
  - Concrete behavioral strategies
  - Caregiver training essential
  - Lower starting doses
  - Environmental medication modifications

LGBTQ+ Youth

- **Unique Considerations**

- Higher rates of depression, anxiety, suicidality
- Minority stress impacts
- Family acceptance critical to outcomes
- Gender-affirming care needs
- School safety concerns

Supportive Approaches

- Affirming stance essential
- Family acceptance interventions
- Connection to community resources
- School advocacy when needed
- Trauma-informed care

Foster Care/Adoption

Common Challenges

- Complex trauma histories
- Attachment difficulties
- Multiple placements impact
- Developmental delays
- Coordination with child welfare system

Effective Approaches

- Trauma-informed assessment
- Attachment-focused interventions

- Caregiver support and education
- Stability in treatment providers
- Coordination with multidisciplinary team

Medically Complex Children

- **Considerations**
- Medication interactions
- Impact of chronic illness on development
- Differentiate medical from psychiatric symptoms
- Adjustment to illness/treatment
- Family impact of medical care
- Coordination with medical providers
- Hospital-to-home transitions
- **Integrated Approaches**
- Illness management strategies
- Pain management considerations
- Addressing medical trauma

Clinical Pearls for Practice

- **Developmental Lens**
  - Always consider behaviors in developmental context
  - Symptoms may manifest differently across age groups
  - Developmental delays affect presentation

- **Family-Centered**
- Child treatment rarely succeeds without family involvement
- Parents are co-therapists in most effective interventions
- Family functioning impacts treatment outcomes
- **Systems Approach**
- Coordinate with schools, primary care, specialists
- Consider impacts across all environments
- Advocate for needed services in all settings
- **Longitudinal Perspective**
- Symptoms and needs change with development
- Regular reassessment essential
- Treatment plans should evolve with the child
- **Strengths-Based**
- Identify and build on child and family strengths
- Focus on resilience factors
- Celebrate small improvements
- **Cultural Humility**
- Cultural factors influence symptom expression and help-seeking
- Adapt assessment and treatment to cultural context

- Consider family beliefs about mental health

Documentation Focus

- Clear safety planning
- diagnostic decisions

Rationale for

- Treatment response tracking
- Growth and development monitoring
- Educational impact and interventions

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